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INSIDE

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When the healer needs help — SDS setting is ripe for addiction

Anesthetists particularly are at risk for drug dependence

(Editor's note: In this first part of a two-part series on addictions among health care professionals, we explore why same-day surgery professionals are particularly at risk and give you three suggestions for addressing the issue. We provide a warning list of signs of addiction and give you a list of additional resources. We also share one nurse's nightmare when she had one incident of misusing a drug. In next month's issue, we'll examine why anesthetists are more at risk, tell you signs that an anesthetist is addicted, and discuss return-to-work issues.)

Susan graduated in the top third of her class at nursing school. She was committed to her career in outpatient surgery and loved being a nurse. Along the way, she sacrificed her own personal health by working long hours, taking extra shifts without a break, and rarely asking for a day off. As the number of surgery cases increased, she tried to maintain perfectionism. She began using drugs to keep her going until

Same-Day Surgery launches web site!

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EXECUTIVE SUMMARY

Professionals in outpatient surgery are particularly at risk for alcohol and drug addiction due to the high volume and quick turnover of cases.

- You may be liable if you are aware of a dependence problem among your staff or physicians and you don't act.
- Designate a person to be available to address this issue. The goal is treatment, not punishment.
- Have a strict accountability system for drugs that aren't used. Consider a hand-held device that performs on-site chemical analyses.

the end of the day. As she became addicted, her life began to spiral downward. She never meant for her situation to get this bad, but she had been caught stealing drugs from her employer. She couldn't face anyone, not even members of a recovery group.

Reluctantly, she joined a group of five other health care professionals who had gone through similar experiences. She learned that her addiction was a disease and that she needed to get well. Susan completed her recovery and successfully returned to work.

The average person doesn't hear about the success stories such as this one, says **Nancy Kehiayan**, RN, MS, CS, director of the Colorado Nurse Health Program in Lakewood.

"The only people we hear about are people like Robert W. Downey Jr., who's famous," says Kehiayan, referring to the actor who, after a series of drug troubles and criminal run-ins, recently was sentenced to spend a year in a live-in drug rehabilitation program.

Kehiayan's program was developed by the state board of nursing as an alternative to the board's disciplinary process. It provides nurses with opportunities and support for recovery and treatment. The program has graduated 73 nurses. A large percentage of them are still practicing "and taking care of hundreds and hundreds of patients," Kehiayan says.

In general, about 85% of health care professionals avoid relapses after receiving treatment, says **Eric B. Hedberg**, MD, associate medical director of the Talbott Recovery Campus in Atlanta, which specializes in chemical dependency treatment of medical professionals. "The 15% that do relapse generally have other psychiatric diagnoses or other circumstances that play into the relapse," Hedberg says.

People who work in outpatient surgery particularly are at risk for addictions, says **Diana Quinlan**, CRNA, MA, chairwoman of the Peer Assistance Advisors Committee at the American Association of Nurse Anesthetists in Park Ridge, IL. **(See warning signs to look for, p. 112.)** One reason is the high volume of cases, Quinlan says. "Every time you set up drugs for another case, you increase risk," she says. "When you're doing 10 cases a day and have rapid turnover, things can get a little slipshod as far as narcotic accountability."

In fact, surgery centers have gained a reputation as sorely lacking in accountability for unused narcotics, Quinlan says. "Sometimes I hear the story that no one counts [unused] drugs for weeks at a time," she says.

Your word against someone else's

The lack of accountability puts every professional in the facility at risk because anyone can appear to be the offender when drugs are misused, Quinlan says. "It can be my word against someone else's word," she says. "I want something more concrete than that to protect me as a provider."

Also, surgery centers often don't have resources for "fancy" systems for narcotic accountability, Quinlan says. "That's makes them vulnerable," she says.

The stress of being pushed to handle a large volume of cases, coupled with rapid turnover, can create an environment that makes it easier for professionals to start using narcotics, Quinlan says. "Life is stressful, you get pushed to the limit, and you never know what you'll do," she says. **(See one nurse's nightmare, p. 113.)**

Anesthetists, in particular, are overrepresented among health care professionals with addictions, according to Quinlan and others. In fact, "The greatest occupational hazard facing the CRNA

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[certified registered nursing anesthetist] is not hepatitis B, nor HIV, but rather substance abuse," Quinlan maintains.[1]

Hedberg agrees that anesthetists are most at risk. "For ORs and surgicenters, the population that's going to have the largest incidence of substance abuse is anesthesia," he says.

According to the Epidemiologic Catchment Area program of the Bethesda, MD-based National Institute of Mental Health, the lifetime prevalence of substance-use disorders among adults in the United States is 16.4%, Hedberg says. "So you have to assume that at least as many health care professionals will have substance-abuse problems, and it may be higher among health care professionals due to availability," he says.

