Mission: “AORN supports registered nurses in achieving optimal outcomes or patients undergoing operative and other procedures.”

By: Rorie Chinnock

On December 11, 2017 our AORN Chapter 2401 celebrated its 50th anniversary. It was a time to reminisce about the past, celebrate our accomplishments, and look to the future of peri-operative nursing.

We gathered at Children’s Hospital Education Center. There was time to network and catch up with former members who had been invited to join in the celebration. Anne Jones had worked hard at updating our scrapbooks, which are now in great shape! It was fun to scan these books and remember past events and the people who have made our chapter what it is.

A wonderful meal was provided by BD Company compliments of Sherri Briggs.

After a brief meeting, we took time for people to introduce themselves and share their connection to the chapter and the part they had played in the past or future of Chapter 2401. The night concluded with a presentation by Georgia Dinndorf-Hogenson speaking on Moral Courage in PeriOperative Nurses.

Thank You to all who helped in making this event a great success! A good time was had by all.

Let’s keep the chapter alive!
When I was a new OR nurse back in the early 80’s, our Friday morning speaker was a Plastic Surgeon who had traveled on a mission trip to repair cleft lip and palates. It was always my goal to participate in mission work and use my talents to help other people.

I was able to reach this goal in 2006 when family and job commitments allowed me to be away. Last week I returned from my ninth medical mission trip to Peru with Programa San Francisco Dias, based out of St. Paul and started by Dr. Frank Pilney. I have also been involved in two other mission trips to the Philippines and Hermosa, Mexico. Each trip is unique and very satisfying.

During my week in Peru we were able to operate on 39 children to change or improve their lives. Our mission is to repair or revise cleft lip and palates for these children. It takes the work and cooperation of the whole team from anesthesia to surgery to recovery room to make a safe environment for our special patients. The program started in Lima, Peru but is now based in Arequipa, Peru, which is in the mountains east of Lima. The patients come from all over Peru. This is an easier access for our patients who may travel by bus for 16 hours to reach us verses 30 hours when we were in Lima.

In the last AORN Journal, President Natalie Walker talks about Embrace Action: Make Personal and Professional Resolutions. She is referring to your New Year’s resolutions. According to wikipedia, a New Year’s resolution is “a tradition in which a person resolves to change an undesired trait or behavior, or to accomplish a personal goal or otherwise improve their life.”

I would like to challenge everyone to apply this to our Professional Practice in some way. It might be as small as mentoring a new peri-operative nurse to build confidence or a goal of a weeklong mission trip in a third world country. I guarantee you will get back tenfold the effort you put into your resolution.

Enjoy the rest of Winter and Spring is just around the corner! Please take note that we will have a Monday night March meeting during the month of EXPO, followed by our Spring Workshop on Saturday, April 14th and the election of new officers. This year our chapter meetings will end in May with the installation of officers. There is a board / transitional meeting only in June. Also, remember to Vote for National Officers before March 26th, 2018!

Embrace Action: Make Personal and Professional Resolutions!
AORN CHAPTER #2401
2018 MEETING CALENDAR

Meeting Location – Children’s Hospital, 2525 Chicago Ave, Minneapolis, MN
Chapter and Board meetings are held in the 2nd floor Education Center

Monday, January 8th
NO Chapter Meeting - Board Meeting Only Via Email or Web X

Saturday, February 10th
7:30am Chapter Meeting (Combining January and February meetings)
8:00-10:00am Education Hosts: HealthPartners
11:00am-12:30pm Serve Ronald McDonald House Lunch

Monday, March 12th
5:30pm Board meeting
6:00pm Delegate Meeting / National Ballot Presentation
6:45pm Chapter Meeting
7:00pm Education Hosts: Allina/North Memorial

March 24-28th
AORN International Conference and Expo in New Orleans, LA!

Saturday, April 14th
Spring Workshop (half day) – (must register)
7:30 am Chapter Meeting (Including Election of Officers)
8:00am-12:00pm Education Hosts: Children’s/ Northfield

Monday, May 14th
5:30pm Board Meeting
6:00pm Socializing / Officer reception
6:30pm Chapter Meeting including Installation of Officers
7:00pm Education Hosts: Fairview/ VA/U of M

Monday, June 11th
5:30pm Transitional Board Meeting
(Location to be determined) Hosts: Board and Officers
AORN OF TWIN CITIES #2401
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PEDs (personal electronic devices) are everywhere. Donna Ford’s presentation on Dangerous Distractions explains why we need to have our hands on them at all times. PEDs are addictions and have led us to believe that we can multi task. She highlighted several incidences where patients experienced adverse events as we “do it all.”

Distractions are detrimental to our ability to “perform complex tasks that require high level of cognitive processing.” The job gets done but part of our attention was to our phone. We don’t allow interruptions that can be harmful to our patients, why do we allow our phones to do the same? Why are they in our ORs?

Distracted practice maybe a significant factor to health care errors which are the 6th leading cause of death. We are bombarded with stimuli from everywhere.

**Five concerns she identified are:**

1. **Human and Addictive Behaviors-Studies have been completed showing PEDS cause behavioral addiction. A large amount of money and time is spent with them, not with our families. We text while driving. We panic without them.**

2. **Societal and Generational Factors-Younger adults are tolerant of phones being used everywhere. We now live “Alone Together.” We are “online” or on social media daily.**

3. **Ineffective Multitasking. Bruce Knepper says “We’re messaging while we’re emailing while we’re on a call.” MacMillan says we suffer from intentional blindness.**

4. **Prevalence of Personal Electronic Devices-92% of all adults have a cell phone. Almost half “rarely” turn their phones off. Most think their PED is harmful and disruptive but must have it.**

5. **Infection Control Concerns- Kelly M. Pyrek says that studies have shown that PEDs are contaminated, rarely cleaned and disinfected as we don’t know what to use or how to do this.**

Remember our inattentiveness can cost someone their life. Don’t our patients and our families deserve our all?

