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Latest SDS dilemma: Should surgeons be tested for bloodborne pathogens?

Take steps to decrease risk of transmission to patients

In the past, a don't ask, don't tell mentality permeated the issue of surgeons and their possible infection with bloodborne pathogens such as hepatitis B. However, recent research and publicized cases of transmission to patients are heralding a call for change. Proponents say surgeons should self-test to determine whether they are infected with a bloodborne pathogen.

The movement has the support of the Chicago-based American College of Surgeons, according to **Donald Fry, MD**, chair of the Governor's Committee on Bloodborne Infections and Environmental Risks at the American College of Surgeons, and chairman of the department of surgery at the University of New Mexico Health Sciences Center in Albuquerque.

The American College of Surgeons has updated its "Statement on the Surgeon and Hepatitis," and at press time, the updated statement was scheduled to be published in late March.

Some outspoken individuals are going further and advocating a controversial step: universal testing of surgeons for bloodborne pathogens. Some supporters want to include scrub nurses as well.

The United Kingdom has had mandatory hepatitis B virus (HBV) testing and vaccination for all students entering medical school since

EXECUTIVE SUMMARY

With increased attention on the transmission of bloodborne pathogens — particularly hepatitis — from surgeons to patients, managers are facing difficult questions on how to address this issue.

- Ensure that universal precautions are followed carefully.
- Encourage surgeons to self-test. For surgeons who test positive and perform "exposure-prone procedures," the CDC recommends notification of patients if they continue practicing.
- Expert panels can determine modifications, if any, for surgeons who test positive.

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1993, explains **John W. Wickenden**, MD, a retired surgeon in Camden, ME, who has been infected with HBV for more than 30 years.

At a presentation at the most recent annual meeting of the Washington, DC-based Association for Professionals in Infection Control and Epidemiology (APIC), Wickenden said he would like to see the United States follow the practice. And he doesn't stop his recommendations there.

"Periodic renewal of licensure and hospital

privileges will need to be contingent upon mandatory serologic testing and vaccination. Established surgeons who test positive must be required to withdraw from procedural practices." The issue is a patient safety one, he maintained.

"There is a very real potential for transmission of hepatitis B or C, during surgery, from a surgeon who is serum antigen positive for these," said Wickenden. "Of interest, in the context of all of the concern expressed a decade or more ago, there is *very little* evidence of transmission of HIV, during surgery, from infected surgeons to patients."

Preventing the transmission of bloodborne pathogens requires "a more stringent strategy for vaccination and testing of surgeons and optimization of infectious disease surveillance," say authors who have researched this topic.¹ (See story, p. 15.)

Specifically, many infection control experts recommend these steps:

- **Follow universal precautions diligently.**

"The practice of universal precautions is often somewhere between absent and sloppy," added Wickenden.

Although there has been improvement in adherence to universal precautions due to concerns about HIV transmission, it's only a relative improvement, he said. "The realities of the surgical environment still cause injuries. There has been, and there still is, frequent exchange of blood between surgeons and patients."

Experts point to orthopedic procedures as one example of surgeries that involve a lot of blood.

Few physicians thoroughly adopt, in their daily practice, demonstrably valuable infection control techniques, Wickenden pointed out. "They far too often behave as though they deemed the risk to be insignificant," he said. "Just close your eyes, and think for a moment how often surgeons and other health care workers don't even wash their hands."

- **Encourage self-testing.** Because there are significant treatments available or upcoming to treat viral infections, surgeons should self-test, Fry says. "I would consider it appropriate for surgeons to know their status relative to these viruses, just as they should know they're hypertensive and diabetic. It's a matter of their own health and, in the case of HBV, it may be a matter of patients' health."

The Denver-based Association of periOperative Registered Nurses (AORN) supports voluntary testing after informed consent and counseling for patients and all health care workers regardless of the practice setting.²

Many experts shy away from required testing, however. "From my perspective, universal testing

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Editorial Questions

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is neither warranted from an infection control standpoint, nor advisable, from a civil rights perspective, i.e., the surgeons' rights," says **Jeffrey Driver, JD, MBA, DFASHRM**, chief risk officer at Stanford (CA) University Medical Center. Driver recommends an approach that requires surgeons to self-assess based on personal risk, self-test, and disclose to hospital professionals.

