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INSIDE

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Can your ASC meet the credentialing challenge of new tools, techniques?

Design process to handle change

Laparoscopic Nissans, endoscopic carpal tunnel repair, and intrauterine balloons to treat menorrhagia are only a few of the newer surgical techniques seen in ambulatory surgery programs today. Some new procedures don't require extra training for the surgeon to acquire competence while other procedures do mean additional training and even proctoring to ensure competence before the first surgery.

How does an ambulatory surgery program manager make sure surgeons are properly trained and competent? The key to knowing patients are safe and your program is not exposed to undue liability is the credentialing process that grants surgeons specific surgical privileges, experts say.

"There are a number of different ways to organize privileges," explains **Jack Zusman**, MD, a professor at the University of South Florida in Tampa, who specializes in medical staff operations, credentials, and privileges. "Years ago, hospitals used to just give whatever privileges the surgeon requested by checking off items on a surgical laundry list produced by the hospital or its surgery center." Now, surgeons have to document training and experience, so it is rare to find a

EXECUTIVE SUMMARY

The challenge of credentialing surgeons for new surgical techniques or the use of new technology is a challenge faced by all ambulatory surgery program managers. To ensure a credentialing process that protects the facility from liability and the patient from injury, experts recommend that you should:

- Clearly define privileges being granted.
- Check all references for education and training.
- Review existing guidelines to develop your own credentialing requirements.
- Be specific about training requirements to include continuing medical education courses, proctoring, and equipment demonstrations.

surgeon asking for privileges outside his or her area of specialty, he points out.

The simplest way to organize privileges is to set up core privileges that cover all surgeries that involve the same skill sets, says Zusman. For example, hand surgery could be used to grant privileges for any surgery involving hands, such as tendon repair or biopsy. "Privileges for an ambulatory surgery program would differ from an inpatient surgery program because you would not want a surgeon reattaching a finger in an outpatient setting," says Zusman. For this reason, the medical staff bylaws or a policy attached to the privileges need to explain clearly which procedures are allowed within the operating rooms. This is especially important for ambulatory surgery programs that are affiliated with or located within a hospital, he adds.

Review existing guidelines

One way to start developing new privilege guidelines or reviewing existing ones is to refer to credentialing guidelines that have been recommended by other groups.

"There is no reason to reinvent the wheel," says **Steven D. Wexner**, MD, chief of staff for Cleveland Clinics Florida in Naples, and chairman of the credentialing committee for the Society of American Gastrointestinal Endoscopic Surgeons (SAGES) in Santa Monica, CA. "Not only does SAGES have guidelines, but other medical societies have developed them as well."

Referring to guidelines developed by different medical societies can be a good starting point, but you need to be aware that some turf battles are being fought, says Zusman. "Guidelines for a society that includes plastic surgeons may exclude maxofacial surgeons, dermatologists, otolaryngologists, or general surgeons from performing certain procedures because [the organization doesn't] want to give up these patients," he explains. For this reason, Zusman recommends reviewing a variety of guidelines from different societies with an eye toward finding which approach works for each individual outpatient surgery program.

The best way to evaluate or update your credentialing process is to talk with peers, says Zusman. "Find out how the outpatient surgery program down the street or in the next community handles credentialing."

'New' presents problems

Even if an ambulatory surgery program has a good process in place for awarding privileges, new technology and new surgical techniques can pose problems.

Laparoscopy once presented a credentialing challenge, but it is not as much of a problem as it used to be. "When laparoscopy first came into use for more than gynecological surgery, we had general surgeons who had never been trained. They had to take CME courses, practice on animals, and perform several cases with a proctor. Now, most surgeons receive laparoscopic training in their residencies," says **Doug Yunker**, MD, medical director at Upper Arlington Surgery Center in Columbus, OH.

If a surgeon asks for laparoscopic privileges, it is important to make sure he or she is competent with the open procedure, says Wexner. "With Nissans or cholecystectomies there is always the chance that the procedure has to be converted to an open procedure, so you need to make sure the surgeon can handle the open procedure," he adds. If the surgeon has been performing the open procedure and wants to add the laparoscopic technique, another surgeon with the laparoscopic privileges should proctor the first few procedures, says Wexner.

The number of cases that should be proctored for any new procedure is hard to determine, he says. There is a debate about how to determine the right number, so the trend is not to use numbers but to let the proctor evaluate the surgeon's competence. For some surgeons, this may mean two procedures; for others, it may mean more, he adds.

