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INSIDE

AHC Media

Joan Rivers' death puts spotlight on safety of freestanding centers

By **Joy Daughtery Dickinson**

From *The New York Times* to *The Dr. Oz Show,* it seems that everyone in the national media became an armchair quarterback in the weeks following the unexpected death of comedian Joan Rivers on Aug. 18. A loud, critical unified voice was aimed at outpatient surgery providers, particularly freestanding facilities.

Rivers died several days after going into cardiac arrest during an undisclosed procedure at Yorkville Endoscopy in New York City. Consider these publicized comments:

- *The New York Times* described Yorkville Endoscopy as a "for-profit center" and said that the management structure of outpatient surgery centers "is often explicitly designed to maximize profits for doctors, who are typically the majority owners."[1] The news article said that the management

EXECUTIVE SUMMARY

Following the death of Joan Rivers, the national media raised questions about the safety and emergency response capability of freestanding surgery centers.

- Define what types of patients are appropriate for your facility.
- Consider the patient's American Society of Anesthesiologists score, Mallampati score, and the degree of sedation when deciding whether to have an anesthesiologist present.
- Designate a nurse to monitor patient, and have a crash cart, staff trained about the crash cart, and CO_2 monitoring. Have a transfer-of-care agreement with a hospital.

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company, Frontier Healthcare, is run by three persons, including an ex-salesman, an ex-investment banker, and a gynecologist. It said that Frontier's web site refers to their taking advantage of "favorable reimbursement market trends."

• An article by Bloomberg News said that outpatient surgery centers are "created by physicians to attract patients and higher revenues from routine procedures and minor surgeries."[2]

• Another article by Bloomberg News said that River's death was a rare event but that "an aging population could boost the numbers at such outpatient centers in the future."[3]

• On *The Dr. Oz Show*, **Mehmet Oz**, MD, vice-chair and professor of surgery at Columbia University, New York City, questioned what would have been handled differently if Rivers' surgery had been conducted in a hospital.[4] One of his physician guests touted the immediate availability of emergency care and emergency personnel in a hospital. **Jonathan Aviv**, MD, author and ear, nose, and throat physician, suggested that patients ask these questions: Is the facility licensed and accredited in that state? Is the facility affiliated with a hospital? Does the physician have privileges at that hospital? Oz added that patients also should ask about their risk of heart attack, and if they are determined to be at high risk, they should have their surgery in a hospital.

The publicity following River's death has focused on whether a freestanding center was an appropriate surgery setting, especially considering her age and her admitted history of heart arrhythmia and bulimia. Rivers' death is under investigation by the New York City Office of Chief Medical Examiner and the New York State Health Department, as well as the facility's accrediting agency: the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF).

The attention given to her death, due to her celebrity status, is likely to result in increased scrutiny for you from patients and the media, and potentially regulators and accreditors. For that reason, outpatient surgery managers must ensure they have taken essential steps to provide the best possible patient outcomes. Such preparation will help ensure your program can withstand the sudden attention that comes with the news coverage and/or potential liability resulting from an unexpected outcome. Beyond being compliant with your state and accreditation requirements, leading experts interviewed by *Same-Day Surgery* emphasize these points:

• Spell out for what types of patients your facility will include.

Accreditation agencies typically require statements as to what specific types of patients are appropriate for your facility, says **Jane C.K. Fitch**, MD, president of the American Society of Anesthesiologists (ASA). "For example, extremes of age aren't well-suited for outpatient and ambulatory and office-based procedures," Fitch says.

ASA offers guidelines and standards on safe ambulatory anesthesia (http://bit.ly/1mr3U3b) (and safe office-based anesthesia http://bit.ly/1mr40YF). "They should guide anesthesiologists and others in making the best decisions for patient in terms of the correct place to have surgery," Fitch says. "A young, healthy 21-year-old is quite different from someone who's 81, who might have heart, lung, or kidney disease."

Some surgery centers have criteria that say they won't perform surgery on children under age 13 or patients who are over a certain body mass index (BMI), says **Leilani Kicklighter**, RN, ARM, MBA, CPHRM, LHRM, patient safety & risk management consultant, The Kicklighter Group in Tamarac, FL. "It carries some inherent risk," Kicklighter says.

