# Same-Day Surgery®

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

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## IN THIS ISSUE




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# Prank in surgery puts facility, staff on wrong end of lawsuit

*Patient says he woke with nails painted, words written on him*

A Texas hospital, its parent company, two surgical nurses, a nurse anesthetist, and a surgical tech are facing a lawsuit charging them with assault and intentional infliction of emotional distress after what the plaintiff says was a prank played on him while he was anesthetized for surgery. An appeals court recently ruled that the defendants should stand trial.

The lawsuit was filed by Chauncey Drewery, previously a surgical tech at Metroplex Adventist Hospital in Killeen, TX, who underwent a tonsillectomy at the same facility where he worked. In his lawsuit, he claims that upon emerging from general anesthesia, he discovered that two RN co-workers had painted his fingernails and toenails pink.

In addition, Drewery claims, they also wrote each of their names and "was here" on the soles of his feet. The co-workers also taped up Drewery's thumb to mock his private and embarrassing habit of sucking it, he says. The lawsuit alleges that the two nurses continued to harass Drewery after he returned to work by falsely telling people that he was gay. The harassment was so significant that Drewery resigned from his job, the lawsuit claims.

Drewery sued the nurses for assault and intentional infliction of emo-

## EXECUTIVE SUMMARY:


A hospital and several members of a surgical team are facing legal action and possibly other discipline after a patient claimed they played a prank on him while he was anesthetized for surgery. The patient was an employee of the hospital and claims the prank was part of ongoing harassment that eventually led him to resign.

- The employee has sued for assault and intentional infliction of emotional distress.
- A Texas appeals court has ruled that the defendants should face trial.
- Such pranks are not uncommon but signal serious problem with the hospital's culture, one legal expert says.

tional distress, and he also accused a surgical tech and anesthesia provider of aiding and abetting the prank by failing to intervene. The lawsuit also names the hospital and its parent company, Adventist Health System, and claims they did not act when Drewery reported the prank and other harassment, thereby fostering a hostile work environment.

Soon after the lawsuit was filed in April 2009, the defendants requested that the case be dismissed because it lacked the medical expert reports necessary for healthcare liability claims to proceed. A county trial court granted this request, but a state appeals court recently reversed that decision and sent the case back to the trial court. *(See the state appeals court ruling at http://bit.ly/nLpW1A. See the story on p. 103 for excerpts from the ruling.)*

The appeals court ruled that the case is not a healthcare liability claim and therefore does not require the filing of experts' reports. The court noted that the alleged prank was "extreme and outrageous, in that all Defendants were in positions that required them to provide medical care and treatment" to a patient who "was under general anesthesia and muscular paralysis and was physically incapable of defending himself against this assault committed by the very professionals charged with protecting him from these horrific actions."

A spokesman for Metroplex Adventist Hospital, **Desirae Franco**, says hospital leaders declined a request for comment from AHC Media, the parent company of *Same-Day Surgery*. An attorney for Drewery, the plaintiff, did not return calls to AHC Media seeking comment.

Legal observers say the defendants are in deep trouble. They say the abuse alleged in this case isn't just a wild aberration: This kind of prank could be happening in your own surgery suites.

## Surgery pranks not uncommon

The case speaks to two legal issues: hospital risk management and employment law, says **Alex J. Keoskey**, JD, a partner specializing in healthcare litigation with the law firm of DeCotiis, FitzPatrick & Cole in Teaneck, NJ.

"That sounds like a serious breakdown in discipline at several levels," Keoskey says. "First, there would be a real lack of leadership in their particular department's supervisory staff, failure of education and enforcement with regard to the bylaws and/or department rules. I do know that those types of pranks are not uncommon."

Keoskey suggests that, if the allegations are true, the hospital must have a serious problem with its culture. Even if the surgery prank was not intended as harassment, but rather just harmless horseplay among colleagues, supervisors and hospital leaders should have instilled a culture in which that prank would not be tolerated, he says. *(See the story on p. 104 for more on how common such pranks are.)* Sources contacted by *Same-Day Surgery* indicated that this type of behavior is

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addressed in medical staff bylaws, employee handbooks, and/or codes of ethical conduct.

The case is "disturbing" and suggests a failure of policies and procedures at every level, says **Susan H. Patton**, JD, counsel with the law firm of Butzel Long in Ann Arbor, MI. "If these allegations are true, this is a failure of the hospital to create a culture of compliance and to address bullying and other destructive behavior," Patton says. "There is a lot to dislike about this case."

