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AHC Media

You can obtain a million dollars without a major capital campaign

By **Joy Daughtery Dickinson**, Executive Editor

How would you like to save your facility a million dollars annually without any major capital money being spent? Bethesda North Hospital in Cincinnati, OH, accomplished that feat by simply purchasing a modern control system for its heating, ventilation, and air conditioning (HVAC) system that helped it to reduce its energy use by 30%.

Like many healthcare facilities, Bethesda North had undergone many renovations and expansions over the years, moving from 150,000 square feet to a million square feet. Each time the facility expanded, it typically added an air handling unit to serve the new parts of the buildings. The result was freezing cold temperatures in the lobby on one side of the building.

"The poor people at the registration desk were wearing coats," says **Rich Hertlein**, manager of engineering and maintenance at Bethesda North Hospital. The hospital hired a consultant: Dan Buchanan of Pathian in Cincinnati (http://pathian.com). Buchanan identified the problem as the "stack effect," similar to

This month: Million dollar cost-saving and revenue generating ideas

This month's issue is one of the most anticipated of the year because it's full of ideas to cut costs and generate revenues at your facility. In our cover story, we share big and small environmentally friendly ideas that can save you money every year. In this issue, we also tell you how a patient care intern program offers an easy, inexpensive way to hire new employees. Our SDS Manager column tells you about 10 "silent" expenses that could be hurting your bottom line. We also give you several ideas for generating money, including a way to avoid going through the expense of setting up your own foundation. We even have a special offer for Same-Day Surgery subscribers to renew their newsletter subscription or order a webinar series! ■

the effect from a chimney. When there is a vast difference in temperature inside a building and outside, the top of the building is at positive pressure, and the bottom is a negative pressure. The result is that air gets sucked out of the building, Hertlein says.

Instead of buying new air handling units and new chillers, the hospital staff learned how to operate the existing units better. "A modern control system allows us to give a common signal, or orchestrate the operation of all the different air handling units, so they operate in unison instead of against each other," he says.

Once the hospital was able to control the amount of air being released to the outside, it was able to better control the amount of air that was pulled in and conditioned. "That's where the major cost savings and energy reduction has come," Hertlein says.

Hospitals and surgery center leaders are learning that reducing energy use and other environmental efforts can result in significant cost savings. Beaumont Health System in Detroit reports savings hundreds of thousands of dollars by using the Japanese "kaizen" approach that targets efficiency, quality, and productivity.[1] Kaizen is a process-improvement initiative by a group of staff members, sometimes with the help of outside experts, who look at every piece of facility operations as they look for inexpensive, easy ways to improve efficiency, reduce waste, and boost quality.[1] Beaumont has environmental kaizen teams made up of staff from various department as well as third-party staff who work in facility management. Every month, different people are selected to serve on teams that walk inside and outside of Beaumont's three hospitals and surgery center. They look at every aspect of operations to see if water and utility costs can be reduced. They look at specific areas and educate staff there about changes. For example, the system found that replacing T12 light bulbs with T8 bulbs, which are more energy-efficient, in several areas saved about half a million dollars annually.[1] Inexpensive timers allow coffee pots to automatically start one hour before employees arrive and turn off when they leave. The estimated annual savings is $34,000.[1] Here are some of their other changes:

- **Reduced items in surgical packs.**

All 40 custom surgical packs were reviewed over three days, "and during that time we had nurses and surgical technologist from each specialty review their specific pack," says **Patricia Bechtel Cady**, BSN, RN,

EXECUTIVE SUMMARY

Healthcare facilities report that they are realizing savings of up to a million dollars annually through efforts that target environmentally friendly practices such as energy and water reduction, as well as recycling.

- One facility purchased a modern control system for its heating, ventilation, and air conditioning (HVAC) system that helped it reduce its energy use by a million dollars annually.
- The same facility saved $34,000 with inexpensive coffee pot timers and half a million dollars with more energy-efficient light bulbs.
- Simply adding recycling containers saved one healthcare system hundreds of thousands of dollars.

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Questions or comments? Call Joy Daughtery Dickinson at (404) 262-5410.

CNOR, ONC, nurse clinician in the operating room at Beaumont Hospital, Royal Oak, MI. "It allowed the OR staff to take responsibility and give input as to what goes in the packs."

The hospital deleted products from the packs that were not being used and put in the trash. "We used the 80% rule: If you use the items 80% of the time, then it was to stay in the packs," Bechtel Cady says.

• Increased recycling from 40 tons a month to 120 tons a month.

The increase in recycling translates into $80,380 in avoided costs associated with not paying for dumping charges at the landfill and an additional savings of $53,484 from recycling, says **Geraldine Drake**, NCIDQ, LEED green associate, interior design program and standards manager, real estate development and planning at Jones Lang LaSalle at Beaumont Health System. The system spent about $100,000 for recycling containers and carts.

Bechtel Cady said staff members at the Beaumont West Bloomfield Ambulatory Surgery Center are recycling many materials. These include sterilization wrap, plastics, balanced salt solution (BSS) glass bottles for eye cases, cardboard, plastics, and batteries. "They also have the reprocessing bins at their facility for reprocessing of single use devices [SUDs]," Bechtel Cady said. *(For information on how another hospital system saved with recycling, see story, right.)*

• Reduced water consumption.

When staff members were washing their hands at sinks, approximately four to five gallons of water were used per minute because the faucets ran continuously. Food pedals were installed and reduced the average amount of water used to 1.5 gallons per minute when someone is using the sink.[1]

The Kaizen teams realized that the hospital system's irrigation systems were watering rocks and sidewalks and overwatering shaded areas. The teams redirected and cut back on water use in those areas. Also, an inexpensive water-collection system helped. Implementing these changes helps the hospital system save more than 468,000 gallons of water every year.[1]

Communication is a critical piece of the cost savings, say those involved in Beaumont's efforts.[1] For example, members a kaizen team had removed some light bulbs that they decided were unnecessary. A maintenance employee replaced them.

Also, ensure your efforts don't compromise job performance, employee comfort, or operational standards, say leaders of the Beaumont effort.[1]

REFERENCE

1. Staton G, Winokur K. 5 lessons from the Japanese "kaizen" approach to sustainability. Dec. 3, 2013. Accessed at http://bit.ly/1eN3wnu.

RESOURCE

The **American Society for Healthcare Engineering** outlines many energy-saving strategies on its recently expanded Sustainability Roadmap website at sustainabilityroadmap.org. ■

Johns Hopkins reduces amount of trash by 17%

Officials at The Johns Hopkins Hospital (JHH) have decreased the amount of trash they produce each month by 17% (200,000 pounds) after a system-wide rollout of a thousand recycling bins.

The campaign began in October 2012. "We began working to reduce our hospital waste by 15%." said **Kristian Hayes**, MPH, assistant director of general services at Johns Hopkins Medicine. "By February, we'd already exceeded that."

In addition to reducing overall hospital waste, JHH has dramatically reduced regulated medical waste since last fall, Hayes said. In September 2012, regulated medical waste was more than one-third of the total waste produced at the hospital. By February 2013, the figure was reduced to less than 14%.