As a result, we need to educate our staff:

- Establish guidelines for PEDs use.
- Decrease the distractions in our ORs.
- Create a sterile “cockpit”- use nonverbal ques to stop interruptions.
- Try to disconnect-instead of multitasking, stay focused.
- Never post anything about patient care on social media.
- Teach staff how to clean PEDs and use proper hand hygiene.
- Never read social media or surf the internet while doing patient care; be it your PED or work computers. This is tracked by date and time. This is one of first thing lawyers search during a law suit.
I know what you’re thinking—BORING! What would make me pick a topic with that title? Well, besides the fact that I love this stuff, haven’t you ever wondered just a little bit, why it is that even when we know what is the right thing to do - we have the data, we have the resources, we have the training, we have the guidelines, we have the policy - even with all that, it’s so darn hard to get everybody to do it?!

Among the many practice changes and improvements in which I participated over the years at the University Hospital, the elimination of straight-edge razors for hair removal remains perhaps the most confounding. We have known for decades that shaving the surgical site with razors causes micro-abrasions in the skin which can become colonized with bacteria which then increase the risk of a surgical site infection. We know that we should use clippers, not razors, and perform hair removal outside the OR suite as close to the time of surgery as possible, and remove hair near the incision only if it will interfere with the procedure.

I was a staff nurse, a clinical nurse educator, and a nurse manager at an academic medical center, for over 35 years, where we dealt with surgeons who had trained in a variety of different programs and who were all sure that their preferences were based on solid scientific rationale - not personal preference or folklore. I clearly remember this being part of my training as a floor nurse on a surgical unit back in the early ‘70s, and then again as a OR nurse in the early ‘80s.

Use of straight-edge razors hung on forever. It seemed that every time we set out to make a practice change and eliminate those razors, once and for all, we would be sabotaged. We had support from the surgeons on the OR committee, the infection control department, the staff, the supply area. They’re gone from the inventory. Yay!

Eventually, we even had support from the big guns in the American College of Surgeons (ACS) with SCIP - Surgical Care Improvement Project protocols. SCIP grew out of a collaboration between the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control (CDC). I thought this was it - the capper - no more room for argument. We buy the right equipment, inform and train the staff, stock the clipper heads, provide chargers, include clip-not-shave in the pre-op skin prep procedure. We write the policy and procedure, orient the staff, change all the preference cards, set a start date for the new practice. This will be a piece of cake, right?

Well, not all surgeons belong to the ACS. Every surgical specialty has its own national organization. And every specialty at the U has its own chair with separate channels of communication. The Infection Control Department works for the hospital, not the U of M, or the surgical services departments. The OR Committee was supposed to help with standardizing processes and protocols. And you’d think that the CDC and CMS would outrank all of them. Wouldn’t you?

Now, since this article is true confessions, let me share with you a thought that intrudes into my consciousness in moments of greatest frustration. How is it that every surgeon wants the latest and greatest gadget that they saw at the most recent conference, or got from...
Some product rep, whether or not it’s on the list from the supply chain controllers, yet they cannot handle a “change” in practice that is evidence-based, organizationally supported, and easily accomplished with the supplies at hand? How is that? I am reminded of a phrase in an article by Dr. Atul Gawande, a surgeon who wrote Checklist and Being Mortal, in addition to numerous pieces for The New Yorker. He said that change in health care happens “at a glacial pace.” This is a small comfort, given the speed and volume of the information for which we are responsible in the era of information technology.

All of this is prelude to the reason for my interest in this topic. Most professionals in clinical practice today would agree that we are in the era of evidence-based practice. We believe in the primacy of data and science over “the way we’ve always done it.” So, why is the focus on implementation? According to the presenters, Steelman and Osborne, “Studies estimate an average of 17 years for new knowledge from randomized controlled trials to be incorporated into practice.” They call this the “Evidence-Practice Gap.” I’ve certainly experienced it. Implementation of new practices range from very to somewhat to not very successful, even when the practice is well-supported and critical to patient care.

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...So, in addition to the science embedded in a particular clinical practice change, leaders and staff need to take into account something called “Implementation Science”, to help us “understand the behavior of the healthcare professionals and all of the stakeholders as key variables in the sustainable uptake, adoption, and uptake of evidence-based interventions.” “Implementation science provides a systematic set of principles and methods to identifying and addressing barriers and facilitators to system change.”

Changing behavior involves understanding capability, motivation, and opportunity. Never underestimate the tendency to revert to the familiar.

Key factors to consider are the innovation, the people, the context, and the process. Six reasons that implementation fails are:
1. Lack of clarity in the aim or the innovation.
2. Not including people in the plan/planning.
3. Lack of understanding of the context.
4. Bad planning.
5. Measuring nothing or measuring everything.
6. Failing to build support to sustain, scale up, or spread.

While it sounds obvious, assure that all stakeholders are in agreement and hold a shared view of the evidence. Changes in practice are often not optional but it can be helpful to engage early adopters, build success with smaller pilot projects to remove barriers and make it easier to do the right thing than the wrong thing, adjust processes as needed, report progress and outcomes to everyone involved. Expand and sustain the change in a planned way and monitor for success.

Key messages from the presentation:
• Patients who receive evidence-based care have better outcomes.
• Good evidence does not guarantee uptake in practice.
• Consideration of not only the what, but also the why and how is important for successful, effective, and sustainable implementation of evidence-based practices.
• It is imperative to continually evaluate practice in the light of new and emerging evidence.

Effective implementation is as important as evidence-based practice.

So, what about those darn razors? Years, and I mean years, after we implemented clippers in the OR at the U, I was doing a case with one of our more senior GYN staff surgeons. She asked for a razor to shave above the pubis before the skin prep and I said we didn’t have them anymore. I offered her the electric clipper. She went to the drawer in the supply cupboard and pulled out a razor. I asked the GYN room nurse how those happened...
PEDIATRIC UROLOGY TUBE MANAGEMENT: YOU PUT WHAT TUBE, WHERE?

Presented by Katie Willihnganz-Lawson, MD at the AORN of the Twin Cities Fall Workshop November 4, 2017
Attended and Reviewed by Caroline Ness

Katie Willihnganz-Lawson, MD
Dr. Willihnganz-Lawson provided a great presentation reviewing the urinary tract anatomy and discussing some common GU procedures along with a review of different types of tubes and drains used in these procedures.

