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Covering Hospitals, Surgery Centers, and Offices for More than 30 Years

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IN THIS ISSUE

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Should you ban latex or latex-allergic patients? Providers weigh in on issue

How can patients with latex allergies be taken care of in a manner that keep the patients safe and you free from liability? What products will keep your staff free from allergic reactions?

In recent years, there has been a growing movement toward having latex-free or latex-safe facilities. Because of their greater exposure to latex, health care workers are significantly more likely to be sensitized or allergic. Estimates vary, but anywhere from 3% to 22% of all health care workers are sensitized to traditional latex.

A latex-safe environment means that every effort has been made to switch out items containing latex to nonlatex products, along with removing the latex allergen sources from the environment, says **Connie Jenkins**, RN, BSN, MBA, director of River View Surgery Center in Lancaster, OH. A latex-free environment simply means that all latex products have been removed or eliminated," Jenkins says. She points to latex guidelines from the Association of periOperative Registered Nurses (AORN), published in the March 2004 AORN Journal, which say, "This state is considered unattainable due to the ubiquitous nature of latex products." River View went latex-free earlier this year. Other facilities also are seeking alternatives to latex products as a way to protect latex-allergic patients and employees.

Improvements in alternatives to latex have enabled Johns Hopkins to

EXECUTIVE SUMMARY

Increasingly, outpatient surgery providers are moving toward having latex-free or latex-safe facilities.

- Form a team to complete research and look at best practices. Trial latex-free sterile and nonsterile gloves. Have carpets and the duct work cleaned.
- Many providers agree that patients with latex allergies can be handled as outpatients, with proper precautions.
- Earlier this year, the Occupational Safety and Health Administration updated its guidance on latex sensitization and latex allergy.

replace its sterile latex gloves, which still were in use in the hospital's operating rooms, says **Robert Brown**, MD, MPH, professor in the departments of environmental health sciences and anesthesiology at the Johns Hopkins School of Medicine and chair of the hospital's latex task force. In fact, Johns Hopkins has eliminated most latex. Brown estimates that 98% or 99% of the hospital's products are latex-free. Polyisoprene surgical gloves have a feel that is similar to natural rubber latex and that surgeons are more willing to accept. "It's easier than you think to be latex-safe," he says.

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Editorial Questions

Questions or comments? Call **Joy Daughtery Dickinson** at (229) 551-9195.

Norton Healthcare in Louisville, which includes a children's hospital, still uses powder-free latex surgical gloves, but otherwise seeks nonlatex products wherever possible. "I think we owe it to our employees to stay diligent on this," says **Claire Rupert**, RN, division director for value analysis and technology assessment at Norton. "The question we ask our vendors when they come in with a new product is, 'Does it contain latex?'"

Even Premier, a health care alliance and group purchasing organization based in Charlotte, NC, has published a catalog for its members listing products that are latex-free.

River View Surgery Center converted to a latex-safe environment because of increasing allergies among health care workers and the public. Reports of allergic reactions to latex have increased, Jenkins says. "In our 11 years of operation, we have had fewer than five employees develop latex sensitivity, but because latex allergies and sensitivity seems to be growing across the country, we decided to be proactive in eliminating latex products," she says.

Steps to going latex-safe

For River View, the first step was to develop a team to complete research and look at best practices. The team consisted of clinical support, administrative support, and materials management support.

"Our goal was to provide a latex-safe environment for River View Surgery Center which supports the pursuit of providing safe patient care," Jenkins says.

Next, the center developed a template to determine the appropriate action steps. "The first action step, after identifying what items in inventory contained latex, was to trial latex-free sterile and nonsterile gloves," Jenkins says.

They developed a list of supplies and began switching inventory when they reordered our supplies. "Therefore, we had little, if any, waste of inventory," Jenkins says. Synthetic surgical gloves were used as replacements.

"Our surgeons were on board with the conversion to becoming a latex-safe environment," she says. "They feel the importance of safety cannot be underestimated; therefore, they had no objection to switching gloves or any other supplies."

River View managers also had carpets and the duct work cleaned. "This was an effort to remove any latex allergens or residual latex dust in those areas that could potentially cause an airborne

RESOURCE

For more information on latex, go to:

- **American College of Allergy, Asthma and Immunology**. Web site (www.acaai.org/public/linkpages/latex.htm) contains guidelines for the management of latex allergies, information on safe latex use in health care facilities, review on reactions to latex, information on how to identify at-risk and high-risk patients, information on how to manage an allergic reaction, and guidelines for health care providers with latex allergies.

release of latex particles," Jenkins says. "We even switched our rubber bands from the brown latex brand to an orange, nonlatex rubber band." **(For opinions on whether latex-allergic patients should be handled in surgery centers, see article, right. For federal guidance on latex sensitization and latex allergy, see article, below.)** ■

FDA approves material for examination glove

The Food and Drug Administration (FDA) has cleared for marketing a device made from a new form of natural rubber latex, guayule latex. The Yulex Patient Examination Glove, made by Maricopa, AZ-based Yulex, is derived from the guayule bush, a desert plant native to the southwestern United States.

Available data on the guayule latex show that even people who are highly allergic to traditional latex do not react on first exposure to guayule latex proteins. "This approval has the potential to make a significant difference to both the general public and the medical community at large," said **Daniel Schultz**, MD, director of the FDA's Center for Devices and Radiological Health. "Gloves made from guayule latex may prove to be a safer alternative for some people with sensitivity to traditional latex, and yet they will not sacrifice the desirable properties of traditional latex such as flexibility and strength."

