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IN THIS ISSUE

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Are you prepared for a pandemic? Leading facilities share how to gear up

Outpatient surgery has role to play during patient surges

When *Fatal Contact: Bird Flu in America* aired this spring on ABC, many health care providers dismissed the movie as pure, exaggerated fiction about what could happen in terms of a pandemic or other patient surges.

Or is it?

Officials at the Centers for Disease Control and Prevention, in responding to issues raised about pandemic flu in the movie, point out that some scenarios portrayed in the movie *are* likely to happen. What's more, some of those scenarios are likely to affect outpatient surgery providers. According to the Department of Health and Human Services[1]:

• The film does depict scenarios that could unfold should a severe pandemic develop, including limited availability of antivirals and vaccines as well as the potential for disruption of supplies, medicines, and other essential services.

• A substantial percentage of the world's population will require some form of medical care. Health care facilities can be overwhelmed,

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Without question, outpatient surgery providers would be affected by a pandemic as health care facilities struggle with an overwhelming surge of patients.

- Hospital-based areas might become a holding area for higher-acuity patients, including patients who need to be isolated. Surgery centers might handle lower-acuity patients.
- Ensure your staffing plans are prepared to handle patient surges and absenteeism. Cross-train staff to handle all types of responsibilities, including clerical.
- Educate your staff regularly on pandemic plans, including signs of influenza, and hold pandemic drills.

which would create a shortage of hospital staff, beds, ventilators, and other supplies.

• The numbers of health care workers and first responders available to work will be reduced as they will be at high risk of illness through exposure in the community and in health care settings, and some may have to miss work to care for ill family members.

• In some good news, medical workers and public health workers who are involved in direct patient contact, other support services essential for direct patient care, and vaccinations (8 million to 9 million) would be among the first individuals to receive the vaccine, if available.[2]

Outpatient surgery managers who don't think a pandemic would affect them are "missing the mark," says **James McGowan**, DHA, administrator of the perioperative region at University of Virginia (UVA) Health Sciences Center in Charlottesville. Every health care setting would be affected as the country struggled to deal with a large volume of very sick patients, he maintains. "It's hard to understand how any health care facility, an ambulatory surgery center or any other type, will not be affected."

So what should outpatient surgery managers be doing to prepare? Take steps to limit the spread of respiratory illnesses. **(See story, p. 112.)** Consider these other suggestions from those health care facilities at the forefront of preparations for pandemics and other emergencies:

• Prepare your outpatient surgery areas to handle patient surges.

In a pandemic or other emergency that causes a sudden patient surge, elective cases already in motion would be ended quickly, in line with regional emergency management plans, McGowan says. Scheduled elective cases would be canceled, he adds.

Perioperative areas usually are well suited to handle patient surges, McGowan points out. "Just the nature of our book of business in the OR and pre- and post-care areas is that we are surging every day," he says. At McGowan's facility, the admission rooms for the ORs already are set up similarly to patient care rooms, and the recovery areas are located almost adjacent to the surgery admission suites. "With the combination of an area like that, if we had an influx of patients and needed to care for them quickly, if we need to handle isolation patients — and a pandemic almost assuredly would present us with those — our preoperative area and that of most hospitals in similar regions could serve as a pretty quick initial surge area," he says.

At UVA Health Sciences Center, the main OR is in proximity to the ED and inpatient areas and probably would serve as a holding area for higher-acuity patients, McGowan says. The hospital also has a freestanding surgery center, he says. "We would take lower-acuity patients and use the outpatient center for that type of care."

• Prepare your staffing.

UVA Health Sciences Center also has developed a central staffing pool, and they have incorporated

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HHS Pandemic Influenza Plan, Supplement 3 Healthcare Planning — Nonhospital Health Care Facilities

The hospital planning recommendations (see S3-III.A) can serve as a model for planning in other health care settings, including nursing homes and other residential care facilities, and primary care health centers. All health care facilities should do the following:

- Create a planning team and develop a written plan.
- Establish a decision-making and coordinating structure that can be tested during the Interpandemic Period and will be activated during an influenza pandemic.
- Determine how to conduct surveillance for pandemic influenza in health care personnel and, for residential facilities, in the population served.
- Develop policies and procedures for managing pandemic influenza in patients and staff.
- Educate and train health care personnel on pandemic influenza and the health care facility's response plan.
- Determine how the facility will communicate and coordinate with health care partners and public health authorities during a pandemic.
- Determine how the facility will communicate with patients and help educate the public regarding prevention and control measures.
- Develop a plan for procuring the supplies (e.g., personal protective equipment [PPE]) needed to manage influenza patients.
- Determine how the facility will participate in the community plan for distributing either vaccine or antiviral drugs, including possibly serving as a point of distribution and providing staff for alternative community points of distribution.

Source: Department of Health and Human Services, Washington, DC. Accessed at www.hhs.gov/pandemicflu/plan/sup3.html#nonhosp.

that pool into their surge capacity plan.

"By surge, I mean how far and by how many beds can we expand hospitals to take care of those patients thrust upon us by a national emergency . . . or a pandemic that is slower in coming but has droves of patients a few days later?" McGowan says. "We use that pool every day to handle our [normal] surges," he adds.

• Prepare to move outpatient surgery staff to other areas.

In any pandemic situation, expect 30%-40% absenteeism, due to staff being sick, taking care of sick family members, or not wanting to work, advises **Linda Burton**, BSN, CIC, infection control practitioner at the University of Colorado Hospital, Denver. The expected absenteeism means that outpatient surgery staff members are likely to be shifted to other areas to assist in patient care, Burton says. For this reason, outpatient surgery staff members at her facility are among those designated to receive antivirals and/or vaccines, if available and needed, she says.

"We're going to train them for cross over," Burton says. Outpatient surgery staff may even be trained for clerical duties, she says. "Everyone will have to pitch in. There are going to be absences everywhere, all the way down to guys at the warehouse where you get your supplies." Staff who are Class C licensed potentially could be used to drive trucks, Burton adds.

At press time, University of Utah Hospital in Salt Lake City was preparing to survey employees to determine how many would be willing to come to work in a pandemic and if not, why, says **Colleen Connelly**, RN, BSN, emergency preparedness manager. The hospital will look at how many employees would need protective equipment and prophylaxis.

• Educate your staff.

Nashville, TN-based Vanderbilt University Medical Center performs annual competencies on communicable diseases. Influenza is but "one of several options that could show up on our door at any time," says **Nancye Feistritzer**, RN, MSN, assistant hospital director of perioperative services.

Outpatient surgery staff members need to be able to recognize the signs of influenza, Burton says. "You could have someone scheduled for surgery and they come in coughing, with flu symptoms," she warns. "They need to know what to do to protect themselves and who to call."

University of Colorado Hospital is developing a dedicated web site on pandemics, Burton says. That web site will explain what to do during a pandemic, who to call, and how to follow the emergency plan in each department, she says.

Unit-based clinical educators will be educating staff as units and, when needed due to irregular work schedules, will be educating individuals, Burton says.

UVA Health Sciences Center educates staff at least twice a year on its emergency preparedness plan. "When we go through training, we test how many people we can get responding to the hospital when we do a drill," McGowan says. The OR and freestanding ASC are involved as the hospital has a variety of mock patients overwhelm the ED, he says.