The lawsuit could result in significant liability, Keoskey says. In another work environment, a jury might not be sympathetic to what seems a harmless practical joke among co-workers. But a jury is likely to see the situation differently when a patient is anesthetized, helpless, and dependent on medical professionals for not only his safety but his dignity, he says. (*See the story on p. 104 for more on possible disciplinary action by the Texas nursing board.)*

The appeals court determined that the alleged surgery prank was assault and battery, Patton says.

An employee who stands by while others perform a prank in surgery might be in just as much trouble, Patton says. Such staff members might have owed the patient a duty of due care and it might be alleged that they breached this duty by failing to act to stop the actions of the others.

Charges of negligence for the omission of an act required by law are common against healthcare providers, Patton notes. Negligence might be defined as harm done as a result of neglecting duties, procedures, precautions, or otherwise failing to act as a reasonable person would have acted in a similar situation, she says. Examples of negligent failure to exercise due care might include failing to follow standard protocols and procedures, such as not stopping or reporting inappropriate conduct or contact; failing to prevent injury to patients or other employees; or failing to maintain patient privacy and confidentiality.

The hospital's actions, or lack of action, after the surgery prank and claims of harassment might be what ultimately leads to the greatest liability, suggests **Brian Inamine**, JD, a shareholder with the law firm of LeClairRyan in Los Angeles. The surgery prank was "dumb" but did not leave lasting damage to the plaintiff, Inamine says, whereas the ongoing harassment and management's alleged failure to intervene could result in a significant payout. "Any one of the claims he makes in the lawsuit could be the basis for a hostile work environment claim," he says. "There can be actionable workplace harassment here, no doubt. I see plenty of actionable claims here."

All of the attorneys consulted by AHC Media expressed wonder that the hospital had not yet settled the case. The hospital might have attempted to settle, of course, but Patton says it should have been willing to pay even a large sum to make the case go away.

"It strikes me as amazing that the hospital let this go as far as it did without settling," Patton says. "I would think they would want to just get it off the radar because it is such a horrible fact situation and such a developed fact situation. I can't imagine the damage this is doing to them in terms of public perception among people who have a choice about where to have surgery."

**SOURCES**

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# Court: Prank 'extreme, outrageous, horrific'

The state appeals court hearing the lawsuit brought by Chauncey Drewery against his former employer and former coworkers was appalled by the alleged prank played on him during surgery. These are some excerpts from the ruling by the Texas Court of Appeals, Third District, at Austin, TX:

"In addition to the assault claim, Drewery alleged causes of action against [two nurses] for intentional infliction of emotional distress, claiming that the incident and its aftermath created a hostile work environment that caused him severe emotional distress. He asserted that when he returned to work after the surgery, the individual defendants continued to tease him and make jokes about his sexuality, telling other hospital employees that he is gay, even though he is not, and that they had painted him to look 'like a little girl.'"

"Regarding the taping of his thumb, Drewery

argued that the significance of this act was to call attention to his 'very private, but embarrassing habit' of sucking his thumb, which [one nurse] was aware of and had exploited in an attempt to humiliate him."

"He alleged that he experienced nausea and loss of sleep and appetite as a result of feeling that he had been violated by his coworkers and from not knowing what else might have been done to him while he was under anesthesia."

"According to his pleadings, Drewery suffered further emotional distress after administrative personnel at the Hospital ignored his complaints regarding the assault, failed to acknowledge any wrongdoing, and failed to punish the perpetrators."

"Drewery brought the same causes of action for assault and intentional infliction of emotional distress against … a surgical technician, and … a nurse anesthetist, claiming that both of them had been present in the operating room before and during his surgery, yet neither of them had intervened to stop the assault; in fact, Drewery alleged, [they] had aided and encouraged [the nurses] by joking and laughing. Drewery also brought these claims against the Hospital under the doctrine of respondeat superior, arguing that the individual defendants had been acting in the course and scope of their employment."

"The actions described above, which were directed towards Plaintiff, were intentional. Defendants' conduct involved an extreme degree of risk considering the probability and magnitude of potential harm to Plaintiff and all Defendants proceeded with conscious indifference to the rights, safety and welfare of Plaintiff despite all Defendants' actual, subjective awareness of the risk involved."

"The acts of all the Defendants described above were extreme and outrageous, in that all Defendants were in positions that required them to provide medical care and treatment to Plaintiff. Plaintiff was under general anesthesia and muscular paralysis and was physically incapable of defending himself against this assault committed by the very professionals charged with protecting him from these horrific actions."

