



Same-Day Surgery®

Covering Hospitals, Surgery Centers, and Offices for More than 30 Years



Centers come under tighter scrutiny for infection control practices

IN THIS ISSUE

- Ready to come under the infection control spotlight? cover
- Center dramatically improves its finances 26
- **SDS Manager:** A simple system to boost your center's performance 27
- Online preregistration makes phones, staff more available 28
- New Medicare Conditions for Coverage take effect May 18 — Are you ready? 29
- Update on Israeli surgeon who is HIV-positive 29
- How to simplify patient materials. 31
- **Inserted in this issue:**
— 2009 Reader Survey

Financial Disclosure:

Senior Managing Editor Joy Dickinson, Associate Publisher Coles McKagen, Board Member and Nurse Planner Kay Ball, and Board Member and Columnist Stephen W. Earnhart report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Mark Mayo reports that he is an employee of Magna Health Systems and a consultant for DayOne Health. Steven Schweitzberg, MD, Physician Reviewer, discloses that he is on the speakers bureau for Stryker Corp. and Merck & Co., he is a medical advisor to Surgiquest, and he is a stockholder in Starion Instruments.

MARCH 2009

VOL. 33, NO. 3 • (pages 21-32)

Desktop sterilizer that have had no preventive maintenance and calibration, and no spore tests are being done to ensure sterility. Anesthesia staff members who use a manifold device connected to the IV drugs, and the tubing from the manifold to the patient's IV is not changed between patients. Drugs hanging all day, unlabeled. Instruments soaked in glutaraldehyde and then put into the autoclave, which needlessly exposes staff to chemical fumes in an unventilated room. Endoscopes not thoroughly cleaned before soaking, soaking in a solution that was not checked for potency before each use, and scopes that are not leak tested.

These "horror stories" from ambulatory surgery centers (ASCs) point to the need for a specialist in infection control at the facilities, says **Marcia Patrick**, RN, MSN, CIC, director, infection prevention and control, MultiCare Health System in Tacoma, WA. Patrick is a board member for the Association for Professionals in Infection Control and Epidemiology (APIC).

"The growing number and complexity of minimally invasive procedures and the procedures that are now done in the outpatient setting have

EXECUTIVE SUMMARY

Recent reports of infection outbreaks at surgery centers causing increased activity at the state and federal level and among national associations.

- Educate staff about the principles of asepsis, cleaning, disinfection and sterilization processes, hand hygiene, and instrument management. Pay particular concern to injection safety. Train new employees in standard precautions, and review procedures at least annually.
- Establish a mechanism through which anyone can report a concern. Ensure that oversight is ongoing.
- Meet with the janitorial service and be clear about who is responsible for cleaning each item.

NOW AVAILABLE ONLINE! www.ahcmedia.com/online.html for access.
For more information, call: (800) 688-2421.

led to a need for the same kind of infection prevention oversight that is found in most hospitals," Patrick says. The risks are significant, she says, and in many states there aren't any regulations.

"Physicians can hire someone off the street and teach them to clean scopes or do anything else with no formal training," Patrick says. Physicians often aren't experts in cleaning, disinfection, and sterilization, she maintains. "This is a specialty area that requires a specialist's attention," Patrick says.

There is a growing tide of similar sentiment from

Same-Day Surgery® (ISSN 0190-5066) is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to **Same-Day Surgery**®, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m. to 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), \$495. Add \$17.95 for shipping & handling. Outside U.S.A., add \$30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are \$83 each. (GST registration number R128870672.)

Photocopying: No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact AHC Media LLC. Address: P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421, ext. 5491. Fax: (800) 284-3291 Web: <http://www.ahcmedia.com>.

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 16.5 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 16.5 Contact Hours.

AHC Media LLC is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AHC Media LLC designates this educational activity for a maximum of 20 *AMA PRA Category 1 Credits*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This activity is intended for outpatient surgeons, surgery center managers, and other clinicians. It is in effect for 24 months after the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Associate Publisher: **Coles McKagen** (404) 262-5420
(coles.mckagen@ahcmedia.com).

Director of Marketing: **Schandale Kornegay**.

Senior Managing Editor: **Joy Daugherty Dickinson** (229) 551-9195
(joy.dickinson@ahcmedia.com).

Senior Production Editor: **Nancy McCreary**.

Copyright © 2009 by AHC Media LLC. **Same-Day Surgery**® is a registered trademark of AHC Media LLC. The trademark **Same-Day Surgery**® is used herein under license. All rights reserved.



Editorial Questions

Questions or comments?
Call **Joy Daugherty Dickinson**
at (229) 551-9195.

government groups, national associations, and researchers. (See more about developments at the national level, p. 23.) A just-published review of outbreak information revealed 33 outbreaks of hepatitis B virus (HBV) and hepatitis C virus (HCV) in nonhospital health care settings in the past decade, which the authors say is the "tip of the iceberg."¹ The study, published in the *Annals of Internal Medicine*, reported 12 outbreaks in outpatient clinics, including an ambulatory surgery center, multiple endoscopy clinics, and two physician practices. There were six outbreaks in hemodialysis centers and 15 in long-term care facilities. The final result of these outbreaks was 448 people acquiring HBV or HCV infections. The cause? Patient-to-patient transmission through failure to adhere to fundamental principles of infection control and aseptic technique, such as reuse of syringes or lancing devices, the authors say.

"Difficult to detect and investigate, these recognized outbreaks indicate a wider and growing problem as health care is increasingly provided in outpatient settings in which infection control training and oversight may be inadequate," the authors wrote. "A comprehensive approach involving better viral hepatitis surveillance and case investigation, health care provider education and training, professional oversight, licensing, and public awareness is needed to ensure that patients are always afforded basic levels of protection against viral hepatitis transmission." (For specific tips on avoiding infection control problems in your facility, see story, p. 24.)

States are targeted

The concern at the national level is manifesting itself in tighter scrutiny during state surveys. A total of 68 ASCs in Maryland, North Carolina, and Oklahoma participated in a pilot test during summer 2008 that expanded surgery center surveys with changes to the infection control tool. [See copy of the draft infection control survey instrument with the online version of *Same-Day Surgery*. For assistance, contact customer service at (800) 688-2421 or customerservice@ahcmedia.com.] A final report is expected this fiscal year, according to sources at the Centers for Medicare & Medicaid Services (CMS).

The draft tool was intended to allow inspection of basic infection control practices that were not specifically addressed by routine surveys, sources say. "We wanted to get a sense of whether the types of issues that we saw in Nevada might be

more generally prevalent in ASCs in other parts of the country," says a CMS official, who isn't identified according to department policy. "At the same time, we also wanted to pioneer some innovations or refinements in our survey methodology to ASCs and evaluate those to see whether those ought to be incorporated permanently, according to our guidance on the survey process for ASCs."

Surveyors in those states were instructed to follow one case from start to finish, if possible, the official says. Surveyors also followed equipment through the sterilization process, says **Barbara Fagan**, program manager, Office of Health Care Quality within Department of Health and Mental Hygiene in Maryland. Maryland already has adapted CMS' infection control tool in its state survey process, she says.