Additionally, drill your staff on pandemics so they can practice those plans. Vanderbilt conducted one drill specific to SARS, says Feistritzer. By conducting that drill, staff learned about proper use of personal protective equipment, the importance of hand and respiratory hygiene as a role in prevention, how to establish effective communication with appropriate agencies such as the state Department of Health and the Centers for Disease Control and Prevention, what issues surrounded patient/family isolation — such as the impact on staff schedules, communication issues with families, and coordination of public information from the Department of Homeland Security.

Burton's facility has a steering committee that has been meeting for more than six months to prepare for pandemics. "We're getting ready for anything that flops out of the sky at us to include a resurgence of SARS, even maybe smallpox," she says. "Who knows? In this day and age, you stand back and hold on."

The repercussions could be serious if you ignore the potential threat or your program's ability to respond appropriately, sources says. "Regulatory agencies and state health departments and Homeland Security are assessing institutions' ability to deliver that," Feistritzer says. "Their medical/legal liability if they should fail to have appropriate response is pretty significant." **(For more information on preparing for a pandemic flu, hospitals should go to www.hhs.gov/pandemicflu/plan/sup3.html. Also, hospitals should see, "New JCAHO standard requires flu vaccine,"** ***Same-Day Surgery,*** **August 2006, p. 90. Surgery centers can follow advice for nonhospital health care facilities published in this issue, p. 111. Also, all readers should see "Canadian warning: ORs need to prepare for SARS,"** ***Same-Day Surgery,*** **March 2004, p. 30.)**

SOURCES/RESOURCES

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- **Nancye Feistritzer**, RN, MSN, Assistant Hospital Director of Perioperative Services, Vanderbilt University Medical Center, 1161 21st Ave. S., Nashville, TN 37232. Phone: (615) 322-3354. Fax: (615) 343-1500. E-mail: nancye.feistritzer@ vanderbilt.edu.
- **James McGowan**, DHA, Administrator of the Perioperative Region, University of Virginia Health Sciences Center, Box 800688 Lane Road, Charlottesville, VA 22901. E-mail: jm4u@virginia.edu.

For more information on preparation for pandemics, see:

- **Center for Infectious Disease Research & Policy.** Web: www.cidrap.umn.edu.
- **Centers for Disease Control and Prevention.** Web: www.cdc.gov/flu/avian.
- **Department of Health and Human Services.** Web: www.pandemicflu.gov. Click on "health care planning."

References

1. Department of Health and Human Services. *ABC TV Movie: Fatal Contact: Bird Flu in America.* Washington, DC. Accessed at www.pandemicflu.gov/news/birdfluinamerica.html.
2. Department of Health and Human Services. *Table D-1: Vaccine Priority Group Recommendations.* Washington, DC. Accessed at www.hhs.gov/pandemicflu/plan/appendixd.html. ■

How to limit spread of respiratory illnesses

To avoid the spread of respiratory illness in a pandemic situation and every day, Vanderbilt University Medical Center in Nashville, TN, has established "sneeze stations" in all of its waiting rooms, including those at seven OR sites.

These stations, which can be used by patients

RESOURCE

The sneeze stations were developed and are being sold for $250, plus shipping and handling, by Vanderbilt University Medical Center. For ordering information, contact:

- **Gail England**, Administrative Assistant, Department of Emergency Management, Office of Emergency Preparedness, Vanderbilt University Medical Center. Phone: (615) 343-3189. E-mail: gail.england@vanderbilt.edu.

suffering from any respiratory illness, offer tissues, waste disposal cans, and antimicrobial hand rinse solutions, says **Nancye Feistritzer**, RN, MSN, assistant hospital director of perioperative services.

"In general, we are raising people's awareness, both staff and patients', that if they have any symptoms that potentially fall in that [respiratory illness] category, we ask patients to notify staff immediately so we can refer them to appropriate areas," Feistritzer says.

In fact, Vanderbilt has a protocol for patients and staff suffering from respiratory illness. **[A copy of this protocol is available with the on-line version of *Same-Day Surgery*. If you're accessing your on-line account for the first time, go to www.ahcpub.com. Click on the "Activate Your Subscription" tab in the left-hand column. Then follow the easy steps under "Account Activation." If you already have an on-line subscription, to go www.ahcpub.com. Select the tab labeled "Subscriber Direct Connect to Online Newsletters. Please select an archive." Choose "Same-Day Surgery," and then click "Sign on" from the left-hand column to log in. Once you're signed in, select "2006" and then select the September 2006 issue. For assistance, call Customer Service at (800) 688-2421.]**

The hospital also has an exposure control plan that ensures patients with communicable diseases don't walk through waiting rooms on their way to be treated, Feistritzer says. ■

Educate your staff, and hold pandemic drills

Education and competency testing for all employees and physicians regarding pandemics should be mandatory, according to new guidance from the Association of periOperative Registered Nurses (AORN).[1]

Educational activities should include information on etiology of human and avian influenza, the importance of vaccination, standard precautions, respiratory hygiene and cough etiquette, masking, and drop precautions, according to AORN. In terms of Severe Acute Respiratory Syndrome (SARS), the guidance says "health care providers should be able to demonstrate behaviors that are required to successfully implement standard precautions, respiratory hygiene and cough etiquette, masking, droplet precautions, and the use of fit-tested respirators if SARS is suspected."[1]

Vanderbilt University Medical Center performs annual competencies on communicable diseases. Influenza is but "one of several options that could show up on our door at any time," says **Nancye Feistritzer**, RN, MSN, assistant hospital director of perioperative services.

Outpatient surgery staff members need to be able to recognize the signs of influenza, says **Linda Burton**, BSN, CIC, infection control practitioner at the University of Colorado Hospital, Denver. "You could have someone scheduled for surgery and they come in coughing, with flu symptoms," Burton warns. "They need to know what to do to protect themselves and who to call."

University of Colorado Hospital is developing a dedicated web site on pandemics, Burton says. That web site will explain what to do during a pandemic, who to call, and how to follow the emergency plan in each department, she says. Unit-based clinical educators will educate staff as units and, when needed due to irregular work schedules, will also educate individuals, Burton says.

Importance of drills

University of Virginia (UVA) Health Sciences Center in Charlottesville educates staff at least twice a year on its emergency preparedness plan, says **James McGowan**, DHA, administrator of the perioperative region. "When we go through training, we test how many people we can get responding to the hospital when we do a drill," McGowan says. The OR and freestanding ASC are involved as the hospital has a variety of mock patients overwhelm the ED, he says.

Vanderbilt conducted one drill specific to SARS, says Feistritzer. By conducting drills, staff learned about proper use of personal protective

equipment, the importance of hand and respiratory hygiene as a role in prevention, isolation and how that affected staffing patterns, the need to establish effective communication with appropriate agencies such as the state Department of Health and the Centers for Disease Control and Prevention, communication issues with families, and coordination of public information from the Department of Homeland Security.

"We have a disaster drill where you practice what happens; you practice your plans, basically," says Feistritzer.

Reference

1. Association of periOperative Registered Nurses. AORN guidance statement: Human and avian influenza and Severe Acute Respiratory Syndrome. *AORN J* 2006; 84:284-298. ■

To tape or not to tape: How do you handle jewelry?

