Volume 17 Issue 1
ASPAAN

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Welcome to ASPAAN

The Australian Society of Post Anaesthesia and Anaesthesia Nurses (ASPAAN) was convened to promote the professional development of post anaesthesia and anaesthesia nurses through regular meetings, study days, educational forums, and publication of newsletters. Membership is open to Registered Nurses or Enrolled Nurses working in the specialties of Anaesthesia and Post Anaesthesia care, Associate membership is open to others (e.g. Representatives of Trade Companies and other Health Professionals) with a genuine interest in the field.

How can you help us enhance Peri anaesthesia nursing?

- Become a member
- Be involved in your State Branch or National committee
- Share your knowledge and ideas with the other members
- Take advantage of the education grants available to further our knowledge by being published in our newsletter
- Present at State Seminars and National Conferences
- Promote Peri anaesthesia Nursing as a fulfilling career

National Committee

Jamie Mann-Farrar, President
Valerie Howell, Vice President and Membership Officer
Megan Bumpstead, Secretary
Chris Nielson, Treasurer
Jilda Levene, Web Officer
Gabrielle Blake, Newsletter Editor
Penny Christie, Merchandising and Marketing Officer
Ruth Welch, General Committee
Melanie Murray, General Committee
Dear Colleagues,

It is with great pleasure and enthusiasm that I introduce myself as the newly elected National President of our organization in our first newsletter for 2013!

I would like to share the vision and priority work areas for 2013 which were identified at the ASPAAN National Committee planning day held on Saturday 2nd of February.

We welcomed Melanie Murray and Ruth Welch to the National Committee, who together with Valerie Howell, Chris Neilson, Meg Bumpstead, Jilda Levene, Gabrielle Blake, and Penny Christie complete the national team driving us in 2013.

At the National Committee planning meeting, the current position of ASPAAN was reviewed in light of our constitutional purpose. It was identified that to achieve our stated purpose, ASPAAN needs a stronger profile and voice as the National professional body for peri-anaesthesia nursing and to provide members with tangible standards for clinical, education and administration practice within peri-anaesthesia nursing.

A number of activities or work areas were identified as essential to achieving this goal, including:

- Establishing position statements on issues affecting Anaesthesia and Post Anaesthesia Nursing;
- Strengthening relationships with existing interest groups such as ACORN and ANZCA;
- Strengthening relationship with government departments to ensure ASPAAN is consulted on issues affecting Anaesthetic and PACU nursing;
- Providing appropriate support to the states to deliver seminars and membership drives;
- Ensuring that structures are in place for member benefits to be realised.
The priority work areas committed to for 2013 are:

- Strengthening relations with existing industry interest groups including ACORN and ANZCA.
- Membership growth within all jurisdictions
- Position Statements on the following significant matters:
  - Education and Training Standards for the Assistant to the Anaesthetist role
  - Education and Training Standards for the PACU Nurse role
  - Safe Staffing Standards for PACU
  - Recommended criteria for safe discharge from the PACU
- Providing enhanced support to the state committees

Whilst I will undertake formal relationship building with ACORN, ANZCA and the Federal and State Departments of Health, working parties will be established to develop the position statements, with expression of interest being circulated to all members for the development phase of our standards. A review process will then occur, with the final drafts presented at this year’s National Conference for vote by the general membership.

Other initiatives to be undertaken this year include:

Formation of the ‘ASPAAN Peri-anaesthesia outstanding student of the year award’ in each jurisdiction, an award of 1 year’s membership will be available for award by the State’s committee to a post-graduate student at an institute determined by that states’ committee.

Enhancing the content of our Newsletter

Whilst our newsletter is not seeking to be a peer-reviewed scientific journal, we believe we can enhance the content with your contributions. The new look Newsletter will have a section for submission of quality project summaries, book or journal reviews, case reports and case studies. We will also consider letters to the editor to provide a forum for robust discussion on contemporary issues effecting peri-anaesthetic nurses. Four issues are produced each year, and the templates and guides for submissions are available to make submission easy! The submission deadlines for issues are contained further in this month’s issue.
Establishing an ASPAAN intern

All volunteer committees share the same challenges of balancing the competing demands for time on committee members, with the expectations of the membership. To assist with some of our activities, we have initiated discussions with a university School of Business. Our intention is to provide a work-experience internship for an undergraduate in the Bachelor of Business program for 12 month terms. The intern will assist with marketing, membership and Newsletter publication. There is also potential for the intern to work on special projects when they arise.

At this time I feel it is really important to recognize the tireless effort of members of both State and National Committees. These individuals are passionate about our profession and delivering for our members. For this I would like to personally thank them for their on-going energy and enthusiasm towards our purpose.

2013 represents an opportunity for ASPAAN to thrive, cementing our position as the peak representative body for peri-anaesthetic nurses in Australia. I have every confidence that both the National Committee and State Committees have the required talent to stimulate and invigorate our organisation to higher levels of achievement.

I wish to congratulate you for your on-going membership of ASPAAN and I look forward to frequently sharing news of our success!

Yours sincerely,

Jamie Mann-Farrar, RN, BN (UTS), MHSM (CSU), MCN, MRCNA
National President
Mr Jamie Mann Farrar

Biography

Jamie is the Nurse Unit Manager of Anaesthetics at Concord Repatriation General Hospital, a metropolitan tertiary referral facility in Sydney. Presently, Jamie has been seconded to a Clinical Nurse Consultant position coordinating the Medical Emergency Team at Concord.