New survey tool to go nationwide?

Joseph F. Perz, DrPH, MA, health care epidemiologist, team leader, prevention activities, Division of Healthcare Quality Promotion at the Centers for Disease Control and Prevention (CDC), says, "Given the increasing attention, higher expectations in this area, it wouldn't surprise me if we saw broader application of that kind of tool, or including that kind of content in surveys, moving forward." Perz is one of the authors of the recent study in the *Annals of Internal Medicine*.

As if all of this increased scrutiny wasn't enough to get the attention of outpatient surgery managers, the Oklahoma State Department of Health reports that there is a billboard displaying the words, "Hepatitis C? Call law firm" with the lawyers' phone number listed.

Is such a billboard an indication that hepatitis outbreaks are not isolated incidences? "Some of the misperceptions and practices in question are more widespread than we would have expected," Perz says. "Nonetheless, it really is a wake-up call for us to address this before you have one. We want patients to have confidence in the care they're receiving."

Reference

1. Thompson ND, Perz JF, Moorman AC, et al. Nonhospital health care-associated hepatitis B and C virus transmission: United States, 1998-2008. *Ann Int Med* 2009; 150:33-39. ■

National groups take a closer look at infections

The Government Accountability Office (GAO) has conducted a nationwide study to determine what role ambulatory facilities play in the spread of health care-acquired infections (HAIs). At press time, the study was expected to be completed by February.

If the GAO determines that ambulatory facilities play a role in the spread of infections, many changes may be forthcoming, says **Kathleen B. Stoessel**, RN, BSN, MS, senior manager, clinical education at Kimberly-Clark Health Care, Atlanta. "These changes might include more stringent infection prevention oversight; emphasis on staff training, compliance monitoring, government reporting of HAIs; impact on reimbursement from [the Centers for Medicare & Medicaid Services] and private insurers; and pay-for-performance mandates," she says.

Also at the national level, the Steering Commission for Prevention of Healthcare-Associated Infections, part of the Department of Health and Human Services (HHS), has been formed to address the concerns raised in a 2008 GAO report that criticized HHS for "needless suffering and death" caused by health care infections. The Commission will work with the Healthcare Practices Advisory Committee (HICPAC) at the Centers for Disease Control and Prevention (CDC). The committee is charged with developing an HHS action plan to reduce HAIs, including the development of prevention guidelines, data collection and analysis, and outreach and education. The committee will concentrate on the leading HAIs, including surgical-site infections. [For more about national and state action, see "GAO, Others to Study Infections at Surgery Centers," *Same-Day Surgery Weekly Alert*, Dec. 19, 2008. To receive our ezine, free to subscribers, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]

Additionally, The Joint Commission and all the major infection prevention associations are creating a compendium that is essentially a synthesis of established prevention guidelines to prevent the major HAIs. Also, under the 2009 National Patient Safety Goals, ambulatory surgery programs will be required to implement best practices on prevention of surgical-site infection. (For more information, see "Some may have a 'bit of stress' from new goals," *Same-Day Surgery*, August 2008, p. 85.) ■

2 more incidents raise questions

Are you handling scopes correctly?

There's another investigation under way to determine whether patients might have been exposed to infection from colonoscopies at the York Veterans Administration (VA) Hospital in Murfreesboro, TN.

One volunteer who said she's seen instruments delivered in the women's and dental clinics for 20 years, was quoted in a news report as saying they're often dirty.¹ She said they were supposed to have been sterilized more than 30 miles away.

There are two ways to clean and disinfect the scopes used for colonoscopies: manually and with an automated reprocessor, says **Marcia Patrick**, RN, MSN, CIC, director, infection prevention and control, MultiCare Health System in Tacoma, WA. Patrick is a board member for the Association for Professionals in Infection Control and Epidemiology (APIC). "In both cases, the scope must be manually wiped off externally, then the lumens — scopes are tubes within a tube — scrubbed with a brush and an enzymatic cleaner to physically remove all the debris," she says. "This step is critical."

In another incident, Nevada officials have completed an investigation of a Las Vegas outpatient surgery center after the center reported improperly setting machines to reprocess endoscopes.

"The facility self-reported that its automatic endoscope reprocessor had been incorrectly set at one minute vs. the manufacturer's recommended time of five minutes," says **Marla McDade-Williams**, MPH, bureau chief of the Bureau of Health Care Quality and Compliance, State Health Division, in Carson City. Because the facility self-reported, there will not be any sanction, but the bureau released a formal statement of deficiencies that said the facility failed to ensure employees followed the equipment manufacturer's instructions and failed to ensure employees received annual training on the instructions.

In an unrelated incident publicized last year in Las Vegas, public health officials urging about 50,000 patients to be tested for hepatitis C virus (HCV), hepatitis B virus, and HIV. The practices under investigation then included alleged reuse of syringes and re-entry into single-dose vials of pain medication for different patients undergoing

colonoscopies. Nine HCV infections have been linked to the outbreak, and another 101 are being investigated as possible cases.

A state law has been proposed in Nevada to include periodic inspections by infection prevention consultants. "The proposal is to require the bureau to conduct some type of review process at doctor's offices where certain levels of sedation are performed," says McDade-Williams.

To avoid problems, ensure that you are following manufacturing guidelines for reprocessing of equipment, such as endoscopes, says **Joseph F. Perz**, DrPH, MA, health care epidemiologist, team leader, prevention activities, Division of Healthcare Quality Promotion at the Centers for Disease Control and Prevention (CDC). Don't reprocess or reuse equipment if you don't have the equipment to do it properly, he says.

Also, check the soak time each time an item is placed in the processor, Patrick

Be proactive, Perz says. "Be able to say, 'We have checks in place. We're doing everything correctly in terms of reprocessing equipment and using equipment the way it was intended,'" he says.

Reference

1. Lambert D. VA Volunteer calls hospital tools dirty, sterilization occurs more than 30 miles from hospital. WSMV-TV. Jan. 5, 2009. Accessed at www.msnbc.msn.com/id/28474082. ■

Educate, train, and ensure it translates into practice

One of the critical steps to avoiding health care-acquired infections is to educate and train staff.

All staff must know the principles of asepsis, cleaning, disinfection and sterilization processes, hand hygiene, and instrument management, says **Marcia Patrick**, RN, MSN, CIC, director, infection prevention and control, MultiCare Health System in Tacoma, WA. Marcia is a board member for the Association for Professionals in Infection Control and Epidemiology (APIC).

Injection safety is an overlooked area, says **Joseph F. Perz**, DrPH, MA, health care epidemiologist, team leader, prevention activities, Division of Healthcare Quality Promotion at the Centers for Disease Control and Prevention (CDC). Perz recently published a study on hepatitis outbreaks

in the *Annals of Internal Medicine*.

"Where we've seen problems include reuse of medications or flush solutions that are intended for single-patient use," Perz says. Examples include a single-use vial of propofol, he says. "Some providers don't realize that's provided in a vial that is not actually a multidose vial," he says. "Even though you can order a large vial, and it may look outwardly like your other multidose vials, it's not."

