AANA Supports Listing Propofol on Schedule IV

Dear Colleagues,

In October 2010, the Drug Enforcement Administration (DEA) formally proposed placing propofol into Schedule IV of the Schedules of Controlled Substances. A notice of the DEA’s proposed rulemaking was published in the Federal Register on Oct. 27, 2010 (75 Fed. Reg. 66196), and the comment period ended Dec. 27, 2010.

I am writing to inform you that the AANA provided written comments to the agency in support of the proposed rule, which is consistent with AANA Position Statement 2.14 Securing Propofol. Adopted by the AANA in 2009, Position Statement 2.14 recommends that facilities maintaining propofol on formulary develop and implement methods to reduce the possibility of propofol being diverted and abused.

As you know, the AANA is deeply committed to protecting our members and their patients. To that end, we applaud the DEA for acting to place propofol on Schedule IV as a positive step in meeting the ongoing challenge of preventing the diversion and misuse of propofol by healthcare professionals. It is entirely unacceptable that a single CRNA or student nurse anesthetist might perish as the result of drug abuse, or that any patient might be placed at risk by an impaired provider. The AANA is joined in expressing support for listing propofol on Schedule IV by the American Nurses Association and the American Society of Anesthesiologists, among others.


For all you do for the patients, practice and profession of nurse anesthesia, thank you.

Sincerely,

Paul W. Santoro, CRNA, MS
President

Upcoming Events

For the latest AANA News, visit the AANA Facebook page and follow "aanawebupdates" on Twitter

February 18-20, 2011: Federal Political Directors Conference

February 24-26, 2011: Assembly of School Faculty

August 6-10, 2011: AANA 78th Annual Meeting
The Pulse

Inside the Association

- Hot Topics
- Federal Government Affairs and PAC
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Healthcare Headlines

Healthcare Headlines is for informational purposes, and its content should not be interpreted as endorsements, standards of care, or position statements of the American Association of Nurse Anesthetists.

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- Hand Contamination of Anesthesia Providers Is an Important Risk Factor for Intraoperative Bacterial Transmission
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- Survey of Nurses From America's Leading Hospitals: 93 Percent Feel Hospitals More Prepared to Handle Flu Season Demands Than Last Year

Dates to Remember

- January 15, 2011: Federal Political Director of the Year Award Deadline
- January 15, 2011: John F. Garde Researcher of the Year Award Nomination Deadline
- January 15, 2011: Rita L. LeBlanc Philanthropist of the Year Award Nomination Deadline
- January 15, 2011: Advocate of the Year Nomination Deadline
- January 15, 2011: Jack Neary Pain Management Award Application Deadline
- January 31, 2011: Request to serve on CRNA-PAC Committee Application Deadline
- January 31, 2011: Delegate to the Education Committee Application Deadline
- February 1, 2011: Evidence Based Practice Projects Grants Application Deadline
- February 1, 2011: General Research Grant Proposals Application Deadline
- February 1, 2011: AANA Foundation Board of Trustees Application Deadline
- March 15, 2011: Agatha Hodgins Award for Outstanding Accomplishment Deadline
- March 15, 2011: Helen Lamb Outstanding Educator Award Deadline
- March 15, 2011: Alice Magaw Outstanding Clinician Practitioner Award Deadline
- March 15, 2011: The Ira P.

Important Member Alert!
Public Notice from the AANA Continuing Education Department
Posted on the AANA Website on Dec. 21, 2010
Recently we have become aware that Premier Anesthesia Services, Inc. of Middletown, Delaware, which is operated by James Caccamo, has conducted an education program for CRNAs for which no prior approval had been granted. Attendees were given an AANA code number that was not, in fact, assigned to the program and attendees, consequently, did not receive continuing education credit for attending the program. CRNAs may, therefore, wish to inquire of the AANA's Continuing Education Department (847-655-1190 or continuineducation@aana.com) as to whether Continuing Education credits will be available before attending programs sponsored by Premier Anesthesia Seminars, Inc.