The urinary system structures include the kidneys, ureters, bladder and urethra. Some Urologic Surgeries related to these structures that are part of the urinary system are:

Urethra:
• Hypospadias
• Posterior urethral valves

Bladder:
• Transurethral resection of bladder tumor (TURBT)
• Incision of ureterocele
• Suprapubic tube
• Vesicostomy
• Bladder Augmentation

Ureter:
• Ureteral stones
• Ureteral strictures
• Ureteral Re-implant

Kidney:
• Pyeloplasty
• Nephrectomy, partial
• Kidney stones
• Kidney tumors

Other:
• Mitrofanoff procedure (appendicovesicostomy)
• ACE procedures (appendicoceostomy)

The purpose of Post-Surgical Urinary Drainage tubes is to:
• Keep natural urinary tracts open during healing process
• Diverts urine away from healing organ and suture lines
• Helps avoid fistula, stricture, urinoma or abscess formation.

The types of urinary catheters are and their locations:

Type:
• Foley: a catheter with balloon
• Council tip Foley: hole through tip to pass wire
• Coude Foley: bend at tip to navigate urethra
• Malecot catheter: looped end, no balloon
• Straight catheter: no balloon, intermittent use

Location:
• Urethra
• Suprapubic
• Continent channels

Foley and Straight Catheters are used to keep the surgical site drained or new urinary channel open (ie- Vesicostomy, Suprapubic tube, Continent catheter channel). Catheters are typically kept in

Continued...
for a minimum of 24 hours up to four weeks.

Urethral Stents are used to keep the urethra open and the bladder draining and are used in hypospadias, posterior urethral valves, and urethral stricture surgeries. Stents are typically kept in place for 7-14 days.

In reviewing the pediatric anatomy, Dr. Willignganz-Lawson noted that placing a foley catheter in a young girl may be a 2 person job in order to visualize the urethral meatus.

Common pediatric procedures:

**Ureteral Reimplant** is indicated when vesicoureteral reflux (VUR) causes urine to travel from the bladder up to the kidney. Depending on the grade of reflux surgical intervention is indicated when there is a high grade VUR, recurrent febrile UTI’s or failed medical management. The goal is to create a longer tunnel for ureter to prevent reflux of urine to kidneys thereby preventing pyelonephritis. There are a variety of operations: extra-vesical, intra-vesical, open vs. robotic. The tubes typically placed in this type of procedure are a double-J stent or feeding tube into the ureter (overnight to 1-3 weeks), possible penrose drain next to the bladder for 1-2 days, and a foley in urethra, usually removed post op day 1-2.

**Percutaneous Nephrolithotomy (PCNL)** is indicated when there are large renal stones. Drains typically placed in this procedure are a stent in the ureter, foley in the urethra and nephrostomy or foley in the PCNL tract.

**Pyeloplasty** is indicated when there is a UPJ(ureteropelvic junction) obstruction which is a narrowing of the junction between the ureter and renal pelvis. The procedure can be performed as an open procedure or robotically. Nephrostomy tubes are a percutaneous placed kidney tube inserted by the surgeon or interventional radiologist to divert urine from the healing area for 2-3 weeks after surgery.

**Bladder Augmentation** is indicated when there is poor bladder compliance or capacity. Most commonly a portion of the ileum is used as a patch. Typical drains are bladder catheters kept in for 3-4 weeks to allow anastomosis to seal, prevent leakage, and allow kidneys to drain. Irrigation of bladder catheters (urethral or suprapubic) prevents mucous plugs in the catheter.

**Bladder Neck Reconstruction** is indicated when there is incontinence due to incompetent bladder neck. The tubes used in this procedure are ureteral stents, suprapubic catheters, and urethral catheters.

**Continent Catheterizable Stomas-Mitrofanoff or Monti** are indicated for intermittent catheterization, difficult to catheterize through the urethra. The procedure is an appendicovesicostomy. The tubes used in this procedure are a straight catheter in newly created channel, suprapubic tube, and JP drain.

**Antegrade Continence Enemas (ACE)** is indicated for neurogenic bowel, and paradoxical diarrhea. Tubes used are a straight catheter or Chait tube placed for 3 weeks. A continent channel can be intermittently catheterized after healing. Chait tubes are changed every 6-12 months. Adapter is attached to the opening of the tube and enema fluids are infused through the adapter into the colon.

Some other tubes and drains in urology occasionally used in ACE or Mitrofanoff openings are Mic-KEY, Chait, Penrose and Jackson-Pratts.

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Search continuing education. Courses presented can also be found on Pfiedler site.
Each year the AORN board of directors establishes a policy agenda based on recommendations from the National Legislative Forum. The Government Affairs team pursues these goals in legislative and regulatory arenas nationwide. Our team collaborates with health care colleagues, organizations, and decision-makers to advance patient safety and health care improvements in all operative settings, but we don’t endorse specific candidates.

**Current Policy Agenda**

- **RN CIRCULATORS**
  We work to ensure every surgical patient has a dedicated perioperative registered nurse circulator for the duration of each operative and invasive procedure. Our team also actively promotes laws and regulations to ensure the supervisory presence of the perioperative RN in the perioperative setting.

- **WORKPLACE SAFETY INITIATIVES**
  Our team supports legislative and regulatory initiatives for safe perioperative work environments. Perioperative nurses deserve surgical smoke-free operating rooms, strong workplace violence protections, and safe patient handling programs focused on injury prevention.

- **PROFESSIONAL PRACTICE**
  We protect the perioperative registered nurse’s scope of practice and patient safety by engaging in legislative, regulatory, agency, and other stakeholder approaches to RN education, certification, supervision, roles, competencies, and duties.

- **RN FIRST ASSISTANT**
  We support the expanded role of the RNFA by actively working to achieve reimbursement parity for RNFAs. RNFAs work in collaboration with the entire surgical team to achieve optimal patient outcomes nationwide and yet private payer reimbursement is only guaranteed in 17 states.

- **PATIENT SAFETY CULTURE**
  We encourage legislative and regulatory efforts to establish an accountable, trusting patient safety culture in the perioperative setting, including robust whistleblower protections for healthcare providers and mandatory reporting of safety incidences, such as surgical site infections and wrong site surgery.

- **HEALTH SYSTEM IMPROVEMENTS**
  Our team promotes the role of the perioperative registered nurse in achieving the reform goals of cost containment and improved patient experiences and outcomes. Healthcare system reform efforts should recognize the contributions of the perioperative registered nurse in improving patient outcomes. AORN also promotes standardized data collection and analysis to advance improvements in patient safety and care quality.
This presentation discussed the impact of catheter-associated urinary tract infection (CAUTI) on patients and hospitals and the methods implemented in perioperative services by Abbott Northwestern Hospital (ANW), part of Allina Health, to reduce CAUTI in surgery patients.