Additionally, some providers use bags of saline solution for multiple patients, which is a risky practice, he says. "If microbes are introduced, there's a growth opportunity," Perz says.

Multidose vials also are a concern, he says. "The risks we identified in many outbreaks were related to health care workers going back to a vial with a syringe that already had been used," Perz says. Often providers needed an additional dose for a patient, but they don't realize that they could be contaminating the vial, he says. "Subsequent patients could be exposed to hepatitis C or other bloodborne pathogens," Perz adds.

Review practices at your facility to ensure such practices aren't happening, he says. Train new employees in standard precautions, including injection safety, and review infection control procedures at least annually thereafter, Perz advises. **(An infection control Q&A is included with the online issue.)**

Establish a mechanism through which anyone can report a concern, Patrick says, "and know that there is someone who is looking at these to ensure all the items needed for safe care are available, that staff and patients are safe."

Take the next step, says **Kathleen B. Stoessel**, RN, BSN, MS, senior manager, clinical education at Kimberly-Clark Health Care, Atlanta. Stoessel says "knowledge does not necessarily lead to compliance with recommended guidelines and best practice policies and procedures. Therefore, ongoing monitoring of actual practice and embedding reliability of performance within the system are critical to ensure adherence to evidence-based care."

One of the reasons that problems have cropped up in ambulatory care is that inspections are often inadequate or nonexistent, Patrick maintains. When Patrick first started working in infection control, she had to learn every step of the process. "I learned to look for a small metal pipe with four to six nipples coming off the cold water supply pipe in the soiled utility room," she says., "That meant the staff was flushing and reusing cardiac catheters to save money." These catheters

are labeled "single patient use," Patrick says.

"With no oversight, staff can be doing *anything*," she emphasizes. "Most are not willfully trying to hurt someone, but bad practices are very dangerous."

Have someone responsible for ensuring daily cleaning and disinfection is occurring and that every item has a designated person to clean and disinfect it, Patrick says. Managers should meet with the janitorial service and be very clear about who is responsible for cleaning each item, she says.

"Often, ambulatory staff think the janitorial service is cleaning and disinfecting exam tables, gurneys, countertops, etc., when all they are really doing is emptying trash, mopping floors, and vacuuming rugs," Patrick says. ■

Educational resources are abundant, sources say

Use materials as basis for policies

When looking at infection control resources, the "foundation for infection prevention" is the standard precautions from the Centers for Disease Control and Prevention (CDC), says **Joseph F. Perz**, DrPH, MA, health care epidemiologist, team leader, prevention activities, Division of Healthcare Quality Promotion at the Centers for Disease Control and Prevention (CDC). *(Editor's note: These precautions are available at www.cdc.gov/ncidod/dhqp/gl_isolation_standard.html. For other resources, see box, below.)*

"No matter what setting you're in, these are essentially universal recommendations," Perz says. This document could be the basis for educational materials and outreach, he says.

RESOURCES

The following infection control resources are available from the Centers for Disease Control and Prevention (CDC):

- A presentation on unsafe injection practices, along with audio and a transcript of the presentation. Web: www.cdc.gov/ncidod/dhqp/COCA_Unsafe_Injection_Practices.html.
- Hand hygiene in health care facilities. Web: www.cdc.gov/handhygiene.
- Home page for infection control. Web: www.cdc.gov/ncidod/dhqp/index.html.

EXECUTIVE SUMMARY

Melville (NY) Surgery Center reduced staffing costs (from 52% to 20% of revenues), cut supply costs (from 29% to 14% of revenues), reduced accounts receivable (from 94 to 29 days outstanding), and increased average revenue per case (from \$846 to \$2,586) in seven months.

- Staff positions were consolidated, and overtime for nurses was eliminated.
- Contracts were renegotiated. Claims now go out within 48 hours.
- Physicians were educated about supply costs. They agreed to consolidate brands, not open supplies that weren't needed, and educate coders about complex cases.

Colantuoni says. "We schedule staff according to the OR schedule," she says. When the day's cases are completed, staff members go home, Colantuoni says. Additionally, staff members were cross-trained to work across services and departments, she says.

Initially, most of the nurses were per diem, Colantuoni says. "Now that our volume is increasing, we have added more full-time nurses," she says.

Another success was achieved when supply cost went from 29% to 14% of revenues. "We made a lot of aggressive changes," Colantuoni says.

Previously, the center had a poor credit rating and, therefore, was paying top prices for many items. "We renegotiated with a lot of vendors," she says. Colantuoni took over responsibility for accounts payable and ensured that bills were paid within 30 days. Once vendors realized that the center would pay bills on time, they were willing to reduce prices, she says. Additionally, the center signed up with a distributor (Cardinal) and a group purchasing organization (GPO), which was Amerinet.

Supplies were streamlined for items such as gloves and sutures, which allowed better pricing, Colantuoni says. "We did trials and said, 'These gloves are less money,'" she says. "Everyone across the board used the same item."

All purchasing now goes through one individual, Colantuoni says. The material manager uses a software system (Advantx, Source Medical) that documents every item in an inventory control program. Previously, nurses in charge of different services would order their own supplies, she says. The result? Multiple ordering of the same items,

Also, the Association for Professionals in Infection Control and Epidemiology (APIC) has infection preventionists available for consulting, Perz points out. (*Editor's note: This information is available at www.apicconsulting.com//AM/Template.cfm?Section=Home5.)*

"Strong collegial relationships with other facilities in the community to discuss best practices, to look at quality measures, and to ensure best practice are also helpful," Perz says.

Have written policies and procedures that comply with those from national organizations, including the CDC, says **Marcia Patrick**, RN, MSN, CIC, director, infection prevention and control, MultiCare Health System in Tacoma, WA. Patrick is a board member for the Association for Professionals in Infection Control and Epidemiology (APIC).

Policies must include the following, she says:

- management of patients and staff with an infectious condition;
- operation of sterilizers;
- cleaning of instruments;
- high-level disinfection;
- medication management;
- storage of sterile and nonsterile supplies;
- sharps safety and management of sharps;
- infectious waste;
- hand hygiene;
- dress code;
- employee screening requirements.

Always be mindful of your state requirements, Perz adds. ■

Surgery center turns around in 7 months — Here's how

How would you like to reduce your staffing costs from 52% to 20% of your revenue in seven months? It is possible, based on the successes at Melville (NY) Surgery Center.

The surgery center was filing for bankruptcy and was taken over, says **Rita Colantuoni**, administrator. A staff of nine was narrowed to three. Among the positions eliminated: the credentialing coordinator, accounts payable clerk, secretary for anesthesia, and human resources manager. "We reclassified their job descriptions, and we combined roles," she says.

When volume later increased, two people were added, Colantuoni says.

Overtime for nursing staff was eliminated,

Colantuoni says. "The storeroom was stocked to the ceiling," she says. "People didn't know where items were kept, so they had to order more."

Accounts receivable (A/R) went from 94 to 29 days outstanding.

