Words of wisdom: OR leaders offer tips for new managers

Surgical services is endowed with a large number of senior nurse leaders. The average age of perioperative nursing managers and directors is 55, and on average, they have been in nursing 30.5 years, according to the 2012 OR Manager Salary/Career Survey. Nearly half plan to retire by 2020.

As ORs plan for succession, OR Manager asked experienced leaders to reflect on principles and practices that have served them well over the years. Some common characteristics of a good leader include authenticity, honesty, and integrity—traits that successful leaders in any field share. What’s unique about successful perioperative managers is their ability to balance the demands of all OR team players in a way that ensures the best possible care for their patients.

We hope this shared wisdom will help readers who are newer to a management role to follow in the footsteps of those who have led long, successful careers.

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Three-part strategy suggested to improve patient throughput

Efficient throughput—difficult to achieve, yet essential to long-term financial success—is a Holy Grail for OR nurse leaders, who spend much time and energy seeking it. Given all the demands of their role, how can leaders best use their time to gain the most benefit from throughput initiatives? One method is to focus on communication—the underlying component of any successful throughput effort.

But leaders need to narrow the broad topic of communication to be most effective. “You have to pick something specific to work on,” says Randy Heiser, MA, president and CEO of Sullivan Healthcare Consulting, Inc, in Ann Arbor, Michigan. “Too many people try to do everything at once.”

Three strategies to improve communication are building trust, implementing technology, and using checklists effectively.

Trust
In the frenetic perioperative environment, it’s easy to forget the basic principle that good communication depends on trust. “The only way I’ve found to build trust is to hold everyone accountable

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Data on inpatient and outpatient hospital charges released in May and June by the Centers for Medicare and Medicaid Services (CMS) have fueled the fire started in March with Steven Brill’s Time magazine cover story, “Bitter Pill: Why Medical Bills Are Killing Us.” Brill cited sometimes staggering amounts charged for items such as acetaminophen or chest x-rays, and the CMS data found significant pricing discrepancies among the more than 3,000 hospitals and 30 hospital outpatient charges examined.

Reports like those from CMS reflect the Obama administration’s efforts to improve transparency of prices for health services and thus help consumers make more informed decisions. But some researchers argue that the information available isn’t really useful.

In a study of 62 publicly available state websites with price information, researchers at the VA Center for Clinical Management Research and the University of Michigan found that most sites reported billed charges but did not show what patients were expected to pay. CMS’s Hospital Compare website (www.medicare.gov/hospitalcompare) has been offering information since 2005, and other websites have emerged in the past decade, but “we’re still not reporting the key information patients need to maximize the value of their health care spending,” said lead author Jeffrey T. Kullgren, MD, MS, MPH. He and his colleagues recommend reporting allowable charges for full episodes of care (ie, including facility, professional, and other fees).

One website cited as a positive example is the New Hampshire HealthCost website (www.nhhealthcost.org), which gives patients an estimate of their health care costs at facilities in their community based on their health insurance plan. OpsCost (www.opscost.com), a new website that compares what hospitals billed Medicare vs what Medicare paid for certain procedures at various locations, had some 15,000 visitors during its first week, says co-founder George Kalogeropoulos.

Others are jumping on the bandwagon: The Arizona state health department recently announced the launch of an online hospital comparison tool that’s based on 2011 discharge information (www.azdhs.gov/plan/crr/crrreports/az-hospital-compare.htm), and the Robert Wood Johnson Foundation (www.rwjf.org) has planned a competition for web developers to build digital products to facilitate comparisons for consumers.

With the proliferation of websites and other tools designed to enhance comparison shopping, there will be ever greater pressure on hospitals to make pricing information publicly available. This is no small feat, as evidenced by this month’s revenue cycle column (see p 24) on coding and charge capture—a complex and laborious process. As if it’s not daunting enough to understand your own hospital’s pricing structures, you also have to think about how those costs are measured against what other hospitals are charging.

Elizbeth Wood

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Surviving a disaster: Nurses recall Moore’s fierce tornado

It had been a busy morning in the OR at Moore Medical Center in Moore, Oklahoma, on May 20. By 3 pm, the surgery patients had left the postanesthesia care unit (PACU) and gone home. PACU nurses Debra Breshears, RN, and Barbra Barrow, RN, were getting ready to leave when they heard an alert that a tornado was in Newcastle, some 12 miles away.

“We could see on the television how big the tornado was and that the hospital was directly in its path,” Breshears told OR Manager. Breshears called the nurses on the second floor medical-surgical (med-surg) unit to see if they needed additional stretchers or wheelchairs to move patients to a safe area in the emergency department (ED) on the first floor. The nurses said they had enough.

As Breshears and Barrow arrived at the safe area, the med-surg nurses were bringing in the last of the patients.

“What we didn’t realize until then was that between 250 and 300 people from the community were coming into the hospital for shelter,” says Breshears. They were being directed to the cafeteria.

Dire warning

“Watching the television in the ED, we could see the tornado coming closer and closer to the hospital,” says Breshears. Then the news broadcaster announced that if people in the path of the tornado were not below ground, they would not survive.

They began discussing what they could do to protect themselves. They gathered blankets and pillows. Breshears ran to the PACU for flashlights, and she could hear debris hitting the building when she got back to the safe area.

Just before the tornado hit, an ED nurse announced, “there are 40 of us in here,” says Breshears. “It was his way of telling us that if we were buried in rubble, and someone was pulled out alive, we could tell rescuers how many had been in the safe area,” she says.

“We all lay flat on the floor and covered ourselves and the patients with blankets and pillows, and we prayed,” says Breshears.

When the tornado hit, it was extremely loud, with huge blasts and sounds of ripping metal, and every alarm in the hospital went off. The pressure made everyone’s ears pop, and it was hard to breathe.

“Just when we thought we couldn’t stand it any longer, it stopped,” says Breshears. Everyone was afraid to move at first. The room was pitch black.

Breshears turned on her flashlight and stood up. Then others stood up. “Then we all hugged each other,” she says.

Treacherous trek

As Breshears walked out of the safe area and shined her flashlight, she saw people from the community walking from the cafeteria toward the ORs, each one hanging onto and following the person in front of them. There was total darkness, and no one knew where they were going.

When Breshears told them there was no exit in the direction they were headed, a man said, “you have a flashlight; show us where to go.”

Breshears took the lead. As she shined her flashlight around, she could see wires, sharp objects, and glass everywhere.

“I would go forward a few feet and then turn and shine the flashlight behind me so the people could come toward me, and I kept repeating this as we inched our way forward trying to find a way out,” she says.

But every time she led them to an area where she knew there was

Continued on page 12
I’ve been in perioperative nursing for 40 years, and in spite of how much we think things change, many things really do remain the same.

Every surgical nurse leader should focus on these constants; I use them more now than I did as a new manager (when I didn’t think I had the time):

- **Relationships with your surgeons:** Know your surgeons and their volume. Seek and implement some of their ideas. Remember: without surgeons, you have no surgery program! You have to learn to work closely with the anesthesia team, but it is the surgeons who bring the patients to you. The whole surgical team needs to understand this simple business fact.

- **Relationships with your colleagues:** Find a “best friend” at work, someone to whom you can vent and with whom you can test ideas and get advice, even if this person is in another department. Get to know other managers and department heads; you cannot survive on an island by yourself, no matter how tempting it is. You will need their help, and they will need yours. This collaboration is how work gets done right the first time. Be a systems thinker; every decision you make affects someone downstream.

- **Technology:** Push your information system and your IT department to the limit. Stop any manual data capture that could be done by a system. Move your organization toward data-based decision making.

- **Take risks and stay educated:** Do your homework and stay connected to operations. Network through whatever medium you prefer; read everything you can get your hands on. It is OK to use the ideas of others; get over the notion that your hospital is somehow different. Build a vision, and sell it to your team. Don’t be afraid to ask for help.

—Jayne Byrd, MSN, RN, is vice president, surgical services, at Rex Hospital, Raleigh, North Carolina, part of the UNC Healthcare System.

**Human resources**

### Tips for new managers

Continued from page 1

At your first staff meeting, outline your expectations. It will be easier for staff to live up to them if they know what they are. This should be done in a nonthreatening and friendly way. For example, these are some expectations I have used with staff:

- Provide a safe environment for patients.
- Know and uphold your nursing practice standards.
- Work for the hours you are paid.
- Treat each other with respect.
- If you come to me with a problem, have at least one possible solution so I know you have given it thought.
- If you’ve come up from the ranks, don’t play favorites with staff friends. Above all, be fair and consistent in your decisions regarding policy, your staff, and your physician groups.
- Be sure to stay visible and available to staff and physicians. Keep an open-door policy.

- Ensure patient safety by knowing and implementing practice standards and best practices. Stay current by reading and attending educational events.

- When faced with problems you are unsure how to solve, seek out the solution. Don’t profess to “know it all.” It’s OK to say “I don’t know, but I will find out.” Build a treasure trove of resources that you can tap into. Give credit to those who helped you.

- It’s easy to get caught up in management meetings, budget planning, and hospital committees. Be true to yourself. Keep a good work-life balance. Know when to say “no” to serving on another hospital committee or joining a leadership group.

- Let go of the things over which you have no control.

—Kathleen F. Miller, MS, RN, LNC, CNOR (retired), lives in Rockford, Illinois. Miller’s OR management career extended from 1987 through 2012. She served as OR Manager consulting editor, as a member of the OR Manager Advisory Board, and as a member of the planning committee for the OR Manager Conference.

