



# JOHN T. MATHER MEMORIAL HOSPITAL 2016 Nursing Annual Report

I am proud to be a  
Mather Hospital nurse because ....



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## MESSAGE FROM OUR CHIEF NURSING OFFICER NURSING OFFICER

Dear Colleagues,

Welcome to the 2016 Nursing Annual Report for John T. Mather Memorial Hospital. Once again we are very proud to share this report as we reflect upon the exceptional care that is delivered by the nurses here at Mather to our patients and the community. In reflecting upon our journey since our last annual report I am proud of our accomplishments. We have hired over 88 clinical nurses including new graduates, while continuing to have one of the lowest turnover rates in our geographic area 0.06% (reported in ANCC Magnet Designation DDCT submitted June 2016). The role of the professional nurse continues to be the hallmark of a Mather nurse. The foundations of nursing at Mather are reflected and demonstrated in our professional practice model. In this report we will share examples of how nurses participated with the Advisory Board in Washington, D.C. to improve processes and sustain measurable positive patient outcomes. The continuation of nurses partnering with the community and members of Inter-professional teams to live our vision to be a leader in transforming healthcare for the patients we serve. As a Magnet designated organization, our nurses are the “gold standard” in leading healthcare. I value the ongoing and open conversations I have with nurses regarding their practice environment, which includes opportunities to make innovative improvements. As we dialogue and problem solve together we are building a lasting culture of nursing excellence and professionalism. On behalf of the nursing team here at Mather, we hope you enjoy learning about the important contributions of the nurses at Mather in our vision to be a leader in the region, and nationally recognized in transforming healthcare.

Sincerely,



Dr. Marie Mulligan, PhD, RN, CNOR, NEA-BC  
CNO Vice President for Nursing



## FACTS AND FIGURES

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71% of nurses hold a BSN degree

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HCAHPS Scores 2016  
88th percentile  
for all nursing indicators

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Press Ganey Scores 2016  
81st percentile  
for all nursing indicators

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### John T. Mather Memorial Hospital



Medicare/Medicaid Services awarded Mather a Four Star Rating for Patient Experience, Safety, and Timely Effective Care Measures

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### **Magnet® Recognition**

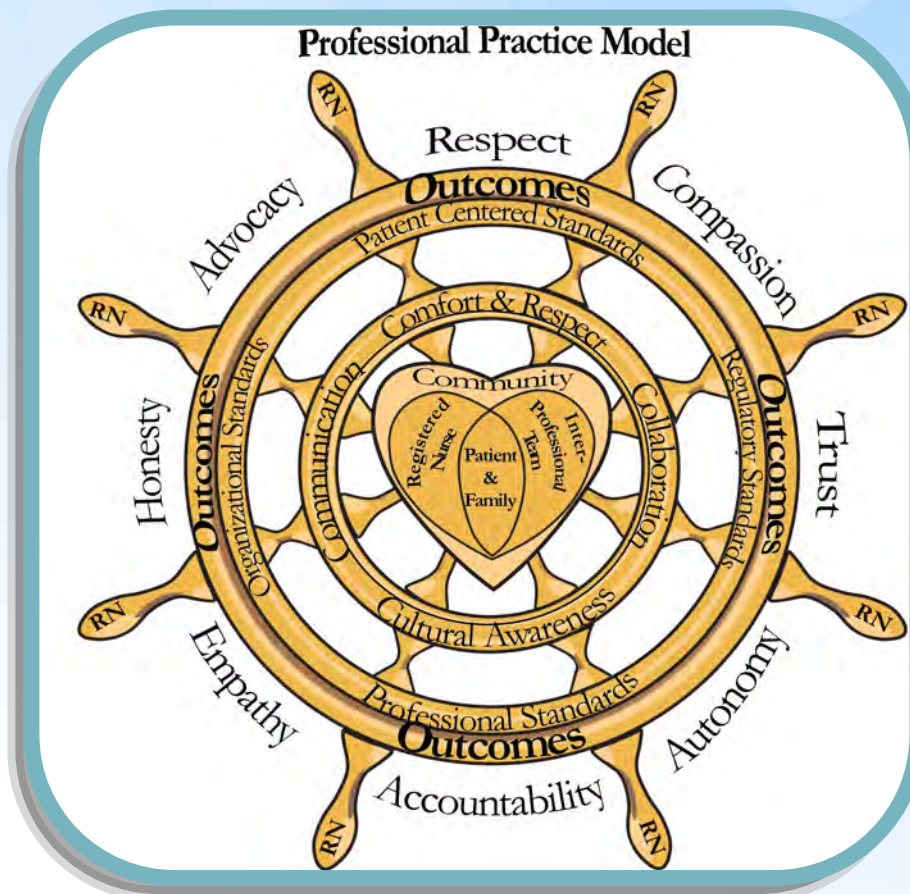


## VOYAGE TO EXCELLENCE AND MAGNET® RECOGNITION

The Voyage to Excellence is a cultural transformation at John T. Mather Memorial Hospital whose goal is become the best community hospital in New York State. The foundation of the Voyage to Excellence is represented by four pillars; People, Service, Quality and Safety, and Innovation & Growth. There are currently seven teams that work to continuously improve the delivery of high quality healthcare and enhance satisfaction for patients, visitors and employees. These are the Bright Ideas Team, Communication Team, Employee Engagement Team, Leadership Team, Patient Experience Team, Physician Engagement Team and the Standards Team.

Incorporated into the organizational structure are 12 standards of performance. These are expectations of behaviors and job performance for all employees. These include accountability, appearance, attitude, call lights, commitment to the organization, commitment to patients, commitment to co-workers, communication, diversity, leadership, noise, and safety & risk identification. In June 2013, John T. Mather Memorial Hospital was recognized as a Magnet® organization. Magnet recognition is a reflection of our commitment to nursing excellence and the delivery of safe, high quality, evidence-based patient care. It is a tribute to the dedication of the entire inter-professional team as we work together to enhance patient outcomes.

Building a Magnet culture, a culture of nursing excellence, has helped to reinforce a work environment with positive collaborative relationships where the team works together to accomplish the best outcomes for the patient, families and community. The presence of a Magnet culture signifies our commitment to patient outcomes, shared governance and the development of nursing leaders. In 2016 nurses evaluated and revised the Professional Practice Model (PPM) to include cultural awareness, family and community. Our Magnet application and new Magnet document will be submitted to the ANCC for re-designation in June 2017.