National Nurse Anesthetists Week Comes to Social Media
National Nurse Anesthetists Week (Jan. 23-29, 2011) is fast approaching. Promotional materials have been sent on their merry way to CRNAs across the country to use in their efforts to hail the nurse anesthesia profession. However, there's another promotional
campaign that is free, easy to use, and could even reach more people than posters and advertisements could do, and that campaign is via social media. Twitter (http://twitter.com) is particularly suited to a promotional campaign such as National Nurse Anesthetists Week. If you haven’t seen it, Twitter is a micro blog website where you can broadcast pretty much anything you wish in 140 character texts. Visit http://www.aana.com/essential_publicrelations.aspx to find out more about how to use Twitter and Facebook to spread the good word during National Nurse Anesthetists Week.

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**Federal Medicare Affairs and PAC**

**Medicare Posts 2011 Anesthesia Conversion Factors**
The Centers for Medicare & Medicaid Services (CMS) has published its 2011 Medicare Part B anesthesia conversion factors, averaging $21.26 per unit, down 2.43 percent from the 2010 mean of $21.79 per unit. The Medicare anesthesia conversion factor sets payment for Part B anesthesia services provided to Medicare patients, as well as for services provided to other patients whose health plans pay rates tied to Medicare. CMS pays by the formula (base units + time units) times a dollar value anesthesia conversion factor. Medicare anesthesia conversion factors vary by locality around the country based on local costs, from a low of $19.54 per unit for services delivered in Nebraska, to a high of $28.85 in Alaska. All other things being equal, nurse anesthetists providing nonmedically directed services and anesthesiologists personally performing anesthesia services are paid the same Medicare fee. When a nurse anesthetist is medically directed by an anesthesiologist, the CRNA is paid 50 percent of the fee, and the anesthesiologist is paid 50 percent of the fee for each of up to four concurrent cases for which he or she is providing the seven required services associated with medical direction. In addition, the mean 2011 Medicare conversion factor for physician services that are not anesthesia services is $33.98, down 7.8 percent from $36.87 in 2010. CRNA services billed under the regular physician fee schedule (as opposed to the anesthesia fee schedule) include line insertions and interventional pain management services. For further information, read the Medicare 2011 anesthesia conversion factors by locality (requires AANA member login and password).

**AANA Takes to the Hill on the First Day of New Congress**
The new 112th Congress elected last November took office on Wednesday, Jan. 5, and to bring CRNA interests before the new Congress, the AANA Federal Government Affairs team was out in force, visiting more than 100 lawmakers and their staffs at their office open houses and receptions. Changes from the previous Congress that completed work just before Christmas were evident immediately. While the previous Democratic majority House was led by Speaker Nancy Pelosi (D-CA), the new 435-member House has a substantial Republican majority with some 87 new GOP first-term legislators, and its top officer will be Speaker John Boehner (R-OH). The 100-member Senate, however, has a narrower Democratic majority than that of the previous Congress and a dozen new senators.

**Scheduled House Vote to Repeal Affordable Care Act Postponed as Congress Grapples with Attempt on Life of Rep. Giffords**
House consideration of a bill to repeal the major health reform law, slated for Jan. 12, was postponed as Congress grappled with its shock over the assassination attempt on Rep. Gabrielle Giffords (D-AZ-8) on Jan. 8 in Tucson. At the direction of the House Majority Leader Eric Cantor (R-VA-7), House action for the week of Jan. 10 was put off at least a week. The House had slated two bills for consideration on Jan. 12: the “Repealing the Job-Killing Health Care Law Act” (H.R. 2), and a resolution “Instructing certain committees to report legislation replacing the job-killing health care law” (H. Res. 9). They were expected to clear the GOP-controlled House, but their fate in the Democratic majority Senate was regarded as less rosy. On Jan. 3, Senate Democratic leaders wrote the House that consumer benefits are “too important to be treated as collateral damage in a partisan mission to repeal health care.” For further information, read the text of the House health reform repeal bills awaiting action.

