The Newsletter of the American Society of PeriAnesthesia Nurses

Breathline

Volume 34, Number 3
May/June 2014

INSIDE:

PRESIDENT'S MESSAGE:
Igniting Professionalism

We just completed another fabulous ASPAN National Conference in Las Vegas. I hope those of you who attended took this great opportunity to network with old friends, meet new ones and advance your perianesthesia knowledge through the vast educational offerings provided by Sue O'Day and her team. Hopefully, you were able to "play" as well, and enjoy the sights and sounds that Las Vegas has to offer.

Jacque Crosson
MSN, RN, CPAN
ASPAN President 2014-2015

Now, if you were NOT in Las Vegas for a conference, you would have on average: stayed 3.7 days, spent 4 hours per day gambling, budgeted $560 to spend gambling, been one of the daily 315 weddings AND would have seen the ghost of Elvis back stage at the showroom![1] However, since those of you who attended spent ALL of your waking hours in educational sessions, viewing research and Celebrate Successful Practices posters, symposia, a Development Reception, a certification luncheon, Component Night celebration or President's Reception, you had no time for any Las Vegas fun!

Nursing at the Top!

However, here is a very real fact: As of December 2013, in a Gallup survey asked to rate the "honesty and ethical standards" of professions, nursing ONCE AGAIN tops the leader board at 82%.[2] This consistent honor emphasizes the impact nursing has on patients. With this recognition comes great responsibility to maintain and preserve these precious relationships nurtured each day. In the perianesthesia setting, contact may be abbreviated, but the responsibility of getting patients safely through the surgical process can be daunting.

The ability to continue as the most trusted profession lies in our core values: honesty, integrity, responsibility, belief in human dignity, patient equality and the desire to prevent and alleviate suffering. The wisdom of Florence Nightingale remains with us today. As she was quoted in 1859: "The very first requirement in a hospital is that it should do the sick no harm."[3] Demonstrated daily, perianesthesia nurses ensure that patients are comfortable, educated, safe and as calm as possible throughout his/her perianesthesia experience. Our ability to alleviate fears, provide comfort and gain patient trust creates the special bond between patient and nurse.

Professional Responsibility

We have a huge responsibility as a profession! Think of all the non-negotiable characteristics that are necessary! These characteristics include honesty, attitude, appearance, compassion, integrity, ethical standards, respectfulness, being responsible and demonstrating a willingness to help others. We are accountable for this huge list of qualifications. It is also imperative that we remain current in our practice, utilizing the best evidence and research to support the bedside nurse. Your professional organization, ASPAN, publishes the *Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements* so that you have evidence and best practice to support your practice.[4] Continually

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seeking the knowledge necessary to provide competent, quality and evidence based care is what our patients deserve. We have all heard the results of the 2010 Institute of Medicine report which are significant for nursing:

- Nurses should practice to the full extent of their education and training
- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression
- Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States
- Effective workforce planning and policy making require better data collection and information infrastructure[5]

This is not new information. What is new, is that there is now national recognition of the importance of nursing in the future of healthcare in the United States! Florence Nightingale understood how important research, advocacy and a focus on total patient care was to patient outcomes.[6] She was responsible for improved sanitation of hospital wards during the Crimean War, and raised the level of nursing from the bottom rung of the domestic ladder to that of professional. She was considered a visionary with an impact on nursing that continues to this day. Perianesthesia nurses must also be present to advocate for patients and ensure thoughtful solutions to healthcare delivery. You have incredible influence on patient perceptions regarding wellness and appropriate utilization of the healthcare system. As perianesthesia nurses, you have a valuable resource in your society. Through the *Journal of PeriAnesthesia Nursing*, important clinical content regarding patient safety, evidence-based practice and research has much to offer so that you remain "connected" to the pulse of perianesthesia practice and continue to provide accurate, timely information to your patients. ASPAN's *Breathline* newsletter keeps you apprised of all the activities and accomplishments of its membership, also featuring patient safety and clinical information. ASPAN's established liaison relationships allow the organization to affiliate with other associations in continuing collaboration on important initiatives that help meet the ASPAN's missions. As healthcare resources continue to be challenged, it is up to all participants providing care to work together to ensure our patients continue to receive appropriate, quality care while maximizing wellness at a reasonable cost.

Igniting Professionalism

My hope is that each of you who attended National Conference will spend time sharing the value of being part of ASPAN and ignite professionalism within your colleagues. Encourage certification. Challenge your peers to achieve a CAPA or CPAN credential or offer to mentor them in their journey. Encourage them to be lifelong learners responsible for the future of nursing, patient outcomes and how healthcare will look in the future.

As stated by Florence Nightingale: "Unless we are making progress in our nursing every year, every month, every week, take my word for it we are going back."[7] It is my honor and privilege to be president of ASPAN and to follow in the footsteps of so many professional, visionary leaders before me. Embrace your perianesthesia nursing practice as it is today, the product of so many brilliant minds that have collaborated to make ASPAN "the leading association for perianesthesia education, nursing practice, standards and research."

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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

ASPAN Scholarship Program Accepting Applications

ASPAN Scholarship Program is a member benefit designed to provide financial assistance to ambulatory surgery, postanesthesia, preanesthesia and pain management nurses aspiring to enhance their abilities to contribute to the perianesthesia nursing community.

Applicants must be current Active Category members of ASPAN and a component for the past two full years prior to the application deadline. Scholarship information is available online only. Specific eligibility requirements for each type of scholarship are detailed in the instructions and required items lists on the Scholarship Program Web page, or from www.aspan.org, select Members / Scholarship Program.

Scholarships Offered:

- $1,000 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
- $500 for Humanitarian Mission
- Two Nurse in Washington Internship (NIWI) program scholarships

ASPAN's Scholarship Program postmark deadline is July 1, 2014.

Specialty Practice Groups

ASPAN Specialty Practice Groups (SPG) allow perianesthesia sub-specialty practice nurses to network and nurture their commitment and desire to provide safe practice, sound clinical practice standards and quality patient care. Any Active, Affiliate or Retired Category member may join an unlimited number of SPGs, with each membership requiring a nominal participation fee.

SPG members are encouraged to network with each other and share information on perianesthesia practice and professional issues associated with the SPG's specialty area.

For more information and to contact a SPG Coordinator, please review the list below or visit the SPG Web page.

SPG Coordinators and Contact Information:

Advanced Degree SPG
Debbie Hurley BSN MHA RN
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Informatics SPG
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Preoperative Assessment SPG
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Save the Date

Leadership Development Institute

What do the Country Music Hall of Fame, Grand Ole Opry and ASPAN's 15th Leadership Development Institute all have in common? They are all located in Nashville, Tennessee!

Save the date, September 5-7, 2014 for the ASPAN Leadership Development Institute!

