The Newsletter of the American Society of PeriAnesthesia Nurses

Breathline

Volume 32, Number 3
May/June 2012

INSIDE:

Sir Isaac Newton once said, "If I have seen further it is by standing on the shoulders of giants."[1]

A SOLID FOUNDATION FOR THE FUTURE

National Conference is always a time of change, transition and opportunity. ASPAN held another exceptional conference that, as always, presented opportunities to learn cutting-edge perianesthesia updates from a cornucopia of excellent speakers. Regardless of whether this was your first conference or your 31st conference, Orlando provided avenues to gain new knowledge and experiences, meet and enjoy the company of old friends and colleagues as well as create new and lasting friendships.

Susan Carter, BSN, RN, CPAN, CAPA
ASPAN President 2012-2013

A time of transition also occurs within ASPAN as the newly elected officers and appointed committee and strategic work team (SWT) leaders meet for the first time with their work teams. Members new to ASPAN volunteerism and those returning, who have expressed a willingness to participate in the many projects and work to continue moving ASPAN forward, begin their discussions and planning. Whether you are a seasoned leader or a first time volunteer, it is a time of positive energies, excitement, enthusiasm and creativity.

Solid Connections Past and Present

For each of us, this transition time is the ideal time for reflecting on the stellar, motivational and inspiring nursing of ASPAN leaders who came before us and those who currently stand beside us. From those past dynamic and visionary leaders we have learned valuable lessons and can build on the strong foundation they created. We have learned from them, and from our own experiences, that nursing is an incredibly relational profession.

Daily we are surrounded by patients, families, nursing and physician colleagues, and we constantly touch people's lives with compassion, unique knowledge and skills and a connection unlike any other profession. We care for patients at some of their most vulnerable times. Each day we are thrust into the most intimate moments of the lives of people who were strangers to us only moments before.

Relationships

This relational work touches our own humanity in ways we often do not anticipate. Each and every one of us has stories about patients who continue to live within our hearts and minds. Although our work is demanding both physically and intellectually, often it is the emotional and relational aspects of nursing that are the most rewarding while at the same time difficult, frightening and exhausting. Recognizing these shared emotions and vulnerabilities brings us close.

As nurses, we need each other for support and understanding. In order for us to do our work for our patients' safety and comfort as well as that of their families, our work must be coordinated and well-communicated: nurse-to-nurse, colleague-to-colleague and shift-to-shift. If our work is truly to make a difference, we must depend on each other, respect each other, and collectively encourage our strengths while supporting our weaknesses.

Connectivity

Nurses are banded together in ways most people in other professions simply cannot understand. We tend to know our co-workers well, to care about them, and understand them much more deeply than is typically the norm in other professions. We tend to recognize the interdependence and acknowledge the support we received from others along our career path. We

continued on page 2

continued from page 1

cherish the tapestry created by the threads provided to us by teachers, mentors, and the many colleagues who lent a shoulder when it was most needed. This is the firm foundation we stand on each and every day. Our strength and success has to do with those who came before us and those who held us up and kept us going. This interdependence and support is best demonstrated by a quote from Sir Isaac Newton who once said, "If I have seen further it is by standing on the shoulders of giants."[1]

At the bedside, in the boardroom; in clinics and classrooms; whether we are working as leaders, lobbyists, mentors, military or managers, nurses make a difference every day in the lives we touch. We are nationally over three million strong[2] and the largest sector of the nation's healthcare workforce. The unique role nursing plays in the lives of patients is being recognized and our voices are being heard. Opportunities and possibilities for nursing's future are unlike any other time in history.

Solid Foundation: Future Possibilities

You have undoubtedly heard of the 2010 Institute of Medicine/Robert Wood Johnson (IOM/RJW) report entitled, "The Future of Nursing: Leading Change, Advancing Health."[2] This report calls for nursing to have a much larger part in shaping national healthcare reform and implementation of the recommendations developed in the milestone report. Both the *Breathline* and the *Journal of PeriAnesthesia Nursing* (*JoPAN*) have discussed or cited the many recommendations that promote unprecedented opportunities and possibilities for nursing now and in the future.

What are the past lessons learned that will help us in furthering the work of ASPAN and aiding in the decisions that will be made? It is up to each of us, individually to know that history, understand it and use it. As with all times of change and transition, let each of us take some time to think about our individual and collective future – one that is bright with promise, opportunity and possibilities – and spend time to reflect on our personal leadership role and the part each of us has in the future of nursing and the future of ASPAN. Let us remember all those who came before us and focus on their contributions that can still be measured and their words that still resonate within us.

Nursing history is not just a course taught in school, or a fleeting memory of the leaders who paved the road making our journey easier. It is part of our own personal tapestry, the fabric of what we are and what we do as nursing healthcare professionals. Our past is our foundation. It is strong and stable and has provided us with the tools we need to continue building and moving forward; expanding our knowledge, wisdom, skill and influence. We have gained much from those who came before us and worked to construct the framework of what we have today. We will continue to create opportunities and possibilities for the future of ASPAN and for nursing as a whole. Eleanor Roosevelt once said, "You must do the things you think you cannot do."[3] As ASPAN, and as part of the larger global collective of nursing, we are building the future.