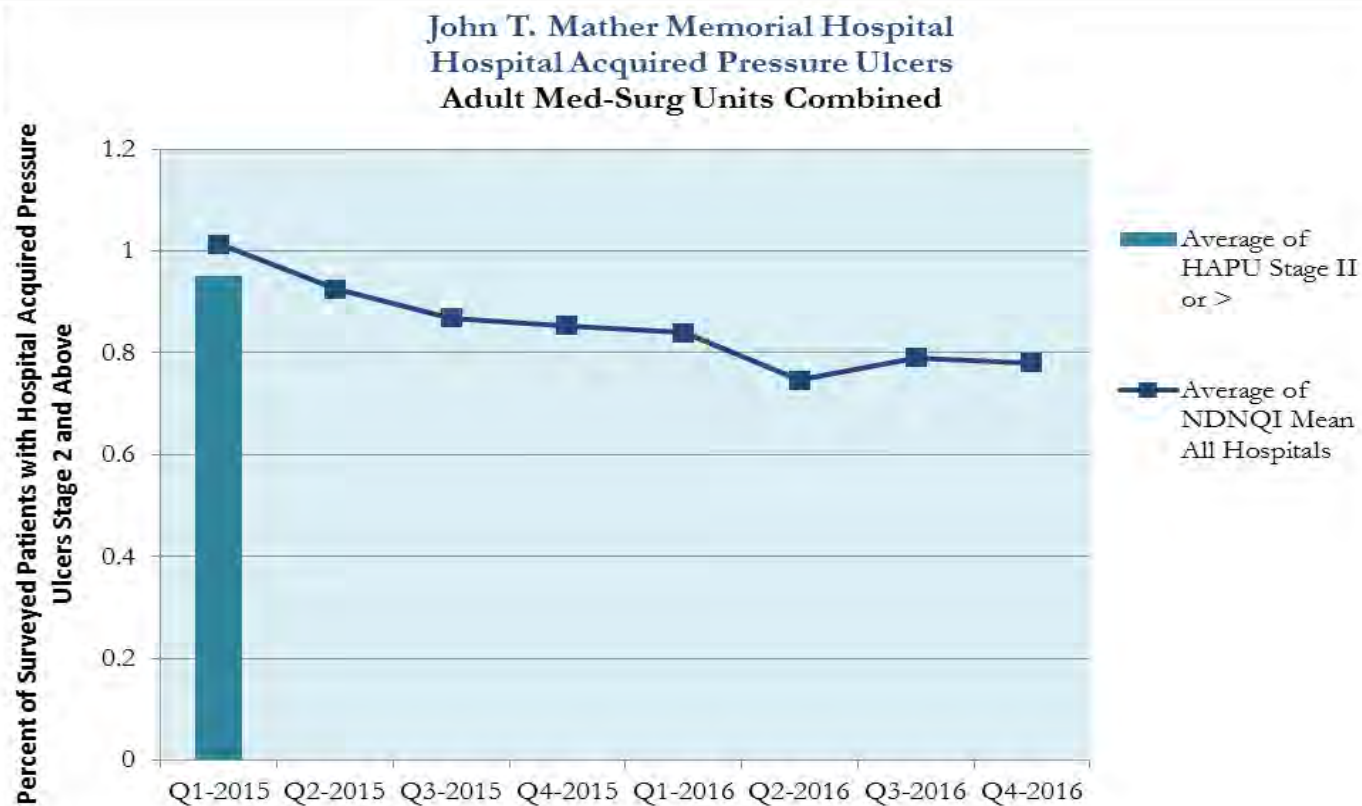




# Falls with Injury

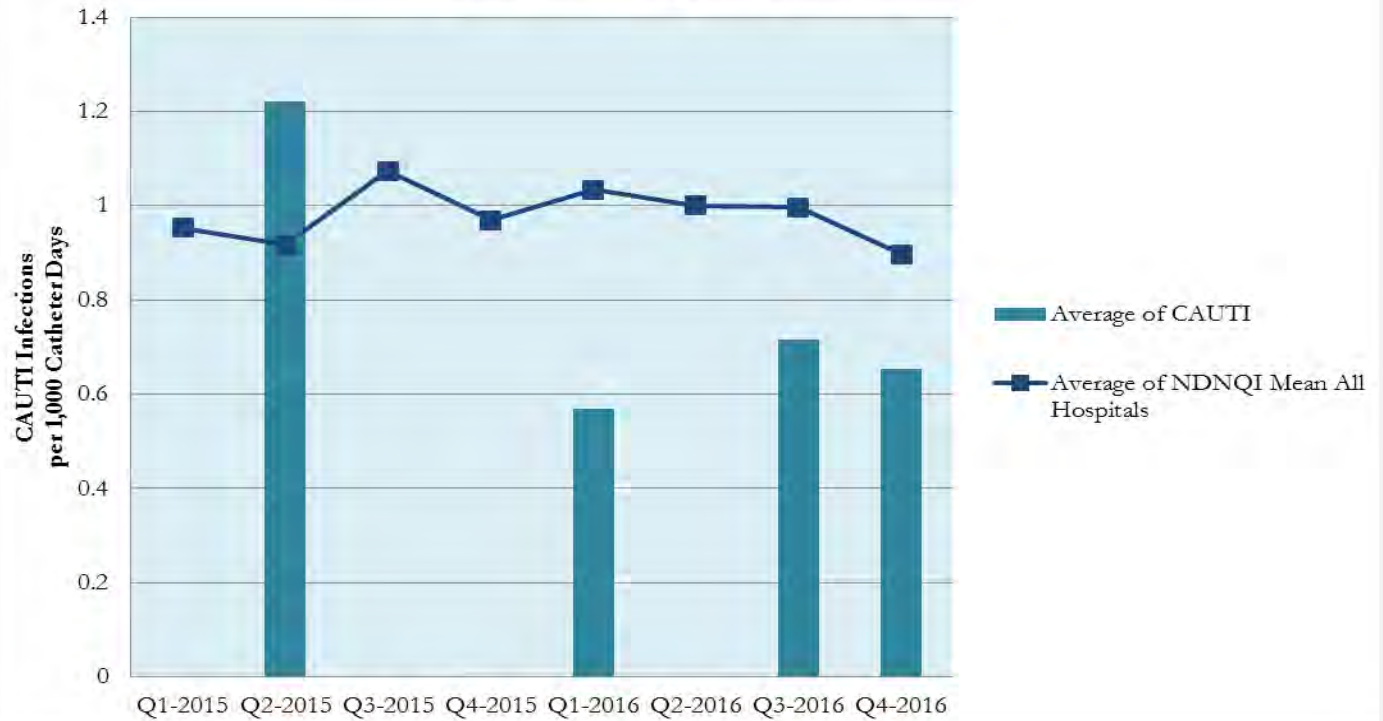


## HAPU



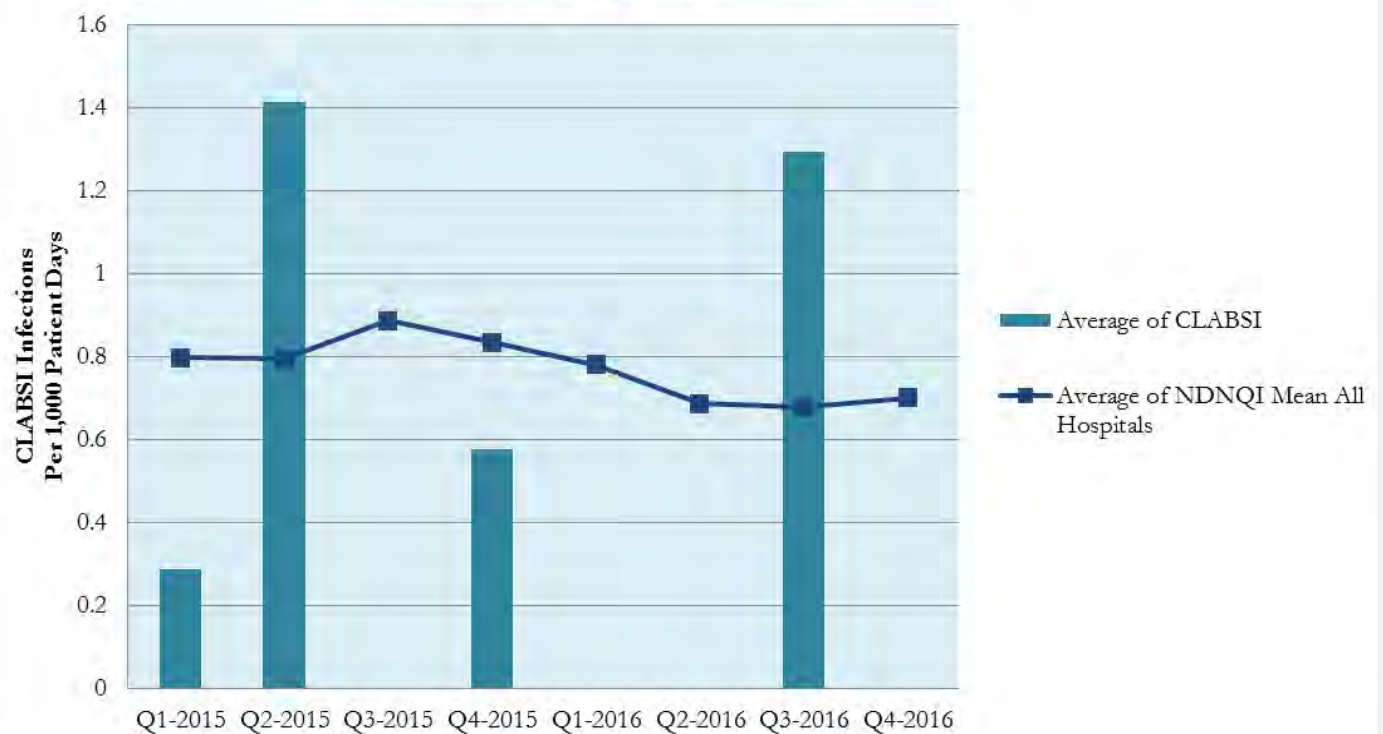
# CAUTI

John T. Mather Memorial Hospital  
Catheter Associated Urinary Tract Infections (CAUTI)  
Adult Med-Surg Units Combined



# CLABSI

John T. Mather Memorial Hospital  
Central Line Associated Blood Stream Infections (CLABSI)  
Adult Med-Surg Units Combined





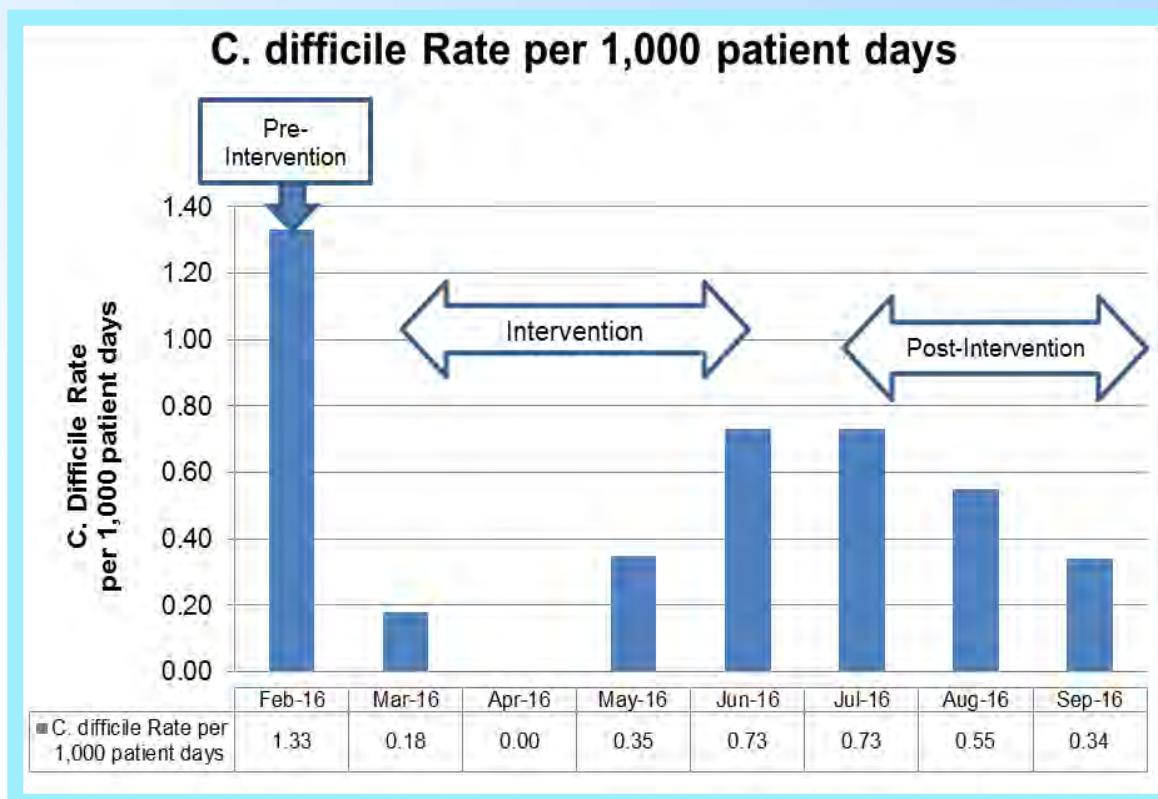
# Transformational Leadership





## IMPROVING C. DIFF RATES

The 2016-2018 John T. Mather Memorial Hospital Nursing Strategic Plan states in part “to deliver an exceptional patient experience and care.” In February 2016 the staff in the Infection Prevention department noticed an increase in the rate of Clostridium Difficile (C. diff) infections. This was a higher than average rate and the Infection Preventionists discussed ideas to improve the C. diff rates. In March 2016 Infection Prevention began to review charts for each rule-out C. diff case admitted to the organization. The date of admission was compared to the date the physician order was placed for C. diff collection. They discovered that the patient may have had sign and symptoms of C. diff infection (CDI) and that physician orders were delayed from time of the onset of symptoms to actual order placement. Clinical nurses and nursing assistants were interviewed for all rule-out C. diff patients. Through these collaborative interviews it was discovered there was a lack of knowledge regarding the signs and symptoms of CDI and the importance of obtaining a specimen within the National Healthcare Safety Network (NHSN) three day timeframe. There was also a lack of communication with the physicians for obtaining a C. diff order when signs and symptoms were present. Engaging the nursing assistants was also imperative as they actually collect the specimens. In April and May 2016 clinical nurses and nursing assistants were educated and coached through the ongoing collaborative interviews as well as during mandatory education sessions with MaryEllen Lasala, MSN, BSN, RN, and Christine Viterella, MSN, RN, RN-BC, inpatient Behavioral Health clinical instructor. The education consisted of recognizing the signs and symptoms of C. diff, the NHSN three day time frame for specimen collection, knowing the day of admission is acknowledged as day one, risk factors associated with CDI, and the significance of early identification and transmission precaution placement for potential CDI patients. Once educated, nurses began to incorporate all these actions into their practice. In June 2016 the CDI rates, while improved, were noted to be on the rise. Never underestimating the power of appreciation and acknowledgment for a job well done, Holly and Patty began to use Mather Hospital’s We Are Voyaging to Excellence (WAVE) program to recognize employees for their efforts in the early identification of CDI and for obtaining stool specimens for C. diff within the NHSN time frame. The WAVE program is a hospital-wide recognition program designed to reward behavior that exceeds Mather Hospital’s set standards of performance. An employee may earn a WAVE by exceeding their scope of service in one or more of the four pillars which are the values the organization has deemed imperative to our success. The four pillars are People, Service, Quality & Safety, and Innovation & Growth. The WAVE form was then submitted to the nurse manager for their signature and it was then presented to the employees during the daily line-up which is a communication tool designed to share information and a common message with all Mather Hospital employees. The recognition has been appreciated and C. diff rates have decreased.



## ANCC ANNUAL NURSING CONFERENCE

Every year the American Nurses' Credentialing Center (ANCC) sponsors the National Magnet Conference®. The theme for 2016 was Empowering Nurses to TRANSFORM Health Care™. The conference was held October 7-9, 2016 in Orlando, Florida.

Over 9,000 registered nurses attended the conference from every state in the USA and many international countries, namely: Australia, New Zealand, Lebanon, Saudi Arabia, Singapore and Canada.

Unfortunately due to extenuating weather conditions called "Hurricane Matthew", the conference ended early.

In 2016, over 1,900 abstracts were submitted by nurses from the 424 Magnet-designated hospitals located throughout the world. The selection process is a rigorous, blinded, peer-review

evaluation conducted by 98 highly respected nurse experts from areas of clinical nursing practice, administration, education and research. Less than 16% of abstracts submitted are accepted for presentation. Nurse leaders at John T. Mather Memorial Hospital received the prestigious honor of having two abstracts accepted for podium presentations at the ANCC National Magnet Conference in 2016®.



Sarah Eckardt, MS Nursing Statistician with Joanne Lauten, MSN, RN, SCRNP, CPHQ Nursing Quality Director and Stroke Coordinator

### **Designated Today, on the Journey Tomorrow: Making the Best of Internal and External Resources**

#### **Session: C729**

**2016 ANCC National Magnet Conference®**

**October 7, 2016 9:30-10:30am**

**Teresa Anderson, EdD, MSN, RNC-OB,  
NE-BC; ANA-NKC Consultant**

**Brandy Feliu MSN, RN, Assistant Vice President Nursing  
Professional Development & Magnet® Program Coordinator;**

**John T. Mather Memorial Hospital  
Port Jefferson, New York**





## ADVISORY BOARD FRONTLINE PROGRAM

### **Advisory Board Front Line Impact-“Engaging and Empowering Frontline Staff.”**

The nursing department partnered with the Advisory Board in Washington, D.C. to translate frontline staff potentials into clinical and operational performance gains. Frontline staff members are often an untapped resource for innovation and performance improvement initiatives. In September, 2016 37 clinical nurses and nurse managers presented their findings to hospital administration and members of the management staff at the Hilton Garden Inn in Stony Brook, New York. The clinical nurses and nurse managers developed and implemented meaningful, measurable improvement initiatives. This program yielded successful results in both concrete performance gains and unprecedented clinical nurse leadership growth. The clinical nurses, known as “participants”, were mentored and supported throughout 2016 by their coaches.

Out of the 37 participants, the coaches nominated 1 nurse to represent their team. These nurses presented a power point and poster on their projects and findings to the attendees. In addition, the remaining nurses were able to present their findings in a poster presentation to the audience. Many of the projects identified in this frontline staff initiative resulted in organizational wide, interprofessional practice changes and improvements.



Advisory Board Director Dan Dangler Presenting for Frontline Summit



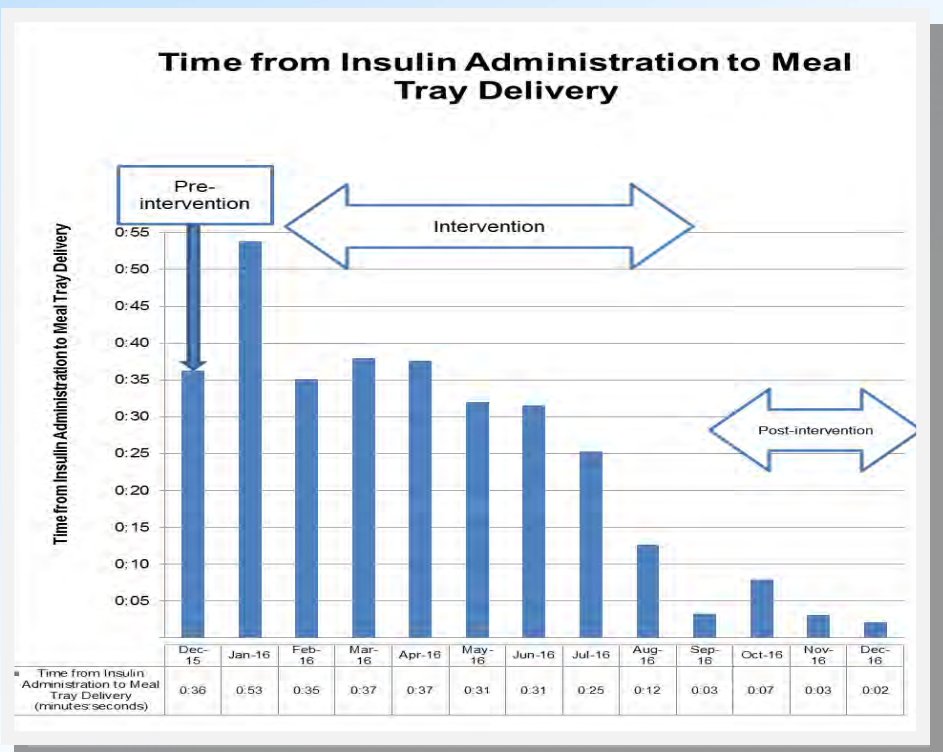
From left to right: Merritt Love, BSN, RN; Julie Tegay, BSN, RN, RN-BC; Cameron Gittens, RN, CEN, CRN; Patricia Alban, BSN, CEN, PCCN; Donna Blaskopf, BSN, CRN; Vivian Langford, RN, CRN

