Palmetto Pulse

South Carolina Association of Perianesthesia Nurses

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Inside this issue:

CINDY MORGAN WINS 2012 BEV ZEIGLER AWARD AT FALL CONFERENCE

Cindy Morgan (c) with Faye Baker (r), Immediate Past President and Donna West, President accepting the Bev Zeigler award.

SCAPAN Fall conference held at Greenville Memorial Hospital, Greenville, SC on Oct. 13, 2012

Attendees check in for the conference and drop off donated food for the Harvest Hope Food Bank

Fall Conference: A Cornucopia of Ideas for PeriAnesthesia Nurses

by: Donna West, RN, MSN, President 2013

A Cornucopia of Ideas for PeriAnesthesia Nurses: The 2012 Annual SCAPAN Conference Update

We had an outstanding State conference October 13th in Greenville, South Carolina. The weather was perfect, and it was also time for the "Fall for Greenville" event downtown. Some of our local as well as out of town members sampled the great shopping and food/wine experiences in the off hours. We had 58 attendees from all over the state, and it was good to see all of the networking between the new and seasoned members. Though I was busy keeping things on track, I even reconnected with one of my long lost nursing buddies that I had not seen in approximately 37 years.

Several of the attendees commented how much they enjoyed the four speakers that shared their great insights into current issues facing the PeriAnesthesia Nursing arena. The topics ranged from Value Based Purchasing (VBP), Medications being used during all three stages (preoperatively, under anesthesia and post operatively), Pediatric Blocks and complications, and Sleep Apnea and "What do we do about it?"

Martha Stratton, the Director of Nursing, Surgical Services at AnMed Health and current member of the AORN National Board of Directors started our morning off with discussing VBP. Her discussion was centered around the changes in healthcare reimbursements process due to the VBP. The hospital payments will now be linked to patient satisfaction and improvements in quality scores, which means that patient care reimbursements will be based directly on performance. Payments to hospitals are to be decreased by approximately 1.25% in 2013, and while it may seen a slight percentage, healthcare facilities are being hit hard financially due to these reductions. Martha provided several tips on what PeriAnesthesia Nurses could do to help deal with this crisis. She stressed that everyone needs to be on their "A" game for every patient 100% to improve the quality of care as well as the overall patient satisfaction scores. Also with 7 of the 12 performance measures directly related to the Surgical Care Improvement Project (SCIP), nurses need to place extra emphasis on these measures. She noted that hospitals will be scrutinizing for any "missed opportunities" , and we as healthcare providers need to assist by examining "each and every process" to recover any possible save.

We switched gears for the next two speakers, and they each focused on Anesthesia related topics. Richard P. Wilson, CRNA, MNA, the Assistant Program Director for the Nurse Anesthesia Program on the Greenville Hospital System, provided a very indepth review of pharmacology for each phase of the perioperative process. The audience received a comprehensive rundown of the various types of drugs, such as anti-anxiety, anti-emetics, pain management medications along with the various inhalent gases and intravenous drugs used for anesthesia. He broke down some of the contraindications (age, comorbidities, and allergies) along with the various types of side effects frequently seen with the medications. His lecture seemed to catch everyone's attention, and he was very happy to clarifying any of the audience's concerns.

Richard F. Knox, MD, Pediatric Anesthesiologist, Medical Director of Anesthesia for Shriner's Hospital of Greenville, SC, shared his knowledge of pediatric regional blocks, potential complications of nerve blocks, lipid rescue, and multimodal approach to pain relief. His lecture was very detailed and thorough, and he provided valuable side notes from some of his past experiences. To help illustrate his points on some of the nerve blocks, he provided a short video of him performing a nerve block on a pediatric patient. The audience also received a surprise when Dr. Knox showed a photograph of himself holding a very long endotracheal tube and extra large laryngoscope that he had used on a very tall giraffe during his training days. With everyone being on the alert for Autumn's (the Greenville Zoo's giraffe) impending delivery, his photo and story was a big hit.

The last presentation was provided by Pam Rice, RN, a SCAPAN member and staff nurse in the PACU at Greenville Memorial Hospital, on the subject of "Sleep Apnea and what do we do about it?" With Pam's vast knowledge about sleep apnea and the various CPAP apparatuses, she provided everyone with a down and dirty review of the subject matter. She captured the audience's attention right away, and several asked for her contact information afterward to seek additional information on sleep apnea and apparatuses. With the annual officer election and the excellent speakers time delays, Pam was a real trooper for us; she was able to complete her presentation on time.

I want to sincerely applaud the Piedmont District of SCAPAN's Board of Directors for helping me with all of the planning and preparing for the event. This year's Silent Auction was very profitable for SCAPAN, and it was fun watching attendees try to best each other for the donated items. We had a wide variety of auction items thanks to Jaci Gibson, and I am very grateful for all of her hard work. Our next annual conference will be handled by our Midland District, so please send any suggestions regarding topics, speakers, or offers to help plan the next Cornucopia of Ideas for PeriAnesthesia Nurses event.

Where is your membership money spent?

By: Melissa Postell, BSN, RN, CPAN,
Treasurer 2013

SCAPAN is so grateful for all of the members. We have an average of 250 members. Have you ever wondered where your membership money is spent? Did you know that half of the $20 membership fee to SCAPAN goes back to your local component? Yes, $10 is sent to either the Piedmont district, the Midlands district, or the Coastal district depending on which region of the state that you live or work. They use this money in the same way as SCAPAN but on a more local level. The only other income for SCAPAN is from our yearly State Conference held every year in the Fall.

In alignment with ASPAN's vision, we work hard in supporting and promoting Peri-Anesthesia nursing through education and research. The SCAPAN board works hard to keep all costs to a minimum without sacrificing quality. For example, the cost of travel, food, and hosting sites for conferences continue to increase in this economy. In an effort to provide an affordable educational opportunity to all of peri-anesthesia nurses, SCAPAN has not increased the registration fee for the State conference in many years. In addition, we also continue to give back to our members no less than ever before through ASPAN membership raffles (Two every year), and recognition awards. We award recognition to our members to celebrate accomplishments such as the Bev Ziegler award, the Points System and Certification Awards. Please look under "news" and "awards" on the SCAPAN website for more information, we would love to see more applicants for these awards.

It is amazing what all of the State and Local leaders are able to accomplish with membership's money. Below is an approximate breakdown of where money was spent this past year.

47% - Representation, Promotion, and Education of 2 Component Leaders to ASPAN National Convention and ASPAN's Yearly Component Development Institute.
17% - New SCAPAN Website and Webmaster Fee
14% - Membership Awards and Incentives (ASPAN membership raffles, Bev Ziegler Award, Points Award, Certification Awards and even more when the budget allows)
13% - SCAPAN State Conference
3% - Quarterly Newsletter
2% - ASPAN Foundation
2% - Postage/Office Supplies
2% - Support of Student Nurses to their State Conference

Looking ahead to next year's budget we want to continue working hard to promote our unique nursing practice with the same passion and excellence. The SCAPAN board proposed a $5 membership increase to the entire membership at the 2012 State Conference and again in an email. The Board was well prepared for opposition and prepared to continue to function even harder next year to maintain our high level of support to peri-anesthesia nursing. We were so surprised at the supportive response during our State Conference and from the email sent to members. So beginning in 2013, SCAPAN's membership will increase from $20 to $25. (Just a side note - SCAPAN is one of forty components of ASPAN. There are currently only three components with membership fees less than $25.)

