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IN THIS ISSUE

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Is there reason for routine pre-op tests? New research raises question

Is routine preoperative testing an outdated concept? Despite the fact that many outpatient surgery programs continue to perform the testing, even for simple eye operations, a recent study raises the question about whether such testing has an impact on clinical outcomes.[1]

In the pilot study, 1,061 eligible patients were randomized to have indicated pre-op testing or no pre-op testing. The pre-op testing included, as needed, a complete blood count, electrolytes, blood glucose, creatinine, electrocardiogram, and chest radiograph. The primary outcome measures were the rate of peri-op adverse events and the rates of adverse events within seven to 30 days after surgery. Patients' age, gender, American Society of Anesthesiologists status, type of surgery, and anesthesia were similar between the two groups. All ages and types of outpatient surgery were included. The study was randomized, single-blind, prospective, and controlled.

The finding? There were no significant differences in the rates of peri-op adverse events and the rates of adverse events within 30 days after surgery between the no-testing group and the indicated testing group. Hospital revisits seven days or later were higher in the indicated testing group. None of the adverse events were related to the indicated testing or no testing.

"This pilot study showed that there was no increase in the perioperative adverse events as a result of no preoperative testing in our study

EXECUTIVE SUMMARY

A just-published study questions the value of routine preoperative testing for outpatient surgery patients.

- The study of more than 1,000 patients found no increase of adverse events perioperatively or within seven to 30 days after surgery for the no-testing group. The research included all ages and outpatient surgery procedures.
- A larger study is needed to confirm the finding.

population," the researchers wrote. "A larger study is needed to demonstrate that indicated testing may be safely eliminated in selected patients undergoing ambulatory surgery without increasing perioperative complications."

The bottom line is that the value of routine pre-op testing is questionable, as long as a thorough history is performed, say sources interviewed by *Same-Day Surgery.* Providers point to earlier research by **Oliver Schein**, MD, MPH, professor of ophthalmology at The Wilmer Eye Institute, Johns Hopkins University School Of Medicine, Baltimore, in *The New England Journal of Medicine,* which indicated that patients who did not have routine pre-op tests before cataract surgery fared as well as patients who did have the tests. **(For more information, see "Will you ID diseases or waste time, money on routine pre-op tests on elderly?" and "A quick tip on when to test," December 2000, *Same-Day Surgery*, p. 145 and p. 148.)**

"The additive value of additional testing continues to be questioned," says **Lee A. Fleisher**, MD, Robert D. Dripps Professor and chair of anesthesiology and critical care at the University of Pennsylvania School of Medicine in Philadelphia.

At the ambulatory surgical unit at the University Health Network in Toronto, routine pre-op testing was stopped for eye patients after the Schein study was published, reports **Frances Chung**, FRCPC, lead author of the recently published research and professor of anesthesia at the University of Toronto and medical director of the ambulatory surgical unit. A history and physical (H&P) is obtained by a physician, she adds.

What Chung's study illustrates is that if you're certain patients are stable, and you have had a thorough H&P, that the likelihood that testing would have any additional value is "extremely rare," Fleisher says. A large-scale study still might be needed to prove that finding, he adds.

Fleisher's opinions about pre-op testing aren't rare, particularly in terms of cataract surgery. "Routine pre-op testing confers no value for cataract surgery and presumably for other low medical risk surgical interventions," says Schein. At Johns Hopkins, no routine lab testing is required for cataract surgery. "Lab testing occasionally — rarely — changes management, but we usually don't know if it actually affects the clinical outcome," Schein says.

Don't uniformly throw out pre-op evaluation or even all pre-op testing, providers warn.

"This is not to say that if you stop taking a good history, and therefore stop identifying conditions that warrant further evaluation because they're less stable, we won't be developing increasing complications," Fleisher says.

At the University of Pennsylvania, the nurse practitioners conduct a thorough history in the surgeons' offices, he reports. "Between the patient self-assessment and the nurse practitioner assessment, we get that info, and we have a very low cancellation rate," Fleisher says. Pre-op tests are conducted only if they find some progression or some type of unstable symptom, he adds.

Selective patients will need pre-op testing,

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Chung says. She points to patients with significant heart disease and obstructive sleep apnea.

"I don't think we need to indiscriminately do [pre-op testing] in every single patient now," Chung says. "Testing is still overutilized at present." **(For more information, see these *Same-Day Surgery* stories: "Save $250,000 a year with testing guidelines," January 1996, and "Pre-op procedures: Check all women for pregnancy?" July 2002.)**

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1. Chung F, Yuan H, Yin L, et al. Elimination of preoperative testing in ambulatory surgery. *Anesth Analg* 2009; 108:467-475. ■

Same-Day Surgery Manager

7 suggestions on how to grow your revenues

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

Business does not succeed on its expenses, or lack thereof. Healthy companies rely on revenue and then *appropriate* expenses to thrive. Surgery is no different than any other service industry: We need revenue to grow and become or stay profitable.