Policies vary as much as what patients wear

Asking a patient to remove a treasured wedding ring or body jewelry that defines their persona is not easy. However, with the increased focus on patient safety and the risks for injury posed by jewelry, as well as the increase in the popularity of piercings and body jewelry, many outpatient program managers are looking at ways to improve their policies to address all situations.

Lynn Barrett, RN, operating room educator at Overlake Hospital in Bellevue, WA, is looking to revise the policy for surgical patients, and she sits on a hospitalwide committee that is considering the need for a policy throughout the hospital. "But even if there is not a policy for all departments of the hospital, I believe it is important for surgical services because body jewelry increases the risk of contamination and infection as well as the risk of arcing that can cause fire or burns to the patient," Barrett says.

Overlake Hospital's surgical policy states that all jewelry must be removed, but Barrett admits that staff members don't adhere strictly to the policy and will make decisions on a case-by-case basis. "I think we need a clear policy, not only about the removal of jewelry, but also about how to store it if there is no family member present to accept responsibility for the jewelry," she says.

At a hospital in Ohio, the surgery director is evaluating the policy that currently calls for removal of all jewelry, to the point of cutting wedding rings off in the operating room if the ring cannot be slipped over the knuckle. The policy is very specific and leaves no room for other options, according to the surgery director, who asked not to be identified. After she researched information from the Association of periOperative Registered Nurses in Denver and ECRI in Plymouth Meeting, PA, she says, "I believe that a patient can safely go through surgery with a wedding ring taped on a finger, if the patient, surgeon, and anesthesiologist agree."

The Ohio hospital is reviewing the policy to allow rings that cannot be removed or that the patient will not remove due to sentimental reasons. "This will be the exception rather than the norm," says the director. The ring will be removed if the hand on which the ring is located is to be operated, she says. The anesthesia department at the hospital also has stated that mouth jewelry must be removed, and all surgeons agree that all body jewelry must be removed, adds the director.

Moore (OK) Medical Center has revised its policy to address all jewelry, including body jewelry, says **Patricia E. Mayo**, RN, RNFA, CNOR, director of surgical services. **[A copy of this protocol is available with the on-line version of *Same-Day Surgery* at www.ahcpub.com. For assistance, call Customer Service at (800) 688-2421.]** "The patient is informed that he or she will have to remove all jewelry when they initially discuss the procedure with the physician," Mayo says. If patients show up on the day of surgery with jewelry, staff ask them to remove it and give to the family member or friend who came with them, she explains. "We

EXECUTIVE SUMMARY

Most outpatient surgery programs have policies that require the removal of jewelry, but many managers are looking at their policies to evaluate their effectiveness and their practicality.

- Design a clear, simple policy that is easy for staff members to follow so that all decisions regarding jewelry are not made on a case-by-case basis.
- Beware of set policies that leave no room for options such as taping over jewelry in specific cases where the jewelry poses little risk.
- Get physician and anesthesiologist input and support for jewelry policy so that the policy can be implemented in the same manner for all patients.

SOURCES

For more information about body piercing policies, contact:
- **Lynn Barrett**, RN, Operating Room Educator, Overlake Hospital, 1035 116th Ave. N.E., Bellevue, WA 98004. Telephone: (425) 688-5000. Fax: (425) 688-5654. E-mail: lynn.barrett@overlakehospital.org.
- **Patricia E. Mayo**, RN, RNFA, CNOR, Director of Surgical Services, Moore Medical Center, 700 S. Telephone Road, Moore, OK 73160. Telephone: (405) 912-3465. Fax: (405) 912-3095.

explain that any type of jewelry that can conduct electricity poses a risk for burns," Mayo says.

If the patient refuses to remove, or cannot remove the jewelry and the jewelry is not in the sterile field, a nonconductive tape is placed over the jewelry, if the surgeon and anesthesiologist agree, says Mayo. "Not only do we need to place the tape over the jewelry to prevent arcing, but we also need to make sure that the jewelry will not snag the drapes, causing us to pull on the jewelry or causing the drapes to slip out of place," she explains.

Anesthesiologists almost always require the removal of tongue jewelry, and usually genital jewelry must be removed as well, Mayo says. This jewelry can interfere with urinary catheterization as well as airway access, she explains.

While most patients understand the safety implications of removing jewelry, Mayo admits that occasionally a patient does not want to remove jewelry. "We explain all of the potential risks and then we explain that if we cannot safely perform the surgery with the jewelry in place, we may cancel the procedure," she says. Although no procedures have been canceled, the policy does allow for cancellations, she adds.

"Most of our physicians have been very proactive in helping us make sure the jewelry policy is presented to patients before the day of surgery," says Mayo. "We always do find some surprises because a physician doesn't always know about every piercing a patient may have." ■

Surveyors want to see follow up to studies

Med labels, credentialing, staff training important

(Editor's note: This month, we look at tips and suggestions from outpatient surgery programs that have been surveyed by the Accreditation Association for Ambulatory Healthcare. Other tips were in the July 2006 issue of "SDS Accreditation Update," p. 3.)

A focus on the outpatient surgery building, quality improvement, and an emphasis on credentialing processes were priorities for surveyors from the Association for the Accreditation of Ambulatory Health Care who visited two ambulatory surgery centers this year.

"We felt well prepared for our survey because we approach accreditation as an ongoing process and stay abreast of changes as they occur," says **Nikki Folger**, RN, manager of Aesthetic Surgical Images in Omaha, NE. "I was surprised at the detailed look at our facility," she admits. Not only was the walk through of the facility thorough, with the surveyor looking at all facets of the building, but the surveyor also looked at all maintenance records, she adds.

Inventory records also were examined, but the surveyor did not simply look at the book listing medications and expiration dates. Instead, he also went to the supply room and looked at the medication containers to verify that the labels with expiration dates were in place, says Folger. "In past surveys, the surveyor just looked at our books, so this was different," she explains.

Properly labeled medications in the operating room were a focus of the surveyor who visited the Advanced Family Surgery Center in Oak

EXECUTIVE SUMMARY

Staying on top of standards' changes and making sure that all documentation for employees and physicians is up-to-date and complete are two ways to be prepared for surveys by the Association for the Accreditation of Ambulatory Health Care. Other tips from recently surveyed organizations include:
- Be sure that medications are properly labeled with drug name and expiration date.
- Document actions taken after a performance improvement study identifies ways to improve clinical or business operations.
- Document all employee inservices or continuing education activities.
- Have complete, thorough credential records that include use of verification sources such as the National Practitioner Database.

Ridge, TN. "He looked at the medications on the back table to make sure that all syringes were labeled," says **Alana Booth**, RN, CASC, administrator of the center.

While in the operating room, the surveyor observed the center's site verification procedure, says Booth. "We follow universal protocol for surgical site identification and write 'yes' on the surgical site, then have the surgeon initial the site to verify it," she explains. "If there are no initials on the site, we do not proceed with the surgery." The surveyor also looked for documentation of time-outs prior to the start of procedures, she adds.

Show changes following PI studies

Performance improvement projects were examined, and surveyors at both facilities focused not just on the fact that studies were undertaken, but also how the information was used to improve the facility.

Kelly Norman, RN, clinical director at the Oak Ridge center, says, "In one of our studies, we evaluated the use of the Neptune Waste Management System [Stryker Instruments, Kalamazoo, MI] compared to the use of multiple canisters to collect surgical waste. We evaluated costs, employee safety, and time involved."