ASPAN Member-Get-A-Member Campaign

January 1 – December 31, 2014

Invite your colleagues to join ASPAN today! To thank you for your recruitment work, a variety of new awards are available for members who participate.

You can obtain promotional materials and membership applications by contacting ASPAN's National Office toll free at 877-737-9696 or emailing: dhanisch@aspan.org. Request as many copies as you like, and be sure to place your name as the recruiting member on each application you distribute.

Coming in the July/ August Issue of *Breathline:*

Full Coverage of the 2014 ASPAN National Conference in Las Vegas!

Do you know this person? Could she be an ASPAN leader?

ASPAN Operational Expenses…Defined

Katrina Bickerstaff, BSN, RN, CPAN, CAPA – ASPAN Treasurer

Katrina Bickerstaff
BSN, RN, CPAN, CAPA
ASPAN Treasurer

At this year's ASPAN Representative Assembly in Las Vegas, Nevada, I reported on the state of ASPAN finances, which included the details of ASPAN's organizational expenses, operational expenses and income. Covering the ASPAN organizational expenses, along with its operational expenditures, is an integral part of the finance report. ASPAN continues to be committed to transparency and reporting on outlay of its members' dues.

What Exactly are "Operational Expenses"?

In business, "operating expenses" are also known as overhead or overhead expenses. These expenses refer to the ongoing costs of running a business or a non-profit organization. The operating expenses include the cost of administrative staff, rent or mortgage, utilities, phones, office equipment and supplies, insurance, cleaning supplies along with other expenses. These expenses occur day to day, and are known as fixed expenses. Another area of operational expense is derived from fundraising or membership expenditures.

These expenses include costs for publicizing and conducting membership campaigns, maintaining mailing lists, marketing and any other activities that involve soliciting contributions or recruiting members. Operating costs are those expenses that cover the costs of running a business, and making a product or service. For nonprofits that do not make or sell a product, fundraising or development costs are considered similar to manufacturing costs. Operating costs represent the price of keeping a nonprofit organization's doors open.

Who Oversees the "Operational Expenses"?

Together, administrative expenses and fundraising expenses make up a nonprofit's "overhead" or "operating expenses." The Internal Revenue Service (IRS) does not require that nonprofits spend any particular portion of their income on either category, operational or organizational. The IRS just wants nonprofits to report how they spend their money. Each year ASPAN files a 1090 form with the IRS. This report is part of public record, which anyone can review. The ultimate responsibility for all nonprofit organizations lies with the boards' of directors. They have the responsibility of insuring that the organizations they lead are accountable to the public and their membership. The boards of directors are also responsible to make sure their associations have the necessary infrastructure to execute their missions. At each ASPAN Board of Directors meeting, a detailed review of expenses and income are reviewed. Questions arise and are answered to the satisfaction of the ASPAN Board of Directors.

It was an honor to be able to report the state of ASPAN's finances at the Representative Assembly in April. I look forward to providing the entire detailed ASPAN finance report in the next issue of *Breathline*.

President's Message *continued from page 2*

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Are You Inspired to Speak at the National Conference?

Nancy Strzyzewski, MSN, RN, CPAN, CAPA – ASPAN Director for Education

Nancy Strzyzewski MSN, RN, CPAN, CAPA
ASPAN Director for Education

May is my favorite month in the ASPAN calendar. Back home from national conference (NC), I am grateful to have had the opportunity to renew friendships with old friends from around the world. Some years, I have been fortunate enough to have made new friendships too. Every year, I am inspired by at least one speaker! May is a very busy month because it is also the time we begin planning the next national conference.

Deadlines

One of the most important steps in planning NC begins with the review of the presentation proposals. The deadline to submit a presentation proposal for the 2015 NC in San Antonio, Texas, was May 15, 2014. However, it's not too early to start thinking about 2016. Presentation proposals have a new format this year, and must be computer generated and emailed to ASPAN Meeting Manager Courtney Papp at cpapp@aspan.org. Handwritten, faxed or PDF presentation proposals will not be accepted. Incomplete proposals will also not be considered.

Evidence-Based Proposals

Every proposal starts with just one idea - the topic! Turning that idea into a complete presentation requires a lot of work, including a literature search to ensure the content is evidence-based. National conference participants are eager to earn continuing nursing education contact hours for their license renewal and certifications. According to the American Nurses Credentialing Center's Commission on Accreditation (ANCC-COA), operational requirements for Accredited Provider Units, all presentations must be evidence-based and presented by a qualified speaker. Gone are the days a speaker can present on a topic based on personal experience alone.

Details of the Proposal

First impressions are extremely important! If you are submitting a presentation proposal for NC, be sure you create a professional impression. The first opportunity to create that impression is the presentation proposal. All proposals must be submitted using the official proposal document found on the ASPAN Web site. The proposal must be computer generated, complete and emailed by the deadline. Take the time you need to complete the presentation proposal completely and accurately. The gap analysis section of the proposal gives you the opportunity to justify the importance or need for the topic. The presentation objectives must be correctly written and measurable. The content outline for each objective must be comprehensive and evidence-based. The biographical data form and your curriculum vitae will demonstrate why you are qualified to speak on the topic. The references must be no older than five years. All proposals must be unique, and cannot be a topic you have presented at another conference. Make sure you complete the presentation proposal in its entirety, and do not leave any questions blank!

Target Audience

Planning a good presentation also includes considering who the audience is and what the audience needs to learn from the presentation. Remember, nurses attending NC represent our peers from all levels of practice, various roles, and a variety of work environments. When proposals are reviewed, topics are selected to meet the needs of ASPAN's target audience.

Think About the Opportunity

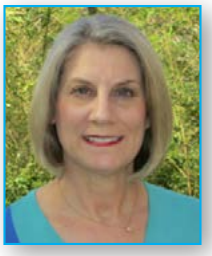
Have you ever listened to a speaker at NC and thought "I'd like to do that!" The first official step to becoming a NC speaker is submitting a presentation proposal. However, before a proposal can be submitted, a good deal of planning and research needs to be done. If your presentation proposal was not ready for the 2015 NC, remember this – there is another opportunity for 2016!

Frequently Asked Questions

Phase II Discharge After Neuraxial Block

Susan Russell, BSN, RN, JD, CPAN, CAPA – ASPAN Director for Clinical Practice

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.



