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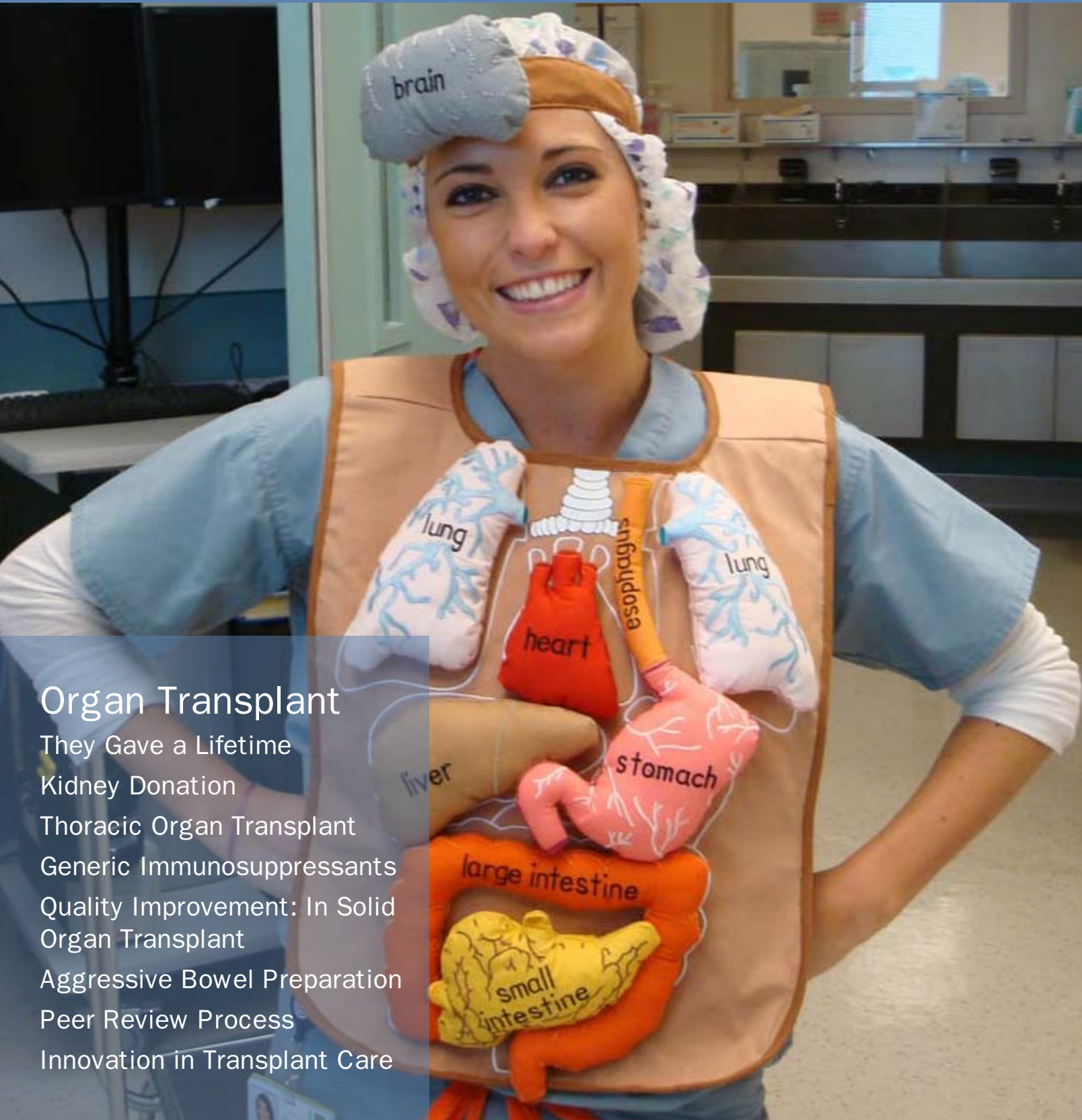
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Peer reviewed



Organ Transplant

They Gave a Lifetime

Kidney Donation

Thoracic Organ Transplant

Generic Immunosuppressants

Quality Improvement: In Solid
Organ Transplant

Aggressive Bowel Preparation

Peer Review Process

Innovation in Transplant Care



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1. Quality of Nursing Leadership
2. Organizational Structure
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From the Nursing Shared Governance Council

Magnet committee membership is a great way to become personally involved in the Magnet journey and to help shape the future of nursing at UCSD. For more information go to our nursing website at <http://medinfo.ucsd.edu/nursing/committees/> to learn about committee membership opportunities.



Message from the The Chief Nursing Officer

Our third issue of the UCSD Journal of Nursing brings much celebration for our Transplant Team. UC San Diego Medical Center is proudly celebrating its 40th anniversary of the Kidney Transplant program and the 20th anniversary of the Heart and Lung Transplant program. Along with this celebration we recognize and honor the many transplant patients, donors and staff. In addition to having our transplant program running for 40 years we were also the first hospital in San Diego County to perform "Good Samaritan" donor transplants and even more recently we

completed a successful paired donation transplant, another first for our county.

I congratulate the entire Transplant Team for the continued improvement of the transplant process. I am grateful for the patients and donors who entrust their lives in the care of our staff. These patients are often here for an extended period of time and they rely on our team to be more than just their "caregiver" but more like a friend or family member. The quantity of drugs these patients have to take is overwhelming and daunting. Knowing that thousands of people die each year as a result of medication error our talented staff adapted the MedActionPlan. This is a great example of how multiple disciplines work together to make sure the patient is receiving the correct medication, the correct dosage, understanding when and why to take it, therefore making a more educated patient.

I continue to be amazed by the talented staff we have at UC San Diego Medical Center and by reading the following articles you will be too. Our Lifesharing department continuously pushes the envelope to find new ways to make donors available for our growing transplant list, the Transplant Nurse Coordinators work tirelessly making sure those transplants actually happen, transplant pharmacists handle the complicated medication regimen of these patients, and our physicians constantly make new strides. Looking back 50 years at the history of transplants it is obvious we are moving in the right direction and will continue to be a pioneer in this field.

The following articles include many touching stories and valuable information about what our Transplant nurses do on a day to day basis. I am privileged to be a part of this team and proud to share in the achievements of our nurses as they touch the lives of our patients.

Sincerely,

Margarita Baggett RN MSN
CHIEF NURSING OFFICE

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On the front cover:

Thalisa Van Rensburg, Lifesharing Tissue Coordinator, graphically demonstrating options for organ donation. The photograph was taken in the UCSD operating room on "Bring Your Kids to Work Day."



Solid Organ Transplant at UC San Diego

Alexander Aussi, BSN, RN, MBA
Transplant Administrator



As the Administrator for the Organ Transplant Service Line at the University of California, San Diego Medical Center, and I am especially pleased to provide an introduction for this edition of the UC San Diego Journal of Nursing. The programs that make up the UC San Diego - Center for Transplantation have provided more than forty years of service to the community. Since 1968, our teams have performed 2,500 kidney, pancreas, liver, heart and lung transplant procedures, as well as cardiac assist device placements. These numbers include all of the "First" solid organ transplants performed south of Los Angeles. The UC San Diego - Center for Transplantation currently operates programs at both Medical Center Campuses, North and City Center, using state of the art technologies, as well as upgraded physical inpatient and outpatient facilities. But more important than technologies and facilities is the knowledge that patients referred to the UC San Diego - Center for Transplantation are cared for by an interdisciplinary team of skilled transplant professionals. Our Transplant teams offer world-renowned surgeons, dedicated transplant physicians and nurses, as well as specialists in all pertinent areas of patient care, such as Infectious Diseases, Psychiatry, Pharmacy, Radiology, Social



Work, Nutrition, and Physical and Occupational therapy, to name a few. As part of our research mission as an academic institution, the UC San Diego Center for Transplantation sponsors active investigation into the biology of organ rejection, organ

preservation, and management of long term medical problems of transplant patients. There are a number of clinical trials available for patient participation.

This journal features multiple examples of the specialized contributions of our nursing transplant professionals at UC San Diego Medical Center.. Our nurses, along with the clinical transplant and procurement coordinators, play a crucial role in the coordination and delivery of all aspects of transplant patient care. We take great pride in celebrating their contributions to the ongoing development of our programs and to the wellbeing of our patients.

Alexander Aussi RN, BSN, MBA has spent 16 of his 19 years in healthcare in the field of organ transplantation. His experience includes transplant administration, new transplant program setup, marketing, managed care relations, contract management and management of multi-organ transplant Medicare Acquisition Cost Centers. He completed his BSN in 1990 at the American University of Beirut, receiving nursing board certification from the University of the State of New York, Albany, in 1994. He received his MBA, graduating with high honors, from Oklahoma City University in December 1995. After serving as operational coordinator of the Oklahoma Transplant Institute from 1993-1995 and becoming one of the founding directors of the CHRISTUS Transplant Institute at CHRISTUS Healthcare in San Antonio, Texas (1999-2006) .Alexander came to UCSD as service line administrator for Organ Transplantation in January 2006.



In Their Last Hour They Gave a Lifetime

Lisa Stocks, RN, MSN, FNP



An organ procurement organization (OPO) is the final link at the end of a person's life and first link in the process of saving the life of someone waiting on the organ transplant list. As the federally designated organ procurement agency for San Diego and Imperial counties and one of only 58 OPOs in the United States, Lifesharing has a mission - to coordinate the recovery of organs for transplant, to provide support for the donor's family, and to find recipients for the donated organs. Staff members at Lifesharing play a vital role in the complex process of providing lifesaving organs to needy recipients, but they also guide hospital staff through the process of ensuring that every family has the opportunity to have a living memorial of their lost loved one through organ and tissue donation.

