



Same-Day Surgery®

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INSIDE

- **Hand-hygiene guidelines:**
Your practice will change? . . . 4
- **Journal Review:** Hand-rubbing solutions compared to surgical scrubbing 6
- **SDS Manager:** Making a profit, but have no cash? . . . 6
- Do surgical programs need to be concerned about the West Nile virus? 7
- Obtain information on needlestick devices. 8
- Computerized inventory saves money. 8
- Prevent wrong-site surgery with stickers 10
- **Enclosed in this issue:**
— **New Supplement:** *SDS Accreditation Update*
— *Patient Safety Alert*

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Sniper, terrorist threats teach lesson to SDS managers: Be prepared

Emergency preparedness takes on new emphasis as violence spreads

On Oct. 7, 2002, a 13-year-old victim of a sniper shooting is brought by his aunt to the nearest medical facility: an outpatient clinic. The clinic makes a quick call to the attached surgery center; a surgeon, anesthesiologist, and several nurses come running to help stabilize the patient.

In November, hospitals in Chicago, Houston, San Francisco, and Washington, DC, were alerted about a terrorist threat, and the outpatient surgery providers in those areas have been reviewing and revising their disaster plans in preparation for a worst-case scenario.

Many outpatient surgery managers have thought they'd never have to be prepared for anything worse than a single patient "crashing" in the OR. However, with the current threat of violence, you have to be prepared for disasters of every type and proportion.

"All communities are beginning to take a close look at all the available medical resources that are available in the community and the important role that ambulatory surgery centers can play in the initial

EXECUTIVE SUMMARY

Recent events have made same-day surgery managers refocus their preparedness efforts for disasters of any type and proportion. The Association of periOperative Registered Nurses is developing an emergency preparedness manual for perioperative services that will be presented at the March meeting. Consider these suggestions from disaster planning experts:

- To meet accreditation requirements, have a policy in place, even if your policy is to call 911. Ensure your policy is scalable and sustainable.
- Hold disaster drills, even if you are a freestanding facility. Consider putting clerical staff in one location with a manager and using them for duties such as family assistance.
- Instead of simply directing an emergency patient off the street to another facility, call emergency medical services and offer supportive care until they arrive.

care of the 'walking wounded,'" says **Ramona Conner**, RN, MSN, perioperative nursing specialist at the Association of periOperative Registered Nurses (AORN) in Denver.

With this role in mind, AORN has assembled a task force to prepare an emergency preparedness manual for perioperative services. The manual will address internal and external disasters and will be released at the March 22 annual AORN meeting, according to **Donna Pritchard**, RN, BSN, MA, CNOR, CNA, director of nursing, perioperative services, at NYU Downtown Hospital in New York City. Pritchard, whose facility is located four blocks from Ground Zero, is a member of the AORN task force.

To those who think that a disaster will never happen to them, keep in mind that no one thought that terrorists would fly into the World Trade Center either, says **Theresa Levert**, RN, continuous quality improvement coordinator for Gastroenterology and Associates/Louisiana Endoscopy Center (LEC) in Baton Rouge.

"No one thought a sniper would be able to hit as many people as he did over several days," she says. "It's always best to be prepared."

When the sniper victim showed up next door to Dimensions Surgery Center, the team of physicians and nurses helped to sedate the teen and put him on a ventilator. A chest tube was inserted, and three intravenous lines were set up. An X-ray was taken that showed damage to his spleen. Once the teen was stabilized, the hospital was contacted. Maryland state troopers transported the victim by helicopter. The team from the surgery center was praised for an "amazing job" of stabilizing the victim. According to one media report, much of the work that the physicians expected to do before sending the teen to surgery already had been done. The victim spent five weeks in the hospital and has returned home.

To prepare for an unexpected disaster, consider these suggestions:

- **Ensure your employees are prepared. Hold disaster exercises.**

Work closely with organizations in your community and coordinate your response with the hospitals and first responders, Conner says. "I recommend that their staff be involved in a community disaster exercise at least once a year," she adds.

Gastroenterology and Associates/LEC held its own disaster drill this year that simulated an explosion at a local oil refinery that resulted in eight patients being brought to the center. "Our facility is in the city near the Exxon chemical plant, which potentially could be a target for terrorist attack," Levert says.

The drill was held on a Friday after hours. A room with a television and telephone was set up as the command center so that the center would be able to keep in touch with the media. Clinical staff had various responsibilities, including triage in the preoperative and postoperative areas. Clerical staff and one manager went to the conference room and were called out individually by an in-house speaker as needed. "That way, they weren't running around not knowing what to do, without a specific assignment," Levert says.

Some clerical staff directed traffic outside, while others assisted those designated as family

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Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).

Editorial Group Head: **Valerie Loner**, (404) 262-5475, (valerie.loner@ahcpub.com).

Senior Managing Editor: **Joy Daughtery Dickinson**, (229) 377-8044, (joy.dickinson@ahcpub.com).

Senior Production Editor: **Ann Duncan**.

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Editorial Questions

Questions or comments?
Call **Joy Daughtery Dickinson**
at (229) 377-8044.

members. Those “family members” presented staff with various demands, such as information on the cases or food and drink.

Key staff, including the manager in the conference room, used cell phones. This system was determined to be less chaotic than paging, Levert says. “Also, we had cell phones as a backup in case something happened to our in-house phone,” she says.

Patients were brought in wheelchairs and on stretchers. A nurse met them at the door and triaged them using 3"x5" homemade cards in four colors that designated the patients' acuity levels. The cards were attached to patients' wrists with large rubber bands. The pseudo-patients were “stabilized” and then “transported” using the 911 system. The drill lasted approximately 30 minutes.

Keep in mind that in an actual mass disaster, the ambulances may be tied up, Levert warns. “Our stabilization may require more time with the patient,” she acknowledges.

In terms of lessons she learned, Levert urges managers to know staff members' strengths and weaknesses. “Know that some of these people are going to be stronger at triage, or a person may be stronger with IV skills,” she says.

After the drill, managers contacted one of the local hospitals to let administrators know that they were prepared to respond in an emergency. After the drill, the plans were put in the form of a policy. [See **Emergency Management Plan** at www.same-day-surgery.com. Click on “toolbox.” Your user name is your subscriber number. Your password is sds (lowercase) plus your subscriber number. The checklist is under “disaster planning.”] “The staff have the idea and layout of our plan and the areas they will be in, and they are familiarized with it and what they're supposed to do,” she says. “It would help prevent a chaotic situation.”

- **To meet accreditation requirements, have a policy in place.**

The Joint Commission on Accreditation of Healthcare Organizations and the Wilmette, IL-based Accreditation Association for Ambulatory Health Care (AAAHC) require that facilities have a disaster plan. How organizations respond to a disaster may vary from organization to organization, says **Michael Jarema**, associate project director at the Joint Commission.

“They may call 911, because they may say, ‘We're just basic life support and CPR-certified,’” Jarema says. Their disaster plan may be to call employees and tell them to stay home because they don't want people in the disaster area, he

says. “Or they may work with their public health department which says, ‘We want you to bring physicians and be part of our triage system.’ But each organization has to decide what its role is, and what its role is in the community,” Jarema says.

Your disaster plan needs to be scalable and sustainable, “meaning that if they have an effective disaster plan in place, they can respond to one victim or multiple victims showing up at their doors,” Conner says.

NYU Downtown Hospital's plan calls for an assessment of the current status of the operating room and the postoperative care unit (PACU). [See **NYU Downtown Hospital policy on disaster plan and Emergency Management & Disaster Plan** for operating rooms and for PACU at www.same-daysurgery.com. Click on “toolbox” and

SOURCES AND RESOURCE

For more information on disaster planning, contact:

- **Ramona Conner**, RN, MSN, Perioperative Nursing Specialist, Association of periOperative Registered Nurses, 2170 S. Parker Road, Denver, CO 80231. Telephone: (800) 755-2676. Fax: (303) 338-5165. E-mail: rconner@aorn.org.
- **Joseph Hageman**, RN, Executive Director Perioperative Services, Craven Surgery Center, P.O. Box 12446 New Bern, NC 28561. Telephone: (252) 633-2000. Fax (252) 633-9045. E-mail: jhageman@crmnet.com.
- **Jerry Henderson**, Executive Director, Surgi-Center of Baltimore, 23 Crossings Drive, Suite 100, Owings Mill, MD 21117. Telephone: (410) 356-0300. E-mail: jerryh@surgicenterofbalt.com.
- **Theresa Levert**, RN, Continuous Quality Improvement Coordinator, Gastroenterology and Associates — Louisiana Endoscopy Center, 8150 Jefferson Highway, Baton Rouge, LA 70809. Telephone: (225) 927-1190. Fax: (225) 927-6605.
- **Donna Pritchard**, RN, BSN, MA, CNOR, CNA, Director of Nursing, Perioperative Services, NYU Downtown Hospital, New York City. E-mail: donna.pritchard@msnyuhealth.org.

For information on accreditation standards from the Joint Commission on Accreditation of Healthcare Organizations, contact:

- **Standards Interpretation Group**. Telephone: (630) 792-5900. To submit a question by e-mail, go to www.jcaho.org. Under “Latest from JCAHO,” click on “standards FAQ.” Then click on “Go to the Standards Online Question Submission Form.”

look under “disaster planning.”]

- **Stabilize and transfer.**

SurgiCenter of Baltimore in Owings Mill, MD, has a policy for handling patients that come off the street looking for emergency care. “Even if it is not a patient who is expressly looking for an urgent care center, we get all the patients who fall in the parking lot or like situations, just because they know we are a medical facility,” explains **Jerry Henderson**, executive director. “We stabilize and transfer to an emergency department if indicated.”

Although it’s sometimes tempting, the last thing you would want to do is simply direct a person who presents to your facility with a medical condition to the hospital for care, says **Joseph Hageman**, RN, executive director of perioperative services at Craven Surgery Center in New Bern, NC. “Murphy’s law would be in full effect that some tragic result would occur during that drive,” Hageman says.