Jamie is a lecturer in High Acuity Nursing at the School of Nursing and Midwifery, University of Western Sydney, and is a visiting lecturer for the College of Nursing in Anaesthetics & Recovery.

Jamie is the NSW president of ASPAAN as well as the newly appointed National ASPAAN President. He is on the working party for the development of a national curriculum for Anaesthetic Nurses through NSW Health’s Agency for Clinical Innovation (ACI).

Jamie has recently been appointed to the Australian Nursing & Midwifery Accreditation Council as an academic and clinical assessor of courses leading to registration and enrolment in nursing.

This year Jamie received the 2012 Judith Meppem innovation study tour Scholarship, from the Chief Nursing and Midwifery Officer of NSW Health.
What position do you hold and where do you work?
I hold two concurrent positions Firstly I am the NUM of Anaesthetics at Concord Repatriation General Hospital & I am a lecturer for the School of Nursing at the University of Western Sydney.

What is the best part of the work you do?
Concord Hospital has a really good service ethos and community spirit, this shows in the people who work at our facility. In terms of personal satisfaction, I find the ability to effect positive change and implement practice that is supported by evidence, together with forming effective partnerships within the anaesthetic and broader perioperative departments highly rewarding.

At UWS I derive so much satisfaction from the enthusiasm that developing nursing students have, it can be really up-lifting and inspirational.

What quality projects have you been involved in or would like to initiate in your unit?
Together with my team, we have implemented quality projects including:

- Self-rostering system for anaesthetic nurses
- Daily anaesthetic nurse service provision (stand-up) meetings
- Implementation of a Difficult Airway Rescue Trolley (D.A.R.T) with associated training
- Implementation of a Mass Transfusion Protocol, that re-orientated practice in Theatres, ED, Pathology Specimen Reception, and Haematology/Blood bank.
- Out of Department Difficult Airway Response Kit
- Surgery-related Hypothermia mitigation in exposed patients
- Standardised education and competency assessment package for anaesthetics
If you could work anywhere, in any field what would that be?

I would like to be part of a contingent that provides critical care services in developing countries or hostile environments. Stripping back anaesthetics to the fundamentals, that we thought were long gone, really challenging your skills and knowledge in difficult environments. I also would not mind a stint as a resort nurse, although I fear I would not be able to spend as much time by the pool with cocktail in hand as I imagine!

What advice would you give to someone who is thinking about working in peri anaesthesia?

Peri anaesthesia nursing is a huge responsibility, and it may take you some time to truly get it! The vulnerability that some patients are experiencing is often hard to express. Some are coming to find out if their lump or mass is dreaded cancer, some are fearing having private body areas being exposed and “on show for all to see” and some have been waiting many years for their procedure which they hope will cure their pain!

Some fear dying, others fear waking up in the middle of the procedure. Some fear the cannula being inserted. Some will cry, some you will perceive as rude and others as complainers, but all are demonstrating an individual reaction to having all control and body function taken away from them and put in the hands of the surgical and anaesthetic team. You will need to come to terms with this!

As an anaesthetic nurse you and the anaesthetist are the patient’s life-support system, and this responsibility is not to be taken lightly, nor is it to be taken to the tea-room. Your greatest skill-set includes cognitive abilities to anticipate the needs of the patient and anaesthetist, the ability to detect, communicate and escalate deterioration based on your knowledge of normal and abnormal responses to anaesthetics. Your ability to respond decisively and appropriately in crisis, would be matched with your ability to instill confidence in the patient with sincerity.

In PACU, you are the first line against so many complications of surgery. Your attention to the patient and their physiology should be enviable. You vigilantly combat the patient’s pain using your knowledge and clinical experience in acute pain and multi-modal analgesia. You manage post operative nausea and vomiting, you are the first to detect post-op deterioration, incomplete reversal of muscle relaxants, airway compromise and post-op hemorrhage. Peri anaesthesia nursing is about applying clinical expertise and knowledge in a personable, empathetic manner to safe-guard the patient through all planes of anaesthesia.

Many say that peri anaesthesia nursing is perfect for people that don’t like to, or don’t have the skills to talk to patients. I say otherwise. I believe that Peri anaesthetic nurses need to have the strongest of people skills. Your interaction with a conscious patient could be limited to under 1 hour, and in that time, you need to convince them that you are a reliable and dependable nurse!

This is a role for people who actually give a damn!
What do you do when you aren’t working?
This makes me laugh... those who know me well will attest, I am a work-a-holic. I enjoy travel, and I do a fair amount of it! I also volunteer as a Nursing Officer with St John Ambulance. I am known to relax with a good glass of wine, and I love cooking. I am learning French (slow progress) and I never miss a Sydney Swans match!

What temptation can you not resist?
I will always cave for a Demi-Sec style of Champagne. I spent two days in Reims and Epernay last year and will not pass up Moet & Chandon’s Nectar Imperial or a Demi-Sec from Veuve Clicquot, Billecart-Salmon or Taittinger.

What are the top three things on your bucket list?
*Return to Epernay
*Sky-dive
*Obtain a Civil Aviation License

Name three famous people you would like to have dinner with and why?
The Dali Lama, Mother Teresa & Ghandi (supposing mother Teresa and Ghandi were alive) I am curious as to how humanistic they were/are and whether they have transcended normal human thinking. If so, whether they think it is out of reach or every day people who are bogged down with the worries of everyday living. I would also love to play 20 questions with them!