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Jayne Byrd, MSN, RN

Kathleen F. Miller, MS, RN, LNC, CNOR (retired)
I believe being an effective leader in this increasingly challenging regulatory, economic, and clinical environment requires establishing a vision with appropriate goals, implementing effective strategies and practices, and accurately measuring outcomes from a clinical, regulatory, and economic perspective.

A leader must recognize that exceptional outcomes are not the result of one person but of the team of people involved in patient care. It is important as a leader to engage stakeholders in a shared vision, establish relationships, and acknowledge the contributions of the team. To be successful, one must be visible to experience the patient environment and abilities of the team, able to recognize what is and is not working, and willing to make changes to improve patient care.

—Lisa Morrissey, MBA, RN, is associate chief nurse, perioperative services, at Brigham and Women’s Hospital, Boston.

Being an OR manager can be challenging and rewarding. As a staff nurse, your job was to directly take care of the patients that you served. As an OR manager, you are still taking care of patients—through the staff that you serve. In my career as an OR nurse and 25 years in OR management, I found that there are many skills a manager has to learn, such as constructing a budget, writing performance appraisals, writing policies, and developing a business plan. These skills can be learned, but they are not what will make you a great leader.

The most important trait to be a successful OR manager is to be an authentic leader. If you are not, you are always walking around in someone else’s clothes. To be authentic, you cannot be afraid to look deep within yourself and to be comfortable with the person you are. Continual self-evaluation is essential for your personal growth.

In addition to authenticity, you need to have integrity. This is critical as you foster relationships with physicians and staff. Integrity and honesty must not be compromised; if they are, relationships will quickly be damaged.

When I was younger and someone would ask me what my leadership style was, I would always say it was participatory. There is not one style that fits all situations, and you need to alter your style for the group and the situation. One of the greatest improvements I have seen in my career is the practice of working in multidisciplinary teams. Caring for patients has become so complex that no one individual can know all of the answers. Foster this concept, and value each individual’s knowledge and contribution.

There will be many times in your career when you will be criticized by staff, anesthesia providers, surgeons, and administration. This can be demoralizing. You need to listen and take whatever part of that criticism that you own, and if improvements are needed, work on them. Let the rest of it go because it is not your issue—it is someone else’s.

Never forget that the main focus of your position is the patient. You will be busy, and there will not be enough hours in the day to accomplish everything. Schedule time every day to be with patients. This can be accomplished by providing scrub or circulating reliefs, talking to patients in the preoperative or postanesthesia care units, or visiting with family members in the surgical waiting room. Not only will the staff and physicians appreciate this, but it can help ground you and feed your soul. Make every decision with the patient as the center of focus, and you will never make a bad decision.

The demands of your role can be overwhelming. Work-life balance is critical for you to have the energy to be an effective leader. What this means will be different for every person. By practicing this yourself, you are a role model for others to follow, helping to create a healthy work environment for your department.

—Mary Murphy, BSN, RN, CNOR (retired), served as the director of surgical services at Munson Medical Center, Traverse City, Michigan. After retiring from Munson Medical Center, Traverse City, Michigan. After retiring from Munson Medical Center, Traverse City, Michigan.
I have been fortunate to serve in senior leadership in perioperative services in all types of facilities, including university settings, community hospitals, and for-profit and not-for-profit facilities. What I have learned has served me well, and I hope will serve as a guide for others:

- Always base your decision on what is right for the patient. This will result in what is best for the patient, and your decision will be solid and defensible.
- Live by your values and rules. Walk the talk in all situations, demonstrating to staff and physicians your integrity and what you believe to be the patient’s best interests.
- When in doubt, don’t. If you are uncomfortable in your gut, take no action. As a director, I made a serious mistake by not listening to my intuition.
- Take time to make your decisions. Think through the pros and cons. Be sure you can live with your decision.
- Set high expectations for your staff and leaders. Communicate in writing and orally. Staff members like to be challenged and usually rise to the occasion.
- Integrity and relationships are the 2 most important factors in your success as a leader. Build relationships with other senior leaders beyond the OR doors. When introducing a change or an initiative requiring support from surgeons, do your politicking outside of the meeting room. Have lunch or meet with them in their office to introduce them to the initiative you need their support for, and tell them why you need it.
- Develop time management skills that maximize your productivity. You need to be available to staff and physicians but not at the cost of your schedule. Manage your schedule and stick to it.
- Develop relationships with peers outside of nursing. They have a different business perspective that can be invaluable.
- Promote your departmental activities to the rest of the hospital. Take every opportunity to let people know what is going on behind the doors of the OR.
- Never surprise your boss. Always keep your superiors in the loop about personnel, physician, and operational changes. This way, any differences can be worked out between the 2 of you, and the boss will have your back.
- One of the best ways to increase business is to develop relationships with surgeons’ office managers and schedulers. A quarterly breakfast to introduce my staff and to hear their concerns had a significant impact. A box of cookies to each surgeon’s office was also appreciated.
- Document all encounters with staff. I always kept duplicate chronological notes and wrote a summary of what an employee and I discussed—both positive and negative. We both signed the form, and they left with their copy.
- When making a change with staff, plant the seeds about the change and then form a sub-taskforce to develop recommendations for how the change might be implemented.
- Always follow through on what you have committed. Failure to do so will result in loss of credibility and respect.
- Tell people what you need and want. If they don’t know, there is no way they can help you.
- Encourage your staff to attain their next higher level of education—BSN, MSN, or MS.
- Encourage staff to sit for the CNOR exam. When they have successfully completed it, they will have a stronger self-image of themselves as perioperative nurses.
- Celebrate the success of all certified staff with a wall of excellence containing their pictures and a plate indicating their certification and date achieved.
- Provide cookies for office staff at special occasions like secretaries week.
- Support and be active in your professional association, AORN. Staff will listen and follow your lead.
- Balance work and home life. If you are not energized and recharged, it is difficult to give to others.

—Beverly A. Peratino, MS, RN, CNOR, a perioperative leader for 25 years, is president of Surgical Services Solutions in Greeley, Colorado.

I have been a nurse for 43 years, and I spent many of those years in management. I have found that the ability to be authentic has served me well in all areas of practice. First, you must be honest 100% of the time and be true to yourself, making sure that your actions match your words.
Performance improvement

Patient throughput

Continued from page 1

for doing their job,” says Heiser. Otherwise, staff will waste time checking the work of others. For instance, if an OR circulating nurse discovers the preoperative area nurse hasn’t ensured the patient’s most recent lab work is in the medical record, the circulator will feel the need to check for this with every patient. “You create an environment where the circulator does everything the preop nurse was supposed to do, adding as much as 15 minutes to the case,” Heiser says.

Another way to create trust is to bring departments closer together by rotating staff. “Have a circulator in the OR spend 1 day every 3 or 4 weeks in the preoperative area, or have surgical techs spend a day in instrument processing,” Heiser suggests. This low-cost initiative encourages team members to identify ways to ease the work of others. For example, a surgical technologist may realize he can easily organize used instruments in a way that speeds cleaning.

Using the team specialty model can also build trust. You might choose to have a core group of preoperative nurses focus on orthopedic patients. These nurses can then work with orthopedic OR staff, creating a longitudinal team. “Use the team concept in the PACU [postanesthesia care unit], preop, and instrument processing,” says Heiser, adding that instead of having all sterile processing technicians work on all instruments, subspecialties such as orthopedics should be created to further build connections across departments.

The challenge of these types of initiatives is that it can take more time to manage staff. “Now I have to be sure to schedule people to fit the service they work on,” says Heiser. “It can create a scheduling nightmare.” Yet the additional time invested in these efforts can pay off in improved throughput—and better patient outcomes.

One way to minimize scheduling challenges is to be sure everyone is competent in procedures that are done on an “on-call” basis, so specialization doesn’t extend to this area. Heiser points out that the number of on-call procedures is limited.

A final, yet vital, advantage of holding people accountable is that, Heiser says, “You can more easily see where the system is broken.”

Technology

Technology can be a useful tool for improving throughput. Matthew Boles, MD, MSc, interim clinical leader for surgical services at Salem Hospital in Salem, Oregon, says the hospital uses large computer monitors in the OR, preoperative area, special processing department (SPD), and PACU to provide staff, managers, and physicians with “real-time data on how we are doing with various metrics.” For example, by 8:30 am, everyone knows which ORs started on time. Those in ORs with low turnover times can claim “bragging rights” at the end of the day for a job well done.

“It’s fun for everyone to see the data in real time,” says Dr Boles. “We can express appreciation and

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Kathy Shaneberger,
MSN, RN, CNOR

Those with whom you interact need to be confident that what they are seeing in you is what they are also getting from you.

The authentic leader empowers others to have and to share ideas. That leader also recognizes others publicly when ideas are implemented and found to be worthwhile. An authentic leader should never take credit for someone else’s work.

It is important to respect others’ personalities, needs, and wants. This principle has served me well over the years, especially in my interactions with physicians. I’ve found that surgeons, in particular, mostly want to be heard and have their wants and needs acknowledged—even if the end result of pursuing their wants and needs is not favorable in their eyes.

And, finally, always assume that the intent of others is to do good and to do their best job. This is especially true in the service role we play as health care professionals.

Because our profession engages in the art and science of caring, we thrive when we experience caring from our colleagues. So my best advice is to be authentic in all interactions—both with others and with yourself.

—Kathy Shaneberger, MSN, RN, CNOR, is director, surgical services, at Holland Hospital in Holland, Michigan.

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Nothing happens without strong leaders.
Performance improvement

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Salem Hospital has taken checklists to new heights, using them at key points in time—during scheduling, the day before surgery, and the day of surgery.