Urinary tract infections cause 40% of hospital acquired infections. Most of these infections are due to urinary catheters. Up to 25% of hospital inpatients are catheterized. CAUTI can lengthen a patient’s hospital stay, cause pain, restrict ambulation and even lead to death. Healthcare costs related to CAUTI are increased $0.4-0.5 billion nation-wide. CAUTI identified in ICU and on med/surg units are reportable to the CDC. CAUTI reduction is an Allina-wide priority.

On any given day, a majority of Foley catheters in patient use in the hospital are inserted in surgery. The number of Foley catheters placed in the perioperative care areas (pre-op, intra-op, and PACU) was determined. Data collection identified CAUTI developing within 5 days of insertion, and these “5-day CAUTIs” /1000 Foley catheters inserted in surgical services *1000 was used to determine the rate. 27% of all CAUTIs in the hospital were identified within 5 days of insertion in surgery.

**Improving Insertion Asepsis:**
ANW performed an assessment of 24 RNs inserting a Foley catheter into a manikin. These RNs represented a broad range of nursing experience. 1 out of 24 attempts were observed to be aseptically inserted. These results were not unlike insertion assessment results at other hospitals nation-wide. The Minnesota Hospital Association identified establishment of criteria for catheter insertion, and use of 2-person insertion technique, having a “buddy” assist and monitor for breaks in asepsis, in their “Cut CAUTI Bundle” practices. Starting in the ICU, RN CAUTI Champions provided training to review best practices for catheter insertion, including 2-person insertion technique, with one RN using a step by step aseptic insertion checklist.

Surgery nurses were engaged as CAUTI Champions to participate in a team to collaborate with the hospital CAUTI reduction efforts. To reduce CAUTI in surgery patients, the strategy aimed at improving insertion technique to prevent breaks in asepsis, and reduce unnecessary placement of catheters. CAUTI Champions elected to teach a standard insertion technique for all Foley catheters inserted in the perioperative setting. Three standard practices for surgery were established to enhance aseptic technique:
- Use of sterile surgical blue towels to define the sterile field.
- A 2-person team for indwelling catheter insertion, using surg techs as the “buddy” for observing aseptic insertion and assistance to the RN.
- Securement of the device in the OR to minimize urethral tears during positioning and transfer.

A video was filmed in the OR to engage staff in perioperative services and facilitate training the new standard practices. Mandatory return demonstration using a simulation model was required for all perioperative nurses. CAUTI data specific to surgical services insertion technique was shared with the surgery teams at staff meetings.

Continued...
Perioperative Bladder Assessment Protocol

At the same time, to reduce unnecessary Foley catheter insertions, orthopedic surgeons approved a perioperative bladder assessment protocol for patients having total hip and knee joint surgery. Over 1200 total joint surgeries were performed each year with routine Foley catheter insertion. The total joint protocol aligned with CDC guidelines to use urinary catheters only as necessary, rather than routinely. Bladder scanning devices were purchased for use in surgery. Educational sessions were conducted to train nursing staff on use of bladder ultrasound scanning (BUS) devices.

CAUTI Champions helped to facilitate communication and promote use of the total joint surgery bladder management protocol.

- Pre-Op RNs screened patients presenting for total joint surgery for risk factors for urinary retention and need for Foley catheter.
- Patients mobilized in pre-op area to void prior to procedure and a post void residual BUS performed.
- Time of last pre-operative void and the amount of post void residual documented and communicated to OR RN.
- End of procedure, BUS assessment for urinary retention was performed by intra op RN.
- Intermittent straight catheter algorithm followed by OR and PACU RNs.

Outcomes:
The communication between the perioperative units and patient bladder management awareness was increased. The “5-day CAUTI” rate in patients with a Foley catheter inserted in the surgery department decreased from 1.94 to 1.44 the first year after implementation of the 2-person technique. The annual goal to reduce CAUTI by 20% was achieved. The implementation of the bladder management protocol has been successful, reducing the number of Foley catheter use in patients on the orthopedic inpatient unit.

More recently, there has been an increase in CAUTI rates in patients having their Foley catheter placed in surgery. A CAUTI Clinical Action Team (CAT) was implemented to continue to investigate CAUTI cases, review charts for trends, and continue to audit practice and champion best practices. The success of the perioperative bladder assessment protocol is now well established. Surgeon groups are reviewing the protocol for use in other surgical populations.

Community Relations Update

Submitted by Mary Kay Boell RN

I want to give a big thank you and a shout out to our chapter members! Thank you for your financial donations and time given to the organizations our chapter supports. Here is the latest contributions update for community relations:

September - We collected $291.00 for Second Harvest Heartland. Our donation was matched by Excel Energy creating a $582.00 donation that will feed many families in our communities.

October - We collected for Feed My Starving Children. We collected $125.00. As many of you are aware, it is an organization that turns hunger into hope for malnourished children throughout the world. Thank you for your financial support and volunteer hours spent at...
The objectives of the presentation were to describe Healing Touch (HT), incorporate evidence based practice, describe the relevance to nursing and include personal stories. HT is an energy therapy. Healing touch practitioners consciously use their hands in a heart-centered and intentional way to enhance, support and facilitate physical, emotional, and spiritual health and self healing.

Healing Touch utilizes light or near-body touch to clear, balance and energize the human energy system in an effort to promote healing for the whole person, mind, body and spirit. The goal of HT is to accelerate the patient’s own healing processes by restoring balance in the energy system of the patient and of the environment. HT can be incorporated in Holistic nursing practice. Using their hands in an intentional way, an HT practitioner can affect a patient’s energy field to promote self-healing and well-being.

Nursing literature describes many benefits of HT to patients. HT may provide the nurse with another resource that can be used in conjunction with pharmacologic therapy to decrease pain and anxiety for postoperative Total Knee patients. In this study, HT was used to promote relaxation, accelerate wound healing, diminish depression, and increase a patient’s sense of well-being. Clients reported a statistically significant reduction of stress after HT, and one month after surgery, 95% of the HT group felt their pain was adequately controlled, compared with 87% of the group that received standard therapy during their hospital stay.