If you could be someone else for a day who would it be and why?
I would not mind being a 747 pilot for a day….I have never grown out of my childhood fascination with flying.

Describe your perfect holiday...
Island hopping on my own chartered sea-plane, snorkeling, seafood and champagne sunset dinners on a different beach each night & tropical fruit breakfasts in the morning!
What is your favorite book/movie/song?
Well the book that had a profound effect on me was Roll of Thunder, Hear My Cry by Mildred Taylor. It is a children's novel published in 1976 and tells the story of an African-American family struggling through the great-depression in Mississippi and retells a number of haunting scenes including the activity of the Klu Klux Klan in the 1930's.

I have also found inspiration in Four Fires by Bryce Courtney.

Favorite movie possibly the shawshank redemption.

Favorite song….Can you really skip past Billie Jean on your ipod, really??

What sport/team do you follow?
The mighty Bloods…..Sydney Swans!

Do you do any community/volunteer work?
Yes, as I mentioned before, I Volunteer with St John Ambulance as a Nursing Officer. I have volunteered for nine or so years now, and it has provided me with amazing experiences, both clinically and socially. I have met a number of A-list celebs, I have been assigned as a personal medic to a number of international mega-artists, and I have coordinated and rendered care in both significant trauma and medical emergencies. I really find the challenge of the pre-hospital care environment stimulating as it requires modification to your normal intra-hospital thought processes. The scene you are thrown into is not as controlled, nor controllable as what we are accustomed, so it really comes down to adapting on the run!
A warm welcome to all our ASPAAN members for 2013.

We hope all of you have had a lovely break and are enjoying this wonderful Australian Summer of ours.

A number of changes to ASPAAN are being implemented this year and the first is that we are going green. Therefore this edition is the last issue that will be printed and posted out. If any of our members would like a hardcopy then please email me at aspaan.newsletter@gmail.com and I will forward your names to Valerie Howell our Vice President and Membership Officer for posting.

If we don't hear from you, then we will assume you are happy to view future issues online.

With this issue, we are pleased to welcome our new National President, Mr Jamie Mann-Farrar to the role. Jamie comes with an enormous wealth of experience and we look forward to working with him to make ASPAAN a bigger and bolder role in PACU and Anaesthetic Nurses professional lives, Australia wide. Please see our new section on “five minutes with” on page 6 of this issue. We plan to make this column a permanent fixture in our newsletter and will be interviewing all our State Presidents for our next issue.

This edition is coupled with a number of new features: ‘Medicines under the microscope’ and ‘Quality capers’. We are also delighted to have received a book review and would encourage any of our members to try their hand at this or at least write on a quality project they have instigated at work.

To help members get started on writing for the newsletter, maybe try writing a small piece on a movie you have seen, a book you have read or even a wine you would recommend. Remember this is your newsletter and its as good as its members. See you online for our Winter edition.

Good health and blessings

Gabrielle

Gabrielle M Blake
ASPAAN Newsletter Editor
New Anesthesia Drugs Developed to Be 'Fast, Clean, and Soft'


Researchers are using sophisticated and powerful new tools to develop and evaluate new anesthetic agents with important advantages over current drugs, according to a set of papers in the August issue of Anesthesia & Analgesia, official journal of the International Anesthesia Research Society (IARS).

The new techniques open the way to rapid development of better, safer anesthetics with real benefits for patient care, according to an accompanying editorial by Dr Ken B. Johnson of University of Utah, Salt Lake City.

Advanced Techniques Used to Design Better Anesthetics The August A&A reports on the development and initial evaluation of two new anesthetic agents. Separate research groups are using a combination of older and newer techniques -- including molecular-level techniques and computer stimulations -- for "fast, clean, and soft" drug development. Using these advanced techniques enables researchers to achieve "faster" development of anesthetics that are "softer," with more predictable effects and metabolism; and "cleaner," without unwanted side effects.

Researchers at Massachusetts General Hospital, Boston, report on the development of an improved version of etomidate -- a sedative commonly used to induce general anesthesia in patients who are elderly, critically ill, or in unstable condition. Unfortunately, etomidate also causes suppression of adrenocortical function. This can interfere with production of steroid substances that play an important role in immunity and other key functions.

The researchers identified the specific feature of the etomidate molecule -- a "pyrrole ring" -- responsible for blocking adrenocortical function. Armed with this knowledge, they modified the pyrrole ring to create new versions of etomidate. They report initial pharmacological studies of a new "MOC-carboetomidate" that combines the potent sedative activity with rapid metabolism and clearance from the brain. The new drug promotes hemodynamic stability, without suppressing adrenocortical function.

A group of researchers from PAION UK, Ltd, and Johns Hopkins University School of Medicine report on the development a new benzodiazepine-type sedative drug called remimazolam. Again, molecular-level techniques were used to create a new benzodiazepine drug with more favorable properties: "fast onset, a short, predictable duration of sedative action, and a more rapid recovery profile than currently available drugs."

The researchers report the use of computerized models and simulation techniques to explore the basic properties of the remimazolam. The results suggested very rapid sedation, reaching peak effect within three minutes, which should allow more accurate tailoring of the final dose.

The new techniques may facilitate the evaluation of remimazolam from initial human studies to final clinical trials. Dr Johnson also notes that some of the simulation techniques used in the studies provide useful and detailed information for anesthesiologists to use in comparing the effects of different anesthetics.
The new reports provide a timely illustration of the way anesthesiology researchers are using advanced techniques to develop and introduce new agents that will help to make anesthesia more effective and safer for patients.

