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Should clothing and shoes be a priority in surgery's battle against infections?

You know you need to enforce infection control practices such as proper equipment sterilization. But should you require "bare below the elbows" for clinicians? Enforce dedicated shoes or shoe covers in the OR? Ban scrubs outside the facility, and go to one-color scrubs to help with enforcement?

These are just some of the infection control issues being debated as European facilities go to stricter rules. Earlier this year, the British National Health Service implemented a "bare below the elbows" rule that banned doctors from wearing long sleeves, as well as ties.[1] England's Department of Health also enforces such a rule and includes wristwatches and jewelry, because they can accumulate germs from patients.[2] "The new clothing guidance will ensure good hand and wrist washing," the department says. It also has banned the doctor's traditional white coat, because the cuffs are likely to be heavily contaminated, the department says. When staff members have direct patient contact, they should wear "suitable protection — for example, plastic aprons," it says.

There is some scientific basis: A study from The New York Hospital Queens compared the ties worn by 40 doctors and medical students with those worn by 10 security guards. The study was presented at the 104th General Meeting of the American Society for Microbiology. Half of the ties

January issue to feature salary survey, economic survival strategies

The *Same-Day Surgery* Salary Survey Report with salary comparisons and career advice will run in the January 2009 issue. In addition, we'll offer a special focus on the economy that will offer survival strategies and cost-cutting tips, and we'll look at the impact of the new administration. Don't miss out on this valuable resource for making your outpatient surgery program, as well as your career, a success! ■

EXECUTIVE SUMMARY

Recent infection control changes at European hospital have raised questions about whether infection control procedures in the United States are sufficient.

- Use shoe covers, or have dedicated shoes, when there is opportunity for shoes to be contaminated by blood.
- Focus on areas proven to reduce infections, such as flu shots and hand hygiene.

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worn by the clinicians in surgery and other areas were contaminated with bacteria, while just 10% of the security guards' ties showed contamination. Also, a just-published study from the University of Maryland Medical Center in Baltimore found that a large proportion of health care workers' lab coats, including those of surgical staff, might be contaminated with *Staphylococcus aureus*, including methicillin-resistant *S. aureus* (MRSA).[3] White coats might be an important mode of patient-to-patient transmission of *S. aureus*, the study concludes.

For its part, the Association of periOperative Registered Nurses (AORN) recommends that providers who wear warm-up style jackets roll down the sleeves to the wrists to prevent skin shedding, according to **Joan Blanchard**, RN, MSS, CNOR, CIC, perioperative nursing specialist at the AORN Center for Nursing Practice. "Skin shedding makes up most of what dust is," she says.

Pushing the pendulum in the other direction

Some hospitals in Europe are requiring staff to change into scrubs and sanitized plastic shoes provided by the facility when they arrive for work.[1]

"Europeans have pushed the pendulum way in the other direction," says **Ann Marie Pettis**, RN, BSN, CIC, infection prevention director at the University of Rochester (NY) Medical Center and a spokeswoman for the Association for Professionals in Infection Control and Epidemiology (APIC). "There's not much scientific evidence to support that, especially I think with shoes."

While providers want every surface to be as germ-free as possible, floors are not typically as involved as clothing in causing infections such as those in surgical wounds, Pettis says. For that reason, many U.S. hospitals have dropped requirements for shoe covers, she says. At one of the facilities that is part of the Rochester system, dedicated shoes are required for ORs, which she describes as a somewhat "old-fashioned approach." The other facility requires shoe covers. "We look at covering of shoes as an OSHA [Occupational Safety and Health Administration] situation, protecting the health care worker from body fluid exposure," she says.

OSHA says shoe covers or boots, as well as surgical caps or hoods, must be worn when gross contamination reasonably can be anticipated [OSHA 910.1030(d)(3)(wii)]. Circumstances where such equipment may be necessary would include autopsies and orthopedic surgery, OSHA says.

Pettis prefers that her staff not wear Croc

brand shoes with holes. "It's not for infection control, but for the safety of the employee," she says. However, "in terms of evidence that these are the sorts of things that protect patients, it's weak at best," Pettis says. While clothing is not at the top of her list of priorities, her facility has designated one-color scrubs for the OR to make it easier to enforce the requirement that those scrubs be worn only inside the facility.

Infection prevention in outpatient surgery settings should focus on areas that are known to make a difference, Pettis maintains. "Honestly, I prefer for health care workers to focus on hands and hand hygiene, and gloves," she says. Also, she emphasizes devices and equipment being sanitized from one patient to another. **(See story on markers used to designate the surgical site, right.)**

"We're really trying to focus on things we do have all the evidence for: not coming in sick, getting flu shots, hand hygiene before and after patient contact — those are things we're trying to continue to hammer," Pettis says. **(For more on flu shots, see story, p. 128. For story on infection control concerns about contracting for cleaning and catering services, see story, below.)**

References

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2. Department of Health (National). Johnson outlines new measures to tackle hospital bugs. Sept. 17, 2007. Accessed at nds.coi.gov.uk/environment/fullDetail.asp?ReleaseID=314953&NewsAreaID=2&NavigatedFromDepartment=False.
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Contracts for catering and cleaning scrutinized

Most hospitals in Scotland are going to be banned from contracting out cleaning and catering services to private firms as part of a new drive toward cutting the spread of deadly superbugs.[1]

While few if any health care facilities in the United States are taking this approach, that doesn't mean that those responsible for infection control in those facilities are against the idea.