The center’s policy is to provide supportive care until emergency medical services arrives and transports the patient to the medical center, Hageman says. “This might mean we deliver a baby or initiate CPR, but that hasn’t happened at the surgery center in 20 years,” he says.

People in need of medical care are apt to look to your facility as medical professionals, regardless of what their needs might be, Levert warns. “If in an emergency situation, they don’t say, ‘you’re a gastroenterology facility; you can’t help me.’ If you’re the closest facility, [there’s] no telling what might walk through your door,” she warns. ■

CDC approves alcohol gels for pre-op hand cleaning

Alcohol-based products are effective for preoperative cleaning of surgical staff members’ hands, when preceded by use of a nonantimicrobial soap, according to *Guidelines for Hand Hygiene in Health Care Settings* released recently by the Centers for Disease Control and Prevention (CDC).

In examining the research, the CDC said alcohol-based solutions were more effective than washing hands with plain soap, and they reduced bacterial counts on the hands more than antimicrobial soaps or detergents most of the time. In addition, most alcohol-based preparations were more effective than povidone-iodine or chlorhexidine, the agency said. In addition, the CDC says alcohol-based

products are more effective for standard hand washing or hand antiseptics by health care workers than soap or antimicrobial soaps.¹

“I think [the new guidelines] are great and long overdue,” says **Etta Hodge**, RN, MBA, director of surgical services at Christus St. Joseph Hospital in Houston. “This concept has been used in other countries for some time now.”

In the guidelines, the CDC also said staff should not wear artificial fingernails or extenders when having direct contact with patients at high risk, such as those in operating rooms. (**See excerpt of guidelines, p. 5.**)

The Joint Commission on Accreditation of Healthcare Organizations is considering ways in which these guidelines may be incorporated into the accreditation process. The Accreditation Association for Ambulatory Health Care in Wilmette, IL, had no comment.

One of the advantages of the alcohol-based antiseptics is that they save time, Hodge says. They require three minutes, vs. five to seven minutes for soap, she says. “It should be ideal for [ambulatory surgery],” Hodge says. “Time is an added value, but the efficacy is what everyone should be interested in.”

Alcohol-based products also result in better compliance with hand-hygiene protocols, according to the CDC. Pocket containers of alcohol-based hand-rub solutions, combined with bedside dispensers, has been associated with significant improvement in adherence to hand-hygiene protocols.^{2,3} Data show that health care workers may be more inclined to use alcohol-based hand rubs because they are more convenient to use.

Don’t throw out the soap yet, however.

Some alcohol products require you to start with clean hands, even outside of the preoperative hand-hygiene area, Hodge says. “It is important that you have some kind of way to ensure hand-washing compliance if you use the product that requires washing before application,” she says.

Since the alcohol-based solutions don’t remove visible dirt or blood, when those substances are present, health care workers still need to wash their

RESOURCE

To view the hand-hygiene guidelines, go to the web site: www.cdc.gov/handhygiene. At press time, the Centers for Disease Control and Prevention expected to have materials available soon on the web site to promote hand hygiene in health care facilities.

System for Categorizing Recommendations

Category IA. Strongly recommended for implementation and strongly supported by well-designed experimental, clinical, or epidemiologic studies.

Category IB. Strongly recommended for implementation and supported by certain experimental, clinical, or epidemiologic studies and a strong theoretical rationale.

Category IC. Required for implementation, as mandated by federal or state regulation or standard.

Category II. Suggested for implementation and supported by suggestive clinical or epidemiologic studies or a theoretical rationale.

No recommendation. Unresolved issue. Practices for which insufficient evidence or no consensus regarding efficacy exist.

RECOMMENDATIONS (Excerpt)

Surgical Hand Antisepsis

- A. Remove rings, watches, and bracelets before beginning the surgical hand scrub. (II)
- B. Remove debris from underneath fingernails using a nail cleaner under running water. (II)
- C. Surgical hand antisepsis using an antimicrobial soap or an alcohol-based hand rub with persistent activity is recommended before donning sterile gloves when performing surgical procedures. (IB)
- D. When performing surgical hand antisepsis using an antimicrobial soap, scrub hands and forearms for the length of time recommended by the manufacturer, usually 2-6 minutes. Long scrub times (e.g., 10 minutes) are not necessary. (IB)
- E. When using an alcohol-based surgical hand-scrub product with persistent activity, follow the manufacturer's instructions. Before applying the alcohol solution, prewash hands and forearms with a nonantimicrobial soap and dry hands and forearms completely. After application of the alcohol-based product as recommended, allow hands and forearms to dry thoroughly before donning sterile gloves. (IB)

Other Aspects of Hand Hygiene

- A. Do not wear artificial fingernails or extenders when having direct contact with patients at high risk (e.g., those in operating rooms). (IA)
- B. Keep natural nails tips less than ¼-inch long. (II)
- C. Wear gloves when contact with blood or other potentially infectious materials, mucous membranes, and nonintact skin could occur. (IC)
- D. Remove gloves after caring for a patient. Do not wear the same pair of gloves for the care of more than one patient, and do not wash gloves between uses with different patients. (IB)
- E. Change gloves during patient care if moving from a contaminated body site to a clean body site. (II)
- F. No recommendation can be made regarding wearing rings in health care settings. Unresolved issue.

Administrative Measures

- A. Make improved hand-hygiene adherence an institutional priority and provide appropriate administrative support and financial resources. (IB)
- B. Implement a multidisciplinary program designed to improve adherence of health personnel to recommended hand-hygiene practices. (IB)
- C. As part of a multidisciplinary program to improve hand-hygiene adherence, provide health care workers with a readily accessible alcohol-based hand-rub product. (IA)
- D. To improve hand-hygiene adherence among personnel who work in areas in which high workloads and high intensity of patient care are anticipated, make an alcohol-based hand rub available at the entrance to the patient's room or at the bedside, in other convenient locations, and in individual pocket-sized containers to be carried by health care workers. (IA)
- E. Store supplies of alcohol-based hand rubs in cabinets or areas approved for flammable materials. (IC)

Source: Centers for Disease Control and Prevention. Guideline for hand hygiene in health-care settings. Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. *MMWR* 2002; 51(RR16):1-44.

hands with soap and water, according to the CDC.

Surgical gloves still are necessary, the CDC emphasizes. "Gloves reduce hand contamination by 70% to 80%, prevent cross-contamination, and protect patients and health care personnel from infection," the agency says.¹ Hand rubs should be used before and after each patient, just as gloves should be changed before and after each patient, the CDC adds.¹ Hand lotions and creams used twice a day can help prevent and treat irritant

contact dermatitis caused by hand-hygiene products, the agency advises.

The CDC is asking health care facilities to develop and use a system for measuring improvements in compliance with the hand hygiene recommendations. Some of the suggested performance indicators include:

- periodic monitoring of hand-hygiene adherence and providing feedback to personnel regarding their performance;

- monitoring the volume of alcohol-based hand rub used/1,000 patient days;
- monitoring adherence to policies dealing with wearing artificial nails;
- focused assessment of the adequacy of health care personnel hand hygiene when outbreaks of infection occur.¹ (For more information, see *Same-Day Surgery*, January 2002, p. 4, and July 2001, p. 73.)

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1. CDC. Guideline for hand hygiene in health care settings. Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. *MMWR* 2002; 51 (RR16):1-44.
2. Pittet D, Hugonnet S, Harbarth S, et al. Effectiveness of a hospitalwide programme to improve compliance with hand hygiene. *Lancet* 2000; 356:1,307-1,312.
3. Pittet D. Compliance with hand disinfection and its impact on hospital-acquired infections. *J Hosp Infect* 2001; 48(suppl A):S40-S46. ■



JOURNAL REVIEW

Study shows hand-rubbing solution safe alternative

A recent study published in the *Journal of the American Medical Association (JAMA)* found that hand rubbing with a liquid aqueous alcoholic solution can be safely used as an alternative to traditional surgical hand scrubbing.¹

The study included 4,387 consecutive patients who underwent surgery between Jan. 1, 2000, and May 1, 2001, at six surgical services at hospitals in France. The surgical services used two hand-cleansing methods alternately every month. They were a hand-rubbing protocol with 75% aqueous alcoholic solution containing propanol-1, propanol-2, and mecetronium etilsulfate; and a hand-scrubbing protocol with antiseptic preparation containing 4% povidone iodine or 4% chlorhexidine gluconate. The main outcome measures were 30-day surgical site infection rates, as well as the operating room teams' tolerance of and compliance with hand washing.

The two protocols were comparable in terms

of surgical site infection risk factors. Surgical site infection rates were 55 of 2,252 (2.44%) in the hand-rubbing protocol and 53 of 2,135 (2.48%) in the hand-scrubbing protocol. The difference was 0.04% (95% confidence interval, - 0.88% to 0.96%).

Hand rubbing with aqueous alcoholic solution was preceded by a one-minute nonantiseptic hand wash before each surgeon's first procedure of the day and before any other procedure if the hands were soiled. This protocol was as effective as traditional hand scrubbing with antiseptic soap in preventing surgical site infections, the authors conclude.

Based on subsets of personnel, compliance with the recommended duration of hand antiseptics was better in the hand-rubbing protocol than with the hand-scrubbing protocol (44% vs. 28%, respectively; P = .008). Tolerance also was better, with less skin dryness and less skin irritation after aqueous solution use, the authors report. (For more information, see *Same-Day Surgery*, January 2002, p. 4.)

Reference

1. Parienti JJ, Thibon P, Heller R. Hand-rubbing with an aqueous alcoholic solution vs. traditional surgical hand-scrubbing and 30-day surgical site infection rates. *JAMA* 2002; 288:722-727. ■

Same-Day Surgery Manager



Do you understand the dynamics of cash flow?