“We have robust presurgical screening,” Dr Boles says. Physician office staff must complete a checklist and fax it to the scheduling department before they can schedule a case (see checklist on p 11). He says getting office staff to use the checklist “was a hard sell. We let them know that getting the information in a standardized fashion lets them use their block time more efficiently.” It also helps reduce the likelihood of cancellation because of failing to obtain insurance preauthorization. “We gave office staff input into the development process so they would feel ownership,” adds Dr Boles.

Each day, key stakeholders, including representatives from “every area where the patient will be touched,” meet in a “huddle” and use a checklist to focus on the next day’s cases. “It’s one last time to make sure all our i’s are dotted and all our t’s are crossed,” Dr Boles says. The 15-point checklist covers critical areas such as whether a patient is a Jehovah’s Witness and whether blood is ordered.

On the day of surgery, nurses in the preoperative areas complete a checklist on the computer and use a handoff tool for communicating with the anesthesiologist and OR staff. Staff in the OR use 3 main time-out checklists:

• Preinduction. The circulator and the anesthesiologist complete this checklist, which includes the patient’s American Society of Anesthesiologists score and critical information such as whether suction is available.
  • Immediately before the incision, which includes site identification.
  • At the end of the case, but before the patient leaves the room, which includes blood loss and any anticipated problems.

To encourage participation, Dr Boles says OR leaders involved surgeons in the decision process and added a surgeon champion. Noting the value of humor, he adds, “We also did a funny video to launch the last revision of the checklist.”

Heiser recommends that staff sign checklists so they can be held accountable. If during the time-out, for example, it’s discovered that a laboratory report is missing, the circulator must speak up and then contact the staff member who signed the checklist. “You only have to do that once or twice before it takes hold,” he says. Keeping track of problems can also help identify larger issues. For example, if the OR is always waiting for someone to check an ECG, perhaps a change in process is needed.

Checklists are also embedded in perioperative services at Jefferson University Hospital in Philadelphia. The hospital system, which consists of 58 ORs in 3 hospitals and a surgicenter and performs about 35,000 cases each year, collaborated with the Joint Commission Center for Transforming Health Care to audit their procedures related to preventing wrong-site surgery.

An audit in which consultants observed the use of a surgical checklist in the OR found that although staff were compliant in using the checklist, “there was a wide range of how people were doing the process despite receiving training,” says Monica Young.
DNP, MBA, RN, CNOR, vice president of perioperative services. She adds that it’s important to “watch people live to see if they are doing what you want them to do. Often that is where you fall short.” A 2013 study of 107 OR staff supports Young’s point: It found a “lack of rigor” when it came to applying the surgical checklist.

In response to the findings, Young identified a core group of about 8 people who used the checklist correctly and had them serve as trainers during cases. For 1 month, the trainers, who included charge nurses, managers, and a physician, watched the time-out and modeled the appropriate behavior when the process wasn’t conducted according to set standards. “They were third parties who could correct behavior without having to then be in the room all day with those whom they had corrected,” says Young.

Young adds that the audit also found that “nursing was carrying too much of the responsibility for the checklist.” Surgeons, anesthesiologists, and nurses had to learn their specific responsibilities based on their roles.

Other best practices
At Jefferson, the staff in the holding area and the anesthesiologist implemented a handoff communication tool to ensure needed information was in the patient’s medical record. The tool decreased the number of times information was missing and “both staff and anesthesia felt it promoted a meaningful dialogue and made communication more structured,” says Young.

The team also holds a “mapping” meeting each day at 1 pm to discuss the next day’s schedule. Attendees include Young; managers for the OR, SPD, preadmission testing, and holding area; and the nurse specialty team supervisors. Before the mapping meeting, staff in preadmission testing enter missing information into a database and run a report that the team reviews. The team addresses problems such as missing consents or laboratory test results and discusses other factors such as needed equipment and staff experience with complicated procedures.

Leadership commitment
As with most change in the OR, nothing can happen without strong leadership.

“When communication works well, jobs get easier, but you need an effective governance structure to make good communication happen,” says Heiser. He adds that such a structure “starts at the top. You need strong surgeon, executive, and nursing leadership and commitment.” The structure should focus on the right outcomes, including quality care, improved customer service, and increased case volume. Heiser suggests that with every decision leaders ask themselves, “How will this decision contribute to these 3 goals?”

He adds that leaders should establish the metrics to be measured and evaluated so that “people aren’t working on their own metrics.”

Of course, involving the right people is key. “If we get all the stakeholders together, that’s when we succeed,” Dr Boles says. ❖

—Cynthia Saver, MS, RN

Cynthia Saver, a freelance writer, is president, CLS Development, Inc, Columbia, Maryland.

Reference
a way out, the way was blocked.

A little girl started crying. She was scared and barefoot. Breshears told a man who was holding her hand to pick her up and hold her close but not to raise her up higher than him. Then she shined the light up higher so he could see the wires hanging down. At the time they didn’t know if any of the wires were live or not.

Finally, they could see daylight down a hallway. The light was coming from a 2 ½-foot hole in the wall. Breshears told them to crawl through the hole and run from the building as fast as they could. The smell of natural gas was overwhelming in this area, making it even harder to breathe and fueling fear that the building might blow up.

Outside, there was more danger. Everyone had to run around mangled, compressed cars that were hissing like they might explode.

In the end, however, all of the people from the community got out safely, as did the patients and their care givers.

Moving patients
While Breshears was leading the townspeople out, the other nurses in the safe area made their way with the patients to a back loading dock, notes Kelly Wells, the media relations coordinator for the Norman Regional Health System.

They had to roll patients over debris. If they got stuck, they would help patients stand up and lift the chairs over the debris, and then the patients would sit back down and they would keep going. The loading dock was the only place where the ambulances could get to the patients.

The safe area the patients were in was about 50 yards from the closest outside entrance, but everyone had to go about 150 yards to get out because all of the entrances were blocked with cars that had been flung up against the building by the tornado, says Wells.

Patients were taken to 2 other hospitals in the Health System—Norman Regional Hospital or HealthPlex—and some went home.

Lessons learned
“Going forward, there is a lot we can learn from this,” says Breshears.

Hospitals should have a tornado disaster cart with flashlights, masks, and whistles in their safe areas. “Masks would have been a big help [in] finding our way through the dust created by the debris. Whistles would have been invaluable if we had been buried in the debris. We totally expected to be dug out,” she says.

Breshears is now working in the PACU at Norman Regional Hospital, about 8 miles from Moore. Norman Regional Health System is working to find jobs for all of the 200 staff members who were at Moore.

Moore Medical Center was deemed a “total loss” by structural engineers and insurance adjusters. Demolition of the building began on June 25. Plans are underway to determine what type of facility Norman Regional Health System will rebuild in Moore.

—Judith M. Mathias, MA, RN

Human resources

Surviving a disaster
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The 45-bed Moore Medical Center in Moore, Oklahoma, was destroyed by an EF-5 tornado on May 20. Courtesy of Norman Regional Health System Media Services Department.

Human resources

Surviving a disaster
Continued from page 5

The 45-bed Moore Medical Center in Moore, Oklahoma, was destroyed by an EF-5 tornado on May 20. Courtesy of Norman Regional Health System Media Services Department.
## OR Manager Conference at a Glance

### Monday, September 23

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<th>Time</th>
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| 8:30 a.m. – 3:00 p.m. | **Preconference Seminars:**  
- Hone Your Leadership Skills for Turbulent Times  
- The Joint Commission’s Latest Facts  
- Safer Surgery: Ten Elements for Safer Patient Care  
- Don’t Become Tomorrow’s News Headline  
- Energizing Your Life and Career with Purpose, Protocol, & Passion  
- Driving Culture Change: A Lean Daily Management System  
- Meeting Today’s Regulatory and Operational Demands in the ASC  
- Reacting or Preparing for ACA and Health Care Reform: Strategies for Proactive Perioperative Leaders  
- Kick-Off to CCI Certificate Program for Surgical Services Management |
| 3:30 p.m. – 4:00 p.m. | **CE Program:** Catching the Waterworks: Hysteroscopic Fluid Management  
Presented by: Thermidx |
| 3:30 p.m. – 4:00 p.m. | **CE Program:** What Did You Say? 5 Keys to Effective Communication  
Presented by: STERIS |
| 4:30 p.m. – 6:00 p.m. | **Keynote Address:** Creating a Culture of Safety — Marty Makary, MD, MPH |
| 6:00 p.m. – 8:00 p.m. | Harborfest Reception in the Exhibit Hall |

