INSIDE

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Clinical Quality & Infection Control

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8 Problem Areas for ASCs in a Medicare Survey

By Leigh Page

John J. Goehle, COO of Ambulatory Healthcare Strategies in Rochester and Albany, N.Y., is author of "The Survey Guide for ASCs - A Guide to the CMS Conditions for Coverage & Interpretive Guidelines for Ambulatory Surgery Centers." He identifies eight problem areas for ambulatory surgery centers in a Medicare survey.

1. Obtaining advance directives. Most ASC staff members probably already know they are now required to ask patients about advance directives prior to the day of surgery, but they may not know what to do if the patient actually wants to make a directive. "It is not

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10 Steps to a Thorough Physician Credentialing Process

By Rachel Fields

Credentialing physicians for a surgery center is quite an undertaking, considering the amount of information that must be double-checked before a provider is accepted into the facility. Dare Hartsell, RN, MSN, vice president of clinical services for Practice Partners in Healthcare, discusses 10 essential steps to a thorough, effective physician credentialing process.

1. List potential applicants. Ms. Hartsell recommends surgery centers start the credentialing process by making a list of potential applicants. She says when Practice Partners is developing a facility in a new area, the company starts the credentialing process with the finite group of physicians who will invest in the facility. "That's how we get the short list," she says.

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5 Tangible Benefits of an Effective Risk Management Program

By Rob Kurtz

There's an element of risk management in almost every function and process that occurs in an ambulatory surgery center, says Carol Hiatt, RN, LHRM, CASC, a licensed risk manager in Florida and Accreditation Association for Ambulatory Health Care surveyor who recently joined the consulting team of Healthcare Consultants International, a subsidiary of AAAHC.

Ms. Hiatt discusses five tangible benefits of an effective risk management program and why risk management must be a significant issue of focus for ASCs.

1. Compliance. One of the most important benefits of an effective risk management program is it helps ensure an ASC is in compliance with several key aspects of accreditation, Medicare Conditions for Coverage, and in some states, licensure requirements, says Ms. Hiatt.

"And what all agencies and organizations are looking for — first and foremost — is that the risk management program receives oversight by the governing body," she says. "That oversight has to be documented in the governing

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Answering Questions regarding the New FDA Guidance on Liquid Chemical Sterilant Processing and the STERIS System 1E™

By Barbara Trattler, RN, MPA, CNOR, CNA

On June 30, updated U.S. Food and Drug Administration (FDA) provided new guidance and recommendations for liquid chemical sterilant processing. This is important for healthcare facilities that process critical devices and are evaluating options to replace the STERIS System 1®. At Advanced Sterilization Products (ASP), we've received so many questions regarding the effect this new guidance will have for healthcare facilities that we felt it important to provide our advice.

NEW FDA GUIDANCE REGARDING LIQUID CHEMICAL STERILANT PROCESSING:

- "FDA believes that **sterilization with liquid chemical sterilants does not convey the same sterility assurance as sterilization** using thermal or gas/vapor/plasma low temperature sterilization methods."
- "FDA recommends that the use of liquid chemical sterilants be limited to reprocessing only critical devices that are heat-sensitive **and incompatible with sterilization methods such as steam and gas/vapor/plasma low temperature processes**."
- "**Biological Indicators are not appropriate or required for monitoring liquid chemical sterilization process.** They are generally used for monitoring traditional sterilization processes where an SAL 10^{-6} is achieved. FDA has not cleared any biological indicators for monitoring liquid chemical sterilization process."

Q. Does this affect the deadline to transition away from the STERIS System 1®?

A. No. The deadline remains February 2, 2012. However, this updated guidance affects your replacement options. The STERIS System 1E™ is a liquid chemical sterilant processing system, and according to FDA, liquid chemical sterilant processing systems should be used only to reprocess critical devices that are heat-sensitive and incompatible with other sterilization modalities, such as steam or gas/vapor/plasma low temperature sterilization methods.

Q. Will the FDA clear a Biological Indicator for the STERIS System 1E™?

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Q. How can my healthcare facility assure the sterility of our heat-sensitive critical devices?

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Q. What if I already purchased a STERIS System 1E™?

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Q. Can ASP help me transition?

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enough simply to ask patients on a form what they want to do," Mr. Goehle says. If the patient checks the 'yes' box, staff members need to ask what the directive is. It is enough to get a verbal directive from the patient, something like, "If anything happens to me, I want my husband to decide what the doctors should do." Site surveyors will look for this directive in the patient's medical record.

2. Choosing an infection control coordinator. ASCs sometimes designate the wrong person to be the infection control coordinator. This person has to be a licensed professional — that is, a physician or nurse, and not a tech. Appointing a physician, however, is generally not a good idea. The position requires taking training courses and spending time on extensive data reviews. "It is unlikely a physician would have the time for this," Mr. Goehle says.