Dr Johnson concludes, "Through their efforts, remimazolam and the MOC etomidate analogs will likely bring interesting advances to our specialty in the coming years!"

**New Evidence Suggests Certain Anesthetics Highjack the Brain’s Natural Sleep Circuitry**

**Latest Findings in the Quest to Discern How Anesthetics Induce Unconsciousness.**

A new study by researchers at the Perelman School of Medicine at the University of Pennsylvania demonstrates in an animal model that a commonly used inhaled anesthetic drug, isoflurane, works by directly causing sleep-promoting neurons in the brain to activate, thereby hijacking our natural sleep circuitry. The findings are the latest work by investigators in the Center for Anesthesia Research at Penn who are exploring how anesthetics interact within the central nervous system to cause a state of unconsciousness.

The new research is published in the latest edition of the journal *Current Biology*.

"Despite more than 160 years of continuous use in humans, we still do not understand how anesthetic drugs work to produce the state of general anesthesia," said study author Max B. Kelz, MD, PhD, assistant professor of Anesthesiology and Critical Care. "We show in this new work that a commonly used inhaled anesthetic drug directly causes sleep-promoting neurons to fire. We believe that this result is not simply a coincidence. Rather, our view is that many general anesthetics work to cause unconsciousness in part by commandeering the brain's natural sleep circuitry, which initiates our nightly journey into unconsciousness."

In the new study, Kelz and colleagues focused on a particular part of the brain, deep within the hypothalamus, which is known to increase in activity as one drifts off to sleep. Through a combination of direct electrical recording and other methods, they found that the isoflurane boosts activity in this sleep-promoting brain area in mice. As further evidence of a connection, animals lacking the function of those neurons exhibited acute partial resistant to entering states of anesthesia.
Solt, Ken; Cotten, Joseph F.; Cimenser, Aylin; Wong, Kin F. K.; Chemali, Jessica J.; Brown, Emery N. Methylphenidate Actively Induces Emergence from General Anesthesia. Anesthesiology, 2011; 115 (4): 791-803

Stimulant May Speed Recovery from General Anesthesia

Administration of the commonly used stimulant drug methylphenidate (Ritalin) was able to speed recovery from general anesthesia in an animal study conducted at Massachusetts General Hospital (MGH). The report, appearing in the October issue of Anesthesiology, is the first demonstration in mammals of what could be a safe and effective way to induce arousal from general anesthesia. While there are drugs to counteract many of the agents used by anesthesiologists -- such as pain killers and muscle relaxants -- until now there has been no way to actively reverse the unconsciousness induced by general anesthesia.

"Currently at the end of a surgical procedure, the anesthesiologist just lets general anesthetic drugs wear off, and the patient regains consciousness," says Emery Brown, MD, PhD, of the MGH Department of Anesthesia, Critical Care and Pain Medicine, senior author of the paper. "If these findings can be replicated in humans, it could change the practice of anesthesiology -- potentially reducing post-anesthesia complications like delirium and cognitive dysfunction in pediatric and elderly patients."

General anesthesia has been an essential tool of medicine since it was first demonstrated at the MGH in 1846, but only in recent years have researchers begun to investigate the neurobiology of general anesthesia and to understand exactly how anesthetic drugs produce their effects. Studies by Brown and other scientists have shown that the state of general anesthesia is actually a controlled and reversible coma and bears little similarity to natural sleep.

Several neurotransmitter pathways in the brain are known to be generally involved in arousal, but which ones may contribute to recovery from general anesthesia is not yet known.

The stimulant drug methylphenidate, widely used to treat attention-deficit hyperactivity disorder, is known to affect arousal-associated pathways controlled by the neurotransmitters dopamine, norepinephrine and histamine. The current study was designed to see whether methylphenidate could stimulate arousal in rats receiving the anesthetic drug isoflurane.
The first experiments showed that animals receiving intravenous methylphenidate five minutes before discontinuation of isoflurane recovered significantly faster than did rats receiving a saline injection. Another experiment showed that methylphenidate induced signs of arousal -- movement, standing up, etc. -- in animals continuing to receive isoflurane at a dose that would have been sufficient to maintain unconsciousness. EEG readings taken during that experiment showed that brain rhythms associated with arousal returned within 30 seconds of methylphenidate administration. Giving a drug that interferes with the dopamine pathway blocked the arousal effects of methylphenidate, supporting the role of that pathway in the drug's effects.
Austin Health is one of the largest teaching hospitals in Melbourne, providing both adult and paediatric services. At the Austin campus the operating suite run one elective paediatric list per week in addition to a daily emergency list inclusive of paediatric. Austin Health has a paediatric section in the Emergency Department, and a paediatric and adolescent ward.

A survey of staff knowledge and confidence related to caring for paediatric patients in recovery room found the necessity to standardise the information and learning resources related to paediatric care post operatively; hence a paediatric learning package was created. The learning package is comprised of a general information section, recommended internet links and a paediatric drug calculation section. It has been designed as a self directed learning tool which contributes towards each individuals CPD requirements. The paediatric learning package was approved for use by the Nurse Unit Manager and paediatric anaesthetist and distributed to all nurses who work in the recovery room and incorporated as a hurdle requirement for participants of the peril operative post graduate course.

Introduction of the learning package has ensured a common level of knowledge for all recovery room nurses and remains an ongoing resource for staff new to the unit.

Comparison of the pre implementation survey with a post implementation survey demonstrated increased staff knowledge and confidence in care of the paediatric patient post operatively.

