Population of heavier patients demands planning, education

With over 60% of adults in the US overweight, and half of those obese, health care facilities need to be prepared for a population of heavier patients.

Most dramatic is the rapid rise in clinically severe obesity—100 lb or more overweight—which is increasing twice as fast as obesity in general. Severe obesity is more serious for a person’s health and creates added challenges and expense for health care.

Many hospitals have programs specifically for weight-loss surgery, one of the nation’s fastest-growing procedures. But increasingly, every hospital and health care facility needs to be competent in the care of large patients. Obese patients have a variety of needs, ranging from sensitive care to proper equipment. Among issues requiring attention from OR managers and directors are:

• education of staff to meet psychosocial as well as physical needs
• clinical management, including protocols that address aspects of care such as pressure ulcer prevention, sleep apnea, and difficult airways
• ergonomics for patient and staff safety
• special equipment to meet the needs of heavier patients.

This issue of OR Manager examines issues in caring for obese patients.

Clinical management

Obese patients present challenges for assessment and care planning.

In planning care, draw on resources in your institution, suggests Judy Crouch, RN, MSN, APRN, BC, weight management and bariatrics nurse practitioner at Mercy General Health Partners in Muskegon, Mich. Anesthesiologists can provide information on airway and pain management. The hospital pharmacist can assist with proper medication dosing. Ostomy nurses have expertise in skin care, and physical therapists can help in managing patient transfers and mobility.

Hospitals are beginning to develop model protocols for care of the obese. One of the first such protocols is scheduled to be published this spring in Ostomy/Wound Management by authors led by Susan Gallagher, RN, PhD, CWOCN, a wound and ostomy nurse who specializes in clinical and ethical aspects of caring for obese patients.

This is an overview of clinical issues perioperative nurses and physicians need to be prepared to manage.

Preoperative planning

Good communication with surgeons’ offices and clinics helps ensure information is received before obese patients arrive for surgery.
Please see the ad for INTEGRATED MEDICAL SYSTEMS in the *OR Manager* print version.
Regional anesthesia gaining ground

What you need to know about this growing movement.

Improving the CS department

Leaders share their strategies for improving this critical department.

OR of the Future

Prototype tests new staffing models, processes, and technology.

Editorial

Your surgery department undeniably is considering a heavier patient population in planning for equipment and staff training—and that’s not just if you’re opening a bariatric surgery program.

With more than 30% of Americans obese and 5% severely so, the need can’t be ignored.

As you do your planning, don’t overlook a major concern—sensitivity.

Sensitivity was the first item mentioned by experts we talked to in writing the articles for this issue.

Many obese patients have serious health conditions. But too often they delay care because they worry about how they will be treated. This isn’t just an impression—a study from Yale documents that health professionals harbor a strong anti-fat bias, characterizing people who are obese as “lazy” and “stupid.”

The need for sensitivity needs to go far beyond public relations, as a California hospital found.

The hospital ran an ad touting its new weight-loss surgery program. “It’s not what you have to lose,” the ad said. “It’s what you have to gain. Pride. Dignity. And better health.”

A local activist took offense, feeling the ad implied people who were obese didn’t have pride or dignity. When the hospital held a seminar on bariatric surgery, she and several others blended into the crowd. At the right moment, she blew a whistle and, according to the Los Angeles Times, they jumped up, threw off their clothes, and clad only in bathing suits, danced through the audience with Fat+Pride and Fat+Dignity written on their stomachs.

And better health.”

What is considered sensitive care?

One good way to find out—ask patients.

A bariatric surgeon has invited patients who have had weight-loss surgery to come back to the hospital after they recovered. They talk to the staff about their experiences with hospitalization both before and after the surgery.

“They experienced very different,” the surgeon says. “I think that just hearing from patients helps the staff care for bariatric patients better.”

Instructions don’t have to be complicated.

Simple things like touch and eye contact can make a big difference, notes Susan Gallagher, RN, PhD, an expert in care of the obese.

Janine Gesek, RN, MSN, risk management manager at ECRI, suggests encouraging the staff when uncertain about how to provide care for an obese patient to ask, “What works for you?” or “How has this been done in the past?” This shows consideration and gives the person some control over the situation.

It comes down to common courtesy and respect.

—Pat Patterson
Please see the ad for MEDLINE INDUSTRIES INC in the OR Manager print version.
Patient-flow fixes ease ED crowding

The ambulance diversion crisis appears to be easing. Part of the reason may be a downturn in inpatient utilization. But hospitals’ efforts to improve patient flow apparently also have made a difference, a new report finds.

One strategy hospitals have shied away from is smoothing the elective surgical schedule. Most have elected not to tackle the schedule even though research shows when surgery is done can make a big difference in the availability of beds.

Hospitals hesitate because they worry about reducing surgeons’ productivity, which might prompt them to take their business elsewhere, notes the Center for Studying Health System Change, a nonprofit organization.

In fact, hospitals are pursuing more elective surgery, especially high-margin procedures like heart surgery, to boost revenues and keep physicians from shifting this profitable business to ambulatory surgery centers and specialty hospitals, the center found. That is true even though heart surgery affects availability of critical care beds for emergencies.

The report is based on visits to 12 cities across the country where researchers conducted interviews and did other analysis.

Emergency department (ED) diversions stem primarily from a lack of intensive care and other beds, creating bottlenecks and forcing hospitals to delay emergency admissions and send ambulances to other hospitals.

Better management

Though many hospitals are expanding their EDs, better management of inpatient capacity seems to have been a critical factor in easing diversions, the report finds.

Strategies that have made a difference:

• Hospitals have redoubled their efforts to fill nursing vacancies, enabling them to keep more beds open. They are offering financial incentives and more flexible work schedules. They also have recruited foreign nurses and used agency personnel.

• To improve physician coverage in the ED, hospitals in 6 of the 12 communities have started paying certain medical specialties for on-call coverage and, in some cases, are paying physicians for care of uninsured patients.

• Many hospitals have appointed “bed czars” to expedite patient flow. Some have appointed senior physicians and nurses to lead efforts to speed patient discharges. They also have increased the number of observation beds, worked to make housekeeping more efficient, and added space for discharged patients to wait for rides home.

• Communities have improved communication among hospitals. Most of the communities had guidelines for how long ambulance diversions can last, the types of patients or conditions that are off limits to diversions, and the type of capacity limits that warrant diversions.

Impact of elective OR schedule

The impact of the elective surgical schedule on ambulance diversions has been documented by Eugene Litvak, PhD, and his colleagues at Boston University. They found the elective

---

### Advisory Board

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amy Bethel, RN, MPA, CNA</td>
<td>Executive director, surgical services</td>
</tr>
<tr>
<td></td>
<td>Iowa Health, Des Moines</td>
</tr>
<tr>
<td>Mark E. Bruley, EIT</td>
<td>Vice president of accident &amp; forensic investigation, ECRI</td>
</tr>
<tr>
<td></td>
<td>Plymouth Meeting, Pa</td>
</tr>
<tr>
<td>Judith Canfield, RNC, MNA, MBA</td>
<td>Associate administrator of surgical services</td>
</tr>
<tr>
<td></td>
<td>University of Washington Medical Center, Seattle</td>
</tr>
<tr>
<td>Christy Dempsey, RN, BSN, CNOR</td>
<td>Director, perioperative services</td>
</tr>
<tr>
<td></td>
<td>St John’s Regional Health Center, Springfield, Mo</td>
</tr>
<tr>
<td>Franklin Dexter, MD, PhD</td>
<td>Associate professor</td>
</tr>
<tr>
<td></td>
<td>Department of Anesthesia</td>
</tr>
<tr>
<td></td>
<td>University of Iowa, Iowa City</td>
</tr>
<tr>
<td>Mary Diamond, RN, MBA, CNOR</td>
<td>Director of surgical services</td>
</tr>
<tr>
<td></td>
<td>Sharp Healthcare, San Diego</td>
</tr>
<tr>
<td>Marion L. Freehan, RN, MPA/HA, CNOR</td>
<td>Nurse manager, main operating rooms</td>
</tr>
<tr>
<td></td>
<td>Massachusetts General Hospital, Boston</td>
</tr>
<tr>
<td>William J. Mazzei, MD</td>
<td>Medical director, perioperative services</td>
</tr>
<tr>
<td></td>
<td>University of California, San Diego</td>
</tr>
<tr>
<td>Mary M. Murphy, RN, BSN, CNOR</td>
<td>Director, surgical services</td>
</tr>
<tr>
<td></td>
<td>Munson Medical Center</td>
</tr>
<tr>
<td></td>
<td>Traverse City, Mich</td>
</tr>
<tr>
<td>Barbara Pankratz, RN, MSN</td>
<td>Director, surgical services</td>
</tr>
<tr>
<td></td>
<td>University of Wisconsin Hospital &amp; Clinics, Madison, Wis</td>
</tr>
<tr>
<td>Robert V. Rege, MD</td>
<td>Professor and chairman</td>
</tr>
<tr>
<td></td>
<td>Department of surgery</td>
</tr>
<tr>
<td></td>
<td>UT Southwestern Medical Center</td>
</tr>
<tr>
<td>Marimargaret Reichert, RN, MA</td>
<td>Administrator, Surgical Care Center</td>
</tr>
<tr>
<td></td>
<td>Southwest General Health Center, Middleburg Heights, Ohio</td>
</tr>
<tr>
<td>Kathy E. Shaneberger, RN, MSN, CNOR</td>
<td>Director, perioperative services and ortho/neuro service line</td>
</tr>
<tr>
<td></td>
<td>Mercy General Health Partners, Muskegon, Mich</td>
</tr>
<tr>
<td>Sallie Walker, RN, BA, CGRN</td>
<td>Baptist Physicians Surgery Center</td>
</tr>
<tr>
<td></td>
<td>Lexington, Ky</td>
</tr>
<tr>
<td>Allen Warren</td>
<td>Business manager, surgical services</td>
</tr>
<tr>
<td></td>
<td>Mission St Joseph’s Hospital, Asheville, NC</td>
</tr>
</tbody>
</table>

Continued on page 7
Please see the ad for
LAWSON SOFTWARE
in the OR Manager print version.
schedule puts more strain on the system than the random cases that arrive through the ED.