Any patient with comorbidities should have clearance from their primary care physician and a specialist to have surgery, she says. "Any patient who has comorbidities should be evaluated first by the surgeon as to the risks and whether the risks would be better dealt with in an acute care setting or ambulatory setting, before they ever schedule it," Kicklighter says. Secondly, a specialist, such as a cardiac specialist for a patient with heart issues, should provide clearance, she says.

• Consider a patient's overall health when making decisions about having an anesthesiologist present.

Chronological age has become less of an issue than a patient's overall health condition, when looking at the need for anesthesia staff, says **Brian Dunkin**, MD, FACS, president elect of the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES). The ASA classification system provides a good basis for decision-making, Dunkin says. Consider having an anesthesiologist present for patients who are ASA 3 or higher, he advises.

A patient who has had heart arrhythmia for years that's well-controlled might not be an indication to have an anesthesiologist present, Dunkin says. However, you would want to make sure the patient has a heart rhythm that is expected, he says.

A potentially difficult airway might be a reason to discuss the case beforehand with an anesthesiologist, he says. A patient who has a Mallampati score, which measures the potential difficulty of an airway, of 3 or 4 typically means an anesthesiologist should be present, he says. "If there's trouble, the airways are likely to be difficult to get access to," Dunkin says.

Whether an anesthesiologist should be present depends on the degree of sedation required, Fitch says. "Any time you get into the realm of deep sedation or general anesthesia or regional anesthesia, that's when it becomes critical. You need physician anesthesiology oversight," she says.

• The capability of an outpatient surgery provider should be a determining factor in location of a procedure.

Whether a procedure is done in a freestanding or hospital-based outpatient surgery program isn't so much a matter of location as is the capability of that location, Dunkin says.

"For example, I've working in a freestanding endoscopy unit that had anesthesiologist-administered sedation," he said. "They had a full code cart and a person who can intubate. That's probably not a lot different than in a hospital." He also has worked in office-based surgery programs that didn't have any of that type of emergency assistance available.

If an elderly patient has a problem during a scope procedure, the problem usually is respiratory, Dunkin says. "You must be prepared in your setting," he emphasizes.

• Ensure you have the equipment and staff who are trained to respond to an emergency.

Fitch says, "You can never be too well-educated or too well-trained."

Members of your professional staff, including your physicians, should be certified in advanced life support (ALS), Kicklighter says, and if you have pediatric patients, they should be certified in pediatric ALS (PALS), she says.

Have one nurse designated to monitor the patient and communicate with the physicians during a procedure, Dunkin says. "The physician may be directing sedation, but the person performing [the scope procedure] is not the one to monitor vital signs," he says

Also, ensure you are using CO_2 monitoring, not just a pulse oximeter, for moderate or deep sedation, as recommended by the ASA, he says. A patient's oxygen level, as measured by pulse oximetry, can remain high even though the patient isn't breathing, "then you fall off a cliff" when the oxygen goes down, Dunkin says.

Have emergency equipment available to manage respiratory or cardiac events during the procedures, he says. "Essentially, have a code cart available and personnel who know how to use things on that code cart," Dunkin says. Also, have medication readily available that can quickly reverse the sedation, he says.

"You need to have availability of emergency personnel that can take [care] to the next level if there's a problem," Dunkin says.

Have processes set in place for transfer of care, Fitch says. "If there is something that happens, there is seamless transfer to an inpatient facility," she says.

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RESOURCES

For more information on endoscopy safety, consider the following resources:

The American Society for Gastrointestinal Endoscopy (ASGE) has issued *Guidelines for safety in the gastrointestinal endoscopy unit.* These guidelines were published in *GIE: Gastrointestinal Endoscopy* online. To read the guidelines, go to http://bit.ly/1lqFpyu. *(Editor's note: The April 2014 issue of* Same-Day Surgery *newsletter covers these guidelines and includes 10 safety tips. See "Guidelines address safety in GI endoscopy unit" on p. 43.)*

The Society of Gastroenterology Nurses and Associates (SGNA) has a *Statement on the Use of Sedation and Analgesia in the Gastrointestinal Endoscopy Setting.* To access the SGNA statement, go to http://bit.ly/ZD8HEt. ■

Plaintiffs obtaining records previously thought safe from discovery by other side's lawyers

Hospital, plaintiff fight over surgery incident report

Medical malpractice plaintiff's attorneys are increasingly confident about obtaining potentially game-changing documents that managers assumed would never be seen by the other side.

