SAME-DAY SURGERY

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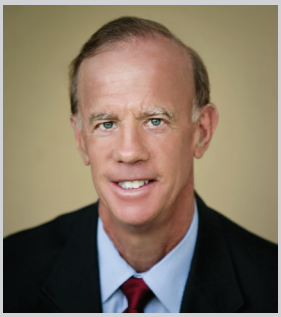
AHC Media

2 assaults on anesthetized patients by staff members lead to lawsuits

Facilities were responsible for attacks, litigation claims

Two recent incidents of patients being sexually assaulted during or immediately after procedures in which they were anesthetized have resulted in lawsuits against the physicians and their facilities. The assaults and pending litigation have raised concerns among surgery providers about how best to protect vulnerable patients, including those who are anesthetized.

In one case, a patient has filed a lawsuit that accuses her gastroenterologist of sexually assaulting her while she was under anesthesia, according to a news report.[1] The physician is under investigation, and his privileges to practice have been revoked, according to the lawsuit quoted in the report.



"EVERY PATIENT MUST BE PROTECTED AND BE ASSURED THAT THEY ARE IN A SAFE ENVIRONMENT."
— PAUL B. HOFMANN, DRPH, FACHE, HOFMANN HEALTHCARE GROUP

About one week after she had a colonoscopy, the patient was informed by law enforcement officials that she had been sexually assaulted by the gastroenterologist, the report says. The physician put his hands inside her hospital gown, touched her breast, and used his finger to repeatedly penetrate her vagina, according to the lawsuit. "One or more employees" at the hospital witnessed the incident, the lawsuit says, and those employees reported the assault to administrators. The lawsuit claims that the patient is not the first to be sexually assaulted by the physician

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during a colonoscopy. It names his gastroenterology practice as a defendant, and it says that the practice should have known the physician had sexually assaulted other female patients prior to her procedure.

In another case, a civil suit filed by a female patient against her male surgeon claims that the physician already faced 26 felony counts in multiple sex assault allegations against him when he assaulted her after she underwent a thyroidectomy at a hospital, according to a news report.[2] She says the assault happened while she was unconscious from the general anesthesia, the report says.

She claims that the surgeon also came to her private recovery room three times, claimed the patient had a rash in her vaginal area, and touched her genitals twice. She says that the morning he came in to discharge her, he asked about the rash, and she told him that she had checked and there was no rash. She reports that the surgeon was "kind of startled, and set aback."[2]

A lawsuit has been filed against the surgeon, his former partner, his hospital, its owner, and the surgeon's medical group. The lawsuit says the defendants enabled the surgeon to sexually abuse the patient. It also says the defendants were aware of accusations of sexual misconduct that had been made against the doctor, but they continued to refer female patients to him. The lawsuit alleges that there was sexual harassment by a physician; negligence; civil rights violations; gender violence; negligent hiring, training, and supervision; and medical malpractice.

Two other civil suits from six plaintiffs alleging sexual assaults have been filed against the same surgeon. One of the patient's lawyers is quoted as saying the surgeon was on a "sexual rampage." The surgeon's license has been suspended, the news report says.[2]

Prevent incidents

Consider the following steps to prevent similar incidents at your facility:

• Perform background checks, and consider personality tests.

"If folks are looking to 'up' their game, here are some due diligence things they can do," says **Alan C. Lynch**, CHPA-L, CHSP, HEM, network director of safety and security at St. Luke's University Health Network in Bethlehem, PA.

At St. Luke's, job applicants are given a pre-hiring online personality test. If the applicant doesn't reach

EXECUTIVE SUMMARY

Two recent incidents of patients being sexually assaulted during or immediately after procedures in which they were anesthetized have resulted in lawsuits against the physicians and their facilities. To avoid similar incidents at your facility:

- Perform background checks. Fingerprint checks are more thorough and typically are national.
- Have an employee handbook and training materials.
- Don't allow doors to lock from the inside, and ensure a second person is present when a patient is vulnerable.

a set minimum score, then their information is not forwarded for an interview. "The screening tools help because they have measured fundamental personality traits that are needed to be successful in healthcare and a customer service environment," Lynch says.

All applicants for manager and professional positions must complete the California Psychological Inventory (CPI) test no. 434, Lynch says. *(For more information, go to http://bit.ly/23M2c1t.)*

If your state doesn't require background checks for new employees, and you want them, consider a fingerprint background check, Lynch advises. "Those are more thorough and, typically, national," he says.