Endoscopic carpal tunnel repair, operative

COMING IN FUTURE MONTHS

- Wound care program generates new revenue, decreases downtime
- Tips to reduce turnover time between surgeries
- Patient registration on the World Wide Web
- Should you be asking about herbal therapies?
- New anesthesia update

Protect yourself with good documentation

Documentation is critical when the issue is granting privileges to surgeons, but what happens when the surgeon is literally the first or one of a very few in the country to perform a procedure?

Documenting the decision to allow a new procedure is a challenge because the review committee may have to rely on scientific literature and anecdotal results from other facilities, says **Jack Zusman**, MD, a professor at the University of South Florida in Tampa.

The first step in documenting the process your facility has undertaken is reviewing the procedure or the technology to show that a committee of medical staff, such as a credentialing committee or a management committee, has properly evaluated the surgeon's request. "This proof can take the form of minutes of the meeting," says Zusman. The minutes must show that the committee considered scientific reports, medical journal literature, manufacturer's information, and existing surgery program policies to arrive at the decision. Another good idea is to attach the literature that was considered, he adds.

In addition to the minutes of the meetings needed to make a decision, an attachment that clearly defines the policy governing the privilege should be developed. This policy should define training and proctoring requirements if necessary, says Zusman.

If it is a new procedure, be sure to ask if it is research, he warns. "If it is research, patients need to be told that it is research for full, informed consent."

If your policy requires a proctor in addition to training for a new procedure, it may be difficult to find a proctor for this requirement. Some facilities bring an expert to their facility to proctor surgeons learning a new procedure while other facilities will send their physicians to another facility to be proctored at the expert's facility, says Zusman.

While telemedicine promises the lower cost option of video proctoring, there are problems with this method, warns Zusman. "Not only do you have to investigate the different regulations within each state because some states do not allow telemedicine broadcasts outside of the state, but you also have to consider that something can go wrong during the surgery. How does a proctor who is not in the room step in to help when the unexpected happens?" he asks.

The best thing to do during any type of credentialing or privileging process is to document every detail, advises Zusman. "Make sure that anyone looking at your documentation can see that the issue was fully evaluated and the decision-making process was logical and based on fact." ■

laparoscopy, and laser surgeries do require proctors for surgeons first applying for the privileges in his surgery center, says Yunker. "If they received training within their residencies, we waive the proctor requirement, but the surgeons have to show proof that they were trained in the specific procedures for which they are applying," he adds. Surgeons also have to document that they have been trained on the specific lasers that they intend to use in the procedures. Proof of training can consist of a letter from the surgeon's school at which the residency was served.

In addition to showing proof of training, surgeons at Yunker's facility have to show that they have performed the procedure at least twice in the previous year. This proof involves patient names, case numbers, and locations if the procedure was performed elsewhere.

When the issue is a new tool, such as the intrauterine balloon, surgeons with privileges to perform a hysteroscopy only have to receive training on the machine from the manufacturer's representative, says Yunker.

"Usually, the manufacturer's representative attends a procedure and demonstrates how to use the equipment," he adds.

Manufacturers' demonstrations are adequate for most new equipment unless the equipment requires extra knowledge or skill to be handled safely, says Wexner. "Lasers or radiation used in surgery require extra credentialing to address safety issues."

While manufacturers' training is useful and can properly train the surgeon and nursing staff on the use of new equipment, the representatives' presence in an operating room does raise questions of liability, points out Zusman. "If a manufacturer's representative is in the operating room, the patient needs to give consent. From a risk management point of view, this is important," he explains.

If the issue is a new technique, a committee such as a credentialing committee must review the proposed procedure. In addition to documenting whether the procedure will be allowed, the decision-making process itself must be documented, says Zusman. **(See article on documentation, above.)**

Even when a surgery program has a solid

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credentialing process in place, Zusman has seen some organizations exposed to liability risks by ignoring the process.

"The most common way an ambulatory surgery program manager or physician ignores credentialing requirements is when a visiting surgeon who is a recognized expert, or even a family member who is a surgeon performing a new procedure in his or her hometown, is allowed to demonstrate new procedures to the program's medical staff," he says.

"Physicians may think they know this visiting surgeon's qualifications, but unless there is some reference check and documentation of the surgeon's experience or training, the surgery program manager places the facility at great liability risk," Zusman says.

