OPANA President:
Jeanne Guess
MSEd, RN, CAPA

ASPAN National Conference
“1st Timer”

OPANA members…it was a privilege to be a part of the 31st ASPAN National Conference in Orlando. I was proud to represent Ohio, and hope that I did not look too inexperienced with my folder and papers to keep organized. I was clearly identified as a first timer with the “salad” of ribbons that we select and attach to our name tag. Once I obtained this ID, it dutifully hung around my neck.

The conference theme was “Beacons of Change Focusing on the Future.” President Chris Price used many examples of how we can be beacons of light in this ever changing world. It was with this theme that I navigated the many offerings of instructional and social events. I met with the candidates for positions on ASPAN’s Board of Directors. They spoke of change and their vision for the future of ASPAN and perianesthesia nursing. The candidates were open to conversation and the casual setting offered many opportunities to talk.

I participated in the ASPAN Development Dream Walk early Sunday morning.

This event raises money for member scholarships and other development programs. Judy Evans RN from Alaska raised the most money for the dream walk. She has now won this honor 4 years in a row. We had a great time as we walked around the beautiful grounds of the Orlando Hilton. Little did I know that I would not see much of the Florida weather!

The RA (Representative Assembly) convened on Sunday at 9AM and this was a very formal setting. The Representative Assembly, facilitated by President Chris Price, met for the formal hearings during the morning to discuss questions, issues, and topics related to ASPAN. The candidates for National Office were presented. I was impressed with the business format of this assembly. We had lively discussions as the timekeeper kept all questions to a limit.

The voting progressed after the discussion period. I now understand the process and how decisions for the organization are made. I also understand how to be an effective member. I will certainly be able to bring this information back to the state level and assist members who are uncertain of the process.

Continued on page 5
OPANA Board Members 2011

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Deadlines for Publication-Snooze News

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The Snooze News Volume 33, Issue 1 2
This was my second year as OPANA’s representative to the Representative Assembly in Orlando, Florida. This year there were many lively and exciting discussions on several proposals and resolutions. Below are some of the highlights from the Representative Assembly meeting on April 15, 2012.

- Membership is up, with 15,000 members.
- Finances are strong with net assets of $351,000+ due to increased income this past year from conferences, publications, and educational seminars.
- ASPAN has additional liaisons to other professional organizations.
- Barbara Godden is the new Breathline editor.
- There will be 7 geriatric seminar modules on-line for contact hours, with the hopes of having more in the future.
- The Clinical Practice Committee answered 1166 questions, some coming from foreign countries.
- 17 Gold Leaf applications this year. (Kentucky won)
- 51 people were nominated for the Above and Beyond Award.
- 27 scholarships were awarded, the most ever.
- 2 components received financial aid.

The Representative Assembly passed several resolutions:

- Position statement on Substance Abuse in Perianesthesia practice.
- Name change for the ASPAN Standard’s and Guidelines to Perianesthesia Nursing Standards, Practice

Recommendations, and Interpretive Statements 2012-2014.
- A practice recommendation for Obstructive Sleep Apnea.
- Transparency in the ASPAN election process. (This was put forth by MNDAKSPAN, and believed to be the first time a component has ever presented a resolution to the Representative Assembly.)
- There will be an increase in dues of $5.00 for all ASPAN members, $2.00 of which will be used in part to increase the number of scholarships and research grants awarded.
- The other $3.00 will be used to secure membership to the Joanna Briggs Institute to allow all members access to online databases.

Newly elected ASPAN board members are as follows:

- Twilla Shrout-VP/President elect
- Joni Brady-Secretary
- Director of Clinical Practice-Susan Russell
- Region 2 Director-Armi Holcomb
- Region 4 Director-Laura Kling
- Nominating Committee-S. Hoff, D. Morgan, S. Norris, C. West.

The next International Conference of PeriAnesthesia Nurses will be held September 13, 2013 at the Citywest Hotel and Golf Resort in Dublin, Ireland. Go to www.icpan.com for more information.
Those of us that work in the operating arena are familiar with several of the transdermal medicine patches that our patient may be wearing, namely scopolamine, fentanyl, nicotine, clonidine, nitroglycerine and estrogen. The reasons that our patients are wearing them are also familiar: prevention of post-op nausea and vomiting, pain control, prevention of withdrawal from smoking, blood pressure control, prevention of angina, protection of coronary vessels, and contraception or post hysterectomy hormone replacement.