REFERENCES:

1. Standing on the shoulders of giants. Available at: http://en.wikipedia.org/wiki/Standing_on_the_shoulders_of_giants" Accessed 2/12/12.
2. The Future of Nursing. Available at: http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx Accessed 2/12/12.
3. http://www.brainyquote.com/quotes/authors/e/eleanor_roosevelt_4.html Accessed 2/12/12.

ASPAN® Breathline

Published by the American Society of PeriAnesthesia Nurses™

Indexed in the Cumulative Index to Nursing Allied Health Literature (CINAHL)

Address changes and administrative correspondence to:

ASPAN
90 Frontage Road
Cherry Hill, NJ 08034-1424
877-737-9696
Fax: 856-616-9601
aspan@aspan.org
www.aspan.org

Editorial Comments or Letters to the Editor to:
Barbara Godden
9320 Erminedale Drive
Lone Tree, CO 80124
bgodden@aspan.org

Deadlines for inclusion in *Breathline*:

Issue	Deadline
January	November 1
March	January 1
May	March 1
July	May 1
September	July 1
November	September 1

Tracy Underwood, BSN, RN, CPAN

Raquel Evans, BSN, RN

STAFF NURSES in Research

Nursing research is essential in developing the way new therapies are applied to the care of our patients. Research is the driving force in defining our nursing practice. The idea for our first research project came after hearing many experts advocate for a finger stick blood glucose on every preoperative patient. A speaker stated in a lecture that the gold standard of care would be for every patient to have a finger stick blood glucose prior to surgery.

As novices in research, we conducted a literature review and found that Type II diabetes can take six to ten years to diagnose. Patients who go to surgery with elevated blood glucoses are at a greater risk for complications, some of which are surgical site infection, cardiac arrhythmias, renal failure, and poor wound healing.[1] We designed a protocol to screen for Type II diabetes leading to earlier diagnosis, prevention of surgery cancellations and complications associated with undergoing surgery with high blood glucose.

All patients 18 and over being seen in the Preadmission Unit have a finger stick blood glucose. If the finger stick is high by set parameters, these patients have an A1c drawn and a brief education sheet on diabetes. At this time, they receive a brief education sheet on diabetes. The next day a nurse checks the A1c values. If the level is elevated, the nurse generates an appointment with a primary care physician (PCP) to control the diabetes before the day of surgery. A letter is sent to the patient's PCP. The day of surgery, these patients receive an information packet and education postoperatively.

This procedure allows us to identify Type II diabetics earlier and prevent known complications. There are fewer cancellations the day of surgery due to high glucose. The patients have fewer complications such as infection, and length of stay is decreased. We are currently collecting data on a research study evaluating the effectiveness of our protocol to provide our patients with the resources and education which allow them to better control their newly diagnosed diabetes. We look forward to publishing the results of this study.

Although research can be intimidating, staff nurses can conduct research. You do not have to have a doctorate to participate in research, but it is helpful to have someone holding a doctoral degree on your team. Doctorate prepared professionals have extensive education related to the research procedure. A mentor is also very helpful to mentor one through this complicated process. With desire, interest, and the right mentor, any nurse can contribute to the practice of nursing through research.

REFERENCE

1. Schick L, Windle PE, eds. PeriAnesthesia Nursing Core Curriculum: *Preprocedure, Phase I and Phase II PACU Nursing*. 2nd ed. St. Louis, MO: Saunders; 2010: 271, 868, 1235.

New Member Benefit!

ASPAN members now have access to the **Joanna Briggs Institute (JBI)**, a renowned organization for obtaining research data. To access the JBI portal, *Click here*

ON THE WEB SITE HOME PAGE NOW!

Free FDA webinar on "Preventing Surgical Fires" scheduled for June 12, 2012. Go to the ASPAN Web site home page with instructions on how to access and participate in this webinar. Contact hours available.

◀ *Safety initiative: Preventing surgical fires*

▲ *President Chris Price relaxing at Component Night*

COMING IN THE JULY/AUGUST ISSUE OF *BREATHLINE*:

Full coverage of the 2012 ASPAN National Conference in Orlando, Florida

▲ *President Chris Price presiding over the 2012 Representative Assembly in Orlando*

continued on page 5

ASPAN News *continued from page 4*

SCHOLARSHIP PROGRAM ACCEPTING APPLICATIONS – Application Deadline July 1

The ASPAN Scholarship Program is a member benefit designed to provide financial assistance to ambulatory surgery, post anesthesia, preanesthesia, and pain management nurses aspiring to enhance their abilities to contribute to the perianesthesia nusing community. ***Applicants must be current Active Category members of ASPAN and a component for the past two full years prior to the application deadline.*** The Scholarship Brochure/Application is ONLY available online, with specific eligibility requirements for each type of scholarship detailed in the Scholarship Brochure.