The package was created by a team of 3 core nursing staff (Siok Ch, Sonia R, Faye D), with the support of the Recovery Nurse Unit Manager, the operating suit pharmacist, and the staff anaesthetist.

The paediatric learning package is a modest tool which enables nurses to take responsibility for their own self education.

Upon completion of the learning package an answered sheet is provided along with a paediatric drug calculation quick reference card.

Acknowledgements: Siok CH, Sonia R, Faye D, Jane B, Dishan CH, Fiona H.
The Paediatric Learning Package (PLP) in a Teaching Hospital

Introduction
A survey of staff knowledge and confidence related to caring for paediatric patients in recovery room found the necessity to standardise the information and learning resources related to paediatric care post operatively.

Survey 2010
Do we need a PLP

- Yes: 97%
- No: 3%

Survey 2012
Yrs in PARU

- 1-2 Years: 27%
- 2-4 Years: 24%
- 4-6 Years: 21%
- 6 or more years: 28%

The paediatric learning package has:
- General information section.
- Recommended internet links.
- Drug calculations.
- It also contribute to CPD requirements.

January-December 2011
Elective and Non Elective Surgery

- Elective Male: 18%
- Non Elective Male: 12%
- Elective Female: 16%
- Non Elective Female: 18%

Survey 2012
Number of years working in the recovery

- 1-2 years: 16%
- 2-4 years: 18%
- 4-6 years: 28%
- 6 or more years: 26%

Before and after applied the PLP

- Contributors: 52%
- Improvement: 26%
- No difference: 24%

Conclusion
Comparison of the pre implementation survey with a post implementation survey demonstrated increased staff knowledge and confidence in care of the paediatric patient post operatively, and remains an ongoing resource for staff new to the unit.
10 things you should know about.........

Succinylcholine

1  The only depolarising muscle relaxant in use today

2  Rapid onset of action (30-60secs) duration <10mins.
   The duration of action is prolonged by high doses or by abnormal
   metabolism. Such as in hypothermia.

3  Should be stored in the fridge at 2-8° and should be used within 14 days
   after removal from refrigeration and exposure to room temperature.

4  It is used when profound neuromuscular blockade is required,
   ie to facilitate tracheal intubation and for the modification of its post
   ECT.

5  Patients who have received succinylcholine have an increased incidence
   of postoperative myalgia. This appears to be more common in females.
   Administration of rocuronium prior to succinylcholine has been
   reported to be effective in preventing fasciculations and reducing post
   operative myalgias. Perioperative use of nonsteroidal anti-inflammator-
   y drugs may reduce the incidence and severity of myalgias.

6  Repeated doses may cause bradycardia and a slight increase in MAP.

7  A potent triggering agent in patients susceptible to malignant
   hyperthermia.

8  Transiently increases some muscle tone in the masseter muscles.
   Some difficulty may initially be encountered in opening the mouth
   because of incomplete relaxation of the jaw. However a marked increase
   in tone preventing laryngoscopy is abnormal and may be premonitory
   sign of MH.
9 The onset of paralysis is usually signaled by visible motor fasciculations. Fasciculations are typically not observed in young children and the elderly.

10 Contraindicated in the routine management of children and adolescents because of the risk of hyperkalaemia, rhabdomyolysis and cardiac arrest in children with undiagnosed myopathies.

REFERENCES
Morgan, EG, Mikhail, MS and Murray, MJ; *Clinical Anesthesiology*, 4th Edition. 2006.

ASPAAN is a non for profit organisation and our quarterly newsletter is distributed to RN Clinicians, Educators, Hospitals and to some businesses who are members of ASPAAN.

ASPAAN provides its members with seminars, study days, a national conference and of course this newsletter.

This is an ideal medium to market your products to clinicians in the field of perianaesthesia nursing. Your help allows us to provide these services to our members.

Compared to other advertising mediums, we believe that we are cost effective, for example:

⇒ Newsletter, full page, colour, $400 (limited opportunities due to printing space)
⇒ Newsletter, double page, colour $800, with your poster or artwork
⇒ Pack in, separate A4 full page, colour $300
⇒ Advertising space in the National Conference Program: $800 one full page, colour.
⇒ Satchel drop with your flyer, brochure, or product, $1200 for both forms of promotion.

Don’t forget, online right now are recent back issues which are available to members for download and your advert (if printed in the newsletter) will always be there!

This quarterly newsletter is just one of many possible advertising mediums available, we also offer poster space, web presence and trade displays.

For more information, please email: info@aspaan.org.au
ASPAAN was formed with the idea of providing continuing education, research and professional development opportunities for nurses in the specialty of Anaesthesia and PACU Nursing.

Study days, combined group Seminars and conferences have all contributed to furthering education and providing the networking opportunities so important in this area.

All of these events contribute to providing our patients with optimal care.

With all of this in mind, the committee is keen to encourage members to make use of grants available through ASPAAN.

An Education and Research Fund has been established and the ASPAAN committee extends to members an invitation to apply for these grants. We would like to see an enthusiastic response to the research challenge. There must be a lot of questions out there, and you may be able to solve some dilemmas or at least give us your educated (and well researched) opinion.

For further information about our education and research grants, please either write to us for an application form, or go to http://www.aspaan.org.au and follow the Education link.
Quality in Nursing refers to the ongoing process of assessing what you are doing and making changes to improve best practice. It also measures the effect of the change instituted. To assist you in producing a quality/safety article for the newsletter, we have developed the following steps to assist you in formatting.