Thank you for your continued support of SCAPAN!

Board of Directors

AROUND THE STATE

Costal District Report

CAPAN members participated in the American Heart Association 2012 fundraiser and heart walk as team "CAPAN cruisers" to support the AHA as peri-anesthesia nurses. Team members raised money for the team with bake sales, raffles and donations. Total amount raised was $873.04. Visors with "SCAPAN" printed on them were also sold with half the proceeds going the the American Heart Association.

Team members also supported by walking on September 29, 2012. The following team members supported the CAPAN Cruiser team:

Carol Walker-team captain, Debra Boulware, Melissa Postell, Marcie Livingston, Shirley Wetzstein, Sarah Willis, Dianne Jenkins, Ryan Parnell, Sarah Smail, Ali Cannaday, Rachel Roxbrough, Eileen Owen, Donna Daniel, Callie Baxley, Jeanie Roberts-Baxley, Lisa New, Rose Fredlaw and Geneane Ludgate.

On December 11, 2012 CAPAN is having their quarterly meeting at St. Francis Hospital mall classroom 3. Cindy Anderson, NP for the Neurospine physician Group will be speaking on

"Everything you wanted to know about Brain Tumors". Free contact hour and food provided for members, $5 for nonmembers.

Refreshments start at 5:30pm, speaker starts at 6pm and CAPAN meeting starts immediately following the speaker. Everyone come with ideas for next year and names of those willing to serve as an officer for 2013.

Piedmont District Report

See fall conference report on page 2 by Donna West , President

Congratulations to Paige Wilson who was chosen to receive a scholarship to the State Conference next fall. Her name was randomly chosen at the recent SCAPAN board meeting.

AROUND THE STATE CONT.

Central Midlands District Report

The Midland's Chapter of SCAPAN met at Providence Hospital in Columbia. Thanks to Marilyn Jefferies for having reserved this site for our meeting. After socializing around over Dianne Jackson President informed the group of future events, openings on the board of directors, access to Joanna Briggs Institute, and ASPAN scholarship winners. These winners were Suzanne Steele, Lori Sutton and Dianne Jackson. Congratulations to Angela Gwinn, the evening's winner of a year's ASPAN/SCAPAN membership!

Penny Bradley, Midland's chapter vice president, led our round table discussion. Penny reported the successful practice of Palmetto Health Baptist's PACU II fast tracking procedure.

After discussing our upcoming 2013 Spring Conference members volunteered to help. The Spring Conference will be held at Lexington Medical Center March 9, 2013, with Kim Noble as our guest speaker.

Our next regularly scheduled meeting will be December 4, 2012 at Palmetto Health Baptist. We hope to offer education along with another round table discussion.

Sue Lutz's Impossible Quiche Recipe

A delicious dish for any setting – brunch, lunch, as well as dinner. Every time Sue brings several of these in to the PACU, we all make a mad dash to get a slice before the quiche disappears.

12 slices of Bacon (approximately ½ lb. - crisply fried and crumbled)
1 cup of shredded Swiss cheese
1/3 cup chopped onion
2 cups of milk
½ cup of Bisquick Baking Mix
4 eggs
¼ tsp salt
1/8 tsp pepper

Optional items:
Chopped ham bits, chopped tomato bits, spread some spinach over the top of the meat/onion/cheese layers.

Preheat oven to 350°. Lightly grease a 9-10 inch quiche pan. Sprinkle bacon/ham, cheese and onion evenly over bottom of the pan. Place milk, eggs, Bisquick mix, salt and pepper in blender. Cover and blend on high speed for 1 minute. Pour mixture in the quiche pan. Bake until golden brown and knife inserted in center comes out clean. (Approximately 50 to 55 minutes). Let stand for 5 minutes.

Board of Directors Cont.

- Gwendolyn Whitcomb
  District Director
  rivarocci12@gmail.com

- Kristie Alvey, MSN, RN, CCRN, CPAN, ACNS-BA
  District Director
  kristie.alvey@palmettohealth.org

- Tanya Spiering, BSN, RN, CPAN
  Region 5 Director
  lspiering@hotmail.com

- Katie Collins, RN, CPAN
  District Director
  katherine.collins@rsfh.com

- Carol Walker, BSN, RN-BC, CPAN
  President - Coastal District
  carol.walker@rsfh.com

- Helena B. Williams BSN, RN
  President - Piedmont District
  HBWilliams@ghs.org

- ABPANC Representative

- Rebecca Wilkin, BSN, RN
  Newsletter Editor, District Director
  rlwilkin215@gmail.com

CDI REPORT

By: M. Dianne Jackson, RN, CAPA, Vice President 2013

CDI Report – St Louis Missouri - September 7-9, 2012

Have you heard the "buzz" about CDI and wondering what in world it is???? I remember not long ago wondering that same thing. Allow me to give you a brief explanation of what this acrostic is all about.

CDI stands for "Component Development Institute". This is an annual meeting offered by ASPAN to state component leaders. The purpose is to give component leaders the tools they need to build their individual components. These tools include, networking with other leaders, and attending breakout sessions which focus on what is needed to build and improve individual components. Some of the subjects included: finance, how to offer effective education, productive board meetings, standards, guidelines, EBP, succession planning, legal issues, publishing newsletters and making applications for Gold Leaf.

This year SCAPAN sent Nancy Zarczynski and me to represent our component. Pam Spires from Central Midland's and Jeanie Baxley from Coastal were also in attendance. Spending the weekend with other ASPAN leaders was very stimulating. It was similar to attending National Conference, but on a much smaller scale. One of the highlight for me was being able to network with other peri-operative nurses from around the country. It was refreshing to hear that what we are working to improve, and or struggle with in our units, occurs all around the country! Friendships with nurses of like minds and passions are developed. Then anticipating being able to see them at other conferences is like having family all over this great nation.

A highlight of the week-end was the Mock Representative Assembly and Town Hall Meeting. Each state component had their selected representatives to participate in the Assembly. There were Mock Resolutions brought before the assembly that were discussed and vote on. Of course it is not as serious as a true RA, but gives a flavor of how changes are made in our specialty organization.

Do you have ideas for change in your unit, or in your specialty area of practice??? Do you have evidence to show why change needs to occur???? Have you pondered how to improve your practice???? Well one great way to facilitate those changes is through your nursing organization. That is where you can get the support and guidance that is so helpful in improving your practice. Do you personally desire to become a part of those changes? Then how about becoming involved in your specialty nursing organization? Contact one of the SCAPAN board members and/or district leaders to see how YOU can make a difference. I look forward to hearing from you!!!