"We hired a collector to work on outstanding claims," Colantuoni says.

Also, the center required physicians to dictate the operative reports within 24 hours so they could be coded, she says. "Within 24-48 hours, claims go out," Colantuoni says.

Electronic billing was another step that decreased A/R delays, she says.

Also, average revenue per case increased, from \$846 to \$2,586. Some of the contracts hadn't been updated since 1988, Colantuoni says. "By default of changing ownership, we were out of network and needed to renegotiate," she says. "We brought in a consultant, who got contracts that were very fair for us." The consultant was Naya Kehayes of Eveia Health Consulting and Management of Issaquah, WA.

Benchmarking, aggressively recruiting physicians, and renovations were other key elements, they say. **David Benisch**, MD, president of the board at the center, says, "Success breeds success." (For information on how physicians were involved, see story, below.) ■

Get physicians on board to help with supplies, billing

Physicians are a key component of putting your finances in order, according to **David Benisch**, MD, president of the board at Melville (NY) Surgery Center. For example, physicians helped the Melville center reduce its supply costs from 29% to 14% of revenues.

"Make surgeons cognizant of the costs of different things, Benisch says. Case costing alerted physicians to the possibility of items that were just as good, he says. "For the physician owners, it became a simple decision to switch to less expensive items," Benisch said.

Physicians also helped to reduce costs by not expecting sutures and other items to be opened prior to their decision that they were needed, Benisch says. "We had to educate nurses: Don't open what's not to be used," he says. "That reduced some of the costs as well."

Physicians also are involved with billing, Benisch

says. "With tricky case with tricking billing issues, such as our lateral cases and things like that, surgeons go over proper coding with the coding people," he says.

You must have physician compliance in areas such as these to achieve your goals, Benisch emphasizes. "If you don't get the doctors to buy in, it just won't work," he says. ■

Same-Day Surgery Manager



Communication can be key — but what system works?

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

Looking back into 2008, I noticed that a few things worked well, considering what a miserable year it was. However, many other things did not. I found there to be some consistency in the stuff that worked and the stuff that didn't, with the common ground being communication.

There are some things I know hands down, and there are other things I don't know squat about but can bluff my way if need be. It seemed that the things that worked well were in the area of which I consider myself more knowledgeable. Conversely . . .

I decided to test my assumption. I called the administrator at the center where things went exceedingly well and asked him a simple question, "Did I communicate to you exactly what you needed to carry out my request? Was there any gray area whatsoever?" His answer was a resounding "No. I knew exactly what you wanted."

Sooo . . . I called the other administrator clear across the country, one of the ones where things did not go as I expected, and I asked the exact same question. Her reply was, "Not really. I didn't understand exactly what you wanted, so I had to sort of fill in the blanks with my interpretation."

Apparently, most of the world cannot read minds, which is unfortunate and ultimately

time-consuming for those of us who need to communicate. I have struggled to find some computer software that can do all this for me without effort, but what I did find that works is decades old: who, what, when, where, and why. It works! For example, "Mary (who) is going to schedule cases (what) on days when the Sally (the regular scheduler) is off (when) or not at the surgery center (where) so we can keep consistency with the surgeon's offices (why)." It is so easy!

I know it sounds hokey and low tech and probably somewhat silly, but when you are communicating with anyone, just mentally run through that list. I have learned that leaving out any "W" kills the whole process.

Try this method for yourself. See if it makes a difference and let me know. This would be helpful information for me. Thanks, and have a great year! (Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of outpatient surgery development and management. Contact Earnhart at 13492 Research Blvd., Suite 120-258, Austin, TX 78750-2254.) E-mail: searnhart@earnhart.com. Web: www.earnhart.com.) ■

Online preregistration frees up phone registrars

8% of surgical patients preregister electronically

Allowing patients the option of preregistering online is good for patient satisfaction and also frees up patient staff for those who prefer to speak with a representative.

At all four campuses of California Pacific Medical Center at Sutter Health in San Francisco, surgical patients can preregister online 24 hours a day, up to one week prior to their procedure. Patients go to the hospital web site, where there is a link to a secure site for preregistration. The patient enters his or her demographics, insurance or billing information, primary care physician, and date-of-service information. Then, the patient sets up a telephone appointment to speak with a nurse facilitator.

"Once they've submitted it, they are sent an automatic e-mail, thanking them for completing Step 1 online and reminding them about Step 2: the telephone appointment," says **Janice M. Grey**, interim manager of patient registration services for California and Davies Campuses at California Pacific Medical Center.

These data are directed to a secured e-mail account, and only three registrars have access to that account. The information is printed and entered into the hospital's secured registration system. Staff process the online preregistrations twice each day Monday through Friday, in the morning and afternoon. Once this is done, the patient is sent another e-mail to confirm the date and time of his or her telephone appointment. If patients choose not to share their e-mail address, they are contacted by phone.

One benefit is that patients from out of town or out of state now can preregister. "Also, when patients go online to register, they are also introduced to valuable health information available to them on their procedure," says Grey.

Training covered basic skills

Training for staff was minimal and covered basic registrar skills for preregistration, e-mailing, and basic knowledge of the online process, Grey says. "Patients are pleased that they have been able to complete part of the process online," she says. "I believe it gives them a sense of involvement and control for their own care."

With about 8% of these patients preregistering online, phone availability has opened up, so staff can be more available for incoming calls from patients who don't have online access or who prefer to speak with a representative, adds Grey. "We have the option to have the online preregistrations processed by our clinical receptionist/registrars, who do this function in between scheduled patients when they have down time. This gives even more availability to have registrars available for patients calling in," says Grey.

Staff didn't have much difficulty implementing this new process, which saves them time just as it does for patients, says Grey. "Getting the information out to our patients that this process was available was one little glitch," she says.

This was handled with informational fliers on the new service, and on how to access the hospital's web site. These were given to all physicians using the surgery department. Managers also had luncheon meetings with the physicians' office staff to let them know this system was an additional way for their patients to preregister.

"The online system is actually easier for the staff," says Grey. "They are basically just doing data entry, instead of face-to-face interviews with the patients or spending time trying to contact them by phone to do the registration." ■

Conditions for Coverage have new requirements

May 18 is deadline for policies and procedures

The new Medicare Conditions for Coverage (CfC), which take effect May 18, 2009, have several changes for ambulatory surgery centers (ASCs), according to the ASC Association. According to the association, they include:

- A comprehensive history and physical (H&P) must be conducted within 30 days prior to surgery. The H&P must be conducted closer to the date of surgery if required by your state's law, your payer contracts, or your program's policies.

- ASCs must have a disaster preparedness plan. The written plan must be coordinated with state and local authorities, as appropriate. You must hold annual drills and implement changes "promptly."

- ASCs must provide, verbally and in writing, a notice of the patient's rights to the patient or the patient's representative before the date of the procedure. The notice must include several items, including disclosure of the physician financial interest in the ASC, and policies on advance directives. This notice must be in a language and manner that the patient or the representative understands. The patient must be provided with a description of applicable state health and safety laws. If request, the patient must be provided official state advance directive forms.