## **BEST PRACTICE AWARD RECOGNITION**

**Melissa Pearson, BSN, RN**



In January 2016 Melissa Pearson, BSN, RN, clinical nurse on 3 North, Intermediate Care unit began to trend data on 3 North diabetic patients, insulin and the time between insulin administration and morning meal tray delivery as part of a quality improvement initiative for the Advisory Board Frontline Leadership Program. She was advised by Marie Mulligan, PhDc, RN, CNOR, NEA-BC, CNO/Vice President for Nursing to expand her data mining across the organization as many patients are insulin dependent. Melissa met with Elizabeth Giordano, MA, RN, CCRN, Diabetic Nurse Educator who helped collect the organizational data. In late March 2016 Melissa's data analysis revealed night nurses' work flow required a patient assessment prior to administration of morning insulin before the shift change at 0745. Conversely, morning meal tray delivery occurred any time between 0805 and 0935, far exceeding the FDA's recommendation of 15 minutes. Melissa presented her data and concerns in regard to patient safety and potential decrease in quality outcomes related to ineffective collaboration between nurses on 3 North and Food and Nutritional Services. Melissa implemented an evidence-based practice pilot study on 3 North to see if the time between insulin administration and morning meal tray delivery could be decreased. Recognizing this as an organization-wide issue, Marie directed the intervention be initiated hospital-wide. In May 2016 Nursing and Food and Nutritional Services collaborated to optimize patient safety and patient-centered care. A task force was developed which emphasized a schedule for earlier morning meal tray delivery times which would coordinate with nursing workflow. Melissa worked with Nursing Informatics to develop an electronic daily insulin-dependent patient list. This list was made accessible to Food and Nutritional Services to enable them to identify patients receiving rapid acting insulin requiring the delivery of earlier meal trays. Melissa then established a "Communication Alert Process" between nursing units and Food and Nutritional Services. As meal trays were on route from the main kitchen, the line leader would call each unit and alert the charge nurse that meal trays were on their way to the unit. Elizabeth developed an educational in-service for clinical nurses on evidence-based medication safety guidelines, with emphasis placed on coordinating proper timing of insulin administration with meals. A goal of less than fifteen minutes from insulin-to-tray was established. After 3 months, the timing from insulin administration to meal tray delivery had drastically improved. With this data, a nursing practice change occurred to benefit all diabetic patients receiving insulin.





# Evidence Based Practice Project

## Project Title– Coordinating Meal Tray Delivery with Insulin Administration to Enhance Patient Outcomes



### Safety Initiative for the Diabetic Patient: Coordinating Meal Tray Delivery with Insulin Administration

Melissa Pearson BSN, RN, 3 North, Intermediate Care Unit  
Frontline Impact Program



#### PURPOSE AND BACKGROUND

**Purpose:** Improve meal tray delivery to insulin administration time for diabetic patients via enhanced inter-professional communication and coordination between Nursing and Food and Nutritional Services.

**Problem:** Stress and illness exacerbate blood glucose levels and have negative effects on target glycemic control, **limiting healing and recovery.**

According to the Food and Drug Administration (2015) "Humalog is rapid acting insulin to be given with or within fifteen minutes of food consumption".

**Time delays placed patients at risk for poor quality outcomes,** such as: hypoglycemic events, which can extend **hospital length of stay (LOS).** In addition Houck, et al, (2013) explained: "The Joint Commission expects organizations to develop a comprehensive approach to performance improvement, to evaluate patients' perceptions of quality care and to use comparative data to review interventions".

**Hospital-wide data revealed a significant time delay with an average of 60 minutes between insulin administration to meal tray delivery in the morning.**

#### PARTICIPANTS

Name	Department
Melissa M. Pearson, RN	3 North, Nursing, Frontline Leader
Denise Driscoll, RN	Team Coach, Nursing
Marie Mulligan, RN	Chief Nursing Officer, Nursing
Teresa Pickel, RN	3 North Unit Nurse Manager, Nursing
Constance Calisi, RN	Director, Information Technology
Petra Robinson	Director, Food and Nutritional Service
Celeste Gorman	Manager, Food and Nutritional Service
Joseph Aliano, DTR	Assistant Director, Food and Nutritional Service
Sarah Eckardt, MA	Statistician, Nursing
Elizabeth Giordano, RN	Diabetic Educator, Nursing
Nutritional Service Staff	Food and Nutritional Service
Staff Nurses	Nursing, all units except ICU/CCU

#### METHODS or APPROACH

**Qualitative and quantitative data** was collected from clinical nurses on 3 North.

Data collected revealed:

- Nurses' perception of unsafe time gaps with insulin administration to meal tray delivery.

- Concerns related to the following:**

- Patient safety.
- Nursing accountability.
- Liability.

Quantitative data, collected hospital-wide from the EMR and glucometers on three separate dates, validated RN's concerns with time gap disparities.

**A verbal and electronic communication system was created, as follows:**

- An electronic daily insulin-dependent patient list was created. Morning meal tray delivery times were scheduled earlier to coordinate with nursing workflow.
- A "Communication Alert Process" was established between nursing units and the Food/ Nutrition Department.

Clinical nurses have been educated on evidence-based medication safety guidelines.

**GOAL** of 15 minute from insulin-to-tray was established.

#### OUTCOMES AND IMPACT

Insulin Administration		Meal Truck Arrival Time	Variance
Average	07:52:41	Average	07:40
Median	07:28:00	Median	07:39
Earliest Insulin Admin	06:36:00	Earliest Truck Arrival	07:07
Latest Insulin Admin	09:59:00	Latest Truck Arrival	08:27
			00:12
			00:11
			00:31
			01:32

The following outcomes are anticipated:

Post qualitative data findings will indicate improved communication/collaboration between Nursing and Food/Nutritional services.

Post quantitative data from the EMR will identify improvement in insulin-to-tray times.

**Goal:** Time difference from insulin-to-meal tray delivery will decrease from the **current average time of 60 minutes to an average of 15 minutes.**

#### LESSONS LEARNED

This leadership experience showed me the complexities involved to bring about a change project.

Taking my passion for this change project to **improve patient safety** required inspiring others to perform at the best of their abilities to have shared success.

## PROJECT PARTICIPANTS

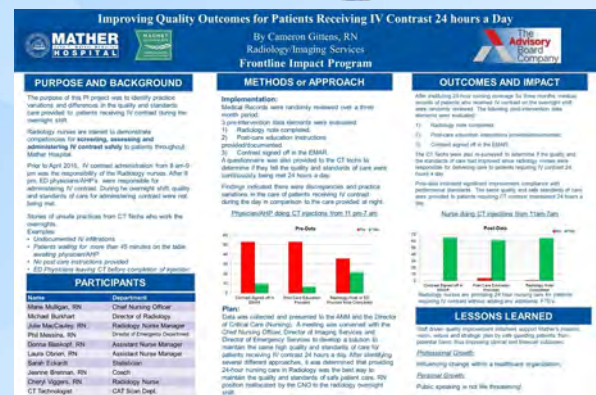
Name	Credentials	Discipline	Title	Department
Marie Mulligan	PhDc, RN, CNOR, NEA-BC	Nursing	Chief Nursing Officer Vice President for Nursing	Nursing Administration
Melissa Pearson	BSN, RN	Nursing	Registered Nurse	3 North
Denise Driscoll,	NPP, RN-C, PMHCNS-BC, CARN	Nursing	AVP of Behavioral Health	Behavioral Health
Teresa Pickel	MSN, RN, CCRN	Nursing	Nurse Manager	3 North
Constance Calisi	RN, MBA	Nursing	Director of Informatics	Information Technology
Petra Robinson	MBA, BA, RD	Food and Nutritional Service	Director of Food and Nutritional Services	Food and Nutritional Service
Joseph Aliano	DTR	Food and Nutritional Service	Assistant Director of Food and Nutritional Service	Food and Nutritional Service
Celeste Gorman	MS, RD, CDN	Food and Nutritional Service	Manager of Food and Nutritional Services	Food and Nutritional Service
Sarah Eckardt	MS	Nursing	Statistician	Nursing Administration
Elizabeth Giordano	MA, RN, CCRN	Nursing	Diabetic Nurse Educator	Nursing Education
Clinical nurses	RN	Nursing	Registered Nurses	All inpatient Nursing units

# TOP FRONTLINE PROGRAM PROJECTS

## Improving Quality Outcomes for Patient's Receiving IV Contrast 24 Hours a Day by Cameron Gittens, RN

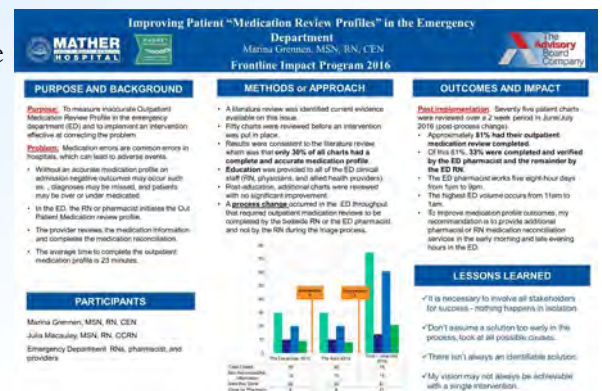
The purpose of this PI project was to identify practice variations and differences in the quality and standards care provided to patients receiving IV contrast during the overnight shift.

Plan: Data was collected and presented to the ANM and Director of Critical Care (Nursing). A meeting was convened with the Chief Nursing Officer, Director of Imaging Services and Director of Emergency Services to develop a solution to maintain the same high quality and standards of care for patients receiving IV contrast 24 hours a day. It was determined that by providing 24 hour nursing care in radiology was the best way to maintain the quality and standards of patient care. After instituting 24 hour nursing coverage for three months, medical records of patients who received IV contrast were reviewed. Post data indicated significant improvement compliance with performance standards.



## Improving Patient "Medication Review Profiles" in the Emergency Department by Marina Grennen, MSN, RN, CEN

The purpose of this PI project was to measure inaccurate Outpatient Medication Review Profile in the emergency department (ED) and to implement an intervention effective at correcting the problem. A Literature review identified current evidence available on this issue. Fifty charts were reviewed before an intervention was put in place. Education was provided to all of the ED clinical staff. A process change occurred in the ED throughout that required outpatient medication reviews to be completed by the bedside RN or the ED pharmacist and not by the RN during the triage process. Post Implementation seventy five patient charts were reviewed. To improved medication profile outcomes, the recommendation is to provide additional pharmacist or RN medication reconciliation services in the early morning and late evening hours in the ED.





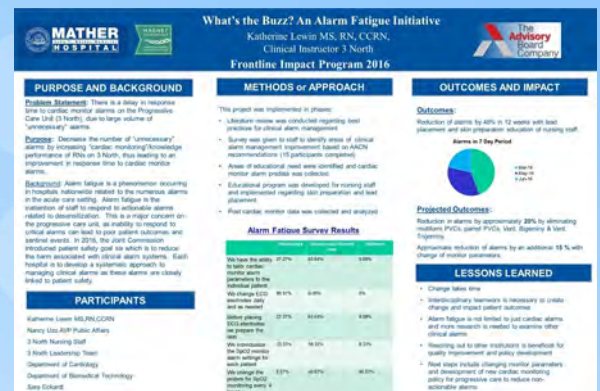
## What's the Buzz? An Alarm Fatigue Initiative by Katherine Lewin MSN, RN, CCRN

The purpose of this PI project was to decrease the number of “unnecessary” alarms by increasing “cardiac monitoring”/knowledge performance of RNs on 3 North, thus leading to an improvement in response time to cardiac monitor alarms.

**This project was implemented in phases:**

- Literature review was conducted regarding best practices for clinical alarm management.
- Survey was given to staff to identify areas of clinical alarm improvement based on AACN recommendations.
- Areas of educational needs were identified and cardiac monitor alarm predate was collected
- Educational program was developed for nursing staff and implemented regarding skin preparation and lead placement.
- Post cardiac monitor data was collected and monitored

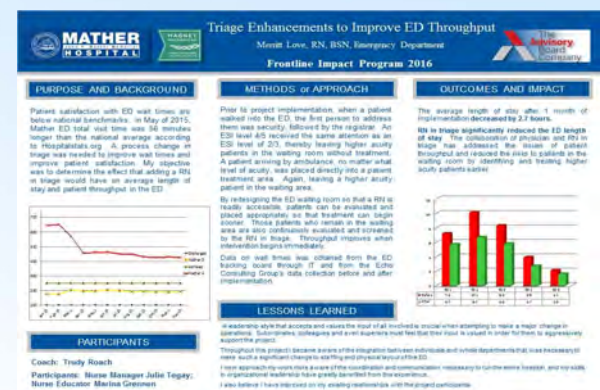
Outcomes: Reduction of alarms by 48% in 12 weeks with lead placement and skin preparation education of nursing staff.



## Triage Enhancements to Improve ED Throughput by Merritt Love, BSN, RN

A process change in triage was needed to improve wait times and improve patient satisfaction. The objective was to determine the effect of adding a RN in triage would have on the average length of stay and patient throughput in the ED. By redesigning the ED waiting room so that a RN is readily accessible, patients can be evaluated and placed appropriately so that treatment can begin sooner. Those patients who remain in the waiting area are also continuously evaluated and screened by the RN in triage. Throughput improves when intervention begins immediately.