To access ASPAN Scholarship Program information and application form *Click here* or select "Scholarship Program" from the "Members" dropdown menu at www.aspan.org

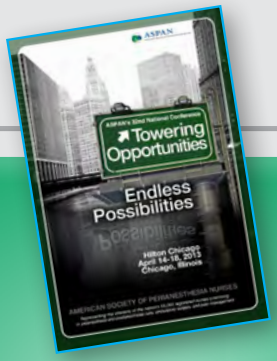
Scholarship Offered

- $1000 for Bachelor of Science in Nursing, Master of Science in Nursing or Doctorate in Nursing
- $500 for ASPAN National Conference attendance
- $285 for CPAN or CAPA Certification Exam fees
- Two Nurse in Washington Internship (NIWI) program scholarships
- A minimum of one $500 Humanitarian Mission scholarship

SAVE THE DATE

ASPAN Component Development Institute (CDI)
September 7-9, 2012
St. Louis, Missouri
Crowne Plaza Hotel

▲ *The famous St. Louis arch*



SAVE THE DATE

ASPAN's 32nd National Conference
April 14-18, 2013
Chicago, Illinois
The Hilton Chicago

▲ *Evening skyline of Chicago*

continued on page 10

"MAKE IT ZERO" CAMPAIGN

The American Society of PeriAnesthesia Nurses (ASPAN) is proud to support "Make It Zero": a global campaign to raise awareness of the pulse oximetry gap, and supply pulse oximeters, training and support to anesthesia providers in low-resource countries.

We encourage our members to donate to Lifebox and to spread awareness of the need for surgical and anesthesia safety.

Donate here **More information about Lifebox**

Below is the official letter from ASPAN supporting this initiative.

ASPAN
American Society of PeriAnesthesia Nurses

ASPAN ANNOUNCES PARTNERSHIP WITH LIFEBOX GLOBAL TO IMPROVE SURGICAL SAFETY AND CARE WITH LIFE-SAVING PATIENT MONITORING TOOLS

CHERRY HILL, NEW JERSEY, April 10, 2012—The American Society of Perianesthesia Nurses (ASPAN) today announced its partnership with Lifebox, a global not-for-profit organization aimed at reducing unnecessary deaths through safer surgery. ASPAN is joining a two-year international campaign titled "Make it Zero," which seeks to distribute 5,000 pulse oximeters to operating rooms across Africa, Asia, Eastern Europe and Latin America. To help support this important initiative, ASPAN is urging its 14,500 members to donate to the campaign. $250 USD is enough to send one pulse oximeter and educational materials to a hospital in need.

Pulse oximeters, a component of the World Health Organization Surgical Safety Checklist, measure the level of oxygen in a patient's blood during anesthesia, sounding an early warning alarm if a patient is becoming short of oxygen, providing an opportunity to prevent brain damage, heart failure, and, in some cases, death.

While pulse oximeters are the standard of care in many hospitals, they are critically missing from thousands of operating rooms globally. According to a recent estimate, approximately 77,000 operating rooms worldwide are working without pulse oximeters.[1]

Speaking of the partnership, ASPAN Chief Executive Officer, Kevin Dill, said, "We are honored to help Lifebox in its endeavors to help ensure that no patient dies because basic safety checks and a pulse oximeter were not used during surgery. We encourage our members to learn more about the organization and support this important campaign."

"Lifebox is very thankful for the generous support from ASPAN, which allows us to supply medical facilities around the world with life-saving tools and educational materials," said Atul Gawande, MD, MPH, founder of Lifebox, Surgeon at Brigham and Women's Hospital in Boston, Associate Professor of Surgery at Harvard Medical School and Associate Professor in the Department of Health Policy and Management at the Harvard School of Public Health. "Lifebox hopes to cut death rates in surgery by up to a half worldwide with increased access to pulse oximetry and use of the World Health Organization Surgical Safety Checklist."

The "Make it Zero" campaign is running from April 1, 2012, to April 1, 2014. Donations can be made online at www.lifebox.org.

ASPAN represents the interests of over 55,000 nurses who practice in preanesthesia and postanesthesia care, outpatient surgery, and pain management settings. Its mission includes providing members with the latest in perianesthesia education, research, standards, networking, and advocacy. ASPAN is available online at www.aspan.org.

1. Funk LM et al. Global operating theatre distribution and pulse oximetry supply: an estimation from reported data. *Lancet.* 2010 Sep 25;376(9746):1055-61. Epub 2010 Jul 2.

Contact: R. Douglas Hanisch
Marketing and Communications Manager
American Society of PeriAnesthesia Nurses
dhanisch@aspan.org · 877.737.9696, x. 15
90 Frontage Road, Cherry Hill, NJ 08034

Frequently Asked Questions

Barbara Godden, MHS, RN, CPAN, CAPA – Immediate Past ASPAN Director for Clinical Practice 2008-2012

The Clinical Practice Committee receives many questions via the ASPAN Web site each month. Committee members then research the answer and respond to the query. This is one frequently asked question.

Barbara Godden, MHS, RN, CPAN, CAPA
Immediate Past ASPAN Director for Clinical Practice 2008-2012

Q: *Is capnography required in Phase I PACU?*

A: The American Society of PeriAnesthesia Nurses (ASPAN) does not currently have a practice recommendation requiring continuous monitoring of end tidal carbon dioxide (etCO2 or capnography) in the Phase I PACU. Practice Recommendation 2 comprises Components of Initial, Ongoing, and Discharge Assessment and Management. It states that vital signs are monitored, including "capnography monitoring if available and indicated" and to "monitor, maintain, and/or improve respiratory function."[1]

ASA Standards

Monitoring etCO2 has long been a standard of care for anesthesiologists delivering general anesthesia to intubated patients in the operating room.[2] This practice has expanded to areas outside of the operating room. The American Society of Anesthesiologists (ASA) recently updated its standards for basic anesthetic monitoring.[3] The Standards state that "the adequacy of ventilation will be continuously evaluated … continual monitoring for the presence of expired carbon dioxide shall be performed."[3] The ASA goes on to state that "during moderate or deep sedation the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and monitoring for the presence of exhaled carbon dioxide."[3] This applies to nurse monitored sedation as well.[2]

The ASA states in its Standards for Postanesthesia Care that "particular attention should be given to monitoring oxygenation, ventilation, level of consciousness and temperature."[4] The ASA does not specifically state that capnography is required in the PACU, but that ventilation is to be monitored. The most effective way to monitor ventilation is through capnography.

