



# SLEEPY TIMES

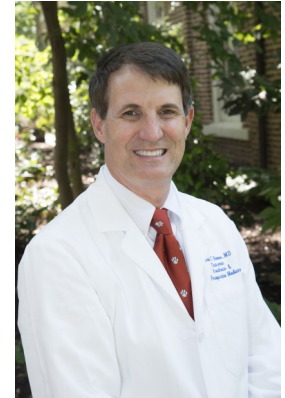
VOLUME 17, ISSUE 5 MAY 2023



## Inside This Issue:

Opening Statement	1-2
New SMP Director	2
Battle on the Bricks for MUSC Children's Hospital	3
First Aid Perioperative Ultrasound Acute Pain Manual for Surgical Procedures	3
Pain Medicine News Article	4
Making an EXIT	5-6
HFES Healthcare Symposium	7
Research Corner	8
Cultural Awareness and Education	9
SC Opioid Education Requirement for License Renewal	9
DEA Registered Practitioners Requirements	9-12
Outstanding Facilitator of Interprofessional Courses	12
Annual Mandatories	13
Central Line Placement Note Change	14
Grand Rounds	15
I Hung the Moon	16

## MESSAGE FROM THE CHAIRMAN: ALAN FINLEY, MD AWARDED THE INAUGURAL SCOTT T. REEVES, M.D. ENDOWED CHAIR IN CARDIOTHORACIC AND VASCULAR ANESTHESIOLOGY

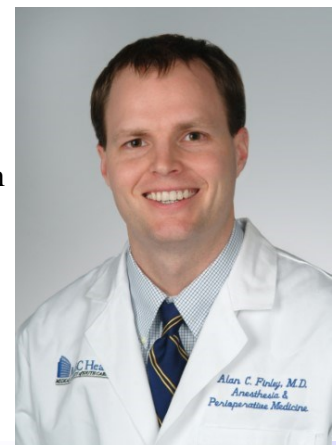


### -SCOTT T. REEVES, MD, MBA

Prior to the departure of the College of Medicine Dean Dr. Ray DuBois to his new role as Director of the Hollings Cancer Center, Dr. DuBois recognized the creation of the Scott T. Reeves, M.D. Endowed Chair in Cardiothoracic and Vascular Anesthesiology. This endowed chair was established in recognition of Dr. Reeves' thirty years of service to MUSC and seventeen years as Chairman of the Department of Anesthesia and Perioperative Medicine. He holds the rank of Professor with Tenure. The fields of cardiothoracic anesthesiology and transesophageal echocardiography have been a primary focus of his practice, research and education and have produced funded research, national and international lectures, and over one hundred publications in professional journals, book chapters and over ten textbooks. His textbook, *A Practical Approach to Transesophageal Echocardiography*, (now on its fourth edition) has been a world leader in sales and has been translated into Chinese, Japanese, Portuguese and Russian. The textbook's success resulted in his having the name recognition to become the President of the Society of Cardiovascular Anesthesiologists and ultimately be recognized by that society through their distinguished service award.

Dr. Alan Finley received his undergraduate degree from North Carolina State University. He received his medical degree from the Medical University of South Carolina. He completed his anesthesiology residency at the University of North Carolina Hospitals and a cardiothoracic anesthesiology fellowship at Emory University. Following his fellowship, he became a faculty member at the Medical University of South Carolina. He holds the rank of Professor and is board certified in Anesthesiology by the American Board of Anesthesiology and Perioperative Echocardiography by the National Board of Echocardiography.

Dr. Finley maintains a heavy clinical practice in the area of adult cardiothoracic anesthesiology while serving as the Division Chief of Cardiothoracic Anesthesiology. His leadership of the division has been stellar. His previous leadership roles include Medical Director for the Ashley River Tower Operating Room, Director of Perioperative Echocardiography and Director of the Perioperative Echocardiography Resident Rotation. Additionally, he serves on the Board of Directors of the American Society of Echocardiography.



**OPENING STATEMENT CONTINUED**

Two important relevant factors qualified him for consideration of the Scott T. Reeves Endowed Chair:

His interest in coagulation management which led to collaboration with the Department of Medicine's Division of Hematology to successfully implement the use of rotational thromboelastography during cardiac surgery for bleeding management which resulted in a significant decline in transfusions.

His expertise in perioperative echocardiography. His expertise is recognized at MUSC as a lead developer of the Transcatheter Aortic Valve Replacement and Mitral Clip programs and course director for a transesophageal echocardiography simulator course. Through his service on the Council of Perioperative Echocardiography he was the second author of a consensus statement on the basic perioperative transesophageal echocardiography examination.

I am very humbled to receive this recognition through the creation of this endowed chair and cannot think of a better first recipient than Dr. Alan Finley.

