



ASPS NEWS

AMERICAN SOCIETY OF PLASTIC SURGICAL NURSES, INC.

JANUARY/FEBRUARY 2010

From the Boardroom

Happy New Year!

I hope that everyone had a wonderful and blessed holiday season. For the year 2010, my wish is that you take the time to renew old acquaintances and to make new friends. May you continue your endeavor to gain knowledge, share ideas, and renew your commitment to our profession as well as to our organization. ASPSN is an outstanding nursing organization, and we are proud of what we have accomplished as well as what we will continue to do as an organization. The goal of the ASPSN executive board is to move forward, to bring our organization to new and greater heights!

The board wishes to express our appreciation to each ASPSN member. There is a treasure in each and every one of you. Take the time to think about what you can offer to this organization; you are the experts in your field, and that qualifies you to come forward and share your knowledge and experience. Participate on a committee; run for an office; get more involved; and most of all, adopt this motto for 2010, "I can do it!"

Sharon

Sharon Fritzsche, MSN, RN, FNP-BC, CPSN
President-Elect, 2011

CPSN Exam Reminder

The 2009 CPSN was a great success. We had several nurses sit for the exam. We are certain they all did well! A special thanks goes out to Allergan for their scholarships to help the members attain the goal of CPSN. Please remember that this scholarship continues to be available for ASPSN members. Also remember how important it is to be a plastic surgery nurse specialist, and how much this designation enhances your practice. Encourage other nurses in your office or operating room to become CPSN. Please contact the ASPSN National Office for more information. Watch for an Aesthetic Certification questionnaire, coming to you soon. Please be sure to respond as soon as possible.

Sheri Levin- RN, BSN, CNOR, CPSN
PSNCB TREASURER

2	Editorial
2	An Article Specific to Craniostenosis
3	Community Awareness Projects
3	Newsletter Update
4	The Next Big Breakthrough?
4	2010 Scientific Sessions Update
6	Save the Date
6	Aesthetic Certification Exam Survey
7	Aesthetic Lines
8	Learning with Miss Adventures
9	Know Your Board Members!
10	ASPSN Mentorship Program
12	Clinical Pearl
13	Looking for a Chapter?

The ASPSN National Office sends out frequent e-mail communications with information relevant to your practice needs. Do we have your current e-mail address? If we do, you will have received this newsletter by e-mail from the national office. If you did not receive the newsletter through e-mail, please log onto the ASPSN website and update your profile.

Editorial

As we produce the ASPSNews this year, we will be focusing on special topics within our bimonthly publications. You may also know that the newsletter will be emailed to you on a bimonthly basis. Please update your email on the ASPSN website if you would like to receive your newsletter to a new email address. In the last edition, we listed the annual agenda of topics. This agenda list is also included in this newsletter, so please look and see if there is a topic you would like to contribute. We are looking for any tasty tidbits of information you can give to other members. This month, we are focusing on craniofacial anomalies. Members have submitted helpful hints, case scenarios, and clinical pearls they have learned throughout their years of experience for the those of us who do not have much experience in that field. This will allow all readers to stay more in touch within the vastness of our plastic surgery specialty. I hope each of you had a blessed Christmas and New Year holiday! Remember, there is strength in numbers so talk about ASPSN to your fellow coworkers who are not members and encourage them to join the educational and social wave of our society!

Haley Wood, MSN, WHNP, and now.....CPSN!

An Article Specific to Cranioostenosis

Spear, M., Bailey, A., & Cornelius, M. (2009). Craniofacial surgery making touch decisions. *OR Nurse*, 3(6), 30-40.

Fellow ASPSN members, Marcia Spear, ACNP-BC, CPSN, CWS, Amanda Bailey, ACNP-BC, CWS, and Melinda Cornelius, CNS authored a thorough article on craniofacial anomalies, published in the clinical journal *OR Nurse*, November 2009. The titled article, Craniofacial surgery Making tough decisions gives a nursing centered review of anatomy, pathophysiology, risks, nursing considerations, treatment, pre/intra/post operative considerations and complications. Appropriate for nurses who are familiar with this topic and those unfamiliar, this article is an easy and quick read leaving plastic surgery nurses well armed with knowledge. Included in the article is a nice explanation of the process a patient will take from the moment of detection to the end of treatment.

If you do not have access to the article and would like to purchase a copy go to http://www.nursingcenter.com/library/journalissue.asp?Journal_ID=682710&Issue_ID=941333

American Society of Plastic Surgical Nurses Board of Directors 2009-2010

President

LuAnn Buchholz, RN, CPSN
Manager
Vanderbilt University Medical Center • Nashville, TN
luannrncpsn@comcast.net

President-Elect

Sharon Fritzsche, MSN, RN, FNP-BC, CPSN
Plastic and Reconstructive Surgery
Family Nurse Practitioner
LLUMC • Loma Linda, CA
sfritzsche@roadrunner.com; sfritzsche@llu.edu

Treasurer

Debby Booth, RN, CPSN
Case Manager
Vanderbilt Medical Center • Nashville, TN
debby.booth@vanderbilt.edu