Because there are no data on people's long-term experience with the Yulex glove, the product will carry a warning for now about the potential for allergic reactions. The gloves' manufacturer has not yet been named. ■

Should you handle latex allergies as outpatients?

The following information is excerpted with permission from the April 2008 issue of *SAMBA Talks*, published by the Society for Ambulatory Anesthesia:

Question: I am looking for the general consensus on whether patients that have a history of true latex allergy, not just sensitivity, are acceptable outpatient surgical candidates or should they be only done as inpatients?

Answer: The precautions needed to avoid exposure to natural rubber latex are well documented in a variety of sources, including a booklet produced by the American Society of Anesthesiologists, says **Gary Kantor**, MD, of Cleveland. **(See editor's note at end of story.)** If your facility follows those guidelines, the risk of a serious allergic reaction has to be extremely low, he says.

"The only exception I can think of relates to the rare individual whose extreme latex sensitivity engenders reactions to small amounts of inhaled antigen," Kantor says.

Is your facility still using high-antigen powdered latex gloves? These gloves might be a problem for such patients, Kantor says. You would want to ban such patients or, more appropriately, switch to low-antigen powder-free latex gloves or to synthetic (neoprene) gloves that don't disperse latex antigen into the environment of the surgical suite, he says.

A thorough history should document the nature of previous allergic responses, the type of exposure that provoked the reactions, the veracity of the diagnosis, and how reactions have been treated, Kantor says. "Anaphylaxis is always a possibility in any patient undergoing anesthesia and surgery, and your center should have standard airway and resuscitative equipment and trained staff who can deal with such a reaction," he says. "In my view, if your outpatient center cannot perform this role, it probably shouldn't be doing outpatient surgery at all."

Physician would not perform surgery in office

Melinda Mingus, MD, of New York, says she would not take care of a patient with a history of latex anaphylaxis in her offices.

"While we are prepared to take care of unanticipated anaphylaxis to latex and other triggers, we would not electively treat that patient," Mingus

says. "A lot of the reason is due to postoperative concerns and what might develop after the patient is out of our care."

However, **F. Barry Florence**, MD, of Stony Brook, NY, feels strongly that latex allergy cases should be treated the same as malignant hyperthermia: "Don't expose them to the allergen, and it'll be safe to proceed," Florence says. "These cases should be treated as any other allergy."

Adam F. Dorin, MD, MBA, of San Diego has set up and managed several surgery centers for the past 15 years that always have a "latex-free" cart to cover the anesthetic and surgical needs for such patients. "I've personally done dozens of these cases myself without incident — proper supplies, open vials with wrench, [pre-treatment] with prophylactic decadron, H1 and H2 blockers, etc.," he says. "I feel that these are acceptable cases to be performed in an outpatient setting." *(Editor's note: The American Society of Anesthesiologists has a booklet titled, "Natural Rubber Latex Allergy: Considerations for Anesthesiologists." Single copies are free and can be downloaded at www.asahq.org/publicationsAndServices/latexallergy.pdf. Additional copies are $5 each.)* ■

Federal agencies address latex allergies

Earlier this year, the Occupational Safety and Health Administration (OSHA) issued an updated Safety and Health Information Bulletin on latex sensitization and latex allergy. In it, OSHA suggests the following measures to reduce health care worker exposure to latex:

- If selecting natural rubber latex gloves for employee use, designate natural rubber latex as a choice only in those situations requiring protection from infectious agents.
- If selecting natural rubber latex gloves, choose those that have lower allergenic protein content. Selecting powder-free gloves affords the additional benefit of reducing response to environmental exposure.
- Provide alternative suitable non-natural rubber latex gloves as choices for employee use and as required by OSHA's bloodborne pathogens standard [29 CFR 1910.1030, paragraph (d)(3)(iii)] for employees who are allergic to natural rubber latex gloves.

OSHA also recommends that facilities identify all products that contain natural rubber latex and monitor the natural rubber latex content of incoming products. Facilities also need a system for reporting, evaluating, and managing latex-allergy cases among employees, the bulletin says.

The Food and Drug Administration (FDA) requires labeling of medical devices that contain natural rubber latex. But keeping track of products that contain latex can be difficult, especially if the label is on the box rather than on individual items. *(Editor's note: The full bulletin is available at www.osha.gov/dts/shib/shib012808.html.)* ■

7 steps to reducing flash sterilization rate

Nationwide Children's Hospital in Columbus, OH, has reduced its rate of flash sterilization from 17% to 1.85%.

The project was featured at this year's poster presentation at the annual meeting of the Association of periOperative Registered Nurses (AORN). Earlier this year, AORN's *Standards, Recommended Practices and Guidelines* were amended to say that "flash sterilization should not be used as a substitute for sufficient instrument inventory. . . . The process may be associated with increased risk of infection to patients. This increased risk of infection may be caused by pressure on personnel to eliminate one or more steps in the cleaning and sterilization process." Surgery centers might particularly struggle with the issue of flash sterilization because

EXECUTIVE SUMMARY

Nationwide Children's Hospital in Columbus, OH, reduced its rate of flash sterilization from 17% to 1.85%.

- Inventory was increased, and one-of-a-kid instruments were custom manufactured. More general instruments were kept up sterile.
- Case scheduling was adjusted to avoid demand for one-of-a-kind instruments in back-to-back cases.
- When instruments weren't available, staff were told to obtain additional ones from other sets.
- Vendors ensured instrument sets they owned arrived 24 hours before cases.
- All instrument decontamination and sterilization was moved to central processing.
- They bought a computerized instrument tracking system.