However, disclosure raises another significant issue. "Most doctors don't want to get tested, and I know why: Because it opens a whole bag of worms that no one has a clear answer to," said **William P. Fiser Jr., MD**, assistant professor of

surgery at the University of Arkansas for Medical Sciences in Little Rock.³ Fiser voluntarily left his position as a cardiac surgeon when he tested positive for the hepatitis C virus (HCV) and was diagnosed with advanced liver disease.

Those unanswered questions may include: Should surgeons who test positive continue practicing? What procedures, if any, should they be allowed to perform, and who decides? If they aren't allowed to perform procedures, how will they make a living? Should their status regarding bloodborne pathogens be disclosed to patients? (Some states require disclosure to patients.)

How significant is the risk of transmission?

Since 1970, more than 375 patients around the world have been infected with hepatitis B virus (HBV) from their surgeons.¹

"The risk is significant," **John W. Wickenden, MD**, said at the most recent meeting of the Washington, DC-based Association for Professionals in Infection Control and Epidemiology. Wickenden, a retired surgeon in Camden, ME, has been infected with HBV for more than 30 years.

Concerning the hepatitis C virus (HCV) — in addition, some 1.8% of the population is infected, and the figure is believed to be higher among health care workers.²

Cases of transmission may be difficult to determine. Only a small number of surgical patients infected with HCV become symptomatic, and even fewer do so early enough to recognize the possible relationship with their prior surgery, according to **William P. Fiser Jr., MD**, assistant professor of surgery at the University of Arkansas for Medical Sciences in Little Rock.² Fiser voluntarily left his position as a cardiac surgeon when he tested positive for HCV and was diagnosed with advanced liver disease.³

Poor infection control practices aren't always to be blamed for transmission, infection control experts say.

A study of 1,564 patients in the Netherlands found that a surgeon who tested positive for hepatitis B surface antigen and hepatitis B e antigen definitely transmitted the virus to eight patients, probably transmitted the virus to two more, and possibly transmitted it to 18 others. The surgeon's infection control practices were adequate, and transmission occurred even when there was no break in infection control procedures or proper surgical techniques.⁴

In a study of HCV transmission from surgeons and anesthesiology staff to patients, researchers

reviewed seven cases of surgeons or anesthesiology staff infected with HCV transmitting the disease to their patients.⁵ In most cases, patients were infected through inadvertent exposure to the workers; in fact, only two incidents were caused by clear breaches of infection control practices. In the same study, HCV transmission rates in various retrospective investigations varied from 0.04% to 2.7%.⁵

In the Netherlands' study, although the risk of HBV infection during high-risk procedures was seven times higher than that during low-risk procedures, at least eight (28.6%) of the 28 patients were infected during low-risk procedures.⁶ "Policies allowing HBV-infected surgeons to perform presumably low-risk procedures should be reconsidered," the researchers concluded. An editorial accompanying the article stated that "even the simplest procedures may not be risk-free."⁷

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If the information is disclosed, how should it be handled?

Before his HCV infection, Fiser opposed mandatory testing of physicians for bloodborne pathogens. He now goes one step further and says not only surgeons, but scrub nurses should be tested when they join a facility's staff.⁴ After that initial testing, both groups should be tested when there is a percutaneous injury or other significant blood exposure, he said.

• **Surgeons who test positive for bloodborne pathogens should, at a minimum, modify their practice.** Some experts point to a Minnesota law as a good example of how infected surgeons should be handled. Physicians infected with HBV, HCV, or HIV are assigned a monitor by the state health department. They also sign a contract in which they agree to eliminate exposure-prone procedures and make other modifications to their practice that are recommended by the monitor. **(For information on the Minnesota law, see resource box, below right.)**

The Centers for Disease Control and Prevention (CDC) doesn't recommend restricting health care workers infected with HCV because of the low risk, according to **Miriam Alter**, acting associate director for science in the CDC's division of viral hepatitis.³

• **Establish a policy on informing patients.** The current CDC guidelines on the issue, developed in 1991, recommend that infected providers who perform "exposure-prone procedures" (such as surgeons) and are infected with HIV or HBV antigen are to inform patients of their status if they continue practicing.

However, not all experts agree with that position, and not all states require disclosure.

"The last time I researched the issue from a risk management perspective, I did not draw a conclusion that surgeons owed a duty to inform patients of potential risk because of the extremely remote odds," Driver says. There have been lawsuits in which patients have been exposed and converted, he acknowledges. Also, there are fears in the risk management community of cases in which a patient has a procedure performed by a surgeon who later is determined to have a bloodborne pathogen, he adds.

