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IN THIS ISSUE

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Should you allow live broadcasts of cases? Some answer definitive 'no'

As part of his efforts to educate the public about heart health, **Frederick Meadors**, MD, a surgeon at St. Vincent Infirmary Medical Center in Little Rock, AR, had planned to perform surgery on a patient while 330 people watched the procedure live through a video feed in a hospital auditorium.

However, that plan was scuttled when Meadors' professional group, the Society of Thoracic Surgeons, announced recently that such broadcasts no longer are considered acceptable. The hospital had put six months into planning the event, but officials confirm that the plan was changed abruptly in response to the society's move. Instead of watching the surgery live, the group watched a videotape of a surgery as Meadors explained it in person.

Live surgery broadcasts have grown in popularity in recent years, due partly to technological advances such as in-light cameras that make them relatively easy to produce. The cameras add about $12,000-$30,000 to the cost of each light, and most ORs use at least two lights, according to sources.

The public's fascination with medical procedures that, in previous years, might have been considered unpleasant to watch also has been

EXECUTIVE SUMMARY

Some facilities and professional organizations are backing away from live surgery broadcasts. Critics cite patient safety concerns and liability risks.

- There is disagreement about whether surgeons are distracted during broadcasts, but plaintiffs' attorneys will claim the surgeon's attention was divided.
- Consider offering a taped broadcast, but explore associated liability with that format.
- Decide on the audience, format, procedure, surgery, and gatekeeper/moderator (for a webcast). Also determine who will do the taping/broadcasting and how to handle an emergency.

growing. But some surgeons and surgical groups are expressing concern that having a surgeon perform live for an audience isn't such a great idea.

In 2006, the American College of Surgeons in Chicago banned live surgery broadcasts at its meetings. "The safety and welfare of patients is the foremost consideration for all involved in health care," the college said. "Live televised surgery is viewed as essentially weighing the benefits to surgeons with the possibility of increased risk to patients. Given the lack of substantive data regarding these areas, the decision was made that safety and the interest of patients must take precedence." Use of videotaped procedures was permitted and encouraged.

Earlier this year, the Society of Thoracic Surgeons also banned live surgery broadcasts at its meeting, but it went a step further by saying that its members should not perform live surgery broadcasts to the general public because they may be distracted from their primary duty to the patient, explains **Robert A. Wynbrandt**, JD, executive director and general counsel of the society. The society's board of directors is approving a more extensive policy that addresses a wide range of ways in which surgery may be viewed by others, he says. It includes everything from having residents standing nearby to participating in live television shows. At press time, that policy had not been published, but it was expected soon.

"The tricky thing is that there is no empirical data to base these decisions on. There are no studies that have shown it is risky or not risky to have the surgery broadcast live," Wynbrandt says. "You hear anecdotal evidence about mishaps that people have had during live surgery, but nothing documented. So we have to base our policies on what is good for the patient and where our priorities should be."

Worries about distracted surgeons

The basic concern is that the surgeon's attention will be divided by having to perform for the camera and narrate what he or she is doing, and that this scenario would compromise patient safety, Wynbrandt says. That risk is only theoretical, he notes, and many surgeons argue that they are adept at multitasking. Their attention is divided already, they say, and having a camera in the room does not create any extra risk. Wynbrandt says the society can't prove otherwise but would rather err on the side of patient safety.

Others look at the issue of broadcasting surgery differently. "Many surgeons are very comfortable teaching and operating at the same time," says **C. Lowry Barnes**, MD, president of Arkansas Specialty Orthopaedics, St. Vincent Infirmary, also in Little Rock. "Some might suggest that a surgeon might even be more 'careful' or 'safe' if being viewed by others." In fact, St. Vincent had broadcast a live surgical procedure to a group of attorneys, including plaintiff's attorneys.

There is considerable concern that live surgery broadcasts can increase the liability risk for surgeons and hospitals, but Wynbrandt says that

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still is only a theoretical risk with no cases to show any certain threat.

To avoid potential problems, consider these suggestions:

• Consider taping surgical procedures for broadcast.

Steven D. Schwaitzberg, MD, FACS, chief of surgery for Cambridge Health Alliance, says in terms of broadcasting live surgery, "I think there are inherent problems if things do not go well."

St. Vincent had broadcast live orthopedic and cardiovascular procedures in the past, but has moved to more pre-taped procedures, says **Jon Timmis**, vice president and chief strategy officer. "We're evaluating the risk to the patient associated with doing live surgery and evaluating and risk differential between cardiac and orthopedic surgery," he says. "Live orthopedic surgery has been a lot more mainstream and more refined over the years than live cardiac surgery, which is still fairly progressive and the patient is in a more compromised state."