Items Being Sterilized and Reasons

- Specialty instruments flash sterilized due to insufficient inventory: arthroscopy instruments, laparoscopy instruments, surgical drills, cannulated screw sets, etc.
- One-of-a-kind, custom-manufactured instruments flash sterilized because there was insufficient time between the cases for sterilization to be done by Central Processing Department.
- General instruments flash sterilized for convenience and time-saving purposes: scissors, forceps, needle holders, etc.
- Vendor-owned or surgeon-owned instrument sets flash sterilized because of arrival on day of surgery immediately prior to the surgical case.

Source: Timmerman RR. Reducing the rate of flash sterilization in a pediatric operating room. Poster presentation. 2008 Congress of Association of periOperative Registered Nurses.

of less equipment to substitute and limitations in central processing staff.

Flash sterilization is no longer used as a routine substitute for insufficient inventory at Nationwide Children's, according to **Roberta R. Timmerman**, RN, CPN, MSN, perioperative services education nurse specialist. Specialty and general instruments are decontaminated and sterilized in the controlled environment of the Central Processing Department, she says. Vendor-owned instruments arrive 24 hours in advance of care. Vendor-owned instruments are cleaned, packaged, and sterilized in a consistent manner by central processing.

Data were collected from 2002 to 2007 to identify overall rate of flash sterilization, rate of flash sterilization for each surgical services, items being flash sterilized, unit practices that contributed to the use of flash sterilization, and type of surgical cases that used flash-sterilized instruments (nonemergent vs. emergency/urgent surgical cases). Most cases of flash sterilization were for scheduled surgical cases, Timmerman says. **(See types of instruments being flash sterilized and reasons, above.)**

Here were the steps taken:

• Action plans were developed by specialty leaders of each surgical service that increased inventory and led to custom manufacture of one-of-a-kind instruments, such as a rongeur and scissors.

• Case scheduling practices were adjusted and relieved the demand for one-of-a-kind instruments in back-to-back scheduled cases.

• More general instruments, such as hemostats, scissors, and forceps, were kept up sterile. Central processing increased the quantity of these on the master instrument cart.

• Awareness of staff members increased so that when an instrument was needed, they would open other sufficiently inventoried sets to obtain the instruments rather than flash sterilizing.

"We increased staff's awareness when we communicated to them the quarterly results of the monitors," Timmerman says. "We showed them what was being flash sterilized and talked through our other sources of those instruments."

• Vendor agreements were established that ensured vendor-owned instrument sets arrived in-house 24 hours prior to scheduled surgery.

• Nationwide Children's discontinued the practice of decontaminating and sterilizing instruments in the OR. They transferred FTEs and responsibility for all instrument decontamination and sterilization to central processing.

• They bought a computerized instrument tracking system [Sterile Processing Microsystem (SPM)] from Materials Management Microsystems, which facilitated timely location of instruments. The cost was approximately $80,000, including hardware.

Annual competency assessment is needed for newer staff members who have had limited experience running the sterilizer. **(See how a daily planning meeting helped, below.)** ■

Daily planning limits flash sterilization

One step that helped dramatically decrease flash sterilization at Nationwide Children's Hospital in Columbus, OH, was daily planning between the OR and central processing, according to **Roberta R. Timmerman**, RN, CPN, MSN, perioperative services education nurse specialist, Nationwide Children's Hospital.

This meeting facilitated quick turnaround of limited quantity instruments, she says.

The OR charge nurse met with the charge person in central processing at the beginning of the day, Timmerman says. They would discuss, for example, how many cases would need video cameras and discuss the plan to reprocess the cameras for the day. "It was a very quick meeting, but it helped central processing plan for the current day," she says. ■

Same-Day Surgery Manager

Surgeons, staff share what they like about surgery

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

Press Ganey's report *Hospital Check-Up Report: Physician Perspectives on American Hospitals* includes a discussion of what surgeons don't like. (For information on accessing the report, see the note at the end of this column.) I thought it was a good report, but it needed some balance. I thought I would do some research on what surgeons and other staff *like!* (The glass is always half full.)

This is not a scientific study, but it is balanced between hospital outpatient departments and ambulatory surgery centers (ASCs). Here are their responses:

- ENT surgeon, hospital: "I like the fact that the staff are asking my opinion on issues before they just change things."
- Plastic surgeon, ASC: "I like the hospital better than this place." (I guess that is a positive.)
- General surgeon, hospital: "I like the way that most of the staff around here smile at me when I come into the lounge. It makes me feel at ease."
- GI surgeon, ASC: "I like that everyone helps each other around here. They all seem to understand each other's job and help each other out. It makes my day here so much nicer."
- Orthopedic surgeon, hospital: "I like it when the staff ask me if I want something before they pop it on the back table. I know that means they are being cost-effective."
- Orthopedic surgeon, ASC: "I like it when someone asks me questions about what I am doing. It shows they are taking an interest in what is happening on the field."
- Pain surgeon, hospital: "I like the smiles on the staff."
- GYN surgeon, ASC: "I like knowing what the expectations are of me. I like it when they push me to start on time. They care."
- Plastic surgeon, hospital: "I like it when people don't ask me stupid questions like this."

Since I am also an RN, I wanted to get their thoughts as well:

- RN, hospital: "I like the job security of working in a large hospital."
- RN, ASC: "I like the security of working in a for-profit environment."
- RN, hospital: "I work hard to make my patients feel good. I like that feeling."
- RN, ASC: "I enjoy working with professionals — my peers."
- RN, hospital: "I am making a difference in people's lives. Not many jobs offer that."
- RN, ASC: "l am proud of what I do. That makes me happy, and that is what I like best about this place."