Another critical piece of the credentialing process is reappointment. "Physicians should be reappointed every two years," says Zusman.

Evaluation of the physician during the reappointment process should include a review of cases to show at least two of each of the procedures for which the physician has privileges and any morbidity and mortality reports that apply to the physician, adds Yunker.

"There are no national credentialing guidelines that can be applied to each and every surgery program," says Zusman.

"Each ambulatory surgery program manager needs to look at what the market demands, what surgeons in the area are doing, and what the facility's physical configuration and staff can handle to design an effective credentialing process." ■

Send Parkinson's patients home in hours, not days

Gamma Knife moves surgeries to outpatient arena

Stereotactic neurosurgery has been used to treat the symptoms of Parkinson's disease for years, but use of the Gamma Knife, manufactured by Elekta of Norcross, GA, has moved the surgeries for Parkinson's from the inpatient to the outpatient arena.

Traditional surgical treatments for the tremors or rigidity of Parkinson's are a thalamotomy for tremors and pallidotomy for rigidity. In each of these operations, a small hole is made in the thalamus or globus pallidus to reduce the signals that trigger those symptoms.

Tremors and rigidity are common with Parkinson's disease because the patient's brain lacks dopamine, a neurotransmitter that suppresses irregular messages that cause the afflictions. Usually the surgery requires a 48- to 72-hour stay.

Patients who undergo either of these surgeries with the Gamma Knife go home four to six hours after surgery, says **Michael L. Goodman**, MD, director of The Georgia Gamma Knife Center at Piedmont Hospital in Atlanta. Because the procedure is non-invasive and there is no general anesthesia used, side effects and complications are uncommon, he adds. More than 90% of patients report excellent results, he says.

The Gamma Knife uses radiation as a surgical

EXECUTIVE SUMMARY

Although Parkinson's disease cannot be cured, the symptoms of tremor and rigidity can be controlled with surgery. Traditional surgery required a two- to three-day stay in the hospital, but treatment with a Gamma Knife, manufactured by Elekta, a medical equipment company based in Norcross, GA, enables patients undergoing a thalamotomy or a pallidotomy to go home the same day. Benefits of the radiosurgical technique include:

- effective treatment with more than 90% of patients reporting excellent results;
- checkout times for surgery center patients of four to six hours after procedure;
- few complications, with nausea being the most common after-effect.

SOURCES

For more information about the treatment of Parkinson's with Gamma Knife, contact:

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- **Deane "Skip" Jacques**, MD, Medical Director, Neurosciences Institute, Good Samaritan Hospital, 637 South Lucas Ave., Suite 501, Los Angeles, CA 90017-2395. Telephone: (213) 977-2234 or (800) 762-1692. Fax: (213) 482-2157.

For information on the Gamma Knife, contact:

- **Elekta**, 3155 Northwoods Parkway, Norcross, GA 30007. Telephone: (404) 315-1225 or (800) 535-7355. Fax: (404) 315-7850. Web site: www.elekta.com.

tool by enabling the surgeon to target 201 individual beams of gamma radiation on one point of the brain. Other areas receive a trivial dose of radiation, says Goodman.

The targeted area is destroyed, with the effect of the radiation taking up to one month to create the hole, says **Deane "Skip" Jacques**, MD, medical director of the Neurosciences Institute at Good Samaritan Hospital, Los Angeles.

Patients receive IV sedation and a local anesthetic to block the discomfort of the stereotactic frame placement. This frame is attached to the head to help the surgeon target the beams of radiation, says Goodman. "The most common side effect of the procedure is nausea that is related to the sedation and anxiety, but antiemetics such as Zofran help control the nausea," he adds.

Patients coming into the Georgia Gamma Knife Center are admitted through outpatient admissions, then go to the center's work area to receive a mild sedative and have their hair and scalp washed. There is no need for hair to be shaved, points out Goodman. A stereotactic frame is attached, and an MRI scan is performed to ensure the frame is positioned correctly.

After the radiation treatment, patients get a bandage, but it is primarily for sympathy, says Goodman. After a few hours in recovery to make sure the nausea is under control or not a problem, the patient goes home and resumes normal activities the following day.

Parkinson's typically affects people between 40 and 70 years of age with the peak age of onset in the 50s. The average age of patients seen at the Georgia Gamma Knife Center is between 70 and 75, says Goodman. For this reason, most treated for Parkinson's are Medicare patients, but there has been no problem with reimbursement for the treatment, he adds.