• **Use expert review panels.** The CDC's 1991 guidelines concluded that providers who have HIV or HBV e antigen should go before confidential expert review panels to determine whether they should continue practicing and under what conditions. AORN supports this conclusion.²

Why follow this advice? "To minimize the risk that these pathogens will be transmitted to patients — a risk for which there is some evidence even in minimally invasive surgery," said Wickenden. **(For more on this evidence, see story, p. 15.)**

The American College of Surgeons supports the involvement of an expert panel when an HBV surgeon tests positive for the e antigen, Fry says.

"In general, we have recommended that the expert panel decide the scope of what should be done, rather than there being some arbitrary list of what are exposure-prone procedures," he says.

Wickenden has expressed strong opinions on what such a panel should decide. "My personal bias is that surgeons who test positive for HBV or HCV should not be given privileges to perform surgery," he added.

The Americans with Disabilities Act protects employees with bloodborne infections and requires that employers provide reasonable accommodations for those individuals competent to perform the job without undue hardship to their employers, AORN points out.²

Wickenden acknowledged that the issues surrounding surgeons and the potential for transmission of bloodborne pathogens are complex. "This is, for good reasons, an emotionally laden problem for everyone concerned," he said.

[Editor's note: Should surgeons be universally tested for bloodborne pathogens? Or do you have another question or comment on this topic? Post your views on our Same-Day Surgery web site, www.same-daysurgery.com. Click on "forum." Your user name is your subscriber number from your mailing label. Your password is sds (lowercase) plus your subscriber number (no spaces).]

SOURCES AND RESOURCE

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To view the Minnesota law on hepatitis and HIV, go to www.revisor.leg.state.mn.us/stats/214/17.html. Click on "Table of Contents for chapter 214." That hyperlink will take you to statute 214.17 to 214.25, which is the "HIV, HBV, and HCV Prevention Program; Purpose and Scope."

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Hip surgery moves to outpatient arena

Shorter recovery with minimally invasive approach

- An attorney receives minimally invasive hip surgery and is back in court the next day.
- A warehouse operator drives his forklift three days after the same hip operation.
- A yoga instructor is doing yoga three weeks after the operation and is teaching at six weeks.

Those actual cases from Rush University Medical Center in Chicago compare with a four- to five-day hospital stay for traditional hip replacement surgery.

"We're measuring recovery in terms of days, rather than weeks or months," says **Richard A. Berger**, MD, orthopedic surgeon and assistant professor of orthopedics at Rush.

Approximately 300,000 hip surgeries are performed annually, and it is projected that as many of 600,000 hip replacement will be performed

EXECUTIVE SUMMARY

Minimally invasive hip replacement allows patients to go home the same day and recover in days.

- A proponent says that 80% of hip replacement patients are eligible for this procedure.
- The procedure doesn't cut any muscles or tendons. It requires specialized training and instruments.
- A skeptic raises concerns about the effect of early discharge on long-term outcomes. Also, he raises concerns about early discharge of elderly patients who may lack adequate support at home.

every year by 2015.¹

Berger says that 80% of hip replacement patients are eligible for this procedure, which involves two small incisions. The procedure has not been attempted on the morbidly obese.

The minimally invasive two-incision total hip arthroplasty technique uses one incision for preparation and insertion of the acetabular component and the other for preparation and insertion of the femoral component.

"Unique instruments have been developed to aid in this technique," Berger adds. "Fluoroscopy aids in many steps in this procedure to ensure the proper placement for the incisions and accurate component positioning and alignment."

He performed minimally invasive hip surgery on 85 patients in 2003, and he says that 100% of the patients left the facility the same day. In an initial study of 120 patients, 93% left the same day, and the other 7% left the following day.² The same-day discharges included a 76-year-old patient.

Data from the initial group show a low complication rate and no readmission from the group. Patients ranged in age from 29 to 76. The average age of the last 100 consecutive patients undergoing this procedure at Rush is virtually identical to that of patients at Rush undergoing traditional total hip replacement, 55 years old vs. 56 years old, Berger explains.

"We have done older patients up to 80 years old and patients with major medical problems," he points out. "They have also gone home the same day."

Berger says there are multiple benefits to the minimally invasive procedure. For example, no muscles or tendons are cut as part of the exposure, he says. "This allows the surgery to be performed without tissue trauma," he adds. "Therefore, it results in less pain and a much quicker recovery."

