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INSIDE

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Clinicians debate whether wounds should get wet after same-day surgery

CDC guidance is limited — here's what the experts say

One of the great controversies in same-day surgery is whether sutured wounds should be allowed to get wet after surgery. Some surgeons insist that surgical wounds be kept dry for days to weeks.

"Overall, the general public as well as the general medical community still persists in believing that wound management should be carried out under dry conditions, so the wound can form a scab," says **Liza G. Ovington**, PhD, CWS, president of Ovington & Associates, a wound care education and consulting firm in Dania, FL. However, she says, "That may not be the case."

There's a tendency to associate wetness with infection. "We're so used to dry wound healing, seeing scabs; it seems intuitive that the wound should be dry to the point that it forms scab or dries out," Ovington says. Proposed guidelines on surgical site infection from the Centers for Disease Control and Prevention (CDC) say clinicians should protect a primarily closed incision site with a sterile dressing for 24 to 48 hours post-op.

EXECUTIVE SUMMARY

Should the sutured wound be allowed to get wet after same-day surgery? Proposed guidelines on surgical site infection from the Centers for Disease Control and Prevention state clinicians should protect a primarily closed incision site with a dry sterile dressing for 24 to 48 hours post-op.

- Research supports moist wound healing and the use of occlusive or semi-occlusive dressings, wound experts say. Wounds should be maintained in a physiologically moist state, they say.
- Transparent film dressings might be most appropriate because they allow the clinician to see the wound through the dressing and are waterproof.
- Patients should be able to wash the wound area after 24 to 48 hours with soap and water, if the cleaning is done gently, one expert advises.

Initially, the recommendation included the wording "dry sterile dressing," but "dry" was dropped due to questions surrounding the definition of a dry dressing, according to **William Trick**, MD, medical epidemiologist in the Hospital Infections Program at the CDC.

The proposed guidelines fall under Category 1A: Strongly recommended for all hospitals and strongly supported by well-designed scientific studies. In the proposed version, there is no recommendation on covering the incision beyond 48 hours nor on an appropriate time to shower / bathe with an uncovered incision. Therefore, the issue is unresolved. **(For more information on the proposed CDC guidelines, see *Same-Day Surgery*, October 1998, pp. 127-131.** The CDC will publish the guidelines this spring, according to Trick.**)**

Research supports occlusive dressings

While there has been an extensive amount of nurse research on the topic of wound healing and wetness, the physician literature is limited, says **Wendelyn Valentine**, RN, MSN, CNOR, CRRN, COCN, clinical nurse specialist, surgical, at the University of Washington Medical Center in Seattle.

The research supports moist wound healing and the use of occlusive or semi-occlusive dressings, say sources interviewed by *SDS*. Technically, occlusive dressings don't transport liquid or gas, Ovington says. Semi-occlusive dressings won't transmit liquids, but will transport gases such as oxygen, she says. However, the terms are often used interchangeably.

Ovington points to several human clinical trials of occlusive dressings, which don't allow a wound to dry out, vs. conventional (gauze) dressings in surgical wounds,[1-4] including a randomized controlled trial that minimizes bias.[5] These studies support the use of occlusive dressings, she says.

Valentine refers to two benchmark studies: The first study demonstrated lower rates of infection for wounds, even surgical wounds, when occlusive dressings were used.[6]

"That's the optimal research-based treatment for most patients," she says.

The second study gives an overview of wound healing in a moist environment.[7] Sutured wounds heal faster if the environment is physiologically moist, Ovington says. Physiologically moist refers to the naturally moist state of tissue. "As natural organisms, we're mostly composed of water. With a wound, it's actually healthier if it's physiologically moist."

The idea of allowing a moist healing environment has not gained full acceptance, however, Ovington says. "Often, this is new and, therefore, uncomfortable information to a clinician."

Valentine says she believes wound healing in a moist environment makes the shower / bath issue insignificant. "If you're keeping a moist environment intentionally, that would lead you to believe that the wound getting wet makes no difference."

Semi-occlusive dressings maintain the physiologically moist state of wounds, Ovington says. "The wound is kept moist because the transparent film slows the evaporation of moisture from the tissue."

Transparent film dressings might be the most appropriate for sutured surgical wounds, she says. The transparency allows the clinician to see the wound through the dressing. Also, the wound is waterproof, so patients can bathe or shower.

Keeping the wound free of bacteria is also critical because sutures can allow bacteria to gain access to tissue, Ovington points out.