A review of the current medical and nursing journals provide additional cautions that we should all be aware of. Burns from the patches have been reported during MRI’s (3) and defibrillators (internal and external) (4). Uneven absorption of the drug with adverse effects such as acute toxic delirium from a transdermal fentanyl patch, which were reversed twenty-four hours after the patch was removed, has also been reported. (5) There is also a report of a patient with a fixed and dilated pupil (unilaterally) and altered mental status from a scopolamine patch, which was again reversed when the patch was removed. (6)

But in the OR and recovery room there exists an additional caution; the forced hot air warming blankets. As an anesthesia provider, a personal experience led me to investigate transdermal patches. After reviewing the process of the patches and how they work along the current literature it seems rather intuitive that as the patient becomes warmer, more of the drug is released since the blood vessels of the skin dilate with heat. The anesthesia journals also support this fact. Warm air convection heating blankets have caused increased absorption of nitroglycerin (7) and respiratory depression from a transdermal fentanyl patch intra-operatively. (8)

However, neither of these medicines where involved with my recent experience. The drug was rivastigmine, trade name Exelon, which is used for Alzheimer’s disease in the elderly, a population that we struggle to keep warm in the operating room. Rivastigmine is a cholinesterase inhibitor and its name should raise a red flag for all of us in the peri-operative period. Under anesthesia it can prolong the effects of succinylcholine and it can also interact with the other drugs that we give our patients.

A check of the FDA website for professionals of April 2011, shows the following cardiac effects of the drug when given to patients with Alzheimer’s to be:

A) Frequent cardiac effects: atrial fibrillation and bradycardia
B) Infrequent cardiac side effects (my patient was in this category): A-V block, bundle branch block, sick sinus syndrome, cardiac arrest, supraventricular tachycardia, extrasystole and tachycardia. (9)

In the same year, a blog showed up supporting this caution and the intra-operative treatment of a patient’s bradycardia. (10)

Remember that using forced air warming units will increase the absorption of the drug that is contained in the patch.
So in summary, ask your patient and their family about transdermal medicine patches, familiarize yourself with the drugs that your patient is wearing, and remember that using forced air warming units will increase the absorption of the drug that is contained in the patch.

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ASPAN National Conference
“1st Timer”
Continued from page 1

Sunday night was Component night with Alice “Through the Looking Glass.” The fun filled party night was complete with food, music, raffles and dancing. Each state featured a booth and we of course had buckeyes for all to enjoy. The many characters from Alice in Wonderland were seen throughout the night.

Many awards were given out to states and individuals. Congratulations to Kentucky for winning the Gold Leaf Award this year! I would also like to congratulate Christine Price from Mentor Ohio for being one of the winners of the JOPAN Cover Photo Contest!

Now that I successfully completed 2 days of the conference, I began Monday morning with the educational sessions. I increased my knowledge of research, evidence based practice and informatics to name a few highlights. I saw familiar faces as we navigated the many conference rooms. I appreciated the opportunity to speak to the presenters, nurses from all states and especially those who published articles in JOPAN. I cheered in the ABPANC presentation as we had a lively shout out for certification and what it means for our practice.

In closing, the days were full and I used every opportunity to attend the sessions and specialty practice meetings. I was ready to head home on Thursday with the many ideas and knowledge that I gained. I want to thank the OPANA Board and membership for giving me this wonderful opportunity.

Jeanne Guess MSED, RN, CAPA
In the Legislative Update, I would like to focus on two issues, the Affordable Care Act and BSN in Ten. Both of these issues will greatly impact healthcare and the nursing profession.

Affordable Care Act

Since the Affordable Care Act (ACA) will have a major impact on the future of healthcare, the final Supreme Court ruling on the ACA is much anticipated. In accordance with the Constitution of the United States, the Supreme Court is responsible to “check” the legislative activity and the use of its powers as defined by the constitution. In the case of the ACA, twenty seven states and other plaintiffs are asking the Supreme Court Justices to overturn the ACA in the belief that the Congress overstepped its constitutional boundaries. Based on the definition of the powers of the Supreme Court as defined in the Constitution, the Court’s decision will determine whether Congress' lawmaking activity in enacting ACA lies within the constitutional confines of provisions, not if the ACA will have a positive impact on care delivery and affordability.