Consider the following suggestions for addressing drug and alcohol addiction in your program:

• **Be familiar with legal issues.** Know your state's requirements regarding chemical dependence among health care professionals, advises the Park Ridge, IL-based American Society of Anesthesiologists (ASA) in a brochure titled *Chemical Dependence in Anesthesiologists: What You Need to Know When You Need to Know It*. **(For information on how to access the brochure, see resource box, below.)**

"Hospitals, medical staffs, and individual physicians have occasionally been found negligent for failure to monitor or restrict the privileges of an impaired physician," the association warns. "Therefore, to be aware of and yet to ignore chemical dependence may result in legal liability."

Most states provide immunity to members of a professional society or medical staff committee whose purpose is to review the quality of medical

RESOURCES

For more information on hand-held devices that perform chemical analyses, contact:

- **Misco**, 3401 Virginia Road, Cleveland, OH 44122. Telephone: (800) 358-1100 or (216) 831-1000. Fax: (216) 831-1195. E-mail: sales@misco.com. Web: www.misco.com.

Every state medical society has a program for the identification and management of chemically dependent physicians. Most of these will provide assistance with confidential investigation, intervention, treatment referral, and aftercare monitoring, and will advocate for the recovering physician with the state board of medicine.

The telephone number for the American Society of Anesthesiologists' (ASA) Hotline on Chemical Dependence is (847) 825-5586. With strict confidentiality, personnel will provide callers with the appropriate telephone numbers for their locality and, if possible, will offer the name of a confidential consultant who can provide additional information and resources.

A brochure titled *Chemical Dependence in Anesthesiologists: What You Need to Know When You Need to Know It* is available on the web: www.ASAhq.org/ProfInfo/chemical.html. The brochure is also available in printed form for $2 per copy. Also, providers can contact the ASA to be provided with appropriate treatment telephone numbers for their locality and, if possible, the name of a confidential consultant who can provide additional information and resources. Contact:

- **American Society of Anesthesiologists**, 520 N. Northwest Highway, Park Ridge, IL 60068. Telephone: (847) 825-5586.

For help addressing addiction among health care professionals, contact:

- **Pat Green**, Secretary/Treasurer, International Nurses Anonymous (INA), 1020 Sunset Drive, Lawrence, KS 66044. Telephone: (785) 842-3893. E-mail: Patlgreen@aol.com. INA is a network of nurses in recovery. Membership is open to any nurses (student or former nurses included) who consider themselves members of a 12-step group. It offers a geographic listing of nurses who have given permission for their names to be distributed to other recovering nurses. Confidentiality is assured.
- **Rusty Ratliff**, Anesthetists in Recovery (AIR), 2205 22nd Ave. S., Minneapolis, MN 55404. Telephone: (612) 724-8238. E-mail: rusty4air@aol.com. AIR is a national support organization of certified registered nursing anesthetists recovering from chemical dependency and offers education and peer assistance.
- **American Association of Nurse Anesthetists** (AANA), 222 S. Prospect Ave., Park Ridge, IL 60068-4001. Peer Assistance Hotline: (800) 654-5167. Web: www.aana.com/peer. The AANA's Peer Assistance Advisors Committee assists individuals and organizations in formulating guidelines for intervention, treatment, aftercare, and re-entry into the workplace. For a free informational packet (item 1052) on peer assistance, e-mail: bookstore@aana.com or call (847) 692-7050, ext. 3009. The web site (www.aana.com/peer/directory. asp) has a peer resource directory by state. A free copy can be obtained by contacting Susan Burger by mail at the address above, by e-mail at sburger@aana.com, or by fax at (847) 692-6968.

What Are the Warning Signs of Chemical Dependency?

Listed below are some signs and symptoms that may indicate a nurse is experiencing problems with drugs or alcohol and needs to be referred for help.

Job Performance

- ❒ Inconsistent work quality, alternate periods of high and low efficiency
- ❒ Increased difficulty meeting deadlines
- ❒ Unrealistic excuses for decrease in work quality
- ❒ Job shrinkage, doing the minimum work necessary for the job
- ❒ Sloppy or illogical charting
- ❒ An excessive number of mistakes or errors of judgment in patient care
- ❒ Long breaks or lunch hours
- ❒ Frequent or unexplained disappearances during the shift
- ❒ Lateness for work and/or returning from lunch
- ❒ Volunteering to work overtime despite difficulty showing up for scheduled shifts
- ❒ Excessive use of sick time, especially following days off
- ❒ Absences without notice or last-minute requests for time off
- ❒ Repeated absences due to vaguely defined illnesses

Behavior, Attitude, Mood, and Mental Status

- ❒ Wide mood swings from isolation to irritability and outbursts
- ❒ Difficulty in concentration
- ❒ Marked nervousness on the job
- ❒ Decrease in problem-solving ability
- ❒ Diminished alertness, confusion, frequent memory lapses
- ❒ Difficulty in determining or setting priorities
- ❒ Isolation from others, eats alone, avoids informal staff get-togethers, or requests transfer to the night shift
- ❒ Unwillingness to cooperate with co-workers or inability to compromise
- ❒ Avoided contact with supervisor
- ❒ Overreaction to real or imagined criticism
- ❒ On the unit when not on duty