3. Board's involvement in ASC operations. All too often, ASC boards are detached from day-to-day operations at the center. Medicare standards require they have an active role in overseeing all aspects of operations, including quality improvement and infection control processes. Board members should meet on a regular basis — at least quarterly — and document their meetings. "Some boards don't even meet, while others meet but don't document it," Mr. Goehle says. "And even when there is documentation, it is usually much too brief." Board minutes should be at least a page long for a small center and three or more pages long for a larger center.

4. Adherence to infection control manual. ASCs must have an infection control manual. They can base it on a variety of sources, such as recommendations from the CDC, APIC or AORN. But buying ready-made manuals instead of compiling them personally alerts surveyors that ASC staff may not know what is in the manual, much less follow the requirements it spells out, Mr. Goehle says.

In these cases, "surveyors are more likely to select some standards in your manual and check to see whether you are following them," he says. A ready-made manual may obligate the center to take steps beyond what Medicare or ASC accreditors require. "The danger is they would be required to do something but never bothered to read about it," he says.

5. Meeting quality benchmarks. ASCs will soon have to meet national quality standards that were recently published. CMS has indicated it will be monitoring ASC oversight of eight measures, including patient burn, patient fall, wrong site, hospital transfer or admission, timing of prophylactic intravenous antibiotics, appropriate method of hair removal, selection of prophylactic antibiotic and surgical site infection rate. This involves not just comparing the ASC's outcomes to a national benchmark, but also doing something about it. "If you have a high infection rate, examine why it is high and what process could reduce the rate," Mr. Goehle says.

6. Overseeing contracted workers. Surgery centers need to monitor maintenance contracts, such as for outside cleaning services, to ensure they are in accordance with rules and regulations. The cleaning service needs to follow infection control guidelines. Surveyors may ask whether anyone is watching the service. Someone on-staff should be coming in when the cleaning crew is at the ASC and checking up on them. If no one comes in, the ASC should be using surveillance cameras.

The same applies to maintenance of equipment by outside vendors. "Make sure they are doing the maintenance," Mr. Goehle says. "Are they following the manufacturer's requirements?" Also, when monitoring reports are made, what is being done to follow up?

7. Conducting peer review. CMS requires physicians to review each other as part of the ASC recredentialing process, but this is often overlooked. Mr. Goehle recommends quarterly reviews so that any problems can be discovered early on, but they could also be semiannual or even annual. The process involves a colleague in the same specialty reviewing a few charts and making a report that would be put into the physician's recredentialing file. Infections, complications, complaints and grievances involving the physician would also go into that file.

8. Meeting QI standards. Frequently, the quality improvement process at a surgery center does not include enough people and is not truly evidence-based. "Sometimes there is only one nurse involved in the QI process, but actually it should include representatives from all departments at the center," Mr. Goehle says. He says this is less of a concern at smaller ASCs, where staff split their time among several tasks.

In addition, the QI process should do more than just react to a particular incident at the center. QI also involves having an evidence-based protocol examining quality data over time. "For example, people at the ASC should be looking at their current infection rates compared with a year ago," he says. ■

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10 Steps to a Thorough Physician Credentialing Process
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If the center is a multi-specialty facility and the owning entity determines the ASC will have an open staff, the company goes through each specialty and identifies available physicians in the community. A staff member will visit with interested physicians and determine whether the provider would like to apply for credentialing. Ms. Hartsell says Practice Partners does not send out credentialing application packages to physicians before the providers have requested it.

2. Collect up-to-date contact information. Ms. Hartsell says ASC leaders should make sure the center has an up-to-date database of physician contact information. Some physicians will want to be contacted directly, while others will prefer the ASC go through an office manager or nurse. "Direct contact information is a very simple issue that can cause a lot of difficulties if you don't have it," Ms. Hartsell says. Up-to-date contact information is important because you will need to check in with the physician throughout the process and send multiple forms to his or her office.

3. Provide specific instructions on required information. Make sure physicians and their practice staff have specific instructions on which information is required for credentialing, Ms. Hartsell says. Practice Partners requires a laundry list of information from applying physicians, including information on work history and education, a current CV, board certification and state licensure information, malpractice

liability certificate and any controlled substance certificates, among other information. The physician should receive detailed instructions on which information they need to send back to the surgery center and when. Don't leave it up to the practice to determine deadlines and prioritize the importance of the information you need.

Ms. Hartsell says the application should also include a waiver statement that asks the physician to attest to the truth and completeness of the application. Practice Partners then sends a copy of the waiver to the malpractice carrier, any applicable hospitals and peer references.

