Happy Summer from Your Oregon AWHONN Chair

by Deb Castile, MN, RNC, CNS, NE

Summer is finally here. It has been nice to have the sun come out and yes, even experience my first sunburn of the season. If you are like me, you are looking forward to this season and the opportunity it allows for relaxing with family and friends. Attending the AWHONN National Convention in Orlando, Florida provided the ideal opportunity for me and several other Oregon AWHONN members just to relax and hang out together while “celebrating the magic of nursing excellence.”

Two lucky Oregon AWHONN members — Theresa Morescalchi and Diana Richardson — were first time attendees at the National Convention this year. Theresa was the 2013 Oregon Section Fall Conference winner of the drawing for convention airfare and lodging. Diana was selected from all individuals who contributed to the 2013 Every Woman Every Baby (EWEB) Campaign to receive free convention registration. It was through your generosity that Oregon AWHONN received this free convention registration as the result of the greatest participation rate in EWEBs Campaign based on the percentage of our total Section membership. Thank you all for your continued on page 10

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“Smile at strangers and you just might change a life.” — Steve Maraboli

Catch the Wave: Oregon AWHONN Fall Conference

by Nancy Alt, BSN, RNC-OB and Robin Cothrell-Tubbs, MN, RN

The Oregon AWHONN conference committee is very excited about the upcoming fall conference which will be held at the Salishan Lodge on the beautiful Oregon coast September 14 – 16, 2014. We have some wonderful local and national speakers lined up this year who are well known for their expertise on women, pregnancy and newborns. The conference schedule also includes plenty of time to relax and have some fun at the spa, beach, swimming pool, tennis court, and golf course.

Continued on page 10
Ten Tips for Surviving a Deposition
by Lisa Miller, CNM, JD

If you work long enough in perinatal or neonatal nursing, it is very likely that you will go through the experience of being deposed in a medical malpractice case. And regardless of your role (named defendant or just witness to events), it will likely be a nerve-racking experience. Although your lawyer will be the one who provides “preparation,” it is not a bad idea to give some thought to the process before you are actually involved in litigation. Here are my top ten tips for surviving your swim with the “sharks.”

1. Be prepared...early on!
By this I mean be up to date in your practice. Introductory questions in a deposition will cover basic knowledge issues for your specialty, make sure you are prepared to answer questions related to common skills, such as fetal monitoring or neonatal assessment. Be sure you have kept your certifications and continuing education files current, and be prepared to answer using correct terminology and current practice standards.

2. Be involved actively with your defense.
Your defense attorney is not there to be your friend. You want to make sure they prepare you using the tough questions that they anticipate the plaintiff’s attorney will ask in the real deposition. Insist that your defense attorney prepare you at least 1-2 weeks before your deposition date, not on the morning of the deposition (when you will be too nervous to really take in any helpful advice).

3. Learn to be a literal thinker and use this skill in listening.
If the attorney asks you “Can you tell me the time?” – there are only two possible answers, “yes” or “no.” Don’t look at your watch and say “Yes, it is 2:30.” We all have a natural tendency to try to give the answer we think is wanted, but in a deposition you want to think carefully and answer only the question that is asked, in as succinct a manner as is possible.
Surviving a Deposition
(Continued from page 2)

4. Take your time.
Do not feel pressured, you can take as much time as you want (and this is probably the only time in your life that will be true!!). Taking a slow deep breath and thinking about the question before you answer will allow you to feel more relaxed and help you follow tip #3, above. So take it slow and easy, this also allows your lawyer to raise an objection to the question prior to you giving an answer.

5. Think about your presentation, don’t personalize the deposition.
This may be the hardest tip to really follow, as I know it is going to feel personal, no matter what you do or what the circumstances. But you need to come across as the competent professional that you are, so sit up straight, remember the plaintiff’s attorney’s job is just that, a job, and answer the questions without getting emotional. Preparation with your defense attorney can really help with this step.

6. Do not volunteer information.
See Tip #3, above. ANSWER ONLY WHAT IS ASKED. And yes, this does need to be in here twice, so don’t complain about the reinforcement.

7. Pay attention to your attorney.
If the attorney objects to a question, stop and think for a moment. Do you understand the question? You may want to ask for the question to be repeated or rephrased, and you want to look to your attorney who may even instruct you not to answer the question.