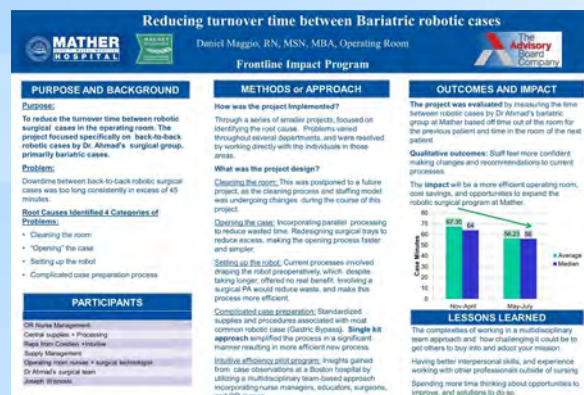
The average length of stay after 1 month of implementation decreased by 2.7 hours. Having a RN in triage significantly reduced the ED length of stay. The collaboration of physician and RN in triage has addressed the issue of patient throughput and reduced the risks to patients in the waiting room by identifying and treating higher acuity patients earlier.



## Reducing Turnover Time Between Bariatric Robotic Cases

by Daniel Maggio, MSN, MBA, RN

To reduce the turnover time between robotic surgical cases in the operating room. The project focused specifically on back-to-back robotic cases by Dr. Ahmad's surgical group, primarily bariatric cases. Root causes identified 4 categories of problems: 1-Cleaning the room, 2-"Opening" the case, 3-Setting up the robot, 4-Complicated case preparation process. Through a series of smaller projects, focused on identifying the root cause. Problems varied throughout the root cause. Problems varied throughout several departments, and were resolved by working with the individuals in those areas. The project was evaluated by measuring the time between cases by Dr. Ahmad's bariatric group at Mather based off time out of the room for the previous patient and time in the room of the next patient. Qualitative outcomes include staff feeling more confident making changes and recommendations to current process. The impact will be a more efficient operating room, cost savings, and opportunities to expand the robotic surgical program at Mather.



## Positive Impact on Volunteer Operating Room RN Facilitator Role on Patient Satisfaction

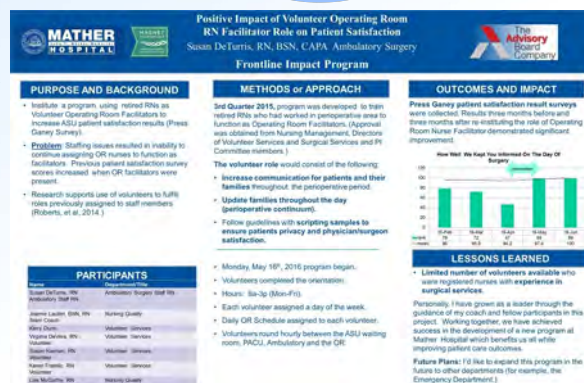
by Susan DeTurris, BSN, RN, CAPA

Staffing issues resulted in inability to continue assigning OR nurses to function as facilitators. Previous patient satisfaction survey scores increased when OR facilitators were present. A program was developed to train retired RNs who had worked in perioperative area to function as Operating Room Facilitators. Approval was obtained from Nursing Management, Director of Volunteer Services and Surgical Services and PI Committee Members.

**The volunteer role would consist of the following:**

- Increasing communication for patients and their families throughout the perioperative period.
- Update families throughout the day.
- Follow guidelines with scripting samples to ensure patients privacy and physician/surgeon satisfaction.

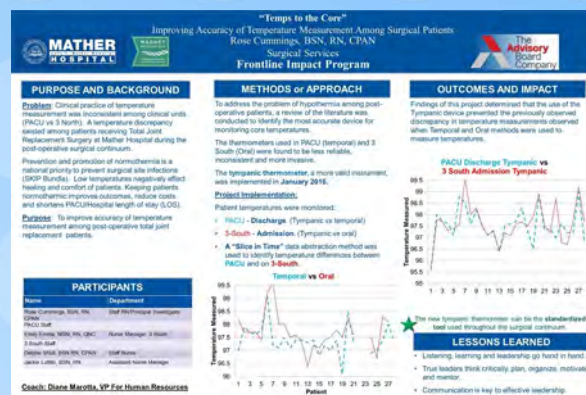
The program began on Monday, May 16, 2016. Volunteers completed orientation and were assigned to a day of the week. Press Ganey patient satisfaction result survey were collected. Results three months before and three months after re-instituting the role of Operating Room Nurse Facilitator demonstrated significant improvement.





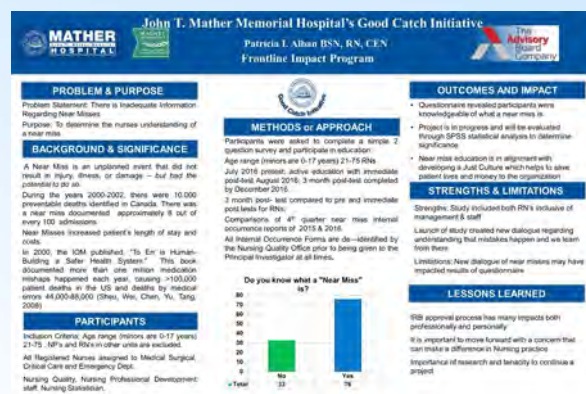
## "Temps to the Core"-Improving Accuracy of Temperature Management Among Surgical Patients by Rose Cummings, BSN, RN , CPAN

Clinical practice of temperature measurement was inconsistent amount clinical units (PACU vs. 3 North). A temperature discrepancy existed among patients receiving Total Joint Replacement Surgery at Mather Hospital during the post-operative surgical continuum. To address the problem of hypothermia among post-operative patients, a review of the literature was conducted to identify the most accurate device for monitoring core temperatures. The tympanic thermometer a more valid instrument was implemented in January 2016. Findings of this project determined that the use of the Tympanic device prevented the previously observed discrepancy in temperature measurements observed when Temporal and Oral methods were used to measure temperatures.



## Good Catch Initiative by Patricia Alban, BSN, RN, CEN

The purpose was to determine the nurses understanding of a near miss. A near miss is an unplanned event that did not result in injury, illness, or damage-but had the potential to do so. Participants were asked to complete a simple 2 question survey and participation education. A pretest and post-test were completed. Questions revealed participants were knowledgeable of what a near miss is. Project is in progress and will be evaluated through SPSS statistical analysis to determine significance. Near miss education is in alignment with developing a Just Culture which helps to save patient lives and money to the organization.



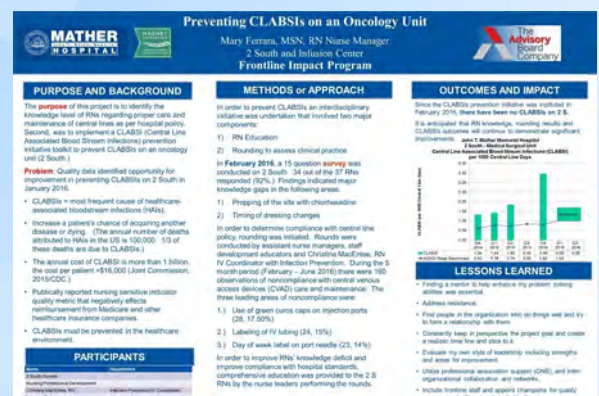
## Preventing CLABSIs on an Oncology Unit

by Mary Ferrara, MSN, RN

The purpose of this project is to identify the knowledge level of RNs regarding proper care and maintenance of central lines as per hospital policy. Second was to implement a CLABSI (Central Line Associated Blood Stream Infections) prevention initiative toolkit to prevent CLABSIs on an oncology unit (2 South).

In order to prevent CLABSIs an interdisciplinary initiative was undertaken that involved two major components: 1– RN Education, 2-Rounding to assess clinical practice. In February 2016 a 15 question survey was conducted on 2 South, with a 92% response rate.

Findings indicated major knowledge gaps in the following areas: Prepping of the site with chlorhexadine and Timing of dressing changes. In order to determine compliance with central line policy, rounding was initiated. Rounds were conducted by Assistant Nurse Managers, Staff Development Educators and Christine MacEntee, RN IV coordinator with Infection Prevention. During the 5 month period (February-June 2016) there were 160 observations of noncompliance with central venous access devices care and maintenance. In order to improve RNs knowledge deficit and improve compliance with hospital standards, comprehensive education was provided to the 2 South RNs by the nurse leaders performing the rounds. Since the CLABSIs prevention initiative was instituted in February 2016, there have been no CLABSIs on 2 South. It is anticipated that RN knowledge, rounding results and CLABSIs outcomes will continue to demonstrate significant improvements.



Deborah Tuttle, Valerie LaSala,  
Joanne Lauten, Susan DeTurris,  
Kathleen Krygier-Rate



Natalie Mathias, Denise Driscoll,  
Melissa Pearson, Lori Accetta



## GROUPS FROM FRONTLINE PROJECT



Diane Marotta, Teresa Pickel, Michelle Gustaferrri, Elizabeth Picozzi, Rose Cummings



Maria Hofbauer, Julia Macauley, Brittany Greco



Marianna David, Dana Cardiello , Katherine Lewin, Lori Fusco, Nancy Uzo



Joseph Wisnoski, Daniel Maggio, Nancy Rochler, Julie Tegay



Jeannette Voelger, Merritt Love, Trudy Weekes-Roach, Lisette Callahan



Linda Hill, Junielon Adame, Cameron Gittens, Shirlee McKenna, Jeanne Brennan



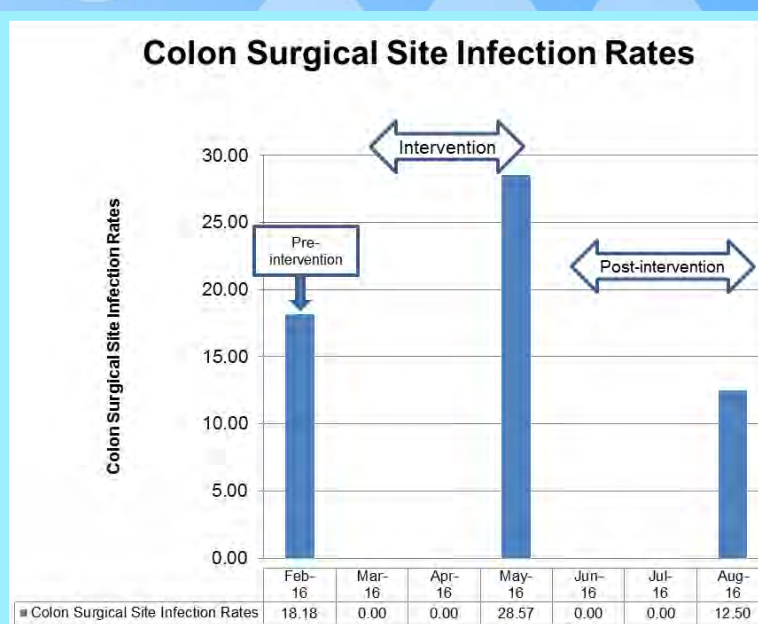
# Structural Empowerment





# DECREASING COLON SURGICAL SITE INFECTIONS

In February 2016 the rate of colon SSIs was 18.18 and strategies were needed to improve the rates. The interprofessional Colon Bundle Committee met and began to formulate an action plan to enhance the colon bundle. Committee members include nurses, physicians, a surgical tech. and the statistician. The committee adapted guiding principles from the New York State Partnership for Patients (NYSPFP) and the Greater New York Hospital Association (GNYHA). Discussions included the incorporation of NYSPFP guidelines for hypothermia, the use of a glycemic management protocol, antibiotic selection, and the use of an electronic audit tool. Donna Hughes, BSN, RN, Assistant Nurse Manager (ANM) of the Ambulatory Surgery Unit (ASU), clinical nurse mentioned the need to develop hypothermia protocols along the perioperative continuum in order to maintain normothermia for patients. Kathleen Long, BSN, RN, ANM of Pre-surgical testing (PST), clinical nurse was concerned with finger sticks being done in PST. Glycemic management strategies were discussed with a focus on identifying diabetic and potential diabetics in PST so blood glucose levels were maintained less than 200 on the day of surgery and throughout the post-operative period. The committee's consensus reflected the need for a referral process to contact the patient's primary care physician, surgeon, and/or endocrinologist when the HgA1c was elevated. Antibiotics were to be given within one hour of incision with subsequent re-dosing schedules. Glucose control protocols and guidelines were established to be used throughout the perioperative process which included the frequent monitoring of blood glucose for all patients; both known diabetics and non-diabetics. This monitoring would begin in PST and move along the perioperative continuum into ASU, the operating room (OR), post-anesthesia care unit (PACU) and on the nursing units. Strategies for normothermia included the active warming of patients through standardized warming interventions and temperature monitoring protocols. The patient's temperature would be taken upon admission to ASU and if greater than or equal to 36 degrees Celsius, the Bair paw's gown would be placed on the patient and the temperature would then be checked throughout the OR procedure.