"We do know for a fact that when you have your own employees, not matter what service, you have more control in terms of the quality control approach," says **Ann Marie Pettis**, RN, BSN, CIC, infection prevention director at the University of Rochester (NY) Medical Center and a spokeswoman for the Association for Professionals in Infection Control and Epidemiology. "You can hire and fire, and all of that." While most facilities don't feel a need to take such a "legalistic" approach, "it makes some common sense to me," Pettis says.

Many U.S. facilities prefer to have contracts for cleaning services. While the Association of periOperative Registered Nurses (AORN) doesn't endorse any cleaning companies, there is one company that follows AORN guidelines for cleaning, says **Joan Blanchard**, RN, MSS, CNOR, CIC, perioperative nursing specialist at the AORN Center for Nursing Practice. The company, Jani-King (www.janiking.com), won't sign a contract if it doesn't include terminal cleaning, Blanchard says.

Reference

1. Kelbie P. Private cleaners barred in war on hospital bugs. *The Observer.* Oct. 19, 2008. Accessed at www.guardian. co.uk/society/2008/oct/19/mrsa-health-scotland-private-cleaners. ■

Should you reuse markers after designating site?

Many outpatient surgery providers throw away their markers after designating the surgical site. But could you save money and help the environment by reusing them? One recent study points to that possibility, at least for one brand of markers.

Healthcare facilities in Alberta, Edmonton, Canada, were spending thousands of dollars discarding their one-use markers, costing $2 each, due to infection control concerns. However, the Sharpies brand markers don't spread infection, say researchers **Sarah Forgie**, MD, FRCPC, associate professor in pediatrics, University of Alberta, along with **Catherine Burton**, MD, BSc, resident in pediatric infectious diseases. One of the surgeons raised a question about whether wiping the outside of the marker like a stethoscope would kill the bacteria." I said that because its alcohol-based, it shouldn't transmit anything," Forgie said.

Because many of the surgical teams in Edmonton liked Sharpie-brand markers, Forgie and Burton

tested that brand with a sterile marker specifically intended for single use in operating rooms. Marker tips were heavily contaminated with four types of bacteria that can cause surgical-site infections; two of the germ types are of particular concern in hospitals since they are antibiotic-resistant, Burton explained. "With our little agar plates, we put way more bacteria on these little nibs than you would ever find on a human, and the alcohol effectively killed them from the Sharpie marker," said Forgie.

After recapping the markers and letting them sit for 24 hours, Burton and Forgie found that the sterile, one-use marker, which has a nonalcohol-base ink, still was contaminated, but the Sharpies were not. The finding led to a policy change within Alberta Health Services.

"As long as surgeons or their designate wipe off the outside of the pens after each use, they don't have to throw them out," said Forgie, "which means there is a cost savings, and, most importantly, the markers are still safe for the patient."

However, not everyone is sold on the idea. "They cultured 24 hours after the first use, so the question remains if it would be safe to use the same marker on the next patient one, two, three, or more hours later," says **Marcia R. Patrick**, RN, MSN, CIC, director of infection prevention and control at MultiCare Health System in Tacoma, WA. "We use a new one for each patient."

The Association of periOperative Registered Nurses (AORN) also gives a thumbs down to reusing markers. "We wouldn't approve, because you don't know if the alcohol in that Sharpie is no longer effective," says **Joan Blanchard**, RN, MSS, CNOR, CIC, perioperative nursing specialist at the AORN Center for Nursing Practice. You could be spreading methicillin-resistant *S. aureus or C. difficile* from patient to patient — or any pathogen, and a host of skin bacteria — so they wouldn't recommend reuse, she says. ■

States and providers tackle influenza

Declination statements boost vaccinations

Declination statements are being used in widespread efforts to have large numbers of outpatient surgery staff members and others vaccinated for the flu.

At the University of Rochester (NY) Medical Center, "We say either get a flu shot or sign a declination," says **Ann Marie Pettis**, RN, BSN, CIC, infection prevention director and a spokeswoman for the Association for Professionals in Infection Control and Epidemiology. The declination form says the hospital reserves the right to make employees wear a mask the entire flu season and reassign them to another area, Pettis says. **[A copy of the declination form is available with the online issue of *Same-Day Surgery* at www.ahcmedia.com. For assistance accessing your online subscription, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]**

The Association of periOperative Registered Nurses (AORN) supports declination statements for staff, says **Joan Blanchard**, RN, MSS, CNOR, CIC, perioperative nursing specialist at the AORN Center for Nursing Practice. If they get the flu, give it to a patient, and the patient dies, it becomes an ethical issue, she says.