By **Stephen W. Earnhart, MS**
President and CEO
Earnhart & Associates
Dallas

When we start a new business or invest in a going concern, most of us do so in anticipation of some reward for our efforts. Personal satisfaction and the knowledge that we are doing something that is meaningful are important.

The key to continuing that effort usually involves some profits (cash).

Many of the individuals I meet with do not understand the way the finances of a surgery center work. Let's discuss.

How many times have you heard your surgeons say, "We are busting our butts, but not making any money"? You wonder, how can that be? Actually, there are many surgery centers that are making a profit, but no cash. The average surgery center costs about \$4.5 million to develop the operating entity; add on a chunk more if you buy the building. This includes startup cost, improvements to the existing space, equipment, and money on hand to pay the expenses until you start doing cases and getting reimbursement.

Most investors do not pay all that money up front in cash; they leverage it with some debt financing, i.e., bank loans or equity loans. I don't like equity loans with which they get money from noncontributing individuals, the so-called passive investor. But regardless of how the investors get the money, much of it must be in the form of cash. We recommend about half of it be in cash.

A serious problem we encounter is that groups of surgeons build a center and put up only a small amount of cash (usually a loan from a bank), and they essentially charge the rest. Those charges, not unlike credit cards, require payments on a monthly basis. This "debt service" is usually the first bill that is paid each month. The rationale is that once the business gets going, the flow of cash through the business will pay for all the expenses and cover the debt service of the loans, and whatever is left over is profit. That profit is then divided among the investors (and of course, the staff!), and everyone is happy with the flow of cash.

Unfortunately, many physician groups put down the minimum amount of cash to get started, and subsequently, all their profits go to paying the debt. It's like only paying the minimum on your credit card: You never will get out of debt. Physicians obtain loans for the equipment, the leasehold improvements, lines of credit, etc. So while your surgery center may make lots of money on the profit and loss statement, all the cash goes to service the debt. To make matters worse, your surgery center essentially is making money as an investment, and the investors still have to pay taxes on that "income." However, the cash flowing through the business never gets past debt service, so the investors have to take money out of their pockets to pay taxes on the profits they never received cash for in the first place.

At some point in time, that debt service will go away, and that cash will become available to give

out to the investors. But that process can take many years, and there are a score of surgery center investors who retire before getting out what they put in. Proper planning capitalization minimizes that risk, but surgery centers are a risky business even today.

There is no other way but to accept that investment in any new business is always a risk, but the best way to help the business grow is to provide as much capital as possible in the form of cash and not debt. With the lower interest rates available today, refinancing existing debt is a great option to consider. If you want to help the center increase cash flow, focus on reducing personnel cost and supply cost. Those two items generally make up 60% of your monthly expenses. Then, once that cash starts to flow, get in line to get your share.

(Editor's note: Contact Earnhart at 5905 Tree Shadow Place, Suite 1200, Dallas, TX 75252. E-mail: searnhart@earnhart.com. Web: www.earnhart.com. Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management.) ■

West Nile virus appears after surgical case

The Centers for Disease Control and Prevention (CDC) is investigating a case of West Nile virus infection in a Mississippi resident diagnosed almost four weeks after receiving multiple units of blood during a surgical procedure. The patient reported having been bitten by mosquitoes several times before the procedure; however, as a precaution, remaining blood products from donors of blood to the patient voluntarily have been withdrawn from use.

Those donors are being contacted so they can be tested for the virus. Recipients of blood components from the donors also are being contacted and tested. In addition, the CDC has received reports from 10 states of 15 patients with confirmed West Nile infection diagnosed after receiving blood products within one month of the onset of illness.

"It is likely that not all of the 15 patients were infected via blood products; all lived in areas with active West Nile virus activity and thus may have been infected via mosquito bites," according to the CDC (web: www.cdc.gov/od/oc/media/pressrel/r021003.htm).

SOURCES

For more information, contact:

- **Dorothy Fogg**, RN, BSN, MA, Senior Perioperative Nursing Specialist, Center for Nursing Practice, Health Policy, and Research, Association of periOperative Registered Nurses, 2170 S. Parker Road, Denver, CO 80231. Telephone: (800) 755-2676. Fax: (303) 338-5165. E-mail: dfogg@aorn.org.
- **Centers for Disease Control and Prevention**, National Center for Infectious Diseases, Division of Vector-Borne Infectious Diseases, P.O. Box 2087, Fort Collins, CO 80522. Fax: (970) 221-6476. Web: www.cdc.gov/ncidod/dvbid/westnile. E-mail: vbid@cdc.gov. CDC Voice and Fax Information Service: (888) 232-3228.

As of Nov. 20, 2002, the number of West Nile virus cases reported to the CDD had reached 3,698, with 212 deaths, in 40 states. And lest you think that you don't have to worry about the virus during the winter, heed this warning: "In warmer climates, it's a year-round concern," says **Dorothy Fogg**, RN, BSN, MA, senior perioperative nursing specialist in the Center for Nursing Practice, Health Policy, and Research, Association of periOperative Registered Nurses (AORN) in Denver. There are no approved tests that can be used to screen blood products or organs for the virus.

The CDC, Food and Drug Administration, and other groups are investigating possible cases of virus transmission through blood transfusion and organ transplantation. The CDC has asked that physicians notify public health authorities of any patients who develop symptoms of West Nile virus infection within four weeks of receiving a blood transfusion or organ transplantation. Also, physicians should report patients with West Nile virus infection whose symptoms begin in the weeks preceding blood or organ donation. Most people who have West Nile virus do not show symptoms, but some individuals develop fever and headache. [See Patient Information sheet www.same-day-surgery.com. Click on "toolbox." Your user name is your subscriber number. Your password is sds (lowercase) plus your subscriber number. The checklist is under "patient documentation/patient education."]

Universal precautions are sufficient to prevent transmission of the virus, according to AORN. However, there is a risk of transmitting the virus with needle sticks, according to AORN. (See information on web site, above right.)

Take the usual needlestick precautions for

disposables, such as no recapping and no bending, Fogg suggests. Comply with the Occupational Safety and Health Administration (OSHA) directive on needlestick precautions to the degree possible, she advises. (For more on the OSHA directive, see *Same-Day Surgery*, November 2001, p. 134. For more information in the virus impact, see *SDS*, November 2002, p. 143.) ■

Web site lists devices for needlestick safety

List designates primary prevention technologies

The National Alliance for the Primary Prevention of Sharps Injuries in Carlsbad, CA, has a new web site that categorizes needlestick safety devices based on whether the device offer primary or secondary prevention against needlesticks. The web site address is www.NAPPSI.org. Click on "Safety Device List."

The alliance is made up of health organizations, medical device manufacturers, and health care professionals who are working to reduce the number of sharps in the workplace. The group estimates that 800,000 sharps injuries occur each year in U.S. health care facilities. Any health care worker who handles sharp devices or equipment such as lancets, suture needles, or scalpels is at risk, the alliance emphasizes. (For more information on needlestick prevention, see *Same-Day Surgery*, January 2001, p. 3.) ■

To use inventory system effectively, plan ahead

Designate staff, prepare preference cards

As reimbursement levels fall, same-day surgery managers are faced with the task of improving profit levels. Because increasing volume can increase profits, managers often look at increasing the number of cases that can be handled within the workday.

"Same-day surgery programs can't just add a third shift to increase the number of cases that can be performed, so managers have to find other ways to improve efficiency and productivity,"

EXECUTIVE SUMMARY

Features of a computerized inventory system that result in cost-savings for a same-day surgery program include:

- integration with scheduling and billing systems;
- preference cards that help system track supplies and monitor inventories;
- automatic generation of purchase orders;
- alerts that signal low levels of supplies.

says **F. Craig Veach**, associate vice president for Source Medical Solutions, a health care software company based in Birmingham, AL. One way to become more efficient and to improve the bottom line is to handle inventory control and purchasing in a better way, he suggests.

By computerizing your inventory and integrating it with your scheduling and billing systems, you can improve your efficiency and enjoy a cost-savings, Veach says. "Same-day surgery staff members tend to overstock, but a computerized inventory system with a perpetual inventory means that you know what you have on a day-to-day basis and can order every other day rather than weekly or biweekly," he says. The ability to order more frequently without having to do a manual inventory means that less stock is kept on hand, and this situation improves cash flow, he adds. For example, a same-day surgery center that spends \$1.2 million each year on supplies when ordering on a weekly basis, can order every other day and reduce spending to \$700,000, Veach says.

A good inventory system will utilize preference cards as a way of tracking supplies that are used and also will monitor your stock and alert you when a supply falls below your preset par level, Veach says. The system should help you identify supplies that are not used so you can evaluate whether you should continue stocking them, he adds.

When you have seven operating rooms and three procedure rooms in a freestanding multispecialty same-day surgery program, inventory control can be overwhelming, says **Terri Gatton**, RN, CNOR, administrator of the Zanesville (OH) Surgery Center. While many managers may cringe at the thought of developing preference cards to integrate with the inventory and scheduling systems, the effort is worthwhile, Gatton says.

Her facility is only three years old, so developing the preference cards was part of the start-up, she explains. "I have gone through a conversion from a system that did not use preference cards

to one that did, and I still recommend that preference cards be developed to ensure the best use of the inventory system," she adds.

Although Gatton chose to develop preference cards for all 40 surgeons and their procedures, Veach suggests that same-day surgery managers who are converting to a computerized system consider producing preference cards for their highest volume procedures. "Because 20% of your cases produce 80% of your revenue, focus your efforts on them," he says. Other cases such as eye procedures may require a generic procedure cards that can be edited as needed, he adds.