Future of Capnography

Capnography can be valuable in the PACU for very sedated patients, those receiving high doses of opioids, and for the patient with diagnosed or undiagnosed obstructive sleep apnea. In situations where the patient's respiratory status has been compromised, capnography monitoring and assessment may lead the PACU nurse to intervene and recommend enhanced patient safety measures following the PACU phase of care. He/she may advocate for a higher level of care for the patient after leaving the PACU.[5]

Capnography may be also useful in the period of time after the patient leaves the PACU. Postanesthesia nurses are well aware of situations on the medical-surgical floors, where increased nursing work loads are limiting the frequency with which post surgical patients are monitored. A new trend is for patient-controlled analgesia pumps to incorporate both pulse oximetry and capnography monitoring into the pump mechanics. This type of system alerts the nurse through early warning for opioid induced respiratory depression and potentially averts a crisis situation for the patient.[2]

Trends in perianesthesia nursing are regularly discussed as potential additions to the ASPAN Standards. Capnography has proven its need and value to patient outcomes in the anesthesia and sedation venues. With the increasing vigilance needed in Phase I PACU for patients in such a vulnerable state, capnography is a monitoring tool that may be beneficial and recommended in the very near future.[5]

REFERENCES

1. American Society of PeriAnesthesia Nurses. *Perianesthesia Nursing Standards and Practice Recommendations 2010-2012*. Cherry Hill, NJ: ASPAN; 2010: 74-76.
2. Odom-Forren J. Capnography and sedation: A global initiative. *Journal of PeriAnesthesia Nursing: 26*(4), 221-224, 2011.
3. American Society of Anesthesiologists. Standards for basic anesthetic monitoring. Available at: http://www.asahq.org/For-Healthcare-Professionals/Standards-Guidelines-and-Statements.aspx. Accessed August 7, 2011.
4. American Society of Anesthesiologists. Standards for postanesthesia care. Available at: http://www.asahq.org/For-Healthcare-Professionals/Standards-Guidelines-and-Statements.aspx. Accessed August 7, 2011.
5. Godden B. Where does capnography fit into the PACU? *Journal of PeriAnesthesia Nursing: 26*(6), 408-410, 2011.

The Director's Connection

Martha Clark, MSN, RN, CPAN – Regional Director, Region 3

Martha Clark,
MSN, RN, CPAN
Region 3 Director

"Blessed is the influence of one true human on another."[1] *The summer of 2011 brought the war in Afghanistan closer to us more than the nightly news ever could. One of our ASPAN colleagues and former ASPAN President, Myrna Mamaril, was called to care for our servicemen in a foreign land. As ASPAN began to receive e-mails from Myrna, it became clear that ASPAN's membership could make a huge difference in the lives of not only our servicemen and women, but also in the lives of Afghanistan men, women, and children. The gathering of items for Myrna began at the Component Development Institute (CDI), continued throughout Region 3 Fall component meetings, and on into 2012. We will never know the total number of items sent, but we can be assured that our packages served as a "Blessed influence of one true human on another."[1] I thank all Region 3 components for sharing their blessings and a few of their achievements.*

Illinois Society of PeriAnesthesia Nurses:

- ILSPAN was rewarded March, 2011 when the Illinois legislature granted the right for visitation in the PACU
- Spring conference sold out with registrations of 205 to hear speaker Lois Schick
- Possible collaboration with AORN was discussed for an educational presentation

Indiana Society of PeriAnesthesia Nurses:

- INSPAN has suggested formation of a research Specialty Practice Group (SPG)
- The research SPG could help components seeking the Gold Leaf Award

Kentucky Society of PeriAnesthesia Nurses:

- Received the Gold Leaf Award for Component of the Year at the 2012 National Conference in Orlando!
- KSPAN celebrated a milestone membership of 209
- KSPAN completed transition from a one year to a two year term for President and President-elect
- Plans are underway to embark on their first component research project

Michigan Association of PeriAnesthesia Nurses:

- MAPAN celebrated the 35th anniversary of their founding by offering discounted prices for their conferences and held giveaways
- Bed sheets and $600 were collected for two board members to shop for items to be sent to Myrna. A total of seven boxes were mailed

continued on page 10

▲ *Region 3 component and national leaders at ASPAN National Conference 2012*

ASPAN GOES TO THE HILL!

Nurse In Washington Internship (NIWI)

Donna Goyer, BS, RN, CPAN, CAPA – ASPAN Governmental Affairs Strategic Work Team Coordinator
Sue Carter, BSN, RN, CPAN, CAPA – ASPAN Vice President/President Elect 2011-2012
Seema Hussain, MS, RN, CAPA – Governmental Affairs Chair for the Chesapeake Bay Society of PeriAnesthesia Nurses

Donna Goyer, Susan Carter, and Seema Hussain had the privilege of attending the Nurse In Washington Internship program (NIWI) February 26-28, 2012. Having heard multiple prior attendees detail how exciting, inspiring and wonderful the NIWI experience was, we can now, whole heartedly, echo this sentiment!