I grow weary of managers who focus on expenses. They bore me. They should get out of their cubby and get a life.

Any surgery program, be it hospital-based or freestanding, can succeed only if it draws blood. No blood, no profit. Suction it up, cauterized it, bandage it, wipe it; it makes no difference: You have to do actual surgery to make it happen.

If managers spend half as much of their time focusing on *revenue* and not expenses, there would be many more successful programs out there. Simple formulas for the financially savvy, based upon production, can all but eliminate time-consuming expense justification. The same goes for silly, nonproductive meetings that are held under the guise of actually producing something of value in the workplace. How many times have you had discussions that centered on "How can we retain our surgeons?" or "What can we do to attract new surgeons into our program?" or, the completely unheard-of topic these days, "How can we help our surgeons see more patients and bring more of them to our operating rooms?"

The auto industry quickly discovered that everything they had built over the decades quickly came crashing down when people stopped buying cars. Dud! The housing industry is falling apart because people stopped buying houses. The stock market crashed when people stopped buying stock. Surgical programs die when patients stop having surgery or start having surgery someplace else. Surgeons bring patients; patients bring blood. Simple logic determines that encouraging surgeons to bring more patients encourages more success. After that happens, you can start working on your expenses and attend meetings again.

Let me suggest a few things:

- **Set a goal for yourself.** Make it obtainable but make it revenue-driven, not expense-driven. For example, your goal could be "perform 5% more cases per month starting in (pick a month about three months away)" instead of "reduce staffing expense by 2%."
- **Select a team of two or three people to help you.** If you choose any more than that, it is a worthless venture.
- **Review the monthly surgical volume of all of your surgeons for as far back as you can go.** Is it increasing, decreasing, or steady?
- **Target two or three "significant users" whose cases are flat or decreasing.**
- **Make an appointment to meet with those surgeons' offices, and meet with the person who books their cases.** Flat out ask what you can do to get more of the doctors' cases. Leave your pride at the door. Humble yourself.
- **Now do the same thing with the office where surgeons are increasing and ask their staff what you are doing so right for them to garner so many of their cases.**
- **Assemble your team again, and compare notes.** Look for common occurrences or outcomes that you can apply to others.

Clearly, this method will not work for all of you, but what happens if it works for your competition?

Surgeons are creatures of habit. It is difficult to get them to change their preferences or get their staff to change *their* modus operandi. That can work in your favor in many ways. However, when you throw in all the variables to that scenario, i.e.,

ownership in another facility, slow staff, long turnover time, inadequate or outdated equipment, lackadaisical behavior, or indifference to their issues and values, you set a stage for them to change their alliance very quickly. So, focus on what you do best: surgery, not accounting. Get the cases first, keep the cases — exquisitely — and lastly, grow the cases.

The singer Kenny Rogers has a song called the "Gambler." Some of the lyrics stand out: "You never count your money, when you're sitting at the table, they'll be time enough for counting, when the dealings done."

Go deal. Count later. *(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.)* ■

North Carolina SPICE is model for other states

Ambulatory outbreaks draw attention to education

(Editor's note: In this first of a two-part series on infection control issues in ambulatory surgery, we tell you about a model program in North Carolina, as well as recent incidents as a hospital and surgery center. In next month's issue, we'll give you information about how infection rates actually have been reduced dramatically in an outpatient surgery setting.)

As recurrent hepatitis outbreaks continue to be reported in ambulatory care nationally, there are increasing calls for more oversight and training for health care workers in this setting. A possible model that could be used by states is a North Carolina law that requires an individual in each health care organization in which invasive procedures are performed to complete an approved infection control course.

Funded by the state, the Statewide Program for Infection Control and Epidemiology (SPICE) is located at the School of Medicine at the University of North Carolina at Chapel Hill.

"There is actually a law in our state, effective 1994, that all health care organizations that do invasive procedures, as defined by using a needle," must receive training, says **Karen K. Hoffmann**, RN, MS, CIC, associate director and clinical instructor at SPICE. "If you give an injection, you are covered under this rule, and you have to have attended a state-approved course for your area of practice."

For hospitals, training lasts two weeks. Ambulatory facilities, physician's offices, and dental practices must take a one-day program. "I do the training and actually developed the curriculum for these outpatient areas," Hoffmann says. "So, dental has its own, home health and hospice has its unique curriculum, and outpatient settings have a unique curriculum."

The infection control curriculum is not a substitute for the training required by the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogen Final Rule. "We focus on issues that OSHA does not address: disinfection, sterilization, housekeeping, environmental issues, medical waste handling," Hoffmann says. "Then, while we have them there, we go over needle safety. We have broken that out and made it a whole focus because of the recent outbreaks."

