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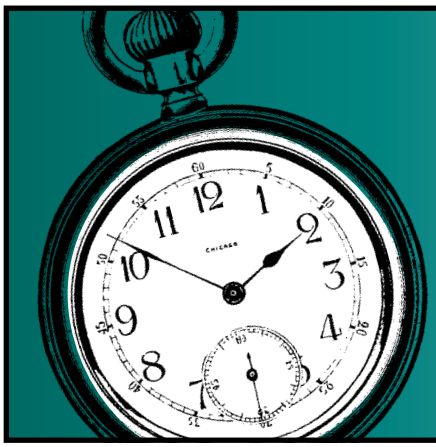

Same-Day Surgery®

Covering Hospitals, Surgery Centers, and Offices for More than 20 Years

INSIDE

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Joint Commission crackdown: Are you doing flash sterilization properly?

Cost of more instruments leaves SDS managers in a quandary

The word on the street is that accreditation surveyors are issuing citations for flash sterilization. For its part, the Joint Commission on Accreditation of Healthcare Organizations says it has no set policy, and facilities are expected to follow industry guidelines. **[For information on ordering guidelines from the Association for the Advancement of Medical Instrumentation (AAMI), see resource box, p. 103.]** This leaves same-day surgery managers scratching their heads and wondering why facilities are being cited.

"It's primarily human error," says **Victoria M. Steelman**, RN, PhD, CNOR, advanced practice nurse for Intensive and Surgical Services at The University of Iowa Hospital in Iowa City.

"One problem is just inadequate cleaning of lumens and joints — not taking instruments completely apart," she explains. "Another common area [for citations] is inadequate preparation for sterilization — instruments aren't put into a tray so that steam can penetrate all parts."

Another human error is not selecting the correct parameters, she says. "Another one is not verifying that the correct parameters have been met." And last but not least, instruments are contaminated en route to the sterile field, Steelman says. "People who are doing sterilization for immediate use are doing many other tasks. National standards

SPECIAL ISSUE ON INFECTION CONTROL

This month, we target a topic that has the ability to make or break your program: infection control. We tell you how to avoid citations from the Joint Commission on Accreditation of Healthcare Organizations regarding flash sterilization. We have the latest information on how bronchoscopes can cause transmission of respiratory infections and what you need to do to avoid contamination. We also fill you in on the recently released surgical site infection guidelines from the Centers for Disease Control and Prevention.

We hope you enjoy this special issue of *Same-Day Surgery*.

EXECUTIVE SUMMARY

Same-day surgery managers have come under fire for improperly performing flash sterilization. Some of the problems can be attributed to human error such as not performing the process correctly. However, much of the criticism stems from routine use of flash sterilization. Consider these suggestions:

- Use flash sterilization only when there's insufficient time to sterilize a device. Maintain adequate instruments, particularly for quick-turnaround cases.
- Don't flash sterilize implants.
- Explore new technologies, which offer quicker turnaround than traditional methods.
- Maintain a flash sterilization log.
- Use mechanical, chemical, and biological indicators.
- Perform annual competency assessment.

are based on that understanding."

Flash sterilization was originally intended as a last resort sterilization method when a unique instrument was unavailable for a procedure or was dropped on the floor, says **Chris Lavanchy**, engineering director at ECRI, a technology assessment firm based in Plymouth Meeting, PA.

Groups such as ECRI are concerned about the abuse of flash sterilization, Lavanchy says. "It has become a primary means of sterilizing some instruments rather than once-in-a-while, under unique circumstances, sterilization."

The Association of periOperative Registered Nurses (AORN) in Denver advises using flash sterilization "when there's insufficient time to sterilize an item," adds **Ramona Conner**, RN, MSN, perioperative nursing specialist at AORN. AAMI guidelines don't address this debate.

Routine flash sterilization appears to be a problem that is more common in the ambulatory surgery market, experts say. Particularly in ambulatory settings, providers often have only one or two sets of instruments for procedures with a quick turnaround, such as cataracts, Conner says.

"And I have heard of some hospital-based programs doing similar things, particularly with endoscopes and arthroscopes," she says. "Unless they purchase adequate instrumentation, they're going to have very difficult time getting completely away from flash sterilization."

It's expensive, Conner points out. "It's a real dilemma that's difficult to deal with. Certainly costs have to be weighed against the risks of flash sterilization."

Because a device that is flash sterilized doesn't have any wrap around it, it is exposed to air and potentially contaminated when you remove it from the flash sterilizer, Lavanchy says. "The key is that you have to maintain sterilization." Use it immediately; flash sterilization can be compared to using a microwave, Lavanchy adds. "It gets you what you want quickly, but it might not be as controlled as a conventional oven."