SCAPAN MISSION STATEMENT

The core purpose of the South Carolina Association of PeriAnesthesia Nurses is to promote excellence in all aspects of PeriAnesthesia Nursing practice through education, specialty certification, nursing research, support for specialty certification, and ASPAN Standards in an environment that is respectful of others and adaptive to change.

CDI PICTURES

NAME THAT CAROL

Bleached Yule

Castaneous-colored Seed Vesicated in a Conflagration

Singular Yearning for the Twin Anterior Incisors

Righteous Darkness

Arrival Time 2400 hrs - Weather Cloudless

Loyal Followers Advance

Far Off in a Feeder

Array the Corridor

Diminutive Male Walloping on a Percussion Instrument

Monarchial Triad

Nocturnal Noiselessness

Jehovah Deactivate Blithe Chevaliers

Red Man En Route to Borough

Frozen Precipitation Commence

Proceed and Enlighten on the Pinnacle

The Quadruped with the Vermilion Proboscis

Query Regarding Identity of Descendant

Delight for this Planet

Give Attention to the Melodious Celestial Beings

The Dozen Festive 24 Hour Intervals

Retrieved from: http://www.his-forever.com/carol_game.htm

Answers on page 10

A Message from SCAPAN'S President

By: Donna West MSN, RN

To all SCAPAN Members,

It has been an honor to serve as President Elect last year, and I am really excited about my upcoming year as President of SCAPAN. As I contemplate my term as President, I have two goals that I would like everyone to focus upon. The first goal is see us continue building upon all of the great accomplishments that have occurred over the past several years. By working together as a team, we will be able to keep the momentum going as we strive to enhance our PeriAnesthesia Nursing practice through leadership, education, and research.

Over the years, nurses have had to work hard to keep up with the changes in healthcare and technology, and though it has been difficult at times, PeriAnesthesia Nursing is still a force to reckon with regarding patient safety and care. For SCAPAN to continue to grow and remain a sustainable organization, we need to take a deep look at our current situation. The SCAPAN leadership team and I need you to assist us by getting more involved with our organization.

Q: Our current membership varies approximately 251 members per month dependent upon the number of renewals and new applicants. Much of our membership is comprised of "seasoned" PACU Nurses, so what we can do to entice our younger counterparts to step up and bring new life into our professional organization?

A: Everyone needs to share the benefits of being a member of ASPAN/SCAPAN. Mentor and encourage a coworker to attend a meeting or educational event. For example, Kim Noble, who is such a great speaker, is slated to return to for the Midland's "Spring" education session, so mark your calendar and bring a "friend".

Q: What are some of the benefits does SCAPAN / ASPAN membership provide?

A: There are several educational events held yearly by the ASPAN and SCAPAN, these sessions are a great place to network, connect with one's fellow PeriAnesthesia Nurses, and share concerns or ideas. Members receive hardcopies of the Journal of PeriAnesthesia Nursing that provides up to date evidence based articles. And recently, members were given access to the Joanna Briggs Institute website which "promotes and supports the synthesis, transfer and utilization of evidence through identifying feasible, appropriate, meaningful and effective healthcare practices to assist in the improvement of healthcare outcomes globally". ASPAN and SCAPAN make some scholarships available to assist members in furthering their nursing education, partially funding their certification exam, as well as any Humanitarian Mission trips.

Q: What are some things that your President and fellow Board of Directors leadership team do to improve SCAPAN?

A: Only you as members will be able to help us answer this question. Please submit any ideas or suggestions that you may have in regards to things to focus upon:

- Is there any specific education we can provide to help fill in anyone's knowledge gaps - speakers or subject matter
- What can we do to encourage you to become advocates or "change agents" for patient safety and improved healthcare. With the new healthcare changes coming, nurses are going to need to get involved and advocate for patients as well as staff needs.
- Are you interested in helping our Directors with their identified committees, such as the Education/Research, Governmental Affairs, Finance, and Community Service, and Bylaws committees? We are always looking for members that are willing and thinking about becoming a future leader. SCAPAN is committed to mentoring our new and current leadership team.

Communication – Were you aware that along with our website, we also have an email account (contact.scapan@gmail.com) as well as a face book page (https://www.facebook.com/groups/137330746961/)? Rebecca Wilkins, a District Director and our Newsletter Editor, is currently trying to clean up our email address book to help us stay in touch. Throughout the years, our list of members addresses have been corrupted due to job changes, switched email systems, multiple emails to the same person, and so on. With us having approximately 251 members, we had over 500 email addresses listed, and many would return as "unable to deliver" messages. We have also found that some employers have set up firewalls that automatically reject emails from groups. Please send us a note to ensure that we have your correct contact information.

- Do you have any new processes in place that are working well in your perioperative areas? Share the premise so everyone does not have to keep inventing the wheel, especially with the changes in the Value Based Purchasing system.
- The new buzz word in nursing is research, so we are always looking for anyone interested in learning more about evidence based practices and research. Even if you are not available, please let us know if you have developed a project or have any knowledge of projects being conducted in your work areas.

And the second goal is for SCAPAN to receive the Gold Leaf Component of the Year award that is awarded to one ASPAN component at the National Conference every year. The award is given the state component with the most cumulative points for outstanding distinction and visibility in meaningful activities and results. Each year, we have received positive reviews on our Gold Leaf applications, but we haven't been chosen for as the recipient. With this past year's accomplishments and efforts, this might be our greatest chance to take the top award.

What is Tranexamic Acid and How is Used?

By: Kristie Alevy, MSN, RN, CCRN, CPAN, ACNS-BA

- Tranexamic acid is an inexpensive synthetic lysine amino acid derivative which produces antifibrinolytic effects through its interactions with plasminogen.
- Tranexamic acid is FDA approved to treat menorrhagia (heavy menstrual bleeding) and prevention of hemorrhage during tooth extraction for the patient with hemophilia.
- Non-labeled indication (among many) is to prevent blood loss leading to blood transfusions in patients undergoing total joint arthroplasty.
- Cochrane Database and other Meta-Analysis conclude a significant reduction in blood loss during orthopaedic surgeries resulting in a significant reduction of patients requiring blood transfusions.
- No significant difference documented in prothrombin time (PT/INR), activated partial thromboplastin time (aPTT), deep-vein thrombosis (DVT) and pulmonary embolism (PE).
- Timing and dosage protocols are not yet clear. Some safe and effective protocols recommend IV administration:
  - 10 to 20 mg/kg pre-operatively or intra-operatively, followed by 10 to 15 mg/kg every three to eight hours for twenty-four hours.
  - 10 to 20 mg/kg once a day for three days
  - Intra-articular injection of 50mg/kg once postoperatively
  - Our organization administers 10mg/kg pre-operatively (as the patient rolls to the OR) and then again 3 hours postoperatively.

Administration

- Not compatible with solutions containing pencillin
- Many incompatibilities not known.
- Compatible with electrolyte solutions, carbohydrate solutions, amino acid solutions, and dextran solutions and heparin sodium
- Administer slowly; do not administer more than 10mg/min. Faster administration may cause hypotension.

