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IN THIS ISSUE

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Research, reimbursement support: Motivate patients to stop smoking

Physicians, anesthesiologists reimbursed for cessation counseling

A just-released study showing that smokers have significantly more complications post-surgery than non-smokers, including a higher death rate, coupled with new Medicare reimbursement for physicians who provide counseling to prevent tobacco use for outpatients and hospitalized patients have outpatient surgery managers taking a new look at smoking cessation programs.

The results from the study conducted by The Cleveland (OH) Clinic, released at the recent Anesthesiology 2010 meeting of the American Society of Anesthesiologists, show increased incidents of adverse outcomes among smokers, including surgical site infections, respiratory complications, pneumonia risk, unplanned intubation, artificial mechanical ventilation, cardiac arrest, heart attack, stroke, and death. The more patients smoke, the more complications they were likely to experience, the study found. *(See details of study's findings, p. 135.)*

"Hopefully, surgeons can utilize the upcoming operation as a "teachable moment" to educate their patients about their risks of postoperative wound

Next month: Cost-saving tips in outpatient surgery

Next month's issue will focus on saving money and generating revenue in outpatient surgery.

We'll look at the impact of health care reform and what you should do now. We'll look at changes one hospital made that added $10 million in revenue in the OR alone. We'll tell you about a change one center made that saved more than $15,000 per month. We'll tell you about a center that reduced its preop overtime by more than 11 hours per nurse per pay period. We'll tell you about a manager who felt overcharged by an IT support service and developed her own. We'll also tell you about some free software that significantly reduces the cost and time for you to compile, analyze, and post quality data.

Don't miss this special issue of *Same-Day Surgery!*

infection, failure of the intended procedure — i.e. recurrence of an incisional hernia — hospital readmission, prolonged intubation, and postoperative pneumonia, which are clearly documented in the medical literature," says **John Maa**, MD, FACS, assistant professor in the Department of Surgery and assistant chair, Surgery Quality Improvement Program, at the University of California — San Francisco.

And now physicians have another incentive.

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Executive Editor: **Coles McKagen** (404) 262-5420 (coles.mckagen@ahcmedia.com).
Senior Managing Editor: **Joy Daughtery Dickinson** (229) 551-9195 (joy.dickinson@ahcmedia.com).
Production Editor: **Neill L. Kimball**.

Editorial Questions

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

EXECUTIVE SUMMARY

A just-released study and a new Medicare reimbursement policy have outpatient surgery managers taking a new look at smoking cessation programs.

- The Cleveland (OH) Clinic study results show that smokers have significantly more complications post-surgery than non-smokers, including a higher death rate.
- Since Aug. 25, 2010, Medicare has reimbursed physicians who provide counseling for outpatients and hospitalized patients to prevent tobacco use.
- The American Society of Anesthesiologists (ASA) encourages anesthesiologists to ask all patients about their tobacco use, advise those who do use to stop, and refer patients to other resources that can get them the assistance, such as the toll-free number (800) QUIT NOW.

Since Aug. 25, 2010, the Centers for Medicare & Medicaid Services (CMS) has covered counseling services to prevent tobacco use for outpatients and hospitalized patients. CMS will cover tobacco cessation counseling for outpatient and hospitalized Medicare beneficiaries:

- who use tobacco, regardless of whether they have signs or symptoms of tobacco-related disease;
- who are competent and alert at the time that counseling is provided; and
- whose counseling is furnished by a qualified physician or other Medicare-recognized practitioner. *(For more information, see resources, p. 135.)*

Some private payers have followed Medicare and also are reimbursing physicians for tobacco cessation counseling. There is no reimbursement from Medicare that covers the facility fee.

Some studies have indicated that people are more likely to quit smoking when they have a surgical procedure scheduled. *[For more information, see "Surgery Is Good 'Teachable Moment' to Help Smokers Quit,"* Same-Day Surgery Weekly Alert, *July 16, 2010. To subscribe to our free ezine, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]* During informed consent, surgeons can discuss active smoking and its risks "and many patients, once they are made aware of the potential adverse outcomes resulting from their active smoking, will choose to delay surgery and try to stop smoking in their own interest of safety," Maa says.

Smoking cessation is not without its challenges, he acknowledges. "Smoking cessation is indeed a lengthy and challenging process, which often requires multiple efforts to achieve success," Maa says. "It is indeed difficult for surgeons to counsel patients in this time-intensive process, and recruiting the assistance of additional staff and resources

is essential, as attempting to achieve this task alone is unlikely to be fruitful."

Consider involving the patient's referring provider, as well as family and children, anesthesiologists, administrators, and respiratory therapy staff, Maa advises.

Anesthetists play a role

The American Society of Anesthesiologists (ASA) encourages anesthesiologists to use a three-step method of "ask, advice, and refer," says **David O. Warner**, MD, professor of anesthesiologist, Mayo Clinic, Rochester, MN, and leader of the smoking cessation initiative of the ASA. According to Warner, anesthesiologists should:

- Ask all patients about their tobacco use.
- Advise those who do use to stop.
- Refer patients to other resources that can get them the assistance they need to quit successfully.

The primary resources are free telephone quitlines, which provide extended counseling services, Warner says. Those services can be accessed through the toll-free number (800) QUIT NOW, which directs callers to quitline services in their area. The quitline counselors tailor a quit plan and advice for each individual caller, Maa says.

Maa says, "Having adequate brochures and cards to refer patients to quitlines and outpatient counseling services ... can help save time."

Physicians can prescribe low dose nicotine replacement, Maa says, "and it may be worthwhile to familiarize oneself with the types of medications and services that Medicare, Medicaid, and standard insurance companies will reimburse for patient out-of pocket expenses."