A trend in court rulings shows that plaintiffs in litigation against healthcare providers are gaining access to more documents that traditionally have been considered off limits. Many of the documents in question previously were protected by the attorney-client privilege. Notes made immediately after an adverse event are among those that might be accessed.

Documents following an incident might be safe if investigations are conducted only at the behest of your attorney, because in most jurisdictions that would make the resulting document protected under attorney-client privilege, says **Leilani Kicklighter**, RN, ARM, MBA, CPHRM, LHRM, a patient safety and risk management consultant with The Kicklighter Group in Tamarac, FL, and a past president of the American Society for Healthcare Risk Management (ASHRM) in Chicago.

That distinction might mean making a quick call to the attorney to report the incident and asking "Should I go out and investigate this?" When the attorney says yes, Kicklighter says it provides a foundation for gathering information on the instruction of your counsel, which can make it protected.

Elective surgery incident

One web site seeking malpractice plaintiffs recently discussed the Aug. 21, 2014, decision of the Supreme Court of Kentucky. In that case, the defendant hospital claimed a federal confidentiality privilege to refuse to provide the medical malpractice plaintiff with a copy of the incident report. The incident report was written by a surgical nurse at the defendant hospital concerning an elective surgery that resulted in the death of the patient.

The plaintiff obtained the incident report. MedicalMalpracticeLawyers.com provides this summary of the case:

The decision was not easily reached. As the Kentucky Supreme Court noted, the Patient Safety and Quality Improvement Act of 2005 was enacted by the U.S. Congress to encourage healthcare providers to voluntarily associate and communicate privileged patient safety work product (PSWP) among themselves through in-house patient safety evaluation systems (PSES) and with and through affiliated patient safety organizations. In furtherance of the act's purpose, the act provides a confidentiality provision establishing that "patient safety work product shall be confidential and shall not be disclosed," except as authorized by the act itself [42 U.S.C.A. §299b-22(b); 42 C.F.R. § 3.206(b.)]

After a patient died as a result of complications from elective spinal surgery, her estate filed a medical

malpractice and wrongful death case during which the estate sought to be provided a copy of the post-incident or event report generated by a surgical nurse at the defendant hospital concerning the surgery through the defendant hospital's patient safety evaluation system. The defendant hospital objected to producing the report, alleging that the only post-incident report that existed was a report created through its patient safety evaluation systems and therefore was protected from discovery by the federal privilege for patient safety work product created by the act.

The plaintiff argued, however, that the act's definition of patient safety work product expressly does not include information that is collected, maintained, or developed separately, or exists separately, from a patient safety evaluation system. Therefore, according to the argument, such separate information reported to a patient safety organization is not by reason of its reporting considered to be patient safety work product.

The Kentucky Supreme Court came around to that way of thinking. The court noted that Kentucky administrative regulations with regard to Kentucky hospitals provide that "administrative reports shall be established, maintained and utilized as necessary to guide the operation, measure of productivity and reflect the programs of the facility" and these reports "shall include: . . . (5) [i]ncident investigation reports; and (6) [o]ther pertinent reports made in the regular course of business."

Because these types of reports are required in the regular course of the hospital's business, they are hospital records, and, therefore generally are discoverable under Kentucky law. *(See the story below for additional information on what materials you should collect.)* ■

Avoid danger of disclosure: Just the facts, ma'am

With plaintiffs getting their hands on more documents that previously were off limits, the best way to avoid that danger is to be strict about separating fact and opinion, says **Patrick J. Hurd**, JD, senior counsel with the law firm of LeClairRyan in Norfolk, VA.

The facts might be discoverable for a plaintiff, so don't mix in your thinking about how or why an adverse incident occurred, or anything else besides what actually happened. Opinions and analysis still have more protection from prying eyes, so don't unnecessarily give those away when you are required to hand over factual material.

"While the likes of mental impressions, conclusions, opinions, or legal theories can be redacted, you cannot assume that they will be," Hurd says. "If the purpose of an investigation is to gather facts in the wake of an incident, then the training, policies, and procedures should hew closely to that purpose, never straying into matters of conjecture or opinion."