"The defendants are mistaken in relying on the sole fact that they were 'acting' as health care providers at the time the alleged assault occurred," which would require expert testimony. "The fact that the actions were taken by a physician or health care provider does not necessarily mean that the suit is about a patient's treatment, lack of treatment, or other departure from accepted standards of health care. Otherwise, *every* claim based on the conduct of a physician or health care provider in a health-care setting would be subject to the expert-report requirement." (See the state appeals court ruling at http://bit.ly/nLpW1A.) ■

# Attorney: Discipline likely from nurses board

In addition to any monetary payout from the defendants in the surgery prank case involving Metroplex Adventist Hospital in Killeen, TX, the individual defendants also might find their careers in jeopardy, says **Alex J. Keoskey**, JD, a partner specializing in healthcare litigation with the law firm of DeCotiis, FitzPatrick & Cole in Teaneck, NJ.

"All of these nurses are individually regulated by the Texas Board of Nursing, so they may have violated rules and regulations there that will make them individually susceptible to discipline by that board," he says. "The hospital may have a problem from a regulatory standpoint with the Texas Department of State Health Services."

Keoskey says that if the allegations are true and two staff members stood by and did not interfere with two nurses playing a joke on an anesthetized patient, that inaction signals a serious problem within the hospital. Other staff members, such as those in post-op recovery, must have seen the prank but did not report it either, he says.

"I just can't believe this is an isolated incident at this hospital," he says. "The plaintiff also claims that his reports of harassment and a hostile work environment went unanswered by hospital leadership, and I find that amazing. That is inexcusable. If that person did complain and those complaints were ignored, that is a serious transgression — and I'm talking about any supervisor who heard the complaint and certainly the risk manager." ■

# OR is no place to get casual

*Practical jokes are common*

Healthcare attorneys tell AHC Media, parent company of *Same-Day Surgery*, that they are privy to some things that might shock a manager, such as what really happens in the OR.

Surgical pranks and horseplay in surgery are sur-

prisingly common, says **Alex J. Keoskey**, JD, a partner specializing in healthcare litigation with the law firm of DeCotiis, FitzPatrick & Cole, Teaneck, NJ. He bases that statement on what he has seen from lawsuits in which a too-casual OR atmosphere was revealed during the litigation of malpractice cases.

The pranks, or staff becoming too familiar with one another and acting unprofessionally, are a result of the same stress that can lead to outbursts and abuse by physicians, Keoskey says. "It's not uncommon, and I think most nurses who work in surgery will tell you this. You do see these practical jokes quite a bit," Keoskey says. That statement is supported by comments made by nurses about the case at http://allnurses.com/nursing-news/nail-polish-prank-574481.html.

The manager and other leaders often don't know about the problem because members of surgical teams will straighten up and act appropriately if supervisors are present, he says. Managers should instill a culture in which all staff understand that, though camaraderie is encouraged, there must be a bright line beyond which all behavior is strictly professional.

"Lawyers joke with each other all the time, but we don't do it in the courtroom because we have great reverence for that particular place and we know that it demeans the entire profession when we joke around in an area that is at the core of what we do," Keoskey says. "The surgical suite should be the same way. Joke around in the locker room or the break room all you want, but that has to stop when you walk in the OR and you're responsible for a human being lying on the table."

Managers should establish a zero tolerance policy for practical jokes in the workplace, with a special emphasis on the OR and any other patient care, Keoskey says. "Rules like that don't just need to be on paper, they need to be enforced," he says. "People need to sign off on them and agree that they will not only not engage in this type of behavior but will report others who do." ■

# Infection control surveys planned for hospitals

*Is 'pay for prevention' on the horizon?*

The Centers for Medicare and Medicaid Services (CMS), which is the single largest payer for healthcare in the United States, is creating a hospital inspection program focused specifically on infection control.

"We have a problem in this country with far too many infections and too many deaths due to infections in hospitals," said **Daniel Schwartz**, MD, MBA, chief medical officer of the Survey and Certification Group at CMS. "So what can we do to fix this? I don't think it's necessarily CMS alone that is going to fix this, but a hospital should be able to detect when they have a problem. They should have systems in place to recognize and fix those problems."

It doesn't take a great leap of imagination to see this fledging survey concept eventually morphing into CMS "pay for performance" requirements, though the program is being pitched initially as a non-punitive collaborative that can help hospitals improve quality. In the boldest move yet in its dramatically expanding oversight of infection prevention, CMS is planning to train a cadre of inspectors to assess basic infection control measures and follow single hospitalized patients using a "tracer" concept similar to that used by surveyors from The Joint Commission (TJC). The CMS program was discussed earlier this year at a meeting of the Healthcare Infection Control Practices Advisory Committee (HICPAC) of the Centers for Disease Control and Prevention (CDC).

"Obviously, if we are writing regs and you are writing guidelines, we really want to be on the same page," Schwartz told the HICPAC panel. "We want this to have a major impact on infection control and help reduce healthcare associated infections."