SOURCES/RESOURCES

- The American Cancer Society has resources to stop smoking. Web: http://www.cancer.org/Healthy/StayAwayfromTobacco/GuidetoQuittingSmoking/index.
- The American Society of Anesthesiologists has information for patients and anesthesiologists about its stop smoking program. The site includes information about anesthesiologist billing for smoking cessation counseling. Web: http://www.asahq.org/stopsmoking.
- The Medicare Learning Networks offers information on physician reimbursement for tobacco cessation counseling. Web: http://www.cms.gov/MLNMattersArticles/downloads/MM7133.pdf.
- The U.S. government offers information on methods to help smokers quit. Web: http://www.smokefree.gov.

Also, it might be appropriate to cancel the operation, even on the morning of surgery, if there is evidence that a patient has not been compliant with required preop smoking cessation, or if the anesthetic and cardiopulmonary risks to the patient are significant, he says. "For some patients at risk of noncompliance, it is useful to encourage compliance by alerting the patient that a serum cotinine concentration or a urinary test strip for nicotine content can be performed the morning of surgery to monitor their tobacco use," Maa adds.

Physicians have a "special and unique opportunity" when it comes to smoking cessation, he says. Discussing smoking cessation not only will provide benefits for the surgical procedures, "but also for their patient's overall health looking beyond the procedure," Maa says. He advises physicians to "not allow this excellent opportunity to improve the overall health of Americans to be lost." *(The Agency for Healthcare Research and Policy has a smoking cessation guideline enclosed with the online issue of* Same-Day Surgery. *For assistance, contact customer service.)* ■

Details on complications smokers have after surgery

Smokers have higher rate of adverse outcomes

A recent study from The Cleveland (OH) Clinic found increased incidence of adverse outcomes among smokers. The study was presented at the Anesthesia 2010 meeting of the American Society of Anesthesiologists.

The researchers evaluated 635,265 patients from the American College of Surgeons National Surgical Quality Improvement Program database. There were more than 200 participating centers prospectively collecting data with standardized methods. The study compared 82,304 smokers with 82,304 non-smoking patients who had similar surgical procedures and similar preoperative risk factors using sophisticated statistical techniques.

Some of the increased incidence of adverse outcomes among smokers included:

- Smokers were 40% more likely to develop major complications and die within 30 days of surgery.
- Smokers had an increased risk for respiratory complications.

• Pneumonia risk was doubled among smokers.
• Smokers were 87% more likely to experience unplanned intubation.
• Smokers were 53% more likely to require artificial mechanical ventilation that lasted more than 48 hours after surgery.
• Smokers saw a significant increase in cardiovascular complications and were:
— 57% more likely to experience cardiac arrest;
— 80% more likely to have a heart attack;
— 73% more likely to have a stroke.
• Surgical site complications also were higher among smokers. Smokers were:
— 30-42% more likely to have a surgical site infection;
— have a 30% increase in the risk for serious systemic infections such as sepsis. ■

How one facility helps patients stop smoking

Interventions offered before elective surgery

The University of California — San Francisco (UCSF) Medical Center uses a variety of interventions to help patients stop or reduce smoking before elective surgery.

In the outpatient setting, patients are referred to an in-hospital smoking cessation leadership program, tobacco education center, and a habit abatement center. "The goal is to facilitate the referral of active smokers to these resources, which offer inexpensive smoking cessation counseling, social support, and guide the use of cessation medication," says **John Maa**, MD, FACS, assistant professor in the Department of Surgery and assistant chair, Surgery Quality Improvement Program, UCSF.

As a first step, surgery patients are directed to smoking cessation quitlines through a national toll-free number (800-QUIT-NOW), Maa says. "They are also evaluated for immediate intervention with nicotine replacement therapy prescribed by the surgeon, which can be further coordinated with their referring primary care provider," he says.

Before most surgeries, patients are seen in the Prepare (pre-anesthesia) clinic. "The anesthesiologists or nurse practitioners will remind the patient of the benefits of preoperative smoking cessation, and again offer the resources of quitlines, the habit abatement clinic, or other measures to assist in smoking reduction," Maa says. ■

Alert fatigue leads to OR fatalities

Alert fatigue can lead to behaviors in health care that might seem fine until the day they cause a tragedy, says **John Banja**, PhD, assistant director for health sciences and clinical ethics at Emory University in Atlanta.

Banja was involved in the investigation of a sentinel event involving a patient who died in surgery. The patient was undergoing an abdominal surgery, and the operating room team had turned off all the alarms on the equipment, because they found them annoying, mostly because they went off too often, at too low a threshold. They had turned them off before many times before with no negative consequences, Banja says.

The procedure was proceeding well, and at one point the physician needed to obtain an X-ray of the patient's abdomen.

Because the patient's breathing would blur the X-ray, the surgeon asked the anesthesiologist to turn off the respirator while the X-ray was taken — not an uncommon request. The anesthesiologist turned off the respirator and the X-ray was made.

The procedure continued, but the anesthesiologist never turned the respirator back on. Because the alarms on the respirator, and everything else, were turned off, no one realized the patient was suffocating until it was too late.

"The patient was left in a vegetative state and died 11 days later," Banja says. "Here was a catastrophe that happened because of the way that a defense mechanism had been disabled in this hospital. The anesthesiologist made a slam-dunk error, but if the alarms had been functioning, they would have caught that error immediately, and you wouldn't have this horror occurring."