A just-released study found that universal vaccination in Ontario, Canada, was associated with reductions in influenza-related deaths, hospitalizations, and doctor visits.[1] California was the first state to require either vaccination or declination statements from hospital workers. Other states, such as Minnesota, have established goals of 90% immunization of health care workers. The Iowa Health Care Collaborative in Des Moines, a nonprofit quality improvement organization created by the Iowa Hospital Association and the Iowa Medical Society, set goals for Healthy Iowans 2010 that are significantly higher than the federal Healthy People 2010 goal of immunizing 60% of health care workers.

Consider these ideas from providers around the country for improving your vaccination rates:

- **Cook Children's Health Care System** in Fort Worth, TX: 77% of the health system employees received the vaccine. Strategies: Theme: Do it for all the children in your life. Message e-mailed from the president of the organization. Reminders about vaccinations sent once a week for six weeks. FluMist for employees who dislike injections. POWs: Point of Work vaccinators who provided the vaccine to co-workers. Declination statements. Employee health staff notified managers about employees who had not gotten the vaccine or signed a declination. Units tracked their vaccination rates. Vaccinations continued until the vials expire in late spring.
- **The Children's Hospital of Philadelphia:** 89% of employees received the vaccine; 93% of units had at least 80% immunization of nurses.

Strategies: Flu "captains" led other vaccinators in each unit. Every two weeks, the captains received a report with their vaccination rates and a comparison with other units. "No-flu" logo — a circle with a slash through "flu" — was used on posters, T-shirts, and the campus shuttle bus. Participation in vaccine program was mandatory — either with a vaccine or signature on a declination. Everyone who received the vaccine entered a raffle for an iPod and iTunes gift card.

• **Genesis Health System** in Davenport, IA: Raised its vaccination rate from 76% to 89%. Strategies: The CEO and his executive team were among the first to receive the shot, and a photo was put in the hospital newsletter. Employees received daily updates with the vaccination rates for the next two weeks. Each unit had flu "champions" who helped lead the campaign. Mobile clinics worked from early morning to late night. Vaccination team tracked vaccinations with a database. Employees who declined vaccination still needed to speak to a vaccinator, who could talk to them about their reasons. Every employee also was required to complete an annual online flu education module. This year, employees won't be able to decline for any reason other than medical contraindications. The health system is trying to meet a state mandate for a 95% rate of immunization by 2010.

• **Emory Healthcare in Atlanta:** Achieved 72% vaccinate rate. Strategies: Created a "No-Flu Zone," a red logo with the international symbol for "no" on posters, T-shirts, and educational materials. Mobile carts and monthly meetings of a flu vaccine steering committee. Employees were asked to sign a declination statement if they did not receive the vaccine. Developed a 10-minute educational video featuring employees that addressed myths. Video was showed at flu forums and staff meetings, and it was available online. Vaccinators went to every clinical unit.

Reference

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Payment rates decline for some specialties

Final outpatient payment rule released for '09

Newly released 2009 payment rates for ambulatory surgery will be painful for certain specialties, says **Kathy Bryant**, president of the Ambulatory Surgery Center Association. For example, gastrointestinal cases have a 7% decrease, which is added to a 5% decrease last year, Bryant says.

Despite objections from the ASC Association, the Centers for Medicare & Medicaid Services (CMS) insisted on using secondary rescaling of ASC relative weights in setting payments for the final rule, Bryant says. The ASC Association and others groups strongly support the use of the same ambulatory payment classifications (APCs) and relative weights in creating a payment system encompassing the services offered by both hospital outpatient departments (HOPDs) and ASCs. Rescaling the ASC relative weights the second time reduces payments to ASCs and further exacerbates the growing gap between ASC and HOPD payments, the ASC Association contends. If CMS hadn't used secondary rescaling, the rates would be about a 1½ percentage higher, she says.

"I'm so discouraged. It's that the rates are now lower than what they should be," Bryant says.

The final payment rates apply to services furnished on or after Jan. 1, 2009.

The rule includes final changes to the Medicare Conditions for Coverage (CfCs) for ASCs that is less restrictive than a revision proposed last year. In response to comments submitted in response to a proposed rule, the new CfCs are less restrictive than first proposed. Changes resulted from comments from the industry that were critical of the draft language. The new CfCs says this definition is applied to ASCs: ". . . ASC means any distinct entity that operates exclusively for the purpose of providing surgical services to 'patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission.'" The proposed rule would have provided that the patient's treatment was not expected to require an overnight stay, defined as requiring active monitoring by qualified medical personnel, regardless of whether it is provided in the ASC, after 11:59 p.m. on the day of admission.

In the final rule, CMS says, "There may be rare instances when a Medicare patient is required to stay beyond 24 hours due to an unexpected result from a surgery that would require further

monitoring and care. Such a stay would be unplanned, and the ASC would continue to be responsible for the patient and provide care until the patient is stable and able to be discharged in accordance with the ASC regulations and facility policy."