- ASCs are required to have a grievance procedure. The patient has the right to exercise his or her rights without being subjected to discrimination or reprisal, and the patient has to right to voice grievances.

- ASCs are required to have an infection control program. The program must meet certain requirements, including being under the direction of a designated and qualified professional who has training in infection control. The Association for Professionals in Infection Control

and Epidemiology (APIC) has launched APIC Consulting Services Inc. (ACSI), a wholly owned, for-profit subsidiary of APIC that works with ambulatory and other organizations. For more information, go to www.apicconsulting.com.

- Each patient must be given written discharge instructions and overnight supplies. [Editor's note: Do you have a disaster preparedness plan, patient rights statement, or grievance procedure that you're willing to share with your peers? Contact Joy Daughtery Dickinson at joy.dickinson@ahcmedia.com or (229) 551-9195.] ■

Israeli HIV+ surgeon cleared to continue work

Provider-to-patient transmission exceedingly rare

In a case that recalls the national hue and cry of the Florida HIV dental outbreak in the early 1990s, investigators have determined that HIV provider-to-patient infections remain exceedingly rare.

A surgeon in Israel was found to be HIV-positive in January 2007 during evaluation for fever of recent onset. The duration of infection was unknown. A look-back investigation of patients operated on by the infected surgeon during the preceding 10 years was conducted under the auspices of the Israel Ministry of Health to determine whether any surgeon-to-patient HIV transmission had occurred. Of 1,669 patients identified, 545 (33%) underwent serologic testing for HIV antibody. All results were negative.

"The results of this investigation add to previously published data indicating a low risk for provider-to-patient HIV transmission," the Centers for Disease Control and Prevention reported.¹

After considering the clinical details of the surgeon's case, the published literature on HIV transmission from infected health care workers to patients, and the findings of this investigation, a review panel recommended allowing the resumption of work, with no restrictions on the types of procedures the surgeon could perform, provided the surgeon met the following conditions:

- Instruction by infection control personnel at the surgeon's hospital regarding safe practices, including adherence to standard precautions and hand hygiene requirements, double-gloving during all surgery, and immediate reporting of any cuts in gloves or fingersticks, plus agreement by the surgeon to abide by these practices.

RESOURCE

Go to www.ascassociation.org/coverage to examine all of the changes between the existing Conditions for Coverage (CfC) and the revised regulations. View a redline version of the new rule, which shows the changes, at www.ascassociation.org/cfcredline.pdf.

- Routine health care follow-up at three-month intervals, including measurement of CD4 T-cell count and HIV RNA.

- Adherence to a prescribed antiretroviral regimen, maintenance of good health, and continued CD4 T-cell level > 200 cells/ μ L, with HIV RNA below the threshold of detection.

On the basis of the published literature, the panel did not require notification of prospective patients of the surgeon's HIV status because of the extremely low likelihood of transmission to patients if the conditions for resuming surgery were met, the CDC concluded.

The conditions were consistent with the recommendations contained in the position paper of the Society for Healthcare Epidemiology of America in 1997.² By agreement with the surgeon and the administration at the hospital of current employment, an infection control physician on the hospital's staff familiar with the case was charged with ensuring compliance with these conditions. As of June 2008, none of the 1,669 patients included in the initial contact list was listed in the national HIV registry.

In the early 1990s, CDC reported on six patients infected by a Florida dentist.³ Subsequently, only three additional cases have been reported:

- probable transmission from an orthopedic surgeon to a patient in France;
- probable transmission from a nurse to a patient, also in France;
- probable transmission from a gynecologist to a patient during a cesarean delivery in Spain.⁴

In 1991, CDC issued guidelines to prevent transmission of HIV and hepatitis B virus (HBV) to patients, which required health care workers infected with either of these viruses to refrain from performing exposure-prone procedures before obtaining counsel from a review panel and to notify prospective patients of the health care worker's seropositivity before performing exposure-prone invasive procedures.⁵ The guidelines provide general characteristics of exposure-prone procedures, which include digital palpation of a needle tip in a body cavity or the simultaneous presence of the health care worker's fingers and a needle or other sharp instrument or object in a poorly visualized or

highly confined anatomic site. Although medical organizations and institutions are advised to identify specific procedures falling into this category, the guidelines include types of invasive surgical procedures that should be considered exposure-prone. Regarding retrospective notification of patients who have had exposure-prone procedures performed on them by infected health care workers, the guidelines note that more data are needed to determine the risk for transmission during such procedures. The guidelines say notification should be considered on a case-by-case basis, and it should take into consideration an assessment of specific risks, confidentiality issues, and available resources.

During the 17 years since the CDC guidelines were issued, data based on published look-back investigations of bloodborne pathogen outbreaks and mathematical modeling indicate that the risk for transmission of HIV from an infected surgeon to a patient is considerably lower than that for HBV or hepatitis C virus. The degree of blood infectivity of HIV carriers has been shown to vary, in part, as a function of viral load, which now can be rendered undetectable via use of antiretroviral regimens that were unavailable at the time the guidelines were issued.

References

1. Centers for Disease Control and Prevention. Investigation of patients treated by an HIV-infected cardiothoracic surgeon — Israel, 2007. *MMWR* 2009; 57(53):1,413-1,415.
2. D4+ Recovery in HIV-1 Infected Patients is Independent of Class of Antiretroviral Therapy. AIDS/TB Committee of the Society for Healthcare Epidemiology of America. Management of healthcare workers infected with hepatitis B virus, hepatitis C virus, human immunodeficiency virus, or other bloodborne pathogens. *Infect Control Hosp Epidemiol* 1997; 18:349-363.
3. CDC. Update: Investigations of persons treated by HIV-infected health-care workers — United States. *MMWR* 1993; 42:329-331, 337.
4. Perry JL, Pearson RD, Jagger J. Infected health care workers and patient safety: A double standard. *Am J Infect Control* 2006; 34:313-319.
5. Centers for Disease Control and Prevention. Recommendations for preventing transmission of human immunodeficiency virus and hepatitis B virus to patients during exposure-prone invasive procedures. *MMWR* 1991; 40(No. RR-8). ■

COMING IN FUTURE MONTHS

■ How to prevent lawsuits at the source

■ Medication order reduces duplication

■ Simple way to notify pre-op that patient is ready

■ Joint Commission standards that will be scored starting in July

■ How to get a handle of overstocking of supplies

Reading grade levels rise with difficult medical terms

For easy-to-read text, use med terms sparingly

When difficult medical terms are used in a text, the reading grade level is higher.

Many think that medical terms will skew results on readability formulas, says **Audrey Riffenburgh**, MA, president of Plain Language Works based in Albuquerque, NM, and a specialist in health literacy and plain language. What they actually do is accurately reflect the difficulty of the text, Riffenburgh says.

“If ‘laparoscopy’ is in a document 10 times, that means the inexperienced readers who have to sound it out each time they come to it, will have to do so 10 times,” she says.