He acknowledges that the procedure takes about 20-30 minutes longer than the traditional procedure and is technically difficult, "but with proper training, it can be performed well with a low complication rate, lower than traditional surgery, and patients truly recover remarkably quicker."

The procedure requires specialized training that is offered at only a few places around the country, Berger says. In addition, specialized instruments are required. **(For more information on the procedure, see resource box, p. 18.)**

Because the procedure has not been performed on morbidly obese patients, proponents of the minimally invasive approach recommend patients

have a body mass index (BMI) of less than 30 for the procedure.³

Although proponents are enthusiastic about the procedure and its potential, some surgeons are taking a more skeptical approach.

"All of us hope that people can get back to normal as soon as possible after a joint replacement," says **John J. Callaghan**, MD, Lawrence and Marilyn Dorr chair and professor in the Department of Orthopedic Surgery at The University of Iowa Hospitals and Clinics in Iowa City. "However, if this has any effect on the long-term outcome of this procedure, it wouldn't be worth it."

Potential issues include infection, death from pulmonary embolism, higher rates of early revision, and dislocation, Callaghan says. He also raises concerns about the patients' ages. "The problem is that two-thirds of patients who need hip replacement are elderly patients who have other medical problems and other social issues, including some who may live alone or only having other elders who can help take care of them," he says.

Callaghan is more pessimistic about the growth potential for this procedure than others such as Berger. "Five to 10 years from now, I can envision 10% to 15% of people having some sort of so-called minimally invasive [hip] surgery," he says.

Callaghan compares the push for minimally invasive hip surgery to the movement to perform carpal tunnel surgery endoscopically. Currently, only 5% to 10% of surgeons perform the procedure with the endoscopic approach, he says. With minimally invasive hip surgery, "I feel the data are not there yet for large numbers of patients and with large numbers of surgeons doing it," he says.

In a published article, Callaghan pointed out major complications following total hip replacement that require revision, including failure of fixation, instability, and infection.³ To minimize failure of fixation, implant bone interfaces must be optimally prepared, he wrote. To minimize dislocation, components need to be positioned optimally, bony impingement, including osteophytes removed, needs to be eliminated, and stability needs to be assessed, he pointed out. To minimize infection, tissue trauma and time of the operation need to be minimized, as does the time of operation, Callaghan wrote. "Small incisions do not address these problems, and they could potentially increase each of these problems, especially in the hands of the less skilled surgeon or the surgeon who is doing fewer procedures."

Berger contends the complication rate is lower than traditional total hip replacement. "I've had

one small intraoperative fracture in the first 150 cases," he says. "There have been no readmissions, no dislocations, and no reoperations in this group."

To avoid medical liability issues, patients must understand there is a learning curve including potential for increased nerve palsy and component malposition, Callaghan wrote. "Legally, the surgeon should recognize he or she will be judged by the same standards as the surgeon using conventional incisions. It will be hard to defend a new norm, which allows for a higher complication rate." Patients may have extremely high expectations of the surgery and may not understand the complications well, he warned.

Still, many surgeons are attracted to the new procedure. About 100 surgeons have been trained, and about 20 to 25 are performing this surgery on a regular basis, according to Rush University Medical Center.

As more surgeons are trained, Berger predicts, "minimally invasive surgery is able to move from the academic setting into the community, so those who need the surgery have access to it across the country, not just at an academic medical center like Rush."⁴

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SOURCE AND RESOURCE

For more information, contact:

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For information on the surgical procedure, go to www.zimmer.com. Click on "Medical Professional," "What's New at Zimmer," and "MIS 2-Incision Hip Replacement Procedure."

Avoid PCA errors with education, wise selection

Don't let family members administer medication

Medication errors associated with patient-controlled analgesia (PCA) pumps most often are caused by inadequate patient and staff education, misuse by well-intentioned family members, and improper patient selection, according to results of a recent survey by the Institute for Safe Medication Practices (ISMP) in Huntingdon Valley, PA.

"Although our survey was informal, the health care practitioners who responded identified a number of reasons for PCA errors," says **Hedy Cohen**, RN, BSN, MS, vice president of the nonprofit organization that reviews and provides education on medication errors and adverse events to the health care industry.

One of the most frequently cited practice-related problems is incorrect programming of the PCA pump, she says. Staff may misplace a decimal point, misread a prescription, or neglect to double-check settings before beginning infusion, Cohen says. "It is essential that staff members not only receive initial training on the pump, but that they also be retested on the pump's use frequently," she suggests.