Six years ago, Lifesharing began a journey of performance improvement. We knew that we could save more lives if we had more organs for transplant. We started by assessing past performance with the goal of increasing the numbers of available organs. We implemented procedures to increase hospital awareness of the donation process so that we would receive notification of

potential donors. We also ensured that our nurses could respond to every hospital in San Diego County within 2 hours of initial notification. We worked with the staff at our donor hospitals to ensure that every family was given the opportunity to donate. We then went on to offer out all acceptable organs for transplant. We have been very successful, increased organ donation dramatically and in 2009 are projected to facilitate more transplants than ever. By providing extensive support to the local hospitals, we have become one of the highest functioning OPOs in the United States. While the average consent rate in the U.S. is 65%, Lifesharing has an 86% consent rate and overall donation rates exceeding 80%. This is just the beginning as we strive to maintain or exceed our prior successes.

Who can become a donor? An organ donor can be anyone up to 80 years of age or younger who has sustained a brain injury which they cannot survive. Once brain death has been declared by two physicians, a Lifesharing family services staff member and a nurse coordinator will approach the family



Lisa Stocks, Executive Director
Lifesharing: A Donate Life Organization

to obtain consent for transplant of the organs. Once consent has been obtained, the clinical staff take over medical management of the patient in order to maximize function of all the organs. They implement specialized physiologic management techniques to improve lung and heart function,



Lifesharing team meeting

By Sharon Ross
Lifesharing Community Outreach Manager

Lifesharing's staff embraces a very challenging, very rewarding role – a delicate balance of supporting donor families while also representing people on the national organ waiting list. At 86%, Lifesharing's consent rate is one of the highest in the nation because team members understand donation not only saves lives, but helps their donor families heal.



One such bittersweet day involved the death of a young son and the potential lifetime salvaged for another son. Seventeen-year-old Sam McCrow was vacationing in San Diego with his family. As the avid surfer stepped out of the water, he collapsed. Despite every effort to save his life at UCSD Medical Center, the Vancouver high school student died from a brain aneurysm.

Sam



Stunned by their loss, his family did something heroic. In the midst of their tragedy, they said yes to donation. The day Sam McCrow lost his life, he saved four lives, including 3-year-old Xavier McLeod - a little boy who had been waiting for a kidney since he was 18 months old.

Separated by 1000 miles, Lifesharing helped the two families meet by phone on the first anniversary of Sam's death. The day Xavier now celebrates as his 're-birthday.' The day he received his precious second chance at life.

Today Sam's and Xavier's moms are Facebook friends. They exchange stories, laugh together and sometimes cry together. And they share pictures like Xavier's first day at kindergarten

with his brand new Spiderman backpack. It was a day his family thought might never happen. No dialysis. No special diets. No pain nor fear. All thanks to Xavier's hero Sam.

Xavier

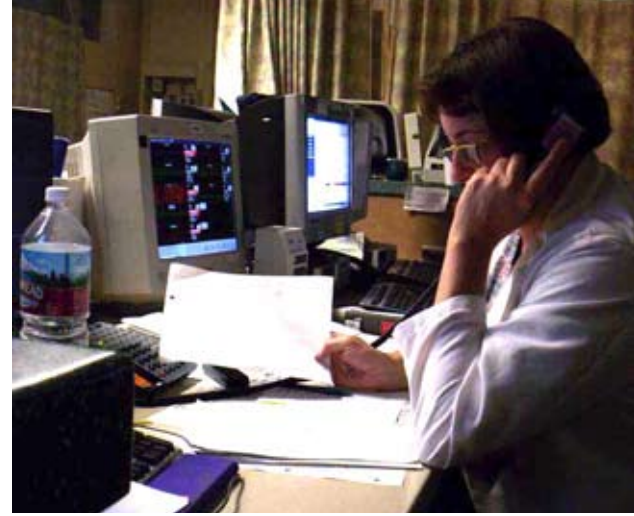
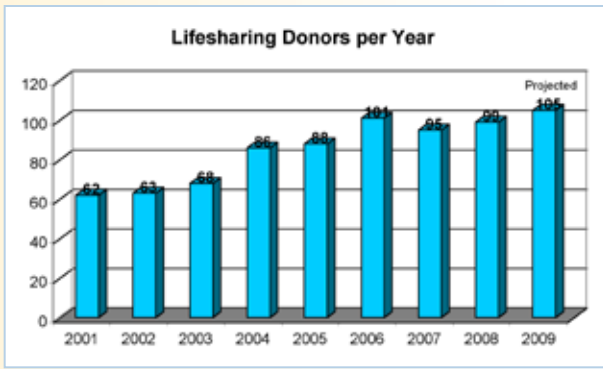
Photos from top to bottom: Donor coordinator Becky Dodd-Sullivan; donor mom Jasmine McCrow and recipient mom Valerie James who met recently at Lifesharing's Symphony of Life, an annual symposium for healthcare professionals; Jasmine hugs Lifesharing Surgical Coordinator Billy Snyder, who coordinated Sam's recovery. Like her son, Billy also is a surfer.



improve urine output and electrolyte levels, in an attempt to prepare all organs for transplant. Organ procurement coordinators are highly trained specialists who understand that the long hours they spend in optimizing organ function will result in lives saved when the organs are transplanted.

An important part of the process is to match the donor with potential recipients based on blood type, size, severity of illness, and geographic proximity. Organs from a given donor may be designated for multiple transplant centers. Procuring surgeons from each center accepting an organ arrive at the donor hospital in preparation for organ recovery. In the

donor operating suite the Lifesharing surgical coordinators manage the organ recovery to ensure that all possible organs are taken and packaged appropriately for transport. They also ensure that the organs arrive quickly and safely at their final destinations. This process can take up to three days! A successful transplant is an important goal, but the Lifesharing staff also feel a deep responsibility to the donor families. Donor families are provided with a two year follow up program of letters, support, gatherings, and activities designed to acknowledge their grieving, as well as their generous gift. Additionally, Lifesharing brings donor families and transplant recipients together to participate



Sandy Leyden working up a donor for transplant.

in community awareness programs throughout the year. They visit schools, churches, and hospitals and other community venues to share their stories. These programs have been successful in increasing the number of people who say “yes” to donation.

All members of the Lifesharing staff are proud to honor our donor families, and their loved ones – the donors themselves - for their gift of organ donation. Each story is heart breaking because it involves the tragic loss of a beloved family member or friend. These stories, and the people

who tell them, reach the hearts of the Lifesharing staff. The coordinators, family service specialists, and surgical staff give, not only of their time and energy, but a piece of themselves as they pursue organs for transplant. They, along with the donor families, have the satisfaction of knowing that they have given someone the blessing of renewed health and a chance for a longer life. As for the donors, we will never forget that

In their last hour they gave a lifetime.



Transplant patients held a bake sale to raise money for the Transplant Olympics.

The Changing Face of Kidney Donation

By Tina J Kress, RN, BSN, CCTC
Living Donor Transplant Coordinator

UC San Diego Medical Center recently celebrated the 40th anniversary of the opening of its kidney transplant program. We are proud to have been instrumental in providing transplants to needy kidney recipients since 1968. Ours was the first transplant program in San Diego and still remains the largest in the city. To this date, over 2,500 kidney transplants have been performed at UC San Diego, making us one of the largest and oldest kidney transplant programs in the country. I started with UCSD in 1981 and have been a part of a transplant team that I am very proud of. I have witnessed significant changes in the field of transplantation and UCSD has always been at the forefront of this innovation. Unfortunately, the dire shortage of donor organs for transplant still prevents us from helping an even greater number of kidney recipients.

According to the United Network for Organ Sharing, there are over 80,000 patients in the United States currently waiting for a kidney transplant. In 2008, there were only 16,518 kidney

transplants performed in the entire country. This number included both deceased and living donor transplants. Sadly, this has led to long waiting times for patients on the UNOS waiting list. Some patients are unable to survive long enough to wait for a cadaver donor. Even though dialysis can temporize the disease and prolong the patient's life, it is not without hazards and difficulties. Knowing that the donor shortage is what limits us, the UCSD kidney transplant team has put greater effort into increasing the number of living donor transplants in order to increase the number of patients being transplanted and decrease the size of the waiting list. I have witnessed first hand the efforts put forth by this institution to successfully promote living donation.

When I started with this program in 1981, the criteria for accepting individuals for kidney donation was very different. Donors at this time were always under the age of 50. Only blood relatives were accepted for donation and were limited to the immediate family. They were aggressively screened for any



Tina Kress RN, BSN, CCTC has been a nurse since 1975. She has over 25 years of experience in organ donation and transplantation working as a procurement and clinical coordinator and as the Manager of Recovery Systems. She currently holds the position of Living Donor Transplant Coordinator and is responsible for coordinating all of the living donor transplants performed at UCSD Medical Center.

medical history or current condition that might have even remotely affected their kidney function in the future. The surgery for a living donor was much more invasive. The kidney was removed using an open flank procedure, requiring a long hospitalization and a long and painful recovery time. Many things have changed over the years to increase the number of living donors.

As time went on, a biological relationship with the transplant recipient was no longer required in order to be considered as a candidate for donation.





On August 19, 2009 Patti Ford of San Carlos, who had been on the national kidney waiting list and on dialysis for four years, received a kidney from Robyn Bryan of Escondido. Ford's husband, Patrick, gave one of his kidneys to Bryan's husband, Paul, who had been waiting for six months and was weeks away from needing to start dialysis. Both Patti and Paul wanted to donate to their sick spouses, but unfortunately their blood types were not compatible. Living donor coordinator Tina Kress realized that although the Bryants were not compatible with each other, they matched perfectly with the Fords. The UC San Diego transplant team facilitated the paired exchange to ensure that the transplanted organs were likely to be accepted by the recipients. Such donor and recipient couple transplants are becoming more common as regional kidney networks look for creative ways to match donor and recipient pairs and to decrease the long waiting period for kidney transplant recipients.

Initially we determined that donors with an emotional bond with the recipient could also be considered. Over time we learned that the success rates for these types of non-related living donor transplants are equal to those of living related donors. Today, many of our transplants are from spouses, friends, co-workers, and acquaintances. But we did not stop there. In February 2003, UCSD Medical Center performed the first two "Good Samaritan" donor transplants in San Diego history. These individuals graciously donated one of their kidneys to recipients they had never met and who were waiting on the UNOS waiting list. We continue to get offers from kind individuals willing to give of themselves so another person's quality of life will be enriched.