Indeed, one of the outbreaks occurred in North Carolina last year where seven patients reportedly acquired hepatitis infection while undergoing stress tests at a cardiology practice. An epidemiological investigation pointed to patient-to-patient transmission due to unsafe injection practices, a common theme in the outbreaks. The outbreak occurred after the clinic started injecting a radioactive "tagging agent" used to identify potential heart problems via nuclear imaging.

"For any hepatitis B and C cases that are sent to the local health department, there is an exposure work-up [that includes] recent dental or medical procedures," Hoffmann says. "And they do have the health department follow each of those up as a possibility. I have helped with a couple of those investigations."

While the outbreak underscores that no training program will eliminate all outbreaks, Hoffmann contends that infection control in ambulatory settings is improving in the state. "I think it's getting much better," she says. "One of the reasons is that so many of these outpatient settings are coming under the umbrella of one of our five or six major medical facilities across the state."

Plans call for putting the training online in recorded modules. "I think that is going to make the doctors' practices much more compliant," she says. "I think they are a weak area in terms of sending people. We don't have an easy way to [reach them]."

Settings that have had problems typically are those that have not sent any staff members in for

Outline of SPICE Training — Infection Control in Outpatient Settings

- Review of NC laws concerning infection control
- Epidemiology and risk of infection
- Outbreaks and safe injection practices
- Principles/practices of asepsis and hand hygiene and environmental issues in disease transmission
- Principles of cleaning, disinfection, and sterilization
- Application of cleaning, disinfection and sterilization principles to patient equipment
- Complying with OSHA's bloodborne pathogen final rule

Source: Statewide Program for Infection Control and Epidemiology (SPICE), University of North Carolina at Chapel Hill School of Medicine.

the SPICE training, Hoffmann notes. "I think it does help to have someone — just like [IPs] in hospitals — to have enough basic knowledge to say, 'That doesn't look right,'" she says. "They may have been taught that in school, but that is so far removed from actual practice that they don't feel that they have the knowledge or authority." **(See outline of outpatient training, above. For more information on the SPICE program, including an outline of the hospital program, go to www.unc.edu/depts/spice/courses.html.)**

Apparently, no one felt empowered enough to say anything at the site of one of the most recent national outbreaks, a dialysis center in New York City.

Recently reported by the Centers for Disease Control and Prevention (CDC), the outbreak was uncovered last year when health officials found that three patients seroconverted for HCV after receiving treatment in a hemodialysis center that was subsequently shut down.[1] State health officials conducted patient interviews and made multiple visits to the hemodialysis unit to observe hemodialysis treatments, assess infection control practices, evaluate HCV surveillance activities, review medical records, and conduct interviews with staff members. They found that six additional patients had HCV seroconversion between 2001 and 2008. The hemodialysis unit had numerous deficiencies in infection control policies, procedures, and training, the CDC reported. **(For information on more recent problems with infection control practices at outpatient surgery programs, see story, right.)**

"Visible blood remained on dialysis chairs, dialysis machine surfaces, and the surrounding floor between patient treatments," the CDC reported. "Moreover, direct care staff members failed to don gloves with every patient encounter, change gloves between patients, or perform hand hygiene after contact with patients and soiled surfaces. Supervisory staff members failed to address these breaches. Many of the direct care staff members were unaware of the hemodialysis unit's written infection control policies, including those pertaining to cleaning and disinfection."

Given such flagrant violations, the Association for Professionals in Infection Control and Epidemiology (APIC) is urging patients to look out for their own safety when receiving ambulatory care. **[For more information, see "APIC Warns: Patient, Protect Thyself in Ambulatory Care," *Same-Day Surgery Weekly Alert*, March 20, 2009. To sign up for this free weekly ezine, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]** It also would appear that training programs such as the one in North Carolina could serve as a model for other states to build on. "I think this is working well in our state, and one of the things we are trying to do is make it more accessible," Hoffmann says. **(For information on more infection control deficiencies found in Nevada, see story, p. 46.)**

Reference

1. Centers for Disease Control and Prevention. Hepatitis C Virus Transmission at an Outpatient Hemodialysis Unit — New York, 2001 — 2008. *MMWR* 2009; 58:189-194. ■

Hospital, ASC report improper sterilization

Two health care facilities recently have reported that their improper infection control techniques could have put patients at risk.

In Georgia, a surgery center exposed more than 1,000 people with improperly sanitization of endoscopes, according to a news report.[1]

The center sent a letter to 1,300 patients who had surgery between Sept. 10, 2007, and Feb. 9, 2009, according to the report. The letter said the center isn't aware of any related infections and the risk of infection is near zero. *(Editor's note: To access the letter, go to images.bimedia.net/documents/evens_surgery_center_documents.pdf.)* The manufacturer's recommendations weren't followed in one step of a

Infection control problems found at NV centers

More than half of 49 surgery centers inspected by the state in Nevada had "infection control-type deficiencies," according to a recent news report.[1]

The investigation by the state health division investigation began after 50,000 patients were advised in 2008 to be tested for potential exposure to hepatitis C at two Las Vegas surgery centers. Nine cases have been linked to two centers, and state health officials have listed an additional 105 cases from those centers as "possibly related."