It is important to ask your payers how the procedure is reimbursed, says Jacques. Although his center performs the same procedure for Parkinson's as the Georgia center, his payers require Gamma Knife patients to stay overnight. "Parkinson's patients could go home the same day because they are not sick, but it is not recognized by our payers as an outpatient procedure," he explains.

Approximately $100 of the cost of the procedure is related to disposable items, such as gloves and sponges, says Goodman. Salaries, the equipment, and the building are the biggest overhead costs, and the per-case cost differs from facility to facility. "A Gamma Knife costs about $2.2 million, and construction of the room in which to place it runs about $1 million," says Goodman. The room must be constructed to hold the equipment, which weighs approximately 40,000 pounds, and the walls must be solid concrete with lead shielding.

The advantage of making this type of investment is that the Gamma Knife is used for more than treatment of Parkinson's. It can be used to treat malignant and benign brain tumors, vascular malformation, and other neurological disorders, says Jacques. ■

New book gives guidelines for the outpatient setting

Why do outpatient surgery patients have to undress completely for all procedures? What is the best way to reduce anxiety without overmedicating so the patient will recover sooner?

These are only two of many questions asked by Denver-based Association of Operating Room Nurses (AORN) members who have been trying to adapt AORN-recommended practices and principles to the ambulatory surgery setting, says **Denise L. Geuder**, RN, MS, CNOR, vice president

EXECUTIVE SUMMARY

As the number of nurses working in and managing outpatient surgery programs has grown, so has the need for organizations such as the Association of Operating Room Nurses in Denver to respond to the needs of their members. This year the organization has published a book that focuses on ambulatory surgery settings. The publication covers:

- patient care;
- business issues;
- practice issues;
- nontraditional settings such as offices, endoscopy labs, and mobile lithotripters.

of St. Francis Hospital in Tulsa, OK, and chair-elect of AORN's Ambulatory Surgery Specialty Assembly.

Because its members have moved into nontraditional settings, AORN has targeted a version of its annual publication of *Standards, Recommended Practices & Guidelines* to ambulatory surgery program managers and nurses.

In addition to moving from inpatient to outpatient surgery settings, AORN members have moved from hospital-based ambulatory surgery programs to freestanding centers and to physician office-based surgery settings, says Geuder.

Streamlining the new version

"*Ambulatory Surgery Principles and Practices* recommends practices that are adaptations of the AORN Standards. The adaptations take into account the different physical and staffing resources within an ambulatory surgery program," she says. "They are more streamlined because we've pulled out sections, such as critical care, that aren't applicable to ambulatory surgery."

Chapters in the ambulatory surgery publication cover:

- standards and recommended practices that apply specifically to ambulatory surgery;
- patient care including preoperative care, conscious sedation, postoperative care, and pain management;
- practice issues such as materials management, competency, quality measurement, medical records, and risk management;
- business and regulatory issues such as business concepts, human resources, emergency preparedness, accreditation, and regulation;
- special considerations such as office-based surgery, endoscopy labs, and mobile lithotripsy.

While the ambulatory surgery publication does contain a full range of practices and guidelines, it is also important for surgery program managers to use the publication in combination with the full AORN standards publication, says Geuder. Because the ambulatory publication is streamlined, a surgery program manager may need additional information if her or his surgery program handles some cases not normally handled by ambulatory programs, she explains.

The most important thing a day surgery program manager must do is anticipate what can go wrong in different situations, says Geuder. While ambulatory surgery patients are pre-screened to eliminate emergency situations, problems can occur, she says.

"It is critical for a day surgery program to have emergency equipment such as crash carts available and have staff prepared to handle a crisis during surgery," she says.

"Arrangements for care and transport of the patient must be made by contract with local emergency rooms if you are a freestanding or office-based center, and your staff need to know the procedure to follow," she adds. "This is the type of advice offered in the new publication." ■

SOURCES

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To order a copy of the AORN publications, contact:

- **Association of Operating Room Nurses**, 2170 South Parker Road, Suite 300, Denver, CO 80231-5711. Telephone: (303) 755-6304 or (800) 755-2676. Web site: www.aorn.org/. *Ambulatory Surgery Principles and Practices/1999* (Item #MAN-262) costs $35 for non-members and $30 for members. *Standards, Recommended Practices & Guidelines/1999* (Item #MAN-005) costs $48.75 for non-members and $40 for members.
  Payment can be made by money order, VISA, MasterCard, Discover, or American Express. Orders of $50 and more can be billed with an authorized purchase order.

