

AANA



NewsBulletin

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The staff of AANA Insurance Services in 1998, close to its 10th anniversary. The staff has grown to 25.

AANA Insurance Services Celebrates 25 Years of Service to Members

From its beginning, AANA Insurance Services has existed to serve the members of the Association. Now in its 25th year, the agency has consistently created new products to safeguard the practice of nurse anesthetists in all 50 states.

The agency opened its doors in March 1989, at a time when it was much more difficult for CRNAs to obtain malpractice insurance. Its creation resulted from the work by AANA Executive Director John Garde, CRNA, MS, FAAN; President Peggy McFadden, CRNA, BS; and legal counsel Gene Blumenreich, JD. They were constantly responding to members who were not satisfied with the service they received from the Association's insurance partner. That dissatisfaction, coupled with the difficulty in obtaining malpractice coverage for anesthetists, spurred their decision to create the Association's own insurance agency.

"It was to ensure the long-term viability of malpractice insurance for members," said current Director of Insurance Services John Fetcho, CPCU, ARM, a 20-year veteran of the agency. "Not only did they want to provide the members with a level of customer service that

couldn't be found elsewhere, they wanted to make sure that the availability of malpractice insurance would never be an obstacle for the members or the profession." And, unlike most agencies that service the needs of their clients in a particular city, state, or region, AANA Insurance was formed to address the needs of members in all 50 states and the District of Columbia.

Being one of the few insurance agencies devoted to a single profession, as well as one of the few owned by an association, AANA

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NEW Column!

See the Business of Anesthesia Column on page 20 for more resources to help ensure you have the right insurance coverage

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INDUSTRY TRENDS



The Impact of Continuous Monitoring in Preventing Unrecognized Respiratory Depression on the General Care Floor

Unrecognized respiratory depression on the general care floor resulting in respiratory arrest or a code blue event is a nightly occurrence at hospitals across the United States. A significant portion of these respiratory arrests occur in postoperative patients receiving opioid analgesics and sedatives, which contribute to respiratory depression.¹

Respiratory depression among postoperative patients is reported to average about 0.5 percent.² Patients in “unmonitored” beds, which include the majority of postsurgical patients on opioid analgesics, are twice as likely to receive delayed defibrillation therapy and by corollary, venti-

latory support, than patients in monitored beds.¹

Of the opioid-related adverse drug events, including deaths, that occurred in hospitals and were reported to The Joint Commission’s Sentinel Event database (2004-2011), 47 percent were wrong dose medication errors, 29 percent were related to improper monitoring of the patient, and 11 percent were related to other factors, including excessive dosing, medication interactions, and adverse drug reactions. When opioids are administered, the potential for opioid-induced respiratory depression should always be considered because the risk may be greater with

higher opioid doses. Rates are always higher for patients with sleep apnea, or who are morbidly obese, young, elderly, ill, or who concurrently receive other drugs that are central nervous system and respiratory depressants (e.g., anxiolytics, sedatives).²

Postoperative respiratory depression due to opioids and sedatives cannot be eliminated. However, continuous monitoring solutions, including central surveillance on the general care floor, may enhance a clinician’s ability to identify patients at risk earlier. The earlier a clinician can identify the risk of a patient, the lower the chance of

respiratory depression on the general care floor.

A recent ECRI report regarding low-acuity continuous monitoring provided an overview of available solutions for continuous vital signs monitoring in non-critical care areas. The report described three categories of low-acuity continuous monitoring systems: bedside patient monitoring systems, wearable patient monitoring systems, and non-contact patient monitoring systems. The piece of technology that was presented by the ECRI Institute in the non-contact patient monitoring systems category was The EarlySense System by EarlySense.

The EarlySense System is a continuously and contact-free monitoring of the two most important predictors—heart rate and respiratory rate³, allowing opportunities for early intervention.

The system uses a sensor placed under the bed’s mattress which never comes into contact with the patient. There are no leads or cuffs to connect to the patient, who has freedom of movement and is not burdened by any cumbersome attachments.

The system has been developed specifically for general care patients who are usually monitored by nurses once every four to six hours. In the event of a change in a patient’s status, the system alerts nurses



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at the Central Display Station (CDS), on large screens in prominent locations and on handheld devices. In one general-care patient's case, low respiratory rates detected by EarlySense ultimately led to timely detection of respiratory depression caused by narcotic treatment. Specifically, a 34-year old female was hospitalized after a spinal fusion surgery due to spondylolisthesis. Following the surgery, she was treated with morphine to alleviate the pain, which is considered typical post-surgery care. However, the EarlySense System alerted nurses that the patient had an abnormally low respiratory rate—only 6-7 breaths per minute—and shortly after, respiratory depression due to narcotics was identified, and a physician was called to discontinue morphine. Shortly after, the patient's respiratory rate returned to normal, and she was discharged with no further complications.

Many products now used in the non-acute areas of the hospital environment to monitor deterioration were originally designed for use in the ICU, operating rooms, or post-anesthesia care environments. These environments have clinician-to-patient ratios that are typically four patients to one caregiver. Sometimes in non-acute care environments, this ratio will increase to six, or even 10 patients to one caregiver. The added burden of false alarms due to lead problems can be burdensome for the staff. Contact-free technology that provides updates on patients can be used to alleviate patient deterioration. With The EarlySense System, the alarm frequency in a typical eight-hour shift will only be two or three alarms, compared to the hundreds of alarms per shift experienced when using devices intended for acute care environment. This allows nurses to respond to the pertinent needs of patients, instead of checking in routinely due to the sound of an alarm.

In the case of one patient, who was hospitalized for a left leg fasciotomy and open reduction internal fixation, narcotic-induced postoperative respiratory depression was identified when EarlySense provided the caretakers with a low respiratory rate alert. The patient was stabilized and Narcan (narcotic antagonist) was administered before the patient's health deteriorated. Caregivers on the general care floor have to maintain cadence despite being



required to care for more patients at once. The EarlySense System is a contact-free way for nurses to ensure patients remain safe and avoid deterioration.

An environment in which low activity-level patients reside requires much different technology than the post-operative or ICU units of a hospital. With the non-contact patient monitoring systems like EarlySense, patients who are experiencing respiratory depression or a sudden change in their heart rate can be properly and promptly treated. There are a variety of factors that contribute to the deterioration, or even death, of a patient, including administering narcotics to a sensitive patient, a sudden repercussion from a surgical procedure, or a number of other situations. By using contact-free technology to monitor general care patients on a continuous basis, nurses can prevent patient deterioration and lessen the risk of patient death and complications. ■

References

1. <http://initiatives-patientsafety.org/Initiatives1%20.pdf>
2. Joint Commission Sentinel Event #49 - Safe use of opioids in hospitals
3. Chaboyer, W et al. *Am J Critical Care*. 2008;17: 255-263