Problems with sterilization and disinfection led to almost half of the infection control deficiencies at 25 centers in fiscal year 2008, according to the draft report. Inappropriate use of items labeled as single use, such as syringes, amounted to nearly one-third of the deficiencies, the report said.

The report doesn't list the centers that had deficiencies, but they will be posted on a web site by summer, according to a spokeswoman for the Nevada Health Division.

The state will conduct more frequent inspections, the spokeswoman was quoted as saying. They will be conducted every 18 months, if the division's request for more surveyors is granted, she said. The money for surveyors would come from increased licensing fees charged to facilities, including ambulatory surgery centers, the report said.

Reference

1. Harasim P. Deficiencies found at Nevada ambulatory surgical centers. *Las Vegas Review-Journal,* March 9, 2009. Accessed at www.lvrj.com/news/breaking_news/40999672.html. ■

five-step cleaning process, the center said. The mistake left the instrument in heated disinfectant for less than the recommended five minutes, it said.

The center voluntarily contacted the Georgia Department of Human Resources as a proactive measure, the news report said. The center underwent a full inspection and had no violations, it said. The center offered patient testing for diseases including HIV and hepatitis and provided a toll-free number for them to call, according to the report.

In other news, a Florida veterans' hospital has temporarily suspended performing colonoscopies after equipment was improperly cleaned, according to a news report.[2]

Water tubes and reservoirs used in colonoscopies and endoscopies were being rinsed between procedures, but not disinfected as required by manufacturer's specifications, an earlier report said.[3]

About 3,260 veterans had medical procedures since May 2004 on the improperly disinfected equipment, the report said.

The chance that the veterans could have been expected to infectious disease was described as "very small, but more-than-negligible chance" by the chief of staff in the news article.

According to one of the reports[2], Olympus America, the manufacturer, notified facilities earlier this year that some providers were not assembling the equipment correctly or were not cleaning it properly. Two months before that notice, Olympus America issued a safety warning when company representatives found that some veterans' hospitals were using the wrong connectors on tubing, the report said.

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2. Kripalani J. Colonoscopy Procedures Suspended At Miami VA. WFOR-TV, March 29, 2009. Accessed at cbs4.com/local/va.hospital.colonoscopy.2.970711.html.

3. Tasker F. Miami VA hospital flooded with calls about HIV, hepatitis. *The Miami Herald,* March 25, 2009. Accessed at www.miamiherald.com/living/v-print/story/966157.html. ■

GUEST COLUMN

Thyroidectomy mistake brings $4.7M settlement

By **Radha V. Bachman**, Esq.
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and **Ellen Barton**, JD, CPCU
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In a recent case that led to a $4.7 million settlement, a 50-year-old woman's calcium level fell from 9.4 mg/dL to 7.3 mg/dL following an elective thyroidectomy for removal of an enlarged thyroid.[1] The woman eventually was diagnosed with hypocalcemia.

Hypocalcemia is known to be the most common complication after total removal of the thyroid. As many as 6% of patients having a total thyroidectomy

EXECUTIVE SUMMARY

Following an elective thyroidectomy, a woman was diagnosed with hypocalcemia. Although calcium was ordered, it was never administered, despite persistent symptoms of the calcium deficiency. The woman eventually went into cardiac arrest, sustained anoxic encephalopathy, and became comatose. She is in a vegetative state and requires nursing coverage 24 hours a day, seven days a week.

- The hospital claimed that the woman's calcium level was within a normal range and, therefore, the failure to administer calcium was not the cause of the woman's injury.
- The parties settled prior to the lawsuit being filed for $4.7 million.

suffer this complication. Hypocalcemia is the presence of low serum calcium levels in the blood, typically less than 2.1 mmol/L or 9 mg/dL or an ionized calcium level of less than 1.1 mmol/L (4.5 mg/dL) and is an electrolyte disturbance. The common symptoms for hypocalcemia are neuromuscular irritability, muscle cramps, numbness, irritability, and confusion.

Calcium was ordered for the woman but never administered, despite the fact that the calcium was taped to her hospital bed. As the evening progressed, the woman became increasingly nervous and agitated and also had difficulty swallowing. A second-year resident, who had only been at the hospital for a total of three weeks, visited the patient, but did not administer the calcium — despite the fact that the calcium was provided in the patient's room.

The next morning the woman awoke groggy and complained of shortness of breath and increased swelling where the operation had taken place. The resident was called again for a consult. At the time of the consult, the woman went into respiratory failure and cardiac arrest. A code was called, and the woman was intubated. While her breathing was restored, the woman sustained anoxic encephalopathy and became comatose. The woman never recovered from the coma, and she now requires around-the-clock nursing care for her vegetative state.