Same-Day Surgery Manager

Waiting room audits tell much about your facility

By **Stephen W. Earnhart**, MS
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Keeping track of everything that is happening in your facility each month is becoming more and more difficult. However, it doesn't mean that you still don't have to conduct and update benchmarks. You might want to benchmark and update your existing benchmarks on a more frequent basis than that, but quarterly is the minimum. This month, we will look at the waiting room issue.

One of the best ways I know to find out how your staff and facility operate is to spend time in your waiting room. You can do this yourself (not recommended — who has time?) or have staff do it for you.

Have someone sit in the waiting area with a clipboard. (The auditor might want to conceal the clipboard with a magazine; you don't want to be too obvious.) Obviously it is best if they are in street clothes so they will blend in with the crowd.

Listen and learn

Consider the following suggestions to grade the area. It is only a partial list — you can add more that will personalize it to your facility.

Most of the time, the audit involves listening. What are the patients and their families saying about the center? You should hear many comments on the decor, the age of the magazines, the frustrations — "I can't believe I had to come in three hours before my surgery" — and similar remarks.

Also, after awhile, you will be able to see the center through the patient's eyes. However, most of the comments will be made by famly members with way too much time on their hands — which is perfect — the more critical the analysis, the more improvements you can make.

Did you ever notice that water spot on the ceiling before? Is the carpet showing its age? What is the condition of the patient bathrooms? Make a chart that covers, at the minimum, the following points:

❒ Comfort of the chairs (standard American seat width: 18 inches across)
❒ Condition of the waiting area
❒ Cleanliness of area
❒ Chairs
❒ Carpet
❒ Water fountain
❒ Phone area
❒ Play area
❒ Registration area
❒ Lobby
❒ Reading material
— Appropriate?
— Outdated?
❒ Comments from patients
❒ Comments from family members
❒ Conversations overheard from staff members
— Are you hearing things from a staff member about a patient you shouldn't hear?
❒ Sounds heard that shouldn't be heard or that startle people in the area
❒ Smells
❒ Unnecessary traffic from staff or others
❒ Level of privacy of patients and their families
❒ Registration desk
— Clean?
❒ Registration staff
— Friendly?
— Helpful?
❒ Forms appropriate?

Don't forget the parking lot

While you are checking out the lobby, have your auditor check out the parking lot; drive by it at night to make sure there are no burned out lights. Again, is it clean, available, and something that you can be proud of? Or, does it immediately set your patients blood pressure soaring because there is no place to park or it is too far away from the door?

If you can, consider spots right in front of your door. One thing that physicians state in their comments about patient satisfaction is access to the facility. Painful though it may be, you may have to have your staff park off-site in order to accommodate your patients. (Oh, that is a lovely

agenda item for your staff meeting!)

In my opinion, your lobby / waiting area begins at the front door of the building in which you are located. How easy are you to find? Is the signage to your unit legible? Are signs still there or have they been knocked down? Has the floor plan changed with new construction? You may think you are only judged on your internal department, but the patients will judge you on the entire experience.

Clearly there is a wealth of information available to you in the lobby. Now that you have it, what are you going to do with it? Share it at your staff meeting and ask for suggestions on how to improve your image. Sometimes a "paint party" to repaint the waiting area over the weekend works. Certainly a "How can we improve your wait?" survey in the waiting room will give you a wealth of information. When you get a good suggestion, invite the person who suggested it to come in and see the results if applicable.

Consider a picture of each staff member in the lobby with their name (first name only is best) and their titles. It makes the staff feel good and gives the patients something to focus on.

Personalize your waiting room as much as you can; a small bookcase with previously read paperbacks is a good way to get rid of them, and at the same time, give your patients or family members something to occupy their time. Do not forget to send the results of your audit to your surgeons. This would be a great time to put together a small newsletter and get the results out to them.

Remember, the time a patient or family members spends in the waiting area may be their most critical appraisal of you. Maximize that time.

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ACCREDITATION TIP

Don't get tripped up by the 'No. 1 trouble spot'

Step-by-step guide to resolving problems with QI

Accreditation associations say that health care facilities often struggle the most with the standards that examine quality improvement / performance improvement (QI / PI) measures.