Director

Robert Dybec, MS, RN, CPSN, CNOR
Nurse Manager
Winthrop University Hospital • Mineola, NY
RobRNCPSN@aol.com

Director

Georgia Elmassian, M.A., RN, CPSN, CFLE
Plastic Surgery Nurse Consultant
and Educator
East Lansing, MI 48823
missgme@comcast.net

Director

Sue Kunz, BS, RN, CPSN
Roger C. Mixer, MD • Milwaukee, WI 53217
skunzcpsn@aol.com

Director

Marcia Spear, APRN-BC, CPSN, CWS
Nurse Practitioner
Department of Plastic Surgery
Vanderbilt University Medical Center • Nashville, TN
marcia.spear@vanderbilt.edu

Executive Director

Jon Dancy
ASPSN National Office • Pensacola, FL
Work (850) 473-2443 • Toll Free (800) 272-0136
Fax (850) 484-8762
jon.dancy@dancyamc.com

Mailing Address

ASPSN National Office
7794 Grow Drive
Pensacola, FL 32514

Community Awareness Projects

Sue Kunz, BS, RN, CPSN

In October, at our national convention, I suggested a community awareness project that would span the year and impact every community where a plastic surgery nurse resided. Please read the following article, and I encourage ASPSN members to request the template from the National Office and contact your local newspaper to publish the article. I suggest that we alert the public to the dangers of outdoor equipment such as lawn mowers and snow blowers. Wouldn't it be great to get our name out there as a society of concerned nurses, educating the public about possible injuries while using these machines; and if by chance the warning is not heeded, provide some advice as to seeking treatment?

The American Society of Plastic Surgical Nurses (ASPSN) would like to call your attention to the potential dangers of snow blowers. Each year an average of 5,700 people are treated in emergency rooms due to injuries suffered while using a snow blower. Most of these injuries occur to the hand, some as minor as lacerations, most however are severe injuries such as finger amputations and or fractures. These injuries are devastating resulting in loss of function of the hand or fingers, which can lead to prolonged rehabilitation to re-learn activities of daily living (buttoning a shirt, preparing a meal, etc) without a hand or a portion of a hand. In 2000, there were 3 deaths related to snow blower injuries.

Members of ASPSN work in many different areas, some in

operating rooms, hospitals, clinics, or private offices. We see patients of all ages and for many reasons: some cosmetic and some reconstructive. With our educational campaign, we hope to decrease the number of injuries by reminding the public of the importance of following these basic tips to prevent injury.

1. Do NOT use a hand or foot to remove debris in snow blowers.
2. Turn off the machine and wait at least 10 seconds for the blades to stop rotating before attempting to clear a clogged chute or blades.
3. Use a broom handle or large stick to remove debris/clogged snow in the chute.
4. Be aware that once a clog is cleared, there is recoil or "kick back" of the blade.
5. Do not disable safety mechanisms.
6. Add fuel before starting; do NOT add fuel to a running or hot machine.
7. Never let children operate snow blowers.
8. Be aware of your surroundings; are other people, children, or pets in the area?
9. Wear protective eye shields/glasses/goggles.
10. Do not leave a snow blower unattended while it is running.

What should you do if you have an accident? Wrap the injured extremity in a clean cloth and call 911 or have a responsible adult take you to the nearest Emergency Room.

For more information:

www.cdc.gov

www.consumerreports.org

<http://orthoinfo.aaos.org>

Newsletter Update

Beginning January 2010, the newsletter changes to a bimonthly edition. In order that the newsletters are rich with valuable content, we are making a few changes to enhance your reading pleasure! Each bimonthly edition will continue to have articles submitted by board members; however, a special feature section will be added. The special feature section will highlight an important field in plastic surgery nursing. For example, the January/February edition highlights craniofacial anomalies. Within the special topic, we will include clinical pearls, new research articles, articles to discuss within journal club, and possibly a great success story. WE NEED YOUR EXPERT HELP to make this a success. Below, you will see the agenda of special topics. I, personally, ask that if you have anything to contribute, please contact me at Haleyjohnston-wood@gmail.com. A small clinical pearl you have learned throughout the years, a pertinent rule of thumb guideline,

or a great success story you have to share, are all wonderful ways to enhance our newsletter!

In addition, we have added a great new column featuring board members and other members who contribute to our society! The member will answer a few interview questions and submit a friendly photo! It's nice to tag a face with a name!

2010 Newsletter Special Feature Agenda:

Jan/Feb: Craniofacial anomalies

March/April: Noninvasive rejuvenation techniques incl. neurotoxins, fillers, lasers, chemical peels

May/June: Hands, Wounds/Burns

July/Aug: Breast augmentation and reconstruction

Sept/Oct: Pediatric issues

Nov/Dec: Body contouring

The Next Big Breakthrough?

