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INSIDE

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With few attack survivors to treat, surgery center staff collect blood

Terrorist attacks raise question: Are you prepared for a disaster?

On the morning of Sept. 11, when terrorists attacked the World Trade Center towers and the Pentagon, nearby same-day surgery departments already were handling their first cases of the day. When they received word of the disasters, they finished those cases, canceled surgeries for the remainder of the day, and then stood by ready to offer minor treatment to a heavy caseload of survivors that never came.

See steps to prepare for a disaster, p. 124.

But one group of enterprising same-day surgery personnel, one of whom had a husband at the Pentagon she couldn't reach, refused to wait and do

Disaster Planning Audio Conference

The unimaginable has happened in New York City. At Saint Vincents Hospital, less than three miles from the site of the World Trade Center attack, the disaster plan was put to the test as dedicated professionals rose to the unique challenge of responding to the attack. American Health Consultants, publisher of *Same Day Surgery,* invites you to learn from the firsthand experience of the professionals at Saint Vincents how to take a new look at your disaster plans so that you will be ready if the unimaginable happens in your community:

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EXECUTIVE SUMMARY

When the terrorist attacks occurred the morning of Sept. 11 at the World Trade Center and the Pentagon, the staff at Inova Surgery Center in Falls Church, VA, set up a makeshift blood donor center and handled 150 donations.

- First cases of the day were canceled at facilities near both disaster sites. Elective cases were canceled for the remainder of the day.
- In New York City, police and car services helped transport outpatient surgery patients and staff.
- Outpatient surgery providers who are accredited are required to have a plan for external disasters and to educate staff on that plan.

nothing. By 11:30 a.m., the staff at Inova Surgery Center in Falls Church, VA, noticed that a few hundred patients were lining up outside to donate blood at the donor center, which is located downstairs from the surgery center.

Shifting gears to fill a need

"Obviously the blood donor center was not prepared for that, so our nurses became very proactive," says **Sheree Lopez**, RN, director of ambulatory surgery at Inova Surgery Center and Inova Fairfax Hospital Surgery Center, also in Falls Church.

The surgery center staff turned the center into a makeshift blood donor center, and in doing so, they found purpose in the face of senseless tragedy.

"We saw the positive, the best part of what happened," Lopez says. "We saw community members coming together to do something that was so uplifting."

The nurses brought about 150 waiting blood donors into the facility, she says. "We put them in the waiting area, in every nook and cranny we could find," she says.

The atmosphere was highly emotional, as donors hugged and even exchanged telephone numbers. "We watched three romances blossom while people were waiting to donate blood," Lopez says.

The outpatient surgery nurses handled pre-assessments, screenings, blood pressure checks, and needlesticks. One anesthetist, who remained on site after others were told to report to the hospital, helped start the IVs. The blood donor center sent a phlebotomist to handle blood draws.

"We helped with nourishment and post-procedure recovery: getting patients into recliners and giving them something to eat or drink," she explains.

At the end of the day, the nurse whose husband worked at the Pentagon had learned he was not injured, and 150 persons had donated blood at the surgery center. The blood donor center handled an additional 200.

"The [surgery center] staff was phenomenal," Lopez says. 'They were proactively looking for things to do. It made them very uncomfortable to play the waiting game. When they said this is something we could do, this was a win-win for everyone." **(See information on the relief effort by a surgical supply company, p. 124.)**

Near the World Trade Center

At Saint Vincents Hospital Manhattan, less than three miles from the World Trade Center towers, the first cases were under way in outpatient surgery when the hospital declared a disaster. The outpatient surgery ORs are combined with the inpatient rooms, says **Dorothy O'Neill**, RN, senior staff nurse.

"We immediately tried to finish up rooms and free up as many ORs as possible," O'Neill says.

In fact, the Albany-based New York State Health Department asked hospitals across the state to consider delaying elective surgery scheduled for that day.

Lisa Autz, BSN, director of ambulatory unit and recovery room, said the stage one recovery area was used for all of the patients in the ORs, including inpatients. The main recovery room was used as an extension of the emergency

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department, Autz says. Several nurses from the outpatient surgery staff went to the recovery room and treated a few burn victims and several firemen, police officers, and bystanders with injuries, O'Neill says.

One early priority was to contact patients who had cases scheduled for later that day, Autz says. The staff realized that those people might not be watching television.

Also, the staff notified patients already at the center, whose procedures hadn't started, that their cases were canceled. The staff calmly explained that because the nearby streets were closed and many subways and trains were stopped, the patients would have difficulty going home.

Getting patients home

People were reassured that they could stay in the hospital until transportation was available, Autz says. "When transportation opened up, we let them know," she says.

The managers also had to address transportation home for patients who had completed surgery and for staff who had completed their shifts. They coordinated transportation with the police department, which had set up a temporary satellite office at the hospital. Car services picked up most patients and staff.

The ambulatory surgery staff kept police informed when the car services needed to go through the police barricades. In fact, the police department assisted a few nurses by providing transportation home or to a bus or train.

Managers of the facilities involved with the Sept. 11 disaster emphasize that planning, policies, and drills are critical elements of being prepared for an external disaster. In fact, the Inova Fairfax system held an external disaster drill the Saturday before the attacks, Lopez notes.

"I feel we were very prepared," she says.

The policies and procedures are being re-examined in the light of what happened on Sept. 11, Lopez adds.

For example, the facility administrators realized that there are more than 70 potential entrances and exits into Inova Fairfax Hospital. "They have tightened up on security, and they are looking at [how to secure] doors," she says.

In the aftermath of the terrorist attacks, the Chicago-based American Hospital Association (AHA) issued a disaster readiness advisory that includes descriptions of likely biological or chemical agents that might be used in a terrorist attack, along with a self-assessment checklist to ensure readiness. **(See Chemical/Biological Agent Checklist enclosed in this issue. For information on how to access the advisory and other materials, see resource box, p. 124.)**

What is required for accreditation?

The Accreditation Association for Ambulatory Health Care of the Joint Commission on Accreditation of Healthcare Organizations says facilities need to have a plan for the role they play in a disaster, says **Ann Kobs**, MS, RN, president and CEO of Cape Coral, FL-based Type One Solutions, which advises health care organizations on accreditation issues.

"It's not just a disaster in your building, such as if you're hit by a tornado, but you also have a role in community disasters," Kobs says.

Your requirements are based on your scope of service, she says. She suggests that outpatient surgery providers pay particular attention to the following Joint Commission environment of care (EC) standards:

- **EC1:** lists seven plans you must have: utilities, fire, employee safety, hazardous materials, security, emergency preparedness, and medical equipment;
- **EC2:** explains that you must not only have a

SOURCES

For more information on disaster training, contact:

- **Lisa Autz**, BSN, Director, Ambulatory Unit and Recovery Room, Saint Vincents Manhattan, 153 W. 11th St., New York, NY 10011. Telephone: (212) 604-7598. Fax: (212) 604-3920. E-mail: lautz@saintvincentsnyc.org.
- **Ann Kobs**, MS, RN, President and CEO, Type One Solutions, 166 S.E. 18th Terrace, Suite A, Cape Coral, FL 33990. Telephone: (941) 574-8318. Fax: (941) 574-8814. E-mail: Aejbbk@aol.com.
- **Sheree Lopez**, RN, Director of Ambulatory Surgery, Inova Fairfax Hospital Surgery Center, 3300 Gallows Road, Falls Church, VA 22042-3000. Telephone: (571) 226-5931. Fax: (571) 226-5919. E-mail: sheree.lopez@inova.com.
- **Lori Theriot**, RN, Director of Nursing, Acadiana Surgery Center, 110 Andre St., Suite 300, New Iberia, LA 70563. Telephone: (337) 364-9680. Fax: (337) 364-9689. E-mail: asc@drpstokes.com.

RESOURCE

The Oct. 3 Disaster Readiness Advisory from the American Hospital Association (AHA) in Chicago can be accessed at www.aha.org/Emergency/Readiness/ReadinessIndex.asp. Another Disaster Readiness Advisory was sent Sept. 21 and is available at www.aha.org under "Disaster Readiness." That web page contains other information from the AHA and other sources on disaster readiness.

plan, but your staff members must know their role;

• **EC3:** explains how you evaluate your plan.

One outpatient surgery manager interviewed by *Same-Day Surgery* says she is completing a hazard vulnerability analysis, as required by the Joint Commission, that identifies whether your disaster plan addresses the disasters most likely to occur.

"Anything that we score a 3 or 4 on [meaning some elements of the plan are not in place], we're going to make the policy more specific," says **Lori Theriot**, RN, director of nursing at Acadiana Surgery Center in New Iberia, LA. **(See disaster plan enclosed in this issue.)** The center scored a 100 on its last survey.

"My external disaster plan is not very specific, in terms of if there is a war or terrorist attack in Acadiana Parish," she says. ■

Steps to prepare for a disaster

AHA issues Disaster Readiness Advisory

A letter attached to a Oct. 3 *Disaster Readiness Advisory* from the Chicago-based American Hospital Association (AHA) encourages health care providers to address these three questions:

1. Has the local health care infrastructure been convened since Sept. 11?

"This should include representatives from your hospital, the local police, fire, and public health departments, and emergency medical services teams," the advisory says. "Unless all of your response plans are coordinated, the whole may be less than the sum of its parts."

2. Are staff properly trained in recognizing symptoms resulting from the most common biological or chemical agents?

"This is key, because a terrorist attack utilizing these agents might not be immediately identifiable, but reveal itself only through large numbers of people with the symptoms of exposure to such agents," the advisory says. **(See Chemical/Biological Agent Checklist enclosed in this issue.)**

3. Have procedures for sharing information with local or state health departments about unusual cases been reviewed and updated?

"Every hospital in America must be ready to share this information with the health department so that it can be passed on to the Centers for Disease Control, which will identify and track the possible use of biological or chemical agents," the AHA says.