Should you order more instrument trays?

To avoid routine use of flash sterilization, order more instrument trays or have a person dedicated to the reprocessing of those trays, Steelman advises. It would be expensive to completely eliminate flash sterilization, she acknowledges. "You'd have to have inventory that's beyond your usage on a regular basis so that you could accommodate any situation that could possibly occur. I don't think that's reasonable or achievable. But you should have enough to manage daily operations. Many facilities, especially surgery centers, don't have that because of the cost."

Implants should never be flash sterilized, so maintain an adequate inventory, Conner emphasizes. When done properly, flash sterilization can be a safe method of sterilizing nonheat-sensitive instrumentation, experts advise.

Consider these suggestions:

1. **Investigate new technologies.**
There are some technologies that offer

COMING IN FUTURE MONTHS

- Cross-training: How to make it work
- Outcomes monitoring in same-day surgery
- Newer anesthetics: Know the pros and cons
- Patient registration on the Internet
- Construction in SDS: Build or renovate?

short-term sterilization, Lavanchy points out. For example, gas plasma sterilizers have about a 75-minute cycle.

Liquid sterilization is another quick option. Conner points to the Steris Process offered by the Steris Corp. in Mentor, OH. The Steris Process is low-temperature sterile processing of immersible, heat-sensitive surgical and diagnostic instruments. Each cycle takes about 30 minutes. The cost of the system is $16,200. **(For more information, see resource box, at right.)**

However, providers should be attentive to the issue of compatibility, Lavanchy warns. "You have to be careful what you put into a sterilizer," he emphasizes.

2. Provide proper documentation.

Staff often fail to maintain proper records for flash sterilization, Conner says. AORN recommends that providers maintain a flash sterilization log with, at minimum, the name of the operator, identification number of the sterilizer, date and time of the cycle, general contents of the load, and the length and temperature of the exposure portion of the cycle. The patient's name and operating room location also may be included in the log. **(For further direction from AORN, see *Same-Day Surgery*, January 1998, p. 14.)**

In addition, the log should include the results of monitoring and indicators, such as test strips, Steelman says.

3. Offer a sound quality assurance program.

After human error, the next reason most often cited by the Joint Commission for problems with flash sterilization is inadequate biological monitoring, Steelman says.

AORN's Recommended Practice states, "Sterilizer function should be monitored with mechanical, chemical, and biological indicators to meet all of the monitoring standards established for pre-vacuum or gravity displacement sterilizers." **(See AORN's Recommended Practice regarding flash sterilization, inserted in this issue.)**

4. Perform competency assessment.

Staff need annual competency assurance in flash sterilization, Steelman says.

"It's an extremely important part of their job, and they need to know how to do it well," she says. "They have to understand it and understand the process of cleaning, not just that you clean, but how you clean, and how errors happen — why some of those practices are incorrect." **(For information on an orientation and competency assurance tool that Steelman helped develop, see resource box, above.)** ■

RESOURCES AND SOURCES

Flash Sterilization: Steam Sterilization of Patient Care Items for Immediate Use (ANSI/AAMI ST37-1996) is available from the Association for the Advancement of Medical Instrumentation (AAMI). The cost is $40 for AAMI members and $80 for nonmembers. Shipping and handling is $5 for members and $8 for nonmembers. To order, contact:

- **Association for the Advancement of Medical Instrumentation**, 3330 Washington Blvd., Arlington, VA 22201-4598. Telephone: (800) 332-2264, ext. 217 or (703) 525-4890, ext. 217. Fax: (703) 525-1424. Web site: www.aami.org.

An orientation and annual competency assurance course titled "Flash Sterilization: Sterilization for Immediate Use" is available to *Same-Day Surgery* readers for $149 (normally $179) plus $4.95 for shipping and handling. Contact:

- **MetaSource**, P.O. Box 1075, Iowa City, IA 52244. Telephone: (319) 341-8667.

For more information on the Steris Process, contact:

- **Steris Corp.**, Customer Service, 9260 Progress Parkway, Mentor, OH 44060-1834. Telephone: (800) 548-4873 or (440) 354-2600. Fax: (440) 639-4450. Web site: www.STERIS.com.

For more information about flash sterilization, contact:

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Re-examine processes for cleaning bronchoscopes

CDC says infectious complications are occurring

The Centers for Disease Control and Prevention (CDC) in Atlanta is urging providers to re-examine their processes for cleaning bronchoscopes after the New York State Health Department found the transmission of respiratory infections at three unnamed facilities between 1996 and 1998 was due to inadequate cleaning of bronchoscopes.