"This was mostly done by changing habits — not by spending money," Hayes says.

JHH had recycled for years, but in a less-coordinated way. "When we discussed putting a plan in place, we found that there was a real appetite for it from the hospital community," Hayes said. "The 'going green' movement meant that a lot of people were already used to recycling in their homes, so when it came time to implement our plan, it happened really quickly."

Reducing hospital waste is just one of the goals in a plan set forth by the Johns Hopkins Health System's Sustainability Network. The network, a group of concerned Hopkins leaders and vendors, released an environmental plan in mid-2011 with the goal of using natural resources responsibly, increasing recycling, and making sustainability an institutional top priority.

Next steps for the sustainability network include conserving energy and water across the entire health system.

"The key is to make it as easy as possible, and that's how the plan is designed," Hayes said. ■

Hospital saves money: uses patient care interns

When hiring for a patient care intern (PCI) program at Riley Hospital for Children at Indiana University (IU) Health in Indianapolis, the hospital prefers RN students who already have completed the OR elective. The OR elective closely mirrors the "Periop 101: A Core Curriculum" course offered by the Association of periOperative Registered Nurses (AORN). *(For more information, go to http://bit.ly/1dOINz2.)*

"This results in substantial cost savings for us," says **Amy Boone**, MBA, BSN, RN, administrative director of Riley Perioperative Services. "This means minimal investment for us, and the PCI is able to 'hit the ground running' after initial orientation to the department." In last month's issue of *Same-Day Surgery*, in our annual salary survey report, a source estimated that the savings to facilities for not having to perform a full-blown orientation is $10,000 to $30,000. *(For more information, see "Can't find nurses for your program? These surgery programs grow their own," January 2014* SDS *supplement.)*

The PCIs who have not had the course need to be oriented about the basics, such as sterile technique, the opening of supplies, assistance for anesthesia, room equipment and devices. "It is what we would teach a new patient care assistant coming into the OR," Boone says.

The perioperative services department has four PCIs. They work at least eight hours per week and are paid $9.30 to $15.04 an hour.

IU has a systemwide PCI program. The PCI program has been adapted for Riley Hospital for Children, which is a smaller, more specialized facility. For example at Riley, PCIs provide support to the OR team, but they don't document.

Some OR staff, including many nurses, are less receptive to students than others, Boone warns. She has emphasized the impact of self-motivation to the PCIs. "We find that students who are truly motivated to learn and gain experiential knowledge have a much better learning experience and as a result are more satisfied as employees," Boone says.

The results are dramatic. "Of our 12 new employees, five were PCIs in the program," Boone says. *(Boone has shared several documents related to her PCI program, which are available with the online issue of* Same-Day Surgery.*)*

SOURCE

• **Amy Boone**, MBA, BSN, RN, Administrative Director, Riley Perioperative Services, Riley Hospital for Children at IU Health, Room RI 2031, Indianapolis, IN. Phone: (317) 944-9971. E-mail: aboone@iuhealth.org. ■

Same-Day Surgery Manager

Silent expenses eat away at profits

By **Stephen W. Earnhart,** MS
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It's pretty easy to control costs you are aware of and see every month, but what about those expenses you don't see? What about those expenses that you don't think about or would not even consider an expense? They're eating your profits just as quickly as overtime and supplies. They are the silent expenses you rarely think about. I have listed a few of them, in no particular order, for you to consider:

• **Re-credentialing.** Just about anyone who touches your patient who is not an employee must be credentialed. You did this years and years ago with surgeons, RN first assistants, anesthesia personnel, etc. Every couple of years they need to be re-credentialed, even if they have not been there or are no longer active or haven't done a case in forever. That re-credentialing costs money! Go through your list of credentialed personnel and see who can come off of the list going forward and save time for your re-credentialing staff. Remember: When you save time, you save money.

• **Initial credentialing.** The average cost to credential a surgeon or anesthesia provider is becoming expensive as the "primary source verification" process becomes more and more of an issue. Surgeons who aren't really surgeons sneaking into your facility have created more of a legal liability that you are paying for as a result. Consider a new applicant to your facility paying for their credentialing or at least a portion of that process. You don't want to scare them away, but you also need to make a profit. Unnecessarily credentialing a surgeon who might never step foot into your

facility is a waste. Also, if you have a new anesthesia group covering your facility, don't think you need to credential all 76 of them. Insist upon only those who will be rotated through.

• **Vendor access.** Every time a vendor enters your facility, it costs you money. You are paying for those meals and doughnuts in other ways. We all need our vendors, and most are helpful in getting us out of tight situations at times; however, set some boundaries for them. No vendor should be allowed to simply walk into your facility without an appointment. We all know that there are some vendors who can slide a product in without us being aware that we ordered it. Don't see vendors when you know your schedule is going to be hectic or you will not have time to sit down and really listen to what they are pitching. Schedule around your convenience and not when they "happen to be in the area." *(For more on handling vendors, see stories in December 2013 and January 2014 issues of Same-Day Surgery.)*

• **Rotate your supplies.** First in, last out (FILO). Supplies outdate quicker than you think. Sending back supplies because of outdates is expensive and often unnecessary if you rotate your supplies as they come in. FILO makes cost-control simpler. Educate your staff.

• **Chasing phantom surgeons.** How much time have we all spent chasing the surgeons who say they are interested in doing cases at your surgery center or hospital but never do? I am guilty, for sure. How many dinners do you buy them? How many phone calls do you make? How much time do you spend in their waiting room before you see them to pitch, once again, the merits of your hospital or surgery center? What works for me, after many years of doing it wrong, is only three attempts. At the third meeting, I simply let them know that this contact is my last one with them outside of the hospital or surgery center. The next time we meet will be at the facility or not at all. I'm surprised, but it works if they are serious about doing cases there. If not, you have saved time and money. Again, time is money.

• **Wasted equipment purchases.** We all have equipment our surgeons insisted we buy that they saw at some trade show. We have all heard that it was going to increase their cases by 200%. We all have trouble finding a place to park it in a dark room, and then they use it only once or twice. Challenge the surgeons on these purchases (and anesthesia can be just as bad)! Insist on a simple statement by them that documents that if you buy this equipment, they will use it a minimum of XX times on new patients. Get it in writing! It is not a contract or binding or anything legal; it's more like a pledge. It will take you a while to get this pledge from them, if ever, but during that time the excitement of the new toy will wane and probably, and appropriately, go away, saving you thousands.

• **Staff apathy.** It cost you more than you might think. This trait can cause significant decreased productivity and can be expensive. Most of the time, the staff member is simply bored. Motivate or eliminate staff members by giving them specific goals or tasks that are different from their day-to-day ones. When they reach the goal or finish the task, reward them! Give them movie tickets, a promotion, an extra day off, a small trophy, or anything else that demonstrates to them and to others that they are being acknowledged for something special.

• **Let others pay for your stuff.** Stop paying for new canned pictures in your lobby when there are artists everywhere that would love to display their art in your facility free of charge! They are out there. Look for them, and also ping your own budding artists among your staff and surgeons. Let them come in and change out your drab store-bought pictures. Magazine subscriptions are expensive. Let local vendors (local and franchised pharmacies love this!) buy them and put them in neat, orderly jackets for your waiting room. They also will maintain and rotate them. Your patients love them, and it cost you nothing to stay up to date on publications.