Another timesaver for same-day surgery programs that are starting up a new system can come from your vendors, says Veach. Most vendors can supply you with a downloadable supply and

SOURCES AND RESOURCES

For more information about computerized inventory systems, contact:

- **F. Craig Veach**, Associate Vice President, Source Medical Solutions, Two N. Plains Industrial Road, Wallingford, CT 06492-2381. Telephone: (800) 562-7069, ext. 503 or (203) 949-6290, ext. 503. E-mail: Craig.Veach@source med.net.
- **Terri Gatton** RN, CNOR, Administrator, Zanesville Surgery Center, 2907 Bell St., Zanesville, OH 43701. Telephone: (740) 452-5145. Fax: (740) 454-7748. E-mail: terrigatton@zanesvillesc.com.

For more information about computerized inventory systems specific to same-day surgery, contact:

- **Camberley Systems**, 175 Highland Ave., Third Floor, Needham, MA 02494. Telephone: (800) 886-4325 or (781) 444-1424. Fax: (781) 444-2805. Web: www.camberley.com. Camberley Systems offers SurgeOn, a software package designed for same-day surgery programs that includes scheduling, billing, managing materials, report writing, and variance reporting. Prices vary according to number of users and specific services included in software package.
- **Source Medical Solutions**, 100 Grandview Place, Suite 400, Birmingham, AL 35243. Telephone: (205) 972-1222. Fax: (205) 968-6161. Web: www.sourcemed.net. In 2002, Source Medical Solutions merged with Wallingford, CT-based HealthIS, and it now offers SurgiSource. SurgiSource's features include OR scheduling, preference card management, materials management, medical record and surgical note integration, and billing and accounts receivables. A typical system for a surgery program that has five users is \$26,000 for software, project management, and training, and \$20,000 for hardware.

equipment list so you don't have to enter all the information, he explains.

Gatton knew what features she was looking for in a system, but she says that the key to successfully using your inventory system is to have a dedicated materials management coordinator. (See recommended features, below.)

"Don't expect a staff member to assume these responsibilities on top of other jobs," she says. By having one person who manages the inventory, purchasing, and receiving, you can keep a close control on your inventory, she says. Quarterly manual inventory counts that are done to double-check the inventory show that the computerized system is usually within \$2,000 of the actual count, Gatton adds.

The materials management person doesn't have to be a clinical person, but Gatton has found that there are advantages if you find a nurse to handle the position, as she has.

"Not only does she understand medications and recognize inconsistencies, but she can also filter out vendor representatives who want to see me," she says. ■

Inventory system should include these features

When shopping for an inventory system, look for one that addresses the specific needs of your same-day surgery program, suggests **Terri Gatton**, RN, CNOR, administrator of the Zanesville (OH) Surgery Center. Otherwise, you invest too much time and money in a new system to try something that may not be designed for surgery, she adds.

"There are many practice management systems that have an inventory system, but they generally don't work for same-day surgery because there are more variables and a higher volume of purchasing," says **Scott Palmer**, group vice president for SurgiSource, a product that includes inventory management produced by Birmingham, AL-based Source Medical Solutions. Palmer and Gatton suggest that you look for the following features to make sure you have a system that will save you time and costs:

- **Item master.**

Your item master should support multiple vendors, manufacturers, and locations, he says. The system also should be able to generate purchase

orders as needed and even send them electronically if your vendor supports that capability, Palmer says.

Electronic purchase order transmission is a must, Gatton says. "This feature saves a lot of time and manpower," she explains.

- **Preference cards and pick lists.**

Preference cards need to be integrated into the system because they are the basis for the ordering advice, says Palmer. Preference cards cut down on staff time because only the exceptions must be entered, he adds.

Although some same-day surgery managers choose to create preference cards for the procedures performed most often, Gatton suggests cards for each physician and each procedure. "This keeps our ordering process accurate, and nurses don't have to list as many exceptions," she adds.

- **Reporting systems.**

You should be able to get reports that show your current costs in relation to historical costs, as well as to industry standards, Palmer suggests. This helps you make informed decisions and to identify trends that need to be investigated, he adds.

- **Physical count reconciliation.**

You should plan on a quarterly manual count to verify your computerized inventory, Gatton says. Updating your computerized inventory to reflect actual, manual count should be a simple process, she suggests.

- **Alerts when supplies are low.**

Using par levels set by the same-day surgery program manager, a computerized inventory system should alert the materials manager that a certain item has dropped below a predetermined level, Palmer says. ■

Stop wrong-site surgery with a simple sticker

Stickers aren't just for kindergartners. In fact, using them in a same-day surgery program can help you make sure you are performing the correct procedure on the correct patient in the correct location.

The SurgiGuard Labeling system (Colby Manufacturing in Tullytown, PA) is comprised of two labels. One shows the words "NO CUT," and the other is a VeriSite label that provides a place for the pre-op nurse to write the patient's name, the site, the procedure, the surgeon, and the date.

RESOURCE

For more information, or to place an order for the SurgiGuard labeling system, contact:

- **Colby Manufacturing Corp.**, 1016 Branagan Drive, Tullytown, PA 19007-6301. Telephone: (800) 969-3718 or (215) 949-2860. Fax: (215) 949-1680. Web: www.colbymfg.com.

Also included on the VeriSite label is an extra label with the same number as the VeriSite label that can be pulled off and placed on the medical chart.

"The presence of this number on the chart shows that the site, patient, and procedure were verified according to policy," says **Kathy G. Feuerman**, general manager of Colby Manufacturing. When introducing this product, allow time to introduce the product to the appropriate committees, write the policy or procedure to accompany the use of the labels, and educate staff, Feuerman advises.

The advantage of this system over the practice of marking and signing the site directly on the skin, is that the label in the chart is a quick way to find the notations that document verification and extra proof that verification did occur, she explains.

Application of the label begins prior to surgery with the pre-op staff completing the information and placing the labels, says **Mark Vandersnick**, RN, nurse manager of the operating room at Black Hills Surgery Center in Rapid City, SD. The labels stay on the patient until the operating room team again has verified the patient's identity, procedure, surgeon, and site, then the VeriSite label is removed to prep for surgery.

The only downside to the labeling system is the reaction of some patients who object to the graphics on the "No Cut" label, which shows a scalpel, or who object to having a sticker placed on their skin, Vandersnick says.

This doesn't happen often, and when it does, nurses don't place labels, he adds. "We use it for almost every procedure except eyes, ears, and procedures such as vasectomies," Vandersnick says. The labels come in 3" round, 1.5" round and 1"x 3" rectangular shapes, Feuerman says. The cost is \$1.35 per label, but volume discounts are available, she says.

The company also will provide sample policies

and procedures to same-day surgery programs interested in the labeling system. (See resource box, at left.) ■

Nearly one-fourth of hospitals reuse SUDs

More than 24% of all U.S. hospitals reuse single-use medical devices (SUDs), according to the Food and Drug Administration (FDA).

According to a recent telephone survey of all hospitals conducted by the FDA, the most commonly reused SUDs are:

- sequential compression device sleeves (15.8% of all hospitals);
- drill bits, saws, blades, or burrs (7.3% of all hospitals);
- biopsy forceps and snares (6.2% of all hospitals).

Nearly half of all hospitals with more than 250 beds reused SUDs, while only 12% of hospitals with fewer than 50 beds reuse them.

Of the hospitals reusing SUDs, 84% use third-party reprocessors. The remaining 15.4% of hospitals reprocess at least some in-house. To see the survey results, go to: www.fda.gov/cdrh/Reuse/survey-execsum.html.

CD-ROM offers details

The FDA active enforcement of premarket notification submission requirements for class II SUDs is in effect for hospitals. The FDA is making a CD-ROM set available that explains the regulatory requirements for hospitals that reprocess SUDs.

The CD-ROM set, *An Overview of the Regulatory Requirements for Reprocessing of Single-Use Devices by Hospitals*, covers labeling, medical device tracking, problems with reprocessing, registration and listing, premarket review, and corrections and removals.

Free copies of the discs are available at www.fda.gov/cdrh/reuse/reuse-important.shtml.

Facilities that use outside reprocessors should ensure that the reprocessing company is registered

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with the FDA and meets all the agency's premarket certification requirements, advises **Mark Mayo**, executive director of the Illinois Freestanding Surgery Center Association in St. Charles.

While only hospitals fall under the federal mandates on reprocessing SUDs, this step also is advisable for surgery centers, Mayo says. "Also, facilities should make sure the company is insured for malpractice and make sure items are properly labeled and coded to keep track of when and how many times they are reprocessed," he says. ■

CE/CME questions

Save your monthly issues with the CE/CME questions to take the two semester tests in June and December. A Scantron form will be inserted in those issues, but the questions will not be repeated.

- How often should facilities hold disaster exercises, according to Ramona Conner, RN, MSN, perioperative nursing specialist at the Association of periOperative Registered Nurses?
 - at least once every six months
 - at least once a year
 - at least once every 18 months
 - at least once every two years
- In examining hand hygiene research, how did alcohol-based solutions compare with washing hands with plain soap, according to the Centers for Disease Control and Prevention?
 - Alcohol-based solutions were more effective.
 - Alcohol-based solutions were less effective.
 - Alcohol-based solutions were equally effective.
- A recent study published in the *Journal of the American Medical Association* found that hand rubbing with a liquid aqueous alcoholic solution compared with traditional surgical hand scrubbing in the following way:
 - The two protocols were comparable in terms of surgical site infection risk factors.
 - Alcohol hand scrubs require the same amount of scrub time.
 - Alcohol hand scrubs are less effective than traditional scrubs.
- What is a key to successfully using a computerized inventory system, according to Terri Gatton, RN, CNOR, administrator of the Zanesville Surgery Center?
 - a dedicated materials management coordinator
 - thorough physician education
 - rotation of materials management responsibility to avoid staff burnout
 - inventory list that includes items you may need in the future

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Conflict-of-Interest Disclosure:
Rebecca Twersky reveals that she is on the speaker's bureau and performs research for Stuart/Zeneca Pharmaceuticals, Roche Laboratories, Anaquest, Abbot, Marrison Merrill Dow, and Glaxo Wellcome.