### Tuesday, September 24

<table>
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<tr>
<th>Time</th>
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| 7:00 a.m. – 8:00 a.m. | Continental Breakfast and Presentation  
Sponsored by: ECOLAB |
| 8:00 a.m. – 9:15 a.m. | **General Session:** The Golden Age of Nursing — Kathleen Sanford, DBA, RN, CENP, FACHE |
| 9:15 a.m. – 9:45 a.m. | **CE Program:** Catching the Waterworks: Hysteroscopic Fluid Management  
Presented by: Thermidx |
| 9:30 a.m. – 10:00 a.m. | **CE Program:** What Did You Say? 5 Keys to Effective Communication  
Presented by: STERIS |
| 10:45 a.m. – 12:00 p.m. | **Concurrent Breakout Sessions:**  
- Ten Technologies Leaders Should Keep Their Eyes On  
- Preoperative Guidelines for the Geriatric Surgical Patient  
- Managing Add-on Cases in Perioperative Services  
- Electronic Surgical Scheduling Improves Patient Safety and Productivity  
- Improving Surgical Outcomes: A College Structure for Specialty Teams  
- Collaboration REQUIRED: Cardiovascular Services Present and Future  
- When OSHA Comes Calling: Preparing for an Unannounced Visit  
- Structuring Charges in the EHR Era |
| 12:00 p.m. – 12:45 p.m. | OR Manager of the Year Award Presentation and Luncheon |
| 1:30 p.m. – 2:00 p.m. | **CE Program:** What Did You Say? 5 Keys to Effective Communication  
Presented by: STERIS |
| 2:00 p.m. – 3:15 p.m. | **Concurrent Breakout Sessions:**  
- A Culture of Safety: Gaining Buy-in Across Multiple Hospitals  
- Electronic Etiquette: Managing Electronic Distraction in the OR  
- Project Management at the Front Line of Perioperative Services  
- Turning Around a Troubled Unit  
- Promoting a Healthy Work Environment: Zero Tolerance for Lateral Violence  
- Preoperative Preparation: Creating an Effective Program  
- Greening the Ambulatory Surgery Center  
- Product Trials and Product Conversions in a GPO World |
| 3:15 p.m. – 4:30 p.m. | Afternoon Break  
Sponsored by: MTF Healthcare |
| 3:30 p.m. – 4:00 p.m. | **CE Program:** What Did You Say? 5 Keys to Effective Communication  
Presented by: STERIS |
| 4:30 p.m. – 5:30 p.m. | **General Session:** Leading a Multigenerational Perioperative Workforce — Rose O. Sherman, RN, NEA-BC, FAAN |

### Wednesday, September 25

<table>
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<th>Time</th>
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| 8:00 a.m. – 9:15 a.m. | **Concurrent Breakout Sessions:**  
- It is the Outcome that Counts! Surgical Site Infection Reduction Initiative  
- Taming Distractions and Interruptions in the OR  
- Successfully Growing a RNFA Program  
- Looking Out for the Staff's Mental Well-Being  
- Reprocessing Medical Devices: The Role of the Perioperative Nurse  
- Perioperative Practice: Rating the Evidence  
- A Creative Path to Organizing the Sterile Processing Area |
| 9:30 a.m. – 10:45 a.m. | **Concurrent Breakout Sessions:**  
- Surgical Unit-based Safety Program: Improving Patient Safety at the Front Lines  
- Managing Implants: Successful Approaches  
- Managing Labor Productivity in the OR  
- OR Efficiency Made Easy  
- Scheduling Integration for Maximizing OR Efficiency  
- Health Care Reform: The Perioperative Perspective  
- Implementing the Surgical Checklist in an ASC  
- Compliance for the OR Revenue Cycle |
| 11:15 a.m. – 12:15 p.m. | **General Session:** Time-Out! Creating Your Own Checklist for Success — Vicki Hess, MS, RN, CSP |
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Preconference Seminars that dive deep (way deep!) for a full understanding into the topic you choose

Keynote Address with Marty Makary, MD, MPH, author of Unaccountable – Creating a Culture of Safety

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The Golden Age of Nursing with Kathleen Sanford, DBA, RN, CENP, FACHE

Leading a Multigenerational Perioperative Workforce with Rose O. Sherman, RN, NEA-BC, FAAN

Time-Out! Creating Your Own Checklist for Success with Vicki Hess, MS, RN, CSP

Celebrate our first ever Harborfest! Filled with festive food and drink inspired by the 2013 OR Manager Conference location

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OR Business Management Track

Understand how to effectively manage the finances of your OR by learning from leading industry experts.

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- Structuring Charges in the EHR Era
- Product Trials and Product Conversions in a GPO World
- A Creative Path to Organizing the Sterile Processing Area
- Compliance for the OR Revenue Cycle

New OR Manager Track

Perfect for the new OR manager — this enlightening track will help put you on the path to success with seasoned OR managers to guide you.

Sessions include:
- Preconference Seminar: A Dialogue with Sages of Perioperative Management
- Successfully Growing an RNFA Program
- Managing Labor Productivity in the OR
- Managing Add-on Cases in Perioperative Services
- Project Management at the Front Line of Perioperative Services

Ambulatory Surgery Centers (ASC) Track

Focusing on the particular needs and situations of managing an ASC, this track delivers detailed educational sessions on how to run a successful ASC.

Sessions include:
- Preconference Seminar: Meeting Today’s Regulatory and Operational Demands in the ASC
- When OSHA Comes Calling: Preparing for an Unannounced Visit
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2. SELECT YOUR PACKAGE

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<tr>
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Proper safety precautions will minimize dangers posed by lasers

Despite their benefits, lasers pose risks no matter where they are used. Lasers expose patients and staff to hazards that can injure, disable, or kill. Patients have been severely burned by laser-ignited fires, health care staff members have been harmed by misdirected laser beams, and service personnel have been electrocuted while working within the laser’s enclosure.

Health care facilities that perform laser procedures must have a comprehensive laser safety program in place to address safe equipment operation, proper use of protective equipment, fire prevention, education and training of laser operators and support staff, and credentialing of physicians who perform laser-based procedures.

Laser hazard classification and oversight
Many organizations, regulators, and standards bodies rely on the laser hazard classification system developed by the American National Standards Institute (ANSI) in its American National Standard for Safe Use of Lasers (ANSI Z136.1).

The US Food and Drug Administration (FDA) uses ANSI’s laser hazard classification system to require various manufacturers’ safety features and warning labels based on the laser’s class (21 CFR § 1040.10).

The Occupational Safety and Health Administration (OSHA) regulates the safe use of lasers in the workplace. While OSHA does not have a specific standard for lasers, the agency can cite organizations for failure to provide safe working conditions for staff operating lasers under its General Duty Clause, which requires employers to provide a safe workplace environment “free from recognized hazards” (29 USC § 654[a][1]; OSHA).

ANSI’s American National Standard for Safe Use of Lasers in Health Care Facilities is the recognized standard for laser safety in hospitals and other health care settings (Andersen). The AORN Perioperative Standards and Recommended Practices also provides recommendations for keeping patients and users safe when lasers are in use in the perioperative setting (AORN).

Health and safety risks
Eye injuries and flashback
Because the retina has no nerve endings and can’t sense pain, harmful exposure from a laser may go undetected until considerable damage is done. Many eye injuries occur because the eye protection used is inappropriate; everyone in the laser treatment area, including the patient, must wear protective eyewear with appropriate filtering capabilities, optical density, and side shields.

Protective eyewear recommendations vary depending on the wavelength and power density of the laser energy in use. ANSI’s and AORN’s standards provide specific guidance on eye protection. Additionally, the laser supplier can advise on proper eyewear selection. Personnel must check the wavelength and optical density printed on the eyewear to confirm its appropriateness before each procedure. To minimize confusion, some facilities match the laser and appropriate safety eyewear by color coding the laser handpiece and eyewear (Bader and Lui). It is also important to inspect the laser safety eyewear before each use; a crack in the lens may allow light to be transmitted directly to the eye.

ANSI and AORN recommend that health care staff involved in laser procedures have an eye exam at the start of employment to establish a baseline level of visual performance against which damage can be assessed in the event of a laser accident. Examinations should be performed routinely during all accident investigations in which laser exposure is suspected.

To eliminate the risk of flashback (unintentional reflection of the laser beam), a thorough examination of the laser procedure area must be conducted to identify reflective surfaces, materials, and instruments that are present. All reflective materials or surfaces should be replaced, modified, or covered. AORN’s standard recommends that only anodized, dull, nonreflective, or matte-finished instruments be used near the laser site.

Continued on page 18
Limit the laser output to the Z136.3; AORN; ECRI Institute): lasers are highlighted below (ANSI to minimize the risk of fires from (ECRI Institute). Specific measures annually, about 10% involve lasers that occur in health care facilities estimated 550 to 650 surgical fires mon, but they do happen. Of the Fires in ANSI’s and AORN’s standards. plume control are also addressed evacuation and room suction sys- tems. Measures for smoke and plume control are also addressed in ANSI’s and AORN’s standards. Fires Fires caused by lasers are uncom- mon, but they do happen. Of the estimated 550 to 650 surgical fires that occur in health care facilities annually, about 10% involve lasers (ECRI Institute). Specific measures to minimize the risk of fires from lasers are highlighted below (ANSI Z136.3; AORN; ECRI Institute):

- Limit the laser output to the lowest clinically acceptable power density and pulse dura-
tion.
- Test the laser on a safe surface before starting the surgical pro-
cedure to ensure that the beams are aligned.
- Place the laser in standby mode whenever it is not in active use.
- Activate the laser only when the tip or aiming beam is in direct view.
- Never clamp laser fibers to drapes; clamping can break the fibers.
- When performing laser surgery through an endoscope, pass the laser fiber through the en-
doscope before introducing the scope into the patient. Verify the fiber’s functionality before inserting the scope into the pa-
tient.
- During lower airway surgery, keep the laser fiber tip in view and make sure it is clear of the end of the bronchoscope or tracheal tube before laser emission.
- Use a laser backstop, if possible, to reduce the likelihood of tissue injury distal to the surgical site.
- Use appropriate laser-resistant tracheal tubes during upper air-
way surgery. Follow all direc-
tions in the product literature and on the labels.
- Place moistened gauze or sponges next to the tracheal tube cuff to protect the tube from laser damage, and keep the gauze or sponges moist.
- Consider using towels soaked in saline or sterile water around the operative site to minimize the risk of igniting the towels, as long as this will not compro-
mise aseptic technique for the procedure.

Extreme caution is necessary when a laser is used during sur-
gery in the airway or on the head, face, neck, or upper chest.