Contraindications

- Acquired defective color vision
- Hypercoagulation clotting disorders; active DVT, PE, cerebral thrombosis
- Subarachnoid hemorrhage

Precautions

- Monitor for anaphylactic shock and/or severe allergic reactions
- Not recommended to administer in patients on hormonal contraceptives
- Patients in DIC should have strict supervision of experienced physician
- Adjust dosing in patients with renal insufficiency
- Monitor for visual abnormalities and report

References:

MacGilliyray, R., Tarabichi, S., Hawari, M., Raoof, N. Tranexamic acid to reduce blood loss after bilateral total knee arthroplasty: a prospective, randomized double blind study. *Journal Arthroplasty,* 2011 Jan: 26(1): 24-28.

Yang, Z., Chen, W., Wu, L. Effectiveness and safety of tranexamic acid in reducing blood loss in total knee arthroplasty: a meta-analysis. *Journal of Bone and Joint Surgery,* 2012; 94: 1153-9.

Micromedex

ANSWERS

White Christmas

Chestnuts Roasting on an Open Fire

All I Want for Christmas is My Two Front Teeth

O Holy Night

It Came Upon a Midnight Clear

O Come, All Ye Faithful

Away in a Manger

Deck the Halls

Little Drummer Boy

We Three Kings

Silent Night

God Rest Ye, Merry Gentlemen

Santa Claus is Coming to Town

Let it Snow

Go, Tell It on the Mountain

Rudolph, the Red-nosed Reindeer

What Child is This?

Joy to the World

Hark! The Herald Angels Sing

The Twelve Days of Christmas

Retrieved from: http://www.his-forever.com/carol_game_answers.htm

ASPAN DEVELOPMENT

ASPAN Development encourages giving from individuals and organizations to advance the practice of perianesthesia nursing. ASPAN uses such gifts for programs that focus on scholarships and awards, professional education, national advocacy, and evidence-based research. When you support ASPAN, you help bring about many good things. Your contribution:

- Demonstrates that our constituents care
- Supports nurses in perianesthesia practice
- Helps optimize patient care
- Encourages philanthropy among other prospective donors
- Ensures ASPAN programs continue at the lowest possible costs

Contributions can be made on your membership application/renewal form, through the Hail, Honor, Salute! program, or by contacting Doug Hanisch, Marketing and Communications Manager at: **dhanisch@aspan.org** or toll-free: 877.737.9696, x. 15.

The Perianesthesia Nurse and the Affordable Care Act: How it Will Affect Those at the Bedside

By: Katie Collins, RN, CAPA,
District Director

On Mar 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law with the full support of the American Nurses Association (ANA). President Karen Daley testified before Congress on behalf of heath care reform and the ANA worked closely with the writers of the 906-page bill to insure that nurses would play an indispensable role in the sweeping changes proposed by the law. Whether "Obamacare" turns your stomach or gives you hope, it will affect our nursing practice as it's statutes become effective over the next eight years.

The PPACA is nothing short of staggering in its scope. Although most of the controversy has been over the "individual mandate" that requires all individuals be enrolled in a health insurance plan by 2014 or pay a fee to the government, that is only one small part of a much larger plan to attempt to streamline America's health care system.

The parts of the bill that have already been enacted include extending healthcare coverage for young adults up to age twenty six under their parents' insurance plan and the prohibition of denying coverage to children with pre-existing conditions. Most of these involve forcing the insurance industry to expand coverage for the "underinsured" and provide coverage to those who would have been unable to get it without these reforms. Insurance companies must now spend a minimum of 85% of all premium dollars on patient care. More people will be eligible for Medicaid as it will be expanded to those with incomes up to 133% of the poverty line (excluding those in SC, FL,TX, MS, MI, and LA which have all opted out of the Medicaid expansion).

One of the changes that I believe affects us the most as nurses began this year. Starting this past Oct, the Centers for Medicare and Medicaid Services (CMS) began linking payments to quality of care in the form of the Value-Based Purchasing Program. Hospitals will be reimbursed by Medicare for acute care services based on how well they follow 13 evidence-based clinical measures. Six of these involve surgical care and are almost identical to the Surgical Care Improvement Project measures we are all familiar with. These include prophylactic antibiotic received within 1 hour of cut time, appropriate prophylactic antibiotic selection, beta blocker administration during the perioperative period, and VTE prevention in the surgery patient. Perianesthesia nurses make sure patients get their beta blocker before surgery if they take it at home, they remind physicians to order SCDs postoperatively, and they make sure the correct antibiotic is hanging as the patient rolls off to the OR. We do these things every day and now the organizations we work for are going to be reimbursed based partly on how well we do our part to insure better outcomes for our patients.

I have only touched the very tiniest tip of the massive iceberg that is the PPACA and I encourage everyone to go to the website "www.healthcare.gov" just to see what we as healthcare professionals will face in the coming years. Some of it really frightens me but I was also encouraged as I learned that nursing as a profession will benefit from increased funding for education and nurse practitioners are being recognized as qualified primary care providers. Check it out!

An Evidence-Based Approach to Management of Postoperative Urinary Retention (POUR) for Outpatient Surgery

By: Faye Baker BSN, RN, CPAN, Immediate Past President 2013

POUR is defined as the inability to void in the presence of a full bladder and continues to be a common complication after surgery. The true incidence of POUR is unknown because of lack of a consistent definition. POUR can cause overdistension of the bladder which leads to pain, vomiting, bradycardia, hypotension, hypertension, cardiac dysrhythmias, and asystole. Bladder rupture can also occur. Prolonged bladder overdistension can further cause permanent bladder dysfunction. It can certainly cause prolonged length of stay, especially for ambulatory patients. Although there is plenty of research available in the literature regarding POUR, there are no evidence-based guidelines for management of this problem. Baldini et al. (2009) has proposed an evidence based approach to prevention and management of POUR during the perioperative period. The following is a summary of their article.

In order to understand the risk factors of POUR, one must first understand the physiology of bladder storage and micturition. The normal adult bladder holds 400-600 ml of urine. The urge to void is felt at about 150ml. Parasympathetic nerve fibers innervate the bladder and cause contraction of the detrusor muscle and relaxation of the bladder neck to allow bladder emptying when bladder fullness is sensed. Storage of urine in the bladder is a completely different matter. Sympathetic nerve fibers that innervate the bladder cause the detrusor muscle to relax and cause the internal urethral sphincter to close. Voluntary control of the bladder involves coordination of the cortex, the brainstem centers, and the spinal segments related to bladder control.

Certain medications can interrupt this coordination required for voiding. Inhalation agents and intravenous opioids interrupt both parasympathetic and sympathetic nervous systems causing bladder atony. Diazepam, Phenobarbital and propofol can decrease contractions of the detrusor muscle. Spinal and epidural anesthesia block nerve impulses that travel between the brain and bladder and patients loose the sensation to void. Anticholinergic agents block detrusor contractions. β blockers, α blockers and sympathomimetics can also cause bladder dysfunction leading to POUR.