For ASCs that are doing overnight care, the change from the proposed to final rule is a huge improvement, Bryant says. "The language in the proposed rule wouldn't have allowed any procedures to be done if there was going to be overnight care anywhere," she says. "Now it says there can be overnight care in the ASC, and even there, it allows up to 24 hours. That's a big improvement beyond midnight, which is what they had in proposed rule."

According to CMS, the new CfCs will help ensure ASCs are safely equipped and qualified to perform a broader range of services under the ASC payment system. They also will help improve assurance of the quality and safety of the care patients receive in ASCs, CMS says.

New procedures added to ASC list

CMS is adding 27 surgical procedures to the list of procedures for which Medicare will pay when furnished in an ASC. The Healthcare Common Procedure Coding System (HCPCS) code and procedures are:

- 15170, Acell graft trunk/arms/legs;
- 15171, Acell graft trunk/arm/leg add-on;
- 15175, Acellular graft, face/neck/hands feet/genitalia;
- 15176, Acell graft, face/neck/hands feet/genitalia add-on;
- 20696, Comp multiplane ext fixation, $1,206.09;
- 20697, Comp ext fixate strut change, $802.10;
- 34490, Removal of vein clot;
- 36455, Blood exchange/transfuse nonnewborn;
- 41530, Tongue base vol reduction, $695.85
- 43273, Endoscopic pancreatoscopy, $885.21;
- 46930, Destroy internal hemorrhoids, $127.68;
- 49324, Lap insertion perm ip cath;
- 49325, Lap revision perm ip cath;
- 49326, Lap with omentopexy add-on;
- 49652, Lap vent/abd hernia repair, $1,529.28;
- 49653, Lap vent/abd hern proc comp, $1,529.28;
- 49654, Lap including hernia repair, $1,529.28;
- 49655 Lap inc hern repair comp, $1,529.28;
- 49656, Lap inc hernia repair recur, $1,529.28;
- 49657, Lap inc hern recur comp, $1,529.28;
- 55706, Prostate saturation sampling, $466.09;
- 62267, Interdiscal perq aspir, dx, $180.53;
- 64448, N block inj fem, cont inf;
- 64449, N block inj, lumbar plexus;
- 64455, N block inj, plantar digit, $18.75;
- 64632, N block inj, common digit, $34.26;
- 65756, Corneal trnspl, endothelial, $1,532.41;

There were a number of procedures deleted from the inpatient list, but they weren't added to the ASC list, Bryant points out. However, CMS did examine those procedures and considered adding them, as they will every year, she says. "As we can accumulate evidence, we'll be able to demonstrate that it is appropriate for the ASC, and get more and more [procedures] added," Bryant says.

ASCs do not receive an inflation update in 2009, because it will be the second year of a four-year transition to having the ASC payments match those of hospitals under the OPPS. **(For information on the final hospital payment rule, see story, p. 131.)**

In another change in the file rule, CMS revised the proposed language to state that when the ASC conducts drills, at least annually, to test the disas-

SOURCES/RESOURCE

For more information on the final payment rule, contact these people at CMS about the following issues:

- **Sheila Blackstock**. Phone: (410) 786-3502. Reporting of quality data issues.
- **Dana Burley.** Phone: (410) 786-0378. Payment changes for ambulatory surgical centers (ASCs).
- **Alberta Dwivedi**. Phone: (410) 786-0378. Payment changes or hospital outpatient departments.
- **Jacqueline Morgan**. Phone: (410) 786-4282, **Joan A. Moliki**. Phone: (410) 786-5526. **Steve Miller**. Phone: (410) 786-6656. **Jeannie Miller.** Phone: (410) 786-3164, ASC conditions for coverage issues.

At press time, the final rule with comment was scheduled to appear in the Nov. 18, 2008, *Federal Register*. Comments on designated provisions are due by 5 p.m. Eastern on Dec. 29. To access the final rule, go to http://frwebgate6.access.gpo.gov/cgi-bin/TEXTgate.cgi?WAISdocID=2783934 21516+0+1+0&WAISaction=retrieve. *[Editor's note: An e-mail alert about the final rule was sent Oct. 31, 2008. If you didn't receive the alert, we don't have your e-mail address. Contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]*

ter preparedness plan's effectiveness, the ASC must complete a written evaluation of each drill and "promptly" implement any corrections to the plan, instead of "immediately" as proposed. ■

Hospitals receive 3.6% inflation update

The final Medicare outpatient payment rule includes a 3.6% annual inflation update for hospital outpatient departments (HOPDs).

In 2009, hospitals that report seven outpatient quality measures will receive the full inflation update. Hospitals that don't submit data will receive a 1.6% update. The reduction will not apply to payments for separately payable pass-through drugs and devices, separately payable drugs and biologicals, separately payable therapeutic radiopharmaceuticals, brachytherapy sources that are paid at charges adjusted to cost, and services assigned to new technology ambulatory payment classifications (APCs). The final rule outlines a voluntary validation process that hospitals can use to test their quality data during calendar year (CY) 2009.

