Get ready for a different survey process. Starting in 2004, you can expect leaner standards, a more targeted survey, and a focus on direct-care staff during the on-site visit by surveyors from the Joint Commission on Accreditation of Healthcare Organizations.

JCAHO is overhauling the survey process in its Shared Visions—New Pathways project. The intent is to pare down the standards to make them clearer and less redundant and to shift the survey process away from paperwork and more toward the actual process of care (sidebar).

Organizations got their first look at the 2004 standards in June when JCAHO posted a prepublication copy on its website. The new standards and survey process apply to all types of accredited organizations, including hospitals and ambulatory surgery centers.

The 2004 Patient Safety Goals were scheduled for release in July. As part of the new survey process, organizations will complete a web-based self-evaluation midway through the 3-year accreditation cycle. They will then develop action plans based on any deficiencies they find. The on-site survey will focus on reviewing evidence that the action plans corrected the problems and help organizations evaluate their systems for identifying...
Please see the ad for MEDLINE INDUSTRIES in the OR Manager print version.
Growing role of specialty coordinators

Read how this key role is expanding.

What strategies can help?

Growing role of specialty coordinators

The monthly publication for OR decision makers

August 2003 Vol 19, No 8

OR Manager is a monthly publication for personnel in decision-making positions in the operating room.

Elinor S. Schrader: Publisher
Patricia Patterson: Editor
Judith M. Mathias, RN, MA: Clinical editor
Billie Fernsebner, RN, MSN: Consulting editor
Janet K. Schultz, RN, MSN: Consulting editor
Kathy Shaneberger, RN, MSN, CNOR: Consulting editor

OR Manager (USPS 743-010), (ISSN 87505-5303) is published monthly by OR Manager, Inc, 1807 Second St, Suite 61, Santa Fe, NM 87505-3499. Periodicals postage paid at Santa Fe, NM and additional post offices. POSTMASTER: Send address changes to OR Manager, PO Box 5303, Santa Fe, NM 87502-5303.

OR Manager is indexed in the Cumulative Index to Nursing and Allied Health Literature, the Hospital Literature Index, and the National Library of Medicine’s Health Planning and Administration Database.

Copyright © 2003 OR Manager, Inc. All rights reserved. No part of this publication may be reproduced without written permission.


Editorial Office: PO Box 5303, Santa Fe, NM 87502-5303. Tele: 800/442-9918 or 505/982-0510. Fax: 505/983-0790. E-mail: ppatterson@ormanager.com

Advertising Manager: Anthony J. Iannetti, Inc East Holly Ave/Box 56, Pitman, NJ 08071. Telephone: 856/256-2300. Fax: 856/589-7463. John R. Schmus, national advertising manager. schmus@ajj.com

Stafﬁng update

How are ORs doing on recruitment and retention? Read results from our 2003 career/salary survey.

Meeting staffing challenges

Is your OR suffering from “gaposis”—surgeons want to operate late in the day but staff want to go home? What strategies can help?

An elderly woman falls and severely fractures her shoulder. She comes to the ER. The physician on duty finds she needs surgery. But when he calls the orthopedic surgeon on call, the surgeon refuses to come in. He says the surgery can wait, and a trip to the ER would be “a waste of his time.”

Outrageous? The ER doctor thought so.

In fact, he decided to leave his position in the ER at St Vincent Hospital in Santa Fe, NM, where he’d been for 23 years, citing lack of support by hospital administrators and the medical staff on on-call issues. The case was reported in the local newspaper, The New Mexican.

Scenes like this are being repeated across the country.

Hospitals have a hard time getting specialists to agree to take ER call. The situation is particularly serious for small rural hospitals where there are too few specialists to share the call burden.

Surgeons and other specialists say there are legitimate reasons for their reluctance. They say too often patients aren’t properly evaluated and don’t have genuine emergencies.

No pay for many emergencies

But the big reasons are ones affecting doctors throughout the country—reimbursement and malpractice premiums.

On-call specialists often get no pay for emergency cases. An orthopedic surgeon quoted in The New Mexican said that of the legitimate emergencies he sees, about 40% of the patients are uninsured. If he gets called in the middle of the afternoon, he may have to leave an office full of paying patients, delaying their care.

“The reason we have a problem is because of EMTALA,” Angela F. Gardner, MD, president of the Texas College of Emergency Physicians, told OR Manager.

EMTALA—the federal Emergency Medical Treatment and Labor Act—requires hospitals to make emergency care available to all who need it, regardless of insurance, citizenship, and ability to pay. Hospitals must also make sure specialists are available. Hospitals and on-call physicians can face federal penalties for not complying.

It truly is an access-to-care issue for patients.

“The problem is there is no funding,” says Dr Gardner. “Doctors are required to take ER call, but there is no guarantee they will be paid.”

And despite EMTALA’s threatening sound, it is a toothless tiger. Fewer than 30 physicians were cited for violations in the first 15 years the law was in effect.

Adding fuel is the malpractice crisis. “Not only is there a risk of not being paid when you’re on call, you put all of your assets on the line,” Dr Gardner adds.

She notes there is a “huge difference” in premiums for physicians who take ER call. Physicians say patients they see in the ER are more likely to sue, perhaps partly because they don’t have an ongoing relationship with the physician.

Premiums already are astronomical. Insurance premiums for emergency physicians grew on average more than 50% from 2002 to 2003 to $53,500, according to the American Medical Association (AMA), with some paying more than $100,000 annually. Other high-risk specialties, such as neurosurgeons and OB-GYNs, are paying $200,000 to $300,000 annually.

“It truly is an access-to-care issue for patients,” Dr Gardner says.

In the past 10 years, hundreds of emergency departments have closed while the number of ER visits climbed 20%, according to the American College of Emergency Physicians.

Any light at the end of this tunnel? Some states are taking steps toward tort reform, which Dr Gardner finds encouraging.

But it seems no one yet has a solution to paying for emergency care.

Until we get some national leadership from our politicians on that issue, ER care for all of us is vulnerable.”

—Pat Patterson
Please see the ad for
BOVIE MEDICAL
in the OR Manager print version.
Find your mantra, popular speaker advises

O
t managers and directors are under pressure with multiple departments to run, staffing challenges to contend with, and costs to contain.

How do you juggle it all without letting your spirit sag?

“Know what you value. Find your message. And don’t forget to have a little fun.” That’s the advice of DeNene Cofield, RN, BSN, CNOR, who will give the closing address at the Managing Today’s OR Suite conference Sept 17 to 19 in San Diego.

“It’s the role of the leader to inspire people. Find a message and make it your mantra,” says Cofield, who is administrative director of surgical services and orthopedic and bariatric service lines at Medical Center East in Birmingham, Ala.

“It should be something everyone understands,” she says. “Maybe your message is, ‘We take care of every patient as if that person is our mom or dad.’ Or maybe it’s, ‘Never punish a learner.’”

Then find your personal style for bringing that message home to your colleagues in the workplace—that creates your legacy.

Cofield, known for her positive attitude and sense of humor, does it by getting in touch with her inner child.

On Halloween, she might show up at a staff meeting in an orange boa. Or she might give a humorous bit of encouragement as she walks around the units.

Every year, the department has an “academy awards” ceremony with funny videos taken by staff and physicians in the department. The humor builds camaraderie and helps keep morale high. Then it’s no problem to keep everyone focused on the mission.

“What happens when you’re a leader is that your mantras get adopted by both the medical staff and the OR staff,” says Cofield. “Then people understand what you value. They will value what you value, and that will be your legacy.”

Advisory Board

<table>
<thead>
<tr>
<th>Name</th>
<th>Title and Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gail Avigne</strong>, RN, BA, CNOR</td>
<td>Nurse manager, Shands Hospital at the University of Florida, Gainesville</td>
</tr>
<tr>
<td><strong>Mark E. Bruley</strong>, EIT</td>
<td>Vice president of accident &amp; forensic investigation, ECRI, Plymouth Meeting, Pa</td>
</tr>
<tr>
<td><strong>Judith Canfield</strong>, RNC, MNA, MBA</td>
<td>Associate administrator of surgical services, University of Washington Medical Center, Seattle, Wash</td>
</tr>
<tr>
<td><strong>Michele Chotkowski</strong>, RN, MSHA</td>
<td>Director of perioperative services, Lawrence Hospital/Healthstar Network, Bronxville, NY</td>
</tr>
<tr>
<td><strong>DeNene G. Cofield</strong>, RN, BSN, CNOR</td>
<td>Director of surgical services, Medical Center East, Birmingham, Ala</td>
</tr>
<tr>
<td><strong>Larry Creech</strong>, RN, MBA, CDT</td>
<td>Vice president, perioperative services, Clarian Health System, Indianapolis, Ind</td>
</tr>
<tr>
<td><strong>Cheryl Dendy</strong>, RN</td>
<td>Administrative director, Ambulatory Satellites, St John Hospital and Medical Center, Detroit</td>
</tr>
<tr>
<td><strong>Franklin Dexter</strong>, MD, PhD</td>
<td>Associate professor, Department of Anesthesia, University of Iowa, Iowa City</td>
</tr>
<tr>
<td><strong>Aileen Killen</strong>, RN, PhD, CNOR</td>
<td>Director of nursing, perioperative services, Memorial Sloan-Kettering Cancer Center, New York City</td>
</tr>
<tr>
<td><strong>Robert V. Rege</strong>, MD</td>
<td>Professor and chairman, Department of Surgery, UT Southwestern Medical Center, Dallas, Tex</td>
</tr>
<tr>
<td><strong>Marimargaret Reichert</strong>, RN, MA</td>
<td>Administrator, Surgical Care Center, Southwest General Health Center, Middleburg Heights, Ohio</td>
</tr>
<tr>
<td><strong>Kathy E. Shaneberger</strong>, RN, MSN, CNOR</td>
<td>Director, perioperative services and ortho/neuro service line, Mercy General Health Partners, Muskegon, Mich</td>
</tr>
<tr>
<td><strong>Shelly Schwedhelm</strong>, RN, BSN</td>
<td>Director, perioperative services, Nebraska Health System, Omaha</td>
</tr>
<tr>
<td><strong>Sallie Walker</strong>, RN, BA, CGRN</td>
<td>Baptist Physicians Surgery Center, Lexington, Ky</td>
</tr>
<tr>
<td><strong>Allen Warren</strong></td>
<td>Business manager, surgical services, Mission St Joseph’s Hospital, Asheville, NC</td>
</tr>
<tr>
<td><strong>Anny Yeung</strong>, RN, MPA, CNOR, CNAA</td>
<td>Assistant vice president for perioperative services &amp; associate hospital director, SUNY Downstate Medical Center, New York City</td>
</tr>
</tbody>
</table>