To further promote living donation and make it more appealing to potential candidates, our center continues to re-evaluate our procedures and make appropriate changes. Starting in 1999 the laparoscopic procedure

was introduced at UCSD. While some transplant programs still use the open flank procedure on some or all of their donors, our program begins all donor surgeries with the laparoscope and converts to the open flank only if problems occur during the surgery. This has only been necessary one time in the past 4 years. This new procedure allows our donors a faster recovery time, results in less discomfort and makes potential donors more likely to go forward. Over the years our acceptance criteria has also changed, allowing the older person and the potential donor with mild hypertension to go forward if their kidney function is good. These individuals are counseled regarding any additional risk to themselves and are given ample opportunity to reconsider their decision to donate.

Development of the technology era brought computer sites dedicated to linking individuals needing transplants with those willing to donate. A careful and diligent screening is done on

all potential internet donors at our institution. Potential donors are required to come to San Diego for a full workup prior to the transplant to insure that they are an appropriate candidate. Careful effort is made to ensure that they are not pressured into donating or motivated by financial considerations.

There are also internet sites devoted to 'Paired Kidney Donation'. 'Paired Kidney Donation' is an option for patients awaiting kidney transplantation who have friends or family who are willing to donate a kidney, but who are unsuitable because their blood or genetic markers are not compatible with those of the patient. With a paired kidney transplant, two incompatible donor recipient pairs exchange kidneys, making two living donor transplants possible. In August of this year the first paired donation transplant in San Diego took place at UCSD Medical Center. Two recipients received living donor transplants as a result of this exchange.

At UCSD Medical Center we recognize the importance of the living donor. We have a dedicated living donor team who insures that donor needs are met and that they are treated with 'TLC'. All donors are given a 'hero' medal, letting them know how special they are to us. Hopefully, by aggressively pursuing all living and deceased donors we can eliminate the waiting list for transplants and offer all potential recipients 'The Gift of Life'.

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Thoracic Organ Transplant at UC San Diego A Twenty Year Journey

By Stephanie Osborne, RN, BSN, CCTC
Heart and Lung Transplant Coordinator

In January of 1978 Dr. Stuart Jamieson arrived in the United States from England, where he had been actively involved in transplant research. He came to work with Dr. Norman Shumway at Stanford University. Over the following 6 years Dr. Shumway's team became a leader in the development of surgical techniques and post transplant management of human heart and lung transplantation. The Stanford team performed its first human heart transplant using cyclosporine in December 1980. For technical reasons this patient received a heterotopic transplant where the donor heart was "piggybacked" on to the native heart, the only transplant of this kind ever performed at Stanford. The patient survived with his new heart for 30 years. The first heart-lung block transplant, also using cyclosporine, was performed at Stanford in March of 1981. The patient survived and did well. In addition to developing surgical techniques and immunosuppression protocols, the Stanford team pioneered early preservation solutions for organ allografts, as well as new diagnostic criteria and techniques for diagnosing lung transplant rejection.

In 1986, Dr. Jamieson became the Chief of Cardiothoracic Surgery at the University of Minnesota. He continued to perform and to perfect heart and heart-lung transplantation procedures. It was during this time that his team adopted the sequential double lung transplant technique pioneered by Dr. Joel Cooper, using a clamshell incision.

Solid organ transplant is a phenomenon of the last half of the twentieth century. A long development process was required before surgical techniques, instruments and equipment, and immunosuppressant medications allowed for transplant to become anything more than an experiment.

Transplant Timeline:

1954: First successful transplant performed by Dr. Joseph Murray – a kidney transplant between identical twins (no immunosuppression was necessary in genetically identical individuals).

1963: First successful deceased donor lung transplant by Dr. James Hardy in Jackson, Mississippi – demonstrated that the surgery could be performed and that lung function could resume after transplant, but the patient survived only 18 days and died of renal failure.

1964: Dr. James Hardy attempted the first human heart transplant - early rejection led to retransplant of a chimpanzee heart, which also failed quickly.

1967: First successful human heart transplant performed by Dr. Christiaan Barnard in Capetown, South Africa – patient survived for 18 days.

1968-1969: Over 100 heart transplants performed – nearly all patients died within 60 days.

1972: Discovery of immunosuppressive effects of cyclosporine.

1979: First use of cyclosporine in a transplant recipient.

1983: FDA approval of cyclosporine as an immunosuppressive agent.

By 1984 2/3 of all heart transplant recipients survived for 5 years or more.



The surgery has been modified further in the last few years. Whenever possible, sequential double lung transplants at UC San Diego are being performed through bilateral small thoracotomies, avoiding the transection of the sternum, and leading to a faster patient recovery.

In the late 1980s UC San Diego was growing, both in size and in reputation. It was felt that an in-house cardiothoracic surgery division, which would offer heart and lung transplantation, along with the expansion of the pulmonary thromboarterectomy program, was needed. Dr. Jamieson was recruited as head of this new division, which came into being on July 1, 1989. He knew that for a transplant program to be successful it was necessary to establish a structure that would permit adequate assessment of candidates, management of patients pre-transplant so that they would be optimized for the surgery, an excellent team of surgeons, physicians, skilled pharmacy support, and social work support, with a highly educated, experienced team of nurses to provide coordination of the process, as well as education and support to patients and staff alike. Two experienced nurses came with the Minnesota group to San Diego and they were instrumental in developing the program as it evolved. At UC San Diego, heart and lung transplant nurse coordinators are among the earliest contacts the patients have with the transplant program. They are the ones who interpret the process to the patient and family, from evaluation through testing and listing, during the period of time the patients are on the waitlist, through the transplant process and hospitalization, and afterward, both in clinic and as the first contact if the patient has a problem or concern. They provide education for the patients and families at every step of the transplant process. Transplant nurse coordinators also receive the donor offers and present the pertinent information, present it to the surgeon who makes the decision if the organ is acceptable for a given patient. They also coordinate the process of recovery of

organs from calling the patient, booking the OR, getting orders into the system, and arranging for transportation to the donor hospital. During the first 15 years of the program's existence the coordinators also accompanied the procurement team to provide perfusion for the organs in the donor OR and delivered the organs back to the OR at UC San Diego for transplantation.

Transplant coordination was (and is) a big job! It challenges intellectually, educationally, functionally, physically (those long hours!), and emotionally. That is why we love it! Heart and lung transplant patients, by definition, have endstage disease. They have no options for improving their health or quality of life other than transplant. But transplant is not a "sure thing." The entire process is full of uncertainty for the patients. Those who choose to take the risk, to follow through with the biggest surgery you can have, to swallow all those pills and change their life patterns to allow for transplant considerations, knowing that there is great risk and no guarantees, are among the most courageous people you will ever meet.

Every transplant nurse coordinator has stories that chronicle the interpersonal rewards of the job. But, there are other rewards, as well. As a discipline, transplant has the added bonus of being at "the edge of the envelope." There is so much to know, so much to learn. The field is evolving every day and it is a challenge to keep up with new information and innovations. Nurse coordinators can develop areas of interest in transplant and pursue them with clinical research, either independently or with other team members. They can become clinical educators in the hospital setting for patients and for staff and also participate in community education and outreach.

March 2010 will mark the 20th anniversary of the first thoracic organ transplant at UC San Diego. There is much to celebrate: 180 heart transplants, 197 single lung transplants, 146 double lung transplants and 19 heart lung transplants, to date. But we are not resting on our laurels. We are listing



Stephanie Osborne received her BSN from the University of Connecticut in 1973. She has had experience in both outpatient nursing (in the community, as well as hospital clinics) and inpatient nursing (medical ward, medical and surgical intensive care, cardiac intensive care and stepdown, dialysis and emergency department), in clinical research and in clinical education. She came to UC San Diego as a Heart and Lung transplant coordinator in August of 1996, and achieved certification as a clinical transplant coordinator in February 2006. In April Stephanie was recognized as the UC San Diego 2009 Nurse of the Year.

patients daily and remain ready to add to these numbers. Our success rate has been excellent and we continue to meet or exceed our expected outcomes, as noted in the United Network for Organ Sharing (UNOS) database. The most important successes, however, are individual ones, as expressed by our patients.

20 YEARS!

(Katherine) Renee Bora became the first transplant patient at the new UC San Diego program, receiving a heart lung transplant on March 13, 1990. For Renee it was a leap of faith – in herself and her transplant team. She was 34 years old and had a job she loved as a labor and delivery nurse.



Renee first noticed symptoms when she became short of breath while scuba diving in Hawaii . After the dive she started wheezing. She was treated for asthma, but the only effect she noted was an increase in heart rate. Over the next months Renee continued to have respiratory compromise, but it was not until she was “breaking the bed” for a delivery and suffered a syncopal episode that she began to suspect that her problem might be more serious. When she recovered consciousness, she was cyanotic and had an oxygen saturation of 78%. She finally saw a cardiologist who performed an angiogram. He discovered that she had developed a large patent foramen ovale, due to right ventricular overload, and made the diagnosis of primary pulmonary hypertension (now referred to as idiopathic pulmonary arterial hypertension). IPAH is a disease characterized by elevated pulmonary artery pressure, which over time, leads to right ventricular hypertrophy and eventual failure. (1) Histologically patients with PAH demonstrate a proliferative vasculopathy in the lungs, which is characterized by vasoconstriction, cell proliferation, fibrosis and often thrombosis. (2, 3) The

cause, in Renee’s case, was not known . In 1990, there was no real treatment for the disease. Her cardiologist referred her to UC San Diego for consideration for transplant. She was evaluated and found to be a good candidate. Since she had significant heart damage, as well as PAH, the decision was made for her to receive both heart and lung allografts. Renee was listed for transplant on New Year’s Day in 1990 and waited 3 months for organs to become available.

Renee is a very positive person and says that she is blessed to have had such a great life. She has had many complications through the years related to transplant medication side effects, but when you ask her about her problems, she says “Oh, but everybody has those!”