Robert B. Dybec, RN, MS, CPSN, CNOR

Huge breakthroughs in plastic surgery seem to be few and far between. During recent years Botox became very popular (a chemical not a procedure) and there was big growth in liposuction over the years (usually as a result of newer equipment, not the procedure). But it always seemed that flaps were flaps and even though there were some modifications to existing procedures, both cosmetic and reconstructive, there was no big exciting news in plastic surgery. OK, maybe the face transplant was big, but it's not a procedure that every plastic surgeon is doing.

One of the most exciting and recent developments, which has the potential to impact plastic surgeons and patients worldwide, is the recent news coming out of Cincinnati that surgeons have successfully used a patient's own stem cells to grow bone that was used in facial reconstruction. To date, stem cells have been used to repair tissues in things such as damaged hearts and collapsed tracheas and now have proven to be effective in growing human bone.

Dr. Jesse Taylor spearheaded the team at Cincinnati Children's Hospital that performed the incredible surgery. "We think this will benefit millions of people who, through traumatic injury or disease, have significant bone defects," Dr. Taylor stated. It will give plastic surgeons new options for correcting bone defi-

ciencies along with the current options of using cadaver bone, autologous bone as well as synthetic materials. The benefit of using the patient's own cells to grow bone is that it reduces the risk of the patient rejecting or absorbing donor materials.

Brad Guilkey, from Cincinnati, was the teenager who underwent the surgery on May 28, 2009. Brad had a rare genetic condition known as Treacher Collins syndrome in which the cheek bones are underdeveloped or missing.

Surgeons created allografts from donor bone, then filled holes that were drilled into these grafts with mesenchymal stem cells obtained from the patient's abdominal fat along with bone morphogenetic protein-2 (BMP-2), which directs the stem cells to become bone cells, and a covering of periosteum, which is needed for normal production of BMP-2. CT scans done four months after the surgery confirm that Brad's cheekbones have filled in with viable bone.

Dr. Taylor and his research team continue to do studies on growing mandible bones in pigs and plan to see if the process can be used to produce bones of varying lengths and sizes. He stated that we may someday have the ability to grow almost any bone in the human body.

For more information regarding Dr. Taylor's research and this breakthrough surgery, visit www.cincinnatichildrens.org/bone-growth. The site includes photographs and video.

2010 Scientific Sessions Update

Georgia Elmassian, M.A., RN, CPSN, CFLE
Director, American Society of Plastic Surgical Nurses
Scientific Sessions Chair

Are you seeking new knowledge, or interested in learning a new skill? Have you thought about participating in the CPSN review course prior to taking your plastic surgical nurses certification exam? Well, the 2010 ASPSN Scientific Sessions Planning Committee is busy at work exploring various curriculum and proficiency strategies to ensure expert faculty for the October 2010, 36th Annual ASPSN National Convention to be held in Toronto, Canada.

The SSPC is committed to exploring careful stratagems and objective educational pearls for all plastic surgical nursing needs. The committee has paid close attention to past convention feedback as well as assessing and integrating new forms of professional development for this year's innovative programming. Once again this year, we will conduct the annual meeting with a three-track system thus fostering a stronger and more united ASPSN.

The program for the Toronto convention is being designed with the intent of exploring and providing specific plastic surgical nursing evidence based practice issues, supporting the national certification process of preparation, structured review, and testing, and targeting the ever expanding scope of practice expertise for the meeting attendees.

I am pleased to report that the 2010 Scientific Sessions Planning Committee is committed to presenting the plastic surgical nursing community with a variety of topics and subject material pertinent to the Aesthetic, Reconstructive, and Management arenas of our specialty. Therefore, we suggest you make application for your passport and be certain to mark your calendars and join us for the 36th Annual ASPSN Convention 2010: *A Strong and United ASPSN*.

Location:
The Westin Harbour Castle
October 1-5, 2010
Toronto, Ontario, Canada

She'll Start on the Web. Get Her Kit. And Look For You.

Includes
\$170 in
Rebates!



The *Natrelle*® Pre-Consultation Kit is offered right where women research their breast augmentation options — on the web. It delivers the answers they look for, all in one place. All with the Surgeon in mind.

Valuable and complete, her purchase of the *Natrelle*® Pre-Consultation Kit motivates her for a consultation. Now she can explore her procedure goals through an elegant at-home approach, featuring a beautiful set of trial implants and sizing bra. And valuable incentives offset her cost. Each kit comes with a \$50 patient rebate for her *Natrelle*® gels and more than a \$100 in savings for her on BOTOX® Cosmetic (Botulinum Toxin Type A), JUVÉDERM® and LATISSE™ (bimatoprost ophthalmic solution) 0.03% treatments.

Join Allergan for this extensive consumer program to bring new patients into *Natrelle*® implant practices.

Are you on Natrelle.com?

The *Natrelle*® Pre-Consultation Kit. Bringing motivated patients to Surgeons listed on Natrelle.com.



GO CREATE

 **ALLERGAN**

©2009 Allergan, Inc. ® and TM marks owned by Allergan, Inc.
JUVÉDERM ® mark owned by Allergan Industrie, SAS
MDOC-03372-01

Save The Date

7th Annual Aesthetic Symposium of the American Society of Plastic Surgical Nurses

The annual aesthetic symposium of the American Society of Plastic Surgical Nurses will be held in conjunction with the American Society of Aesthetic Plastic Surgeons annual meeting on April 24-25, 2010, at the Gaylord National Hotel and Convention Center, National Harbor, MD, outside of Washington DC.