EXECUTIVE SUMMARY

Patient safety is threatened by clinical alert fatigue, which arises when clinicians either ignore alerts, because they hear them so often, or disable alarms that are annoying. Managers should address the issue with staff training and technological solutions.
• A significant number of alerts are ignored or overridden.
• Some of the alerts are unnecessary and could be eliminated.
• Evidence of alert fatigue or tampering would be detrimental in court.

Clinical alert fatigue remains a vexing problem for health care providers, and the risk to patient safety is high. When clinicians become so annoyed by alarms that they disable them or so accustomed to hearing them that they do not respond appropriately, patient's lives can be at stake.

Part of the problem is that modern medicine just has too many beeps, buzzers, bells, and warning signs flashing on the screen, says **Linda Peitzman**, MD, chief medical officer of Wolters Kluwer Health in Indianapolis. If too many alerts are triggered when medications or tests are being ordered, for example, the likelihood is high that physicians eventually will tune out or actively override even high-severity alerts, she says.

Physicians may bypass CPOE

A Wolters Kluwer Health white paper on clinical alert fatigue noted that alert fatigue also can cause physicians to bypass or remain skeptical of computerized physician order entry (CPOE), resulting in low adoption rates that impact outcomes and the hospital's return on its technology investment. "This is typically the end result when, as one hospital [chief medical information officer] noted, alert fatigue drives clinicians to view CPOE as a challenge to their autonomy or the flavor of the month," the report says.

Alert fatigue is particularly prevalent with medication orders. Medication alerts are so common that they have created a situation in which "systems and the computers that are supposed to make physicians' lives better are actually torturing them," the white paper says. A 2009 study of nearly 3,000 prescribers in three states found that physicians ignored alerts more than 90% of the time, a rate that varied little based on severity.[1] That figure is consistent with earlier studies, such as one in 2003 that showed prescribers overrode 80% of the medication alerts triggered in a hospital practice and another in 2003 that found prescribers overrode 91.2% of drug allergy alerts and 89.4% of the high severity drug interaction alerts.[2,3]

Some alerts unnecessary

The research suggests that some alerts are unnecessary and only serve as a nuisance to clinicians, but the white paper notes that nuisance alerts also might lead a facility to turn off entire alert groups, including some that might be relevant. Alert fatigue ultimately can generate dissatisfaction with the CPOE system as a whole, the report warns.

ECRI, the non-profit medical technology research group in Plymouth Meeting, MA, reports that alarm issues are among the most frequent problems reported by clinicians. ECRI advises that staff members must understand the purpose and significance of alarms and they should know how to set alarm limits to appropriate, physiologically meaningful values.[4] "We continue to learn of incidents in which staff unintentionally disable critical alarms by setting them far outside reasonable bounds," ECRI writes. "Low-saturation alarms on pulse oximetry monitors and low-minute-volume or high-peak-pressure alarms on ventilators are regular subjects of this sort of error.

Peitzman says, "In my experience, alert fatigue is directly related to the level of sophistication and thought in how they were designed and implemented. This is not just a matter of people getting tired of hearing them or seeing the alerts pop up and overriding them just to make their lives easier. A lot of times the alerts are unnecessary, and in some cases inaccurate, and that can be a big contributor to alert fatigue."

The more often alerts activate, and especially the more often they activate inappropriately, the more likely a physician or other caregiver will override them, Peitzman says. Ideally, the alerts should be tailored to the particular patient, which would cut down on the number of inappropriate alerts, she says.

When you purchase a system

Alert fatigue should be considered when purchasing systems, especially CPOE and other systems that can include many alerts, Peitzman says. Look for systems that not only have good content in terms of what triggers an alert, but also offer the ability to customize the system to different situations, she suggests. *(See p. 139 for more advice on reducing alert fatigue.)*

"Interruptive alerts" are particularly annoying when they are unnecessary, Peitzman says. This type stops the act of, for example, ordering medication until the physician orders the blood test required by the medication. In most cases, the physician must order the test or document why it is not being ordered before the medication order can continue. Peitzman says such alerts can be neces-

sary, but they should be kept to a minimum. When the interruptive alert is not based on sound reasoning or does not apply to this particular patient or this type of care, the alerts can be frustrating and create time delays.

Alert fatigue also can be a problem with telemetry monitoring, says **Kim Bonzheim**, MD, director of the Heart and Vascular Center and Beaumont Hospital in Royal Oak, MI. Either with decentralized monitoring at nurses' stations or a centralized monitoring system for an entire hospital, the same problems arise, she says. Those monitoring the system hear the same alarms and see the same alerts so often that they can become inured to them, Bonzheim says.

Beaumont has a central monitoring system that works well, Bonzheim says. However, when a monitor sees a clinical alarm that needs to be passed on to the nurse, the alarm used to be sent by alpha-numeric pager. "Our problem was that it was a one-way communication device," Bonzheim says. "If the nurse didn't call to say she got the page, our system was set to keep sending that page every three minutes. As you can imagine, we drove the nurses crazy, and pagers were left on desks."

That system led to a near-miss and a sentinel event, Bonzheim says, so the hospital had to address the problem. The hospital switched to a two-way communication system that allows them to talk directly to the telemetry monitor. The time for completing a communication loop between the telemetry monitor and the nurse was cut from an average of about eight minutes to 39 seconds.

Deviation becomes the norm

Alert fatigue is another example of the normalization of deviance, says **John Banja**, PhD, assistant director for health sciences and clinical ethics at Emory University in Atlanta. When clinicians become accustomed to hearing alarms and seeing alerts, and when it becomes common and acceptable to override them, a wrong behavior has been normalized in the culture, he says.