The final rule emphasizes that the Centers for Medicare & Medicaid Services (CMS) will develop and implement a policy that will not pay hospitals for care related to illness or injuries acquired by the patient during a hospital outpatient visit. Such a policy, which CMS expects to propose in the future, will be known as hospital outpatient health care-associated conditions (HOP-HACs). It will make adjustments to outpatient prospective payment system (OPPS) payments, similar to those in the inpatient setting. CMS Acting Administrator **Kerry Weems** said, "In this final rule, we are continuing to pay appropriately for care while working with health care providers as we look for ways to make sure beneficiaries who come in for treatment of one complaint don't leave with two as a result of adverse events during their outpatient visits."

The final rule adopts four new quality measures for imaging efficiency. CMS will continue to consider 18 additional quality measures, including screening for fall risk, that were identified in the CY 2009 proposed rule.

Under the final rule, the amount beneficiaries will pay for outpatient services will continue to decline based on a formula that is designed to provide a gradual transition to 20% coinsurance for all APCs. CMS estimates that nearly 25% of all types of services furnished in hospital outpatient departments (HOPDs) will be subject to the 20% coinsurance rate in CY 2009. ■

Same-Day Surgery Manager

How to get patients out of the recovery room

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

Question: Please explain the difference between pushing patients out the door versus letting them become lounge lizards that seemingly have no place to go after their surgery. We are not a hotel here, and I am tired of dragging out the recovery period and getting complaints when the patients or the surgeons say they felt rushed.

Answer: One of the most frequent complaints of surgery centers or hospitals is patients complaining to their surgeon that they feel they were "rushed" or "pushed out" too soon after surgery. In many cases, sad to report, the complaints have merit. But, here are some clues to reducing the patient stay and also eliminating many of the complaints:

- As soon as the patients are able to understand you when they come into the recovery room, tell them exactly what the process will be for discharge. Explain to them that they can expect to spend up to 30, 45, or 60 minutes (or whatever time) in the recovery room before they can go home. Set that expectation right from the start.
- Let the patient's family in to be with them as soon as possible. Nothing gets old quicker than watching a family member drool, complain about everything, or just sleep. The family members will come to you and ask when they can get out of there.
- Get rid of the TV. If that is not an option, set the channel to the "Home Shopping Network" or

some infomercial about a juicer or some silly thing. Don't let them get involved in a sitcom or soap opera.

• Avoid giving carbs as a snack. They put me to sleep, and they probably do the same for most others.

• Avoid conversations other than superficial chitchat. You do not want a political debate on your hands.

• All your activities with the patient and their family should be purposeful. Every time you interact with the patient, there should be a reason for it, and you should explain what it is.

• Make sure that all interaction with the patient is positive. Most complaints come from patient (or their irritating family members) if they perceive (PERCEIVE — not based upon REALITY) that you have been rude or "short" with them.

• Make believe to yourself that you are a waiter or waitress at a restaurant, and suck up to them just before they are discharged. Hey, it works.

• Have their surgeons stop by their beds as soon as possible after surgery. You don't want them to wait until the end of their scheduled cases to "visit" with the family.

• Plant the seed in the family members head about how hungry you know they must be getting and "I wish we had something to feed you" so they will help push the patient out the door so they can go out for a late lunch.

• Avoid having recent magazines in the area. Nothing spells boredom and "get me out of here" quicker than nothing to read.

• Encourage other staff members to walk by the patient's bed frequently and make comments like, "Wow, are you still here?"

• Test the alarms repeatedly on the monitors near the patients.

All joking aside, every facility is only as fast as its slowest patient — or surgeon. Avoid as much as possible the situation in which patients are using the recovery area for catching up on their sleep. The surgeons do respond to their patients' complaints (and praise — thought not as often), so be aware of balancing the discharge time against patient satisfaction. *(Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of outpatient surgery development and management. Contact Earnhart at 1000 Westbank Drive, Suite 5B, Austin, TX 78746. E-mail: searnhart@earnhart.com. Web: www.earnhart. com.)* ■

NV looks at oversight for surgery centers

Bills would require infection preventionist

In the wake of a highly publicized outbreak of the hepatitis C virus (HCV) in Las Vegas, proposed state laws in Nevada include proposals to hire infection preventionists (IPs) as consultants to oversee practice in freestanding centers.

"It's possible that we could have that sort of requirement within the state of Nevada," says **Brian Labus**, MPH, a lead investigator in the case for the Southern Nevada Health District in Las Vegas. "We have had those sorts of discussions with the [state] Legislative Committee on Healthcare. Our legislature meets every other year, and they will be meeting again in the spring of 2009."

With another recent HCV outbreak reported in a North Carolina cardiology practice, there is growing sentiment that something must be done to beef up infection prevention oversight in ambulatory care. Whether it involves IPs or some other approach such as increased health department inspections, the aftermath of the Vegas outbreak is expected to set the tone — and possibly the legislative model — for the rest of the nation.

"Nevada must be in the forefront," says **William Schaffner**, MD, chairman of the Department of Preventive Medicine at the Vanderbilt University School of Medicine in Nashville. "They are grappling not only with what happened in the past, but dealing with this going forward. They might be in a position to instruct us all."