Medication-Centered Problems

- ❒ Consistently volunteering to be the medication nurse
- ❒ Offering to hold narcotic keys during report
- ❒ Volunteering to work with patients who receive regular or large amounts of pain medication
- ❒ Frequently found around medication room or cart
- ❒ Insists on administering drugs via intramuscular when other nurses give it by mouth to same patient
- ❒ Patient charting reflects excessive use of as-needed pain medication compared to shifts when other nurses are assigned to the same patient
- ❒ Patients complaining of little or no relief from pain medications when nurse is assigned to patient
- ❒ Use of two smaller tablets of medication to give prescribed dose (two 30 mg codeine tablets instead of one 60 mg tablet)
- ❒ Use of larger than necessary dose, wasting the rest (100 mg Demerol when patient is to receive only 50 mg)
- ❒ Missing drugs or unaccounted doses
- ❒ Frequently reporting spills, wastage, or breakage of medications
- ❒ Charting errors include medication errors
- ❒ Defensive when questioned about medication errors

[For further information or assistance, call the Colorado Nurse Health Program at (877) 716-0212 or (303) 716-0212, or the program's Western Slope office at (970) 261-5770.]

Source: Colorado Nurse Health Program, Lakewood. Adapted from Hughes TL, Smith LL. Is your colleague chemically dependent? *Am J Nurs* 1994; 94:31-35; and Catanzarite A. *Managing the Chemically Dependent Nurse: A Guide to Identification, Intervention, and Retention.* Chicago: AHA Books; 1992.

services, the ASA says. "Persons who give information to such committees are also usually granted immunity, providing they believe the information is true; they are not reporting it with malice; and they discuss it only with the committee," the association says.

• **Designate an individual to deal with addiction concerns.** Have a designated person in your program that an individual can go to and expect care and concern, not punitive action, urges **William P. Arnold III**, MD, associate professor of anesthesiology at the University of Virginia Health System in Charlottesville and former chair of the ASA's Task Force on Chemical Dependence.

What's the proper response? Show "tough love," Arnold says, "which might imply saying, 'You're not going to be working for a while, and we'll refer you for evaluation and treatment if indicated.'"

Initially, professionals typically are worried

about the impact on their careers, Arnold says. "I have a couple of responses," he says. "One is that, 'Your career is already in jeopardy.' The second is that, 'trying to predict the future is not the right thing to do at the time. Initially, it's one day at a time.'"

Human resource staff and employee assistance program staff can be helpful, Kehiayan suggests. "It's very hard for managers to get involved in psychiatric and chemical dependency," she says. The important step is to make a referral and ensure the professional gets treatment, Kehiayan says.

• **Have a better accounting system for wasted drugs.** The standard practice in health care facilities is for the wasting of drugs to be observed by another person, Kehiayan says. However, "nurses are very busy and trust each other," she says. "They think, 'OK. I'll sign for that,' but they don't always observe."

If you're not accounting for every drug, you're not doing your best for your patients or employees, Quinlan maintains. She contends that no drug should be "wasted."

"If it's not all administered, it should be returned to a responsible individual to dispose of it properly," she advises. "Having a nurse watch you as you dump a clear liquid substance in a trash can, and you say it's fentanyl, and the nurse signs off, is ridiculous. We don't know it's fentanyl."

Misco in Cleveland offers hand-held products that perform quick chemical analysis on site. **(For contact information, see resource box, p. 111.)** These devices, which cost approximately $300, perform quick chemical analyses. You can perform random tests as part of your quality assurance process, Quinlan suggests.

Your staff may see this as another layer of "red tape" that slows down their day and makes it more difficult, she warns. "But another level of accountability is another level of protection," Quinlan advises.

SOURCES

For more information on impaired health care professionals, contact:

- **William P. Arnold III**, MD, Associate Professor of Anesthesiology, University of Virginia Health System, P.O. Box 800710, Charlottesville, VA 22908-0710. Telephone: (434) 924-2283. E-mail: wpa@virginia.edu.
- **Nancy Kehiayan**, RN, MS, CS, Director, Colorado Nurse Health Program, 44 Union Blvd., Suite 630, Lakewood, CO 80228. Telephone: (303) 716-0212, ext. 103. Fax: (303) 716-0789. E-mail: nkehiayan@cnhp.com.

Reference

1. Quinlan D. Peer assistance: A historical perspective. *AANA NewsBulletin* 1996; 50:14-15. ■

Misuse of drugs: One nurse's nightmare

A health professional's misuse of drugs or alcohol can be a nightmare for the provider, the facility, and even the community. One anesthetist's story is a testimony:

A certified registered nurse anesthetist (CRNA) had been one of two anesthesia providers at a small community hospital for 30 years. Her anesthetic partner contracted cancer and had to leave his job, so she handled the practice by herself for two years without asking for a vacation or an extra day off. In the meantime, her husband became disabled and required $10,000 for his monthly treatment. He was dependent on her health insurance for his treatment. Also during a two-year period in which these events occurred, her father died.