Susan Russell BSN, RN, JD, CPAN, CAPA
ASPAN Director for Clinical Practice

Q. ***Does ASPAN have a policy regarding discharge criteria for patients receiving neuraxial anesthesia in an ambulatory surgery center (ASC)?***

A. ASPAN's *2012-2014 Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements* apply to all perianesthesia settings, including ambulatory surgery centers. The Standards address discharge criteria in "Practice Recommendation 2, Components of Assessment for the Perianesthesia Patient." For Phase II, applicable components of discharge assessment include ambulation, voiding as indicated and arrangements for safe transportation from the facility.[1]

Neuraxial Assessments

Assessment parameters following neuraxial anesthesia should include motor, sensory and sympathetic/autonomic function. The anesthesia provider's choice of local agent, baricity of the solution and technique employed affect the duration of the neuraxial block.[2]

> "...Before discharge, the patient should meet the standards for discharge criteria that are applicable to all patients recovering from anesthesia. Additional concerns include a less than 10% decrease in blood pressure with position change and a sensory level equal or less than T10 with evidence that the block is receding by at least two sensory segments. There is no required minimum stay time, but length of stay should be tailored to the individual patient..."[3]

Motor Assessment

One of the tools available for motor assessment is the Bromage score for motor function.[4] It is important to assess an outpatient's lower extremity strength prior to discharge, including any restrictions on weight-bearing indicated by the surgeon's discharge instructions and/or the procedure performed. Some anesthesia providers and/or surgeons may require patients receiving neuraxial blocks to void prior to discharge. Neuraxial blocks place patients at higher risk for urinary retention. Bladder scanners are a simple and useful adjunct to assessment, and can be quickly and easily employed before invasive interventions such as catheterization.[5]

Proprioception and movement return before touch, pain, and temperature sensation. Dermatomes can be assessed using an alcohol wipe, a small pin or a wet cotton ball. Alcohol wipes are readily available, easy to use and painless. The alcohol wipe should feel cool to the patient when sensory function returns to tested dermatome level. Autonomic or sympathetic function is the last to return. Orthostatic blood pressures can be used to test hemodynamic stability. The patient should maintain his blood pressure and heart rate within ten percent following a position change, such as raising the head of the bed or dangling on the side of the bed. Patients who are dehydrated may require additional fluids to maintain adequate blood pressure and heart rate, prevent or reduce nausea and neutralize dizziness.

Consideration should be given to the patient's overall functional ability. Patients with pre-existing sensory or motor deficits may require a lengthier stay to compensate for these disabilities. Examples include patients with balance issues from inner ear disorders, limb amputation or limited use of upper extremities.

Summary

Patients undergoing neuraxial blocks should have the same postoperative care and meet the same discharge criteria as those having general anesthesia. Ensuring recovery of motor, sensory and sympathetic function is essential. Criteria for assessment may include normal sensation at dermatome level S4-5, plantar flexion and proprioception of the great toe.[4] Written discharge criteria following neuraxial anesthesia should be developed in conjunction with the department of anesthesia. Individual facilities are encouraged to develop policies and procedures using the ASPAN *Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements* as guidelines. Policies and procedures should comply with state and federal laws, regulatory and accreditation requirements, and his/her state Nurse Practice Act.

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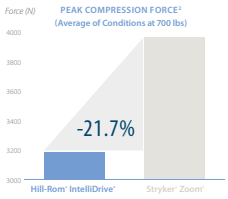

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THE DIRECTOR'S CONNECTION 3

Tracy Underwood, BSN, RN, CPAN – Region 3 Director

Tracy Underwood BSN, RN, CPAN
Region 3 Director

In the past several months, the theme in Region 3 has been education. Each component is striving to uphold the compelling vision of ASPAN to be recognized as the leading association for peri-anesthesia education, nursing practice, standards and research by delivering education in creative ways, and sometimes under difficult circumstances. We all know this was a very rough winter. I have had the privilege of being involved with several components that made tough decisions with competence and grace to deliver amazing educational offerings to its members. I am so proud of each one of them, and am honored to work with such a great group of people.

Region 3 Highlights

Illinois Society of PeriAnesthesia Nurses: www.ilspan.org

Despite a snowy start, ILSPAN has a wonderful spring conference on March 8, 2014. The number of attendees was impressive and several received scholarships for their attendance that day. Election of officers was also held.

Indiana Society of PeriAnesthesia Nurses: www.inspan.org

INSPAN received a proclamation from Governor Mike Pence for PeriAnesthsia Day on February 5, 2014. They had reason to celebrate on March 19 for Certified Nurses Day because 44% of its membership is certified.

Kentucky Society of PeriAnesthesia Nurses: www.kspan.org

KSPAN's spring seminar was held March 1 in Edgewood, KY, with 79 nurses in attendance. The program for the day included care of the robotic surgical patient, pain modalities, regional techniques for post-op pain control, OSA, a simulation scenario, the impact of heroin addiction on healthcare, and a humorous approach to surviving cancer, presented by a cancer survivor. Three KSPAN members were selected to present their posters at "Celebrate Successful Practices Poster Grand Rounds" at the National Conference in Las Vegas.

Michigan Society of PeriAnesthesia Nurses: www.mapan.org

MAPAN had its annual meeting and spring conference on March 29 in Mt. Pleasant, MI. The program was entitled "Balance in Practice," and the sessions included documentation, standards and malpractice. New officers were installed during the annual membership luncheon. This year MAPAN presented eight scholarships for its educational conferences. Members also received rewards for participating in ASPAN and/or MAPAN activities.

Minnesota/Dakotas Society of PeriAnesthesia Nurses: www.mndakspan.org

MNDAKSPAN, in the midst of its worst winter storm of the season, had a spring conference entitled "We The People" with 155 in attendance! The component has approved a research grant policy, application, and scoring system to assist its members in conducting research. The application is on its Web site and can be completed and submitted online.

Ohio PeriAnesthsia Nurses Association: www.ohiopana.org

This is OPANA's 35th anniversary! The NOPANA District (Northern Ohio Perianesthesia Nurses Association) held its annual spring conference on May 17 at St. Luke's Hospital Maumee, Ohio. Members had a special cake to celebrate the component's 35 years. Take a look at their new Web site, which contains links to all six districts.

Wisconsin Society of PeriAnesthesia Nurses: www.wispan-aspan.org

WISPAN is planning two conferences. On May 31 they will have the spring seminar. On September 27-28, WISPAN will partner with AORN to present a conference at the Kalahari Resort. WISPAN's research committee offers research resources and the opportunity to receive a research grant on its Web site.

West Virginia Society of PeriAnesthesia Nurses: www.wvspan.com

WVSPAN held a soup dinner for the residents of the family house at West Virginia University (WVU) Healthcare as its community service project. WVSPAN's spring conference, "Partners in Perioperative Care," will be held in collaboration with the local AORN chapter.