The woman's guardian filed suit against the ENT physician who performed the thyroidectomy and the operator of the hospital.[1] The guardian introduced head and neck surgery and neurology experts. The plaintiff alleged that the resident had failed to respond in a timely manner to the woman's shortness of breath and difficulty breathing, and the plaintiff claimed that those symptoms were caused by the hypocalcemia, which, if low enough, could have caused the woman's breathing to be substantially reduced. Or, the plaintiff suggested, it could have been caused by a surgical-site hematoma, which could have compromised the woman's breathing passage. Despite records to the contrary, the resident claimed he responded quickly and was at the woman's bedside 11 minutes prior to the time the code was called.

The plaintiff also claimed that the administration of the calcium to the woman would have avoided the subsequent injury. The resident responded and claimed that he had properly opened the surgical site and removed clotted blood that was potentially compromising the woman's airway or lymphatic system. The defendant claimed that the woman's calcium level, at 7.3, has never been shown to cause cardiac arrest or difficulty breathing and, therefore, was not the cause of the woman's subsequent injury.

The physician who performed the thyroidectomy was removed as a defendant from the lawsuit. Ultimately, the plaintiff reached a settlement with the hospital in this case for $4.7 million.

What this means to you

Based on the facts presented here, clearly this case was one to settle. While the hospital attempted to articulate certain defenses, they were almost embarrassingly weak.

The medical literature recognizes that hypocalcemia is a well-known complication after total removal of the thyroid. However, regardless of the cause (which the hospital attempted to raise as a defense), in this case the hypocalcemia was diagnosed and appropriate treatment (calcium) was ordered. Unfortunately, it was never administered. Cardiac arrest also is clearly recognized in the medical literature as a life-threatening complication of untreated hypocalcemia. The patient went into cardiac arrest in this case, which resulted in catastrophic injuries.

The care (or more appropriately, the lack of care) provided to this patient is very troubling. After recognizing the complication, appropriate treatment was ordered but never carried out. The facts contain no explanation as to why the calcium was not given. Even more disturbing is the fact that the calcium had actually been "taped to the woman's hospital bed." There is no acceptable reason (or defense) for not administering the

medication, and "taping" it to the bed only adds insult to injury.

The actions and inactions of the resident physician aggravate an untenable position. Unfortunately, the facts do not fully detail why the resident visited the patient the evening before she suffered a cardiac arrest. Was the resident called by nursing staff because the patient was exhibiting certain symptoms? Did the resident notice that the calcium was taped to the bed? What did he do, if anything? The resident's acts of omissions — in not administering the calcium and/or further treating the patient — are disturbing. Also, the resident's claims of being present prior to the patient's cardiac arrest the next day do very little to support a defense. If, in fact, the resident was present at the patient's bedside at the time of the patient's cardiac arrest, why were life-saving measures not taken sooner?

It is a nurse's responsibility to administer medications ordered by a physician. Why was the calcium not administered? The facts do not reveal the time lapse between the recognition of the hypocalcemia and the ordering of the calcium; however, it would appear that this was timely. What did the documentation indicate? Or, was the hospital dealing with a lack of documentation? Regardless of the answers, there are several lessons from a risk management perspective. **(For these lessons, see story, below.)**

Reference

1. Westchester County (NY) Supreme Court, Case No. 11285/05. ■

Case offers lessons for risk management

By **Radha V. Bachman**, Esq.
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The case of an elective thyroidectomy, followed by the patient developing hypocalcemia but never given calcium[1], provides several risk management lessons:

• **Periodic medication audits can prove very helpful in identifying weak spots in compliance, from transcribing orders to administering them to documenting them.** Such information then can serve as a basis for nursing education.

• **Supervision of residents is critical.** A second-year resident should have been capable of recognizing the significance of the patient's symptoms and taking appropriate action. The hospital should have assessed the mechanisms that were in place to ensure that the resident's actions/inactions were being reviewed and further determine what communications took place between the nursing staff, resident, and attending physician.

• **The attending physician bears ultimate responsibility for the care provided to his or her patient and should be involved in the event there is a complication or suspected complication.** The hospital should have monitored what communication was taking place between the attending physician, nursing staff, and resident.

This case proves again what has been demonstrated by research: A significant number of claims involve "system" errors, such as medication-related errors, communications errors, and documentation errors. It appears clear from the facts that the implementation and monitoring of good "systems" through consistent audits could have prevented the plaintiff's devastating injuries in this case.

Reference

1. Westchester County (NY) Supreme Court, Case No. 11285/05. ■

8 warning signs of violent behavior

(Editor's note: This is the second of a two-part series on workplace violence. Last month, we gave you information about recent activity and how you should manage this problem. We also gave you a checklist, sample policies, and advice on how to handle layoffs. This month, we give you warning signs, advice on when to call the police, and an extensive list of resources.)

The recent fatal shootings by an employee's estranged spouse at a nursing home in North Carolina have served as a harsh reminder that workplace violence can happen anywhere, anytime.