CE objectives

- Identify how often disaster exercises should be held. (See "Sniper, terrorist threats teach lesson to SDS managers: Be prepared," in this issue.)
- Compare alcohol-based solutions with washing hands with plain soap. (See "CDC approves alcohol gels for pre-op hand leaning.")
- Compare hand rubbing with a liquid aqueous alcoholic solution with traditional surgical hand scrubbing in terms of surgical site infection risk factors. (See "Study shows hand-rubbing solution safe alternative.")
- Understand the different components required for an effective computerized inventory control system. (See "To use inventory system effectively, plan ahead.")

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SDS

ACCREDITATION UPDATE

Covering Compliance with Joint Commission and AAAHC Standards

Avoid the most common Type 1 recommendation: Learn to credential physicians, staff properly

Simplicity and standardization create strong credentialing process

Keeping up with credentials and privileges for 85 physicians plus the staff members of a busy four-operating room multispecialty center is not an easy task, but the staff at Salinas (CA) Surgery Center has developed a system that works.

"Our surveyors have always complimented my staff and me on our process for credentialing staff members and physicians," says **Christine S. Gallagher**, RN, BSN, CNOR, executive director.

That's quite an accomplishment, because the most common reason for Type 1 recommendations for ambulatory programs from the Joint Commission on Accreditation of Healthcare Organization (JCAHO) surveyors relates to credentialing standards, and those standards are the reason for many recommendations from the Accreditation Association for Ambulatory Health Care (AAAHC) in Wilmette, IL.

The Joint Commission reports that almost 22% of ambulatory care facilities surveyed during the first six months of 2002 did not meet Standard HR.7.1, which relates to credentialing criteria.

Failing to apply credentialing criteria in the same manner to all physicians results in the most Type 1 recommendations following a Joint Commission survey, says **Stephen C. Anderson**, RN, MBA, a consultant with Chicago-based Joint Commission Resources. "This standard [HR.7.1] requires that credentialing criteria be applied uniformly. This standard is not met when your medical director signs off on his or her own privileges just as he or she did for all other members of the medical staff." Another physician must review and approve the medical director's privileges, he adds.

Remember that when you are first credentialing a physician, check primary sources of information

about the physician's training and licenses, says Anderson. Seeing the physician's diploma or having a copy of the diploma does not qualify as verifying the diploma, he says.

"You must contact the organization that granted the diploma and receive verification from that organization," he explains.

Another option is to use American Medical Association's Physician Profile Service but be sure that you read the report correctly, says Anderson. **(See resource box, p. 2.)**

"Be sure that you see the word 'verified' next to the physician's name," he says.

One aspect of credentialing that is harder for freestanding centers is the peer-review requirement for re-credentialing, says **Jerry W. Henderson**, RN, CNOR, executive director of the Surgicenter of Baltimore in Owings Mill, MD. "When you have a single specialty center and one group of physicians involved, it is tough to get the physicians to evaluate each other's outcomes, complication rates, documentation, and other patient care issues," she admits.

New supplement to solve your accreditation problems

In response to reader interest, we are adding a new quarterly supplement covering accreditation issues. We're here to answer your most pressing questions, solve your most difficult problems, and share your best tips. Contact: Sheryl Jackson, American Health Consultants, P.O. Box 740056, Atlanta, GA 30374. Fax: (404) 262-5447. E-mail: SherylSmJackson@cs.com. ■

EXECUTIVE SUMMARY

With credentialing mistakes causing the most Type 1 recommendations for ambulatory programs, same-day surgery manage should do the following:

- Make sure medical directors don't approve their own privileges.
- Check primary sources for medical staff credentials.
- Use tickler files or other reminders to make sure you re-credential in a timely manner.
- Centralize credential files, and designate one person to oversee process.

One way to make the process easier is to appoint a peer-review committee, says **Cheryl Munsinger**, RN, BSN, CNOR, director of clinical services at First SurgiCenter, Kearney, NE. "The members of the peer-review committee review charts on a quarterly basis and handle any problems that are identified," Munsinger says.

If the members of the committee think they need an objective opinion, they call upon a respected physician who is not a member of the surgery center's staff to review the issue, she explains. Using an outside, objective physician removes the personality issue from review of a colleague's performance, she adds.

Even with the challenges of peer review, freestanding centers do have an advantage over hospital-based programs in credentialing, Henderson says. "I think that it is easier for freestanding same-day surgery centers to make sure they are up-to-date with credentialing information because everything is in the center and the manager is not relying upon another department within the hospital," she says.

Gallagher improved her facility's credentialing process by centralizing everything. All of the licenses, list of privileges, Drug Enforcement Agency (DEA) numbers, and physician's information is kept in one place, in one file for each physician, she says. "We have a standard format for each file as well, with all of the information placed in the same order in each file," she adds. This standardization makes it easy for anyone to find needed information, she says.

When The Surgery Center at Nacogdoches (TX) opened, there were three people responsible for different parts of the credentialing process, says **Jeanie Suhor**, RN, CNOR, director of the center. "There was just too much for one person to handle, but it also made it more important for each of us to thoroughly know our bylaws and

policies related to credentialing to make sure nothing was missed," she says.

Now, that the center has been open for a couple of years, staff members are not having to credential large groups of physicians at one time. There is now one person to oversee all credentialing and re-credentialing activities, and the process goes much more smoothly, she adds.

Munsinger also has one person responsible for maintaining the credential files. "Each credential file is in a portfolio file, with each section labeled clearly so the surveyor can find information on source verification, educational information, and licenses," she says. "We try to make it easy for the surveyor to find the information and to see how our process works." ■

SOURCES AND RESOURCE

For more information on accreditation tips, contact:

- **Stephen C. Anderson**, RN, MBA, Consultant, Joint Commission Resources, and CEO, Healthcare Information Access, P.O. 17940, Seattle, WA 98107. Telephone: (206) 795-2831. E-mail: nadvisors@qwest.net.
- **Jerry W. Henderson**, RN, CNOR, Executive Director, Surgicenter of Baltimore, 23 Crossings Drive, Suite 100, Owings Mill, MD 21117. Telephone: (410) 356-0300. E-mail: jerryh@surgicenterofbalt.com.
- **Christine S. Gallagher**, RN, BSN, CNOR, Executive Director, Salinas Surgery Center, 955-A Blanco Circle, Salinas, CA 93901. Telephone: (831) 753-5800.
- **Cheryl Munsinger**, RN, BSN, CNOR, Director of Clinical Services, First SurgiCenter, 3500 Central Ave., Kearney, NE 68848. Telephone: (308) 865-1462.
- **Jeanie Suhor**, RN, CNOR, Director, The Surgery Center of Nacogdoches, 4948 N.E. Stallings Drive, Nacogdoches, TX 75965. E-mail: jeanie.suhor@tenethealth.com.
- **American Medical Association's Physician Profile Service**. You can access the service online at www.ama-assn.org. From the home page, click on "physicians," then choose "products and services," then choose "credentialing products." Cost for a search is \$26 per physician name. You can pay by credit card or establish an account. You can set up an account online or call (800) 665-2882. If you want to order a search by fax, send the request to (312) 464-5801. Send mail orders to: AMA Remittance Control Area/PPS, P.O. Box 109054, Chicago, IL 60610.

Keep track of staff license renewals, certifications

Use calendars, computerized reminders

You know that you have a competent, well-trained staff, but if your documentation doesn't reflect up-to-date training, certifications, and licenses, you don't meet accreditation standards.

In addition to credentialing standards, staff competency standards also show up in the Joint Commission on Accreditation of Healthcare Organization's list of standards most often cited as the reason for Type 1 recommendations. Joint Commission's Standard HR.5, which requires the organization to assess staff members' ability to perform their job duties, was responsible for 16.1% of Type 1 recommendations during the first six months of 2002.

"Make sure you can document that staff members know how to physically perform their tasks, possess the cognitive skills needed for making decisions in their jobs, and have the interpersonal skills needed to work as a team member, communicate with patients, and interact with physicians," points out **Stephen C. Anderson, RN, MBA**, a consultant with the Chicago-based Joint Commission Resources.

Also, when you are measuring competencies, test the staff member's competency for all age groups with which they work, Anderson adds. Although the same-day surgery staff plans to simplify the process, Joint Commission surveyors praised the annual competency assessment's age-related component at The Surgery Center at Nacogdoches (TX).

"We don't assign age-related competencies throughout the entire competency test, but we have a two-page checklist that measures staff members abilities to provide care to different age groups," says **Jeanie Suhor, RN, CNOR**, director of the center. [See checklist at www.same-day-surgery.com. Click on "toolbox." Your user name is your subscriber number. Your password is sds (lowercase) plus your subscriber number. The checklist is under "staffing documents."]

For example, for infants and toddlers, the center checks to confirm that the nurse provides a safe environment, which includes watching the child at all times, Suhor says.

To measure communication skills with infants, toddlers, and young children, we make sure that

the staff member smiles and uses a soft and reassuring voice," she adds.

Don't forget that if you teach a new skill to staff members, you have to document that they performed that skill in their working environment, Anderson says. "If you have a note in a file that an employee was oriented for use of a new laser, the surveyor will ask to see the chart for the patient who was undergoing a procedure with the laser," he says. "It is not acceptable to say that the employee never saw the laser used, just had a demonstration given by a vendor."

Same-day surgery program managers with large staffs may be overwhelmed by the task of making sure employee training and certifications are current, but **Christine S. Gallagher, RN, BSN, CNOR**, executive director of Salinas (CA) Surgery Center has found a straightforward way to make sure employees know when they need to renew certifications.