During a hospital’s busiest times, they found nearly 70% of diversions from the ICU were associated with variability in the scheduled surgical case load—when elective surgery peaked, so did the diversions.

The study also found smoothing out the schedule actually enables surgeons to get more work done and increase their revenue (Anesthesiology. June 2003;98:1491-1496; also November 2003 OR Manager).

But hospitals apparently are not eager to embrace this strategy, according to the center’s site visits.

New JCAHO standard

Meanwhile, the Joint Commission on Accreditation of Healthcare Organizations issued a new leadership standard (L.D.3.11) for managing patient flow, which takes effect January 1, 2005. Though the standard originally was supposed to focus on ED overcrowding, hospitals protested they didn’t have control over all the factors that contribute to overcrowding.

The standard directs leaders to assess flow issues and plan to mitigate their impact. Among these issues are planning for care of patients who must be held in temporary locations such as the postanesthesia care unit or emergency department, as well as in overflow locations such as hallways.

Specific indicators to measure the patient flow process are to include:

- available bed space
- efficiency of patient care and treatment areas
- safety of patient care and treatment areas
- support-service processes that affect patient flow.

The indicators are to be available to the personnel accountable for patient flow.

Perioperative services is not specifically mentioned, though leaders would likely be included in addressing patient flow issues.

The report, entitled Emergency department diversions: Hospital and community strategies alleviate the crisis, is available at www.hschange.org.

Lessons for managers from the Mt Everest climbing disaster

In May 1996, 8 expert mountain climbers died as they descended from the summit of Nepal’s Mount Everest, the world’s highest mountain.

What went wrong?

The sudden turn in weather? Altitude-impaired thinking? Lack of stored oxygen?

Each is a possible explanation.

“The important thing is not to pinpoint blame on one person or one root cause,” counsels Michael Roberto, DBA, assistant professor at Harvard Business School. “If you search for only one root cause, you may find something that contributed to the disaster, but the same situation could happen again because you didn’t get to all the issues in the system that led up to it.”

Roberto, a featured speaker at the Managing Today’s OR Suite conference October 6 to 8 in Chicago, will demonstrate how studying the Mount Everest disaster provides OR managers insight into patient safety accidents. His talk is sponsored by the J2 Group.

“The best learning about poor decision making often comes from outside of business,” he says. “Business managers usually aren’t willing to be studied.” He points to Three Mile Island, the Challenger and Columbia space shuttle disasters, and wildfires in the West as examples of disasters caused by complex factors.

“We now know the technical cause of the Columbia space shuttle accident was that foam insulation broke off and damaged the left wing,” Roberto says. “However, if NASA only addresses the foam problem, the accident could happen again. They have to address the organizational issues that led to the mistake, such as knowing about the foam problem for years before the accident occurred.”

Roberto will help conference attendees break down complex problems by examining three levels of a system—individual, group, and organizational—to discover the multiple factors that go into poor decision making.

For instance, at the individual level, Roberto has people examine mental traps they often fall into. At the group level, he looks at how team members interact. “This is one area in which managers can have a great deal of control—building unified teams and better group dynamics,” he says. “A lot of problems can be solved with good group dynamics. Team members can speak with candor, and you can catch each other’s mistakes.”

At the organizational level, Roberto helps managers look at the underlying systems processes that contribute to accidents. The main theme is to stop finger pointing. “I don’t say that you should never blame individuals, but be careful about just looking to the individual,” he says. “Too much emphasis on finding a person to blame when something goes wrong in your own unit actually prevents you from getting to the real issues.”

A conference brochure was in the April OR Manager. The brochure is also at www.ormanager.com.

Addition to waste disposal directory

An additional listing for manufacturers of liquid waste disposal products in the April OR Manager.

Bemis

www.bemismfg.com
920/467-4621

Vac-U-Port/Vac-U-Station

Canister has a bottom port that when placed in the Vac-U-Station allows the contents to be drained into a sanitary sewer. Cost for the Vac-U-Station is about $4,000.

Cardinal Health

www.cardinal.com/mps
800/964-5227

Saf-T Pump System

Wall-mounted closed system uses suction created by tap water, with no need for motorized pump or moving parts. Fluid drawn out of suction canister flows directly into the sanitary sewer connection, eliminating need for worker exposure. The cost of the unit is about $4,500 plus plumbing.
Please see the ad for
CTC CARDINAL HEALTH
in the OR Manager print version.
A new standard helps take the guesswork out of choosing the right barrier protection for the amount of blood and body fluid exposure expected during surgery. The standard from the Association for the Advancement of Medical Instrumentation (AAMI) requires manufacturers to classify and label their surgical gowns, drapes, and certain other products for the level of barrier protection they provide.

Once the labeling is in place, OR staff should be able to go to the shelf and select a gown labeled Level 4, for example, and know it has been tested for conditions found in a procedure with exposure to high levels of blood and body fluids, such as a trauma or open-heart case.

In an interview, Fran Koch, RN, MSN, co-chair of the committee that developed the standard, explained what to expect from the new standard.

Q What is the purpose of the standard?
Koch: The standard has two basic purposes:
• to assist manufacturers in establishing levels of protection for their products
• to help users be able to understand what level of protection they can anticipate when they select a product from the shelf.
Our goal was to have terminology people could relate to and understand.

Q What is covered by the standard?
Koch: The standard covers surgical gowns, both disposable and reusable. It also covers decontamination garments, isolation gowns, sleeve protectors, and laboratory attire and other protective apparel, as well as drapes and drape accessories. It does not cover the glove-gown interface.

Q What will manufacturers be expected to do?
Koch: The standard, though voluntary, says each device (or product) with a barrier claim will be labeled with that barrier claim for its critical zones. Also, each package that contains a barrier product will have every barrier product in the package identified with the level.

We had a great group of users on the committee, and they highly recommended that each device be labeled. For example, if someone comes in after a case has begun, and the package has already been opened, they need to know what level of protection they will have for that case.

Manufacturers are required upon request to provide technical information about the level of barrier performance for each critical zone. The critical zone is the area where you expect to have bloodborne exposure. For gowns, the entire front must be at least Level 1. The back is a nonbarrier and must be labeled as a nonbarrier.

Manufacturers must provide technical information and/or training for the staff on the classification system and its implications for users so they can make good judgments.

It’s also important to note that once the manufacturers have done that, it becomes the institution’s responsibility to make sure their people understand and can make judgments about barrier protection. Obviously, that is a legal issue.

Q Please describe briefly how the surgical fabrics are going to be classified.
Koch: The standard establishes four levels for classifying protective apparel and drapes based on industry-accepted test methods.

The tests for Level 1 and 2 are water tests that people may be familiar with if they have visited manufacturing plants. In the first test, AATCC 42, the fabric is placed at a slant with a blotter below it. Water is released above, and the blotter is weighed to see how much water came through the fabric. The second test, AATCC 127, measures fluid penetration under hydrostatic pressure.

Level 3 uses AATCC 42 and 127 with more stringent test results for AATCC 127.

Level 4 uses the new ASTM standardized tests 1670 and 1671 that measure artificial blood and virus penetration. (See table.)

Q Does the standard apply both to disposables and reusables?
Koch: Yes. For reusables, there are some specific requirements. Manufacturers will have to indicate the number of times a product can be reprocessed, give instructions for reprocessing, and supply a means for tracking the number of reuses, such as a marking grid or bar code system.

Also extremely important to know—once a reusable product has reached the...
end of its life, it cannot be downgraded. That means a Level 4 could not be downgraded to a Level 1, for example. It must be considered a nonbarrier.

[Another standard, ANSI/AAMI ST65, addresses handling, laundering, and quality control for reusable textiles.]

Q **How will this standard help OR managers and staff?**

Koch: They now will have consistent definitions for measuring the barrier performance of products. They can make judicious judgments on what level of protection they want.

Within each facility, you will have to look at your own situation and make a determination of how much fluid you expect for specific procedures and surgeons. Then you can decide the level of protection that is necessary.

For example, you might decide that Level 1 barriers will be for lumps and bumps; Level 2 will be for simple orthopedic procedures with a tourniquet, or for hernias; Level 3 will be for procedures with more substantial fluid or blood loss, such as mastectomy; and Level 4 will be for trauma, open-heart, and AAA [abdominal aortic aneurysm].

Q **How soon can people expect to see labeling?**

Koch: I think people will be seeing it come out this year.

Q **What is the role of the Food and Drug Administration in this?**

Koch: I have been working on this issue for 23 years. The first committee was in 1980 but was unable to develop a consensus document. We then developed a Technical Information Report in 1994 that included criteria for judging products. We are in the process of rewriting that report because we still feel people need to know about criteria for issues such as linting and strength.

The FDA has been supportive of the effort and actively participated in development of this AAMI standard.


---

**Examples of barrier classifications**

**Example of surgical gown.** Entire front of gown (A, B, and C) is to be at least Level 1. Critical zone is at least A and B. Classification is based on the lower performing component of the two. The back of the gown may be nonprotective.

**Example of surgical drape.** Entire drape (A and B) is to be at least Level 1. Seams between two protective areas must have at least the barrier performance of the lower-performing area.

Care of obese patients

Continued from page 1

“The sooner you have a heads up, the better,” says Crouch. That allows time to gather the proper equipment, including rental if necessary, which is important not only for patient care but sensitivity.

The staff’s look of surprise when a large patient arrives can be insulting, as can comments such as, “Guess we’ll need the big-boy table for this one,” or when taking a blood pressure, “This cuff is too small. Where’s the thigh cuff?”

Crouch suggests having a kit with items such as an extra-large blood pressure cuff, tourniquet, assessment tools, and proper-sized gowns.

Being weighed is a particularly sensitive issue. Make sure suitable scales are available. “Weighing should be done in private, without comment,” Crouch emphasizes. “People are embarrassed and fear they will be lectured about their weight. I’ve heard of patients being sent to the loading dock to be weighed, which obviously is excusable.”

She believes obese patients should be seen for a nursing assessment before the day of surgery, rather than simply being screened by phone—“the needs of these patients are too specific.”

Preparation of the OR

Provide advanced notice to the OR staff and anesthesia providers to allow for adequate time for vascular access, airway evaluation, skin prep, and other activities, advised Janine Gesek, RN, MSN, program manager for risk management services at ECRI, who spoke recently in an ECRI audioconference on surgery for the obese patient.