While not specifically addressing the NC situation, **W. Barry Nixon**, SPHR, executive director of the National Institute for the Prevention of Workplace Violence, Lake Forest, CA, says when a

person resorts to violent behavior, there often were warning signs that might have gone unnoticed.

"Training supervisors and employees to recognize the early warning signs and to report them is a crucial step in a workplace violence prevention program," Nixon says.

The following are warning indicators of potential workplace violence, based on advice from the federal government[1]:

- intimidating, harassing, bullying, belligerent, or other inappropriate and aggressive behavior;
- numerous conflicts with patients, co-workers, or supervisors;
- bringing a weapon to the workplace (unless necessary for the job), making inappropriate references to guns, or making idle threats about using a weapon to harm someone;
- statements showing fascination with incidents of workplace violence, statements indicating approval of the use of violence to resolve a problem, or statements indicating identification with perpetrators of workplace homicides;
- statements indicating desperation (over family, financial, and other personal problems) to the point of contemplating suicide;
- direct or veiled threats of harm;
- substance abuse;
- extreme changes in normal behaviors.

Once you have noticed a subordinate, co-worker, or patient showing any signs of the above indicators, you should take the following steps, the federal government advises[1]:

- If you are a co-worker, you should notify the employee's supervisor immediately of your observations.
- If it is a patient, notify your supervisor immediately.
- If it is your subordinate, then you should evaluate the situation by taking into consideration what might be causing the employee's problems.
- If it is your supervisor, notify that person's manager.

It is very important to respond appropriately, i.e., not to overreact but also not to ignore a situation, according to the federal government. Sometimes that reaction might be difficult to determine, it says. Managers should discuss the situation with expert resource staff to get help in determining how best to handle the situation, the government says.

Reference

1. U.S. Department of Agriculture, Washington, DC. Web: www.usda.gov/news/pubs/violence/wpv.htm#four. ■

When should you call in the police?

An employee is dismissed, and he threatens co-workers and managers. What should you do?

Police should be called any time there is a critical concern for the safety of any employee or individual on the business premises, says **Corinne Peek-Asa**, PhD, professor of occupational and environmental health and director, Injury Prevention Research Center, at the University of Iowa, Iowa City.

A threat assessment team should track any individuals of concern, she says. The team should include representatives from human resources, security, facilities management, and other departments. "One important thing is that upper administration gives full support to the team, and they have the ability to collect the information they need," Peek-Asa says. "They also need to be well trained so that they can treat every case fairly and impartially."

Police can be partner

Alert police of any individuals of concern that are being followed by the team, she says. "Law enforcement agencies can be a critical partner when making decisions about individuals of concern, especially if for smaller businesses that don't have formal plans and procedures," Peek-Asa says. Contact your local law enforcement agencies to find out what types of general resources are available and who to call to obtain more information, she advises.

Call police whenever there's a violence or a threat of violence, says **Sandy Seay**, PhD, president of Seay Management Consultants, a human resources management consulting firm in Orlando, FL. "A threat is one of the most dangerous things," he says.

Better to have no regrets

Situations can escalate to a level above the capability of the [ambulatory surgery program] to handle, says **Dawn Q. McLane**, RN, MSA, CASC, CNOR, chief development officer of the Nikitis Resource Group, a Broomfield, CO-based company that specializes in surgery center development, management, and consulting. "It would be better to have the police present, who are

trained to de-escalate these kinds of events, than to later wish you had, after someone has been injured or worse," she says.

The staff who are responsible for human resources and/or security should be knowledgeable of many new laws that address threats because, in many cases, the police officer who responds to an incident might not be updated, says **W. Barry Nixon**, SPHR, executive director of the National Institute for the Prevention of Workplace Violence, Lake Forest, CA. "Frequently, employers that call the police get the response that 'the alleged perpetrator has not actually done anything to violate the law, call us if they actually do something,'" Nixon says. "Employers should be able to respond to this statement with, 'Please check state/local regulation XYZ, which states that . . . and I believe you will see this is a violation of the law.'" ■

SOURCES

The following resources are available for addressing violence and vandalism by co-workers:

- A **sample workplace violence prevention plan** is available from Oregon's Occupational Safety and Health Division at www.orosha.org/educate/training/pages/120plan.html.
- The **National Institute for the Prevention of Workplace Violence** provides a resource center, model policies, a self-audit, training, a pre-employment services directory, and an "ask the expert" e-mail resource, and other resources. Web: www.WorkplaceViolence911.com.
- **Brightline Compliance** offers online courses on workplace violence prevention for supervisors and nonsupervisors. Course pricing ranges from $18 (501+ learners) to $149 (one to five learners). For more information, go to www.brightlinecompliance.com/images/Brightline/PDFs/workplace_violence_prevention.pdf.
- ***Handy Reference Card.*** Web: permanent.access.gpo.gov/lps23/maincard.htm.
- ***Maintaining a Safe Workplace*** from The University of California, Davis. Go to hr.ucdavis.edu and click on "Employee & labor relations," then "Manager and Supervisor Toolkit." Under "Helpful Links," click on "Violence in the Workplace." Click on "Violent Prevention Brochure: Maintaining a Safe Workplace."
- ***Preventing Workplace Violence Minibooks for Employees.*** Five minibooks cost $25 for nonmembers and $20 for members of the California Chamber of Commerce. Go to www.calbizcentral.com. Click on "All Products (A to Z)."