A background check is essential, says **Paul B. Hofmann**, DrPH, FACHE, president of the Hofmann Healthcare Group in Moraga, CA, which consults on ethical issues in healthcare and specializes in performance improvement efforts. "It is absolutely inexplicable, unconscionable, and indefensible for a healthcare organization not to conduct a thorough and comprehensive due diligence of prospective employees, whether they be staff members or physicians, regardless of the role," Hofmann says. "Every patient must be protected and be assured that they are in a safe environment." *(For more tips from Hoffman, see "Alleged patient assaults by docs raise question: What would you do?"* Same-Day Surgery*, May 2011, at http://bit.ly/1Vjpsiv.)*

Stay up to date on what can be included in your background check, advises **Damian Capozzola**, Esq., founding attorney of the Law Offices of Damian D. Capozzola in Los Angeles. "It is obviously important to perform thorough background checks on the employees working in the hospital and surgery center, but as part of that process, the facility should coordinate closely and often with counsel to be sure that the facility is complying with ever-shifting rules about what can and what cannot be checked," Capozzola says. "These rules often vary by state and may require that the employee be provided with copies of the results, or at least have that opportunity, and may also limit the extent to which credit histories and/or criminal records, particularly expunged records, can be pursued."

The Joint Commission's standards address the processes around hiring employees, performing background checks, verifying licensure, and job-related training. The standards vary by setting and by job. Some standards also include requirements for the organized medical staff. The Accreditation Association for Ambulatory Health Care does not have any specific requirements for background checks or education related to violence in the workplace.

• Have an employee handbook, and train employees.

Consult with legal counsel who has experience in employment law and healthcare regarding your training, Capozzola suggests. "The applicable state law may have requirements for periodic training and documentation thereof, and even if a given state does not have such requirements, it is a good practice and helpful in defending against lawsuits to have a clear written policy regarding training frequency, and then implement training on that schedule and document the participation," he says.

Have an employee handbook, Capozzola says. "Having an employee handbook and other written training materials is critical, both substantively in terms of actually conveying the information you want the employees to absorb, and procedurally in terms of defending against lawsuits later, as it will be useful to have written evidence of what has been communicated to the employees."

Sources suggest that your legal representative or human resources staff member should periodically review the employee handbook to see if any material needs to be updated.

• Set up the facility to protect patients.

To protect patients, one simple step that you can take is to remove locking hardware that allows an individual to lock the door from the inside, Lynch advises.

Also, keep in mind that a patient can be assaulted by another patient, he says. If you have a patient coming in with a psychological and/or criminal history, you need to plan, Lynch says. Use a public access background check, such as Intelius (intelius.com), to see what you can find out about the patient, he says.

"You want to know who you're dealing with," Lynch says. "The patient may be given to violence."

Select the room where the procedure should take place and determine who should be present, he says. "Be proactive. Trust your instincts. Plan ahead," Lynch says.

• For vulnerable patients, have a second person present.

At St. Luke's, when a patient is under 18 years of age, the system requires someone who represents the child's interests to be present for an imaging procedure, Lynch says.

"These sorts of things can happen in imaging studies, because there's only one technician," he says.

If a patient is vulnerable on any level, "the best practice consideration is to have a witness present," Lynch says. He suggests that policy should be used for anesthetized patients as

well.

Taking steps to protect patients also protects you against false accusations, Lynch says. "Where there is no physical evidence, it is the complainant's word against the caregiver," he says. "Even if a caregiver is found not guilty or liable, it can be damaging to their reputation."

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Thousands of patients seek testing after healthcare worker charged with drug diversion

Healthcare facilities in at least four states alert patients

(This story originally ran in Hospital Employee Health*, also published by AHC Media. For more information on* Hospital Employee Health, *go to http://bit.ly/1TjuJTF.)*

In an all-too-familiar scenario, a healthcare worker charged with diverting drugs in Colorado had a history of moving from facility to facility, which has prompted several other facilities to advise thousands of patients to get tested for bloodborne pathogens.

According to a federal indictment, Rocky Allen, 28, a former surgical technologist at Swedish Medical Center in Englewood, CO, is charged with tampering with a consumer product and obtaining a controlled substance by deceit.[1] On Jan. 22, 2016, Allen took a syringe containing fentanyl citrate and replaced it with a similar syringe containing another substance, the indictment charges.