“You also will want additional instruments on hand and sufficient personnel to assist in moving and positioning the patient prior to the procedure.”

Maintaining a sterile field can be more difficult than for a normal-sized patient. The surgeon and assistants may need to use step stools to obtain proper access.

Anesthesia, airway management

Anesthesia and airway management require careful assessment and planning. Patients who are severely obese have short, thick necks and large tongues, which can make intubation difficult and increase the risk of airway obstruction. They also have a variety of respiratory and cardiac issues, such as reduced lung capacity and function; potential for aspiration, atelactasis, and pneumonia; impaired lung compliance and resistance; obesity hypoventilation syndrome (formerly known as Pickwickian syndrome), and hypertension.

Obese patients need experienced anesthesia providers who understand the risks and take precautions so as not to get into the situation of “unable to ventilate and unable to intubate.”

“Develop a competency list or use an existing one related to difficult airway intubation and reassess competency on a routine basis,” Gesek advises. Have alternative rescue airway devices available, such as a laryngeal mask airway or bougie.

Staff in the recovery room should be competent in the immediate care of obese patients, particularly ventilatory support.

Obese patients have a high prevalence of obstructive sleep apnea, which

Fast facts about obesity

Body mass index
Body mass index is a measurement of the level of obesity.

\[ \text{BMI} = \frac{\text{Weight in pounds} \times 704.5}{(\text{Height in inches})^2} \]

Clinically severe obesity
Clinically severe obesity is increasing much faster than obesity overall. Between 1986 and 2000, the prevalence of people with a body mass index (BMI) of:

- 30 or greater doubled
- 40 or greater quadrupled
- 50 or greater increased by a factor of 5


Costs

- Moderate obesity (BMI 30 to 35) is associated with health care costs 20% to 30% higher than normal weight. A BMI over 35 is associated with a 60% to 70% increase. With a BMI of 40 or more, costs double.
- By 2020, 1 in every 5 health care dollars in 50- to 69-year-olds will be spent to treat health consequences of obesity.

Some hospitals estimate additional costs of treating or accommodating the severely obese can reach up to $500,000 a year per institution.

Health impact

- Obesity appears to lessen life expectancy, particularly for young adults. White men aged 20 to 30 years with severe obesity could lose up to 13 years of life, and white women could lose 8 years.
- About 300,000 US deaths a year are associated with obesity and overweight (compared with 400,000 for cigarette smoking).
- Overweight and obesity “could wipe out some of the gains we’ve made in areas such as heart disease, several forms of cancer, and other chronic health problems.”

Comorbidities of morbid obesity

- Arthritis
- Sleep apnea
- Gallstone disease
- Hypertension
- Lipidemia
- Diabetes mellitus
- Cardiac dysfunction
- Respiratory dysfunction
- Urinary stress incontinence
- Menstrual and fertility irregularities
- Increased incidence of certain cancers.

Continued on page 13
Care of obese patients

Safety in mobility for patients and staff

How do you take good care of heavier patients without risking injury to your staff?

Good education and the proper equipment are critical.

“Many facilities find out too late they have overlooked the need for special equipment, resulting in patient and worker injury,” said Janine Gesek, RN, MSN, program manager for risk management services at ECRI, Plymouth Meeting, Pa.

“You want to be sure to train the staff in patient safety issues, particularly for proper body mechanics for moving and holding of these patients,” she said in a recent ECRI audioconference.

“Verify that all staff caring for bariatric patients have received documented training in the special technology needs and clinical management of these patients.” Education should include:

• good manual transfer techniques
• proper use of assistance equipment to reduce back injury.

Surgery departments have been caught off guard with the increase in the bariatric population because they have not had access to lifts and bariatric stretchers the way the staff on patient units have.

Though there aren’t good statistics, anecdotally, the number of staff injuries seems to be increasing.

“I’ve never talked with one hospital that did not see a relationship between the increase in the severely obese patient population and staff injuries,” comments Michelle McCleerey, RN, PhD, manager of safety programs for Hill-Rom.

So far the impact is hard to track because reporting systems for OSHA and workers’ comp do not collect data on patient weight. She encourages hospitals to begin tracking patient weight so data will be available in the future.

No-lifting environment

Every facility should strive for a “no-lifting” environment, regardless of patients’ weight, says Michael Dionne, PT, of Choice Physical Therapy, Inc, Gainesville, Ga, who teaches seminars on bariatric rehabilitation and staff safety.

“No one can define a weight where it is safe to lift. We are putting our backs on the line when we lift patients.” Ergonomics also is important to patient safety. Obese patients are particularly vulnerable to falls.

“You can have catastrophic injuries to patients and staff,” he says. “Obese patients fall differently than other patients and are more susceptible to fractures and dislocations, such as fractured knee caps.”

He is aware of one lawsuit where a patient fell despite having a gait belt and six persons assisting him.

Part of planning for obese patients is to have the proper equipment, notes McCleerey, because without the necessary equipment, “it is not humanly possible to repeatedly perform patient lifts, transfers, and mobility assistance safely.”

Transferring patients

The two major concerns McCleerey hears from OR staff are:

• transferring obese patients onto a stretcher or bed after surgery
• transporting them to their room.

Lateral transfer devices are particularly useful for moving surgical patients because they reduce friction. They can help staff move patients from a gurney to OR table with much less effort, Dionne notes.

Three types of transfer devices include:

• Air-driven mattress systems. Two brands are the AirPal (www.airpal.com) and HoverMatt (www.hovermatt.com). These devices can be used to transfer patients of any weight and are compatible with x-ray and other imaging systems. Make sure the mattresses have a non-porous cover that can be wiped cleaned between patients, he advises.

• Patient transfer board. A new type of patient transfer board, available in a long length, is lighter than traditional roller boards, requires no special training, and folds for storage. The board is made by Allen Medical (www.allenmedical.com).

• The friction-reducing sheet. The Slipp (www.apc.net/ipi/slippinfo.htm) is a two-layer vinyl sheet with silicone sealed inside that is not air powered.

The air-driven mattresses have the advantage of being able to bridge up to a 7-inch gap between gurney and table, while the Slipp can bridge a 2-inch gap, Dionne says.

The air mattresses are more expensive because they require a blower, which sells for about $1,500, plus reusable mattresses that cost $2,000 to $2,500. The Slipp costs about $200.

Consider convenience

It’s not enough for mobility equipment to promote safety for the patient and staff. It also must be readily available and easy to operate.

“If there is extensive setup involved, the nurses will not use it, and you will not have gained anything,” McCleerey says. Dionne echoes that advice.

“One of the greatest predictors in reducing staff injury is the availability of the product,” he says. “If the staff have to walk further to get it, they are less likely to use it.”

Web resources

Dionne’s web site (www.bariatricrehab.com) has a key for evaluating transfer equipment based on four criteria:

• portability
• storage ability
• skill ability
• infection controllability.

See also the equipment directory in this issue.
Sensitivity to patient needs

A major part of improving care for obese patients is making sure the staff is attuned to their emotional needs, advises Rona Scott, program coordinator for bariatric surgery at Medical Center East, Birmingham, Ala, who has had bariatric surgery herself.

“You don’t want patients to have to check their dignity at the door,” she says.

Clinicians need to guard against bias. A recent report from Yale showed health professionals in a survey had a strong pro-thin, anti-fat bias. Respondents also assigned stereotypes of “lazy,” “stupid,” and “worthless” to the obese.

At Medical Center East, employees who care for bariatric surgery patients must attend a 1-hour class that covers issues such as stereotypes about the overweight. The hospital also is adding a second day to its orientation that will include obesity sensitivity for all employees, including the medical staff.

“You don’t want to leave anyone out of this training,” Scott advises. A cafeteria worker’s comment can be just as hurtful as one by a nurse or physician. Developing sensitivity is not a one-time check-off but has to be ongoing, Scott adds.

The hospital provides additional “blue-ribbon” training for nurses who specialize in care of bariatric patients. The nurses receive continuing education units and wear blue enamel pins. When obese patients need special care, perhaps with personal hygiene, they know to request a nurse with a blue ribbon.

Scott has a few suggestions for comments to avoid:

“Probably the most hurtful thing you can do is to question a person’s obesity or offer unsolicited advice,” she says.

One patient came to her in tears after a hospital volunteer asked, “Why are you so fat? Is it because you can’t lose weight, or you won’t?” The volunteer was counseled.

Another comment to steer away from—“you have such a pretty face.” What the patient hears is, “The rest of me must be ugly,” Scott notes.

Fear of how they will be treated often keeps obese patients away from the doctor, and they may not be seen until they are quite ill, says Susan Gallagher, RN, PhD, CWOCN, a wound and ostomy nurse who specializes in clinical and ethical aspects of caring for obese patients.

“Patients tell me one reason they hesitate to go to the doctor is that they don’t want to be weighed,” she says. “If we can learn to accommodate and accept them, they might come in a more timely manner, which would in turn lead to shorter stays.”

Simple actions by nurses and other staff members can make a difference, Gallagher notes.

“A lot of it has to do with how you relate to patients—do you touch them and make eye contact? These patients often feel untouched and unlovable. So touch and eye contact are especially important.”

Wound healing

Obese patients have impaired wound healing, discussed in a recent review by Wilson and Clark. A major challenge is avoiding complications such as seroma, hematoma, infection, and wound separation. Clinicians need an understanding of the changes in body systems induced by obesity and how these impede wound healing.

Obese patients also are susceptible to other skin problems, including candidiasis and dermatitis. Some suggestions:

• Maintain clean, dry skin. Be aware patients may be embarrassed to ask for help.

• Be aware that skin folds can lead to skin irritation, breakdown, and pressure ulcers. Judy Davidson, RN, MS, a clinical nurse specialist who has written about care of obese patients, advises lifting, cleansing, and drying all skin folds. Reinspect folds often to make sure lines and tubes aren’t caught in the folds.

• Allow enough time for the skin prep to dry and separate skin folds.

• Avoid letting the patient lie on tubes, catheters, wires, and cords, particularly for procedures longer than 1 1/2 hours, because these can cause pressure necroses. Consider tube holders for these devices.

Pressure ulcer prevention

Obese patients are at high risk for decubiti, particularly if they have long procedures. They may already have been immobile at home and had trouble turning themselves in bed, which increases their risk.