Another study aimed at improving physical and psychological symptoms caused or arising from...
energy imbalances in the body. Reported benefits of HT include: reducing anxiety, increasing relaxation, decreasing pain, diminishing depression, and increasing a sense of well-being. While no significant decrease in the use of pain or anti-emetic medication was observed (many of which were scheduled), significant differences were noted in anxiety scores and length of hospital stay compared to the control group.

Our presenter works as the night shift RN in a metro hospital PACU. When there are no patients in the PACU, he assists in other units in the hospital. He has been trained as an HT practitioner, and his manager approves his use of HT as an integrative therapy. He presented personal stories where he has been able to improve care to patients using HT. Examples included reducing patient’s fear and anxiety related to surgery and more effective pain control.

Following the presentation, several HT practitioners and HT students were present to provide HT to the workshop attendees. All volunteers were able to experience a healing touch session.

Dr. Michael Ehlert is a Female Pelvic Medicine and Reconstructive Surgeon with Metro Urology. He spoke on the difference between mesh for prolapsed bladder versus slings for urinary incontinence. According to Dr. Ehlert, when mesh was used for prolapse, a high percentage of women continued to have symptoms because of the lack of training for the surgeons in its use and the problem was more a lateral defect and not getting fixed properly. There were many cases of mesh erosion until 2011 when the FDA issued a warning about vaginal mesh and many companies pulled it from the market.

Slings were excluded from the 2011 warning and have become the standard of care for urinary incontinence. The FDA stated “Safety and effectiveness of multi-incision slings is well established in clinic trials.” Prolapses are treated in a variety of ways, including standard tissue repair, abdominal mesh (usually done laparoscopically without a vaginal incision), or tissue graft like fascia latte or vaginal mesh. Incontinence is typically treated with a TVT/sling or fascia latte for failure or high-risk. Dr. Ehlert was a very engaging speaker and enjoyable to listen to.
Do you have Moral Courage?

Presented by Georgia Dinndorf-Hogenson, PhD, RN, CNOR on December 8th, 2017
Article written by Leah VanGorp

Georgie is an Assistant Professor in the Department of Nursing at the College of St. Benedict/St. John’s University and also works as a part-time Charge Nurse for St. Cloud Hospital in Surgery. I previously had heard Georgie speak on the topic of Moral Courage in Boston last April at AORN’s National Conference and Expo. I left the education session feeling inspired and challenged as a peri-operative nurse. It was moving to hear her describe stories of when nurses stepped up and faced fear on behalf of their patients. It was also heartbreaking to hear of stories when nurses wanted to speak up for their patient but didn’t for whatever reason.

The purpose of her research study was to understand how and which factors influence the peri-operative nurse’s moral courage in the OR. The focus was to explore the associations of institutional culture, fear, previous experience, peer support, motivational value systems and the report of intensity and frequency of occurrence of moral courage among peri-operative nurses currently working in the Midwest & Western states of the U.S. Focus was also given to explore the peri-operative nurse’s likelihood to exhibit moral courage when faced with a hypothetical preventable patient harm event. The obstacles to speaking up that were identified in her research were: fear, institutional culture, smaller institutional size, rural institution, less years of OR experience, lack of nursing leadership/management support, and lack of peer support.

Georgie stated that “if fear is high, then moral distress is high.” Nurses have fear of reprisal (both unofficial and official), fear of job loss, and fear of retaliation. Fear can be decreased if a nurse feels he/she is supported by their institution and listens to employee concerns. When leadership ignores staff who speak up it creates a barrier, which in turn increases moral distress and conflict and affects staff retention. Georgie stated “Listen to the complainers or they will leave.” There are many reasons nurses speak up, and it is essential that nurses feel supported to intervene on behalf of their patients without having fear or lack of leadership support. So as you go back to work next time, remember the importance of moral courage and what it means for each one of your patients that day. Your patients are counting on you and trust you to speak up for them with integrity as their advocate.
NORTHSTAR SURGICAL INVITES YOU TO THEIR ANNUAL EXPO GATHERING IN NEW ORLEANS 2018

SUNDAY, MARCH 25TH, 2018 FROM 7:00-9:00 PM
AT BOURBON HEAT, 711 BOURBON STREET, NEW ORLEANS
Cocktails and Hors D’oeuvres

Please RSVP to jzak@northstarsurgical.com or 866-928-1490

Dear Friends,

Working with Operating Room professionals around the world since 1921, we recognize your ongoing commitment to patients and their families. Thank you for your continued dedication to providing high quality patient care before, during & after surgery.

Please join me and my family to celebrate our continued partnership… now and into the future.

Timothy M. Scanlan
President and Chief Executive Officer
The names of candidates for the 2018 NATIONAL ELECTION appear on the ballot below. The candidate’s biographical information and election statements can be found online or in the January 2018 AORN JOURNAL. Voting opens February 26th and closes at midnight on March 27th. All members in good standing can vote from home at www.aorn.org/vote after logging in with your AORN username and password. Members can elect to vote in person during EXPO. Please consider reviewing and making your elections. THEY ARE YOUR VOICE at AORN! It is truly amazing to read their bios and see the accomplishments they have made as they each continue to pursue to support and improve our organization and profession!

**PRESIDENT ELECT** (Vote for one)
- Missy Merlino
- Dawn Yost

**VICE ELECT** (Vote for one)
- Holly Ervine
- Carrie Simpson

**SECRETARY** (Vote for one)
- Elizabeth S. Pincus
- Mary Russell

**BOARD OF DIRECTORS** (Vote for three)
- Elizabeth Austin
- Meridith Lewis Cooney
- J. Stephen Balog
- Darlene B Murdock
- Laura Gayton
- Kristy Simmons

**NOMINATING COMMITTEE** (Vote for three)
- Nanette Hanauer
- Shirley Pollard Ramsey
- Nicole Meredith
- Jamie Ridout
- Ramie Miller
- Leilani Salimone
- Heidi Nanazati
EMBRACE ACTION: UNDERSTANDING AND CARING FOR TRANSGENDER PATIENTS

AORN #2401 OF TWIN CITIES - SPRING WORKSHOP
Saturday, April 14th, 2018

7:00 Registration
7:15 am - Chapter Meeting (Election of Officers)
8:00 am - Caring for the Transgender Patient
9:00 am - Surgical Procedures for the Transgender Patient
10:15 am - Dad, I’m Really a Girl
11:15 am - Becoming Grayson

Location: Minneapolis Children’s Hospital
2nd floor Education Center
2525 Chicago Ave, Minneapolis, MN

(Park in the green ramp and take the 2nd floor skyway over to the hospital.
The education center is on the left before the information desk).