The CDC estimates that 497,000 bronchoscopies were performed in 1996. "Although reported infectious complications caused by bronchoscopy are rare,[1] the incidence is probably underestimated, with many episodes unrecognized or unreported," the CDC states.[2]

William A. Rutala, PhD, MPH, director of hospital epidemiology at the University of North Carolina (UNC) Hospitals and professor at UNC School of Medicine in Chapel Hill, says, "Use of contaminated scopes may also result in pseudoepidemics in which cultures obtained at the time of bronchoscopy represent colonization of the scope as opposed to colonization or infection of the patient. More than 35 outbreaks or pseudoepidemics have been reported through 1997." **(For details on how bronchoscopes were implicated in two deadly TB outbreaks, see *Same-Day Surgery*, March 1998, p. 36.)**

To reduce the opportunity for contaminated scopes, consider these suggestions from the CDC[2] and other experts:

✔ Bronchoscope users should obtain and review model-specific reprocessing protocols from both bronchoscope and automated reprocessing system manufacturers. User education should include on-site training and observation during the setup of each bronchoscope model to clarify device- and model-specific differences in procedure.

"The CDC guidance in [reference 2] should be followed religiously to include model-specific reprocessing protocols." Rutala comments.

Jan Schultz, MSN, RN, president of Jan Schultz and Associates, agrees. "If you are buying a new device, make sure part of the purchasing specifications includes training on reprocessing," says Schultz, whose consulting service focuses on the reprocessing continuum.

Representatives from the manufacturer can be of great assistance, agrees **Nancy Gondzur**, RN, clinic manager of the Ambulatory Procedure Center at the University of Wisconsin Hospital and Clinic in Madison. "They come in and review equipment and go through the cleaning steps," Gondzur says.

The first step is manual cleaning of the scopes, she says. "It is different for different scopes and for different manufacturers."

The process is repeated for reprocessing equipment, she says. "We have a representative from the company actually walk us through hooking up the scope in the reprocessor. They offer little tips on how to do it a little smoother or easier, or they make sure you go through steps in a specific sequence."

✔ Connector systems should be clearly labeled (e.g., color coded) to ensure proper selection and use.

You can ask the manufacturer to label the connector systems before signing the contract. Or use colored tape to do it yourself, Schultz advises.

Gondzur says this step would make it easier for the person handling the reprocessing, "especially if you have a larger staff in which people float in and out."

At Gondzur's facility, a decentralized central processing area has freed endoscopy nurses and staff from reprocessing responsibilities. "Nurses hated having to do all of that cleaning," she says. "The central processing staff is trained, and it's very controlled. They're competent and consistent."

✔ Quality-control procedures should be developed in each health care facility to include visual

EXECUTIVE SUMMARY

Inadequate cleaning of bronchoscopes can cause the transmission of respiratory infections, the Atlanta-based Centers for Disease Control and Prevention reports. To avoid problems, follow these steps:

- Have representatives from the bronchoscope and automated reprocessing system manufacturers educate your staff on device- and model-specific differences in procedures.
- If the manufacturer does not label the connector systems, use colored tape to ensure proper selection and use.
- Visually inspect the scopes and perform leak testing after each use.
- Ensure your reprocessing policies and procedures are up to date. Supervise new employees, and perform annual competency testing.

SOURCES

For more information on disinfection/sterilization of bronchoscopes, contact:

- **Nancy Gondzur**, RN, Clinic Manager, Ambulatory Procedure Center, University of Wisconsin Hospital and Clinic, 600 Highland Ave., C7-254-2451, Madison, WI 53792. Telephone: (608) 263-8284. Fax: (608) 265-8852. E-mail: nj.gondzur@hosp.wisc.edu.
- **Jan Schultz**, MSN, RN, President, Jan Schultz and Associates, 8015 Sandorn Drive, Roswell, GA 30075. Telephone: (770) 649-9493. E-mail: jsassoc@msn.com.

inspection of the bronchoscope, regular testing for bronchoscope integrity, maintenance, and surveillance for unusual clusters of organisms.

Leak test scopes after each use, Gondzur advises. "Look for leaks throughout the instrument, not just in the bending rubber [the flexible distal tip of the scope], but channel leaks in the main channel of the scope." Over time, biopsy forceps and metal reusable brushes can wear down the channel, which leads to leaks, she says. "You want to catch the leaks right away; otherwise, you can have water damage and a more expensive repair."

Manufacturers recommend that providers store scopes in a hanging position, she says. "Don't leave them curled up in a cabinet or drawer. You're not throwing things on top of them. You want to avoid trauma to the scope."