I am also a CRNA, so I wanted to get feedback from them:

- CRNA, ASC: "This place has a different feel from the hospital. Not good or bad, just different. I like that."
- CRNA, hospital: "I like a challenging case. I like seeing what comes up from the emergency room. It tests my skills."
- CRNA, ASC: "I like the smiles."
- CRNA, hospital: "I like the diversity over here."

And, because I am also a Navy-trained surgical tech, I wanted to hear from them:

- Tech, hospital: "I like a case that goes smooth from start to finish with everyone happy."
- Tech, ASC: "I like having only one break room. We all hang out together."
- Tech, hospital: "I feel needed here. I like that."
- Tech, ASC: "I like the shorter cases."

In conclusion? The No. 1 factor that people across the board mentioned was working with happy people. Smiling people. People who enjoyed their job.

What makes me happy? A good cup of coffee, and a smile that lights up a room. Give your co-workers a little smile, and go have a great day. Make a difference.

(To access the Press Ganey report, go to www.pressganey.com and click on "news and notes" and then "news archive." Next to the date 07/24/08, click on "Hospital Check-Up Report: Physician Perspectives on American Hospitals Released." The hyperlink for the report is at the bottom of that page. Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of outpatient surgery development and management. Contact Earnhart at 1000 Westbank Drive, Suite 5B, Austin, TX 78746. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.) ■

ASCs: Re-examine these specialties for 2009

Ambulatory surgery centers (ASCs) should re-examine their specialty services as they enter 2009 reimbursement, which will be 50% of the hospital outpatient department (HOPD) rate, according to **Judith L. English**, vice president of business operations and partner at Surgery Consultants of America (SCA) and Serbin Surgery Center Billing, both in Fort Myers, FL. English recently presented an audio conference on 2009 reimbursement for AHC Media, publisher of *Same-Day Surgery.*

Perform case costing to determine if you want to add some specialties, she advises. "If it doesn't cover the cost now, evaluate it year after year to see if sooner or later it will give you sufficient reimbursement to include in the list of procedures you want to do," she says.

Consider the following tips from English for specific specialties. **(To order the audio conference CD, see resource box, above right.)**

• **Ear, nose, and throat (ENT).** Carefully evaluate before adding ENT cases because the equipment is expensive, especially for sinus endoscopy, English says.

• **Gastrointestinal.** Monitor block utilization. For example, you may be staffing two rooms in order to keep procedures moving quickly, but your surgeon might be using only one-third of his or her day.

• **General surgery.** General surgery sees several additions, including cardiac and vascular procedures, ancillary procedures, and office-based reimbursement for simpler procedures and lesions, English says.

• **GYN.** Evaluate the practicality of adding procedures against equipment and supply purchases, English advises. "Several procedures can be done on Medicare-age patients," she says.

• **Ophthalmology.** Consider adding or increasing retinal cases, which show an increase for 2009.

• **Orthopedics.** Perform careful case costing to determine your profit margin on these cases during the transition to HOPD reimbursement, English advises. You might need to wait until year three or four before reimbursement will be sufficient to make a profit, she suggests.

• **Pain management.** Injections and other procedures are very low cost, English says. Consider these cases if you already are offering orthopedic or spine cases, which are good referral sources, she adds.

• **Podiatry.** This is a good specialty to evaluate if you are offering orthopedic cases, because they have similar equipment and supplies, English says.

• **Urology.** "This is a sleeper," English says. Lithotripsy, brachytherapy, and prostate surgeries have increased in reimbursement for 2009, she says. "It takes special equipment, usually a special table," English says. "It's an investment, but you might want to look at it as a specialty to add." *[Editor's note: In the Sept. 5* Same-Day

RESOURCE

The CD from the audio conference "Ready, Set, Go! Preparing for the 2009 CMS Payment Systems for Ambulatory Surgery Centers" is available for purchase for $249. Call (800) 688-2421 or go to www.ahcmedia.com. Click on "products and services" and then view "By Media Type." Under "Audio Conference CDs," click on the CD title. Mention product code 10T08269.

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. 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

■ Program incorporates suggestions from patients

■ When you renovate, should you integrate?

■ Steps to integrating an electronic health record

■ How to reduce patient wait time in the PACU

Surgery Weekly Alert, *we told you about nine new non-office-based procedures that will be paid 100% for the first year. If you haven't yet signed up to receive the weekly alerts, contact customerservice@ahcmedia.com or call (800) 688-2421.]* ■

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.

13. What is a latex-safe environment, according to Connie Jenkins, RN, BSN, MBA?

A. Latex products are banned.
B. Every effort has been made to switch to nonlatex products, along with removing the latex allergen sources from the environment.
C. Latex products are used when they are considered to be the most cost-effective.

14. Earlier this year, OSHA issued an updated Safety and Health Information Bulletin on latex sensitization and latex allergy. In it, OSHA suggests which of the following measures to reduce health care worker exposure to latex?

A. If selecting natural rubber latex gloves for employee use, designate natural rubber latex as a choice only in those situations requiring protection from infectious agents.
B. If selecting natural rubber latex gloves, choose those that have lower allergenic protein content.
C. Selecting powder-free gloves affords the additional benefit of reducing response to environmental exposure.
D. All of the above

15. Earlier this year, the Association of periOperative Registered Nurses (AORN) amended its Standards, Recommended Practices and Guidelines to say:

A. Flash sterilization is safe for patients if used in moderation.
B. Flash sterilization may be associated with increased risk of infection to patients.
C. Flash sterilization is definitely associated with increased risk of infection to patients and should never be used.

16. One step that helped dramatically decrease flash sterilization at Nationwide Children's Hospital was:

A. A ban on flash sterilization except in dire circumstances.
B. Staff education.
C. Daily planning between the OR and central processing.
D. Central processing staff designated for the outpatient surgery area.