AORN of Twin Cities is an approved provider of continuing nursing education by the Wisconsin Nurses Association, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation. The purpose of this activity is to learn about the transgender culture, surgical procedures, and our role as a perioperative nurse. The goal of this activity is to improve the healthcare professional’s understanding of gender dysphoria experienced by transgender individuals along with personal stories of transition. Education committee members are Barb Wiemann, Cheryl Langford, Marilyn Westphal, Sheri Debates, Rorie Chinnock, Lynette Marks, Leah VanGorp, Jenny Wills, and Anastasia Johnson

Mail Registration and Payment to: Cheryl Langford, 6254 Dent Ave, Webster, MN 55088
Contact info: (c) 952-212-5228 or email me at cherylllangford@gmail.com

Make checks payable to: AORN of Twin Cities Chapter #2401 Fee $50.00 (4 Contact Hours)

Name: ______________________________ Email: ______________________________

City: ______________________________ State: _______ Zip: _______ (Home/Cell): ____________________

Registration Deadline: April 9th, 2018
President
(1 year term)
Denise Edelman
We support each other by being active in our chapter and organization. Over the years I have been involved with the board and worked closely with Rorie, our president, this past year to prepare me for my new role. I feel I have skills and knowledge to offer and also to learn. Thank you for this opportunity to support our great chapter as President as we continue to grow and improve.

President-Elect
(1 year term)
Caroline Ness
I first joined AORN in 1986. I have had the opportunity to attend Expo four times, three times as a Twin Cities chapter delegate in 2015, 2016, and 2018. I obtained my CNOR in 2013. When I was invited to the chapter meeting to recognize those earning their CNOR, I made the decision it was time to get more involved in the chapter. Prior to my involvement in the Twin Cities chapter, I served as secretary of the Bismarck and Fargo chapters. Within #2401, I’ve served in several roles: secretary, newsletter editor, co-chair of the communication committee and board of directors. In 2015, I received the Rising Star Membership Award. I am also a Certified Administrator Surgery Center (CASC). Besides managing a Surgery Center and my AORN role, I am on the Board of Directors for the Chaska Rotary. I would be honored to serve the chapter as President Elect this coming year.

Secretary
(2 year term)
Leah VanGorp
I became a nurse in 2004 and obtained a job in the OR in 2011 after working in the ICU, telemetry and ER. I joined AORN and obtained my CNOR in 2014 (thanks to my mentor and co-worker, Jane Oksnevad). My OR career started at Unity Hospital as a staff nurse. Currently, I’m working as a staff nurse at M Health ASC at the University of Minnesota. I attended the AORN National Conference & Expo twice as a delegate in 2017 & 2018. I have been on the Nominating Committee for the last two years and helped expand our social media presence for our AORN chapter on Facebook, Instagram, and Twitter. In 2016, I received the Promising Clinical Star Award. I find being involved in AORN gives me a deeper connection to my career by allowing me to continue learning with peers and colleagues outside of my job. I look forward to taking on the challenge of Secretary for our local AORN chapter.

Board of Directors
(1 year term)
Jane Oksnevad
I joined AORN in 2005. I have held several positions including Board of Directors, President elect, President, and nominating committee. I was also the Awards chair for several years and I have attended the Surgical Conference a few times. I have worked at Unity Hospital for many years as a staff nurse and orienting new employees. I have gained much through AORN like enhanced leadership, networking, and service. I look forward to serving on the Board of Directors for one year to complete Caroline’s term.

Dick Hebrink
(2 year term)
I have worked at St. Joseph’s Hospital since 1980, spent 10 years in SPD as an Assistant, Supervisor, and Asst. Manager before becoming a nurse in 1990. I transitioned to the OR in 2007 and joined AORN right away, and obtained my CNOR in 2009. I recognize the importance of Certification and what it means. I have been active nationally in many nursing arenas. I attend local educational opportunities and encourage co-workers to do the same. I try to galvanize my peers to pursue CNOR. Connecting and networking with others. Continued...
Continued...

is important. I have created two bulletin boards in the OR to promote AORN. I also announce all events and educational opportunities during staff huddles. I believe AORN provides us with a lot of opportunities and being involved helps to elevate our practice. I will be attending my first EXPO this year and look forward to serving on the Board of Directors.

Nominating Committee
(2 year term)

Melissa (Missy) Domogalla
I became an OR RN at Park Nicollet Methodist Hospital in 2013. I received my CNOR certification in 2015. In 2016, I assisted with the opening of the Maple Grove - Park Nicollet ASC. In May 2017, a FT position at Cambridge Allina opened up. I have attended 3 AORN conferences, Chicago, Los Angeles, and this year in New Orleans. My passion is the operating room, but I have cross-trained to the PACU, and I like the variety this opportunity brings. This year I signed up with CCI to be a certification coach for those interested in obtaining the CNOR status. I’m looking forward to meeting more of our Chapter members and serving on the NC.

Ruth Mitchell
(2 year term)
I’ve been a nurse since 1977. I transitioned to the OR in 1988. This OR was an all RN OR. My boss and the educator went to Congress in Texas and presented about our Preceptor program (ever since then I have wanted to be a member of AORN). My roles in the OR include: scrubbing, circulating, working charge both in the hospital/ASC setting, teaching new peri-op nurses, being the ENT coordinator and educator, assistant nurse manager in a level one trauma center, and an infection prevention nurse in an ASC. I became a member of AORN in 2017 and my goals are to become certified and to attend congress. I believe in providing quality, efficient and safe care and that the circulator needs to be an RN and the voice for our patients. I look forward to serving on the NC.

Voting / Approval will take place on Saturday, April 14th, 2018 during our chapter meeting at 7:15am prior to the Spring Workshop at Children’s Hospital, 2nd floor Education Room, 2525 Chicago Ave S., Minneapolis, MN

Basics of Health Care Financing Policy in the U.S.:
“What is the role of professional nursing in advocating for patients and families?”