Gunn Award for Outstanding Professional Advocacy Deadline
March 15, 2011: Clinical Instructor of the Year Award Deadline
March 15, 2011: Didactic Instructor of the Year Award Deadline
March 15, 2011: Program Director of the Year Award Deadline
April 1, 2011: Request to serve on AANA Committees Application Deadline
April 1, 2011: Student Writing Contest Deadline
April 15, 2011: Anesthesia College Bowl Application Deadline
May 15, 2011: Student Excellence in Education Award Deadline
June 1, 2011: Student Representative to the Education Committee Application Deadline

Founded in 1931, the American Association of Nurse Anesthetists (AANA) is the professional association for more than 42,000 Certified Registered Nurse Anesthetists (CRNAs) and student nurse anesthetists.

Anesthesia E-ssential is an executive summary of noteworthy articles of interest to nurse anesthetists. It is distributed bimonthly to AANA members.

Anesthesia E-ssential is for informational purposes, and its contents should not be interpreted as endorsements, standards of care, or position statements of the American Association of Nurse Anesthetists.

If you are interested in advertising in Anesthesia E-ssential contact Mindworks Communications at 800-257-8290.
Year-End Session Extends Military CRNAs’ ISP through 2011 and Title VIII Funding Through Mid-March

Incentive special pay (ISP) programs for Military CRNAs are extended another year, and Title VIII funding for nurse anesthesia educational programs is extended at current levels through March 2011, under provisions of legislation enacted late December in the last days of the lame-duck session of Congress. Enacted by Congress on Dec. 21, the “Ike Skelton National Defense Authorization Act” (H.R. 6523) includes a provision extending the expiring ISP program authorization for military CRNAs from Dec. 31, 2010, through Dec. 31, 2011. The AANA had testified to Congress in favor of this critical military readiness and CRNA recruitment and retention provision earlier in 2010. That same date, Congress also enacted a “continuing resolution” funding many federal government programs, including Title VIII nurse workforce development programs, at 2010 levels through March 4, 2011. The bill, H.R. 3082, also implements a two-year statutory pay freeze for federal employees as President Obama had proposed. The pay freeze is effective through Dec. 31, 2012.

CMS Issues Updated ASC Interpretive Guidelines Regarding the Comprehensive Medical History and Physical Assessment

In late December 2010, the Centers for Medicare & Medicaid Services (CMS) made publicly available updated Ambulatory Surgical Center (ASC) interpretive guidelines regarding the comprehensive medical history and physical (H&P) assessment, an important policy issue for CRNAs. The new guidelines state that the comprehensive H&P may be performed on the same day as the surgery. Further, while the comprehensive H&P and the presurgical assessment remain distinct procedures, some elements of the presurgical assessments may be incorporated into the H&P. The updated guidelines do not change who can conduct the anesthetic risk and evaluation of the procedure to be performed prior to surgery. The guidelines state, “In those cases, however, where the comprehensive history and physical assessment is performed in the ASC on the same day as the surgical procedure, the assessment of the patient’s procedure/anesthesia risk must be conducted separately from the history and physical, including any update assessment incorporated into that history and physical.” The interpretive guidelines also do not change who can perform the H&P, which must still be completed and documented by a physician or other qualified licensed individual practitioner in accordance with State law. For further information, read the new ASC interpretive guidelines.

