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AHC Media

Are staff pressured on sterilization? Intervene, or risk device compromise

Peer pressure. The problem isn't limited to middle and high schools across America. In fact, the problem has infiltrated outpatient surgery programs across the country as surgeons and other staff members pressure the central sterile supply (CSS) technicians to sterilize instruments quickly.

Where does the problem start? With facilities planning and management of reusable supplies, says **David Jagrosse**, CRCST, manager of the Central Service Department at Middlesex Hospital in Middletown, CT. Jagrosse is an executive board member of the International Association of Healthcare Central Service Materiel Management (IAHCSMM).

"More often than not during central sterile supply [processing], technicians are not involved in this planning phase; therefore, turnover times and complexity of the devices are not taken into consideration," Jagrosse says. As a result, a facility that is planning to perform six eye surgeries per day might purchase only three sets of instruments. "The facility managers think of this as a cost saver when, in reality, the stress and pressure of these turnovers can lead to high turnover rates of staff, poor teamwork, and possible patient infections which are no longer reimbursable." *(For more on planning and quality monitoring, see story, p. 51.)*

Such infections have been in the spotlight recently with a national report that surgeons are using devices contaminated with blood and other debris.[1] The report was published by The Center for Public Integrity, a Washington, DC, nonprofit that focuses on ethics and public service. The report suggests that because facilities aren't required to report contaminated devices, many incidents are unknown.

EXECUTIVE SUMMARY

A national report suggests that surgeons are using devices contaminated with blood and other debris.
- OR staff must be educated on proper cleaning and the time necessary for sterilization.
- Ensure you have an adequate number of instrument sets. Monitor surgical site infections.
- When hiring central sterile supply technicians, look for someone with 3-5 years of experience, and expect certification within 12-24 months, if not achieved already.

Sharon Greene-Golden, CRCST, FCS, president-elect of IAHCSMM, says, "The bottom line is that CSSD [CSS department] staff can't clean fast! The tech in the CSSD must take time to make sure they have followed the IFU [instructions for use] for cleaning the instruments, and the instruments must be clean." If an instrument isn't clean, then it can't be sterilized, says Greene-Golden, who is manager of the Sterile Processing Department at Bon Secours — Mary Immaculate Hospital, Newport News, VA.

The pressure to sterilize quickly is common, says **Ron V. Runyon**, CRCST, manager of supply chain/materials at St. Vincent Indianapolis (IN) Hospital. Runyon is also IAHCSMM's secretary/treasurer. "Staff must be made comfortable to express their concerns if they feel corners are being cut or demands and expectations are placed higher than achievable within the parameters given," he says. "It's a difficult position to be placed in, but the courage to speak up may save a life, on the other side of the coin."

To resist pressures, CSS techs must arm themselves with knowledge and education, Jagrosse maintains. The first step? Certification, he says.

Patti Koncur, CRCST, CHMMC, ACE, IAHCSMM's educational specialist, points to Association for the Advancement of Medical Instrumentation (AAMI) ST79 4.2.2, which recommends that "all personnel performing sterile processing activities be certified as a condition of employment. At a minimum, all such personnel should successfully complete a central service certification examination within two years of employment and should maintain that certification throughout that employment." However, since certification is not mandatory across the country, it isn't always possible to hire certified techs, she acknowledges. In the absence of certification, surgery centers, which often don't have time for on-the-job training, should look for someone with 3-5 years of experience, Jagrosse advises. Certification is preferred, but if absent, could be required within 12-24 months, he says.

Training central processing techs

The issue of training central processing technicians is "huge and never-ending," says **Darlene Stephenson**, vice president of operations at Bon Secours Mary Immaculate Hospital in Newport News, VA.

Focus on your high volume procedures, she suggests. "If you handle every piece of instrumentation, you need to understand it, and we need to educate you on the personal risk of handling contaminated devices and make sure you comply with regulations," Stephenson says.

Your total focus should not be solely on mandatory annual classes, sources say. Instead, consider local and national seminars, digital media, subscriptions to central sterile supply-related trade magazines, department in-services from the equipment manufacturers, as well as IAHCSMM membership and access to its website, Jagrosse advises. *(For information on IAHCSMM, see resource at end of this article.)*

In terms of the topics that need to be covered, Koncur says "programs in cleaning, assembly, sterilization, storage, and distribution need to be an integral part

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of any education program." Additionally, techs must be educated on the importance of avoiding pressures and following set cleaning, assembly, and sterilization instructions, she says. AAMI St79 2010 guidelines can support any resistance to deviate from established best practices, Jagrosse adds. Also, ensure you have access to instructions for use (IFU) and decontamination instructions for your devices, and that they are understandable. Make sure your instructions are updated on an ongoing basis. *(See resource at end of this article that offers electronic access to these and other documents.)*

Don't limit your education to your central sterile supply staff, Stephenson emphasizes. The OR nurses begin the sterilization process when they remove blood and bone off the instruments, she says. "Education is critical all the way across the board," Stephenson says.