Certain types of surgeries place patients at risk for POUR. Joint arthroplasty, anorectal repair, hernia repair and previous pelvis surgery all have increased risk of POUR. POUR after Gynecological surgery has been reported but with conflicting results.

Intravenous fluids during surgery can also affect the incidence of POUR. An amount of greater then 750ml of IV fluids during hernia or anorectal surgery increases the risk by 2.3 times. Large amounts of IV fluids over distend the bladder and inhibit normal detrusor function.

Long duration of surgery has been shown in some studies to increase the risk of POUR. This finding could be related to a larger amount of IV fluids or longer exposure to inhalation agents. Also, longer surgery times lead to more bladder filling time which may over distend the bladder.

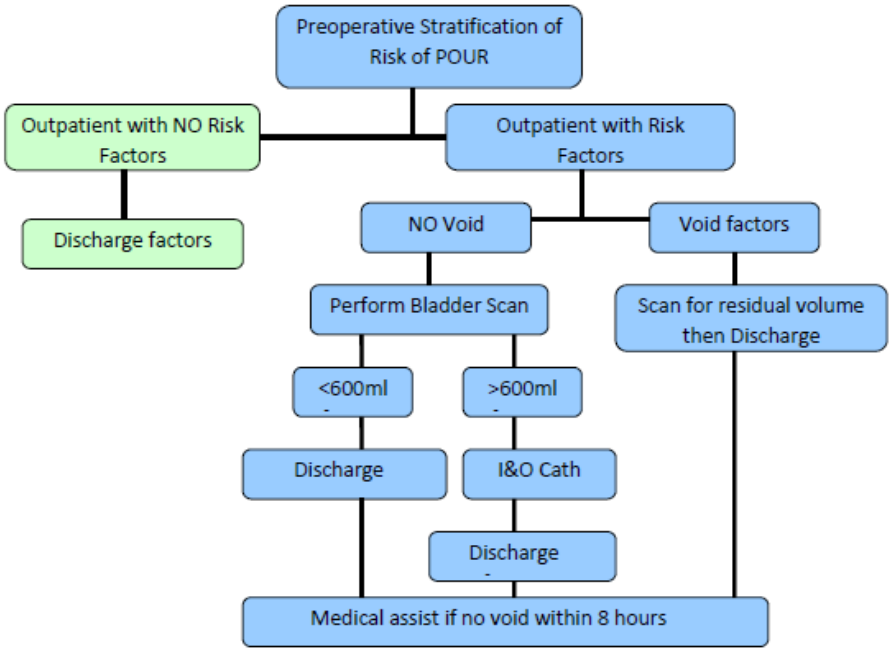
Age and gender also place the patient at a higher risk for POUR. Patients over the age of 50 have an increased risk by 2.4 times. Male gender also doubles the risk of POUR. BPH may play a factor in this phenomenon.

After reviewing 190 studies with regard to the effects of anesthesia and analgesic techniques on the incidence of POUR, Baldini and colleagues concluded that general anesthesia had less incidence of POUR than did spinal and epidural anesthesia. The use of long acting local anesthetics in spinal injections further increases the risk.

POUR CONTINUED

The authors also found that when opioids are omitted from the intrathecal anesthesia the incidence of POUR is decreased. Use of small doses of local alone or in combination with low doses of opioids can minimize the effects on bladder function and cause earlier return of bladder function. Epidural anesthesia with morphine had less incidence of POUR than intrathecal morphine. Adding epinephrine also prolongs blockade and leads to increased POUR. Epidurals at the thoracic level have less urinary retention that those placed at the lumbar region. Continuous epidurals and patient controlled epidurals have a higher incidence of urinary retention. In contrast, peripheral nerve blocks and local anesthetic injection is associated with less incidence of POUR.

Management of POUR starts with identification of risk factors and diagnosis of urinary retention. Methods used are history and physical exam, ultrasonographic bladder scanning, and bladder catheterization. Bladder distension can be felt with proper palpation and percussion. Ultrasound bladder scanning can be used to monitor bladder volumes and to measure post void volumes. Bladder catheterization is invasive and can cause infection, urethral trauma, and patient discomfort. Therefore it should be used only for treatment of POUR. Based on their review of the literature Baldini and colleagues have proposed the following algorithm for management of POUR in the ambulatory surgical patient.



Using an evidence-based algorithm can decrease length of stay for patients waiting to void prior to discharge. It requires fewer phone calls to physicians and directs the nurse's actions. It can also decrease the adverse effects of unrecognized POUR and decrease return visits to the ED for emergent catheterization.

Baldini, G., Bagry, H., Aprikian, A., Carli, F. (2009, May). Postoperative Urinary Retention. *Anesthesiology*, 110(5), 1139-1157.

MEET THE NEW SCAPAN BOARD OF DIRECTORS

Fall conference brought with it elections and a few new faces to the SCAPAN Board of Directors. **Faye Baker** moved up to Immediate Past President. **Donna West** became the President while Dianne Jackson moved into the Vice President/President Elect. **Carol Beckett** became the Secretary and **Michelle Long, Gwen Whitcomb**, **Marilyn Jeffereies** and **Rebecca Wilkin** were all elected as District Directors. The four newest members submitted bios so everyone can get to know them.

CAROL BECKETT

Secretary

Carol Beckett was born is southern California, but soon moved to a suburb of Boston, Massachusetts were she was raised. After graduating high school in 1985, she enlisted in the United States Army and received basic training at Fort Dix, NJ and advanced individual training as a surgical technologist at Fort Sam Houston, TX. She was transferred to the United States Military Academy - West Point for her first assignment where she worked as a certified surgical technologist for four years. While at West Point, Carol earned the coveted Expert Field Medical Badge and served as an instructor for future candidates. She also created a formal training program for other surgical technologist who desired national board certification. She attended both St. Thomas Aquinas College and Rockland Community College at night, earning general college credit. She met and married her husband in 1988.

In 1989, she was awarded a 3 year ROTC Nursing Scholarship and transferred to Columbia, SC. were she enrolled in the University of South Carolina. As an ROTC cadet, she attended the United States Army Airborne School at Fort Benning, GA and the ROTC Cadet Advanced Camp at Fort Lewis, WA. Between her junior and senior year at USC, she spent the summer developing both leadership and nursing skills at Tripler Army Medical Center in Honolulu, HI. In 1993, she graduated magna cum laude from USC and was commissioned a 2nd Lieutenant in the United States Army Nurse Corps.

Upon graduation, Carol's husband returned from an overseas assignment and was assigned to Fort Jackson, SC. Carol joined him in this assignment and became a staff nurse on the surgical floor at Moncrief Army Community Hospital. Carol worked on the surgical floor as both a staff nurse and charge nurse for two years and served on several nursing leadership committees. In 1995, she became the Nurse Manager of the Post Anesthesia Care Unit and had the great fortune of being mentored by a very knowledgeable, senior civilian PACU nurse. During her tenure as the nurse manager, Carol served as an ACLS and PALS instructor, joined ASPAN/SCAPAN, and became CPAN certified.