As a result, Swedish Medical Center has advised some 3,000 patients who had surgery between Aug. 17, 2015, and Jan. 22, 2016, to be tested for HIV, hepatitis B, and the hepatitis C virus (HCV). The charges set off patient notifications in several other states and facilities, some of which apparently had fired Allen for alleged drug diversion. These include two hospitals in Washington state and hospitals in Arizona and California, which brings the total of potentially exposed patients to more than 5,000. According to published reports, Allen pled not guilty, surrendered his passport, and is out on a $25,000 bail. A judge ordered him to stay at a halfway house and to obtain drug treatment.

Authorities have confirmed that the worker has a bloodborne infection, but they have not identified which one. Typically, these cases involve HCV, but patients also are being advised to be tested for HIV and hepatitis B. There are reports of two former Swedish surgical patients testing positive for hepatitis, but it was not immediately clear if they were infected during care or had pre-existing infections.

Lawsuit filed

On March 8, 2016, former patients at Swedish filed a class-action lawsuit charging that "despite Rocky Allen's well-documented drug addiction and erratic and … suspicious employment history, defendants hired him as a surgical technician."

The suit accuses the hospital and its corporate parent of negligence in hiring and failing to properly supervise Allen, failing to take steps to prevent employees from drug diversion, and subjecting patients to significant risk and anxiety by potentially exposing them to a life-threatening bloodborne pathogen. *(The lawsuit can be accessed online at bit.ly/22I7hr0.)*

EXECUTIVE SUMMARY

A healthcare worker charged with diverting drugs in Colorado had a history of moving from facility to facility, which has prompted several other facilities to advise thousands of patients to get tested for bloodborne pathogens.

- Patients at the facility where he last worked filed a class-action lawsuit.
- Those patients accuse the hospital and its corporate parent of negligence in hiring and failing to properly supervise the worker, failing to take steps to prevent employees from drug diversion, and subjecting patients to significant risk and anxiety.

The suit alleges that an employee at Swedish Medical observed Allen taking a syringe filled with fentanyl and replacing it with another syringe in an operating room. The employee told investigators that Allen walked into OR 5, spoke with other individuals, then went to the Pyxis station, picked up a syringe, and replaced it with another one before quickly leaving the room. Allen, who apparently was scheduled to be in OR 12 that day, later tested positive for fentanyl, the lawsuit alleges. *(For tips on how to prevent such an incident, see story in this issue.)*

According to the suit, Christy Berg, a special agent for the Food and Drug Administration, testified on Feb. 19, 2016, that Allen was terminated from numerous jobs for drug-related reasons. In 2011, Allen was court-martialed by the U.S. Navy and pled guilty to making a false official statement, wrongfully possessing approximately 30 vials of fentanyl, wrongly possessing a syringe containing fentanyl, stealing fentanyl, and stealing a syringe containing fentanyl, the lawsuit claims.

Other specific incidents cited in the lawsuit include that Allen was fired in June 2013 by Scripps Green Hospital in La Jolla, CA, after he was caught switching a fentanyl syringe with a saline-filled syringe. Scripps said in a statement that it notified the U.S. Drug Enforcement Agency after taking the action. However, Allen was able to move and find subsequent employment at John C. Lincoln North Mountain Hospital in Phoenix, where he was fired in September 2014 after testing positive for fentanyl, the lawsuit alleges.

The case is similar to one discovered in a New Hampshire hospital in 2012, when an HCV-infected traveling radiology technician was linked to a cluster of HCV patient infections. The subsequent investigation uncovered a large HCV outbreak spanning several years, involving more than a dozen hospitals, and affecting thousands of patients in eight states. The technician was stealing syringes filled with narcotics, self-injecting, refilling them with saline, and placing them back into the procedure area, officials reported. He was sentenced to 39 years in prison. *(For more on that case, see "39-year sentence given in HCV infection case,"* Same-Day Surgery, *February 2014, which can be viewed at http://bit.ly/1Wem9rO. For more cases, see CDC timeline in this issue.)*

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Look for weak links to prevent drug diversion

Kimberly New, RN, JD, founder of Diversion Specialists in Knoxville, TN, who frequently consults with healthcare facilities on drug diversion, cites the following common areas of weakness in diversion prevention programs:

- lack of internal controls over controlled substances stored in emergency kits for urgent needs;
- pain response documentation not regularly reviewed for patterns;
- inadequate segregation of duties;
- end user passwords not changed per hospital policy;
- end users not terminated from system after job/responsibility changes or termination;
- discharged patient list remaining available for hours after discharge;
- drug testing not done at pre-employment screening and drug testing not performed randomly for staff with drug access;
- staff with little or no training/competency on system (poor practices);
- built-in system controls "turned off" because they are too cumbersome.[1]