**NEW SUMMEY MEDICAL PAVILION DIRECTOR—JEN SMITH, MD**

I am excited to continue the mission of pediatric ambulatory anesthesia as the new SMP medical director. I am originally from Massachusetts and spent time in Philadelphia for undergrad, medical school, and pediatric anesthesia fellowship. I did residency at the University of Massachusetts and then worked in a mixed peds/adult practice there for 7 years prior to coming to Charleston. Having previously been an associate medical director at University of Massachusetts University Campus hospital, I knew I wanted a smaller family like atmosphere for my next leadership role. The team at SMP is amazing, providing high quality, efficient anesthesia care. They are always willing to go the extra mile to make a family's experience better. Harnessing this positive energy and working with the solid foundation in place, I am sure I can make great strides as the new SMP director. I am excited for this opportunity!



## DR. CAREY BREWBAKER ENTERS THE RING



**David Bailey**

Age: 37 | Height: 6' | Weight: 175

[LEARN MORE ABOUT DAVID](#)



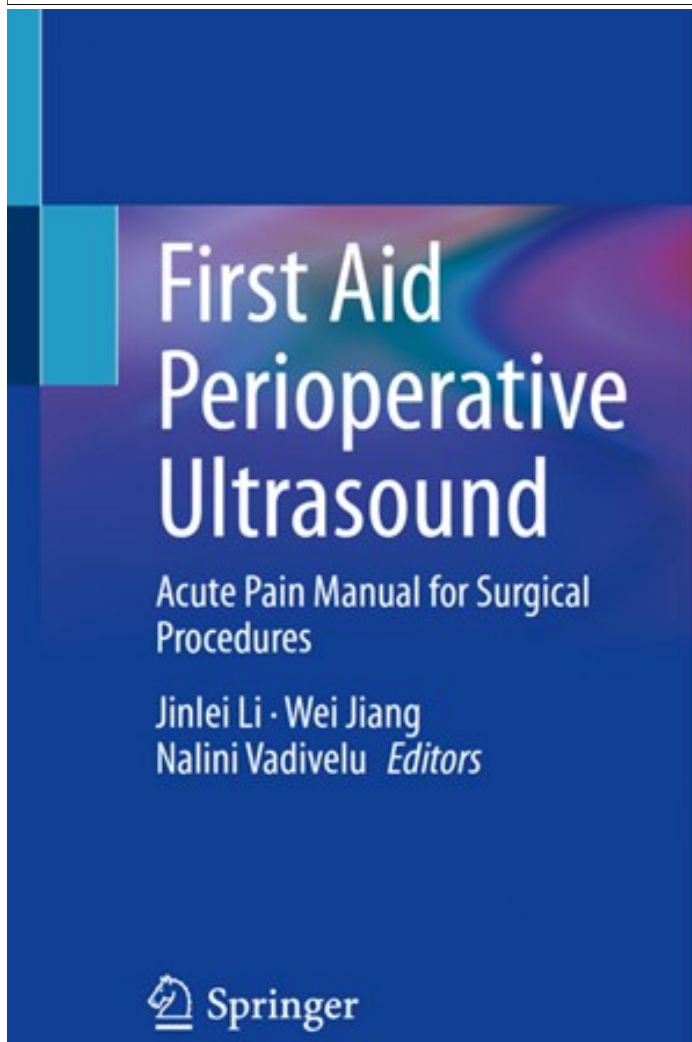
**Carey Brewbaker**

Age: 36 | Height: 6' | Weight: 184

[LEARN MORE ABOUT CAREY](#)



## FIRST AID PERIOPERATIVE ULTRASOUND ACUTE PAIN MANUAL FOR SURGICAL PROCEDURES



Multiple faculty recently contributed chapters to this new textbook.

### **Methadone**

Jackson Condrey, Andrew Klein, and Carey Brewbaker

### **Buprenorphine, Buprenorphine/Naloxone (Suboxone)**

William F. Barrett and Carey Brewbaker

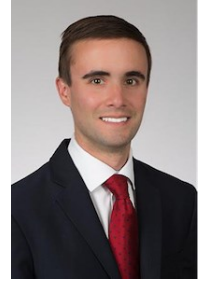
### **Complimentary Non-pharmacological and Non-opioid Options**

Christopher D. Wolla and Tara Kelly

## PAIN MEDICINE NEWS—CERVICAL SCS IMPROVES UPPER EXTREMITY IMPAIRMENT SYMPTOMS AFTER STROKE BY STEVEN VRANIAN, MD

### PAINMEDICINE NEWS

Steven Vranian was born in Richmond, Va., and is a graduate of Washington and Lee University. He obtained his medical degree at the Medical University of South Carolina.



He is currently chief resident in the Department of Anesthesiology at the Medical University of South Carolina. He will be completing a pain medicine fellowship at Duke University upon completion of residency training.

There are 12.2 million strokes diagnosed every year. Nearly one in four individuals will suffer a stroke in their lifetime.<sup>1</sup> Of those who experience strokes, nearly 80% will have some form of upper extremity impairment. Post-stroke recovery efforts are largely focused on targeted rehabilitative therapy, with a number of noninvasive and invasive therapies under investigation. Patients who suffer a stroke experience variable recovery in both the acute and chronic phases, with functional impairment being a long-term problem with great impact.