Ambulatory surgery track, breakouts for new managers

The Managing Today’s OR Suite conference offers a special track on ambulatory surgery as well as breakout sessions identified as especially helpful for new managers.

**Ambulatory surgery**

The ambulatory surgery track features an all-day seminar and four breakout sessions designed for ambulatory surgery personnel:

**All-day seminar**

- Clinical Management of the Ambulatory Surgery Patient

**Breakouts**

- Patient Safety Program for the ASC
- What is Needed to Staff a Surgery Center
- Strategic Planning for an ASC
- Why Are Not-for-profit Hospitals Entering the For-profit Market?

**Sessions for new managers**

Breakout sessions that have been identified as valuable for new managers of the surgical suite include:

- Complying with JCAHO Patient Safety Standards
- Emotional Competence: The Essential Core of Leadership
- HIPAA: What it Means for Your Facility
- Dialogue and Partnership in the Workplace
- JCAHO’s New Survey Process
- Why Health Care Workers Quit
- Following Your True Spirit to Effective Leadership
- Managing Block Scheduling

For the complete conference brochure, go to www.ormanager.com or call 800/442-9918. You can register online at the OR Manager web site.

August 2003 OR Manager Vol 19, No 8
Please see the ad for
KIMBERLY-CLARK CORPORATION
in the OR Manager print version.
been doing a “tremendous number of fire investigations lately,” having received at least a dozen reports in an 8-week period ending June 30.

The day after the alert appeared, the Birmingham News in Birmingham, Ala, ran a front-page article headlined: “Patient’s ‘face ignited’ in surgery.” The article reported on a patient who recalled emerging from anesthesia “with her head ablaze.” She said the doctor told her the fire ignited when he was using an electrosurgical instrument to cauterize a blood vessel on her forehead and the “dressings on her face caught fire.”

The head and neck area is one of the most common surgical fire locations, accounting for 28% of cases, ECRI reports. Other common sites are:

- the airway 34%
- other sites on the body 38%

In the vast majority—74%—an oxygen-enriched environment is a contributing factor. In more than two thirds, the ignition source is an electrosurgical unit (ESU).

Be proactive on education
The Joint Commission alert “has raised the bar” on what hospitals need to do proactively for fire prevention, Bruley says.

Virtually all surgical fires can be prevented, and their impact can be lessened if the team understands fire and how to fight it, he says. That will require collaboration among all three disciplines in the OR—surgeons, anesthesia providers, and nurses.

The alert says all members of the team need to understand the “fire triangle,” the elements needed for a fire to start—heat, fuel, and oxygen. And each member of each discipline needs to understand his or her role in controlling the sides of the triangle.

One of the Joint Commission’s three recommendations on preventing fires is to:

- inform staff members, including surgeons and anesthesiologists, about the importance of heat sources by:
  - emphasizing the importance of controlling heat sources by following laser and electrosurgery unit safety practices
  - managing fuels by allowing sufficient time for the patient prep

—establishing guidelines for minimizing oxygen concentration under the drapes.

The other two recommendations are:

- developing, implementing, and testing procedures to ensure appropriate response by all surgical team members to OR fires
- strong encouragement to report any surgical fires to JCAHO, ECRI, the Food and Drug Administration, and state agencies, among others, so awareness is raised and fires can be prevented.

“The big issue will be how to define ‘staff,’” Bruley says. “It’s not just OR nursing. It’s the triumvirate and how all of those people are going to get education.”

Because most fires involve an oxygen-enriched environment, oxygen management is a major issue.

“Controlling and minimizing excess oxygen under the drapes is one of the keys, and that must involve anesthesia,” Bruley says.

Surgeons typically control the heat source, which may include the ESU, lasers, and high-intensity fiberoptic light sources.

Nurses often control the fuels, flammable materials such as alcohol preps and drapes.

The Joint Commission’s Sentinel Event Alert on preventing surgical fires is at www.jcaho.org

ECRI’s fire resources
ECRI is offering an audio conference on surgical fires Sept 17. Check the ECRI web site for details. www.mdsr.ecri.org. Enter search term, “fires.”

The Free poster, Only You Can Prevent Surgical Fires, is there along with about a dozen other publications on surgical fire causes, prevention, and extinguishment.

A clinician’s guide to surgical fires: How they occur, how to prevent them, how to put them out [guidance article]. Health Devices. 2003; 32(1):5-24. Check with your biomedical or risk management department to see if your facility subscribes. Otherwise, to purchase a copy, contact ECRI at 610/825-6000 ext 5888.

Special lecture: Preventing surgical fires

Mark Bruley of ECRI, who has investigated OR fires for 25 years, will give a special lecture on preventing surgical fires at the Managing Today’s OR Suite conference.

The lecture will be Friday, Sept 19, from 7 to 8 am at the Manchester Grand Hyatt, San Diego.

Surgical fires are the subject of a June 25 Sentinel Event Alert from the Joint Commission on Accreditation of Healthcare Organizations.

ECRI is a nonprofit organization that specializes in health care technology.
Please see the ad for
OLYMPUS ENDOSCOPY
in the *OR Manager* print version.
Participants at the OR Business Management meeting June 4 to 6 learned about the dynamics of group purchasing, practical strategies for implementing a perioperative information system, and working through a design and construction project, among other topics.

About 200 surgical services business leaders attended the meeting in Washington, DC. Next year’s meeting is May 12 to 14 in Albuquerque, NM (box).

Kicking off the meeting, Gail Scott, coauthor of The Indispensable Healthcare Manager, gave the audience tools to help lead their staff through change.

In one exercise, she had the audience share with their small group a time they had made a difference as a manager.

She then told about a woman who was head of the laundry at a major hospital for 50 years. The woman shared what she thought she had done to make a difference. “Most of my staff have learned to read and write, and I’ve encouraged them to get their GEDs,” she replied.

When a new supervisor expressed surprise and asked her what that had to do with laundry, the woman said gently, “This isn’t really about laundry—it’s about life.”

In a half-day workshop on automation, leaders Jeanne Parkes, MA, and Jeanne Lattanzio, RN, of the J2 Group, New York City, who consult on implementing perioperative information systems, gave the audience a variety of tools and strategies they could use to guide their projects.

“In a project, 85% of the implementation difficulties are organizational, not technical,” Parkes said. One hospital had a one-person project team for an implementation, which wasn’t realistic.

“This will be a long-term project, and it needs resources and support,” they emphasized. The project will need backing from the administration and an executive champion, who can give those involved license to make the project a priority.

At the workshop on group purchasing organizations (GPOs), led by Ed Gravell and Judy Pins, RN, MBA, MHRD, of Cardinal Health, Medical Products and Services, attendees learned about the market forces that are shaping GPOs and the services they provide. They had a chance to play out market dynamics by acting in roles of a GPO, small rural hospital, manufacturer, distributor, or large integrated delivery network.

Attendees tried out a part of the Six Sigma process developed by GE Medical Systems at the process improvement workshop. Six Sigma, a systematic approach to reducing defects, uses a variety of tools, such as the Work-Out and Change Acceleration Process (CAP).

In small groups, participants used CAP to analyze an OR process, like having case carts ready, and develop an action plan to improve the process.

Other half-day workshops included managing an orthopedic implant program, working through an OR construction project, and designing an integrated OR.

Closing the meeting, Pins advised the group that despite the need for business skills, leadership is what will keep their departments moving ahead.

“Your job as a leader is to get people to talk and collaborate,” she said. “Few things get done without teamwork.”

Gail Scott talks about leading staff through change.

2004 OR Business Management Conference to be in Albuquerque

The fifth annual OR Business Management Conference will be May 12 to 14, 2004, in Albuquerque, NM, at the Hyatt Regency Downtown.

The program, which focuses on business and financial management of the OR, will include a special track on establishing a bariatric surgery service line.