There is a clear precedent for partnership. In the wake of continuing hepatitis outbreaks in ambulatory care settings — most of them linked to improper use of needles and medication vials — CMS worked with the CDC to create an infection control checklist to use for inspecting outpatient facilities. CMS inspectors would likely look for such breaches while assessing basics principles such as hand hygiene, barrier precautions, instrument processing and the like.

As discussed at the CDC meeting, the CMS will create a hospital infection prevention survey that will be reviewed by HICPAC and other key stakeholders and possibly will be opened for public comment. The survey will be "pre-tested" in selected participating hospitals, with an emphasis on using it as a self-assessment tool to improve infection control practices. In that sense, the CMS appears to be trying to launch this inspection process without incurring a lot of pushback from hospitals. For their part, infection preventionists are viewed as an important part of the process and could leverage the CMS involvement into upgraded program

resources.

"We want to go into the hospitals and use [the survey] to see what works and what doesn't, get feedback and really make it better," Schwartz says. "In the end, we want everybody to be kind of happy with it. We want it to be, obviously, something the surveyors find to be useful, and we want it to be an assessment opportunity for the hospitals. We want them to be comfortable that if they do these things, not only will they do well on the surveys, but they might be able to [prevent more HAIs]."

### Codifying CDC guidelines

With the death of 100,000 people annually due to HAIs, critics have been saying for years that the CMS should use its considerable influence on the hospital bottom-line to put some teeth in the CDC's voluntary infection control guidelines. However, Schwartz rejected that analogy in an interview with AHC Media, parent company of Same-Day Surgery.

He said CMS was charged to create the hospital inspection program as part of the newly formed Partnership with Patients. This recently announced federal, state, and private collaborative will focus on improving patient safety by reducing healthcare associated infections (HAIs) and other hospital-acquired conditions.

"[In terms of the] state of the art in the field I can't think of a better organization, and one that has a better reputation in infection control than the CDC, he says. "It really helps to have this working arrangement with them so that was our starting point [for this survey].

Schwartz said CMS officials have been considering taking this step anyway because the agency have been dealing with ambulatory surgery centers and has had conversations with CDC leaders about infection control issues.

Whatever the program's origin, the future result, possibly within the next nine months, could see CMS inspectors making fairly thorough visits to hospitals. "This will probably involve two surveyors over two days to do the assessment," Schwartz told HICPAC. "We are hoping to make this an easy to use tool that is highly effective."

While CMS usually comes into hospitals only to respond to specific complaints, the scale of the program discussed at the meeting would be much more ambitious in terms of oversight and routine inspection. "When CMS goes into hospitals most of the time the reason is a compliance investigation and we do maybe 4,000 to 5,000 of those, but that's a very limited survey," he said.

The hospital survey initiative certainly reflects the influence of new CMS chief **Don Berwick**, MD, a longtime healthcare quality and transparency advocate. Under Berwick, the CMS has continued to step up fiscal pressure on hospitals to adopt quality measures and best practices to reduce HAIs. In an interview prior to his CMS appointment in July 2010, Berwick said he hopes the public "gets a bit outraged and mobilized as voters," he said. "[They should] ask why we pay systems the amount of money we are and not have them adopt the best practices."

In that regard, liaison HICPAC member **Lisa McGiffert**, senior policy analyst on health issues at the Consumers Union, expressed strong support for the CMS initiative, and she described the survey tool as "very important." She does agree it can be used for hospitals "to have help in improving care, but I think ultimately it's [CMS'] responsibility that the environment is safe for patients. You are not there just to help the hospitals."

In particular, McGiffert urged the CMS to ensure that hospitals are tracking and reporting all infections, something that has been questioned as more and more states mandate rate data.

**Carolyn Gould**, MD, a CDC medical epidemiologist who is collaborating on the CMS project, said, "We do touch on that in the interview portion of it. There are a lot of questions related to the infection prevention program and resources, and that includes surveillance." *(For the likely categories of the hospital tool, see story below.)* ■

# CMS hospital tool will go beyond ASC survey

*Hand hygiene, needle use likely included*

A survey tool to assess infection control in ambulatory surgery centers (ASCs) was created by the Centers for Disease Control and Prevention for use by inspectors for the Centers for Medicare & Medicaid Services. As the two agencies discuss creating a similar tool for hospital inspections, an expansion beyond the ambulatory care model is expected. That survey tool included some basic environmental cleaning, disinfection and sterilization requirements along with soliciting a "yes" or "no" response in the following areas:

**I. Hand Hygiene**

A. Soap and water are available in patient care areas

B. Alcohol-based hand rub is available in patient care areas

C. Staff perform hand hygiene:

a. Before and after an invasive procedure (e.g., insertion of IV catheter, intubation/extubation, surgical procedure) even if gloves are worn

b. After contact with blood, body fluids, or nonintact skin (even if gloves are worn)

c. After contact with used, contaminated medical equipment or visibly contaminated environmental surfaces (even if gloves are worn)

Note: To ensure consistency between site visits, hand hygiene should be observed during the "follow-through" of patients from arrival to discharge, with particular attention paid to invasive procedures.