Valentine agrees. "If a fresh wound is put under an occlusive dressing, that protects it from any external bacteria," she says.

In terms of showering or bathing, patients should be able to wash the wound area after 24 to 48 hours if the cleaning is done gently, emphasizes **John Fildes**, MD, FACS, professor of surgery at the University of Nevada School of Medicine in Las Vegas. Fildes spoke on acute wound failure at the October Clinical Congress of the Chicago-based American College of Surgeons.

"It's been shown that the wound forms a scab," Fildes explains. "At the level of the epidermis, it is sealed within 24 hours."

Soap and water are appropriate cleaning

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agents, he maintains. "I tell them after 24 to 48 hours, they can remove dressing; they can shower and wash the area very gently with soap and warm water, and then pat it dry."

It's not uncommon medical practice for a surgeon or nurse to inspect or clean a wound the day after surgery, Fildes points out. "When they clean, they commonly use solutions like Betadine or alcohol, which are far more likely to damage the immature healing tissues than simple soap and water."

Fildes admits that his advice is an exception to what most surgeons practice. "Most will keep an occlusive dressing in place for several days or until the first office visit to inspect the wound."

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SOURCES

For additional information on wound healing, contact:

- **John Fildes**, MD, FACS, 2040 W. Charleston Blvd., Suite 302, Las Vegas, NV 89102.
- **Liza G. Ovington**, PhD, CWS, President, Ovington & Associates, 429 S.E. Third Terrace, Dania, FL 33004. Telephone: (954) 929-1902. Fax: (954) 929-2308. E-mail: lizao@msn.com.
- **Wendelyn Valentine**, RN, MSN, CNOR, CRRN, COCN, Clinical Nurse Specialist, Surgical, University of Washington Medical Center, 1959 N.E. Pacific St., Box 356090, Seattle, WA 98195-6090. Telephone: (206) 548-4532. E-mail: wendyv@u.washington.edu.

Salesman in OR leads to lawsuits after patient dies

Salesman performed part of procedure, reports say

A New York hospital is facing major malpractice lawsuits, a state-imposed fine, and a public relations disaster after an incident in which a woman died during what should have been a routine procedure. Investigators claim the woman died because two surgeons made gross medical errors. They also claim that an equipment salesman actually performed part of the procedure.

The incident should be a warning about the risks of allowing salespeople in the operating room without adequate constraints, some observers say. Even though the salesman's alleged participation in the procedure apparently was not the cause of the woman's death, it greatly complicates the defense of the malpractice cases and creates extremely bad publicity for the facility, Beth Israel Medical Center in New York City.

The immediate fallout from the incident was a $30,000 fine imposed on Beth Israel by New York state health officials. The officials concluded that a salesman of hysteroscopy equipment participated in the procedure, actually manipulating the new electrosurgery system because the doctors and nurses did not know how to operate it.

But that is only the beginning of the hospital's troubles. The woman's husband has filed suit against the hospital, both surgeons, the anesthesiologist, and Ethicon, the company whose salesman allegedly participated in the procedure. Ethicon is a division of Johnson & Johnson.

Observers also expect the incident will be considered a sentinel event by the Joint Commission on Accreditation of Healthcare Organizations, which will obligate the hospital to conduct a thorough analysis of how it happened and how it can be prevented in the future. Sentinel event status is likely because the incident was widely reported in the general media, one of the Joint Commission's main sources for identifying sentinel events, and because it so obviously signals a major problem at the hospital.

Sam Bishop, ARM, vice president of compliance and insurance services for Wellstar Health System in Marietta, GA, says the incident shows that staff may need to be educated and reminded

about issues that seem obvious to managers, Bishop says. It may be time to remind surgical staff about proper conduct of visitors in the operating room. **(See p. 21 for more on how such incidents can be avoided.)**

Procedure should have been routine

The incident began in October 1997, according to a report from the New York state health department. Ethicon salesman David Myers reportedly met with Allan Jacobs, MD, chairman of the hospital's OB-GYN department, to introduce an Ethicon product used for hysteroscopies, a minimally invasive procedure. The product, the Versapoint Bipolar Hysteroscopy Electrosurgery System, allows the surgeon to cut and ablate with electrosurgery probes.

Jacobs made no commitment to purchase the product but did not dissuade Myers from seeking the support of surgeons and other administrators, according to the report. Myers arranged to have the product used in surgery about a month later with OB-GYN partners Marc Sklar, MD, and Robert Klinger, MD. The patient, Lisa Smart, 30, was a healthy accountant and financial analyst undergoing hysteroscopy for the removal of a benign fibroid tumor — a routine procedure with relatively little risk.