Researchers from UMPC reported promising results from a two-patient study in which cervical spinal cord stimulation (SCS) was used to test its efficacy in assisting strength and dexterity, and whether it affected spasticity. In this study, Powell et al implanted two subjects who had experienced strokes years ago with two percutaneous SCS leads positioned laterally near the entry of the dorsal root staggered to cover C3-T1. After implantation, varying stimulation frequencies were applied via external generator targeting specific contacts to provide maximal benefit of assistive therapy. Next, the two subjects were put through strength and dexterity testing that targeted their individual abilities for four hours, five days per week. The subjects were assessed over a four-week period, after which the stimulation arrays were explanted.

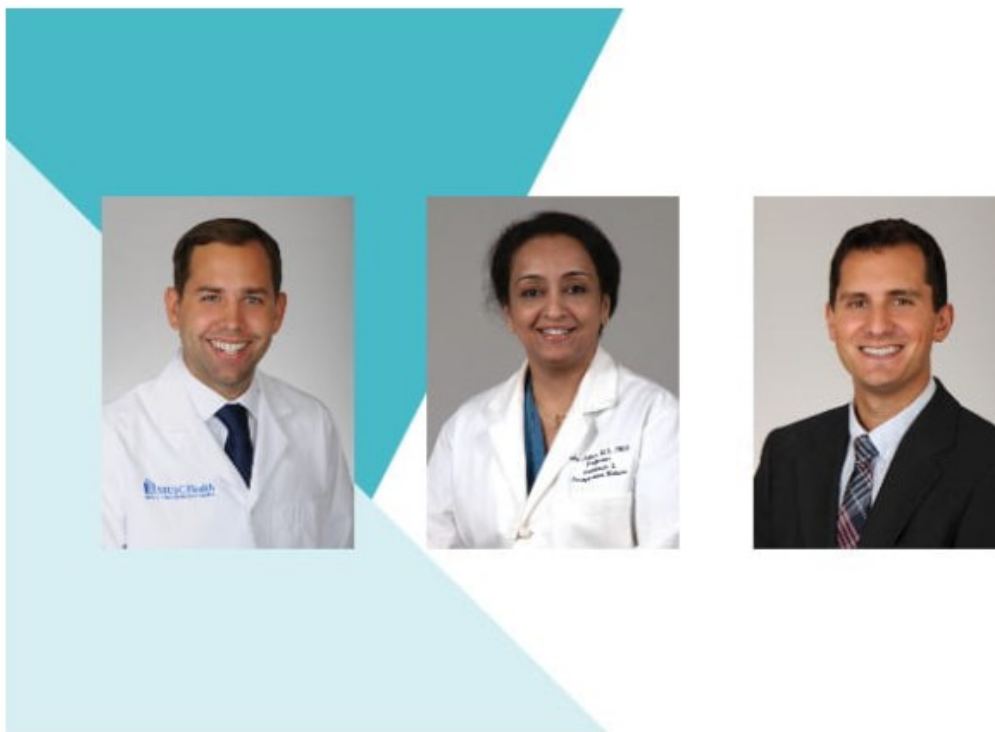
The results of this pilot study are promising. Regarding grip strength, both subjects exhibited greater than or equal to 40% improvement with stimulation, as measured by a hand dynamometer. Subjective improvement in functional range of motion of the hand was also observed. Dexterity was assessed using reaching tasks both with and without stimulation. Both subjects were able to reach farther with greater speed and accuracy with stimulation, although the tasks had to be tailored to each subject's degree of underlying deficit. To assess the potential for functional benefit, the subjects were put through a series of tasks to assess for improvement in completion of activities of daily living. With stimulation, improvement was seen in the ability to lift objects, move items accurately and produce drawings. Stimulation did not worsen symptoms of spasticity as measured by the Modified Ashworth Scale. Stimulation was well tolerated by both subjects without notable complaints of paresthesia or discomfort. At the conclusion of the study period, the leads were explanted. Significant sustained improvements were not seen after cessation of therapy as was expected.

The results of this pilot study indicate that cervical SCS may prove immediately beneficial in an assistive capacity for patients with upper extremity paresis. There are clear limitations to this pilot study, as only two subjects were included and potential long-term improvement was not captured due to the short study period. Further research targeting a larger study population, the impact of stimulation combined with rehabilitative therapies and the long-term effects of stimulation on functional impairment is warranted.