While most facilities perform visual inspections and regular leak-checking, few are performing surveillance for organisms, Schultz says. "For many same-day surgery programs, that's difficult to do," she acknowledges. "However, it might be possible if copies of the lab results were sent not just to the patient's chart, but to the infection control person for that facility."

✔ Ensure employees are performing disinfection / sterilization correctly.

Ensure your written policies and procedures are up to date, Schultz advises. "You use those as basis for teaching and demonstration and return demonstration by the employee," she says.

Bronchoscopes are complex, and new employees should be carefully supervised for the first couple of weeks that they are performing cleaning and sterilization, Schultz says. "Someone needs to be sure they're following all the steps and that they know why the steps are important."

Conduct at least a yearly review of competency for all staff who are involved in reprocessing, she advises.

References

1. Martin MA, Reichelderfer M. APIC guidelines for infection prevention and control in flexible endoscopy. *Am J Infect Control* 1994; 22:19-38.

2. Centers for Disease Control and Prevention. *MMW* 1999; 48:557-560. ■

How can outpatients be tracked for infection?

CDC releases new SSI guidelines

In releasing recent guidelines on surgical site infections (SSIs), the Centers for Disease Control and Prevention (CDC) emphasizes the importance of tracking infections for outpatient surgery patients, acknowledges the particular challenges of tracking such patients, but stops short of recommending a consensus approach on how to do it.

The CDC guidelines address the compelling shift to outpatient surgery and note that an estimated 75% of all operations in the United States will be performed in outpatient settings by the year 2000. While it may be appropriate to use common definitions of SSI for inpatients and outpatients, the types of operations monitored, the risk factors assessed, and the case-finding

EXECUTIVE SUMMARY

Newly released guidelines on surgical site infections (SSIs) from the Centers for Disease Control and Prevention (CDC) acknowledge the particular challenges of tracking outpatient infections.

- High return rates for questionnaires sent to patients and/or surgeons don't necessarily mean you are successfully tracking SSIs.
- The CDC is studying new ways to collect outpatient SSI data.
- The CDC stopped short of endorsing the collection of surgeon-specific SSI rates, but suggested periodic collection of "operation-specific" SSI rates.

Assess SSI risk in patients, procedures

Recently released guidelines on surgical site infection (SSI) from the Centers for Disease Control and Prevention (CDC) emphasize basic infection prevention principles and minimizing risk where possible, says **Alicia Mangram**, MD. She was the lead author of the guidelines while at the CDC hospital infections program and now is in surgical residency at the University of Texas in Houston.

"Prior to planning an elective operation, look at the risk factors that we have mentioned and see if there is anything that can be done to change them," she recommends. While same-day surgery managers should consult the CDC SSI guidelines for specific guidance on particular factors, the following were listed as the prime characteristics that can contribute to SSI development:

1. **Patient risk factors**
   - age
   - nutritional status
   - diabetes
   - smoking
   - obesity
   - coexistent infections at a remote body site
   - colonization with microorganisms
   - altered immune response
   - the length of preoperative stay

2. **Operation risk factors**
   - duration of surgical scrub
   - skin antisepsis
   - preoperative shaving
   - preoperative skin prep
   - duration of operation
   - antimicrobial prophylaxis
   - operating room ventilation;
   - inadequate sterilization of instruments
   - foreign material in the surgical site
   - surgical drains
   - surgical technique (i.e., poor hemostasis, failure to obliterate dead space, tissue trauma)

methods used may differ.

"At some point in time, I'm sure we're going to have data comparing ambulatory-setting surgical site infections with inpatient-setting SSIs," says **Alicia Mangram**, MD, lead author of the guidelines written while at the CDC hospital infections program and now in surgical residency at the University of Texas in Houston. "There is going to be a statistical difference between the two because the patients who have ambulatory care surgical procedures performed have decreased risk."

Though many outpatient infections are likely be relatively minor, it is still important to track ambulatory procedures, Mangram adds. "Despite that our own intuition tells us that the number of SSIs in the outpatient population is going to be substantially smaller, we could be wrong. What we may find is that there are no deep organ/space surgical site infections, but the number of superficial site infections may not be any different [than inpatient] and that may be something we need to know. So I think it will be important."

But surveillance for such procedures is difficult, she says, and notes that it is difficult enough to keep track of hospitalized patients post-discharge. "The chances that [outpatients] will even go back to the surgeon other than to have their sutures removed are minimal," she says. "They will go to their primary care physician. So I think surveillance in the ambulatory care setting is going to be difficult."