Infection prevention oversight might come in the form of a consulting role for an infection control specialist, a state resource, or an infection reporting system through licensure, some sources say.

A "half-dozen" bills are being drafted in Nevada for consideration at the legislative session, but the specifics still are being hammered out, Labus notes.

"Something needs to be done after our large outbreak here," he says. "We're hoping it could serve as a model for other communities. At this point, we will have to see how the legislature wants to move on it. There will be a lot of discussion. [The involvement of IPs] is something that was discussed, and it is a strong possibility for the upcoming session."

The outbreak resulted in the largest look-back investigation in medical history, with some 50,000

patients seen at one endoscopy clinic and 13,000 at another advised to be tested for HCV, HIV and hepatitis B. The practices under investigation in Nevada include alleged reuse of syringes and re-entry into single-dose vials of pain medication for different patients undergoing colonoscopies. A total of 114 cases have been linked to the two clinics, according to Associated Press (AP).[1] The health district has not attributed any deaths to the outbreak, but the widow of a former patient has filed a lawsuit blaming her husband's hepatitis C diagnosis and death in 2006, at age 60, on unsafe medical practices, the AP says. Former clinic owners face more than 120 lawsuits that allege medical negligence and a class-action lawsuit by patients who weren't made ill but claim emotional distress, according to AP. **(For more information on the outbreak, see "CDC: Hepatitis C outbreak at surgery center isn't isolated," *Same-Day Surgery*, April 2008, p. 37, Also see follow-up stories and educational handout in May 2008 *SDS*.)**

The legislative activity in Nevada could result in similar bills elsewhere. "How to provide the oversight is something that needs to be debated at the national and state level," Schaffner says. "They could require these institutions for licensure to demonstrate that they have an association with some sort of infection control activity. Something that would do immediately is create a new industry of infection prevention consultants." **(For more information on HBV outbreaks, see story, below.)**

Reference

1. Ritter K. Nev. agency links 114 hepatitis cases to 2 clinics. Associated Press. Oct. 23, 2008.. ■

Outbreaks draw attention to ambulatory practices

In recent years, large outbreaks of hepatitis B virus and hepatitis C virus infections have occurred among patients in private medical practices, pain clinics, endoscopy clinics, and a hematology/oncology practice.[1]

"Speaking generally, the vast majority have not developed a consultative relationship with anyone in infection control to come in and give them periodic guidance and oversight," says **William Schaffner**, MD, chairman of the Department of Preventive Medicine at the Vanderbilt University School of Medicine in Nashville.

A physician anesthesiologist in Long Island was investigated by the New York State Department of Health for allegedly reusing syringes to draw up medicine from multidose vials. The department contacted thousands of patients who had been treated by the physician and urged them to be tested for hepatitis and HIV.

Indeed, hospital systems have turned to infection preventionists (IPs) for oversight of rapidly expanding networks of affiliated clinics. **Judie Bringhurst**, RN, BSN, CIC, an IP who oversees infection control in ambulatory settings at Duke University Medical Center in Durham, NC, says, "I have over 80 clinics now; and a year from now, I will have over 100. We are building by leaps and bounds."

With health care delivery rapidly moving beyond the hospital, infection prevention activities must follow, providers say. "Ambulatory care has to change," Bringhurst says. "If we can't do our duty to take care of our patients properly, somebody is going to have to make us do it."

Duke insists that its affiliated ambulatory facilities be accredited by The Joint Commission accreditation, to help avoid problems such as the recent hepatitis B outbreak in Nevada, where infection control practices are under scrutiny. "Look at what happened in Las Vegas — my gosh, 50,000 people [advised to be tested]," she says. "I would hope some kind of regulation would result. But it has happened before, and nothing changed." **(The Association for Professionals in Infection Control and Epidemiology has developed a consulting arm. See *Same-Day Surgery Weekly Alert*, Nov. 7, 2008.)**

Reference

1. Williams IT, Perz JF, Beel BP. Viral hepatitis transmission in ambulatory health care settings. *Clin Infect Dis* 2004; 38:1,592-1,598. ■

National Quality Forum endorses surgery standards

The National Quality Forum (NQF) has endorsed 13 clinician-level consensus standards related to perioperative care and four facility-level measures in surgery and anesthesia. **(See box, p. 134.)**

The new NQF-endorsed voluntary consensus standards include clinician-level and facility-level performance measures for critical care and anesthe-

Measures Endorsed

Perioperative Care — Clinician-Level

- Perioperative temperature management — clinician-level (harmonization)*
- Recording of clinical stage prior to surgery for lung cancer and esophageal cancer resection*
- Participation in a systematic national database for general thoracic surgery
- Recording of performance status prior to lung or esophageal cancer resection*
- Pulmonary function tests (PTF) before major anatomic lung resection*
- Risk-adjusted morbidity: Length of stay after 14 days after elective lobectomy for lung cancer
- Risk-adjusted morbidity and mortality for esophagectomy for cancer*
- Discontinuation of prophylactic antibiotics (non-cardiac procedures)*
- Selection of prophylactic antibiotic — First- OR second-generation cephalosporin*
- Timing of antibiotic prophylaxis — ordering physician*
- Anesthesiology and critical care: Prevention of catheter-related bloodstream infections (CRBSI) — central venous catheter (CVC) insertion protocol
- Perioperative anti-platelet therapy for patients undergoing carotid endarterectomy
- Use of patch during conventional endarterectomy*