#### References

1. Feigin VL, Brainin M, Norrving B, et al. World Stroke Organization (WSO): Global stroke fact sheet 2022. *Int J Stroke*. 2021;17(1):18-29.
2. Lawrence ES, Coshall C, Dundas R, et al. Estimates of the prevalence of acute stroke impairments and disability in a multiethnic population. *Stroke*. 2001;32(6):1279-1284.
3. Hatem SM, Saussez G, Della Faille M, et al. Rehabilitation of motor function after stroke: a multiple systematic review focused on techniques to stimulate upper extremity recovery. *Front Hum Neurosci*. 2016;10:442.
4. Powell MP, Verma N, Sorensen E, et al. Epidural stimulation of the cervical spinal cord for post-stroke upper-limb paresis. *Nat Med*. 2023 Feb 20. doi:10.1038/s41591-022-02202-6

## MAKING AN EXIT (EX-UTERO INTRAPARTUM TREATMENT)



Dr. Matthew Finneran, Dr. Latha Hebbar, and Dr. William Carroll.

**Obstetricians, ENT (ear, nose, and throat) surgeons and anesthesiologists, among other specialists, painstakingly prepare for, practice and perform one of the most complex fetal medicine surgeries to enable safe delivery of babies with a severe airway blockage.**

**By Gary Logan**

[Matthew Finneran, M.D.](#), notes that in medical school he decided on a residency and career in general obstetrics and gynecology because it would allow him to experience the full scope of practice, including both surgery and primary care. Then he took a rotation in high-risk obstetrics that widened his vision to the challenges of managing two patients simultaneously, the mom and baby. Among the most complex conditions he would face, the high-risk obstetrician at the [Medical University of South Carolina](#) (MUSC) found, are conditions that compress fetal airways and pose a high risk of brain damage or death upon delivery.

Other causes include an underdeveloped lower jaw, tumors and a blockage of the trachea or larynx called Congenital High Airway Obstruction Syndrome (CHAOS).

"The airway can be malformed or obstructed, which makes it really difficult for the pediatric and neonatal team to take care of that baby before suffering brain damage from lack of oxygen," says Finneran. "Sometimes there are large lung masses needing immediate surgery for the baby."

That surgery is the EXIT procedure, or Ex-utero intrapartum treatment, which is as complicated as it sounds. In the simplest terms, Finneran says, the baby is partially delivered through a delicate incision in the uterus and remains attached to the umbilical cord and on placental support to allow time for surgeons to secure the baby's airway and fully repair the underlying condition another day. Once a baby is delivered and takes its first breath, the lungs kick in to do their job and the placenta, no longer required as a source of oxygen, detaches.

"An EXIT procedure extends mom's support of the baby for the critical period needed to provide some treatment so that baby can breathe again," says Finneran. "It provides pulmonary cardio bypass through the placenta."

In other words, the EXIT procedure is a potential on-ramp to a safe delivery for these vulnerable babies. But it doesn't happen without communication, coordination, planning and practice by the team members involved, including physicians in fetal medicine, neonatology and otolaryngology, or ear-nose-throat (ENT), and nurses. Detailed preparations begin following ultrasound detection of an airway obstruction or another anomaly indicating the need for the surgery. Considering the fetal indications and the gestational age required for delivery, an EXIT delivery is typically planned for between 33 and 39 weeks of gestation.

## MAKING AN EXIT (EX-UTERO INTRAPARTUM TREATMENT)

"We need to recommend delivery in this time frame—who is available and where and when can we coordinate the procedure and what supplies do we need?" says Finneran. "Much of the complexity of the procedure is in the coordination and communication between all the teams. There is no such thing as an emergent EXIT—it has to be planned for."

Obstetric anesthesiologist [Latha Hebbar, M.D.](#), adds, "In deciding how we're going to carry out the procedure we create a road map of where each one of us is situated in the operating room. Before the surgery, we do a rehearsal."

In the OR, first steps in making an EXIT include a small incision into the uterus. As bleeding from uterine muscle is the major concern here, surgeons choose the location of the incision carefully, ideally away from the placenta, and use a hemostatic stapler to reduce that risk. They then deliver only the head, neck and one arm—a partial delivery Hebbar calls "a C-section with a twist." At the same time the uterus, stimulated by the partial delivery, is now at risk of contracting and bleeding.

"When you deliver part of the baby, the uterus wants you to deliver the baby the rest of the way," says Hebbar. Anesthesiologists counter that risk by filling the uterine cavity with saline via a transfuser and canula and administering medications to relax both the baby and the uterus and delay contractions. "The uterus needs to be as floppy as ever," says Hebbar. "You have to trick the uterus into thinking it is still full and that the baby is still there." These actions are designed to give the [ENT](#) team time to obtain the compromised airway and place a breathing tube down the throat. In some cases, if regular intubation doesn't provide access to the obstruction, bronchoscopy or, as a last resort, tracheostomy through the neck may be required. However, these are more technical procedures that take time to administer while the clock is ticking and increasing the risk of oxygen deprivation to the baby.

"ENTs may spend about 15 minutes attempting to get an airway in a patient that we deliver, and 15 minutes without breathing is a major problem," says Hebbar. ENT surgeon [William Carroll, M.D.](#), agrees the procedure is a race against time and among the most challenging and stressful anatomical surgeries he performs. Why? "You're working in unusual quarters up against the mother with the baby partially out," says Carroll. "The anatomy is usually going to be very challenging and then there's amniotic fluid everywhere making it more difficult to see."