Same-day surgery managers have used questionnaires to patients and surgeons with little success, says **Teresa Horan**, MPH, CIC, epidemiologist at the CDC. "You may get a good response rate, but that doesn't necessarily mean good surveillance data," she says. "I talk to a lot of people who say, 'We have 90% of surgeons responding to our questionnaire about their patients.' But that doesn't mean they're finding 90% of infections."

Surgeons aren't always the best at identifying or reporting infections, Horan says. "Patients aren't that good either," she says. "So while we might be able to reach them, what we're looking for is more objective ways to get information.

For example, if a patient picks up an antibiotic or returns to a clinic, that might be a sign of an SSI, she says. "We have a study going on looking at integrated health care systems to determine if there's other ways to access existing databases in a managed care environment to see if we can identify [patients who get] SSIs after they leave inpatient or outpatient surgery."

While a variety of surveillance approaches are being tried to capture post-discharge infections, the CDC concluded there is no consensus approach to recommend. The final guidelines for SSI prevention essentially advise providers to weigh their local situation and available resources in adopting the most feasible and effective method to track post-discharge infections. Regardless of the approach taken, the CDC recommended using its definitions for SSIs without modification in both

Rankings run from strongly recommended to unresolved

Surgical site infection prevention guidelines by the Centers for Disease Control and Prevention's Healthcare Infection Control Practices Advisory Committee are ranked according to the following system. **(See guidelines, enclosed in this issue.)**

- ☐ **Category IA.** Strongly recommended for implementation and supported by well-designed experimental, clinical, or epidemiological studies.
- ☐ **Category IB.** Strongly recommended for implementation and supported by some experimental, clinical, or epidemiological studies and strong theoretical rationale.
- ☐ **Category II.** Suggested for implementation and supported by suggestive clinical or epidemiological studies or theoretical rationale.
- ☐ **No recommendation; unresolved issue.** Practices for which insufficient evidence or no consensus regarding efficacy exists.[1]

Reference

1. Mangram AJ, Horan TC, Pearson ML, et al. Guideline for prevention of surgical site infection, 1999. *Infect Control Hosp Epidemiol* 1999; 20:257-280. ■

inpatient and outpatient settings. As integrated health information systems expand, tracking surgical patients through the course of their care may become more feasible, practical, and effective, the CDC states.

Though some studies state that collecting and reporting surgeon-specific infection rates reduce SSIs, the CDC found the data insufficient to endorse the controversial practice in its recently finalized SSI guidelines.[1]

One recent study attributed major cost savings and a 49% reduction of SSIs to surgeon-specific reporting, though advocates of the practice concede it is not completely understood how the feedback lowers subsequent rates.[2] Such suggestions of efficacy are not compelling enough to specifically endorse the practice, which could unfairly reflect on surgeons who operate on patients at higher risk for infection, Mangram notes.

Nevertheless, the SSI prevention guidelines issued by the CDC Healthcare Infection Control Practices Advisory Committee do not specifically prohibit the practice. **(See rankings, above, and an excerpt of the guidelines, inserted in this issue.)**

However, the CDC recommends that providers periodically calculate "operation-specific" SSI rates stratified by risk factors. "We are talking about the rate [for example] of all of the appendectomies performed in the hospital," Mangram says.

(Editor's note: Readers can access the full SSI guidelines on the CDC Web site: www.cdc.gov/ncidod/hip. Readers can receive free CME or CE contact hours on-line.)

References

1. Mangram AJ, Horan TC, Pearson ML, et al. Guideline for prevention of surgical site infection, 1999. *Infect Control Hosp Epidemiol* 1999; 20:257-280.

2. Smyth E, Barr J, Webb C, et al. Potential savings achieved due to a reduction in surgical site infections over a twenty-four month period. Abstract 58. Presented at the Society for Healthcare Epidemiology of America (SHEA). San Francisco; April 18-20, 1999. ■

Same-Day Surgery Manager

The medical director's role in same-day surgery

By **Stephen W. Earnhart**, MS
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Surprisingly, the role of the medical director in a surgery center or surgical department is confusing to some. This confusion is coming either from the medical director or those who work with him or her. Often, the problem is coming from the administrator who claims that he or she is not getting the necessary support from the director's position.

This situation may become more pronounced when the medical director is not an anesthesiologist. I'm not certain why, but usually when the position is filled from a member of the anesthesia

department, there is a greater sense of global understanding of the issues going on in the center as opposed to, for instance, a urologist who is in the facility infrequently. For the most part, the medical director is an anesthesiologist. In fact, the state of Pennsylvania is updating their new ambulatory surgery center standards and will require that medical directors be anesthesiologists.