One day at work, when the end of the shift was long away, she developed a migraine headache. Although she had never misused drugs, she self-administered 25 mg of Demerol subcutaneously. Afterward, she was anguished that she had misused the drug, so she reported herself to her supervisor. Her supervisor's response was that she was required to report her to the state board of nursing.

'The first major mistake'

"That was the first major mistake," says **Diana Quinlan**, CRNA, MA, chairwoman of the Peer Assistance Advisors Committee at the American Association of Nurse Anesthetists, Park Ridge, IL. "If someone comes to you for help, then you help him or her," she says.

If your state doesn't have a program for impaired nurses, call the state medical society's peer assistance program for advice, suggests **Eric B. Hedberg**, MD, associate medical director of the Talbott Recovery Campus in Atlanta, which

specializes in chemical dependency treatment of medical professionals.

In the case of the CRNA who had misused drugs once, the sheriff took her away in handcuffs within 24 hours and charged her with diverting narcotics in the workplace. The CRNA's name appeared on the front page of her newspaper; she was fired from her job; she lost her license; and she faces the possibility of five years in prison and a $5,000 fine.

She and her husband have had to declare bankruptcy. They lost their home of 30 years, although they had not previously missed a mortgage payment. The CRNA is currently working three minimum-wage jobs in an attempt to keep her health insurance to pay for her husband's treatment.

"Now tell me where the justice was in all of that," Quinlan says. "This was nursing's response to a nurse in need."

The CRNA lived in a state in which the board of nursing doesn't understand that addiction and misuse of substances is a professional hazard, she says. Instead, its response was to be maximally punitive, says Quinlan, who declined a request to identify the state.

"[The board] thought [it was] doing the right thing to protect public by disciplining the nurse, but [it] disabled a community and destroyed a nurse and her life," she says. "All of this was for want of someone who knew what to do appropriately and a mechanism in place in that state to help a nurse who asked for help."

Discrepancy between doctors and nurses

Physicians in that state are escorted to treatment and allowed to re-enter the workplace, Quinlan points out. State medical societies have physician health programs that refer addicted physicians to approved treatment facilities. In comparison, only 34 states have diversion programs for nurses, and some of those programs are more disciplinary than helpful, she says.

If you are a nurse, be familiar with the law in your state, she advises. "If nurses ask for help because [they have] abused a substance, depending on the state [in which they work], they are helped to treatment and re-entry into the workplace, or they are sent to jail," Quinlan says. It's purely a geographical determination, she adds.

When there's no alternative to a discipline process with a state's board of nursing, all nurses in that state are at risk, Quinlan adds. "Anyone of us, at any time, can become addicted," she says. ■

Same-Day Surgery Manager

Plotting your course to management success

By **Stephen W. Earnhart**, MS
President and CEO
Earnhart & Associates
Dallas

I have a saying that I share with all of my facilities: "If you are 'making your numbers' each month, you can do anything. If you are not, then you can do nothing."

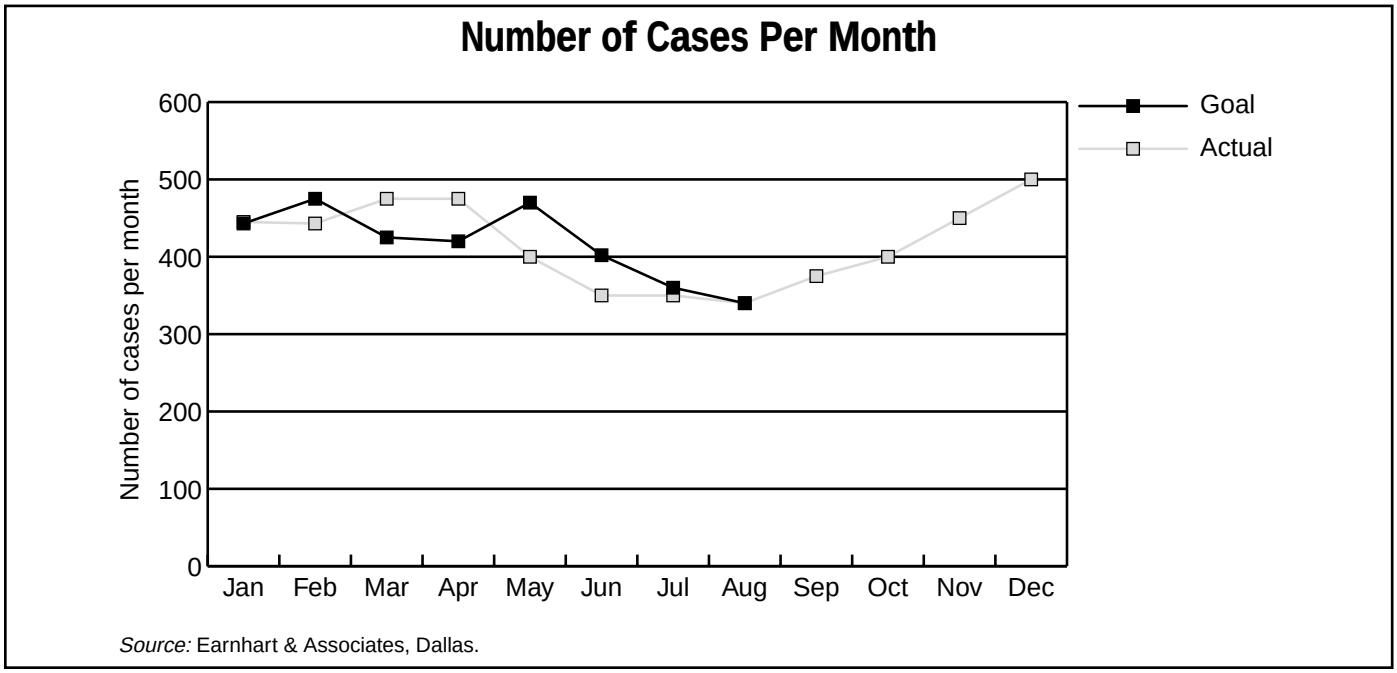
What do I mean by making your numbers? We all have a job to do in our chosen career, and we all have a yardstick by which we are measured. If you don't know what that yardstick measurement is, then I am very sympathetic. How difficult it must be to get up everyday and perform a task and never be quite sure if you are doing what is expected of you. One thing I don't like about owning my own business is that I don't have a "boss" to tell me what to do each month.