The AHA recommends that hospitals do the following:

• maintain disaster plans that, while flexible enough to respond to a wide range of events, are tailored to the specific needs of their communities;

• increase coordination with local agencies such as police, fire, and emergency medical systems;

• expand training of nurses, doctors, and other caregivers in chemical/biological incident response;

• review inventory levels and sources of drugs and other supplies, to ensure that adequate amounts are available if a disaster occurs. ■

Surgical supply company gets products to hospitals

Allegiance Healthcare Corp. in McGaw Park, IL, which manufactures and distributes surgical, medical, and laboratory products, assisted health care providers in the wake of the Sept. 11 terrorist attacks on the World Trade Center and the Pentagon.

Order volumes for supplies in New York City jumped 60% in the first 48 hours after the attack. Fifty police vehicles assisted Allegiance

in transporting the supplies by truck and helicopter. Allegiance sent more than 130 tractor-trailers of medical supplies into Manhattan, and more than 35 helicopter deliveries took supplies to makeshift landing zones at the company's Northeast distribution center.

The landing zones were lit with strobes and floodlights so the helicopters could land at night.

In Maryland, sales reps and their spouses worked overtime to help wrap medical-surgical pallets for Washington, DC, hospitals and nearby military bases.

In addition, Allegiance donated products to AmeriCares, an emergency-relief organization based in New Canaan, CT. The organization normally sends donated products overseas, but made an exception and donated the supplies to facilities in the United States after the terrorist attacks. ■

Same-Day Surgery Manager

Establish a professional environment of success

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

The operating room environment can be such a scary place of business to our patients. Full of the unknown. Strange smells and people walking around with masks — ugh! We, the staff, are used to it for the most part, but we are there every day and have become sensitized to it. It's not so for our patients and their families.

Patients and staff want a professional, yet happy upbeat environment. It is tough to "spin" having surgery into a "good thing" to patients. But there are ways that we can make our workplace and patient setting a more enjoyable and less frightening place of business. This column offers inexpensive suggestions to do just that.

- **Photographs of staff.**

A very easy way to immediately put your patients at ease is to have all the members of your staff introduce themselves, let the patients and visitors know who they are and what they do at the center, and give them a great big smile. Wouldn't that take away much of the apprehension of who is behind the mask and what is going on behind those doors? Unfortunately, that is not practical to do all at once. But you can get the same effect with an inexpensive digital camera and color printer.

Using the same background, take a individual picture of each member of your staff. (Force them to smile.) Print an 8 by 10 of the photo, put it in an inexpensive frame, and mount it on the wall in the waiting area.

Put the staff members' first name and title underneath the picture. The staff should be in their normal operating room attire, i.e. office staff in street clothes, nurses in scrubs, etc., for the picture. You can bunch the pictures together or spread them around the room. Print a legend, and post it with a brief description of the title underneath the picture so the patients and family members know what "scrub techs" are and the job they do at the facility.

Make sure you keep it up to date with new staff as they come on board. The staff name tags need to mirror what is at the bottom of their picture.

Cost? The camera will cost under $300 and can be used over and over. The printer is $198, and the photography paper is $15 for 20 sheets. The frames can be inexpensive as well.

I started doing these pictures 18 years ago, and they continue to receive the most positive comments on patient satisfaction replies. You can afford it.

- **Smells.**

Operating room environments have an odor. You cannot smell it because you have grown accustomed to it, but trust me, it is there. I smell it in every center and department I visit.

Ideally, a fragrant candle burning can mask the smell, but that's probably not a good idea in a crowded waiting room. Consider placing those scented plugs in the wall sockets to add a better aroma. Avoid heavy floral smells, as they can be overpowering. Vanilla is always a good choice. Cost is $1.49 a plug.

- **Pictures.**

It is probably me, but I am tired of seeing the same pictures of flowers in every waiting room I visit. Do we all buy these pictures from the same

vendor? Consider the more inspirational type of posters that have a cool mountain climber going up a rocky cliff with a caption such as, "The climb is rough . . . yadda, yadda, yadda." They are more expensive at about $29 per poster.

• **Magazines.**

It is time to throw away those 1993 *National Geographic*s. They do not become more valuable with time. Lighten the room up with more contemporary magazines! Cost is about $12 per year for each subscription.

• **Lab coats.**

Let's toss those dingy yellowish lab coats for a brighter shade of white, OK? Better yet, get a new color completely! Go crazy on color. (Avoid red and yellow, please — the colors of body fluids.) Cost is about $24 per coat.

• **Dress code.**

I know we are much more informal in what we can wear to work nowadays, but it might be time to make the office environment a bit more professional. I really do not need to see Mary's tattoo on her chest or count freckles on someone's thigh through skintight clothing when I'm checking in. This is a place of business and not personal expression. Cost? I have absolutely no idea!

(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.) ■

Have policies in place for managing addictions

(Editor's note: In this second part of a two-part series on addictions among health care professionals, we discuss return-to-work issues, examine why anesthetists are more at risk, and list signs of addiction. In last month's issue, we explored why same-day surgery professionals are particularly at risk and gave you suggestions for cutting that risk. We provided a warning list of signs of addiction and gave you additional resources. We also shared one nurse's nightmare when she had one incident of misusing a drug.)

Warning: Clinicians who are impaired by the use of drugs or alcohol can invoke the Americans with Disabilities Act (ADA).

The ADA could be invoked if a facility decides not to permit a recovered health care provider to return to work, solely on the basis of the history of addiction, warns **William P. Arnold III**, MD, associate professor of anesthesiology at the University of Virginia Health System in Charlottesville and chair of the Task Force on Chemical Dependence of the Park Ridge, IL-based American Society of Anesthesiologists (ASA).

The ADA defines addiction as a disability, Arnold says. Thus, an employer may not refuse employment to a recovering individual solely on the basis of that disability.

"One key for the entity is whether or not it has a real or imputed employer-employee relationship with the anesthesiologist," the ASA says. "If this relationship does not exist, then the law would not be applicable."

In addition, the ADA doesn't offer protection to addicts who are currently engaging in the illegal use of drugs, according to the association.

If your facility is accredited by the Joint Commission on Accreditation of Healthcare Organizations, you are required to have a policy for handling impairment.

There are four goals of substance abuse policies, according to the ASA's brochure, *Chemical Dependence in Anesthesiologists: What You Need to Know When You Need to Know It.*[1] **(See "Sample Policy/Procedure for Departments of Anesthesia on Chemical Dependency," enclosed in this issue.)** The goals are:

• identification in a timely manner of the individuals who have misused drugs or alcohol;

• intervention in the form of rapid entry into a treatment program;

• adequate time for treatment;

• follow-up care, which will facilitate the provider's successful return to the workplace.

When addiction is *suspected*, report the problem to the proper person or committee at your facility, the ASA suggests.

For example, the problem may need to be reported to the physician well-being committee of the state medical society, a peer assistance committee, the department's chair, a direct supervisor, or another relevant individual, according to the ASA.

This person or committee should confidentially investigate the information and seek corroborating documentation, the association says.

"The investigation may involve interviews with associates, colleagues, family members, friends, and others acquainted with the person in

Guidelines to Help Evaluate Anesthesiologists Who Desire to Continue Their Careers in Anesthesia

I. Return after appropriate treatment (for health care professionals)

1. Accepts and understands disease of addiction
2. Bonding with Alcoholics Anonymous/ Narcotics Anonymous (AA/NA) with active sponsorship
3. Good relapse prevention skills
4. Other psychiatric disorders in remission
5. Healthy family relationships
6. Balanced lifestyle
7. Anesthesia department supportive
8. Committed to five-year monitoring program
9. Confident to be in operating room, administer anesthetic drugs and not relapse
10. All of the above required for immediate return to anesthesia

II. Possible return, with reassessment after one or two years

1. Incomplete bonding to AA/NA but improving
2. Some denial/minimizing
3. Lacks complete confidence to be in operating room and not relapse to chemical use
4. Recovery skills improving
5. Brief relapse may have occurred
6. Other psychiatric disorders improving
7. Dysfunctional family members improving (may require therapy)
8. Healthy attraction to anesthesia

III. Never return to clinical anesthesiology (any of these conditions)

1. Prolonged addiction history
2. Significant relapse despite adequate treatment
3. Lacks confidence to return to operating room and not self-administer anesthetic drugs
4. Significant Axis I or II psychopathology
5. Inability to follow treatment and monitoring contract
6. Poor bonding to AA/NA and recovery skills
7. Significant family pathology

Source: Excerpted from article by Eric B. Hedberg, MD, Associate Medical Director, Talbott Recovery Campus, Atlanta, in *American Society of Anesthesiologists Newsletter*, copyright 2001 of the American Society of Anesthesiologists. A copy of the full text can be obtained from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573. Based on guidelines in Angres DH, Talbott GD, Bettinardi-Angres K. *Healing the Healer: The Addicted Physician.* Madison, CT: Psychosocial Press; 1998.

question, as well as reviews of anesthetic and pharmacy records," the ASA says.

Don't go directly to the police, the association suggests. "Anyone who has diverted controlled drugs for personal use has, by law, committed a felony and is subject to prosecution," the ASA says. "This individual is, at the same time, however, acutely ill and urgently in need of treatment. Prosecution may be in the individual's future, but treatment should be the primary intent of the initial investigation."

Should a recovering health care provider return to work? The issue is controversial, and there are no easy answers, experts advise. **(See policy enclosed in this issue. See "Guidelines to Help Evaluate Anesthesiologists Who Desire to Continue their Careers in Anesthesia," above.)**

Consider these factors:

- **Attitude of peers plays a significant role.**

The attitudes of colleagues, surgeons, other members of the medical staff and the administrators play a major role, the ASA points out.

"If these individuals are unwilling to accept the recovering physician and the stipulations outlined in the aftercare contract, then the likelihood of successful return will be slim," the association says. "On the other hand, if they have a basic understanding of the disease of addiction and are amenable to gradual return to work in keeping with the contract, then the outcome in most cases will be positive."

- **The drug that was abused.**

The preliminary analysis of data obtained in an ASA survey of anesthesia training programs, indicated that only about 50% of physicians with a history of fentanyl abuse returned to the specialty following treatment.[2]

"Of those who returned, nearly half were terminated either voluntarily or involuntarily," the ASA says. In that group, the apparent relapse rate was nearly 20% per year over a maximum period of 18 months. In contrast, for those who abused nonopioid drugs, the relapse rate was about 4% per year.