Her husband, Brian, has been with her for the entire transplant journey. When they talked about how they felt as they waited for the call, they mentioned the contributions of both nurse coordinators. There was no support group for them – she was the first patient. They stated categorically that Becky and Anne were the best support group anyone could have had. They also mentioned that every single nurse in the ICU was wonderful, as were the transplant social worker, the transplant pulmonologist and the surgeons. Renee says she accepted that she had no other choice if she wanted to live. So she stepped out into the unknown, with confidence and faith that the entire UC San Diego transplant team cared about her and would be with her every step of the way. She has continued to receive her care at UC San Diego for the entire 20 years – what could be a better endorsement?! And, although many of the team members have changed, Renee continues to be an inspiration to those who have followed. Happy 20th transplant birthday, Renee! And also to the UC San Diego thoracic transplant program!

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Generic Immunosuppressants

By David Lewino RN, CCTC, CPTC

Generic formulations of brand name drugs have been approved by the FDA for over 20 years (1). In fact, generic drugs account for most of the pills currently dispensed in United States pharmacies. Use of these alternatives saved American consumers \$121 billion dollars last year alone, according to the Generic Pharmaceutical Association. Many insurance companies now offer coverage only on generic medications, as a cost conserving measure.

Immunosuppressant medications are extremely costly. Because they are essential for the preservation of allografts in transplant patients, the introduction of generics, though a welcome relief from the cost burden, was of great concern. The first major immunosuppressant to become generic was cyclosporine in May, 2000. At that time there were differing opinions on the significance of this release. Within a matter of weeks several versions of cyclosporine were available: for example, Eon, Pliva and Gengraf to name a few. The competition amongst the manufacturers was vigorous. A pharmacy might offer one brand one week, only to get a better price from a different manufacturer the next week and switch brands accordingly. There were stories of patients being given different strengths from different manufacturers in a single prescription. Though generic drugs need, by definition, to be bioequivalent to the brand name drug, they can still differ in shape and color. Tablets may have different scoring configurations. They

may also have different expiration dates. It was a confusing time for patients and health care providers alike. The recent release of a generic tacrolimus (Prograf), as well as seven different versions of mycophenelate mofetil (CellCept), brings back memories of the confusion experienced in the first round with cyclosporine. It is likely to keep transplant physicians, pharmacists and nurses busy, as they attempt to ensure that their patients stay healthy.

As we start down this road again it may be helpful to look back on what we have learned from the cyclosporine experience. Although use of generic medications is well established and plays a crucial role in keeping health care costs down, medical professionals still have concerns about their use in some patient populations, including transplant recipients.(2-5) We know that transplant medications are critical to ensuring that the patients maintain their allografts. We also know that there is a narrow range between toxicity and under dosing of these medications. Concerns remain about how the FDA (Food and Drug Administration) currently defines bioequivalence and whether these requirements are appropriate for the approval of generic formulations of Narrow Therapeutic Index (NTI) or critical dose drugs (2). Drugs are regarded as having a NTI if there is only a small difference between plasma concentrations that achieve efficacy vs. those that will result in toxicity. While some variations in concentration may be “acceptable” in antibiotic or statin therapy, it is felt



David Lewino obtained his nursing degree from Prince Henrys Hospital, Melbourne Australia in 1984. He moved to San Diego in 1988 and shortly after commenced at Scripps Mercy Hospital in the Surgical Intensive Care Unit. In 1991 he joined the staff at The Organ & Tissue Acquisition Center (OTAC), now known as Lifesharing), as an organ Procurement Coordinator. While at OTAC he obtained his Certified Procurement Transplant Coordinator (CPTC) credential. He was Co-Chair of the Ethics Committee for the North American Transplant Coordinators Organizations (NATCO), as well as a member on the International Coordinators committee.

In 1999 David joined Stadtlanders Pharmacy (now known as Pharmacare) as Western Regional Manager for Sales, in the Transplant Division. It was during this period that the first generic Cyclosporine was released. In 2001 David returned to UC San Diego as a kidney transplant coordinator, obtaining his Certified Clinical Transplant Coordinator (CCTC) credential in 2004. David is currently a pre-Transplant Coordinator at the UC San Diego Center for Transplantation. He is also a member of the Astellas Speaker Bureau .



that in the case of immunosuppression potential variations are unacceptable. Patients on immunosuppressive drugs require blood level monitoring. They have highly individualized dosing requirements, and there are serious consequences for overdosing or under dosing.

When seeking approval of a new drug, the pharmaceutical company must submit a New Drug Application (NDA) to the FDA. An NDA must include clinical studies demonstrating that the new drug is clinically safe and effective for its proposed indication(s), and whether the benefits of the drug outweigh the potential risks. Therefore, many preclinical (animal) and clinical (human) studies need to be conducted to collect the required safety and efficacy data. Completion of these studies can take several years, require enrollment of many thousands of patients, and considerable investment on the part of the pharmaceutical company (6).

Alternatively, the generic drug company is only required to submit an Abbreviated New Drug Application (ANDA). As the name implies, the information the sponsor is required

to submit is abbreviated. The ANDA process does not require the generic company to submit preclinical or clinical data establishing the safety and efficacy of the active ingredient of the generic, because these data were previously submitted during the approval process for the innovator/brand drug. Generally, only a single pharmacokinetic clinical study in healthy volunteers demonstrating bioequivalence to the innovator is required (7). A typical pharmacokinetic bioequivalence study involves measuring the drug pharmacokinetics (levels of drug in the blood) after the administration of an oral dose of both innovator and the generic formulation to 24 to 36 healthy adult volunteers. No clinical trials in the actual patient population are required by the FDA to validate these results(8).

Critics of this process believe a single dose study in healthy individuals does not capture many of the issues facing transplant recipients, such as medication interactions, genetic factors, GI motility, age, diabetic status, smoking and dietary interactions. For example, SangCya a generic

cyclosporine formulation initially demonstrated regulatory bioequivalence to Neoral, the brand name drug. However the product was recalled in the United States because cyclosporine concentrations were significantly affected by co-administration with apple juice, an interaction that was not seen with Neoral.

In May 2000, the FDA approved Gengraf, a generic version of the innovator brand Neoral (cyclosporine) capsules. In an effort to validate whether the bioequivalence of Neoral and Gengraf translated into the same clinical efficacy and safety, several studies were conducted. In 2002 (Roza and colleagues) (9) and 2003 (Carnhahan and Cooper) (10) assessed conversion from Neoral to Gengraf in 50 and 41 stable renal transplant patients, respectively. The results of these studies indicated that similar plasma drug concentrations were achieved both before and after the switch to Gengraf and NO dose adjustment was required.

However in 2006 (Qazi and associates) (11) evaluated 82 stable kidney patients, 73 of whom were randomized to conversion from Neoral to Gengraf. In this study 20% of the patients on Gengraf required dose adjustment. Those remaining on Neoral required no dose adjustment. In 2005 (Taber et al)(12) assessed 188 de novo kidney transplant patients who received either Neoral or Gengraf. Patients receiving Gengraf experienced a significantly higher incidence of acute rejection. In addition, higher inpatient variability was reported in CsA blood levels in the Gengraf treated patients.

Both the American Society of Transplantation (AST) and the National Kidney Foundation (NKF) independently convened experts and released position statements on the substitution of immunosuppressant agents. The availability and use of generic formulations was welcomed and endorsed because of the potential economic benefits. However based on concerns previously mentioned in this piece recommendations on

safety and efficacy were provided. The cyclosporine experience has also taught us that generic immunosuppressants will work their way into our patients' pharmacy profile. Managed care, assistance programs and financial concerns will remove choice for many of our patients. Therefore it is imperative we develop a strategy to provide safe and cost effective care to our patients.

When making a prescribing decision for an immunosuppressant patient welfare must be the preeminent concern. Is the potential for variations in blood levels appropriate for a particular patient? Is that patient high risk, i.e. second transplant (15% of patients on the national waiting list have received a prior transplant), African American or with a history of fluctuating blood immunosuppressant levels? Additionally, since a prescription can be valid for 12 months, thorough patient education is essential. We must:

- Inform patients that multiple medications are available.
- Educate patients to be able to recognize his/her prescriptions, the names of the drugs, the dosages, and the

formulations (look) of the medications.

- Prior to leaving the pharmacy with their medications, encourage patients to verify that the medication dispensed is indeed the medication prescribed.

- As always, stress the importance of medication adherence and encourage patients to call the transplant program with ANY questions.

It is clear that the use of generic medications will continue to grow. The transplant team will often not be contacted when the decision to substitute a generic medication for a name brand is made. Whenever a patient is started on a generic immunosuppressant, blood levels during transition can be very helpful and should be obtained. Finally, if there are concerns that generic substitution may not be appropriate for a particular patient or group of patients, the physician must protect his or her decision by writing "Dispense as Written" on the prescription and be prepared to engage the patient's insurance company with supporting data.

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COMPONENTS OF WRITTEN PRESCRIPTIONS

PATIENT'S FULL NAME AND ADDRESS

PRESCRIBER'S FULL NAME, ADDRESS, TELEPHONE NUMBER

PRESCRIBER'S DEA AND NPI NUMBERS

DATE OF ISSUANCE

DRUG NAME, DOSE, DOSAGE FORM, AMOUNT

DIRECTIONS FOR USE

REFILL INSTRUCTIONS

PHYSICIAN SIGNATURE

**DISPENSE AS WRITTEN (DAW) OR GENERIC PERMITTED
NOTED ON PRESCRIPTION**

Quality Improvement:

A Multi-Disciplinary Initiative in Solid Organ Transplant

By Suzanne Reed, RN, BSN, CPTC, CCTC

It is estimated that 44,000 to 98,000 people die annually in the United States from healthcare associated mistakes. Many of these deaths are the result of medication errors, prompting National Patient Safety Goal # 8 which demands the accurate completion of medication reconciliation across the continuum of care. Research studies have shown that medication errors in the transplant setting are common and often lead to significant adverse events, including hospitalizations and failed allografts. Compliance can be especially challenging in this setting since patients must comply with complex medication regimens.