How do adults with weak reading skills make their way through text with unfamiliar, difficult-to-pronounce medical terms? Riffenburgh says every time they come to a word that’s not in their sight word vocabulary, which means they know it on sight without needing to sound it out, they have to stop and begin sounding out the unfamiliar word. For example, laparoscopy has 11 letters that make up five syllables that readers have to figure out, put together in the proper sequence, and then say correctly to compare it with words they know in their heads to determine if they can understand it.

When readers don’t know what the word means or have never heard it pronounced, they don’t have an auditory memory of it to which they can link a visual image. Therefore, they must remember the 11 letters and five syllables, their order in the word, and what the word means if they are able to determine its meaning from the context. However, they are very likely to have lost track of the context by that time, explains Riffenburgh.

Should readers find the word “laparoscopy” again in a sentence, the fact they have sounded it out one time does not mean they now have it in their sight word vocabulary. Most new readers have to see a word in context many, many times before they are able to recognize it quickly enough that it doesn’t interrupt the flow of their reading.

The author’s priority is most likely to make sure the reader understands all the concepts in the document. For example, if the document is describing a laparoscopy to enable the reader to make an informed decision about whether to have one, the most important information is not

the name of the procedure. The reader needs to know what will happen during the procedure and the benefits and risks. Therefore, to get the necessary information, the reader does not need to see the word laparoscopy again and again.

A writer might describe how doctors can make very small cuts in a person’s stomach and put a long tube with a light and camera inside to look around, explains Riffenburgh. Then he or she might state, “This kind of surgery is called a laparoscopy,” and include a pronunciation guide. The author can then continue to describe the procedure as necessary.

It’s more important to make sure readers get the concepts tied to the word, even if they don’t learn the word. Patients always can talk to their doctors about the surgery where tiny cuts are made and a tube with a camera on the end is inserted. The health care provider will know what the patient is talking about, states Riffenburgh. ■

Resources for producing clear language documents

Many resources are available to help patient education managers produce clear, readable patient handouts. To write documents in plain language, **Doug Seubert**, guideline editor in Quality Improvement and Care Management at Marshfield (WI) Clinic, frequently uses the following resources:

- *The Health Literacy Style Manual*. Web: coveringkidsandfamilies.org/resources/docs/stylemanual.pdf.
- *Scientific and Technical Information Simply Put* (Centers for Disease Control and Prevention). Web: www.cdc.gov/od/oc/simpput.pdf.

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. After completing this semester’s activity with the **June** 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. ■

- **Pfizer Principles for Clear Health Communication, Second Edition.** Web: www.ihconline.org/toolkits/HealthLiteracy/PPForClearHealthCommunication.pdf.
- **Readability Toolkit from the Group Health Center for Health Studies.** Web: www.uams.edu/irb/PRISMReadabilityToolkit_ThirdEdv3_042908.pdf.
For alternative word lists, go to these sources:
- **"Simple Words and Phrases"** from Plain Language gov. Web: www.plainlanguage.gov/howto/wordsuggestions/simplewords.cfm.
- **Words to Watch — Fact Sheet** from Partnership for Clear Health Communication. Web: www.npsf.org/askme3/pdfs/words_to_watch.pdf. ■

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.
- How did the Melville Surgery Center reduce its accounts receivable from 94 to 29 days outstanding?
 - Hired a collector to work on outstanding claims.
 - Required physicians to dictate the operative reports within 24 hours so they could be coded.
 - Went to electronic billing.
 - All of the above.
 - What does Stephen W. Earnhart, MS, say is the most effective communication system he has found?
 - Who, what, when, where, and why.
 - Writing down everything that is said to him.
 - Requiring those to whom he is speaking to write down everything he is saying.
 - The new Medicare Conditions for Coverage (CfC), which take effect May 18, 2009, require that a comprehensive history and physical (H&P) must be conducted within 30 days prior to surgery. The H&P must be conducted closer to the date of surgery if required by:
 - Your state's law.
 - Your payer contracts.
 - Your program's policies.
 - Any of the above.
 - Medical terms skew the results of readability formulas making the reading level higher than it actually is.
 - True
 - False

Answers: 9. D; 10. A; 11. D; 12. B.

EDITORIAL ADVISORY BOARD

Consulting Editor: **Mark Mayo**
Corporate Director of ASC Operations
Magna Health Systems
Chicago
Executive Director
Surgery Center Association of Illinois

Kay Ball

RN, MSA, CNOR, FAAN
Perioperative Consultant/
Educator, K&D Medical
Lewis Center, OH
E-mail: KayBall@aol.com

Stephen W. Earnhart, MS
President and CEO
Earnhart & Associates
Austin, TX
E-mail: searnhart@earnhart.com

Ann Geier, RN, MS, CNOR
CASC
Vice President of Operations
Ambulatory Surgical Centers
of America
Norwood, MA

Paula R. Graling
RN, MSN, CNS, CNOR
Clinical Nurse Specialist,
Perioperative Service, Inova
Fairfax Hospital Falls Church,
VA

Rebecca S. Twersky, MD

Medical Director
Ambulatory Surgery Unit
Long Island College Hospital
Brooklyn, NY
E-mail: twersky@pipeline.com

Kate Moses,

RN, CNOR, CPHQ
Chair, Ambulatory Surgery
Specialty Assembly
Association of periOperative
Nurses
Denver
Quality Management Nurse,
Medical Arts Surgery Centers
Miami

Roger Pence

President
FWI Healthcare
Edgerton, OH
E-mail: roger@fwihealthcare.com

Steven D. Schwaitzberg, MD

Chief of Surgery
Cambridge (MA) Health
Alliance

David Shapiro, MD, CHCQM,

CHC, CPHRM, LHRM
Partner, Ambulatory Surgery
Company, LLC
Tallahassee, FL

To reproduce any part of this newsletter for promotional purposes, please contact:

Stephen Vance

Phone: (800) 688-2421, ext. 5511

Fax: (800) 284-3291

Email: stephen.vance@ahcmedia.com

To obtain information and pricing on group discounts, multiple copies, site-licenses, or electronic distribution please contact:

Tria Kreutzer

Phone: (800) 688-2421, ext. 5482

Fax: (800)-284-3291

Email: tria.kreutzer@ahcmedia.com

Address: AHC Media LLC
3525 Piedmont Road, Bldg. 6, Ste. 400
Atlanta, GA 30305 USA

To reproduce any part of AHC newsletters for educational purposes, please contact:

The Copyright Clearance Center for permission

Email: info@copyright.com

Website: www.copyright.com

Phone: (978) 750-8400

Fax: (978) 646-8600

Address: Copyright Clearance Center
222 Rosewood Drive, Danvers, MA 01923 USA

INFECTION CONTROL SITE VISIT

Facility name:

CMS Certification Number _____

Date of site visit: ____/____/____

Name of individuals performing site visit:

Date of most recent federal survey: ____/____/____

Participate in Medicare via accreditation by:

- Accreditation Association for Ambulatory Health Care (AAAHC) _____
- American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) _____
- American Osteopathic Association (AOA) _____
- The Joint Commission (JC) _____

Date of most recent accreditation survey: _____

Types of procedures performed at facility (check all that apply):

- Orthopedic
- Pain
- Ophthalmologic
- Plastic/reconstructive
- Endoscopy
- Dental
- Podiatry
- Other, specify: _____

- Pediatric
- Adult

v06022008

Page 1 of 13

Number of procedures performed per month: _____

Number of procedure rooms (including ORs): _____

Indicate if the following are provided via contract, in-house, or both:

Service	Contract (Name of Agency)	In-house	Frequency of Service
Linen Cleaning			
Waste Management			
Environmental Cleaning Services			
Pharmacy			
Anesthesia			
Nursing			
Infection Control Practitioner			

How does staff receive infection control training (check all that apply)?