*Time-limited

Facility-Level Surgery and Anesthesia

- Postoperative DVT or PE
- Protocol for glycemic control with IV insulin implementation
- Surgery patients with perioperative temperature management (SCIP Inf 7)
- Urinary catheter removal on postoperative Day One or postoperative Day Two

Source: National Quality Forum, Washington, DC.

siology; perioperative management; and general thoracic surgery. Additionally, prophylactic antibiotic measures previously endorsed by NQF were updated to include foot and ankle procedures.

Darrell Campbell, MD, professor of surgery and chief of staff at University of Michigan Hospitals and Health Centers, Ann Arbor, and **Rome Walker**, MD, medical director at Anthem Blue Cross Blue Shield of Virginia, in Richmond, co-chaired NQF's perioperative care steering committee. Walker said, "All stakeholders, including employers, physicians and the government, are looking for endorsed standards like these perioperative performance measures that are feasible, reliable, and valid. The newly endorsed perioperative performance measures on a clinical level will be the driving force for improvement in both processes and health outcomes for patients."

The standards measure the quality, efficiency, and care coordination of surgical care, including preoperative, intraoperative, and postoperative care within the surgical facility, as well as coordination with appropriate external providers. This includes perioperative temperature management for surgery patients and postoperative urinary catheter removal. There was a significant effort to ensure the facility-level standards were harmonized with the clinician-level perioperative standards.

Measures were developed by the Agency for Healthcare Research and Quality, the American Medical Association's Physician Consortium for Performance Improvement, the Centers for Medicare & Medicaid Services, LifeScan, the National Committee for Quality Assurance, the Society of Thoracic Surgeons, the Society for Vascular Surgery, and the Vascular Study Group of Northern New England.

Helen Burstin, MD, MPH, senior vice president for performance measures at the NQF, said the standards "offer additional quality measures — particularly for those who practice in outpatient and related clinics." *[Editor's note: For more information, go to the National Quality Forum web site at www.qualityforum.org. Contact Burstin at the National Quality Forum, 601 13th St. N.W., Suite 500 N., Washington, DC 20005. Phone: (202) 783-1300.]* ■

Scoping for knee OA revisited: It's still not OK

Source: Kirkley A, Birmingham TB, Litchfield RB, et al. **A randomized trial of arthroscopic surgery for osteoarthritis of the knee.** *N Engl J Med* 2008; 359:1,097-1,107.

Six years ago, *The New England Journal of Medicine* reported[1,2] Moseley's study of the use of arthroscopy to treat knee osteoarthritis (OA). The conclusion was that patients randomized to surgery did not experience reduced pain

or improved function. **(For more information, see "Is knee arthroscopy helpful for osteoarthritis?" *Same-Day Surgery*, September 2002, p. 116.)** After the study was published, several concerns were raised, namely, the study group was composed of elderly male veterans,[3] X-rays during posterior-anterior flexion in a weight-bearing position were not performed,[4] the pain scale was not validated, and the study was underpowered.[5]

Alexandra Kirkley, MD, and colleagues from the University of Western Ontario report their trial that answers those concerns. Patients had to be at least 18 years old and without large meniscal tears. They screened 277 patients for eligibility, and after appropriate exclusion, they randomized 188. Reasons for exclusion included more than 5° of misalignment, inflammatory or post-infectious arthritis, previous arthroscopy, history of major knee trauma, severe OA, and corticosteroid knee injection in the last three months, among others. Subjects were X-rayed to grade the severity of OA, received a detailed physical examination of the knee, and completed several questionnaires and clinical scoring tools, including the Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC) and the Short Form-36 Physical Component Summary, both validated instruments.

Patients were randomized to the study group, which received optimized physical and medical therapy and arthroscopic treatment, or the control group, which received only the physical and medical therapy. Arthroscopic therapy could involve synovectomy, debridement, or excision of meniscal degenerative tears, cartilage fragments, or chondral flaps and osteophytes. Physical therapy involved one-hour weekly sessions for 12 weeks. Participants also were instructed in a home exercise program.

Medical therapy began with acetaminophen and nonsteroidal anti-inflammatory drugs, and progressed to hyaluronic acid injection if necessary. Patients also were offered oral glucosamine. Patients were seen periodically by a nurse who was blind to treatment, and all patients wore a neoprene sleeve over their knees to hide the study groups' surgical scars. There were 94 patients assigned to surgery; two withdrew consent, and six declined to undergo arthroscopy. The same number was assigned to the control group. Eight withdrew consent. The two groups were similar in all respects. They were in their late 50s and predominantly female, with a body mass index of 31 kg/m^2.