"That is the No. 1 trouble spot," says **Mary M. Fogel**, RN, president of Fogel and Associates in Lindenhurst, IL, and surveyor for the Accreditation Association for Ambulatory Health Care in Skokie, IL. Why? "Many times when we go to survey, the actual format of the study is one of the problems," Fogel says.

Many facilities follow a format they created themselves or obtained from another facility, but the format isn't as user-friendly as it needs to be, she maintains. For example, it should allow for documentation of the QI process. Evaluate your format, she advises, "and don't try to make it real fancy."

Consider these other suggestions from the accreditation groups:

✔ **If you're hospital-based, don't develop a separate QI plan. Ann Kobs**, MS, RN, former director of the department of standards and current sentinel event specialist for the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, says organizations need to have a "planned, systematic, organizationwide approach" to performance improvement.

"You do not need a separate quality improvement plan. You never did," she says of hospital-based ambulatory surgery programs. "You don't have to have 57 indicators," Kobs says. "If you do, stop."

Often, organizations that have such a large

EXECUTIVE SUMMARY

Many ambulatory surgery programs struggle with quality improvement/performance improvement (QI/PI) standards. Consider these suggestions:

- Have a user-friendly format that allows documentation of the QI process.
- Quantify with percentages or numerals.
- Track and trend improvement over time.
- Re-evaluate the corrective measures you've taken, and report to the appropriate group.
- Restudy if you think the problem hasn't been resolved.
- Determine if your quality is improving over time with internal benchmarking.

number of indicators have several that are 100% or zero consistently. "Drop those," she advises. "What a waste of time. Instead, be enmeshed in the organization's quality improvement activities. That's what we'll look for."

✔ **Measure patient satisfaction.** The Joint Commission is examining measures of patient needs, expectations, and satisfaction, Kobs says. For example, did patients say they were prepared for the surgical episode? Did they feel like they knew enough? Did they have a pleasant experience coming out of the anesthesia? Did they understand the teaching that you did? Expect such questions from surveyors, she advises.

✔ **Quantify.** When you evaluate your problem, indicate how often it is happening, Fogel says.

"Give either percentages or numerals," she says. "When you [go] back and re-evaluate, then you actually have something to measure it against."

✔ **Track and trend.** Health care facilities tend to do a good job of data collection, Kobs acknowledges. "The place where we all fall apart is that you have sheets and sheets of numbers, but you never take them to the next step and make them tell you a story," she says. "And telling the story is the turning point because telling the story is when you get employees' attention, management's attention, so that they say, 'This is something we need to watch and track and trend over time.'"

Fogel recommends that facilities demonstrate the format of the study by identifying the problem, evaluating the problem (frequency, source of the problem, and severity of the problem), and showing solutions or corrective measures implemented. "After that, you must go back and re-evaluate the problem and the measures you took to correct the problem," she says.

Each QI study needs to have a re-evaluation, but each QI study doesn't necessarily need a restudy, Fogel emphasizes. A restudy is only done when you've re-evaluated the measures that were implemented and you think the problem might reoccur, she says.

✔ **Benchmark against other programs and/or internally.** According to Kobs, the critical question is: Has the problem improved? "One of the things that the surveyors do with any performance improvement activity is they will take a particular problem and go through the minutes or memos or whatever you have about that particular issue and see if it ever was resolved or did it just fall through the cracks," she says.

To prepare for a survey, identify a challenging area in performance improvement and look at your 1998 records to follow it through to resolution. "And then six months later, check it out to see if the fix was holding," Kobs says. "That's a big piece: Are you tying it all into a big bundle?"

Conduct an internal comparison of processes and outcomes to ensure a continual process of performance improvement, she advises. "One of the things that you want to look at is where were we a year ago, and where are we today? Are we improving as we go along over time? What are you able to demonstrate that you improved?"

Refer to current literature and to other organizations to compare your performance if that's possible, Kobs suggests. However, "if you're measuring apples and they're measuring oranges, that's not really a useful measure. Your best measure is measuring against yourself."

✔ **Close the loop.** Report your results to the appropriate group, such as the QI committee, the governing body, or the medical executive committee, Fogel says.

"And once you have done that, you're closing the loop," she says. "Everybody has been made responsible, has been accountable, and has heard about what has happened in solving this problem."