Regard these figures with caution because they don't take into account the length and type of treatment, the willingness of the department to accept the individual, and other factors that are felt to be important to long-term recovery, the ASA says.

• **Talk to the therapist.**

"We usually ask for therapists to be involved in that decision, as would any release to work for any medical condition," says **Nancy Kehiayan**, RN, MS, CS, director of the Colorado Nurse Health Program, in Lakewood. Kehiayan's program was developed by state board of nursing as an alternative to board's disciplinary process. It provide nurses with opportunity and support for recovery and treatment.

• **Consider another work setting.**

Often, recovered health care providers should not return to the same work environment as the one in which they were addicted, particularly if the area is high stress such as the surgical area, Kehiayan says. "They should try to practice in areas where there's less access [to drugs] and less stress," she adds.

Most recovered addicts aren't allowed to have access in the first six to 12 months anyway, Kehiayan points out. The employer has to accommodate that practice restriction, she says. Also, recovered addicts are usually limited to a 40-hour workweek and are required to work on a shift where they can be well supervised.

"We don't want them floating from unit to unit," Kehiayan says.

Fentanyl, sufentanil, and their metabolites are challenging but not impossible to detect, the ASA says. If indicated by the drug of choice, these relatively expensive assays should be specifically requested, the association says.

Many treatment programs insist that their patients sign an aftercare contract prior to discharge, the ASA says. According to the association, that contract may include the following:

— recommendations concerning returning to work in writing by the treating facility, state medical society, and/or other organization with expertise in managing aftercare in anesthesiologists;

— details such as whether the person should return to the practice of anesthesiology, the administration of controlled drugs, rate of resumption of responsibilities, and hours worked;

— regular monitoring of recovery by a physician who has been trained to perform this task;

— mandatory collection of random urine or blood screens for a period of five years or more, which is mandated by most programs;

— collection of specimens being witnessed to avoid the possibility of deception;

— management in the event of relapse, which usually will include re-evaluation by experts and return to treatment if indicated by the evaluation.

What to Look for Inside the Hospital

1. Addicts sign out ever-increasing quantities of narcotics.
2. Addicts frequently have unusual changes in behavior such as wide mood swings, periods of depression, anger, and irritability alternating with periods of euphoria.
3. Charting becomes increasingly sloppy and unreadable.
4. Addicts often sign out narcotics in inappropriately high doses for the operation being performed.
5. They refuse lunch and coffee relief.
6. Addicts like to work alone in order to use anesthetic techniques without narcotics, falsify records, and divert drugs for personal use.
7. They volunteer for extra cases, often where large amounts of narcotics are available (e.g., cardiac cases).
8. They frequently relieve others.
9. They are often at the hospital when off-duty, staying close to their drug supply to prevent withdrawal.
10. They volunteer frequently for extra call.
11. They are often difficult to find between cases; they are taking short naps after using.
12. Addicted anesthesia personnel may insist on personally administering narcotics in the recovery room.
13. Addicts make frequent requests for bathroom relief. This is usually where they use drugs.
14. Addicts may wear long-sleeved gowns to hide needle tracks and also to combat the subjective feeling of cold they experience when using narcotics.
15. Narcotic addicts often have pinpoint pupils.
16. An addict's patients may come into the recovery room complaining of pain out of proportion to the amount of narcotic charted on the anesthesia record.
17. Weight loss and pale skin also are common signs of addiction.
18. Addicts may be seen injecting drugs.
19. Untreated addicts are found comatose.
20. Undetected addicts are found dead.

Source: Excerpted from *Chemical Dependence in Anesthesiologists: What You Need to Know When You Need to Know it.* American Society of Anesthesiologists. A copy of the full text can be obtained from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573. Web: www.ASAhq.org/ProfInfo/chemical.html. This table is adapted from Farley WJ, Arnold WP. Videotape: *Unmasking Addiction: Chemical Dependency in Anesthesiology*. Produced by Davids Productions, Parsippany, NJ, funded by Janssen Pharmaceutica, Piscataway, NJ. 1991.

References

1. Excerpted from *Chemical Dependence in Anesthesiologists: What You Need to Know When You Need to Know It*, copyright 1999 of the American Society of Anesthesiologists. A copy of the full text can be obtained free on the web site (www.ASAhq.org/ProfInfo/chemical.html) or for $2 per copy from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

2. *Survey of Chemical Dependence in Anesthesiology Training Programs in the United States: 1986-1995*. (Analysis of data and preparation of report are in progress.) ■

RESOURCE

Providers can contact the American Society of Anesthesiologists 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 60068-2573. Telephone: (847) 825-5586.

Anesthetists are more likely to be addicted

Drugs of choice: Fentanyl and sufentanil

The statement that anesthetists are more likely to misuse drugs is a controversial one. But now there's research to back up the claim.

One recent mortality study shows that the adjusted risk of drug-related suicide was more than two times greater in anesthesiologists than in internists, and the risk of all drug-related causes of death was almost three times greater in anesthesiologists.[1] The same study showed that anesthesiologists are overrepresented in substance abuse programs for physicians.

"The risk is about one in 10 that anesthetists will develop a substance abuse problem sometime in their career," says **Diana Quinlan,** CRNA, MA, chairwoman of the Peer Assistance Advisors Committee of the American Association of Nurse Anesthetists in Park Ridge, IL.

Quinlan points to a survey of 10% of the national certified registered nurse anesthetist (CRNA) population in which 9.8% of the CRNAs surveyed admitted to misusing anesthesia substances.[2]

What's the reason for the increased use among anesthetists? Access and stress, Quinlan maintains.

In about 70% of drug abuse cases involving anesthesiologists, the physicians have used fentanyl and/or sufentanil, according to a publication from the Park Ridge, IL-based American Society of Anesthesiologists (ASA) titled *Chemical Dependence in Anesthesiologists: What You Need to Know When You Need to Know It*.[3]

"Over a six- to 12-month period, a fentanyl addict may attain a habit of 80-100 ml of fentanyl per day," the ASA says. "Within weeks of the onset of addiction to sufentanil, daily use may be as much as 10-20 ml. A 10th of these doses would kill a person who is drug-naive."

Frequently, addiction becomes apparent within weeks, the ASA says.

"Unless the disease is recognized and treated appropriately, it will result in social, psychological, and physical harm to the abuser, and may end in death," the association warns. **(See list of what signs to look for in anesthetists, p. 128.)**

It's important to identify an addict before the professional suffers impairment, the ASA points out.

However, identification can be difficult because signs are subtle. "Individual family members and colleagues typically see only a part of the constellation of clues, making it easier for the addicted individual to hide the disease," the association says.

Expect addict to deny the problem

Expect denial, the association warns. Providers often fear losing their jobs, their practices, and the respect of others, the ASA points out.

Not everyone agrees with the research that points to increased abuse among anesthetists.

For example, the 2000 *Anesthesiology* study didn't study other subpopulations of physicians other than internists, says **William P. Arnold III**, MD, associate professor of anesthesiology at the University of Virginia Health System in Charlottesville and chair of the ASA's Task Force on Chemical Dependence.

When anesthetists become addicted, their disease becomes apparent more quickly than in other professionals because fentanyl and sufentanil are the most potent, mind-altering drugs used in medicine, Arnold says.

"I am firmly convinced that the rate of onset of addiction is directly related to the potency of drug of abuse," he says.

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1. Alexander BH, Checkoway H, Nagahama SI, et al. Cause-specific mortality risks of anesthesiologists. *Anesthesiology* 2000; 93:922-930.

2. Bell D, McDonough JP, Ellison JS, Fitzhugh EC. Controlled drug misuse by certified registered nurse anesthetists. *AANA J* 1999; 67:133-140.

3. Excerpted from *Chemical Dependence in Anesthesiologists: What You Need to Know When You Need to Know It*, copyright 1999 of the American Society of Anesthesiologists. A copy of the full text can be obtained free on the web site (www.ASAhq.org/ProfInfo/chemical.html) or for $2 per copy from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573. ■

Infection control requires ongoing education

(Editor's note: In this second part of a two-part series on infection control, we tell you how to educate on a continuing basis; we discuss the important of good preparation of the surgical site; and we tell you about a facility that achieves a 75% return rate on its physician surveys. In last month's issue, we told you how to control infections in the outpatient surgery setting.)

Infection control is not something to discuss only at inservices, says **Ellen O'Connor-Graham**, RN, CNOR. She is 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.

Informal education can take place anywhere at anytime, even in the operating room, O'Connor-Graham says.

"The circulating nurse is ultimately responsible for protecting the sterile field and should be watching for things that other members of the team may not see," she says.

For example, the circulating nurse is in the best position to see a team member touch a nonsterile item, then move back to the sterile field, O'Connor-Graham says. The circulating nurse's job is to make sure the contaminated item or glove is removed and replaced with a sterile one, she adds.

Keep staff updated on new techniques

The same-day surgery staff at Henry Medical Center in Stockbridge, GA, also have ongoing inservices that cover infection control techniques, descriptions of new infections, latest trends, and other topics related to infection control, says **Sherron Kurtz**, RN, MSA, CNOR, CNAA, director of perioperative services.

"We make sure our staff members know that they are an important part of our infection control program," says Kurtz.

"If anyone overhears a physician mention a postoperative infection, a report is made to our infection nurse so she can follow up with the physician," she explains. These "leads" help the infection control nurse ensure accurate data, she adds.

A post-op infection rate of less than 1% is the norm at St. Alexius Same Day Surgery Center in Bismarck, ND, because infection control is covered in every monthly staff meeting, says **Sandy Berreth**, RN, director of the surgery center.

"We discuss the results of our post-op infection monitor," Berreth says.

"If there was an infection, I present the type of infection and how it was treated, she says. "We then talk about what we could have done to prevent the infection." **(See stories on how to prevent infection at the surgical site, below, and monitoring programs, p. 131.)** ■

A clean site reduces infection

Because skin bacteria is the most likely cause of surgical site infections for same-day surgery patients, good preparation of the surgical site is important in the prevention, says **Farrin A. Manian**, MD, MPH, chief of infectious disease division at St. John's Mercy Medical Center in St. Louis.