Gallagher recommends developing a pressure ulcer prevention plan, which should be a multidisciplinary effort that includes perioperative nurses.

“When patients move from department to department, nurses don’t always see consequences of their care,” she observes. For example, OR and ICU nurses might not see the results of pressure injuries that develop later on the med-surg unit.

Gallagher believes there is a correlation between prolonged surgery and the risk of pressure injury, though there is no guideline for the length of the procedure. She advises each organization to develop its own criteria based on its patient population and procedures performed.

“Patients are filing claims against hospitals for pressure injuries that developed in the OR,” Gallagher says. Claims may be filed even though the patient had early signs of a pressure injury when admitted.

“The recommendation is to do a thorough skin assessment before patients enter your OR. Think about the criteria you would use to decide which patients need a thorough skin assessment.” (See January 2003 OR Manager.)

Care of obese patients

Continued from page 11

can cause serious postoperative complications. The physiology of obstructive sleep apnea is “intimately linked to obesity,” according to a recent review by Gami and colleagues. Nasal CPAP (continuous positive airway pressure) is the initial treatment of choice for most patients, these authors say, but has limitations because many patients don’t like to use it. Hospitals are developing sleep apnea assessment protocols to help address the risks. (See February OR Manager.)

Continued on page 14
Care of obese patients

**Obesity and the ADA**

Health care providers are considered “public accommodations” under the Americans with Disabilities Act (ADA) and are required to provide “reasonable accommodation” for people with disabilities. That includes patients who are obese.

The ADA defines a disability as “a physical or mental impairment that substantially limits one or more of the major life activities of an individual.”

“Under the ADA, you need to provide the same necessary medical care to a disabled patient that you would for patients who are not impaired,” says Brenda Premo of the Center for Disability Issues and the Health Professions at Western University in Pomona, Calif (www.cdihp.org).

For example, if you need to weigh all patients to determine medication dosages, you would need to provide accessible scales.

Two key concepts in the ADA are “reasonableness” and “undue hardship.” A provider is expected to do what is reasonable, which would not include, for example, rebuilding a building. The law also has an exception for “undue hardship”; that is, a provider would not be required to provide an accommodation that would cause it to go out of business.

Thus, a rural 30-bed hospital with a $35 million budget might find buying $8 million in equipment for obese patients would be a budget breaker, but buying a $100,000 item would not.

What about multimillion-dollar imaging equipment, such as MRI units, that aren’t accessible?

The important thing is to have a plan for the future when new equipment is bought.

“We do recommend that as you change over, you get accessible equipment. That’s not only for the obese but also for people in wheelchairs, the elderly, those who are short, and so forth,” Premo says.

Rental programs enable most hospitals to obtain some bariatric equipment on short notice, within 2 to 24 hours.

**Patient positioning**

Positioning must consider a variety of issues in addition to the surgery including airway management.

If appropriate for the procedure, reverse Trendelenburg’s position (head up) is preferred because it increases the ability to ventilate the patient. Having the patient in Trendelenburg’s (head down) makes ventilation difficult and can be dangerous.

Placing the Foley catheter probably should be done after the patient is anesthetized because it saves embarrassment, Gallagher suggests. Additional staff members in addition to the person placing the catheter will likely be needed to hold the legs and expose the urethra. Patients should be secured to prevent sliding.

**Pain management**

Pain management presents challenges in obese patients. Most have chronic pain, which makes assessing their acute pain more difficult, Gallagher notes. They also metabolize medications differently than other patients because of their higher percentage of body fat. Obese patients are susceptible to the “resedation phenomenon,” in which lipophilic anesthetics and sedatives are redistributed from the fatty tissue back into the bloodstream. This can be life threatening if not identified in a timely manner, notes Davidson.

Crouch recommends consulting with the hospital pharmacist “if there is any doubt about dosing.”

**DVT prevention**

Obese patients are at high risk for deep vein thrombosis (DVT) and pulmonary embolism. In a new report of a prospective registry of 5,400 patients with ultrasound-confirmed DVT, 27%

**Obesity surgery patient rate hospitals**

Want to find out how hospitals in your state rate with patients who have had bariatric surgery?

Go to ObesityHelp.com. Look on the left-hand menu under Information and Resources, then Hospital Directory. Selecting that will bring up a state map you can click to get a list of hospitals in your state that perform bariatric surgery.

Then click on the name of the hospital and read patient reviews on aspects of care such as Oversized Sensitive, Oversized Equipment, Quiet, Privacy, Pain Medication, Staff Responsiveness, and Overall Value.

The site managers caution readers that the reviews are subjective and do not represent a scientific sample.

**Costly care**

Hospitals will have to meet needs of obese patients for the most part without additional reimbursement.

Gallagher says there is hope that as clinicians develop protocols for care of obese patients, some will study whether preventive measures help reduce costs by avoiding expensive complications. If and when that information becomes available, managers and clinicians will have more evidence to take to administrators and insurers to justify additional education and equipment that is required to provide safe care for these patients.
Selecting equipment for obese patients

Planning for appropriate care for obese patients starts the moment the patient pulls into the parking lot.

Among issues to consider, says Judy Crouch, RN, MSN, APRN, BC, weight management and bariatrics nurse practitioner at Mercy General Health Partners in Muskegon, Mich, who completed a hospitalwide assessment:

• Is parking convenient?
• Does the sidewalk have handrails, particularly if there is an incline?
• Does the waiting area have furniture that can accommodate heavier patients and their families?

Finding “bariatric” furniture expensive, Medical Center East in Birmingham, Ala, purchased all love seats for its waiting area. It started with a few love seats, then found those were often occupied by other patients, leaving the obese patients to stand. More love seats were added.

Determine weight limits

Organize a team to determine the weight limit for all existing patient care equipment—OR tables, imaging tables, scales, wheelchairs, and so forth, suggests Susan Gallagher, RN, PhD, CWOCN, a wound and ostomy nurse who specializes in clinical and ethical aspects of caring for obese patients.

“Then you will know in advance, for example, that your MRI can only take patients up to a certain size,” she says. One hospital, faced with an emergency involving an obese patient, cut out a wall so the patient could be taken into the room with the CT scanner, only to find the table would not accommodate the patient’s weight.

Finding it’s not always easy to get weight limit data or labels from manufacturers, some facilities are designing their own labels for transfer equipment, OR tables, specialty beds, and so forth, adds Janine Gesek, RN, MSN, program director of risk management services for ECRI, who spoke at a recent ECRI audioconference on surgery for obese patients.

SizeWise Rentals, a company that rents bariatric equipment, has a protocol on its web site for selecting equipment based on patient measurements and body mass index (www.sizewise.net).

Long-term approach

Many hospitals are taking a long-term approach for expensive capital equipment.

Mission St Joseph’s Hospital in Asheville, NC, has been changing over to heavier-duty equipment gradually for 4 or 5 years.

“This has been part of our OR budget for the past few years,” says Al Warren, business manager for surgical services. “We now have several 1,000-lb tables, longer laparoscopic instruments, and so forth.” The hospital purchased them although it did not begin a weight-loss surgery program until about a year ago. One OR will be equipped specifically for bariatric surgery.

Equipment tips

Some suggestions on equipment:

Toilets. Wall-mounted toilets are rated for about 250 lb to 280 lb and can break off if heavier patients use them, notes Rona Scott, Medical Center East’s program coordinator for bariatric surgery. Her hospital found a simple and inexpensive solution—sliding a bariatric commode with pan removed over the wall-mounted stool. The commode has handles, an added safety feature. The commodes cost about $180. The hospital has installed a couple of toilets for large patients, but Scott says they look like “prison toilets,” stainless steel with no seat.

Scales. Weighing devices should accommodate patients up to at least 600 lb, preferably 800 lb, Scott recommends.

Wheelchairs. Have a bariatric wheelchair available on every floor.

Beds. Inventory all patient beds and gurneys and document weight limits, Gesek suggests. Consider width of beds, doors, elevators, and corridors.

“When reviewing with the staff the policy that any patient who exceeds the stated weight limit for the gurney must be transported in a bed or in a patient-lift device,” she adds. Consider gurneys and beds with larger wheels because they move more easily over carpet with less stress on the staff. Instruct the staff to lock wheels when the gurney or bed is stopped to prevent patient or staff injury.

Medical Center East uses a special bariatric bed that eliminates the need for a gurney. After surgery, patients are transferred from the OR table directly to the bed, which is wheeled to the postanesthesia care unit and on to the med-surg unit. The bed has a “comfort zone” of 350 lb and a weight limit of 500 lb.

“Even our 400- to 500-lb patients are comfortable. It’s rare we have to rent a bed,” says Scott.

When an obese patient is ambulating, she suggests that nurses, rather than taking the patient’s arm, have the patient use a bariatric walker. The nurse walks behind with a bariatric wheelchair. Then if the patient feels unsteady, he or she can just sit down in the wheelchair.

Blood pressure cuffs. Even extra-large blood pressure cuffs tend not to fit well on large patients because of the shape of their upper arms. The forearm is often easier, and frequently a normal-sized cuff can be used.

Sequential compression devices (SCDs). Check circumference of thighs and calves to purchase the correct size of SCDs used for the prevention of deep vein thrombosis. In general, there is no clinical difference among foot-squeezing, knee-high, or thigh-high stockings. Though foot-squeezing devices work well, many obese patients have plantar fasciitis, so some physicians prefer not to put anything on the feet.
Care of obese patients

Equipment directory

Equipment for care of obese patients in surgery.

Air Pal
1-800-633-4725
www.airpal.com
Inflatable patient transfer mattress creates less friction for moving patients.

Allen Medical Systems
800/433-5774
www.allenmedical.com
Products for bariatric patients include table pads and accessories and the new Long Patient Transfer Board.

Burke Bariatric
1-800-255-4147
www.burkebariatric.com
Tri-Flex II bariatric bed with 1,000-lb capacity has integrated scales and trapeze option.

Dale Medical Products, Inc
800/343-3980
www.dalemed.com
Latex-free care products include tracheostomy tube holder, Foley catheter holder, abdominal binders, bendable arm boards, and postsurgical bra.

Gendron
1-800-537-2521
www.gendroninc.com
Bariatric beds, stretchers, powered wheelchairs, shower and commode chairs, patient lifts, and furniture.