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

SDS ACCREDITATION UPDATE

Covering Compliance with The Joint Commission and AAAHC Standards

Are you prepared to address 'health care road rage'? Jan. 1 deadline is looming for TJC

The orthopedic surgeon was running late for two procedures, and there were two new nurses in the room. He became frustrated with a pair of scissors. The surgeon threw them and almost hit a nurse. His hospital requires physicians to treat colleagues with "civility and respect," so he was disciplined. The hospital required team training for all OR staff. The surgeon hasn't had another incident in the year since then.[1]

At another hospital, an orthopedic surgeon yelled at the staff over six years, including name-calling such as "lame-brain." He called one nurse an "idiot" for seeking additional patient consent before a procedure. He later threw two 10-pound sandbags to the floor, and one hit a nurse's foot. That was the ninth complaint against the surgeon, and he was suspended.[1]

It's called "health care road rage." And it not only harms staff relations, but it also has the potential to endanger patient safety.

Surveyors with The Joint Commission (TJC) regularly hear stories about offensive language, yelling, and occasional throwing of objects when they visit facilities, says **Peter Angood**, MD, vice president and chief patient safety officer for TJC. Some attribute the rise in reports to providers' frustration over increasing financial pressures.[1] Angood said many health care facilities have tolerated bad behavior to the point where it's become an accepted norm of behavior. That acceptance can be particularly prevalent in surgery, which has high stakes and attracts physicians with intense personalities who are accustomed to being in charge, some say.[1]

Joint Commission alert issued

The problem has the attention of TJC, which in July issued a *Sentinel Event Alert* addressing bad behavior. **[For more information, see "Joint Commission Sends Alert on Rude Language, Hostile Behavior," *Same-Day Surgery Weekly Alert*, July 18, 2008. If you aren't currently receiving our weekly alert, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]** By Jan. 1, TJC is requiring all hospitals and ambulatory centers to adopt a code of conduct and

EXECUTIVE SUMMARY

As of Jan. 1, all hospitals and ambulatory organizations accredited by The Joint Commission are required to adopt a code of conduct and establish a formal process for managing unacceptable behavior. Consider these suggestions:

- Ideally, the code should specify acceptable and unacceptable behaviors.
- Consider nonconfrontation interaction strategies, such as discussing problems with systems that may lead to outbursts.
- The policy should recognize that some behaviors are more serious than others and can result in termination. **(Samples of codes of conducted are included with the online version of this month's issue of *Same-Day Surgery.)***

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establishes a formal process for managing unacceptable behavior. Standards for the Accreditation Association for Ambulatory Health Care say that organizations should address appropriate behavior and expectations and disciplinary actions as a result of policy infractions.

North Shore Medical Center in Salem, MA, which disciplined the scissor-throwing physician, said in a statement, "Our commitment to civility is promoted, not merely because it creates a better working environment, but also because it creates a safer one." The hospital's Civility and Respect Policy says that, among other things, all employees are expected to refrain from using abusive language, racial slurs, threats of violence, and sexual innuendos; refrain from favoritism and criticizing staff in front of others; and communicate to others with respect and respond to requests appropriately.

"The code of conduct is meant to be one that sets the tone for respectful civil behavior in an organization," Angood says. TJC doesn't prescribe what the contents should be. "In an ideal world, it would state what unacceptable behavior won't be tolerated," he says. "It's up to the individual organization to develop and state which unacceptable behaviors won't be tolerated." **(For steps to developing a code of conduct, see story, below. For a discussion of contributing causes and strategies for bad behavior, see p. 3.)**

Reference

1. Kowalczyk L. Hospitals try to calm doctors' outbursts — Medical road rage affecting patient safety, group says. *The Boston Globe,* Aug. 10, 2008. Accessed at www.boston.com/news/local/massachusetts/articles/2008/08/10/hospitals_try_to_calm_doctors_outbursts. ■

How do you handle bad behavior by staff?

Do you have an example of bad staff behavior and how you handled it? All information will be anonymous. Contact Joy Daughtery Dickinson, Editor, *Same-Day Surgery*, at joy.dickinson@ahcmedia.com or (229) 551-9195. ■

Steps to developing a code of conduct

When developing a code of conduct and addressing inappropriate behavior, consider these suggestions from your peers:

• Define disruptive and/or inappropriate behavior.

Vanderbilt University Medical Center in Nashville, TN, says that disruptive and/or inappropriate behavior may include behavior that prevents or interferes with individual or group work, or creates an environment that is unprofessional, unsafe, intimidating, hostile, or offensive. **[A copy of the professional conduct policy is included with the online version of this issue of *Same-Day Surgery* at www.ahcmedia.com. For assistance, contact customer service at customer service@ahcmedia.com or (800) 688-2421.]**

The Vanderbilt policy says disruptive and/or inappropriate behavior may include, but isn't limited to, behavior that prevents or interferes with an individual's or group's work or academic performance, or that creates an unprofessional, unsafe, intimidating, hostile, or offensive work or academic environment or that violates the medical center's policies. Examples include:

— verbal abuse, sexual or other harassment, or threatening or intimidating words or actions;

— yelling or inappropriate language;

— threats of harm or behavior reasonably interpreted as threatening.

Spell out expectations

Massachusetts General Hospital in Boston has a "credo" document that specifies, among other things, that staff will remain calm when confronted with or responding to pressure situations; treat colleagues with dignity, respect and compassion; promote interdepartmental cooperation; recognize and encourage positive behaviors; and provide private constructive feedback for inappropriate behaviors. **(Mass General's Credo and Boundaries documents are included in the online edition of this month's *Same-Day Surgery* at www.ahcmedia.com.)**

• Outline disciplinary/corrective actions.