- In-service
- Computer-based training
- Other, specify: _____

Which staff receive infection control training (check all that apply):

- Employee
- Contracted
- Other, specify: _____

Indicate frequency of infection control training (check all that apply):

- Upon hire
 - Annually
 - Periodically/as needed
 - Other, specify: _____
- Is there documentation to support this? Yes No
 Is there documentation to support this? Yes No
 Is there documentation to support this? Yes No
 Is there documentation to support this? Yes No

If training is not provided periodically, a deficiency must be cited.

Do staff receive annual OSHA bloodborne pathogen training? Yes No

What is the facility's policy for reporting notifiable diseases to the State health agency (check all that apply)?

- Telephone
- Fax
- Electronically
- Mail
- Other, specify: _____
- No policy

If the facility does not have a reporting system, a deficiency must be cited. However, CMS does not specify the means for reporting. Generally this would be done by the State health agency.

How does facility identify infections related to procedures performed at facility (check all that apply)?

- Phone call to patients
- Letter to patients
- Follow-up with primary care providers
- Follow-up with physician performing procedure
- Other, specify: _____
- Not done

If the facility does not have an identification system, a deficiency must be cited

Instructions: The following is a list of items that should be assessed during the site visit. Items are to be assessed either by interview, observation, or both, as indicated by the shading in the boxes.

The interviews and observations should be performed with the most appropriate staff person(s) for the items of interest (e.g., the staff person responsible for sterilization should answer the sterilization questions).

A minimum of one (although at least two would be preferable) procedure should be observed during the site visit. The inspector(s) should identify at least one patient and "follow-through" from arrival to discharge with that patient to observe pertinent practices.

When performing interviews and observations, any single instance of a breach in infection control would constitute a breach for that practice. *A breach of any question highlighted in yellow must also be cited as a deficiency. Breaches related to highlighted questions with an asterisk generally would be cited at the condition level. However, this does not mean that other breaches of infection control may not be cited at the condition level; surveyors must use their judgment as to how widespread and serious the breach is.*

Names and titles of facility staff persons providing answers to interview questions:

Number of Procedures Observed During Site Visit: 1 2 3 4 Other, specify: _____

TEST VERSION

Infection Control Practice	Observation	Interview
I. Hand Hygiene		
A. Soap and water are available in patient care areas	Yes No	
B. Alcohol-based hand rub is available in patient care areas	Yes No	There are LSC requirements at 42 CFR 416.44(b)(5) for installation of alcohol-based hand rubs
<p>C. Staff perform hand hygiene:</p> <p>a. Before and after an invasive procedure (e.g., insertion of IV catheter, intubation/extubation, surgical procedure) even if gloves are worn</p> <p>b. After contact with blood, body fluids, or nonintact skin (even if gloves are worn)</p> <p>c. After contact with used, contaminated medical equipment or visibly contaminated environmental surfaces (even if gloves are worn)</p> <p>Note: To ensure consistency between site visits, hand hygiene should be observed during the "follow-through" of patients from arrival to discharge, with particular attention paid to invasive procedures</p>	<p>Yes No</p> <p>Yes No</p> <p>Yes No</p>	
<p>D. Regarding gloves, staff:</p> <p>a. Wear gloves for procedures that might involve contact with blood or body fluids</p> <p>b. Wear gloves when handling potentially contaminated patient equipment</p> <p>c. Remove soiled gloves before moving to next task</p>	<p>Yes No</p> <p>Yes No</p> <p>Yes No</p>	
E. If a surgical scrub is required, the surgical team performs surgical hand scrub	Yes No	
Comments:		

Infection Control Practice	Observation	Interview
II. Injection Practices (medications, saline, other infusates)		
*A. Needles and syringes are used for only one patient	Yes No	Yes No
*B. Injections are prepared in a clean area that is free from contamination with blood, body fluids, other visible contamination, or used contaminated equipment	Yes No	Yes No
C. The patient's skin is prepped with an antiseptic before IV placement.	Yes No	Yes No
D. List all injectable medications/infusates that are in a vial/container used for more than 1 patient: Name: _____ Size of vial (cc/mL): _____ Typical dose per patient (cc/mL): _____		
*E. Single dose medications/infusates are used for only one patient and not collected or combined (bags of normal saline are ALWAYS single use)	Yes No	Yes No
F. Multi-dose medications/infusates are used for only one patient (Note: a "No" answer here is not necessarily a breach in infection control. Circle N/A if no multi-dose medications/infusates are used.)	Yes No N/A	Yes No N/A
*G. Medication vials used for more than 1 patient are always entered with a new needle and new syringe	Yes No N/A	Yes No N/A
H. The rubber septum on a medication/infusate vial is disinfected with alcohol prior to piercing after initial entry	Yes No N/A	Yes No N/A
*I. Medications/infusates that are packaged as prefilled syringes are used for only one patient	Yes No N/A	Yes No N/A

Infection Control Practice	Observation	Interview
J. Medications/infusates are drawn up at start of each procedure	Yes No	Yes No
*K. Fluid infusion and administration sets (e.g., intravenous bags, tubing and connectors) are: *a. Used for one patient only *b. Disposed of after use	Yes No Yes No	Yes No Yes No
*L. Needles and syringes are discarded intact in an appropriate sharps container after use	Yes No	Yes No
Comments:		
III. Sterilization, High-level Disinfection, and Single Use Devices		
<p>Pre-cleaning should always be performed prior to sterilization and high-level disinfection</p> <p>Sterilization should be performed for instruments and equipment that enter normally sterile tissue or the vascular system</p> <p>High-level disinfection should be performed for items that come into contact with non-intact skin or mucous membranes (reusable flexible endoscopes, endotracheal tubes, anesthesia breathing circuits, and respiratory therapy equipment)</p>		
<p>*A. Items are thoroughly pre-cleaned and decontaminated according to manufacturer instructions or evidence-based guidelines prior to high-level disinfection and sterilization.</p> <p>What method is used for pre-cleaning:</p> <ul style="list-style-type: none"> a. Automated (including ultrasonic baths) b. Manual <p>List the agent(s) used for cleaning and decontamination:</p>	Yes No	Yes No