8. Know the medicine (or midwifery or nursing) behind the issues.
OK, this is really a repeat of Tip #1 — the being prepared tip. You have to be able to demonstrate your clinical competence through your deposition answers, and the best way to never have a case of the nerves is to know your stuff cold. This means that you have to keep up to date and spend some personal time reading and reviewing materials. AWHONN provides a multitude of resources, both written and on the web, so it is a great way to utilize your membership benefits.

9. Realize that “I don’t know” and I don’t recall” are acceptable, yet distinctly different answers.
“I don’t know” means you don’t have the knowledge to answer the question, while “I don’t recall” means you have the knowledge, but simply cannot remember. For areas within your daily scope of practice, “I don’t know” should not really be your answer, unless you mean to say you don’t know information that any reasonable nurse in your practice area would have readily available. But under the stress of a deposition, even routine things might be temporarily difficult to recall, a very different scenario than “not knowing.”

10. Use the “KISS” vs. the “Kiss off” approach.
KISS stands for Keep It Simple, Silly. Be professional, be concise, demonstrate your clinical competency by providing the correct answers to basic questions, and the deposition will be over in a flash. Remember, it is only one case, it is not your entire career, and under no circumstances should you become emotional or angry. Calm, cool, collected is the way to go!

In closing, let me state for the record that I know how frightening the deposition process can be, but you can prepare for it and get through it with less stress if you follow these tips. And if you get too nervous, just take a break and do what public speakers often do. Imagine the lawyer in their underwear. That really will provide a needed distraction. Just don’t bust out laughing when you take that imaginary break!! §

If you would like to submit an article for the next newsletter, please send your ideas for review to our Editor, Donna Talain, at newsletter.orawhonn@outlook.com
Member Spotlight: Ginnie Kim

This past February nine of us (five from Southern Oregon) headed to Rwanda, known as the “Land of a Thousand Hills” to provide classes whereby birth attendants and healthcare workers could be certified in a program of newborn resuscitation skills called Helping Babies Breathe (HBB).* HBB is specifically designed for resource-poor countries. The skills are easy, don’t require medications or electrical equipment, and focus primarily on what is done during the first 60 seconds after birth. All of the training supplies — mannequins, manuals, ambu bags, suction devices, including equipment for patient use — are donated, and our team was all volunteer.

This small, remote hospital perched on the shores of Lake Kivu is the referral center for 17 tiny clinics that serve a large geographical area of about 80,000 villagers. The majority of births occur in these clinics, with complications being sent to the hospital where c-sections may be performed. While at the hospital, the patients must provide their own food and linens during their stay.

We trained and certified four midwives, 17 nurses, two nurse anesthetists, five physicians and two clinic workers. This trip was particularly successful because our group was able to train four of the above as HBB Trainers! This is a critical step in the process of creating sustainability whereby they’re able to locally manage equipment inventory, maintain skills and decrease reliance on foreign support.

In March of 2015, we’re planning a return trip to not only follow up with getting more of the outlying clinic workers HBB trained, but to offer the Helping Mothers Survive** program focusing on postpartum hemorrhage — the leading cause of maternal death globally. Additionally, in December a group of us will be taking HBB to India. The plan is to train public health workers in the application of these life-saving skills.

Please contact Ginnie Kim at getbodywise@hotmail.com if you have questions, are interested in coming on a trip, or have ideas that might help us connect with additional resources.

* Helping Babies Breathe is a program endorsed by the American Academy of Pediatrics and was created by an international research committee focusing on the WHO Millennium Development Goal #4 — to reduce the under-five mortality rate by two-thirds between 1990 and 2015.

**To reduce maternal deaths (WHO Millennium Development Goal #5), Jhpiego (Johns Hopkins University affiliate) in conjunction with Laerdal Global Health has designed Helping Mothers Survive (HMS), a simulator-based training package for frontline providers in countries with high burdens of maternal mortality.