Continuing the interest in OR design and construction, a track will cover topics of interest to those involved in building or renovating OR suites.

Attendees at the conference include OR directors, business managers, materials management personnel, and others interested and involved in the financial management of the OR.

Albuquerque offers an opportunity to explore its Native American and Hispanic cultures. The Indian Pueblo Cultural Center and new National Hispanic Cultural Center are nearby. In Old Town, with historic adobe buildings, are unique shops and galleries with local arts and crafts and restaurants, many offering Southwest cuisine. The city’s many museums feature a range of subjects from archeology to rattlesnakes.

Within an hour’s drive is historic Santa Fe, which offers art galleries, museums, and other attractions. Those interested in the pueblo Indians can visit Acoma, a pueblo perched on a high mesa overlooking the desert about an hour’s drive from Albuquerque. The city of Taos and the famous Taos pueblo are about a 2-hour drive north.

Mark your calendars now. The full program will be available in late fall.
What you can expect from JCAHO’s new survey process

Trimmed-down standards
Hospital and ambulatory care standards have been reduced by roughly half.

Less focus on paperwork
JCAHO says the process will focus less on having the right documents ready for the survey and more on assessing how care is actually delivered.

Self-evaluation process
This new process, called a “periodic performance review” (PPR), takes place halfway into the 3-year accreditation cycle. The PPR involves:
- A self-evaluation of compliance with standards via a secure JCAHO web site. The PPR takes about 3 months to complete and much be submitted by the 18-month point in the cycle.
- A corrective action plan for any deficiencies found in the PPR. There is a 90-day window to complete corrective action plans, followed by a discussion with JCAHO.
- A follow-up review of the results of corrective actions during the on-site survey.
- As an incentive to complete the PPR, if your organization identifies a problem, completes an action plan, and shows how the plan addressed the problem, the problem will not have an impact on the accreditation decision. But if surveyors identify a problem on site that wasn’t addressed in the PPR, it could be subject to a recommendation, and there will be a shorter time for correcting it.

Data-directed surveys
JCAHO will use automation to analyze data about your organization to target the survey. For example, if MEDPAR data shows your volume for some procedures is higher than others, surveyors might focus on high-risk aspects of those procedures.

Focused on-site survey
Key differences in the on-site survey include:
- No formal document review session will be held. Documents may still be examined, but these reviews will be woven into the survey process.
- The leadership conference will be a discussion of corrective action plans and results.
- Surveyors will focus on direct-care staff instead of managers. They will follow the patient care process, interview staff, and review documents as they go.
- Department visits will be driven by randomly drawn patient charts and open medical records. Surveyors will follow selected patients through the process to see how care is given.

Leaner standards
The number of hospital standards has been reduced by more than half and the ambulatory standards by almost half. The final standards, which will be published in September, should be very close to the on-line version posted in June. “There won’t be any surprises,” Kupka says.

Mainly, what they have done is to take out the redundancy,” says Denise Geuder, RN, MS, CNOR, a perioperative nurse and chair of JCAHO’s ambulatory care Professional and Technical Advisory Committee (PTAC).

For example, rather than being surveyed for age-specific competencies under several chapters as before, facilities will be surveyed under the Human Resources (HR) chapter.

There are two new chapters. A new Provision of Care chapter includes standards from the previous assessment, care, education, and continuum of care chapters. The second new chapter, on medication use, includes revised standards from the care chapter. The accreditation manuals will have cross-walks to identify standards that have been consolidated, moved, or removed.

The revised standards follow a new format that includes:
- a brief statement of the standard
- a rationale or background
- elements of performance that state what is expected.

Gone are the confusing “Examples of Implementation” at the end of each chapter. JCAHO will augment the on-site survey using a process called the “tracer methodology.” This automated data analysis is intended to zero in on problems. JCAHO may still be examined, but these reviews will be woven into the survey process.

They might ask the patient about informed consent, for example. If they find informed consent is an issue, they might dig into that process. They might request more charts, ask to see the policy, and query the staff about education they received on informed consent.

“We want to encourage the staff to be able to speak about the process of care,” Kupka emphasizes. “We’re not asking the staff to memorize and be able to recite the standards.”

Shift toward caregivers
A key point—when surveyors come on site, they will spend less time with your leaders and policy manuals.

“The focus is not on document review. The focus is shifting to the direct patient-care givers,” stresses Nancy Kupka, RN, MS, MPH, associate project director in JCAHO’s Division of Research.

In a process that some call “pulling the thread,” surveyors will assess compliance by following the actual process of care. They will spend time talking with front-line staff about how care is given. They will randomly pull patient charts and use open medical records to guide their visit. For example, a surveyor might draw a chart for a surgical patient who is in your facility that day.

“They might look at whether the preoperative testing was done if it was ordered,” says Kupka. “They might talk to the person at the registration desk, the OR staff who were with the patient during surgery, and the recovery room staff about what happened during recovery. They might also talk to the patient, if that is possible.”

Continued from page 1
standard. These were intended to give tips on how to meet a standard, but they were often interpreted both by facilities and surveyors as what organizations had to do to comply. Instead, JCAHO plans to put tips on its website that can be updated.

In reducing the standards, there is a danger wording could be watered down.

“I was very concerned about that going into the process,” Geuder acknowledges. But she found JCAHO was responsive to input from the PTACs. “I feel the standards are pretty strong. I don’t feel we compromised anything.”

Operative, anesthesia standards combined

The new Provision of Care chapter combines the standards for operative procedures and/or moderate or deep sedation or anesthesia. The section has three basic standards to say:

• care is planned
• patients are monitored during the care
• patients are monitored immediately after the care is given.

The only requirement that has been deleted is one requiring a postprocedure nursing care plan preoperatively, Kupka says.

The section preserves the standards on sedation and anesthesia introduced in 2001. Those standards defined four levels of sedation and anesthesia and said, among other things, that qualified individuals were provided in sufficient numbers to:

• evaluate the patient
• provide the sedation and anesthesia
• perform the procedure
• monitor
• recover and discharge the patient.

The gist of the 2001 standards remains.

“We continue to have the expectation that competence will be established for whatever an individual is doing,” Kupka says. “We do not expect that anyone will be operating where they have not had the proper preparation or are out of their scope of practice.”

Nurse staffing

The only mention of nurse staffing for operative procedures states: “A registered nurse supervises perioperative care.” This language is also in the current standards. All reference to the circulating nurse in the operating room was removed several years ago.

Nurse staffing in general for hospitals is addressed in the Nursing chapter and the HR chapter. The ambulatory care manual does not have a separate nursing chapter.

The Nursing chapter states that a nurse executive will direct the organization’s nursing services and defines that role. The HR chapter covers planning for staff, orientation, and competence assessment. It is also home of the staffing effectiveness standard that took effect last year.

Kupka explains that standards related to staffing are broad because they cover a variety of organizations and situations.

“We’ve tried to say, ‘We don’t know all the answers.’ We are trying to let organizations have latitude. We are saying that based on your scope of services, you need to look at who you choose and what their job responsibilities are. You need to make sure you have the right number of people with the appropriate credentials who are functioning under the appropriate laws and regulations, have on-going evaluations, are functioning within their scope of practice, and are maintaining quality and safety.

“Where the rubber meets the road is in the survey process,” she adds. “If the surveyor asks, ‘How are you staffing in your OR?,’ and the answer is you are taking people off the street, that probably won’t cut the mustard.”

Did the revision help the HR standards, which have been a tough area for compliance?

“This is the one chapter I don’t think is clearer. They made a valiant attempt,” says Geuder. “Perhaps having the standards in one chapter will make it easier.” (Some standards were previously under the Leadership chapter.) But competence assessment is a tough standard organizations may continue to struggle with.

Less paperwork?

Will the new process help reduce paperwork for nurses, as JCAHO says?

Probably not the everyday documentation. But the redesigned survey process will help cut down on the big push to compile notebooks in the year before a survey.

“So much of your time during that year is spent getting the documentation and paperwork ready,” says Geuder. Now much of that activity will be replaced by the self-evaluation process.

For managers, the new challenges will be to keep policies and procedures up to date and to make sure the staff understand and follow the standards in their daily practice. During surveys, the staff will be under more pressure to respond to surveyors, and they will need to be prepared for that.

Obesity costs rival those of smoking

About 9% of the nation’s annual health care bill goes for care related to being overweight or obese, about the same as the cost of treating smoking-related illnesses.

Health care for overweight individuals costs 37% more than care for persons of normal weight.

More than half of those covered by insurance—54%—are overweight or obese. The percentage is even higher for Medicare patients (56%).

Obesity is a major risk factor for diabetes, hypertension, and heart disease and should be addressed as aggressively as smoking, the researchers advise.

The authors say their analysis points out how much of the cost is borne by government health programs such as Medicare and Medicaid.

Please see the ad for SKYTRON, INC. in the OR Manager print version.
Please see the ad for SKYTRON, INC. in the OR Manager print version.
A quarterly column on complying with Joint Commission standards.

Q. What will the surgical services director notice is different about the 2004 standards compared with the current standards?

A. The standards manuals will be much “thinner.” With over half of the standards removed or integrated into other standards and all the Examples of Implementation gone, the Comprehensive Accreditation Manual for Hospitals and the other standards-only books will be noticeably thinner.