**Laser plume**

The plume of smoke produced by a laser when it interacts with tissue has an acrid smell and contains potential health hazards. At high concentrations, the smoke plume can cause ocular and upper respira-
tory tract irritation and can inter-
fer with the visibility of the surgi-
cal site. Analysis of airborne con-
taminants has shown that the laser plume contains gas and vapors, dead and living cellular material, and viruses (National Institute for Occupational Safety and Health, NIOSH). As the laser destroys human tissue, it creates an aerosol with mutagenic and carcinogenic properties that may be capable of disease transmission (Bigony).

NIOSH recommends control-
lining airborne contaminants with ventilation techniques using gen-
eral room and local exhaust ven-
tilation, such as portable smoke evacuators and room suction sys-
tems. Measures for smoke and plume control are also addressed in ANSI’s and AORN’s standards.

**Fires**

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mise aseptic technique for the procedure.

Extreme caution is necessary when a laser is used during sur-
gery in the airway or on the head, face, neck, or upper chest.

**Airway fires.** A laser beam or a piece of heated material on a stand-
ard tracheal tube in an oxygen-
enriched atmosphere can produce an intense fire in and around the tube, which can cause extensive and life-threatening injury to a patient’s air passages and lungs.

While laser safety guidelines recommend that laser-resistant tra-
cheal tubes (LRTTs) be used dur-
ing laser procedures, no LRTT is completely safe from all types of laser energy under all conditions during surgery. The manufactur-
er’s specifications usually define the conditions under which the tube supposedly will not ignite. Inflatable cuffs at the distal end of tracheal tubes should also be con-
idered. The cuff is not usually laser resistant because it must in-
flate and conform to the trachea.

**Fire response.** When any signs of a fire are present, the surgical team should halt the proce-
dure and, if a fire is confirmed, announce that there is a fire, stop the flow of gases to the patient, remove burning materials from the patient, and care for the pa-
tient. Water or saline solution for quenching flames should be im-
mediately available to the team.

Although fire extinguishers should not be the first choice, they may be needed in the extremely rare instance in which a fire is extensive and continues to burn on the patient, involves materials that continue to burn after being removed from the patient, or in-
volves equipment in the treat-
ment area. ECRI Institute and the American Society of Anesthesiolo-
gists recommend CO2 extinguish-
ers for use in the OR and other surgical settings. Staff training in the use of fire extinguishers is es-
tential in all settings.

At the first sign of an airway fire, the surgical team should im-
nediately disconnect the breath-
ing circuit from the tracheal tube and remove the tube, remove cuff-protective devices and any segments of burned tube, pour saline or water into the airway to ensure that any remaining em-
ers are extinguished and to cool the tissues, reestablish the airway,
and resume ventilating with air until nothing is left burning, then switch to 100% oxygen. ECRI Institute provides 2 posters to remind staff about surgical fire prevention and response steps; they are available at https://www.ecri.org/Surgical_Fires.

**Minimizing the risks**

**Laser safety program**

The most common deficiency of health care facilities that use lasers is the failure to establish a laser safety program with clear policies and procedures as well as oversight by a laser safety officer (Stanton). Both ANSI’s and AORN’s standards outline the components of the program as follows:

- **Support the multidisciplinary laser safety committee and enforce policies and procedures for laser use.**
- **Name a laser safety officer responsible for laser safety program oversight and for the evaluation and control of laser hazards (ANSI Z136.3).**
- **Comply with criteria and authorization procedures for all personnel working in the laser nominal hazard zone.**
- **Educate and train personnel on laser hazards and measures to control them.**
- **Manage and report adverse events related to laser procedures to the risk manager.**

**Area and equipment controls**

Lasers should be used only in controlled areas. Appropriate protective eyewear should be clearly marked and readily available outside the laser treatment room so laser team members can don the eyewear before entering the room. Entryways and windows in the laser use area must be covered with nonreflective material that prevents excessive laser energy from escaping the room. Doors to the laser treatment area must remain closed when a laser is in use, and signage should be posted (ANSI Z136.3).

FDA requirements for medical lasers include protective housing, automatic shutoff of the laser beam when the protective housing is opened, key control to activate the laser system, emergency shutoff buttons, and signals to alert staff to the activation of the laser beam (21 CFR § 1040.10). Health care facilities should also adopt procedures to prevent the inadvertent activation of a laser beam (AORN).

**Staff training and qualifications**

The responsibility for operating the laser system and monitoring its safe use should be limited to approved, trained individuals (typically physicians, laser safety nurses, and technicians).

The physician seeking privileges for laser use should demonstrate completion of a basic training program on the principles of lasers, their instrumentation and physiological effects, and safety requirements, as well as training for the specific wavelength laser to be used during the particular procedure. The American Society for Laser Medicine and Surgery Inc. (ASLMS) has developed broad guidelines for credentialing for laser use (ASLMS Standards). Safety training should be tailored to the various groups, such as laser safety nurses and technicians who will be operating the system. All training activities should be documented and maintained in personnel files.

**Policies and procedures**

Working with the laser safety officer, OR managers should ensure policies and procedures are in place.

**Documentation.** The perioperative record should include type of laser used; laser setting and parameters; safety measures implemented during laser use; on/off laser activation and de-activation times for head, neck, and chest procedures; and patient protection provided (eg, eyewear). AORN recommends that the facility maintain a laser log in addition to the perioperative documentation. This log should include patient information; procedure performed; laser type, model, and serial numbers; staff present; laser team members’ use of protective eyewear; number of joules used; and total energy and wattage used (AORN; Andersen).

Laser safety standards also recommend that facilities use a laser safety checklist as a guide for clinical staff to ensure that safe practices are followed before, during, and after a laser procedure. Completion of the laser safety checklist should be noted in the laser log.

**Event reporting.** OR managers can help educate the laser safety team about the importance of reporting adverse events, near misses, or unsafe conditions involving a laser. The team should understand the need to impound a laser and any other equipment involved in an event and to leave the laser’s control settings untouched. In many health care facilities, the OR manager will work closely with the risk manager and the laser safety officer to investigate incidents and identify measures to prevent their recurrence.

**References**


American National Standards Institute.

Continued on page 20
American Society for Laser Medicine and Surgery Inc.
Collaborate with surgeons and vendors to control high-end supply costs

Surgical supplies are a major component of OR expenses. In the July issue of OR Manager, we showed how controlling spending on low- and mid-priced supplies can reduce overall costs. High-priced supplies and equipment represent an even greater cost control opportunity.

Savings targets vary by specialty. In orthopedic surgery, joint replacement hardware typically makes up 50% to 70% of total procedure costs. That figure rises to 90% for many spine procedures. Even general surgery can generate high expenses. Biologic grafts used in hernia repair can cost $10,000 or more per procedure. Many high-cost operations are the strong revenue drivers that underpin OR financial performance. For these procedures, controlling supply costs is critical to maintaining profitability.

Vendor prices are not set in stone.

There is no single strategy for reducing spending on high-priced surgical supplies and equipment. Bringing these costs in line requires a multipronged approach.

Gain surgeon cooperation

In any effort to control OR costs, surgeon preference is the 800-pound gorilla. Surgeons rightly take a strong interest in the clinical performance of key supplies, but supply preferences can lead to unsustainable variation in procedure costs. OR leaders need to engage surgeons in the goal of cost containment.

One effective strategy is to publish cost-per-case dashboards. Use the materials management information system to identify average supply costs per surgeon for key procedures. Create a bar chart that plots procedure costs for the entire department (see chart on p 22). To preserve anonymity, identify individual surgeons by a private letter code. Present the dashboards at surgical staff meetings, and post them within the OR.

Cost dashboards educate surgeons about their individual supply spending and help them understand how they compare to their peers. This creates positive competition among surgeons to perform well on costs. It also lays the groundwork for a productive dialogue with surgeons on supply preferences. Are cost variations justified? Can surgeons adopt lower-priced items that offer the same clinical benefits? Cost dashboards roll up all procedure expenses, so they can be used to frame discussions about the whole range of supplies, from low-cost sutures to the most expensive surgical hardware.

Some hospitals have successfully used incentives to engage surgeons in cost control. One option is to give surgeons a portion of any dollars saved through supply cost reductions. Another is to ask them to lead service line operations under a Management Service Agreement (MSA). Building a revenue-sharing clause into the MSA will give surgeons a direct incentive to reduce preference costs.

Control new product entry

As you begin working to reduce spending on existing preference items, you should also take steps to control the entry of new products into the OR. Managing the point of entry is the best way to keep unjustifiably expensive items out of your department.

The first priority is to create a Value Analysis Committee (VAC) to evaluate all new products presented by vendors or requested by surgeons. The purpose of the committee is to assess the clinical and financial impact of new surgical supplies and technologies. In many cases, the VAC will find that the benefits in clinical outcomes and efficiency offered by a new product balance any cost increase. In other instances, a product will represent increased costs with no gain in utility.

The most successful VACs report to a surgical services executive committee (SSEC), and that sponsorship ensures strong surgeon involvement. If you have trouble recruiting surgeon volunteers, consider engaging a third-party value analysis group to fulfill the VAC role until a fully functioning committee can be formed in-house.

For the most expensive products and technologies, perform a complete cost-benefit analysis (CBA) to understand the total financial impact (see chart on p 23). A thorough CBA can help protect against expensive purchasing mistakes and can serve as a business plan to help ensure optimal return.
on a costly equipment investment. Some new products are difficult to evaluate or offer only a marginal benefit. In these cases, request that the vendor agree to a 45-day, no-cost “evaluation agreement.” Evaluation agreements allow products into the department on a trial basis to enable staff to assess any potential benefits.

Work with vendors
Vendor representatives provide a valuable service by educating providers about new options in supplies and materials. However, they also exert steady pressure on surgeon preference and new product entry. Surgical services directors need to minimize vendor influence within the department.