Reservations can be made through the ASAPS website starting in January, 2010 @ www.surgery.org/meeting2010 or by contacting the hotel directly at 301-965-4000.

For any questions you may have, contact marcia.spear@vanderbilt.edu or suekunz@att.net. Hope to see you there.

Aesthetic Certification Exam Survey

Many members have expressed an interest in an aesthetic certification exam. Please take the time to complete the needs assessment survey on the ASPSN website at https://www.aspsn.org/component/option,com_surveys/Itemid,279/act,view_survey/survey,Aesthetic+Certification+Exam/ The survey will be available until January 31, 2010. **Your opinion counts.**



Step 1:

Kick back in your favorite armchair and prop up your feet.



Step 2:

Start up your laptop and enjoy free CME/CE at www.ieaesthetics.com



World-Class Aesthetic Education

Aesthetic Lines: FRESH, NOT FROZEN!

Marilyn Cassetta, RN, BSN, CPSN

In March 2009, The American Society for Aesthetic Plastic Surgery reported the most frequently performed non-surgical procedures performed in 2008 were Botox injections. Over 2,464,123 Botox procedures were performed in America alone. As I write from Australia, that phenomenon was also repeated here, with both Botox and Dysport available in Australia for over 10 and 8 years, respectively.

Despite the fact the glabellar folds and axillary hyperhidrosis are the only areas *cosmetically* approved by the FDA for Botox and glabellar folds is the only area approved for Dysport, we all know of the many *off-label* areas of the face and neck that are and have been safely treated over many years with neurotoxins being used not only to minimize wrinkling, but to create a more relaxed, almost lifted look to a tired looking face.

The most commonly treated areas include the frontalis, glabella and obicularis oculi. An overactive frown often creates a harsh, even angry look, but by *lifting* the lateral aspects of the obicularis oculi and the glabella, a subtle but effective lift to the upper face is achieved. In many cases by not treating the frontalis, an extremely natural look ensues allowing the eyebrows and upper forehead to lift completely. When treating the obicularis oculi for crow's feet, you might offer a choice of three options: lateral canthus to lateral brow injections to lift and smooth; lateral canthus to lower lines to diminish those early "Clint Eastwood" lines that crawl downwards over the zygoma; or if needed, offer complete smoothing *and* browlift by injecting from the lowest lines to the lateral brow.

The lower face can also benefit from a *softened* look by addressing the platysmal plate horizontally, just under the mandible "the Nefirtiti Lift" and/or vertically down the platysmal bands; the "marionettes" are improved by injecting the depressor anguli oris (and enhance the longevity of fillers); and the dimply chin can be treated by injecting the mentalis reflecting a more relaxed, youthful look to the lower face. There are many other "off label" indications: nasalis for "bunny lines," levator labi superioris alaque nasi for a "gummy smile," obicularis oris for vertical liplines, and masseter reduction.

In Australia, it is perceived that in the USA and Los Angeles, in particular, that too many people are being *overtreated*,

frozen (and don't even get me started on supersized lips). Once again the dilemma becomes one that the injector must face: do you do exactly what the patient wants, regardless of the outcome, or does the injector have an ethical or professional duty of care to ensure a natural looking result?

Of course, it is possible to minimize *many* muscular contractions of the face *and* maintain a fresh and youthful look. The *secret* is in the skillful practitioner's *placement*, use of the appropriate *dosage*, and a keen *aesthetic* eye not to overdo or *freeze* facial animation. Create a fresh, soft, more relaxed look by using a lesser dose or placement of neurotoxins in your pan-facial rejuvenation. You might decide that by "lightening your touch," as I did many years ago, you will be sought out, amongst your peers, and become better known for "keeping it natural."

<http://www.surgery.org/media/news-releases/liposuction-no-longer-the-most-popular-surgical-procedure-according-to-new-statistics>

<http://www.surgery.org/media/news-releases/liposuction-no-longer-the-most-popular-surgical-procedure-according-to-new-statistics>

<http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/DrugSafetyInformationforHeathcareProfessionals/ucm174949.htm>

<http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/DrugSafetyInformationforHeathcareProfessionals/ucm174949.htm>

<http://www.ncbi.nlm.nih.gov/pubmed/18236245>

<http://www.ncbi.nlm.nih.gov/pubmed/18236245>

http://findarticles.com/p/articles/mi_hb4393/is_4_39/ai_n29425732/

http://findarticles.com/p/articles/mi_hb4393/is_4_39/ai_n29425732/

http://www.nursingcenter.com/_PDF_.aspx?an=00006527-200807000-00010

http://www.nursingcenter.com/_PDF_.aspx?an=00006527-200807000-00010

Learning with Miss Adventures

Dear Miss Adventures,

I am so confused! I just started working in a Level I trauma center in the operating room. It's great and I have learned a lot so far. In particular, I have really enjoyed learning about facial fractures. Last week, I had a healthy young patient booked for a Le Fort I osteotomy not fracture. I set up the same as I would for a fracture, but found I was not prepared at all! I didn't have half of the instruments that I needed and couldn't figure out what the surgeons were doing. In addition, I had the wrong plating system. The surgeons were furious and said I delayed the case. I didn't ask for any help before the case because I thought I knew what I was doing. What was I doing?