Examples of the facts include the date of the occurrence, the diagnosis, the treatment provided, and the patient's outcome and progress. Squelch any tendencies to jot down your thoughts about why the incident occurred, any relation to past incidents, or possible corrective action. Keep those thoughts completely separate.

A standardized form can help you collect only the facts after an incident, says **Leilani Kicklighter**, RN, ARM, MBA, CPHRM, LHRM, a patient safety and risk management consultant with The Kicklighter Group in Tamarac, FL, and a past president of the American Society for Healthcare Risk Management (ASHRM) in Chicago. State laws vary on requiring incident reports, and some, such as Florida, proscribe what data must be collected. That type of form, whether prompted by state requirements or not, can be an effective strategy, she says.

"If your state does not proscribe what information you must have, you can develop an incident report form that provides the demographic information of the patient and other meaningful information such as who the doctor was, where it happened, and so forth," Kicklighter says.

Managers also should gain a thorough understanding of how the electronic medical record can be accessed, what digital connections make that possible, and what electronic footprints are left after accessing the document.

Another important step is to ensure a clear demarcation between investigative fact-gathering and review or root cause analysis related to opportunities for improvement of quality care and patient safety. "Healthcare organizations must preserve their ability to take factual information and place it in the hands of quality review organizations," Hurd said. "This process necessarily involves evaluating, assessing, and even opining about how changes in policies, procedures, processes, training, education, and credentialing could improve patient safety and quality of care." ■

Newly published research suggests sleep apnea screening before surgery

Newly published research suggests that patients scheduled for surgery might may want to get screened and treated for obstructive sleep apnea (OSA) before going under the knife. According to a first-of-its-kind study in the October issue of *Anesthesiology,* patients with OSA who are diagnosed and treated for the condition prior to surgery are less likely to develop serious cardiovascular complications such as cardiac arrest or shock.

An estimated 18 million Americans are thought to have clinically significant OSA and, even more alarming, about 16 million of those people remain undiagnosed.

"As many as 25% of surgical patients may have OSA, but the vast majority of these patients aren't treated or don't know they have the disorder," said **Thomas Mutter**, MD, lead author, Department of Anesthesia and Perioperative Medicine, University of Manitoba, Winnipeg, Canada.

Symptoms of apnea might include heavy snoring, pauses in breathing during sleep, and excessive sleepiness during the day.

The study compared postoperative outcomes in 4,211 patients with OSA, who were diagnosed by a sleep study before or after surgery, with a matched control group of patients who did not have the condition. Those who were diagnosed with OSA prior to surgery were prescribed treatment with continuous positive airway pressure (CPAP) therapy.

The study found that although patients with untreated OSA were at an increased risk of developing cardiovascular complications, patients who were diagnosed and treated with CPAP therapy before surgery were less than half as likely to experience cardiovascular complications such as cardiac arrest or shock. Additionally, researchers found that respiratory complications were twice as likely to occur in patients with OSA, compared to patients without the condition, regardless of when patients were diagnosed or if CPAP therapy was prescribed. For both cardiovascular and respiratory complications, increasing severity of OSA was associated with increased risk. Age, type of surgery, and other diseases also were important risk factors.

The authors acknowledge limitations related to their retrospective study, as well as the potential resources needed to implement widespread screening. Nonetheless, this study adds to the knowledge base of how to care for this increasingly large segment of the population, according to the American Society of Anesthesiologists. *(To access this article, go to http://bit.ly/1vmbSKI.)* ■

Meridian Surgical Partners to pay more than $5M — Company settles suit alleging kickbacks

Meridian Surgical Partners, a healthcare company specializing in managing ambulatory surgical centers (ASCs), has agreed to pay $5.12 million to settle a False Claims Act lawsuit brought by a whistleblower.

The FCA whistleblower provisions permit private citizens known as "relators" to bring *qui tam* lawsuits on behalf of the United States and receive a portion of proceeds of any settlement or judgment.

Thomas Reed Simmons sued Meridian in the U.S. District Court for the Middle District of Tennessee under the whistleblower provisions of the False Claims Act for allegedly engaging in an illegal kickback scheme that defrauded taxpayers out of millions of dollars in Medicare payments.