Visit the following links to learn more:
www.helpingbabiesbreathe.org
www.helpingmotherssurvive.org

Know an Oregon AWHONN member that deserves to be in the spotlight?
Send us your story.
From the Editor’s Desk

This year, I had the opportunity to go to the AWHONN Convention in Orlando, Florida. And what a convention it was. I learned so much and met so many other amazing men and women working to improve outcomes for women and babies. If you’ve never been to a national convention or even a state conference, I highly recommend it. You’re guaranteed to learn something new and have fun doing so. Not to mention the connections you’ll make or the inspiration you’ll gain to remind you why you work so hard every day.

We hope you’ll join us at Salishan Spa and Golf Resort for this year’s Oregon AWHONN Fall Conference. We’ve got a jam-packed schedule of learning and fun! §

Donna Talain

Report From the 2014 AWHONN Convention

From Theresa Morescalchi

I had the amazing opportunity this year to attend my first AWHONN convention in Orlando. I consider myself a lucky winner. I won the trip from last Fall’s Oregon AWHONN conference and I had a BLAST. I mingled with other AWHONN members from all over the country, and I learned so much from the presenters. The posters were informative with great ideas to bring back to my facility. The President’s Ball was a blast!

It was so much fun. The conference left me feeling proud of my profession and provided me with so many ideas for my facility and my own personal growth.

Next year it’s in Long Beach, California, and I can’t wait to go! If you have never been to a national convention plan for next year! Thank you to my fellow Oregon AWHONN members for making this so special. §

Pictured (L to R): Diana Richardson and Theresa Morescalchi
Delayed/Timed Cord Clamping Made Easier… Spread the Word!

by Pat Scheans, DNP, NNP-BC

Delayed cord clamping increases hemoglobin in the neonatal period decreasing the risk of iron deficiency, a mineral very important in brain development. Iron is necessary for neurotransmitter chemistry, organization and morphology of neuronal networks, and neurobiology of myelination. Lack of iron can impact neuro- and cognitive development (Georgieff, 2011). There are even more benefits for preterm infants: cardiovascular stability, reduction in necrotizing enterocolitis, and, best of all, reduction of the risk of intraventricular hemorrhage by 50 percent.

What few of us think about is the abnormal physiology of immediate cord clamping. Cord clamping causes a sudden decrease in preload to the heart by blocking 40% of venous return from the placenta via the umbilical vein, and a sudden increase in afterload of the heart by obstructing the umbilical arteries, increasing peripheral vascular resistance. This can lead to a fall in cerebral circulation, a fall in cardiac output, and bradycardia (Raju, 2013).

The Back Story
Immediate cord clamping was part of the intervention to reduce postpartum hemorrhage; this has not held up to scrutiny. It can, however, deprive the newborn of part of its blood volume as up to 30 percent of the newborn’s blood can be left behind in the placenta with immediate cord clamping. Supporting normal physiology is cheap, easy to do, and has no down side, despite initial worries about increased hematocrit and bilirubin levels (Raju, 2013).
We get nervous when a limp baby emerges, so they are often handed off right away after immediate cord clamping. But, think about the shoulder dystocia or cord prolapse baby who might benefit the most from the return of their own blood volume. How could we provide the initial steps of NRP while delaying cord clamping for those 30 seconds of drying and stimulating? Study of this very thing is going on in Nepal — stay tuned for an update as their findings are released — and a resuscitation trolley has been developed in the UK for this very purpose (Grand Challenge for Development, 2011; University of Liverpool, 2011).

**The WHO recommended delayed umbilical cord clamping for one to three minutes after birth**

In 2012, the WHO updated its 2006 report on neonatal resuscitation and recommended delayed (or timed) umbilical cord clamping for one to three minutes after birth, with the infant held at or below the level of the placenta. However, holding the slippery, wriggling newborn at the level of the placenta is awkward, especially while the mother is waiting anxiously to hold her baby.

Recently, a study of 546 infants demonstrated efficient blood transfer from the placenta to the newborn when positioned on the mother’s abdomen or chest (14–15 mL/kg for an infant who weighs 3.5 kg at birth). This practice might increase OB provider compliance with this procedure and enhance maternal-newborn bonding (Vain, Satragno, Gorenstein, et al., 2014).