Baffled

Dear Baffled,

I do believe there is a point when it all comes together for a craniofacial/maxillofacial reconstruction nurse, but not until one understands Le Fort procedures. Rene Le Fort (1869-1951) was a French surgeon who classified types of facial fractures. It is often told that at the turn of the century, Dr. Le Fort (also spelled LeFort) was known to repeatedly drop skulls off the rooftop of a local tavern to later study the fracture patterns. He was able to identify three very specific fracture patterns which he simply named Le Fort I, II and III. A Le Fort I fracture is horizontal in presentation. It is a maxillary fracture located immediately above the teeth and palate. A Le Fort II fracture is paramyodial, which means it is a fracture of the mid-maxilla that extends in a pyramid formation to include the nose. This type of fracture is usually associated with high impact injuries such as a high speed motor vehicle accident. The third type of fracture, the Le Fort III, is transverse. A Le Fort III fracture is considered a craniofacial separation as the face is traumatically separated from the cranium. In a Level I trauma center, you may also come across "pan facial" fractures, which is a combination of any of the three types of Le Fort fractures. The word pan indicates that there is horizontal movement of the face, but is not specific to the area of trauma. It would be important to communicate with the surgeon preoperatively as to which area of the face was to be repaired. Often pan facial fractures are repaired in stages due to the serious nature of the injuries and medical instability of the patient. Putting trauma aside and turning to reconstruction, the Le Fort classifications are also used to describe various functional and aesthetic surgical procedures. Insuf-

ficient growth of the midface, also known as maxillary hypoplasia, can be an isolated facial anomaly or can be associated with a number of congenital syndromes (such as Crouzon Syndrome). Apart from aesthetic considerations, there are functional deficiencies that can include airway obstruction and serious malocclusions. Surgical reconstruction of the midface would require a horizontal osteotomy of the maxilla, immediately above the teeth and palate and is therefore known as a Le Fort I osteomy. The bones are cut, realigned and held in place with plates and screws. This type of reconstruction requires advanced planning and orthodontia. It is known as orthognatic (straight bone) reconstruction. Orthognatic reconstruction is generally performed by oral maxillofacial surgeons and not craniofacial surgeons, unless there is direct collaboration with an orthodontist. Sometimes, realizing who is performing the surgery can clarify which type of Le Fort I will be performed. Le Fort III reconstruction is far more complex but is called upon for frontal orbital advancement in the case of severe craniosynostosis or Apert Syndrome. These procedures do not involve the jaw and are performed by craniofacial surgeons. The approach to a Le Fort III osteotomy or fracture repair is coronal (sometimes called bicoronal) and often necessitates that a neurosurgeon be standing by in the case of a dural tear. A Le Fort II classification is always indicative of trauma and is not used as a craniofacial reconstructive approach. Osteotomies and subsequent reconstruction require different surgical instrumentation and set up to allow for the deconstruction (osteotomy) as well as the reconstruction. In the case of trauma and reconstruction, the "osteotomy" was a result of the trauma. Also in the case of orthognatic surgery for repair of congenital anomaly, the goal is function and aesthetics. In the case of trauma, it is to return the patient to baseline anatomical function, even if that includes a previously untreated malocclusion. Each of these procedures requires significant surgical skill and specific nursing knowledge. Patients are at risk for bleeding, loss of function, nerve injury, infection and other serious postoperative complications, in addition to the associated risks of general anesthesia and lengthy operative time. Fortunately, through the magic of endoscopy and distraction these reconstructive and reparative procedures are slowly evolving into less invasive surgeries. But that is a topic for another day!

Sincerely,

Miss Adventures

(continued on page 9)

Know Your Board Members!

Sharon Fritzsche, MSN, RN, FNP-BC, CPSN
President-elect

Current position:

Family Nurse Practitioner in Plastic and Reconstructive Surgery Department

Current affiliation:

Loma Linda University Medical Center



What influenced you to go into plastic surgical nursing?

I was working with a pediatrician in heart transplant whose husband was the chief of plastic surgery. This pediatrician told her husband to call me as he was looking for a NP; she thought I would be good in this department, and here I am 12 years later. I was initially enticed because there was no call, no weekends or holidays, all of which I endured in heart transplant. I love the reconstructive part of plastic surgery the most, my CF kids, my breast reconstruction patients, my replants, etc.

What are the biggest challenges and joys of your current position?

My greatest joys include the opportunity to make a difference in someone's life and to work with residents, helping them survive the rigors of residency and patient care. I love the challenge of organizing and facilitating change as well as having the opportunity to provide "whole person care." The greatest challenge for me personally is working within the confines of insurance companies, welfare (etc.), and the limits that these entities place on providing the quality and type of care I want for my patients in today's environment.