Tracking required education or certification for staff members is simply a matter of printing out a spreadsheet with all employees' names and the dates by which they need to complete CPR or other training, Gallagher says. "

We post the spreadsheet in our employee lounge, so everyone can keep up with what they need to complete," she says. "The incentive to meet all training and certification requirements is pretty strong. We don't allow them to work if they haven't met their requirements."

For staff members with professional licenses, a note is sent to them several weeks before the expiration, says Gallagher. The expiration dates are tracked by computer, she adds. "Often the nurse has already received the new license and has just forgotten to bring it to us," she points out.

Managers at First SurgiCenter in Kearney, NE, have further simplified the process for many certifications. "Regardless of their hire date, all of our staff renew their [basic cardiac life support] and [advanced cardiac life support] certification at the same time each year," says **Cheryl Munsinger, RN, BSN, CNOR**, director of clinical services at the center. License renewals, which happen throughout the year, are monitored by the office manager, who serves as human resources coordinator. "She checks with employees a few weeks prior to their license expiration date to get a copy of the current one," Munsinger explains.

Track the number of staff who do and don't meet training and certification requirements in a timely manner, Anderson suggests. Joint Commission Standard HR 4.2 requires the organization to

use staff competency data to identify ways to improve education and training, he says. Failure to meet this standard was responsible for more than 12% of Type 1 recommendations for ambulatory care facilities throughout 2001, he adds.

A manager should look at data such as how many staff members complete CPR training on time, says Anderson. If there are large numbers of staff who don't meet the requirement, identify ways to increase the timeliness of training, and be sure to write up your plan, he suggests. Those ways might include offering CPR classes on-site, after regular work hours, or planning to use PRN staff to cover for staff members to attend classes.

In addition to reviewing your training and educational requirements, be sure to have job descriptions that truly match the employee's job responsibilities, Anderson points out. "It's hard to adequately assess someone's competency if the responsibilities are not clearly defined," he says. ■

Where should you start? Read the standards

Accreditation survey. These two words elicit many different reactions from people, but everyone agrees that preparing for and undergoing a survey is time-consuming, stressful, and sometimes unpleasant. Sometimes, the overwhelming question is, where do you start?

"My first recommendation is to read the manual," says **Stephen C. Anderson**, RN, MBA, a consultant with Joint Commission Resources in Oakbrook Terrace, IL. "If someone doesn't read the manual, he or she misses some fundamental concepts of the survey process that will cause problems."

In addition, mark up your standards manual, suggests **Jerry W. Henderson**, RN, CNOR, executive director of the Surgicenter of Baltimore in Owings Mill, MD. Henderson's facility is accredited by the Accreditation Association for Ambulatory Health Care (AAAHC) in Wilmette, IL, and she has served as a surveyor for AAAHC.

"Standards in the AAAHC manual are set up in priority order, so a same-day surgery program manager can tell which areas should receive the most focus," she says. "When I get my manual, I go through it standard by standard and use the margins to make notes of how my facility meets each standard."

For example, for standards related to a patient's right to participate in his or her own health care decisions, Henderson makes a note that her facility has a policy on informed consent, a patients' rights policy, and that patients' rights are posted in visible areas within the facility. ■

Impress surveyors with preparation, organization

The key to a successful accreditation survey is organization, according to accreditation experts.

Your same-day surgery program should have clearly defined mission, values, goals, and objectives, says **Stephen C. Anderson**, RN, MBA, a consultant with Joint Commission Resources in Oakbrook Terrace, IL. "Then make sure you have a planned systematic process to identify and solve problems," he says.

Ensure your employees know what the policies and procedures are, Anderson says. When a surveyor asks an employee how something is done, you don't want the employee to use phrases such as "we usually," or "we often," or "I guess we," or "I don't know how others do it, but I," he says.

"The answer that should be given to the surveyor should start with 'our process is,' or 'our policy is,'" he explains.

A good way to start preparing for a survey is to develop an internal checklist, Anderson suggests. In the ambulatory care manual for the Joint Commission on Accreditation of Healthcare Organizations, there is Appendix B, which is a checklist for policies that must be addressed, he points out.

Unfortunately, there is no checklist for hospital-based programs, but they can create one based on the standards manual, he adds.

Make sure that you have up-to-date organizational charts, policies and procedures, and patients' rights programs, Anderson says.

"Most importantly, make sure you have organized the information so that it is easily available to the surveyor," he says. For example, set up your policy book in sections that correspond to the accreditation manual and use tabs to clearly identify the sections, Anderson suggests.

"This will reinforce the impression that you are prepared and will not waste any of the surveyor's time," he says. ■

PATIENT SAFETY ALERT™

A quarterly supplement on best practices in safe patient care

Construction brings opportunity to boost patient safety

Safety-oriented planning should precede building process

Health care facility construction, whether a new building or an expansion of an existing medical center, can present a number of challenges, not the least of which is maintaining quality of care and patient safety if the work involves adding on to a currently functioning hospital. However, two far-sighted facilities have demonstrated that new construction projects actually can present an opportunity to *improve* safety — if you plan far enough ahead.

For example, even before the first spade was turned in the ground, the new St. Joseph's Hospital building in Westbend, WI, was far safer than its predecessor. This was by design.

"One of our administrative staff said we should start thinking about how to increase safety through hospital design," explains **John Reiling**, MBA, MHA, CEO at St. Joseph's, part of a small regional health system.

Plan for safety before work begins

About a year ago, Reiling had the opportunity to discuss the construction/safety issue with national leaders in the area of patient safety, including representatives from the American Hospital Association, the Joint Commission on Accreditation of Healthcare Organizations, the American Medical Association, the Institute for Healthcare Improvement, and several nursing schools. This was made possible through a "learning lab" program funded by a grant from the University of Minnesota.

The bulk of the work took place even before the design process began, Reiling notes. "We developed two key themes," he says. "First, that facilities design can impact patient safety; the

very nature of a facility can cause you to make errors. It can be something as simple as where to put a sink so people will be more likely to wash their hands."

The second theme revolved around learning about designing safety. "The people we spoke to were not aware of any institution that had done homework on this subject, so there was nowhere to go to find out about designing safety," Reiling notes. "However, we realized [what we learned] could be helpful to the industry."

The learning lab was held April 18-19, 2002. "We were really honored by the caliber of participants," Reiling says. In addition to the aforementioned organizations, participants included key physicians, board members, nurses, management, frontline employees, and supervisors.

"We also included health systems we compete with and collaborate with in the region," he says. The architects and contractors, who by then had been retained, participated in observing the learning lab, and some actively participated in the discussions.

"We talked about safety relative to the process of design and whether there was something we should do differently," Reiling observes. "We also talked about precarious events, which are somewhat similar to sentinel events. We went through major errors; for example, with falls, we discussed how to use facility design to lower the fall rate."

Through this series of discussions and breakout sessions, a series of recommendations was created, detailed in a six-page brochure. "We came up with our guiding principles of design and a checklist for employees to use to see if they were hitting the mark," Reiling explains.

In a traditional hospital design process, Reiling explains, you go through what is called a roll-in program, which encompasses how many beds you need to fill, what your patient volume will be, and so on. "Then, you basically translate rooms into spaces, then department adjacencies, and then you design a detailed drawing of each space," he notes.

The St. Joseph process was impacted by the safety emphasis. "When we talked about the rooms we needed, and the size required for, say, nursing rooms or radiology, we asked ourselves if they should be the same size if safety was our goal. This led to some changes," Reiling notes.

One of the areas affected was adjacencies. "We conducted a failure mode analysis around each design phase," Reiling reports. "We tried to figure out the impact of adjacencies on safety."

For example, a draft of the adjacencies was studied for its impact on the most vulnerable patients. "We went through the ED [emergency department] and asked what would happen if we had to do a direct admit to the ICU [intensive care unit]," Reiling observes. "We talked about what could go wrong. As result of those exercises, we did modify our adjacencies."

Uninterrupted flow of care

At Rockdale Hospital in Conyers, GA, work has just begun on a project that will more than double the capacity of the ED, adding more than 18,000 sq. ft. to enhance treatment of minor care and major illnesses and injuries. Eight minor care rooms will be added to the current four, and 10 rooms will be added to the 10 existing rooms in the acute care center. In addition, a 14-bed, 23-hour observation unit is under construction.

Despite the extensive nature of the construction work, hospital officials anticipate that the ED will remain fully operational throughout the process.

At Rockdale, extensive planning helped ensure an uninterrupted flow of care during construction. This is due in large part to the fact that the staff became involved in the construction planning process approximately 18 months before work started on the ED expansion.

"It's very important to have everybody's participation," notes **Kay Neal**, RN, clinical nursing director for the Rockdale ED. "That means not only the ED staff but administration, the lab, radiology, pharmacy, materials management, and the facilities department."

When the ED first became aware of the planned expansion, a planning team was organized with representatives from both the day shift (supervisors) and night shift (charge nurse) as well as staff physicians. "For awhile, we were meeting every two weeks," Neal recalls. "Our biggest concerns were the safety of the patients and having as little interruption to patient flow as possible."

To that end, the team provided input not only on the layout of the department, but on each of the rooms, indicating how patients would move through the system.

Once their portion of the construction plans was finished, they turned to the issue of staging the construction in such a way as to optimize safety. This called for regular meetings with the contractor, Batson-Cook Company, whose Atlanta office had extensive experience with hospital construction.

"We would meet weekly with Batson-Cook to talk about the staging of construction," Neal says. "Facilities management and infection control conduct a hazard vulnerability surveillance prior to each staging of construction."

Potential hazards include such things as dust, which patients must be kept from inhaling, to the creation of inclines that might be too steep for some patients, she notes.

Interfacing with the builder

The ED's interface with Batson-Cook will be an ongoing, and very necessary, process until construction is completed.

"Take patient flow," Neal offers. "We have created many new operational efficiencies that have been incorporated not only into the new plans, but into the staging as well. For instance, we have identified the fact that for a nurse to be able to assess patients in triage, you need more than one nurse during that process. Accordingly, Batson-Cook will build us a temporary second triage room during construction, so we can begin to benefit from this new efficiency even before the construction is done."