Because different brands of pumps require staff members to learn a variety of programming steps, it is best to choose one pump for the entire facility, Cohen adds. "It is not only more efficient but also more effective if your nurse has to learn how to program and how to teach the patient to operate only one pump," she says. **(For information on a report that evaluates different pumps, see resource box, at right.)**

Another frequent reason for misuse of PCA pumps is a well-meaning family member, Cohen points out. One of a PCA pump's safety features to prevent an overdose of medication is a lockout interval that prevents a patient from administering a dose within a certain time period, she says. "Patients are supposed to evaluate their own pain level and administer medication when they feel the need. This means that a drowsy, sedated patient won't push the button for more medication."

Unfortunately, well-meaning family members or nurses may push the button and think that they are helping the patient avoid pain, when, in fact, they may be oversedating the patient, she says.

While PCA pumps are designed to prevent over-medication, this safety feature works effectively only when the patient is pushing the button, Cohen explains. If a patient is already drowsy or sedated from anesthesia or pain medication administered in the recovery area, the patient won't push the button for more medication because he or she feels comfortable, she explains. If, however, a family member decides to push the button to help the patient avoid pain, the pump may administer the medication because the request for medication falls within proper time frames and doses, she says.

"This extra medication has resulted in oversedation, respiratory depression, and even death," she adds. One way to avoid "PCA by proxy" is to hang a sign on every PCA pump that clearly states that the patient is the only person who should push the button, Cohen suggests. "It's also important to emphasize this fact to nurses in their own education and to family members during patient education," she adds.

Proper patient selection also is critical when determining who will use a PCA pump, adds Cohen. "The patient must be mentally alert and capable of managing his or her own pain in order to be issued a PCA pump," she says.

When an infant, small child, or cognitively impaired elderly patient is assigned PCA, the staff are relying upon PCA by proxy, and that process often has errors associated with it, she adds.

RESOURCES

A copy of the report on patient-controlled analgesia can be viewed at no cost on-line at www.ismp.org. Choose "Medication Safety Alerts" from the top navigational bar, then choose "Archives." The report is in two parts and appears in the July 10, 2003, and July 24, 2003, issues. For more about the *ISMP Medication Safety Alert* that reviews safety issues with patient-controlled analgesia, contact:

- **The Institute for Safe Medication Practices**, 1800 Byberry Road, Suite 810, Huntingdon Valley, PA 19006. Phone: (215) 947-7797. Fax: (215) 914-1492.

For a free review of patient-controlled analgesia pumps conducted by ECRI, a nonprofit health research organization in Plymouth Meeting, PA, go to: www.ecri.org and click on the "Patient Safety" button on the right side of the home page. Scroll down the left navigational bar to "Health Devices Alerts Special Reports," and choose *JCAHO's 2003 National Patient Safety Goal for Infusion Pump Free-Flow Protection: Assessing General-Purpose and Patient-Controlled Analgesic Pumps*.

PCA is an effective, safe way to control pain, Cohen explains. "The only problem is that we've become complacent because 99% of the time there are no problems," she says. "We need to make sure we stay alert to the errors that can occur infrequently." ■

Timely surgeon arrival affects procedure times

Anesthetics can quicken cataract discharge

Most of the 62 same-day surgery programs that participated in the 2002 and 2003 *Cataract Extraction with Lens Implantation Study* experienced a decrease of five minutes or more in at least one aspect of procedure time. The study was coordinated by the Wilmette, IL-based Accreditation Association for Ambulatory Health Care's Institute for Quality Improvement.

One organization experienced a notable decrease of five minutes or more in three aspects of procedure times and reported an overall facility time decrease of almost 20 minutes.

One of the changes made between 2002 and 2003 at Balian Eye Center in Rochester, MI, occurred when the medical director reviewed his center's data related to delay of first case.

"I discovered that the first case of the day was usually delayed five to seven minutes as a result of me being late when it was my patient," admits **Mike Raptis, MD**.