[Editor's note: Do you have an accreditation tip you'd like to share or a question for the surveyors? Contact: Joy Daughtery Dickinson, P.O. Box 740056, Atlanta, GA 30374. Fax: (404) 262-5447. E-mail: joy.daughtery@medec.com.] ■

Latex allergies: What you should know

Here's how to protect yourself and your patients

According to some estimates, approximately 8% of health care workers are allergic to latex. Other sources put the proportion higher — as great as 17%. Whichever number you settle on, the fact is the problem of latex allergy is growing. And like other health care professionals, same-day surgery managers need to be aware of the dangers and ways to prevent exposure.

One reason for the problem's growth may be that an individual's risk of latex sensitization increases with the number of latex contacts.

EXECUTIVE SUMMARY

The problem of latex allergy is growing. Some studies estimate that as many as 17% of health care workers are allergic to latex. The main source is latex gloves. Therefore, some institutions have taken aggressive steps to stem the latex threat.

- At Optima Health Visiting Nurse Services in Manchester, NH, employees receive two pages of questions and answers about latex allergy.
- Optima's health system even has a latex allergy committee dedicated to protecting employees and patients from unnecessary exposure to latex.
- St. Joseph Hospital in Bellingham, WA, formed a latex task force to develop a policy on latex allergy, conduct hospital-wide inservices, and create a latex-free cart.

Ironically, the widespread use of universal precautions designed to protect health care workers from pathogens such as HIV and hepatitis has resulted in an ever-growing use of latex gloves — clinicians tend to respond automatically and don latex gloves whenever patient contact is required. Though dozens of medical products contain latex, gloves are ubiquitous, and the common design of most of them (high-protein content, powdered) only adds to the threat.

Within the medical community, nurses might be at even higher risk than physicians because they tend to wear gloves more often. Of course, patients as well as health care workers are at risk for latex allergy, and those with chronic wounds are in a high-risk category because latex contact often occurs in areas where the skin is broken.

NRL is the culprit

The allergic responses are caused by one or more allergens in the protein component of natural rubber latex (NRL).

NRL comes from the sap of the rubber tree and consists of from 30% to 40% hydrocarbon and 2% to 3% protein. Gloves are made by dipping porcelain molds into a solution of liquid latex. In subsequent steps, some of the water-soluble protein is leeched out and the rubber is vulcanized. Glove powder can be removed as well. It is the protein component that causes allergic reactions.

Powdered latex gloves present an even greater threat to allergic individuals than nonpowdered gloves. The powder binds to the NRL proteins, and when the powder becomes aerosolized, it can be breathed in by individuals nearby. Therefore, even those who do not come into direct contact with latex are at risk for sensitization simply by breathing in airborne NRL protein particles. Aerosolization commonly occurs when latex gloves are put on and removed. Low-protein, nonpowdered gloves also can generate airborne particles, but in notably less quantities.

Food and Drug Administration requirements will make it easier to identify products containing latex. As of Sept. 1, 1998, any medical product that comes into contact with humans must have a warning label if it contains latex. Keep in mind that common balloons that often accompany flower arrangements delivered to hospitalized or long-term care patients are usually powdered and contain high amounts of NRL protein. Some hospitals have begun to restrict balloons to those made of mylar.

Reaction intensity varies

Adverse reactions to latex can range from mild to severe and include hives, rashes, dermatitis, and anaphylaxis. Symptoms may develop on the hands within minutes after donning latex gloves. When mucosal sites of allergic individuals come into contact with latex, the reactions are generally more severe.

For example, dental patients who are allergic to latex can suffer severe mouth swelling and can even experience narrowing of the airway. Mucosal contact also can lead to life-threatening conditions such as anaphylaxis, which may manifest as hives, swelling, hypotension, asthma, and arrhythmias. Anaphylaxis has been reported after latex has come in contact with disrupted skin. Anaphylaxis also has been reported during surgery, vaginal examinations, and catheterization.

Airborne exposure to NRL proteins can lead to asthmatic reactions, allergic rhinitis and conjunctivitis, hives, swelling, and occasionally anaphylaxis.

Interestingly, people allergic to latex are sometimes allergic to foods containing cross-reacting allergens. These include avocado, banana, chestnut, kiwi, and mango.

Eating these foods may cause swelling of the lips and mouth and potentially anaphylaxis. Allergies to these foods occur in a minority of

latex-sensitive individuals.