The study showed that switching to the new system not only saved money for the center, but also reduced employee exposure to bloodborne pathogens because employees did not have to handle emptying the canisters after procedures as often, she explains. "We not only saved $9.54 per case, but we were able to increase our operating room turnover time because the new system handles more procedures than the old system," she says.

In addition to performing internal benchmark studies, Folger's surveyor suggested that the center also include some studies that utilize external benchmarking data. "He suggested that we use information in journals or from other facilities to evaluate our performance compared to other surgery centers," she says.

In the surveys of both facilities, surveyors paid close attention to credentialing records. "Even though we are a physician-owned facility, the surveyor recommended that we use the National Practitioner Database for credentialing all of our physicians, including those on our governing board," says Folger. **(For information on how to access database, see resource box, right.)**

Booth says, "I was complimented on our system that ties together all of our peer review data with our credentialing records." Her software (AdvantX, Source Medical; Birmingham, AL) enables her to enter all quality or peer review information, then sort by type of occurrence or by physician. "When the surveyor asked to see information on specific physicians, I just entered the physician's name and printed a report," she says. The surveyor liked the easy, efficient access to information, not only for the surveyor's use, but also for management of the facility, Booth adds.

Although her credentialing process was thorough, Booth's surveyor did surprise her with one recommendation. "I have a framed list of the names of our physician owners in the registration area, but he said that I should have a list of all credentialed providers displayed in the lobby or registration area," she says.

AAAHC surveyors also looked closely at employee records. Folger says. "Our surveyor also recommended that we use templates in the back of the accreditation handbook to organize our employee records. Although our records were complete, he suggested that standardizing the order of the records would make them easier to review and evaluate for completeness," she explains. Some programs put a checklist in the front cover of each employee file for managers to be certain all of the information is present and current.

"Above and beyond" were the words used by the surveyor to describe the use of Bispectral Index (BIS) monitors at her facility, says Booth.

"We do an exceptional job in our anesthesia department," she says. Not only has the facility used BIS monitors since the center opened, but the anesthesiologists have developed their own form that describes complications and benefits of

SOURCES/RESOURCE

For more information about Association for Accreditation of Ambulatory Health Care survey experiences, contact:

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For more information about the National Practitioner Database, go to www.npdb-hipdb.hrsa.gov. Query fees start at $4.75 per request.

anesthesia, but it also serves as an informed consent form for both patient and physician to sign, she says."Employee training and continuing education were important to our surveyor," says Booth. One inservice that Booth's center regularly offers is how to respond to a code when dantrolene is needed. "We have pictures describing how to mix the drug properly, but we give employees a chance to actually mix the drug by using the expired drug vials," she says.

Making sure that her staff members were prepared for the survey meant putting them in the right frame of mind, Booth says. "An accreditation survey is not a punitive thing; it is a chance for us to show off our facility," she says. "I remind everyone that we invited the surveyor, in fact, we paid a fee for the survey, so we want to show how well we care for patients, and we want the surveyor to let us know how we might do better." ■

Same-Day Surgery Manager

Time to celebrate reimbursement changes?

Q&A: Expansion, investors, and late staff

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

Question: We looked at the new rates for surgery center reimbursement and were delighted to see the increase in our procedure reimbursement. Is it safe to open the champagne?

Answer: Keep the cork in the bottle. There are still many months of politicking and lobbying efforts to go on both sides of the issue. About the only thing you can count on is that what we see today we will not see in 2008. **(Editor's note: For more information on the proposed changes for surgery centers, see "Under proposed rule, ASCs would be paid 62% of the hospital outpatient payment rate," *Same-Day Surgery*, September 2006, p. 97; and "CMS adds 14 procedures, but cuts other payments," p. 100.)**

Question: I'm sick of putting up with the hospital politics. Do you have any job openings?

Answer: Believe me; the grass is not always greener. We all have to put up with politics. At least you get to be at home at night.

Question: We are expanding our hospital inpatient operating rooms. I have tried to explain to our administration that we need to add more area for outpatient surgery instead of inpatient. What are the trends for outpatient surgery vs. inpatient?

Answer: Obviously, there are many factors included in your question to consider, but the short answer is that you should be expanding your outpatient areas more than inpatient.

Question: How many cases can be done in a surgery center operating room? We are expanding, but don't know how many rooms to add. Got any free advice?

Answer: Sure. On average, you can perform between 1,000 to 1,500 cases per year per operating room. Typically, you can do about 2,500 gastrointestinal (GI) cases per year per GI room. More free advice: You typically can plan on three to four cataract cases per hour per room if you flip-flop rooms.

Question: What is the best way to deal with chronically late staff members? We have tried changing their shifts, giving them flex hours, and offering free wake-up services, all to no avail. What other ideas might work?

Answer: Try this: Fire them! Chronically late staff members have no respect for their jobs or the people they work for or with. Kick them out the door and be done with them.

Question: Is it common for all surgeons to own a piece of a surgery center? We have lots of surgeons at our center that do not. So why do they use it? I feel silly asking anyone around here because I think I should know the answer.

Answer: Most surgeons at surgery centers are not investors in the operating entity of the center. While they usually are given an opportunity to invest if they wish, many do not for a variety of reasons. If you have many noninvestors using your center, they probably are there because of your efficiency and great staff members like yourself.

(Editor's note: Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Contact Earnhart at 3112 Windsor Road, Suite A-242, Austin, TX 78703. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.) ■

CMS posts data on ASC payments

Consumers now have on-line access to information on facility costs and Medicare payments for 61 procedures performed in ambulatory surgery centers (ASCs).

The information is labeled "Commonly Performed Procedures in ASCs" and contains charge and Medicare payment data for ASC facility costs. The data are broken down at the county, state, and national level. CMS also is releasing data on "Other Commonly Performed Procedures in ASCs," which contains similar charge and payment data, but for facility costs related to high-utilization services. Information on what Medicare pays for 41 inpatient procedures was posted in June. The CMS postings can be viewed at www.cms.hhs.gov/HealthCareConInit.

"This new data builds on the president's commitment to making more quality and price data available," said **Mike Leavitt**, secretary of the Department of Health and Human Services in a prepared statement. "By posting data about federal health care programs like Medicare, we are putting in motion efforts that will give Americans the information they need to make informed health care decisions."

On Aug. 22, President Bush signed an executive order to promote efforts led at the federal level to implement more transparent and high-quality health care. Patients, providers, and others will be able to access information from several potential sources, including insurance companies, employers, and Medicare-sponsored web sites. **(Editor's note: For more information on the executive order, go to www.whitehouse.gov/news/releases/2006/08/20060822-2.html.)** ■

Drugs can cause problems during cataract surgery

Eye surgeons need to know if patients are taking alpha-blockers to treat benign prostatic hyperplasia (BPH) because those drugs can cause complications during cataract surgery, say several national associations. Tamsulosin (Flomax, Boehringer Ingelheim Pharmaceuticals; Ridgefield, CT) and other alpha-blockers potentially can cause difficulty, particularly if the eye surgeon has not been forewarned, says the American Society of Cataract and Refractive Surgery (ASCRS), the American Academy of Ophthalmology, and the American Urological Association.