So, in the example of the urologist, the administrator doesn't think the medical director is doing what he or she was hired or elected to do for the facility. Not surprisingly, when I discuss the problem with the medical director (as tactfully as possible), I frequently get the same response everywhere: "I have no authority here, and everyone just gives me their problems. It is very frustrating." It's a different story than the administrator is portraying.

The solution in this situation is easy: better communication. That solution and a comprehensive job description are requirements. In the vast majority of these situations, I find that there is either no job description, there is a job description but no one knows where to find it, or it is outdated.

There is a specific role the medical directors play in the same-day surgery program. You need to detail their responsibilities to eliminate that doubt. Some areas that should be included are:

- assist with the scheduling of cases to ensure that the needs of the anesthesia department and the facility are met;
- make sure that an anesthesiologist is on the premises until the last patient leaves the facility;
- oversee the recovery areas and ensure the medical standards are functioning properly;
- discharge patients (optional);
- serve as chairman of the quality assurance committee and participate on other committees;
- attend and contribute to the professional staff and board of directors meetings;
- work with the same-day surgery program on the development of policies and procedures, bylaws, and protocols of the facility;
- perform whatever administrative or supervisory functions are required to make sure the facility is in compliance with licensure and / or certification and accreditation needs;
- serve as a functioning part of the team of the same-day surgery program;
- use professional judgment to oversee the practice of safe, quality medicine, and surgery at the facility.

Clearly, there are other areas where medical directors can assist the program. Often special projects will come up that need their invaluable input in the decision-making process. However, to be effective, medical directors need to understand their roles.

A frequent question regards compensation for this important position. It is a tough one, and there is no right or wrong answer. I would guess that medical directors, (50% of the time, assuming they are working anesthesiologists) receive a stipend or compensation between $15,000 to $30,000 per year for their services. There are some who make significantly more, especially if they own the center or have dedicated their career to running the center. Like a good administrator, the medical director can be the difference between a good facility and a great facility.

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Teamwork keeps turnover time low

Even in a managed care environment, surgeons and patients often have some choice in deciding where an outpatient surgery will be scheduled. For this reason, it is important that you make your program as attractive as possible to both patients and surgeons.

Make your day-surgery program attractive to surgeons by ensuring their time will be spent making money, not wasting time, says **Jeffrey Love**, RN, staff nurse at Saddleback Memorial

EXECUTIVE SUMMARY

Reducing your turnover times between surgeries increases staff productivity, increases the number of cases you can schedule for one room, and keeps surgeons satisfied with your day-surgery program. Keeping turnover times low and surgeons happy can be accomplished by:

- communicating turnover times with staff and physicians;
- evaluating activities of staff with lower turnover times and sharing ideas with other staff members;
- setting up rooms to handle similar cases so equipment doesn't have to be moved.

SOURCES

For more information about reducing turnover time between surgeries, contact:

- **Jeffrey Love**, RN, Staff Nurse, Saddleback Memorial Medical Center, 24451 Health Center Drive, Laguna Hills, CA 92653. E-mail: jlove@memorialcare.org.
- **Nancy Burden**, Director, Trinity Outpatient Center, 2101 Trinity Oaks Blvd., New Port Richey, FL 34655. Telephone: (727) 372-4010. Fax: (727) 372-4065. E-mail: nburden@mpm.baycare.org.

Medical Center in Laguna Hills, CA.

"A surgeon is making money when he or she is in surgery, so it's important for times between surgeries to be as short as possible," he explains. Turnover times between surgeries have dropped steadily at Saddleback since 1993 when Love's facility, which handled inpatient and outpatient surgeries in the same OR, began tracking and posting turnover times for cases classified as minor, major, and extended major.

Day-surgery cases fall into the categories of minor, such as cataract and hysteroscopy, and major, such as laparoscopic cholecystectomy and shoulder arthroscopy, says Love. Turnover times for minor cases dropped from an initial goal of 20 minutes to an average time of 17 minutes. Turnover for major cases has dropped from an initial goal of 30 minutes to 20 minutes. "We post the average times on the door to each operating room so staff members and physicians can see how we are doing," he says. The circulating nurse for each case logs the turnover times. The averages for each category are posted each quarter.

"We find out how one person is lowering times and share that information to help everyone turn over the rooms more quickly," he adds.

The program to log turnover times began when staff reductions reduced the number of housekeepers assigned to the operating room, explains Love. Turning over a room meant even more teamwork, with everyone picking up trash, keeping the room neat during surgery, and moving equipment in and out as needed, he adds.

"By having the trash bagged and sitting at the door, all the housekeepers had to do was wipe down and mop the room, so they could have it ready much quicker," he explains.