Presented and written by Anne Jones MA, BSN, RN

It was my privilege to give a talk to our AORN of Twin Cities chapter on October 9th, 2017, on an issue that matters to all of us as nurses, patient advocates, individuals, and family members. I spoke on the “Basics of Health Care Financing Policy in the U.S.: What is the role of professional nursing in advocating for patients and families?”

My purpose was to take a look at health policy and the high cost of health care in the U.S., explain where we are and how we got here, describe the impact on individuals, families, and society, remind ourselves of the many attempts over the years to address these costs, review some of the barriers to change, and describe the principles of a health care financing system that would provide a comprehensive, affordable, high quality health care system that covers everyone. I ended by listing several areas for advocacy for us as nurses to let elected officials know how concerned we are about ongoing problems with cost and coverage.

Health care in the U.S. costs too much, does too little, and leaves too many people out. Nurses have an opportunity to build on the high level of public trust enjoyed by the profession to

Continued...
use our role as advocates to champion and fight for real reform in how we pay for health care in this country. The health care industry currently consumes over 17.8% of GDP - one-sixth of an almost $18 trillion dollar economy - yet even with the premium subsidies and the Medicaid expansion associated with the Patient Protection and Affordable Care Act (PP & ACA), passed in March of 2010, some 27 million people are still uninsured. Many more are underinsured or find themselves spending so much money on premiums, co-pays, and deductibles that they cannot afford to use the insurance that they supposedly have other than for a catastrophic illness.

Total health spending in the U.S. is $3.2 trillion, one-third of which goes to the administrative overhead associated with our multi-payer system. These costs are incurred as a result of the numerous, complex processes related to billing, coding, pre-authorizations, denials, appeals, documentation, marketing, executive pay, shareholder return, etc., required on both the payer and the provider sides of the system. Health spending has now reached $10,035 per capita, two to three times the per capita spending of other developed countries - all of which, unlike our country assure universal coverage - and on many measures achieve health outcomes superior to that of the U.S.

Please see a report from The Commonwealth Fund, “Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care” for details.

We are the only developed country in the world that does not guarantee health care to all of its people. Our employment-based model, largely an accident of World War II wage and price controls, means that when you lose your job, you lose your health insurance, if your health insurance is linked to your employment. Furthermore, two-thirds of total health spending is publicly funded, yet many Americans have extremely high out-of-pocket costs or go without. The cost to employers of providing health insurance coverage holds down wages and reduces the ability of American businesses to compete around the world.

Other consequences of how we pay for health care are that two thirds of personal bankruptcies are medical bankruptcies - 70% of those persons had health insurance, and half of the U.S. population report forgoing needed care, including not filling prescriptions, due to cost. The harm to individuals and families related to health care costs include reduced ability to save for education or retirement, make investments, meet basic needs for housing and food, or improve their standard of living. The harm to society as a whole is lack of funds for infrastructure investment, schools, social programs, and public services. Physicians report a high level of burnout and loss of job satisfaction due to the administrative burden associated with our multi-payer system.

Complicating the efforts to contain costs is a medical-industrial complex that consumes one-sixth of the economy, creates huge profits for certain sectors, and fails to meet the test of any sort of a functioning marketplace. The phenomenon of “health care as a business” which seems to have taken hold since around the 1980s, has created a monster that consumes an ever-increasing share of personal and public resources. According to Elizabeth Rosenthal in An American Sickness: How Healthcare Became a Business and How You Can Take It Back, a noticeable shift in focus from science and healing has taken hold, encouraged by the influence of consultants from the business sector, that is failing society as a whole. We seem to accept the high cost of health care in this country with relatively little critical analysis or scrutiny.

It isn’t as though we haven’t tried. Attempts over the last 40 years to rein in costs have included literally dozens of strategies designed and implemented with good intentions, often at the cost of significant additional administrative burden. These efforts include such initiatives as diagnosis related groups, health maintenance
organizations, utilization review, accountable care organizations, preferred provider organizations, cost-sharing and consumer-directed care insurance plans, and on and on. None of these have resulted in significant or sustained reductions in health spending.

Efforts to reform how we pay for health care and to assure universal coverage in this country actually go back over a hundred years. Even when people agree that cost is a serious issue, real reform has faced significant ideological and political barriers to change, along with opposition from the well-funded for-profit side of the health care industry and physician groups, resulting in the current unsustainable economic trajectory. The major political parties differ sharply on solutions to health spending and access to coverage for health care. What has been lacking is the political will for change fueled by demand from an organized, informed public.

The PP & ACA accomplished two important things - regulation of the private insurance market to prohibit the most harmful measures used to control their costs including lifetime caps, denials based on pre-existing health conditions, dropping coverage, gender and age-based charges, etc. - and an increase in the number of insured through the expansion of Medicaid eligibility and public subsidies for purchase of private insurance coverage. The PP & ACA did not address the underlying problem of the administrative burden associated with our multi-payer system nor the out-of-control prices for drugs, devices, diagnostics, hospitalization, and fees, due to the political reality facing proponents of the ACA in 2010 in getting the law passed.

According to recent surveys, threats to the health care law have served to increase the percent of people who agree that there is a role for government in assuring access to health care. Numerous professional associations and patient advocacy groups including the American Nurses’ Association and the American Medical Association oppose the changes proposed by the majority party. Efforts to “repeal” or “repeal and replace” failed in 2017 but various changes are already underway to reduce funding needed to support provisions in the law.

So, now that we’ve tried everything else, I believe it’s time to agree that health care is a basic human need rather than a commodity. We have already demonstrated that we can provide high quality health care under an other-than-private insurance model with Medicare and Medicaid, and Minnesota Care in our state.

I offered as a solution a system that is publicly financed and administered, privately delivered-guided by the principles of a system that is affordable, accountable, comprehensive, efficient, equitable, effective, safe, accessible, that controls costs by negotiating fair prices and fees. This solution would also emphasize primary care, prevention, chronic disease management, preservation of the provider-patient relationship, workforce utilization, and public health, and is portable - not linked to employment. Either we continue to defend the status quo or we embrace a future free from the fear of financial ruin due to health care costs.

Organizations working for change, in addition to numerous advocacy groups, are the Minnesota Nurses’ Association, Health Care for All Minnesota www.healthcareforallmn.org, and Physicians for a National Health Program www.pnhp.org. Watch this newsletter and chapter meetings for opportunities for advocacy.