• **Ask and ye shall receive.** Need something for your department or facility that you don't want to spend money on yourself? If you need a new TV in the lobby or lounge, electronic medical record software, a cable subscription, uniforms, just about anything you can think of, ask for it! You would be amazed at the things that stores and vendors will donate to your waiting room, lounge, locker room, parking lot, and supply rooms. They will donate just about anything, and it cost you nothing. Advertising outlets are huge with vendors. They are looking for areas to promote their services and goods. Let a local business sponsor your next board meeting, or staff meeting, or party. All you need to do is ask!

• **Spend money to save money.** It seems as if when businesses, including us, are trying to save or control their costs, they cut back on marketing and staff education and training. This mistake is the worst one you can make. An educated staff is a cost-effective staff. Spend money on educating them so they can become rejuvenated at their job and can find other products that work better and are less expensive. Newsletters and meetings — local, regional, and national — truly do make a difference. Spend money where it does the most good. *[Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Earnhart*

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Need a zero cost way to provide free surgeries?

Set up a donor-advised fund in a community foundation

In the past, it's been much easier to provide free surgery to uninsured persons in your community because pharmaceutical companies and medical device manufacturers were free to donate to such efforts. However, new federal regulations have impacted such donations, which makes it more difficult for outpatient surgery programs to provide such surgery.

"The cost of providing free surgery just went up," says **David W. Shoemaker**, MD, founder/director of cataract and lens replacement surgery at the Center for Sight in Sarasota, FL.

At the same time, large numbers of persons are unemployed or have lost their health insurance. Shoemaker's facility has come up with a solution that could be replicated across the country for any type of surgery or medical care. The solution was to set up a donor-advised fund in an already existing community foundation, Gulf Coast Community Foundation. The other option, setting up a 501(c)(3), is fairly complicated and expensive, he says. By going to an existing foundation, your administrative costs are almost zero, Shoemaker says. "The end result is that 100% of all money donated goes directly toward purchase of necessary supplies for surgery," he says.

The community supports the foundation through tax-deductible donations. Two days a year, the center offers free eye surgery to patients who have a surgically correctible condition and no others means to pay, Shoemaker says. The program has existed for 16 years, and the total value of donated services is $2.4 million.

EXECUTIVE SUMMARY

With the lack of contributions from vendors to provide free surgery for uninsured patients, one center set up a donor-advised fund in a community foundation so that 100% of donations go toward the free surgeries.

- "Dinners in the Dark," in which attendees are blindfolded during wine tasting in order to experience blindness, can raise funds.
- Provide testimonials at fundraisers and on the web site.
- Ensure your community foundation is willing to do the work to assist.

The center piggybacks much of their effort onto the Mission Cataract campaign that already has a national reputation. (Web: http://www.missioncataractusa.org.) However, the Center for Sight has expanded its free surgeries beyond cataracts. To publicize the surgeries, employees wear buttons that say, for example, "Ask us about Mission Cataract – Miracles still happen." Also, the center uses banners and newspaper advertisement to solicit patients, says **James Dawes**, chief administrative officer at the Center for Sight. The center also reaches out to community shelters, religious organizations, and referring doctors to spread the word, Dawes says.

Money has been raised for the foundation in a variety of creative ways. When Shoemaker was married a couple of years ago, he asked for contributions to the foundation as wedding gifts. The fund is publicized through office materials, he says. "People who are sitting in our reception area are touched by it and want to help out," he says.

The foundation also has sponsored "Dinners in the Dark." Members of the community are invited to a dinner, as well as a blind tasting at which they are blindfolded so they can experience blindness temporarily and understand the purpose of the foundation. Additionally, they hear recorded testimonies from patients whose lives have been changed. The testimonies also are available on the foundation web site: cfsfoundation.org. Social media, including facebook, also has been used to drive traffic to the web site.

One caveat to keep in mind when setting up such a fund is that you need a good community foundation as a partner, Shoemaker says. "It's not necessarily simple for them to do this," he says. "They have to want to help you."

The advantages of such a program extends to your employees, Dawes says. "We really are connecting to the community, and we see how we're changing people's lives," he says. "It helps them connect spiritually to their career choice, whether they are at the front desk, or a scrub tech, or an optometrist or surgeon." *(For information on how a foundation can be set up to award scholarships, see "ASC foundation awards $58,000 in scholarships,"* Same-Day Surgery, *December 2012, p. 133.)* ■

Training is key to collecting pre-surgery

Greensboro, NC-based Cone Health Systems recently revamped its processes for upfront collections and reduced denials for scheduled surger-

ies and outpatient appointments by creating a new department named the PreService Center.

"Some benefits of the PreService Center include educating our patients prior to the visit of their benefits, copays, out-of-pocket amounts, and co-insurance responsibility," says **Sebrena Johnson**, team lead specialist. "Due to the training, staff are more confident in their new roles. They have a better understanding of the necessity of upfront collections and reducing denials."

The PreService Center staff receives ongoing training on customer service and effective collection processes, including verification of insurance and using credit card machines. "We are noticing successful results are coming from educating the staff and making sure staff are prepared with accurate information prior to contacting the patients," says Johnson.

The PreService Center is collecting for outpatient and inpatient surgeries and outpatient scheduled appointments for MRIs, CT scans, ultrasound, and vascular studies.

Employees are more comfortable in collecting because they can explain the information to the patient with greater confidence.

"Even though our collections have increased immensely, there is still opportunity to bring in more revenue," says Johnson. "It is an ongoing training and learning process."

Having your billing office track the percentage of anticipated copays and visit fees that are collected pre-surgically will help you and your staff members know how they are responding to education and collection activities, sources say.

Have staff learn from top collectors

One of the most powerful tools to use when requesting monies from a patient is silence, says **Aaron Robison**, CHAA, a patient financial advocate at University of Utah Health Care in Salt Lake City.

When asking for a copay, he says, "It looks like you have a $40 copay due today. How would you like to pay it?" He then waits patiently for the patient to respond.

"Waiting for patients to break the silence, instead of doing so myself, usually results in them responding with a form of payment," he says.

Robison says if he were to break the silence first by saying, "Are you able to take care of this today?" "then the patient has been given an easy out of the responsibility, by simply saying that they cannot pay anything at that time."

Robison suggests looking within the department for someone who successfully collects from patients, so others can learn from that person. "Having a fellow coworker give tips or advice on how to better collect from patients could possibly work better than an outsider," he says. "Your coworker knows the intimate workings of the department."

Working alongside a successful collector can also give a team member phrases or methods that they didn't know about before, at a very low cost to the department, he says.

Robison says that the simpler your approach, the more likely you will collect from a patient. "Both tone of voice and eye contact can make or break your opportunity for getting anything from a patient," he adds.

By maintaining eye contact and voicing your request in a steady and firm manner, Robison says you are communicating to the patient that this request for money is part of their responsibility and participation in their care. He uses these words: "Your insurance has determined that for a certain procedure your responsibility will be XX."