Signs of healthcare worker diversion/impairment include:

- tardiness, unscheduled absences, and an excessive number of sick days used;
- frequent disappearances from the work site and taking frequent or long trips to the bathroom or to the stockroom where drugs are kept;
- volunteers for overtime and is at work when not scheduled to be there;
- arrives at work early and stays late;
- pattern of removal of controlled substances near or at end of shift;
- work performance alternates between periods of high and low productivity;
- may suffer from mistakes, poor judgment, and bad decisions;
- interpersonal relations with colleagues, staff, and patients suffer, and rarely admits errors or accepts blame for errors or oversights (denial);
- insistence on personal administration of injected narcotics to patients;
- heavy or no "wastage" of drugs;
- pattern of holding waste until oncoming shift.

Surgery-related outbreaks from drug diversion

The Centers for Disease Control and Prevention (CDC) assisted state and local health departments in the investigation of the following infection outbreaks stemming from drug diversion activities that involved surgical healthcare providers who tampered with injectable drugs. (*For more information, visit 1.usa.gov/1RJhjjs.)*

• 1992: There were 45 cases of HCV infection associated with a surgical technician at a Texas ambulatory surgical center.

• 2004: There were 16 cases of HCV infection associated with a certified registered nurse anesthetist at a Texas hospital.

• 2009: There were 18 cases of HCV infection associated with a surgical technician at a Colorado hospital.

• 2016: A surgical tech charged with drug diversion in an Englewood, CO, hospital leads to testing of thousands of patients in several other states where he worked previously.

Prevention tips from the Centers for Disease Control and Prevention include:

• Prepare medications as close as possible to the time of administration.

• Properly label pre-drawn syringes to include patient name.

• Consider use of tamper-resistant and tamper-evident syringes and automated dispensing cabinets with security and tracking features.

• Conduct audits by pharmacy staff, with testing to verify the identity or concentration of unused drugs that are returned to the pharmacy or discarded by healthcare workers.[2]

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Healthcare facilities could face liability from recall of duodenoscope

Healthcare facilities and providers face potential liability related to the use of a scope that has been recalled and is the subject of lawsuits against the manufacturer.

Olympus Corp., manufacturer of about 85% of U.S. medical scopes, has announced a recall and redesign of its duodenoscope, which has been linked to deadly infections. The announcement came after a U.S. Senate committee report that found that the medical device manufacturer knew about a design flaw in the device for years without taking action.

Hospitals, surgery centers, and surgeons are unlikely to face strict liability related to the questionable scopes because they didn't sell the scope to the patient, but, rather, provided a service using the scope, says **Amy Alderfer**, JD, an attorney with the law firm of Cozen O'Connor in Los Angeles. However, there could be liability if plaintiffs allege that the facility or provider didn't follow the manufacturer's cleaning guidelines, she says.

Olympus updated its cleaning guidelines once concerns were raised about the scope, so a hospital or

EXECUTIVE SUMMARY

Healthcare providers could face liability related to the recall of an Olympus duodenoscope. Failure to properly clean the device or report adverse events could create liability exposure.

• Facilities are unlikely to be involved in strict liability claims. Failure to report scope-related infections creates liability.

• The manufacturer updated its cleaning guidelines after safety concerns.

• Two pieces of legislation were introduced after an investigation found gaps in a law contributed to superbug outbreaks due to duodenoscopes.

surgery center could be held liable for not following the updated procedures, Alderfer says. "There were very rigorous requirements for how the scope had to be cleaned," she says. "You want to see documentation that you were very strictly following those cleaning requirements so that you are not exposed to a negligence action by a plaintiff."

Another potential area of exposure involves adverse event reporting and patient notification. The Senate committee report noted a lack of adverse event reports and patient notifications from hospitals. The widow of a Seattle area man who died after contracting a drug-resistant infection at Virginia Mason Medical Center in Seattle is suing the hospital and Olympus, and part of the case hinges on allegations that the hospital did not tell his family that the infection came from an Olympus duodenoscope. Virginia Mason recently began notifying patients and family members who were part of an outbreak that infected 32 people between 2012 and 2014. *(For more information, see "New duodenoscope, recalls, and revised reprocessing instructions,"* Same-Day Surgery*, March 2016, at http://bit.ly/1roTlSv.)*

Facilities and providers that used the recalled scope should assess their liability exposure by determining how well they followed the updated cleaning guidelines, whether they reported adverse events, and whether they properly notified patients involved with any scope-related infections, Alderfer suggests.