Contraindications to delayed clamping include things that relate to placental or umbilical cord disruption, or a flat, limp, non-pulsatile cord (i.e., the cord is no longer working). Examples of this include placental abruption, vasa previa, cesarean section where the placenta has to be cut through to reach the baby and unstable maternal conditions such as hemorrhage. Fetal conditions include fetal anomalies that need immediate care, such as congenital diaphragmatic hernia (although intubation while cord clamping makes physiologic sense). Obviously, tight nuchal cords requiring cutting before delivery interfere with timed cord clamping. Lastly, more study on multifetal gestation is needed (Scheans, 2013).

As perinatal and neonatal nurses, we advocate for improved patient care daily. Delayed cord clamping is one of those evidence based practice improvements. Go for it. §

**References**


I am Woman, Hear Me Roar: The New Science of Gender Medicine

by Nancy Irland, DNP, RN, CNM

All around the world, more women than men are in pain (Gureje & VonKorff, 1998). A study reported in 2002 showed that 46% of American women reported daily pain, compared to 37% of American men (Jackson, 2002). Sadly, women’s pain is commonly minimized and thought to be psychogenic or emotional, especially if she is attractive (Hoffman & Tarzian, 2001). A woman is more likely to receive a sedative when she reports pain, in contrast to a man, who will likely receive a powerful pain killer (Hoffman & Tarzian, 2001). This difference in treatment is hard to understand, given that researchers have thought for years that men and women are fundamentally the same animal.

A long-held belief among clinical researchers that women respond to treatment very similarly to men has justified their practice of restricting women from clinical trials. The excuse was that our pesky menstrual cycles were an uncontrollable variable which would make it impossible to obtain “pure” (my word) data. Read that again: while acknowledging that women’s hormones could make a difference in treatment response, scientists continued to believe that women could be treated with therapies based solely on studies performed only on men. Fortunately, there’s change on the way. A report from the Institute of Medicine (IOM) in April 2001 mandated research on both men and women [The Society for Women’s Health Research (SWHR)]. What researchers have discovered by including women in clinical trials in spite of their pesky hormones, and by tracking those hormones in the studies, is amazing. We are not “mini-men.” In the area of pain control, especially, some interesting gender differences in male and female responses to pain might give us pause.

Early clues to sex differences in the opioid receptor system were anecdotal. Clinicians noticed that nalbuphine (nubain, a kappa-receptor agonist) provided better pain relief for women during childbirth than morphine (a mu-receptor agonist) which was mens’ preference for pain relief (Wilson, 2006). However, what’s the first medication an emergency room turns to when any patient presents for pain? Morphine. It works for men, so why not women?

Recent studies have supported the previously anecdotal evidence. It is thought that males and females have distinctly different pain processing neurochemicals and genes (Wilson, 2006) and that sex hormones are a major factor in pain sensitivity.
Pain response is mediated by different brain circuits in men and women, with most of the sex differences in the opioid pain modulatory system. Kappa-opioid drugs are more effective analgesics in young adult women than in young adult men for uniquely biological reasons — the kappa-specific pain pathway exists only in women (Wilson, 2006).

Women report more pain when their estrogen levels are low (during the menstrual cycle). That report is now understood by the use of positive emission tomography, which has shown that more kappa-opioid receptors are available in the presence of high estrogen levels at midcycle than during the menstrual cycle (Wilson, 2006). Perhaps we should schedule elective surgical procedures at mid-cycle for better pain control?

Redheaded, fair-skinned women feel pain more intensely and may require more pain medication because they have Mc1r gene variations which have the “unexpected” role of modulating the kappa-specific pain pathway (Wilson, 2006, p 462).

You’ll notice that females respond best to kappa-opioids. Interestingly, Fentanyl, which is a mu-receptor agonist in the morphine family, is not a kappa-opioid, yet we use it in labor. One wonders if this practice should be re-evaluated in light of the new research on women’s pain. If only our old stand-by, Nubain (a kappa-receptor opioid) didn’t have the side effects it did.

It is important to find answers to the following questions identified by the IOM: How can information on sex differences be translated into preventative, diagnostic, and therapeutic practice? How can the new knowledge about and understanding of biological sex differences and similarities most effectively be used to positively affect patient outcomes and improve health and health care? Perhaps someday a patient’s pain medication protocol will be uniquely dictated by genetic studies. It’s a brave, new world for us women. §

References


Happy Summer 
(Continued from page 1)

financial contributions to a worthy project! Please consider joining me in making an EWEB donation in 2014. Wouldn’t it be great if Oregon can win a 2015 Convention registration based on our 2014 participation? Read more about Theresa and Diana’s experiences at national convention in this Newsletter.