D. Regarding gloves, staff:

a. Wear gloves for procedures that might involve contact with blood or body fluids

b. Wear gloves when handling potentially contaminated patient equipment

c. Remove soiled gloves before moving to next task

E. If a surgical scrub is required, the surgical team performs surgical hand scrub

**II. Injection Practices (medications, saline, other infusates)**

A. Needles and syringes are used for only one patient

B. Injections are prepared in a clean area that is free from contamination with blood, body fluids, other visible contamination, or used contaminated equipment

C. The patient's skin is prepped with an antiseptic before IV placement

D. List all injectable medication/infusates that are in a vial/container used for more than one patient. This should include the medication name, size of vial (cc/mL) and the typical dose per patient (cc/mL)

E. Single-dose medications/infusates are used for only one patient and not collected or combined (bags of normal saline are ALWAYS single use)

F. Multidose medications/infusates are used for only one patient (note: a "No" answer here is not necessarily a breach in infection control. Circle N/A if no multidose medications/infusates are used.)

G. Medication vials used for more than one patient are always entered with a new needle and new syringe

H. The rubber septum on a medication/ infusate vial is disinfected with alcohol prior to piercing after initial entry

I. Medications/infusates that are packaged as prefilled syringes are used for only one patient

J. Medications/infusates are drawn up at start of each procedure

K. Fluid infusion and administration sets (e.g., intravenous bags, tubing, and connectors) are:

a. Used for one patient only

b. Disposed of after use

L. Needles and syringes are discarded intact in an appropriate sharps container after use. ■

**Same-Day Surgery Manager**

# A compilation: Lessons that I've learned

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

After a talk I gave last month, someone came up to me after the meeting and asked me this question, "After all the years you have been doing this [surgical consulting], what are some of the things you have learned?"

I sort of blew off the question with a short quip, but the more I thought about the question, the more I wondered: What have I learned? I enjoy writing, fiction mostly, but I can and do plan on writing a book about my experiences in this industry. The following will certainly be within the pages:

- I learn something from everyone I meet. It could be a surgical tech, the instrument processor, or the CEO. Everyone has a story, and if you listen, you can hear it.
- If you build it, they will come. Oh, no they won't!
- The rudest people are the loneliest people.
- Surgeon's perceptions are reality. Don't confuse them with facts. Demonstrate with actions.
- Ninety percent of the meetings I've ever attended were a waste of time.
- Vomiting just comes with our industry.
- A screaming child in PACU is mostly scared and needing a hug rather than in pain and needing a shot.
- A pre-op patient that says they are going to die

during surgery should not have surgery that day.

• If I had to be stranded on an island — I would want an OR nurse with me.

• The louder the people talk, it seems like the less they know, but don't want you to know it.

• Breaks in surgical techniques happen more than we realize. We can thank our immune system for keeping us out of trouble.

• I use to think that a good "boss" could not be a good "friend" to the people he or she worked with. I've changed my mind on that.

• Every "rep" works off of commission. I have bought many a surgical product not fully understanding that!

• It often costs more to store the equipment after the orthopedics trade shows then the equipment itself cost.

• Most administrators are afraid of the OR staff. Way to go!

• It just plain is not true that the older the building, the greater the character! It is actually the older the building, the more odors it has.

• Old patients are just as scared as young patients in pre-op.

• Some staff members are content where they are in the scheme of things and do not want added responsibilities.

• Lastly: Sometimes things are just meant to be.

I know that many centers are having a slowdown in activity and reimbursement from Medicare and Medicare is getting tougher and tougher. I do see turnaround but not in the near future. We all need to dig in and ride it out, because it will get better.

I talk with a lot with people in the industry that think they understand what is going on — (I don't think they really do!) but they all feel that all of us are in the right place at the right time. Hang in there. *[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. Twitter: @SurgeryInc.]* ■

# Center shares lessons from water damage

*Sprinkler head damaged during cleaning*

Managers at surgery centers have learned that, similar to a Code Blue, you must react quickly when you have a water leak to prevention serious damage, including mold.