Begin by developing a vendor management system with clear policies:
• Require product registration. Require vendors to register all new products with the materials management department. Create a written policy stating that any product not preregistered will be considered a donation from the vendor.
• Forbid drop-ins. Require vendors to have an appointment when visiting the hospital, sign in with materials management, and wear an ID badge while on site.
• Create a designated vendor meeting space. Tell vendors they are not allowed in the surgeons’ lounge except by physician invitation.
• Flag vendors in the OR. In the surgery suite, require vendors to wear different-colored scrubs or bonnets. Tell them they must announce the cost of an implant to the entire OR staff when they are placing it on the sterile field.

Doing so will make surgeons more aware of the differences in price among preference items.

Negotiate
OR leaders should be proactive in managing vendor negotiations. Surgical services directors often take vendor price structures as a given. In fact, vendor prices are not set in stone, and the flexibility in pricing can be surprising.

First, do your homework. Talk with peers at other organizations to understand what other hospitals are being charged for orthopedic implants and other high-end supplies. Hospitals that are part of a health system can often get detailed price and volume data from sister facilities. In addition, identify your own costs and payment per procedure. Knowing your own bottom line will bolster your efforts in the negotiation room.

Next, consolidate vendors as much as possible. This strategy was discussed in last month’s OR Business Performance column on low-cost supplies, and it applies to high-dollar items as well. We analyzed implant prices paid throughout a large US health system. One vendor sold uncoated knee implants to 10 hospitals within the system, but just 3 hospitals accounted for 65% of sales. From a vendor point of view, hospital ORs that deliver high volume are extremely important to net revenue. The more market share you can commit to a vendor, the more leverage you will have in negotiating price.

Several negotiation strategies have been used effectively:
• Establish ceiling prices. Use price benchmarks and internal cost data to establish the price your OR is willing to pay for various products. Many organizations should not be content with paying the average price. At the system noted above, the best price on porous stem/ceramic head hip implants differed from the average price by 32%. Negotiating the lowest available rate would save the system more than $2,100 per procedure.
• Institute a bidding process.

Use dashboard reports to educate surgeons about supply costs. In the example above, bars plot the total supply cost (hardware plus variable and fixed supplies) of total knee replacement surgery per provider. The line shows each surgeon’s annual volume for the procedure. In this example, the surgeons who “spend” the most on supplies are not the ones who bring in the most volume. In fact, bringing the 3 highest-cost surgeons in line with Surgeon E (the volume leader) would yield total annual supply cost savings of $127,800 on this procedure alone.
**OR Business Performance**

**Cost-Benefit Analysis: Key Questions**

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<th>Revenue impact</th>
<th>Other benefits</th>
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<tr>
<td>What is the unit cost of the product?</td>
<td>What impact will the product have on payment? (Medicare, managed care, etc.)</td>
<td>How will the product impact operating times and staffing? (Time or labor savings can justify higher supply costs.)</td>
</tr>
<tr>
<td>How does the cost compare to existing options?</td>
<td>Is the product FDA-approved? How would any “off label” use affect payment?</td>
<td>How does the product affect downstream costs? (Reducing complications, LOS, or readmissions may justify higher up-front spending, but ask the vendor for published studies.)</td>
</tr>
<tr>
<td>For equipment, what are the expected maintenance or service contract costs?</td>
<td>Will the product drive new case volume? (Competitive analysis required.)</td>
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Choose three vendors (based on overall price/product performance) and invite them to bid on select product categories. Evaluate bids in collaboration with the VAC. In some cases, a vendor’s offer will meet your price ceiling, but it may include older implant products that may not meet surgeon expectations. Counter by focusing on your hospital’s potential commitment of volume.

- Enforce price caps. In some instances, an ultimatum may be necessary. Use your peer research to establish a capitated price on like items in key high-cost categories. Explain your move to hospital leadership and surgeons, and then set an effective date for the price caps. Having a strong SSEC will ensure that physicians and administrators maintain a “common front” on price caps.

The combination of price caps, vendor competition, and volume commitments usually enables you to get better prices from implant vendors.

**Contain inventory**

Orthopedic implants and other high-priced surgical supplies can have a big impact on inventory costs. If these inventories are not managed well, carrying costs can skyrocket. Large implant inventories pose additional risks. Product expiration, obsolescence, and changes in surgeon preference can leave an OR with unwanted and/or unusable hardware.

Make it a priority to reduce existing inventories of surgical implants and other high-priced supplies. Use the materials management information system (or your annual inventory report) to identify large inventories and slow-turn products. Halt reorders, if necessary, and work directly with surgeons to consciously “spend down” high inventories. If your hospital is part of a larger health system, consider offering excess hardware to sister facilities at cost to get the inventory off your books. Sometimes you can negotiate a vendor “take back” in exchange for credit toward new purchases. Vendors will resist this option, but negotiation leverage can prevail—especially in situations where vendor pressure and tactics are to blame for high inventories in the first place.

Going forward, make it a policy to hold as much product as possible on consignment. All new vendor negotiations should include this option, and often you can renegotiate existing agreements to maximize consignment opportunities. New product entry is the perfect time to put a consignment strategy into place. However, sometimes you can work with vendors to convert existing inventory to consignment. Again, successfully using organizational leverage is the key to negotiation success.

**Coming up**

Implementing these strategies to reduce supply costs will yield significant spending reductions. The next opportunity is labor spending. In the September “OR Business Performance” column, we will outline several techniques for effectively managing labor costs. Learn how to use planning, budgeting, and schedule management to control labor expenses while minimizing staff turnover and increasing staff satisfaction.

This column is written by the perioperative services experts at Surgical Directions (www.surgicaldirections.com) to offer advice on how to grow revenue, control costs, and increase department profitability.
Diligence in coding and charge capture will help prevent revenue loss

With the evolving nature of health care regulations, accurately capturing revenue can be a challenging process for all hospitals. At the OR Business Managers Workshop in April, key concepts about hospital billing, coding, and reimbursement were clarified by revenue expert Keith Siddel, JD, MBA, an attorney with HBL Concepts LLC, Creede, Colorado.

Here are some of his take-home points.

Get off to a good start
The revenue cycle begins as soon as first contact with the patient is made. About 40% of the information needed on a health care bill should be collected before admission and when a patient enters the hospital, but many hospitals fail to gather all of the information at that time. This sets the stage for increased length of time to bill the claim denials and reduced patient satisfaction.

Know which part of Medicare applies
With 10,000 individuals turning 65 years old each day, the number of patients covered by Medicare is growing significantly. Medicare coverage amounts differ according to the type of care provided.

Medicare Part A—which covers inpatient care, specialized nursing care, home care, and hospice care—is what most patients think of when they think about Medicare. Although qualifying for most patients over 65 is free, patients must still pay a deductible per benefit period, and if they remain in the hospital too long, they must begin to pay a coinsurance daily.

Medicare pays the hospital under a medical severity diagnosis-related group (MS-DRG), which is based on the patient’s condition and severity of illness.

Under Medicare Part B, which covers outpatients, patients pay both a premium and a deductible. For most services, Medicare pays 80% of a Medicare-approved amount and the patient pays 20%. Many of the new policies under the Affordable Care Act are aimed at improving Medicare Part B’s coverage of preventive health care procedures. The recent growth of patients in observation in the hospital has had a direct impact on the patients because observation is considered an outpatient status.

Medicare Part C operates much like a health maintenance organization; it is essentially a company that is paid by Medicare to negotiate with providers on behalf of the patient and ultimately ends up paying the bills.

Medicare Part D covers prescriptions. Generally, a patient who is eligible for Part A or B is also eligible for D. Insurance options for D are available once a year, and the coverage offered by D has a gap built into it called the “donut hole,” where coverage drops off for a certain period and picks up again after the patient has paid a certain amount.

Understand the charge master
The charge master is a list of all items that are billable to a patient or the patient’s payer. Becoming familiar with the charge master and its features is essential because all charges originate from the charge master.

The average charge master has approximately 10,000 line items, of which there are 10 key elements:

- Revenue code—general categories that tell the payer the area from which the charge originates.
- Department number—an indication of who is responsible for entering the charge.
- Charge master number—the unique number assigned to each item/service that allows proper capturing of the charge.
- Description—a method for the hospital and patient to identify the charge based on a description of the item.
- Fee—the gross charge amount for that item before any discounts or adjustments are applied.
- HCPCS (Healthcare Common Procedure Coding System) codes—codes that correspond to certain procedures or services. Level 1 is the American Medical Association’s current procedural terminology (CPT) codes. Level 2 codes are alphanumeric and indicate nonphysician services. Anything that the Centers for Medicare and Medicaid
Services (CMS) wants to track that isn’t a procedure, such as prosthetics or ambulance usage, goes here.

- Effective date—when the charge becomes effective.
- Department name
- Billing description—many charge masters have two descriptions—one for the patient, which is used on the bill, and one for the caregiver to quickly identify the charge.
- General ledger—this tells the hospital where the revenue is to be assigned in the accounting system.

**Structure OR charges appropriately**

Once an OR charge is identified and assigned appropriate coding and pricing, it must be structured in a way that allows CMS to properly verify and process the charges. There are typically 5 main categories of charges in most hospitals.

- Room—any room maintained by the hospital, whether it be staffing, supplies, or procedural space, is accounted for in 1 form or another. It is important to identify what makes the room unique and price it accordingly, even when bundling the charge.
- Personnel—the number of people in the room, length of time, their skill level, and corresponding cost. Staff costs are bundled, but accurately identifying the cost before bundling is key.
- Equipment—while most equipment cannot be billed separately, it is important to have a mechanism to accurately assign appropriate costs to each patient.
- Supplies—Structuring charges for supplies has a series of terms that must be known in order to correctly determine how items are charged. You should also use a flow chart to make sure the supply item is correctly categorized.