At Vanderbilt, corrective/disciplinary action or performance improvement counseling is initiated, depending on the facts and circumstances. Significant violations or a pattern of disruptive behavior can result in termination. The policy also says even a single instance of disruptive behavior might be sufficient for disciplinary or

corrective action, including termination.

At North Shore Medical Center in Salem, MA, not following the Civility and Respect Policy can lead to corrective actions that may include formal apology; written warning; written reprimand; report to the professional societies and/or licensing agencies; restriction of privileges; and referrals for counseling, education, or other interventions.

• Provide details on who should receive reports of disruptive behavior.

Vanderbilt's policy explains that all staff are responsible for reporting disruptive, inappropriate, or unprofessional behavior. It spells out who should be given violation reports. It also says individuals who don't believe their complaints have been resolved should report the conduct up their chain of command. It also says any retaliation should be reported.

• Include zero tolerance.

The Joint Commission (TJC) recommends, but doesn't require, that the policy have a zero-tolerance approach.

"Zero tolerance is more about having the [facility] organized in a way that says it is acceptable to report intimidating or disruptive behavior, or says [such behavior] is not accepted within the code of conduct," says **Peter Angood**, MD, vice president and chief patient safety officer for TJC.

• Recognize a range of behaviors.

Not all incidents are serious, Angood emphasizes. The code of conduct should promote desirable behaviors and clearly delineate unacceptable behaviors, recognizing that a range of behaviors occur, he says. "The reactions from an organization to any reported incidences should also have a range of actions and reactions in place," Angood says. "It's not one-size-fits-all here."

All staff members have days when, for example, they might be having personal issues and will display grumpy attitudes, he says. "If one incident happens, and it's not a reoccurring problem for an individual, the organization should not overreact," Angood says.

• Encourage nonconfrontational interaction strategies to address intimidating and disruptive behaviors.

TJC recommends such nonconfrontational strategies, Angood says. For example, an individual might exhibit mild behavior problems and be perpetually unhappy, disrespectful, and/or passive aggressive. "That type of behavior should be recognized early," he advises. Peer interaction often is best, Angood says. He says there needs to be more intense counseling and a more specifically established time frame by which an organization can expect changes, he says.

There should be a "gradation of involvement based on gradations of behavior," he says. "It should be clearly stated, and there should be an end point in the whole process."

When developing an atmosphere of professional conduct, it's not a matter of simply taking a policy from another facility, putting your logo on it, and saying, "OK. We solved the problem. We're ready for The Joint Commission," warns **Gregg Meyer**, MD, MSC, senior vice president of quality and safety at Massachusetts General Physicians Organization in Boston and Massachusetts General Hospital. "Documents alone aren't the answer," Meyer says. "It's much more than that." Your documents are only as good as the communication and culture around them, he says. "In and of themselves, they have relatively little impact," Meyer says. "When you couple development of these with engaging clinical leadership, and are mindful of the culture of the institution in terms of rolling these out and making then a part of what we do every day, that is more cohesive plan." **(For more information on unprofessional behavior, see Stephen W. Earnhart's column on "Tips on how to set limits on staff conduct,"** ***Same-Day Surgery,*** **October 2003, p. 115. Also see "Code of conduct attracts and keeps nurses,"** ***Same-Day Surgery,*** **April 2003, p. 42.)** ■

Why does surgery setting lead to more outbursts?

Consider these contributions, strategies

Surgeons are disproportionately represented in attendance at a course on disruptive behaviors offered by the Center for Professional Health at Vanderbilt University in Nashville, TN. Also, many anesthesiologists attend. Is there something about the surgery setting that can cause disruptive behavior? Or do these medical specialties attract personalities who are more prone to outbursts?

"I think that there are situations where they are expected in be in charge of a lot of people that they aren't necessarily in charge of or can control," says **William H. Swiggart**, MS, LPC/MHSP, co-director of the Center for Professional Health. The center offers one of the most extensive programs in the

nation to track and address poor staff behavior. "If something goes wrong, they're the captain of the ship; they're responsible," he says.

Sometimes physicians and others who are prone to outbursts will use the reason, "I'm doing this for patient care. I have to do this because I'm responsible for the patient," Swiggart says. "That can't be an excuse for abominable behavior," he adds.

Some staff members are lacking in people skills, Swiggart says. "To get someone to perform better, they may scream or throw something at them," he says. "That might have worked for their mentors, the people who trained them, but in this day and time, it doesn't slide."

The Center for Professional Health, among other activities, offers continuing education on maintaining proper boundaries. Vanderbilt began focusing on staff outbursts 10 years ago when administrators found that physician lawsuits often were related to patient complaints.[1]

"To get someone to perform better, they may scream or throw something at them. That might have worked for their mentors, the people who trained them, but in this day and time, it doesn't slide."
— William H. Swiggert, Center for Professional Health

'They're issues for everyone'

It's important to keep in mind, however, that nonprofessional behavior isn't solely a physician issue, says **Gregg Meyer**, MD, MSC, senior vice president of quality and safety at Massachusetts General Physicians Organization and Massachusetts General Hospital, both in Boston. "They're issues for everyone across the organization," he says.

SOURCE/RESOURCE

The Center for Professional Health at Vanderbilt Medical Center offers three CME courses, including the Program for Distressed Physicians. The three-day course includes three follow-up days over the next six months. The cost of the course is $4,000. The web site also has links to articles on the topic. For more information, contact:

- **William H. Swiggart**, MS, LPC/MHSP, Co-Director, Center for Professional Health, 1107 Oxford House, Vanderbilt University, Nashville, TN 37232-4300. Phone: (615) 936-0678. Fax: (615) 936-0676. E-mail: william.swiggart@vanderbilt.edu. Web: www.mc.vanderbilt.edu/cph.