New Anti-Fraud Initiatives Unveiled by U.S. Health and Justice Departments

On Dec. 16, U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius and Attorney General Eric Holder announced that the Centers for Medicare and Medicaid Services (CMS) would be acquiring new analytic tools to prevent wasteful and fraudulent payments in Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP). The development is important to CRNAs who prevent wasteful and fraudulent payments in Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP). The development is important to CRNAs who prevent wasteful and fraudulent payments in Medicare, Medicaid, andCHIP. The CMS is actively exploring using similar systems to identify background information on potential fraudulent actors and links to questionable affiliations. Other tools will track billing patterns and other information to identify real-time aberrant trends that are indicative of fraud. The AANA believes that fraud is a serious matter that can have negative implications for federal programs such as Medicare, Medicaid, and CHIP by increasing costs at the expense of patient care. In November 2010, the AANA commented on a rule proposed to help combat fraud in Medicare, Medicaid, and CHIP. The AANA responded that fraud concerning these federal programs should be prosecuted, the rights of the accused should be protected, and accused healthcare professionals should be subject to fair consideration and due process. Specifically, the AANA asked CMS to provide explicit guidance and further clarification on the proposed additional requirements outlined above. For further information, see the HHS Press Release Announcing New Fraud Tools, the 2009 Health Care Fraud and Abuse Control Program Report, and the AANA’s comments (requires AANA login and password).
CRNA-PAC to Unveil 'Care to be Counted' Development Campaign; Invites AANA Members to Apply for CRNA-PAC Committee Membership
The CRNA-PAC Committee will soon unveil its new "Care to be Counted" campaign, an exciting initiative to help us raise $1.75 million over the 2011-2012 election cycle supporting the federal election campaigns of candidates influential to CRNAs’ interests in federal health policy. Some of the new tools that Care to be Counted will roll out include a CRNA-PAC video and website, AANA member personalized website names, and other innovations. The Care to the be Counted campaign will be launched in January on the heels of CRNA-PAC's successes in 2009-2010, including raising more than $1.5 million and helping elect nearly four out of five candidates it supported to the 112th Congress. In addition, the Jan. 31 deadline to submit an application for your seat on the CRNA-PAC Committee is drawing near. The CRNA-PAC Committee has openings for two CRNA positions and one student position. To find out more about serving on the CRNA-PAC Committee, please visit www.aana.com/crnapac.aspx (requires AANA member login and password).

AANA Foundation and Research
REMINDER! AANA Foundation Applications due February 1, 2011
The following AANA Foundation Applications are due Feb. 1, 2011. Please click on the following links or visit the AANA Foundation homepage at www.aanafoundation.com for applications and for more information about these and other AANA Foundation programs:

- Evidence Based Practice Projects Grants
- General Research Grant Proposals
- AANA Foundation Board of Trustees
- Student Position on the AANA Foundation Board of Trustees

Risk of Burnout in Perioperative Clinicians: A Survey Study and Literature Review
Burnout—characterized by emotional and physical exhaustion, depersonalization, and low levels of personal achievement—has long been recognized as a concern in the healthcare profession, and the latest research suggests that the problem is escalating among doctors and nurses. Previous investigation has tended to examine the phenomenon as it pertains to individual healthcare specializations, but a new study gauges the risk of burnout in multiple disciplines—including surgeons, nurses, and scrub technicians, among others—working within the same perioperative unit. The researchers evaluated the responses of 145 participants who completed a modified version of the Maslach Burnout Inventory-Human Services Survey, the commonly accepted authority for measuring the risk of burnout on the job. Physicians accounted for 46.2 percent of the study subjects, nurses or nurse anesthetists made up 43.4 percent of the group, and assorted medical personnel represented the other 10.3
percent. The questionnaire results revealed that physicians—and, in particular, residents—were more likely than nurses and nurse anesthetists to suffer from burnout. The study findings suggest that boosting personal support, increasing work satisfaction, and improving overall health could help lower the incidence of burnout among members of a perioperative team.

From "Risk of Burnout in Perioperative Clinicians: A Survey Study and Literature Review"
*Anesthesiology (01/11)* Hyman, Steve A.; Michaels, Damon R.; Berry, James M.; et al.