Sue Carter, Seema Hussain, and Donna Goyer at NIWI

NIWI was attended by approximately ninety nurses including students, educators, nurse practitioners and clinical nurse specialists, representing a variety of nursing specialties from all over the nation. In addition to the extensive networking opportunities, we heard national speakers share top nursing priorities. We also received detailed advocacy training to prepare us for our day on Capitol Hill where we would meet with our elected senators and congressional representatives.

Advocacy Training

The advocacy training was divided into two sessions based upon previous experience and training. Through participation in the advocacy sessions, we gained a greater understanding of the important role nurses play in advocating for healthcare-related policy. Nurses are most comfortable and familiar with advocating for their patients. While less comfortable advocating for legislative, regulatory and media aspects of healthcare, we discovered that it is equally important for us to develop skills to assist in gaining confidence and competence in these areas. During our training sessions we learned how the various types of advocacy can impact public policy. For example, an individual may feel that grassroots efforts, such as signing onto scripted e-mail messages, is not very effective. However, the volume of responses received is monitored and validates the importance that an elected official's constituents place on particular issues. Furthermore, coalition work brings value through representation of multiple organizations sharing and advocating for common concerns.

The direct (face-to-face) lobbying was the focus of most of our preparation time in order to be ready to apply the skills and techniques learned for our Capitol Hill visits. Direct lobbying is extremely impactful; as a constituent we are sharing our knowledge and personalizing the impact that proposed legislation, appropriations and/or regulations may have, in the elected representative's state or district. Our lobbying efforts were focused on three "asks" – what we specifically were asking our representatives to support in the current year: (1) Support $251 million for the Nursing Workforce Development Programs (Title VIII, Public Health Service Act); (2) Support $150 million for the National Institute of Nursing Research a section of the National Institute of Health; and (3) Support $20 million for Nurse-Managed Health Clinics.

Now to Capitol Hill

As we embarked upon our Capitol Hill journey to meet with our senators and congressmen, we were well-prepared, yet many admitted to a bit of "stage fright." We all returned at the end of the day to share our experiences which ranged from brief hallway conversations, to high levels of engagement by the legislators or their staff, to full tours of the Capitol. As we were wrapping up our time in Washington, it was abundantly clear that the attendees had influenced their respective legislative leaders by being well-rehearsed, sharing a common message and establishing relationships with the legislators. We came to Washington as "grassroots" advocates, and left with a determination to continue these relationships at an elevated level of advocacy, to become "grasstops" advocates.

Attending NIWI has been a goal for some time. Now that it has been realized, there are fresh and exciting new goals….advocacy mentoring and greater local, state and federal advocacy involvement. While becoming involved in advocacy efforts for legislative and healthcare policy can seem intimidating at first, the training and experience of NIWI have created the spark to share what was learned. With this new knowledge, we hope to fan the fires of involvement for ASPAN leaders and members so they too can know the thrill of being "grasstops" advocates.

continued from page 5

SAVE THE DATE
2013 International Conference

The 2nd International Conference for Perianesthesia Nurses (ICPAN) is heading to Dublin, Ireland! *"Converging Practice – Celtic Style"* will be held on September 19-22, 2013. In addition to networking time with international perianesthesia colleagues, you will share practices, view poster presentations and hear from presenters from around the globe! Be sure to plan some additional time to explore Dublin and the rest of the Emerald Isle while staying at the Citywest Hotel. Check out the web site at www.icpanconference.com

▲ *One of many historical buildings to visit in Dublin*

The Director's Connecton *continued from page 8*

Minnesota-Dakotas Society of PeriAnesthesia Nurses:

- MNDAKSPAN continues to conduct board of directors meetings using SKYPE
- *Par Excellence* newsletter is now electronic
- President Julie Somheil shipped 320 sheets to Myrna. Imagine the moment when Myrna received those bed sheets!

Ohio PeriAnesthesia Nurses Association:

- OPANA shared their winning "Gold Leaf" application at CDI
- Exploring enhanced communication methods for members
- Awarded ABPANC's Shining Star

Wisconsin Society of PeriAnesthesia Nurses:

- Carroll Peeper, WISPAN Webmaster, has updated the Web site! It looks great and serves as a reminder for all components to periodically review and update their Web sites
- A Director for Membership has been added.
- WISPAN Fall Conference will be at "The Dells" with the Milwaukee Chapter of AORN as possible co-sponsors for one half-day

West Virginia Society of PeriAnesthesia Nurses:

- WVSPAN has thrived over the past several years, going from 48 members three years ago to 69 members as of February, 2012. WOW! They anticipated bringing 12 members to National Conference with five members giving oral or poster presentations
- Certification is on the horizon as study groups have formed and many members are attending ASPAN's Certification review in Pittsburg

Congratulations to: ILSPAN, MAPAN, MNDAKSPAN, and OPANA for achievement of thirty years as ASPAN chartered components.

Contact Martha Clark at mclark@aspan.org

REFERENCES

1. www.goodreads.com/quotes/show/7803 Accessed May 14, 2012.