By telling a patient this information, Robison reminds the patient that the insurance company makes the rules as to what amount the patient pays. "The healthcare provider doesn't determine what you will owe. That's up to your coverage plan," he says. ■

Creative fundraising: Farmers give gift of grain

One Iowa hospital foundation has involved its local farmers in a creative way to raise funds to build a new surgery center and clinic and make renovations to the hospital. Farmers are given the opportunity to pledge a portion of their grain toward a capital campaign fundraising effort. At press time, 11 farmers had donated $18,000 worth of grain, and more donations were expected.

Farmers were requested to donate harvested or stored bushels to the Harvest for Your Hospital program by the Floyd Valley Hospital Foundation in Le Mars, IA. The campaign included the statement "Leave a legacy, one bushel at a time."

The hospital developed a pamphlet, then spread the word about the grain campaign through local radio, the state corn growers association, and the local farm bureau. Farmers were given the option of donating grain at 17 area elevators. In return, the farmers potentially could avoid federal and state income taxes as well as self-employment taxes on those gifts, said **Chuck Jespersen**, manager of the Floyd Valley

Hospital Foundation. They also might be able to deduct input costs, Jespersen said.

He contacted all of the local grain elevators to set up accounts. Some of the elevators allowed him to post a banner saying the hospital was accepting donations. Farmers were asked to contact Jespersen about wanting to make a gift. The farmers told the elevator workers that they wanted to gift grain to the foundation's account. The elevator staff gave receipts for the donated bushels. The elevator sent the contract-to sell for signature to the foundation to sell the grain. The grain elevator issues the check for the sale to the foundation along with the "bill of sale" indicating the number of bushels and the sale price. *(For more information, go to http://bit.ly/1b31knP.)* ■

'Toast and Taste' raises funds for surgery center

Shriners Hospitals for Children in Erie, PA, recently raised $2,300 for its Erie Ambulatory Surgery Center and Erie Outpatient Specialty Care Center with a "Toast and Taste" beer, wine, and food pairing event. All of the food and alcohol was donated by 17 local restaurants, wineries, and microbreweries.

The businesses developed unique food and beverage pairings. Individuals circulated among the participating establishments and sampled the pairings. A DJ provided music. The event included a silent auction of donated prizes. Many of the prizes were gift packages. For example, an Elton John package included two tickets to his Erie concert and a copy of his newest CD. The silent auction also included two large gift packages of toys: one for a girl and one for a boy. Another popular item was a large handcrafted ceramic bowl donated by a local artist.

Tickets were $25 and sold at the hospital, the event location, and the branches of one of the bank corporate sponsors.

The three-hour event was held on a November Sunday at a train station now used primarily for social events. "It was held on a Sunday afternoon because we felt people are often looking for things to do on Sunday afternoons, especially now that the weather has turned cold and outdoor activities are very limited," says **Bob Howden**, MS, public relations manager at Shriners Hospitals — Erie. "We expect to continue to hold it on Sunday afternoons," Howden says.

Expenses for the event included graphics/printing for the mailed announcements, posters, and tickets; rental of the venue; Department of Health food license fees; and supplies such as plastic dishes, plastic utensils, and napkins. Corporate sponsors contributed funds and services. "For example, one of the local TV stations contributed production and airing of 30 event promos," Howden says. The event also was promoted through news releases and on social media.

Shriners Hospitals – Erie expects to make this event an annual one. ■

SDS publisher offers discounts

As part of this month's issue's special focus on cost savings, AHC Media, publisher of *Same-Day Surgery* and dozens of other educational materials for clinicians and managers, is offering the following discounts for our readers:

• *Same-Day Surgery* newsletter. *SDS* subscribers are being offered a one-time renewal price of $349, which is approximately one-third off the regular price. To obtain the discount, call (800) 688-2421, ask for Sharon, and use code SDS33 to receive the special rate.

• Ambulatory Surgery Center Series (webinars). *SDS* subscribers are being offered access to the webinar series, originally priced at $2,244, at a 60% discount price of $898. For more information about the webinar or to subscribe, go to http://bit.ly/1kVL2mo. To subscribe, use coupon code SDS-SUB60. ■

ASCA disappointed with final payment rule

The Ambulatory Surgery Center Association (ASCA) expressed extreme disappointment over the final calendar year (CY) 2014 hospital outpatient and ambulatory surgery center (ASC) payment rule (CMS-1601-FC) from the Centers for Medicare & Medicaid Services (CMS).

ASC payment rates will increase by 1.2% in 2014. This increase is based on a projected rate of inflation of 1.7% minus a 0.5 percentage point productivity adjustment required by the Affordable Care Act, according to the ASCA. This payment update is higher than the 0.9% update in the proposed rule.

"While we are pleased to see a slight increase in our payments over the proposed rule, sequestration will still result in a negative update for ASCs in 2014 unless Congress acts," said ASCA CEO Bill

Prentice. "As usual, we are extremely disappointed that CMS continues to undervalue ASC payments by using the CPI-U [Consumer Price Index for All Urban Consumers] to update them, a factor that even their own actuaries believe is inappropriate. Using different update factors for ASCs and HOPDs [hospital outpatient departments] widens the gap between HOPD payments and ASC payments, further incentivizes a disturbing trend of conversions of ASCs to HOPDs, and increases costs to the Medicare program, its beneficiaries, and taxpayers who support the program."

Quality measures finalized

CMS also finalized three of the four new quality measures that were in the proposed rule, according to the ASC Association. The new measures, which will affect payment in CY 2016, with data collection beginning in CY 2014, are as follows:

endoscopy/polyp surveillance: appropriate follow-up interval for normal colonoscopy in average risk patients;

endoscopy/polyp surveillance: colonoscopy interval for patients with a history of adenomatous polyps — avoidance of inappropriate use;

cataracts: improvement in patient's visual function within 90 days following cataract surgery.

Although the three measures were finalized, the rule indicates centers will be required to report only on a sample of cases for each measure, the ASCA said. Sampling specifications will be published later in the ASC Quality Reporting Specifications Manual on the QualityNet web site (https://www.qualitynet.org).

"We regret that CMS has rejected our very valid concerns about the new quality measures it has proposed, burdening ASCs to provide data on three measures that the facilities do not routinely possess," said Prentice.

CMS did not finalize the "complications within 30 days following cataract surgery requiring additional surgical procedures" measure that was included in the proposed rule. Thus, for now, ASCs will not be required to report this information, the ASCA said. *(For more information on quality rules, see resource at end of story.)*

CMS also finalized its proposal to exempt smaller facilities, defined as those ASCs with fewer than 240 Medicare claims per year, from complying with the quality reporting requirements.

Although there were no new procedures in the proposed rule, CMS did move the following four codes to the ASC setting in the final rule: 27415, osteochondral knee allograft; 27524, treat kneecap fracture; 60240, removal of thyroid; and 60500, parathy-roidectomy or exploration of parathyroid[s].