Getinge USA
800/475-9040
www.getingeusa.com
Maquet Alphamaxx surgical tables with 1,000-lb patient weight capacity designed for patient ergonomics with full articulation in normal and reverse orientation.

Hill-Rom Services
800/445-3730
www.hill-rom.com/USA
Magnum II bariatric patient care system holds patients up to 800 lb and functions as a bed, a chair, and transport vehicle. Total Care bariatric bed system has 500-lb limit.

HoverTech International
800/471-2776
www.hovermatt.com
Inflatable HoverMatt patient transfer mattress has no weight limit and can be used with x-ray and MRI.

Invacare
800/333-6900
www.invacare.com
Bariatric and heavy-duty products include beds, wheelchairs, lifts, slings, and trapezes.

Inventive Products Inc
800/356-6911
www.apc.net/ipi/slippinfo.htm
The Slipp is a two-layer vinyl patient transfer sheet that is not air powered.

KCI
800/275-4524
www.kci1.com
EZ Lift battery-powered patient lift/transfer system with 1,000 lb capacity. BariMaxx II bed system with pressure reduction environment for patients up to 1,000 lb.

Kendall
800/962-9888
www.kendallhq.com
SCD sequential compression system in large sizes for prophylaxis for deep vein thrombosis.

Liko Inc
888/545-6671
www.liko.com
The UltraTwin FreeSpan freestanding patient lifting device for patients up to 880 lb.

Rehab Seating Systems
800/525-7328
www.rehabseating.com
Ascender bariatric chair assists patients in rising from a chair while lessening the chance of caregiver injury.

Scale-Tronix
800/873-2001
www.scale-tronix.com
Stand-on scale for patients up to 1,000 lb.

Skytron
800/759-8766
www.skytron.us/
Hercules 6500HD bariatric/general purpose surgical table provides full body imaging capability, including 1,000-lb lift, 850-lb articulation, and 180-degree top rotation. Optional table extensions.

Steris Corporation
800/548-4873
www.steris.com
Bariatric table extensions for Amsco 3080/3085 SP surgical tables rated for patients up to 1,000 lb. Electric-powered stretcher with extra-wide top and pressure care mattress has 625-lb capacity.

Stretchair
800/237-1162
www.stretchair.com
Combination wheelchair-stretchers for bariatric patients with capacities up to 1,000 lb.

Stryker
800/787-9537
www.strykermedical.com
Bariatric stretchers and tables.

Trumpf Medical Systems
843/534-0606
www.us.trumpf-med.com
Titan surgical table has a 1,000 lb capacity. It is fully articulated, modular, split leg, and mobile with complete longitudinal movement and extreme low-height adjustment.

Wheelchairs of Kansas
800/537-6454
www.wheelchairsofkansas.com
Bariatric products such as wheelchairs, beds, lifts, and walkers.

We have attempted to provide a complete list. If any vendor has been omitted, we apologize.
Care of obese patients
Continued from page 14

Rona Scott and DeNeene Cofield, RN, BSN, CNOR, of Medical Center East will present an all-day seminar on bariatric surgery at the OR Business Management conference May 12 to 14 in Albuquerque.

Cofield will also present a breakout session, Caring for the Obese Patient in the OR, at the Managing Today’s OR Suite conference October 6 to 8 in Chicago.

Conference brochures are at www.ormanager.com

References


Gallagher S. Postoperative care of the bariatric patient. Perspective in Nursing Online. www.perspectivesinnursing.org


Internal Bleeding: Compelling tales of errors in health care

After being inundated with patient safety information over the past four years, you might not think of picking up a book on the subject.

But Internal Bleeding (Rugged Land, 2004), a new book by two doctors, carries you along. You find yourself turning the pages as you read about Joan Morris, who, while waiting to go home after a treatment for a brain aneurysm, ends up having an electrophysiology procedure because she is confused with another patient, Jane Morrison. You feel your stomach tighten as you read about Duke’s renowned bariatric transplant surgeon, James Jaggers, MD, receiving the news in the OR that he has just given Jessica Santillian new organs that didn’t match her blood type. And you read about a patient who is resuscitated despite a DNR order—only for the code team to find out after they stop the code that they have been working on a different patient, who actually is on full code status. The code is resumed, but the patient dies.

The stories are compelling, heartbreaking, and make you realize once again why patient safety deserves so much attention. The book has won favorable reviews from the New York Times and the San Francisco Chronicle, among others.

Dr Shojania interviewed Kaveh Shojania, MD, who wrote the book with Robert M. Wachter, MD. Both are at the University of California, San Francisco.

Q Why did you get interested in patient safety?

Dr Shojania: It was a combination of personal experience and general research interests.

I actually was involved in a very serious error that we talked about at the beginning of the book that affected me tremendously. I even considered dropping out of medicine. [The case took place in the emergency department while Dr Shojania was a beginning resident. He sent a 29-year-old man with chest pain home after a review by the attending physician only to learn the patient was readmitted later with a massive heart attack.]

That was filed away at the back of my mind when the Institute of Medicine report, To Err is Human, came out in 1999. It seemed like this was a natural thing for a general physician or internist to do research on because it requires broad clinical interests and familiarity instead of focusing just on a specific disease.

Q OR managers and directors have heard a lot about medical errors and patient safety in the past few years. Why do you think they should read your book, and what do you think they would gain?

Dr Shojania: I think it is easier to explain why a health care worker would read it than a regular person. Usually, when people write for nonclinicians, they feel they have to give an easy answer. What the book tries to do is show that it is a lot more complicated than that. That often is not a fun message to hear.

I think for an OR manager, this is really important stuff. It is also complicated.

You can say, “sign the site,” to take an obvious type of error that affects OR managers—avoiding wrong-site surgery. But if all you have done is to introduce a protocol that requires physicians and patients to sign the site—if everything
If you were going to speak to an OR committee today, what would you say are the key things they could do to make surgery safer?

Dr Shojania: There are certain things like standardization, which your readers know more about than I do. There are variations in the way surgeons do things, but you have to balance allowing them a certain zone with the fact that unnecessary variation produces quality and safety problems.

Every time the tray is set up a little differently or, say, they like to give their own local anesthetic in the incision before final closure—all of these can give rise to errors.

Just like in internal medicine, people have their own idiosyncratic way of doing things. If your way of doing things is not clearly based on evidence and is not the same as the way other people are doing things, there are bound to be problems at some point.

So standardization is a theme in patient safety. That is why hospitals are trying to make sure all wards have the same type of programmable IV pump and the same kind of defibrillator—so people don’t have to learn to do things five different ways.

I think the same applies in the OR. A given hospital should decide, “This is how we do this procedure. These are the appropriate things to have on hand and what to expect.”

The other general lesson is not to try to do too many things at once in improving safety. A lot of times people get the idea that here are the five or 10 things JCAHO is talking about, and we are going to try to fix all of them. What ends up happening is you don’t do a really good job at any of them. But if you sink your teeth into one area, maybe wrong-site surgery, postoperative infections, or something that came out of a recent event, you may have more success.

It is better to pick one or two things and succeed at them than to pick five or 10 things and not succeed at any of them.

Q Toward the end of the book, you say this whole fight against medical errors is kind of like the aftermath of the war in Iraq—it seems like it’s going to go on and on.

Dr Shojania: This is a problem we will always have with us—it is not going to suddenly be won one day. We’ve had errors for thousands of years—that’s why the Hippocratic oath says, “First do no harm.” They realized back then that there are collateral effects to everything we do.

I think the answer to, “Is this a war we are going to win?” is, “I think it depends what you mean by that.” What we want to do is to say there are certain problems right now we really want to reduce, and I think we could succeed in that. It may take five to 10 years to make wrong-site surgery a thing of the past. But for every success, I am sure there will be some new problem. That is true every time we invent a new technology. In surgery, the main example in the 1990s was laparoscopic surgery. It was an incredible advance in technology; yet, we found there were learning curves and adverse events as patients, surgeons, and nurses tried to become more familiar with the new techniques. There is going to be something like that every decade.

So the watchword of safety is “always vigilant.” We can’t ever get complacent and think we have won the war on error, because that is exactly when safety problems start happening again.

Someone wrote an interesting book on the Challenger disaster in the 1980s. In interviewing people a number of years after the event—this was before Columbia—she found some people at NASA were already admitting confidentially that people were going back to the way things were. Initially, there was the shock, and everyone was being so careful, and there were new attitudes, but then sure enough, things went back a little to the way they were before, and there was another disaster. Now that’s not necessarily cause and effect, but I think it is an important lesson for health care—we can’t stop being vigilant. We can’t look at patient safety as a fad or as something that we’ll fix and move on to the next thing. This is always going to be with us, and it is always going to have to be a priority for us.

Nominate OR Manager of Year

As surgical services leaders juggle departments, cope with staffing, and strive to keep quality high, they deserve to be recognized.

Each year at the Managing Today’s OR Suite conference, a manager or director is named OR Manager of the Year. This year’s conference will be October 6 to 8 in Chicago.

The OR Manager of the Year will receive an expense-paid trip to the meeting, including air fare, hotel, meals, and registration.

Readers of OR Manager are invited to nominate a manager for the award. Simply write a letter of about 300 words describing why the manager is deserving of the award.

Address specific accomplishments such as leading the staff, inspiring others, improving recruitment and retention, and encouraging collaboration. The letter may be accompanied by letters from colleagues, including physicians, administrators, staff, and other managers.

Send the letter to OR Manager, Inc, OR Manager of the Year Award, PO Box 5303, Santa Fe, NM 87502-5303. The deadline is July 1.

Nominations are judged by members of the OR Manager advisory board. The winner will be notified in August.

A conference brochure is at www.ormanager.com or phone 800/442-9918.
Managing Today’s OR Suite

Chicago Hyatt Regency
October 6–8, 2004

Sneak preview
General session speakers already on board…
• Carl Hammerschlag, MD, The Way it Was is Not The Way it Is
• Michael Roberto, Harvard Business School, Leadership Lessons Learned from the Everest Disaster
• Mary Murphy, RN, 2002 OR Manager of the Year

You’ll have eight all-day seminars and more breakout sessions to choose from. A sampling of what’s to come…

All-day seminars
• Transformational Leadership
• Six Sigma for Process Improvement
• Working with Difficult People
• Managing a Central Processing Department
• Supply Chain Management

Breakouts
• Creating a Just Culture
• Ambulatory Track: Holistic Patient-Centered Model, Credentialing
• Fire Safety
• Pain Management
• Improving Patient Flow
• Managing Intraoperative Medication
• Service Recovery Programs
• OR of the Future

And much, much more…
Networking, receptions, exhibits, and other educational opportunities
Hospitals, MDs compete for core business

A

new surgery center is opening down the street. Ads appear for a new imaging center where patients can have their MRIs or PET scans.