Switching to videotaped procedures, which is a "much more controlled setting," was more effective than trying to have the surgeons moderate while performing live surgery, he says. "Surgeons could be in the auditorium and speak through the surgery, rather that in the operating suite," Timmis says. "We don't think we lost anything by making that conversion." However, experts in risk management warn that even videotaped procedures carry some risks because there is a recording if anything goes wrong in the case.

• Do your research.

Visit a facility that has been broadcasting for a while, Barnes suggests.

Several items must be determined before you broadcast, says **Brett M. Harnett**, MS-IS, research assistant professor and associate director of experimental IT at the Center for Surgical Innovation, University of Cincinnati. University Hospital in Cincinnati has broadcast live procedures including laparoscopic gastric bypass, minimally invasive heart procedures, and lung/lobectomy to the public and primary physicians with Harnett's help.

"Know exactly why you are doing this, who your audience is, and how it will benefit the institution," he says.

If you are conducting the broadcast for the public, a webcast usually is the format, Harnett says. The advantage is that the broadcast can be sent to a large audience; however, the video is significantly compressed and is grainier.

Webcasts are one-directional, so to obtain feedback, you need a chat or e-mail function, plus a gatekeeper/moderator in the OR, Harnett says. "Point-to-point video conferences are easier because they are usually bidirectional," he adds.

• Consider doing the taping internally.

University Hospital has taped some procedures and has outsourced some. "Outside firms are very invasive and costly," he says. University Hospital spent about $120,000 for five broadcasts, with the tapes kept in archive for one year. When they have used an outside firm, the hospital did stipulate that the company had to create minimal distractions to the OR staff.

Your biggest challenge will be audio, due to high ambient noise in the OR, Harnett says. If your budget allows, use the services of an audio expert, he advises. Find an audiovisual (AV) expert in your area by doing a web search, or call a local university, Harnett suggests.

At a minimum, use a quality microphone that is wired. Wireless microphones magnify the interference, Harnett says. However, he admits surgeons don't like a wired microphone, although they often are tethered elsewhere.

Also, train the surgeon and the staff for doing a broadcast, he says. "In other words, keep the background chatter to a dull roar," he says.

• Pick the right team members.

Know your staff, Harnett emphasizes. "Some surgeons are very good in this scenario," he says. "Others are not."

The surgeon should be accustomed to teaching, Barnes says. Also, ensure the anesthesia staff is top notch, he says. The OR team should be one that is highly trained and "does the same thing day in and day out," Barnes says.

Additionally, have a moderator who

SOURCES

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understands the operation and can answer questions during the operations, he says. St. Vincent uses an advanced nurse practitioner who has worked with Barnes for 13 years.

• If you broadcast live surgery, have a plan for emergencies.

"Patient safety always comes first," Harnett says. The fact it is being sent out as a live feed is irrelevant, Harnett. However, he adds, "we did have a plan to cut the live broadcast in the event of an emergency — obviously."

When planning a broadcast, don't make a decision in isolation, Timmis suggests. Instead, work closely with your surgeons, he says. "If the physician is interested, make sure all the benefits and risks are fully understood," Timmis says. **(For more information, see "Teleconference requires upfront planning," *Same-Day Surgery*, December 2002, p. 149.)** ■

ASA advisory addresses operating room fires

Educate, assess risk prior to surgery

The effects of operating room fires can be devastating. An estimated 50 to 100 surgical fires per year is one of the reasons that the American Society of Anesthesiologists (ASA) has developed a practice advisory to address the issue.

"The development of the advisory stems from ASA members personally involved in fire situations in the operating room [OR] and members who have dealt with the aftermath of catastrophic operating room fires," says **Charles E. Cowles**, MD, an anesthesiologist at the University of Texas — Houston and a member of the advisory development committee.

"The Practice Advisory for the Prevention and Management of Operating Room Fires" appears in the May 2008 issue of *Anesthesiology* and identifies situations that are conducive to fires, tips to reduce the risk of fires, techniques to reduce the adverse outcomes associated with OR fires, and elements of effective fire response. **(To obtain a copy of the advisory, see resource box, p. 65.)** The advisory includes an algorithm that describes specific actions that an anesthesiologist can take to minimize the risk of fire and respond if a fire occurs, points out **Robert A. Caplan**, MD, anesthesiologist at Virginia Mason Medical Center in Seattle and chairman of the ASA Task Force on Operating Room Fires. "The algorithm is suitable for posting in ORs and procedure areas and was specifically designed for this use," he adds.