The standards also use a new numbering system.

The other major difference is the new Elements of Performance, which are part of each standard and state what is expected. The elements will be scored on a three-point scale:

- 0: Unsatisfactory compliance
- 1: Partial compliance
- 2: Satisfactory compliance
- NA: Not applicable

To me, the Elements of Performance seem to have a better focus on required activities. Now I think the standards are getting closer to providing what everyone has asked for over the years: “Just tell us what you want us to do.”

Q. Are there any new requirements or is this just a reorganization?

A. The medication use standards have been placed in a separate chapter, but they still focus on safety and patient monitoring. I believe what we’ll see in the final manuals for 2004, scheduled for release in September, are accreditation standards that have been simplified and reorganized into more logical units or chapters.

Q. JCAHO says this will reduce the paperwork burden for nursing staff. Will this reduce documentation requirements for perioperative staff?

A. Frankly, I don’t see any reduction in documentation requirements for patients and the care they receive. If the hospital or ambulatory surgery center uses a computerized charting system already, I’m sure there wouldn’t be any reduction in documentation requirements. However, if the standards’ focus is truly on the patient, I believe some of the “onerous paperwork” that has been perceived to be required in the standards (without actually saying you have to have something) will be gone. We’ll all have to wait and see on this one.

### Examples of Joint Commission standards

<table>
<thead>
<tr>
<th>Std</th>
<th>2003 Version</th>
<th>Std</th>
<th>2004 Version</th>
</tr>
</thead>
<tbody>
<tr>
<td>RI.1.2.1</td>
<td>Informed consent is obtained.</td>
<td>RI.2.40</td>
<td>Informed consent is obtained.</td>
</tr>
<tr>
<td>PE.1.8</td>
<td>Before surgery, the patient’s physical examination and medical history, any indicated diagnostic tests, and a preoperative diagnosis are completed and recorded in the patient’s medical record.</td>
<td>IM.6.30</td>
<td>Deleted here; covered in IM.6.30. The medical record thoroughly documents operative or other procedures and the use of moderate or deep sedation or anesthesia.</td>
</tr>
</tbody>
</table>
| TX.2 | Moderate or deep sedation and anesthesia are provided by qualified individuals. | PC.13.20 | Two of the elements of performance say:
1. Sufficient numbers of qualified staff are available to evaluate the patient, perform the procedure, monitor, and recover the patient.
2. Individuals administering moderate or deep sedation and anesthesia are qualified and have the appropriate credentials to manage patients at whatever level of sedation or anesthesia is achieved, either intentionally or unintentionally. [“Qualified” is defined in footnotes.] |
| PE.1.8.4 | The patient’s postoperative status is assessed on admission to and discharge from the postanesthesia recovery area. | PC.13.40 | Patients are monitored during the period immediately after the procedure and/or administration of moderate or deep sedation or anesthesia. |
| IC.1 | The organization uses a coordinated process to reduce the risks of nosocomial infections in patients and health care workers. | IC.1.10 | The organization uses a coordinated process to reduce the risks of nosocomial infections in patients and health care workers. |
Q&A

Patterson in person

Carole Patterson will be discussing JCAHO’s new survey process and what it means for your OR at the Managing Today’s OR Suite conference, Sept 17 to 19, at the Manchester Grand Hyatt, San Diego.

Q. In the new integrated operative and sedation/anesthesia standards, the language on sedation/anesthesia regarding qualifications and competency of staff has been condensed. Is there any reason to worry that these standards have been diluted? Do the standards still protect nurses from being expected to monitor patients without the proper additional education? Would they protect a nurse who is asked to monitor a patient in addition to circulating?

A. Yes, the new standards still “protect” nurses because in the Human Resources chapter, there still are requirements for a “sufficient number of qualified staff” to carry out patient care activities. If a surveyor found a nurse who was monitoring a patient undergoing a procedure covered by these standards, the surveyor would undoubtedly want to check the nurse’s education, training, experience, and competency assessments.

Q. Would it be possible to give an example of a requirement that applies to surgical services and explain how the old and new standards compare?

A. The chart on page 14 has some before-and-after examples. Note that the standards numbers change in 2004. For example, pain management is RI.1.2.9 in the 2003 manual: “Patients have the right to appropriate assessment and management of pain.” The rewritten requirement in 2004 is in the Ethics, Rights and Responsibilities chapter at RL.2.160: “Patients have the right to pain management.” Similar words; same requirement.

—Carole H. Patterson, MN, RN
Senior Consultant
Critical Management Solutions, Inc
Wilmington, Del

Critical Management Solutions is a private health care consulting company specializing in sentinel event management and error reduction. Visit www.nomoreerrors.com

Workplace

California nurse ratios to go into effect Jan 1

California issued revised nurse-to-patient ratios July 1, which are expected to go into effect Jan 1. The state is the first to require ratios by law.

The California Department of Health Services said it received more than 24,000 letters about the controversial ratios, which were mandated by law in 1999.

As proposed, the ratio for the OR will be 1:1, which is already required by state regulation. The regs clarify that an RN will be assigned to OR circulating duties, and a minimum of one additional person will serve as scrub assistant. The scrub assistant “may be a licensed nurse, an OR technician, ‘or other person who has demonstrated current competence to the hospital as a scrub assistant’ but will not be a physician or other licensed professional who is assisting in surgery.

The ratio for the PACU will be 1:2, also the same as proposed. The med-surg ratio will start at 1:6 and change to 1:5 in 2005. After the comment period, the state decided to phase in tighter ratios for three units in 2008: Step-down units will move from 1:5 to 1:3; telemetry will move from 1:6 to 1:4, and specialty care units, such as oncology, will change from 1:5 to 1:4.

Licensed vocational nurses (LVNs) can make up 50% of the required nurses, with certain exceptions. Nurse managers can be counted in the ratio only when engaged in direct patient care. Nurse managers can relieve staff nurses during breaks but only if they have demonstrated current competence on that unit.

The state decided not to delay the ratios until 2006, as requested by the California Healthcare Association, which represents hospitals.

—www.dhs.ca.gov

More RNs could be exempt from overtime under new rules

New rules proposed by the US Department of Labor (DOL) could make it possible to exempt more employees, including RNs, from overtime.

Under the proposed rule changes to the Fair Labor Standards Act, employees who earn between $22,101 and $65,000 who meet one of three tests could be defined as overtime exempt. That would be a boon to low-wage managers. Currently, a restaurant manager who makes $18,000 a year, for example, does not have to be paid overtime.

But new tests for executive, administrative, or professional employees could make it possible to include more in the exempt category.

The “executive” test would include directing work of more than two employees and having authority to hire and fire. The “administrative” definition say employees must hold a “position of responsibility.” The “professional” test would recognize as exempt “learned professionals who gain equivalent knowledge and skills through a combination of job experience, military training, and technical or community college education.”

The American Nurses Association (ANA) is particularly concerned about the “professional” test because it would give employers the option to save on their labor budget by excluding more RNs from overtime pay. ANA also fears it would encourage more mandatory overtime.

But employers would have to weigh the impact on recruitment and retention. They’d also have to consider the possibility that more RNs would unionize because collective bargaining agreements take precedence over federal overtime rules.

The new rules would not apply in states that have stricter regulations.

Comments on the proposal to update the 50-year-old rules were due June 30, and a final rule could be issued next year.

—www.wagehour.dol.gov

FASA seeks seat on Joint Commission committee

The Federated Ambulatory Surgery Association (FASA) is seeking a seat on a key committee of the Joint Commission on Accreditation of Healthcare Organizations to help increase input from ambulatory surgery centers (ASCs). FASA would like to join the Professional and Technical Advisory Committee for ambulatory care.

FASA leaders led JCAHO officials on a tour of an ASC in Illinois recently to illustrate the patient care process and discuss accreditation issues.

A total of 365 ASCs were accredited by JCAHO in 2002.
Please see the ad for DUPONT in the *OR Manager* print version.
Please see the ad for DUPONT in the OR Manager print version.
Practical steps for boosting staff retention

It is a manager’s job to ensure the staff is giving excellent care to patients. But are staffs receiving adequate care from their managers? With the staffing crisis, the attention you give your staff—whether in scheduling, training, workload, or compensation—may just be what it takes to improve retention.

Of course, not all turnover is under a manager’s control. About 40% is for reasons such as retirement, relocation, medical and maternity leaves, and family circumstances.

But exit interview data from 28,000 health care workers gathered in 2002 by JWT Specialized Communications Health Care Group found bad management was the most common cause for resignation over any other controllable reason.

JWT recently updated the data specifically for OR staff (chart).

Some of the leading reasons staff leave—the stress of understaffing, work schedules, and lack of support and guidance—are areas managers can influence.

The good news—with care and attention, managers can greatly influence the fate of their staff. Here are practical ideas for addressing these issues.

How are you managing?

“I went to the manager and she told me she didn’t have time for me.”

“After 29 years of service, my supervisor would not let me take my vacation when I requested it.”

—Exit interviews

In exit interviews, nearly one quarter (24%) of staff rated their managers’ overall performance as poor or unacceptable.

In fact, the level of dissatisfaction with management is the most reliable predictor of whether an employee will quit.