State health investigators say the OR nurses told the surgeons they were not familiar with the new electrosurgery system, but that the surgeons dismissed the nurses' concerns and said Myers would operate it. The salesman was scrubbed and did operate the electrosurgery system during the procedure, according to the health department report.

However, the report does not claim the salesman's actions led to the woman's death. As a normal part of the procedure, the patient's uterus was filled with saline, and nurses monitored the fluid output closely to make sure the patient was not overloaded with fluids. The salesman reportedly was operating the electrosurgery equipment and had no involvement in the fluid administration. The state report says that a nurse told the doctors several times during the surgery that the fluid output was too low, but her concerns were dismissed.

But immediately after the surgery, the patient appeared bloated from excess fluid. According to the state report, one of the OR nurses claims Klinger admitted to shutting off the fluid outflow so he could get a better view of the uterus, an action that could lead to fluid overload if not corrected quickly. Klinger denied shutting off the flow or making the statement afterward, according to the report.

As a result of the fluid overload, the woman went into cardiac arrest soon after surgery and died in the emergency department. The autopsy determined she had died of "excessive infusion and absorption of normal saline."

Sklar's and Klinger's offices, as well as the attorneys representing both doctors, declined comment. Beth Israel released a statement saying, "those who acted inappropriately violated Medical Center rules and procedures and have been severely disciplined."

Salespeople in the OR are nothing new, and managers have expressed concern about them in the past. The Beth Israel incident raises troubling questions nonetheless. If the state health report is accurate, the nurses knew before the procedure was under way that the salesman would be operating the electrosurgery system, which means there was, presumably, time to try to stop the procedure.

The implications of that scenario would differ significantly from those resulting from an infraction occurring after a procedure begins; in that case, the damage may be done before the staff can protest.

Nurses should act

If the incident happened as state health officials say, the nurses should have reported the surgeons' intent to their supervisors and not proceeded with the surgery, says **Margaret Douglass,** MPH, RN, director of risk management at FPIC, a physicians' insurance company based in Jacksonville, FL. Such an incident would serve as a clear example of a situation in which nurses must refuse improper orders and report the problem through the chain of command, she says.

"Absolutely, the nurses should know just from being a nurse that it's not right for a salesperson to perform patient care," she says. "They should have questioned the doctor's orders on the spot and then should have run right out and grabbed their OR supervisor. This certainly was out of the ordinary, and they should have acted to protect the patient.

"I would want to see the policies in place at the time, the chain of command policies, and shoot the charts through peer review to see if any education is needed for the physicians involved. In addition to the chain of command questions, I'd

want to know whether there had been any education on fluid overload," says Douglass.

When nurses observe inappropriate behavior in the OR, they should determine if patients are in immediate danger and resolve that first, suggests **Ramona Conner**, RN, MSN, perioperative nursing specialist at the Center for Nursing Practice, Health Policy, and Research at the Association of Operating Room Nurses in Denver.

If the patient isn't in danger, but doctors or salespersons need to have their behavior addressed, follow the chain of command at your facility, she says. Typically, the policy is to report the situation to your immediate supervisor. "And it goes on up the chain of command until it's resolved. Some actions have to be reported clear to the top and require administrative action. Others can be resolved by the immediate supervisor or the administrator of the OR."

Often the effort should be multidisciplinary by involving persons such as the chief of the medical staff, Conner suggests.

Douglass and Bishop advise you to establish two policies on OR visitors, if you have not already done so, and formally remind staff about the policies, even if you have reminded them before. The first policy should require that physicians obtain informed consent from the patient for any unlicensed visitor to the OR, including salespeople. The second policy should state that the visitor must never touch the patient or operate medical equipment in any way.

That second policy may seem painfully obvious, but Bishop and Douglass say it is necessary to remind staff and visitors. **(For more on policies, see story, below.)** ■

SOURCES

For more information on sales staff in the OR, contact:

- **Margaret Douglass**, Director of Risk Management, FPIC, 1000 Riverside Ave., No. 800, Jacksonville, FL 32204. Telephone: (904) 354-5910.
- **Sam Bishop**, Vice President of Compliance and Insurance Services, Wellstar Health System, 805 Sandy Plains Road, Marietta, GA 30066.