In order to rule on this case, the Court must first decide if the Tax Anti-Injunction Act of 1867 plays a role in this decision. Under the ACA, the Internal Revenue Service will collect penalties from people who do not have health insurance. However, the Tax Anti-Injunction Act of 1867 prevents a suit aimed at preventing the assessment or collection of a tax. So the Court must first determine if the penalty equates to a tax. Secondly, if the penalty is determined to be a tax, the Court must decide if a case involving a penalty can even be actionable at this point since no one has been assessed a penalty, nor has anyone been “injured” financially as a result of the ACA penalty provision. The Supreme Court’s authority is limited to actual cases and controversies, meaning that the Court has no advisory power. So if the Court rules that an immediate challenge to the ACA is allowable, the Court must consider additional questions.

Individual Mandate - Can the federal government require that people maintain insurance coverage? Opponents argue that the law “forces healthy and voluntarily uninsured individuals to purchase insurance from private insurers and pay premiums in order to subsidize private insurers’ costs in covering more unhealthy individuals under the Act’s reforms.” Defenders of the ACA state that everyone uses healthcare, though timing and frequency of use is often unpredictable. Healthcare costs continue to rise and these costs are being shifted because millions of people use healthcare services but do not pay for the care they receive. The hefty price tag, which runs into the billions, is left for others to pay. The problem is further compounded when the insurance industry responds by raising premiums, and through underwriting practices make insurance harder or impossible to get for those with “pre-existing” conditions.

Severability - If the Court outlaws the individual mandate requirement in the ACA, the Court must determine which, if any, remaining provisions survive. Briefs submitted to the Court suggest three possible outcomes:

1. Inseverability - The law cannot function without the individual mandate.
2. Partial severability – Some, but not all, provisions will need to be stricken.
3. Complete severability – The remaining provisions of the law are not capable of standing without the individual mandate.

The Court will review the arguments based on Congressional content to determine what parts of the law, if any, Congress would have enacted without the unconstitutional provision. It seems unlikely that inseverability will occur since some provisions of the law are already in place and are capable of surviving without individual mandate.

Coercion of States – How does ACA relate to the expansion of Medicaid? Since Medicaid programs are largely state-directed and primarily federally funded, a group of states are suing the federal government over the enactment of ACA, claiming that the ACA Medicaid expansion provisions essentially hijack the power of state government by tying compliance to receipt of federal Medicaid funds. The states claim that this is a violation of the 10th Amendment because Medicaid is the only means of covering our most needy citizens under ACA.
Supporters of ACA state that Medicaid expansion provisions are no different than prior expansions of federal programming such as the Individuals with Disabilities Education Act and federal foster care and child support enforcement programs. If the Court determines that the ACA encroaches on states’ rights, laws like those supporting these programs may also be in jeopardy, however, Medicaid remains unchanged because it is voluntary. The Supreme Court should make its final ruling in June so stayed tuned.

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Nina Totenburg and Julie Rovner, shots: NPR’s Four Questions that Could Make or Break the Healthcare Law, available at http://www.npr.org/blogs/health/2012/03/26/149218060/4-questions-that-could-make-or-break-the-healthcare-law


BSN in Ten

Several states, including Ohio, are considering the concept of BSN in Ten. Below is a statement developed by Dr. Doris Edwards and Dr. Geri Milstead explaining the reasoning behind BSN in Ten. Nursing has been recognized as playing an important role in the future of healthcare.

Case Statement for the Legislation of BSN Degree Completion within Ten Years of Initial Licensure March 2012

Research has shown that every 10% increase in the proportion of BSN nurses in hospital staff is associated with a 4% decrease in the risk of death. (1) Nursing staffs with higher proportions of Bachelor of Science (BSN) or Master of Science in Nursing (MSN) prepared nurses demonstrate increased productivity and better patient outcomes. (2, 3, 4, 5, 6) At a time when care delivery systems must improve outcomes to assure reimbursement, the educational preparation of nurses is a factor to be addressed.

The Institute of Medicine (IOM) 2010 report The Future of Nursing: Leading Change, Advancing Health contains a recommendation for an 80% BSN workforce by 2020. The IOM Report describes the current US registered nurse (RN) workforce as 50% BSN prepared. (7) Dr. Susan Hassmiller, Senior Advisor on Nursing at the Robert Wood Johnson Foundation (RWJF), in a personal communication on December 29, 2011, indicated that members of the IOM panel expected legislation would be needed.