Infection Control Practice	Observation	Interview
<p>B. Are sterilization procedures performed on-site? Yes ___ No ___ (If No, Skip to “H”)</p> <p>Please indicate method of sterilization, brand of equipment, and number of machines:</p> <p>a. Steam autoclave Number:</p> <p>b. Peracetic acid Number:</p> <p>c. Flash only autoclave: Number:</p> <p>d. Other (specify):</p>		
<p>*C. All critical equipment (i.e., items that enter sterile tissue or the vascular system) is sterilized appropriately</p> <p>*a. Medical devices and instruments are visually inspected for residual soil and re-cleaned as needed before packaging and sterilization</p> <p>*b. A chemical indicator is placed in each load</p> <p>*c. A biologic indicator is performed at least weekly and with all implantable loads</p> <p>*d. Documentation for each piece of sterilization equipment is maintained and includes results from each load and are up to date</p> <p>*e. The facility uses flash sterilization only in circumstances in which routine sterilization procedures cannot be performed</p>	<p>Yes No</p> <p>Yes No</p> <p>Yes No</p> <p>Yes No</p> <p>Yes No</p> <p>Yes No</p>	<p>Yes No</p> <p>Yes No</p> <p>Yes No</p> <p>Yes No</p> <p>Yes No</p>

Infection Control Practice	Observation	Interview
*D. There is a procedure in place for identification and recall of sterilized instruments that were not adequately sterilized.	Yes No	Yes No
*E. After sterilization, medical devices and instruments are stored in a designated clean area so that sterility is not compromised.	Yes No	Yes No
*F. Sterile packages are inspected for integrity and compromised packages are reprocessed	Yes No	Yes No
<p>G. Is high-level disinfection performed on-site? Yes ___ No ___ (If No, skip to "M")</p> <p>What methods are used for high-level disinfection? Indicate method and if high-level disinfection is manual or automated.</p>		
*H. Semi-critical items (items that come in contact with nonintact skin or mucous membranes) receive at least high-level disinfection.	Yes No	Yes No
*a. Medical devices and instruments are visually inspected for residual soil and recleaned as needed before high-level disinfection	Yes No	Yes No
*b. High-level disinfection equipment is maintained according to manufacturer instructions or evidence-based guidelines	Yes No	Yes No

Infection Control Practice	Observation	Interview
<p>*c. Chemicals used for high-level disinfection are</p> <p>*i) prepared according to manufacturer instructions or evidence-based guidelines</p> <p>*ii) tested for appropriate concentration according to manufacturer instructions or evidence-based guidelines and are replaced before they expire</p> <p>*iii) Documented to have been prepared and replaced according to manufacturer instructions or evidence-based guidelines</p> <p>*d. Equipment is high-level disinfected according to manufacturer instructions or evidence-based guidelines</p>	<p>Yes No</p> <p>Yes No</p> <p>Yes No</p> <p>Yes No</p> <p>Yes No</p>	<p>Yes No</p> <p>Yes No</p> <p>Yes No</p> <p>Yes No</p> <p>Yes No</p>
<p>I. Items that undergo high-level disinfection are dried before reuse</p>	<p>Yes No</p>	<p>Yes No</p>
<p>*J. Following high-level disinfection, items are stored in a designated clean area in a manner to prevent recontamination</p>	<p>Yes No</p>	<p>Yes No</p>
<p>*K. If single-use devices are reprocessed, they are sent to an appropriate reprocessing facility. (Choose N/A if single-use devices are never reprocessed and used again) Name the reprocessing facility:</p> <p><i>(Surveyor to confirm there is a contract with a reprocessing facility by viewing it)</i></p>	<p>Yes No N/A</p>	<p>Yes No N/A</p>
<p>Comments:</p>		

Infection Control Practice	Observation	Interview
IV. Environmental Infection Control		
A. Objects and environmental surfaces in the operating room that are touched frequently (e.g., bed, IV poles, medication preparation areas) are disinfected with an EPA-registered disinfectant(s). Name the disinfectant(s) that are used:	Yes No	Yes No
B. Objects and environmental surfaces that are touched frequently in patient care areas outside of the OR (e.g., procedure tables, bedrails, toilet surfaces, waiting area surfaces) are disinfected with an EPA-registered disinfectant(s). Name the disinfectant(s) that are used:	Yes No	Yes No
C. The facility has a procedure in place to decontaminate gross spills of blood or other body fluids	Yes No	Yes No
D. Surgical and invasive procedure rooms are cleaned and disinfected daily		Yes No
E. All sharps are disposed of in a puncture-resistant sharps container	Yes No	Yes No
F. Sharps containers are located in appropriate patient care areas and are secured	Yes No	Yes No
G. Sharps containers are replaced before the fill line is reached	Yes No	
Comments:		
Infection Control Practice	Observation	Interview

<p>V. Glucometer Skip this section if facility does not have a Glucometer:</p> <p>Does facility have a Glucometer? Yes _____ No _____</p> <p>If yes, Brand: Model:</p>		
<p>A. A spring-loaded lancing penlet is used for multiple patients (Note: A "No" answer indicates no breaches in infection control)</p>	Yes No	Yes No
<p>B.* A new single use lancing device is used for each patient</p> <p>Specify brand/model of lancing device used: _____</p>	Yes No	Yes No
<p>C. The glucometer is cleaned/disinfected between <u>every</u> patient</p>	Yes No	Yes No
<p>Comments:</p>		

Additional Comments:

Source: Centers for Disease Control and Prevention, Atlanta.

TEST VERSION

Infection Control Q&A

Question: Is it OK to use the same syringe to give an intramuscular (IM) or intravenous (IV) injection to more than one patient if I change the needle between patients and I don't draw back before injecting?

Answer: NO. A small amount of blood can flow into the needle and syringe even when only positive pressure is applied outward. The syringe and needle are contaminated and must be discarded.

Question: If I used a syringe only to infuse medications into an IV tubing port that is several feet away from the patient's IV catheter site, is it OK to use the same syringe for another patient?

Answer: NO. Everything from the medication bag to the patient's catheter is a single interconnected unit.

- Separation from the patient's IV by distance, gravity, and/or positive infusion pressure does not ensure that small amounts of blood are not present in these supplies
- A syringe that intersects through ports in the IV tubing or bags also becomes contaminated and cannot be used for another patient.

Question: Can I reuse a syringe during a procedure for a patient who requires additional medication as long as the vial will not be used for another patient?

Answer: It is preferable to always use a new sterile syringe to withdraw medications, even if the medication will be used only for one patient. This provides an extra layer of protection for patients and is encouraged.

Question: Why can't I just visually inspect syringes to determine whether they are contaminated or can be used again?

Answer: Pathogens, including hepatitis C virus (HCV), hepatitis B virus (HBV), and human immunodeficiency virus (HIV) can be present in sufficient quantities to produce infection in the absence of visible blood.

Similarly, bacteria and other microbes can be present without clouding or other visible evidence of contamination.

Just because you don't see blood or other material in a used syringe or IV tubing, e.g., does not mean the item is free from potentially infectious agents.

All used injection supplies and materials are potentially contaminated and should be discarded.

For DHQP Inquiries (inquiries about safe injection practices), call (800) 311-3435, option 1 or e-mail hip@cdc.gov.

Source: Centers for Disease Control and Prevention, Atlanta.