Because the use of oxygen increases the risk of fire, the task force looked closely at incidents involving OR fires and oxygen, says Cowles. "The task force reviewed many cases of injury to patients due to the unnecessary use of supplemental oxygen, especially in nonintubated, conscious patients," he says. "Many of these patients had no medical reason for needing oxygen supplementation, and the oxygen just contributed to making a perfect environment for fire to break out."

The best recommendation is to limit the use of oxidizers, except as medically necessary, and to restrict use of flammable prep solutions and allow adequate drying time if used, he explains. "If medical necessity mandates the use of oxidizers, use only the amount specifically needed to optimize patient care and allow adequate time for the oxidizers to dissipate prior to activating an ignition source," suggests Cowles.

EXECUTIVE SUMMARY

A task force of the American Society of Anesthesiologists (ASA) has addressed surgical fires with a practice advisory that addresses identifying procedures at high risk of fire, reducing the risk, and managing a fire.

- Supplemental oxygen is not medically necessary in all cases and should not be used if not necessary, because oxygen increases the risk of fire.
- Anesthesiologists need specific education related to surgical fires.
- An assessment of the risk of fire should occur before every procedure, and the OR team should discuss responsibilities to reduce the risk.

Fire-specific training needed

One of the advisory's recommendations is that all anesthesia providers have training in OR fires, says Cowles. **[To see other recommendations, see the *Same-Day Surgery Weekly Alert* dated April 25, 2008. If you haven't yet signed up to received the weekly alert, contact customer service at (800) 6988-2421 or customerservice@ahcmedia.com.]**

"The general fire response training received in most facilities is not sufficient to address the specifics of dealing with high-risk situations presented in the operating room," he says. Several

RESOURCE

To download a copy of the "Practice Advisory for the Prevention and Management of Operating Room Fires," go to www.anesthesiology.org and select "Archive" from the navigational bar. Choose "May 2008" and scroll down to "CME Practice Advisory for the Prevention and Management of Operating Room Fires."

mediums are available for this education, Cowles says. "Both the Anesthesia Patient Safety Foundation and ECRI have videos and educational programs designed specifically for fires in the OR," he says. **(For more information, see resource box, above.)**

The ASA annual meeting and other local anesthesiology association meetings also are outlets to feature presentations and clinical forums to educate anesthesia providers about the specifics of OR fire safety, he adds. "The advisory was written in such a manner that it is easily understood by anesthesia providers and others who work in the OR and one need not be an expert to create a lecture, grand rounds presentation, or CE module, which follows the advisory," he says.

Another key recommendation is that before a procedure, the risk of surgical fire should be determined by the OR team, Caplan says. The Joint Commission requires that the pre-procedure timeout include an understanding that all members of the team are empowered to act on behalf of patient safety, and that can include assessment of fire risk, he says. Since this is an advisory for anesthesiologists, this recommendation is addressed to the anesthesiologist, Caplan says. "However, the advisory recognizes that the anesthesiologist is a part of the OR team, and that all members of the OR team must work together," he says. From a practical standpoint, this is a recommendation for the anesthesiologist to take a proactive role, Caplan adds.

Cowles says, "I think the anesthesiologist is in a good position to oversee the process because we are with the patient at all times and can observe how the patient is prepped and positioned, which may contribute to creating a high-risk situation." The circulating nurse often is busy with room coordination and equipment issues, the surgical technologist is focused on anticipating the needs of the surgeon, and the surgeon often is focused on the complexity of a particular procedure, he says. Thus, the anesthesia provider should be focused on the patient, the OR environment, and the patient's well-being, Cowles says.

"I believe that providers become too complacent with respect to what could happen if case of fire," he says. It is exactly like finding the fire escape doors on your floor when you check into a hotel. Cowles says. Most people agree that this is a wise step, however, few people actually go to the effort to do so, he says.

"When a fire breaks out and you know how to escape, even when the smoke is very thick and other people are in panic mode, it pays off," Cowles says. ■

Be prepared for wide range of patient questions

Patients more aware of credentials, experience

Ask questions. These words of advice are offered to patients, especially surgical patients, by accreditation organizations, medical societies, health care institutions, and individual physicians.