Often, physicians are the driving force for these ventures. They’re becoming hospitals’ biggest competitors, and they’re taking millions in revenue out the door.

An estimated 80% of hospitals are competing with their physicians for traditional hospital services.

“These new physician ventures directly threaten the core business of hospitals,” according to a new report from VHA, an organization of community hospitals and health care systems.

Though doctors have been building their own surgery centers for more than 30 years, the movement is picking up steam.

Two-thirds of freestanding ambulatory surgery centers (ASCs) have physicians as majority owners. Physicians own 60% of urgent care centers and all or part of 61% of imaging centers. Office-based surgery facilities and ASCs are seeing more rapid growth than hospital outpatient surgery (graph).

But alarm bells really went off for hospital CEOs when physicians began building their own heart and orthopedic hospitals, which traditional hospitals see as a threat to their key business.

Though so far there are only about 90 specialty hospitals concentrated in 7 states, they target high-revenue services, such as cardiac surgery.

Loss of these services could harm the future viability of hospitals, says VHA.

Cardiovascular surgery is a top revenue generator for hospitals, bringing in an average of $3.1 million annually per physician, according to recruiters Merritt, Hawkins & Associates. Neurosurgery brings in $2.4 million per physician, and orthopedic surgery and general surgery, about $1.8 million per MD.

Driving the competition

What’s driving the competition?

Like hospitals, physicians are under economic pressure, Eric Schaefer, VHA’s director of strategic planning, told OR Manager.

“Physicians’ real incomes have been declining in recent years. They feel that to boost their bottom lines, they have to boost their top lines and capture some of these services.”

Cardiology practices, for example, saw their net revenue drop by 2.25% from 2001 to 2002, according to the Medical Group Management Association.

Income isn’t the only issue. Another big reason—control over their work live. Surgeons say they can be more productive in a facility they own that is designed for their specialty.

New technology is making it easier to move procedures out of the hospital. That could soon include minimally invasive hip and knee replacements. Other enabling factors are the regulatory environments in some states and corporate partners who help with financing and facility management. An example is MedCath, a company that partners with physicians to build heart hospitals.

An 18-month moratorium on physician investment in specialty hospitals, passed by Congress in the fall, could be a temporary lull rather than a permanent damper on their growth. Because the moratorium creates a focus on this issue, there might be even more interest once the moratorium is lifted, Schaefer observes.

Strategic response

In some areas, hospitals and doctors are lobbing legal cannonballs. In others, they’re sitting down around the conference table to form joint ventures. In still others, hospitals and physicians are joining forces so both of their businesses will grow. VHA identified these three core strategic approaches:

• build barriers
• cultivate common interests
• extend the enterprise.

Build barriers

Hospitals move to block physician competition by erecting barriers such as economic credentialing or lobbying for tighter regulations on new facilities.

The surgical hospital moratorium is one example.

In one widely reported case, OhioHealth, an 8-hospital system, in January revoked the privileges of 17 physicians who invested in a competing for-profit orthopedic hospital. The physicians are contesting the action in court. Similar battles are being fought in Arkansas, Idaho, and elsewhere.

Cultivate common interests

Physicians and hospitals cultivate their long-standing symbiotic relationships by working together to improve efficiency and address physicians’ concerns.

“There is active engagement by both parties to make each better off,” Schaefer comments.

VHA tells of a 5-hospital system, Parkview in Fort Wayne, Ind, that teamed with physicians to build an
orthopedic hospital that the hospital owns and staffs.

“The hospital has learned the importance of talking with physicians about the issues they face,” the report says. It has restructured management positions so senior managers spend 40% of their time on physician issues.

**Extend the enterprise**

Instead of the two sides fighting, the idea is “to partner with the physicians—not just to split the pie but grow the pie,” Schaefer says.

An orthopedic group, for example, might partner with a hospital system to create a specialty hospital or surgery center in a growing part of town.

“They might both do better than if they were acting independently and grow market share,” he says.

Learning that physicians were determined to build their own heart hospital, Community Medical Centers in Fresno, Calif, offered to joint venture with them, heading off a possible deal with MedCath.

These three strategies can blend. A hospital might decide to erect barriers for one specialty while cultivating the commons or extending the business with another.

Hospital CEOs have had a variety of reactions to the report, Schaefer noted. Some still characterize physician competition as “greed.” But others recognize “the world has changed, and it is better to partner with a would-be competitor so both sides can win.”

**For OR leaders, the E-word**

Where do OR leaders fit into these strategies?

It’s about the E-word: efficiency, says Schaefer. A quest to greater efficiency is a major reason physicians go out on their own.

Improvements that make the OR more efficient and increase physicians’ throughput can be a big part of a strategy to keep them from taking their business elsewhere.

An executive summary of the report, *The Doc is Out*, is available at [www.vha.com](http://www.vha.com)

**Pilot study finds no pathogens on scrubs laundered at home**

A small pilot study has found no pathogenic bacterial growth on scrub suits laundered in the hospital or at home.

Culture swabs were taken of the left shoulder of scrub suits worn by 50 OR personnel—30 who laundered their scrubs at home and 20 who wore hospital-laundered scrubs.

None of the cultures grew pathogenic microorganisms. There also were no significant differences in normal skin flora on the suits that were home- or hospital-laundered.

The cultures were taken on a convenience sample of staff within 2 hours after arriving at work. The staff did not know in advance their suits would be cultured.

The study was conducted at Boulder Community Hospital, a 200-bed facility in Boulder, Colo, where the surgical staff have been home laundering scrub suits for about 7 years.

“My purpose for doing the study was to make sure that if we were requiring the staff to home launder their scrubs, we didn’t do any harm,” says Priscilla Jurkovich, RN, MSN, Boulder Community’s educator for surgery and service coordinator for presurgery testing. Her report of the study is in the March/April *MCN/ American Journal of Maternal Child Nursing*.

**Questions about home laundering**

To learn more about home laundering, the staff were asked five questions:

1. Did you wear the scrubs into the hospital or store them in a locker?
2. Do you have a cat or a dog at home?
3. Was your home laundry temperature set to hot, warm, or cold?
4. Did you wash the scrubs separately or with other household clothes?
5. Did you dry the scrubs in a dryer?

Of the 30 people in the home-laundering group:

- 21 washed their suits in warm water, 6 in hot water, and 3 in cold water.
- 18 wore their suits into the hospital, and 12 stored them in a locker.
- 22 washed them separately, and 8 washed them with other clothing.
- 22 had pets, and 8 did not.

Though pets are a possible source of contamination, the study found only normal skin flora on the scrubs worn by 11 of the 22 pet owners, while 11 scrubs had no growth. Skin flora are of human origin and not pathogenic. The growth of skin flora approached but did not reach statistical significance.

Jurkovich decided to swab the left shoulder because that was the protocol used in a 1986 study of cover gowns by Copp and colleagues from Stanford University Hospital, one of the few other studies of contamination of surgical apparel.

**Home-laundering instructions**

Boulder Community began allowing home laundering in 1997 after some of the staff reported sensitivity to the hospital’s detergent. Others wanted to buy their own suits because the hospital’s scrubs didn’t fit properly, and some wanted to wear more colorful cloth caps and warm-up jackets.

Now all of the staff in the OR, preop, and postop areas launder their own scrubs, which are provided by the hospital. Each full-time staff member is given 6 scrub suits, enough for 5 shifts and 1 night of call. Physicians are provided with hospital-laundered suits. The hospital estimates it saves $17,000 a year in laundry costs.

The staff are given basic laundering instructions, which include using regular laundry soap, washing the suits separately in warm water, and drying them in the dryer. There is no recommendation for the dryer temperature. They are expected to launder their suits daily and may either wear them into work or put them in their locker.

**Reference**


New guide to safer sharps for the OR

A quarterly column on technology trends for surgical services from ECRI.

Many health care workers—from physicians and nurses to housekeeping personnel and waste handlers—are at risk of accidental injuries from needles and other potentially contaminated sharps, with potential for exposure to bloodborne pathogens.

Sharps and needlestick safety has received a lot of attention, especially since Congress passed the Needlestick Safety and Prevention Act in 2000 requiring hospitals to implement protective devices. Many facilities have successfully implemented injury prevention devices, such as protective blood collection needles and needleless intravenous connectors.

Though needlestick injuries generally receive the most attention, dangerous injuries also can be caused by other sharps, such as sutures, scalpels, and glass capillary tubes. In fact, a detailed analysis from the International Healthcare Worker Safety Center’s EPINet data from 2000 and 2001 led Perry et al to conclude that “scalpel blades are more likely than needles to cause deep or otherwise severe injuries.” Thus, facilities need to take steps to protect workers from injuries caused by these types of devices as well.

Comparative evaluations

ECRI has evaluated five protected scalpels and three blunt suture needles in the second edition of the Sharps Safety and Needlestick Prevention guide, published in December 2003. The guide has comparative evaluations and ratings of 91 protective devices. The evaluations are designed to assist in determining whether—and to what degree—a product can protect health care workers from injury without compromising the patient’s safety or comfort. In addition, we provide guidance for ensuring safe use of these devices once selection decisions have been made.

The guide has device-specific assessment forms for documenting employee involvement in evaluation and selection of protective devices, a requirement of the Needlestick Safety and Prevention Act. Copies of the scalpel and blunt needle assessment forms are on the OR Manager web site at www.ormanager.com. Look under OR Manager Tool Box.

Guide has ratings on 91 protective devices.

Protective scalpels

Protective scalpels resemble traditional reusable and disposable scalpels but have a mechanism that allows the user either to retract the blade into the handle or to cover the blade with a protective sheath before and after use.

When we first evaluated protective scalpels, all of the protective devices were disposable. Recently, reusable protective scalpels have been introduced by at least two suppliers.