"You start doing the short cuts and deviating from the protocols and the rules and regulations, and pretty soon you start exposing the patient to growing levels of risk," he says. "You don't even realize you're doing it and, in fact, you think you're doing it for the good of the patient, or for your own good and whatever enhances your own good is, in turn, good for the patient."

Managers should encourage a culture in which deviation is not accepted and alert fatigue is openly acknowledged as a potential problem, Banja says. The issue should be addressed in grand rounds, incident reports, weekly meetings with staff, and any other situations in which the problem can be discussed, he says.

Banja notes that such deviations are common in all industries. The recent BP oil spill in the Gulf of Mexico was traced, in part, to a series of deviations from standard procedure, including managers overriding alarms because they didn't want to wake up the crew who were sleeping, Banja notes. The deviations can seem innocuous or even a wise decision, until something goes wrong.

"Maybe you make all these risky deviations, but nothing bad happens and that convinces you more and more that it's OK," Banja says. "When you look at these disasters, what you [find] is that the deviations went on for months and years and nothing bad ever happened until the rig blows up, or you do a wrong-side surgery, or you give the patient an overdose of medicine. Then people get very bent out of shape and we start blaming and punishing, when we should have been holding them more accountable all along the way."

REFERENCES

1. Health Data Management. Avoiding 'Alert Fatigue.' *Health Data Manag*. Oct. 1, 2009. Available at http://www.healthdatamanagement.com/issues/2009_71/-39039-1.html.
2. O'Reilly KB. Doctors override most e-Rx safety alerts. Amednews.com. March 9, 2009. Available at http://www.ama-assn.org/amednews/2009/03/09/prsa0309.htm.
3. Isaac T, Weissman JS, Davis RB, et al. Overrides of medication alerts in ambulatory care. *Arch Intern Med* 2009;169:305-311.
4. ECRI. "2010 Top 10 Technology Hazards." *Health Devices* 2009;38:11-16. ■

SOURCES

For more information, contact:

• **John Banja**, PhD, Assistant Director for Health Sciences and Clinical Ethics, Emory University, Atlanta. Telephone: (404) 712-4804. E-mail: jbanja@emory.edu.
• **Kim Bonzheim**, MD, Director of the Heart and Vascular Center and Beaumont Hospital in Royal Oak, MI. Telephone: (248) 898-5000.
• **Linda Peitzman**, MD, Chief Medical Officer, Wolters Kluwer Health, Indianapolis, IN. Telephone: (317) 735-5300.

Take these steps to reduce alert fatigue

Involve physicians in the development and implementation of alert systems, rather than simply training them in the systems when you're ready to go live, says **Linda Peitzman**, MD, chief medical officer of Wolters Kluwer Health in Indianapolis.

"Get their input into how and when they want these things to fire, so that when they do fire, they won't be surprised," Peitzman says. "They will understand why they were included, and they will be much more apt to pay attention to them."

With technology growing so rapidly and health care providers wanting to improve safety by standardizing processes, there is a temptation to keep adding more alerts, she says. "There are many other tools you have for clinical decision support [that can be added] into the work flow," Peitzman says. "So, ask whether another alert is the right thing. Maybe we could do an order set that automatically has this in it instead of reminding them. Or when they document it, this action automatically happens instead of reminding them to do it."

When implementing computerized physician order entry (CPOE) or any system with built-in alerts, the threshold for alerts should be turned down, at least initially, to ensure there is buy-in and not a perception that there's interference with the clinical workflow, says **Dan O'Keefe**, MD, executive vice president for the Society for Maternal-Fetal Medicine, chief medical officer for PeriGen, and an OB/GYN and maternal-fetal medicine expert. O'Keefe offers this further advice:

- Introduction of clinical alarms as a part of any system should be a deliberate and gradual process. Otherwise, a hospital risks alienation of staff, who already are busy and trying to get up to speed on new technology and new behavior.
- Alerts absolutely must be clinically relevant or the doctors and other staff will certainly ignore them.
- The frequency of alerts and the use of hard stops, which prevent doctors from taking any further action, are important. Overuse will only cause frustration and disillusionment with the system. Choose carefully when deciding which interruptive alerts are necessary.
- Alerts should be evaluated by hospital staff on a quarterly basis to make sure they are clinically relevant. If they are not relevant, but simply a nuisance, they may be removed. Conversely, if the alerts are relevant and support the practice of evidence-based medicine, then the hospital must instruct the doctors to comply.

Peitzman agrees that health care providers should monitor the use of alerts within their systems, looking for chances to improve. "You should not only measure how many of them are being acted upon, but you also should talk to your physicians and find out about the effectiveness, the value, the appropriateness, and you can continue to modify them over time," she says.

Also, don't be afraid to disable alerts that came as part of a system package, she says. Ask yourself if this alert is something truly important to your patients or if it will just add to the cacophony of alerts. A warning about dietary restrictions or food interaction might be valid, for instance, but is it important enough to justify an alert screen for the physician? Pare down the alerts to the ones that really matter, and clinicians will pay more attention to them, Peitzman says. ■

AORN deletes guidance for home laundering

Revised recommended practice released

In its previous "Recommended Practice for Surgical Attire," the Association of periOperative Registered Nurses (AORN) didn't recommend home laundering, but for those facilities that did it, it offered some guidance on how to do it as safely as possible. AORN has changed its stance in its just-revised recommended practice (RP).

"In the new edition, as we did the literature review and looked into the issue, we found there is

EXECUTIVE SUMMARY

The Association of periOperative Registered Nurses (AORN) has revised its "Recommended Practice for Surgical Attire."