Web sites, brochures, and checklists offer suggestions about what patients should ask. The questions range from credentials, to experience, and to specific information about the proposed procedure. Add this information to the thousands of hits you get when you search for information on surgical procedures, and surgeons and surgery center staff must prepare for a wide range of questions, says experts interviewed by *Same-Day Surgery*.

"Today's patients are more educated about their procedures and the importance of credentials,"

EXECUTIVE SUMMARY

Because open, complete communication increases patient safety and satisfaction, be prepared to answer questions and volunteer information even if not asked about specifics.

- Volunteer information about surgeons' credentials, experience, and training.
- Emphasize facility accreditation and explain how it ensures that high standards in patient care are maintained.
- Prepare all staff members to answer questions. Let staff know that it is appropriate to say that they don't know a particular answer but will find out immediately.

says **Sam Speron**, MD, FACS, CEO of Park Ridge (IL) Center for Plastic Surgery. More questions lead to better communication, and this is good for surgeons and patients because it gives the surgeon the opportunity to make sure that patients understand the procedure and the potential outcome, he says. "Some people do not have realistic expectations for plastic surgery and it is better to be able to discuss expectations up front," Speron says. "Patients who have had their questions answered and who fully understand the procedure and what to expect after the surgery are generally more satisfied than patients who didn't get all of the information they needed."

Patients who are shopping for a plastic surgeon can find a list of questions they should ask any surgeon on Speron's web site. It is important to offer information and prompt questions when patients are looking for physicians, he says. **(For resources and checklists you can use for your web site, see resource box, right.)** "Patients don't ask me directly about my credentials or the accreditation of my facility, but they've usually visited my web site first, and all of the information is available on the site," he explains. "My staff and I also volunteer information about my credentials and accreditation of our facility."

Because many plastic surgery procedures are elective and may not qualify for reimbursement by the patient's insurance plan, patients shop around for surgeons and compare prices. "I encourage patients to ask about credentials and accreditation because they need to make sure that the physician and the facility staff is qualified to perform their procedure before they compare prices," Speron says. "It is a safety issue."

Allow time for questions

During the patient's initial consultation, Speron encourages the patient to "ask anything," he says.

"A consultation can last 30-45 minutes, with 10 minutes or more devoted to answering the patient's questions," Speron adds.

Even if the patient doesn't initially have questions, Speron asks open-ended questions about the patient's reason for seeking plastic surgery, takes a detailed history, and discusses options. Once he has finished that part of the consultation, the patient usually has some questions, he adds. "I never schedule patients for surgery immediately after the first visit," Speron explains. "I encourage them to go home and think about it, and contact me with questions before making their decision."

Although some physicians are reluctant to volunteer information about their credentials or accreditation of the facility in which they perform the surgery, it is in the best interest of everyone to make sure patients are well educated, says Speron. Make sure that staff members are prepared to answer questions as well, he suggests. "We make sure that all employees know how to answer questions that a patient may believe are too personal to ask the physician, such as training and experience, but we also teach staff members not to overstep the boundaries of their knowledge," he adds. "Although all members of my staff want to be helpful, they know that it is OK to say that they need to ask someone else for information and get right back to the patient."

Although most patient education begins in the physician's office, surgery center staff should not assume that patients have had all of their questions answered, points out **Emilie M. Keene**,

SOURCES/RESOURCES

For more information about handling patients' questions, contact:

- **Emilie M. Keene**, MHA, Interim Administrator, Parkridge Surgery Center, Columbia, SC. Telephone: (803) 407-4940. Fax: (803) 407-4955. E-mail: emilie.keene@palmettohealth.org.
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For materials and information that can encourage and guide patients' questions, contact:

- **The Joint Commission.** The Joint Commission's Speak Up program publicizes the importance of patients taking an active role in their health care. For brochures and other materials that can be used to prompt patients' questions, go to www.jointcommission.org and select "Patient Safety" from the top navigational bar. Choose "Speak Up" to see materials available and find link to the Joint Commission Resources store to order materials. There is a charge for buttons and posters, but Speak Up brochures can be downloaded from the Speak Up page at no charge.
- **The Agency for Healthcare Research and Quality offers a free brochure** titled *Having Surgery? What You Need to Know*. To find the brochure and a checklist of questions, go to www.ahrq.gov. Under the "Consumers and Patients" heading, select "Surgery."

MHA, interim administrator of the Columbia, SC-based Parkridge Surgery Center. "Our pre-op nurse calls patients two to three days prior to their procedure to confirm the day and time as well as the type of procedure," she says. "The nurse also describes our facility, our experience, and what they can expect during the day of their surgery."