Runyon says that when OR staff place impractical demands upon the CSS department, it is because they don't understand the processes and the time required. "We must educate our customer so our concerns are understood, not dismissed," he says.

Education requires the involvement of your vendor reps, Stephenson emphasizes. "With technology changing so rapidly and designs so advanced, it's critical to work closely with reps on the intricacies of equipment," she says.

At Bon Secours Mary Immaculate, 100% of new instruments are targets of vendor education, Stephenson says. The vendors provide one-on-one education, as well as group instruction, on topics such as minute areas that have to be cleaned, she says.

Education goes a long way in reducing staff turnover, which is a common problem in central sterile supply, Koncur says. "In some areas of the country a well-trained CS technician can make as much or more money working in a fast food restaurant without the stress of the CSSD daily pressures," she says.

Education, knowledge, and certification lead to competence and confidence, and greater retention, says Runyon. "It's not always about pay," he says. "It's about knowing you're making a difference and being given the work environment in which to succeed."

Workers are more likely to stay in a job where they are comfortable with the processes, Koncur says. "That includes working with service departments to keep stress at a manageable level by treating each other with respect and dignity," she says.

The easiest and least expensive method to retain staff? "Show appreciation for a job well done," Koncur says. "A simple heartfelt thank you goes a long way and doesn't cost a thing."

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RESOURCES

• One Source is an electronic database of manufacturers' Instructions for Use documents. The price for facilities of 100 bed size or less ranges from $1,776 to $3,536, depending on which databases are purchased. The price for other facilities ranges from $1,995 to $3,772. For more information, contact: Best Practice Professionals, 1800 East 900 S., Salt Lake City, UT 84108. Phone: (800) 701-3560 or (801) 582-6470. Email: contact@onesourcedocs.com. Web: Onesourcedocs.com. When sending an e-mail, provide facility name, address, your name, phone number, and e-mail.

• International Association of Healthcare Central Service Materiel Management (IAHCSMM).
Web site offers publications, frequently asked questions, information on certification, and more. Web: http://iahcsmm.org. ■

Sufficient number of instruments is key

Quality monitoring also critical

Want to avoid having dirty surgical instruments? Two critical pieces to achieving that goal are having a sufficient number of instruments and monitoring quality, according to sources interviewed by *Same-Day Surgery*.

"You get pressure to hurry up and rush," says **Darlene Stephenson**, vice president of operations at Bon Secours Mary Immaculate Hospital in Newport News, VA. "You can't cut corners in sterile processing."

Check your par level on instruments, Stephenson advises. "You want to make sure you have a sufficient number of instruments so you can control the amount of [turnaround] time and when those instruments need to be sterilized," she says. This step will help you minimize flash sterilization, Stephenson says.

Bon Secours Mary Immaculate now has a 24-hour sterile processing department, she says. "If the department runs later, there is a shorter time to turn instrumentation over if you have traditional business hours," Stephenson says. "We run 24 hours a day to ensure that when the last case ends, to when the first case starts tomorrow morning, we have had the proper resources and time to process instruments for that day."

Involve central sterile supply (CSS) technicians in the planning and design of outpatient surgery programs, suggests **David Jagrosse**, CRCST, manager of the Central Service Department at Middlesex Hospital in Middletown, CT. Jagrosse is an executive board member of the International Association of Healthcare

Central Service Materiel Management (IAHCSMM). Otherwise, "needed space and specific required equipment is often left out of the plan and only realized once the facility opens," Jagrosse says.

Additionally, OR and CSS staff should configure instrument sets so they are workable for the OR and compact in size to allow for quicker processing, advises **Patti Koncur**, CRCST, CHMMC, ACE, IAHCSMM's educational specialist. "With budgets tight and not allowing for the purchase of many expensive instruments (sets), working together to schedule the order of surgeries to allow for proper turnaround of instrumentation will also help," Koncur says. Administrators also must back up the policies for cleaning and sterilizing instruments, sources say. *(For a story about how the Food and Drug Administration and other organizations have unveiled a program to monitor medical devices used in cataract surgery to stem outbreaks of Toxic Anterior Segment Syndrome [TASS], see* Same-Day Surgery Weekly Alert, *Jan. 12, 2012.)*

Don't neglect quality monitoring

In terms of continuous monitoring, ask these questions, she advises:

- How do instruments arrive to you?
- What time do they arrive?
- When they are coming from an outside vendor for the case, ask: Do you allow enough time to process that instrument per guidelines? Are vendors working with you cooperatively? What are rules and expectations you set with them?