EDITORIAL

Barbara Godden, MHS, RN, CPAN, CAPA
***Breathline* Editor**

Background

I'd like to take this opportunity to introduce myself. I'm Barbara Godden, and I have the privilege of assuming the role of *Breathline* Editor. I began transitioning into this role in January 2012 under the wonderful guidance of the previous *Breathline* editor, Joni Brady. Joni set the bar high for *Breathline,* and I intend to carry on her legacy.

I have had a love of writing since high school, and have had the opportunity to continue that love of writing within the American Society of PeriAnesthesia Nurses (ASPAN) with such projects as articles for *Breathline* and the *Journal of PeriAnesthesia Nurses* (*JoPAN*). I've also edited two editions of *ASPAN's Competency Based Orientation and Credentialing Program for the Registered Nurse in the Perianesthesia Setting*, and assisted editing several editions of the ASPAN Standards. I also have a deep passion for clinical practice and practice standards, and was the ASPAN Standards and Guidelines Committee Chair from 2006-2008, and the ASPAN Director for Clinical Practice from 2008-2012. I've been a perianesthesia nurse for over 25 years, and I'm currently a full-time bedside PACU nurse.

Goals for *Breathline*

Feedback from member surveys and ongoing monitoring of Web pages indicates that readership of *Breathline* remains low. The readership rate stays at about 16%. *Breathline* is intended to be a newsletter that brings you, the member, information that will be helpful in your practice setting, as well as information related to the goals and activities of ASPAN.

I'm currently in the learning process, and want to continue with the current format for a few additional issues, but I am looking at different platforms for the newsletter as well as ways to bring the news to you more frequently. At the current time, I'm not sure what this will look like. However, the way we acquire news today and the time we have to read it has changed, and the method of delivery for ASPAN news may need to change as well. The possibilities for the delivery of ASPAN's newsletter seem endless.

Feedback and Submissions

As I learn about *Breathline* and how to best meet your needs, I welcome your feedback. I want to know what you like, what you don't like, and what would make you read *Breathline*. What would be valuable to you and your fellow perianesthesia colleagues? I also encourage you to submit original articles to the newsletter. Do you have a practice in your setting that you want to share? Do you have a case study that you think would benefit your colleagues? Do you have questions about what is happening in ASPAN? I welcome all ideas.

Conclusion

I'm enjoying this new role, and my intent is to master the process and develop creative ways to bring you the newsletter. I look forward to hearing from you and how we can make this YOUR newsletter. You can submit your ideas to me at bgodden@aspan.org

CERTIFICATION

Buy One, Get One Free!

CPAN® and/or CAPA® practice exams are currently on special offer: "Buy One, Get One Free" until July 2012. Buy two practice exams for only $35! These online practice exams are useful for nurses studying for CPAN or CAPA certification. Each exam contains 50 questions and contact hours can be earned. For all the details you need to pursue perianesthesia nursing certification, visit www.cpancapa.org.

Contact ABPANC

475 Riverside Drive
6th Floor
New York, NY 10115-0089
Phone: 800-6ABPANC
Fax: 212-367-4256

Email:
abpanc@proexam.org

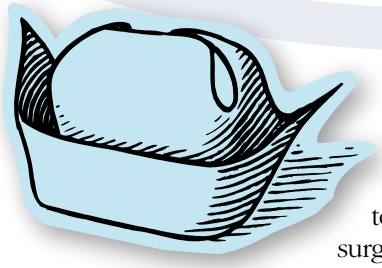
Web site:
www.cpancapa.org

Periodically, we feature a book review that may be of interest to the members. Our peer review team found this book review to be of particular interest in looking back and giving us a glimpse of perianesthesia nursing in the early 20th century.

PERIOPERATIVE NURSING IN 1918

A Book Review

Joy Shiller, BSN, MS, RN, CAPA



Warnshuis FC. *Principles of surgical nursing. A guide to modern surgical technique.* Philadelphia and London: W.B. Saunders Company; 1918.

In 1918, W.B. Saunders published the nursing textbook, *Principles of Surgical Nursing,* by Frederick Warnshuis, M.D., F.A.C.S. Since that time there have been extraordinary changes in perianesthesia nursing practice, although many of the basic concepts are the same. The following is a brief summary of preoperative and Phase I care in the early 20th century.

Patient Preparation for Elective Surgery

Prior to surgery, the physician was required to perform a thorough physical examination and to order lab work as indicated. A urine specimen (catheterized on females) was the main diagnostic test. It was highly recommended that every patient remain on bed rest at least 24-36 hours prior to surgery. The belief was that the longer patients were confined to a bed, the better physical condition in which he/she would be in to withstand the operation. During this time, the patient was given several baths and massaged with alcohol or cocoa butter.

Preoperative teaching usually took place while the nurse was bathing the patient since this was considered a time instilling confidence in the nurse. Patients were taught about the proper use of a toothbrush and the use of bedpans, urinals, and "douche pans." Patient education also included a discussion of postoperative expectations and the need for patients' cooperation. The nurse was expected to be honest and to consider the emotional needs of the patient.

The NPO guideline was no nourishment for six hours prior to an anesthetic and 10 hours if surgery was to be performed on the stomach. Water was permitted to within one to two hours before the procedure. Patients were also given calomel (a mercury-based cathartic) 48 hours prior to surgery, one ounce of castor oil on the day preceding surgery, and one or two enemas on the day of surgery.