“They don’t quit a hospital or health care delivery system, they quit a manager,” says Greta Sherman, recruitment and retention expert for JWT Specialized Communications.

In exit interviews, 8% of respondents specifically cited “supervision and management” as the main cause of their leaving. But that rose to about 25% when other manager-influenced areas, such as lack of communication, work schedules, poor morale, lack of recognition, and limited employee input, were included.

Add 12% of terminations due to “better career opportunity,” which can be attributed to not providing better career guidance and all-around compensation, and another 6% due to salary, which is often designated with the manager’s recommendation, and managers can be considered responsible for 43% of respondents’ resignations.

What managers can do

“Teach managers the language of the four different generations that work together today, teach them how to build a team, teach them how to manage conflict, and teach them to embrace diversity,” says Sherman.

Understaffed?

“The workload was so large, sometimes employees would be rushed and would make mistakes.”

“I was putting my license at risk every day.”

—Exit interviews

“Everyone is understaffed, and it is going to become worse,” says Sherman. Staffing shortages drive up the worker-to-patient ratio, taking a physical and psychological toll on staff. Twelve-hour shifts are more common, and patients are sicker. This often leads to low morale, which 39% of survey interviewees said was unsatisfactory in their previous job.

“The number two reason RNs in particular leave is because they feel they don’t have enough staff under them,” she says.

What managers can do

• Be aware of employees’ working conditions while you work to resolve staffing shortages. Provide more breaks and limit overtime and shift lengths, for example.

• Recognize employees who are under the greatest stress and make efforts to hire, for example, LPNs, nurses’ aides, and technicians to share in the workload, Sherman advises.

Keep those new hires

“They did not allow me enough time to learn everything the job entails.”

“I felt unwelcome. The nurses who had been there a long time would not talk to me or help me.”

—Exit interviews

Meeting offers retention strategies

Greta Sherman Jennifer Ahmad

Practical advice on retention will be offered at the Managing Today’s OR Suite conference Sept 17 to 19 in San Diego.

• At an all-day seminar on Wednesday, Sept 17, Jennifer Ahmad of JWT Specialized Communications will provide national benchmarks on vacancy, turnover, and other indicators. She will describe how managers can develop their own metrics for measuring and managing retention.

• In a general session, JWT’s Greta Sherman will give an update on recruitment and retention and provide an update on recruitment and retention.

For a conference brochure, visit www.ormanager.com or call 800/442-9918. You can register online on the OR Manager web site.
Perhaps the most alarming statistics came from new hires. More than one third (34%) left within the first 6 months, more than half (54%) quit within their first year, and 79% left in less than 3 years.

New hires complained their training did not adequately prepare them for their job responsibilities. Unskilled, constantly rotating preceptors were also to blame. New employees concluded that the institution was not investing in them, and they in return were not willing to commit to the institution.

In 2002, the nursing profession permanently lost 41% of RNs aged 30 and younger. Hospitals are relying on these members of Generations X and Y to replace the fast-retiring Baby Boomers. Yet Baby Boomers, who dominate nursing staffs, often do not have an understanding of or sympathy for the different conditions and stress levels under which younger staff are hired. Younger employees then feel unwelcome.

“We don’t look entry-level people in the eye, we don’t embrace them, and we don’t make them feel like part of the team,” says Sherman.

**What managers can do**

- Mentorship can make a difference. Be aware of who you pair with new hires.

  “Forget the experienced employee and connect the generations,” advises Sherman. Many new hires are in their 20s and feel more comfortable with 2- to 3-year veterans who often are of the same generation rather than the 25-year veterans who were trained in a different era and can be perceived by the new hires as “too edgy.” Giving the 2- to 3-year veterans a new challenge may help retain workers in this group, who also have a high attrition rate. “Make it an honor to mentor,” advises Sherman.

- Strive to meet needs of employees from each generation: job security for the Matures and Baby Boomers, career challenges and opportunities for Generation X, and flexibility and work-life balance for Generation Y.

  “If you train a manager to speak the language of all generations and then train them on how to build a team, the results are remarkable,” says Sherman.

**Compensation—more than money**

“I trained someone who was making $2 an hour more than me. That was humiliating.”

“There was a lack of respect for employees.”

—Exit interviews

Exit interview data make clear that respondents were looking for more than higher pay. Only 6% cited “salary” as their reason for leaving, although some of the 12% who left for a “better career opportunity” probably also were going to receive an increase in salary. Also important are stress-reducing measures, such as flexible work schedules.

**What managers can do**

- Provide more flexible schedules and job sharing to help reduce stress and acknowledge the importance of employees’ personal lives.

  “You may have a Gen Xer who wants Wednesday off to coach his son’s Little League and a Baby Boomer who wants Fridays off to go to the lake house,” notes Sherman. “Have employees cover for each other, know what is important to each employee, and work toward giving that to them.”

- On-site continuing education, grants, and tuition reimbursement are also ways to let employees know their desires and goals matter and to involve them in decision making. When employees are asked for their suggestions and then see their ideas come to fruition, they take more pride in and ownership of their jobs. That could lead to higher retention.

- Be aware of salaries and ensure everyone is compensated fairly—particularly tenured employees. Between initial salary offerings, sign-on bonuses, and raises, new hires are often making more money than their predecessors. Tenured employees may then look to leave to become new hires elsewhere. Managers clearly are under pressure not only to retain but to expand their staffs. The task is difficult but not impossible.

  “The strongest will survive, and those will be the organizations who have trained their managers on how to build teams,” says Sherman. “When you build teams, you create a work environment where people feel they have come home, and you value each of them.”

With this accomplished, exit interviews may be few and far between.

—Sandra Nissen

Sandra Nissen is a freelance writer in Livingston, NJ.
Infection control

CDC issues new environmental guidelines

What are the current recommendations for air handling in the OR? What infection control measures should we take if we’re planning a construction project?

The Centers for Disease Control and Prevention (CDC) address these and other issues in new *Guidelines for Environmental Infection Control in Health-Care Facilities.*

The guidelines make final a 2001 draft and address preventing infections associated with air, water, surfaces, medical waste, and other environmental aspects of health care facilities. Included is advice for infection control during construction, demolition, renovation, and repair.

The recommendations section of the guidelines was published June 6. The background and references will appear on the CDC’s web site later.

The recommendations apply to US health care facilities across the continuum, including hospitals, ambulatory surgery centers, doctor’s offices, and nursing homes.

For the OR, recommendations differ little from the draft. OR managers will find it helpful that the CDC has combined a number of previously separate recommendations in this document, such as those for isolation precautions, hospital pneumonia, and TB.

Two issues not addressed are evacuation of electrosurgical smoke and home-launched scrub suits. The guidelines for smoke refer to the laser plume only. Home-launched scrubs are discussed in the CDC’s 1999 Guideline for Prevention of Surgical Site Infection and are considered an unresolved issue.

The CDC rates the recommendations according to the strength of the evidence (sidebar). These are highlights pertaining to the OR. Keep in mind that other aspects of the guidelines may also apply to the OR.

**Recommendations: Air Infection control and ventilation for ORs**

- Implement environmental infection-control and ventilation measures for ORs:
  - Maintain positive-pressure ventilation with respect to corridors and adjacent areas. *IB, IC*
  - Maintain at least 15 air changes per hour, of which at least 3 should be fresh air. *IC*
  - Filter all recirculated and fresh air through appropriate filters providing a minimum of 90% efficiency. *IC*
  - In rooms not engineered for horizontal laminar air flow, introduce air at the ceiling and exhaust air near the floor. *IC*
  - Do not use ultraviolet lights to prevent surgical-site infections. *IB*
  - Keep OR doors closed except for passage of equipment, personnel, and patients, and limit entry to essential personnel. *IB*

**TB precautions**

- Follow precautions for infectious TB patients who require emergency surgery. *IB, IC*
- Use an N95 respirator approved by NIOSH without exhalation valves in the OR. *IC*
- Intubate the patient in either the airborne infection isolation (AII) room or the OR; if intubating in the OR, do not allow doors to open until 99% of the airborne contaminants are removed. *IB*
- When anesthetizing a patient with confirmed or suspected TB, place a bacterial filter between the anesthesia circuit and patient’s airway to prevent contamination of anesthesia equipment or discharge of tubercle bacilli into the ambient air. *IB*
- Extubate and allow the patient to recover in an AII room. *IB*

**CDC rating categories**

- **Category IA.** Strongly recommended and strongly supported by well-designed studies.
- **Category IB.** Strongly recommended and supported by certain studies and a strong theoretic rationale.
- **Category IC.** Required by regulation or an established association standard.
- **Category II.** Suggested and supported by suggestive studies or theoretic rationale.