Most hospitals allow salespeople in the OR

Although you hope they aren't poking around in the patient, salespeople are a common sight in almost any hospital's operating rooms. That is the conclusion of a report from ECRI, the independent health care research organization in Plymouth Meeting, PA. Researchers there recently conducted a survey of 180 hospitals and found it is common to find salespeople and other types of visitors in hospital operating rooms. A firm 95% reported they allow salespeople and others to be present during surgery.[1]

How far do they go?

Ostensibly, the salespeople are there only to give pointers on how to use a surgical item and to schmooze with decision makers who are trying out the new items. But sources say it is not exactly a rarity for a salesperson to step over that line and actually use the instrument on the patient, especially during high-tech procedures in which the salesperson might be much more familiar with the device than the surgeon.

Ramona Conner, RN, MSN, perioperative nursing specialist at the Center for Nursing Practice, Health Policy, and Research at the Association of Operating Room Nurses in Denver, says, "I want to emphasize that the sales rep should never scrub in or become part of the sterile field in any way. They should not touch the patient or operative equipment. The sales rep should participate only by providing verbal guidance."

Although nearly all of the hospitals surveyed by ECRI allow salespeople in the OR, there were many different policies regarding their presence, and some facilities had no policy specifically addressing them. ECRI advises having a policy that outlines exactly what is and is not acceptable. The group makes these suggestions:

- **Obtain a legal release and require prior approval.** The company represented by the visitor should provide a document releasing the hospital from any liability related to the sales representative's presence. Any visitors, including sales representatives, should be required to make appointments to visit the OR. Even with an invitation from the surgeon, the visitor should notify the OR manager and obtain permission.
- **Make sure the visitor knows proper OR conduct.** Any non-OR personnel must be educated, either with written materials or an informal verbal

discussion, on topics such as OR apparel, traffic patterns, avoiding the sterile field, universal precautions, fire safety, electrical safety, and radiation safety.

The education does not have to be repeated for each procedure if the visitor has been in the OR before, but ECRI advises at least an informal reminder if this is his or her first time in your facility's OR.

Document any noncompliance with proper OR conduct, including accidental violations. Report the incidents to the OR manager, who should have the authority to ban the visitor from the OR for causing serious disruptions.

• **Do not take any guff from the salesperson.** The salesperson or other visitor is always a guest in your OR and should act accordingly. If you determine that the OR is too crowded to allow the visitor even though there was prior approval, for instance, your determination is final. Do not let the salesperson argue about it.

The visitor also must comply with any instructions in the OR, and if the visitor interferes with the procedure in any way or upsets any member of the OR team, he or she should be told to leave immediately.

• **Prohibit wandering.** If the visitor is allowed to observe surgery, he or she should be escorted to and from the OR area. Clearance to observe the surgery should not be construed as clearance to wander the OR area and chat with anyone in sight. The visitor should not be allowed in the doctors' lounges unless invited there by a doctor.

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New Procedures

Sentinel node biopsy considered for breast

Is it better than full axillary node dissection?

(Editor's note: This is the third in a four-part series highlighting innovative outpatient surgery procedures. In the previous two issues, we've covered cosmetic procedures and pain management procedures. Don't miss next month's issue, which will highlight another cutting-edge procedure that can yield profits for your same-day surgery program.)

At what point should you expand beyond the traditional approach for a procedure and add a new operation as an option? This is the question many same-day surgery managers are struggling to answer regarding sentinel lymph node biopsy for breast cancer. To assist readers, we're highlighting how Johns Hopkins Outpatient Center in Baltimore is approaching the dilemma and we're telling you about the latest published research on the topic. We'll also preview some upcoming studies. **(See story, p. 23.)**

Sentinel lymph node biopsy is a diagnostic test used to determine the status of regional lymph nodes.[1] The question is whether this procedure can replace the traditional axillary node dissection. A recent report in the *New England Journal of Medicine* reported that "it is feasible to perform the sentinel-node procedure successfully in a variety of surgical settings."[2]

At Johns Hopkins, the new approach is being studied in conjunction with using the traditional approach. The study began in January 1998, and 67 patients have undergone sentinel node biopsy in addition to axillary node dissection. Study leaders hope to prove that the approach reduces morbidity such as lymphedema.

Johns Hopkins study leaders want to conduct a significant number of cases before they can fully evaluate all the technical issues such as accuracy, says **Mary Donnelly Strozzo** , CRNP, MPH, MS,

EXECUTIVE SUMMARY

Same-day surgery programs, including those at Johns Hopkins Outpatient Center in Baltimore, are considering the switch from axillary node dissection to sentinel lymph node biopsy for some breast cancer patients.