To read the fact sheet on the CY 2014 final rule with comment period, go to http://go.cms.gov/18iCoM6. The final rule with comment period and final rules appeared in the Dec. 10, 2013, Federal Register and can be downloaded at http://1.usa.gov/1d3PQW3 *ation on how the final rule impacts hospitals, see story, below.)*

RESOURCE

The Ambulatory Surgery Center Association has posted ***2014 Final Rule Quality Reporting FAQs.*** Web: bit.ly/1bTKqhz. ■

Hospitals disappointed with final payment rule

The final calendar year (CY) 2014 hospital outpatient and ambulatory surgery center (ASC) payment rule [CMS-1601-FC] indicates that the Centers for Medicare & Medicaid Services (CMS) "will move forward with sweeping changes that may hurt hospitals' ability to provide outpatient care," said **Rick Pollack**, executive vice president of the American Hospital Association (AHA). He said the AHA is "extremely disappointed."

Provisions in the final hospital Outpatient Prospective Payment System (OPPS) rule package the payment for multiple supporting items and services into a single payment for a primary service, similar to the way Medicare pays for hospital inpatient care, according to CMS. Supporting items and services that will be included in a single payment for a primary service to the hospital and not paid separately include the following:

- drugs and biologicals that function as supplies when used in a surgical procedure, including skin substitutes;
- drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure;
- device removal procedures;
- certain clinical diagnostic laboratory services;
- certain procedures that are never done without a primary procedure (add-ons).

Also, CMS will finalize its comprehensive ambulatory payment classifications (APCs) to replace the existing device-dependent APCs, such as cardiac stents and defibrillators, but has delayed their implementation until Jan. 1, 2015.

Pollack said the AHA is glad that CMS won't be

collapsing its codes for emergency department visits. However, he says, "we are very concerned that CMS is moving forward with consolidating all outpatient clinic visit codes into a single code representing a single level of payment. Hospitals that provide care for large numbers of complex patients will receive payment well below the cost of treating these patients."

Pollack said CMS might not have used accurate information in developing the policies. He also expressed concern "that hospitals will have neither the time nor the data to understand how these changes will affect their ability to provide patient services"

"In adopting these proposals, CMS has put hospitals in the difficult position of having only 35 days to implement significant changes in Medicare's policies, procedures, and payment formulas," he said.

Pollack also expressed disappointment that CMS is moving forward with enforcing its direct physician supervision policy. "Given the shortage of medical professionals, this policy may force small and rural hospitals and critical access hospitals to limit their hours of operation or cut services to comply with the provision, resulting in reduced access to outpatient care in communities across America," Pollack said.

CMS increased overall payments for hospital outpatient departments (HOPDs) by an estimated 1.7%. The hospital increase is based on the projected hospital market basket of 2.5%, minus a 0.5% adjustment for economy-wide productivity and a 0.3 percentage point adjustment required by statute.

To read the fact sheet on the CY 2014 final rule with comment period, go to http://go.cms.gov/18iCoM6. The final rule with comment period and final rules appeared in the Dec. 10, 2013, Federal Register and can be downloaded at http://1.usa.gov/18D2a0n. Comments are due by Jan. 27, 2014. ■

N95 use questioned for surgical smoke

More data needed, CDC panel decides

Surgical smoke plumes might contain intact viral DNA, but with no definitive evidence to show it's infectious, a federal advisory panel said the use of N95 respirators during smoke-generating procedures is not warranted.

The hazards of surgical smoke have long been a concern of perioperative nurses. The Association of periOperative Registered Nurses (AORN) recommends the use of smoke evacuation systems for electrocautery and laser procedures and says facilities "should consider" N95 respirators as personal protective equipment when procedures involve infectious material.

The issue before the Healthcare Infection Control Practices Advisory Committee (HICPAC), an expert advisory panel to the Centers for Disease Control and Prevention, related to laser and electrocautery procedures for human papilloma virus (HPV), such as smoke-producing procedures to remove HPV warts. A CDC research review of 25 articles found evidence of whole HPV genome in smoke plume. In one study, viable bovine papilloma virus was generated in smoke plume and then injected into cows. All three of them acquired the infection. But that didn't mimic occupational exposure, and other studies did not clearly show a link between occupational exposures and HPV infection, said **David Kuhar**, MD, medical officer with CDC's Division of Healthcare Quality Promotion.

"The epidemiology of disease is not here," says Kuhar. "With that piece missing, it makes it difficult to say there's disease transmission happening, because it hasn't been demonstrated.

Case reports also are lacking, he says. "We've had 20 years of these exposures happening and no clear signal of disease," he says.

Smoke evacuation use lacking

Nurses have long complained about irritation from surgical smoke plume, including exacerbation of asthma and allergic sensitivities. A 2010 web-based survey found that only about one in four (24%) of OR nurses said smoke evacuation was used "always" or "often" during cosmetic or plastic surgery that involved electrocautery or electrosurgery.[1]

The National Institute for Occupational Safety and Health (NIOSH), a division of the CDC, recommends the use of smoke evacuators within 2 inches of the surgical site in laser or electrosurgery procedures. There is no regulation from the Occupational Safety and Health Administration (OSHA) related to surgical smoke.

In a 2001 health hazard evaluation at a Virginia hospital, NIOSH researchers found formaldehyde, acetaldehyde, and toluene in OR air samples during five procedures that used electrocautery. Half of the OR nurses, technicians, and nurse anesthetists said they had symptoms associated with surgical smoke, including physician-diagnosed asthma.[2]

Amber Jones, MSN, RN, CNOR, CIC, CPN, a perioperative nursing specialist and AORN liaison to HICPAC, said she was glad that the panel addressed the issue. "The message is getting out about the haz-

ards of surgical smoke," Jones says. "We feel that further research is needed on this topic."

Several toxic and carcinogenic chemicals have been detected in surgical smoke, and as Kuhar noted in his HICPAC presentation, "live and infectious HPV seems likely to be in smoke plumes."

HICPAC members agreed that smoke evacuation is important, but they worried that respirator use could have other consequences, such as healthcare workers touching their faces with contaminated hands to adjust uncomfortable respirators. "We have to base [recommendations] on the risk we think is associated with exposure," said **Mark Russi**, MD, chair of the Medical Center Occupational Health section of the American College of Occupational and Environmental Medicine (ACOEM) and director of occupational health at Yale — New Haven Hospital. Russi is the ACOEM liaison to HICPAC.

"The data are pretty scant … on the impact of respirator use in operating rooms," he said. [Editor's note: AORN provides a free surgical smoke toolkit that includes a sample policy and awareness posters at www.aorn.org/smoketoolkit.]

REFERENCES

1. Edwards BE and Reiman RE. Comparison of current and past surgical smoke practices. *AORN Journal* 2012; 95:337-350.
2. King B and McCullough J. Health Hazard Evaluation Report 2000-0402-3021, National Institute for Occupational Safety and Health. November 2006. Available at http://www.cdc.gov/niosh/hhe/reports/pdfs/2000-0402-3021.pdf. ■

39-year sentence given in HCV infection case

(Editor's note: The following story was reprinted from the HICprevent *blog, also published by AHC Media. To access the blog, go to http://hicprevent.blogs.ahcmedia.com.)*

The med tech who caused some 45 hepatitis C virus (HCV) infections by diverting and contaminating drugs in numerous hospitals has been sentenced to 39 years in prison.