Your article can be a case study, a review of evidenced based care, an audit, a best practice guideline or a topic you are especially passionate about related to Anaesthetic and/or PACU nursing.

- **Title** of your project
  
  Author(s) and Identification/Affiliation.

  Names and contact details of the authors involved in the study.

  What was the problem to be solved? Investigation undertaken?

- **Methodology** define the steps undertaken to solve your problem; who was involved in the development, did it require input from your Medical Advisory Committee/Ethics Committee?

  Research undertaken?

- **Evaluation**
  
  - findings

  How did you evaluate the outcome of changes/introduction of new practice; time frame for evaluation example, two months; does re-evaluation need to occur?

- **Conclusion**
  
  critique & conclusion

  Illustrations, Tables, Figures and Legends

  Acknowledgements

  References

  Permissions
Do you have something to discuss, a great case study or have a passion for a particular area of Anaesthetic and PACU Nursing? Well, Why not write an article for your newsletter? Not only would it assist your newsletter editor, but you gain valuable CPD points. Please contact me at aspaan.newsletter@gmail.com and I will be more than happy to assist you in any way I can.

REMEMBER THIS IS YOUR NEWSLETTER, PLEASE CONTRIBUTE TO ALLOW US TO GROW.

Newsletter submission deadlines:

- February 20th 2013 Autumn edition
- May 20th 2013 Winter edition
- September 20th 2013 Spring edition
- November 20th 2013 Summer edition

As a mature aged nursing student, the incivility of the hospital environment shocked me. Coming from a professional public sector career, I had never been part of a workplace where rudeness, bullying, disparaging behaviour and verbal abuse were not only tolerated, but my constant companions. I’d heard the rumours that "nurses eat their young," but my previous professional, educational and life experiences had failed to prepare me for nursing.

I don’t know how I survived my graduate year. As new nurses, we faced the challenges of shift work, high acuity patients and resource-strapped wards. At the same time, I watched junior nurse friends and colleagues slowly sinking, emotionally and psychologically harmed by the very act of working together with other health professionals. This just hadn’t happened in my previous jobs and I just couldn’t get my head around it.

Having coffee, a friend of mine, a physiotherapist tried to make me understand. She discussed shouting at a nurse on her ward, rationalising it as an expression that she was having a bad day, something, from her perspective, the nurse had understood. Further, my friend announced that this was what she liked about clinical environments, her ability to "keep it real" - let her emotions out, without having to worry about it too much. I wondered out loud if the nurse had really understood that my friend hadn’t meant her harsh comments, and hadn’t intended to cause offense, understood that she was just letting off steam. My friend thought I was just thin-skinned.

There are lots of reasons why interprofessional relationships in healthcare are sub-optimal- hierarchies, female dominated workforces, nurses’ subordination to medical staff, cultures of bullying in medicine and nursing training, limited resources and time constraints. Perhaps it is just that many of us, on a daily basis, care for people at the worst, most stressful time of their life. At the same time however, it seems incongruous that workplaces populated by professionals committed to helping others, in an era of Employee Assistance Programs and staff helplines, of anti-bullying legislation and payslips printed with anti-bullying slogans, healthcare environments continue to be complicated by poor interpersonal relations and incivility.

Reading about Leekley and Turnure’s book The Real Healthcare Reform: how embracing civility can beat back burnout and revive your healthcare career in Critical Care Nurse (December 2012), I clicked onto Amazon.com and bought a copy. The authors promised solutions for the incivility epidemic that "ruins trust among healthcare teams and leaves you feeling exhausted, hopeless and dissatisfied with your job and your future in healthcare.” It looked like these nurses had some answers.
I expected a nuanced consideration of the issues of workforce incivility, focused on healthcare, as well as practical, motivating strategies for developing personal skills and resilience in the face of incivility. Instead, The Real Healthcare Reform is the literary equivalent of your mother lecturing you to unhold your personal standards, in the face of others’ incivility, to ensure that you don’t sink to the same level as the bully. Good advice, but not always practical nor empowering.

The Real Healthcare Reform is unrelentingly American, and in a sense the Americans have it easy. In 2009 the United States Joint Commission issued a statement on professional behaviours in healthcare environments, after surveys indicated that nearly all healthcare workers had witnessed or experienced workplace incivility. As a result, incivility, at least officially, has been listed as a patient safety issue, with healthcare employers required to provide staff education on appropriate professional behaviours. Leekley and Turnure’s text essentially is a workbook intended to facilitate this mandated education.

I have often wondered if I am particularly thin skinned, or if, perhaps, my expectations are just unreasonable. No one else seems that worried about workplace incivility. When, in introducing the topic, Leekly and Turnure incorporate demeaning or disparaging language or behaviour, gossip, intimidation, sabotage, bullying, offensive written communication and hate-ism (rankism, racism, ageism and sexism) - I could bring to mind a recent personal experience of each. Perhaps I wasn’t imagining things…

The authors’ solution however, is to essentially kill your colleagues with kindness. Sensibly, they emphasise that individuals can only control their own behaviours, and can’t influence colleagues through anything other than modelling civility. As a result, The Real Healthcare Reform focuses on self awareness. Using a workbook style, with fill-in-the-blank, mind mapping and reflective exercises, the authors encourage readers to reflect on their own behaviour and motivations, to develop self-awareness and personal and professional integrity. Subsequent chapters work through developing teamwork skills and professional relationships, as well as conflict resolution skills.