The 2008 American Nurses Association (ANA) House of Delegates resolved to support initiatives that require associate degree (AD) or diploma prepared RNs to obtain a BSN within ten years after initial licensure, exempting those individuals who are licensed or enrolled as a student in an AD or diploma program when legislation is enacted. (8) The Tri-Council for Nursing (American Nurses Association, American Organization of Nurse Executives, National League for Nursing, and the American Association of Colleges of Nursing) issued a consensus statement calling for all “registered nurses to advance their education in the interest of enhancing quality and safety across healthcare settings.” (10) The Ohio Student Nurse Association (OSNA), with over half its members enrolled in AD programs, endorsed BSN in Ten legislation, in its 2011 House of Delegates as necessary for the future of nursing.

Growing numbers of US hospital chief nursing officers, citing increasing complexity in the practice environment, are implementing policies that require the BSN in hiring and retention decisions. Nurses practicing in long term care and all community-based care delivery settings also work in complex high acuity environments. Competencies in planning, implementing and evaluating population-based care as well as health promotion, known to improve outcomes and control cost, are gained in baccalaureate and master’s degree programs.

The Institute of Medicine (IOM) 1999 Report To Err is Human: Building a Safer Health System publically acknowledged that too many mistakes were being made in health care delivery. The report enumerated the human toll of mistakes: unnecessary suffering and needless deaths, loss of trust in the system, and frustration and lowering of morale among health care professionals. At that time, the cost of preventable mistakes was estimated to be between $17 and $29 billion per year in hospitals nationwide. The IOM identified systems problems as the chief culprit and recommended strategies for the improved functioning of health care delivery. A goal of a 50% reduction in medical errors in five years was established. (13)

The American Nurses Credentialing Center (ANCC) Magnet Hospital Recognition Program has achieved prominence among strategies for achieving quality care. Proportion of BSN prepared nursing staff is one of the components in Magnet status designation. (15)

Problems with health care errors remained sufficiently unresolved in 2007 to the extent that the Center for Medicare and Medicaid Services (CMS) announced that, beginning in 2009, Medicare would no longer pay for the costs of preventable conditions, mistakes and infections resulting from a hospital stay. Such errors include surgical and catheter related infections, pneumonia, falls, bed sores, and air emboli. (14) Nearly all these problems are nurse sensitive.
Our national professional organization ASPAN provides golden opportunities to meet new people from all over the country, connect with old acquaintances, regroup with your state members, and continue friendships for a lifetime. Over the years I have developed many friendships, but two special friendships have grown as I have seen our ASPAN membership grow as well. A special colleague and friend is Robin Erchinger, retired Major USAF Nurse Corps. In 2000, Robin was active duty allowing us to work closely together at Wright Patterson Medical Group, Dayton, Ohio. Then, as the Air Force does, a person moves on. Since then, Robin has retired from the military, moved several times, and now relocated in San Antonio, Texas. Robin and I were once again able to meet up in Orlando for the ASPAN 31st conference. We have met over the years networking on nursing issues, being roommates and sharing about our families. In 2002 at ASPAN’s 21st National Conference held in San Diego, California, I was fortunate to meet Joanne Lockwood who has now become my dear friend and colleague. Jo is the Director/manager of a Free standing Ambulatory Surgery Center in New Jersey. We were reviewing the paperwork from the conference and began talking about the upcoming speakers. From that moment on our friendship and networking began. Besides attending the awesome speakers, we even found time to travel to Tijuana, Mexico via trolley to do a bit of shopping...as we both remember going into the Mexican grocery store to buy “real baking vanilla.” Of course a few silver bracelets for gifts and a fine authentic Mexican lunch followed. At the end of the conference, we hoped we would meet again AND we have over several national conferences. Due to busy home and family life, many times we do not connect until shortly before the conference but then we do, and it’s like old home week, never missing a beat. We have seen and discussed our family growing from school age to college to grandchildren, along of course, with discussing the latest nursing issues and healthcare changes. The theme “Transforming Our Vision into Reality” is how I feel these friendships have evolved over the years. What a great and special opportunity ASPAN has provided for me. Not only do I network with my own state members, but have developed friendships from other states. ASPAN has allowed me the opportunity to learn the latest changes going on in my profession and bring back information to my district and state. I hope this will provide an encouraging word to you all to attend the next national conference to be held in Chicago 2013. Hope to see you there and find a friend(s) for life!
Welcome ASPAN National Conference Attendees