**Antisepsis in the Time of Antibiotics: Following in the Footsteps of John Snow and Joseph Lister**

Researchers are seeking to determine whether anesthesia providers could be the source or mechanisms for bacterial transmissions that lead to surgical-site infections (SSIs). Their research has established an association between contamination of the anesthesia operating room work area and contamination of IV stopcocks, between contaminated stopcocks and nosocomial infections, and between contamination, nosocomial infection, and hand hygiene by anesthesia providers. Improved hand hygiene among providers has been shown to reduce healthcare–associated infections (HCAs). If bacterial contamination of anesthesia equipment and IV stopcocks originates from an anesthesia provider, and the bacteria causing an SSI matches that carried by the provider, then the level of contamination may identify him or her as the cause of SSI. Among even supporters of improved hand hygiene, better data has been requested in two areas. One area is that many HCAs develop after the patient has been discharged, and the infections are often left out of outcomes data, which leads to the problem being underestimated. Also, measures that reduce contamination must, at the same time, reduce the rate of SSIs, and so policies and procedures must be evidence-based. The authors of this editorial conclude that there is not yet a solution to the problem of HCAs or SSIs, but it should receive more attention from the anesthesia community. Providers, they note, should determine the effectiveness of anesthesia work area decontamination protocols, maintain proper antibiotic administration, and maintain hand hygiene.

From "Antisepsis in the Time of Antibiotics: Following in the Footsteps of John Snow and Joseph Lister"
*Anesthesia & Analgesia (01/11)* Vol. 112, No. 1, P. 1 Hollmann, Markus W.; Roy, Raymond C.

**Hand Contamination of Anesthesia Providers Is an Important Risk Factor for Intraoperative Bacterial Transmission**

A new study has found that the contaminated hands of anesthesia providers can be a significant source of patient environmental and stopcock set contamination in the operating room. The study focused on Dartmouth–Hitchcock Medical Center, a tertiary care and level 1 trauma center with 400 inpatient beds and 28 operating suites, in New Hampshire. Researchers randomly selected the first and second operative cases in each of 92 operating rooms for analysis, ultimately analyzing 82 paired samples and 164 patients. Investigators identified cases of intraoperative bacterial transmission to the patient IV stopcock set and the anesthesia environment in each operating room pair with a previously validated protocol. Using biotype analysis, the researchers compared transmitted organisms to organisms isolated from the hands of anesthesia providers obtained before the start of each case. Researchers identified intraoperative bacterial transmission to the IV stopcock set in 11.5 percent of cases, 47 percent of which originated from providers. Intraoperative bacterial transmission to the anesthesia environment was identified in 89 percent of cases, 12 percent of which originated from providers. Independent predictors of bacterial transmission events that were not directly linked to providers include the number of rooms that an attending anesthesia provider supervised simultaneously, patient age, and patient discharge from the operating room to an intensive-care unit. “The most striking finding of this study,” the authors note, “was the evidence that bacterial organisms found on the hands of providers in a ‘snap shot’ in time immediately before patient
contact explained a fairly large proportion of the subsequent overall environmental and patient IV stopcock set contamination.” Repeated measurements of hand contamination throughout the study period might have explained an even greater portion of the overall bacterial transmission.


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FDA Helps States Get Execution Drug

Without any fanfare, the Food and Drug Administration (FDA) has quietly assisted Arizona and California in obtaining an overseas source of lethal sodium thiopental to be used for executions. The agency bears the burden of ensuring “the identity, safety and effectiveness” of drugs imported for medical use—including approving the use of those drugs—but it insists that a 1985 Supreme Court decision relieved it of any authority to regulate drugs brought in for executions. Many states are in short supply of sodium thiopental, and some have had to postpone executions because of it. The ACLU has accused the agency of holding two contradictory positions, as it is not ensuring the drugs will work properly and it also is not enforcing the law. Currently in Arizona, there is a pending lawsuit that challenges the overseas drugs, claiming that they might not be of the same quality and could lead to flubbed executions.

From "FDA Helps States Get Execution Drug"
Charlotte Observer (NC) (01/12/11) Welsh-Huggins, Andrew

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General Anesthesia More Like Coma Than Sleep

According to a review of general anesthesia, sleep, and coma in the Dec. 30 online issue of the New England Journal of Medicine, coma and general anesthesia appear to share key similarities. The researchers found that when patients are under general anesthesia, their brain is not “asleep” but instead enters a state comparable to a reversible coma. In the review, the three doctors—each specializing in one area of the study—discuss how a fully anesthetized brain more closely resembles the deeply unconscious brain that is seen in coma patients and is less like that of a sleeping brain. They go on to conclude that being under general anesthesia is tantamount to being in a drug-induced coma, in which states of consciousness and unconsciousness operate on different time scales. The researchers hope the findings will help to create new approaches to general anesthesia and improve the diagnosis and treatment of sleep abnormalities and emergence from coma.