Michael D. Palmer, JD, senior litigation counsel at Sanford Heisler in New York City, said, "This settlement reaffirms that relators who choose to pursue their claims after the government has declined to intervene can achieve successful results. While we were fully prepared to take this case through trial, we are pleased with the recovery obtained on behalf of Mr. Simmons and the government."

Simmons worked as a business office manager for an ASC that was managed and principally owned by Meridian. In his complaint, Simmons alleged that that Meridian offered and paid remuneration to physicians of the ASC to secure patient referrals for services paid for by Medicare, in

violation of the federal Anti-Kickback Statute and the False Claims Act. Simmons accused Meridian of paying more than fair market value for a majority ownership of the ASC and rewarding physicians for referring patients by offering them minority ownership stakes.

Simmons initiated the case on behalf of the U.S. government in May 2011 while he was still employed by Meridian. After the government declined to intervene, Simmons and his counsel Jonathan Kroner, JD, MBA, of the Jonathan Kroner Law Office in Miami Beach, FL, decided to litigate the case on the government's behalf. The federal government permits whistleblowers to take cases to court on behalf of the public. Reed and Kroner brought Sanford Heisler into the case to act as lead litigation counsel. The case was scheduled to go to trial starting Sept. 23, 2014.

Ross Brooks, JD, co-chair of Sanford Heisler's whistleblower practice, said, "This is one of very few cases to allege successfully that payments of ownership interests in an ASC to physicians in exchange for patient referrals are kickbacks that violate the False Claims Act. Those seeking to disguise illegal kickbacks as legitimate business transactions or standard industry practice should take heed that the government will be scrutinizing more of these arrangements in future *qui tam* investigations."

Your facility's managers and members of your boards should stay refreshed on state and federal regulations, urges **Steve Earnhart,** MS, president and CEO of Earnhart & Associates, an Austin-based healthcare consulting firm specializing in all aspects of outpatient services. "I preach this to our clients repeatedly: not to dip into the grey zone of these regulations," Earnhart says. "Not only is it illegal and unethical, but it undermines creditability for all of the industry." ■

SDS Manager

Could you use another "Groundhog Day"?

By Stephen W. Earnhart, MS
CEO
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Austin, TX

Wouldn't we all like the idea of trying things several times until we get it right, like Bill Murray's character did in the movie *Groundhog Day*? My life would be so dramatically different, and so would yours! It would be so cool to tell your staff members or surgeons something, see their reaction, and then phrase it another way if that didn't work. The concept is staggering!

Well, I might be able to share some of my "groundhog" moments with you today. Some of you might like them, and some of you might not. Some will make you question why you are even reading this, but all will make you stop and think.

1. If you have an existing ambulatory surgery center (ASC) that is just perking along, no highs, no lows, consider developing a second surgery center for just out-of-network surgery. Crazy? Hardly. Think about the implications of having another surgery center that has no contracts with payers, and you can strictly go out of network with them. Cost prohibitive? No! Explore it as an option, because others around you are!

2. Hospital surgical departments need to consider a management services agreement that allows surgeons to provide input into the management of the surgical department. No equity, no management; just structured input that they can be compensated for their input. Why are most surgeons doing their own ASC? Input into the decision-making process of where they do their cases! Open up, and let them in.

3. Spine surgery in ASCs is happening now for non-Medicare patients. Rumors are Medicare is going to start reimbursing for selected spinal procedures next year. If you wait until then, it might be too late to jump on the bandwagon. Think about combining point number one above with this one.

4. Most surgery centers have become so complex that it is very difficult to oversee all the details to be done without outside services that a management company can provide. (We do not provide management services, so this is not a plug.) I sat in on a presentation that an ASC management company made to a group of surgeons last week. The company detailed all the compliance issues related to ASCs going forward, and I was amazed at how the industry has matured and become complex and overwhelming for a solo ASC.

5. Outsourcing billing for hospitals and surgery centers soon will become a must. Hospitals, you say? Yes. Hospitals might collect the dollars, but all of the "change" is

left uncollected. Again, billing and collections is too complex for even hospitals to do, let alone an ASC. Focus on safety, quality, and customer service, and let others deal with the billing. You cannot afford it, you say? The fact is, you cannot afford not to!

6. Pain procedure reimbursement continues to get beaten down by payers, but there is still gold in there if you look for it. Rumor has it that 2015 reimbursement is looking better. Read point number one again.