Making Friends for Life
Continued from Page 8

JOPAN Editor, Jan Odem and Catherine Prince
JOPAN Cover Contest Winner

ASPAN Past President
Kim Kraft

Pam Windle, Pat Dempsey, Sue Fossum, Meg Beturne
If you have ever attended any ASPAN conferences over the years, you certainly would have run into Ester E. Watson. For me, she symbolizes ASPAN and its Foundation. Esther received her RN in 1950 at the Arnot-Ogden Hospital in Elmira Main, NY and then received her BSN in 1984 at St. Joseph Maine College of Nursing. Ester presently resides in Morristown, New Jersey.

I first met Ester in 1999 at my initial ASPAN conference in San Diego, CA. I have attended 10 national conferences and at each one you are sure to see Ester greeting old and new attendees, making them feel welcome to the organization. Ester is always assisting as Hostess and directing participants to the correct conference room with a smiling, loving face. During the 31st ASPAN National Conference in Orlando, Florida I ran into her many times and decided I wanted to know a little more about this smiling, white haired woman who seemed to remember my name over the years. Well, I learned Ester has been involved with ASPAN before it even had become a national organization, over 31 years ago. She was involved in 1980 during the “talking stages of PeriAnesthesia nursing” becoming an organization. In 1980 the Founding meeting of the American Society of Post Anesthesia Nurses (ASPAN) convened. In 1982, the first ASPAN National Conference was held in April, in St. Louis, Missouri. Over the years, ambulatory surgery centers have grown due to legislative action, economics, hospital bed shortages, growth of laparoscopic and fiber optic technology along with improved anesthetic medications. Ester has seen it all and continues to support the organization as a Charter member of 31 years. Ester is a true symbol of what nursing is about; dedication, commitment, and a continued desire to learn and participate in your professional organization. Thank you Ester for being a true role model.

Sincerely, Rosemary (Rose) Durning, MS, BSN, RN, CAPA, President-elect OPANA

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Notes from The ASPAN Board of Directors Mid-year Meeting

Martha L. Clark MSN, RN, CPAN
Regional Director Region 3

The ASPAN Board of Directors meets in face to face sessions three yearly. One of those meetings occurs on the Saturday before National Conference, Pre-Conference, and the second on the Friday after National Conference, Post-Conference. The third meeting occurs in November and is known as Mid-Year. All meetings are open to ASPAN members. The 2011 mid-year meeting was held in San Antonio, TX. The Agenda for each meeting is prepared well in advance of the meetings and includes reports of all Committees, SWTs, SPGs, Regional Directors, Directors for Research, Clinical Practice, and Education, as well as Presidential and Nominating.

Highlights from the 2011 Board Meeting included the following:

- ASPAN membership – 14,176
- CDI Attendees-143
- New marketing Plan to be rolled out January, 2012
- Resignation of Breathline Editor, Joni Brady.
- Report of nominating Committee by Kim Kraft, ASPAN Immediate Past President.
- ASPAN Standards and Recommendations for Practice will be voted upon at conference.
- Proposal for increase in membership fee.
- Proposal to offer all ASPAN members access to the Joanna Briggs Institute for Nursing Research.
- Donation ($500) to Life Box by ASPAN to assist in Providing Pulse Oximeters to Third World Countries.

Continued on Page 13
Hospitals take the prevention of errors quite seriously, as does the Joint Commission (JTC). In the Joint Commission “Annual Report on Quality and Safety 2011,” detailed information on improvements in quality over time is provided and top performing hospitals are identified. (18) Yet, the voluminous literature on hospital quality, error reduction, and litigation prevention rarely mentions nursing. Focus falls on the practice of physicians. Why?

The US Army Nurse Corp, (19) the Navy, (20) and the Air Force (21) require the BSN; military nurses are commissioned as officers for leadership roles. Preparation for leadership is emphasized in BSN programs. The IOM report directs nurses to lead change and advance health; education to do so is needed.