David M. Kwiatkowski, who worked in hospitals in eight states as a traveling medical technician, was sentenced Dec. 2 in Concord, NH, after pleading guilty.

U.S. Attorney John P. Kacavas of New Hampshire said the sentence sends a strong warning to healthcare workers who might be tempted to steal or divert narcotic painkillers and other drugs from patients, the New Hampshire Union Leader reported.[1] "Those who are contemplating drug diversion, those who are engaged in drug diversion as we speak, should hear the message loud and clear: that 39 years [in prison] are in your future. It's a harsh sentence," Kacavas said.

Kwiatkowski, 34, stole syringes filled with the fentanyl, refilling the syringes with saline to cover his tracks. At some point he became infected with HCV, spreading the virus to unsuspecting patients in a series of infections that culminated with a large outbreak at Exeter (NH) Hospital in 2012. *(For more information on this case, including tips for handling temp workers, see "Avoid nightmares with temp workers — Take steps now, and avoid liability,"* Same-Day Surgery, *November 2012, p. 117. This story includes "Best practices for Healthcare Background Searches.")*

REFERENCE

1. Marchocki K. Medical technician gets 39 years for triggering hepatitis C outbreak. New Hampshire Union Leader, Dec. 2, 2013. Accessed at http://bit.ly/JiY6qs. ■

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 emailed to you instantly. ■

COMING IN FUTURE MONTHS

- Avoiding lawsuits with medical devices
- How to handle a poor patient outcome
- Lessons learned from stabbing at surgery center
- Don't risk accusations of Medicare fraud

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. How much did Beaumont Health System in Detroit save when it replaced T12 light bulbs with T8 bulbs, which are more energy-efficient, in several areas?
   A. About $20,000 annually
   B. About $100,000 annually
   C. About a quarter of a million dollars annually
   D. About half a million dollars annually.

2. How does Stephen W. Earnhart, CEO of Earnhart & Associates, suggest you avoid wasted equipment purchases?
   A. Tell the physician that you want to wait two months before making the purchase.
   B. Ask the physician to make a pledge in writing that they will use it a minimum number of times on new patients.
   C. Ask the physician for published research on the equipment.

3. How did the Center for Sight address the need for money to provide free surgeries to the uninsured?
   A. It set up a donor-advised fund in an already existing community foundation,
   B. It set up its own foundation.
   C. It paid for vendors for supplies at their cost.

4. According to Aaron Robison, CHAA, a patient financial advocate at University of Utah Health Care, what is one of the most powerful tools to use when requesting monies from a patient?
   A. Information about their copays and deductibles from their payer
   B. Documentation that explains the individual expenses and total cost of the procedure
   C. Silence

Orientee:

Start Date:

	Reviewed:		Demonstrated:	
	Yes	No	Yes	No
PERIOPERATIVE CARE CENTER				
A. Organizational structure				
B. Mission Statement				
C. Professional Development				
1. Tuition reimbursement				
2. Annual mandatory education/ eLMS				

Signature of Intern:_____ **Date:**_____

Signature of Preceptor:_____ **Date:**_____

O.R. POLICIES AND GUIDELINES

A. Initial Employment Period				
B. Attendance Management				
C. Time Recording				
D. Paid Time Off (PTO) Policy/Payroll				
E. Procedure for department job postings (internal and external)				
F.Smoke free environment				
G. PCA/PCI job description				
H. Annual performance review- Contribution Management				
I. Hours				
1. Leaving unit				
2. Procedure to request time off / trade days or shifts - Charge nurse				
3. Procedure to sign up for vacation				
J. Dress Code and Appearance				
K. Location of Emergency Procedure Guides				
L.. Location of Policy and Procedure Manuals				
M. Procedure for Needle /sharps stick injury- Employee Exposure Report				
N. Procedure to complete Patient Incident Report				
O. E Mail & Computer Use				
P. Healthy hands initiative				

Signature of Orientee:_____ **Date:**_____

Signature of Preceptor:_____ **Date:**_____

TOURS

A. Hospital				
B. Unit				
C. Key Codes/Locker				
D. Scavenger Hunt				

	Reviewed:		Demonstrated:	
Aseptic Technique	**Yes**	**No**	**Yes**	**No**
A. View Video Aseptic technique				
B. Practice opening Sterile supplies				
C. How to open instrument pans/ return instrument pans				
D. Care of instruments: cleaning/ bagging/ taking to be processed				
E. How to restock implants				
Sterilization				
A. Indicators;tape and biologicals for steam, gas and sterrad				
B. Solid pans, Cloth, peel packs, paper wrappers				
C. Shelf Life				

Signature of Orientee_____**Date**_____
Signature of Preceptor_____**Date**_____

	Reviewed:		Demonstrated:	
Room Equipment	**Yes**	**No**	**Yes**	**No**
A. Identify name; purpose, and placement of routine room equipment				
B. OR Table				
1. Types (Hercules; carbon; fracture; Jackson-plain top/spine top/sling top)				
2. Correct operation of routine table - Different positions; armboard attachment; kidney rest; manual controls; locking mechanism				
mayfield attachments (what are they and where they live)				
Hand tables				
C. Code button				
D. Correct operation of phones (regular and red emergency)				
E. Correct use of paging system (paging and answering a page)				
F. OR Lights- operation of/ procedure to change bulbs				
G. Operation of suction/ connecting/ how to turn over suction in room				
H. Line isolation monitor/ electrical safety in the OR				
I. Operation of nitrogen lines				
J. How to stock warmer-blankets, linens, fluids (rotate & exp dates)				
K. Gel rolls-how to check rooms for them, where they belong				
L. Case specific equip: examples				
a. Tourniquets				
b. Slush makers				
c. headlights				
d. Stealth equipment				
e. Towers/scopes				
f. Cast carts-how to resupply/clean/prepare for a case				
N. ESU (Bovie)/ Bipolars/Irrigating Bipolars				

Signature of Orientee_____**Date**_____
Signature of Preceptor_____**Date**_____

	Reviewed:		Demonstrated:	
Room Preparation/Turnovers/Closing	**Yes**	**No**	**Yes**	**No**
A. Case carts: how to find for a case/how to return				
B. Procedure to open room				
C. Procedure for room turn-over				
a. gather instruments				
b. gather supplies for TF case				
c. Assist in anesthesia turnover				
D. Procedure to close room				
E. SIMS area- procedure to obtain missing supply or get case cart				

Signature of Orientee_____**Date**_____
Signature of Preceptor_____**Date**_____

Patient Care	Reviewed:		Demonstrated:	
A. Transport to OR or PACU-wagon/wheelchair/bed/isolette				
B. Safety Measures:				
a. never laeve child alone				
b. securing with safety strap/blanket/tape				
C. Assist anesthesia				
a. How to hook up and tape IV				
b. How to tape in an IV				
c. How to make an IV				
d. How to assit with the tube during induction				
D. Patient Positioning				
E. Blood maintanence-coolers/tube station/coolants				
F. Care of specimens-permananet/neuro/frozen/cultures				
G. How to assist with OR room running smoothly				
a. Obtain supplies for circ				
b. Obtain drugs for room				
c. Wait at tube station for items/blood/blood products				

Signature of Orientee_____**Date**_____
Signature of Preceptor_____**Date**_____

	Reviewed:		Demonstrated:	
Downtime/Miscellenaeous	**Yes**	**No**	**Yes**	**No**
A. How to restock carts-suture/shunt/cast cart				
B. Check x-ray gowns-each service's in correct place/yearly exam				
C. Check expiration dates on supplies and suture				
D. Organize video tower room				
E. Organize basement storage room.				