- A recent report in the *New England Journal of Medicine* reports that the procedure is feasible for various surgical settings.
- The biggest concern is the false-positive rate. Also, the procedure is technically challenging for surgeons, radiology staff, and nuclear medicine staff.
- Contraindications include patients who have multifocal cancer within the breast, pregnancy, and enlarged lymph nodes.

adult nurse practitioner at The Johns Hopkins Breast Center, which is part of Johns Hopkins Outpatient Center.

Here's how the sentinel lymph node biopsy is performed at Johns Hopkins: First, the tumor area is identified with ultrasound or by mammography. Next, a localization procedure is done in which needles are placed to physically identify the tumor. Patients are transferred to the nuclear medicine department because, in Maryland, only those staff can inject a nuclear isotope.

"It takes an hour for the radioactive material to travel from the tumor site to the first node, which we identify as the sentinel node," Strozzo says.

Patients go to surgery, where they have the same incisions as with the traditional axillary node dissection. However, a gamma probe acts as a Geiger counter and identifies where the radioactive material has traveled, which is the sentinel node. The sentinel node is confirmed by counting for radioactive activity and sent to pathology for microstaging and other tests. However, since Johns Hopkins hasn't completed its study, the patient undergoes a traditional axillary node dissection at that point, which involves removing a sampling of the lymph nodes.

Beware of false-negative rate

The biggest concern regarding conversion to sentinel node biopsy appears to be the false-negative rate. Strozzo cites the "sounding board" report that accompanied the study in the *New England Journal of Medicine*. In the sounding board, physicians reported that the false-negative rate is the most important factor regarding sentinel lymph node biopsy because it could lead to incorrect treatment.[1]

Thus far, the experience at Johns Hopkins has been positive, Strozzo says. "Our false-negative rate seems to be quite low. And that's the whole idea. Will the accuracy be just as good?"

However, in addition to studying this rate, managers who want to add the procedure need to consider the following concerns and contraindications:

❒ **There is a learning curve for staff.**

"One of problems with finding out when you can go to the procedure is making sure all staff are proficient," Strozzo says. Nuclear medicine or other staff need to learn a new skill of injecting the radioisotope, and surgeons need to become adept at using the gamma probe to identify where the material was transported.

What's next for sentinel lymph node biopsy?

What if researchers find out in three or four years that women who only have sentinel node biopsy have a slightly lower survival rate?

There's only one way to answer that question: through a prospective randomized study, says **David N. Krag**, MD, FACS, professor of surgery at the University of Vermont in Burlington. Krag spoke on sentinel node biopsy of the breast at the October meeting of the Chicago-based American College of Surgeons and was the principal investigator of a sentinel node biopsy study recently published in the *New England Journal of Medicine*. **(See reference, p. 24.)**

Such a study is starting this year, Krag says. The study, titled B 32, is being conducted by the National Surgical Adjuvant Breast and Bowel Project (NCABP) in Pittsburgh. Approximately 100 centers across the United States and Canada will participate. The trial will determine whether sentinel node removal is as accurate as full removal of lymph nodes.

[Editor's note: For more information on sentinel node biopsy research, contact David N. Krag, MD, FACS, Department of Surgery, Given Building, Room E 309, University of Vermont, Burlington, VT 05405. Telephone: (802) 656-2262.] ■

The study in the *New England Journal of Medicine* acknowledges that sentinel node biopsy is a technically challenging procedure, "and the success rate varies according to the surgeon and the characteristics of the patient."[2]

❒ **Patients have to be at facility earlier.**

Instead of arriving two hours prior to surgery, patients who are participating in the sentinel lymph node study at Johns Hopkins are asked to arrive four hours prior to surgery to allow time for the nuclear isotope to be injected and travel to the first node.

"That's usually the main obstacle for people in the study," Strozzo says.

❒ **Patients or staff might be concerned about radiation from the nuclear isotope.**

SOURCES

For more information on sentinel node biopsy, contact:

- **Mary Donnelly Strozzo**, CRNP, MPH, MS, Adult Nurse Practitioner, Johns Hopkins Outpatient Center, Eighth Floor, 601 N. Caroline St., Baltimore, MD 21287. Telephone: (410) 614-2587. Fax: (410) 614-1947.

Patients have expressed concern about the level of radiation exposure, Strozzo says.

"What we're saying is that it's equal to a standard chest X-ray, or it's equal to 1/20 dose of a bone scan," she says. "People seem familiar with those, and they aren't concerned once we tell them about the low level of radioactive material. "Staff haven't expressed any concerns, Strozzo reports.