"They can't bring them in an hour before the case starts and think that can be processed appropriately," Stephenson says.

Monitor your surgical site infection rate, she advises: "Evaluate it through root cause analysis or failure mode analysis to determine: Where were opportunities to reduce risk of patient harm?"

Central sterile supply is a complex area, she emphasizes. "It takes continual education, oversight, and monitoring to ensure both patient and staff safety," Stephenson says. ■

Why so many outbreaks? Myths about safe injections

The Institute of Safe Medication Practices (ISMP) is focusing on unsafe injection practices, and it points out that according to statistics from the Centers for Disease Control and Prevention (CDC), these practices have caused more than 50 outbreaks of bloodborne diseases in the past 10 years.[1] More than 600 patients were infected, according to the CDC.

"These outbreaks represent only a portion of the incidence of bloodborne pathogen transmission caused by unsafe injection practices," according to ISMP.[2]

There are many misconceptions regarding safe injections practices, reports ISMP, based on its review of previously published research.[3]

Here are some examples of common misconceptions:

- **Reuse of a single-dose vial depends on the size of the vial.**

This misconception reflects the wrong believe that a large amount of medication makes it suitable for several patients, ISMP says.

- **Changing the needle on a used syringe protects against disease as long as there isn't aspiration of blood and no visible blood in the syringe.**

Disease transmission is possible when reusing a syringe even if the needle is changed. A contaminant that isn't large enough to be visible can enter the syringe after injection, especially if the needle and the syringe are still attached.

- **Any residential pathogens from the syringe are stopped by bacteriostatic or preservatives in the multi-dose vial.**

The preservatives used in multi-dose vials do not destroy all bacteria, and they don't destroy viruses or fungi. "Even if the preservative effectively stopped bacteria from reproducing, there is about a two-hour window during which contaminating organisms remain viable in a multi-dose vial before the preservative fully exerts its effect," ISMP says.[2]

3. It is safe to use saline solution to flush or dilute drugs for multiple patients as long as they are discarded after 24 hours.

"Limiting use to 24 hours does not prevent the risk of disease transmission," ISMP says.[2] In fact, using solution that is contaminated for a large number of patients can results in disease being transmitted on a large scale, the agency says. *(See the checkitout! column, p. 53, for safe injection practice recommendations. Also, the Association of periOperative Registered Nurses has released recommended practices for medication safety in AORN's 2012 edition of Perioperative Standards and Recommended Practices. To order, go to the website http://alturl.com/xapaa.)*

REFERENCES

1. Centers for Disease Control and Prevention. Guideline for isolation precautions: preventing transmission of infectious agents

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Checkitout!

Consider these recommendations to ensure safe injection practices and reduce the risk of disease transmission.

• Use aseptic technique.

Follow standard infection control policies and procedures during preparation and administration of medications to avoid contamination of sterile injection equipment, solutions, and medications. Work with pharmacy to establish policies and procedures for the preparation of any parenteral medications in patient care units.

• Never reuse needles or syringes.

Syringes and needles are both single-use devices. They should not be reused for more than one patient or reused to withdraw additional medication for the same patient.

• Never reuse a syringe after changing the needle.

Both the needle and syringe need to be discarded after a single use. Diseases can still be transmitted if the syringe or pen is reused for a different patient, even after changing the needle.

• Use pen devices as intended.

Insulin pens and other pen devices are intended for single-patient use only! They should be labeled with the patient's name and other identifying information to ensure correct use. The needle should be changed between doses.

• Use fluid infusion and administration sets for one patient.

IV tubing is a single-use, single-patient device that is directly or indirectly exposed to the patient's blood once connected. If a syringe is used to inject medication into an injection port, the tubing and syringe are considered contaminated.

• Never re-enter a vial/bag with a used needle/syringe.

Use a new sterile needle and syringe to re-enter a multi-dose vial even for the same patient.

• Never leave a needle in the septum of a vial.

Leaving a needle or other device inserted into the septum of a vial will allow microbes to enter the vial, contaminating the contents.

• Limit the use of multi-dose vials.

When used, multi-dose vials should be dedicated to a single patient whenever possible. They should be accessed using a new sterile needle and syringe each time. Once a vial cap is removed or the vial is punctured, the manufacturer's expiration date is no longer valid and a revised expiration date (not the date the vial was opened), must be documented on the label. This revised date (also called beyond-use date) should be no longer than 28 days unless the manufacturer specifies otherwise, according to The Joint Commission, the United States Pharmacopeia, and the Association for Professionals in Infection Control and Epidemiology recommendations.

• Use single-dose or single-use vials when possible.