"This also is an important learning opportunity, even if you determine that you have little or no exposure related to this particular recall," she says. "There are lessons here regarding the importance of following a manufacturer's infection control guidelines and also the liability that can arise when you fail to notify patients promptly. Even when the injury is the result more of the device than the service the hospital provided, neglecting patient notification is one of the most likely ways you will be involved in messy litigation."

SOURCE

- **Amy Alderfer,** JD, Attorney, Cozen O'Connor, Los Angeles. Email: aalderfer@cozen.com. ■

Bills aim to help prevent superbug outbreaks

Congressman **Ted W. Lieu** (D-CA) has introduced two pieces of legislation after a yearlong investigation that he requested by the House Committee on Oversight and Government Reform found significant gaps in existing law that contributed to a nationwide problem of superbug outbreaks due to tainted duodenoscopes.

The number of potentially deadly infections from contaminated medical scopes is far higher than what federal officials previously estimated, a new congressional investigation shows. As many as 350 patients at 41 medical facilities in the United States and worldwide were infected or exposed to tainted gastrointestinal scopes from Jan. 1, 2010, to Oct. 31, 2015, according to the Food and Drug Administration (FDA). *(For more information, see the* Los Angeles Times *story at http://bit.ly/1pkPvb5.)*

In 2015, at the UCLA Medical Center in Los Angeles, hundreds of patients were exposed to the antibiotic-resistant bacteria (or superbug) Carbapenem-resistant enterobacteriaceae (CRE), due to tainted duodenoscopes in a routine medical procedure, and the *Los Angeles Times* reported three patients died related to CRE-infected duodenoscopes. *(For more information on that topic, see the following story: "FDA says to inform patients about risk of endoscopy linked to CRE infections,"* Same-Day Surgery*, April 2015, at http://bit.ly/1VvCxBv.)*

Shortly afterward, another outbreak, also from CRE-tainted duodenoscopes, occurred at Los Angeles-based Cedars-Sinai Medical Center. These are two of several outbreaks that have occurred across the country. One of the causes of the outbreaks was the difficulty in cleaning the devices and a lack of scientifically verified reprocessing guidance, according to Lieu.

"Patients and hospitals deserve to know that the medical devices being used on patients can be properly cleaned and are designed effectively," said Lieu in a released statement. "Patients should not be worried that undergoing a routine medical procedure could lead to them becoming infected with a deadly superbug."

These two pieces of legislation are:

• **The DEVICE Act (Disclosure; and Encouragement of Verification, Innovation, Cleaning, and Efficiency).** This legislation requires device manufacturers to notify the FDA whenever they change the design or cleaning instructions of their devices. The bill also requires manufacturers to notify FDA whenever safety warnings are issued in foreign countries related to the design and cleaning of devices. Finally, the bill requires FDA to further regulate

tests of medical devices to determine whether bacteria are present.

• **The Preventing Superbugs and Protecting Patients Act.** This legislation requires that the reprocessing instructions for medical devices be scientifically validated. This step ensures that the cleaning instructions for medical devices work. This is the House companion bill to a Senate bill, which Sen. Patty Murray (D-WA) introduced. ■

SDS Manager

Top 10 pet peeves from *Same-Day Surgery* readers

By ***Stephen W. Earnhart****, MS*
CEO
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Austin, TX

A couple of months ago, I asked *Same-Day Surgery* readers to send me a list of their "pet peeves" after I listed mine. I received almost 100 emails from readers listing what irritates them the most. (Several of them listed me!)

I got quite a kick out of them, so I thought I would share those that can be printed.

• **From a nurse in Washington State at a not-for-profit hospital.** "I am just sick and tired of hearing some of our surgeons talk about how much money they are making in 'their' surgery center. It seems like they bring the most difficult, and probably the less profitable — but I can't prove that — cases to the hospital. I wish someone would let the surgeons know how demoralizing this can be to the staff at the hospital."

Response: We just did.

• **From a scrub tech from a hospital in Los Angeles.** "I moonlight at the local hospital from my position in a day surgery center that has all physician owners, and some of these surgeons do cases at the hospital where I work. I am just amazed at the difference in the supplies they use at the hospital! Lots of mesh for hernia cases, almost all endoscopic, and at a much higher cost over the incisional cases they do at the ASC. Robotic surgery for GYN procedures at the hospital, but not at their surgery center. Lots more expensive sutures used at the hospital versus ASC. It just makes me angry, because most of their patients are Medicare or Medicaid, and as a taxpayer, I am paying for this!"