To reduce the effect of skin bacteria on the surgical site, instruct patients to shower or bathe with soap and water prior to surgery and to clean the general area of the incision with an antibacterial cleanser such as chlorhexidine gluconate, says Manian.

Once in the operating room, Betadine and alcohol are typically used. However, **Gordon Laing Telford**, MD, FACS, professor of surgery at the Medical College of Wisconsin in Milwaukee, says, "These are excellent products, but we don't know how long their protection lasts."

In addition to chlorhexidine gluconate, Telford also likes DuraPrep (3M, St. Paul, MN) which is a new, simple solution for skin preparation, he says.

Hair removal for most same-day surgery is not necessary, but if it is needed, use clippers immediately before the incision is made, says Telford. ■

Survey program monitors surgical site infections

A 75% return rate on any survey is terrific, but when this is the average return rate for a monthly survey that goes to surgeons, you wonder why the physicians take the time to complete them.

"Our physicians have seen the importance of monitoring surgical site infection rates," says **Farrin A. Manian**, MD, MPH, chief of infectious disease division at St. John's Mercy Medical Center in St. Louis.

Monthly reports that show overall rates and incidence of surgical site infection as well as twice a year confidential reports that display surgeon-specific information have been well received by the medical staff, he says.

The surgery department at St. John's handles inpatient and outpatient surgery in the same operating rooms, but more than 60% of the procedures are outpatient, says Manian.

While the infection rate for inpatient surgery at the facility between 1988 and 1985 was 1.4% and the rate for the same period of time for same-day surgery was only 0.13%, or one-tenth of the inpatient rate, it is critical that same-day surgery programs have some way to measure surgical site infections, he says.

A monitoring program gives a same-day surgery staff an opportunity to be proactive when controlling infections, says Manian. With more complicated surgeries, such as cholecystectomies and herniorraphies, moving into the same-day surgery program, there are greater risks of infection, he explains.

"A good monitoring program gives you a chance to investigate potential problems before they become big problems," he adds.

Monitoring is ongoing task

Once a month, St. John's 300 surgeons receive a list of patients who have undergone surgery during the previous one to two months, says Manian. The only question the surgeon must answer for each patient is, "Did you observe a surgical site infection?"

If the answer is no, the infection control staff takes no further action. If the answer is yes, a member of the staff calls the surgeon to obtain more details, he says.

"In addition to talking with the surgeon or his staff, we pull the patient's medical chart and review lab reports, operative notes, and any other documentation that give us information on what happened while the patient was with us," adds Manian.

Specific items that are evaluated include the type of procedure, any lab reports on the infection, antibiotics used during and after surgery, and any risk factors identified by the surgeon or anesthesiologist prior to surgery, says Manian.

The infection control staff prepare monthly reports that show overall infection rates and discuss any problems identified during the month. These reports are shared with surgery staff and physicians in regular staff meetings, he says.

Questionnaires track patients' recovery

The monitoring program at St. Alexius Same Day Surgery Center in Bismarck, ND, is run differently. "We send a questionnaire for each patient to the surgeon's office the day after surgery," says **Sandy Berreth**, RN, director of the surgery center.

"The questionnaire is placed on the patient's chart, and the physician completes it during the patient's first post-op visit," she explains.

Five questions are asked on the form:

- Did you notice any signs of infection?
- Is there any redness around the incision?
- Is there any drainage?
- Does the patient have a fever?
- Was it necessary to hospitalize the patient for postoperative infection?

If the physician answers yes to any question, there is a place for further explanation, says Berreth.

The surgeon's office staff mail the forms back

SOURCES

For more information about staff involvement with infection control, contact:

- **Sandy Berreth**, RN, Director, St. Alexius Same Day Surgery Center, P.O. Box 4046, 810 E. Rosser Ave., Bismarck, ND 58502-4046. Telephone: (888) 495-5005 or (701) 530-5049.
- **Sherron Kurtz**, RN, MSA, CNOR, CNAA, Director of Perioperative Services, Henry Medical Center, 1133 Eagles Landing Parkway, Stockbridge, GA 30281. Telephone: (770) 389-2355 or 2357. Fax: (770) 389-2158. Email: Skurtz@hmc-ga.org.

to the surgery center. Since she receives the questionnaires, Berreth handles any follow-up questions with the physician.

Keep the process simple

A simple process is necessary, says Berreth. "We have a high rate of return for our questionnaires; in fact, we have many months with 100% return," she says. A simple form and the surgeons' desire to make sure their patients are at low risk for infection when they come in for surgery are the main reasons for the successful return, she explains.

"Our physicians are just as interested in infection control as my staff, and they know that monitoring infection rates gives us a chance to identify and solve problems early," she adds.

One reason for the success of his monitoring program is his own visibility, says Manian. He is an epidemiologist, but even if you don't have a physician who specializes infectious diseases, a physician should head up the program, he says.

"The physician should be visible and demonstrate respect for the confidentiality of the data and a commitment to providing good patient care," he says. Many of Manian's conversations with surgeons occur informally as he runs into them in the surgery department or physician's lounge.

"It is important that the surgeons see me and know that I understand what they are doing," he adds.

"This accessibility and visibility has built a trust between surgeons and the monitoring program," Manian adds. ■

On-line education covers disinfection, sterilization

While many health care vendors offer web site technical assistance to customers, the web site sponsored by Advanced Sterilization Products (ASP) in Irvine, CA, offers generic information related to disinfection and sterilization as well as continuing education courses that all visitors can utilize for free.

The web site, which can be reached via www.sterrad.com or www.cidex.com, features interactive independent study courses on disinfection and sterilization that can be used to earn 1.8 continuing education contact hours.

A certificate of completion for the course is free, but application for the credits is $20. The credits are awarded by the California Board of Registered Nurses.

In addition to the continuing education programs, the site includes a listing of upcoming seminars and conferences at which disinfection, sterilization, and related topics are discussed. Trends and advances in sterilization as well specific contaminants, such as prions, are among the topics. Some of the programs are also available for presentation at individual facilities, says **Jayme Lorentz**, group manager of marketing programs for ASP.

"The web site is updated as new information or new programs are available, and we do a major upload every quarter," Lorentz says.

Another feature that SDS managers will find helpful is the section of links to other sites related to disinfection and sterilization.

A direct line to the Centers for Disease Control and Prevention's quarterly publication, *CDC Emerging Infectious Disease Journal*, also is available on the site. ■

Medicare proposes outpatient PPS changes

The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration, has proposed changes to the outpatient prospective payment system (OPPS) that will take effect Jan. 1. Those changes were published in the *Federal Register.* **(For information on accessing the *Federal Register,* see resource box, p. 133.)**

Here are the highlights:

• **Reprocessing of single-use devices.**

Currently, Medicare won't pay for single-use devices that have been reprocessed.

However, CMS is proposing a change to line up with current policy from the Food and Drug

Administration (FDA), CMS will consider reprocessed single-use devices eligible for pass-through payments if the devices meet the FDA's regulatory criteria, says **Eric Zimmerman**, Esq., attorney with McDermott, Will, and Emery in Washington, DC. **(For information on how to get the new guidance from the FDA, see resource box, below.)**

• Beneficiary coinsurance adjustments.

CMS is proposed to amend the regulations for provider-based entities, which doesn't apply to freestanding centers, Zimmerman says. The requirement is for hospitals to make the beneficiary aware that, by virtue of receiving services, there will be a facility payment in addition to the physician's professional fee, he says.

Hospitals are required to disclosure this information before services are rendered and to estimate what the additional charge will be, Zimmerman says.

SOURCE AND RESOURCES

For more information on proposed changes to the outpatient prospective payment system, contact:

- **Eric Zimmerman**, Esq., Attorney, McDermott, Will, and Emery, 600 13th St. N.W., Washington, DC 20005. Telephone: (202) 756-8148. Fax: (202) 756-8087. E-mail: ezimmerman@mwe.com.

The proposed rule in the Aug. 24, 2001, *Federal Register* is available free on line at the web site: www.access.gpo.gov/su_docs/aces/aces140.html. Also, many libraries have copies. To order a copy, specify the date, and enclose a check or money order for $9 made out to the Superintendent of Documents, or enclose your Visa or MasterCard number and the expiration date. Send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954. Credit card orders also can be placed by calling (202) 512-1800 or faxing the request to (202) 512-2250.

The Food and Drug Administration's (FDA's) Center for Devices and Radiological Health has released a documents about reprocessing of devices labeled for single use. This document offers labeling guidance can be found on the web: www.fda.gov/cdrh/comp/guidance/1392.pdf. This document provides guidance to hospitals and third-party reprocessors about their responsibility. Hospital and third-party reprocessors are subject to all of the same regulations as manufacturers of the original devices. The document includes definitions and labeling requirements.

• Outlier payment.

Under current policy, Medicare determines outlier payment adjustment in aggregate fashion for all outpatient services, Zimmerman says. "What they're proposing is to calculate them based on each individual outpatient service," he says.

• Provider-based status rules.

CMS has taking some of its guidance that has been published in Q&A format on it's web site and put it into a regulation, which makes it more reliable, Zimmerman says. In addition, CMS is putting into regulation some of the legislation in the *Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA).*

In addition, the provider-based status rules include some new changes — a reporting requirement and EMTALA requirement:

— Reporting.

Currently, CMS requires that a main provider, which creates or acquires an entity that it wants to claim as provider-based, must report it to CMS if the entity is off-campus or the costs of that entity in the main provider's cost report would increase the total costs by at least 5%. The main provider also must furnish all information that CMS needs to determine whether the entity is provider-based.

"This requirement has been criticized as redundant of the requirement that a main provider obtain a provider-based status determination for an entity before billing its services that way or including its costs on its cost report," according to McDermott, Will, and Emery's Sept. 10, 2001, *Health Law Update.*

CMS has proposed deletion of this reporting requirement. "CMS would, however, retain the additional requirement that a provider report any material change in relationship between it and any provider-based facility, such as a change in ownership or entry into a new or different management contract, that could affect the provider-based status of the entity," according to the *Update*.