A hypodermic injection of morphine and atropine was usually given preoperatively. The anesthetic of choice for major procedures was ether. Nitrous oxide was used for short procedures and for patients with "urinary insufficiency." Local infiltration with Novocain was also used with some success; however, it was inconvenient since the solution had to be boiled immediately prior to use.

Immediate Postoperative Care

Following surgery, the patient was placed on a clean bed which was pre-warmed with several hot water bottles under the bottom sheet. The nurse was responsible to keep the bottles at least 10 inches from the patient's body. Unless contraindicated, the patient was placed on his/her back without a pillow with the head turned to one side and an accessible "vomitus" basin.

The "sick room," where the patient recovered, was required to be dark, to provide an abundance of fresh air, and to be kept at 75 degrees. The nurse was never to leave the patient alone until fully conscious. During the immediate postoperative period the patient's general appearance, respirations, and pulse were closely monitored. Since it was not yet customary for nurses to take blood pressures, the rate and quality of the pulse were the best indicators of the patient's condition. The pulse rate was recorded every ten minutes during the first postoperative hour and every 15 minutes during subsequent hours or until conscious. The temperature was recorded every three hours and every hour only if complications arose. In normal recoveries, the temperature received little consideration during the first day. The urine output was also recorded and the surgical site regularly inspected.

continued on page 13

Most patients became arousable within about an hour after the anesthetic. When the patient became responsive, the nurse was to first reassure him/her and then encourage the patient to remain quiet and endeavor to sleep. Absolute quiet was considered beneficial and essential. Patients were also advised to avoid frequent changes in position during the first 12 hours postoperatively.

Medications

Very few medications were given during the immediate postoperative phase. Strychnine (a central nervous stimulant) was almost always given hypodermically every three to four hours. Atropine was administered if the patient was persistently diaphoretic. Camphor oil and whiskey were the remedies of choice if a cardiac stimulant or support was indicated. Morphine and codeine were used for pain. There were no drugs of value for postoperative nausea and vomiting (PONV.)

Visitation

There were no regulations regarding visitors in the immediate postoperative period. Visitation was usually limited to the immediate family who were advised not to disturb the patient. Nurses were to consider individual circumstances and to utilize their judgment.

Postanesethetic Distress

"Postanesthetic distress" included postoperative nausea and vomiting, pain, backache, and delirium. Nausea and vomiting was the most common postanesthetic distress. If a patient was vomiting, the nurse was responsible to support the patient's head to prevent "inspiration pneumonia." Since drugs were of little value in controlling this problem, the common practice was to permit drinking small quantities of water at frequent intervals within one and a half to two hours postoperatively. The expectation was that the water first ingested would be vomited in a few moments. This would serve as a "gastric lavage," and water subsequently given would be more likely to be retained. If vomiting occurred every time water was taken, all liquids were withheld until the stomach was capable of retaining fluids.

If the patient complained of surgical pain, the nurse was to reassure him/her and institute comfort measures, such as bathing the hands and feet with cool water, cold compresses over the forehead and eyes, placing a pillow under the knees, and maintaining "a general appearance of tidiness." Only when the patient experienced extreme pain and the above measures did not allay his/her restlessness was it justifiable to administer morphine hypodermically. The nurse was never to permit a patient to suffer unnecessarily. Morphine was administered judiciously because of the great concern of "meteorism" (gas in the abdomen or intestine) and constipation. Codeine, which was sometimes substituted, was felt to produce rest, but not to be effective for true pain.

Postoperative backache was a major problem related to the patient's position on the operating room table and the relaxation of the spinal muscles produced by the anesthetic. A backache was treated prophylactically by use of a "six inch hair mattress," pillows, or a plaster mold to support the hollow of the back. Nursing interventions were the use of massage and the administration of morphine or codeine. The use of physical restraints was discouraged. Alternative methods, such as hydrotherapy and "elimination," were recommended for postoperative delirium and behavioral issues.

Postoperative Emergencies/ Complications

Emergencies and serious complications frequently occurred in the immediate postoperative period. Nurses were encouraged to handle every emergency in a composed manner and to determine a definite plan of action prior to sending for the surgeon. The nurse was also responsible for keeping the patient and his/her relatives calm. The major complications in the immediate postoperative period were shock, "cardiac fatigue," respiratory failure, hyperpyrexia, and "cardiac collapse."

Hemorrhage was the most frequent cause of shock. Nursing interventions were to control the bleeding if possible, provide an abundance of fresh air, elevate the foot of the bed, apply hot water bottles to the extremities and around the trunk, begin a saline drip by rectum or give a rectal enema with one pint of normal saline. If a nurse was capable and the doctor's arrival was likely to be delayed, 600 – 900 ml of normal saline subcutaneously, preferably under the breasts, could be administered before beginning the "rectal drip." Medications given for the patient in hemorrhagic shock were morphine (dose-dependent upon age), and circulatory stimulants such as camphor oil and whiskey hypodermically. The administration of a circulatory stimulant was determined in amount and frequency by the character and quality of the pulse. Non-hemorrhagic shock was called "Cardiac Fatigue." The treatment was the same with

continued on page 14

"WHAT ASPAN MEANS TO ME"

Keith Schumacher, BSN, RN, CPAN – ILSPAN Member

Keith Schumacher, BSN, RN, CPAN

ASPAN has given me an opportunity to grow and expand my knowledge of nursing. My experience with ASPAN began in 2005. Since that time, I have been involved with various ASPAN committees and SWTs including Clinical Practice, Safety, Membership and Marketing, Nominating, Government Affairs and Education Approver. At the three National Conferences that I attended, I was able to see first-hand the value of networking with nurses from across the country. Additional learning has come through sessions at national conference and through attendance at ASPAN seminars. In addition, I've had the opportunity to write articles for ASPAN's newsletter *Breathline* and ILSPAN's newsletter *PeriScope*.