Like conventional disposable scalpels, protective disposable scalpels have plastic handles and are completely disposable. They also weigh considerably less than reusable scalpels.

Protective reusable scalpels, like their conventional counterparts, have a metal handle that holds the blade.

Our user survey found that the weight difference caused some surgeons to resist use of protective disposable scalpels, but the availability of reusable protective scalpels should help to overcome this objection. Surgeons who already use disposable scalpels with plastic handles should notice little difference in the weight of the conventional and protective disposable models.

With both reusable and disposable models, injuries can occur:

• when a scalpel is passed between staff members (eg, from a nurse to a surgeon)
• between uses (ie, when the scalpel is on the tray, it may fall, or the nurse may be injured while reaching for another instrument on the tray)
• during use
• after use
• during disposal.

With reusable models, injuries can also occur when the blade is mounted on the handle or is removed from the handle or during disposal of the scalpel blade.

Although these protective devices can help prevent some injuries—specifically those before use, during transfers, between uses, after use, and during disposal—they can’t help prevent injuries during use. In addition, to be protected, users must manually activate the safety mechanism to be protected.

Blunt suture needles

According to the latest EPINet data for 1993 to 2001 reported by Perry et al, suture needles are the leading cause of sharps injuries in the operating room, accounting for 41% of the injuries reported. These injuries can occur before and during suture needle use.

Before use, injuries are most likely when the suture needle is mounted in the needle holder or is repositioned in the needle holder, when the needle holder is parked with the needle up, and when the suture is passed hand to hand.

During use, needlestick injuries are most likely to result from actions such as using the fingers as a backstop or to guide the needle, sewing toward the fingers, and tying the suture with the needle attached, notes author Mark Davis, MD. Injuries can also occur to other staff members’ hands in the area where the suturing is taking place. And injuries can occur while disposing of the needle or even after disposal.

Protective products available to replace conventional suture needles are curved suture needles with a tip that is blunter than the tip of a conventional tapered needle. Although the blunt tip can still penetrate tissue for suturing, the blunted needle does not penetrate the skin as easily. Thus, it is less likely that accidental contact with the needle tip will result in a needlestick injury.

The products in this group are used in the same manner and for most of the same applications as conventional
suture needles. Blunt suture needles can’t be used for skin-closure applications, however, because they can’t sufficiently cut or pierce skin.

Because the function of any suture needle is to pierce tissue, devices used for this application, including blunt needles, present some risk of injuries. A number of studies of blunt suture-needle use during wound closure have found, however, that these products reduce the risk of needlestick injuries.

One drawback cited in several studies is that blunt suture needles are slightly more difficult to use than sharp needles, because blunt needles require slightly more force to penetrate tissue. But surgeons remarked that the use of blunt suture needles does not compromise their surgical technique. One such study is a 1997 report from the Centers for Disease Control and Prevention.

Users of blunt suture needles and protective scalpels should recognize that, although the products can help prevent some injuries during use, they can’t completely eliminate the risk of injuries. For this reason, we stress the importance of safe habits in addition to using a protective product. For example:

- Personnel should remain clear of the suture area while a surgeon is suturing.
- Personnel should remain clear of the incision area while a surgeon is cutting.
- The literature suggests that double-gloving may help reduce the risk of injuries.
- Passing suture needles and scalpels using a safe-pass zone can help to reduce injuries.

A safe-pass zone is a dedicated area in the sterile field where surgical instruments are placed to allow safe exchange between health care workers. For example, a nurse places a suture needle in this area, and the surgeon picks up the needle from this area, and vice versa. In this way, instruments are never directly passed between individuals, reducing the likelihood that the individual receiving a sharp instrument would inadvertently be injured during the exchange.

—Robyn Silverman
Senior project officer
Health Devices Group, ECRI
Plymouth Meeting, Pa

Sharps Safety and Needlestick Prevention, 2nd edition, is available from ECRI at www.ecri.org or by calling 610/825-6000. The price is $195 for ECRI members and $295 for nonmembers.

ECRI, a nonprofit organization sometimes called the Consumer Reports of health care, is known for its objective approach to medical device evaluation. www.ecri.org

References
Only nurse can testify on nursing standard of care, court rules

Only a nurse is qualified to give an expert opinion on the nursing standard of care in court, the Illinois Supreme Court ruled in February.

The issue, in brief, was whether a physician should be permitted to offer expert opinion on the standard of care for nurses.

In its ruling, the court referred extensively to an amicus brief filed by the American Association of Nurse Attorneys.

The ruling was in the case of Sullivan v Edward Hospital, no 95409, 2004 WL 228956. More information is available from the nurse attorneys’ national office at 850/474-3646.

Place of refuge for nurses

Quiet rooms for aromatherapy and meditation. A library with places to read and use computers.

The Beatrice Renfield Center for Nurses at Beth Israel Medical Center in New York City is open 12 hours a day to give nurses a place of their own where they can relax and restore. The $5-million center, donated by a long-time hospital trustee, is open to all nurses in Continuum Health Partners, which includes four hospitals and other facilities.

“It’s a place where we can comfortably come and work, learn, and renew ourselves,” Carmen Schmidt, RN, Beth Israel’s director of nursing education and research, told Hospitals and Health Networks (March).

—www.hhnmag.com

Central service techs can take exam in Spanish and English

The International Association of Healthcare Central Service Materiel Management is offering certification exams for CS technicians in both Spanish and English, the association announced April 8.

The new format will allow candidates to switch between English and Spanish while taking the exam if they choose. The exam is practice-based, allowing assessment of skills gained from actual practice rather than only textbooks.

—www.iahcsmm.com

Pay rates for surgical technologists

Average pay for surgical technologists varies from a high of $18 per hour in Washington, DC, to a low of $12.72 in Iowa, the Association of Surgical Technologists reports.

Other high-paying states: Connecticut at $17.47, Hawaii at $17.43, Nevada at $16.92, Alaska and California at $16.72, and New York at $16.35. On the low end were North Dakota at $12.92, and Alabama and Arkansas at $13.03.

The pay information was in the March issue of The Surgical Technologist.

—www.ast.org

Correction

In the January OR Manager, on page 11, the article titled, Changing practice for preop hair removal, should have said, “Gwinnett partnered with 3M, which provides the clippers, with Gwinnett buying the disposable heads.”
Please see the ad for SKYTRON INC. in the OR Manager print version.
Morbidly obese patients were once considered unsuitable for ambulatory surgery because of complicating conditions such as diabetes, hypertension, coronary artery disease, chronic obstructive airway disease, and sleep apnea. But with improved anesthetic and surgical techniques, ambulatory surgery centers (ASC) are treating more patients with multiple medical problems, including those who are obese.

A survey in the United Kingdom published in 2002 found 85% of day surgery units were giving anesthesia to obese patients (BMI > 30). A review of 258 morbidly obese patients (BMI > 35) who had day surgery did not find a significant increase in unplanned hospital admissions or postoperative complications.

OR Manager asked an expert in ambulatory anesthesia and surgery center managers to comment on how they make decisions about care of obese patients in their facilities.

Whether obese patients should have surgery in an ambulatory setting can be site specific, comments Beverly Philip, MD, chairman of the American Society of Anesthesiologist’s committee on ambulatory surgical care.

The issues to consider are the availability of the appropriate equipment as well as personnel expertise and backup. A surgeon’s office may be less suitable than an ASC or hospital unit.

Anesthesia care

Because obese patients are at greater risk for a variety of comorbidities, they need a thorough screening before anesthesia, notes Dr Philip, who is also professor of anesthesiology at Harvard Medical School and director of the day surgery unit at Brigham and Women’s Hospital, Boston.

Not only are obese patients more difficult to intubate, but their care also is harder to manage when there is an intubation problem.

“It is much more difficult to manage their airways and keep them breathing by other techniques while you find alternative ways to put the endotracheal tube in,” she says. Another difficulty in intubation is caused by the fact that obese patients can’t lie flat.

“They can’t breathe with the weight on their chests, so it may be helpful to begin anesthesia with the patient partly sitting up,” she says.

Preoperative planning

The patient appropriateness policy for Morton Plant Health Services, a Clearwater, Fla-based system, says morbidly obese patients generally are considered inappropriate candidates for its ambulatory surgery center.

Sometimes patients who have a significant weight problem are discovered by the RN performing the preoperative phone call, and the anesthesiologist is notified. The surgeon may not always inform the center about patients’ weight, notes Nancy Burden, RN, MS, Morton Plant’s director of health services.

At The SurgiCenter of Baltimore, obese patients must come in for preoperative assessment by an anesthesiologist to check for airway problems or any other comorbidities that might preclude them from having surgery in the ASC, notes Jerry Henderson, RN, BS, CNOR, CASC, executive director of the facility, located in Owings Mills, Md.

Because these patients are thoroughly screened preoperatively, most have uneventful recoveries. The SurgiCenter has not seen an increase in hospital admissions with these patients, she says. The center cares for at least one patient a month weighing about 350 lb.
The Harmony Ambulatory Surgery Center, LLC, in Fort Collins, Colo, is unusual in that it actually performs gastric bypass weight-loss surgery in its center. The surgery is feasible in that setting because, under Colorado regulations, surgery centers are allowed to keep patients for extended stays. The center, a joint venture between Poudre Valley Hospital and local physicians, is in the same building as a general surgery practice that performs a high volume of bariatric surgery. The program has had successful outcomes and is closely monitored by the center’s Medical Quality Assurance Committee. (See August 2002 OR Manager.)

Harmony discussed weight limits at length before starting the program, says Rebecca Craig, RN, CNOR, CASC, the center’s administrator. The center draws the line at 500 lb for patients who meet the BMI criteria. If a patient’s BMI is more than 50 or a patient has comorbidities, such as sleep apnea or a preoperative pulse oximetry reading of less than 90, the medical director must review the patient’s suitability for surgery at the center. Obese patients must have a preoperative electrocardiogram and lab tests, which patients of normal weight usually do not require.

**Equipment limitations**

How much weight equipment, such as OR tables and patient beds, will accommodate is a factor ASCs must consider.

“Our patient weight limit is our table weight limit,” says Henderson. The center has one OR table that will hold patients up to 400 lb, while its other surgical tables hold 350 lb. The center does not plan to buy more heavy-duty tables now, but as tables wear out, it will replace them with tables that can accommodate heavier patients.