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## In May 2016 the Advanced Colon Surgery bundle was implemented

### **This includes:**

- ⇒ Normothermia
- ⇒ Glucose control
- ⇒ Antimicrobial prophylaxis
- ⇒ Increased perioperative oxygenation
- ⇒ Skin prep
- ⇒ Clean standardized fascia closure
- ⇒ Standardized wound management

### **Participants**

Name	Credentials	Discipline	Title	Department
Sarah Eckardt	MS		Statistician	Nursing Administration
Edward Cook			Surgical Tech.	Surgical Services
Trisha Calvarese	RN	Nursing	Clinical nurse	Surgical Services
Theresa Grimes	PhDc, FNP-BC, RN-BC, CCRN	Nursing	Associate Vice President	Nursing Administration
Donna Hughes	BSN, RN	Nursing	Assistant Nurse Manager	Ambulatory Surgery
Kathleen Long	BSN, RN	Nursing	Assistant Nurse Manager	Pre-Surgical Testing
Mary Scannell	BSN, RN	Nursing	Clinical nurse	Surgical Services
Patty Mupo	BSN, RN	Nursing	Coordinator of Infection Prevention	Infection Prevention
Barbara Ruse	BSN, RN	Nursing	Assistant Nurse Manager	Operating Room
Maria Basile	MD, MBA	Surgery	AVP Medical Affairs	Administration
Hesham Atwa	MD	Surgeon	Director	Surgery
Derrick George	MD	Anesthesia	Director	Surgical Services

# NURSING PROFESSIONAL DEVELOPMENT

Our nursing professional development educators work diligently to provide nurses with education both as they enter the hospital, and throughout their careers to ensure that our nurses and our organization earn the national accolades for quality, evidence-based practice and patient safety it deserves.

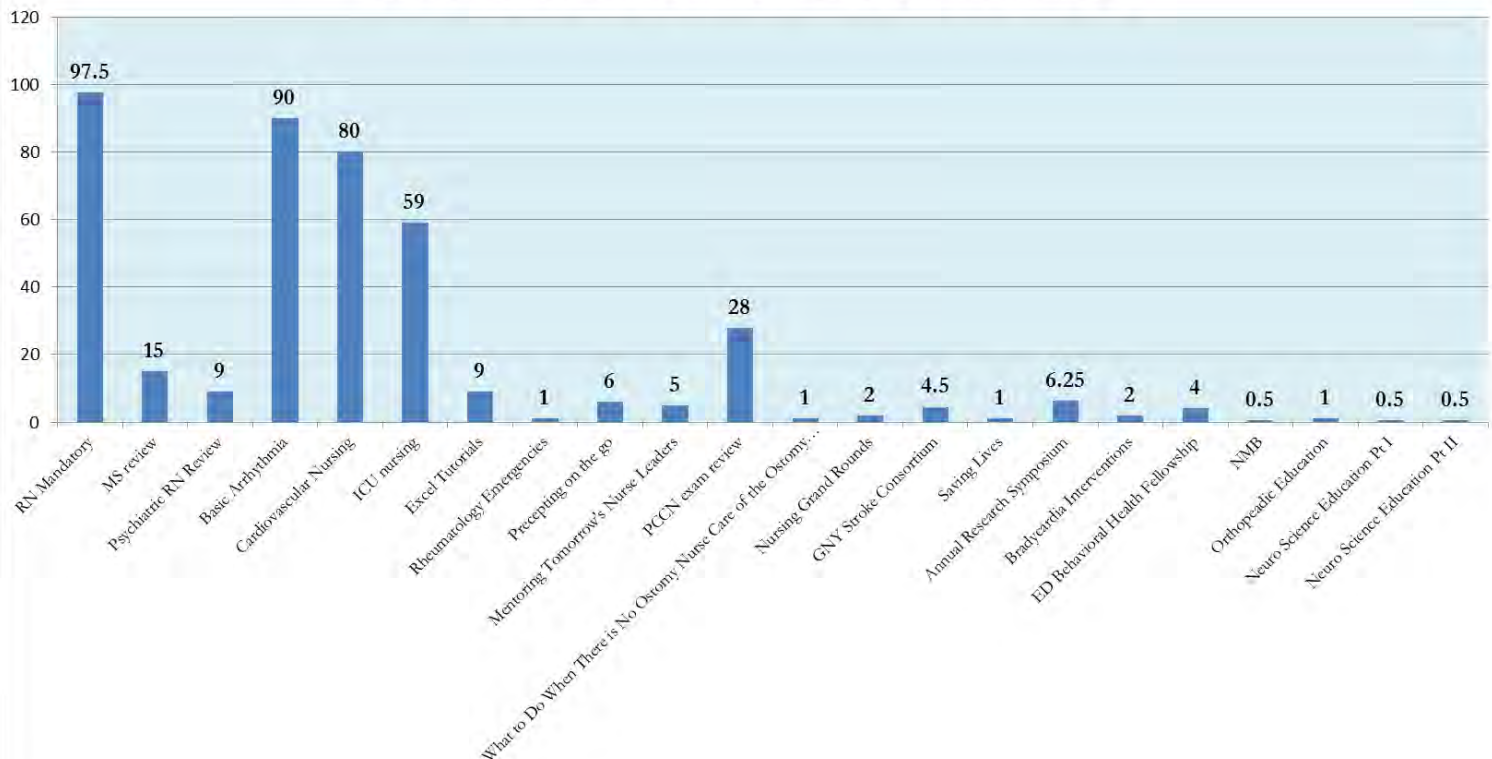
Our NPD colleagues work to provide programs including: CPR, ACLS, PALS, PEARS, Critical Care classes, Specialty Certification Classes, Community Education Classes and many more...

- Orientation and transition to practice programs
- Competency assessment (for new hires and routinely thereafter)
- Continuing education contact hours improving the performance of our nursing staff by offering review classes to achieve national nursing certification recognition
- Education on use of new equipment/policies & procedures
- Coordination of student affiliations (contracts, scheduling, ensuring they have orientation, parking passes, etc.)
- Hospital orientation program to meeting regulatory requirements
- Educational requests provided to nursing staff one on one in real time.

“Nursing professional development is a unique specialty where the clinical instructors and clinical nurse specialists demonstrate a commitment to the profession and to our organization every day. The educator’s in the NPD department are an integral part of lifelong learning in which Mather nurses and staff engage to develop and maintain competence, enhance professional nursing practice, and support achievement of career goals. I am extremely proud and thankful to lead such a group of highly motivated and talented individuals that reflect their knowledge and expertise in providing education to our nursing staff and throughout the hospital”

Brandy Feliu, MSN, RN

**John T. Mather Memorial Hospital  
Nursing Professional Development  
Sum of Amount of Contact Hours Awarded to RN's**





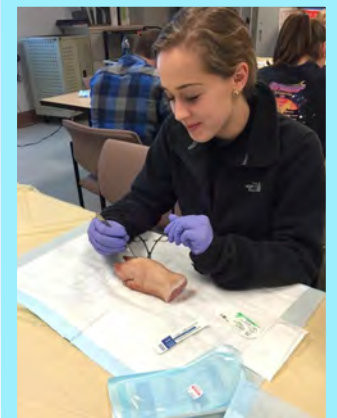
## TRANSITIONING NEW GRADUATE NURSES

As a Magnet designated hospital the transitioning of new graduate RN's is part of the structural empowerment. Re-evaluation of the orientation process is completed with every orientation. After attending the ANPD national conference in July of 2016, changes were discussed and implemented for the transition of the new graduates. Orientation begins in the classroom for three weeks, and then the new graduate nurses transition to the units where they will be working and orient for 4 weeks 8am-4pm ,Monday-Friday. The new graduate remain in the same district each week and may experience a variety of preceptors. After the completion of the day rotation they transition to the night shift for 12 hour shifts for the remainder of the medical surgical orientation. At the conclusion of the medical surgical orientation, the graduates complete a valid and reliable assessment tool, the *Casey-Fink New Graduate Nurse Experience Survey*. At the completion of the initial orientation, new graduates who are successful in applying for a specialty area continue to transition to those specific areas.

In 2017 a new residency program will begin for the new graduate nurses to provide additional support through the first year of practice. This evidenced-based education initiative is supported by nursing administration with the goal of increasing satisfaction and retention of the new graduate nurses.

## EXPLORER PROGRAM

Beginning in the Fall of 2016, the Nursing Professional Development Department in collaboration with our Volunteer Department began an Explorer Program through the Boy Scouts of America and created Troop 1929. The Explorer Program offers young adults between the ages of 14-17 real life experiences, training and exposure to the career opportunities available in the hospital setting. Meetings are held once a month from 6:00 pm to 7:30 pm on the first Tuesday of the month in the Nursing Classroom. Sixteen Explorers participated in monthly sessions highlighting different health careers such as Nursing, Physician's Assistants, Physical Therapists, Physicians and Surgeons. The format of the meetings included didactic instruction of the career that is highlighted, course recommendations for High School and College, annual salary and why the professional choose their career. The remainder time is spent in a hand's on activity that will engage the student. This year the Explorers have started intravenous lines, intubated manikins, sutured pigs feet, wrapped appendages and learned how to stay physically fit. They were also certified in Basic Life Support.



## AFFILIATIONS WITH SCHOOLS OF NURSING

In 2016 John T. Mather Memorial Hospital collaborated with 12 Schools of Nursing and placed 251 students for their clinical rotations and 50 students for their capstone and clinical rotations.

Students completed the required clinical areas in various departments throughout the hospital including Med/Surg, Telemetry, Critical Care Units, Stepdown, Surgical Services, Behavioral Health, Emergency Department and Outpatient areas on both day and night shifts. In addition, students were placed with Nurse Leaders throughout the hospital to fulfill their clinical time in leadership classes.

This would not have been possible without the help and support of Mather Hospital's Clinical Nurses, Assistant Nurse Managers, Nurse Managers, and Nursing Administration.



**Stony Brook University**



## MATHER HOSPITAL'S "BECOMING A NURSE" PROGRAM

In 2016 we continued a nursing education program entitled "Becoming a Nurse" at John T. Mather Memorial Hospital. The purpose of the program is to educate community members about nursing as a career and the steps involved in the process of becoming a registered nurse. The program was developed by Judith Moran-Peters, DNSc, RN, NE-BC, BC, Coordinator of Nursing Research and Professional Development; Brandy Feliu, MSN, RN, Assistant Vice President of Nursing Professional Development; and Annemarie Doodian, MSN, RN, Coordinator of Nursing Recruitment and Retention. These creative nurse leaders envisioned hospital volunteers as a microcosm of the community-at-large. Therefore they enlisted Keri Dunne, BA, Volunteer Services Program Director as an active participant in both teaching and promoting the program among the hospital's 173 volunteers. A review of the literature found the main reason cited by nurses for becoming a registered nurse is they seek to help the community they serve. The Mather program includes information on the history of nursing, nursing theorists, modern day nursing, types of nursing programs, the ANCC Magnet Recognition Program®, resume writing and interviewing skills. Many attendees voiced interest in learning the details involved in applying to BSN Nursing programs, courses required within BSN programs and job opportunities for new graduate RNs. Many junior and senior volunteers have attended the "Becoming a Nurse" class. They complete a pre-test and post-test. Results ranged from 40-60% on the pre-test and 90-100% on the post-test. Findings of the pre-tests and post-tests indicate the class succeeds in increasing the volunteers' knowledge regarding the history of Nursing, the Magnet Recognition Program®, and issues facing modern day nurses. Findings from completed evaluations indicated scores of "very good" to "excellent" and included positive comments regarding the class content. Noteworthy is the fact that several parents have attended classes with their junior volunteer teenage children and seven volunteers have been accepted into nursing programs. In addition, the Mather Hospital "Becoming a Nurse" program was accepted as a poster presentation at a local nursing research conference in March 2016.



## IMPROVING ARRIVAL TO TRIAGE TIME IN THE EMERGENCY DEPARTMENT

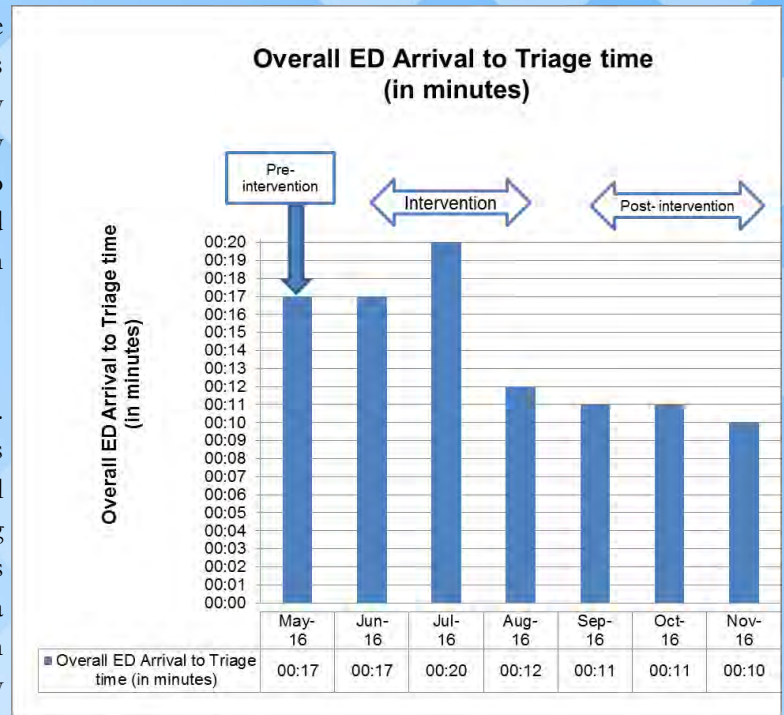
In May 2016 the overall arrival to triage time in the ED was 17 minutes. The time sensitive metric of arrival to triage time is closely monitored daily and then a monthly overall metric is reported in the Emergency Department (ED).

Christine McKeon, MSN, RN, CEN, Assistant Nurse Manager ED, clinical nurse is an active member, as well as immediate past-president of the Suffolk County Emergency Nurses Association (SENA). Christine attended the May 2016 conference and used the opportunity to discuss arrival to triage times with other chapter members. A common thread was the need to decrease the amount of triage questions on the front end of a patients visit.