According to an article on latex allergies by **Susan Tarlo**, MBBS, MRCP(UK), FRCPC, associate professor at the department of medicine at the University of Toronto, there are four primary risk factors for allergy to NRL: allergic predisposition, significant exposure to NRL products, exposure to NRL products at mucosal sites or at sites where the normal skin barrier is disrupted, and as mentioned previously, food allergy.[1]

Allergic predisposition may include a history of preceding infantile eczema, allergic rhinitis, or asthma. Latex-allergic patients are five times as likely to have had these conditions or to test positive to common environmental aeroallergens, Tarlo writes.

Other than many health care workers, groups who have frequent exposure to natural latex products include those who manufacture latex products, children with spina bifida or congenital urological abnormalities who have had frequent NRL contact from sources such as latex catheters, and people who have undergone numerous surgical procedures.

Same-day surgery clinicians and others who find themselves dealing with latex-allergic patients should immediately take steps to make sure that the patient does not come into contact with any products containing latex.

Beware of even mild symptoms

This advice holds true even when the patient has exhibited only mild symptoms, such as hives, because the potential still exists for more serious reactions. If allergy symptoms appear, the individual should be treated with appropriate medications.

Patients who are aware that they are latex-allergic should be instructed to inform all health

SOURCES

- To report your latex allergy to **MedWatch**, the FDA Medical Products Reporting Program, contact MedWatch, Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20852. Telephone: (800) 332-1088. Fax: (800) 332-0178. The patient's identity is held in strict confidence by the FDA and protected to the fullest extent of the law.

- **E.L.A.S.T.I.C**. (Education for Latex Allergy Support Team and Information Coalition) is a national support group with representatives in 40 states that provides numerous resources to latex-allergic individuals. Contact Elizabeth C. Borel at 196 Pheasant Run Road, West Chester, PA 19380. Telephone: (610) 436-4801. E-mail: ecbdmd@ix.netcom.com.

- **Latex Allergy Information Service** offers a newsletter, *Latex Allergy News*. A one-year subscription is $40, and back issues are available for $10 each. To subscribe, contact Debra Adkins, 176 Roosevelt Ave., Torrington, CT 06790. Telephone: (860) 482-6869. Fax: (860) 482-2294. E-mail: debilan@compuserv.com. Internet: http://www.latexallergy help.com.

- **Spina Bifida Association of America** offers information and updated listings of latex-free equipment; 4590 MacArthur Blvd. N.W., Suite 250, Washington, DC 20007. Telephone: (800) 621-3141 or (202) 944-3285. Fax: (202) 944-3295. E-mail: spaa@spaa.org. Internet: http://www.sbaa.org/Latex.htm.

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care professionals before or at the time of care. Tarlo's article suggests that those patients should consider wearing a med alert bracelet for situations where communication with health professionals is impossible. Some clinicians advocate prescribing an auto-injectable epinephrine syringe to highly sensitized patients in case of accidental contact with NRL.

Protecting those at risk

Some institutions have taken aggressive steps to stem the latex threat. At Optima Health Visiting Nurse Services in Manchester, NH, employees receive two pages of questions and answers about latex allergy. The agency's health system even has a latex allergy committee dedicated to protecting employees and patients from unnecessary exposure to latex.

St. Joseph Hospital in Bellingham, WA, formed a latex task force to develop a policy on latex allergy, conduct hospitalwide inservices, and create a latex-free cart.

"This wasn't in response to any particular incident — we wanted to act before a serious problem occurred," says **Janice Taylor**, RN, CEN, a staff nurse in the hospital's emergency department. "We're a small community hospital, so we expected to use the latex-free cart three or four times a year. We were shocked when, during the first six months, we used it over 15 times."

Reference

1. Tarlo S. Latex allergy: A problem for both healthcare professionals and patients. *Ostomy Wound Mgmt* 1998; 44(8):80-88. ■

CE objectives

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After reading this issue, the continuing education participant will be able to:

• Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care and management. **(See "Can your ASC meet the credentialing challenge of new tools, techniques?" p. 65, and "Send Parkinson's patients home in hours, not days," p. 68.)**

• Describe how those issues affect nursing service delivery or management of a facility. **(See "New book gives guidelines for the outpatient setting," p. 69.)**

• Cite practical solutions to problems or integrate information into their daily practices, according to advice from nationally recognized ambulatory surgery experts. **(See "Waiting room audits tell much about your facility," p. 71.)** ■