— Emergency Medical Treatment and Active Labor Act (EMTALA).

"Perhaps one of the most troubling and vexing aspects of the original provider-based status rules is the manner in which CMS applied the requirements of EMTALA to off-campus provider-based entities," the *Update* says. CMS has announced that it intends to re-examine its regulations and reconsider the appropriateness of applying EMTALA to off-campus locations, according to the *Update.* CMS intends to publish a proposed rule to address these concerns shortly, it says. ■

Ensure compliance with OSHA, Joint Commission

Recent program details needle safety tips

How did workers' donning fanny packs ensure needle safety compliance with inspectors from the Occupational Safety and Health Administration (OSHA)?

Here this novel approach and many other "real-world" solutions described by a California infection control professional who has been facing down OSHA inspectors for some two years.

Tape provides guidance to help you prepare

An audiocassette tape is now available for *Needle Safety Mandate: What you must know before OSHA inspectors come calling*, a recent teleconference provided by American Health Consultants, publisher of *Same-Day Surgery*. The cost is $199.

With the Joint Commission on Accreditation of Healthcare Organizations now saying it will enforce the same requirements, the insightful grass-roots guidance and clear explanation of all the requirements in this teleconference can ensure full compliance at your facility. California was the first state to face this issue several years ago.

Tales of actual OSHA inspections — giving precise details of what was regarded as compliant or what drew a citation — are revealed by **Cynthia Fine**, RN, MSN, CIC Infection Control/Employee Health professional in Oakland, CA.

Our expert faculty also includes veteran OSHA observer, **Katherine West**, BSN, MSEd, CIC, an infection control consultant with Infection Control/Emerging Concepts Inc. in Manassas, VA. West provides a straightforward, practical explanation of what the federal changes require.

To order this important teleconference tape, contact our customer service department at (800) 688-2421 or by e-mail: customerservice@ahcpub.com.

2 resources on the web

The National Alliance for the Primary Prevention of Sharps Injuries in South Jordan, UT, has launched a web site (www.NAPPSI.org) that offers information on needlestick prevention, legislative updates, regulatory developments, products, and resources.

The alliance has a speakers' bureau that offers

CE questions

After reading the November issue of *Same Day Surgery*, the continuing education participant will be able to do the following:

- Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care and management. (See *"Anesthetists are more likely to be addicted"* and *"Medicare proposes outpatient PPS changes."*)
- Describe how those issues affect nursing service delivery or management of a facility.
- Cite practical solutions to problems or integrate information into their daily practices, according to advice from nationally recognized ambulatory surgery experts. (See *"Establish a professional environment of success"* and *"Survey program monitors surgical site infections."*)

17. According to Stephen W. Earnhart, MS, president and CEO of Earnhart and Associates, what continues to receive the most positive comments on his centers' patient satisfaction replies?
    A. photographs of staff
    B. close availability of food
    C. current magazines in the waiting area
    D. volunteers

18. What did a recent mortality study indicate about the number of anesthesiologists in substance abuse programs for physicians?
    A. They are underrepresented.
    B. They are represented in proportion.
    C. They are overrepresented.

19. According to Sandy Berreth, RN, director of St. Alexius Same Day Surgery Center, in order for a surgical site infection survey to be returned at a high rate by physicians, the survey form must be:
    A. hand-delivered by the patient
    B. accompanied by a financial incentive to return
    C. simple to complete
    D. sent to the physician multiple times

20. What change has Medicare proposed for devices labeled for single-use that are reprocessed?
    A. Medicare will not reimburse.
    B. Medicare will always reimburse.
    C. Medicare will consider the devices eligible for pass-through payments if the devices meet regulatory criteria.

free presentations on primary prevention of sharps injuries.

The organization defines primary prevention as a technology or practice that eliminates the need for sharps in the health care setting. These technologies include lasers to replace lancets to draw blood and catheter securement devices that eliminate the use of suture needles.

The alliance is a group of health organizations, medical device manufacturers, health care professionals, and others working to reduce sharps injuries. About 800,000 medical sharps injuries occur each year in health care facilities across the country, the alliance estimates.

In other news, the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, has issued a *Sentinel Event Alert* related to preventing needlestick and sharps injuries. The alert covers risks and causes, prevention strategies, *The Needlestick Safety and Prevention Act*, and recommendations. To access the alert, go to www.jcaho.org/edu_pub/sealert/sea22.html. ■

Medicare updates rates for ASCs

As of Oct. 1, 2001, the following Medicare payment rates are effective for ambulatory surgery centers (ASCs):

- Group 1 — $323;
- Group 2 — $433;
- Group 3 — $495;
- Group 4 — $612;
- Group 5 — $696;
- Group 6 — $806 ($656 + $150 for intraocular lens);
- Group 7 — $966;
- Group 8 — $949 ($799 + $150 for intraocular lens). ■

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Employee participation means higher morale, less turnover

Team management and surveys provide meaningful input

Imagine that you're a same-day surgery manager with a busy operating schedule, a full staff, no turnover, and a stack of applications from experienced surgical nurses who want to work in your program.

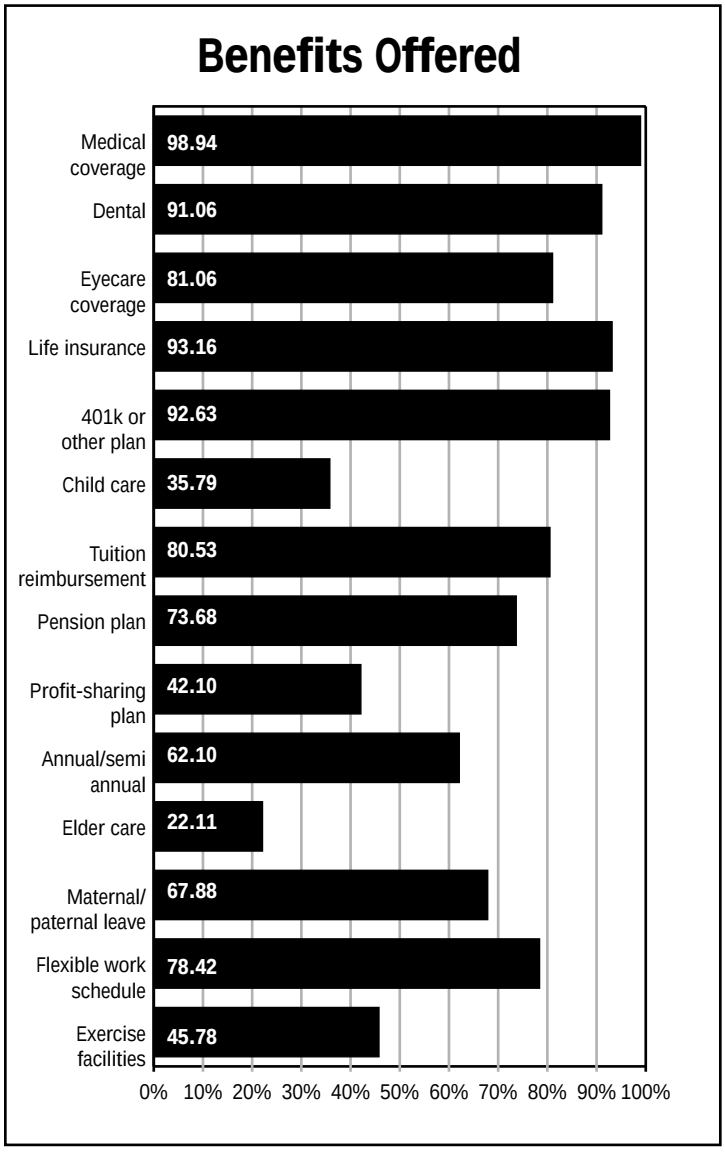
Carol Hiatt, RN, nurse manager at Ocala (FL) Eye Surgery, doesn't have to imagine this scenario. She does have a busy surgery program and a list of people who want to work in her program. Most of these nurses will be called by Hiatt only if she expands the program and needs additional staff because, as she says, "I have no turnover."

About one-third (30.5%) of the respondents to the 2001 *Same-Day Surgery* salary survey indicated that they also experienced no change in the number of their employees. Of the remaining respondents, 52% reported an increase in the number of employees and 16% reported a decrease.

Same-Day Surgery sent the annual survey to 1,035 subscribers. A total of 190 readers responded, for a response rate of 18.36%.

Enabling employees to participate in decisions may be the best way to ensure employee satisfaction, says Hiatt. "We have switched from a supervisory to a team-based management structure," she says.

There are pre-op, post-op and operating room teams that work within each other to identify areas for improvement and solve problems, Hiatt explains. "The teams are empowered to make changes within their areas if the changes are in the best interest of patient care and the surgery center," she says.