I think having parameters and benchmarks set for us goes back to childhood. "Make your bed, eat your breakfast, do your homework, be home by 10 p.m., etc." Those are guideposts — boundaries. As children, there was great comfort in knowing that we did what was expected of us.

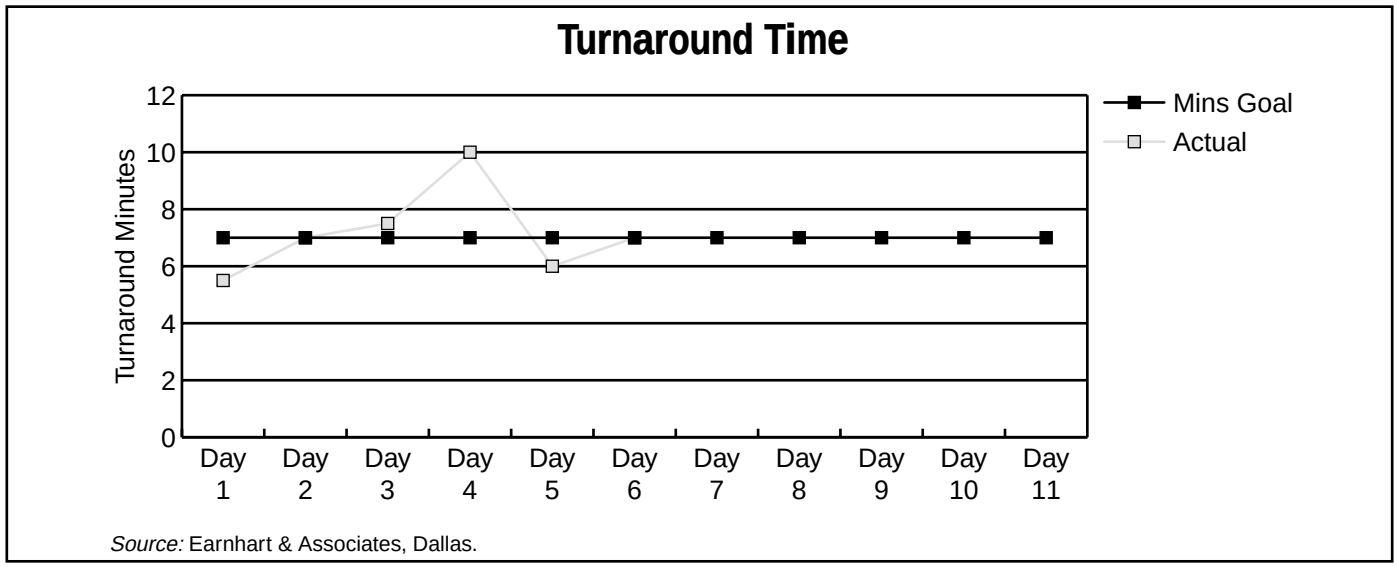
So if they worked then, why can't they work in our facilities? Actually, they can. Ask your boss, "What am I expected to accomplish today?" Chances are, you'll confuse them. If they are confused, then you'll be even more insecure.

Sure, we all have a job description. (I am able to make mine up and change it on a whim.) That job description kind of helps, but you probably looked at it during the interview, thought, "Yeah. Not a problem," and have never seen it again. And, yes, patient safety and quality of care is still job 1, but what is the goal of your role in your facility?

Here is a little insight into a workaholic's brain: In MS Outlook — a computer software scheduling program — I have a "Task List." My tasks for the day may be as short as 20 items or as long as 75. The nights I sleep best are those when every task has a "complete" check next to it. That day, I have



Source: Earnhart & Associates, Dallas.