From "General Anesthesia More Like Coma Than Sleep"
Medical News Today (12/30/10) Paddock, Catharine

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Childbirth Deaths From Spinal Anesthesia Rising

According to a study published in the journal Obstetrics and Gynecology, the number of women in the United States who die from regional anesthesia complications during childbirth has increased slightly since the mid-1990s. While these fatalities are rare, the research spotlights an area of anesthesia that needs to be made safer for women. The data showed that for every 1 million C-sections performed between 1991 and 1996, there were 2.5 deaths related to allergic reactions or heart or breathing problems caused by the regional anesthetic; and the number rose to 3.8 between 1997 and 2002. The study involved gathering information from a U.S. government database on pregnancy-related deaths across the country. Of the 56 women who died of regional anesthesia complications during childbirth, 48 had undergone a C-section. The good news is that women who had a C-section while under general anesthesia were significantly less likely to die due to complications with the anesthesia from 1991 to 2002. Moreover, childbirth deaths tied to any kind of anesthesia were sharply lower

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than in earlier decades, nearly 60 percent so between 1979 and 2002. The rate of incidence declined to slightly more than one death per 1 million births between 1991 and 2002 from a rate of three deaths for every 1 million live births between 1979 and 1990.

From "Childbirth Deaths From Spinal Anesthesia Rising"
Reuters (12/24/10) Norton, Amy

SAMBA Issues Suggestions for Blood Glucose Management in [People With Diabetes]

With the increase in diabetes prevalence, the need to monitor blood sugar perioperatively has also risen. The Society for Ambulatory Anesthesia (SAMBA) has issued a new consensus statement that suggests anesthesia providers gather information about diabetes patients' glycemic control over the previous few months, determine the patient's optimal intraoperative blood glucose level, and manage that level during and after surgery. The new suggestions, published in Anesthesia & Analgesia, address issues particular to outpatient surgery that were not already addressed in the 2009 American Association of Clinical Endocrinologists and American Diabetes Association Consensus Statement on Inpatient Glycemic Control. SAMBA suggests significant practice changes related to pre-operative advice regarding the patient's use of diabetes medication on the day of surgery; postoperative use of rapid-acting insulin rather than regular insulin; use of the 1500/1800 formula for determining insulin dose; and avoiding the temptation to normalize blood glucose levels in patients with inadequately controlled levels. SAMBA suggests that, before surgery, a pre-operative evaluation include glucose level and the HbA1c level. For patients with poorly controlled levels, the anesthesia provider and surgeon should determine together whether to proceed with surgery based on comorbidities and the risk of complications. On the day of surgery, SAMBA suggests that the patient bring all types of insulin used and travel to and from the surgical facility with juice or another type of hypoglycemia treatment. Glucose levels should be checked on arrival to the surgery facility and managed with subcutaneous administration of rapid-acting insulin. Glucose levels should also be checked every one to two hours during surgery. At discharge, patients should be instructed to check their blood glucose levels frequently while fasting and have a hypoglycemia treatment for the trip home. Dosing should be carefully monitored when the patient begins to eat again. Because there is a lack of information about perioperative glucose control in ambulatory surgery patients, SAMBA has begun to consider creating guidance for diabetes patient selection in ambulatory surgery.