7. Hospitals need to outsource outpatient surgery. You have no choice if you wish to stay in the game. Surgery centers need to accommodate hospital outsourcing. Be creative and not greedy, and everyone can win.

8. Lastly, stay in touch with the resources around you. There is so much available to all of us if we are receptive to change – for "change" is the only thing that is not going to change! [*Earnhart & Associates is a healthcare consulting firm specializing in all aspects of outpatient services. Earnhart & Associates' address is 5114 Balcones Woods Drive, Suite 307-203, Austin, TX 78759. Phone: (512) 297-7575. Fax: (512) 233-2979. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.*] ■

Technologies monitor quality of scope reprocessing

The American Society for Gastrointestinal Endoscopy (ASGE) has issued a report on technologies for monitoring the quality of endoscope reprocessing. Emerging technologies offer the ability to perform rapid surveillance of the quality of reprocessing, which potentially might help reinforce adherence to the many steps in reprocessing.

The report, developed by ASGE's Technology Committee, appears in the September issue of

GIE: Gastrointestinal Endoscopy, the monthly peer-reviewed scientific journal of ASGE.

More than 20 million endoscopies are performed in the United States annually. Despite the large number of procedures performed, transmission of infection via endoscopes is very rare. Reported infections usually have been associated with a failure to follow established multisociety guidelines for reprocessing or have been attributed to defective equipment.

The manual component of reprocessing appears most prone to error. Periodic surveillance might potentially help reduce such errors by reinforcing adherence to the steps in reprocessing. However, further studies are needed to determine whether surveillance strategies can effectively identify failures of cleaning, disinfection, or storage that are not detected by process monitoring and that create a risk of transmission of infection. There are no recommendations for monitoring the efficacy of reprocessing of flexible endoscopes in the United States. This report highlights the status of current technology for monitoring the efficacy of flexible endoscope reprocessing.

Endoscope reprocessing comprises manual cleaning steps followed by high-level disinfection (HLD), then by rinsing and drying steps. Meticulous manual cleaning is imperative to achieve subsequent HLD. HLD usually comprises bedside cleaning and suctioning of enzymatic detergent followed by manual washing, flushing, and brushing of accessible channels to remove all residues. These processes were detailed in the 2011 Multisociety guideline on reprocessing flexible gastrointestinal endoscopes." HLD may be performed manually or by automated endoscope reprocessors (AERs). AERs allow for automation and standardization of several reprocessing steps and thereby minimize the risk and impact of human error.

Emerging technologies

Effective surveillance of flexible endoscope reprocessing ideally requires testing methods that allow for rapid assessment of compliance with current reprocessing standards. However, the lack of both widely accepted bioburden/microbial benchmarks and widely validated means of assessing these has limited implementation of such strategies. Potential methods for surveillance include:

• Microbial culture — culturing for bacterial load.

The European Society of Gastrointestinal Endoscopy (ESGE) recommends surveillance cultures of reprocessed endoscopes at intervals of not more than three months. However, culturing for bacterial load is impractical for many endoscopy centers that might not have easy access to microbiology laboratories. In addition, the slow turnaround time (minimum 24 hours) for results does not allow for rapid reuse of the tested endoscope. Furthermore, viruses such as hepatitis B and C and HIV cannot be cultured by using standard methods.

• Bioburden assays — Evaluation of residual bioburden and organic matter.

Available methods allow rapid evaluation of residual bioburden and organic matter from the endoscope channels. Methods include a test for protein residue on the surface of endoscopes, a test able to detect protein and blood residues within the biopsy channel of endoscopes, and a test to detect protein, blood, and carbohydrate residues within the biopsy channel of endoscopes.

• Adenosine triphosphate (ATP) bioluminescence testing.

ATP bioluminescence is present in microorganisms and human cells and therefore offers a means of testing for microbial and biological residue.

ATP bioluminescence testing provides results within a few minutes. ATP bioluminescence was first used for measuring the cleanliness of surfaces in hospitals. Recent studies have demonstrated the measurement of ATP to be effective in monitoring HLD of flexible endoscopes. The ability to obtain immediate results is a significant advantage of ATP bioluminescence over standard microbial cultures. There are multiple ATP measurement tools available.