- Industrial laundering of surgical attire is strongly recommended by a laundry accredited by the Healthcare Laundry Accrediting Council (http://hlacnet.org/laundries.php). No recommendations are given for home laundering.
- Other changes include quality assurance of laundering processes; safe attire fabrics; safe footwear; jewelry; stethoscopes and identification badges; and bags carried into semi-restricted or restricted areas from outside.

no way to provide guidance for safe laundering at home," says **Ramona Conner**, RN, MSN, CNOR, manager of standards and recommended practices at AORN.

The new edition more strongly recommends not only industrial laundering of surgical attire, but also laundering by a laundry accredited by the Healthcare Laundry Accrediting Council (http://hlacnet.org/laundries.php).

One area that was re-emphasized discusses disposable and reusable head coverings.

"Reusable hats are very popular," Connor says. Staff members often feel strongly about these hats because they allow individuality and are considered more attractive than bouffant cap. "We consider the hat part of the surgical attire," Connor says. "If you wear a reusable cloth hat, it needs to be laundered by a healthcare laundry facility, just as the other attire is."

AORN also gives a new recommendation on quality assurance monitoring of laundering processes.

AORN also made the following changes in its revised RP:

• Safe surgical attire fabrics.

The new information includes recommendations that fabrics should be tightly woven, stain resistant, and durable. It also says that 100% cotton fleece should not be worn.

• Safe footwear.

"We recommend, in accordance with the OSHA [Occupational Safety and Health Administration] regulation, closed toe, nonskid soles," Conner says.

Previously, a reference to the OSHA requirement for construction workers misled some health care workers to think AORN was recommending steel-toed shoes for the OR, which it was not.

• Jewelry.

There is more information on wearing of jewelry, including how, where and when jewelry can be worn. AORN more clearly and specifically states what jewelry can be work at what points of entry. "For example, jewelry worn into restricted area of OR should be confined or contained under the surgical attire," Connor says.

• Stethoscopes and identification badges.

"Those personal items need to be cleaned," Connor says. "They need to be cleaned when they become soiled and on a routine basis." Stethoscopes can be contaminated by contact with patient, she points out.

• Bags carried in from outside.

A new recommendation says that fanny packs, brief cases, and backpacks should not be taken into semi-restricted or restricted areas.

This recommendation created a great deal of controversy, Connor says. "We just don't know what contaminants and vectors can be possibly carried into a restricted area of OR on these materials," she says. "You can get infections into the OR from outside." ■

RESOURCE

The Recommended Practices for Surgical Attire can be ordered online from the Association of periOperative Registered Nurses (AORN) at www.aorn.org. Under "Practice Resources" select "AORN Standards and Recommended Practices" then "Order your eDocument today." Or call AORN Customer Service at (800) 755-2676, Ext. 1. The member price is $55, and the nonmember price is $95.

Center's CEO recognized for infection control efforts

Making it a top priority wins national award

The winner of the Healthcare Administrator Award from the Association for Professionals in Infection Control and Epidemiology (APIC) is the chief executive officer of an ambulatory surgery center.

David G. Daniel, FACHE, FAAMA, diplomate of healthcare administration, CEO of the Lakeland (FL) Surgical & Diagnostic Center (LSDC) was given the award for making infection prevention and control a top priority through both facilities that make up the LSDC. Daniel's efforts resulted in a four-fold reduction in already-low surgical site infections at the two facilities, which perform 19,000 cases combined annually.

Daniel set an ultimate target goal of zero infections in 2006, and the infection rate has declined to .04%. "Last year we treated over 19,000 patients and had only two infections," he said. He says his ultimate target of zero infections "is now an attainable goal."

Consider these steps Daniel took:

• Daniel appointed infection control executives at both of LSDC's two facilities.

Daniel established an infection control officer,

EXECUTIVE SUMMARY

David G. Daniel, FACHE, FAAMA, diplomate of healthcare administration, CEO of the Lakeland (FL) Surgical & Diagnostic Center (LSDC), is winner of the Healthcare Administrator Award from the Association for Professionals in Infection Control and Epidemiology (APIC). He was awarded for making infection prevention and control a top priority through both facilities that make up the LSDC.

- Two senior nurse managers were made infection control executives.
- The basis for a systemwide infection control plan is a manual of about 25 policies and procedures. (See table of contents and two policies with our online issue.)
- Staff attend infection control courses offered by APIC, the Association of periOperative Registered Nurses, and the Society of Gastroenterology Nursing. Staff are paid to attend a mandatory quarterly staff meeting on Saturday mornings for continuing education.

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who was a senior nurse manager, at both facilities, Daniel says. **Bobbie Kendrick**, RN, CNOR, CIC, OR director, completed the "grueling" process to obtain certification in infection prevention/control (CIC). The other infection control officer and a supervisor in the GI department are seeking the certification.

• Daniel formed a systemwide infection control plan.

Form an infection control committee with staff committed to preventing adverse events, Kendrick advises. "Begin writing policies and procedures to give guidance to facility staff and the practitioners who use the facility," she advises.

To determine areas which need to be addressed, conduct surveillance, Kendrick suggests. "Understand that it cannot be done overnight, that it is a process," she says. "Ask for help when needed."

A consultant with expertise in ambulatory infection control program helped evaluate the organization in detail, Daniel said. "We knew our strengths and weaknesses before we started out," he said.

There is now one infection control plan for both facilities based on an infection control manual with about 25 policies and procedures. [Same-Day Surgery *has posted the center's table of contents for its infection control and manual and two of the policies with the online issue: non-clinical areas — business office and surgical hand scrub. For assistance, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]* The plan also includes benchmarks, Daniel says.