Response: Me too! You didn't give me any detail on this, but often a patient is too ill to be done in an ASC, and it might be better that they do them in the hospital. Not giving excuses, but that situation is common.

• **From a surgeon who "no longer does cases at the local hospital."** "I find it irritating that no one at the hospital I used to do procedures in takes the time for focus on cost control like they do in the surgery center where I do almost all of my cases. If hospitals spent as much time trying to control their costs instead of bad mouthing the surgeons at the ASC I work in now, there probably wouldn't be as many surgery centers out there!"

Response: Good point. At our surgery centers, we put the price of each item on the surgeon preference cards. They are usually shocked at the costs of items and help us find alternatives.

• **From a receptionist at a surgery center in Connecticut.** "I worked at the [local hospital] for years before I came over here. This is not really a pet peeve, more like an observation, but it just seems like the patients are friendlier at the ASC than the hospital. Anyway, just thought I would pass that on."

Response: Nice.

• **From a VP at local hospital. No location given.** "Our area is full of surgery centers that are being bailed out (bought out) by the local hospitals. It seems like when the surgeons' pockets are full, and the effort is too much for them, they look to us to buy them out of their misery. Sadly, we do, and it shouldn't be right."

Response: Happens more than you might believe!

• **From a surgeon in California.** "We have been doing total joints (hips and knees) at our surgery center for years with great results and at a huge savings. Medicare, which make up about 40% of our patients, will not allow them to be performed in our ASC and must be in a hospital, even though it is so much more expensive. I wish the federal government would start listening to surgeons and realize this is a safe procedure that can be done at a much lower cost than in a hospital!"

Response: I think we are going to see total joints added to the Medicare list of procedures approved for an ASC shortly.

• **From a staff member. No affiliation listed.** "This place makes a lot of money. Be nice if they could at least buy us lunch once in a while!"

Response: Agreed!

• **From a staff member at a surgery center in Kansas.** "No more

cake for staff birthdays anymore. Cheap @#%&!"

Response: I want one too!

• **From a surgeon at an Arizona hospital.** "Room turnaround time average this month: 68 minutes! Don't they understand that I don't get paid for sitting around like they do?"

Response: Well, that's one of the reasons there are so many ASCs.

• **From a biller at a hospital in Texas.** "I don't know if this is what you were looking for, but I hate my stupid computer here at work! Thing crashes all the time, and when I retire next month, I am going to find a way to kill it!"

Response: Get a Mac!

Thanks to all of the *Samw-Day Surgery* readers who sent in their comments. I'm sorry I could not list them all. *[Earnhart & Associates is a consulting firm specializing in outpatient surgery development and management. Contact Earnhart & Associates' at 5114 Balcones Woods Drive, Suite 307-203, Austin, TX 78759. Telephone: (512) 297.7575. Email: searnhart@earnhart.com. Web: www.earnhart.com.]* ■

American College of Surgeons revises statement addressing concurrent surgeries

The American College of Surgeons (ACS) has revised its *Statement on Principles* on the responsibility of the primary surgeon during surgery with new language on concurrent, overlapping, and multidisciplinary operations.

Recent news reports had raised questions about surgeons initiating a second surgery before the first surgery was finished, the American Hospital Association (AHA) said. These reports led to a discussion of why surgeons might leave an operating room during a surgery and the actions that are needed to inform the patient and ensure patient safety, according to the AHA.

ACS states: "The primary attending surgeon is personally responsible for the patient's welfare throughout the operation. In general, the patient's primary attending surgeon should be in the operating suite or be immediately available for the entire surgical procedure. There are instances consistent with good patient care that are valid exceptions. However, when the primary attending surgeon is not present or immediately available, another attending surgeon should be assigned as being immediately available."