This delay is not unusual, according to data

EXECUTIVE SUMMARY

Key findings of the 2003 *Cataract Extraction with Lens Implantation Study* conducted by the Institute for Quality Improvement include:

- The median facility time, defined as the time the patient enters the facility to the time of discharge, was 128 minutes.
- The median procedure time, which is defined as the procedure start time to the time the procedure has ended, was 14 minutes, with times ranging from four minutes to 29 minutes.
- The type of anesthetic used was topical, alone or in combination with oral or intravenous medications, in 52% of the cases.
- Ninety-seven percent of patients reported a change in vision following surgery, with 99% of those patients reporting an improvement in vision.

included in the benchmark study: 31% of the cases included in the study were reported as being delayed five or more minutes, with the delay ranging from six minutes to 205 minutes. Reasons for the delays were previous cases running over time in 69% of the cases, a late-arriving surgeon in 22% of the cases, a late patient in 6% of the cases, and anesthesia-related in 3% of the cases, according to the report.

Although Raptis would be at the center prior to the time of surgery, he might not start to scrub and get ready for the procedure until the scheduled time, he explains.

Now, he starts to prepare prior to the scheduled time so the procedure starts on time, he adds. This improvement contributed to an overall facility time, which is defined as the time the patient enters the facility to the time the patient is ready for discharge, of about 100 minutes. This is 28 minutes less than the median facility time of 128 minutes for all study participants.

Another organization with an average facility time about 75 minutes is Park Eye and SurgiCenter in Flint, MI. The same-day surgery program's average turnover time of slightly more than 10 minutes is better than the overall median time of 13 minutes reported in the study for several reasons, says **Fritz Bruening, MD**, director of the program.

"We use two operating rooms for the surgeon and set up for left eyes in one room and right eyes in the other room," he explains. "This means that we don't have to move equipment around to prepare for the next patient, and this saves time."

Turnover time in the study was defined as the time used to clean up after one procedure and set up for the next procedure.

Other median times reported in the study are:

- The median pre-procedure time, which is defined as the time the patient enters the facility to the time the patient is in the operating or procedure room, is 72 minutes.
- The median procedure time, which is defined as the procedure start time to the time the procedure has ended, is 14 minutes, with times ranging from four to 29 minutes.
- The median setup time, which is defined as the time patient's supplies arrive in the operating room to the time the patient enters the room, is 10 minutes.
- The median cleanup time, which is defined as the time the patient leaves the room to the time the room is ready for the next patient's supplies, is three minutes.

The benchmark study also looks at different

RESOURCES

For information, contact:

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- **Fritz Bruening**, MD, Park Eye and SurgiCenter, 5014 Villa Linde Parkway, Flint, MI 48532. Phone: (810) 733-5450.

The *2003 Cataract Extraction with Lens Implantation Study* is \$50 per report. To obtain a copy, contact:

- **Accreditation Association for Ambulatory Health Care**, 3201 Old Glenview Road, Suite 300, Wilmette, IL 60091-2992. Phone: (847) 853-6060. Fax: (847) 853-9028. To order on-line, go to www.aaahcqi.org, choose "order" on the left navigational bar, then scroll down to *2003 Cataract Extraction with Lens Implantation Study*.

aspects of the patient's care such as dressings and anesthesia. Fifty percent of patients included in the study did not have an eye patch or other dressing, and surgeons did not use sutures in 93% of the cases. The type of anesthetic used was topical, alone or in combination with oral or intravenous medications, in 52% of the cases; peri- and/or

retrobulbar in 41% of the cases; and a combination of topical and block in 7% of the cases.

The study also includes information on patient outcomes such as vision changes, unscheduled follow-up visits, and postoperative pain:

- Ninety-seven percent of patients reported a change in vision following surgery, with 99% of those patients reporting an improvement in vision.
- Ninety-eight percent of patients felt their pain was adequately controlled following discharge.
- Almost 10% of the patients had to contact their physician for an unscheduled follow-up for questions about eye patch, medications, and aftercare instructions, as well as vision problems and pain control.
- The percent of patients needing an unscheduled follow-up reported symptoms associated with infection, such as pain, bloodshot/red eye, or itchy eye, was 1.6%.

The information in the report has been helpful to the center, Raptis says. "The entire staff review it and discusses it in our quality improvement meetings," he says. "This is a great way to review our performance in comparison to others and to find the best ways to improve patient care." ■

The interim final OPPS regulation published

Additions, deletions to ASC list announced

The Centers for Medicare & Medicaid Services (CMS) has published its outpatient prospective payment system (OPPS) interim final regulation for 2004. The rule is consistent with last year's Medicare prescription drug bill and supercedes a previous final rule issued by CMS in November.