Most of the policies and procedures are based on standards that they had been using, such as ones from the Association of periOperative Registered Nurses (AORN), Association for the Advancement of Medical Instrumentation (AAMI), and the Occupational Safety and Health Administration (OSHA). "Therefore, the research for those is easier," Kendrick says.

• Daniel approved funding for extensive infection prevention staff training. Staff members were supported to attend courses offered by APIC, the Association of periOperative Registered Nurses, and the Society of Gastroenterology Nursing.

The Lakeland Center holds a mandatory quarterly staff meeting on a Saturday morning for continuing education. Staff are paid to attend. "Part of that education and training is infection control, Daniel says.

Conduct training during facilitywide staff meetings or, if that is not feasible, during department staff meetings, Kendrick advises "We set aside 10 minutes at each meeting for infection prevention updates/activities," she says.

If a member of your staff belongs to APIC, there are numerous tools available for developing a program, Kendrick says. Another good source is the web site for the Centers for Disease Control and Prevention (www.cdc.gov), she says.

Determine a goal for infection control and patient safety, Kendrick says. "After that is done, education is essential," she says. Centers should develop a library with reference materials, Kendrick advises. ■

Same-Day Surgery Manager

Be inspired to set goals for yourself

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

Like most, I was inspired by the rescue of the Chilean miners in October. I felt an enormous urge to accomplish something significant, to finish projects I had left dangling or follow up on other issues that individually weren't a big deal but collectively were. I've talked with others and have

found that same new sense of purpose in them as well. Perhaps you, too, felt something.

I asked others what they wanted to do, what they felt motivated to change or accomplish. Outside of changes in their personal lives, this is what they wanted to focus on as it relates to their workplace:

• **Administrator of freestanding ASC in Kansas.** "I felt overwhelmed with updating our surgeon preference cards. The task has been too daunting and no one wants to deal with it, and we have put it off for a couple of years. We decided that if those miners could live underground for 69 days — then we could do this, comparatively nothing, task."

• **Materials manager, 190-bed hospital in Texas.** "My goal was to reduce our cost by 2% on our top 100 disposable items. We put together a team and a hit list of the vendors and have gone after them. We are optimistic that we can make it happen!"

• **Surgical tech, 450-bed hospital in Virginia.** "I will admit to being somewhat lackadaisical in anticipation of what my surgeon wants at the table. Over the years I have slowly — and don't even know when it started — lost my enthusiasm for my job. Watching those miners come out of that tube has rejuvenated me to be the best I can be. I have already noticed a change in the looks I get from the surgeons. One even thanked me after the case for anticipating, even before he knew, what he needed. It is a good feeling to be the best you can be."

• **PACU nurse, freestanding ASC in California.** "I have started looking at my patients more objectively and trying to understand their pain, confusion, and helplessness as they are wheeled into PACU. It is a simple thing, but I notice a big difference in me. I like it."

• **Receptionist, freestanding ASC in Texas.** "I actually looked up the word "receptionist" on Google and it said the "title 'receptionist' is attributed to the person who is specifically employed by an organization to receive or greet any visitors, patients, or clients and answer telephone calls." While I have been doing my job for over five years, I had never looked at it like this. I also looked up the word "greet." It said, "Give a polite word or sign of welcome or recognition to (someone) on meeting." Many times in the past, being busy, registering patients, answering the phones and all, I often did not focus on the "polite" in my job. Now I am going to be the nicest, friendly, and most tolerant person in the center. It is my personal goal! Almost everyone that I have used my new attitude on has responded back to me the way I responded to them. It is great to be good at what you do!"

Just like more than one billion (1,000,000,000!) people who watched those miners come out of that hole, if I can change my goals to have just a few notice — even if it is only me — then it is worth it. [Earnhart & Associates is a 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. Tweet address: Earnhart_EAI.] ■

Center evacuates patients and staff

Pungent smell brings fire department visit

It was a busy Friday in September at the Farmington Surgery Center at the University of Connecticut Health Center. Patients were recovering from anesthesia. One was undergoing a procedure in the OR and had open wounds. Suddenly a sulphuric smell permeated one section of the PACU area.

"Our patients were slightly nauseated," says **Chris Jackson**, RN, BSN, nurse manager. Staff members' eyes and throats started to feel a burning sensation.

Jackson called the hospital's Environment of Care Center, and staff there called the fire

EXECUTIVE SUMMARY

The Farmington Surgery Center at the University of Connecticut Health Center had to evacuate its patients and staff after a sulphuric smell was found in part of the PACU.

- Some patients and nonessential staff were evacuated to the parking lot.
- Because the OR was on a different air exchange, patients who were recovering were moved to that area, and one patient in surgery who had open wounds remained in that area.
- The smell was coming from a battery in a mobile computer, only eight months old, that had overheated and deteriorated.

department. When the firefighters arrived, they couldn't immediately identify the source of the smell, but they recognized the air quality was poor in some areas. They pulled the alarm to start an evacuation of the Medical Arts and Research Building, where the center is located.

The patients who had undergone anesthesia were in various stages of recovery, Jackson says. "We explained to fire department that it's not as easy to evacuate a surgery center where people are recovering or just waking up," she says. "It's not just as easy as just moving them out." Another problem was that the weather was slightly rainy that day, she says. The firefighters tested the air quality in the OR, which is on a different air exchange, and agreed to allow some patients to be "evacuated" into the OR. "We moved patients within the facility temporarily where they could recover and be monitored safely by nurses from PACU staff," Jackson says. All nonessential staff were evacuated into the parking lot.