As part of the process, the ED's ambulatory entrance will be moved. The team had discussed with Batson-Cook where the new entrance would be, and how that entrance must be visible to staff so they can see patients arriving and give them assistance getting out of their cars if it is required.

"We also planned the construction to where we won't have to shut down any rooms," Neal adds. The new areas will be built out first, the staff will

move in there, and then the older space will be renovated before staff move back in.

“The connection between the two areas will be the last thing Batson-Cook does, so it won’t affect patient care at all,” she explains.

Hospital/builder interface is critical to optimizing patient safety and quality during any construction project, Neal says.

“We will continue to have weekly meetings throughout the process,” she notes. “In addition, the construction supervisor and myself will have two-way (telephone/walkie-talkies) communications every day. So, for example, if they are doing work that is making a lot of noise when a physician needs things to be especially quiet, I can call him and ask him to stop that particular work for 15 minutes or so. It saves me from putting on a hard hat and running out to find him.”

Right approach can change the culture

Reiling says that the proper design strategy can contribute to a significant, safety-oriented cultural change at a health care facility.

“We wanted this [construction design process] to change the culture of the organization, to make it more centered on safety, and there’s no question it did this. If you focus on patient safety in design, you *will* change the culture,” he adds.

Once people become engaged in the issue, the elements of a patient-safe culture are reinforced, he explains.

“Take reporting what your errors are — you need to know that because you want to design around it,” he says. “Then, we started dealing with blameless cultures.”

Designing a hospital takes a lot of organizational energy, he says. “If throughout the process you talk about safety all the time, that in itself makes it a high priority, and you start to change how you operate. If you really think about facilities, they are the mechanisms through which we create processes.”

The site dedication for the new facility was held place in late October. It will have 80 beds, as opposed to the 100-plus currently operating in the existing facility.

“It will be scaled down, but it will take care of a growing population,” Reiling says.

For other safety professionals facing new construction work, Neal has this advice: “I just think it’s important that when you do construction, you keep patient safety and your employees in mind and think of operation efficiencies — how you can

maintain them during construction and enhance them even while construction is ongoing.”

[For more information, contact:

• **John Reiling**, MBA, MHA, CEO, St. Joseph’s Hospital, Westbend, WI. Telephone: (262) 334-8230. E-mail: jreiling@stjosephswb.com.

• **Kay Neal**, RN, Clinical Nursing Director, Emergency Department, Rockdale Hospital, Conyers, GA. Telephone: (770) 918-3053.] ■

Test interventions for improving safety

Spurred by the Institute of Medicine report and a strong ongoing concern for patient safety, the University of Michigan Health System (UMHS) in Ann Arbor has instituted a far-reaching program called the Patient Safety Enhancement Program (PSEP). Launched in 2000, the PSEP has three overriding objectives:

- Conduct, synthesize, and disseminate research aimed at reducing hospital-associated patient complications.
- Systematically evaluate errors in processes of care that undermine patient safety.
- Operationalize these research findings by systematizing methods to improve the safety of hospitalized patients.

Currently, the PSEP is focusing on the research component, with an emphasis on reducing hospital-associated complications.

“What we are trying to do is to proactively implement new interventions to prevent adverse events before they occur,” notes **Sanjay Saint**, MD, MPH, associate professor of internal medicine at UMHS and the Ann Arbor VA Hospital and director of the PSEP. “And then we will study the results to see if these patient safety interventions make a difference in the real world.”

Determining research targets

How did the PSEP decide which interventions to study first? “We focused on areas we thought were problems associated with patient safety that affected not only our patients, but also patients in other systems — common problems, and areas where we thought we had interventions that were likely to work, based on a synthesis of the literature,” Saint explains.

The team recognized that vascular catheter-related infections are common, costly, and harmful to a large percentage of all patients who are hospitalized. "Having performed a systematic review of the literature, we found a certain type of catheter likely to reduce the risk by about 40%," Saint says.

The catheter, which is coated with the anti-septics chlorhexidine and silver sulfadiazine, was introduced into all of UMHS's intensive care units in the summer of 2001, and pre- and post-evaluations were conducted on rates of infection. "We found about a 36% reduction in infection," notes Saint.

The research team also sought to determine the financial impact of the intervention. "Even though the additional upfront cost was \$25 per catheter tray, when we took into account the reduction in antibiotic usage and lengths of stay, we determined that we will save about \$100,000 a year," he says, "So we view this as a win/win; it's good for both patient safety and for the health care system."

Testing other interventions

Another intervention being tested involves urinary catheters. "Hospital-acquired urinary tract infections are the most common found in hospitals — about 40% of all patients get them, because one in every four patients admitted will get a urinary catheter sometime in their stay," Saint notes. Also, based on the literature, the PSEP team knew that having a catheter was not justified between one-third and one-half of each day a patient had one.

"This doesn't meet the [Centers for Disease Control and Prevention's] criteria," Saint asserts. "We also know that about 40% of attending physicians, when specifically asked, are unaware of whether their patient has a catheter or not."

The research team decided that, rather than relying on the memory of the physician, they would allow the system to help improve patient safety. "We have instituted a pilot study whereby a clinical nurse puts a reminder on the chart of any patient who has had a catheter for two days or more, so the physician will hopefully look at it and decide whether or not to remove it," Saint explains.

"Once we have our CPOE [Computerized Physician Order Entry system, currently under development], the reminder will automatically appear on the screen." With this intervention, "before" and "after" evaluations will be conducted, using a concurrent control group.

Because Saint and his team believe that poor communication is a major contributing factor to poor quality of care, a third intervention currently is in the thinking stage.

"We are going to try to optimize the transfer of information to the outpatient physicians," he adds.

The team will be putting together a one-page computerized document, filled out during the hospital stay, that covers the key portions of the stay that the outpatient provider needs — diagnosis at discharge, medications, a brief hospital course, follow-up appointments, and a new area — what needs to be done by the outpatient provider.

"For example, if the hospital noticed blood in the stool, the patient would likely need a colonoscopy," Saint explains. "Our plan is that the form will be faxed on the day of discharge to all of the patient's referring physicians, so they will have it before the first follow-up visit."

Underlying all of these efforts is an abiding belief that patients ultimately hold the key to improved safety. "The best way for a patient to help prevent a medical error is to have them become an active member in their care," he says.

He recommends that patients:

- Speak up when they have questions or concerns.
- Keep a list of the medicines they take.
- Make sure they get the results of any test or procedure.
- Talk with their doctor and health care team about their options if they need hospital care.
- Make sure they understand what will happen if they need surgery.

"The patients need to ask questions throughout their treatment and be aware of what their diagnosis is, as well as what medications they are being prescribed," Saint concludes.

[For more information, contact:

• **Sanjay Saint, MD, MPH, UMHS.** Telephone: (734) 615-8341.

Also, visit these web sites:

• **U-M Patient Safety Enhancement Program** at www.med.umich.edu/psep.

• **Agency for Healthcare Research and Quality** at www.ahrq.gov/consumer/20tips.htm.

• **American Medical Association — National Patient Safety Foundation** at www.ama-assn.org/ama/pub/category/5343.html.

• **National Patient Safety Foundation** at www.npsf.org.] ■

Competency Checklist (Excerpt)

Provides care for patients related to age-specific guidelines

A. Infants and Toddlers (ages 0-3)

- | | | | |
|--|---|---|---|
| i. Involve child and parents in plan of care pre-op, intraop, and post-op. | 1 | 2 | 3 |
| ii. Provide safe environment, i.e. attends infants and children continuously. | 1 | 2 | 3 |
| iii. Encourages child to communicate, i.e. smiles, talks softly, etc. | 1 | 2 | 3 |
| iv. Instructs parents regarding care post-surgery. | 1 | 2 | 3 |
| v. Maintains body temperature by providing wrap for head, soft roll for limbs, k-pad, warm blankets, and adjusting the thermostat. | 1 | 2 | 3 |
| vi. Starts IVs and other invasive procedures after infant or child is asleep. | 1 | 2 | 3 |

B. Young Children (ages 4-6)

- | | | | |
|--|---|---|---|
| i. Involve parents and child in care, letting child make some choices, i.e. color of hat, etc. | 1 | 2 | 3 |
| ii. Uses games, toys, etc. to reduce fear, i.e. EKG monitor strips, etc. | 1 | 2 | 3 |
| iii. Provides safe environment. | 1 | 2 | 3 |
| iv. Starts IVs and other invasive procedures after child is asleep. | 1 | 2 | 3 |
| v. Encourages child to ask questions. | 1 | 2 | 3 |

C. Older Children (ages 7-12)

- | | | | |
|--|---|---|---|
| i. Allow child to make some care decisions, i.e. do you want us to start your IV before or after you're asleep? etc. | 1 | 2 | 3 |
| iii. Builds self esteem, i.e. praises child for being brave; compliments for being a good patient, etc. | 1 | 2 | 3 |

D. Adolescents (ages 13-20)

- | | | | |
|--|---|---|---|
| i. Treats patient as an adult. | 1 | 2 | 3 |
| ii. Allows to make decisions regarding plan of care. | 1 | 2 | 3 |
| iii. Explains procedures in detail as to how it may alter appearance or lifestyle, i.e. scars, dressings, braces, etc. | 1 | 2 | 3 |
| iv. Provides safe environment. | 1 | 2 | 3 |
| v. Encourages open communication between parents. | 1 | 2 | 3 |
| vi. Guides teen in making positive lifestyle choices. | 1 | 2 | 3 |

E. Young Adults (ages 21-39)

- | | | | |
|--|---|---|---|
| i. Supports person in making health care decisions, i.e. sterility, etc. | 1 | 2 | 3 |
| ii. Encourages healthy and safe habits, i.e. good nutrition. | 1 | 2 | 3 |

F. Middle Adults (ages 40-64)

- i. Address worries about future. Encourages talking about feelings, plans, etc. 1 2 3
- ii. Recognizes the person's physical, mental, and social abilities, and contributions and encourages communication. 1 2 3

G. Older Adults (ages 65-79)

- i. Encourages communication, i.e. loss of work. 1 2 3
- ii. Provides support for coping with any impairment. (Avoids making assumptions about loss of abilities.) 1 2 3
- iii. Maintains patient body temperature by providing warm blankets, k-pads, etc. 1 2 3
- iv. Pads all bony prominences to avoid break down of tissue. 1 2 3
- v. Provides patient privacy. 1 2 3
- vi. Allows patient to keep dentures until in the OR and returns to patient as soon as awake, alert, and oriented. 1 2 3
- vii. Provides safe environment. 1 2 3

H. Geriatrics (ages 80 and older)

- i. Provides safe environment. 1 2 3
- ii. Pads all bony prominences to avoid break down of tissue. 1 2 3
- iii. Handles patient gently to avoid injury, i.e. skin tears, etc. 1 2 3

Source: The Surgery Center of Nacogdoches (TX).