In response to this challenge, the UCSD Center for Transplantation added transplant pharmacists to the team. They, in turn, implemented MedActionPlan™, first in the abdominal transplant setting and then expanding to the cardiothoracic programs. It is utilized in both the inpatient and outpatient settings for patient education. MedActionPlan™ is a printable medication list with pictures, exact timetables for taking medications, as well as the purpose for each. The addition of the transplant pharmacists has improved the safety and quality of care for our transplant patients. The following table summarizes some additional benefits.



Modest estimate of pills per day for a solid organ transplant patient.

Take These Medications		At These Times					
		7am	9am	1pm	5pm	8pm	9pm
	Prograf® (Tacrolimus) 1mg <i>Prevents rejection. **EMPTY STOMACH = Take 1 hr before food of 2 hrs after food** **Take after morning blood test drawn**</i>	1 Capsule				1 Capsule	
	Cellcept® (Mycophenolate mofetil) 250mg <i>Prevents rejection</i>		4 Capsules				4 Capsules
	Prednisone 5mg <i>Prevents rejection</i>		7 Tablets				
	Sulfamethoxazole; Trimethoprim SS = 400mg/80mg <i>Treats/prevents bacterial infections *REPORT RASH*</i>						1 Tablet
	Valcyte® (Valganciclovir Hydrochloride)* 450mg <i>Treats/prevents viral infections</i>		2 Tablets				
	Fluconazole 100mg <i>Treats/prevents fungal infections</i>		1 Tablet				
	Famotidine 20mg <i>Treats/prevents stomach ulcer/heartburn</i>						1 Tablet
	Furosemide 20mg <i>water pill</i>		1 Tablet				
	Metoprolol Succinate 25mg <i>Controls blood pressure</i>		1 Tablet				1 Tablet

In order to evaluate the impact of these practice changes, we developed a brief anonymous questionnaire regarding the MedActionPlan™, the addition of the pharmacist, beliefs related to medications and medication adherence for our transplant patients. We hope that the results of this survey will provide evidence that our initiatives have made a positive impact on patient care and compliance with medications.



Suzanne Reed, RN, BSN, CPTC, CCTC received her BSN at the University of Texas, Medical Branch, in Galveston, Texas. She began her career in transplant as a procurement coordinator for LifeGift in Houston and eventually became a Supervisor of Organ Recovery. She left LifeGift to become a Senior Research Nurse in Organ Transplantation at the University of Texas and then a Transplant Science Liaison for Wyeth Pharmaceuticals.

She joined the recipient side in 2003 as a post transplant Kidney and Pancreas Transplant Coordinator at UCLA. Moving to the San Diego area in December 2004, she joined the UC San Diego transplant team as a Heart and Lung Transplant Coordinator. Suzanne was Transplant Coordinator of the Year in 2008.

MedActionPlan™

Initiative	Action	Benefits
MedActionPlan™	Pharmacist inputs initial medication information into the MedActionPlan™ data base.	<ul style="list-style-type: none"> Medication Reconciliation requirements met On-line access to up-dated medication list for transplant team members and patients Printable medication list with color pictures, exact timetables and purpose of each medication Available in English or Spanish Facilitates patient teaching Easily up-dated, no more hand writing of all of the medications Printable daily log pages Helpful reminder on cover page including transplant center contact information
Patient Education	Transplant Pharmacist provides post transplant medication education prior to discharge from the hospital and in the out-patient clinic setting.	<ul style="list-style-type: none"> Post transplant teaching is more comprehensive and multi-disciplinary Resource for transplant specific questions (ex. drug interactions, drug substitutions, generic equivalence)
Improved Service from Hospital Pharmacy	Transplant Pharmacist is liaison for transplant patients.	<ul style="list-style-type: none"> Able to track compliance more easily when prescriptions are filled at the UCSD Medical Center. Facilitates insurance authorizations that outside pharmacies may refuse to obtain. Manages prescription issues during clinic visits.
Improved Communication and Team Synergy	Pharmacist manages patients in the in-patient and out-patient setting at the UCSD Medical Center.	<ul style="list-style-type: none"> Each team member now more aware of resources and services the other team members can provide. Pharmacist consulted more regularly regarding medication related side effects or issues.

Inspiration

Vanessa Legaspi RN, Fanny Villatoro de Jimenez RN, Juanita Villegas RN

On 11 West in Hillcrest we care for abdominal transplant patients, specifically Liver and Kidney transplants, both pre and post transplantation. Our 11 West care team of Registered Nurses and Clinical Care Partners are proud to provide the constant 24/7 care needed by this complex group of patients. In addition to the procedures and treatments they require, we provide them with the continuous interaction, support, and encouragement they need in order to progress to a successful transplant and to resume their lives. The turnover of patients may be rapid or their stay may be long. There are those who challenge us daily – they may be ill, malnourished, weak, depressed, angry at being sick, frustrated – and they want nothing so much as to go home to their normal life. Our task is to remain constant, to be there for them and to give them the care they need.

Many patients come to us with loving and supportive families, some of whom may be demanding, feeling their loved one needs more attention, but who advocate for them. Others have no family to help them and that is where the "family" on 11 West steps in. We cannot always achieve the goals and the outcomes we would like in these instances, but what defines us is the process. Our family at 11 West was most defined by our interaction with one such patient, Judith Nations.

Judith came to 11 West, hoping to start life anew with a liver transplant.

In October 2006 she received her first orthotopic split liver transplant. She required several months of rehabilitation, eventually developing multiple fistulas, which led to open wounds and drains. During her long hospital stay on 11 West Judith became part of our family. She came to know every staff member, including each new intern and resident, calling us all by our first names. She developed a relationship with every one of us – physicians, RNs, CCPs, pharmacists, physical therapists, dieticians, tray passers, phlebotomists and even the housekeeping staff. Her illness seemed endless and complicated, but she never lost faith. She always had a smile, no matter how difficult her situation became. She radiated hope. A few months passed before she was able to go home. She was readmitted to 11 West very quickly after she fell, sustaining a broken clavicle and rib. Her nausea was uncontrollable. Back in the hospital, she struggled with infections, drains, pain and nausea, but her spirit never broke. Eventually her new liver failed and she was faced with the need to regain strength and improve her nutritional status before she could be considered for a second transplant.

Judith worked her heart out with the physical therapists, nutritionists, pharmacists and her care team. Though she was not fully recovered, after careful thought, the transplant team listed her for a second transplant, which came on December 5, 2007. She was critically ill after the surgery, requiring continuous



Vanessa Legaspi, RN,BSN is a graduate of San Diego State University School of Nursing. She participated in the Nursing Residency Program at UC San Diego and now has 4 years of transplant experience on 11 West.

Fanny Villatoro, CMSRN, BSN is a graduate of the nursing program at Point Loma University. She has ten years of transplant experience at UC San Diego and is a member of the Fall Prevention Committee on 11 West.

Juanita Villegas, CMSRN received her Associate of Science in Nursing from the University of Guam. She has four years of transplant experience on 11 West and is a member of the Skin Committee.



Judith Nations' 11 West Family. Left to right Elvie Sevilla, Dr. Chris Barry, Judith Nations, Ernie Gervacio, Muriel Velicaria, Vangie Quindoza, Merle Quindoza and Pamela Medina

blood products. Sadly her body rejected the new organ within the first week. We feared for her. But, because she was so ill, she was fortunate to receive her third liver transplant on December 11, 2007, just before her 61st birthday. Judith's body welcomed the third liver transplant and she was soon on the way to recovery.

Though Judith moved from floor to floor during the course of her long admission, 11 West was her inpatient home. She was with us for over a year and never once sustained a pressure ulcer. That was a tribute to the tireless care she received from her 11 West care team. Despite all the setbacks, Judith Nation defied the odds and was discharged finally on March 27, 2008. She is a constant reminder to all of

us that faith and courage and a love of life can give strength, even under devastating conditions. Since discharge Judith has given back to the hospital that helped give her a new start. She came to speak at the Transplant Symposium in May 2008 and shared her experiences. She was able to show that she could walk back into the hospital, healthy and even fashionably dressed! Seeing her made us feel pride – in her, of course, but also in our profession and our 11 West family. As a tribute to her and to ourselves as transplant nurses, we remain always ready for the next 'Judith' who may come to us, needing our care.

Statistics

Patient Name: J.N.

Admission Status: End Stage Liver Disease

Length of Stay: 11 months

Admission Date: October 12, 2006

Discharge Date: March 27, 2008

Important facts: Skin Breakdown: 0

Cost of New Life: PRICELESS

Effect of an Aggressive Bowel Preparation on Post Operative Constipation after Donor Nephrectomy

By Zenaida Belardo, CMSRN, CN III, Doug Elmore, MSN, FNP-BC, CCRN, Rebecca Duncan, RN, MSN, CNS, ONC, Elvira Sevilla, CMSRN, BSN, Marlon Saria, RN, MSN, AOCNS

BACKGROUND

The first laparoscopic donor nephrectomy was performed in 1995. It is generally considered to be a safe procedure although significant complications have been reported in the literature. At UC San Diego Medical Center, laparoscopic donor nephrectomy is the standard of care for procurement. Initially the average length of stay ranged from three to five days while national average ranges from one to two days. Anecdotal reports from staff nurses describe multiple post-operative complications that include delayed return of bowel function as evidenced by inability of patients to pass flatus, constipation, nausea or vomiting, and ileus. In March 2009, a more aggressive pre-operative bowel preparative regimen supplemented by a post-operative bowel management program was implemented to decrease gastrointestinal complications and to reduce the length of stay.

METHODS

Thirty-one patients who underwent laparoscopic donor nephrectomy between March 2009 to August 2009 were instructed on an intensive bowel preparation consisting of a clear liquid diet one day before surgery, one bottle of magnesium citrate taken orally the evening before the surgery and fasting after midnight on the day of surgery. Post-operatively, patients received a patient-controlled analgesia with hydromorphone or morphine sulfate



Doug Elmore, MSN, FNP-BC, CCRN received his Masters in Nursing and FNP from the University of San Diego. He has worked in both the Hillcrest and Thornton ICUs. He is currently working with the abdominal transplant program at UC San Diego, through the Department of Surgery.

Aida Belarda, CMSRN, CNIII graduated from nursing school in the Philippines. She has 12 years of transplant experience at UC San Diego, and is currently a member of the 11 West unit Council.