Contraindications for sentinel lymph node biopsy include patients who have multifocal cancer within the breast. "If you have various focuses, the cancer may not go to just one node, but several," Strozzo says. And because radioactive material is used, patients can't be pregnant, she says.

The procedure isn't performed if there is a high degree of suspicion that positive nodes will be found, Strozzo says. "If we felt any lymph nodes were enlarged, you probably have positive nodes."

Sentinel lymph node biopsy isn't the answer for every patient, she emphasizes, "but for grade 1 or grade 2 [cancer], with a low risk of positive nodes, it appears this is what we should do in the future." If the nodes are clinically negative, it might be the appropriate approach for grade 3 also, she adds.

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Same-Day Surgery Manager

Tips for shrinking turnaround time

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

(Editor's note: This is the second part of a three-part series on running an in-house ambulatory surgery program like a highly efficient freestanding facility. Earnhart can be reached at Earnhart and Associates, 5905 Tree Shadow Place, Suite 1200, Dallas, TX 75252. E-mail: surgery@onramp.net. World Wide Web: http://www.earnhart.com.)

Benchmarking as many of your operations as you can is critical to the success of your endeavors. You cannot change what you don't know about. As I said in last month's issue, efficient use of physicians' time is a sign of respect for the job they do.

What is the definition of room turnaround time? So many are confused on this issue. All definitions are logically arbitrary, but my definition is the space of time between when one patient leaves the operating room until the time the next patient is on the table.

Assume that your turnaround time (that you have actually audited and know is accurate) is 40 minutes. This is probably the average for most hospitals. Sit down with the staff and tell them your goal. Find out what the challenges and impediments to reducing that time are. Make a list, and get input for all areas. Set an obtainable goal for the next day, week, month, etc. Adjust your team and procedures to allow you the opportunity to change your current method. Involve as many departments as necessary. Tell your surgeons that you are going to make every effort to become more efficient between their cases and to please help with suggestions.

Post your goal. If your current time is 40 minutes, try to reduce it to 30. Don't attempt more than you can accomplish the first day. You probably will be unsuccessful, and everyone will become discouraged. Plus, you will lose the confidence of your medical staff.

After you reach that first important milestone, reduce it again to 25 minutes, then 20, which is a

good benchmark. Keep going until you feel that you have reached your maximum attainable level. Keep flowcharts of your progress. Publish your results in a one-page newsletter to your physicians. Have a bar graph showing the time between cases before and after.

Clearly, your role in the operating room is not to set land speed records. You are there to provide a safe, quality environment for the patients. Increased efficiently should never replace that credo; however, we all know that we can do just about anything better and not jeopardize quality.

Target your start time

Surgical case starts is a no-brainer. Start time is when the patient is on the table, the staff are in the room, anesthesia is at the head of the table, and the surgeon is in the room.

We do many physicians' interviews on this topic. Here are average start times for hospitals across the country:

- 7 a.m. posted time — 7:45 a.m. actual;
- 9 a.m. posted — 9:50 a.m. actual;
- noon posted — 1 p.m. actual;
- 3 p.m. posted — 4:15 p.m. actual.

Delays increase as the day goes on. There are many factors: emergency cases, cases that go longer than anticipated, tired staff, and staff disincentives. We can't do too much about the first two, but you can address the staff issues.

One thing I hated about the OR was finishing our room early. It was always right around the time to go home, and they would add another case in our room because we broke first (or on time). It didn't take long for all of us, anesthesia included, to realize that the longer it took to get the patient off the table and out of the room, the less likely we would get another case. Certainly that doesn't happen at your hospital! But it might happen at some.

Another reason for cases starting late could be that people are just plain tired. If your staff aren't rotated enough or have enough breaks, they are going to drag toward the end of the shift.

We all know how it happens. The circulators aren't going to put the patients in the rooms because they know that anesthesia isn't going to show up until the surgeon shows up. The surgeon isn't going to get there on time because anesthesia won't have the patient in the room anyway. The floor staff aren't going to send the patients down to the OR because the circulators aren't going to accept them until they can take them into the rooms. If you can break just one of those chains, you can begin to resolve the issue. Start with the easiest to control: your own staff.

Two ways to change behavior are to provide incentives or disincentives. Most staff prefer receiving a reward as opposed to the current punishment of starting another case as payment for efficiency.