Source: Earnhart & Associates, Dallas.

met all my goals. We need to set up the same type of checklist for our centers. We cannot always measure every success target on a daily or weekly basis, but we can monthly. Every center has a target of items it must hit every month or number of cases, turnaround time, supply cost, personnel cost, revenue, start time, etc. Every center needs to measure and post those goals — ideally on a daily basis, and on a monthly basis at the least.

For example, post a chart of the number of cases you are scheduled to do each month to meet your budget or projections. **(See chart at top of page.)** Plot your turnaround time for that day's cases on a chart in the lounge. **(See chart above.)** It will give you a great sense of satisfaction and goal to reach for — to say nothing of how it will impress your surgeons to see your really do care.

The purpose is to set/identify to all staff their goals and help them reach them by identifying where they are in that endeavor. If your administrator doesn't post these, then do it yourself on a piece of paper and post it in your locker.

Every facility and department should have a "Goals Bulletin Board." Post these graphs and plot points not only for yourself but also for the staff. I know of administrators and office managers who say, "I don't need that. It's all up here," (pointing to their heads). Well, that might be good for you, but not your staff. Show them that you are concerned, and maybe they will be as well.

[Editor's note: Earnhart and Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Earnhart can be reached at 5905 Tree Shadow Place, Suite 1200, Dallas, TX 75252. E-mail: searnhart @earnhart.com. Web: www.earnhart.com.] ■

Low infection rate? Don't let your guard down

Aseptic techniques, antibiotics protect patients

(Editor's note: In this first part of a two-part series on infection control, we discuss how to control infections in the same-day surgery setting. In next month's issue, we'll discuss the importance of good preparation of the surgical site, we'll tell you how to do informal education on a continuing basis, and we'll tell you about a facility that achieves a 75% return rate on its physician surveys.)

EXECUTIVE SUMMARY

Controlling surgical site infections becomes more important as more complicated procedures move into the same-day surgery operating room.

- Follow standard aseptic techniques such as gloves, gowns, masks, and drapes.
- Use prophylactic antibiotics for higher-risk procedures such as cholecystectomies and herniorrhaphies.

It makes sense that the types of procedures performed in same-day surgery programs carry a lower risk of surgical site infections. Although the procedures generally are less complicated and require smaller incisions than inpatient surgical procedures, the lower risk of infection does not mean that same-day surgery staff can pay less attention to aseptic techniques, emphasize experts interviewed by *Same-Day Surgery*.

"We can be too lax in the outpatient setting," says **Gordon Laing Telford**, MD, FACS, professor of surgery at the Medical College of Wisconsin in Milwaukee. "Although there is a lower risk of surgical site infection, we should still be concerned about the risk that does exist."

A 10-year surveillance study of nosocomial infections conducted by the Centers for Disease Control and Prevention in Atlanta found that surgical wound infections dropped by 60% between 1990 and 1999. *(To see results of the study, go to http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4908a1.htm.)*

"I'm not surprised at the decrease reported in the study," says **Ellen O'Connor-Graham**, RN, CNOR, chairman of the Ambulatory Surgery Specialty Assembly of the Association of periOperative Registered Nurses in Denver and a surgical nurse in the women's operating room at Huntsville (AL) Hospital. "Because nosocomial infections are caused by airborne bacteria, the simple, proper use of a mask in the operating room has a great effect on the rate of that type of infection," she says. Following normal, aseptic procedures such as gloves, masks, hand washing, and draping are all important to preventing infections, O'Connor-Graham says.

"Many same-day surgery infections are the result of breaks in sterile technique such as a punctured glove or a dropped instrument that is flashed without being totally clean," she says.

A common cause of surgical site infections for same-day surgical procedures is skin bacteria, so site preparation is important, says **Farrin A. Manian**, MD, MPH, chief of infectious disease division at St. John's Mercy Medical Center in St. Louis.

Evaluate the type of surgery to determine if prophylactic antibiotics are needed, Telford advises. "Most same-day surgery procedures are not as high risk for infection as colon surgery in the traditional operating room, but if you are performing a laparoscopic cholecystectomy, antibiotics are a good idea," he says. Other procedures that warrant prophylactic antibiotics include hernia repair and hemorrhoidectomy because of the area in which the surgeon is working, he adds.

There is a debate among surgeons as to the need for antibiotics, but Telford suggests that surgeons follow the standard of care for their community. Even if antibiotics are used, surgeons need to administer the antibiotics properly to achieve the best result, warns Telford. "The biggest mistake made with prophylactic antibiotics is giving the medication too soon," he says.

The antibiotic should be given no more than 20-30 minutes prior to the incision to guarantee the best protection, he explains. "If the procedure is lengthy, a second dose should be given before the patient leaves the operating room," he adds.

Know and discuss your infection rates

Educating staff and monitoring infection rates are two other important aspects of protection against surgical site infections, says O'Connor-Graham. Education should be more than formal classroom teaching, she says. Informal education and reminders should continue in the operating room, she explains.

A good monitoring program also helps you

identify areas in which you need to improve your procedures to protect against infection, says Manian. It is difficult to monitor same-day surgery infection rates because the patient won't show signs of infection the day of surgery, and it becomes the surgeon's responsibility to report infections to the same-day surgery program.