As a Board of Director (BOD) member with the Illinois Society of PeriAnesthesia Nurses (ILSPAN), I was involved with changing the Illinois Department of Illinois Public Health's PACU adult visitation rule. Prior to this, no visitors were allowed in post anesthesia care units per Illinois law. I took another big step and ran for an ASPAN Board of Directors position. I am once again involved with the ILSPAN BOD and am serving as the Vice-Coordinator for ASPAN's Publications Specialty Practice Group beginning this year. I would not have had all of these experiences if I had not become involved with ASPAN.

I challenge you to embrace the chances you have with an organization that offers so many opportunities for knowledge and growth. Get involved. Get others involved. See what ASPAN can mean to you.

BOOK REVIEW *continued from page 13*

the addition of strychnine which was dose-dependent upon the patient's age.

The treatment for respiratory failure was to remove or combat the cause, respiratory stimulation with camphor and strychnine, amyl nitrate (a vasodilator and heart stimulant), oxygen inhalation, artificial respiration and tracheotomy if indicated. If the patient suffered a chill, the nursing interventions were to give the patient a hot drink, cover him/her with blankets, and to surround the body with hot water bottles. When the chill passed and if the patient developed a temperature over 103 degrees, the nurse was to begin tepid sponging. Hyperpyrexia was considered serious and could lead to an "alarming heart action and collapse." The only treatment was active stimulation with whiskey, camphorated oil, and "normal salines." There were no antibiotics in 1918.

"Cardiac Collapse" was a serious condition which could be caused by the anesthetic, an embolus, sudden exertion, valvular or myocardial disease, and infections. Treatment for this condition was placing the patient in a recumbent position, removing or combating the cause, camphor oil, whiskey, nitroglycerin, or a cardiac stimulant. This complication often occurred suddenly and was usually fatal.

Documentation

Even in 1918, the importance of accurate and concise documentation was recognized. The nurse was expected to chronologically record vital signs, medications, intake and output, and any treatments, symptoms, and observations. The use of descriptive adjectives was encouraged. Black ink was used from 7 AM–7 PM and red ink from 7 PM–7 AM. The main purpose of proficient charting was to impress the surgeon so that he would request the nurse's services in the future.

In the Year 2106

Remarkably, the majority of today's basic concepts of perianesthesia nursing practice were addressed in this 94 year old nursing textbook. These concepts include: preparation for surgery to prevent postoperative complications, patient education, emotional support, astute observation and assessment, thermoregulation, control of pain and PONV, interventions during emergencies, visitation, and documentation. Despite the stability of these concepts, there have been numerous advances in our practice. Although it is impossible to predict the future of perianesthesia nursing, one can only imagine the professional opinions of those who read one of today's current textbooks in the year 2106!

Component Education Programs

October 5-6, 2012 The PeriAnesthesia Nurses Association of California (PANAC) meets for their 33rd Annual Meeting/Conference at the Westin South Coast Plaza in Costa Mesa, CA. For information visit www.panac.org or contact Lori Silva at 209-968-4895 or notgoquietly@clearwire.net

Complexities and Challenges of Perianesthesia Nursing: Across the Ambulatory and Perianesthesia Continuum

August 18, 2012
Baltimore, MD

October 6, 2012
Rye Brook, NY

October 27, 2012
Oakland, CA

November 3, 2012
Visalia, CA

Foundations of Perianesthesia Practice

July 14, 2012
Fullerton, CA

July 21, 2012
Ontario, CA

October 6, 2012
Morehead City, NC
Las Vegas, NV

Pediatrics: Beyond The Basics

August 11, 2012
San Jose, CA

September 8, 2012
Annapolis, MD

September 15, 2012
Louisville, KY

November 3, 2012
Alexandria, VA

November 10, 2012
Tucson, AZ

Perianesthesia Certification Review

July 21, 2012
Houston, TX

July 28, 2012
Sacramento, CA

August 4, 2012
Ontario, CA
Denver, CO

August 11, 2012
Lexington, KY

August 25, 2012
Ashville, NC
Springfield, IL

September 15, 2012
Seattle, WA
Richmond, VA

September 22, 2012
Erie, PA

September 29, 2012
Scottsdale, AZ
Louisville, KY

October 5, 2012 FRIDAY
Durham, NC

October 27, 2012
St Louis, MO

Perianesthesia Pathophysiology and Assessment: A Systems Approach

June 30, 2012
Glendale, CA

July 14, 2012
Morehead City, NC

August 11, 2012
St Louis, MO

November 3, 2012
Oak Brook, IL

Surrounding Your Practice With Excellence: Legalities, Standards And Advocacy

June 16, 2012
Costa Mesa, CA

September 8, 2012
San Diego, CA

September 22, 2012
Binghamton, NY

November 3, 2012
Worcester, MA