Some patients have researched their procedure using less than accurate sites, so the nurse might have to answer some off-the-wall questions to reduce the patient's anxiety and provide accurate information, says Keene. "Luckily, we have a kindhearted pre-op nurse who is a very good listener as well as an experienced nurse," she adds.

Shonda Huggins, RN, BSN, the staff nurse at Parkridge who handles the pre-op calls, answers quite a few of questions about anesthesia. "Many people assume that arthroscopy is such a simple outpatient procedure that the only anesthesia needed is a local," she says. "I have to make sure they understand that they will need more than a local and that they understand that this is still surgery, even if we're not making a lengthy incision."

One of the most surprising questions came from a patient who had read a newspaper article about a case in Florida in which an outpatient undergoing plastic surgery died from malignant hyperthermia, says Huggins. "He asked if we had the medications needed to treat this condition in our operating rooms," she recalls. The patient was reassured to hear that the staff were prepared with the medications and the training needed to treat the condition, Huggins explains. "Even though he understood that this is not a common condition, he wanted to make sure we were equipped to handle any emergency during his surgery," she says. ■

Manage schedule closely for steady patient stream

Maximizing the use of your operating or procedure rooms can positively affect your bottom line. Although staff members can reduce turnover time to increase the number of cases each room can handle, what can you do about no-shows on the day of surgery or physicians who don't use all of the time blocked out for their procedures?

Asking patients if they want to be called if an opening occurs in the schedule prior to the date of their scheduled procedure is one way to keep the operating room schedule filled, says **John Gleason**, administrator for The Berks Center for Digestive Health in Wyomissing, PA. "We have a list of ASAP [as soon as possible] patients who have agreed to move their procedures to an earlier day, and we'll call them when we see an opening," he says. "We can't always fill spots with these patients, but it does work sometimes."

His center has only one practice that uses the center, and the physician's office schedules the procedures. They receive the schedule about five days prior to the procedures. Because the physician's practice has implemented a process that doesn't require patients who are undergoing routine screening colonoscopies with no apparent health problems to see the physician prior to the procedure, it is especially important for Gleason's staff to make a pre-op call two to three days prior to the procedure, he says.

"Although the physician's assistant who screens the patients by telephone and collects medical history information does explain the home preparation for the procedure and sends written information, patients don't always read it or understand it," he explains.

A pre-op call, made prior to the day that patients must begin preparation for the procedure at home, cuts down on the number who must be rescheduled on the day of surgery due to lack of preparation, Gleason says. The call also gives staff members a chance to identify patients who will not show on the day of surgery due to schedule conflicts, illness, or other reasons, he says.

The most critical element in having a patient move the time and day of the procedure is timing because preparation for gastroenterology

EXECUTIVE SUMMARY

The only way to ensure that the rooms stay full is to pay close attention to your scheduling process and identify ways to keep patients in the ORs.

- Offer patients the option to move up in the schedule to another day or time if a cancellation is received.
- Consider overbooking your ORs to compensate for no-shows if they are a regular occurrence in your center.
- Have the surgery center manage the schedule as opposed to the physician's office so you can keep patients grouped together earlier in the day to enable you to let staff go home when there is downtime.

SOURCES

For more information about managing an operating room schedule, contact:

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- **Michelle Steele**, RN, Nurse Administrator, Eastside Endoscopy Center, Bellevue, WA. Telephone: (425) 451-7335.

procedures takes a couple of days, he explains.

The most frustrating issue for surgery centers is not patients who let you know a few days ahead of time that they are canceling or rescheduling, but patients who just don't show on the day of the procedure, Gleason says.

"We routinely have two to three cancellations a day," he says.

Although a no-show is good news for patients who may have arrived early for their own procedure, missed appointments can cause gaps that are not productive for staff members or surgeons, Gleason says. To address this problem, his center is taking a bold step with a new process that is scheduled for implementation this year, he says. "We will overbook the center by scheduling two or three extra patients each day," he says.

When they schedule the patient, they will give the date of the procedure but not the exact time, Gleason says. "We'll explain that we will call with the exact time two to three days prior to the procedure," he says. These patients will be scheduled for times for which the center has learned of cancellations in the pre-op calls, or they'll be assigned times throughout the day, based on the existing schedule, Gleason says. Having the extra patients showing up at different points during the day will fill the gaps caused by no-shows, he points out.