St. John's has a program to monitor surgical site infections that has proven successful, says Manian. A 75% response rate to his hospital surgical site infection monitoring survey means that Manian knows what happens to at least 80% of the patients undergoing surgery, because the physicians most likely to respond are usually the busiest surgeons, he says.

"An ongoing monitoring program is important because it gives you a chance to identify problems before they get out of hand," he explains. For example, if you typically have an infection rate of 1% or less, then it jumps to 4% one month, you know that it is time to dig further to find out what might cause the increase," he says.

While most same-day surgical site infections are minor in the eyes of the staff and surgeon as compared to peritonitis caused by a leak in the colon, you need to remember that any infection is upsetting to the patient, says Telford.

"Think about infections from the patient's perspective, and make sure you take every step to avoid them," he suggests. ■

SOURCES

For more information about prevention of surgical site infections, contact:

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- **Farrin A. Manian**, MD, MPH, Chief of Infectious Disease Division, St. John's Mercy Medical Center, 621 S. New Ballas Road, Tower B, Suite 3002, St. Louis, MO 63141. Telephone: (314) 569-6171.

Choosing gloves is a hands-on process

Different materials, uses, features require study

While natural rubber latex is still the gold standard by which all other surgical glove materials are measured, there are a variety of other synthetic materials that may be appropriate for a same-day surgery program when natural rubber latex does not work for one reason or another.

"Most of our physicians and operating room staff members prefer natural rubber latex [gloves] because they believe they fit and feel better than synthetic materials," says **Janet Greenfield**, assistant vice president of HealthSouth, a national company that owns health care facilities including four same-day surgery programs in Redlands, CA, where Greenfield is located.

Physicians and staff probably prefer natural rubber latex because it is the material people have been using the longest and they are more accustomed to it, admits Greenfield. Her facilities do, however, purchase other types of gloves if a physician or staff member wants them. "The most common reasons for purchasing another type of glove are allergies and personal preference," she says.

Milt Hinsch, MS, technical service director for Regent Medical, a glove manufacturer in Norcross, GA, says, "It's hard to beat natural rubber latex for gloves." There are some very real advantages to using natural rubber latex, but if it cannot be used — due to a user's or a patient's allergy — the new synthetic materials offer some safe alternatives, he says.

While natural rubber latex gloves can come in a variety of thicknesses, ranging from 7 mL for ophthalmic procedures that require tactile sensitivity to a thickness of 13-14 mL for orthopedic procedures in which the surgeon is more likely to encounter sharp objects that can tear the glove, synthetics offer less variety, says Hinsch. The most typical surgical glove is 8-10 mL thick, he adds.

There are four synthetics that are commonly used for most surgical gloves, says Hinsch:

• **Polychloroprene.** "Polychloroprene represents only 2% to 3% of the market, so these gloves are typically available only in the 8-10 mL thickness range," says Hinsch. Polychloroprene gloves tend to be stiff at first, so hands might fatigue more quickly, he adds. These gloves are more expensive, but they are a good alternative when there is a latex allergy, and Hinsch predicts the price will come down as more people use them.

• **Styrene-butadiene rubber (SBR), styrene-ethylene-butadiene-styrene (SEBS).** "Gloves

SOURCES

For more information about choosing surgical gloves, contact:

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- **Janet Greenfield**, Assistant Vice President, HealthSouth, 1620 Laurel Ave., Redlands, CA 92373. E-mail: janet.greenfield@healthsouth.com.

made with SBR and SEBS have been used when there is a latex allergy involved, but they cannot be used with orthopedic procedures because they dissolve when they come into contact with uncured bone cement," Hinsch points out.

• **Polyurethane.** The biggest disadvantage with polyurethane gloves is that they dissolve when they come in contact with common alcohols, says Hinsch. "Two to three minutes after contact with alcohol, the gloves become gummy and slippery," he says.

When evaluating synthetic gloves, be aware that synthetics meet a lower manufacturing standard than natural rubber latex gloves, says Hinsch. "If all synthetics were required to meet the same standards of natural rubber latex, we would not have had any other materials developed," he points out.

Synthetics provide an alternative when natural rubber latex gloves are in short supply, and Hinsch points out that "all gloves are inherently safe if they are durable enough for the procedure being performed and are used properly."

One change that has occurred within the natural-rubber-latex-glove market in the last three years was the move to powder-free gloves. Some physicians and staff are allergic to the powder used in gloves, says Greenfield.

"In the beginning, powder-free gloves were very expensive, but as our purchasing groups learned more and as the manufacturers learned more, the costs began to come down," she says.

"There is some powder-like substance used in all glove manufacturing processes," Hinsch points out. "Powder is necessary to release the glove from the form," he explains. The expense of powder-free gloves comes after the glove is made because extra steps must be taken to remove the powder and add a coating inside the glove to make it easy to put on the hand, he says.

Even with the alternatives to traditional, powdered natural rubber latex gloves, people are wary of making changes, says Greenfield. "There is no evaluation process hated more than glove evaluation," she says. Because gloves are an integral part of every surgeon's and operating staff member's jobs, any difference in the glove being evaluated is noticed, she says.