How can you reward a person who doesn't cost you your budget? First, establish the goal as you did for the turnaround time. Consider reducing the start time by percentages — just as the airlines do for on-time departures, etc. We are a much larger industry than the airlines. If they can do it, so can we.

Next month's topic: incentiving your staff to make it happen. ■

ACCREDITATION TIP

Information management: Are policies understood?

When undergoing an accreditation survey, be certain your staff are following your own written policies for information management, suggest your peers. Here are some of their tips:

"This is a lot of work, and you have to keep your staff up to date with your policies," says **Jerry Henderson**, executive director of the SurgiCenter of Baltimore in Owings Mills, MD. The center handles about 11,000 procedures a year. It is accredited by the Accreditation Association for Ambulatory Health Care (AAAHC) in Skokie, IL.

All employees should know your policies, especially the ones that apply to their jobs. "It doesn't do you any good to have your policies in place if your staff don't know they're there and employees are not following them," Henderson says.

A surveyor, for example, may pull aside an employee in your department and ask him or her the policy for sending out notices on late payments. The employee should know the answer.

SurgiCenter posts various policies each month and has employees sign a log showing they read it. When there's a new policy, it's circulated to all

employees, and again they each sign off on it, he says.

• **Handling reimbursement issues.**

AAAHC surveyors will review a facility's reimbursement records only partly to see whether the facility is compliant with standards, says **Cathy Holmgren**, RN, MBA, executive deputy director of AAAHC. "There should be a system of approval on accounts receivable and payable. There should be an authorization process that only certain people are identified as being able to write checks."

The surveyor also will check the center's rates to make sure patients and payers were charged a rate according to policy. And the surveyor will examine the center's financial statements, income statements, balance sheets, and patient volume to see whether the center is billing adequately, she says.

The AAAHC administration chapter includes a policy that the organization has implemented fiscal controls on each of the following:

— authorization and record procedures that are adequate to provide accounting controls over assets, liabilities, revenues, and expenses;

— policies and procedures for controlling accounts receivable and accounts payable and for handling cash and credit arrangements;

— rates and charges for services.

Do you have a budget?

Occasionally an AAAHC surveyor will find a facility that doesn't have an operating budget. Nothing is planned, and there are no controls on what is spent. Instead, each year the facility turns its records over to an accountant to find out how well it did, Holmgren says. "That would be noncompliant with our standards."

• **Presenting thorough documentation.**

Facilities should be thorough, timely, and accurate in all documentation. This includes making it easy for physicians to complete their records, says **Beth A. Boyd**, RN, clinical director and educational coordinator of The Breast Center in Marietta, GA. The center, which is accredited by AAAHC, is a private practice of surgeons who specialize in breast procedures.

The Breast Center's medical records department does not wait for physicians to call and ask them to pull records on a patient who is about to undergo surgery. Instead, the center closely watches the surgery schedule and then pulls charts for the physician before being asked, she says.

Records also must be legible, says **Ann Kobs**, MS, RN, former director of the department of standards and current sentinel event specialist for the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL.

"You wouldn't believe how messy they can be," she notes. This does not mean the records must be on computer. But if some of your records are handwritten, you might expect that a surveyor will hand a page to an employee and ask whether the employee can read it.

Joint Commission standards about documentation include the following:

— The organization takes steps to ensure that the data are complete, reliable, valid, and accurate on an ongoing basis.

— Decision makers and other appropriate staff are educated and trained in the principles of information management.

— Information-management processes allow data and information to be combined from various sources.

— The organization uses external databases and resources as necessary to meet its information management needs.

• **Meeting deadlines.**

Record timeliness is important, Kobs and Holmgren say. A rule of thumb is that physicians should describe the procedure on a written chart within six hours after surgery, Kobs says.

Delinquent records spell trouble

If a facility has delinquent medical records, which are records that are not completed within 30 days, this could be a problem, Kobs says. Joint Commission surveyors will ask a facility to record the average monthly delinquent records for the past four quarters.

If the total is even 2% of all records, this problem could affect the organization's accreditation. SurgiCenter of Baltimore keeps reports up-to-date by having physicians dictate the reports by telephone.

Next, the reports are transcribed and signed, Henderson says. "If we have someone who is delinquent, then we handle that on an individual basis. But we really don't have any trouble with that."