Professional accomplishment of which you are most proud:

I am most proud of obtaining my nurse practitioner licensure.

Personal accomplishment of which you are most proud:

My greatest accomplishment is my son. I am most thankful for the God-given gift of enjoying people from all aspects of life and possessing the capability of being "grey" in my thinking.

What influenced you to get into leadership with ASPN?

I wanted to have a voice and to make a difference. I started out being a moderator, presented a poster, and then I spoke, and eventually ended up on the board.

What is the best thing about serving on the ASPN Board of Directors?

I hope to make a difference for our society. It takes a team effort, and the board members all have different opinions and ways of approaching an issue. But, we all have a common goal: to run this association efficiently, effectively, and to help ASPSN grow and succeed. I am proud to be part of this process.

Hobbies:

I enjoy a good wine and spending time with my friends. I also enjoy reading and dancing.

Pets:

I have two Tonkinese cats: Hot Rod and Ricochet.

What excited you the most about the 2009 convention in Seattle?

We offered a good program that provided different tracts in our attempt to meet the needs of our membership as well as to increase collaboration with ASPS.

If you could have any superpower, what would it be?

I would like to have the power to make all people get along and to treat each other with love and respect no matter what differences they may have.

Learning with Miss Adventures (continued from page 8)

References and suggested reading:

Kaban LB, Troulis M, Pediatric Oral and Maxillofacial Surgery. Saunders, 2004, Chapters 24-25 Mosby's Dental Dictionary, 2nd edition. © 2008 Elsevier, Inc. Dorland, 28th ed, p1203 & p662

<http://www.maxfac.com/facial/jaw.html>

<http://www.maxfac.com/facial/jaw.html>

<http://www.emedicine.com/plastic/topic481.html> *Emedicine Facial Trauma, Maxillary and Le Fort Fractures*

ASPSN Mentorship Program

Georgia Elmassian, M.A., RN, CPSN, CFLE

Director American Society of Plastic Surgical Nurses

Chairperson ASPSN Scientific Sessions

Are you searching to find more pride in your nursing specialty or looking for life to be more fulfilling? The New Year allows you to challenge yourself and bring meaningful change into your life. Therefore, why not consider becoming an **ASPSN MENTOR?**

According to Dictionary.com (2010), a mentor and a mentee are defined respectively as “an influential senior sponsor or supporter, [and] a person who is guided by a mentor.” Many of our nursing colleagues and societies have very successful mentor programs which foster growth and professional development for their membership. Therefore, your ASPSN Board thought what better way to cultivate a stronger and more united ASPSN than to integrate our own national curriculum. For that reason and purpose, a primary objective of the **ASPSN MENTORSHIP PROGRAM** will be to facilitate assurance that the American Society of Plastic Surgical Nurses (ASPSN) will continue to grow and develop by providing role models and helpful pearls of wisdom for its members. This can be accomplished by seeking the voices of plastic surgical nurse “experts” at all levels of the organization, who desire to further their nursing career by becoming a mentor or a mentee. Ultimately, mentorship opportunities will ensure efficiency and efficacy by identifying particularized needs of members and then creating, providing, and supporting interventions for them to reach individual and professional goals in the plastic surgical nursing arena.

The program will be open and inclusive. Members representing a variety of cultural differences, educational qualifications, assorted practice experiences, and divergent generations are invited to participate.

The **ASPSN MENTORSHIP PROGRAM** will focus on the importance of establishing, developing, and strengthening a mentoring relationship between a “seasoned” plastic surgical nurse and an interested, motivated member, who aspires to be a proficient patient advocate and an appropriately diplomatic plastic surgical nurse - whether in an aesthetic or reconstructive environment.

ROLES AND RESPONSIBILITIES OF THE MENTOR/MENTEE

Roles of Mentors:

- **Inspiration Role:** Encourage, share, give and receive from one another

- **Nurturing Role:** Enhance, develop, and promote the mentee as a more than capable plastic surgical nurse
- **Mirroring Role:** Reflect, support, and convince
- **Clarifying Role:** Convey clear possibilities and new potential into focus
- **Service Role:** Mentors empowering mentees to succeed as plastic surgical nurses

Responsibilities of Mentors:

- Develop a personal, beneficial relationship with the mentee once the matches are made.
- Promote and nurture the mentor/mentee partnership while avoiding over dependence.
- Provide and give information, advice, guidance and emotional support unconditionally.
- Facilitate ASPSN involvement opportunities.
- Celebrate successes of mentee with enthusiasm and pride.
- Provide mentee with goals and objectives.
- Instill professionalism, encourage adherence to ASPSN standards and policies and demonstrate ethical behaviors (role modeling) for mentee.
- Assist in professional development by establishing a plan, with follow up to include feedback, ideas, and possible de briefings over time.
- At all costs, a mentor will be generous with praise, encouragement, trust and time for their matched mentee.
- If the opportunity arises where both mentor and mentee will be present at an educational seminar or other organized event, it is essential to make personal contact with mentee.
- Realize that an ASPSN Director is always available to help and suggest ideas for the match to succeed.