As the idea for this scheduling process has been developed, Gleason obtained buy-in from staff members and physicians, he explains. "It is important that all of the surgeons agreed to handle an extra patient or two if we have overbooked and there are no cancellations," he says. "If there are no cancellations, or only one or two cancellations, the patient is seen as quickly as possible."

Although many surgery centers designate blocks of times for each surgeon and then let the surgeon's office staff schedule the procedures, the staff at Eastside Endoscopy Center in Bellevue, WA, assumes responsibility for all schedules, says **Michelle Steele**, RN, nurse administrator.

"Each physician has a block of time in the schedule, and we fill the schedule from the earliest time to the latest time," she says. "If a patient cancels, we call the patient with the latest time in the block to move him or her to the time slot of the canceled patient."

By using this approach, Steele can ensure that she doesn't have staff sitting and waiting on the next patient due to gaps in the schedule. She also has the option of sending staff home once all of the cases are complete. "We do occasionally have patients who cannot arrange transportation during certain times of the day and we will accommodate them, even if it means a gap in the schedule," Steele says. "This is not a frequent occurrence."

Physician practice managers also know to call Steele's staff as soon as a physician plans a vacation or time away from the surgery center, she says. "The practice keeps the block of time if there are other physicians in the practice that want to use it," Steele adds. "The practice manager just lets us know which physician is assigned to the extra time."

If it becomes apparent that the physician won't be able to fill the extra time, Steele's staff checks with the practice manager and releases the time to other physicians.

Although managing the operating room schedule requires constant communication with physicians' offices and patients, it is critical to the financial success of any center, Gleason says. "We need to focus on activities that can keep staff members and physicians busy and productive the entire time they are in the center," he says. ■

Include patient education as part of infection control

Info on symptoms allows early detection

To prevent infection following surgery, proper education is important, and hand washing needs to be at the top of the list.

Improper hand washing is the No. 1 way nosocomial infections are spread, says **Sharon B. Hampton**, MSN, RN, CAPA, patient care nurse manager for the ambulatory care unit, post-anesthesia care unit, pre-op holding unit, short-stay unit, and interventional radiology recovery unit at the University of Texas MD Anderson Cancer Center in Houston. Most patients in the areas

SOURCE

For more information about infection control education and methods, contact:

- **Sharon B. Hampton**, MSN, RN, CAPA, Patient Care Nurse Manager, Ambulatory Care Unit (ACB), University of Texas MD Anderson Cancer Center, Box 1244, Room ACB 4.2537, Houston, TX 77030. Phone: (713) 563-6598. E-mail: shampton@mdanderson.org.

Hampton supervises are having outpatient surgery.

Patients are taught to sing the birthday song while they wash their hands to make sure they have scrubbed for the proper amount of time before changing a dressing or doing anything with their catheter, Hampton says.

Also important is to teach the early signs of infection, including redness, pain, or increased drainage from the site or warmth around the wound. Some patients think an elevated temperature is a sign of infection, but often there are other symptoms that might occur before a patient's temperature reaches 101°F that should trigger a phone call to the physician.

Patients need to know the early signs of infection so they can receive antibiotics if necessary, says Hampton.

When instructions are not followed correctly, it usually is because patients didn't clearly understand them, says Hampton. For example, they may not have heard the instructions "change the dressing every three days," she explains.

To remedy this problem, a family member or responsible adult who will help the patient with his or her care is asked to come to the bedside during discharge instructions. The patient and caregiver verbalize the instructions including the signs and symptoms of infection.

Interpreters are used to help families understand the instructions when English is not their primary language. Some facilities print instructions in other languages.

Education is important because there are many reasons for infection at the site of surgery. Diabetes, obesity, surgical technique, skin preparation, surgical volume, and poor wound healing conditions such as low blood protein all can contribute to surgical site infections, says Hampton. In addition, surgeries that last longer than three hours put a patient at greater risk as well as having drains or a weakened immune system.

In addition to patient education, several protocols have been set in place at MD Anderson to improve infection control. Patients who have certain health problems such as a history of diabetes or a body mass index greater than 35 have their blood sugar checked and are treated when it is high to keep it within normal limits.

Also, certain types of surgery trigger an antibiotic protocol. Patients receive the antibiotic as they are wheeled into the operating room. "Depending on the surgery, there are certain types of antibiotics that are more effective on whatever the bacteria is that is common to that procedure," explains Hampton.

In addition, housekeeping washes the stretchers once or twice a week during evening hours. Between patients, they are wiped down with a germicidal disposable wipe.