1997was a year of transition. Carol had her first child, moved to Lake Murray, resigned her commission in the Army, and took a part time job as a PACU nurse at Lexington Medical Center. Soon her second child arrived and Carol worked prn in preadmission testing, PACU I, and Step Down. In 2000, she assumed a 16hr/week staff nurse/charge nurse position in preadmission testing, where she continues to work today. She has been CAPA certified for the past 12 years. Currently, she is a full time graduate student at Liberty University, Lynchburg, VA, earning her MSN as an Adult, Acute Care, Clinical Nurse Specialist. She will graduate May, 2013.

GWENDOLYN WHITCOMB

District Director

CPT Whitcomb was born on 02 August 1975 in Ware, Massachusetts. She graduated from Ware High School in May of 1993 and graduated from Central Community College, Columbus, Nebraska with her Associate of Science Degree and Diploma for Practical Nursing in May 1998. CPT Whitcomb obtained her Bachelors of Science in Nursing from the University of Kansas Medical Center, Kansas City, KS. With a direct commission, she entered the United States Army on 28 August 2003 and attended the Officer Basic Course at Ft Sam Houston, TX.

CPT Whitcomb was assigned to Bravo Company Womack Army Medical Center, Fort Bragg, NC, where she served as a staff nurse on the medical telemetry unit and on the mother baby unit. CPT Whitcomb deployed with the Medical Task Force 86 in support of Operation Iraqi Freedom from November 2004 to November 2005. She served as clinical staff nurse on the Intensive Care Unit (ICU) in Ibn Sina Hospital, Baghdad. The original “Baghdad ER” she treated the most severely battlefield wounded patients whose intensity of care far exceeds that of any trauma center in the world.

CPT Whitcomb returned to Womack and served as the Assistant Head Nurse in the Post Anesthesia Care Unit (PACU) providing care to more than 500 surgical patients per month. Eager to return to the Intensive

Care Unit CPT Whitcomb attended the Critical Care Course at Fort Lewis Washington and received her skill identifier 8A Critical Care. In December 2006, she was assigned to Bravo Company Tripler Army Medical Center Honolulu HI where she served a plethora of roles including staff nurse in the Neuro/Pediatric ICU, surgical ICU and charge nurse in the Progressive care (Step-down) Unit. She was chosen to be a Critical Care Section bed manager as well as Rapid Response Team nurse responder. She was chosen to attend the Air Force Critical Care Air Transport training Brooks AFB, San Antonio TX, to support fixed wing missions to the Marshall Islands. In October 2007 CPT Whitcomb became the Assistant Head Nurse of the Post Anesthesia Care Unit.

CPT Whitcomb deployed with the Medical Task Force 10 in support of Operation Iraqi Freedom from May 2009 to December 2009. Having returned to Ibn Sina Hospital Baghdad, she served as charge nurse in the ICU. CPT Whitcomb was able to assist in the handing over of the hospital to the Iraqi people and set up a new facility at Sather Air base.

CPT Whitcomb graduated the Captains Career Course in San Antonio TX in May 2010 and was assigned to Alpha Company Martin Army Community Hospital Fort Benning GA. She was the Head Nurse of the ICU and a member of multiple hospital committees. CPT Whitcomb was nominated and selected for the 2010—CJ Reddy Junior Leadership Conference. This Conference brings together the most promising junior officers in the Army Nurse Corps for an intensive session built around learning, skill building, and networking in Washington D.C.

CPT Whitcomb deployed in support of Operation Enduring Freedom from June 2011 until December 24, 2011. In preparation for this mission she attended the Joint En Route Care Course at Fort Rucker AL to conduct rotary wing operations.

She served as an En route Critical Care Nurse (ECCN) or flight nurse attached to Charlie Company 10th Mountain DUSTOFF MEDEVAC. Flying in excess of 220 hours, she was directly responsible for the safe critical care transport of over 100 severely injured post-damage control resuscitation patients with no adverse outcomes.

CPT Whitcomb redeployed to Martin Army Post Anesthesia Care Unit for utilization prior to permanent change of station to Fort Jackson SC.

CPT Whitcomb was assigned to Medical Company Moncrief Army Community Hospital in June 2012. She currently holds the position of Clinical Nurse Officer in Charge of the Same Day Surgery / PACU.

CPT Whitcomb currently holds two national certifications in Critical and Emergency care. Certification is a process by which a nongovernmental agency validates, based upon predetermined standards, an individual nurse's qualification and knowledge for practice in a defined functional or clinical area of nursing.

CPT Whitcomb's awards and decorations include Air Medal, the Army Commendation Medal with four oak leaf clusters, Army Achievement medal, National Defense Service medal, Afghan Campaign medal with two bronze service stars, Iraqi Campaign medal with one service star, Global War on Terrorism Expeditionary Medal, Global War on Terrorism Service Medal, National Defense Service Ribbon, Over Seas Ribbon with numeral 2, NATO (ISAF) International Security Assistance Force Ribbon, Basic Aviation Badge and the Combat Medic Badge.

MICHELLE LONG

District Director

Michelle Long is originally from Hickory, North Carolina, and has been happily married for 5 years. They recently built a new house in the Piedmont area, and their next project is to work on expanding their family. Her initial job in healthcare was working as a Med-Surg CNA for 5 years in North Carolina, while she was in school. She graduated from Western Carolina University with her Bachelors in Nursing, and she has worked as a RN for 6 years. Michelle's first position was in one of the ICU areas at Greenville Memorial Medical Center, and after transferring, has worked in the Post Anesthesia Care Unit for the past 5 years. Along with working as a staff nurse, she takes on the roles of charge nurse and clinical advisor for new orientees. She joined ASPAN/SCAPAN because of peer pressure from two of her coworkers, Cindy Morgan and Donna West, but also, Michelle has to admit that she is excited about hopefully attending her first National ASPAN Conference this year as well gaining new knowledge while networking and making new friends.

MARILYN JEFFERIES

District Director

She has been a nurse for 30+ years with 20 of those years spent working in Emergency Services and the 1ast 10 years in OPS/PACU. She has a Bachelor of Science Degree. Marilyn really enjoys working in OPS/ PACU. She also very much enjoys actively participating in our state and national nursing specialty organization. She is a very willing worker and eager to help in anyway that she can.

Prostate Brachytherapy: A Nursing Perspective

By: Carol Beckett, BSN, RN, CPAN, CAPA

Prostate cancer is the most common male cancer and the second leading cause of male cancer death in the United States (American Cancer Society, 2012). The four main therapeutic modalities for prostate cancer treatment are surgery, external beam radiation therapy (EBRT), hormonal therapy, and brachytherapy. Each modality has its advantages and disadvantages and careful modality selection must be made in relation to specific patient factors and disease characteristics. In recent years, brachytherapy has been increasingly utilized for early stage prostate cancer due to technological advances in imaging, planning, and post implant quality assessment by dosimetry. Outcomes for prostate brachytherapy have shown to be equivalent in selected patients to those of other treatment modalities including radical prostatectomies and EBRT (Marcus, Jani, Godette, & Rossi, 2010).