### Description of the Intervention/ Initiative/Activity(ies)

In June 2016 Christine conducted a review of the literature. The results indicated that over time, emergency nurse leaders had added many screenings and assessments to the traditional triage. This resulted in the triage process becoming insufficient, time intensive, and ultimately leading to backups in the ambulatory entrance. Experts agree there is actually a small percentage of information necessary to determine an accurate acuity level of a patient presenting to an emergency department for care. Triage of incoming patients should only take a few minutes to complete and patients should be immediately placed in the most appropriate treatment pathway, thus reducing delays in care and backups on the front end of the department.

Throughout July 2016 a committee was developed to identify what information was essential to obtain in order to appropriately designate a safe triage acuity level. In reviewing the initial patient screenings and assessments the committee decided to remove past medical and past surgical history, immunization history, visual acuity, and history of bariatric surgery. The consensus was this information could wait in order to expedite the triage process. The final triage template resulted in only five required fields necessary to triage a patient on the front end of the department. The resulting triage template was noted to be much shorter and allowed for quicker assignments of triage acuity. In August 2016 the new triage process was put into practice which resulted in a decreased overall arrival to triage time.



### Participants

Name	Credentials	Discipline	Title	Department
Julie Tegay	BSN, RN, CEN	Nursing	Nurse Manager	Emergency Department
Christine McKeon	MSN, RN, CEN	Nursing	Assistant Nurse Manager	Emergency Department
Marina Grennen	MSN, RN, CEN	Nursing	Clinical Educator	Emergency Department
Laura Hart	RN	Nursing	Charge Nurse/Triage Nurse	Emergency Department
Jennifer Zeman	RN	Nursing	Charge Nurse/Triage Nurse	Emergency Department
Dana Strittmatter	RN	Nursing	Charge Nurse/Triage Nurse	Emergency Department
Constance Calisi	RN, MBA	Nursing	Director	Nursing Informatics
Rebecca Welsch	BS, RN	Nursing	Senior Applications Analyst	Information Services Department

# Exemplary Professional Practice





## USING EVIDENCE TO BETTER MEET THE NEEDS OF PATIENTS

Shirlee McKenna, RN, BA, CAPA, clinical nurse was interested to see if she could change the NPO (nothing by mouth) practice in John T. Mather Memorial Hospital's Ambulatory Surgery Unit (ASU). The current practice had the majority of pre-surgical patients (PST) being directed to abstain from all fluids after midnight and was based on historical precedent and not current scientific evidence.

Shirlee conducted a review of the literature to ascertain current, best practice for NPO guidelines. The results supported clear liquids up to two hours prior to surgical procedures as a best practice. Since this would be an interprofessional practice change for nursing and anesthesiology, Shirlee decided to search for evidence amongst Mather Hospital patients which might reflect measurable discomfort among those who were being kept NPO after midnight. The purpose of her inquiry was to demonstrate the advantages of clear liquids up to two hours prior to surgery.



Shirlee McKenna, RN, BA, CAPA

For a few months Shirlee collected anecdotal evidence from patients who complained of hunger, thirst, and headaches after being NPO since midnight. Under the guidance of Judith Moran, DNSc, RN, NE-BC, Coordinator of Nursing Research and Professional Development, they designed and created a survey for ASU nurses to use as a tool when they interviewed patients on the day they came in for surgery. The survey results demonstrated that 70% were hungry, 77% of patients were thirsty, and 22% had headaches when kept NPO after midnight.

In March 2016 Shirlee met with Dr. Derick George, MD, Director of Anesthesiology, Trudy Weeks-Roache, BSN, RN, CNOR, Nurse Manager OR, Pain Management, and Endoscopy, Dana Boucher, MSN, RN, CCRN, Nurse Manager Perioperative Services, Donna Hughes, RN, Assistant Nurse Manager, ASU, and Kathleen Long, BSN, RN Assistant Nurse Manager PST to discuss the results of her literature review and the survey results. Dr. George acknowledged that while Mather Hospital's NPO guidelines recommended a minimum fasting period of two hours prior to surgery, many of the anesthesiologists were more comfortable when patients were kept NPO after midnight. Dr. George also recognized that best practices need to be incorporated into patient care in order to enhance patient outcomes and so he fully endorsed Shirlee's recommendation to promote clear fluids up to two hours prior to surgical procedures. He invited Shirlee to present her findings at the monthly Anesthesiology Department meeting the following month.

On April 5, 2016 Shirlee presented her findings to the Anesthesiology Department. **This was the first time in the history of Mather Hospital that a clinical nurse had been invited to present a suggested practice change at the monthly Anesthesiology Department meeting.** A motion was made by Dr. George, and then seconded to approve the revised NPO Guidelines as presented with updated references.

Shirlee then designed a preoperative patient instruction sheet to reflect the new information nurses would use to educate patients when physicians recommended clear liquids up until 2 hours prior to surgery. Nurses in Pre-surgical testing and ASU were educated by Shirlee on how to define for patients what clear liquids are, explain that there was still no eating after midnight, and the benefits of being hydrated prior to a surgical procedure.

# NURSING AND PHYSICIAN COLLABORATION

## IMPROVING CARE WITH MOCK CODES

The purpose of this team is to review code blue events to improve the safety and quality of care delivered. In August 2015 it was identified through the Critical Event Review team that code blue events outside of the critical care service area needed improvement. The team recommended the Nursing Professional Development staff should lead a training program for mock codes and rapid responses. Clinical Instructors Katherine Lewin, MS, RN, CCRN, Maureen Chernosky, RN, MSN, CCRN, CEN, ACNS-BS, and Patricia Alban, BSN RN, CEN co-lead a mock code program as a quality improvement initiative. Using the PDSA (Plan, Do, Study, Act) model a plan was devised to evaluate the current code blue process, test on a small scale (3 North), analyze and study the data from the events and debriefing tools, and develop changes to the process in order to improve outcomes.

Maureen worked closely with Lorraine Farrell, FNP, RPAC, AVP Medical Affairs to develop a debriefing form to formalize and track the post-event debriefing process. The data from this form would be used to improve code blue and rapid response processes. Simultaneously, Patricia developed a rapid response education for the nursing staff.

Katherine collaborated with Nirupa Ramjisingh, RPA-C, Operations Director for Hospital Medicine to work together to create an action plan to begin mock codes on 3 North, a 30 bed telemetry/step down unit. The mock code program would include monthly mock codes which would be run like a “real” code blue event in which assigned staff would respond, have a scenario to manage, and complete a debriefing. The additional interprofessional team members were responsible for assisting with the mock codes. For example, respiratory therapy would be responsible for airway maintenance while the advanced healthcare practitioners were responsible for assisting the residents.

Katherine also worked to create a bundle which included mock code scenarios, team leader evaluations, and program evaluations. April 2016 the first mock code was held on 3 North, with participation from an interprofessional team who responded to the code. The PGY-3 resident was responsible for being the team leader with the nursing staff performing other team roles such as IV medication, CPR, and airway management. Nirupa and Katherine evaluated all participants of the mock code and debriefed with the mock code team.

Since April 2016, additional mock codes were held on 3 North to evaluate the educational needs of the interprofessional team. In July 2016 the mock code program was expanded to the entire hospital involving the nurse educators in each area. The debriefing tool continues to be used after each mock code and allows for quality improvement needs to be identified. These needs are brought forward to the Critical Event Review team to help in improving code response time, performance, and patient outcomes.

## AROMATHERAPY FOR PATIENTS

Marie O'Brien, ANP-C, RN-BC, CCRN, a committee member and Pain Management Nurse Practitioner, was interested in providing aromatherapy to patients at Mather Hospital. Patricia Dodd, ANP-C, RN-BC, MS Lac, Dipl Ac, NCCAOM initiated a literature search for aromatherapy nursing practice and classes for aromatherapy. The aim was to implement a structured program at Mather Hospital to train nurses in evidence-based aromatherapy.

The proposal included a two day intensive Aromatherapy with M-technique workshop presented by a certified Aromatherapy Instructor from R.J. Buckle Associates. R.J. Buckle Associates provides complementary health therapies, consultancy and edification in regards to aromatherapy. Their course entitled “*Clinical Aromatherapy for Health Professionals*” was the first evidence-based aromatherapy course to be endorsed by a national nursing organization (American Holistic Nurses Association) in 1997.

In March of 2016 the aromatherapy program and policy was developed and implemented. The policy authorizes the clinical nurse to autonomously request, or enter, an aromatherapy consult from one of the 23 “Aromatherapy Clinicians” via an electronic order selection screen embedded in the electronic medical record. There is also the opportunity for nurses to document an aromatherapy order, aromatherapy provided, and use of aromatherapy as a pain management intervention. This process was rolled out in July 2016. Aromatherapy benefits patients by improving pain and decreasing nausea and anxiety.





# IMPROVING REPORTING ON “NEAR MISSES”

John T. Mather Memorial Hospital’s May 2016 - May 2019 Strategic Plan states in part “achieve excellence in clinical quality and safety management.” In January 2016 Mather Hospital began to focus on becoming a high reliability organization. As part of the Advisory Board Frontline Leadership Impact Program Patricia Alban, BSN, RN, CEN, clinical instructor for the Emergency Department and 3 East, Telemetry Unit decided to examine “near misses” which were associated with the organizational goal of becoming a high reliability organization. Patricia suspected many “near misses” were not reported. No formal education was provided for what “near misses” were or what the process was for reporting them. “Near misses” can be defined as “unsafe acts that have the potential to injure a patient, but do not.” (www.psnet.ahrq.gov). Under reporting could potentially cause injury, illness, or death to a patient. With a “near miss” reporting rate of 0.53 in October 2015, Patricia recognized there was opportunity for improvement.

## Description of the Intervention/Initiative/Activity (ies)

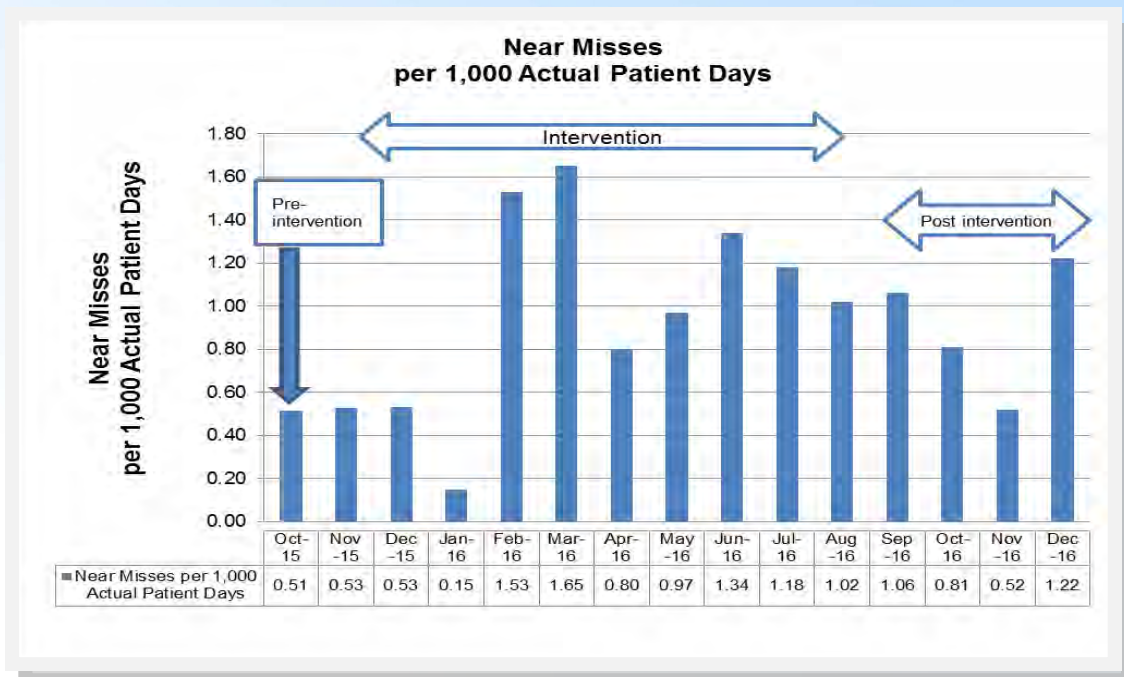
Patricia conducted a literature search on “near misses” and how they can affect an organizations risk assessment. Her literature search revealed there are more than one million medication errors in the United States each year causing greater than 100,000 patient deaths. (IOM “*To Err is Human – Building a Safer Health System*” 2000) “Near misses” can be difficult to track due to the nature of under reporting. In January 2016 Patricia was developing her application for the Institutional Review Board (IRB). Her aim was to survey the nursing staff to identify their knowledge of “near misses”. Her design included disseminating a pre-test to assess the nurses’ knowledge, provide education, and then follow with a post-test. From February through April 2016 she continued to work on the IRB application and also contacted other Magnet® organizations to identify standard safety practices within their organizations related to “near misses”. Feedback was used to restructure Mather Hospital’s “near miss” reporting.

In May 2016 Patricia finalized the survey tool which consisted of two questions for clinical nurses:

- Do you know what a “near miss” is?
- In three sentences or less, please describe what your personal understanding of what a “near miss” is.

In June 2016 she presented her proposal to the IRB. An expedited review permitted her to move forward with the survey and education of the nursing staff. Patricia distributed the survey (pre-test) to the nurses on the medical–surgical units, critical care, and in the Emergency Department. Results demonstrated the majority of nurses thought they were aware of what near misses were but were not certain how to report them. Most were not aware there was a formal reporting process in place.