These vials are intended to provide one dose for one patient and should be discarded after initial entry. Never administer medications from a single-dose vial or IV bag to multiple patients or combine leftover contents for later use. If medication is left in the vial, it must be discarded.

• Use prefilled or pharmacy-prepared single-dose syringes when possible.

Prefilled syringes are intended for single-use only. These devices should not be manipulated to withdraw medication for use in multiple patients.

• Never use bags/bottles of IV solutions as a communal supply.

IV bags/bottles of solution are intended for one patient and should not be used as a source of flushes, diluents, or medication preparation for multiple patients.

• Employ a mask for neuraxial injections.

Wear a surgical mask when placing a catheter or injecting material into the spinal canal or subdural space.

• Educate staff and patients.

The One & Only Campaign — ONE needle, ONE syringe, ONLY ONE time — led by the Centers for Disease Control and Prevention (CDC) and the Safe Injection Practices Coalition offers free posters, brochures, and videos for healthcare providers and patients. Visit www.oneandonlycampaign.org for these and other resources regarding safe injection practices.

Report medication errors or near misses to the Institute for Safe Medication Practices (ISMP) Medication Errors Reporting Program (MERP) at 1-800-FAIL-SAF(E) or online at www.ismp.org.

Source: Used with permission from the Institute for Safe Medication Practices. Nurse Advise-ERR 2012; 10(1):2. Accessed at http://www.ismp.org/newsletters/nursing/issues/NurseAdviseERR201201.pdf. ■

Continued from p. 52

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Patient info on Facebook traced to temp staff

'It's just Facebook ... not reality'

[Editor's note: This is the second part of a two-part series on issues surrounding social media and ambulatory surgery. In this issue, we discuss one facility's nightmare when a temp employee posted patient information on Facebook. We discuss legal issues and employee training. In last month's issue, we gave you some horror stories and told you how to avoid them. We also told you how to be proactive about your online presence, as well as how to develop a social media policy.]

One hospital's experience with a temporary employee who posted a patient's information on online — making fun of her condition and showing no remorse when challenged — is raising questions about how healthcare facilities can ensure temporary staffing agencies provide adequate compliance training.

The temp employee of Providence Holy Cross Medical Center in Los Angeles posted a photo of a woman's medical record, which clearly showed the woman's name and admission date, according to a report by the *Los Angeles Daily News*, which obtained a printout of the Facebook page before it was deleted. The photo was accompanied by the comment, "Funny but this patient came in to cure her VD and get birth control."

When others posted on the page with comments scolding the employee for violating the woman's privacy, the employee responded with "People, it's just Facebook ... Not reality" and "It's just a name out of millions and millions." He refused to take down the information, but it eventually was deleted when hospital officials were notified.

Providence immediately released a statement saying that the employee had been supplied by a temporary staffing agency and would no longer be allowed to work in any Providence facility. *(See statement, p. 55.)* The staffing agency was supposed to have trained the employee in compliance with the Health Insurance Portability and Accountability Act (HIPAA), a hospital spokesman told AHC Media, publisher of *Same-Day Surgery*.

The facility's potential liability from the privacy breach might depend on the quality and effectiveness of its HIPAA compliance polices and training, says **Philip D. Mitchell**, JD, an attorney with the law firm of Epstein Becker Green in Newark, NJ. Providence reports that its contract with the temporary staffing agency requires such training, but Mitchell says a lawsuit could hinge on whether that was just boilerplate language or the hospital actually backed it up by confirming that the agency trained people properly.

"It all depends on their existing policies and procedures," Mitchell says. "How did they hire this person, and how did they train him? If all they can say is that the contract required he be trained by the temp agency, but they didn't do any due diligence to see how that agency complies, that could be problematic. You could argue that they had a responsibility to know how these people were trained before you accept them as an employee."

Could plead willful misconduct

Mitchell notes, however, that the egregious nature of the violation could give the hospital a valid defense of willful misconduct by a rogue employee. Unlike a more nuanced violation of HIPAA, a defense attorney could argue that any reasonable person would know the posting of a medical record on Facebook was wrong, he says.

"It's such a deliberate act and out of the norm that it could be hard to hold the hospital responsible for that," Mitchell says. "This person clearly has no regard for confidentiality, and unless the hospital had some way of knowing that, they can say this was someone purposefully breaking the law regardless of what training was or wasn't provided."

Any legal action taken by the patient most likely would result in only a modest settlement, Mitchell surmises, but he notes that the hospital is taking a bigger hit in the court of public opinion. The negative publicity attached to the hospital's name could be the worst result, he says.

Not easy to escape blame

Another attorney with experience in HIPAA enforce-

ment says the facility's response that the staffing agency was responsible for training the employee might be shortsighted. The employee's comments indicated he had no understanding of HIPAA, much less any respect for it, and the hospital has to take some responsibility for that lack of understanding, says **Joseph P. Paranac Jr.**, JD, an attorney with the law firm of LeClairRyan in Newark, NJ.