Center offers free rides for patients, caregivers

Patients who need to have surgery at the Aurora Surgery Center in Plymouth, WI, have one less thing to worry about, since the center began offering free rides to patients and their caregivers.

Patients and caregivers, who are picked up at their homes, must live within 30 miles of Plymouth. They call ahead to schedule their transportation, which can be one-way or round trip. The van service is provided on a first-come, first-served basis.

Patients who are using the van service are "highly encouraged" to bring along a caregiver on the day of their procedure, says **Christine Larson**, RN, BSN, manager of the center. Up to two caregivers can be transported per patient. The patients must be able to get from their home into the van without assistance from the driver. Arrangement can be made for wheelchairs.

The surgery center is transporting about 12 patients per week, Larson says.

The person behind the wheel is no ordinary van driver, according to Larson. "The van drivers had been previously employed through Aurora Health Care as couriers and are both former firefighters/EMTs," she says. "They have both been trained by the manager of plant services on the appropriate daily safety checks prior to van operation."

In the event of an emergency involving a patient, the drivers have been instructed to pull off the road and dial 911 from a cell phone, Larson says. "In the case of a nonemergent, but urgent matter, they are calling a nurse manager or RN nursing supervisor either at the Aurora Sheboygan Clinic or at the Aurora Surgery Center in Plymouth for guidance/direction," she says. The drivers also have written policies to follow regarding matters involving blood/body fluid exposure and inclement weather. **[Those written policies are available with the online issue of *Same-Day Surgery*. If you need assistance, contact customer service at (800) 688-2421 or customerservice@ahcmedia.com.]**

The van was purchased with contributions to the Aurora Health Foundation. The $40,000 cost covered the van, a paint job, and a small emergency kit.

While the service is free, donations are accepted. Free rides also are offered to the Aurora Health Center in Plymouth. ■

Does childhood anesthesia link to learning disability?

New research study raises possibility

Researchers at the Mayo Clinic in Rochester, MN, have found that children who require multiple surgeries under anesthesia during their first three years of life are at higher risk to develop learning disabilities later.[1]

Several studies have suggested that anesthetic drugs might cause abnormalities in the brains of young animals. The results of this human study are reported in the April 2009 issue of the journal *Anesthesiology.*

The research team, led by **Robert Wilder**, MD, found that although one exposure to anesthesia was not harmful, more than one exposure almost doubled the risk that the children would be identified as having a learning disability before they were 19. The risk also increased with longer durations of anesthesia.

Randall Flick, MD, a co-author of the study, said, "It's very important for parents and families to understand that although we see a clear difference in the frequency of learning disabilities in children exposed to anesthesia, we don't know whether these differences are actually caused by anesthesia."

Wilder says, "The problem is that anyone who underwent an anesthetic also had surgery. It's unclear whether it's the anesthetic, the physiological stress of surgery, or perhaps the medical problems that made surgery necessary that are responsible for the learning disabilities."

According to another one of the co-authors, more studies are planned. **(For more information on this topic, see "Possible Link Found Between Childhood Anesthesia and Disorders," *Same-Day Surgery Weekly Alert*, Oct. 24, 2008.)**

Reference

1. Wilder RT, Flick RP, Sprung J, et al. Early exposure to anesthesia and learning disabilities in a population-based birth cohort. *Anesthesiology* 2009; 110:796-804. Accessed at journals.lww.com/anesthesiology/Fulltext/2009/04000/Early_Exposure_to_Anesthesia_and_Learning.21.aspx. ■

Brain surgery on Monday, then home the next day

Norma Wooley, 54, checked into Loyola University Hospital in Maywood, IL, on a recent Monday morning for brain surgery to repair a life-threatening aneurysm. She went home on Tuesday and was cured of a cerebral aneurysm.

A less invasive technique that's becoming increasingly common in brain surgery was used by **John Whapham**, MD, a neurologist in the Loyola University Health System in Chicago and an assistant professor in the Departments of Neurology and Neurological Surgery, Loyola University Chicago Stritch School of Medicine. Whapham inserted a catheter in an artery in Wooley's leg and guided it up to her brain. The catheter released tiny platinum coils into the bulging aneurysm, effectively sealing it off.

"It's like filling a bathtub with concrete," he said. "She went home the next morning with a [bandage] on her leg."