Preanesthesia Clinic: An Effective Program Created Through LEAN

Margi Bowers, MSN, MHA, RN, BC-NE – Nurse Manager Neonatal Intensive Care Unit
Previously Nurse Manager for Pre Anesthesia Clinic, OR Scheduling and Main Preoperative Unit
Lancaster General Hospital – Lancaster, Pennsylvania

Ian D'Silva, MS; Mitesh Shah, MBA – LEAN Experts – Owens and Minor

Margi Bowers MSN, MHA, RN, BC-NE

Periodically, Breathline *features an original article that may be of interest to the members. Our peer review team found this article to be of particular interest in looking at LEAN management principles to improve a process in a preanesthesia clinic.*

LEAN is a term that means becoming "lean" and using more efficient processes to create value for customers. LEAN, in healthcare, is a tool set, a management system and a philosophy of learned activities for improving the quality of patient care by eliminating barriers, reducing waste and recognizing non-value added activities in processes. An activity is deemed non-value added if it takes up time and/or resources and does not directly benefit the customer. LEAN emphasizes quality, patient safety, costs, wait times, and staff morale. In order to maximize customer value at Lancaster General Hospital (LGH), the organization hired LEAN experts, Ian D'Silva (Director for Performance Excellence) and Mitesh Shah (Project Manager) from Owens & Minor, to create a culture of change in the Perioperative Services Department. D'Silva and Shah facilitated the Pre-Anesthesia Clinic (PAC) Rapid Improvement Event (RIE), or Kaizen Event. A multidisciplinary group of employees from LGH participated in the RIE. The overall goals for this team were to increase the number of PAC patient telephone interviews on the first attempt, improve the anesthesia chart review turn over time (TOT), and increase the percentage of complete charts by 5 pm the evening prior to surgery. An effective PAC can give the hospital a competitive advantage by increasing satisfaction for the anesthesia providers, surgeons and patients. In addition, a lean PAC process can eliminate unneeded testing and day-of-surgery cancellations.

Methods

A RIE is typically a three-day event focused on mapping out the current state of a process, followed by developing and implementing a future state for the delivery of care in the PAC via the elimination of non-value added activities. Historic baseline data was obtained prior to examining current state and developing the future state for the PAC. The RIE team education consisted of the history of LEAN, 6S (Safety, Sort, Set, Shine, Standardize, and Sustain), eight wastes, closed loop process improvement, value stream mapping, value added versus non-value added activities, and SMART (Specific, Measureable, Aggressive yet Achievable, Relevant and Time Bound) goals. After the education, the team documented the current state and all activities within the process were marked as value added or non-value added. After the team collectively documented the current state, they established an improved and more defined future state. Patient safety remained the focus while the non-value added activities were removed from the future process. As the future process was being defined, items needed to ensure successful implementation were added to the "Just Do it" and Parking Lot" lists. Items on the "Just Do It" list could be accomplished immediately. However, the "Parking Lot List" required acceptance and feedback from departments not present at the RIE. Once the future state was agreed upon and solidified, the team members presented their work to LGH's Perioperative Leadership Team, allowing them to provide feedback and express their support for the RIE team. Each week, a 4-Pane communication tool was presented to the leadership team displaying weekly data, accomplishments, items to be accomplished in the near future and any roadblocks the team had encountered.

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Scheduling the Patient Telephone Interview Appointment

One goal set for the PAC RIE was to improve the PAC patient interview process by utilizing the Cadence scheduling system to properly schedule and complete patient telephone interviews. After thorough data collection in regards to the current state of the PAC patient interview process, baseline data indicated PAC nurses were only able to reach 59% of patients on the first attempt. The initial goal was to increase this metric from 59% to 79%. Giving patients the opportunity to provide a convenient time for them to complete their PAC interview will help eliminate the PAC nurses from making multiple attempts to contact patients.

Numerous solutions were identified during the RIE to improve completion of the patient interview on the first attempt:

- Implementation of the Cadence scheduling system (part of EPIC) with training to the PAC staff and the OR schedulers
- Development of the Team Leader (RN) role to manage daily operations and productivity within the PAC department
- 6S projects completed at each RN and unit clerk desk for efficiency when placing and retrieving charts from desks
- Implementation of Televox, an automated call reminder system, phone calls to each patient informing them of their upcoming telephone interview
- Cadence scheduling system training for all PAC RNs to provide accurate data on the volume of Cadence calls each RN completes and the duration of time for each interview
- All Cadence appointments scheduled for a thirty (30) minute duration
- Developed 'The Surgery Journey,' which is provided to the patient at his/her particular surgeon office. This document informs the patient in regards to what he/she should expect and with whom he/she should call to schedule his/her PAC patient telephone interview

Anesthesia Chart Review TOT

Once the PAC RN completes the patient telephone interview and patient history is collected, the chart is transported to the anesthesia department for review. Anesthesia reviews the physical chart as they will implement the electronic record during the last phase of EPIC. Baseline data revealed that only 22% of charts were delivered for anesthesia review greater than three (3) days prior to the day of surgery. The initial goal was to increase the number of charts delivered to anesthesia for review greater than three (3) days prior to the day of surgery to 65%.

Numerous solutions were identified during the RIE to improve anesthesia chart review TOT:

- Development of the 'Anesthesia Review Microsoft Access Database' to document when charts are delivered for anesthesia review and when they are returned to the PAC. This allows for making data driven decisions
- Education completed to PAC RNs in regards to the productivity goal of completing sixteen (16) patient interviews each day
- Posting of individual daily RN productivity, allowing for transparency and accountability
- Scheduling of patient telephone interview via the Cadence scheduling system seven (7) to ten (10) days away from the day of surgery

Percentage of Complete Charts by 5pm the Evening Prior to Surgery

A complete chart is required for a patient to go into the operating room. In order for a chart to be considered complete, it must have the following components: history and physical (H&P), orders, and surgical consent to procedure. After thorough data collection, it was determined that only 46% of the charts distributed to the main preoperative unit were considered complete. The initial goal was to increase the percentage of complete charts to 76%.

Numerous solutions were identified during the RIE to improve the percentage of complete charts:

- Development of the 'Team Leader (RN) Microsoft Access Database' to track completion of the following chart components: history & physicals (H&Ps), orders, and surgical consents to procedure
- Development of the 'Unit Clerk Phone Microsoft Access Database' to track phone calls made by the PAC to surgeon offices for missing chart components
- Because chart completion is dependent on providers supplying all necessary components in a timely manner, quarterly meet and greets are scheduled with surgeon offices to share data and other pertinent information

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Results and Conclusions

The LEAN strategies employed at LGH have transformed the daily operations of the unit and have positively impacted the teams. The increased level of engagement and accountability among staff, administration and physician partners has allowed for tremendous improvements to the PAC patient telephone interview, anesthesia chart review TOT and chart completion processes. Below are figures with baseline, current and goal values in regards to all established metrics being tracked within the PAC.