Managers might have to address immature, offensive staff; staff who bully new staff, or other managers who belittle subordinates or ignore residents. When staff members are having repeated behavior issues, sit down with the persons individually, talk about their issues, and do problem solving to determine what you can do to resolve the issues, Swiggart advises. "Sometimes the system is creating problems," he says. For example, surgeons often complain "my cart is never right. I never get the instruments I'm supposed to."

"I tell them, 'Maybe you need to fill your own cart. Or maybe you need to talk to them 10 minutes ahead of time to say: It's important that you get my cart filled correctly,'" Swiggart says. "Systems issues don't respond well to being yelled at."

A surgeon prone to outbursts might complain that if a staff person is late with a chart at 8 a.m., it puts them behind 15 minutes and, by the end of the day, they are two hours behind. "They explode because someone doesn't bring a chart on time, but they can see the whole day crumble," Swiggart says. "They have a hard time adjusting midflight."

Encourage time to relax

Encouraging an atmosphere in which it's acceptable to relax for a few minutes can be helpful, he says. Also, a time out or a briefing before starting a procedure can be useful, Swiggart says. In a briefing, everyone on staff typically introduces themselves, and the staff discuss the surgery they are about to perform. "The briefing is a way of saying, 'We're in this together; I need your help.' And they get some support before they go in." **(For more on the pre-surgery briefing, see "Expand your mandated pre-procedure timeout to enhance patient safety efforts in the OR," *SDS Accreditation Update* supplement, April 2007 *Same-Day Surgery*.)**

Reference

1. Kowalczyk L. Hospitals try to calm doctors' outbursts — Medical road rage affecting patient safety, group says. *The Boston Globe,* Aug. 10, 2008. Accessed at www.boston.com/news/local/massachusetts/articles/2008/08/10/hospitals_try_to_calm_doctors_outbursts. ■

Professional Conduct, OP 30-10.13

manual:	Operations Policy Manual
categories	Human Resources
section:	none listed
review responsibility:	Operations Policy Committee
effective date:	June, 2006
last revised date:	June, 2006
team members performing:	All faculty and staff, VUSN students, VUSM students
guidelines applicable to:	VUH, VMG *, VCH, PHV, VUSM, VUSN Exceptions: none listed (*VMG includes satellite sites unless otherwise noted)
specific education requirements:	none listed
Physician Order requirements:	none listed

Professional Conduct

I. Outcome Goal:

To establish expectations for appropriate behavior, to foster professional behavior, and promote a positive workplace environment. Each School of Medicine and School of Nursing faculty member, House staff, all other staff, and medical and nursing students (collectively "Healthcare Professionals") have a responsibility to create and protect this environment.

II. Policy:

Vanderbilt University Medical Center (VUMC) desires an environment free from disruptive, threatening, and violent behavior, and does not tolerate inappropriate, unprofessional, or intimidating behavior within the workplace. All persons, including patients, visitors, staff, and faculty are treated with courtesy, respect, and dignity. All Healthcare Professionals who practice at or in affiliation with VUMC conduct themselves in a professional, collaborative, and cooperative manner consistent with the Faculty Manual, Medical Staff Bylaws, Nursing Bylaws, House staff Manual, Human Resources policies, the Vanderbilt University School of Medicine Compact Between Teachers and Learners, and other applicable Vanderbilt policies and procedures.

III. Definition:

A. **Disruptive and/or inappropriate behavior** may include but is not limited to behavior that prevents or interferes with an individual's or group's work or academic performance, or that creates an unprofessional, unsafe, intimidating, hostile or offensive work or academic environment or that violates Vanderbilt or VUMC policies. For example:

1. Verbal abuse, sexual or other harassment, or threatening or intimidating words or actions;
2. Yelling or inappropriate language; or
3. Threats of harm or behavior reasonably interpreted as threatening.

B. **Disciplinary/Corrective Actions:** Corrective action/disciplinary action/performance improvement counseling for "disruptive behavior" is initiated in accordance with the appropriate Vanderbilt and VUMC policies and procedures depending on the specific facts and circumstances. Significant violations or a pattern of disruptive behavior may result in serious action, up to and including termination. A single instance of disruptive behavior may be sufficient to merit disciplinary or corrective action, including termination.

IV. Specific Information:

A. Each VUMC faculty, House staff, staff or affiliated individual is responsible for reporting disruptive, inappropriate, or unprofessional behavior as soon as it is feasible to the appropriate person or office.

B. Process:

1. Faculty violations
    a. Immediately report all faculty violations that appear to involve discrimination, retaliation, or sexual/other harassment to the Vanderbilt University Opportunity Development Center (ODC). (See Web References.)
    b. Report all other faculty violations to one or more of the following individuals depending on the specific circumstances:
        i. The appropriate Chief Medical Officer or the Chief of Staff;

ii. The Chair of the Department(s) involved; the appropriate Chief of Service;

iii. The Dean of the School of Medicine or the Dean of the School of Nursing;

iv. The Chair of the Medical Center Medical Board; or

v. The faculty member's supervisor, who will report it to one of the individuals above.

vi. Staff may also report violations by faculty to Employee Relations, which refers the complaint to one of the individuals listed in (i-iv) above for appropriate corrective action.