Other drugs in this alpha-blocker class include, terazosin (Hytrin, Abbott Laboratories, Abbott Park, IL), doxazosin (Cardura, Pfizer, New York City), and alfuzosin (Uroxatral, sanofi-aventis; Bridgewater, NJ). Such drugs also can be prescribed to women for urinary retention. Patients do not need to stop taking these drugs before cataract surgery, the associations said. Preliminary results of a new study found that these patients can have successful surgery if their eye surgeon knows they are taking or have taken these drugs and alters the surgical technique, according to ASCRS.

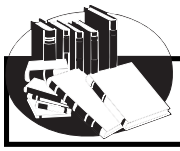
David F. Chang, MD, and **John R. Campbell**, MD, completed a retrospective and prospective study of 1,600 patients. They identified a condition named Intraoperative Floppy Iris Syndrome (IFIS) that occurs during cataract surgery in patients taking tamsulosin. Tamsulosin appears to block the iris dilator muscle, which causes problems with the iris during surgery, according to the ASCRS. The iris tends to be floppy, and the pupil suddenly can constrict during surgery, the association says. "If the iris problems are not anticipated or prevented, there is an increased risk of having surgical complications," the ASCRS said in a prepared statement. The syndrome was found in some patients who had not taken the medications in two years, according to the association.

The Food and Drug Administration instituted a new label warning for tamsulosin and other alpha-blocker drugs that reads, "The patient's ophthalmologist should be prepared for possible modifications to their surgical technique." Surgeons can use small hooks to keep the pupil open or administer stronger dilating medicines directly inside the eye to avoid the syndrome, Chang said.[1] An ASCRS task force has developed recommendations for surgical techniques to be used during cataract surgery on patients taking alpha-blockers. The American Academy of Ophthalmology will include this information in its Preferred Practice Pattern guide (PPPs) for cataract care that will be available free on its web site (www.aao.org) by the end of 2006. **(Editor's note: To see the patient information sheet on prostate drugs and cataract surgery, go to www.ascrs.org/press_releases/ upload/Patient-Information-Sheet-on-Prostate-Drugs-and-Cataract-Surgery.pdf. To see the journal study on IFIS, go to www.ascrs.org/press_releases/upload/**

Journal-Study-on-IFIS.pdf.)

Reference

1. Associated Press. Prostate drug linked to cataract surgery troubles. Aug. 23, 2006. Accessed at www.theolympian.com/apps/pbcs.dll/article?AID=/20060823/NEWS/608230331/1011/LIVING03. ■



JOURNAL REVIEW

Ergonomics research offers patient safety tips

A recent issue of *Human Factors: The Journal of the Human Factors and Ergonomics Society* contains a special section of nine articles that focus on research designed to identify patient safety issues that can be addressed from an ergonomics perspective.[1] Four of the nine articles directly relate to surgery and offer the following insights:

• **Minimally invasive surgery (MIS) relies heavily on imaging devices that display the inside of the body.** Despite its benefits to patients, MIS presents challenges to surgeons because of reduced field of view and degraded depth perception. Research presented in the article *"Toward the improvement of image-guided interventions for Minimally invasive surgery: Three factors that affect performance"* [DeLucia PR, Mather RD, Griswold JA, et al, pp. 23-38] shows that navigation performance in MIS may be improved with the development of a mental model of the surgical environment, with a surgeon-controlled camera, and with an image design that reduces visual illusions.

• **Something as simple as using capital letters to highlight sections of drug names on labels may lead to fewer errors in dispensing drugs that have similar-looking names.** The article *"Labeling of medicines and patient safety: Evaluating methods of reducing drug name confusion"* [Filik R, Purdy K, Gerrett D, pp. 39-47] compares the use of color and capital letters to differentiate between medication names. Results of their research show that the use of capital letters is more effective.

• **When sudden changes occur in patients under anesthesia, anesthesiologists rely on displays to help them identify the problem and solve it.** In *"The right picture is worth a thousand numbers: Data displays in anesthesia,"* authors Frank A. Drews and Dwayne R. Westenskow [pp. 59-71] present a literature review that demonstrates improved patient safety when graphical displays are used.

• **Providing feedback to anesthesiologists as they are administering medications during surgery is critical to patient safety.** The article "Drug delivery as control task: Improving performance in a common anesthetic task" [Drews FA, Syroid N, Agutter J, et al, pp. 84-94] concludes that when anesthesiologists are able to view a display that visualized drug concentrations in a simulated patient, they could more precisely and safely monitor anesthesia. *(Editor's note: To purchase a copy of the issue that contains the special section on patient safety, go to www.hfes.org. Choose "publications" on left navigational bar, then select "Human Factors." Scroll down to section on "back issues" to access order form and request "Volume 48, Number 1, Spring 2006." Cost for*

CE/CME instructions

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 **December** issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

COMING IN FUTURE MONTHS

■ Report on *2006 SDS Salary Survey*

■ New acid reflux procedures

■ OR nursing for elderly patients

■ Where to you draw the line for informed consent?

■ Getting organized: Tips from your peers

back issues for nonmembers is $67 plus $10 for shipping and handling. Copies of individual articles can be ordered on-line for $2 per page. Choose "Publications," then select "Periodicals Article Index" and follow instructions to order articles.)

Reference

1. Special section: Patient Safety. *Human Factors: J Human Factors Ergonomics Society* 2006; 48:1-108. ■

ISMP, FDA provide free toolkit to reduce errors

The Institute for Safe Medication Practices and the U.S. Food and Drug Administration have launched a national education campaign designed to reduce medication errors.

As part of the campaign, a free toolkit that includes:

- an error-prone abbreviations list;
- a brochure for use in staff education;
- a print public service ad;
- a slide show and video that can be used in presentations on the topic.

To access a copy of the toolkit, go to www.ismp.org/tools/abbreviations. ■

CE/CME *questions*

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

13. How does Moore Medical Center handle jewelry that cannot or will not be removed by the patient, according to Patricia E. Mayo, RN, RNFA, CNOR?

A. The ring or other jewelry is cut off the patient in the operating room
B. If the jewelry is not in the sterile field, in the mouth, or in the genitals, it is taped over with a nonconductive tape.
C. The procedure is canceled.
D. Family members are asked to make the patient to remove the jewelry.

14. To what component of a performance improvement project do Accreditation Association for Ambulatory Health Care surveyors pay close attention, according to Kelly Norman, RN, clinical director at the Surgery Center of Oak Ridge?

A. The amount of data collected for the study.
B. The scope of the study.
C. Actions taken to implement improvements identified in the study.
D. The length of time a study takes to complete.

15. What is one incorrect assumption some staff members and physicians make regarding credentials and privileges in an office-based surgery program, according to Scott Trimas, MD?

A. The list needs to reflect only procedures performed in the office.
B. The list must be reviewed by the governing body.
C. A copy of hospital-reviewed credentials and privileges is sufficient.
D. Written policies describing the process must be developed.

16. What are some of the components of a peer review of another surgeon's cases, according to Geoffrey R. Keyes, MD?

A. Type of procedure performed
B. Documentation of history and physical
C. Documentation of laboratory results
D. B and C

Answers: 13. B; 14. C; 15. C; 16. D.