From "SAMBA Issues Suggestions for Blood Glucose Management in [People With Diabetes]"
Outpatient Surgery (12/01/10) Steinriede, Kent

Injection Practices Among Clinicians in United States Health Care Settings

Many bloodborne pathogens, including the hepatitis B and C viruses, have been transmitted between patients through the improper use of syringes, needles, and medication vials. Research shows that unsafe injection practices continue to threaten patient safety, but boosting safe injection practices in healthcare settings requires an approach that includes surveillance, oversight, enforcement, and continuing education among healthcare workers. Investigators conducted an online survey in May and June 2010 of U.S. clinicians in healthcare settings that prepare and/or administer parenteral medications. Among the 5,446 respondents, most reported injection practices that met current recommendations. However, 6.0 percent said they "sometimes or always" use single-dose/single-use vials for more than one patient and 0.9 percent "sometimes or always" reuse a syringe but change the needle for use on a second patient. About 15 percent reported reusing a syringe to enter a multidose vial and 6.5 percent save that vial for use on another patient (1.1 percent overall). Only about 29.0 percent of respondents said that they "sometimes or always" administered medications that someone else had prepared. The study authors note, "Anything less than 100 percent compliance with infection control guidelines and aseptic technique contributes to risk of transmission of bloodborne viruses resulting in infections; both
individual cases and outbreaks may go undetected for some time." The researchers also point out that unsafe injection practices not only increase the risk of patient infection but increase providers' risks of needlestick injuries and potential infections as well as licensing board actions and malpractice suits.


**Bupivacaine Formulation Extends Local Relief**

Advanced studies of a slow-release version of bupivacaine have produced favorable results, elevating hopes of identifying a lasting anesthetic to relieve patients following surgery to remove hemorrhoids. Called Exparel, the liposomal formulation uses the DepoFoam carrier to deliver the dose over a longer period so that the analgesic effect lasts longer. "Instead of having a six- to eight-hour half-life, as bupivacaine usually does, it extends its half-life to two to three days," reported Dr. Paul White, PhD, MD, head of clinical research at Cedars-Sinai Medical Center, who co-authored the study. He and colleagues divided 100 patients into four groups, three of which received different dosages of Exparel following hemorrhoid surgery, while members of the fourth were given a dose of plain bupivacaine. The results of the randomized study revealed improved pain relief with the slow-release form of the drug, regardless of dosage level, when compared to plain bupivacaine. Moreover, patients who were administered Exparel had less need for opioid rescue medication. "As people continue to utilize multimodal analgesia, obviously local anesthetics become an important part of the multimodal anesthetic regime," White noted. "The whole strategy is to reduce and hopefully eventually eliminate the need for opioids, and I see drugs like this as potentially playing a key role in that process."

From "Bupivacaine Formulation Extends Local Relief" *Anesthesiology News* (12/01/10) Levitan, Dave

**Survey of Nurses From America’s Leading Hospitals: 93 Percent Feel Hospitals More Prepared to Handle Flu Season Demands Than Last Year**

A new survey of hospital nurses found that more than 90 percent believe hospitals are better prepared to handle a potential flu pandemic than they were last winter. The survey, jointly conducted by Kimberly-Clark Health Care and Baylor Health Care System in cooperation with the American Nurses Credentialing Center, revealed that 93 percent of nurses said hospitals are "far better prepared" to deal with a possible pandemic than they were at this point in 2009, while 91 percent said their hospitals had fully incorporated flu outbreaks into their emergency preparedness systems. The nurses did express concern about the public's knowledge of healthcare-associated infections (HAIs), with just 40 percent of those surveyed believing the public is well-informed about HAIs. Other key findings from the survey include that nearly 75 percent expect the upcoming flu season to be somewhat severe, but 92 percent plan to get the flu vaccine, 69 percent have flu education materials appropriate for all staff, and 68 percent have a pandemic planning committee. In addition, some 60 percent of the respondents said their hospital's HAI prevention program was about the same or only slightly enhanced from the previous year. Rosemary Luquire, RN, PhD, senior vice president and chief nursing officer of Baylor Health Care System, noted that flu preparedness is a priority for Baylor. "This year, in fact, we revised our Universal Influenza Protocol Policy to emphasize the important role our employees play in flu prevention," she said.

From "Survey of Nurses From America's Leading Hospitals: 93 Percent Feel Hospitals More Prepared to Handle Flu Season Demands Than Last Year" *Business Wire* (12/20/10)