Emergency Management Plan

SUBJECT: Emergency Management Plan

Policy # 5.0a

DEPARTMENT: Facilitywide

Origination Date: 5/02

POLICY:

Gastroenterology Associates/ Louisiana Endoscopy Center (LEC) will coordinate care for individuals with area hospitals, in the event that an emergency within the facility or in the community would occur that would significantly affect the need for this organization's services.

PROCEDURE:

Services will be coordinated from command center that will be set up in the Infusion Room due to the availability of telecommunication devices and central location within the facility. The command center will be operated by administrator, managers, and safety officers. Person receiving the call for community emergencies shall alert the administrator, managers, or safety officers of the nature of the emergency. Employees will be alerted of instructions to follow via overhead page. Teams will be designated to triage and treat under the direction of a physician in the LEC area. Needed supplies will be obtained from the supply room in LEC by appointed staff members. Traffic flow will be directed by designated staff. Family and friends will be allowed to sit in the waiting area (as capacity allows) of LEC, with staff designated to assist with their needs. Additional staff members are to report to the conference room, where a manager will be stationed to receive and inform of instructions from the command center. Cell phones will be given to all key personnel as decided by the command center, at the time the emergency plan goes into action. Victims of the emergency will be stabilized if possible and transported to area hospitals as soon as possible. Victims with injury or health needs that are considered to be too extensive to be managed in the facility will be routed to area facility with capabilities to manage their needs by command center. Victims will be tagged with information to identify needs and identity via wristband with information card attached to be completed by the triage team.

AREA HOSPITALS:

Our Lady of the Lake Regional Medical Center, Baton Rouge General Medical Center, BRGHC, Summit Hospital, Lane Memorial, and St. Elizabeth. BRGMC houses the Burn Center.

Command center will coordinate communication with the area hospitals, ambulance services and other community services as appropriate. Media will be addressed on an as-needed basis only by the administrator.

Emergency generator will be prepared for use by the safety officers. Portable oxygen tanks will be obtained from the lab area to be used as needed.

Annual hazard vulnerability analysis will be addressed by the safety committee. Drills will be conducted as designated by emergency preparedness plan.

Source: Gastroenterology and Associates/Louisiana Endoscopy Center (LEC), Baton Rouge.

**NYU DOWNTOWN HOSPITAL (NYUDH)
DEPARTMENT OF NURSING
PERIOPERATIVE SERVICES
OPERATING ROOM, POSTOPERATIVE CARE UNIT (PACU),
AMBULATORY SURGERY UNIT (ASU)
ENDOSCOPY, PREOPERATIVE TESTING UNIT (POT)**

POLICIES AND PROCEDURES MANUAL

Title:	Disaster Plan
Effective Date:	8/99
Policy#:	D-2
Revised Date:	9/01
Prepared By:	Donna Pritchard, RN Director of Nursing, Perioperative Services
Approved By:	Krystina Candelaria, RN Senior Vice President, Pt. Operations/Chief Nurse Officer

POLICY

The nursing units of Perioperative Services (Operating Room, PACU, Ambulatory Surgery Unit, Endoscopy, and POT) must be familiar with the contents and location of the Emergency Management and Disaster Plan in their respective areas. The plan addresses three types of emergencies:

1. Utility emergencies (Internal Disaster)
2. Patient casualty emergencies (External Disaster)
3. Staff shortage emergencies (Internal Disaster)

The Disaster/Emergency Preparedness Plan Code is Code Yellow. When you hear **CODE YELLOW** announced over the PA or FIRE announcement system, it means that the PLAN has been initiated and you should **IMMEDIATELY** return to your assigned unit. The Incident Command System is used to manage an emergency incident or non-emergency event. It can be used for both small and large situations. Refer to ICS Orientation in Emergency Management and Disaster Plan.

Every nursing staff member must be aware of what his/her role and responsibilities are during an emergency and participate in disaster drills. There are three emergency response levels.

Level 1 — least serious (confined to a single area of operation, lasts less than four hours)

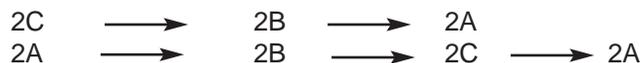
Level 2 — moderate severity (more than one area affected, lasts less than 12 hours)

Level 3 — most serious (incident expected to last more than 12 hours)

Evacuation Plan

If evacuation is necessary, wait for instructions over the PA system.

Depends on location to be evacuated and the area that will receive the evacuees. Horizontal movement:



Vertical movement: Ambulatory patients will be lead down Staircase C and B to main floor lobby exit or ground level ED Gold Street exit. Staircase E also will lead patients to street level.

TYPES OF EMERGENCIES

Utility Emergencies

The Engineering Department has written procedures that address physical plant emergencies. A Code Yellow, utility emergency can be reported by any hospital employee by calling the Telephone Operator at X4444. The caller must provide his/her name and department, nature and location of emergency. The next step would be to alert the Charge Nurse/Nurse Manager and bring her to the scene.

Loss of Steam:

Use disposable bedpans.
Manually wash instruments.
Use glutaraldehyde as a liquid sterilant.
Outsource sterilization if condition persists greater than 24 hours.

Loss of Heating, Ventilation, and Air-conditioning (HVAC):

Acquire supplemental heating or cooling units for PACU, ASU, Endoscopy, and POT. The OR should not be used if these conditions cannot be controlled.

Loss of Water:

Use backup domestic water supply.
Use bottled sterile water to rinse hands after scrubbing.
Use waterless soap.

Loss of Telephone, Beeper, or PA Service:

Use Red Phone System.
OR office red phone
PACU — wall behind the nurses' station
Endo — wall next to nurses' station
ASU — wall next to nurses' station
Recovery — phone numbers are in hospital telephone book
Use of NYUDH PA System if beepers are out
Use Motorola Talkabouts in OR/PACU
Assess need for runners to go to Lab/Blood Bank/Storeroom

Loss of Oxygen, Loss of Medical Vacuum, Loss of Medical Air:

Backup portable oxygen and suction are available in each nursing unit. Identify quantity of backup needed for each gas — notify Respiratory Therapy. Ensure enough manual resuscitation bags are present in each unit.

On weekday day shifts, the Director of Engineering or designee will come to the scene. If the emergency is in Perioperative Services, he will confer with the Director of Nursing (DON), Perioperative Services, Senior Vice President, Patient Operations/Chief Nurse Officer, CEO, and other management personnel if necessary.

On evenings/nights/weekends/holidays, the engineer-on-duty will come to the scene. The Nursing Supervisor must be notified.

Patient Casualty Emergencies

This occurs when there is a sudden influx of patients that exceeds the normal capacity of the ER.

Level 3:

- The DON or Nurse Manager (NM) and Director of Anesthesiology or designee must confer and assess the status of the Operating Room for available suites and PACU space and report to the Command Center. When the Operating Room is informed about the type(s) of casualties they will receive, preparation must begin. Procedures in progress must be finished.
- Staff members must remain on duty.
- Staff members who are not involved in procedures must report to NM or Charge Nurse for assignment.
- NM or Charge Nurse in the Operating Room will assign staff to scrub and circulate on procedures if patients are coming to OR immediately.
- Staff members must report back to NM or Charge Nurse for reassignment when they have finished preparations.
- DON, NM, and/or Charge Nurse will provide information updates to staff as they become available.
- NM or Charge Nurse must plan for bathroom breaks.
- Anesthesiologist(s) will assess immediate postoperative patients in PACU to determine if they can be moved to the ASU to create space for critical disaster victims.
- Elective endoscopy and surgical procedures must be postponed/rescheduled.

Staff Shortage Emergencies

Level 1: (At least 20% of the NYUDH scheduled work force)

All on duty personnel are asked to remain beyond their normal workday hours until dismissed.

Level 2: (20-40% of NYUDH scheduled work force)

Same as "1," and the next scheduled tour of duty nursing personnel are asked to report to work immediately.

Level 3: (40-60% of NYUDH scheduled work force)

Same as "1" and "2," except that all off-duty personnel are asked to report immediately for assignment.

- Staff telephone numbers are readily accessible in the OR Office, PACU nurses' station, and Nursing Department office.
- Call staff members that live the closest first, i.e., 69 Gold St., Southbridge Towers, and Booth House. Next, call all other staff.
- Call listing of per diem nurses in each respective area.
- Agency nurses may be called if all the above measures have been completed and more staff is required.
- Dependent on the level of staff shortage emergency, elective procedures may be postponed/rescheduled. The Operating Room and Endoscopy Unit would function on an emergency procedures-only basis.
- Upon arrival change into scrub attire and report to NM or Charge Nurse for assignment.

Source: NYU Downtown Hospital, New York City.