Rebecca Duncan, MSN, RN, CNS, ONC graduated with a degree in Nursing from Indiana University and went on to receive her masters in Nursing from California State University-Dominguez Hills. She has been with UC San Diego Medical Center since 1979 and has been the Clinical Nurse specialist for 11West for about six years

Elvie Sevilla, CMSRN, BSN graduated with a degree in Nursing from the University of Santo Thomas in the Philippines. She is the Nurse Manager of the 11 West transplant unit and a member of the UC San Diego Medical Center Management Oversight Committee.

Marlon Saria, MSN, RN, AOCNS started as a new graduate nurse on the 11th floor. He is currently the Clinical Nurse Specialist for HSCT/Oncology and is the Co-chair of the Nursing Research Council at UC San Diego Medical Center. Marlon is also pursuing his doctorate at UCLA School of Nursing

Renal Transplant Living Donor Care Chart

Element of Care	Pre-Op	DOS	POD1	POD2/Discharge
	Date: _____ Time: _____ Initial: _____	Date: _____ Time: _____ Initial: _____	Date: _____ Time: _____ Initial: _____	Date: _____ Time: _____ Initial: _____
Activity	Up ad lib	Up ad lib as tolerated	Ambulate TID as tolerated Perform leg exercises	Ambulate TID as tolerated Perform leg exercises
Diet/Nutrition	Clear liquids at noon the day before surgery. 10 oz bottle of Mag Citrate with 8 oz of clear liquid at 6pm. NPO after midnight the night before surgery.	Ice chips Sips of clears	Clear liquid for breakfast Regular diet for lunch	Regular diet as tolerated
Assessment/ Monitoring	Height/Weight Vital Signs	Vital signs with O2 sat q4h x24h Strict I&O Check foley catheter for patency Incision (infection, bleeding) Nausea/vomiting Fall risk	Routine VS with O2 sat q8h Maintain strict I&O D/C foley catheter Incision (infection, bleeding) Nausea/vomiting Fall risk Check for bowel sounds, flatus	Routine VS with O2 sat q8h Maintain strict I&O Incision (infection, bleeding) Nausea/vomiting Fall risk Check for bowel sounds, flatus
Pain Control		PCA Dilaudid Turning & repositioning	Discontinue PCA Oral narcotics Monitor for pain, medicate and document response Toradol 15 mg IV x1 if still has pain,may repeat x1 as ordered Splint with pillow	Oral narcotics Monitor for pain, medicate and document response Toradol 15 mg IV x1 if still has pain,may,repeat x1 as ordered Splint with pillow
Treatments/Procedures	H&P Consent signed	Sequential compression device while in bed	Sequential compression device while in bed	Discontinue sequential compression device Continue ambulation as tol.
Respiratory	Incentive spirometer (IS) teaching	Supervise use of IS 10 x qh while awake Encourage TCDB q2h	IS 10x qh while awake and TCDB q2h	IS 10x qh while awake and TCDB q2h
Medications/IV fluids		IVF IV narcotics Antiemetics PRN Analgesics PRN	Discontinue IV fluids PO narcotics Colace 250mg BID Senna 8.6mg PO daily If needed dulcolax supp. MOM,mineral oil	IVHL PO narcotics Colace 250mg BID Senna 8.6mg PO daily If needed,dulcolax supp.,MOM,mineral oil
Diagnostic/Laboratory tests	Final crossmatch – 2 units PRBC available U/A CBC/CMP	Check CBC 6 hours post - Op to make sure pt. is not bleeding	Monitor labs (CBC,BMP,Magnesium) UA/Cx when foley out	Monitor labs (CBC,BMP,Magnesium)
Psychosocial	Evaluation by independent living donor advocate	Monitor emotional well-being Request consult if necessary Allow patient to follow-up recipient's condition	Monitor emotional well-being Request consult if necessary Allow patient to follow-up recipient's condition	Monitor emotional well-being Request consult if necessary Allow patient to follow-up recipient's condition
Patient/ Family Education	Physician instructions: procedure anticipated, risks Pre-op processes: when, where to arrive for surgery	Post-op processes: routines to anticipate, TCDB, IS use, PCA use	Reinforce teachings: Begin discharge teaching Teach when/how to request for pain medication May have shoulder pain from gas used during surgery Importance of ambulation	Discharge teaching Educate on pain medication, stool softeners Instructions to include balanced fiber/bulk in diet Promote adequate fluid intake to prevent constipation Call transplant clinic if no BM by POD 3 Educate S/S of infection Call if temp>100.5, excessive redness, swelling, bleeding, or increasing pain,low urine output No lifting >10lbs for 6 wks Follow up appmt. POD 7
SIGNATURE	INITIAL	SIGNATURE	INITIAL	SIGNATURE



and prophylactic laxatives including senna and docusate sodium. Results were compared to a control group consisting of twenty-one patients who underwent laparoscopic live donor nephrectomy between the months of July 2008 and February 2009. Retrospective data for the control group was obtained from a review of the medical records.

RESULTS

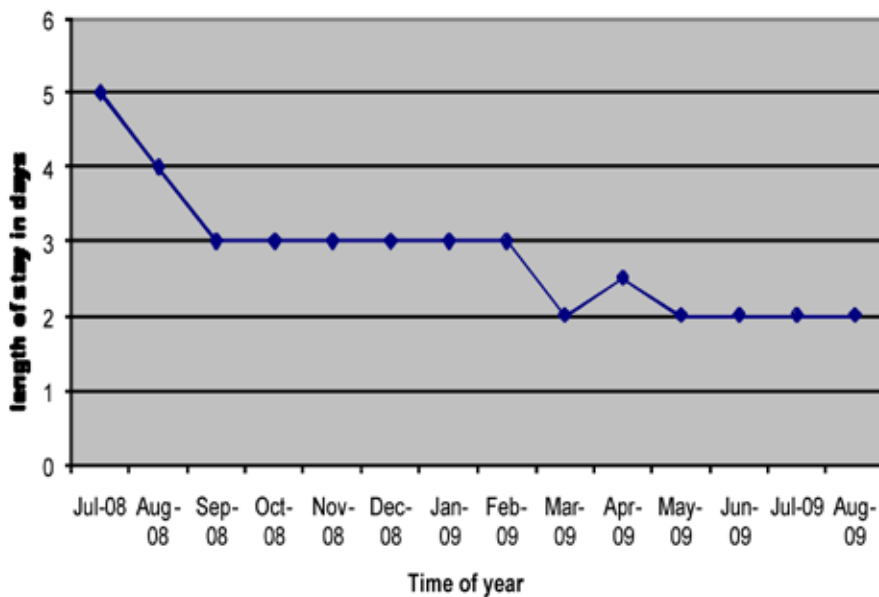
Seventy seven percent of the interventional group (N = 24) were discharged to home on post-operative day two with no complications and no readmissions. Of the remaining seven patients who stayed beyond post-operative day two, six stayed for convenience and patient preference and only one had a significant complication

that required admission to a higher level of care. Implementation of a strict bowel preparation resulted in a reduction of post-operative gastrointestinal complications and in the length of stay from three to five days to one to two days.

CONCLUSIONS

This study was able to demonstrate that the use of a strict bowel preparation and a post-operative bowel management program is associated with a faster return of normal bowel function and reduction in the hospital stay post-operatively for patients undergoing laparoscopic live donor nephrectomy.

Donor Live Nephrectomy Hospitalization



Implementing a Peer Review Process

By Linda Soaft, MSN, ANP-C, CCTC

Magnet Forces

1. Quality of Nursing Leadership
2. Organizational Structure
3. Management Style
4. Personnel Policies and Procedures
5. Professional Models of Care
6. Quality of Care
7. Quality Improvement
8. Consultation and Resources
9. Autonomy
10. Community and Hospital
11. Nurses as Teachers
12. Image of Nursing
13. Interdisciplinary Relationships
14. Professional Development

From the Nursing Shared Governance Council



When UC San Diego nurses began the magnet journey toward shared governance the concept of a nursing peer review process was incorporated into our organization's Nursing Philosophy. The goal was to establish and maintain a high standard for the quality of the care we provide. The American Nurses' Association defined peer review in Nursing in 1988 as 'the process by which practicing Registered Nurses systematically assess, monitor and make judgments about the quality of care provided by peers, as measured against professional standards of practice.'

The liver transplant and hepatology coordinators were among the first at UC San Diego Medical Center to begin to apply the concepts of peer review in their practice.

Purpose

Our goal was to establish a method to measure ongoing practice competency of advanced practice personnel. The peer review process enables advanced practice nurses to develop solutions to improve the existing practices and performance and fosters professional growth. It also identifies strengths and opportunities for improvement in patient care when compared with evidenced based standards of nursing practice. In establishing our Peer Review Meeting, we wanted to include as many advanced practice members in our liver transplant and Hepatology division.



Linda Soaft received her baccalaureate nursing degree from Central Connecticut State University in New Britain Connecticut . During her long career in nursing she has specialized in geriatric care and long term care at various facilities in Connecticut and then worked in cardiology and clinical research at Hartford Hospital in Hartford, Connecticut. She also, did training in case management and became a nurse case manager for several insurance groups, specializing in catastrophic case management, before moving to California in 1998. Linda began working at UCSD in 1999 in the UCSD managed care department as a case manager and a quality nurse analyst. She transferred to the inpatient case management department in 2001, working with a variety of teams, among them liver and kidney transplant.

Linda completed her MSN and NP program at the University of San Diego in 2006. She began her career as a Adult Nurse Practitioner in liver transplant and is a Certified Clinical Transplant Coordinator. Linda says " I am part of a wonderful multidisciplinary team of healthcare providers who provide compassionate and high quality care".



Therefore, our Peer Review group consists of transplant coordinators/nurse practitioners, a surgical nurse practitioner and physician assistant, two Hepatology nurse practitioners, a clinical nurse IV and a peer review advisor. Within our specialty we all have similar clinical competence.