At times, I found suggestions laughable- I can’t envisage establishing a Civility Squad, complete with mission statement and monthly meetings in any of the Australian hospitals I’ve worked at. Further, I can’t imagine calmly using "I statements” to ask a co-worker to sit down and talk privately so we can put ourselves in each other’s shoes and find a new way to interact.

At the same time, reading The Real Healthcare Reform has encouraged me to reflect on my workplace behaviours and implement a few changes to the way I conduct myself during work hours. Making personal disclosures and relying on workmates for emotional support and advice is tempting, particularly when faced with challenging personal circumstances.
The authors are emphatic about maintaining firm boundaries between professional and personal relations, arguing that incivility is inevitable when the professional becomes personal. In fact, they actively discourage development of friendships at work, stating that nurses should avoid regularly meeting with colleagues outside work, or discussing controversial topics, like politics or childrearing, as well as personal relationships or concerns, health or illness or social activities. Initially, I thought this was preposterous advice, and thought of the friendships I value, which have developed from the workplace. On reflection, however, I understand that long shifts, working late into the night and stress can encourage sharing "too much information" with colleagues that you are not particularly close to. This inappropriate intimacy can encourage gossip, judgement and potentially, loss of trust between colleagues. As a result, I have committed to, as the authors state, "Zip my lip" on personal concerns and issues at work.

Leekley and Turnure sensitively consider team work amongst nursing staff—particularly the difficulties that arise when individuals differ in terms of gender, age, education and practical experience. Their simple advice— to be kind to each other, avoid interpersonal dramas by not gossiping, placing patient's needs above all others, being sensitive and efficient, offering and accepting help and listening to other team members—provide a useful framework for an effective nursing team. They also suggest that providing positive feedback can effectively promote staff satisfaction and workplace harmony. Impacted Nurse's (www.impactednurse.com) Note to nurse day—encouraging nurses to write notes expressing gratitude for their colleagues' assistance and expertise, might just be the answer.

The chapter on gossiping and bullying has served as a wake up call for me, too. It reminds me that, no matter how innocuous information sharing seems, or where chatting about others serves as a social glue or relationship builder, gossiping can never build a harmonious or effective team. I may actually find myself attempting to implement the authors' strategies for shutting down a gossipy colleague—countering with a positive statement, suggesting the complainant speak directly to the person being gossiped about, or asking if gossip can be attributed to the individual facilitating it's flow. Finally, I am going to focus on Leekley and Turnure's advice that avoiding workplace conflict is far easier than managing it. They encourage individuals to consider flying under the radar, by picking your battles, steering clear of disagreements that don't directly involve you, acknowledging and accepting different cultures, perspectives and life experiences, separating personality and behaviours and always remaining respectful.

The Real Healthcare Reform concludes by encouraging readers to "just say no" to the culture of incivility that exists in healthcare organisations, by controlling your own reactions to incivility, identifying the causes for poor behaviour and joining with like-minded colleagues to create a kinder workplace. Change, apparently, starts with you. Whilst I don't find this rhetoric particularly empowering, I understand that individuals only have control over their own behaviours and responses. At the same time, the causes of incivility are often systemic, and changing behavioural norms requires the sustained effort of medical and nursing leaders, at all levels of healthcare organisations.
At the same time, the Real Healthcare Reform, offers simple, targeted advice for individuals facing those unprofessional behaviours common in healthcare environments. Whilst I may have mocked the workbook format and the cheesy Americanisms, this text had caused me to rethink my professional behaviours and personal values, and try to reduce my role in perpetuating workplace incivility. Plus my colleague asked if she could borrow, so at least we have started a workplace conversation on kindness. Probably worth the $25.

References


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SPEAKER ABSTRACT SUBMISSION Deadline extended!

For all nurses working in Anaesthetics : Post Anaesthetic Care Unit/Recovery [specialist or general] : Pre-admission : Pre-anaesthesia : Day Surgery

Don’t miss this incredible opportunity to share professional knowledge, research and best practice strategies related to nursing in these acute specialities. Panel discussion, workshops, poster and formal presentations will allow maximum exchange of ideas.

The conference goal is to reflect diversity and shared practice around the globe to improve the quality of patient care during anaesthesia and the PACU.

We welcome speaker and or poster abstracts on any topic covered by the following broad themes:

• Initiatives in the clinical care of a patient undergoing anaesthesia • Initiatives in clinical management of the PACU patient • Managing the PACU: policies, procedures, people • Research and its application to practice • Education and mentorship in the PACU • Quality assurance and audit in action

Specific topics requested for Dublin include, but are not limited to:

• Sleep Apnoea • Paediatric Care • Pain Management • Use of Capnography • Complex Case Management • Autonomous Advanced Practice • Postoperative nausea and vomiting • Malignant Hyperpyrexia/Hyperthermia

Poster abstract submission deadline: 12th April 2013
Speaker abstract submissions now closed

For conference information and to download submission forms for speaker/poster abstracts please access the ICPAN website : www.icpanconference.com
For questions relating to the education programme
email : education@icpanconference.com
Join us on Facebook to post questions for discussion and develop contacts for networking.