Mark your calendars for September 14 - 16 for the Oregon Section Fall Conference

Mark your calendars for September 14 - 16 for the Oregon Section Fall Conference which will be held at Salishan Spa and Golf Resort in Gleneden Beach, Oregon. This year, there will be a focus on how the use of drugs and alcohol impact women, pregnancy and newborns. Additionally, three senior nursing students from Oregon Health and Science University have been selected to join the conference planning committee and are hard at work securing fabulous raffle prizes. This is the third year the Oregon Section has recruited and mentored nursing students who demonstrate a passion for women’s health and maternal-newborn nursing into the AWHONN organization. In exchange for their work on the committee and during the conference, students are provided with a one-year AWHONN membership and conference registration fee. Hope you can join us to learn more about what we can do to provide excellent, up-to-date nursing care to our patients and meet nursing students Branddy Walter, Sierra Anderson and Kaitlin Moore.

I recently ran into a patient I had cared for about 16 years ago. Did I remember her? Sad to say I didn’t, but she immediately remembered me. This dear woman indicated that the things I said and the compassion I showed were instrumental in helping her to see it was time for her to clean up her life, free herself from the bondage of drugs and alcohol and to put her son first. Within a few months of delivering her son, she enrolled in a treatment center and has been drug and alcohol free since. This experience helped me realize that what I do and say, every day, in every circumstance, can have an everlasting impact on the people, including the women and babies, we are privileged to serve every day.

Happy summer! §

Catch the Wave 
(Continued from page page 1)

The pre-conference workshop this year will focus on issues related to newborn feeding as well as provide an overview of Perinatal Core Measure 05 (PC-05), Exclusive Breast Milk Feeding. As always, the annual networking event will provide opportunity to let your hair down, visit with old friends and to make some new ones. Many vendors will be on site during the conference, and of course we have many great raffle and vendor prizes lined up.

One new addition to the conference, in response to conference attendee evaluations, is the inclusion of some pearls or other practical “take-aways” from each presentation that nurses can use in their practice.

Be sure to visit the AWHONN Oregon section website at www.awhonn.org/awhonn/section.by.state.

do?name=Oregon-Fall-Conference&state=Oregon to access more information about the 2014 fall conference, find a link for online registration and to download speaker handouts. So clear you schedule, mark your calendar and Catch the Wave to Salishan. §
Southern Oregon Chapter News

by Linda Veltri, PhD, RN

In May, 2014 the Southern Oregon Chapter held its second annual Oregon Health Science University (OHSU) Ashland Nursing Student meeting on the campus of Southern Oregon University. We had 10 students in attendance who viewed AWHONN’s webinar entitled Care of Newborns Prenatally Exposed to Opiates. Membership Liaison, Nica Pap shared information about becoming an AWHONN member and attendees had the opportunity to network, enjoy some snacks and win raffle prizes.

A hearty congratulations to chapter members Kate Dempsey, Nica Pap, Aliya Shelton, and Kerensa Ritchie (Oregon Section’s 2013 Fall Conference Planning Committee student members responsible for the wonderful raffle items) who have graduated from OHSU-SON and secured employment working with moms and babies in the Southern Oregon area.

A big welcome to Branddy Walter, Sierra Anderson and Kaitlin Moore, senior OHSU nursing students from the Ashland campus who have joined the 2014 Fall Conference Planning Committee. These students have great ideas for raffle items and will be hard at work over the summer to ensure there are plenty of amazing gifts and prizes for conference attendees. Raffle donations are gladly accepted!

Wishing you a safe and fun-filled summer. We look forward to seeing you at Salishan in September. §

Oregon AWHONN is affiliated with the Association of Women’s Health, Obstetric and Neonatal Nurses. AWHONN promotes the health of women and newborns with programs and activities concentrated on childbearing and the newborn, women’s health, and professional issues.

www.awhonn.org/awhonn/section.by.state.do?state=Oregon