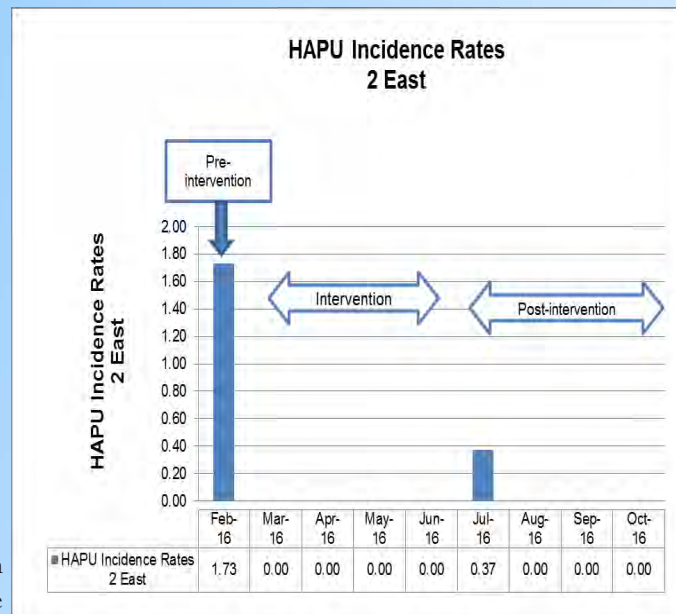
In July and August 2016 Patricia provided education to nurses with the assistance of clinical instructors: Marsha Deckman, MSN, RN, NE-BC, ONC, Suzanne Soltysik, MS, RN-BC, CNE, Marina Grennen, MSN, RN, CEN, and Maureen Chernosky, MSN, RN,CCRN, CEN, ACNS-BC. On the night shift, clinical instructors Tara Hartwell, MSN, RN and Deborah Buganza-Estepa, RN, MBA, CEN provided education regarding “near miss” identification and reporting. The post-test demonstrated an improvement in knowledge of “near misses” from 72% to 98%. There was also an increase in “near miss” reporting.



# 

In February 2016 there were been four pressure injuries on 2 East. Jeanne Brennan, BSN, RN-BC, Nurse Manager 2 East reported this data at the unit council meeting. The clinical nurses were very concerned and discouraged but motivated to make changes that would enhance patient outcomes. In March 2016 Assistant Nurse Managers (ANM) Catrina Shaw, BSN, RN and Denise Bonneville, BSN, RN, began to re-educate staff on the use of available devices to offload pressure points, turning and repositioning, and how to identify high risk patients. Catrina and Denise, along with other clinical nurses Christine Zay, BSN, RN, Kerilyn O'Toole, BSN, RN and Stefanie Stamatiades, BSN, RN developed a list of evidence-based information which included identification of patients at risk, treatments for preventing wounds and treating wounds that are present, and implementation of best practices to decrease incidence of pressure ulcers. This became known as the "skin care bundle" and was disseminated to the nurses and nursing assistants for their input and suggestions.

In April 2016 Jeanne, Catrina, and Denise developed and implemented "skin care rounds". Every afternoon they rounded on patients that scored low on the Braden scale (skin risk assessment tool). Education was provided in real time if needed. In addition, Christine contacted Jean Peterson, AGNP-C, MSN, RN-BC, WCC, Inpatient Wound Care Coordinator to request classes on pressure ulcer education including staging and documentation. In May 2016 Jean provided the in-services which included pressure ulcer staging and documentation. The nursing assistants were also encouraged to take more of an active role in identifying the "at risk" population and communicating with the nursing staff. With the feedback garnered from the nursing staff a "skin care card" was created and became part of the Skin Bundle. The aim was to identify patients at high risk for impaired skin integrity, implement the appropriate interventions on the Skin Care Card and initial upon completion. This card is placed at the bedside of every admission to help facilitate the preventative actions. Upon each admission, two registered nurses assess the patient's skin and initial, time, and date the Skin Care Card. The card is a method of communicating with one another to create awareness of what interventions have already been instituted for the patient. Interventions are listed on the card and serve as a quick reference for staff in determining the treatment for specific wounds. There is also a figure of the human body on the card so the location of the wounds can be marked along with the corresponding treatments/interventions.



## 

**WOUND PREVENTION**

Action: \_\_\_\_\_ Date & time completed: \_\_\_\_\_ Initials: \_\_\_\_\_

2 RN's assess skin on admission or transfer to 2E		
2 RN's observe & stage suspected new pressure injuries		
Photos taken		
Measurements taken		
Notify MD immediately & obtain orders		
Wound care consult as soon as pressure ulcer identified		
Nutrition consult		
Accumax pump on bed		
Heel boots and off loading heels		
Mepilex on sacrum or other bony prominence		
Maximum of 2 layers of materials under patients		
'Turn and position' clock		

PATIENT LABEL

PATIENT LABEL

Skin Abnormality ☐ Surgical ☐ Pressure Ulcer ☐

**TREATMENT:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## 2016 Nurses Week Celebration

National Nurses Week starts each year on May 6th and continues through May 12th, Florence Nightingale's birthday. Mather nurses were recognized by the Flynn family for their excellent nursing care and outstanding compassion.

### Awards Presented:

- Town of Brookhaven Women's Recognition Honoree: Marie O'Brien, NP Pain Management Coordinator
- Nurse of Excellence: Emily Emma, Nurse Manager 3 South
- Clinical Nurse of the Year: Natalie Mathias, RN 2 South
- Rookie of the Year: Kerilyn O'Toole, RN 2 East
- Nursing Assistant of the Year: Taihesha Norman, Critical Care
- Unit Secretary of the Year: Lisa Branca, OR



Spokesman Gerry Flynn  
at the 2016 Nursing Awards  
Ceremony

WITH GREAT APPRECIATION,  
2016 NURSES WEEK FESTIVITIES WERE  
DONATED BY THE FLYNN FAMILY FOR THE  
EXCELLENT NURSING CARE PROVIDED TO  
THEIR LOVED ONE.



NATIONAL NURSES WEEK MAY 6-12







## ANNUAL NURSING RESEARCH SYMPOSIUM

On October 21, 2016 Mather Hospital's Nursing Research and Professional Development Council held our annual Nursing Research Conference "Looking at Nursing through Different Lenses Understanding Quantitative and Qualitative Approaches to Nursing Phenomenon". The conference was held at the Hilton Garden Inn, Stony Brook, NY.

The audience was comprised of 77 Registered Nurses. There were two key note presentations followed by moderated panel discussions. This symposium is a valid method in the dissemination of Nursing Research.



Patricia Alban, BSN, CEN, PCCN; Nancy Rochler, BSN, CCRN;  
Christine McKeon, MSN, CEN



Emily Emma, MSN, RN-BC, ONC; Anne Lasota, BSN, RN-BC, ONC;  
Maryanne Goodman, EMBA, RN, ONC

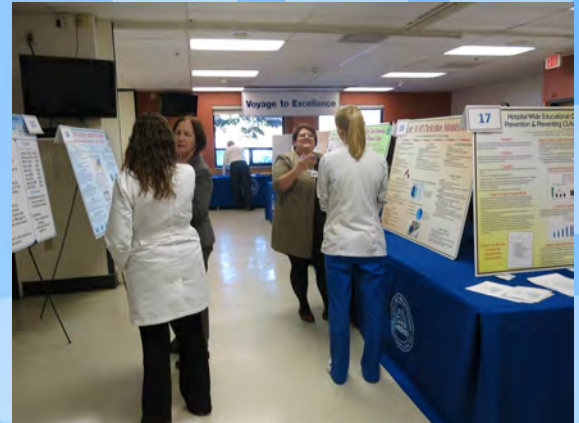


## NURSING QUALITY SHOWCASE

Mather Nurses celebrated Hospital Quality Week with their 6<sup>th</sup> Annual Quality Showcase held on October 31, 2016. The Theme for this year was, *See Quality Through our Care*.

Thirty posters, which present the latest evidence based practices, research and process improvements throughout the hospital were on displayed onsite at the hospital in conference rooms 3, 4, and 5. As a Magnet designated facility, Mather Hospital uses nurse-designed innovations to improve patient outcomes.

The professionally prepared posters showcased what our units have accomplished in the past year. The presenters had the opportunity to engage in dialogue with other department leaders, physicians and board members.



## NASSAU SUFFOLK NURSE OF EXCELLENCE

### **Emily Emma, MSN, RN-BC, ONC, 3 South Nurse Manager**

Emily Emma MSN, RN-BC, ONC, is currently the Nurse Manager of the Orthopedic Unit at John T. Mather Memorial Hospital in Port Jefferson, New York. In addition, Emily works per diem at an inpatient hospice center providing nursing care to patients at end-of-life. Emily is the future of the Nursing profession in America. She exemplifies all of the best qualities that a nurse leader in a Magnet-designated hospital must demonstrate to achieve and sustain exemplar nursing and patient care outcomes in today's dynamic healthcare environment.

As their new Nurse Manager, Emily's colleagues describe her as follows: "a young, energetic, enthusiastic nurse leader with a wide knowledge base. Since Emily has taken charge of the Orthopedic Unit, the nursing care has flourished resulting in high quality outcomes. She is a leader who fosters a practice environment reflective of Nursing autonomy and empowerment. Emily encourages her nurses to think of new and innovative ways to deliver safe, high quality nursing care to patients and their family members."

Emily has worked diligently to create a healthy work environment for the Orthopedic Nursing staff. Emily is a transformational nurse leader, a continuous learner, who shares her knowledge with her staff. Emily constantly strives for excellence in Orthopedic Nursing on her unit. She uses evidence-based information from research to help nurses understand the positive association between board certification in Nursing and improved patient outcomes.



*"My Nursing career continues to grow and inspires change within me, both personally and professionally. I thoroughly enjoy my role as Nurse Manager. I look forward to inspiring my nurse colleagues to advance their own careers in the Nursing profession in the future."*  
- Emily Emma, MSN, RN-BC, ONC

# IMPLEMENTING A NEW ELECTRONIC PATIENT SCHEDULING

## PROCESS TO IMPROVE PRESS GANEY SCORES

At the March 2016 unit-based council meeting at the Port Jefferson Wound Treatment Center, Press Ganey scores were discussed. There was room for improvement in some areas such as the waiting time for tests or treatments. The process for scheduling patient's appointments included the use of a paper appointment book where dates and times of appointments would be written in with little regard for patient acuity and the time it might take for each patient to be seen. Appointments were sometimes scheduled ten minutes apart and double and triple booking was common. This was frustrating to patients and the nursing staff so the nurses resolved to improve their scores.

### Description of the Intervention/Initiative/Activity(ies)

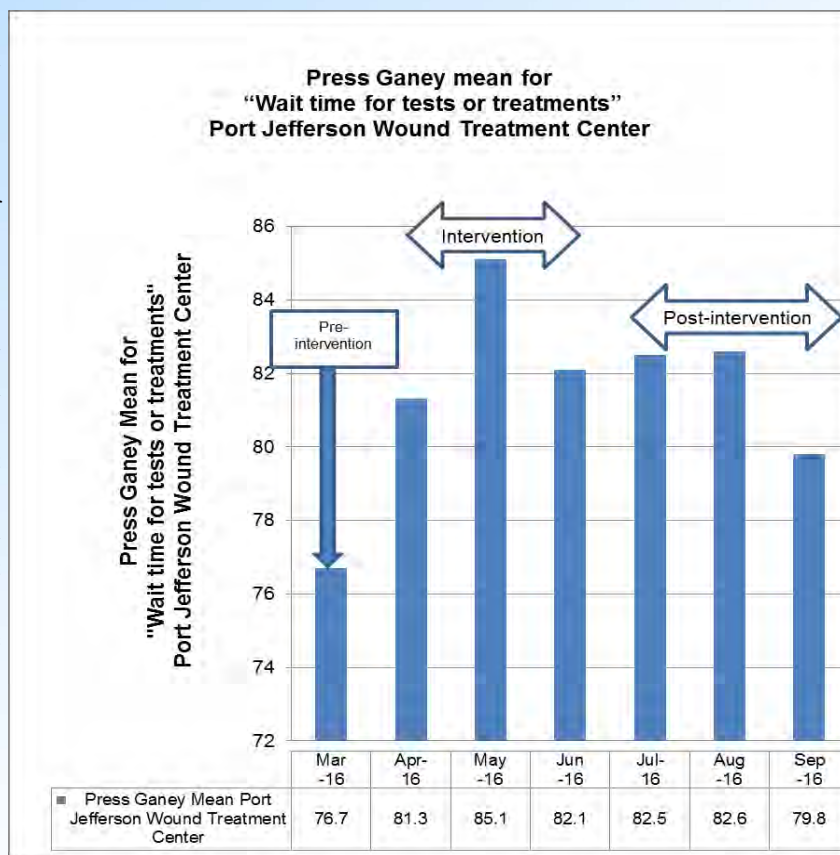
In April 2016 Michele Wyllie, BSN, RN, Program Director Wound Treatment Centers, Deborah Lamendola, MS, ANP-BC, CWCN, Nurse Manager for the Port Jefferson Wound Treatment Center, Karen Petrosino, BSN, RN, WCC, lead clinical nurse Melville Wound Treatment Center, Jennifer Johnston, Application Analyst, Information Services Department and the clinical staff met to discuss scheduling. The decision to go with an electronic scheduling system was made and SCI Schedule Maximizer was chosen as the best option. SCI Schedule Maximizer is a software platform that "guides users through scheduling any services to ensure accurate and efficient completion according to the clinical and operational requirements of providers." SCI Scheduling would help to streamline and standardize patient appointment scheduling with the aim of decreasing wait times with a more organized approach.