Signature of Orientee:_____ **Date:**_____

Signature of Preceptor:_____ **Date:**_____

	Reviewed:		Demonstrated:	
IX. OR EMERGENCIES	**Yes**	**No**	**Yes**	**No**
A. Fire procedure- pull boxes; extinguishers; evacuation routes; bell codes				
B. "Eliminating Fire Hazards in the Operating Room" video /reading				
C. Codes				
1. Cardiac Arrest- "beating the odds" video				
2. Code button				
3. Emergency drugs / O2 tanks/ ambu bags/ trach sets				
4. Defibrillators				
a. Location of/ use				
b. External; internal; pediatric paddles; R2 pads; changing paper				
D. Malignant Hyperthermia video				
E. Preventing Hypothermia				
F. Job Action sheets				

Signature of Orientee:_____ **Date:**_____

Signature of Preceptor:_____ **Date:**_____

	Reviewed:		Demonstrated:	
	Yes	No	Yes	No
IV. OR Needs				
A. Roles in the OR-video and handout				
B. Aseptic Technique-video and handouts				
C. Traffic patterns in the OR-video				
D. Sterilization and Disinfection-Handout				
1. Pans, peel packs, cloth wraps and paper wraps				
2. Indicators: tapes, biologicals, steris				
3. Correct Operation of autoclaves				
4. Correct Operation of Steris				
E. Specimens - check label				
D. Specimen Containers				
Signature of Orientee:_____ **Date:**_____				
Signature of Preceptor:_____ **Date:**_____				
V . ROOM EQUIPMENT				
A. Identify name; purpose, and placement of routine room equipment-how to/demo/handouts				
B. Code/Stat Information				
C. OR lights-correct operation and changing of bulbs				
D. Correct operation of phones (regular and red emergency)				
E. Correct use of Vocera System & Pager				
F Line isolation monitor/ electrical safety in the OR				
G. Autoclave - Clean Drain				
H. Supplies in soiled utility room				
I. Procedure for assisting in opening a room, turnovers and closing a room				
J. Casecart/Tote System				
K. SIMS & Sterile Processing area				
L. . How to utilize a pick list				
Signature of Orientee:_____ **Date:**_____				
Signature of Preceptor:_____ **Date:**_____				
VI Peds Patients and Anesthesia Assist				
A. Taking care of a Pediatric patient-Handouts				
B. Assisting anesthesia-EKGs, pulse oximeter, BP, taping Ivs, making IVs				

VII OR EMERGENCIES				
A. Fire procedure- pull boxes; extinguishers; evacuation routes; bell codes				
B. "Eliminating Fire Hazards in the Operating Room" video /reading				
C. Codes				
D. Defibrillators				

Signature of Orientee:_____ **Date:**_____

Signature of Preceptor:_____ **Date:**_____

Comments

Signature of Orientee_____ Date_____

Siganture of Educator_____ Date_____

Orientee _____ Date _____

Preceptor _____ Service/Specialty _____

Cases _____

1=Unable to Perform 2=Able to Perform w/ Assistance 3=Able to Perform Independently (N/A if appropriate) Place check mark in appropriate column.

	1	2	3
A. Room Set-Up			
1. Arrived in OR at punctual time for shift working.			
2. Displayed proper OR attire: minimal jewelry, hair concealed in cap,proper color warm-up jacket			
3. Review daily assignment, obtain a schedule			
4. Assist in preparing room for operation: validated proper functioning of room furnishings, checked OR bed (locked/position), checked OR lights, assured that all suction was functioning and had suction available for Anesthesiologist.			
5. Assis in the collection all necessary supplies, equipment, and drugs.			
6. Opened sterile supplies utilizing aseptic technique and verified package integrity, indicator changes, and expiration dates.			
B. Physical and Psychological Patient Needs			
1. Participates in intital room "time out"			
2. Assist in the transfer of patient from the bed or cart or isolette to the OR table.			
3. Provide warm blanket to patient. Pull shades to help protect patient's rights.			
4. Help with the assessment of patient physical/medical disabilities, skin integrity, and age specific needs.			
5. Assisted Anesthesiologist with induction and intubation.			
6. Assisted with patient positioning utilizing good body alignment, protecting pressure areas, preventing nerve damage, and maintaining skin integrity.			
7. Properly placed electrosurgical grounding pad.			
C. Competency During Case			
1. Assisted scrub personnel in bringing back table up to sterile field. Does not walk between sterile fields.			
2. Hooked up all necessary equipment: electrosurgical pencil and grounding pad, suction, headlights, etc. Assured that kick bucket is accessible to scrub personnel.			
3. Called any observed breaks in technique and helped to correct.			
4. When observing in the room attentive to needs of patient, scrub personnel, surgeon, and anesthesiologist during the case. Dispensed additional supplies as needed.			
5. Waits for blood in tube room and places in correct cooler. Changes out ice when needed.			

	1	2	3
6. Placed sponges in sponge counter bags.			
7. Assists in handling gross specimens and frozen sections according to policy- and signs them into refrigerator.			
8. Adhered to universal precautions.			
9. Assists in preparing for to-follow cases in a timely manner and helps keep room organized to decrease turn over time.			
10. Resupplied room on an ongoing basis/ or retrieved supplies needed during case.			
D. Competency At End Of Case			
1. Assisted Anesthesiologist with extubation, and stayed near patient if directed to do so.			
2. Brings in patient cart/bed, IV, and Pulse oximetry unit at end of case.			
3. Assists in reassessment of patient: skin integrity, electrosurgical grounding pad site, positioning device sites.			
4. Assists in dressings being appropriately applied.			
5. Provided warm blankets for patient and assisted with transfer to cart. Assured that side rails were up on cart.			
6. Returned supplies and equipment to proper areas. Assisted with cleaning up of room and preparation for next case.			
E. Observations of Learner			
1. Utilizes feedback constructively to enhance performance.			
2. Cooperative with team members, patients, and families.			
3. Organizational skills developing as expected.			

Comments:

DATE:

PRECEPTOR:

ORIENTEE:

Orientee _____ Date _____

Preceptor _____ Service/Specialty _____

Cases _____

1=Unable to Perform 2=Able to Perform w/ Assistance 3=Able to Perform Independently (N/A if appropriate) Place check mark in appropriate column.