As Carroll continues to work on securing an airway, Hebbar and the anesthesia team, which often includes a pediatric anesthesiologist, continue to monitor the mother and baby, keeping a sharp eye on the effects of medications designed to relax the baby that may adversely affect the mother.

"Anytime you administer medications to relax the smooth muscles of the uterus, you are also relaxing the smooth muscles of the mother's blood vessels, which can drop her blood pressure," says Hebbar. "That's the challenge—keeping the mother's blood pressure up while using the mother's placenta to perfuse the baby."

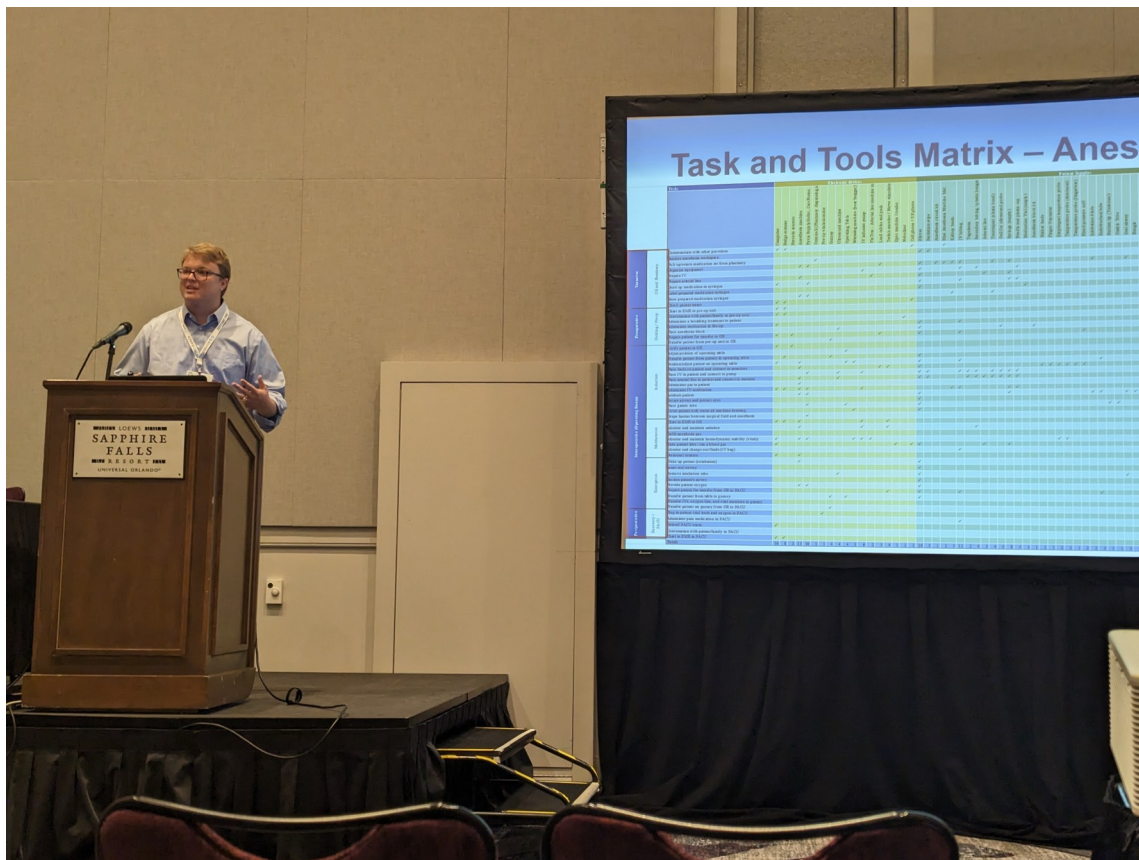
"Literally, you hold your breath until the ENT secures the airway," says Hebbar. Then, once the airway is obtained, there comes the challenge of "transitioning from uterine relaxation to uterine contraction in a jiffy," says Hebbar. "We use short-acting medications to relax the uterus, so once it is turned off, the relaxant effects are reversed." After the baby is delivered, medications are administered to increase uterine tone. A soft and weak uterus, which may occur when uterine muscles don't contract enough to clamp placental blood vessels after childbirth, can lead to life-threatening blood loss. Mothers are made well aware of such risks and what lies ahead for them and the baby early on.

"We have very long and detailed conversations about what this looks like and how we're doing the procedure in a way they really understand," says Finneran. The need for the procedure remains relatively rare, note team members, but add that they are always prepared to prepare for the next case. The establishment of the [Advanced Fetal Care Center at MUSC Shawn Jenkins Children's Hospital](#), they say, has enhanced communication between maternal fetal-medicine health and pediatrics in such complex cases requiring an EXIT procedure. "We understand the uniqueness of having maternal-fetal medicine in a children's hospital and the value of being able to do simultaneous patient consultation with the pediatric team," says Finneran. The rewards of the arduous planning and performing an EXIT in all its complexity?