The Veterans Administration (VA) Office of Nursing Services 2011 Annual Report *Future of Nursing* is devoted to a review of how VA nursing is addressing the implementation of the IOM recommendations, nationwide. The VA Nursing Academy partners with local accredited nursing schools toward increasing the numbers of BSN, MSN, and doctorally prepared nurses caring for veterans.

Canada, Sweden, Portugal, Brazil, Iceland, Korea, Greece and the Philippines require the BSN for the practice of nursing. (25) The UK adopted the BSN standard in 2000. In the United States, where AD and diploma programs produce over half of the new graduates each year, BSN in Ten initiatives in eighteen states represent a country-specific strategy suited to a multi-entry system. (25)

Significant increases in the numbers of nurses attaining the BSN are essential to assure adequate numbers of expert nurses at the bedside. Well qualified nurse administrators, senior executives and nurse researchers are needed to lead in the achievement of acceptable care outcomes.

In summary, BSN in Ten initiatives recognize the contributions of AD and diploma educated nurses and provide bridge time for them to earn the BSN. BSN completion programs are accessible online and in adult degree formats. BSN completion curriculums do not repeat, but extend, what is contained in AD and diploma programs and many employers provide tuition assistance. The profession is responsible for setting standards for the provision of nursing care. State boards of nursing regulate the implementation of state nurse practice acts, with input from the profession on standards that are intended to protect the safety and well-being of consumers.

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Member News

OPANA Remembers our Troops Abroad

Late summer/fall of 2011, our ASPAN Past President Myrna Mamaril was deployed to Afghanistan taking care of our wounded men and women and local children. She worked long hours in the PACU with a 98% save rate for our US Troops once they reached the hospital. At our fall conference, we collected numerous items. There were generous gifts of Beanie Babies, trinkets and toys, lotions, snacks, Chap Stick, candy and books. Also a large amount of money, $156.00 was also donated. With this I bought several packs of snack crackers, microwave popcorn, various Chewy Granola Bars, Fruit flavored snacks, raisins, power bars, crystal light, and 6 twin sheets (a much needed item for the NATO hospital). This filled 3 large boxes weighing 37lbs, 38lbs and 10lbs respectively. The cost of sending these items came to $56.71. It was received in about 10 days, much quicker than I had expected. Myrna wrote a very appreciative note. Two children had come to the NATO hospital the day after receiving these items and they loved the Beanie babies!!

I would like to share with you the following email I received from Myrna shortly after she received these items.

Dear Rose,
Thank you so much for your wonderful care packages. Yes, we got 2 boxes of sheets beanie babies, toys, candy, snacks, toiletries last Friday and received another box of sheets today. Please thank OPANA for their outstanding generosity. We just had 2 little girls come in on Saturday and a couple little boys - they all love the beanie babies. Thank you so much!! Guess what? One of my nurses was the Assistant Director of Nursing Service is from Guam and her husband is Army and is in Korea. It is a small world. I cannot tell you how great it is hearing you. I grew up in Marion, OH and had family in the Dayton area. My cousin went to Wright State and Whittenberg in Springfield OH.

Thanks again for remembering our US soldiers and helping our NATO Hospital. ASPAN members have sent over 240+ sheets. We are now getting fully stocked with all your help. God Bless you and may you have a wonderful holiday season!

Love you,
Myrna

Thank you again for your generosity.
Sincerely,
Rose Durning, MS, BSN, CAPA
President-elect OPANA

Contribution - Resurge International

Martha Clark (Region 3 director) gave over her honorarium for speaking to the following organization.

Dear Jeanne, (Jeanne Guess-President)

I am pleased to tell you that Ms. Martha Clark made a contribution to ReSurge International (formerly Interplast) as a tribute to Ohio Anesthesia Nurses Association. This gift will make possible free reconstructive surgeries for needy children around the world who were born with disfiguring birth defects or suffer from crippling injuries.

Left untreated, a physical deformity can devastate a Child’s life. This gift will help make a child’s Greatest dream come true—the wish for a future free of pain and isolation.

During its 40 years of service, ReSurge International medical volunteers have provided nearly 80,000 such free surgeries to needy people in some of the poorest regions on earth. Thank you for your role in making this possible.

Nicole Friedland
Chief development Officer

Please go to the below website for more information regarding ReSurge International

www.resurge.org
Letter From the Editor
Renee Garbark BSN, RN CAPA

Lateral/Violence In The Workplace (Part II)

In the last edition of the Snooze News I asked members to share what types of policies or measures were being used at their hospitals to combat lateral violence in the workplace. I only got one response which I’d like to share.