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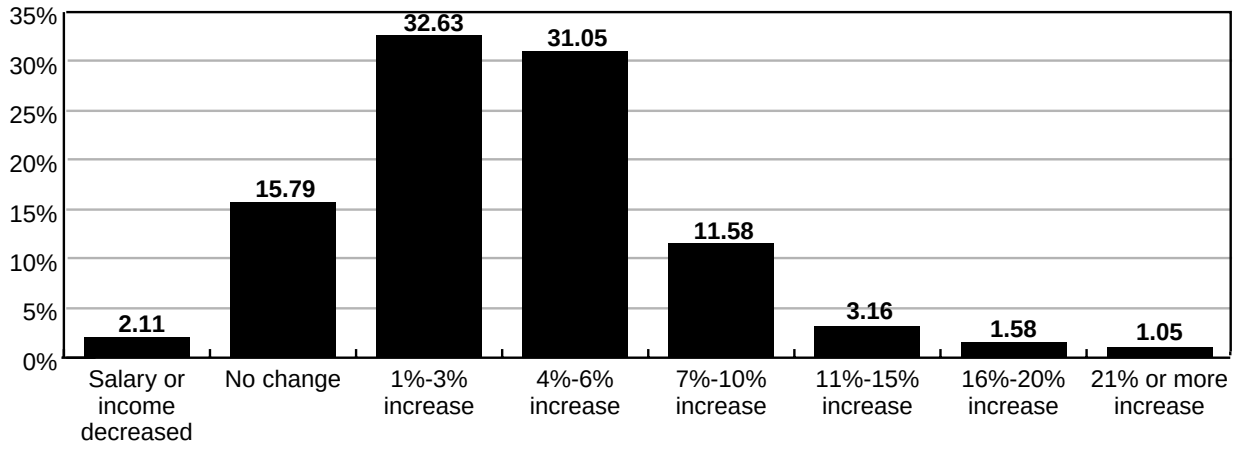


Salary by Title

	Director/CEO	Administrator	Ambulatory Surgery Manager	Nurse Manager	Other
Less than $30,000	0.00%	1.82%	0.00%	0.00%	0.00%
$30,000 to $39,999	0.00%	0.00%	6.67%	2.27%	5.88%
$40,000 to $49,999	0.00%	1.82%	10.00%	18.18%	11.76%
$50,000 to $59,999	11.90%	10.91%	40.00%	29.55%	17.65%
$60,000 to $69,999	23.81%	16.36%	26.67%	27.27%	23.53%
$70,000 to $79,999	21.43%	25.45%	6.67%	13.64%	23.53%
$80,000 to $89,999	16.67%	12.73%	10.00%	6.82%	17.65%
$90,000 to $99,999	11.90%	12.73%	0.00%	2.27%	0.00%
$100,000 to $129,999	14.29%	18.18%	0.00%	0.00%	0.00%

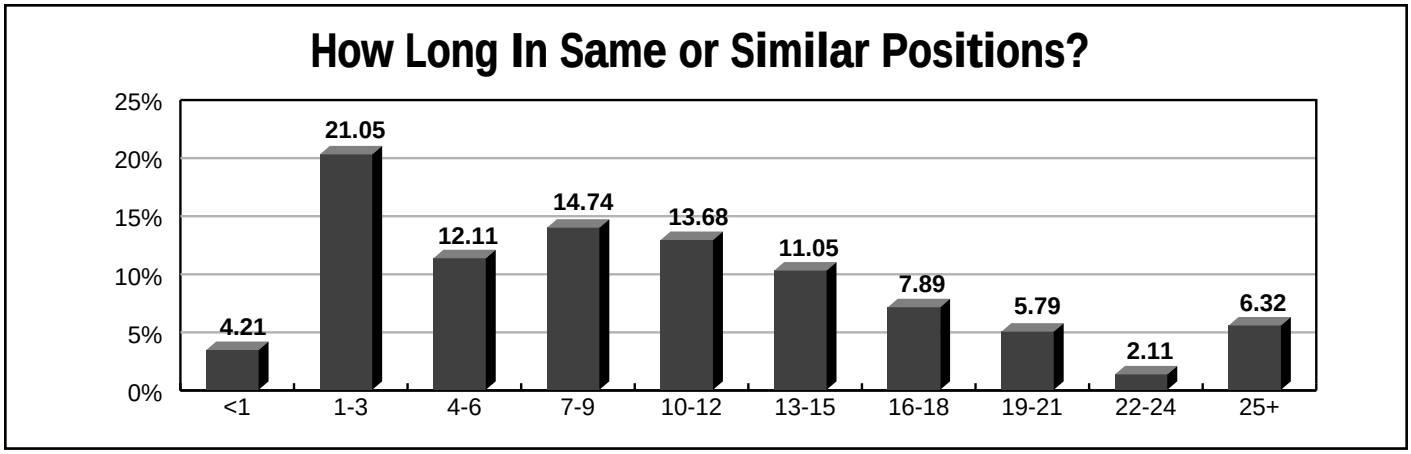
In one case, the operating room team decided that turnover could be better handled if three circulators were assigned to two rooms that a single surgeon was working. Then the nurse who brought the patient into the room could accompany the patient to recovery and another would be setting up the room to be ready for the surgeon. "This was an ideal solution because it kept the surgeon working and maintained a continuity of care with the patient," says Hiatt.

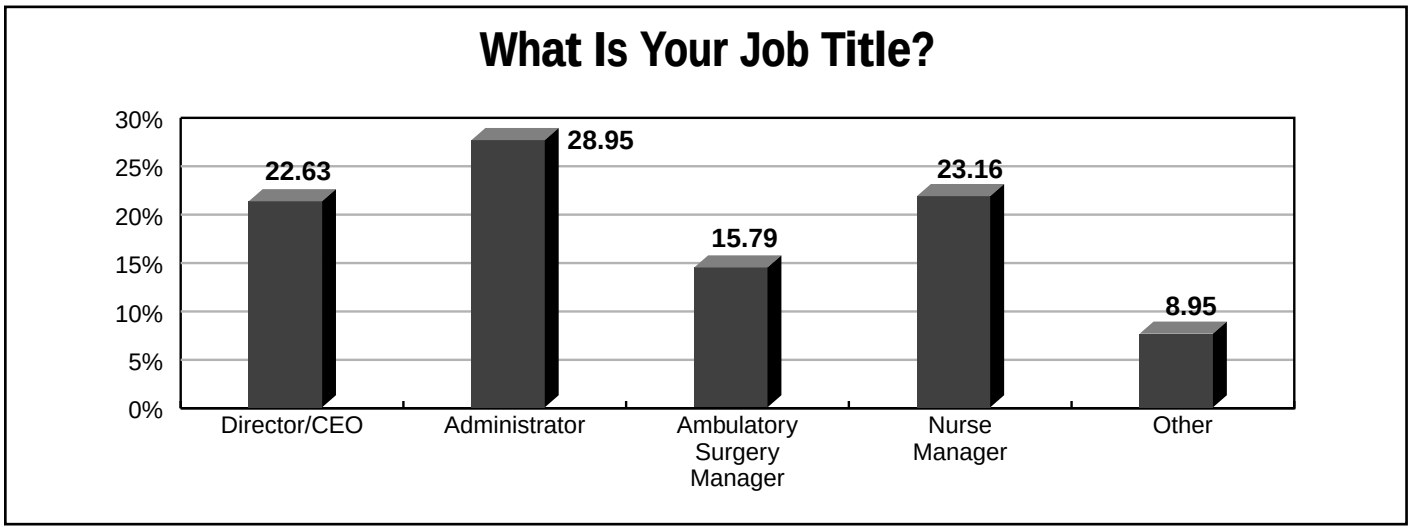
Another way to increase employee satisfaction and reduce turnover is to find out what daily activities may be keeping them from concentrating on patient care, says **Mary K. Ryan**, BSN, CNOR , ambulatory surgery center manager at Tri-State Surgery Center in Dubuque, IA. An employee satisfaction survey identified a need for a new position to help relieve nurses of the frustrating task of tracking and ordering supplies.

"Our different specialty teams had been responsible for ordering their supplies and equipment but the nurses were increasingly frustrated by the amount of time this task required," says Ryan.

The center posted a new position of inventory specialist. "We wanted a person that had a clinical background so he or she would be familiar with the needs of a surgery program," she explains.

A surgical technologist already at the center applied for the job and spends half of her time as inventory specialist and half of her time in the operating rooms. "Our nursing teams still prepare a weekly order from our item master list, but they





now submit it to the inventory specialist," Ryan says.

The specialist reviews the lists, makes sure there are no duplicate orders, ensures that extras of some items are ordered if needed, and places the orders. "The best thing about this person is that she has the time to research new items, review prices, and look at the overall picture," adds Ryan.

Another secret to Hiatt's success is her ability to offer salaries commensurate with experience, she says.

"I'm paying at the top of the scale, but it is more cost-efficient for me to do so," she says. It takes her one and one-half years to train a nurse with no ophthalmology experience to become an ophthalmic circulator. It is less expensive for her to pay one experienced nurse at the top of the pay scale rather than pay two nurses during the training process.

"I'm able to offer salaries and annual increases that attract nurses with the best experience, but when I compare my overall payroll to national averages, my program's payroll is within the norm," says Hiatt.

Salary increases for survey respondents have improved slightly over increases reported in the 2000 survey. An increase of 1% to 3% was reported by 34% of the 2000 survey respondents and by 32.63% of this year's respondents.

There was, however, an increase in the number of respondents receiving 4% to 10% increases. The percentage went from 38.8% in 2000 to 42.63% in 2001.

SOURCES

For more information about team management and employee satisfaction surveys, contact:

- **Mary K. Ryan**, BSN, CNOR, Ambulatory Surgery Center Manager, Tri-State Surgery Center, 1500 Associates Drive, Dubuque, IA. Telephone: (800) 648-6868, ext. 4500 or (563) 584-4500.
- **Carol Hiatt** RN, Nurse Manager, Ocala Eye Surgery, 3330 S.W. 33rd Road, Ocala, FL 34474. Telephone: (352) 873-9311. Fax: (352) 873-9652. E-mail: chiattoesc@aol.com.

A flexible work schedule is important or very important, according to 63.68% of the survey respondents; however, 20% of the respondents indicated that flexible work schedules are not available in their programs.

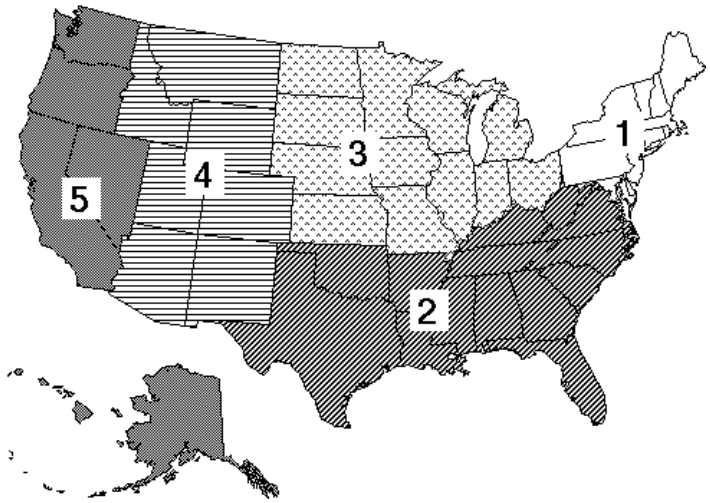
"It's important to offer some flexibility in the work schedule," says Hiatt.