Method

Several members of our team had attended Nursing Grand Rounds January 14, 2009 given by Judith Pfeiffer, PhD, RN, on "Peer Review ... an essential part of being a Professional Nurse". Her power point presentation was the stimulus for our embarking on this new peer review process. We felt by creating this forum for ourselves that we would be able to address our interest in improving our advanced nursing practice. Our first meeting was an open forum for discussion and very informal. The group began meeting monthly to established guidelines for case presentations, and we decided to include professional standards of practice, review of evidenced based literature and UCSD policies and procedures. In Pfeiffer's presentation she

included the ANCC key characteristics of Magnet-recognized hospital which are known as the "Forces of Magnetism". Establishment of our guidelines is tailored to our practice setting and grounded in the core Magnet principles. In our journey for nursing excellence we are working to integrate evidenced based practice into our care delivery system.

Results

Each member takes responsibility for presenting a narrative summary of a case that they feel is an opportunity to improve clinical practice and patient safety. At the completion of the presentation our members discuss the case. Minutes are recorded of each individual case presentation summary with the inclusion of recommendations for an action plan and to provide appropriate feedback that is educational. The benefit will be a greater sense of support within our peer group. In addition we hope to improve team communication and collaborate with nursing staff to integrate our action plans. We realize in order for our group to be successful we must share our outcomes with the nursing staff and

Members of the Hepatology and Liver Transplant peer review group from left to right: Barbara Andrews, Doug Elmore, Katie Anderson, Eileen Chatfield, Linda Soaft, and Joanie Salotti.

to collaborate with other providers of care. Plans are underway for presenting a case at Nursing Grand Rounds.

Conclusions

Mutual respect for each other is strategic to improving practice issues and in improving patient care. It is important for each advanced practice nurse to define for themselves what peer review means for them. Implementation of this peer review framework will result in a stronger collaboration with our nursing and physician colleagues and better quality outcomes for our patient.

I would like to acknowledge the many contributions made by the other founding members of this Peer Review membership: Barbara Andrews NP, Lisa Richards, NP and Joanie Salotti, NP.

Innovation in Transplant Care

By Sandra Leyden, ADN, RN, BA, MA

Transplant care is inevitably seen as 'high tech' care. It certainly qualifies as such considering the invasive procedures, the complex medication regimens and the requisite modification of lifestyles that accompany any transplant. But in transplant, as in other areas of health care, there is heightened interest on the part of patients and family members in what is known as 'integrative care,' which involves the select use of complementary/alternative medicine (also known as CAM) in addition to traditional medical therapy. Health care providers across the spectrum of medical specialties are also becoming aware of some of the benefits of these complementary therapies

in the care of their patients. Once considered anathema to the allopathic medical community, some homeopathic techniques are being actively pursued in medical centers across the country.

At UC San Diego Medical Center we are beginning to see the application of 'integrative care' techniques. Several nurses have become certified in the application of healing touch, a complementary therapeutic option that is intended to promote stress reduction, relaxation and relief of discomfort. Doulas in the peripartum areas use massage and other techniques to enhance the delivery experience for new mothers. Acupuncture and acupressure are being used along



Sandy Leyden is an ANDN, has a BA in Business Administration from Iowa Wesleyan College and an MA in Health Care Management from Webster University. She started her transplant career at Lifesharing in 1999 on the Procurement side. She joined the UC San Diego Kidney Transplant team as a pre-transplant coordinator in 2006. Sandy is currently studying for an MSN at Point Loma Nazarene University, with a graduation date of 2011 with a goal of working in Nursing Education, either in a hospital or an academic setting. Sandy chairs the Transplant Coordinator Council and is an active member of the Research Council at UC San Diego.





with usual medical therapies for relief of pain and other symptoms. There is a whole discipline referred to as 'Integrative Oncology' which applies many of these nontraditional techniques to help relieve symptoms in cancer patients being treated with traditional chemotherapy and radiation.

Clearly the transplant patient faces a number of unique stressors along with the everyday stress we all encounter. Chronic illness, such as End Stage Renal disease (ESRD), or life altering hemodialysis or peritoneal dialysis are the tip of the iceberg. Patients worry about coping day to day, as well as whether the lifesaving organs will come in time. They struggle with loss of function, loss of income, changes in physical appearance, and even their position in the family. The transplant brings a new set of concerns. In an attempt to meet the needs of the diverse and complicated customer population of kidney and pancreas transplantation, the social worker and nursing staff of the UCSD Center for Transplantation Kidney and Kidney/Pancreas program have joined forces and are exploring nontraditional methods of dealing with some of the complaints of this unique group.

As an initial step, on August 11,

2009 Dr Steven Hickman, a clinical psychologist in the UCSD Department of Psychiatry, was invited to be a guest presenter at the kidney and kidney/pancreas patient support group. Dr. Hickman has extensive training and experience in Mindfulness-Based Stress Reduction (MBSR) and is the Director of the UCSD Center for Mindfulness. According to Dr. Hickman "mindfulness is the moment-to-moment awareness invoked by tuning into your breath and to every other aspect of your life. It has been shown to bring about lasting decreases in both physical and psychological symptoms, as well as enhanced quality of life. " Training in mindfulness incorporates ancient techniques, including meditation, breathing and relaxation skills, and a gentle form of yoga and stretching. Regular practice has been shown to reduce perceived stress, to improve sleep, and to increase awareness of what is going on internally and externally in a person's life.

To achieve the benefit of mindfulness training takes practice on a daily basis over time. Dr. Hickman introduced the 30 attendees at the Kidney and Kidney/Pancreas program support group to the first step of focusing on breathing and introducing the concept of meditation, as they tried to turn off

"mental noise." Attendees were very enthusiastic about this first exposure to complementary medicine and how it made them feel. They expressed interest in exploring other practices. Some potential topics under consideration for future support groups include acupuncture, guided imagery, chi gong, healing touch and massage therapy.

Clearly there is potential for helping patients as they cope with transplant related stressors through integrative medicine. One of the most important benefits is the empowerment of patients to actively participate in their care, to bring about improvement through their own actions. There are few side effects. They can practice the techniques at their leisure. And they feel better! Transplant offers a better quality of life for these very sick patients. It may be that increased self awareness and decreased stress will help them to realize the full potential of the transplant intervention.

We proudly recognize.....

Degrees:

Ben Thinnis, RN, BSN received his Master of Science in Nursing (MSN) and Master of Hospital Administration (MHA) degrees. Thinnis is a Performance Improvement and Patient Safety Manager focused on improving patient safety, medication safety and pneumonia care. He is leading the implementation of our new Critical Outcomes program in each of the UC San Diego critical care units.

Certification:

Mel Delarosa, RN, Outpatient Hemodialysis, received his Board of Nephrology Examiners Nursing and Technology (BONENT) Certification.

Linda Soaft, RN, MSN ANP-BC, CCTC, Hillcrest Liver Transplant Coordinator, passed the National Adult Specialties Nurse Practitioner Board examination.

Ilene Gustafson, RN, Hillcrest In-House Kidney Coordinator, received her Certification as a Clinical Transplant Coordinator (CCTC).

Vu Nguyen, RN, Hillcrest 5 West IMU, received her Certification in Critical Care Nursing (CCRN).

Jessica Brady, RN, Hillcrest 5 West IMU, received her Certification in Critical Care Nursing (CCRN).

Dana Bernd, RN, Hillcrest 5 West IMU, received her Certification in Critical Care Nursing (CCRN).

Julie (Gerlie) Taylor, RN, BSN, Thornton 2 West received her Certification in Progressive Care Nursing (PCCN).

Polly Nobienksy, RN, BSN, Moores UC San Diego Cancer Center Radiation Oncology Department, received her Oncology Nursing Certification.

Michelle Russell, RN, BSN, Moores UC San Diego Cancer Center radiation Oncology Department, received her Certification in Oncology Nursing.

Claire Hardy Jenkins, RN, Assistant Nurse Manager 8th Floor Orthopaedics, received her Certification in Orthopaedic Nursing.

Jamie DeYoe, RN, received her Certification in Orthopaedic Nursing.

Erna Soriano, RN received her Specialty Certification in Nephrology Nursing.

Robert Kottman, RN, Hillcrest 6 West, received his Certification Medical-Surgical Nursing (AMSN).

Loida Castro, RN, BSN, Thornton OR, received her Certification in Perioperative Nursing (CNOR).

Kimberly Broms, RN, BSN, Thornton OR, received her Certification in Perioperative Nursing (CNOR).

Justin Hepler, RN, BSN, Hillcrest Emergency Department, received his Certification in Emergency Nursing (CEN).

Mary Hellyar, RN, BSN, Thornton ICU, received her Certification in Critical Care Nursing (CCRN).

Stephanie Drazer, RN, BSN, Thornton ICU, received her Certification in Critical Care Nursing (CCRN).

Diane Brne, RN, BSN, MHA, Thornton IMU, received her Certification in Critical Care Nursing (CCRN).

Liz Soto, RN, Hillcrest 6 West, received her Certification in Medical Surgical Nursing.

Aida Bautista, RN, Hillcrest 6 West, received her Certification in Medical Surgical Nursing.

Claire Cone, RN, Hillcrest 6 East, received her Certification in Medical Surgical Nursing.

Wilmar Flores, RN, Thornton Emergency Department, received his Certification in Emergency Nursing (CEN).

Presentations:

Beverly a. Morris, RN, CNP, MBA, Department of Nursing Education, Development and Research, was invited by the National Association of Orthopaedic Nurses to present the results of UC San Diego Medical Center's Clinical Practice Guideline for Joint Replacement which changed the orthopaedic nursing standard of care by initiating patient mobility on the day of surgery. Previous nursing practice began ambulation on post operative day#1. The project resulted in decreasing the length of stay from 4.3 to 2.8 days, as well as demonstrated improvement in post operative pain management.

Awards:

Stephanie Osborne, RN, BSN, CCTC, UC San Diego Medical Center 2009 Nurse of the Year, was selected as a finalist for a Nurse.com 2009 Nursing Excellence Award in the area of clinical care. She was also a nominee for the San Diego Business Journal's 16th annual Women Who Mean Business awards.