After a patient is discharged, he or she receives a follow-up phone call as a final precaution. During the conversation, patients are asked if they have any issues with the incision, which provides an opportunity to tell the nurse about drainage or redness. They also are asked if they have any questions about the discharge instructions.

"We check on them all to make sure everything is OK and so that they can express their concerns," says Hampton. ■

Same-Day Surgery Manager

Q&A: Getting surgeons to use your facility

Nonnurse administrators, other issues addressed

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

Question: Why are our investors not using the surgery center they built after they convinced us to give up our jobs at the local hospital? I am a pretty savvy RN who understands business as well as the next person, but this doesn't make sense. We built out five operating rooms. We are lucky if we are using two, and that is stretching it. Is it us?

Answer: I wish that it were! What you are talking about is more common than you would believe. The key is having a person or a group to push them. Left to their own devices, many surgeons have a hard time making the change from the "mother ship" hospital to their own center. Perseverance is the only recourse, although it really shouldn't have to be that way. Publish the number of cases the investors do each month, and circulate it to the other investors. Public humiliation works.

Question: The administrator of our surgery center that the management company put in here is not a nurse! He has never even been in the operating room, and he passed out when he observed his first case. Have you ever heard of this before?

Answer: (Gulp!) Well, yes. We have placed a number of nonclinical administrators in for-profit surgery centers over the years and probably will continue when the right nurse is not available. Remember that surgery centers are multimillion-dollar businesses and need to be treated as such. Most hospital CEOs and presidents are not nurses or surgeons either, but they hire wise clinical personnel who make up for their deficits.

Question: Our hospital is developing a GI Center of Excellence within the walls of the actual hospital. However, they are using an outside company to design the "flow" (patient, equipment, staff, surgeons, etc.) and then manage the center. They are even using dedicated staff to operate the center. Apparently, we (the existing staff members) who have been doing the docs cases for years are suddenly not good enough to work in the new "pavilion" with the docs anymore.

Answer: While it is not really a question, I can tell you that developing centers of excellence is becoming increasingly more commonplace in hospitals. It often avoids the development of a costly surgery center and affords a lower-cost option for many surgical cases that compete for time and staff with emergency cases and overtime of staff. We are going to see more of these types of facilities spring up. For your own comfort: It is not that your staff are not good enough, but it's more of a function of having a dedicated staff for the one specialty.

Question: We are working on reducing our supply cost at the hospital. Any thoughts that can help us?

Answer: Oh yes! There are several things to look at:

- Let your staff and the surgeons know what you are doing and post your goals.
- Price your surgeons' preference cards, and let them see what things cost.
- Unit price your sterile supply room so the staff are aware of what things cost.
- Beat your vendors up (regularly) to get better pricing and "samples."
- Compare one surgeon's supply costs with another for the same procedure. Share your finds with both.
- Talk to the materials manager for your center or hospital and ask them why things cost so much. They get buried in the details of thousands of items per year. Let them know you are looking over their shoulder.
- Ask your boss for an incentive to reduce cost. Be careful here. They may say, "Is keeping your job enough?"

I have many people send me great questions weekly, and some I save for publication. Let me know if you have one.

(Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Contact Earnhart at 1000 Westbank Drive, Suite 5B, Austin, TX 78746. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.) ■

Sedation system to raise compliance?

Diagnostic procedures range from easy and unobtrusive (maybe just a quick nasal swab, that's all), to highly obtrusive and uncomfortable (read, colonoscopy), with this spectrum largely determining patient willingness to pursue them.

The result for colonoscopy: Many keep putting off this procedure or avoid it altogether.

The answer to this problem is improved comfort, perhaps through improved sedation, with something better than the current use of a painkilling bolus or opioid injection, according to **Mike Gustafson**, executive director of Ethicon Endo-Surgery in Cincinnati.

Gustafson said the necessary improvement is on deck, with the company's recent filing of an application to the Food and Drug Administration (FDA) for pre-market approval of its SEDASYS system. SEDASYS is billed as "the first computer-assisted personal sedation (CAPS) system," primarily targeting colonoscopy but also esophageal procedures or other such diagnostics with fairly high discomfort levels for the patient. Rather than

simply offering sedation more flexibly, when needed, the system provides continuous monitoring of vital signs of the depth of sedation. Perhaps more importantly, from a patient compliance point of view, Ethicon Endo-Surgery is seeking regulatory labeling for the SEDASYS that enables its use by a physician or nurse and not requiring the presence of an anesthesiologist, thus greatly expanding its potential uptake by providers and acceptance by patients.