In addition to her full-time staff, Hiatt has a group of per diem nurses that can be called upon if the schedule is unusually busy or if a nurse needs a day off, she explains.

Hiatt also cross-trains employees to other areas to help avoid burnout. "I have no turnover because my staff members know that they and their expertise is appreciated and valued," she says.

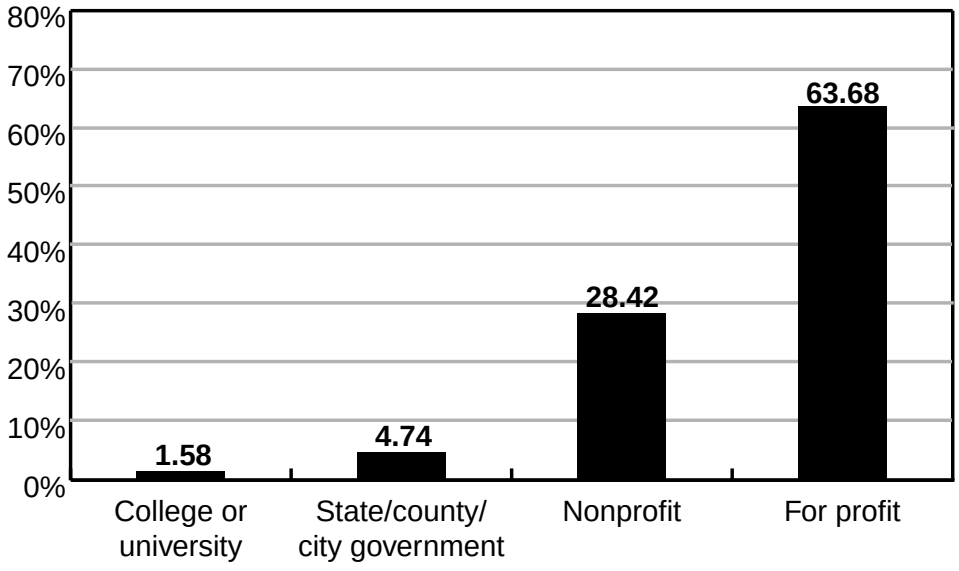
[Editor's note: Do you have success or failure stories for retaining or recruiting staff? Please send your ideas to: Joy Daughtery Dickinson, Senior Managing Editor. E-mail: joy.dickinson@ahcpub.com. Telephone: (229) 377-8044.] ■

Where Is Your Employer Located?



Region 1	17.37%
Region 2	27.89%
Region 3	31.58%
Region 4	7.89%
Region 5	11.58%

Describe the Ownership of Your Program



A Chemical/Biological/Agent Checklist

Biological agents	Effects of inhalation	Incubation	Communicability	Treatment
Anthrax	Fever, headache, fatigue, dyspnea, death if untreated	1-5 days	None, but spores can survive outside host for years	Intravenous antibiotics for 30 days, plus vaccination, effective only if begun before symptoms appear
Botulism	Blurred vision, photophobia, difficulty speaking, progressive paralysis, respiratory failure, death	1-5 days	None	Supportive therapy, antitoxin available only through CDC
Hemorrhagic fever	High fever, low blood pressure, subcutaneous hemorrhage, bleeding from mucous membranes, organ failure, death	4-21 days	From patient fluids	Supportive therapy, ribivirin for some viruses
Plague	Fever, chills, headache, nausea, vomiting, pneumonia and bloody sputum, septicemia, death	2-3 days	Highly contagious via aerosol route	Intravenous antibiotics twice daily for 7 days.
Smallpox	Fever, malaise, headache, backache, abdominal pain, rash, death in 20-30%	7-17 days	Highly contagious via aerosol or contact with pox scabs	Symptomatic treatment only; vaccine only through CDC
Tularemia	Fever, weakness, prolonged weight loss; seldom fatal	2-10 days	None	Antibiotic twice daily for 10-14 days

Chemical agents	Effects	Onset	First aid
Nerve Agents Tabun (GA) Sarin (GB) Soman (GD) GF, VX	Miosis, rhinorrhea, dyspnea, convulsions	Seconds to minutes	Decontamination, atropine, pralidoxime, ventilation, anticonvulsants
Vessicants **(blister agents):** Mustard Lewisite Phosgene oxime	Erythema, blisters, eye irritation, blindness, dyspnea, coughing	Minutes to hours	Decontamination, topical antibiotics, bronchodilators, ventilation, British antiLewisite
Blood agents: Hydrocyanic acid Cyanogen chloride Arsine Methyl isocyanate	Panting, convulsions, loss of consciousness, apnea	Minutes	Nitrites, sodium thiosulfate
Choking agents: Phosgene Chlorine Ammonia	Tightness in the chest, coughing, dyspnea	Minutes to hours	Oxygen, bronchodilators, ventilation

Acadiana Surgery Center External Disaster Plan

PURPOSE

In the case of a community disaster occurring in Iberia Parish, as well as several of the surrounding parishes, it is conceivable that Acadiana Surgery Center might be expected to provide facilities for emergency medical care. The purpose of this plan is to prepare and arrange for efficient utilization of the facilities and personnel in order that the center can meet its responsibilities to the community.

DEFINITION

A disaster is defined as any occurrence that would results in the influx of such a large number of casualties in a sufficiently short period of time as to completely disrupt the center's normal routines and procedures. It may range from large accidents to natural disasters such as hurricanes or tornadoes, and up to warfare. In the event that biological disasters or warfare occur, the center will close in order to provide support to the Civil Defense.

ACTIVATION

The Governing body will activate the external disaster plan.

CENTER NOTIFICATION

The Emergency Medical Scene Commander or Director of Civil Defense will be responsible for notifying the center from the disaster site. The EMS Commander will notify the center of the number and condition of patients and the estimated time of arrival.

TRIAGE TAGS

Medics at the scene will do initial triages and will tag all patients as to the class of care needed. Vital signs and other medical treatment performed will be noted on the card front or back, and this card may be used by the center to document any further treatment rendered. The cards will be used for identification throughout the patient's treatment in addition to any identification number that the center may assign to the patient on their arrival.

Triage Classifications are as follows:

CLASS 1 Immediate urgent care required. High survival probability if given care.

CLASS 2 Urgent care required. Systemic implication or can wait 45-60 minutes; or poor chances of survival regardless of urgency.

CLASS 3 Minimal care required. Minor injuries or can wait 1-2 hours with minimal care.

CLASS 4 DOA

DUTIES AND RESPONSIBILITIES

The Director of Nurses, or delegate, will be responsible for assigning duties to personnel who will be assisting the Medical Staff. Sufficient staffing will be assigned to the following duties:

1. Answering the telephone.
2. Delivery of requested supplies.
3. Assisting in proper identification of patients and placement of patient in proper holding area based on class.
4. A route sheet will be kept with each patient. This sheet will be used for documenting admission, services rendered, transfer to other facilities, and discharge. See attached form.
5. Nurses will perform necessary nursing duties. Current standing orders of the center will serve as treatment protocol.
6. Transport patients from holding to proper treatment room.
7. Coordinate patient transfers to other facilities when appropriate.
8. Schedule necessary patient services with other facilities as needed.
9. Remove soiled linen and trash, keeping fresh supply of linen.
10. Clean equipment.

Volunteers will report to the Director of Nurses, or delegate and be allowed to assist as follows:

1. Volunteers with medical training will be allowed to assist to the level of their expertise as determined by the Governing Body.

2. All other volunteers will be allowed to assist with any nonmedical duties.

Obviously, different scenarios will have different staffing requirements. Assignments are offered as a guideline, and other duties may be assigned as needed.

ADDITIONAL INFORMATION

1. ID cards or name pins will be worn to identify employees and volunteers to other employees and physicians.
2. When making notification calls, in order to expedite procedures, it should not be necessary to give employees a description of the disaster, only that a Code Orange has been put into effect.
3. Personnel making notification calls should inform the Director of Nurses when calls are completed.
4. Good communication is a key asset in any disaster. Communications between areas may be done by phone.
5. In order to calm concerned family members, the staff may either call or go to the treatment areas to find out the status of a patient.
6. Patients may only be discharged by a member of the Medical Staff.
7. Matt Musso, RPh, will provide emergency drug supplies.
8. Doerle's Food Service will provide emergency food supplies.
9. New Iberia City Police Department will provide security personnel. Contact Major Scott at 369-2349.
10. Less than essential services will be discontinued in the event of an external disaster. The attending physician will determine which procedures can be discontinued.
11. In the event of evacuation, patients will be relocated. The magnitude of the disaster will affect the relocation site. In localized disasters involving relatively small geographical areas, patients will be

transferred to undamaged health care facilities. Local relocation sites include Dauterive Hospital and Iberia Medical Center. Ambulances will transport patients. For larger disasters, nondischargeable patients will be relocated to a designated evacuation site.

DISASTER FLOW SHEET

Scene of Disaster (Initial Triage Done by EMS)

Center Waiting Area (Triage Area)

Primary Treatment Areas
(Listed Below)

"Class 1"
All Class 1 patients will be treated in the procedure rooms.

"Class 2"
All Class 2 patients will be treated in the recovery holding area.

"Class 3"
All Class 3 patients will be treated in the corridor.

"Class 4"
All Class 4 patients will be held along empty walls.

OTHER DEDICATED AREAS

Command Center . . . . . Nurses Station
Patient Families . . . . . Staff Lounge
Press Area . . . . . Medical Records

PERSONNEL TO BE CALLED

The local Civil Defense Director will be given the private phone numbers of the Governing Body to call in the event of an external disaster. The Governing Body then in turn will notify all personnel to report immediately to the center for duty.

HAZARD VULNERABILITY ANALYSIS

An analysis will be performed annually and included in the evaluation of effectiveness of the emergency preparedness plan. This analysis will rate the likelihood of incidents (based on Red Cross / Disaster Relief Act of 1974) and their occurrence. All ratings of 3 or 4 need to be addressed in Emergency Plans.

Updated 10/01.

Source: Acadiana Surgery Center, New Iberia, LA.