The rule makes these changes:

- It extends for two years special payments to rural hospitals. The payments ensure that rural hospitals receive at least as much under the OPSS as they did under the prior cost-based system.
- It defines a class of separately payable drugs called "specified covered outpatient drugs" that in 2004 and 2005 is subject to payment floors and ceilings that vary by type of drug (sole source, innovator multiple source, and noninnovator multiple source).
- It changes the way CMS pays for radiopharmaceuticals, drugs, and biologicals in the outpatient setting when those drugs are no longer eligible for pass-through payments. Drugs with

pass-through status will be reimbursed at 85% of the average wholesale price if the Food and Drug Administration approved the drug before April 1, 2003, while those approved on or after that date will be reimbursed at 95% of the average wholesale price.

- Brachytherapy sources will be paid on a cost basis.

The regulation, which was published in the Jan. 6 *Federal Register*, is available at www.access.gpo.gov/su_docs/fedreg/a040106c.html. Go to "Centers for Medicare & Medicaid Services." The rule has a 60-day comment period ending March 8.

In addition, CMS announced 24 additions and 10 deletions to the ambulatory surgery .0center (ASC) list that were effective for services performed on or after Jan. 1, 2004. The additions and deletions are the result of changes in the American Medical Association Physician's Current Procedure Terminology (CPT) for 2004.

These codes are no longer valid as of Jan. 1, 2004, and are being deleted from the ASC list: 36488, 36489, 36490, 36491, 36530, 36531, 36532, 36533, 36534, and 36535.

These CPT codes, which are for cardiovascular services, are added for services provided on or after Jan. 1, 2004:

- **Payment Group 1:** 36555, 36556, 36568, 36569,

36580, 36584, 36589, and 36590.

- **Payment Group 2:** 36557, 36558, 36575, 36576, 36578, and 36581.
- **Payment Group 3:** 36560, 36561, 36563, 36565, 36566, 36570, 36571, 36582, 36583, and 36585. ■

Same-Day Surgery Manager



How you can keep your surgeons happy — Part 2

By Stephen W. Earnhart, MS
President and CEO
Earnhart & Associates
Austin, TX

Last month, we talked about what our surgeons *really* are looking for in the operating room environment, be it freestanding or hospital-based. There were a number of questions posed to surgeons from all over the country based upon our database of 4,500 direct, one-on-one interviews with them. I ended last month's column with some other questions that I told you I would answer in this issue. Here they are, and I've added more:

- **What do you love in the operating room?**

Being top dog in the OR. We enjoy being looked upon with respect, not just for our technical skills, but for our ability to be in charge and help guide the facility into being an efficient place of business. It is nice if the staff could like us. That is not really required to make us whole, but we are like everyone else: We don't like to think the staff don't like or approve of our personality.

Reality check: We think that we should be in charge of the operating room environment, but we also know that we have to be backed up by strong administrative guidance and support. One

thing that a surgery center that we own or have an interest in gives to us is the good old days that every surgeon longs for, at least inside the OR.

- **Do you guys really want to be in control?**

"Control" is a difficult concept. By control, we want to make sure that the hours of operation meet our needs and the needs of our patients. We want to have the ability to have input into the people we work with and the ability to hire and fire staff that makes a difference in patient outcomes and the work milieu. We are tired of being subservient to administrators who do not understand what we do and how we bring value to the organization. If "control" is making sure that we are in charge of the clinical environment, then yes, we want control. Any time someone has 51% of something, they are in control, not the people who have 49%.

- **How hard do you think it is to run a surgery center or hospital OR environment, honestly?**

As a rule, surgeons have **NO** training or expertise in management or administration. Granted, there are those extraordinary surgeons out there who do know what they are doing, but for the rest of us, we generally are unaware of our limitations. Therefore, that question is a difficult one to answer. As surgeons, we are accustomed to running our own offices, admittedly not always efficiently. The perception among many surgeons is, how hard can it be? If hospital departments cannot understand how important turnover time is to a surgeon, then how can a surgeon understand how difficult it is to run the operating room?

- **How can hospitals head off surgeon relation problems?**

I took a different tack on this question; I will give you their comments and then add mine.

Surgeons: Keep a level playing field among the staff. All physicians are equal; none should be "more equal" than others. In other words, stop favoritism with selected surgical staff. We know when administration doesn't like us. How cooperative would you be with someone who does not treat you with respect? Provide us with an efficient place to do business. This is how we make a living! We cannot make a decent pay if half of our day is spend watching staff members

COMING IN FUTURE MONTHS

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take breaks and complain about the paperwork they have to do. Stop sending down policies that affect our workplace without consulting with us. Don't think that the person you have on your staff who is supposed to know what the surgeons want actually does! Rotate the position, and get fresh ideas.