"Everyone may maintain the fiction that those temporary staffers are employed only by the staffing agency," Paranac says. "But in reality, those temporary staffers are probably joint employees of the staffing agency and the hospital. I suspect that on a daily basis, these temps are taking direction from hospital supervisors, so I would make sure that everyone who comes in to the hospital as an employee, and who has access to information, receives a two-hour training course on HIPAA."

Paranac notes that HIPAA puts the onus on healthcare providers to make sure employees are trained, and that responsibility cannot be casually passed on to another party such as a staffing agency. "If you want to hold to the idea these are not your employees and so you don't want to train them, then I would send someone to the staffing agency's training class and document what you see there," he suggests. "If their training is not sufficient, you can offer to help them improve it and not accept any more employees until they do."

Policies must be in sync

In addition to the negative publicity from a privacy breach, the potential ramifications are significant. Healthcare providers and individuals such as directors, employees, or officers of the covered entity, who "knowingly" obtain or disclose individually identifiable health information in violation of the regulations, face a fine of up to $50,000 as well as imprisonment up to one year. Offenses committed under false pretenses allow penalties to be increased to a $100,000 fine, with up to five years in prison. Finally, offenses committed with the intent to sell, transfer, or use such information for commercial advantage, personal gain, or malicious harm permit fines of $250,000 and imprisonment for up to 10 years.

The "knowingly" element requires only knowledge to the actions that constitute an offense, Paranac explains. Specific knowledge of an action being in violation of the HIPAA statute is not required.

Another potential problem is that facilities often have separate policies on HIPAA compliance and social media, and the two don't always mesh well, Mitchell says. In many cases, they are drawn up by different people with different purposes, rather than having one comprehensive policy.

"Often, the social media policies are set up by marketing or the IT folks, whereas the confidentiality policy usually comes from compliance, risk management, or the general counsel's office," Mitchell says. "If they don't sync up, you have potential gaps that will be a problem when you have to show your training was adequate, and there can be ambiguities that allow employees to make mistakes." *(For information about how "user activity monitoring" can help ensure compliance with HIPAA, see story, below.)* ■

Hospital requires agencies to comply

The risk manager at Providence Holy Cross Medical Center in Los Angeles declined to be interviewed about the incident in which a temporary employee posted patient information on Facebook, but the parent company, Providence Health & Services, provided this statement:

"Providence Health & Services, guided by core values that include respect and dedicated to compliance with state and federal privacy laws, takes patient privacy very seriously and regularly trains employees on the importance of guarding patient records.

"As we reviewed this isolated incident, we worked with the staffing agency to ensure the individual is not allowed to work in the future in any Providence facility. We also reaffirmed to the agency involved in this matter that language in our standard contract with staffing agencies requires that any contract workers sent to a Providence facility recognize and adhere to all state and federal laws, particularly those protecting patient privacy.

"Providence also has a social media policy that requires employees, vendors, volunteers, and others working in the hospital to follow laws and policies designed to protect patient privacy on both public and private Web sites." ■

Activity monitoring can spot privacy breaches

With growing attention to the threat of privacy breaches through social media, some healthcare organizations are utilizing "user activity monitoring" to help ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA).

With user activity monitoring, organizations can

monitor, capture, and analyze all user and user group activity on the employer's device, including e-mails sent and received, chat and instant messages, web sites visited, applications and programs accessed, web searches, file transfers, and data printed or saved to removable devices. The system also can take screenshots of employees' activities at pre-set intervals.

McKenzie (TN) Medical Center implemented Spector360 user activity monitoring after noticing high bandwidth usage as well as issues with worker productivity. *(See resource at end of this article for information on purchasing the software.)* The medical center employs more than 30 medical providers and almost 300 support staff. Unrestricted access to the Internet, personal e-mail, and social media presented potential legal liability, and the center wanted to ensure that all employees were complying with HIPAA regulations, says **Don Page**, IT manager and security officer.

User activity monitoring allows hospitals and healthcare organizations to track employees' activity on social networking sites and receive alerts regarding potential suspicious activity based on established key words, Page says. It is also beneficial to employee training, he says, with hospital administrators able to flag issues and discuss them with employees. For example, if an employee posted confidential information on Facebook, hospital administrators can provide proof and discuss with the employee how he or she violated regulations.

With the user activity monitoring software, McKenzie was able to quickly identify more than $18,000 worth of time where employees were spending time on computer use that was not related to work. The clinic director then reminded employees of the company's Internet usage policies and spoke with offenders regarding the new monitoring process.