Harmony, because of its bariatric surgery program, has equipment with higher weight limits. It has OR tables, stretchers, recovery beds, and other equipment such as wheelchairs and walkers with weight limits of 500 lb.

**Preparing for a heavier future**

Anesthesiology programs are beginning to teach students how to mask or intubate obese patients. As a professor of anesthesiology, Dr Philip says she knows her students will need to be able to help these patients and perhaps save their lives. The time to develop that skill is in a controlled situation and practice. That is increasingly necessary as the percentage of obese patients in the population steadily increases.

—Judith M. Mathias, RN, MA

**References**


Getting ready for JCAHO’s tracer method

A big change in the new Joint Commission on Accreditation of Healthcare Organizations survey process, which took effect in January, is the “tracer methodology.”

In this new process, surveyors will spend 50% or more of their time tracing how patient care is delivered through the surgery center. They will spend a lot less time meeting with leaders and going over paperwork.

In effect, the tracer method is like a road map of the patient-care experience that surveyors will use in judging standards compliance.

“For example, surveyors might ask to see all the records for your cases over the next 2 days,” says Michael Kulczycki, MBA, executive director of the Joint Commission’s ambulatory care accreditation program.

Talking with patients and caregivers

From these records, they might select three or four charts either from the current day or a previous day and use these to trace how care is delivered. They might take Mrs Jones’s chart, for instance, and talk with her and her family while she is waiting for surgery. They might talk to the staff and others involved in her care, including surgeons and anesthesiologists.

Some examples of questions surveyors might ask:

- Were you able to understand the information your caregivers provided about your surgery and postoperative care?
- Were you given clear instructions about your medications?
- Was your pain treated adequately?
- Did you feel your rights to privacy and confidentiality have been respected today?
- How was your correct surgical site identified? Did you participate in marking the site?

They might follow this same patient through the entire care process or look at care for several patients.

Surveyors might also ask to examine closed records and talk to the staff about those, such as asking how the staff was educated in taking care of an elderly patient.

“The surveyors will relate the care to the standards, focusing on how the staff performed their roles in dealing with these patients,” Kulczycki said.

As surveyors go through the tracer process, they will take notes and use those later in reviewing staff personnel files and physician credentials for clinicians who were involved in the care of patients they followed.

Medications given to the tracer patients might be a springboard for review of compliance with the Medication Management standards, which are now consolidated in their own chapter. A surgeon might, for example, follow the process for how a particular medication was selected, stored, prescribed, dispensed, given, and monitored for effects.

Similarly, infection control issues that arise during care of the selected patients would lead to a review of how an ambulatory surgery center complies with the Infection Control standards. Surveyors would also look at data management, such as how information about the tracer patients flowed to and from physicians’ offices.

HealthSouth has been reminding its surgery centers to be “survey ready” at all times, notes Donna Slosburg, BSN, LHRM, CASC, senior vice president for surgery operations.

We just need to live the standards daily.

JCAHO says its new survey process, Shared Visions—New Pathways, will improve accreditation reviews in a number of ways:

- Standards have been consolidated, clarified, and reduced by 40%.
- Elements of performance are listed with each standard to show how performance will be scored.
- Less time will be spent on policy and chart review, and more time will be spent on the patient care process.
- No more accreditation scores will be given to shift the focus away from scores and toward continuous performance.
- The survey agenda will be customized using data about each organization.
- The tracer method allows surveyors to assess compliance by seeing how patient care is actually delivered.
- A new Medication Management chapter pulls together medication standards to reinforce the importance of managing medication systems and improving processes for patient safety and quality.
- There should be less surveyor variability because surveyors are receiving more training and taking a certification exam.

“JCAHO surveys will more closely simulate many of our state surveys that are unannounced. We just need to live the standards daily and remain in compliance at all times.”

She encourages quality coordinators, nurse managers, and administrators to sign up on JCAHO’s web site for its free newsletters at www.jcaho.org. The site also has sections for frequently asked
questions, the National Patient Safety Goals, and other issues.

On home turf

Though the staff may be nervous about the tracer method at first, Ron Johanson, MD, an ambulatory care surveyor, says he has found the tracer process allows the staff to be met on “their home turf” instead of around a conference table.

“It seems much more natural to clinicians to view things through the eyes of patients. We are with them more in their comfort zone,” he said in a recent JCAHO audio conference.

“No one is going to grill them about Standard X, Y, or Z,” Johanson explained. “What they do need to know is to be able to express what their job description is and how they care for the patient. They need to show they have some understanding of how to ensure a safe patient environment and how they can address potential areas for improvement.”

Making a bridge

Johanson said he finds the tracer method helps make a bridge between policies and procedures and how patient care actually is delivered.

“The tracer activity helps to put those together so you actually see patient care as it happens,” he noted.

“It allows us as surveyors to get down in the trenches with the staff. It is much more rewarding for the surveyors because you can see what is really happening instead of just looking at it on paper.”

He contends that the value of the tracer method is that it allows “nearly every aspect that is important to the organization to be seen through the eyes of two or three patients. That gives you, I think, a much more appropriate and accurate look at the organization.”

JCAHO accredits about 400 ambulatory surgery centers.

Compliance high with site marking

Ambulatory surgery centers are chalking up a good record with the Joint Commission on the National Patient Safety Goal for preventing wrong surgery.

ASCs have the lowest rate of wrong-site surgery compared with hospitals and office-based surgical facilities.

In recent surveys:
- only 4% were out of compliance with the goal in announced surveys
- only 8% were out of compliance in unannounced surveys.

Please see the ad for ECRI in the OR Manager print version.
Health Policy & Politics

New Stark II regs published
The Centers for Medicare and Medicaid Services (CMS) has published phase II Stark regulations, which address physician referral to entities in which they have a financial interest. The rules apply to 11 designated health services, including inpatient and outpatient hospital services (but not ambulatory surgery centers). The new regs address exceptions to the Stark law not covered in the previous Phase I rules issued in 2001. One of the exceptions is for professional courtesy arrangements. The regulations were in the March 26 Federal Register.

—www.gpoaccess.gov/fr/index.html

Medicare to cover additional outpatient services, drugs
Three drugs and four new technologies will be eligible for additional payments under Medicare’s outpatient prospective payment system.

The technologies include:
- insertion of a pH capsule for measuring and monitoring gastroesophageal reflux disease (GERD)
- noncontact laser vaporization of the prostate
- balloon catheter for interstitial radiation of the breast following partial mastectomy—both concurrent/immediate and delayed.

The drugs include daptomycin, an antibiotic; risperidone, an antipsychotic; and rasburicase, a treatment for high uric acid levels that may result from some cancer treatments.

The changes are in CMS Online Manual, Transmittal 132 dated March 30.

—www.cms.hhs.gov/manuals/pm_trans/AB03132.pdf

Hospitals to report surgical infection measures
In spring 2005, consumers will be able to view data on three surgical infection measures from hospitals participating in Medicare’s quality initiative. The three measures are the timing, selection, and duration of prophylactic antibiotics.

The measures were among 12 new ones added in March to 10 existing measures.

Hospitals have a financial incentive for reporting data. Under the Medicare reform bill passed in 2003, hospitals must report data on the 10 existing measures to qualify for a full inpatient payment update starting in 2005. The new measures are voluntary.

—www.cms.hhs.gov/quality/hospital

Government clarifies specialty hospital moratorium
CMS issued a notice spelling out details for the 18-month moratorium on physician investment in and referral to specialty hospitals. The moratorium was passed by Congress in the fall. The notice describes which specialty hospitals are covered by the moratorium and which are not.


Please see the ad for SURGICAL INFORMATION SYSTEMS in the OR Manager print version.
FDA notice: Paralysis from absorbable hemostatic agent

The Food and Drug Administration issued a notice April 2 reminding surgeons of a rare but devastating effect from an absorbable hemostatic agent. Since 1996, the FDA has received reports of more than 110 such adverse events, 11 resulting in paralysis or neural defects. The common thread in all 11 events was use of an absorbable hemostatic agent on or near a bony or neural space and left inside the patient. When wetted, the material swelled and placed pressure on the spinal cord or other neural structures. Such events continue despite advice and warnings on the device label.

Insurers pull back on obesity surgery

Faced with rising costs, estimated at more than $3 billion last year, a growing list of insurers is canceling coverage of weight-loss surgery, the March 29 Los Angeles Times reported. UnitedHealthcare, the nation’s largest health insurer, has stopped paying for the operations, as has Humana. Blue Cross and Blue Shield of Florida announced it will stop in January. A spokeswoman for America’s Health Insurance Plans, a trade group, says companies are pulling back because of cost and concerns that many hospitals and doctors have started performing the procedure even though some are not qualified and do not have the appropriate equipment. Morbidly obese patients are worried because the surgery cost of about $30,000 is out of reach for many.

Physician intimidation fuels medication errors

More than 60% of 2,000 health professionals responding to a survey on medication practices said in the past year physicians had been reluctant to answer their questions or been condescending or impatient. Nearly half (49%) said intimidation had altered the way they handle clarifications or questions about medication orders. And 7% said they had been involved in a medication error in which intimidation played a role.

On the plus side, 60% said their organization had an effective process for handling disagreements about the safety of an order, and 70% said their organization would support them if they reported intimidating behavior. The survey was conducted by the Institute for Safe Medication Practices.

FBI raids California surgery centers for insurance fraud

The FBI and other law enforcement agencies raided three outpatient surgery centers in Southern California in March as part of a 15-month investigation into what insurers call one of the largest health care frauds ever, the March 18 Wall Street Journal reports. The probe targets dozens of surgery centers and more than 100 providers, mostly in Southern California, investigators said. In the scheme, doctors perform medically unnecessary and overpriced procedures on patients who are paid cash awards. In one case, a recruiter allegedly approached a factory worker and offered to fly him and his wife to Los Angeles and pay them $500 to $1,000 if they would visit a center for a few minor procedures such as bunionectomy and colonoscopy. One such insurance claim was for $220,000.

Patch as good as IV pump for postop pain

Use of a transdermal fentanyl patch to deliver pain medication was found to be equivalent to medication delivered by an IV pump for controlling pain after surgery, according to a report in the March 17 JAMA. The patch, called E-TRANS from Alza Corp, is investigational.