“Charge” simply means that the item or drug has a line item in the charge master and goes on the patient’s bill. It does not necessarily mean the hospital gets paid for it.

“Nonchargeable” means the item or service cannot be separately charged and cannot be placed on the patient’s bill.

“To bill or report” means an item is placed on the bill, but it could be bundled with other items.

“To separately bill or report” means the item has its own line item.

“To package” means to bundle a number of items into 1 charge.

“Integral” means that if a procedure cannot be performed without that particular item, it is integral to the procedure and should be bundled.

“Separately payable” means the hospital receives a separate payment for the item.

- Pharmaceuticals—CMS pays for drugs and biologicals that do not have a pass-through status, either through a package payment into the APC (Ambulatory Payment Classification) or a separate payment for individual APCs. If the cost of a drug for 1 day is low enough, the cost is packaged into another APC payment. If the cost is high enough, it will be paid separately. The current threshold for a packaged or separate charge is $80. Less than that amount means that the charge will be packaged, and more than that means it will be separate. For drugs that are above the $80 threshold, hospitals receive the average sale price of the drug plus 6%.

The success of the OR in producing a solid revenue stream and managing costs is often the bellwether of the hospital’s success. Low margins, unmanaged costs, and inaccurate revenue capture can spell trouble for the department and ultimately the hospital. For this reason, it is incumbent on the OR staff to understand the underlying principles of the revenue cycle, charge capture, compliance, and the payment systems. The more versed the team is in these areas, the more quickly they can alert management to potential problems or opportunities. As payers transition from the old model of paying for whatever was performed to paying for outcomes, the importance of the accuracy of each claim and medical record is exponentially increased.

If you haven’t examined your charge structure, verified your coding, examined your costs, scrutinized your payers’ reimbursement methodologies, and considered your revenue outcomes, you are likely leaving revenue on the table. While it may not be evident now, this lack of focus will ultimately show up on the bottom line.

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**Have a question on the revenue cycle?**

Keith Siddel will respond to questions in the column. Send your questions to Elizabeth Wood, editor, at ewood@accessintel.com.

Siddel can be reached at ksiddel@hblconcepts.com.
Use of the World Health Organization’s surgical safety checklist has reduced surgical complications and mortality, but a narrow escape after a checklist failure at an Italian hospital suggests that more vigilant efforts are needed to avoid errors.

In August 2012, an 81-year-old patient with vascular dementia was brought to the OR at G. Fracastoro Hospital, San Bonifacio (Verona), Italy, for left carotid artery surgery, as indicated on the sign-in sheet when his surgery was scheduled.

In the preoperative area, the anesthetist obtained the patient’s consent, confirmed the surgical site, and asked a colleague to perform an ultrasound-guided cervical plexus block of the left carotid artery because he was not skilled in this technique. The surgeon was absent from the preoperative area while the anesthesia was being given.

During the time-out prior to surgery, however, the surgeon realized that surgery should be performed on the right carotid artery, not the left. The patient was given general anesthesia, and the procedure was performed on the right carotid artery. Afterward, the patient was admitted to the ICU for postoperative monitoring for 24 hours.

How errors creep in
The incident is an example of the “Swiss cheese” model of failure, in which slices of cheese represent barriers against organizational failure and the holes in the cheese slices indicate weaknesses in individual parts of the system. The system as a whole fails when the holes in each slice momentarily align, allowing an error to creep into the defenses designed to protect against failure.

In the carotid case, the holes were as follows:
- The side was listed incorrectly on the initial scheduling sheet.
- The nurse on the patient unit indicated the wrong side (perpetuating the error from the scheduled list instead of double-checking with the surgeon, as should be done in unclear or ambiguous cases).
- The front page of the medical record stated “right occlusion, left stenosis,” which was unclear.
- Two anesthetists were involved in the procedure.
- The patient’s dementia prevented him from recognizing the error.
- The surgeon was not present when the plexus anesthesia was induced.
- The right side was indicated in the electronic memo of the operation created by the surgeon during the patient’s first visit but was not printed in the medical record.
- There was a lack of communication among all surgical team members and the patient.

Role of checklists
Checklists are used in the surgical units and ORs of many hospitals in Italy, although the country in general has been slower to adopt their use than have US hospitals. In 2009, the Italian National Health Service published OR Safety Recommendations that included a surgical checklist, but that checklist was used largely on an experimental basis. In 2012, checklists were put into place in the surgical departments of all Italian hospitals. Nonetheless, the carotid case demonstrates that even with the use of checklists, there’s still a danger of wrong-site surgery.

The carotid case was the first time that the checklist had failed in that particular OR, but it clearly demonstrates poor communication and lack of nontechnical skills among the OR team. These skills are well developed in civil and military aviation environments but are less common in health care organizations. All surgeons, anesthetists, and nurses should have strong situational awareness, decision making, communication, leadership, and teamwork skills.

In conjunction with nontechnical skills, checklists are designed to promote interdisciplinary communication and to provide a framework for the many perioperative steps involved in patient care. To augment these skills at G. Fracastoro Hospital, interdisciplinary teams composed of surgeons, anesthetists, and nurses participated in a project at the hospital led by civil aviation pilots who had had crew resource management training.

As part of this project, an OR checklist prototype tailored to different specialties (general, pediatric, obstetric and gynecological, vascular, urologic, and orthopedic surgery) was developed to
Number of readmissions varies by data collection

Data from the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) led to more accurate tracking of 30-day hospital readmissions among colorectal surgical patients than another popular database, the University HealthSystem Consortium (UHC), a study finds.

Because Medicare penalties on hospitals with higher-than-expected rates of 30-day readmissions are expected to rise in 2014, more hospitals are evaluating the most accurate methods for tracking readmissions.

Researchers examined data for 735 patients who had colorectal surgery at Johns Hopkins University Medical Center, Baltimore, between July 2009 and November 2011.

Comparing how accurately ACS NSQIP, UHC, and patient chart review capture readmission information, the researchers found important differences.

ACS NSQIP data reported that 107 patients had been readmitted, and UHC data said 129 patients had been readmitted within 30 days.

ACS NSQIP identified 9 readmissions not found in billing records because they occurred at another hospital or because of a discrepancy in definition. UHC identified 31 readmissions not identified by ACS NSQIP because of a broader readmission definition or because they were missed by reviewers.

In the ACS NSQIP registry, 72% of readmissions were found to be related to index admission, and physician chart review identified 83% of these.

UHC found 51% of readmissions related to index admission; the entire surgical team whenever any aspect of a case is unclear, and the electronic memo is now included in the official documentation for every surgical patient.

— P Sette, MD, is OR manager at G. Fracastoro Hospital in San Bonifacio (Verona), Italy.

— R M Dorizzi, MD, is with Corelab, Laboratorio Unico di AvR, in Pievesestina di Cesena, Italy.

— A M Azzini, MD, is with the Department of Pathology, Infectious Diseases Unit, at Azienda Universitaria Ospedaliera Integrata, Verona, Italy.

References


Compounding pharmacies have long been valued for their ability to tailor prescription drugs for specific patients. More recently, they have helped conserve scarce drugs by redistributing them from larger to smaller single-use vials.

For an ambulatory surgery center (ASC) that is not associated with a hospital and therefore has no access to a hospital pharmacy, a local compounding pharmacy might be the key to keeping expenses down and providing needed drugs.

However, a confluence of conditions has led to deeper scrutiny of the compounding industry and reluctance to rely on it to provide a safe alternative to mass-produced pharmaceuticals. There is another way, experts agree: ASCs can select compounding pharmacies with confidence in their safety and professionalism if managers understand those companies’ limitations and role in the pharmaceutical industry.

National outbreak
In September 2012, a patient developed fungal meningitis 19 days after receiving an epidural steroid injection at an ASC in Nashville, Tennessee. This began an outbreak that the Centers for Disease Control and Prevention (CDC) would soon trace to the New England Compounding Center (NECC) in Framingham, Massachusetts.

NECC had shipped more than 17,000 doses to customers in 23 states before initiating a voluntary recall. More than 14,000 patients had received injections, resulting in 55 deaths and 741 serious illnesses in 20 states, the CDC reported.

While the NECC episode was not the first distribution of contaminated drugs from a compounding pharmacy, it gained national attention and Congressional interest.

Bills now pending in the Senate and several state legislatures aim to resolve a variety of conflicting laws, Food and Drug Administration (FDA) guidelines, and court decisions regarding compounding pharmacies. “Existing standards are not always enforced,” Simpleman notes, “because there are not enough inspectors.”

An April 2013 report by Rep Edward J. Markey (D-Mass) notes that while pharmacies, including those that compound, are regulated and certified by states, many ship products between states, including over the Internet. There is no requirement to inform the state of origin when an adverse incident occurs. Meanwhile, according to the Markey report, some compounding pharmacies have expanded their business from filling prescriptions for individuals with special medical needs to producing large quantities of drugs whose manufacture is otherwise highly regulated. Specifically, they produce sterile injectables used in connection with surgery—drugs that are among the most frequently in short supply.

Inadequate oversight
Markey has introduced the VALID Compounding Act, which would continue state oversight of...
traditional compounding for individuals but add FDA regulatory power for compounding pharmacies that behave as drug manufacturers, making large quantities not tied to specific prescriptions. On May 22, 2013, the Senate Health, Education, Labor and Pensions Committee approved similar legislation. Representatives Rosa DeLauro (D-Conn) and Nita Lowey (D-New York) are sponsoring the SAFE Compounded Drugs Act, which would allow the FDA to set production standards for compounding pharmacies.