Anesthesiologists are using their wastebaskets, and spills are cleaned up during surgery if at all possible, explains Love. "By keeping the room clean during surgery and taking care of some cleanup while the patient is being awakened, we shorten the amount of time to get the room ready for the next patient," he says.

While her staff do not log turnover times on an ongoing basis, **Nancy Burden**, director of Trinity Outpatient Center in Port Richey, FL, says that periodic surveys of times show that they average five to 10 minutes for procedures such as ear tubes, pain management procedures, or cataracts. Turnover for arthroscopies average 12 to 15 minutes, she says.

One way her staff keep turnover times so low is to set up two rooms for the same procedure and keep the surgeon moving from one to another. "If we have several arthroscopies of the knee scheduled for one day, we alternate the left and right knee procedures in the schedule so we have one room set up to do left knees and one set up for right knees," Burden says.

Once the surgeon has finished the procedure on one patient's left knee, the surgeon goes to the room that has another patient with a right knee prepped. This eliminates the need to move equipment around the room after each procedure. The same practice is used for cataract surgery, she adds.

While the decision to reduce the number of housekeepers in the operating room was the impetus for Saddleback's program to look at turnover times, Love says the use of teamwork actually resulted in increasing the housekeeping staff. "When a productivity expert looked at the efforts of the nursing staff to clean rooms, he suggested that a better use of the nurses' time would be to focus on other areas of turnover. We have the housekeeping staff back to full strength, but we still bag trash and do what we need to keep turnover times low," he adds. ■

Comfort, good information top list of customer needs

Providing buffered lidocaine, using blanket warmers, and letting patients know why they are waiting for surgery to begin are just a few of the ways the day surgery staff at Forrest General Hospital keep their patients satisfied.

Patient surveys are mailed to day surgery patients to determine what their expectations were and how well their needs were met,

EXECUTIVE SUMMARY

Keeping patients satisfied with your service is important to a day surgery program's ongoing success in attracting surgeons, managed care contracts, and patients. Before you can meet their needs, however, you need to find out what is important to them.

- Patient surveys and focus groups are two methods used successfully to identify needs.
- Some of the top needs identified by same-day surgery patients are comfort, information, and convenience.

explains **Jan Odom**, RN, CPAN, FAAN, clinical nurse specialist for the hospital-based and the freestanding day surgery programs operated by the Hattiesburg, MS, hospital.

"Overall, our patients want comfort, information, individualized care, and to be made to feel special." Most often, it is the little things that make a difference, she says. "We discovered that many patients are more afraid of the needle for the IV than they are of the surgery. So, we went to buffered lidocaine to deaden the area of needle insertion. And patients appreciate it so much. We've heard that former day-surgery patients who come in for inpatient surgery request buffered lidocaine." Another item added after patient complaints was a blanket warmer, she adds.

Patients also become anxious and rate their experience poorly when their surgery doesn't start in a timely manner. Using this information from their patient surveys, Odom and the staff kept statistics on surgical start times and reasons for delays.

"Often, the reason for the delay was the surgeon, so we shared the information with them," she says. Although the nurses can't force a surgeon to start on time, staff now make a point to talk to the patient frequently to let him or her know that there has been a delay and to make sure the patient doesn't feel forgotten, she explains.

While surveys mailed to patients on a regular basis are a good way to keep track of ongoing satisfaction rates and identify patient needs on an ongoing basis, focus groups are a great tool to use if you are renovating or restructuring your day surgery program, says **Diane Fecteau**, RN, executive director of Brighton Surgical Services Center in Portland, ME.

When Fecteau's facility was preparing to renovate the day surgery center, she proposed renovating some of the processes as well. To find out what patients thought was important to a good outpatient surgical visit, she conducted focus groups to get input. Dinner meetings were held at the surgery center, and sandwiches were provided to the participants.

"I held two focus groups of about 12 to 15 people in each group," says Fecteau. The groups were randomly chosen from previous patients as well others who had not had surgery at Brighton Surgical Center. "We made sure we included a variety of ages as well as a representation of different payers," she says.

"In addition to me conducting the group, I had a couple of staff members attend each [session] to make sure they could disseminate the information to other staff members." This extra help in communicating ideas to staff was beneficial. "When changes were proposed, the staff knew the ideas came from the focus groups, not just me," she explains.

Acting on requests from focus group

Focus group members said they wanted a caring staff and a lot of information about what was going to happen before and after surgery, says Fecteau. They also indicated they wanted to be with family members as soon as possible after surgery. For this reason, Fecteau combined the first and second stage of recovery. "One-half of our recovery room is a traditional, open PACU, and one-half has curtained cubicles that allow families to sit with patients," she explains.