Facilities might want to consider electronic medical records, which are faster and have more security controls over the physician's signature, Holmgren says. "If it's electronic, then nobody else can apply that physician's signature except the physician." ■

SOURCES

For more information on the accreditation process, contact:

Beth A. Boyd, RN, Clinical Director and Educational Coordinator, The Breast Center, 702 Canton Road, Marietta, GA 30060. Telephone: (770) 428-4486, ext. 203. Fax: (770) 425-6008. E-mail: bethtbc@mindspring.com.

Jerry Henderson, Executive Director, SurgiCenter of Baltimore, 23 Crossroads Drive, Owings Mills, MD 21117. Telephone: (410) 356-0300. Fax: (410) 356-7505. E-mail: surgicen@erols.com.

Cathy Holmgren, RN, MBA, Executive Deputy Director, Accreditation Association for Ambulatory Health Care, 9933 Lawler Ave., Skokie, IL 60077. Telephone: (847) 676-9610. Fax: (847) 676-9628. World Wide Web: http://www.aaahc.org. E-mail: info@aaahc.org.

Ann Kobs, MS, RN, Sentinel Event Specialist, Department of Standards, Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Telephone: (630) 792-5900 or (630) 792-5000. Fax: (630) 792-5942. World Wide Web: http://www.jcaho.org.

Keeping records confidential is not tough

Outpatient facilities sometimes struggle with how far they should go to keep records and patient information confidential. According to two accreditation organizations, they often err on the side of caution because maintaining confidentiality is easier than it seems.

For example, outpatient facility directors sometimes mistakenly think they cannot keep open files or they must not use sign-up sheets or white boards that list cases, says **Ann Kob**s, MS, RN, former director of the department of standards and current sentinel event specialist for the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL.

"I've had people tell me they've been told to put gates with padlocks across filing cabinets. But it's not necessary, she explains.

Facility directors also often express concern over the evening cleaning staff having access to files. But this is why you have them sign confidentiality statements, Kobs says. Likewise, facilities may use sign-in sheets that include the patient's name, the patient's physician, and the time, she explains.

Also, facilities may use white boards for tracking cases. "Just don't put the procedure on it, and if the patient says 'I don't want my name displayed,' then they have to leave it off," Kobs says.

The Accreditation Association for Ambulatory Health Care in Skokie, IL, requires facilities to keep unauthorized people from looking at files. And files should be protected while the office is open by having personnel near the files and able to block access, says **Cathy Holmgren**, RN, MBA, executive deputy director of AAAHC.

"There should be a safe and secure disposal of the records, and if they put records in archives, there should be a confidentiality control over them," she says.

She recalls one case in which an outpatient organization had a policy that all documents older than five years old were destroyed through shredding. "We thought that was over the top, but they said, 'We're in a really small community, and we don't want this information even sitting in a landfill.' We wouldn't require that of everybody." ■

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Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@medec.com).
Managing Editor: **Joy Daughtery Dickinson**, (912) 377-8044, (joy.daughtery@medec.com).
Production Editor: **Ann Duncan**.

Editorial Questions

Questions or comments? Call **Joy Daughtery Dickinson** (912) 377-8044.

Conference to target cost and quality in SDS

Experts will share their proven ideas for managing successful same-day surgery services at "Balancing Cost and Quality: The Secrets of Successful Ambulatory Surgery Programs," to be held March 14-16 in Atlanta. The conference is sponsored by American Health Consultants, publisher of *Same-Day Surgery.*

The timely topics offer something for every same-day surgery manager, whether your program is hospital-based, freestanding, or office-based. Speakers will address the following issues:

- ❒ interpreting financial information;
- ❒ monitoring quality trends and their impact on finances;
- ❒ improving physician, employee, and patient relations;
- ❒ recruiting and retaining physicians;
- ❒ handling contracts with managed care and vendors;
- ❒ addressing sentinel events;
- ❒ understanding new federal regulations;
- ❒ implementing ambulatory patient classifications;
- ❒ following construction requirements;
- ❒ adding pain management services;
- ❒ using creative marketing strategies;
- ❒ cross-training successfully;
- ❒ improving patient satisfaction;
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CE objectives

[For details on obtaining CE contact hours through Same-Day Surgery, *contact: Customer Service, American Health Consultants, P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421. Fax: (800) 284-3291. E-mail: custserv@ahcpub.com. Web: http://www.ahcpub.com.]*

After reading each issue of *Same-Day Surgery*, the reader will be able to do the following:

• Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care and management. **(See in this issue: "Clinicians debate whether wounds should get wet after same-day surgery," "Sentinel node biopsy considered for breast," and "What's next for sentinel lymph node biopsy?")**

• 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 "Information management: Are policies understood?")** ■