Tips for using social media:

- Don’t talk about confidential patient or work information on your website
- Don’t post photographs of yourself engaging in illegal, offensive, compromising or inappropriate activity
- Don’t post photographs of yourself engaging in conduct in the workplace which you know would be deemed inappropriate by your employer. The same goes for comments

Please see the ANF website for further tips.

www.anfvic.asn.au
Case study: Victorian nurses discuss patient on Facebook

Last year ANF represented several members facing disciplinary action and termination of employment for interaction with patients on Facebook or discussions about patients on Facebook. In one case members from the same ward, who were all part of the patient's treating team, had a brief conversation on Facebook about a patient. The discussion was read by a Facebook "friend", who was also a senior nurse at their facility, and reported it to management. Management considered the conversation a breach of the principles of patient confidentiality and professional boundaries. These nurses would have been aware not to have this conversation in a public place within earshot of other people not directly involved in the patient's care, a lift, with a taxi driver or with friends, but the boundaries seem blurred by the still relatively new social media. On this occasion ANF successfully argued for the nurses to keep their jobs and that the employer provide education about using the new media.

This article first appeared in QNU’s journal ‘tqn’ October 2009, pp 22-23.

Thank you to the ANF for these tips
POSTER PRESENTATIONS

- Posters should address one central theme or topic, providing an explicit take home message.
- Posters should have a title, Introduction, contents and a conclusion with acknowledgements.
- Using visual elements, such as pictures, charts, tables and graphs to enhance your poster is a must.
- A poster is an alternative way to present a paper that has equal status within the conference to an oral presentation.
- Poster presentation is designed to allow presenters maximum yet personal interaction with many attendees at one time. This is an excellent way of getting feedback from interested and knowledgeable researchers on your research and also very useful for extending your personal network of relevant researchers.
- Presenters will stand next to their visual presentation as attendees stroll around the meeting room searching for topics of interest. In order to attract attention, presenters need to have an exciting topic and a visually stimulating presentation where organization and clarity are critical. The Presenters will stand next to their visual presentation as attendees stroll around the meeting room searching for topics of interest. In order to attract attention, presenters need to have an exciting topic and a visually stimulating presentation where organization and clarity are critical.
- The presentation must catch attendees’ eyes as they walk by and then be easily conveyed in a short time. After that, a more formal, detailed, one-on-one discussion can be conducted.
- The main goal for presenters is to simulate informed discussion of your research. Below are some guidelines to help you achieve this goal.
- Posters should not be larger than 1.0m wide by 1.4m in height. The poster will be mounted onto a velcro compatible panel that has maximum dimensions 1.8m x 1.2m wide. (Poster can be placed Landscape - please advise below.) The poster should be a single panel, not a series of different pieces.
- The title of the poster, the names of authors and the institution where the work was done should be at the top of the poster.

All financial support/funding must be acknowledged/declared.
POSTER PRESENTATIONS

- After the title, the two most important sections are the introduction and the conclusion. On the basis of these two sections, a reader will decide whether to look at the results and perhaps talk to the presenter. These sections need to be particularly simple, concise and visually attractive. The methods and results should also be stated simply and concisely.

- Handouts can be very useful. A handout should preferably be an A4 version of the poster. Tip: If it cannot be read at A4, the poster is too cramped.

- A pocket for business cards is also useful.

- The Conference Program will list the scheduled Poster Presentation sessions. Posters should be arranged and set up during the first day of the conference. Be sure to be there for the Poster Presentation sessions to answer questions and get feedback on your research.

- Do not try to ill all the available space with daunting text and diagrams – leave some open space for an attractive result. Clear, simple graphic material, including photos, is useful in supporting the poster; particularly avoid large tables of data. Try to attract an audience for discussion, rather than overwhelm them with complex detail.

- The type should be enlarged for easy reading.

- Character height recommendations – Title: 20-40 mm, headings: 10-16 mm, text: 7-10 mm.

Ordinary typewritten copy or text prepared in an all-caps format is not suitable. Use a font like Arial rather than a font like Times or Times Roman or clarity in text, tables and diagrams.

- Use colour with care and to effect. Avoid combinations of background and text of similar tones of red and green; some people have difficulty distinguishing these colours. Matt finished photographs are easier to see because of reduced glare.

- The poster should be put up prior to the commencement of sessions to allow the delegates to read the material and prepare questions for the author.

- The poster should be put up prior to the commencement of sessions to allow the delegates to read the material and prepare questions for the author.
POSTER PRESENTATIONS

- One of the authors must attend the poster during the designated period to discuss the work presented.
- The author in attendance should be capable of responding to questions of all aspects of the presentation.

This has been taken from the ANZAM website with thanks.

http://www.anzamconference.org/docs/Poster-Presentation-Guidelines.pdf
State News

Victoria
Seminar set for 27th April at Cabrini Hospital, Malvern.

NSW
A successful Seminar was held on 23rd February at the Maitland Hospital.

Tasmania
No news to report

Western Australia
No news to report

Queensland
No news to report

Vacancies exist on all State and National committees. Please contact us at Info.aspaan@

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Glenferrie Rd
Line Dandenong/
Pakenham or
Frankston
0800–1300
Registration from 0730–0800
0800–0845 Simon Plapp: Hypoxia & O₂ Therapy
0845–0915 Dr Patrick Hughes: Paediatrics, Parents & PACU
0915–1000 Dr Peter Seal: Pain Management of the Bariatric Patient
1000–1030 Morning Tea
1030–1045 Trade Presentation TBA
1045–1130 TBA: Management of PACU
1130–1215 Dr John Cormack: Craniotomy Care in PACU
1215–1300 Closing & Evaluation
Registration
Members Free/Non Members $65
e-mail aspaanvictoria@hotmail.com
Registration closes 19th April 2013