In June, the group purchasing organization Premier Inc released a survey of its health care provider members, which concluded that 90% believe the compounding industry needs both stricter laws and stronger regulatory oversight. Premier called for “clearly defining the 2 types of drug compounders—traditional compounders and compounding manufacturers—and the clarification of separate regulatory oversight and enforcement mechanisms.”

As of May 2013, states had introduced 55 new legislative proposals aimed primarily at tightening rules governing sterile production.

In the case of NECC, the company had received warnings from Massachusetts inspectors and the FDA, under its 2002 Compliance Policy Guide, which is not legally binding. Among its violations, NECC failed to follow proper sterilization procedures.

Tom Simpleman, CEO of The Fawks Company in Denver, has seen similar conditions during his career as a consultant for drug manufacturers. He recalls encountering contaminated dextrose solutions; a compounder using an incubator designed for veterinary use (“and using it wrong”); and another who diluted chemotherapy drugs to increase profits.

**Use only certified pharmacies**

Simpleman, who is a registered pharmacist, now helps ASCs and other nonacute facilities verify compliance with medication regulations. He says despite the errors he has observed, he has also seen many compounding pharmacies meet manufacturing standards with good quality control. The best way to find one, he says, is to conduct research based on the Internet, the state board of pharmacy, and the national Pharmacy Compounding Accreditation Board (PCAB). “The PCAB inspects compounders like AAAHC [The Accreditation Association for Ambulatory Health Care] inspects ASCs,” he notes.

Simpleman’s Bible is the United States Pharmacopeia (USP). Section 797 covers preparation of sterile products. The standard is the same for every facility that makes sterile preparations, from a physician’s office to a major drug company. Therefore, he advises ASCs not to open in-house pharmacies in an effort to manage drug quality because they could get sued in the event of a mistake.

Under USP Section 797, sterile compounding requires a “clean room,” where air filters remove contaminants. Workers wear protective clothing, and the room may have positive air pressure to prevent entry of contaminants. The more ingredients a compound has, the higher its risk category and the stricter the manufacturing standards. Storage conditions also must be controlled.

Instead, he recommends working with a certified local pharmacy.

The PCAB website, www.pcab.org, contains a list of accredited compounding pharmacies by state, including those newly accredited. The listings indicate whether a pharmacy may compound sterile products but do not specify the exact drugs it may prepare.

Simpleman notes that state and city pharmacy inspectors are familiar with retail practices but may not know much about compounding sterile products.

The International Academy of Compounding Pharmacists (IACP), which represents 2,700 compounding professionals, offers a Compounding Pharmacy Assessment Questionnaire on its website (visit www.iacprx.org or call 800-927-4227). IACP also offers a pharmacy locator.

The questionnaire contains detailed questions on licensing, services provided, quality controls, and testing methods.

For example, among questions to ask an out-of-state pharmacy are:

- If the pharmacy is in a different state than the purchasing institution, is the pharmacy licensed to dispense/distribute/provide medications in this state as well?
- What is the license number?
- What SOPs are in place to show compliance with those procedures?

For additional questions, contact Simpleman at 303-948-6700. The PCAB website (www.pcab.org) is a valuable resource. Visit its FAQ: “Compounding in the United States: What you need to know.”

**Ambulatory Surgery Centers**

Continued on page 30
ASC executives to meet with lawmakers

The Ambulatory Surgery Center Association (ASCA) annually asks members to participate in a “fly-in” to meet with members of Congress to raise awareness about the implications of health care policies. As ASCA vice president of government relations Steve Miller notes, there is nothing like hearing directly from a constituent to get a legislator’s attention.

The 2013 ASCA fly-in to Washington, DC, will take place September 17 and 18. Several state ambulatory surgery centers (ASCs) have appointed delegations to represent them at the fly-in. Any ASC representative may participate individually.

Policy planning

On the first day, participants will meet with ASCA staff to review the most critical issues subject to regulation and to identify policy positions that will benefit the ASC industry.

One such issue is the ASC Quality and Access Act of 2013, which was introduced in the House of Representatives in late June by John Larson (D-Conn) and Devin Nunes (R-Calif). This bill is the companion legislation to S. 1137, which was introduced by Senators Ron Wyden (D-Ore) and Mike Crapo (R-Idaho) earlier in June.

The bill includes a long sought-after feature: Medicare reimbursement for ASCs would be computed using the same market basket price index used for hospitals. The bill also would direct the Centers for Medicare and Medicaid Services (CMS) to add an ASC representative to the advisory committee on payment for outpatient services.

ASCA estimates that Medicare would save $2.5 billion annually if half the eligible procedures now performed in hospital outpatient departments (HOPDs) were moved to ASCs. This is because ASC services are reimbursed, on average, at 58% of the rate paid to HOPDs.

ASCA also hopes to convince Congress to change CMS policy on payment for colonoscopies. For routine screening, patients are not charged a copay. However, if during the examination the physician finds and removes a polyp, the procedure is deemed “diagnostic” and a copay is required.

As an observer notes, the least affluent patients are discouraged from having screening examinations and thus have to accept a health risk for financial reasons.

A third bill ASCs hope to see passed is a modification to the timeline for establishing electronic health records (EHRs).

The 2009 Health Information Technology for Economic and Clinical Health Act (HITECH) requires hospitals and physicians to adopt EHRs or face reductions in Medicare payments beginning in 2015. ASCs have asked for a delay in the implementation timeline. A provision in the Electronic Health Records Improvement Act, introduced in March 2013 in the House of Representatives, would give a 3-year exemption for treatment in ASCs.

Face time in Congress

On their second day in Washington, fly-in participants will meet with their representatives and senators or with staff members to present their views.

It is only through such personal contact that lawmakers will be able to understand the real-life implications of their decisions, according to Keith Metz, MD, chairman of the ASCA government affairs committee. “ASC supporters who commit to spending a day in Washington demonstrate to legislators and their staffs the importance they place on the ability to work and practice in an ASC,” he says.

Protocols

Continued from page 29

Visit and ask questions

After locating a certified compounding pharmacy, the ASC pharmacy specialist should visit it, Simpleman advises. Among things to look for is documentation: he feels “uneasy” if the paperwork is not in place, no matter how organized the rest of the facility is. The ASC representative should ask about compounding procedures, the recall process, and verification of competency. Do not reject a candidate just because of a recall, he adds.

“If somebody had a recall, it doesn’t mean they’re bad people.” However, he says it is preferable to learn that the pharmacy initiated the recall itself rather than wait for regulators to discover a problem.

According to Simpleman, if the pharmacy will be repackaging single-use medications, it must receive products directly from the wholesaler—not the ASC. Although that method is more expensive, it is also much safer. “Remember why it’s single use,” he says. “It’s not sterile. That’s a terrific medium for things to grow.”

—Paula DeJohn

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—Paula DeJohn
I AM A CENTRA NURSE
AND FACING CHALLENGES IS WHAT I DO BEST
Amanda Okuley, R.N. III

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At a Glance

Overall mortality linked to outcomes for 3 publicly reported conditions
Hospital performance on acute myocardial infarction, congestive heart failure, and pneumonia can potentially be used as a signal of overall hospital mortality, an analysis of data from 2,300 hospitals showed.

Hospitals in the top quartile of performance had a 3.6% lower absolute risk-adjusted mortality than hospitals in the bottom quartile.

Performance on the 3 reported conditions correlated with overall mortality rates in medical and surgical performance.


Anesthetic choice does not affect length of stay
Use of a less-expensive, longer-acting anesthetic (isoflurane) did not affect length of stay, compared to a more expensive, shorter-acting anesthetic (sevoflurane), a study finds. Mean hospitalization was 4.1 days for isoflurane cases and 4.2 days for sevoflurane.

Results from this prospective study contradicted results from a retrospective study by the same researchers that showed 2.76 days for isoflurane and 2.49 days for sevoflurane.

The studies illustrate the importance of following a retrospective study with a prospective trial, the authors say.

—Kopyeva T, Sessler D I, Weiss S et al. Anesthesiology 2013; 119(1)61-70

Starch solutions risky for select patients
Hydroxyethyl starch (HES) solutions should not be used to treat critically ill adult patients, says the Food and Drug Administration, because these solutions increase the risk of death and renal injury.

The agency also recommended avoiding HES solutions in patients who are having open heart surgery with cardiopulmonary bypass because of an increased risk of excessive bleeding.

The recommendations are based on an analysis of data on thousands of critically ill patients and almost 1,000 patients undergoing open heart surgery with cardiopulmonary bypass.

No evidence of an increased risk of renal injury was seen in studies of adult and pediatric surgical patients who were given HES in the OR and followed for less than a week.

—www.fda.gov/BiologicsBloodVaccines/SafetyAvailability/ucm358271.htm

Cervical spine surgery patients fare worse in teaching hospitals
Patients undergoing cervical spine surgery in teaching hospitals have higher mortality and complication rates than those in nonteaching hospitals, according to researchers from Rush University Medical Center, Chicago, Northwestern University Feinberg School of Medicine, Chicago, and Georgetown University School of Medicine, Washington, DC.

They studied hospital teaching status, patient demographics, postoperative complications, and mortality data for 212,385 cervical spine surgery patients from the Nationwide Inpatient Sample database (2002-2009).

Mortality rates at teaching hospitals vs nonteaching hospitals were 1.2 per 1,000 patients vs 0.6 per 1,000. Complications were 24.7 per 1,000 patients vs 17.4 per 1,000, respectively.