Mentoring includes the following imperatives:

- A positive attitude and outlook
- A caring manner and understanding towards others
- Professional experience as a seasoned plastic surgical nurse
- Great communication and expert listening skills
- Compatibility with others, flexible, and patient
- Conviction in ASPSN’s Core Ideology and Mission (purpose, values, discipline and envisioned future of plastic surgical nursing)
- A philosophy of life-long learning with an insatiable curiosity of knowledge
- Love of people
- A sense of humor

Responsibilities of Mentees:

- Desires to be helped with an openness to receiving, learning and sharing
- Dedicated to plastic surgical nursing and a quest for learning
- Has respect for mentor’s time and effort
- Admires mentor’s achievements *(continued on page 11)*

ASPSN Mentorship Program

(continued from page 10)

- Models behaviors and attitudes of mentor
- Takes action on information provided
- Explores goals and ideas
- Sets realistic timelines for goal attainment
- Is somewhat of a risk taker; always willing to seek new solutions to challenges
- Possesses integrity, honors change, and demonstrates passion and commitment to purpose and goals
- Receptive to mentors suggestions or alternatives to difficult situations
- Possesses strong self-identity, independence; and is a self-starter
- Good listener who supports regular and interactive communication with mentor
- Possesses a sense of humor
- Patient with self
- Demonstrates professionalism in appearance, actions, and written word

EXPECTED BENEFITS AND OUTCOMES OF MENTORING EXPERIENCE

For Mentors:

- Opportunity to sharpen interpersonal and advocacy skills
- Validation of personal and professional values
- Increased self-esteem resulting from positive relationship and performance
- Satisfaction received from giving “something” back to your organization
- May receive organizational recognition for efforts
- Enhanced sense of team work
- Potential assistance with projects, research, or other initiatives
- Increased professional visibility and exposure

For Mentees:

- Increased skills development and knowledge
- Validation of personal and professional values
- Cultivation of leadership abilities
- Increased self-confidence
- Perceptible professional identity
- Safe, caring relationship with positive feedback
- Enhanced performance of goals and objectives
- Gratified learning experience
- Increased retention of members and future leaders

EFFECTIVE MENTORING ENVIRONMENT

- Non-judgmental acceptance of the mentee
- Provides advocacy

- Demonstration of leadership
- Patience and loyalty exhibited and maintained between mentor and mentee
- Belief in the mentoring process is embraced
- Dynamic, ever changing and flexible
- Empowerment factor - mentor is able to effectively function in role
- Timeless - in that the mentor/mentee relationship can be a one time spontaneous mentoring moment, or an ongoing and supportive relationship. The bond can be determined according to the identified needs of the mentee
- Matched chemistry that makes for an effective interactive relationship
- Permits growth, avoids over dependence and recognizes when goals have been achieved
- Creative- has the ability to keep the mentor/mentee bond alive through technology

Therefore, **Mentoring** involves reflection-insight, guidance-support, and teaching-learning between the experienced plastic surgical nurse and the inexperienced plastic surgical nurse.

Remember, **Mentorship** cannot be seen or touched - it is simply a powerful, enriching experience that can be best described by those who choose to experience it. Will that someone be you?

If you are interested in participating with the **ASPSN MENTORSHIP PROGRAM** by becoming a Mentor or a Mentee, please contact Debbie Blanchard at the National Office: debbie.blanchard@dancyamc.com or me at missgme@comcast.net for further information. This is one journey that will undoubtedly be a high point in your plastic surgical nursing career.

Reference List

Bellefleur, Carmelle. (September 2002). Retain those recruits. *Advance for Nurses*, pp.23-25.

Bensing, Kay. (May 2006). Not just for CEOs - Many nurses don't think they are worthy of a mentor. *Advance for Nurses*, p. 46.

Bensing, Kay. (May 2003). Got mentors? Nurses need mentors who serve as their career guides and road maps. *Advance for Nurses*, p. 33.

Bishop, Jan. (2001). Mentoring crucial to the nurses in the field. *Boston Business Journal*, 21(27), p 55.

Delong, T.J., Gabarro, J.J. & Lees,

(continued on page 12)

Clinical Pearl - Cleft Lip and Cleft Palate Feeding

Sharon Fritzsche MSN, RN, FNP-BC, CPSN

Family Nurse Practitioner
ASPSN President-Elect 2011

An infant who has been born with a cleft of the lip only, or even of the lip and gum ridge, will not typically experience feeding problems. Like most newborns, learning how to “latch on” at the start of feeding will quickly become second nature to him or her. The infants, who have a cleft that involves the palate, will require some alteration in feeding technique, supplies, and positioning. This adjustment is necessary because these infants lack the usual separation that is between the nasal cavity and the mouth. Most of these children may have problems coordinating swallowing and breathing, have longer feeding times, experience nasal regurgitation, or have a weak sucking ability. The infant may swallow a considerable amount of air while feeding.