Since implementing user activity monitoring, McKenzie has increased productivity and reduced non-work related online activities, Page says. Not wanting to be too severe, the center also allows employees limited access to the Internet for personal reasons, such as paying bills online or visiting Facebook. Four computers have been set up in the lunch room for employees' use during their lunch break.

Although McKenzie originally implemented user activity monitoring to address productivity concerns, Page says it has become a valuable tool in HIPAA compliance. During HIPAA compliance investigations, McKenzie Medical is able to replay all activity that took place on an employee's screen or activity logs relating to alleged incident. In some instances, employees have been cleared of wrongdoing after the hospital reviewed their activity.

"Protecting our patients' privacy and ensuring that meet HIPAA compliance regulations is our foremost concern," Page says. "With user activity monitoring, we're able to address and respond to HIPAA concerns in a timely manner."

RESOURCE

• SPECTOR 360 7.3 is available for purchase at www.spector360.com or by calling SpectorSoft Corporate Sales at (888) 598-2788. Standard pricing is $115 per endpoint for a perpetual license. ■

Can your facility limit what workers say online?

When it comes to staff members and comments they might make online, there are two types you need to understand, according to **Paul A. Anderson**, director of risk management publications at ECRI Institute, a Plymouth Meeting, PA-based nonprofit organization that researches approaches to improve patient care.

The first type is named "concerted organizing activities" by the National Labor Relations Board. These comments include discussions about the terms and conditions of employment, such as wages and work hours, or complaints about supervisors, Anderson says.

"Generally speaking, there's not much an organization can do about this kind of discussion," he says. "It's legally protected, and trying to curtail it is illegal."

However, organizations can have policies that limit how employees discuss the organization's services, even when they discuss them on their personal social media profiles, Anderson says. "So, although you can't stop a nurse from going home and complaining that she's underpaid, you can most definitely stop her from going home and saying something like 'the surgeons are all incompetent there,' or 'I'd never let my own kids go here,'" he says.

Usually, if the facility's policy is clear and the employee knew about it, the organization can discipline the employee, including termination. "One thing to consider, though, is whether the organization wants to be known as 'the one that fired a nurse for a Facebook post,' because if the staff member is willing to complain about you while she's still employed, she'll definitely have something to say after you've fired her," Anderson says.

Information created or shared via social media could be subject to discovery in the event of a lawsuit, says ECRI Institute.

Tell staff: They represent you

Social media training must emphasize again and

again the need for "constant vigilance against unprofessional conduct," according to ECRI Institute's recently published guide to healthcare and social media.[1] What employees say reflects directly on the organization, the guide points out.

Mandatory training on the Health Insurance Portability and Accountability Act (HIPAA) should emphasize that all staff members have a duty to protect patients' privacy, even on their personal social media profiles, it says. This guidance includes sharing of success stories and good outcomes, the guide says. You might want a policy that requires someone familiar with the HIPAA privacy rules to review all descriptions of patients to ensure they are sufficiently deidentified, it says.

Your policy also should address whether photos can be taken and how they can be used, ECRI Institute says. "No photos of patients should be taken or used without specific authorization by the patient," the guide says. "The authorization should specify how the photo will be used (e.g., in a brochure, on a website, for clinical purposes), and staff who might seek to use existing photos for any purpose should check to ensure that the authorization covers a second use."

Also, training should include the consequences of violating patient privacy. In addition to discipline from the facility, violators could face up to a $100,000 fine, with up to five years in prison.

And your liability might not end when the employee resigns or is fired, ECRI Institute warns. "It is possible … that a healthcare organization could be sanctioned for privacy violations that occur after employment ends if it can be shown that the organization did not properly educate its staff or volunteers regarding their HIPAA obligations," it says.

HIPAA education for staff and volunteers should include a clear definition of what constitutes protected health information and a reminder of their obligation to protect a patient's privacy, even after their employment or volunteering ends. "Employees should sign an acknowledgment that they received the training and understand their obligations," ECRI Institute says.

If you become aware of violations among former employees, you might want to consider having your lawyer notify them, in writing, that they must remove the posts or comments. "They should be reminded of their ongoing obligation not to violate patient privacy," ECRI Institute says. "This could be perceived as a good-faith effort to comply with the rule should sanctions be considered."

REFERENCE

1. ECRI Institute. Social Media in Healthcare. *Healthcare Risk Control*, November 2011, Supplement A. ■

Social media helps 42% decide on surgery

Survey results released by the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS) in Alexandria, VA, showed more patients sought out social networking sites for advice and information on facial plastic surgery before choosing a procedure in 2011 than in 2010. In comparison, the percentage of patients obtaining information from friends declined between 2010 and 2011.