SDS ACCREDITATION UPDATE

Covering Compliance with Joint Commission and AAAHC Standards

Credentialing & QI pose challenges for office programs

Documentation and policies are not always prepared for a survey

Reviewing the standards requirements, poring over checklists, and preparing staff members for survey questions may be standard procedure for all outpatient surgery programs that prepare for accreditation surveys, but office-based programs face certain challenges that hospital-based and freestanding outpatient surgery programs don't encounter.

The small staff and the few physicians involved in the office-based surgery programs mean that they have not had to think in terms of credentials, privileges, or ongoing quality improvement, points out **Scott Trimas**, MD, chief medical office of Atlantic Surgery Center in Jacksonville Beach, FL, and a surveyor for the Accreditation Association for Ambulatory Health Care (AAAHC).

"Governance and quality improvement are the two chapters that present the greatest challenges for office-based surgery programs," he says.

EXECUTIVE SUMMARY

With smaller staffs and a practice that doesn't focus only on surgery, office-based surgery programs can find preparation for an accreditation survey overwhelming and time-consuming. The good news is that most programs that seek accreditation are already meeting the standards; they just need to fine-tune their activities.

- Make sure credentialing and privileging policies are in writing and that all activities to these processes are included in the governing board's minutes.
- Develop quality improvement studies that evaluate more than just surgical outcomes.
- Plan ahead to make sure all emergency drills and fire inspections are completed every year.

Credentialing and privileging activities fall under the "governance" chapter, and physicians are not accustomed to verifying their own credentials and granting themselves privileges, Trimas explains. "Even if there is one physician in the practice, and he or she has been in practice for many years, the surveyor will look for documentation that primary source verification of credentials has been performed."

Documentation also must be in the physician's file showing what privileges are allowed in the office-based surgery suite, he says. "Younger physicians are not as surprised by these requirements for documentation, but physicians who have been in practice for longer periods of time may just assume that if they've been granted hospital privileges, that is all they need to show," Trimas says. However, the office-based surgery program must have a clearly written policy stating how credentials will be verified, how updates to licenses and certifications will be obtained, and how privileges will be granted within the office-based practice, he adds.

Once the policies are developed and the activities to verify credentials and grant privileges have been performed, be sure to indicate the actions taken in your governing body minutes, Trimas advises. "Even if you've done what you must do, it has to be presented to and approved by the governing board," he adds.

Peer review also can be an overlooked aspect

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Author Sheryl Jackson, Senior Managing Editor Joy Dickinson, Editorial Group Head Glen Harris, and Board Member and Nurse Planner Kay Ball report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Mark Mayo reports that he is an employee of Symbion Healthcare.

of accreditation requirements, says Trimas. "It does not have to be a complicated process, but it must be physician to physician," he says. In a single-physician practice, the surgeon can choose any other physician to conduct peer review activities, even if the surgeon is in a different specialty, he explains. "A cosmetic surgeon can have an internist or a general surgeon review cases, and vice versa," he says. **(For more tips on peer review, see p. 3.)**

QI is more than outcomes

Another challenging area for office-based programs is quality improvement, Trimas says.

"Many physicians think that if their outcomes are good, there is no need to conduct quality improvement studies," he says. "What they don't realize is that quality improvement is not just about good outcomes; it is about constantly looking for ways to improve," Trimas explains.

The surveyor from the Joint Commission on Accreditation of Health Care Organizations who visited East Cooper Plastic Surgery in Mount Pleasant, SC, praised the program for its quality improvement program, says **Gail Lanter**, CPC, administrator of the program. "Our projects that we conducted on infection control and post-op infections were very in depth," she says. "We also demonstrated that we shared the information with staff members and followed up with changes to improve our results," she adds. **(For other tips from recently surveyed office-based programs, see p. 3.)**

Standards related to emergency preparedness and environment of care issues must be thoroughly understood, says **Syed Ishaq**, national director of the accreditation and consulting division of Somnia, a New Rochelle, NY-based anesthesia, pain management, and consulting firm for outpatient surgery providers. "Office-based surgery practices must look closely at safety and security processes and carefully document the drills that take place," he says. Standardized forms such as checklists for emergency drills should be used to make sure that all of the procedures described in policies are conducted, he suggests.

Be sure you understand how many emergency drills you need to perform, points out Trimas. AAAHC requires a minimum of four emergency drills each year, he explains. "This means four within the year, not three one year and five the next year to average out to four," he says. Schedule your drills well ahead of time to make sure that you don't miss scheduling one, Trimas suggests.

Joint Commission requires an office-based surgery practice to test the response phase of its emergency management plan once a year, in response to an actual emergency or in planned drills, according to **Elizabeth Zhani**, spokeswoman for the Joint Commission.

Trimas recommends that office-based practices take advantage of annual inspections by local fire departments. AAAHC does require annual inspections by local fire departments; thus, even if you are leasing space in a building where the building owner isn't required to obtain an inspection, the office-based practice should ask for the inspection to be sure it is conducted, he suggests. While the fire department is there, you can test fire alarms and ask for the department's cooperation in signaling them for fire response, sources say. The fire department can witness the signaling and record the time that it takes as part of their inspection, they say. Also, managers can ask fire officials for suggestions on safety and evaluations. Additional, firefighters or fire extinguisher service company representatives can demonstrate how to properly use extinguishers.

Joint Commission does not require an annual fire department inspection specifically for the accreditation survey because local or state requirements as well as Life Safety Code requirements call for the inspection, says Zhani.

Fire departments will perform the inspections, but you have to remember to ask for them, Trimas says. Plan for this inspection early in the year so that you don't forget to do it, he adds.

Because office-based programs have small staffs, many choose to use a consultant to help them prepare for their initial surveys, says Ishaq. While the consultant can provide tools such as checklists and sample policies, do not expect the consultant to do all the tasks needed to prepare, he warns. Staff members should plan on learning the new policies,

SOURCES

For more information about office-based surgery surveys, contact:

- **Syed Ishaq**, National Director of Accreditation and Consulting Division, Somnia, 10 Commerce Drive, New Rochelle, NY 10801. Telephone: (877) 476-6642 or (914) 637-3510. Fax: (914) 633-3287. E-mail: srishaq @somniainc.com.
- **Scott Trimas**, MD, Atlantic Surgery Center, 1361 13th Ave. S., Jacksonville Beach, FL 32250. Telephone: (904) 249-2580. E-mail: s.trimas@comcast.net.

if any are added, knowing emergency plans, and understanding the questions to expect during the survey, he says. "I'm not the one that will be asked questions by the surveyor," says Ishaq. "If I do all of the work, how will the staff members know the answers to the surveyor's questions?" ■

On-line or on paper — peer review is key

Review random cases as well as complications

Peer review is a key component of any credentialing and privileging process but it does require some effort if the outpatient surgery program is office-based, admit experts interviewed by *SDS Accreditation Update*.

If you have more than one surgeon on staff, you don't have to go to other practices for help, says **Gail Lanter**, CPC, administrator of East Cooper Plastic Surgery in Mount Pleasant, SC. "We have two anesthesiologists and two surgeons in our practice so they review each other's cases," she explains. When Lanter's office-based surgery program underwent its survey by the Joint Commission on Accreditation of Health Care Organizations, the surveyor was satisfied with this approach because the physicians review charts regularly, not just when there is a complication.