Earnhart: I am working under the assumption that those who generate the revenue are the clients and the rest of us are support staff to them. Surgeons are clients of hospitals and surgery centers. Focus on their needs, not the needs of the support staff. Meet with surgeons in their office. The majority of surgeons resent sitting in your waiting room, looking around at everything that they paid for with their support to the organization, and waiting for you to finish your phone calls.

Sit in the surgeons' waiting room for a while and see how they live. It is not nearly as opulent as yours.

Stop thinking of their surgical volume as yours. You provide a place to accommodate them. They decide, ultimately, where to take their patients. The tide has turned, and more surgeons are aware of the value of their contribution to your organization. Stop running your facility by the numbers, and try running it like it should be run: an efficient facility that caters to the needs of those it is trying to attach and keep.

(Editor's note: Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management.

Contact Earnhart at 8303 MoPac, Suite C-146. Austin, TX 78759. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.) ■

JCAHO releases most common sentinel events

The Joint Commission on Accreditation of Healthcare Organizations has released a list of the most common sentinel events since 1995 in ambulatory centers and hospitals.

For ambulatory centers, the most common events are:

- wrong-site surgery (36.7% of sentinel events);
- clinically significant delays in treatment (26.5%);
- operative or post-op complications (14.3%);
- medication errors (8.2%);
- anesthesia-related events (4.1%).

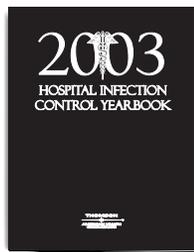
The most common events in hospitals are:

- operative or post-op complications (19%);
- wrong-site surgery (17.6%);
- medication errors (14.7%);
- suicide (5.4%);
- delays in treatment (5%). ■

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CE/CME questions

- According to Miriam Alter, acting associate director for science in the Centers for Disease Control and Prevention's (CDC's) division of viral hepatitis, what does the CDC recommend in terms of restricting health care workers infected with the hepatitis C virus (HCV)?
 - It doesn't recommend restrictions because of the low risk.
 - It recommends the health care provider go before an expert panel to determine whether his or her practice should be restricted.
 - It recommends the health care provider discontinue invasive surgical procedures.
 - It recommends the health care provider discontinue all surgical procedures.
- In a study conducted in the Netherlands, how many patients were infected with the hepatitis B virus from a surgeon during low-risk procedures?
 - at least two (7.15%)
 - at least four (14.3%)
 - at least six (21.45%)
 - at least eight (28.6%)
- Why is "PCA by proxy" unsafe for patients, according to Hedy Cohen, RN, BSN, MS, vice president of the Institute for Safe Medication Practices?
 - Patients should wait until their pain is severe before taking medication.
 - A family member can unknowingly oversedate the patient and cause respiratory distress.
 - Insurance doesn't cover patient-controlled analgesia controlled by someone other than the patient.
 - The nurse is unable to accurately chart use of the medication.
- According to Fritz Bruening, MD, director of Park Eye and SurgiCenter, how does his same-day surgery program keep turnover time between cataract procedures at slightly more than 10 minutes?
 - Patients arrive at the center 45 minutes before their scheduled surgery.
 - Two surgeons are operating at the same time.
 - Patients are prepped as soon as they arrive.
 - Two ORs are used: one for left eyes and one for right eyes.

(For CE/CME answers, see box, p. 23.)

CE/CME objectives

After reading this issue you will be able to:

- Identify clinical, managerial, regulatory, or social issues related to ambulatory surgery care and management. (See "Latest SDS dilemma: Should surgeons be tested for bloodborne pathogens?" in this issue.)
- Describe how those issues affect clinical service delivery or management of a facility.
- Cite practical solutions to problems or integrate information into your daily practices, according to advice from nationally recognized ambulatory surgery experts. (See "Avoid PCA errors with education, wise selection" and "Timely surgeon arrival affects procedure times.")

CE/CME directions

Physicians and nurses participate in this CE/CME program by reading the issue, using the references for research, and studying the questions.

Participants should select what they believe to be the correct answers, then refer to the answers listed in the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing this semester's activity with the June 2004 issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion.

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