**Unresolved issue.** No recommendation. No consensus exists or evidence is insufficient.

- If the patient has to be extubated in the OR, allow adequate time for air changes to clean 99% of airborne particles from the air. *IB*
- Use portable, industrial-grade HEPA filters temporarily for supplemental air cleaning during intubation and extubation for TB patients who require surgery. *II* [Specific advice is given for portable units.]
- If possible, schedule TB patients as the last surgical cases of the day to maximize time for removal of airborne contaminants. *II*

**Other air-handling issues**

- No recommendation is offered for performing orthopedic implant operations in rooms with laminar air flow. *Unresolved issue.*
- Maintain backup ventilation equipment (eg, portable units for fans or filters) for emergency ventilation of ORs, and take immediate steps to restore the fixed ventilation system. *IB, IC*

**Other aerosol hazards**

- In settings where surgical lasers are used, wear appropriate personal protective equipment (PPE), including N95 or N100 respirators, to minimize exposure to laser plume. *IC*
- Use central wall suction units with in-line filters to evacuate minimal laser plumes. *II*

Continued on page 22
Sixteenth Annual

Managing Today’s OR Suite

The Premier Conference on OR Management

San Diego

September 17-19, 2003
Manchester Grand Hyatt San Diego

Discover, discuss, debate the latest in OR management

All-day workshops, general sessions, breakout sessions, exhibits, and networking provide you with the information you need to manage your OR today.

Highlights:
• Track for those who manage an ambulatory surgery center
• Track for those involved with purchasing for the OR
• Track for new managers

You may register online. For a conference brochure, visit www.ormanager.com or phone 800/442-9918.
Infection control

Continued from page 20

• Use a mechanical smoke evacuation system with a high-efficiency filter to manage large amounts of laser plume when ablating tissue infected with human papilloma virus or performing procedures on a patient with extrapulmonary TB. IB

Recommendations: Water

Automatic endoscope reprocessors

Clean, disinfect, and maintain automatic endoscope reprocessor (AER) equipment according to the manufacturer’s instructions and relevant scientific literature to prevent inadvertent contamination of endoscopes and bronchoscopes with waterborne microorganisms. IB

• To rinse disinfected endoscopes and bronchoscopes, use water of the highest quality practical for the system’s engineering and design (eg, sterile water or bacteriologically filtered water [water filtered through 0.1 to 0.2 µm filters]). IB

• Dry internal channels of the reprocessed endoscope or bronchoscope using a proven method (eg, 70% alcohol followed by forced-air treatment) to lessen potential for proliferation of waterborne microorganisms and to help prevent biofilm formation. IB

Recommendations: Environmental surfaces

Surfaces in ORs

• After the last surgical procedure of the day or night, wet vacuum or mop OR floors with a single-use mop and an EPA-registered hospital disinfectant. IB

• Do not use tacky mats at entrance to the ORs or infection-control suites. IB

Antibiotic-resistant Gram-positive cocci

Examples are methicillin-resistant *Staphylococcus aureus* (MRSA) vancomycin-intermediate sensitive *Staph* or vancomycin-resistant *Enterococcus* (VRE).

• Pay close attention to cleaning and disinfection of high-touch surfaces in patient care areas (eg, bedrails, charts, doorknobs). IB

• Ensure compliance by housekeeping staff with cleaning and disinfection procedures. IB

• Use EPA-registered chemical germicides appropriate for the surface to be disinfected. IB, IC

• When contact precautions are indicated for patient care, use disposable items (eg, blood-pressure cuffs), whenever possible to minimize cross-contamination. IB

• Follow the same measures for VRSA patients. II

Cruetzfeldt-Jakob disease

Develop and maintain cleaning and disinfection procedures in patient-care areas to control environmental contamination with agents of CJD, for which no EPA-registered product exists.

• In the absence of contamination with central nervous system tissue, extraordinary measures are not needed for routine cleaning or terminal disinfection of a room housing a confirmed or suspected CJD patient. II

• To decontaminate OR or autopsy surfaces with central nervous system or cerebral spinal fluid contamination from diagnosed or suspected CJD patients, after removing gross tissue from the surface, use either 1N NaOH or a sodium hypochlorite solution with approximately 10,000 to 20,000 ppm available chlorine (dilutions of 1:5 to 1:3 v/v, respectively, of household chlorine bleach; contact manufacturer for advice). II

—The contact time should be 30 min to 1 hour. Blot up chemical with absorbent material and rinse treated surface thoroughly with water.

—Discard the used absorbent material in appropriate waste containers.

Laundry

• Employers must launder workers’ personal protective garments or uniforms contaminated with blood or other potentially infectious materials. IC

• Use sterilized textiles, surgical drapes, and gowns for situations requiring sterility. IB

• No recommendation regarding using disposable fabrics versus durable goods. Unresolved issue.

Medical waste

Sanitary sewers may be used for safe disposal of blood, suctioned fluids, ground tissues, excretions and secretions, provided local sewage discharge requirements are met and the state has declared this to be an acceptable method of disposal. II

The guidelines are on the CDC’s web site at www.cdc.gov/ncidod/hip/enviro/guide.htm

Conference offers track on materials management

The 2003 Managing Today’s OR Suite conference offers a special track on materials management. The conference, in a single location this year, will be Sept 17 to 19 in San Diego at the Manchester Grand Hyatt. On Wednesday, eight all-day seminars are offered, and on Thursday and Friday, the two-day conference offers general sessions and breakouts.

The exhibits, with more than 100 companies, are of particular value to materials managers and purchasing agents.

“It is a setting that provides time for examination of supplies and equipment and meaningful communication with exhibitors,” says conference planner Billie Fernsebner, RN, MSN.

Three breakout sessions are planned for materials management personnel:

• Reducing Costs of Lumbar Fusion

• Strategic Supply Cost Management

• Best Practices for Successful OR Materials Management.
Please see the ad for PERIOPTIMUM in the OR Manager print version.
House, Senate split on specialty hospitals

The US House and Senate took different approaches to specialty hospitals in the Medicare reform legislation passed June 27.

A conference committee must hash out the differences.

The Senate’s measure was the most far-reaching. It would dramatically alter the Stark rules by allowing the Department of Health and Human Services (HHS) to write rules saying physician specialists who own interests in specialty hospitals would not be able to make referrals to them. Physicians would only be allowed to refer to hospitals they own an interest in if the hospital offered a "comprehensive spectrum" of services, and the self-referrals were insignificant compared with the hospital’s overall services. The amendment would not apply to hospitals substantially completed before June 12, 2003.

The House simply called for a study on the impact of specialty hospitals on Medicare. Even if the Senate measure stays in the final bill, it could take a long time for HHS to issue rules.

Nevertheless, “the chill this period of uncertainty would have on the growth of the specialty hospital industry should not be underestimated,” comments Lorin Patterson, an Overland Park, Kan, attorney.

Nurses concerned about flat funding

Programs to promote nursing education, recruitment, and retention would get no funding increase for 2004 under appropriations bills approved in June by House and Senate committees.

Both voted to fund the Nurse Reinvestment Act at $112.76 million, much less than the $175 million nursing organizations believe is needed to address the growing nursing shortage.

The funds go for programs such as advanced nursing education, support for schools, diversity grants, grants for magnet improvements, and the nurse corps.

Nursing research would get a bit of a boost from $131 million to about $135 million.

—www.nursingworld.org

States with malpractice award limits have more doctors

States that have enacted limits on pain-and-suffering damages have about 12% more physicians per capita than states without such a cap, the Agency for Healthcare Research and Quality reported July 7.

Since 1970, the supply of physicians has grown more in states with caps than in states without caps.

“Our broken medical litigation system is affecting patients’ ability to find a doctor,” Health and Human Services Secretary Tommy Thompson said.

Limiting punitive damages is one of the chief strategies for controlling soaring malpractice premiums, which are causing physicians to relocate or retire early.

The Senate took up medical liability reform in early July with the Patients First Act (S 11), which would cap damages, among other things. But the bill faced tough opposition from Democrats, who want to take a different approach.

—www.ahrq.gov/news

Core Curriculum for Perioperative Nursing

Now in its fourth edition, the classic reference, Core Curriculum for Perioperative Nursing, has guided the orientation of thousands of OR nurses since it was first published in 1991.

This respected guide has been updated to reflect changing practice.

The book includes basic competencies for expected performance, lesson plans for classroom activities, outlines for clinical focus days, and performance checklists. The extensive references have also been updated.

As hospitals and ambulatory facilities face an increasing shortage of nurses, many are hiring nurses without OR experience and providing on-site training. This book is the perfect guide for such training.

The book can be used for orientation of nurses who are experienced in perioperative nursing as well as those who are new to this specialty.

Order now from OR Manager

$48 plus $7.95 shipping and handling

Call 800/442-9918 or fax your order to 505/983-0790
Medicare Part B’s new list of procedures approved for freestanding ambulatory surgery centers (ASCs) may hold new opportunities for your center’s business.

The list, published March 28, adds about 280 codes to the list and deletes 140. The list went into effect for services given July 1 and after.

You need to study the list carefully to see which of the added codes have the potential for new business and which of the deleted ones could take business away or reduce your revenue. You also need to anticipate the impact if private payers follow Medicare’s lead.

Poring over the fine print in the Federal Register is enough to make your eyes glaze over.

Stephanie Ellis, RN, CPC, a coding expert with Ellis Medical Consulting, has summarized the significant changes by specialty in a user-friendly list. The list is a guide ASC managers can use to analyze the impact of the Medicare changes and plan a strategy. Ellis described the changes at an audio conference offered in June by the American Association of Ambulatory Surgery Centers (AAASC). The list is posted on the OR Manager web site at www.ormanager.com. Look under the OR Manager’s Tool Box.

“If you get organized, you can look at the changes as an opportunity for your center and add to your center’s bottom line,” she comments.