2. House staff Violations

   a. Immediately report all house staff violations that appear to involve discrimination, retaliation, or sexual/other harassment to the ODC.

   b. Report other House staff violations to one or more of the following individuals depending on the specific circumstances:

      i. Associate Dean for Graduate Medical Education/Office of Graduate Medical Education;

      ii. House staff's Program Director; or;

      iii. Staff may also report violations by House staff to Employee Relations, which refers the complaint to one of the individuals listed in (i or ii) above for appropriate corrective action.

3. Staff Violations

   a. Immediately report all staff violations that appear to involve discrimination, retaliation, or sexual/other harassment to the ODC.

   b. Report all other staff violations to one or more of the following individuals depending on the specific circumstances:

      i. Chief Nursing Officer (if applicable);

      ii. Staff member's supervisor; or

iii. Staff may also report violations by other staff to Employee Relations, who shall refer the complaint to one of the individuals listed in (i or ii) above for appropriate corrective action. Staff conduct, behavior and discipline are governed by Human Resources policies as referenced below.

4. Individuals who do not believe their complaints have been resolved report the disruptive conduct up their chain of command. Report any complaint of retaliation to the ODC.
5. **Patient Complaints** – Refer patients who report complaints of disruptive behavior to the Office of Patient Affairs. The Office of Patient Affairs notifies the appropriate person/office in accordance with this policy.
6. **Reports to Risk Management** – Immediately report instances of disruptive behavior with the potential to result in potential claims to the Office of Risk and Insurance Management.
7. **Reports to Vanderbilt University Police Department VUPD** – Immediately report to VUPD any actions which pose or appear to pose an immediate threat of harm to any individual in order to safeguard the health and safety of others.

V. Web References:

Office of Human Resources Policies & Procedures. Retrieved July 11, 2006.
HR-001 Equal Opportunity and Affirmative Action Policy
HR-002 Anti-Harassment Policy
HR-014 Performance Improvement Counseling (PIC)
HR-015 Discharge Policy
HR-020 Administrative Leave Policy
HR-022 Dispute Resolution Policy
HR-025 Electronic Communication Policy
HR-026 Attendance and Punctuality Policy
HR-027 Work Place Violence
HR-031 Smoking and Tobacco Products in the Workplace Policy
HR-033 Relationships in the Workplace
HR-035 Substance Abuse

HR-039 Solicitation Policy

Vanderbilt University. Retrieved July 11, 2006.
Office of Compliance. Standards of Conduct.
Opportunity Development Center.
Faculty Manual. Disciplinary Actions, Standards of Conduct/Procedures.
House Staff Manual.
School of Medicine Compact Between Teachers and Learners (portal).

VUMC Policies. Retrieved July 11, 2006.
MS 01 Bylaws of the Medical Staff of Vanderbilt University Medical Center. Articles III, X, and XI.

Clinical Policy Manual
CL 20-01 VUMC Guiding Statements

Operations Policy Manual
OP 10-10.25 Service Recovery
OP 30-10.02 Hospital/Clinic Staff/Faculty Conflict of Interest
OP 30-10.03 Primary Source Verification/Reverification
OP 30-10.04 Alcohol and Drug Use
OP 50-10.01 Procurement of Supplies and Equipment
OP 50-10.02 Vendor Representatives, Faculty/Staff Relationship

Safety Policy Manual
SA 10-10.06 VUMC Response to Disruptive or Dangerous Individuals

VI. Endorsement:
Operations Policy Committee – March 2006

VII. Approval:

Kevin B. Churchwell, MD, Chief of Staff, VCH 5/26/06
Colleen Conway-Welch, PhD, RN, Dean, School of Nursing 5/23/06
Marilyn Dubree, Director, Patient Care Services & Chief Nursing Officer 6/09/06
Steve Gabbe, MD, Dean, School of Medicine 5/24/06
Larry Goldberg, Executive Director & CEO, VUH 5/23/06

Allen B. Kaiser, MD, Chief of Staff, VUH 5/04/06
Fred Kirchner, MD, Associate Dean for Graduate Medical Education 6/05/06
C. Wright Pinson, MD, VMG Chief Medical Officer 5/23/06
James E. Shmerling, Executive Director & CEO, VCH 5/26/06

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MGH Credo 2007

MASSACHUSETTS GENERAL HOSPITAL

MASSACHUSETTS GENERAL PHYSICIANS ORGANIZATION

As a member of the MGH community and in service of our mission, I believe that:

- The first priority at MGH is the well-being of our patients, and all our work, including research, teaching and improving the health of the community, should contribute to that goal.
- Our primary focus is to give the highest quality of care to each patient delivered in a culturally sensitive, compassionate and respectful manner.
- My colleagues and I are MGH's greatest assets.
- Teamwork and clear communication are essential to providing exceptional care.

As a member of the MGH community and in service of our mission, I will:

- Listen and respond to patients, patients' families, my colleagues and community members.
- Ensure that the MGH is safe, accessible, clean and welcoming to everyone.
- Share my successes and errors with my colleagues so we can all learn from one another.
- Waste no one's time.
- Make wise use of the hospital's human, financial and environmental resources.
- Be accountable for my actions.
- Uphold professional and ethical standards.

MGH Boundaries 2007

As a member of the MGH community and in service of our mission, I will never:

- Recklessly ignore MGH policies and procedures.
- Criticize or take action against any member of the MGH community raising or reporting a safety concern.
- Speak or act disrespectfully toward anyone.
- Engage in or tolerate abusive behaviors.
- Look up or discuss private information about patients or staff for any purpose outside of my specified job responsibilities.
- Work while impaired by any substance or condition that compromises my ability to function safely and competently.
- Optional, depending on use:

Signature Print Name Date

Source: Massachusetts General Hospital, Boston.