If you do plan to change gloves, go slowly, advised Hinsch. "Set up a committee that represents everyone who will use the gloves, give inservices, and most importantly, give everyone time to get used to the gloves," he adds.

Overall, gloves are a small expense for most same-day surgery programs, says Greenfield. She tries to provide a variety of gloves if physicians or staff members make special requests. She points out, "Providing a specific glove is an easy fix for an unhappy doctor." ■

Alert, advisory issued on medical gas accidents

The Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, has issued a *Sentinel Event Alert* and the Food and Drug Administration (FDA) has issued an advisory to alert providers to the potential for patient injury when cryogenic vessels containing medical gas are misconnected to oxygen delivery systems.

Misconnections cause patients who should receive medical oxygen to receive another gas, such as nitrogen, instead. Over the past four years, the FDA has received reports of seven deaths and 15 injuries associated with medical gas misconnections that occurred in acute care and nursing home settings.

Oxygen supply systems in medical facilities are equipped with gas-specific connectors that fit only the corresponding connectors on the cryogenic vessels in which oxygen is delivered. In the cases reviewed by the FDA, deaths and injuries occurred when two errors were made in sequence. First, a cryogenic vessel containing another gas was mistakenly identified as containing oxygen. Then, the gas-specific connector on this cryogenic vessel was changed or misadapted so that it could deliver the wrong gas to an oxygen-delivery system. In many of the reported incidents, the person connecting the vessel to the oxygen delivery system (either delivery person or staff member) didn't understand that the gas-specific connector was a safeguard

designed to prevent such mishaps from occurring.

The FDA urges health care providers to do the following:

• When connecting a cryogenic vessel, check the label carefully to ensure that it contains the appropriate gas for the intended application.

• Never use adapters or change the connectors or fittings on cryogenic vessels. If a connector will not connect to the oxygen supply system, the contained gas is likely not oxygen and should not be used. Contact the gas supplier for additional information and guidance.

• Ensure that all personnel who will be handling medical gases are properly trained to understand the operations and connections of the medical gas system. Make sure that personnel are trained to examine and recognize medical gas labels.

• If your facility receives medical and industrial grade gases, store them separately.

Health care providers are required to report deaths and serious injuries associated with the use of medical devices, including devices used to deliver medical gases. The FDA also encourages providers to report other adverse events associated with the use of a medical gas. You can report these directly to the device or medical gas manufacturer. You can also report to MedWatch, the FDA's voluntary reporting program. You may submit reports to MedWatch one of four ways:

• on-line at http://www.accessdata.fda.gov/scripts/medwatch;

• by telephone at (800) FDA-1088;

• by fax at (800) FDA-0178;

• by mail to MedWatch, Food and Drug Administration, HF-2, 5600 Fishers Lane, Rockville, MD 20857.

You can find additional information regarding medical gas misconnections at www.fda.gov/cder/guidance/4341fnl.htm. The Joint Commission's *Sentinel Event Alert* can be accessed at www.jcaho.org/edu_pub/sealert/sea21.html. ■

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CE/CME Objectives

After reading The Comprehensive Guide to EMTALA, participants will be able to do the following:

1. Identify the key requirements of EMTALA.
2. Analyze practice behaviors to determine if they are in compliance.
3. Explain the EMTALA considerations pertinent to patient transfers.

CE*questions*

After reading this issue, the continuing education participant will be able to:

• Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care and management (see "*Choosing gloves is a hands-on process"* in this issue).

• Describe how those issues affect nursing service delivery or management of a facility (*see "Low infection rate? Don't let your guard down")*.

• Cite practical solutions to problems or integrate information into their daily practices, according to advice from nationally recognized ambulatory surgery experts.

13. Why are people in outpatient surgery programs particularly at risk for addiction to chemicals, according to Diana Quinlan, CRNA, MA, chairwoman of the Peer Assistance Advisors Committee at the American Association of Nurse Anesthetists in Park Ridge, IL?
    A. little oversight from managers
    B. relaxed environment
    C. high volume of cases, rapid turnover, and poor narcotic accountability
    D. small staffs

14. One procedure that is a good candidate for prophylactic antibiotics, according to Gordon Laing Telford, MD, FACS, professor of surgery at the Medical College of Wisconsin, is a:
    A. laparoscopic cholecystectomy
    B. knee arthroscopy
    C. lesion removal
    D. rhinoplasty

15. Why are styrene-butadiene rubber, styrene-ethylene-butadiene-styrene gloves inappropriate for orthopedic procedures, according to Milt Hinsch, MS, technical service director for Regent Medical?
    A. They don't come in a variety of sizes.
    B. They contain latex.
    C. They are cost-prohibitive.
    D. They dissolve upon contact with uncured bone cement.

16. According to the Food and Drug Administration, what should all personnel who will be handling medical gases should be trained to examine and recognize to avoid medical gas accidents?
    A. medical gas labels
    B. the shape of medical gas containers
    C. damaged medical gas containers
    D. none of the above