In a positive development for payment: Medicare added a new payment Group 9. The group is added to the previous eight groups and provides a higher rate for certain procedures.

Steps to take

Ellis suggests some steps to take to prepare for the changes:

• Review additions to the list to find procedures your center has already been doing that weren’t previously covered by Medicare.

“Perhaps other payers have been covering these. You will be able to expand these procedures now because Medicare will cover them,” Ellis says.

• Inform physicians who currently work at the center about the additions and deletions and how those changes will affect them.

• Look at the additions and get creative about generating new business.

“Analyze procedures that are new to the list that your center has not previously performed and ask whether you should add them to your service line,” she suggests.

Discuss the potential for these new procedures with your physician partners and other physicians who would be affected. Among issues to consider:

—Can these procedures be performed with current staff and physicians?

—Do you need any new equipment or structural changes to the facility?

“When you’ve decided to add procedures, you will need to set fees. You will also need to inform the billing, nursing, verification, and other staff,” Ellis adds.

• Look at the additions for marketing opportunities for bringing new physicians into the center. Discuss with your board and medical staff adding new physicians and whether any new partnerships will be offered.

• Determine how the Medicare updates might affect coverage by your other payers. “Check with the payers you have contracts with to see if they plan to follow Medicare’s changes in their own grouper lists,” Ellis says. If they do, find out when the new codes will take effect and what the payment levels will be.

• Analyze how the significant deletions to the list will affect your ASC. Will other payers delete these codes from their lists as well? In some cases, deletions by other payers could have a more serious effect than the deletion by Medicare.

Continued on page 26
Continued from page 25

Plastic surgery

“The biggest surprise is the addition of four blepharoplasty codes,” she notes. Because Medicare doesn’t pay for strictly cosmetic procedures, ASCs will need to be careful in how they bill for these. Centers will need to check their Medicare carrier’s LMRP (local medical review policy) for coverage of blepharoplasty procedures. The policy provides a list of approved diagnosis codes that must be used when submitting a claim. If the LMRP rules are not followed, your claim will not be paid,” says Ellis. If the doctor does not provide a diagnosis code that is on the LMRP list to indicate that the bleph was done because of compromised visual field test, for example, the claim will be denied for medical necessity reasons.

“It doesn’t matter if a code is added to the ASC list. If there is an LMRP for that procedure, and the claim does not include a diagnosis in the LMRP, the claim will not be paid,” Ellis cautions.

Other noteworthy additions include one abdominoplasty code as well as four codes for liposuction procedures and a group of rhinoplasty and cleft lip and palate codes.

No significant plastic surgery codes were deleted, though one surprise was the removal of code 19364: Breast reconstruction with free flap.

ENT/dental procedures

A significant addition was a section of four codes for cochlear implants.

“If you haven’t had doctors performing these at your facilities, this might be a nice service line to add,” she notes. “All of these are in Group 9, which means they are reimbursed quite well.

“A lot of centers have ENT physicians coming to their facilities. They probably have been doing these procedures in the hospital, and they now can be reimbursed in the ASC.” The codes cover both implantation and replacement of the cochlear implant, allowing an implant that might have been inserted at the hospital to be replaced in an ASC. Codes for the implants include L8614 and L8619. Check with your Medicare carrier to see if they will reimburse for these.

Orthopedics

Among the many changes to the orthopedic codes was the addition of several hip arthroscopy procedures.

“There wasn’t much on the list for hips before, so most of these hip procedures have been done in the hospital,” Ellis notes. “Hip specialists are not used to doing things in the ASC. With these added codes, this is another group you might be able to bring in.”

Two of the most significant changes were the addition of 29827 (Group 5) for rotator cuff repair and 29848 (Group 9) for endoscopic carpal tunnel release.

“We finally got a code for an arthroscopic rotator cuff repair this year, and they immediately put it on the list, which is wonderful,” Ellis says. Previously, rotator cuff repair was coded using an unlisted code, which meant the claim might or might not be paid, and the procedure did not have a payment group.

For carpal tunnel, the only code previously was an open-procedure code, and many of these procedures are done endoscopically.

Ortopedics

Getting paid for implants

For better success in getting reimbursed for implants in your ASC, consider becoming a provider under Medicare’s durable medical equipment program, recommends coding expert Stephanie Ellis. The program processes claims for durable medical equipment, prosthetics, orthotics, and supplies under Medicare Part B.

The program is administered by separate contractors known as DMERCs (Durable Medical Equipment Regional Carriers).

“Don’t automatically become a DMERC provider,” Ellis says. “You have to apply separately to be a provider to be able to file claims for medical equipment, supplies, and implants.”

The upside is that the rules are clearer than Medicare’s other reimbursement rules, and an ASC is more likely to be reimbursed by a DMERC than by the regular Medicare carriers.

“If you don’t do this, you may be leaving thousands of dollars on the table,” she advises.

General surgery

Noteworthy is a group of thrombectomy codes, which are all in Group 9.

“These are procedures that previously had to be done in hospitals, and we were glad to see those added,” she notes.

Medicare also approved more complicated hernia repairs for ASCs with the addition of a group of codes for incarcerated or strangulated hernias.

“Previously, surgeons could only operate on simple hernias in the ASC.
setting. Now they can bring their more complex cases, and they gave these a Group 9,” says Ellis.

Also added was a code for implantation of mesh in hernias: code 49568 in Group 7.

“This is good news. But centers need to understand they can’t bill for the mesh with every hernia surgery,” she cautions. “The mesh is not separately billable except for ventral and incisional hernia repairs.” Mesh is bundled into the rest of the hernia-repair codes.

Among a number of significant deletions in general surgery was code 49000 for exploratory laparotomy.

Urology, genitourinary, and gynecologic surgery

Two of the newer approaches to prostate surgery were added, both in Group 9. These are 53850: Transurethral destruction of prostate tissue by microwave thermotherapy and 55859: Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy, otherwise known as brachytherapy.

“The big thing with brachytherapy is the radioelements, or the seeds, which are expensive,” Ellis notes. “Whether Medicare will pay for the seeds is still a wild card. ASCs need to check with their Medicare carrier about coverage for the seeds.” The seeds have a HCPCS code GO261.

Another new urology code is 54410: Removal and replacement of a penile prosthesis. But, again, it’s not clear whether Medicare will cover the implant. (See sidebar for tips on implant reimbursement.)

There are a lot of changes in codes for hysterectomy and laparoscopy procedures.

“They made these changes because so many codes were added to the CPT list this year,” Ellis notes. The codes are specific for the number and size of lesions removed; an example is 58545: Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas.

“It is important to have the size documented,” Ellis comments. “Lots of times the doctors don’t state the size in the operative report. So you need to get that off the pathology report, which means you need to wait for the pathology report before you send in the bill.”

Stephanie Ellis can be reached at sellis@ellismedical.com

A 13-year-old patient is pregnant: Now what?

A 13-year-old girl is scheduled for a cystoscopy in your ambulatory surgery center (ASC) because of recurrent urinary tract infections. During preoperative screening, her pregnancy test is positive.

What do you do?

Pregnancy testing for teenagers raises sensitive questions that go beyond whether the patient is an appropriate candidate for surgery and anesthesia.

Getting permission to conduct the test can be delicate. Some patients and parents are offended and even angry that pregnancy testing is required, and they must pay for it.

There are also ethical and legal questions. What is the ASC’s obligation to protect the privacy of a young woman who may just be learning she is pregnant and whose parents may not know she is sexually active? What if the staff suspects the pregnancy may be a result of child abuse?

Given these concerns, is it best to mandate testing for all women of childbearing age? Or is it better to take a more selective approach based on a careful history? And what procedures should you have in place in case a young patient is pregnant?

“Most important of all is to be an advocate for the patient,” stressed Barbara S. Gold, MD, associate professor of anesthesia at the University of Minnesota, Minneapolis, who reviewed the issues at the 5th International Congress on Ambulatory Surgery in May in Boston.

What is the effect on the fetus?

The main objective of preoperative pregnancy testing is to avoid surgery and anesthesia in a pregnant patient because of the potential ill effects on the fetus. There also are concerns about liability.

What does the research show?

“There is a lot of literature, but the data are unconclusive at best,” Dr Gold said. Though the literature raises the possibility of teratogenic damage to the fetus and increased rates of spontaneous abortion, the studies have limitations. They are old, retrospective, observational, and have many conflicting variables.

She gave a few examples. A study led by Duncan in Manitoba compared 2,565 pregnant women having elective surgery from 1971 to 1978 with pregnant women living in the same area who did not have surgery. A review of the province’s congenital anomalies registry found that while there was no difference in teratogenic anomalies, there was an increased risk of spontaneous abortion in those who had surgery during the first or second trimester. The risk was greater after gynecologic procedures.

A case-control study of central nervous system (CNS) defects among infants born to women between 1968 and 1980 was inconclusive. Of 694 mothers of infants with CNS defects, 12 reported first semester exposure to anesthesia compared with 34 of 2,984 controls. When CNS defects were specified, there was a striking association between hydrocephalus and first trimester anesthesia exposure. But the relation with other anomalies such as microcephaly and neural tube defects was not substantiated.

A review of the Swedish Birth Registry to examine outcomes for 5,405 pregnant women who had nonobstetric surgery anesthesia found no increased incidence of congenital malformation. There was an increase in incidence of intrauterine growth retardation and prematurity and, thus, an increase in the number of low birth-weight babies born to women who had surgery.