Figure 1 • Patient Telephone Interviews Completed on First Attempt

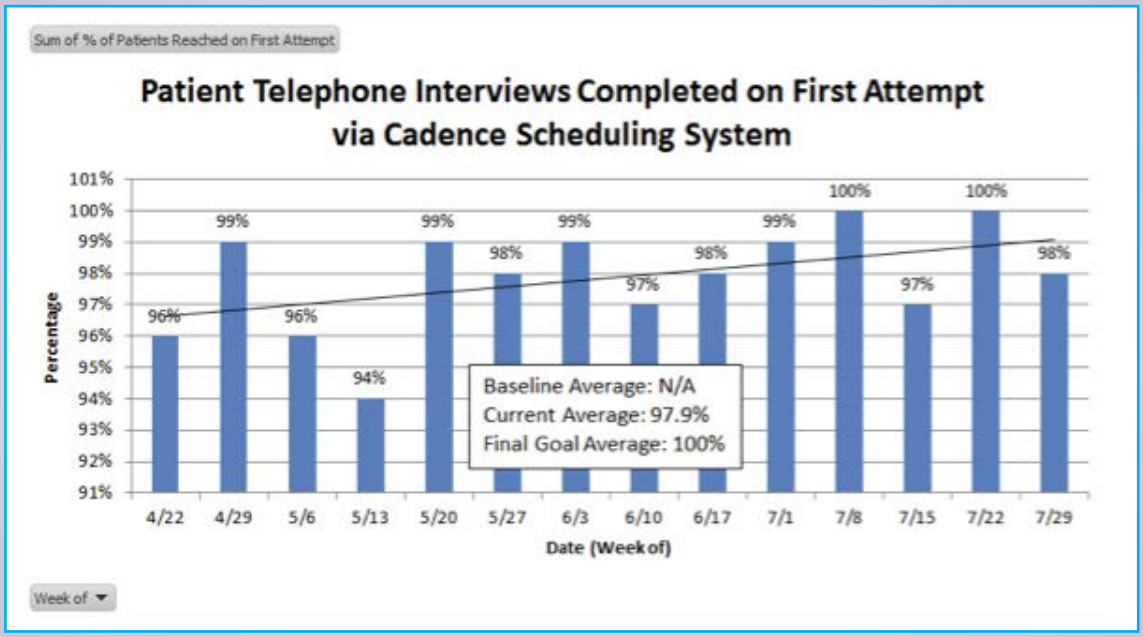

Figure 2 • Anesthesia Chart Review Turnover Time (TOT) BEFORE GO LIVE (NOTE: See Figure 3 for AFTER GO LIVE comparison.)**

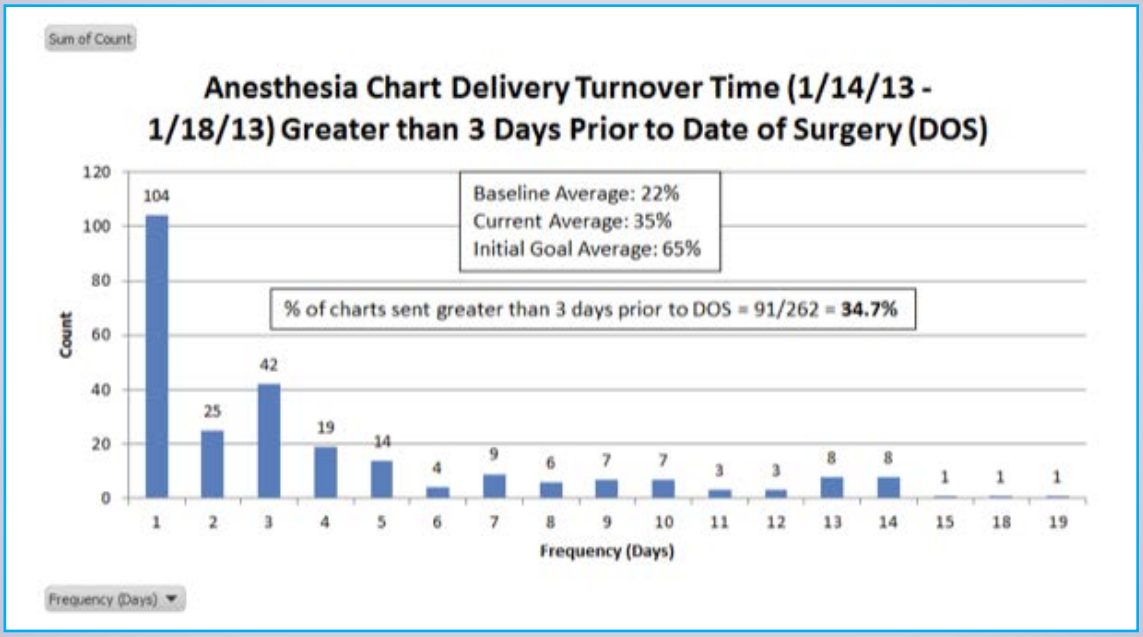

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Figure 3 • Anesthesia Chart Review Turnover Time (TOT) AFTER GO LIVE (NOTE: See Figure 2 for BEFORE GO LIVE comparison.)**