At Powder River Surgery Center in Gillette, WY, a staff member was performing terminal cleaning at about 5 p.m. on a Wednesday earlier this year and accidentally hit a sprinkler head. It immediately began spewing water, says **Michelle Kioschos**, RN, CNOR, executive director of the center.

The employee ran out of the room, closed the door, and yelled for help. An employee sprinted to the main sprinkler room to turn off the water, which took a couple of minutes. "There's a lot of water that comes out of a sprinkler head," Kioschos says.

Members of the staff grabbed blankets, sheets, patient gowns, mops, and whatever else they could find to stop the flow, Kioschos says. The water started seeping through the walls, and the staff members worked quickly to stop it from flowing throughout the center. They then started to clean up the water. "The water was contained and damaged was minimal due to the quick response of staff," she says.

A staff person ran to call the fire department. The firefighters ensured water still was flowing to the rest of the two-level building.

The center called a national disaster recovery company. "They were there in 10 minutes," Kioschos says. The recovery staff cleaned up the excess water and placed blower hoses in the walls just in case any moisture had reached those areas. The air blowing continued for two days. Every couple of hours they performed a humidity check and a mold check. Their visit was followed by an independent construction company that verified the continuity of the walls. "There was no water damage, because the response time was so quick," Kioschos says.

The center cancelled surgical procedures for two days (Thursday and Friday), then staff members worked through the weekend cleaning up to ensure there was no potential for infection or contamination. As a precaution, the staff threw out all sterile supplies in the room with the water leak, even the ones in a closed cabinet, but the equipment was

## EXECUTIVE SUMMARY

Respond quickly to stop water leaks, and clean up any potential moisture to prevent mold damage.

• Know where you emergency shutoff valve is located.

• Contact your insurance company immediately.

• Work with local firefighters to become familiar with your building layout so they will be prepared if a leak occurs when the facility is closed.

saved, Kioschos says.

The center performed cultures immediately after the incident in the rooms and cabinets. The entire center was terminally cleaned twice. The walls were scraped and repainted. All floors were buffed and waxed. "We wanted to make sure there was no residual water anywhere at any point," Kioschos says. "It might sound like I went to the extreme, but in this environment, I don't think you can ever go to the extreme."

She shares these lessons:

• **Consider water damage to be a potential risk.** "I've been administrator for eight years, and one of the things I learned is that not all potential risks are not what we think they are," Kioschos says. "Knowing we terminally clean rooms every day, I had no idea that [water damage] was a potential risk."

• **Know where your emergency shutoff valve is located.** "That reduces significantly the water damage," Kioschos says.

All utility shut-off valves should be marked clearly, including which was is "open" and which is "close," sources advice. Also, list the locations of those shut-off valves in a fire and disaster manual, and use a floor plan to mark where they are, they advise. Some valves, especially sectional valves, might be above the ceiling tiles, they note.

• **Work with your local firefighters to ensure they are familiar with the layout of your building.** While the fire marshal regularly checks out the Powder River facility's sprinkler system, the firefighters and volunteers with that department aren't familiar with the building, even though they are located only a block away, Kioschos says. Also, the building superintendent isn't always on site, she points out.

"If you're at a facility open 24 hours, there's always someone around," Kioschos says. "We're an ASC; we close at 5. What if this happens after 5, and security lets them in? Do they know where to go?"

To address this issue, firefighters have been doing walk-throughs to become familiar with the building, Kioschos says. *(For another water damage incident, see story, below.)* ■

# Rare earthquake causes water leak

In April 2008, the Midwest experienced a small earthquake. When staff arrived the next morning at Kendall Pointe Surgery Center in Oswego, IL, they discovered a small cold water feed supply line to a sink had broken. About 2 inches of water had poured into the PACU area.

"Like a Code Blue, you respond without really thinking about it," says Angie Burns, administrator. "We saw the water, we got towels and piled them around the leak until we could get a plumber to it." The plumber was called immediately to stop the water flow, and then the staff turned to cleaning up.

**Mark Mayo**, executive director, ASC Association of Illinois, said, "Cleanup was not as simple as mopping." As the situation created a start to a mold condition, cleanup required fungicide, air drying, and removal and replacement of a lower portion of drywall and insulation between some walls, as water had seeped up drywall, Mayo says. None of the damage reached the ORs.

When the water leak was discovered, Burns immediately went home and retrieved a shop vac to vacuum up the water. She also called a national firm that brought additional shop vacs to vacate the water. That company also used massive fans to dry the center. The center managers contacted the insurance company to report the damage. This step should be taken immediately, because the insurance company will provide instructions and start a claim, Burns says.

The managers contacted another company to handle the water remediation and mold remediation.