Dr Gold commented, “I think we really don’t know the risk of teratogenicity or other effects, but anesthesiologists fear liability.”

What is the liability?

Here, too, the picture is unclear. Anecdotal reports of litigation abound. But in a query to the American Society of Anesthesiologists (ASA) Closed Claims database, Dr Gold found only two closed claims over the past 20 years involving women with undetected pregnancies who had surgery and anesthesia. One suit was settled in 1979 for $2,500. The second, filed in 1992, was dismissed. This case involved a nurse who had a lumbar sacral fusion for back pain under general anesthesia. The patient had denied she was pregnant during her preoperative screening. The surgery was complicated by a bowel perforation requiring a laparotomy, and a gravid uterus was found. The patient was consulted and decided to have an abortion. She then sued the anesthesiologist because the pregnancy

Pregnancy testing facts

- High school students who are sexually active: 46%
- Rate of live births among teens: 4.9%
- Incidence of unrecognized pregnancy in teenagers presenting for outpatient surgery: 0% to 2.4%
- Facilities with policy for mandatory testing: 30% to 50%

Facilities with policy for mandatory testing: 30% to 50%

- mandatory testing: 30% to 50%
Weighing the pros and cons

What do others do?

It’s estimated that about 30% to 50% of facilities have a policy for mandatory testing.

Dr Gold cited a 1996 survey of anesthesiologists attending the Obstetric Anesthesia and Perinatology meeting in which one third of respondents said their organizations had departmental policies mandating preoperative pregnancy testing. At the 2001 ASA meeting, an informal survey of those attending a panel on pregnancy testing found about 50% worked in hospitals with mandatory preoperative pregnancy testing policies.

ASA’s Practice Advisory for Preanesthesia Evaluation leaves room for discretion, saying simply, “Pregnancy testing may be considered for all female patients of childbearing age.”

Weighing the pros and cons

There are passionate views for both mandatory and selective testing.

Those who favor mandatory testing argue:

- Mandatory testing is justified because you avoid unwittingly anesthetizing a pregnant patient, which may affect the fetus.
- The test eliminates doubt. Pregnancy histories are unreliable, especially in teenagers.
- The test is highly specific and sensitive.

Those who favor a selective approach based on patients’ histories maintain:

- Selective testing is less intrusive for the patient.
- Testing selectively avoids a screening test, which may not be necessary.

Studies have examined the selective approach and made a key point—how reliable the history is depends on how the patient is asked and who is listening.

A study by Wheeler and Cote underlined the fact that histories can be unreliable. The study, conducted at a children’s hospital where pregnancy testing was done as a matter of policy, reviewed 235 pregnancy tests in patients aged 10 to 34 who had ambulatory surgery over a 15-month period. They found 1.3% of tests were positive—and all of the patients denied the possibility of being pregnant. None of the patients under 15 tested positive, however.

But a lot depends on how questions are asked. Malviya and colleagues studied the reliability of histories from adolescent patients who had 525 procedures. All patients also had a pregnancy test regardless of the history. Nurses took the histories in the absence of family members when possible. Patients in 508 procedures denied they were pregnant. Of the remaining 17:

- 8 patients said they might be pregnant; none was with her parents.
- for 6 patients, the parents responded for the patient and denied the possibility of pregnancy.
- 3 patients were unwilling to respond, and all were with their parents.

All of the pregnancy tests were negative except for one that was questionable; that later turned out to be negative. The authors concluded that for their population, pregnancy testing did not seem to be necessary unless the patient history indicated.

There also were 17 patients who refused testing or could not void. For these, the anesthesiologist made an individual decision about whether to proceed with anesthesia without the test.

The results strongly suggest a reliable history depends heavily on asking teenagers in private and not in the presence of their parents, Dr Gold noted.

What if a teen is pregnant?

What to do if an adolescent has a positive pregnancy test has medical, legal, and social implications for everyone involved. The decision on how to handle the situation is governed by state law.

Each ASC needs to know what the law requires in its state. State laws are complex and vary on medical decision making by minors and privacy rights related to pregnancy. For example, about half the states require one parent’s consent for a minor to have an abortion.

On the other hand, according to ASA’s legal counsel, Judith Semo, if a state confers majority rights on a pregnant minor, “(T)hen the minor has complete control over the information. The minor has a right to insist that it not be disclosed to anyone, including the parent.”

The Health Insurance Portability and Accountability Act (HIPAA) defers to state law on whether a minor patient’s protected health information can be disclosed to parents. Dr Gold notes this issue is particularly murky because the parents typically pay for the test.

If child abuse is suspected, health care providers have a responsibility to report that to authorities. Anesthesiologists have been reluctant to do so, as a study by Kempen illustrated. Surveying 300 physicians at a meeting, of 169 responding, the author found only 4% would report such a case to the police, even though 98% recognized the legal requirement to report child abuse, and 82% believed pregnancy in a girl under the age of consent was by definition child abuse.

“In other words,” said Dr Gold, “the results of the test were used to address the immediate situation—proceed with

Continued on page 30
The larger and more difficult issues unfortunately were ignored.

An orthopedic surgeon, William Hennrikus, MD, described in a 2001 article how the community hospital where he works in California would handle the situation. First, the patient who had a positive test result would be informed by the anesthesiologist and surgeon with a social worker present. Surgery would be cancelled. The patient also would be given information about the importance of having prenatal care and how to find obstetrical care.

As required by state law, if the patient was 14 or older or an emancipated minor, she would be given the test results in the absence of her parents. She would be encouraged to discuss the options with her parents. If the patient gave permission, the parents could be informed. If she did not give permission, the anesthesiologist would tell the parents the case was cancelled but would not give them the test results.

If the patient was under 14, she would be given the option of telling her parents personally. If she decided not to, the anesthesiologist would notify the parents of the test result. A referral also would be made to child protective services, and a social worker would contact the patient again within 7 days to give her additional assistance and referrals as needed.

References


New policies for checking organ transplants

The United Network for Organ Sharing (UNOS) adopted new policies and procedures in June to provide more safeguards for patients in organ transplants. The recommendations were developed by a special committee after the death of Jesica Santillan, who received a heart-lung transplant with the wrong blood type in February at Duke.

The policies clarify the specific roles of organ procurement organizations and transplant centers in checking and double-checking information about recipient and donor before an organ is transplanted.

Key recommendations include:

- Blood type will be verified by at least two different staff members at both host organ procurement organization (OPO) and transplant hospital.
- Transplant organizations are to check donor blood type upon arrival of the organ and compare it directly to the potential recipient’s blood type.
- Transplant centers and OPOs must keep records of these verification procedures, which UNOS will examine during routine audits.

If a transplant center wants to accept an offer of an organ for a candidate not on computerized lists, the host OPO will be responsible for determining why the candidate is not on the list and communicating that to the transplant center.

—www.unos.org/news
Please see the ad for ADVANCED STERLIZATION PRODUCTS in the OR Manager print version.
**JCAHO seeks comment on protocol for preventing wrong surgery**

The Joint Commission asked volunteers in June to complete a survey on its draft universal protocol for preventing wrong-site, wrong-patient, and wrong-procedure surgery. The draft was the result of JCAHO’s May 9 summit on wrong-site surgery. Summit participants agreed that a universal protocol would help to prevent the problem.

Among other things, the draft proposed marking only the operative site, marking with a Yes or initials rather than an X, and positioning the mark so it is visible after the patient is draped. The draft also proposed marking, at a minimum, sites involving laterality and multiple structures (eg, fingers and toes). JCAHO has backed off from requiring sites not involving laterality to be marked, as reported in the June OR Manager.

The next steps were to seek approval from the JCAHO Board of Commissioners in July, then request endorsement from a variety of organizations.

—www.jcaho.org

**Smallpox vaccinations slow**

The national smallpox vaccination programs have slowed to a virtual halt.

The military has vaccinated everyone it can and is now vaccinating about 1,000 a week. Nearly 90% of military personnel receiving the vaccine did so before the Iraq war.

—www.nytimes.com

**Distraction, anger, rushing associated with sharps injuries**

Distraction, anger, and rushing were associated with the largest increase in risk of sharps-related injuries in a study from the University of Maryland Medical Center, Baltimore, and the Beth Israel Deaconess Medical Center, Boston.

Distractions were frequently trivial and caused by a coworker, and conflict with a coworker or patient most often was the source of anger.

A trend toward increased risk of injury was seen when workers were fatigued, working on understaffed teams, dealing with an uncooperative patients, and among surgeons working in a noisy operating room.

Multiple attempts to complete a procedure also were associated with increased risk of injury.

The majority of injuries occurred with hollow-bore devices, and definite or suspected exposure to a bloodborne pathogen was reported by almost half of the workers.


**Insuring all Americans could save US up to $60 billion annually**

The approximate 41 million Americans without health insurance cost the US $65 billion to $130 billion annually because of poor health and earlier death. Providing health insurance could cut these expenses roughly in half, according to the Institute of Medicine, which conducted an economic analysis of the costs of being uninsured for society overall.

The estimated value of improved health that an uninsured person would gain with each year of coverage ranges between $1,645 and $3,280 annually, the Institute estimated.