An OPANA member stated that the facility where they work had put into place measures to combat lateral violence. These measures over time actually caused one physician to lose his privileges at the hospital. This physician had been admitting patients to this hospital for years and did have a reputation for verbally abusing staff. The hospital found that the outcome measures for this Dr’s patients were lower than his colleagues in the same specialty. It took 2 years to go through the entire process which included anger management classes, but in the end he was relieved of his ability to admit patients as this hospital. This is good news for those of us who’ve been a target of this type of behavior or those of us who’ve witnessed this behavior in our workplace.

I recently had the privilege of attending the 1st National Conference for Workplace Violence Prevention & Management in Healthcare Settings sponsored by university of Cincinnati, College of Nursing (May 10th-12th 2012). This was an eye opening experience for me. There are too many acts of violence in the health care environment.

But fortunately, there have been many people fighting and researching to bring this to the forefront. Finally after twenty plus years of research this topic is getting noticed. I encourage anyone interested in this topic to plan on attending the conference next year. The conference will be held in a different location, but plans are in place to conduct this conference again. This was a multidiscipline conference with people from security, law, nursing, social work, organizational behavior, occupational health/safety, forensic psychology and physicians.

There are 4 types of workplace violence.

- Type I (Criminal Intent): Results while a criminal activity (e.g., robbery) is being committed and the perpetrator has no legitimate relationship to the workplace.
- Type II (customer/Client): The perpetrator is a customer or client at the workplace (e.g, healthcare patient) and becomes violent while being served by the worker.

Wanted:
Articles for the Snooze News
Research
Process Improvement
Humor
Patient/Nurse Stories
If you have a knack for
Writing
WE NEED YOU!
Send to: garbarks@sbcglobal.net

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Lateral/Horizontal Violence in the Workplace
Continued from page 13

- Type III (Worker-on-Worker): Employees or past employees of the workplace are the perpetrators.

- Type IV (Personal Relationship): The perpetrator Usually has a personal Relationship with an employee (e.g., domestic violence in the workplace). (UIIPRC 2001).

I was surprised to find out how often violent physical acts occurs from co-workers, patients and visitors. I was shocked at how often this is happening and to what degree. Health care workers are killed from this type of violence.

I encourage you to check out Professor David C. Yamada’s (Professor of Law and director, New Workplace Institute Suffolk University law School, Boston, MA) website (http://newworkplace.wordpress.com). He has an outline of his keynote address from the conference called: Responding to Workplace Bullying in Healthcare: Ten Propositions. Professor Yamada has also written many articles on this subject.

This 1st National Conference for Workplace Violence & Management in Healthcare Settings (May 10th-12th 2012) had speakers and researchers discussing all types of workplace violence as defined above. Researchers presented their research over a 2 day period. Attendees also were able to view additional research through poster presentations. Networking was also an important part of this conference, as participants could discuss their research with others interested in conducting more work in this area. Even after years of research there is still much to study in this area.

If you’re looking for a research project to do this may be something to consider. If you need more information from the conference please contact me at garbarks@sbcglobal.net. The last day of the conference we enjoyed a panel discussion with several presenters and researchers. I’d like to share some of the panels suggestions for moving forward in this area of research:

- Focus on interventions and evaluation tools
- Roles of the Union
- Development of better data & survey Instruments
- Reporting systems
- Disruptive behavior particularly toward residents-residents are reporting this type of behavior toward them
- Bring multiple disciplines together for research
- Domestic Violence Intimate Partner
- Development of employee safety matrix—we have patient safety measure but not employee safety measures.

http://newworkplace.wordpress.com/2012/05/
http://nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume92004/No3Sept04/ViolenceinHealthCare.aspx#UIIPRC


Notes from the ASPAN Board of Directors Mid-Year Meeting
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- Selection of Las Vegas for the 2014 National Conference Site.
- Selection of San Antonio for the 2015 National Conference Site.

I encourage each perianesthesia nurse to visit the ASPAN website at: www.aspan.org. The website feature the new ASPAN logo and coordinating color change. While visiting the website, please review the profiles of each candidate running for office and place your vote. It is only by your vote that component leadership will know how to place their votes during Representative Assembly, RA on Sunday, April 15th.