"The patients know that everything possible was done to achieve the best outcome for their baby," says Finneran. "You go into this being as hopeful as possible but also knowing the baby has a severe condition, which is why we do an EXIT, to give the baby a chance."

**HFES HEALTHCARE SYMPOSIUM**



Human Factors research assistants Gabriel Segarra and Jeffrey Woodward presenting at the HFES Healthcare Symposium in Orlando, FL.



**RESEARCH CORNER**

Brief technical report

## Stellate ganglion block catheters for refractory electrical storm: a retrospective cohort and care pathway

Rishi Ashok Patel <sup>1</sup>, Jackson M Condrey,<sup>1</sup> Renuka M George,<sup>2</sup> Bethany J Wolf,<sup>3</sup>  
Sylvia H Wilson <sup>4</sup>



Jackson Condrey, MD



Renuka George, MD



Bethany Wolf, PhD



Sylvia Wilson MD

**NEW BABY IN THE DEPARTMENT**

Megan McManus and family welcomed Joseph William McManus III “JW” on April 10th at 5:23am. He was 6 lbs 8 oz and 18.5 inches long!



**CULTURAL AWARENESS AND EDUCATION: OVER THE COUNTER NARCAN APPROVED BY FDA**

On March 29, the Food and Drug Administration (FDA) approved Narcan nasal spray for nonprescription use, the first naloxone product approved for use without a prescription. This will provide equitable community access to naloxone - a safe, life-saving medication that can rapidly reverse an opioid overdose and significantly reduce the incidence of opioid overdose fatalities - to all patients across the United States as a nonprescription treatment. I would encourage us all to have Narcan available in our emergency kits at home. One never knows when it may be needed to care for a loved one.

**SC OPIOID EDUCATION REQUIREMENT FOR LICENSE RENEWAL**

Many of the faculty are in the SC medical license renewal process. As part of that process, we are required to have completed 40 hours of AMA CME credit with 2 hours including opioid education. During the past two years, we have had many hours available for CME through our anesthesiology grand round series. In addition, I am happy to report that 4 hours involved opioid education.

1. October 5, 2021—Perioperative Management of Buprenorphine —Dr. William Barrett
2. February 1, 2022—Perioperative Management of the Substance Use Disorder Patient—Dr. Sudheer Potru
3. July 26, 2022—Equitable Care in Pain Medicine (A discussion of opioid prescribing patterns based on race) — Dr. Meron Selassie
4. November 1, 2022—Understanding the Role of Cortical Astrocytes in Heroin Addiction (A discussion of the basic science mechanisms of opioid addiction and possible treatment breakthroughs) —Dr. Mike Scofield

If you have documented attendance at these lectures, you can use them for your SC License requirement. Your administrative assistant can assist with the CME documentation.

**DRUG ENFORCEMENT ADMINISTRATION (DEA)-REGISTERED PRACTITIONERS REQUIRED EDUCATION ON THE TREATMENT AND MANAGEMENT OF PATIENTS WITH OPIOID OR OTHER SUBSTANCE USE DISORDERS**

The Drug Enforcement Administration (DEA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) has released a new mandatory 8-hour training requirement on substance use disorder (SUD) treatment. What this means is starting June 27, 2023, you have to complete the requirement by the next time you renew your DEA license. Thus, if you just renewed your license and haven't met the requirement yet, you have a few years to do so. I suspect multiple organizations will be developing courses to fulfill this requirement including the American Society of Anesthesiologists. The complete letter is included below.



**U. S. Department of Justice**  
**Drug Enforcement Administration**  
8701 Morrisette Drive  
Springfield, Virginia 22152

---

[www.dea.gov](http://www.dea.gov)

## DEA Registered-Practitioners

Dear Registrants:

On December 29, 2022, the Consolidated Appropriations Act of 2023 enacted a new **one-time, eight-hour training requirement** for all Drug Enforcement Administration (DEA)-registered practitioners on the treatment and management of patients with opioid or other substance use disorders. Below is information on this new requirement.

### **Who is responsible for satisfying this new training requirement?**

- All DEA-registered practitioners, with the exception of practitioners that are solely veterinarians.

### **How will practitioners be asked to report satisfying this new training requirement?**

- Beginning on June 27, 2023, practitioners will be required to check a box on their online DEA registration form—regardless of whether a registrant is completing their initial registration application or renewing their registration—affirming that they have completed the new training requirement.

### **What is the deadline for satisfying this new training requirement?**

- The deadline for satisfying this new training requirement is the date of a practitioner's next scheduled DEA registration submission—regardless of whether it is an initial registration or a renewal registration—on or after June 27, 2023.
- This one-time training requirement affirmation will not be a part of future registration renewals.

### **How can practitioners satisfy this new training requirement?**

There are multiple ways that practitioners can satisfy this new training requirement.