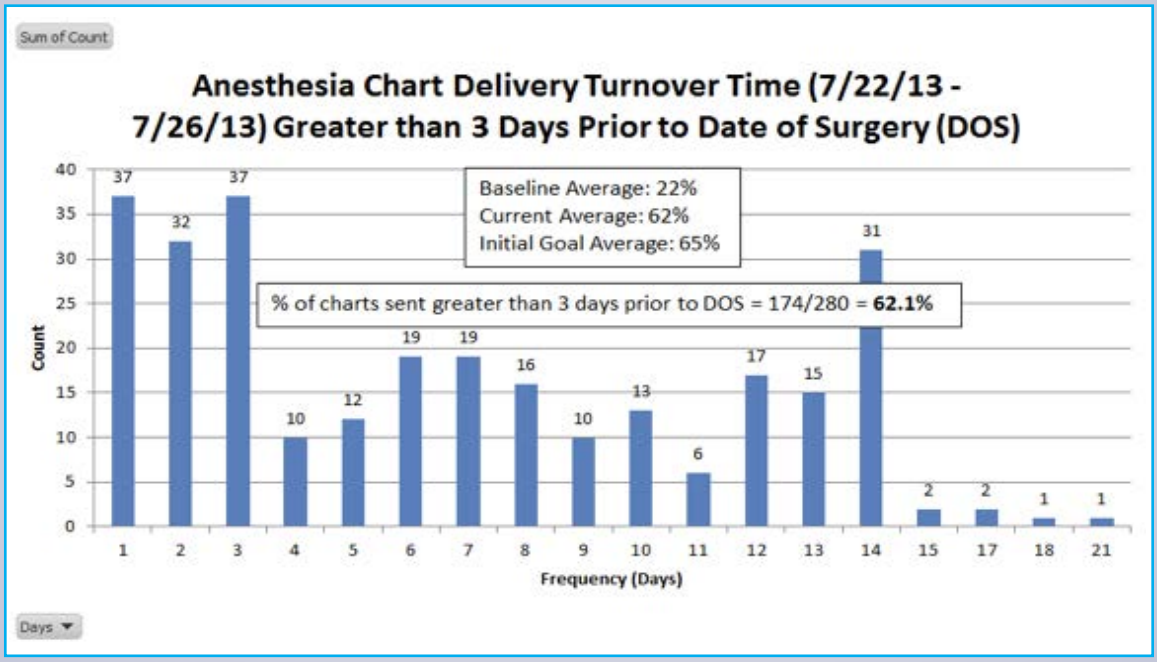
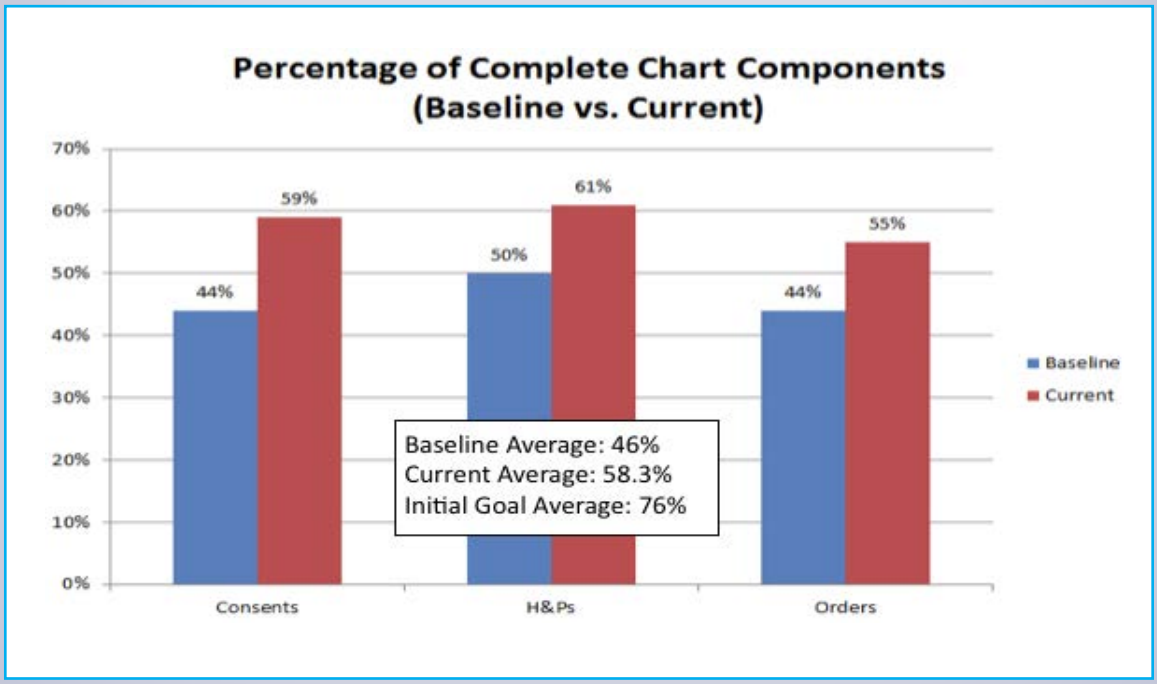


Figure 4 • Percentage of Complete H&Ps, Orders, and Consents (NOTE: These results are dependent on physician offices sending chart components prior to the chart leaving the PAC.)**

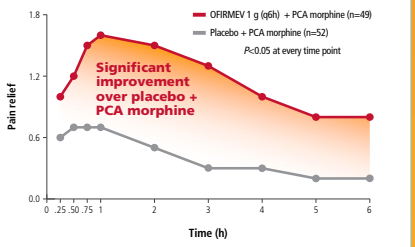


Acute pain management

Less pain

OFIRMEV® provides significant pain relief[1]

Mean pain relief scores, single dose
(Total hip or knee replacement surgery)

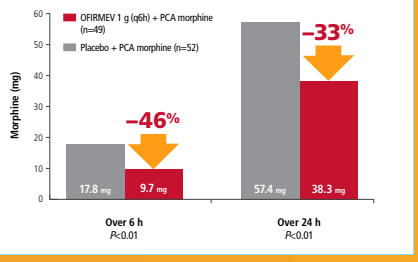


Sinatra et al. (Pain Study 1) Randomized, double-blind, placebo-controlled, single- and repeated-dose 24-h study (n=101). Patients received OFIRMEV 1 g + PCA morphine or placebo + PCA morphine following total hip or knee replacement surgery. Primary endpoint: pain relief measured on a 5-point verbal scale over 6 h. Morphine rescue was administered as needed.

Less opioids

OFIRMEV reduces opioid consumption[1]

Reduction in morphine consumption
(Total hip or knee replacement surgery)



Sinatra et al. (Pain Study 1) Randomized, double-blind, placebo-controlled, single- and repeated-dose 24-h study (n=101). Patients received OFIRMEV 1 g + PCA morphine or placebo + PCA morphine following total hip or knee replacement surgery. Primary endpoint: pain relief measured on a 5-point verbal scale over 6 h. Morphine rescue was administered as needed.

- The clinical benefit of reduced opioid consumption was not evaluated or demonstrated

OFIRMEV®
(acetaminophen) injection
1000 mg/100 mL (10 mg/mL)

Indication

OFIRMEV® (acetaminophen) Injection is indicated for the management of mild to moderate pain; the management of moderate to severe pain with adjunctive opioid analgesics; and the reduction of fever.

Important Safety Information

WARNING: RISK OF MEDICATION ERRORS AND HEPATOTOXICITY

Take care when prescribing, preparing, and administering OFIRMEV injection to avoid dosing errors which could result in accidental overdose and death.

OFIRMEV contains acetaminophen. Acetaminophen has been associated with cases of acute liver failure, at times resulting in liver transplant and death. Most of the cases of liver injury are associated with the use of acetaminophen at doses that exceed the recommended maximum daily limits, and often involve more than one acetaminophen-containing product.

OFIRMEV is contraindicated in patients with severe hepatic impairment, severe active liver disease or with known hypersensitivity to acetaminophen or to any of the excipients in the formulation. Acetaminophen should be used with caution in patients with the following conditions: hepatic impairment or active hepatic disease, alcoholism, chronic malnutrition, severe hypovolemia, or severe renal impairment. Rarely, acetaminophen may cause serious skin reactions such as acute generalized exanthematous pustulosis (AGEP), Stevens-Johnson Syndrome (SJS), and toxic epidermal necrolysis (TEN), which can be fatal.