In May 2016 clinical nurses Colleen Pohmer, RN, WCC, Donna Randone, BSN, RN, WCC, Lydia Malvagno, RN CWCA, Cynthia Mattson, BS, RN, CWOCN, Vilma Rosario, BSN, RN, and Janice O'Connor, BSN, RN were included in meetings for the new electronic scheduling system. They participated in the design and implementation of custom reports that provided them with specialized clinical flow sheets for daily clinic patient schedules. Discussions also included creating a patient inquiry form which would be used to query every patient prior to appointments being scheduled.

**It was agreed five standardized questions would be asked during the scheduling of appointments:**

- Have you traveled outside of the country in the past 21 days? (related to Ebola)
- Have you been seen in the Wound Treatment Center in the past 30 days?
- Will you need assistance transferring? (ie. need a Hoyer lift, wheelchair, etc.)
- Negative pressure wound therapy? (Wound Vac?)
- Multi-layered compression bandages?

In June 2016, SCI Scheduling was implemented in the Port Jefferson Wound Treatment Center. The scheduling system was designed to provide custom reports for the nurse manager to review prospective new patients prior to coming to the Wound Treatment Center. Custom clinical flow sheets were designed by nurses for use by the clinical nurses and physicians that outlined the patient's name, time of appointment, type of visit, compression bandaging, negative pressure wound treatment dressing, ambulatory status, and any other significant issues which would help assist in planning for patient care. These flow sheets also provide key patient acuity information which alerts when additional staffing may be required to deliver safe, quality patient care. The patient inquiry form is used during the initial patient phone call to gather necessary information that is used to schedule appointments more efficiently. They are reviewed weekly and triage new patients appropriately to the Port Jefferson Wound Treatment Center's surgical/podiatry staff. All appointments for new patients and follow-up visits are scheduled fifteen minutes apart to allow appropriate time for the nurses to prepare the patients prior to the physician seeing the patient. Double booking was limited to two spots for specific requesting physicians, triple booking appointments were eliminated completely, and Press Ganey Scores improved for the question "wait time for tests or treatments."





## 2 SOUTH SERENITY ROOM

On May 31, 2016 was the grand opening for the 2 South serenity room. The room was designed by the clinical nurses and nurse management team of 2 South to offer a quiet location to decompress after a stressful event. The relaxing space has assisted staff, patients and patient families during stressful times. It is a calming and relaxing atmosphere which includes aromatherapy, dimmed lighted and comfortable seating. This space was approved by the President of the hospital Mr. Kenneth Roberts to prioritize staff needs related to compassion fatigue, Figley (2002) defined compassion fatigue as “the emotional effect of being indirectly traumatized by helping those who experienced primary traumatic stress”. The organization supports the difficult work clinical nurses complete in efforts to achieve positive patient outcomes.



## IMPLEMENTATION OF A COMFORT ROOM IN THE ADOLESCENT PSYCHIATRIC UNIT

Martha E. Rogers ScD, RN, FAAN stated that the purpose of nursing is to “foster the well-being of humans in our care wherever they are” (1982). It is in this spirit that clinical nurses within the psychiatric interprofessional treatment team implemented a “comfort room” within the adolescent psychiatric unit at John T. Mather Memorial Hospital (JTMMH).

Clinical nurses at Mather Hospital are empowered to initiate autonomous evidence- based interventions to improve the quality of care for their patients. The nurses in the adolescent psychiatric unit are dedicated to the notion, adapted by the New York State Office of Mental Health, to evolve from a focus of negative consequences to one of recovery and hope for their patients. Clinical nurses conducted a literature review on the benefits of “comfort rooms” for the inpatient adolescent psychiatric patient. The review of the literature identified “comfort rooms” as a best practice designed to assist patients in calming the senses by providing a sanctuary in psychiatric facilities. The ultimate goal is to provide patients with an opportunity to develop coping skills that they can continue to use post-hospitalization during the experience of psychosocial stressors and psychiatric symptoms. Studies have demonstrated that “comfort rooms” contribute to higher consumer satisfaction and lower rates of seclusion and restraint. (Cummings and Grandfield). Since a “comfort room” had not been built into the budget there was discussion at the interprofessional unit-based council regarding methods that could be used to gain funding for this project. Jill Snelders, MBS, CTRS, Assistant Director of Rehabilitation services suggested a grant be explored. An application was submitted and \$4,044.00 grant was from the Starlight Foundation to create the “Comfort Room.”

Once the grant was received the design and development of the room began. Clinical nurses Linda Hill, MSN, RN, PMHCNS-BC and Lisa Iuliucci, ADN, RN-BC were active participants through the unit-based council. They spent time searching the literature for best practices regarding the actual physical space and elements that should be included in the room. Traditionally “comfort rooms” feature homelike décor and a multisensory environment intended to assist patients in de-escalating emotional distress.

Planning took place on the physical space purchase orders for supplies and construction were acquired and the room were completed. Linda recognized the importance of obtaining patient input as well. As this was a practice new to the organization she worked with the patients and created a list of “comfort room” responsibilities. The patients provided feedback and compiled a list of positive coping skills and affirmations to share with future patients using the “comfort room”.

# PROFESSIONAL ORGANIZATIONS/ NURSING CERTIFICATIONS

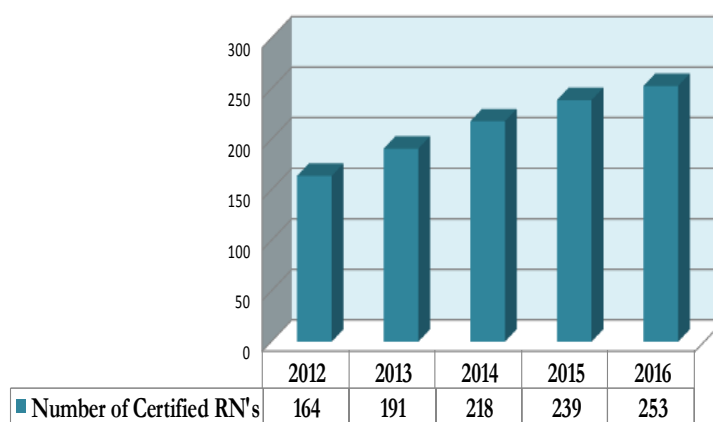
## Offices held in Professional Organizations by Mather Nursing Staff

Employee	Department/Position	Offices Held
Maureen Altieri, MSN, RN, NEA-BC	Director of Service Excellence and Magnet	New York State/Vermont Magnet Hospital Consortium Chairperson 2016-present
Maureen M. Chernosky, RN, MSN, CCRN, CEN, ACNS-BC	Nursing Professional Development/ Clinical Instructor	Emergency Nurses Association-Suffolk County Chapter- Education Chair 2014-2018 New York State Council Treasurer 2017-2019
Mary Ferrara, BSN, RN, ONC/ONS	IV coordinator	Oncology Nursing Society Suffolk County Chapter Vice President 2014-present
Marina Grennen, MSN, RN	Nursing Professional Development/ Clinical Instructor	CEN/Co-Chair Behavioral Health Committee New York State Emergency Nurses Association Board Member at Suffolk Emergency Nurses Association.
Theresa Grimes, PhD, RN-BC, FNP-BC, CCRN	Nursing Administration/ Associate Vice President for Nursing	Awards and recognition committee and research committee of ASPMN. Writing a chapter for the new edition of the Core Curriculum for Pain Management Nursing and have been a reviewer for the new Scope and Standards for Pain Management Nursing for ASPMN; National Quality Forum Incubator task force for Acute Pain Management in the perioperative setting.
Joanne Lauten, MSN, RN, CPHQ, SCRNI	Nursing Quality Director and Stroke Coordinator	Greater NY Stroke Coordinators Consortium (GNYCCC) President
Julia Macauley, MSN, RN, CCRN, WCC	Critical Care/Director	Board Member of Suffolk County American Association of Critical Care Nurses (AACN)
Lilly Matthew, PhD, RN	Nursing Administration/Nurse Statistician/Nurse Researcher	Mentor position at the National Association of Hispanic Nurses (NAHN) NY Region
Marie Mulligan, PhD, RN, CNOR, NEA-BC	Nursing Administration/ CNO VP for Nursing	GNYNONE President
Marie O'Brien, MSN, RN-BC, ANP-C, CCRN	Pain Management Coordinator	ASPMN National Awards and Recognition Committee 2016 and 2017 Master Faculty 2016 and 2017 ASPMN LI – Treasurer elect 2017
Faustina (Tina) Stoebe, MSN, CPAN	Nursing Professional Development/ Clinical Instructor	President for NYSPAN District One ( Nassau/Suffolk ) Board Member NYSPAN

## NURSING CERTIFICATIONS

According to the ANCC, "Certification is the process by which a nongovernmental agency or an association grants recognition to an individual who has met certain predetermined qualifications. Certification can be used for entry into practice, validation of competence, recognition of excellence, and/or for regulation. It can be mandatory or voluntary. Certification validates an individual's knowledge and skills in a defined role and clinical area of practice, based on predetermined standards". Nationally 20% of nurses are certified in their specialty. Here at Mather **46%** of our clinical nurses and **70%** of our nurse leaders are currently certified in a specialty, and the number has grown every year for the last 5 years. Some of the certifications are; Critical Care, Emergency RN's, Medical Surgical RN's, Nursing Professional Development, Psychiatric Mental Health, Nurse Executive, Wound Care, Family Nurse Practitioner, Post-Anesthesia, and Oncology. We have renewed our contract with the ANCC for the *Success Pays* program which assists nurses to become certified at a discounted rate. The nurses are also given the opportunity to participate in a variety of review classes through a certification grant, classes include; critical care, medical/surgical, emergency nurses, psychiatric mental health, oncology and orthopedics.

John T. Mather Memorial Hospital  
Number of Certified Registered Nurses





# CERTIFIED REGISTERED NURSES

Lori Accetta CCRN  
 Junielon Sabas Adame WCC  
 Kathleen Adams CDN  
 Patricia Alban CEN, PCCN  
 Maureen Altieri NEA-BC  
 Lisa Ambrose CPAN, CCRN, NP-C  
 Marret Ida Anderson, NP-C  
 Catherine Andolena ONC  
 Catherine Audus AGPCNP-BC  
 Deborah Aureliano WCC  
 Franco Baingan ONC  
 Christina Baker CCRN  
 Melissa Baranowski CGRN  
 Michael Anthony Barletta RN-BC  
 Virginia Barrington WCC  
 Tara Bauer CEN  
 Elizabeth Becker RN-BC  
 Laura Jeanne Bell NP-C  
 Gertha Benoit-Hollis RN-BC  
 Jacquelyn Berkman RN-BC  
 Jessica Berkman RN-BC  
 Rushelle Oshea Bernett RN-BC  
 Catherine Bertuch PCCN  
 Kathleen Susan Biase RN-BC  
 Donna Blaskopf CRN  
 Denise Bonneville RN-BC  
 Donna Bragg CRN  
 Anna Marie Braslow CCRN  
 Catherine Breitenbach RN-BC\*  
 Jeanne Brennan RN-BC  
 Emily Brinkworth CCRN  
 Christine Brons CAPA  
 Sandra Brown RN-BC  
 Deborah Buganza-Estapa CEN  
 Filomena Buncke PMHCNS-BC  
 Kimberly Buncke PMHNP-BC  
 Indrani Burmanroy OCN  
 Michelle Joan Byrne NP-C  
 Alisa Maria Caliendo NP-C  
 Trisha Calvarese CAPA  
 Glenda Calwag RN-BC  
 Elise Carbonette CNOR  
 Dana Cardiello RN-BC  
 Maria Cassara CMSRN  
 Irene Cassata CPAN  
 Renee Castelli RN-BC  
 Maureen Cataldo PMHCNS-BC  
 Maureen Chernosky CEN, CCRN  
 Nancy Clavin OCN  
 Kristen Clifford CRN  
 Margaret Coffey FNP-BC  
 Kelly Coleman CNOR  
 Donna Collins CPAN, CRN  
 Teresa Collins RN-BC  
 Scott David Colton RN-BC  
 Jennifer Ann Colucci RN-BC  
 Elizabeth Conneally CGRN  
 Elizabeth Contri RN-BC, ACM-RN  
 Victoria Cook PMHCNS-BC  
 Patricia Karlya Cordle RN-BC  
 LoriAnn Crispino CEN  
 Cassandra Cucuzzo RN-BC  
 Maria Antonia Cuisson WCC  
 Rose Cummings CPAN  
 Richard Daly NP-BC  
 Patricia Danowski RN-BC  
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 Marsha Deckman NE-BC, ONC  
 Joyce DeMoore RN-BC  
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 Laureen Anne Diot NP-C, WCC  
 Jennifer Dixon CCRN  
 Patricia Dodd NP-C, RN-BC  
 Lisa Doumas CCRN, PCCN  
 Denise Driscoll PMHCNS-BC, CARN, RN-BC  
 Lisa Dubrow ANP-BC  
 Sarah Joann Dunahay CRRN  
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 Christa Dwyer RAC-CT  
 Ellen Dwyer CEN  
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 Mary Ferrara OCN  
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 Elaine Fox RAC-CT  
 Sandra Helene Galantino RN-BC  
 Nicole Helen Geiss RN-BC  
 Carolyn Germaine OCN  
 Nina Gervais CCRN  
 Elizabeth Giordano CCRN  
 Cameron Gittens CEN, CRN  
 Dina Giulietti CEN  
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 Shirlee McKenna CAPA  
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 Christi McManus CCRN  
 Pauline Meek RN-BC  
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 Tabitha Spinelli WCC  
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 Darlene Steigman RN-BC  
 Renata Sterne NP-C  
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 Mary Sundquist CHRN  
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\* Reflects more than one ANCC certification





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