Be an advocate!
MEETING AND COMMITTEE UPDATES
SEPT 2017-JAN 2018

Membership
As of October 1\textsuperscript{st}, 2017 we had 348 members registered in our chapter. As of January 1\textsuperscript{st}, 2019 we have 370 members. That’s 100 more than last year. If anyone wants to change chapter membership status, one must call or email National directly or wait for their renewal notice.

Awards & Certification
Awards were given at the fall kickoff and recognized in the Fall Newsletter. Award nomination forms are available and we will be needing nominees by August 1\textsuperscript{st} for their involvement during this past year. Recognize those that do outstanding work or are rising stars with a nomination!

Bylaws & Policies
The bylaws were updated to match National wording change “NLDC” to just “Nominating Committee.” Also our quorum was reduced from 8% to 5% at business and chapter meetings. National recommends 3-5%. With a growing chapter and low attendance at meetings, it was difficult to get items passed. The bylaws were finally approved at the December meeting and sent to National Headquarters along with the Chapter Accountability Standards for the year.

Community Relations
See the article in the newsletter for complete community relations update.

Education & Workshops
The Fall Kickoff, Fall Workshop, and 50\textsuperscript{th} Anniversary celebration in December were all very well attended. Incentive and grant monies from National helped to offset costs for these events. The February thaw meeting is Saturday, Feb 10\textsuperscript{th} on Opiate Crisis in America. March 12\textsuperscript{th} topic will be on positioning (it was requested from the Fall Workshop evaluation). The Spring Workshop is Saturday, April 14\textsuperscript{th} on Transgender Concerns (4 CH), registration required. May meeting will be a vendor presentation. The Fall workshop (5 CH) is planned for Nov 10\textsuperscript{th} with Vangie Dennis.

Finance
Beginning balance of $20,953.98 at the start of the financial year (July 1\textsuperscript{st}) Ending balance on February 9\textsuperscript{th} is $17,714.79. Income sources are Chapter dues, national incentives, vendor fair, silent auction, gift card raffle, workshop and kickoff registrations, and stereoscope ad sales. Chapter expenses are related to speaker fees, workshop and event costs, laptop purchase for the chapter, awards, delegate checks, and community relations efforts. All delegate checks have been processed. Ten delegates each received $1100 towards EXPO in New Orleans 2018. The Chapter also donates $1 for every member to the AORN Foundation annually; therefore, a check for $350 was sent in December 2017. A donation of $100 will be sent to the EXPO Silent Auction.
Nominating Committee
The Nominating Committee has reviewed the candidates and completed the ballot for 2018-19. You will find the complete ballot and brief bios on each candidate in this issue. Nominations needed to be completed by February, posted to the chapter in March, approved in April, and new officers installed in May this year. June will be the transitional board meeting. Caroline Ness will move to President Elect and Jane Oksnevad will finish her term on the Board.

Legislative
The MN Legislature is status quo. Anne Jones has contributed several articles to this newsletter from

HealthCare Reform to what is on the agenda at National. Anne will also be working with our December speaker, Georgie Dinghoff-Hogenson on the statewide circulator bill. AORN National does not have MN on the agenda for this topic. This will be a 1-3 year strategy. Thank you!

Newsletter & Communication
Deadline for the Summer newsletter is June 10th. Four companies continue advertising with us. We have recruited a new advertisement with Irisept this year! Scanlan continues to electronically send the Stereoscope out to the majority of members and a small mailing list to hospitals and ASCs and members who have not submitted an email to National. FaceBook has grown to 102 members! This is a closed group. Message Leah VanGorp to join!

New business
Three members will attend the Leadership Meeting at EXPO on Saturday from 8-11. They are Caroline Ness, Stacy Johnson, and Denise Edelman. Chapter Accountability standards were submitted and accepted on December 30th, 2017. Rorie would like to thank everyone for their help with all the activities so far this year. Any pictures from celebrations can be given to Anne Jones. Michelle Nolander no longer works for AORN National due to restructuring. She is working as the Director of a Denver ASC.

Annual 3M Education and Dinner, November 20th, 2017
Mindfulness and Self Care for the Care Giver

Article written by Denise Edelman

Dr. Ruby Nadler’s presentation was a perfect ending to a great evening at 3M. She highlighted that the demands placed on the Peri-Operative Nurse either by our job or ourselves are taking a huge toll. We run on “autopilot” and are sacrificing self care. We need to practice STOP - Stop, Take a breath, Observe and Proceed.

Mindfulness aids in memory, ability to focus, lowers stress, improves resiliency and kindness to self and others. Mindfulness, compassion, and kindness make up self compassion. This improves our emotion regulation and calmness, and decreases our stress. She recommends rest, sleep, play, connecting with friends and being focused.

Be Mindful!

We did an exercise where we closed our eyes, took several slow deep breaths, and focused on every part of our bodies and what you feel. Don’t let your mind wander - it was a real challenge during the exercise. My overall take away from this presentation is the importance to learn to “Be Mindful of yourself and others.” Thank you 3M for hosting this event every year!
KUDOS TO ANASTASIA (STACY) JOHNSON

Congratulations to AORN Chapter #2401! Allina Health employee Stacy Johnson, has chosen this organization as the recipient of a Dollars for Doers reward. Dollars for Doers is a component of the Allina Health employee volunteerism program, Mission Matters. This program exemplifies our ongoing commitment to support the communities we serve. Allina Health takes great pride in establishing relationships with organizations like ours and is committed to investing in causes our employees are passionate about. Our organization received a check for $100 for the volunteer work that Stacy does and acknowledged her good work through us! Thanks again to Stacy and Allina Health.

EXPO UPDATES

Written by Rorie Chinnock and Marilyn Westphal

Expo is just around the corner and will definitely be a fun and educational event in New Orleans, March 25-28th, 2018. This year our Chapter is sending 10 delegates. We have opportunities open yet for being a delegate. We would love to fill all our slots. If you want to find out more about being a delegate, you can check the National website for delegate requirements and responsibilities at EXPO. If there are other chapter members attending, please let Rorie Chinnock at roriechinnock@gmail.com or Denise Edelman at dedelman06@comcast.net know. We can communicate activities such as Northstar and Scanlan Parties and also plan a time to get together as a Minnesota group some night for Supper or Happy Hour.