The center was closed for only one day (Friday). The vendors worked over the weekend, including nights, so the center could reopen Monday. ■

# What should you do about shellac nails?

Have your staff members' shellac nails raised questions about whether they are artificial and an infection control threat?

This relatively new nail product is considered essentially to be nail polish by the Association of periOperative Registered Nurses (AORN), according to **Ramona L. Conner,** MSN, RN, CNOR, Manager, Standards and Recommended Practices, AORN.

While shellac is commonly considered to be more durable than other nail polishes, it will chip, Conner warns.

"Just as with nail polish, the shellac polish should be removed and replaced when it is chipped," she says. "Fingernail polish, including

shellac, that is chipped may harbor pathogens in large numbers."

AORN's "Recommended Practices for Hand Hygiene in the Perioperative Setting" states: "It has been shown that fingernail polish becomes chipped by the fourth day of wear. Chipped fingernail polish should be removed to prevent possible contamination of the environment or the patient. Glove tears occasionally occur during a surgical procedure; chipped fingernail polish could be deposited on the sterile field or in the wound."

Conner suggests that mangers incorporate this position into their policies and procedures.

This viewpoint on shellac nails is supported by the Centers for Disease Control and Prevention. In its "Guideline for Hand Hygiene in Health-Care Settings," it states: "Freshly applied nail polish does not increase the number of bacteria recovered from periungual skin, but chipped nail polish may support the growth of larger numbers of organisms on fingernails."

It is uncertain how long shellac can be worn before it chips, Conner says. She does offer this caveat, however: "We are not aware of any reports of patient infection resulting from healthcare workers wearing shellac nail polish."

Standards from the Accreditation Association for Ambulatory Health Care (AAAHC) do not specifically address nail polish, says **Michon Villanueva,** assistant director of accreditation services. "The standards do require that organizations adopt nationally recognized guidelines with regard to infection control. Within those guidelines there may be specific language about nail polish and any associated recommendations," says Villanueva, who points to the AORN guidance. The Joint Commission takes a similar approach, according to a spokesperson. ■

# Periop complications after noncardiac surgery

**Abstract & Commentary**

By **David J. Pierson**, MD, Professor, Pulmonary and Critical Care Medicine, Harborview Medical Center, University of Washington, Seattle.

**Synopsis:** In a population-based study using hospital discharge diagnosis codes, patients with sleep apnea who underwent knee arthroplasty or open abdominal procedures were more likely to require invasive mechanical ventilation and to be diagnosed with aspiration pneumonia or ARDS than were matched patients without sleep apnea. Knee-replacement patients, but not those undergoing laparotomy, also were more likely to be diagnosed with pulmonary embolism.

**Source:** Memtsoudis S, Liu SS, Ma Y, et al. Perioperative pulmonary outcomes in patients with sleep apnea after noncardiac surgery. *Anesth Analg* 2011; 112:113-121.

In this study of a large administrative database, the incidence of selected complications in patients diagnosed with sleep apnea (SA) was compared to that in patients undergoing similar surgical procedures who were not diagnosed with SA. The authors examined data from the National Inpatient Sample, a database sponsored by the Agency for Healthcare Research and Quality. They looked at patients who underwent total knee arthroplasty or an open abdominal surgical procedure from 1998 through 2007.

This examination yielded 117,283 patients coded as having SA and 5,934,420 patients without this diagnosis. A subset of the latter population was matched to those with SA using demographic variables via the propensity scoring method. The perioperative complications examined in these two groups were aspiration pneumonia, pulmonary embolism, the adult respiratory distress syndrome (ARDS), and the need for perioperative intubation and mechanical ventilation.

Of the 2,610,441 knee arthroplasties, 65,774 patients (2.52%) were coded for SA; the corresponding numbers for abdominal surgical procedures were 51,509 of 3,389,753 (1.40%). Patients with SA were more likely to be male and were five times more likely to be obese than patients without SA; additionally, their average comorbidity indices were higher, and they were more likely to be admitted on an emergent rather than an elective basis.

Aspiration pneumonia occurred more frequently in SA patients after knee arthroplasty (1.18% vs 0.84%) and laparotomy (2.79% vs 2.05%). The same occurrence was found for ARDS (1.06% vs 0.45% for knee procedures; 3.79% vs 2.44% for abdominal procedures) and also for perioperative invasive mechanical ventilation (3.99% vs 0.79%; 10.8% vs 5.94%, respectively), with all these differences being statistically significant. Pulmonary embolism occurred more often after knee arthroplasty in patients with SA (0.51% vs 0.42%, *P*

= 0.0038), but its incidence was not increased with SA following abdominal surgery. From these findings, the authors conclude that SA is an independent risk factor for perioperative pulmonary complications in noncardiac surgery.