Brachytherapy is a type of radiation treatment that is available in two options - high dose rate (HDR) and low dose rate (LDR). Low dose rate brachytherapy is the option most commonly used in prostate cancer treatment. In LDR brachytherapy, tiny radioactive seeds are implanted directly into the prostate in close proximity to the tumor. The seeds resemble a piece of lead from a mechanical pencil and are 1.5mm long (the approximate length of a piece of rice). Because the radiation emitting seeds are placed directly into and around the tumor, there is minimal damage to surrounding normal tissue. This offers a significant advantage to EBRT where the radiation beam must pass from outside the body through healthy tissue to reach the tumor.

Patients with early stage prostate cancer felt to be optimal candidate for this procedure meet with a urologist and a radiation oncologist to develop a plan of care. A preoperative baseline CT, rectal ultrasound, and PSA level is reviewed by the physicians. A medical physicist, using advanced computer software, determines the number of seeds, the dosing of each seed, and the exact placement of the seeds in the prostate. A radiation dosimitrist is responsible for loading the radioactive seeds into the needles in accordance with the physicist's plan.

The Procedure

Prostate brachytherapy in performed as an outpatient procedure and is commonly fully covered by insurance. The patient is given general anesthesia and placed in the high lithotomy position. Members of the surgical staff include an anesthesiologist, CRNA, urologist, radiation oncologist, medical physicist, radiation dosimitrist, and OR nurse. A Foley catheter is inserted and left to bedside drain throughout the procedure. A rectal ultrasound probe is also inserted and remains in place throughout the procedure for real time imaging of the prostate and adjacent anatomy. The patient is prepped and draped in a fashion that allows manipulation of the rectal probe and full exposure to the perineum.

PROSTATE CONT.

A template, resembling a square piece of metal with numerous pinholes, is placed on the perineum to assist with seed placement. Once the needles are loaded with the radioactive seeds, they are methodically inserted through the template and perineum and into the prostate. Real time rectal ultrasound images assist with proper seed placement. Approximately 20–40 needles are inserted into the prostate, containing approximately 60-120 seeds. A goal of the physicist is to utilize the least amount of needles possible to decrease needle trauma to the prostate, while optimizing the location of the seed placement. Once the seeds are placed, the rectal probe and Foley catheter are removed, and the urologist performs a post procedure cystoscopy. The cystoscopy serves to ensure hemostasis, and identify and remove any radioactive seeds that may have unintentionally entered the rectum, bladder, or urethral canal. Placement of the seeds takes approximately 90 minutes and the entire procedure takes approximately three hours. All members of the surgical staff, the patient, and all linens are scanned with a Geiger meter to ensure no radioactive material is inadvertently removed from the OR suite. (Continued pg. 20)

Recipe: Pumpkin Squares

Mix these items together and spread in greased 9x12 pan

- 1 box yellow cake mix (reserve 1 cup)
- 1egg
- 1 stick butter

Combine these ingredients and pour over first layer

- 1.5 cups canned pumpkin
- 2/3 cup sugar
- 2/3 cup milk
- 2 eggs
- 1 tsp. cinnamon
- pinch of salt

Mix together and crumble over top

- 1 cup reserved cake mix
- ¼ cup sugar
- ¼ cup brown sugar
- 1 tsp. cinnamon
- ¼ cup soft butter

Bake at 350 for 50 minutes

PROSTATE CONT.

Postoperative Care

The patients arrives in the PACU accompanied by the CRNA, OR nurse, and the medical physicist. Using the Geiger meter, the physicist scans the patient at a distance of three feet and ensures a safe radiation level in accordance with national standards. Report is given to the PACU nurse in the usual manner and includes the number of seeds implanted and the number of needles used.

Pain: Treat per protocol and clinical judgment.

Incision: None. Seeds implanted through the perineum using needles. Assess perineum for edema. Bleeding or oozing from needle sticks is not expected.

Dressing: None.

Bladder: Bladder emptied after post procedure cystoscopy. Continually assess for urinary retention. The greater number of needles used the greater chance of prostate edema and urinary retention. May need to perform bladder scan and catheterize. Hematuria is not expected unless a seed had to be extracted from the bladder or urethra.

Bowel: A preoperative Fleet enema is given, but patient may complain of a need to defecate postoperatively secondary to intraoperative rectal probe manipulation.

Radiation Safety: The medical physicist has determined the patient is safe to be care for without protective equipment. However, when taking care of patients with implanted radioactive material, it is wise to remember a common radiation safety principle known by the acronym ALARA (as low as reasonably achievable). This principle means you take every reasonable effort to minimize your radiation exposure.

To achieve ALARA:

- bundle your tasks when caring for the patient, encourage self-care when possible.
- if not providing direct care, maintain a distance of three feet or greater between the you and the patient. Exposure to radiation is decreased by 75% for each doubling of the distance between nurse and patient (Eisenberg, 2009).
- if you find a seed in the linen, urinal, Foley bag, stool, etc., do not pick it up. Call your radiation safety officer for proper disposal.

Postoperative Instructions

Patients receiving prostate brachytherapy are usually well instructed by the radiation medicine staff. They receive preoperative and postoperative written instructions prior to arriving for the procedure and are well informed. Phase II PACU nurses can reiterate the following general postoperative instructions for patients receiving radioactive seed implants (2012):

Diet: No restrictions

Physical activity: No restrictions. May want to avoid activity that can irritate the perineum like bicycle riding.

Sexual activity: No intercourse for two weeks. Then use condoms for two months

PROSATE CONT.

Children: Limit the amount of time they sit on your lap. 1st month – <1 minute/day. 2nd month – < 4 minutes/day. 3rd month – < 15 minutes/day.

Pregnant women: No limit to the amount of time they can be around patient, but they should keep a distance of more than three feet.

Examine your linens, urine and stool for seeds that may come out. This is very rare, but call your radiation oncologists immediately if you see one. Do not pick them up.

Your breath, sweat, and body fluids will not contaminate anyone. Your toilet, clothes, and linens can be cleaned without special precautions.