Discontinue OFIRMEV immediately if symptoms associated with allergy or hypersensitivity occur, or at the first appearance of skin rash. Do not use in patients with acetaminophen allergy. The most common adverse reactions in patients treated with OFIRMEV were nausea, vomiting, headache, and insomnia in adult patients and nausea, vomiting, constipation, pruritus, agitation, and atelectasis in pediatric patients.

OFIRMEV is approved for use in patients ≥ 2 years of age.

Do not exceed the recommended maximum daily dose of OFIRMEV.

To report SUSPECTED ADVERSE REACTIONS, contact Cadence Pharmaceuticals, Inc. at 1-877-647-2239 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

Please see accompanying Brief Summary or click here for full Prescribing Information, including complete Boxed Warning.

Reference: 1. Sinatra RS, Jahr JS, Reynolds LW, Viscusi ER, Groudine SB, Payen-Champenois C. Efficacy and safety of single and repeated administration of 1 gram intravenous acetaminophen injection (paracetamol) for pain management after major orthopedic surgery. *Anesthesiology*. 2005;102:822-831.

cadence PHARMACEUTICALS

Brief Summary (For full Prescribing Information refer to package insert.)

WARNING: Risk of Medication Errors and Hepatotoxicity

Take care when prescribing, preparing, and administering OFIRMEV® Injection to avoid dosing errors which could result in accidental overdose and death. In particular, be careful to ensure that:

- the dose in milligrams (mg) and milliliters (mL) is not confused;
- the dosing is based on weight for patients under 50 kg;
- infusion pumps are properly programmed; and
- the total daily dose of acetaminophen from all sources does not exceed maximum daily limits.

OFIRMEV contains acetaminophen. Acetaminophen has been associated with cases of acute liver failure, at times resulting in liver transplant and death. Most of the cases of liver injury are associated with the use of acetaminophen at doses that exceed the maximum daily limits, and often involve more than one acetaminophen-containing product (see WARNINGS).

1 INDICATIONS AND USAGE

OFIRMEV® (acetaminophen) injection is indicated for

- the management of mild to moderate pain
- the management of moderate to severe pain with adjunctive opioid analgesics
- the reduction of fever.

2 DOSAGE AND ADMINISTRATION

2.1 General Dosing Information

OFIRMEV may be given as a single or repeated dose for the treatment of acute pain or fever. No dose adjustment is required when converting between oral acetaminophen and OFIRMEV dosing in adults and adolescents who weigh 50 kg and above. Calculated maximum daily dose of acetaminophen is based on all routes of administration (i.e., intravenous, oral, and rectal) and all products containing acetaminophen. Exceeding the maximum mg/kg daily dose of acetaminophen as described in Tables 1 and 2 may result in hepatic injury, including the risk of liver failure and death. To avoid the risk of overdose, ensure that the total amount of acetaminophen from all routes and from all sources does not exceed the maximum recommended dose.

2.2 Recommended Dosage: Adults and Adolescents

Adults and adolescents weighing 50 kg and over: the recommended dosage of OFIRMEV is 1000 mg every 6 hours or 650 mg every 4 hours, with a maximum single dose of OFIRMEV of 1000 mg, a minimum dosing interval of 4 hours, and a maximum daily dose of acetaminophen of 4000 mg per day (includes all routes of administration and all acetaminophen-containing products including combination products).

Adults and adolescents weighing under 50 kg: the recommended dosage of OFIRMEV is 15 mg/kg every 6 hours or 12.5 mg/kg every 4 hours, with a maximum single dose of OFIRMEV of 15 mg/kg, a minimum dosing interval of 4 hours, and a maximum daily dose of acetaminophen of 75 mg/kg per day (includes all routes of administration and all acetaminophen-containing products including combination products).

Table 1: Dosing for Adults and Adolescents

Age group	Dose given every 4 hours	Dose given every 6 hours	Maximum single dose	Maximum total daily dose of acetaminophen (by all routes)
Adults and adolescents (13 years and older) weighing ≥ 50 kg	650 mg	1000 mg	1000 mg	4000 mg in 24 hours
Adults and adolescents (13 years and older) weighing < 50 kg	12.5 mg/kg	15 mg/kg	15 mg/kg (up to 750 mg)	75 mg/kg in 24 hours (up to 3750 mg)

2.3 Recommended Dosage: Children

Children 2 to 12 years of age: the recommended dosage of OFIRMEV is 15 mg/kg every 6 hours or 12.5 mg/kg every 4 hours, with a maximum single dose of OFIRMEV of 15 mg/kg, a minimum dosing interval of 4 hours, and a maximum daily dose of acetaminophen of 75 mg/kg per day.

Table 2: Dosing for Children

Age group	Dose given every 4 hours	Dose given every 6 hours	Maximum single dose	Maximum total daily dose of acetaminophen (by all routes)
Children 2 to 12 years of age	12.5 mg/kg	15 mg/kg	15 mg/kg (up to 750 mg)	75 mg/kg in 24 hours (up to 3750 mg)

2.4 Instructions for Intravenous Administration

For adult and adolescent patients weighing ≥ 50 kg requiring 1000 mg doses of OFIRMEV, administer the dose by inserting a vented intravenous set through the septum of the 100 mL vial. OFIRMEV may be administered without further dilution. Examine the vial contents before dose preparation or administering. DO NOT USE if particulate matter or discoloration is observed. Administer the contents of the vial intravenously over 15-minutes. Use aseptic technique when preparing OFIRMEV for intravenous infusion. Do not add other medications to the OFIRMEV vial or infusion device.

For doses less than 1000 mg, the appropriate dose must be withdrawn from the vial and placed into a separate container prior to administration. Using aseptic technique, withdraw the appropriate dose (650 mg or weight-based) from an intact sealed OFIRMEV vial and place the measured dose in a separate empty, sterile container (e.g. glass bottle, plastic intravenous container, or syringe) for intravenous infusion to avoid the inadvertent delivery and administration of the total volume of the commercially available container. The entire 100 mL vial of OFIRMEV is not intended for use in patients weighing less than 50 kg. OFIRMEV is a single-use vial and the unused portion must be discarded.

Place small volume pediatric doses up to 60 mL in volume in a syringe and administer over 15 minutes using a syringe pump.

Monitor the end of the infusion in order to prevent the possibility of an air embolism, especially in cases where the OFIRMEV infusion is the primary infusion.

Once the vacuum seal of the glass vial has been penetrated, or the contents transferred to another container, administer the dose of OFIRMEV within 6 hours.

Do not add other medications to the OFIRMEV solution. Diazepam and chlorpromazine hydrochloride are physically incompatible with OFIRMEV, therefore do not administer simultaneously.