	1	2	3
A. Room Set-Up			
1. Arrived in OR at punctual time			
2. Displayed proper OR attire: no jewelry, hair concealed in cap, eyewear.			
3. Helped prepare room for operation; validating proper functioning of room furnishings.			
4. Checked instruments, assisted circulator with checking and gathering of supplies, suture, and equipment as needed, according to age and size of patient.			
5. Assisted circulator with the opening of sterile supplies utilizing aseptic technique. Opened gown and gloves on separate field.			
B. Sterile Set-Up			
1. Performed surgical scrub of hands/arms appropriately, and at appropriate time, allowing sufficient time for set-up.			
2. Gowned and gloved self according to policy and without contamination.			
3. Set up sterile fields in an organized and timely manner including back table/6 foot table, mayo stand, and prep stand. Checked instruments for correct functioning/parts.			
4. Performed sponge and sharp counts with circulator according to policy. Performed instrument counts with circulator when indicated.			
5. Gowned and gloved surgical team using aseptic technique.			
C. Competency During Case			
1. Assisted with draping patient using good aseptic technique: handed drapes in order of use, helds drapes high/did not drag, cuffed drapes over hands to protect from unsterile field.			
2. Brought mayo stand up to sterile field and checked position of patient's feet to assure that there was no contact.			
3. Passed off suction and electrosurgical cord with good aseptic technique, and secured suction/cords to drapes properly.			
4. Assisted with applying light gloves to spot light.			
5. Had sponges ready to hand to surgeon.			
6. Practiced good aseptic technique throughout procedure: passed sterile to sterile, did not turn back to sterile field, was aware of sterile field at all times, and monitored for breaks in technique.			
7. Actions while scrubbed indicated the learner knew the procedures involved, had read the preference card, and had taken appropriate steps to prepare for the case. Was able to anticipate basic needs. Used appropriate instruments for size & age of pt.			
8. Demonstrated good manual dexterity while passing instruments, suture, and supplies. Passed instruments firmly and in the proper position for use.			
	1	2	3

9. Kept sterile field neat and orderly throughout procedure: returned instruments to proper place on field, kept instruments free of blood/tissue.			
10. Demonstrated knowledge of suture: utilized appropriate needle holder for suture, loaded and passed suture appropriately.			
11. Demonstrated knowledge of medications on field: verifying meds with circulator when receiving them onto the filed.			
12. Kept accurate record of irrigation used.			
13. Performed closing sponge, sharps, and instrument counts according to policy.			
D. Competency At End Of Case			
1. Had wet sponge ready to clean incision area, had dressings ready, and assisted as needed with their application.			
2. At end of procedure, properly cleared sterile fields of instruments and supplies. Instruments prepared for decontamination.			
3. Handled specimens correctly: checked with surgeon before handing off field, identified specimen when handing off field, formalin placed on specimen according to guidelines.			
4. Returned extra supplies/equipment to proper areas.			
5. Assisted with room turn over and set up of to-follow case.			
E. Observations of Learner			
1. Able to accept constructive criticism and receptive to suggestions to improve performance.			
2. Cooperative with team members, patients, and families.			
3. Organizational skills developing as expected.			

Comments:

PCA/CNA/PCI

ORIENTATION POLICIES/GUIDELINES TO REVIEW
SOURCE: OR ORIENTATION MANUAL

1. **INITIAL EMPLOYMENT PERIOD (HR 117)**
2. **ATTENDANCE MANAGEMENT (HR 102)**
3. **TIME RECORDING (HR 139)**
4. **TIME AND ATTENDANCE SYSTEM**
5. **PAID TIME OFF HR (129)**
6. **OPERATING ROOM FIRE SAFETY POLICY(POS 1.35)**
7. **DRESS CODE: PERIOPERATIVE DOMAIN (POS 1.07)**
8. **DRESS CODE AND APPEARANCE (HR 1.07)**
9. **SCRUB ATTIRE (ADM 1.08)**
10. **TRAFFIC CONTROL IN THE OPERATING ROOM (POS 1.18)**
11. **SANITATION DURING ROOM TURNOVER AND TERMINAL DECONTAMINATION (P0S 1.14)**
12. **PATIENT OCCURRENCE,SENTINEL EVENT MANAGEMENT(ADM 1.51)**
13. **Workstation Use & Security Policy (IS 1.07)**

After you have reviewed these policies please ask for any clarification from the OR Educator. Please sign the designated sheet stating that you have read and understand these policies and guidelines. Thank you.

NEW STAFF SIGNATURE FORM

I have read the designated IU Health Policies and ROR Operating Room guidelines outlined for my orientation. I have directed any questions to the clinical educator or manager. My signature is validation that I understand the information and expectations associated with these policies in regard to my employment at Riley Operating Rooms.

Signature:_____

Date: _____

PCA/ PCI Orientation

Roles of Team Members
Roles PowerPoint
Provide roles definitions
Provide mini descriptions of Circ and scrub
OR team effort-Video

Environment of Care
Traffic control and Sanitation PowerPoint
Fire Safety DVD
Separating Infectious Waste eLMS module (Let's Talk Trash)
AORN Study Guide for Environmental Sanitation and Terminal cleaning and turnovers
IU Health Cleaning guide (I do not do this with the PCIs)
Room Set-up guide
Orientation to OR rooms

Aseptic Technique/Sterility
Lecture with power point
Provide 12 principles
Can you find quiz?
Video
Later opening packages-pans

Safety
Fire Safety-curriculum and DVD
MH-curriculum and DVD
ESU-curriculum and DVD
Radiation Safety-curriculum and DVD
Tourniquets-lecture Power Point
Latex-safety-article and curriculum
Putting sponges in counter bags

Anesthesia
Monitoring set up
How to tape an IV
How to assist with intubations
How to make an IV-Demo
How to turnover anesthesia

Sterilization
Sterilization PowerPoint and lecture
How to run biologicals
Use of Autoclaves

AIDET-lecture, Power point and check off
Diversity-lecture and Power Point

Safe Passage-lecture and Power Point

Specimen Handling-
General curriculum
Muscle biopsies-guidelines
Neurosurgical specimens-guidelines
Tubing specimens
Signing in Specimens
Blood Handling-Guidelines

Positioning
DVD
PowerPoint
Demo-we go over 4 main positions with a baby and all the positioning devices.

Miscellaneous
Picklists
Care and handling of instruments and pan sets at end of case
Tearing down room

12/2012 mlr

NEW STAFF SIGNATURE FORM

eLMS Modules

- Corporate Compliance
- Environment of Care
- HIPPA Privacy and Security
- Infection Control
- Patient Safety
- IOPO (Indiana Organ Procurement Organization): A donation resource for all multi-specialty units
- Infection Control-patient Transport
- Medical Gas and Cylinder Safety
- Social Media
- Let's Talk Trash
- Active Shooter

- Upon completion of all eLMS modules print an eLMS learning history report and present to your educator.

I have read the designated Indiana University Health Policies and ROR Operating Room policies & guidelines outlined for my orientation. I have directed any questions to the clinical educator or manager. My signature is validation that I understand the information and expectations associated with these policies and guidelines in regard to my employment at Riley Operating Rooms.

Signature:_____

Date: _____

12/24/2012 MLR