At the three-month check, the WOMAC scores in the surgery group showed greater improvement than the control group. After that and through two years of follow-up, there were no significant differences between the groups. Both groups showed improvement. The investigators performed subgroup analysis for patients who were having mechanical symptoms of catching or locking; again, there was no difference between the groups. When physical function, pain, or quality of life was compared, the groups were similar.

References

1. Moseley JB, et al. A controlled trial of arthroscopic surgery for osteoarthritis of the knee. *N Engl J Med* 2002; 347:81-88.
2. Wilke AJ. Should 'my friend Arthur' have a visit from the scope? *Intern Med Alert* 2002; 24:113-114.
3. Jackson RW. Arthroscopic surgery for osteoarthritis of

CNE/CME instructions

Physicians and nurses participate in this CNE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answers listed in the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. **The semester ends with this issue.** You must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

COMING IN FUTURE MONTHS

- Preparing for changes in case volumes
- Simple form that helps you capture more cases
- Impact of new administration on outpatient surgery
- Innovative medication reconciliation form

the knee. *N Engl J Med* 2002; 347:1,717-1,719.

4. Ewing W, Ewing JW. Arthroscopic surgery for osteo-arthritis of the knee. *N Engl J Med* 2002; 347:1,717-1,719.

5. Chambers KG, Schulzer M. Arthroscopic surgery for osteo-arthritis of the knee. *N Engl J Med* 2002; 347:1,717-1,719. ■

CNE/CME *questions*

- **Identify** clinical, managerial, regulatory, or social issues relating to ambulatory surgery care.
- **Describe** how current issues in ambulatory surgery affect clinical and management practices.
- **Incorporate** practical solutions to ambulatory surgery issues and concerns into daily practices.

21. OSHA says shoe covers or boots, as well as surgical caps or hoods, must be worn when gross contamination reasonably can be anticipated. Circumstances where such equipment may be necessary would include what, according to OSHA?
A. Any case in which blood or body fluid is involved.
B. Orthopedic cases and autopsies.
C. Any open procedure.
D. Any open or minimally invasive procedure.

22. Why does AORN disapprove of reusing markers after they've been used to designate the surgical site, according to Joan Blanchard, RN, MSS, CNOR, CIC?
A. Patients will be dissatisfied.
B. Staff will be dissatisfied.
C. The markers don't contain alcohol.
D. You don't know whether the alcohol in that marker no longer is effective.

23. A just-released study found that universal influenza vaccination in Ontario, Canada, was associated with:
A. reductions in influenza-related deaths
B. reductions in hospitalizations
C. reductions in doctor visits.
D. A, B, and C

24. What is the position of AORN on declination statements for staff influenza vaccinations, according to Blanchard?
A. AORN supports declination statements.
B. AORN does not support declination statement.
C. AORN does not have a position on declination statements.

Answers: 21. B; 22. D; 23. D; 24. A.

PRINT NAME_____ DATE_____

Highland Hospital

INFLUENZA VACCINE DECLINATION FORM 2008-09

If you work in a patient care area and you did not receive flu vaccine through Highland Hospital, you must fill out section I, section II, or section III of this form by December 31, 2008.

Section I. Vaccinated elsewhere

☐ I received the vaccine elsewhere for the 2008-2009 Flu Season
Month received _____(This is important in case of a Flu outbreak)

Signature/ Employee ID/ Job title_____

Section II. Contraindication to vaccine

Persons with severe egg allergies should not get the vaccine. If you have a history of Guillain-Barre Syndrome you should consult with your physician to determine the risk/benefit of receiving the vaccine.

☐ I have been advised by my physician not to receive the vaccine due to an allergy or medical contraindication.

Signature/employee ID /Job title_____

Section III. Refusal/declination of vaccine

Highland Hospital, based on recommendations from the Center for Disease Control (CDC), advises me to get a flu vaccine in order to protect myself and the patients I serve from the flu and its complications, including death. It is being offered to me at no charge.

I acknowledge the following facts:

- Influenza is a serious respiratory disease that kills an average of 36,000 persons and hospitalizes more than 200,000 persons in the United States each year.
- If I get influenza (flu), I could spread the virus to patients, staff, or my family, for 24–48 hours before symptoms appear.
- Influenza strains change every year and vaccine received in a prior year does not usually provide immunity to this year's strains of influenza.
- I **cannot** get the flu from the flu vaccine.
- Flu vaccine **is recommended** for women who are pregnant or breastfeeding, and anyone with a weakened immune system. If you have any concerns, consult with your physician to make a decision.
- I understand by not receiving the Flu vaccine, **I continue to be at risk for Influenza infection** which could endanger my health, the health of my patients, and my coworkers.

Highland Hospital may reassign me and/or require that I wear a mask during influenza season in the interest of patient safety.

Despite these facts, I choose not to receive the vaccine for the following reasons;

☐ I never get the flu
☐ Afraid of needles
☐ Afraid of getting the flu from the vaccine
☐ Offered at inconvenient places or times
☐ Other_____

Signature/employee ID/Job title_____

For Highland Employees : Please return this form To EHS Box 33, Fax 585-341-8308

Source: Highland Hospital, Rochester, NY.

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