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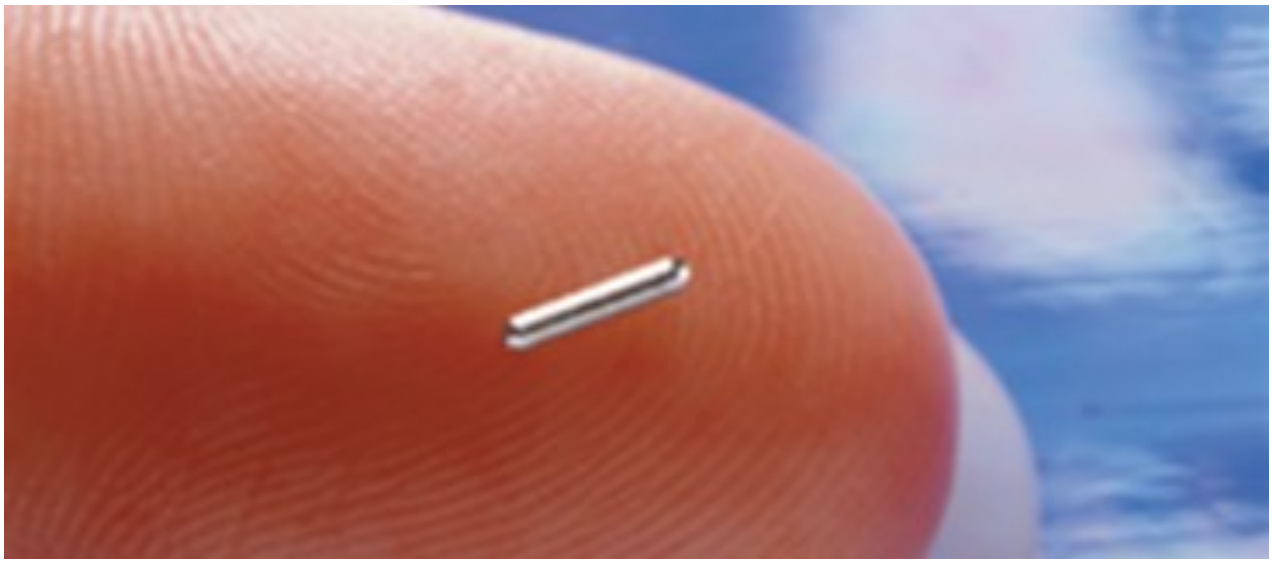

The Obama Effect on Medicaid Expansion in SC

By: Schipp Ames

While the Obama victory ensures the survival of his landmark Affordable Care Act (ACA), the decision whether to expand Medicaid in our state remains in the hands of South Carolina's Republican Governor and Legislature. Therefore, an Obama victory does not mean that his healthcare overhaul will be fully realized in South Carolina. The debate centers on the ACA's direction to expand Medicaid to those citizens with annual incomes up to 138% of the Federal Poverty Level. That's roughly $15,000 a year for a single adult, and around $32,000 a year for a family of four.

An April report from the South Carolina Department of Health and Human Services (DHHS) projects that 236,000 South Carolinians stand to gain coverage from Medicaid expansion, but it's the ones that are already eligible that will really affect South Carolina's bottom line. That's because now that all citizens are required to have health insurance, DHHS will be responsible for enrolling thousands of individuals and families that are already eligible for Medicaid, but have not enrolled in the program. In fact, the majority of costs associated with the ACA come from those that are already eligible for Medicaid coverage.

So what is the State's incentive to expand Medicaid in South Carolina? Not surprisingly, it all comes down to money. While the Federal Government currently offers a 70/30 match for Medicaid in our state, Medicaid Expansion under the ACA will be 100% paid for by the Federal Government for the first 3 years, gradually declining to 90% in 2020 and beyond. That means that the State will recognize a permanent 9 to 1 match on funds associated with the newly eligible population. Rejecting Medicaid expansion in South Carolina will forgo over $11 Billion in federal funds to our state from the increased matching rate.

Not to mention, as part of the compromise to pay for Medicaid expansion under the ACA, hospitals agreed to significant reductions in Medicare reimbursement and Medicare and Medicaid Disproportionate Share (DSH) funds that provide financial assistance to hospitals for uncompensated care provided to uninsured patients. The reasoning was that hospitals could offset these reductions with the additional revenue received from an increase in patients covered through newly created health exchanges and an expanded Medicaid program. Although we will see some of the uninsured covered through the insurance exchange, without Medicaid expansion, statewide cuts in Medicare and Medicaid DSH funds to hospitals total **$2,773,605,270.** These cuts without an increase in the insured population will significantly hurt South Carolina's hospitals.

So where does SCHA stand in all of this? SCHA believe this is a unique opportunity to transform the Medicaid program, producing better health outcomes and controlling costs whether we expand Medicaid as directed by the ACA or negotiate a solution that better suits our state. However, our hospitals literally cannot afford a total rejection of Medicaid expansion due to the cuts already in place. Without an alternative plan, SCHA will support Medicaid expansion as outlined in the ACA.

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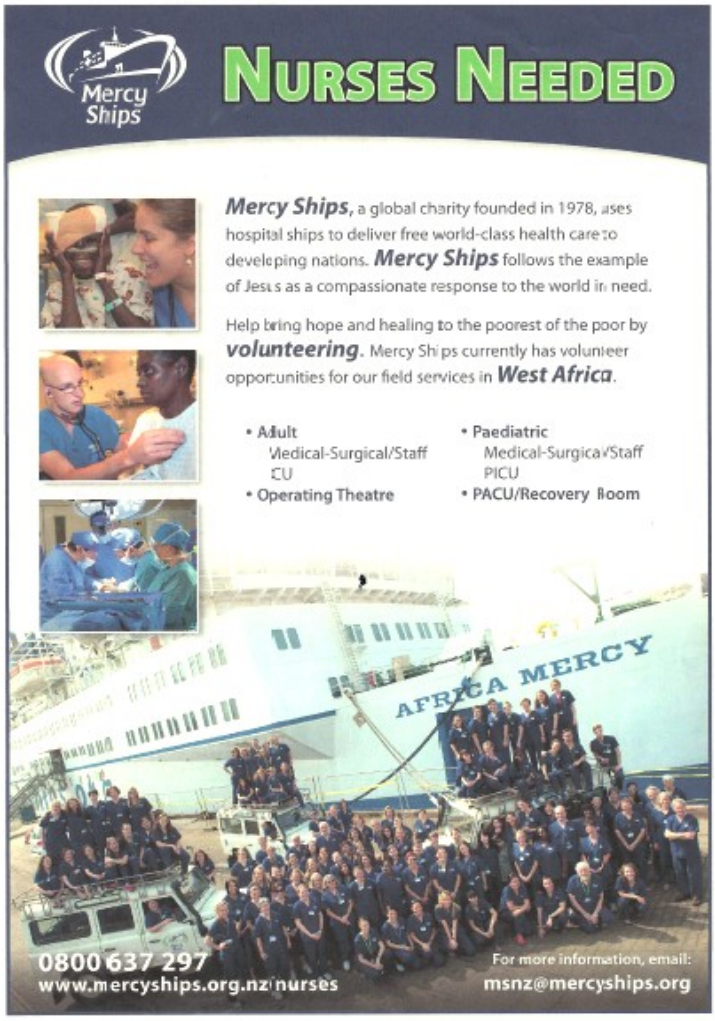

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CALENDAR OF EVENTS

Save the Date: Spring Conference March 9, 2013 Columbia, SC

-Details to follow

ASAPAN National Conference : April 14-18, 2013 Chicago Illinois

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