There are several different bottles and nipples on the market that will help with feeding these infants with a cleft lip/palate. The nipple should be a thin walled nipple that compresses easily and will allow milk or formula to flow at a modest pace; it should not interfere with the normal swallowing mechanism.

Cross-cut nipples have an x-shaped opening, which will allow milk to flow only when the baby squeezes the nipple; you can cross cut manually any type nipple. The Ross nipple is soft and shaped like a tube to direct the milk flow past the cleft. The NUK orthodontic nipple is another choice.

Squeeze type bottles, also known as “assisted delivery sys-

tems” include the Mead Johnson Cleft Palate Nurser, Haberman Feeder, and the Pigeon Cleft Palate Nurser. The Mead Johnson has a very soft and thin-walled, long cross-cut nipple that is intended to help direct milk flow past the cleft. The parent can squeeze the soft bottle in rhythm with the babies suck and swallow. Since infants with a cleft palate are unable to create a vacuum needed to suck milk, this technique is helpful.

The Haberman Feeder has a fairly large squeezable nipple. This nipple is a slit versus cross-cut. There is a disc in the base of the nipple which acts like a one way valve allowing milk into the nipple while reducing the quantity of air that the baby potentially can swallow.

The Pigeon Bottle has a Y-cut versus an X cross-cut nipple; this nipple is slightly bigger and more bulbous. The baby is able to compress this nipple with his or her tongue because it is firm on the top and soft at the bottom. There is an air valve so the nipple will not collapse when the baby is sucking. One is able to control the rate of the flow of milk or formula by tightening or loosening the collar on the bottle. It also has a stopper or back-flow valve so the milk cannot flow back into the bottle from the nipple.

Children born with congenital cleft lip/palate need to have their nutritional needs met, and this can be done with the correct combination of positioning, feeding supplies, and counseling. There are many wonderful materials available through the Cleft Palate Foundation from which some of the above “pearls” were obtained.

Helpful websites include but are not limited to:

www.cleftline.org
www.plasticsurgery.org
www.clapa.com

ASPSN Mentorship Program

(continued on page 12)

R.J. (January 2008). Why mentoring matters in hypercompetitive world. *Harvard Business Review*, pp. 115-121.

Fawcett, Debra. (May 2002). Mentoring - what it is and how to make it work. *AORN Journal*. 75(5). pp. 950-955.

Goran, Susan. (March 2001). Mentorship as a teaching strategy. *Critical Care Nursing Clinics of North America*, 13(1). pp. 119-129.

Hughes, Karen. (May 2003). Ten tips – Nurse manager shares

top 10 tips to recruit and retain exceptional nurses. *Advance for Nurses*, 5(11). pp. 10-113.

Mentor. (2010). Dictionary.com Retrieved January 7, 2010, from <http://dictionary.reference.com/search>

Nielson, Jo, Bozelle, Jenna. (August 2000). Career path: Mentoring -Take a colleague under your wing. *Nursing*, 30(8). pp. 68-71.

Scanlon, Marcia. (September 2002). How lucky I am - A nurse shares her appreciation for a mentoring CNS who helps her learn to think out of the box. *Advance for Nurses*, 2(19). p 7.



**AMERICAN SOCIETY OF PLASTIC
SURGICAL NURSES, INC.**

7794 Grow Drive
Pensacola, FL 32514

LuAnn Buchholz, RN, CPSN
President

Jon Dancy
Executive Director

Haley Wood, MSN, WHNP, CPSN
ASPSNews Editor

LOOKING FOR A CHAPTER NEAR YOU?

CALIFORNIA

Southern California Chapter
Judy Akin Palmer
San Juan Capistrano, CA
judyakin@mac.com

INDIANA

Greater Indianapolis Chapter
Diane Horner
Fishers, IN
dianekhorner@comcast.net

KANSAS/MISSOURI

KS/MO Chapter
Karen K. Harman-McGowan
Lawrence, KS
KarenIof2@sunflower.com

MASSACHUSETTS

New England Chapter
Brenda White
Danvers, MA
bswhite@shrinenet.org

NORTH CAROLINA

Piedmont Chapter
Melba Edwards
Pfafftown, NC
cmelbae@yahoo.com

OHIO

The Greater Ohio Chapter of Plastic
Surgical Nurses
Susan Lamp
Hillard, OH
susan.lamp@osumc.edu

PHILADELPHIA/DELAWARE

Philadelphia-Delaware Valley Chapter
Sheri Levin
Sewell, NJ
sherablevin@comcast.net

TENNESSEE/ALABAMA

Tennessee/Alabama Chapter
LuAnn Buchholz
Franklin, TN
luannrncpsn@comcast.net

WASHINGTON

Western Washington Chapter
April Thomas
jamesthomasclan51238@msn.com

WISCONSIN

Wisconsin Chapter
Cynthia Leu
Iron Ridge, WI
Cindyl@plasticsurgerydoc.org

If you would like information
on starting a local
ASPSN chapter,
please contact
Megan Menth,
Chapter Services
Specialist, at
megan.menth@dancymc.com