A Sample Policy/Procedure For Departments of Anesthesia on Chemical Dependency

Note: This policy and set of procedures are provided as a sample and must be individualized to meet the specific needs of your work setting, take into account the nurse practice act of your state, and any pre-existing policy concerning chemical dependency (i.e., drug testing, pre-employment screening, employee assistance programs, etc.).

PURPOSE
This facility (name) has a vital interest in maintaining a safe, healthy and efficient environment for its employees and patients, an environment free from the misuse of drugs and alcohol. Recognizing that chemical dependency is both a disease and a professional hazard, the purpose of this policy is to provide guidelines for the reduction, confrontation and management of substance abuse within the department of anesthesia.

POLICY
It is the policy of the department to provide a safe, fair working environment for all anesthesia practitioners and their patients.

PROCEDURES
I. Education.
All members of the department will be informed about their risk of becoming chemically dependent, how to recognize impairment in the workplace, the importance of proper intervention, and how to assist those with a prior substance abuse history to (re)enter the department. Supervisory personnel will receive training on the conduct, behavior and indicators of drug and alcohol abuse. They will also be trained in the guidelines and administration of the department and institutional policies on chemical dependency. The department is responsible for conducting an education and training program, as well as providing information on related resources.

A. A minimum of six educational hours specific to chemical dependency shall be provided each member of the department.

B. Offerings will be provided by experts in the community, multimedia resources, and/or practitioners in recovery.

The department will maintain a resource file of:
1. The names, addresses and telephone numbers of community drug and alcohol counseling and rehabilitation programs.
2. Relevant educational materials from the state licensing bodies, and professional associations to include:
a. Medical and Nurse Practice Acts relevant to impairment.
b. State Peer Assistance Committees.
c. Pertinent AANA and ASA resource publications/material on peer assistance.
d. Information on the AANA Peer Assistance Hotline and the ASA Committee of Occupational Health and Safety will be prominently posted within the department.
3. Mental health providers and entities designed to assist employees with personal or behavioral problems.

II. Drug Testing.
Anesthesia providers shall be required to submit to drug testing as a condition of employment. Failure or refusal to cooperate with any aspect of this policy including, but not limited to, refusal to sign forms consenting to drug testing or the refusal to submit to urine or blood sampling for testing to determine

use of, or impairment by, a controlled substance or intoxicant will result in disciplinary action up to and including discharge and the reporting of use to the appropriate authorities.

Applicants and employees will be required to sign an acknowledgment form and consent to this policy. An employee may be required to undergo a blood test or urinalysis under any of the following circumstances:

A. When there is reason to believe in the opinion of this facility that an employee is under the influence of intoxicants, nonprescribed narcotics, hallucinogens, marijuana or other non-prescribed controlled substances.

B. After the occurrence of a reported work-related injury/illness, or accident while on the facility property or during work hours.

C. On a random basis.

D. During any physical examination provided by the facility.

E. When employees who have been on leave of absence, rehire after layoff, or who have not worked within the twelve weeks preceding their return date.

Testing Procedure — Drug testing will be conducted using the following measures.

A. Employees will be required to sign the facility's consent forms.

B. Employees will be required to sign the chain of custody forms provided by the testing laboratory.

C. Employees should disclose any medication, whether prescribed or over-the-counter, as well as any dietary intake that could alter a drug screen.

D. The facility will use a laboratory for testing which meets the current scientific and technical guidelines for drug testing programs.

E. A second test will be used on any positive screen.

F. All positive drug tests will be verified by a medical review officer. If it is determined that there is a legitimate medical explanation for the positive results, the medical review officer shall report the test results as negative.

Confidentiality — Testing and test results will be handled confidentially with disclosure of results provided only to those individuals with a need to know. Upon request, employees will be provided a copy of test results.

Prescription drugs — Employees and applicants who have been taking legally prescribed drugs or over-the-counter medications should disclose this use prior to testing. A confidential consent form requesting information concerning this drug usage will be provided each employee/applicant prior to testing.

III. Insurance Provisions.
Because anesthesia providers are at increased risk of becoming addicted, this department will strive to make available as part of its benefits package both healthcare and disability insurance policies which have provisions for chemical dependency and mental health treatment.

IV. Narcotic Accountability.
A written, consistent process of narcotic accountability will be followed by all members of the department.

The use of all scheduled drugs, and others deemed necessary by the department administrators, will be managed as follows:

A. All scheduled drugs will be kept under double lock and signed for only by authorized individuals according to regulatory guidelines, i.e., the Drug Enforcement Agency (DEA).

B. Narcotics will not be exchanged between department members, not even narcotics signed out for the same patient between primary and relieving anesthetists.

C. All unused portions of drugs will be returned to a centralized, mail slot type of locked compartment that can only be opened by the narcotics control officer, or they may be returned to a staffed pharmacy. If there is no centralized area, all narcotic wastage will follow facility guidelines with documented double witness wastage.

D. Assays on unused portions of narcotics, as well as audits of anesthesia and PACU records, will be conducted periodically and if suspicion warrants.

V. Quality Assurance.
Written periodic evaluations of department members and random audits of written records will be a part of the QA process. This information remain confidential and undiscoverable until such time that intervention or discipline may be required. This review shall include anesthesia records, PACU notes and narcotic inventory / usage.

A. Unusual trends, violations or errors will be documented and investigated within the department.

B. When sufficient evidence exists that inappropriate narcotic usage has occurred, a specific investigation will begin and a more in-depth review of specific records.

VI. Documentation.
Appropriate documentation will commence upon suspicion of misuse of departmental pharmaceuticals, or signs of drug / alcohol abuse. Upon suspicion of substance misuse, documentation shall be as follows:

A. Note changes in behavior such as appearance, demeanor, attendance, and being in the department when off duty.

B. Documentation will be kept by the department head or supervisor in non-discoverable files, but may be made a part of the employee's record should disciplinary action be warranted.

C. Documentation shall include names of those that can substantiate the observations, and should include specific dates and circumstances of all notations.

VII. Confrontation.
When there is sufficient documented evidence of employee impairment, or when evidence exists that the employee is diverting controlled substances from the department, a confrontation will be planned. Employees shall be offered the option to self-report to an impaired professionals program (if such a program or legislation exists within the state of practice). A meeting or intervention shall be planned to confront the employee with documented questionable behavior. The planning and conduct of this confrontation shall be as follows:

A. A confrontation will be planned that includes:

1. Sufficient documented evidence.
2. The presence of the principle observers of the questionable behavior.
3. A trained individual capable of conducting an intervention.
4. Recognition of the potential for immediate placement of the employee in a facility for assessment and possible treatment.

B. An extended leave of absence shall be granted to the employee for chemical dependency treatment that leaves intact all applicable insurance plans and benefits. The individual will be advised how payment will continue to be provided for such benefits.

C. If the employee refuses to comply with a request that they be evaluated for chemical dependency the information collected to date will be submitted to the appropriate regulatory agency for further investigation and probable discipline.

VIII. Re-entry.
Anesthesia providers with a prior history of chemical dependency may (re)enter the department if they can show sufficient evidence of successful completion of treatment and documentation of active recovery. Applicants or employees with a prior history of chemical dependency will:

A. Provide evidence of successful completion of drug / alcohol rehabilitation and sustained active recovery / sobriety.

B. Possess current licensure, or any required registration.

C. Comply with the conditions for active recertification as a CRNA, as determined by the Council on Recertification.

D. Have their history kept in confidence and their anonymity protected until such time that they choose to divulge their anonymity.

E. Be treated with respect and afforded all opportunities granted to others with disabilities.

F. Abide fully with all departmental policies, and shall comply with the conditions set forth in a rigid written reentry contract.

Source: Developed by the American Association of Nurse Anesthetists Peer Assistance Advisors, August 1997, Park Ridge, IL. Web: www.aana.com/peer/policy.asp.

No.	601.00
Chapter:	Returning to Professional Practice
Topic:	Authorization

HPRP participants may be required to withdraw from or limit their professional practice for a period of time in order to protect the public's health and safety. This procedure describes the requirements, which must be met before the participant is to be returned to professional practice.

REQUIRED RECOMMENDATIONS

Recommendations to the HPRP contractor must be made by the treating professional and/or health professional support group facilitator regarding the participant's ability to practice safely.

In evaluating a participant's ability to safely practice, the treatment professional and HPRP team must consider the participant's:

- ☐ stability in recovery
- ☐ compliance with the Recovery Monitoring Agreement
- ☐ ability to return to job environment and practice in a safe and competent manner
- ☐ overall cognitive function
- ☐ recommended restrictions or limitations on practice

The HPRP team will review the records and recommendations and make a determination regarding the participant's return to professional practice.

AUTHORIZATION

Once the designated treatment professionals evaluate a participant and the decision is reviewed and endorsed by the HPRP team, a formal authorization to return to practice with limitations or to practice without limitation shall be given.

RECOVERY MONITORING AGREEMENT

The Recovery Monitoring Agreement shall be amended to reflect the level of practice that has been approved.

Date approved: September 16, 1997
Date amended: September 15, 1998

Source: Health Professional Recovery Committee, Department of Consumer and Industry Services, State of Michigan, Lansing. Web: www.cis.state.mi.us/bhser/hprp.

Fax-Back Survey

Dear *SDS* subscriber:

The survey below refers to the *Same-Day Surgery Reports* supplement, Hypothermia During Laparoscopy: Effects of Warming and Humidification of Insufflation Gas, that was inserted in the September 2001 issue of *Same-Day Surgery.* Please fax to Jean Leverett at (404) 262-5447.

Was the supplement on hypothermia helpful?
❒ Yes
❒ No
Comments (optional)

_____
_____
_____

If you are not a physician, did you share the article with one or more physicians?
❒ Yes
❒ No
Comments (optional)

_____
_____

Would you be interested in having future supplements offer nursing contact hours (as well as CME)?
❒ Yes
❒ No
Comments (optional)

_____
_____

Do you know of any physicians or nurses who would be interested in writing supplements for us? If so, please include the following information:

Potential writer's name: _____
Title:_____
Facility: _____
Address: _____
City: _____
State:_____
Zip: _____
Telephone:_____
E-mail:_____
Fax: _____

Please fax your completed survey as soon as possible to (404) 262-5447. Thank you.