The ACS also says, "A primary attending surgeon's involvement in concurrent or simultaneous surgeries on two different patients in two different rooms is not appropriate." *(To see the revised statement, go to http://bit.ly/1Mwqq8a. For more information on this topic, see "Are concurrent surgeries a good tool to save time and money? Experts express caution,"* Same-Day Surgery, *February 2016, at http://bit.ly/1V7wHsB.)* ■

Seizure drug gabapentin lowers PONV risk

The anticonvulsant medication gabapentin, which already is a useful part of strategies to control pain after surgery, also effectively reduces the common complication of postoperative nausea and vomiting (PONV), reports a study in *Anesthesia & Analgesia.*

"The results support the inclusion of preoperative gabapentin as part of the approach to prevention of PONV," write **Michael C. Grant**, MD, a clinical fellow in the Department of Anesthesiology, and colleagues of The Johns Hopkins Medical Institutions, Baltimore. But they highlight the need for further research, including studies to determine exactly how gabapentin works to prevent nausea and vomiting.

The researchers analyzed pooled data (meta-analysis) from previous randomized trials of gabapentin that provided information on nausea and vomiting outcomes. Most of the 44 studies, which included nearly 3,500 patients, focused on gabapentin's effects on pain and related outcomes. In these studies, nausea and vomiting were evaluated as secondary outcomes, along with side effects.

Grant and colleagues also performed a separate analysis of data from eight studies, which included 838 patients, assessing nausea and vomiting as the main outcome of interest. This analysis addressed a weakness of previous analyses including all data on nausea and vomiting from gabapentin studies.

Meta-analysis of these primary

outcome studies showed reduced rates of nausea and vomiting for patients receiving gabapentin before surgery. The overall risk of nausea and vomiting within 24 hours was about 60% lower with gabapentin, compared to inactive placebo (or other treatments). The individual risks of nausea and vomiting were reduced by about 66% each.

The effects were similar to the results of meta-analysis of all studies, whether nausea and vomiting was evaluated as a primary or secondary outcome. The benefits of gabapentin also were similar on analysis of different subgroups, including patients considered at high risk of nausea and vomiting. Gabapentin also reduced the need for other antiemetic drugs.

There was evidence of a possible side effect of gabapentin, with a 20% increase in the risk of excessive sedation or sleepiness after surgery. It was unclear whether this side effect led to adverse outcomes, such as prolonged time in the postanesthesia care unit after surgery.

The new analysis, including the largest group of studies to date, suggests that gabapentin has a "significant role ... not only for alleviating postoperative pain, but also for preventing PONV," the authors say. ■

Sponge counting system backed with guarantee plus $5 million indemnity protection

Stryker Corp. in Kalamazoo, MI, has announced a risk-sharing program that protects investment in the company's SurgiCount Safety-Sponge System with up to $5 million in product-liability indemnification and a rebate of the cost of implementing SurgiCount.

Retained surgical items continue to be the No. 1 reported surgical "never event," and 69% of all retained surgical items are sponges, according to Stryker. An estimated 11 incidents of retained surgical sponges are reported every day in the United States, with an average annual cost of $2.4 billion to the healthcare system, the company says.

Several organizations, including The Joint Commission, the Association of periOperative Registered Nurses, and the American College of Surgeons, recommend the use of adjunct technology to supplement manual sponge counting to reduce the risk of retained sponges. The SurgiCounter is a scanning device that provides a real-time count in the OR. The SurgiCount Safety-Sponge System uses barcoding. The SurgiCounter displays the number of each type of Safety-Sponge that has been counted in, the number that has been counted out, and the remaining sponges to be accounted for.

Compared with the estimated $600,000 in malpractice risk associated with a retained surgical instrument, which contributes $94.50 to the cost of each surgery in the United States, SurgiCount costs $8 to $10 per procedure to implement, Stryker says.

Through the SurgiCount Promise, if a patient experiences a retained sponge during a surgery in which SurgiCount was used as directed, SurgiCount will pay up to $5 million in legal costs for the provider and refund the participating hospital's incremental cost of implementing SurgiCount over its previous sponge spending for up to three years.

Nearly 170 million SurgiCount Safety Sponges have been used in more than 9 million procedures over the past five years, and Stryker says the system has never failed to identify a retained sponge. *(For more information, see the story "Advice on resolving count discrepancies in the OR,"* Same-Day Surgery*, April 2016, at bit.ly/1PrXbxJ.)* ■

COMING IN FUTURE MONTHS

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- Should you operate on patients who smoke?
- Popular new laparoscopy procedure
- Avoid denials for claims with no authorization

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Impact of patient age, ASA status on OR decisions

In a recently published study, decision tables allowed OR managers at one hospital to schedule procedures more accurately, according to the study's authors.