Eventually the source of the smell was identified: A battery in a mobile computer, only eight months old, had overheated and deteriorated.

The evacuation went well and staff were allowed to return to the building two hours later. The staff recently had held drills for fires and other disasters. "Everyone worked extremely well," Jackson says. "They were familiar with the safety manual."

The lessons learned? "You never know what's around the corner," Jackson says. "Keep your staff apprised of your evacuation procedures and safety policies and procedures of your specific unit."

The center has frequent drills that involve the fire department. A few months before the evacuation, Jackson held an inservice for the fire department to discuss evacuations plans, including evacuation of an active OR. "Since then we have formed a task force that will be organizing a `mock evacuation' involving all the fire department and the staff with a scenario that involves truly evacuating the OR to the outside, according to our unit-specific plan." *(For resources to help with disaster planning, see box, upper right.)* ■

CNE/CME ANSWERS

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

RESOURCES

For more information on disaster planning, go to these online resources:

• **Template Policy on Healthcare Facility Patient Evacuation and Shelter-in-Place**, Arkansas Hospital Association. Web: www.arkhospitals.org/disasterpdf/Template%20Policy%20on%20evacuation.pdf.

• **California Hospital Association.** Links to a hospital evacuation checklist and other resources. Web: www.calhospitalprepare.org/category/content-area/planning-topics/evacuation.

• **Mass Casualty Disaster Plan Checklist: A Template for Healthcare Facilities**, Institute for Biosecurity, Saint Louis University School of Public Health. Web: http://www.bioterrorism.slu.edu/bt/quick/disasterplan.pdf.

• **Pinellas County, FL, Emergency Management.** The "What We Review" section includes common errors the county's emergency management staff see when they review disaster plans. Web: www.pinellascounty.org/emergency/healthcare_facilities.htm.

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 activity with the December issue, you must complete the evaluation form provided and return it in the reply envelope provided to receive a letter of credit. When your evaluation is received, a letter will be mailed to you.

COMING IN FUTURE MONTHS

■ Preparation for Medicare surveys

■ Ensuring quality with reprocessed items

■ Latest target of federal investigations

■ National guidelines guide you to best practices

CNE/CME QUESTIONS

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

21. Which of the following is true since Aug. 25, 2010?
A. Medicare has reimbursed physicians who provide counseling to prevent tobacco use for outpatients and hospitalized patients.
B. Medicare has reimbursed facilities that provide counseling to prevent tobacco use for outpatients and hospitalized patients.
C. A. Medicare has reimbursed physicians who provide counseling to prevent tobacco use for hospitalized patients only.
D. Medicare has reimbursed facilities that provide counseling to prevent tobacco use for hospitalized patients only.

22. Which of the following is true, according to a recent study from The Cleveland (OH) Clinic on adverse outcomes among smokers
A. Smokers were 40% more likely to develop major complications and die within 30 days of surgery.
B. Smokers were 87% more likely to experience unplanned intubation.
D. Smokers were 30-42% more likely to have a surgical site infection.
D. All of the above

23. Which of the following is true of the Association of periOperative Registered Nurses (AORN) revised "Recommended Practice for Surgical Attire."
A. Recommendations for home laundering have been given more detail.
B. Industrial laundering of surgical attire is strongly recommended by a laundry accredited by the Healthcare Laundry Accrediting Council. No recommendations are given for home laundering.

24. The CEO of the Lakeland Surgical & Diagnostic Center won the Healthcare Administrator Award from the Association for Professionals in Infection Control and Epidemiology (APIC). Which of the following are included in his infection control program?
A. Staff members were supported to attend course offered by APIC, AORN, and the Society of Gastroenterology Nursing.
B. The center holds a mandatory quarterly staff meeting on a Saturday morning for continuing education. Staff are paid to attend.
C. They set aside 10 minutes at each meeting for infection prevention updates/activities.
D. All of the above

LAKELAND SURGICAL AND DIAGNOSTIC CENTER
INFECTION CONTROL POLICY

POLICY FOR SURGICAL HAND SCRUB

PURPOSE: To prevent and decrease the risk of health care-associated infections to both the patient and oneself by performing a thorough surgical scrub designed to; remove soil and transient microbes from the hands, nails and forearms; reduce the resident microbial count to as low as possible; and inhibit rapid rebound growth of microorganisms.

POLICY: All persons participating in a sterile surgical procedure shall perform a surgical hand scrub according to AORN standards.

CONTENT:

A. General Considerations Prior to Scrub

1. Scrubbed persons should be in good health
2. Hands and arms should be free from cuts, abrasions, open lesions or breaks in the skin.
3. Scrubbed personnel are not permitted to wear jewelry on hands or arms.
4. Nails should be short, free from nail polish.
5. An initial 3- 5 minute (depending on manufacturer's recommendation) pre-wash should be done by all assigned scrub personnel prior to the first surgical scrub per CDC guidelines utilizing an FDA approved alcohol-based product containing 0.5-1% chlorhexidine gluconate or equivalent for the persistent and cumulative antimicrobial activity.
6. All assigned non-scrubbing OR staff should perform an initial 3 minute traditional hand scrub prior to starting patient care each day.

B. Scrubbing Agents

1. U.S. Food and Drug Administration (FDA) approved antimicrobial cleansing agent approved by the Infection Control Committee will be used.
2. After the initial scrub, new products that are alcohol based in place of the traditional surgical scrub are allowed provided they are used according to manufacturer's recommendations.