Academy surgeons found 42% of patients receive most of their information about plastic surgery from social media, an increase from 29% in 2010. At the same time, the percentage of patients who obtain information on plastic surgery from friends dipped to 48%, down from 63% in 2010. Most surgeons surveyed also reported 70% of their patients request procedures by describing the area of concern rather than requesting a specific product or procedure by name. Full results to the survey can be found on the AAFPRS website athttp://bit.ly/xlWyYL.

Non-surgical procedures performed by the academy's surgeons in 2011 remained steady, but continued to outnumber the amount of surgical procedures performed. The survey results also showed that 63% of procedures performed were cosmetic versus reconstructive procedures.

"We are encouraged by the possibilities that Facebook, Twitter, and other social channels offer for prospective patients, but urge all patients to exercise caution in researching facial plastic procedures to ensure information is from a reliable source," said **Tom D. Wang**, MD, president of the AAFPRS.

Reversing a trend in past years, the average costs of surgical and non-surgical procedures decreased in 2011. For surgical procedures performed by academy members, only otoplasty and implants increased in cost, while non-surgical procedures saw a minimal increase in the average cost of chemical peels (superficial). With the exception of rhinoplasty, most procedures, surgical and non-surgical, were performed on patients between ages 35 and 60.

The most common non-surgical procedures last year were Botox and hyaluronic acid injections, while the number of poly-l-lactic acid injections and fat injections increased slightly. Rhinoplasties, ablative skin resurfacings, blepharoplasties, and facelifts topped the list of surgeries. ■

Same-Day Surgery Manager

How do you keep the porch light on?

Websites draw patients to your facility

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

Way back when, most people had a porch light on their house. It was what we all did. Last night when walking my foo-foo dogs, I noticed that most people don't have their porch light on. I looked behind me at my house, and it was ablaze in petro-sucking electricity. I could hear the electric meter spinning from down the block.

I walked up to one of the houses to see if there was, indeed, a fixture still there. Suddenly the porch was aglow with light! Peeking in closer, I noticed the little motion sensor on the wall and realized that these people would light the way to their home for you, but only if you made the first move toward them. (Author note: Hang with me. I'm building up to a great analogy here!)

After a couple minutes of motionlessness, I backed up, and the light turned off. I returned home, but it did get me thinking.

If you are like many of the surgical environments out there right now, you are focusing on numbers. I love/hate numbers! If I were a presidential candidate involved in one of the debates, they would nail me with one question: "What is your stand on numbers, Mr. Earnhart?" Elective surgery is run on many things: insurance coverage, the economy, ability to get time off from work, the individual's priority (based upon pain and/or discomfort), the surgeon, etc. Nowhere do we as facilities fit in there! We are not a factor in patients having surgery. We probably never will be.

What we need to do is create an environment that, all other factors being equal, they will want to have their surgery with us! Why would they pick us? Because our porch light is on! (I did it!)

Marketing our hospitals and surgery centers is no longer an ad in the yellow pages or a blip or two in some trendy social media campaign. It is not waiting for someone to approach you before you show them how great you are. You do it to make them want you!

For example, your website. That is a beacon of light in the night, and not just to the patients. They will not go to the web site unless invited by their surgeon. You are advertising to surgeons. Splash them on your site! Link their office location, their airbrushed photo, their bios, their office staff (especially their scheduler!), their credentials, etc. When they book a case at your hospital or surgery center, make sure your website is glowing in terms of the material the patient receives. Encourage your patients to register online via your website. *(For more information, see "Online preregistration frees up phone registrars — 8% of surgical patients preregister electronically,* Same-Day Surgery*, March 2009, p. 28.)*

Link them to their surgeon. Remember that many patients are referred to a surgeon by a primary care physician; blast that person's website as well. Close the circle on the link of how that particular patient came to you. Post a video of the procedure the surgeon is going to do at your facility. Animate! If you're not sure of what I mean, go to the website of one of Earnhart & Associates clients and see what we did at http://www.sinuscenterofmaryland.com. Also, if you are a member of a state association, you might be able to link to their website, which can be especially useful if they have a "how to find a facility near you" listing.

We all want to be noticed. If one facility notices a surgeon or makes him or her look good to their patients, then they are going to direct as many cases as they can to that facility. Feed the ego! Make them look good! Look at what we did for **Gary Mason,** MD (above), and imagine what it could do for you! Don't just post Twitters and comments; go all out if you want to be rewarded! Make sure you keep your porch light burning. It is dark out 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.]* ■

TJC gives wake-up call on fatigue risks

OSHA balks at adding enforcement

Healthcare facilities have been put on alert to recognize fatigue among workers as a risk to patient safety. But for now, facilities won't face any regulatory consequences for failing to address it.