- First, the following groups of practitioners are deemed to have satisfied this training:
  1. **Group 1:** All practitioners that are board certified in addiction medicine or addiction psychiatry from the American Board of Medical Specialties, the American Board of Addiction Medicine, or the American Osteopathic Association.
  2. **Group 2:** All practitioners that graduated in good standing from a medical (allopathic or osteopathic), dental, physician assistant, or advanced practice nursing school in the United States within five years of June 27, 2023, and successfully completed a comprehensive curriculum that included at least eight hours of training on:

- Treating and managing patients with opioid or other substance use disorders, including the appropriate clinical use of all drugs approved by the Food and Drug Administration for the treatment of a substance use disorder; or
  - Safe pharmacological management of dental pain and screening, brief intervention, and referral for appropriate treatment of patients with or at risk of developing opioid and other substance use disorders.
- Second, practitioners can satisfy this training by engaging in a total of eight hours of training on treatment and management of patients with opioid or other substance use disorders from the groups listed below. A few key points related to this training:
    1. The training does not have to occur in one session. It can be cumulative across multiple sessions that equal eight hours of training.
    2. Past trainings on the treatment and management of patients with opioid or other substance use disorders can count towards a practitioner meeting this requirement. In other words, if you received a relevant training from one of the groups listed below—prior to the enactment of this new training obligation on December 29, 2022—that training counts towards the eight-hour requirement.
    3. Past DATA-Waived trainings count towards a DEA registrant's 8-hour training requirement.
    4. Trainings can occur in a variety of formats, including classroom settings, seminars at professional society meetings, or virtual offerings.

**What accredited groups may provide trainings that meet this new requirement?**

- The American Society of Addiction Medicine (ASAM)
- The American Academy of Addiction Psychiatry (AAAP)
- American Medical Association (AMA)
- The American Osteopathic Association (AOA), or any organizations accredited by the AOA to provide continuing medical education
- The American Dental Association (ADA)
- The American Association of Oral and Maxillofacial Surgeons (AAOMS)
- The American Psychiatric Association (APA)
- The American Association of Nurse Practitioners (AANP)
- The American Academy of Physician Associates (AAPA)
- The American Nurses Credentialing Center (ANCC)
- Any other organization accredited by the Accreditation Council for Continuing Medical Education (ACCME) or the Commission for Continuing Education Provider Recognition (CCEPR), whether directly or through an organization accredited by a State medical society that is recognized by the ACCME or CCEPR
- Any other organization approved or accredited by the Assistant Secretary for Mental Health and Substance Use, the ACCME, or the CCEPR

We hope this information is helpful. For information regarding the DEA Diversion Control Division, please visit [www.DEAdiversion.usdoj.gov](http://www.DEAdiversion.usdoj.gov). If you have any additional questions on this issue, please contact the Diversion Control Division Policy Section at (571) 362-3260.

Sincerely,

**THOMAS  
PREVOZNIK** Digitally signed by  
THOMAS PREVOZNIK  
Date: 2023.03.27  
16:37:23 -0400  
Thomas W. Prevoznik  
Acting Assistant Administrator  
Diversion Control Division

**OUTSTANDING FACILITATOR OF INTERPROFESSIONAL COURSES GIVEN TO  
CONNER LUSK, PHD**



The Outstanding Facilitator of Interprofessional Courses award is given by the Office of Interprofessional Initiatives to recognize an outstanding facilitator of required interprofessional courses who models effective student engagement, teamwork, and commitment to interprofessional education. This award is given annually at the Interprofessional Education Fellowship Ceremony.

Congratulations!

## 2023 MUSC ANNUAL MANDATORIES

The OurDay Learning Team has now assigned the 2023 annual mandatory online lessons for all members of the MUSC workforce in OurDay Learning ([musc.edu/ourday](http://musc.edu/ourday)). The modules are designed to inform our standards of professional education, enhance workforce and health care outcomes and meet federal and state educational requirements.

These modules are assigned every calendar year and intended for employees and care team members to complete at your earliest convenience. As in past years, all of the annual mandatory training modules and requirements must be completed no later than June 30, 2023, after which disciplinary action will be taken.

Please direct any questions about the mandates assigned to you to the appropriate HR department:

University HR: [university-hr@musc.edu](mailto:university-hr@musc.edu) or 843-792-2071

MUHA HR: [muhahr@musc.edu](mailto:muhahr@musc.edu) or 843-792-0819

MUSC Physicians HR: [muscphysicianshr@musc.edu](mailto:muscphysicianshr@musc.edu) or 843-876-5800

**2023 MUSC General Mandatories** (Enterprise-wide for all MUSC and MUSC related entity employees, contractors, and others who have access to MUSC resources unless otherwise designated.)