These technologies offer endoscopy units the ability to implement surveillance strategies, which might improve the quality of endoscope reprocessing. The data regarding technology for monitoring the efficacy of endoscope reprocessing are limited. The efficacy data for available techniques to measure residual organic material or ATP are noncomparative and small in sample size. ■

Antidepressants for postop pain may be premature, review finds

Antidepressants are known to provide effective pain relief for various chronic pain conditions; however, the jury is still out on their use in treating patients who suffer from acute or chronic pain following surgery. A first-of-its-kind literature review published in the September issue of *Anesthesiology*, the official medical journal of the American Society of Anesthesiologists (ASA), suggests that although most studies report positive outcomes, there is insufficient evidence to support the clinical use of antidepressants for postoperative pain.

Many surgical patients experience chronic postoperative pain many months or even years after their original surgery. "There is a need for improved treatment options in the management of postoperative pain, and antidepressants could potentially be a valuable addition," said **Ian Gilron**, MD, lead author and professor and director of clinical pain research at Queen's University in Ontario, Canada. "Our review of the literature showed several positive trial results, but we also found important research limitations in the studies, indicating a need for higher quality, more definitive trials on antidepressant use for postsurgical pain."

In the study, researchers performed a systematic review of all published clinical trials on antidepressants and postoperative pain. Fifteen studies on acute (985 patients) and three studies on chronic (565 patients) postoperative pain were included. Extracted data from the studies included pain at rest and with movement, pain relief, adverse effects, and other outcomes such as mood, sleep, and physical function.

Nearly half of the studies suggested that antidepressants resulted in significant treatment benefits over placebo. However, the researchers identified several important limitations in many of the trials. Those limitations included too few patients, inadequate safety evaluation and procedure specificity, variable dosing, and limited pain assessment.

The review said future clinical trials should optimize dosing, timing, and duration of antidepressant treatment, trial size, patient selection, safety evaluation and reporting, procedure specificity, and assessment of movement-evoked pain relevant to postop functional recovery. Trials should better define the risk-benefit ratio of antidepressants in postop pain management because these drugs can be linked to serious adverse effects in the time around surgery, the authors note. ■

COMING IN FUTURE MONTHS

- How to avoid the no. 1 sentinel event
- Should you give patients videos of their surgery?
- What you need to know: periop surgical home
- Disparity between Medicare and other surveys

'Flash sterilization' dropped -- CMS looks for properly performed `immediate-use' measures

Agency tells surveyors that the two terms are not equivalent

The Centers for Medicare and Medicaid Services (CMS) is advising its inspectors that the outmoded term "flash sterilization" has been largely dropped in healthcare in favor of the term "immediate use steam sterilization" (IUSS). CMS has issued a memorandum that goes beyond semantics by emphasizing that IUSS is a more rigorous process.

"The new IUSS term is still used to describe the process for steam sterilizing an instrument that is needed immediately, not intended to be stored for later use, and which allows for minimal or no drying after the sterilization cycle," CMS explained in an Aug. 29 memo. "IUSS is now the preferred term, because `flash' does not adequately convey the fact that sufficient time and a number of steps and safeguards are required to accomplish pre-cleaning procedures that are necessary to ensure sterilization. The old terminology is also not necessarily consistent with current recommendations for the length of cycles needed for IUSS and/or the need to use rigid sterilization containers designed specifically for IUSS."

CMS clarifies terms

IUSS is not equivalent to "short-cycle" sterilization, CMS clarified. Regardless of the cycle duration, correct use of a sterilization cycle for a wrapped/contained load that meets the device manufacturer's instructions for use is the equivalent of "terminal sterilization" and is not IUSS if it includes use of a dry time and is packaged in a wrap or rigid sterilization container intended to be stored for later use.