Office-based surgery programs accredited by the American Association for the Accreditation of Ambulatory Surgery Facilities (AAAASF), approach peer review differently from those accredited by Joint Commission or the Association for the Accreditation of Ambulatory Health Care, points out **Geoffrey R. Keyes**, MD, a surgeon in Los Angeles and member of the AAAASF board of directors. The AAAASF peer review process is handled with physicians setting up their peer review group on-line, then submitting the required number of cases for review through the on-line system, Keyes says.

"We require that six random cases and every case with a complication be submitted for review biannually in order to maintain accreditation," he says.

This on-line peer review allows AAAASF surveyors and officials to see that office-based programs are performing ongoing peer review activities rather than waiting until just before the survey to review charts, he explains.

A surgeon can set up his or her own peer review group by submitting the names of other physicians who have agreed to review the cases or by submitting the name of a third-party peer review organization, explains Keyes. The reviews center on patient safety issues such as documentation of the consent for treatment, history and physical, pathology and lab reports, and proper surgical procedures, he says. In addition to providing physicians with an ongoing method to conduct peer review activities, the centralized reporting mechanism also provides data for AAAASF to use in monitoring the safety of office-based surgery, he adds. Physicians who use several physicians outside their facility for peer review should have a standardized format to ensure consistency and the addressing of important issues, sources say.

Data collected by the AAAASF peer review system during 2001 and 2002 resulted in a report that showed only 299 unanticipated complications in more than 411,000 procedures and only seven deaths,[1] Keyes adds, "This data is very important to be able to demonstrate the safety of office-based surgery when performed by board-certified surgeons in accredited programs."

SOURCE

For more information about peer review, contact:

- **Geoffrey R. Keyes**, MD, The Keyes Surgicenter, 9201 Sunset Blvd., Suite 611, Los Angeles, CA 90069. Telephone: (310) 859-9388. Fax: (310) 859-8951. E-mail: geoffreykeyes@sbcglobal.net.

Reference

1. Keyes GR, Singer R, Iverson RE, et al. Analysis of outpatient surgery center safety using an Internet-based quality improvement and peer review program. *Plast Reconstr Surg* 2004; 113:1,760. ■

Patient safety issues need your attention

Surveyors want to see staff follow policies

Involvement of family members in discharge education and use of a comprehensive medication reconciliation form were the reason for two of the compliments paid to the office-based surgery practice of **Gary Burton,** MD, a plastic surgeon in Bowie, MD.

SOURCES

For information on accreditation survey experiences, contact:

- **Marcia Knight**, RN, BSN, 4000 Mitchellville Road, Suite 302, Bowie, MD 20716. Telephone: (301) 441-3375. E-mail: nurse@garyburtonmd.com.
- **Gail Lanter**, CPC, Administrator, East Cooper Plastic Surgery, 1300 Hospital Drive, Suite 120, Mount Pleasant, SC 29464. Telephone: (843) 849-8418. E-mail: glanter@ecplasticsurgery.com.

"We always have family members listen to discharge instructions and give them a chance to ask questions about post-op care," says **Marcia Knight**, RN, BSN, staff nurse. The surveyor liked the communication between the nurse and the family members and the way everyone had a chance to clarify information, she explains.

Improved communications is just one focus of the National Patient Safety Goals from the Joint Commission on Accreditation of Health Care Organizations, but Knight says her surveyor looked carefully at all safety issues identified in the goals. "The surveyor traced two of our patients throughout their visit and observed the staff performing the timeout prior to the procedure and the verification of patient identity, site, and procedure," she says.

Policies should reflect activities

Performing tasks that meet the intent of the patient safety goals is not enough, points out Knight. "Make sure that your policies describe the patient safety activities," she says.

"When working with a consultant to prepare for the survey, we discovered that we were doing everything that was required, but our policies didn't reflect what we were doing. For example, everyone in the office knew what our fire plan was and where the exits are located, but it was not written as a policy," Burton says. In addition to written policies, there should be diagrams on walls in all occupied areas, including the offices and waiting rooms, that show two evacuations routes out of each area, sources says.

Be careful when developing policies to meet accreditation requirements, suggests Burton. "Set rules that you can live by," he says. "Make sure your policies reflect what you are actually doing because once you state your policy in writing, you need to make sure you do what you say you are doing."

Ongoing, regularly scheduled staff meetings are very important, says **Gail Lanter**, CPC, administrator of East Cooper Plastic Surgery in Mount Pleasant, SC. With small staffs, some office-based surgery programs don't think that formal staff meetings are necessary, but when preparing for an accreditation survey, it is critical that everyone understand new policies, the reasons for the policies, what to expect when the surveyor visits, and why the program is undergoing this process, Lanter says. "You can also get a lot of good ideas from staff members to ensure a good survey," she adds.

One area that remains a challenge for office-based surgery programs is benchmarking, says Lanter. Accreditation association surveyors recommend using national or regional studies, or reports published in medical journals, to compare an office's data on infection control, post-op infection, or other clinical or financial issues. However, it is difficult to find the information, Lanter says. When physicians at different facilities agree to conduct peer review on each others' cases, they can agree to a standard set of items for data-sharing and benchmarking, as long as it doesn't violate patient confidentiality or antitrust regulations, sources say.

However, it can be difficult to compare your office-based program to a similar program in your area, Lanter adds. "We are in a very competitive market, and I don't see any office-based surgery programs in the area that want to share information on post-op infections or complications with physicians who are competing for the same patients," she says. ■

Joint Commission updates look-/sound-alike list

The 2006-2007 version of the Joint Commission on Accreditation of Health Care Organizations' list of look-alike/sound-alike drugs can be found on the agency's web site. The list identifies the most problematic drug names used in different settings of health care.

To view the list, go to www.jointcommission.org. Choose "patient safety" on the horizontal navigational bar, then select "National Patient Safety Goals." On this page, go to "Resources" on the right side of page and scroll down to "Look-alike/sound-alike drug list." ■

Policy Title/Number: Respiratory Hygiene and Cough Etiquette IC 10-10.09

Manual: *Infection Control Policy Manual*

Contributors: Kathie Wilkerson, RB, BSN, CIC

Review Responsibility: Operations Policy Committee
Infection Control Committee

Effective Date: January 2004

Last Revised Date:

Team Members Performing:
_X_ RN
_X_ LPN
_X_ Care Partner/Patient Care Technician
_X_ Other licensed staff (specify):All Faculty & Staff
_X_ Other non-licensed staff (specify):All Faculty & Staff

Guidelines Applicable to:
_X_ VUH
_X_ VMG*
_X_ VCH
_X_ PHV
_Other (specify):
_Exceptions (specify):
* includes satellite sites unless otherwise specified.

Guidelines Applicable to:
__ All patient care areas
__ All inpatient areas
__ Adult areas only
__ Pediatric areas only
__ Critical Care/Stepdown areas only
_X_ Selected areas (specify):All waiting areas
__ Exceptions (Specify):

Specific Education Requirements: _X_ Yes No
Part of Mandatory SARS Training for all faculty & Staff

Physician Order Requirements:Yes _X_ No

RESPIRATORY HYGIENE AND COUGH ETIQUETTE

I. Purpose:
To minimize transmission of respiratory infections from the first point of healthcare contact in emergency departments, outpatient clinics and waiting areas throughout the medical center for patients, visitors, and staff.