## Commentary

This study adds incrementally to our appreciation of the importance of SA as a comorbidity in hospitalized patients and as a risk factor for perioperative complications. However, the study has some major limitations, the most important of which for the purposes of this newsletter are shortcomings of the administrative-database approach to studies of disease prevalence and complication incidence, and the article's broad generalizations about the study population and the implications of the results.

Because of its design, this study grossly underestimates the prevalence of SA among the patients in the database. Only patients assigned one of two SA diagnosis codes were included, and the SA prevalence found (2.51% for patients undergoing knee arthroplasty and 1.49% for those who had laparotomies) is probably a 10-fold underestimation of the true prevalence. A recent review of the management of SA in surgical patients[1] cites several epidemiologic studies indicating that sleep-disordered breathing occurs in approximately 20% of adults in this population, with nearly 7% exhibiting moderate-to-severe obstructive SA. For example, one recent study found that 22% of the adult general surgical population had obstructive SA.[2] In that study, 70% of the SA patients were undiagnosed before presentation for perioperative evaluation; other sources estimate that as many as 80%-90% of surgical patients with SA are undiagnosed.[1,2]

The present study examined SA prevalence and associated complications in two specific populations of surgical patients: those undergoing total knee arthroplasty and those having an open abdominal procedure. The fact that the study included only these specific procedures is mentioned only once, in the methods section. However, throughout the paper the authors refer not to these operations but to "orthopedic procedures" and "general surgical procedures," and the title further broadens the population to "noncardiac surgery." The potential implications of the study's results as summarized in the abstract and elaborated in the discussion section of the paper should thus be interpreted cautiously to avoid unwarranted overgeneralization.

These problems with the design of the study and the interpretation of its findings notwithstanding, the article emphasizes the fact that patients with SA are particularly predisposed to perioperative pulmonary problems. Most such patients have not been diagnosed, and they are increasingly encountered by intensivists following elective surgery or when admitted for other reasons. Complete evaluation for suspected SA is not feasible during acute hospitalization, but heightened awareness of this condition and its associated risks for a variety of complications during the perioperative period should aid in prevention, early diagnosis, and appropriate management.

### REFERENCES


1. Adesanya AO, W Lee, NB Greilich, et al. Perioperative management of obstructive sleep apnea. *Chest* 2010; 138:1489-1498.
2. Finkel KJ, AC Searleman, H Tymkew, et al. Prevalence of undiagnosed obstructive sleep apnea among adult surgical patients in an academic medical center. *Sleep Med* 2009; 10:753-758. ■


## CNE/CME INSTRUCTIONS

Physicians and nurses participate in this CNE/ CME program and earn credit for this activity by following these instructions.
1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■

## COMING IN FUTURE MONTHS

- Avoid trouble with feds over narcotics record-keeping
- Can a patient be too old for outpatient surgery?
- Do you have a gap in delivering patient education?
- Lessons learned on evacuating surgery patients

# CNE/CME OBJECTIVES

- **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.

# CNE/CME QUESTIONS

1. In the lawsuit filed by Chauncey Drewery, previously a surgical tech at Metroplex Adventist Hospital, what was the hospital's initial defense?
   A. The hospital denied that the incident occurred.
   B. The hospital denied that the plaintiff had suffered any injury.
   C. The defendants claimed that the lawsuit was invalid because legislation prohibited non-malpractice claims involving surgical procedures.
   D. The defendants requested that the case be dismissed because it lacked the medical expert reports necessary for healthcare liability claims to proceed.

2. The Centers for Medicare and Medicaid Services is creating an infection control inspection survey for hospitals as part of its participation in what recently formed collaborative that includes hospitals, caregivers, patient advocates, and government agencies?
   A. Partnership for Patients
   B. Stop Hospital Infections
   C. Clean Hands Together
   D. Center for Quality Transformation

3. Which of the following were lessons learned by Michelle Kioschos, RN, CNOR, executive director at Powder River Surgery Center, after the center had flooding from a sprinkler head that was damaged during terminal cleaning?
   A. Consider water damage to be a potential risk.
   B. Know where your emergency shutoff valve is located.
   C. Work with your local firefighters to ensure they are familiar with the layout of your building.
   D. All of the above.
   E. None of the above.

4. What view does the Association of periOperative Registered Nurses (AORN) take on shellac nails?
   A. AORN considers them to essentially be nail polish, and no advice is given.
   B. It considers them to essentially be nail polish, and it says the polish should be removed and replaced when it is chipped.
   C. It considers them artificial nails, which it says should be banned in the operating room.