C. Traditional Hand Scrub in accordance with the AORN Surgical Hand Antisepsis Recommended Standard IV, 2008 edition

1. An anatomical timed or a counted stroke scrub method is acceptable.
   a. Initial scrub 3-5 minutes
   b. Each subsequent scrub using traditional method is 3-5 minutes
2. Nails must be carefully cleaned in the subungual area under running water using a disposable nail cleaner.

Revised: October 2009

3. All surfaces of the fingers, hands, and arms for 2” above the elbow must be scrubbed. Some manufacturers recommend using a soft nonabrasive sponge.
4. Visualize each finger, hand, and arm as having four sides and repeat this process for the opposite fingers, hand, and arm.
5. Avoid wetting scrub attire, as wet clothing can act as a wick for bacteria to contaminate the surgical gown.
6. For water conservation, turn off water when not directly using.
7. Rinse hands thoroughly holding hands higher than elbows and away from surgical attire.
8. Discard sponge if used in appropriate container.
9. Dry fingers, hands and arms in the OR using a sterile towel prior to donning sterile surgical gown and gloves.
10. Remember to wash hands thoroughly before and after donning gloves.

D. Standardized use of FDA approved alcohol-based surgical hand rub

1. The standard protocol for use of alcohol-based surgical hand rubs should follow manufacturers’ written instructions for use and may include but not limited to:
   - Dispense the manufacturer’s recommended amount of product.
   - Apply to fingers, hand, and forearms.
   - Apply equally to both sides rubbing until thoroughly dry.
   - In the OR don sterile surgical gown and gloves.
   - General hand hygiene should be performed after removing surgical gloves.

E. FDA approved waterless antiseptic scrub agents

1. May be used for surgical scrub after the initial traditional scrub which does not require the use of exogenous water.
2. The steps above are followed or as per manufacture’s recommendation.

F. Emergency cases or situations

1. Where time does not permit such as in an emergency code 99 situation, scrub procedures and times may be modified.
2. Every attempt should be made to follow recommended hand hygiene procedures at all times.

Source: Lakeland (FL) Surgical & Diagnostic Center

LAKELAND SURGICAL & DIAGNOSTIC CENTER, LLP
INFECTION CONTROL POLICY

POLICY FOR PREVENTION OF INFECTION IN A NON-CLINICAL AREA BUSINESS OFFICE

PURPOSE: To provide guidelines to non-clinical personnel for the prevention of transmission of contagious organisms in the workplace.

POLICY: LSDC will follow facility guidelines for prevention of transmitting contagious diseases to each other.

PROTOCOL:

A. Hand Hygiene-Wash hands or use alcohol rub appropriately:

1. Prior to eating,
2. After toileting (use paper towel to turn off water and open bathroom door),
3. After coughing, sneezing or nose blowing.

B. Hands should not touch eyes, nose, or mouth to prevent transfer of bacteria or viruses to mucous membranes.

C. Surfaces in workplace should be cleaned every Thursday at 3:00 p.m. including computer keyboards, telephones, desks, door knobs, push plates, time clock, refrigerator door handles, microwave doors, etc.

D. Personnel with flu symptoms, such as fever, cough, sore throat, body aches and pains, nausea, vomiting, or diarrhea, should stay away from the office until the symptoms have cleared. If flu is suspected, employee should see his/her physician so that symptoms can be treated. Anti-virals such as Tamiflu are most effective in the early stages of the flu.

E. To prevent the spread of MRSA and other multi-drug resistant infections, any unhealed wound should be covered.

Source: Lakeland (FL) Surgical & Diagnostic Center

Original: November 2009

LAKELAND SURGICAL & DIAGNOSTIC CENTER
INFECTION CONTROL POLICY

TABLE OF CONTENTS

Training/Education 7

- Orientation Check List
- Training and in-service information

Infection Control Supportive Information and Guidelines 8

Forms Available on the Forms G-Drive:

- Annual Infection Control Organizational Risk Assessment # CL0049
- Automated Washer Disinfection Test-Form # CL0039
- Chemical and Biological Monitoring-Form # CL0050
- Flash Sterilization Documentation Page-Form # CL0013
- Hand Hygiene and Glove Surveillance-Form # CL0035
- Incomplete Bioloical Results Release Form # CL0051
- Infection Control Environmental Report (Monthly)-Form # CL0034
- Infection Control-Site Review (Quarterly)-Form # CL0042
- Sonocheck Trouble Shooting Guide-Form # CL0036
- Sonocheck Ultrasonic Cavitation Monitor Function-Form # CL0037
- SPD Intrument –Patient Tracking Record # CL0058
- SPD Tray BI and CI Validation Testing Worksheet # CL0064
- Sterile Processing Department Testing and Load Document-Form # CL0046
- Sterile Processing Testing and Load QI Worksheet FA # CL0061
- Sterile Processing Testing and Load QI Worksheet GR # CL0057
- Steris Chemical and Biological Monitoring QA Record # CL0050
- Terminal Cleaning Check List-Form # CL0038
    - Terminal Cleaning Check List in Spanish-Form # CL0048
- Tuberculosis Risk Assessment Worksheet (Annual)-Form # CL0047
- Warming Cabinet Temperature Check List # CL0052

Source: Lakeland (FL) Surgical & Diagnostic Center

Same-Day Surgery®

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

2010 Index

When looking for information on a specific topic, back issues of Same-Day Surgery *newsletter may be useful. If you haven't activated your online subscription yet so that you can view back issues, go to www.same-daysurgery.com. On the left side of the page, click on "activate your subscription." You will need your subscriber number from your mailing label. Or contact our customer service department. Telephone: (800) 688-2421 or (404) 262-5476. Fax: (800) 284-3291 or (404) 262-5560. E-mail: customerservice@ahcmedia.com.*