Using variables such as patient age and American Society of Anesthesiologists (ASA) physical status can help to better predict turnaround times, and this information can be used for scheduling, the authors wrote. Examples include overlapping induction rooms, to optimize allocating patients to several ORs, which reduces overutilized OR time. They said this information can improve the logistics of listing priorities for transporting patients with advanced age/high ASA physical status to the OR.

The authors wrote that turnaround times are particularly difficult to estimate when dealing with elderly, high-risk patients. The role that patient age and ASA physical status plays in OR management decisions hasn't been clear, they said.

"We hypothesized that evaluating patient age and ASA physical status in the right model would improve accuracy of turnaround time estimates and, thus, would have decisive implications for OR management," the authors wrote.

The authors examined 13,632 OR procedures and modeled turnaround times with respect to variables including surgical list, ASA status, length of the procedure, and length of the preceeding procedure. They developed decision tables for OR management that consisted of 50th and 95th percentiles of estimates of turnaround time that were depending on age and ASA status. "In addition, we applied linear and generalized linear multivariate models to predict turnaround times," they wrote. "The forecasting power of the models was assessed in view of single cases but also in view of critical managerial key figures (50th and 95th percentile turnaround times)."

Using the best models, they achieved an increase in predictive accuracy of 7.7% for all lists, relative to medians of turnaround times that were independent of age/ASA status.

"We constructed a management decision table to estimate age/ASA-dependent turnaround time for OR scheduling at our hospital," the authors wrote. The study is in the April issue of *Anesthesia & Analgesia.* The abstract can be accessed by going to http://bit.ly/26hfXnq. ■

WHO beats CDC handrub method for less bacteria

A recent study of two techniques for hand hygiene using an alcohol-based handrub found that the six-step method by the World Health Organization (WHO) is superior to the three-step method by the Centers for Disease Control and Prevention (CDC).

The study was conducted at an acute care teaching hospital in Glasgow, United Kingdom. The study included 42 doctors and 78 nurses.

Perioperative RNs should consider using the WHO process, says **Amber Wood**, MSN, RN, CNOR, CIC, senior perioperative practice specialist at the Association of periOperative Registered Nurses. "This randomized controlled trial is the first study to compare the two methods, showing that the WHO process is more effective at reducing bacterial counts on the hands," Wood wrote in a statement for *Same-Day Surgery.* "Reduction in bacteria on the hands could equate to reducing the risk of the patient developing a surgical site infection."

Why the WHO method was more effective in the study isn't certain. "There is a possibility that the six-step WHO method is more effective due to longer application times (42.5 vs 35 seconds), and the researchers discussed that compliance with all six steps (65%) is lower than for the CDC method (100%), both of which should be taken into consideration if making a practice change," Wood wrote.

The results were published by *Infection Control & Hospital Epidemiology*. *(To read the abstract, go to http://bit.ly/1SHCJxN.)* ■

CE/CME OBJECTIVES

After reading *Same-Day Surgery,* the participant will be able to:

- identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care;
- identify how current issues in ambulatory surgery affect clinical and management practices;
- incorporate practical solutions to ambulatory surgery issues and concerns into daily practices.

SAME-DAY SURGERY

CE/CME INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

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CE/CME QUESTIONS

1. **According to Alan C. Lynch, CHPA-L, CHSP, HEM, network director of safety and security at St. Luke's University Health Network, why are fingerprint background checks advised?**

   A. Because of identity theft.
   B. Because a false Social Security number may be submitted.
   C. Because they are more thorough and, typically, national.

2. **Which of the following are signs of healthcare worker diversion/impairment?**

   A. Volunteers for overtime and is at work when not scheduled to be there
   B. Arrives at work early and stays late
   C. Insistence on personal administration of injected narcotics to patients
   D. All of the above

3. **Which of the following is true of the recall of the Olympus Corp. duodenoscope, according to Amy Alderfer, JD, an attorney with the law firm of Cozen O'Connor in Los Angeles?**

   A. Hospitals, surgery centers, and surgeons are unlikely to face strict liability related to the questionable scopes.
   B. There could be liability if plaintiffs allege that the facility or provider didn't follow the manufacturer's cleaning guidelines.
   C. A and B
   D. Neither A nor B

4. **What does the American College of Surgeons' revised *Statement on Principles* say regarding the responsibility of the primary surgeon during surgery?**

   A. When the primary attending surgeon is not present or immediately available, another attending surgeon should be assigned as being immediately available.
   B. A primary attending surgeon's involvement in concurrent or simultaneous surgeries on different patients in different rooms is not appropriate.
   C. A and B
   D. Neither A nor B