II. Policy
A number of respiratory agents can be spread through large droplets. These include, but are not limited to, pertussis or whooping cough, adenovirus, SARS or severe acute respiratory syndrome, influenza, and RSV or respiratory syncytial virus. To prevent the spread of respiratory droplets from staff, patients, and visitors, measures

to contain these respiratory secretions will be implemented throughout the medical center.

III. Specific Information
A. Educate staff, patients, and visitors on the importance of containing respiratory secretions to prevent droplet and fomite transmission of infectious agents, especially during seasonal outbreaks of respiratory tract infections.

B. Respiratory Hygiene and Cough Etiquette signs will be posted in all waiting areas, emergency departments, and outpatient clinics, with instructions to cover mouths and noses when coughing or sneezing and to perform hand hygiene after coughing or sneezing into the hands or after using a tissue.

C. Provide tissues and waste containers for disposal in both outpatient and inpatient areas.

D. Provide conveniently located alcohol-based hand rub containers and/or supplies for hand washing in both ambulatory and inpatient areas.

E. Offer masks to coughing patients and accompanying family members or visitors with suspected respiratory tract infection upon entry into common waiting areas.
F. Encourage coughing patients with suspected respiratory tract infections to maintain spatial separation of at least 3 feet from other persons in common waiting areas.

G. Health care personnel will follow Standard Precautions as well as Droplet Precautions and hand hygiene when examining patients with symptoms of a respiratory infection.

H. Healthcare workers who have mild respiratory infections and/or cough and who feel well enough to work should follow scrupulous respiratory hygiene and cough etiquette. They should remove themselves from immediate patient contact while actively coughing and must perform hand hygiene before re-entering the patient area.

IV. Cross-References

Operations Policy Manual

OP 10-50.02, “Hospital Visitor Policy”
OP 60-10.05, “Waiting Room Standards”

Infection Control Policy Manual

IC 10-10.14, “Staff Exposing Patients to Communicable Diseases”

V. Web References
www.cdc.gov/ncidod/sars/pdf/smp_supplementc.pdf

VI. Endorsement:

Operations Policy Committee – December 2003

VII. Approval:

Norman Urmy, Executive Vice President, Clinical Affairs 1-06-04

Jim Shmerling, Chief Executive Officer, Vanderbilt Children’s Hospital 12-23-03

	DEPARTMENT: Surgery/Patient Care	REFERENCE #:03.18.026	
Moore medical center	SUBJECT: **Patient Jewelry**	PAGE 1 of 3	
	DEPARTMENTAL APPROVAL/DATE ADMINISTRATIVE APPROVAL/DATE	EFFECTIVE: August 15, 2005 REVISED: NEW	JCAHO REFERENCE # IC.2.10 PC.2.130 STATE LICENSING REFERENCE # 310.667-25-1

A. PURPOSE:

To provide information, clarification, and guidance for staff preparing a patient for surgery

B. APPLICABILITY:

All Staff preparing a patient for a procedure including RNs, LPNs and CNAs

C. POLICY STATEMENT:

1. Patients will be strongly encouraged to remove all jewelry prior to any procedures. This jewelry includes but is not limited to;
    a. Rings
    b. Bracelets/Watches
    c. Necklaces
    d. Earrings
    e. All body-piercing jewelry (i.e. Tongue, nose, nipple, etc.)
2. Patient education of the need to remove the jewelry will be accomplished. Education to include the why and the potential consequences that can occur with wearing jewelry during a procedure.
3. If the patient cannot physically remove their jewelry (i.e. rings), the nursing staff will employ all reasonable efforts to assist in removing the jewelry. If efforts are unsuccessful, the jewelry will be taped in place to prevent becoming entangled in sheets, drapes, or equipment.
4. If the jewelry will be in the sterile field and cannot be removed, the surgeon must be contacted as soon as possible for guidance.
5. If the jewelry has a potential to inhibit safe administration of an anesthetic and cannot be removed, the anesthesiologist must be contacted as soon as possible for guidance.
6. If the jewelry is a religious item, every effort will be accomplished to accommodate the patient's wishes and yet maintain patient safety and sterile technique.
7. If the patient is able to remove their jewelry but declines to do so, they need to know there is a potential that the case may be canceled.

REFERENCES:

AORN, Inc. *Standards and Recommended Practices (*for *Electrosurgery)* (Denver: AORN, Inc. 2005) 330

Fortunato NH. *Berry & Kohn's Operating Room Technique,* ninth ed (St. Louis: Mosby, 2000) 239 and 317.

Rgon BM. "Body piercing." *The Journal of the Perioperative Nurses Association of the New Zealand Nurses Organization* 29 (August 2001) 12-15.

Moore medical center	**DEPARTMENT: Surgery/Patient Care**	**REFERENCE #:03.18.026**	
	SUBJECT: **Patient Jewelry**	**PAGE 2 of 3**	
	DEPARTMENTAL APPROVAL/DATE **ADMINISTRATIVE APPROVAL/DATE**	**EFFECTIVE:** **August 15, 2005** **REVISED:** **NEW**	**JCAHO REFERENCE #** IC.2.10 PC.2.130 **STATE LICENSING REFERENCE #** 310.667-25-1

BACKGROUND INFORMATION:

Jewelry/body piercing worn by the patient during an invasive procedure may subject the patient to an increased risk for injury. These injuries may include:

- Burns if electrosurgery is used
- Decreased circulation to fingers/toes due to intraoperative swelling
- Aspiration in case of tongue piercing
- Traumatic injury if jewelry becomes caught in bed linen, surgical drapes, or equipment
- Pressure injury due to muscle relaxation and surgical positioning.

In addition, jewelry can:

- Hinder the ability to carry out invasive procedure (i.e., laparoscopy, urinary catherization, IV access)
- Serve as a nidus of infection
- Become lost

PROCEDURE:

1. During the preoperative assessment, ascertain the presence of any jewelry including body-piercing jewelry

2. Determine if jewelry will be either in the sterile field or a hindrance to anesthesia administration
   This is identified as any jewelry within the proximity of where the incision will be made. *OR* Jewelry attached to the face (including eyebrows, eyelids, nose, lips, ears, neck, or cheek) or tongue piercing.

3. Jewelry which will not be in the sterile field and cannot be removed, tape it securely in place.
   Ensure the patient is not allergic to tape
   Secure the jewelry is such a way it will not injure the patient (choking from necklace, tight tape around the finger, etc.) Check with the OR Staff to ensure padding is adequate to prevent electrocautery burns OR positioning problems
   If there is a stone (i.e., diamond in wedding ring) put a small amount of cotton or tissue over the stone in order to prevent tape from coming in contact with the stone. (Prevents tape from pulling stone from the setting as it is removed.

4. If the jewelry is present and can be removed, ask the patient to choose one of the following options:

   Give to a family member/guardian
   Contact Hospital Safety & Security Officer to secure jewelry
   NOTE: Make sure the patient knows how to retrieve jewelry after the procedure.

5. If jewelry is present and the patient refuses to remove it:
   Assess why the patient is unwilling to remove jewelry
   Explain to the patient that removing jewelry is for their protection
   If the patient is still unwilling to remove the item, consult the surgeon

Source: Moore (OK) Medical Center.