Demonstrating a sensitivity to overclaiming for a product not yet approved, Gustafson didn't tout a variety of claims for SEDASYS, but said: "What I can tell you is that our feasibility studies in the U.S. and Belgium demonstrated that [SEDASYS] is able to deliver very precise and personalized delivery of propofol [Diprivan] by the nurse or physician."

Propofol is the sedative drug to be used with the system, with the company emphasizing the system's provision of only "minimal to moderate" sedation in the targeted procedures.

The company's submission includes results from a multicenter randomized trial of 1,000 patients that compared the safety/effectiveness of the SEDASYS to current sedation used in routine endoscopic procedures: physician-administered benzodiazepine and opioids. The study assessed safety based on Area Under the Curve (AUC) for oxygen desaturation, reflecting objective measurements incorporating incidence, duration, and depth of oxygen desaturation and the risk for oversedation.

The trial found SEDASYS effective based on level of sedation, sedation recovery time, and clinician and patient satisfaction, without the aid of an anesthesia professional.

Gustafson said the concept "was originally the idea of an anesthesiologist, and we have had a number of marvelous anesthesiologists actively involved" in development.

He emphasized the system's ability to provide monitoring of the patient throughout the procedure. Tethered to the patient via IV, the system tracks seven physiology parameters, from blood pressure to respiratory activity and providing continuous data via what the company calls "a novel automated response monitor."

Additionally, the system provides for verbal prompting of the patient through an earpiece, to monitor responses via the patients' ability to respond to these prompts (for instance, asking the patient to take a deep breath). With any signs of oversedation, the system can be shut down, or it can sense oversedation and "proactively takes action, stops or reduces the delivery," Gustafson said.

"One of our focuses has been real practice and we've engaged human factor experts [in the development process]," he says. "We feel really good about SEDASYS from a human factor perspective."

Along this same line of thinking, the company will be developing a specific training program and protocols for system use as the product is under FDA review.

Without providing firm expectations, Gustafson didn't argue with a possible approval by the FDA later this year and product rollout in 2009, calling that possible timeline "reasonable." He said Ethicon Endo-Surgery has put nine years and a "significant amount of resources" — though declining to disclose the specific dollar amount — into SEDASYS development.

Price studies, Gustafson reported, are ongoing.

"It's all about the early detection and treatment of colon cancer," he said. Compliance with that type testing, he noted, is unacceptably low, at a rate

CNE/CME instructions

Physicians and nurses participate in this CNE/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. **The semester ends with this 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

- What to do when the patient doesn't have an escort
- Should you have a patient allergic to latex at your facility?
- New procedure avoids large incisions, inpatient stays
- Preparing for changes to leadership accreditation standards

of 20% to 25%, with the company hoping that use of the SEDASYS could push this to as high as 75%.

While Gustafson said that the company is hoping that standard anesthesia codes will cover use of the SEDASYS, he asserted, "There is no technology like this today." ■

CNE/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.

21. What is the position of the Society of Thoracic Surgeons concerning broadcasts of live surgery?

A. Live surgery is banned at its meeting, but no direction is offered for members regarding live surgery broadcasts to the general public.
B. Live surgery is permitted at its meeting, but members should not perform live surgery broadcasts to the general public because they may be distracted from their primary duty to the patient.
C. Live surgery is banned at its meetings, and members should not perform live surgery broadcasts to the general public because they may be distracted from their primary duty to the patient.
D. None of the above

22. Why is the anesthesiologist the best person to assess and monitor the risk of fire during surgery, according to Charles E. Cowles, MD?

A. Fire-specific training received in medical school.
B. The anesthesiologist is using items that are most likely to cause fires.
C. He or she is in best position to focus on patient and overview of all activities.
D. The Joint Commission requires the anesthesiologist to do so.

23. What aspect of their procedure is often questioned by patients during pre-op calls, according to Shonda Huggins, RN, BSN?

A. Credentials of the physician.
B. Accreditation status of the facility.
C. Type of insurance accepted by the surgery center.
D. Anesthesia.

24. What revenue-reducing occurrence is John Gleason, hoping to address with the process of "overbooking" in the surgery schedule?

A. Lack of pre-authorization by insurance companies.
B. Late arrivals of physicians.
C. No-shows on the day of surgery.
D. Patients who want to change their time of surgery when the pre-op call is made.

Answers: 21. C; 22. C; 23. D; 24. C.