- Active Shooter
- Conflict of Interest
- Crime Prevention and Jeanne Clery Act Training
- HIPAA Privacy and Code of Conduct Training
- Prohibited Discrimination and Harassment
- Information Security
- OSHA Review & Bloodborne Pathogens
- Tuberculosis Annual Training
- Health Equity
- Cultural Awareness/Competence

**2023 MUSC University Mandatories** (For all faculty, staff, student workers and contingent workers.)

- Family Educational Rights and Privacy Act (FERPA)

**Overview of Research at MUSC** (Role-based Only)

- Employees and students of the University

**2023 MUSC Health Mandatories** (For MUSC Health care team members only unless otherwise designated.)

- Emergency Management and Campus Security
- MUSC Health Compliance Training, includes Billing (also required of University employees with EPIC access.)
- Infection Prevention and Control
- Magnetic Resonance Imaging Safety for Healthcare Workers
- Patient and Family Centered Care and Patient Engagement
- Patient Safety: A Commitment to Zero Harm
- Stroke, Heart, and Hypoglycemia: Early Recognition
- Workplace Violence

**2023 Annual Clinical Education** (MUSC Health clinical care teams only)

- Varies depending on your clinical role
- Completion date varies based on clinical requirements

**2023 Medical Staff Mandatories** (Credentialed providers only)

- 2023 MS Module 1: Health Information Services
- 2023 MS Module 2: Patient Safety Initiatives
- 2023 MS Module 3: Sleep and Fatigue/Clinical Handoffs

### CENTRAL LINE PLACEMENT NOTE CHANGE

One of the best practices for central line maintenance is to mark the dressing with the date and time the dressing was placed. Our central line procedure notes have been updated to include a “date and time written on dressing” button in the procedure completion section (see below). Please use this new feature as a reminder to date and time the dressing on any central line that we place or central line dressing we change.

#### Central Line

Performed by: Anesthesiologist Four Anesthesia, MD Authorized by: James Kevin O'Kelly, MD

- 8 Fr
- 8.5 Fr
- 9 Fr
- 9.5 Fr
- 10 Fr
- 12 Fr
- 14 Fr

Landmarks identified

Real-time ultrasound used to visualize both artery and vein, guide needle into the target vein, and to confirm wire placement.

Diameter of vessel measured by ultrasound (in cm)

Sterile gel used for ultrasound?

Sterile probe cover used for ultrasound?

Ultrasound image(s)

Number of attempts (1 attempt = 1 skin puncture)

CVC Secured at (cm):   PAC Secured at (cm):

Procedure completion

Catheter Length

#### Post-procedure

Assessment

Outcomes

Complications

Attending Supervision?  No Attending Supervision

Comments

**GRAND ROUNDS- MAY 2023**



**“Lactation in the Perioperative Setting ”**

**May 2, 2023**

**Erin Conner, MD, Assistant Professor  
Anesthesiology & Perioperative Medicine  
Oregon Health and Science University**



**“Acute Kidney Injury in Liver Transplanta-  
tion ”**

**May 9, 2023**

**Joe Whiteley, MD, Associate Professor  
Dept. of Anesthesia & Perioperative Medicine  
Medical University of South Carolina**



**“The Art & Science of Effective Communica-  
tion: Skills for the Healthcare Professional ”**

**May 16, 2023**

**Elisha Brownfield, MD, Professor  
Suzanne Drew**

**Medical University of South Carolina**



**“Research Symposium ”**

**May 23, 2023**

**Sylvia Wilson, MD, Professor  
Haley Nitchie, MHA, Research Program  
Manager**

**Dept. of Anesthesia & Perioperative Medicine  
Medical University of South Carolina**



**“Perioperative ICD Discharge (Irick)  
Postoperative NSTEMI M&M (Campbell) ”**

**May 30, 2023**

**Will Irick, MD, Resident Physician  
Ryan Campbell, MD, Resident Physician**

**Dept. of Anesthesia & Perioperative Medicine  
Medical University of South Carolina**

DEPARTMENT OF ANESTHESIA AND PERIOPERATIVE MEDICINE

Email: hameedi@musc.edu  
Phone: 843-792-9369  
Fax: 843-792-9314



**I HUNG THE MOON**

Please don't forget to nominate your co-workers for going 'Beyond the Call of Duty.' I Hung The Moon slips are available at the 3rd floor front desk and may

[CHECK OUT OUR WEBSITE](#)

**Future Events/Lectures**

**Intern Lecture Series**

5/11—Pulmonary Disease—Pritee Tarwade

**CA 1 Lecture Series**

5/10—Basic Statistics for the Boards—Bethany Wolf

5/24—ABA Basic Exam Review—David Carroll

**CA 2/3 Lecture Series**

Per Rotations



Follow us on Facebook, Instagram, and Twitter:

<https://www.facebook.com/MUSCAnesthesia/>

<https://www.instagram.com/musc.anesthesiology/>

 Follow @MUSC\_Anesthesia



Graduation  
Friday, June 16th, 2023 6:00pm  
Founders Hall

Department Holiday Party  
Saturday, December 9th, 2023  
Carolina Yacht Club

**ONE MUSC Strategic Plan**

**We Would Love to Hear From You!**

If you have ideas or would like to contribute to *Sleepy Times*, the deadline for the June edition will be May 20, 2023.