Whapham is part of a new generation of neurologists who are using catheters to repair aneurysms, open clogged arteries, extract blood clots, and repair blood vessel malformations in the brain. Catheter technology has been modified for narrower and more challenging blood vessels in the brain.

"There has been a huge evolution in devices over the last five years," Whapham said. "Technology is getting better by the week." ■

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. ■

COMING IN FUTURE MONTHS

- Controversy surrounds new outpatient procedure
- Steps to avoid embezzlement
- The Joint Commission's new emphasis
- New ways to educate your staff about timeouts

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.

17. According to recent research on preoperative testing published in *Anesthesia & Analgesia* (2009; 108:467-475), what was the difference in the rates of peri-op adverse events and the rates of ad adverse events within 30 days after surgery between the no-testing group and the indicated testing group?
A. There were 33% more perioperative events in the no-testing group.
B. There was 24% more perioperative events in the no-testing group.
C. There were 9% more perioperative events in the no-testing group.
D. There was no significant differences in the rates.

18. When trying to increase revenue, which of the following is a recommended goal, according to Stephen W. Earnhart, MS?
A. Perform 5% more cases per month starting in (pick a month about three months away).
B. Reduce staffing expense by 2%.
C. Both of these.
D. Neither of these.

19. Which of the following are warning indicators of potential workplace violence, based on advice from the federal government?
A. Belligerent behavior.
B. Numerous conflicts with patients, co-workers, or supervisors.
C. Making inappropriate references to guns or indicating approval of the use of violence to resolve a problem.
D. Statements indicating desperation (over family, financial, and other personal problems) to the point of contemplating suicide.
E. All of the above

20. When Aurora Surgery Center began offering free rides for patients and their caregivers, who were hired as drivers?
A. Former truck drivers
B. Previous couriers with the health system who are former firefighters/EMTs
C. LPNs
D. Nursing assistants

Answers: 17. D; 18. A; 19. E; 20. B.

Aurora Sheboygan Clinic — Patient Van Service Guidelines for Inclement Weather:

Equipment Needed:

→ Cell Phone
→ Patient Contact Information/phone numbers

1. When inclement weather is noted, Van Drivers will need to respond appropriately. Inclement weather is defined as Severe Thunderstorm/Tornado Activity, Blizzard conditions, Heavy Fog, or sleet/ice storms making vehicular travel unsafe. IT IS ALWAYS UP TO THE DISCRETION OF THE DRIVER TO DETERMINE COMFORT LEVEL WITH WEATHER CONDITIONS AND SAFE DRIVING.
2. If the driver deems that the Van should not be driven due to weather concerns, a phone call to the Supervisor/Manager of Plant Services should be made immediately. A second phone call should be made to the Outpatient Surgery Center in Plymouth by calling **893-4749** as soon as possible. A third and final phone call should be made to the clinic Ophthalmology department's CSR (Karen Hilbelink or Susan Pitcher) by calling **457-4461 x1270.** The CSR will make the appropriate phone calls to the patients asking them to contact their "back-up" driver or consider postponing their procedure due to the weather. If the driver has time, the CSR may ask them to call the patients who were scheduled for pick-up that day.
3. If the driver is already "on the road" when inclement weather begins/is noted, the driver should complete the route whenever possible and seek shelter either at the Outpatient Surgery Center or at the Sheboygan Clinic. If a Tornado/Severe Thunderstorm is sited, please use common sense to seek shelter and protect the patients who are riding in the van appropriately. Contact by phone should then be made as described above in #2.

Source: Aurora Sheboygan (WI) Clinic.

Aurora Sheboygan Clinic — Patient Van Service Guidelines for Handling Blood/Body Fluids:

Equipment Needed:

- → Gloves
- → Red Bags
- → Disinfectant wipes/spray
- → Emesis basin(s)
- → 4X4 Gauze pads
- → 1 Roll of surgical tape
- → Alcohol based hand-sanitizer

1. When the need arises to handle a blood or body fluid incident within the confines of the transport Van, please safely pull over to the side of the road as needed. Put on a pair of gloves and assist the patient as needed.
2. All waste materials (Kleenex, emesis basin, gloves, wipes, etc.) must be placed in a red bag. The driver and/or patient should utilize the hand-sanitizer as needed to disinfect their hands when blood/body fluid handling is complete.
3. If the driver feels that more assistance is necessary (surgical site bleeding, etc.), a call should be placed to the Outpatient Surgery Center immediately. **920-893-4749.** Please ask for Debbi Ninnemann or any RN within the outpatient surgery department. If unable to obtain assistance, the second call should be handled by a Nursing Supervisor at the clinic. A complete listing with pager #'s and phone #'s is included on the reverse side of this page.
4. When the driver returns to either the Outpatient Surgery Center or the clinic, the entire RED Bag must be disposed of properly in the appropriate waste can. Please ask site Plant Services for direction on proper disposal/placement.

Source: Aurora Sheboygan (WI) Clinic.