Sal Chiappe, CN, Perlman Oncology Clinic at Moores UC San Diego Cancer Center, was recognized by the campus Environment, Health and Safety Department with a Safety Award for Excellence for his efforts in advocating the unique needs of patient care and its impact on research laboratories in the

Moores Cancer Center.

Special Mention:

Andrea Snyder, BSN, MBA was appointed as the UC San Diego Medical Center's Quality Officer. Prior to this appointment, she was the Director of the Performance Improvement and Patient Safety Department (PIPS) and the director of the DRG program.

Chad Hutchison, RN, BSN has accepted the position of Assistant Nurse Manager for the eighth floor in Hillcrest.

Amanda Topik, RN, MSN, NP has accepted the position of Heart Transplant Nurse Practitioner and Ventricular Assist Device Coordinator for the Thoracic Organ Transplant Program.

Patrick Olsen, RN, BSN, Manager of Hillcrest Eighth Floor Orthopaedic Neuro and Trauma Surgery Unit, was elected President of the National Association of Orthopaedic Nurses (NAON), San Diego Chapter for the year 2009-2011. The San Diego chapter of NAON is a very active professional nursing organization that meets monthly and supports the highly successful annual BONES Symposium and the annual "A Tale of Three Cultures" program. Both programs champion the interests of the San Diego orthopaedic community. Patrick represented UC San Diego and the local chapter of the National Association of Orthopaedic Nurses at their national congress in Florida.

Marlon G. Saria, MSN, RN, AOCNS, Clinical Nurse Specialist for Oncology Services, co-chair for the UC San Diego Medical Center Research Council, and doctoral candidate at UCLA, was selected to be a Predoctoral Intramural Research Training Award Fellow through the Summer Internship Program at the National Institutes of Health. He worked with Dr. Jane Fall-Dickson, tenure track Investigator, Intramural Research Program at the National Institute for Nursing Research, and Director of the Oral Mucosal Injury Unit which addresses the pathogenesis of cancer treatment-related oral mucosal injury and associated pain. Under the mentorship of Dr. Fall-Dickson, Marlon worked on two clinical protocols: Evaluation of Efficacy and Mechanisms of an Anti-inflammatory Intervention for Chemotherapy Related Mucosal Injury (02-NR-0133), and Evaluation of Efficacy and Mechanisms of Topical Thalidomide for Chronic Graft-Versus-Host Disease-Related Stomatitis (04-NR-0069). Marlon was one of the 20% of

applicants who were selected for this program.

Maureen Benetti, RN, Orthopaedic Surgery Nurse Practitioner and Gabriella Rivello, RN, Trauma Nurse Practitioner gave an orthopedic certification review course this year to ensure that the numbers of certified orthopedic nurses on the Hillcrest staff is continuing to rise.

Kim Delahanty, Administrative Director for Infection Prevention, Clinical Epidemiology, and Tuberculosis Control, was named to the Who's Who in Infection Prevention list by Infection Control Today magazine. Kim chairs the California Healthcare-Associated Infection Advisory Committee.

Thomas Collins, RN, staff nurse in Electrophysiology, has been recognized by the City of San Diego for his volunteer work as a forensic nurse with victims of domestic violence at the San Diego Family Justice Center. Thomas has documented injuries in over 200 cases over the last 4 years and is recognized in Superior Court as an expert witness on domestic violence injuries.

CN III Promotions:

Miriam Bender, RN, Thornton IMU, Heart Failure Care Plans

Andrea Lumbang, RN, Thornton 3 East, NRP-Nurse Residency Website

Lee Sepin, RN, Hillcrest Infant Special Care Center, NRP-People Team

Leah Adrid, RN, Hillcrest 5 IMU, NRP-Skin

Michele Carson, RN, Hillcrest Infant Special Care Center, Reducing Infections in ISCC

Glacey Castillo, RN, Hillcrest 6 West, NRC-Care of IV and Central Lines

Brian Platkowski, RN, Hillcrest Burn unit, Revision of Orientation Manual

Emily Graver, RN, Hillcrest Infant Special Care Center, NRP-People Team

Tony Aranes, RN, Shiley Eye Clinic, Post Operative Eye Medications-Discharge Instructions

Renee Turner, RN, Shiley Eye Clinic, Post Operative Eye Medications-discharge Instructions

Dolly Ayapana, RN, Shiley Eye Clinic, Post Operative Eye Medications-Discharge Instructions

Anna Manulis, RN, Outpatient Hemodialysis, TB Screening in Outpatient Dialysis

Yelena Ignatyeva, RN, Hillcrest Surgical ICU, Silent Night Pill Crusher

Dawn Sassi-Dambron, RN, Hillcrest 6 East Med Surg, NRP-Finance Recruitment-Retention

Chad Hutchison, RN, BSN, Hillcrest 8 West Med Surg, NRP-Skills Assessment

Nancy Cawley, RN, OB/GYN Clinic, NRP-Diabetes and Falls

Nanette Burell, RN, Hillcrest SICU, Palliative Care in SICU

Susan Hartnett, RN, Hillcrest 10 East Telemetry, NRP-Looping and Committees

Agnes Ocampo, RN, Hillcrest 11 West, Patient Education for the Renal Transplant Recipient

Ida Belardo, RN, Hillcrest 11 West, Bowel Prep for Donor Nephrectomy

Dalia Shapow, RN, Thornton 3 East, NRP-Nurse Recruitment and Retention

Liberty Arceo, RN, Hillcrest Infant Special Care Center, Orientation and Preceptor Review Class

Cecilia Kasperick, RN, Thornton IMU, Quality Improvement Through Healing Touch

Janet Jackson, RN, Thornton OR, Developed a System to Support Clinical Practice in OR

Cassia Chevillon, RN, Thornton ICU, Post Operative Developed Lung Transplant Staff Education Program and Competency

Christine Justice, RN, Hillcrest CCU/10 ICU, Critical FSC with the Glucometer

Karen de Ferrer, RN, Hillcrest Infant Special Care Center, Standardized PICC Line Blood Cultures Draws

Rina Garces, RN, Hillcrest Infant Special Care Center, Standardized PICC Line Blood Cultures Draws

Amy Navarro, RN, Hillcrest Infant Special Care Center, Standardized PICC Line Blood Cultures Draws

Boris Sterns, RN, Hillcrest Infant Special Care Center, Reduction of CLABSI'S

Michelle Zawada, RN, Thornton ICU, Overflow ICU Patients in PACU

Edna Culp, RN, Thornton PACU, Managing an InPatient with PCA Having a Surgical Procedure

Brenna Lawrence, RN, Hillcrest 10 ICU/CCU, Code Nurse Orientation

Kimberly Broms, RN, Thornton OR, Improving Clinical Practice of the Plastic Surgery Service

Janet Jackson, RN, BSN, clinical coordinator for Plastic Surgery Specialty Service, was awarded her CN III for her work on improvements and enhancements to supplies and equipment at the Thornton Operating Room.

CN III to CN IV:

Jeffrey Tageser, RN, Lifesharing, Kidney Allocation Education Plan to Guarantee Competency of All Lifesharing Procurement Coordinators in the Allocation of Kidneys; Created Teaching Plan with Measurable Goals to Educate all RNs in the Critical Care and Education Departments to Raise Awareness and Increase Referral Volume; Orientation Communication Log for Organ Procurement Coordinators-Developed a Visual Guide for All New Procurement Coordinators; Orientation and Annual Competencies for Kidney Allocation, Brain Death and Obtaining Consent-Developed Competencies for Each of the Above.

The Kindness of Strangers

By Sal Chiappe, RN, AS

Somewhere beneath the shimmering stars,
A heart beats,
Waiting to be given,
To a soul unknown
I wait nervously,
Praying for the donor,
Who will give me new life,
It is an awkward feeling,
Carrying this pager,
Knowing that someone
will leave this world,
So I can walk the breath of spring,
And dance beneath the moon
My wounded heart,
Courses through walls of tired muscle,
I sleep restless, and unsure of tomorrow,
Dreaming of the kindness of strangers...

The pager goes off,
My nurse coordinator,
Tells me they have a heart...
As I dress, my eyes well up
With tears of ambivalence,
And pains of joy
We are two passing hearts,
Who know nothing of each other,
One heart made for the lives of two,
One life remains,
To live, and give thanks,
One moves on to eternity,
And leaves life behind...

At the hospital after surgery,
I find out that my donor is a Marine,
Wounded in the mountains
of Afghanistan,
Fighting for freedom, and
for his country,
He died quietly at Walter Reed
Leaving me a gift that I can never repay,
At 21 years of age,
He is a hero,
Brave beyond his years,
I will carry his heart,
With its walls of resilience,
Coursing, pumping, carrying new life...

Within my chest,
Beats the heart of a warrior,
Wounded in a strange land,
Sharing his pulse with a stranger,
He will never know
I close my eyes,
And in the shadow of his strength,
I see him running,
Falling, with outstretched hand
Handing me his heart,
And in that moment,
I am reborn
Girded by his courage and his hope,
I walk beneath the blazing moon,
And am thankful,
For the kindness of strangers,
Who come bearing gifts,
Yet seek nothing in return...

Stay tuned for
the next journal
which will feature
Women and
Infants Services



Sal Chiappe is a Case Manager at Moores UCSD Cancer Center, working with Dr. Sarah Blair and Dr. Michael Bouvet in Surgical Oncology. He has been a nurse for the past 23 years, but has a number of other interests, which include writing poetry, history, politics, and music. He also compiles an electronic newsletter for the Cancer Center, called Capstone, four times a week.



William (Bill) Hubbert, sometimes known as “Wild Bill,” received a double lung transplant for alpha 1 antitrypsin deficiency emphysema on May 19, 2009. Prior to receiving his new lungs Bill was oxygen dependent, and his function, which had been quite limited, was declining. On August 23 he celebrated his 59th birthday. His family reported their delight when they saw that Bill finally had enough breath to blow out the candles on his cake!

Embrace the vision. Join us at UCSD.

For current opportunities, both internal and external, please log on to www.ucsdhcjobs.org. For more information about nursing at UCSD, log on to our nursing website at <http://medinfo.ucsd.edu/nursing>.