3 DOSAGE FORMS AND STRENGTHS

OFIRMEV is a sterile, clear, colorless, non pyrogenic, preservative free, isotonic formulation of acetaminophen intended for intravenous infusion. Each 100 mL glass vial contains 1000 mg acetaminophen (10 mg/mL).

4 CONTRAINDICATIONS

Acetaminophen is contraindicated:

- in patients with known hypersensitivity to acetaminophen or to any of the excipients in the intravenous formulation.
- in patients with severe hepatic impairment or severe active liver disease.

5 WARNINGS AND PRECAUTIONS

5.1 Hepatic Injury

Administration of acetaminophen in doses higher than recommended may result in hepatic injury, including the risk of liver failure and death. Do not exceed the maximum recommended daily dose of acetaminophen. The maximum recommended daily dose of acetaminophen includes all routes of acetaminophen administration and all acetaminophen-containing products administered, including combination products.

Use caution when administering acetaminophen in patients with the following conditions: hepatic impairment or active hepatic disease, alcoholism, chronic malnutrition, severe hypovolemia (e.g., due to dehydration or blood loss), or severe renal impairment (creatinine clearance ≤ 30 mL/min).

5.2 Serious Skin Reactions

Rarely, acetaminophen may cause serious skin reactions such as acute generalized exanthematous pustulosis (AGEP), Stevens-Johnson Syndrome (SJS), and toxic epidermal necrolysis (TEN), which can be fatal. Patients should be informed about the signs of serious skin reactions, and use of the drug should be discontinued at the first appearance of skin rash or any other sign of hypersensitivity.

5.3 Risk of Medication Errors

Take care when prescribing, preparing, and administering OFIRMEV (acetaminophen) Injection in order to avoid dosing errors which could result in accidental overdose and death. In particular, be careful to ensure that:

- the dose in milligrams (mg) and milliliters (mL) is not confused;
- the dosing is based on weight for patients under 50 kg;
- infusion pumps are properly programmed; and
- the total daily dose of acetaminophen from all sources does not exceed maximum daily limits.

5.4 Allergy and Hypersensitivity

There have been post-marketing reports of hypersensitivity and anaphylaxis associated with the use of acetaminophen. Clinical signs included swelling of the face, mouth, and throat, respiratory distress, urticaria, rash, and pruritus. There were infrequent reports of life-threatening anaphylaxis requiring emergent medical attention. Discontinue OFIRMEV immediately if symptoms associated with allergy or hypersensitivity occur. Do not use OFIRMEV in patients with acetaminophen allergy.

6 ADVERSE REACTIONS

The most common adverse reactions in patients treated with OFIRMEV were nausea, vomiting, headache, and insomnia in adult patients and nausea, vomiting, constipation, pruritus, agitation, and atelectasis in pediatric patients.

To report SUSPECTED ADVERSE REACTIONS, contact Cadence Pharmaceuticals Inc. at 1-877-647-2239 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

7 DRUG INTERACTIONS

7.1 Effects of other Substances on Acetaminophen

Substances that induce or regulate hepatic cytochrome enzyme CYP2E1 may alter the metabolism of acetaminophen and increase its hepatotoxic potential. The clinical consequences of these effects have not been established. Effects of ethanol are complex, because excessive alcohol usage can induce hepatic cytochromes, but ethanol also acts as a competitive inhibitor of the metabolism of acetaminophen.

7.2 Anticoagulants

Chronic oral acetaminophen use at a dose of 4000 mg/day has been shown to cause an increase in international normalized ratio (INR) in some patients who have been stabilized on sodium warfarin as an anticoagulant. As no studies have been performed evaluating the short-term use of OFIRMEV in patients on oral anticoagulants, more frequent assessment of INR may be appropriate in such circumstances.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Category C. There are no studies of intravenous acetaminophen in pregnant women. OFIRMEV should be given to a pregnant woman only if clearly needed.

8.3 Nursing Mothers

Caution should be exercised when OFIRMEV is administered to a nursing woman.

8.4 Pediatric Use

Pediatric Use: The effectiveness of OFIRMEV for the treatment of acute pain and fever has not been studied in pediatric patients less than 2 years of age. The safety and effectiveness of OFIRMEV in pediatric patients older than 2 years is supported by evidence from adequate and well controlled studies in adults with additional safety and pharmacokinetic data for this age group.

8.5 Geriatric Use

No overall differences in safety or effectiveness were observed between geriatric subjects and younger subjects.

8.6 Patients with Hepatic Impairment

OFIRMEV is contraindicated in patients with severe hepatic impairment or severe active liver disease and should be used with caution in patients with hepatic impairment or active liver disease. A reduced total daily dose of acetaminophen may be warranted.

8.7 Patients with Renal Impairment

In cases of severe renal impairment (creatinine clearance ≤ 30 mL/min), longer dosing intervals and a reduced total daily dose of acetaminophen may be warranted.

OFIRMEV®
(acetaminophen) injection
1000 mg/100 mL (10 mg/mL)

Manufactured for:
Cadence Pharmaceuticals, Inc.
San Diego, CA 92130

Revised 1/2014
U.S. PATENT NUMBERS: 6,028,222; 6,992,218

Component Education Program

October 3-5, 2014 Rocky Mountain PeriAnesthesia Nurses Association (RMPANA) will host its annual Retreat in the Rockies. The event will be at Snow Mountain Ranch, just west of Winter Park, Colorado. For more information, please contact Barb Krumbach at barb.krumbach@comcast.net.

FOUNDATIONS OF PERIANESTHESIA PRACTICE
June 7, 2014
Sacramento, CA

September 6, 2014
Macon, GA

September 28, 2014 SUNDAY
Nashville, TN

PEDIATRICS: LITTLE BODIES, BIG DIFFERENCES
September 20, 2014
Eureka, CA

PERIANESTHESIA CERTIFICATION REVIEW
July 19, 2014
Orange, CA

August 9, 2014
O'Fallon, IL

August 16, 2014
Plano, TX

August 23, 2014
Jacksonville, FL
Hoffman Estates, IL
Baton Rouge, LA
Dayton, OH

August 30, 2014
South San Francisco, CA

September 6, 2014
La Jolla, CA

September 13, 2014
Baltimore, MD
Shakopee, MN

September 20, 2014
Fairfax, VA

September 27, 2014
Newark, DE

REFRESHING YOUR PERIANESTHESIA PRACTICE
June 28, 2014
San Antonio, TX

August 2, 2014
Murray, UT

September 6, 2014
Binghamton, NY
Bend, OR

September 20, 2014
New York, NY

September 27, 2014
Twin Falls, ID

SAFETY BEGINS WITH US
August 2, 2014
Lake Charles, LA

SURROUNDING YOUR PRACTICE WITH EXCELLENCE: LEGALITIES, STANDARDS AND ADVOCACY
August 23, 2014
Worcester, MA

September 27, 2014
Indianapolis, IN