"Practices associated with the outmoded term 'flash' sterilization have been implicated in surgical site infections and are considered to pose an increased risk of complications because of potential barriers to thorough completion of all necessary reprocessing steps," CMS concluded. "IUSS also entails an increased risk of inadvertent contamination during transfer to the sterile field and damage to the instruments, as well as risks related to wet instruments and the potential for burns. Therefore use of IUSS, even when all steps are performed properly, should be limited to situations in which there is an urgent need and insufficient time to process an instrument by using terminal sterilization." *(To access the memo, go to http://bit.ly/1uz8rB4. This news item was written by Gary Evans and reprinted from the HICprevent blog, also published by AHC Media. To subscribe to the blog, go to http://hicprevent.blogs.ahcmedia.com.)* ■

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PS Form **3526,** October 1999 *(See Instructions on Reverse)*

Surgery centers provided Ebola checklist

The American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) is providing a facility preparedness checklist for Ebola to outpatient facilities:

☐ Monitor the situation at the Centers for Disease Control and Prevention (CDC) website at http://www.cdc.gov/vhf/ebola.

☐ Assess and ensure availability of appropriate personal protective equipment and other infection control supplies such as hand hygiene supplies.

☐ Review facility infection control policies.

☐ Recognize a case of Ebola, and be prepared to use appropriate infection control measures. signs and symptoms typically include a fever of more than 101.5 degrees Fahrenheit, severe headache, muscle pain, vomiting, diarrhea, stomach pain, and unexplained bleeding or bruising. Symptoms may appear anywhere 2-21 days after exposure to Ebola, with the average being 8-10 days.

☐ Review environmental cleaning procedures.

☐ Begin education and refresher training for providers on Ebola virus disease signs and symptoms, diagnosis, how to obtain specimens for testing, triage procedures, employee sick leave policies, how and to whom Ebola cases should be reported, and procedures to take following unprotected exposures.

☐ Avoid contact with the blood or bodily fluids of an infected patient.

☐ Have the capability to request diagnostic tests or prepare samples for shipping and testing elsewhere.

☐ Ensure laboratories review procedures for appropriate specimen collection, transport, and testing of specimens from patients who might be infected with Ebola virus. ■

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PS Form **3526,** October 1999 *(Reverse)*

Nurses conduct charity drive

Each year **Marlene Roerdon**, RN, clinical coordinator Center for Ambulatory Surgery at St. Anthony Community Hospital in Warwick, NY, asks members of her staff to attend a class or perform a community service for their professional enrichment.

"When nurse **Dee Keegan** came to me with the idea to do a service project for the community, I suggested Mother's Cupboard at St. Stephen's Church in Warwick." said Roerdon. Our Mother's Cupboard collects baby items for parents in need. Roerdon and Keegan asked nurse Deborah Kozlowski, RN, who had been a Mother's Cupboard volunteer, for information on donations. They circulated a flier among the hospital staff members, and the donations poured in. The project is ongoing with donations collected from hospital staff and the public throughout the year in the Surgical Services Department.

"I wanted to do this to give back to the community," said Keegan. "The Mothers' Cupboard was a perfect choice. We gave two boxes of baby items and have more to go. I want to thank all of my coworkers for their generosity. It's a collaboration of all of us." ■

SAME-DAY SURGERY

CNE AND CME INSTRUCTIONS

To earn credit for this activity, please follow these instructions:
1. Read and study the activity, using the provided references for further research.

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5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly.

CNE AND CME QUESTIONS

1. **When should an anesthesiologist be present for outpatient surgery, according to Brian Dunkin, MD, FACS, president elect of SAGES?**

   A. Only consider an American Society of Anesthesiologist (ASA) score of 3 or higher
   B. Only consider a Mallampati score of 3 or higher.
   C. Consider the ASA score and Mallampati score of 3 or higher.

2. **According to Leilani Kicklighter, RN, ARM, MBA, CPHRM, LHRM, with The Kicklighter Group, what is one way managers might better protect the confidentiality of documents in the probe of an adverse event?**

   A. Conduct investigations only at the behest of your attorney, because in most jurisdictions that would make the resulting document protected under attorney-client privilege.
   B. Create documents only on paper, not in the hospital's computer systems.

3. **Which of the following should NOT be documented after an adverse event, according to Patrick J. Hurd, JD, senior counsel with LeClairRyan?**

   A. Thoughts about why the incident occurred
   B. Any relation to past incidents
   C. Possible corrective action.
   D. A, B and C

4. **Patients with obstructive sleep apnea who are diagnosed and treated for the condition prior to surgery are less likely to develop what?**

   A. Serious respiratory complications.
   B. Serious cardiovascular complications

CNE AND CME OBJECTIVES

After reading Same-Day Surgery, the participant will be able to:

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