The Occupational Safety and Health Administration (OSHA) denied a petition to regulate the duty hours

of medical residents, noting that the Accreditation Council for Graduate Medical Education (ACGME) has adopted stricter duty hour limits. Instead, OSHA administrator **David Michaels**, MD, MPH, said the agency will develop guidance on "coping with the effects of fatigue and sleep deprivation."

A *Sentinel Event Alert* from The Joint Commission indicates that the accrediting body is concerned about the impact of fatigue on patient safety. But while the alert offers suggestions on fatigue management, it doesn't direct healthcare employers to limit shift length. "The purpose of the alert is really to educate and create awareness," says **Ana Pujols McKee**, MD, executive vice president and chief medical officer of The Joint Commission. Fatigue has not been widely addressed in healthcare facilities, she says.

The alert should begin a dialogue about fatigue, its impact, and ways to mitigate it, McKee says. "We ask organizations to conduct their own assessments and look at their adverse events and analyze trends and patterns where fatigue might have been [an issue]," she says. "I anticipate there will be more discussion, more information, and more opportunity to provide risk-reduction strategies."

Error rises with longer shifts

Long work hours and rotating shifts make physicians and nurses more prone to error. That fact is supported by a growing body of evidence, which is creating pressure for healthcare employers to limit shift length and overtime.

In 2004, an Institute of Medicine (IOM) panel recommended state rules to restrict nurses to shifts of no more than 12 hours in a 24-hour period and a workweek of no more than 60 hours in seven days.[1] While some states prohibit mandatory overtime for nurses, there are no limits on shift length or voluntary overtime.

Yet studies continue to show an impact on patient safety. In one study, 393 nurses kept track of their work hours and errors or near-errors for four weeks. All of them worked at least one day of overtime, and about one-third worked overtime every day they worked. More than a quarter (28.7%) reported working mandatory overtime at least once during that timeframe.[2]

The number of errors and near-errors rose with length of shift and was significantly higher for nurses working more than 40 hours or more than 50 hours a week.

Lead author **Ann E. Rogers**, PhD, RN, FAAN, Edith F. Honeycutt Chair in Nursing and director of Graduate Studies at the Nell Hodgson Woodruff School of Nursing at Emory University in Atlanta, says, "When a nurse worked 12.5 hours or longer, the nurse was three times more likely to report making an error than when they worked a shorter shift. We also found that nurses invariably worked much longer than scheduled. They got out on time once every five shifts they worked."

The Joint Commission advises healthcare providers to involve employees in designing work schedules that minimize fatigue.

For now, healthcare employers are being urged to monitor themselves. Some chief nursing officers have banned double shifts (16 hours), says Rogers. Chief nursing officers also may monitor timecards to make sure nurses aren't working excessive amounts of overtime, she says.

REFERENCES

1. Page A, ed, Committee on Work Environment for Nurses and Patient Safety. Keeping Patients Safe: Transforming the Work Environment of Nurses. Washington, DC: National Academies Press; 2004.
2. Rogers AE, Hwang WT, Scott LD, et al. The working hours of hospital staff nurses and patient safety. *Health Affairs* 2004: 23:202-212. ■

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

- Surgery center combines 3 disaster drills into one
- Boosting communication with compassion and empathy
- The latest advice for acing your deemed surveys
- Does TJC support your strategies to deal with drug shortages?

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. What does Association for the Advancement of Medical Instrumentation (AAMI) ST79 4.2.2, recommend concerning personnel performing sterile processing activities?
   A. No specific work experience, and no certification.
   B. Work experience of 3-5 years, but no certification.
   C. Working experience of 3-5 years, and certification.
   D. Certification as a condition of employment. At a minimum, they should achieve certification within two years of employment

2. How can you minimize the need for flash sterilization, according to Darlene Stephenson, vice president of operations at Bon Secours Mary Immaculate Hospital?
   A. Ensure you have a sufficient number of instruments.
   B. Ensure your staff are sufficiently trained on the potential dangers of flash sterilization.
   C. Have a policy of never using flash sterilization for the first case of the day.

3. Which of the following statements are true?
   A. Reuse of a single-dose vial depends on the size of the vial.
   B. Changing the needle on a used syringe protects against disease as long as there isn't aspiration of blood and no visible blood in the syringe.
   C. Any residential pathogens from the syringe are stopped by bacteriostatic or preservatives in the multi-dose vial.
   D. It is safe to use saline solution to flush or dilute drugs for multiple patients as long as they are discarded after 24 hours.
   E. None of the above.

4. When the medical record of a patient at Providence Holy Cross Medical Center was posted on Facebook, what did the hospital say happened?
   A. A temporary employee from a staffing agency posted the record, and the person apparently was not properly trained in privacy issues.
   B. The record was on a lost laptop computer.
   C. A longtime employee of the hospital took the record and posted it after being fired by the hospital.
   D. The record inadvertently was posted by the patient.