Fecteau now relies on patient surveys to provide input about ongoing services and makes changes as needed. For example, when the ratings for level of information given stayed at a

SOURCES

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92% level rather than the target goal of 95% satisfaction, Fecteau followed up with phone calls to any patient who gave a fair, poor, or very poor rating on this question.

"I reached 11 of the 14 patients who had given their names and telephone numbers and discovered that the lack of information was on the surgeon's part, not the day surgery staff's," she says. "To address the problem, we presented the information to our multidisciplinary physician advisory board and we wrote letters to physicians whose patients raised that complaint."

Efforts have paid off with the June 1999 report showing a satisfaction level of 96%, she adds. ■

HCFA on track to beef up oversight of facilities

The Health Care Financing Administration (HCFA) isn't wasting any time addressing the "major deficiencies" and "significant weaknesses" detailed in the Office of Inspector General's (OIG) four-volume report on the Joint Commission on the Accreditation of Healthcare Organizations and state agencies. That report was released July 20 following an exhaustive two-year examination by the OIG.

Eager to counter the litany of shortcomings outlined in the report, HCFA has already completed a not-yet-public "detailed action plan" to follow the four-point action plan included in the report.

In an upcoming revision of its conditions of participation (COP) regulations, HCFA will more clearly define its priorities for facility surveys of basic health and safety issues such as surgery mix-ups and medication errors. HCFA spokeswoman **Michelle Robinson** confirms that HCFA's new COPs will be released this fall but added that it is "still very much in draft form."

She also says there is "no timetable for the development of performance measures because that is still very much in a preliminary phase." HCFA has directed peer review organizations to establish and develop measures that will provide benchmarks.

Three of the measures under development include mortality rates following surgery, infection rates following surgery, and the rate of beta-blockers prescribed for patients hospitalized after a heart attack.

HCFA's Hospital Quality Oversight Plan, or action plan, lays out broad objectives. One objective is improving oversight of the Joint Commission's activities.

Specifically, the agency says it will consider supplementing or replacing current validation surveys with observation surveys that would be conducted concurrently with the accreditation survey. These surveys, Robinson adds, should look at both the Joint Commission on-site performance and the facility's ability to meet COPs.

More unannounced surveys are possible

Also included in HCFA's preliminary blueprint for the Joint Commission are these items:

- more unannounced surveys;
- more random selection of records;
- more "contextual information" about facilities provided to surveyors;
- more rigorous assessments of facilities'

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internal continuous quality improvement efforts;

• greater capacity of surveyors to respond to complaints within the survey process.

HCFA says it will also redesign the survey data system — OSCAR — either by linking it to the Joint Commission's accreditation survey data system or expanding it to include data on Joint Commission data survey results, complaints, sentinel events, and performance measures. The Joint Commission has identified surgical procedures and complications as one of five areas for which core performance measures will be developed. **(For more information, see *Same-Day Surgery*, August 1999, p. 99.)**

The Joint Commission has announced significant changes to its random unannounced surveys, including a modification that organizations will receive no advanced notice for random unannounced surveys.

Also, the window of time during which random unannounced surveys may be conducted will be nine to 30 months following the triennial full survey. ■

Will final APC regulations be published in '99?

The Health Care Financing Administration (HCFA) has closed the period for accepting comments on the ambulatory payment classification (APC) proposals. Whether the final APC regulation will be published in 1999 remains to be seen, although that is HCFA's stated goal, says **Dave Fee**, product marketing management for 3M Health Information Systems in Salt Lake City.

HCFA extended the deadline for comments on the APC regulation until July 30. "That doesn't give them a lot of time to go through all those comments," Fee says. However, facilities should continue to prepare for APCs because HCFA has stated recently that they could be implemented for outpatient services in hospitals and surgery centers as soon as early in the year 2000.

The latest changes to APCs were published in the June 30 *Federal Register* and contained "mostly technical changes" to the hospital proposed reg, Fee says. The *Federal Register* is available at many libraries and through an on-line database. (Web address: www.access.gpo.gov/ su_docs/) ■

CE objectives

After reading this issue of *Same Day Surgery*, the continuing education participant will be able to:

• Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care and management. **(See "Comfort, good information top list of customer needs," p. 109.)**

• Describe how those issues affect nursing service delivery or management of a facility.

• Cite practical solutions to problems or integrate information into their daily practices, according to advice from nationally recognized ambulatory surgery experts. **(See "Joint Commission crackdown: Are you doing flash sterilization properly?" p. 101, "Re-examine processes for cleaning bronchoscopes," p. 104, and "Teamwork keeps turnover time low," p. 108.)** ■