4. Perform a thorough background check. The most time-consuming part of the credentialing process is the verification process and background check, Ms. Hartsell says. This process requires a staff member to go through all information provided by the physician and double-check it for accuracy and truthfulness. This might include:

• Verifying training and education through the American Medical Association or the Educational Commission for Foreign Medical Graduates if the applicant was educated outside the United States

- Verifying current medical licensure in the state
- Verifying employment history
- Verifying Medicare sanction information through the OIG sanctions exclusion database
- Querying the National Practitioner Data Bank on closed and settled claims history
- Reviewing any time gaps in education or career (if the applicant has more than a six month period of time when they are not enrolled in a program at a medical teaching institution or employed as a physician, the applicant is asked to provide a detailed explanation on the application)
- Verifying the status of the applicant's privileges at hospitals and other health care facilities as listed on the application

Once the physician's application information has been verified, the surgery center can move on to examining personal references and determining whether the provider is a good fit for the center.

5. Require peer references. Ms. Hartsell says Practice Partners requires three references from applying physicians. All three references must be physicians of the same specialty who are not related by blood or marriage, and none of the references may be members of the physician's practice. "Many times, with new physicians, those references will be program directors from previous facilities where the physicians completed graduate medicine programs such as residencies and fellowships," she says. "We specify all these requirements on the application."

Ms. Hartsell says the reference requirements at her company are slightly different for allied health professionals than for physicians. "[When] we credential allied health professionals, and certified registered nurse anesthetists, for example, we will allow those references to be anesthesiologists," she says. "It doesn't have to be a CRNA, but a professional who is a licensed anesthesia provider."

6. Weed out poor applications to save money. The credentialing process is time-consuming and expensive for ASCs because centers must dedicate a staff member to comb through applications, prepare letters and other correspondence and continually follow up on the status of any outstanding information. Since each application requires a significant amount of time to verify, Ms. Hartsell recommends "culling the herd" prior to starting background checks. "There is a cost associated with this process, so you don't want your credentialing coordinator to be wasting time on an application that's not going to come to fruition," she says.

7. Investigate malpractice claims. While reviewing physician claims history through the National Practitioner Bank and the malpractice carrier, your surgery center may run across information on settlements, closed suits and other malpractice claim information. Ms. Hartsell says the presence of malpractice claims does not necessarily mean the physician should not be credentialed. "It's a red flag, but from our perspective and the way our bylaws are written, a physician can have malpractice claims, closed suits or settlements, and that doesn't mean we won't allow them to have privileges," she says. "It just means we apply additional scrutiny to the application and the physician."

She says the application should include a section for the physician to address malpractice claims and explain, in their own words, the situation. The credentialing coordinator can then compare that information with the physician's claims history to determine whether the information matches. On the other hand, she says a physician who omits information on malpractice claims from his or her application would always raise a red flag.

8. Send applications to the governing body for review. After the credentialing coordinator has verified the information on the physician's application, the application should go to the ASC's governing body for final review. "This is the time when any red flags and additional information is reviewed and discussed," Ms. Hartsell says. She says a physician who seems like a good match for the ASC — but who has one area of concern for the center on his or her application — might be proctored for the first six months, meaning he or she is overseen by another physician of the same specialty.

9. Verify privileges with local hospitals. When an ASC is developed and equipped, the surgery center leadership determines which specialties the facility will offer and bases the procedure list on procedures approved by Medicare for an ASC. When physicians applies for privileges at a surgery center, they receives a list of approved procedures for their specialty at that specific facility. Physicians can then go through the list and request privileges for the procedures they are qualified for and wish to perform.

If physicians want to perform a procedure outside the standard delineation of privileges for their specialty, they can formally request to perform those privileges if such privileges are on the facility approved procedure list. In that case, the surgery center would ask the physician for documentation that shows he or she has been trained in the specific procedure. For procedures that the ASC already offers, surgery center leadership can contact the physician's affiliated hospitals and request a list of privileges that the physician holds there. This lets the ASC ensure that the physician is trained and experienced in the procedures or she has requested.

10. Use a checklist to track physician progress. Ms. Hartsell highly recommends that surgery center staff members and credentialing coordinators keep a checklist of the steps for physician credentialing. "Make sure you're checking that checklist on a weekly basis," she says. She says the coordinator should know when each form was sent to the physician's office and when the physician submitted the completed information to the surgery center. The coordinator should also keep track of references that have not responded to the surgery center's request to assure prompt responses. ■

Learn more about Practice Partners in Healthcare at www.practicepartners.org.

5 Tangible Benefits of an Effective Risk Management Program
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body minutes as well as the quality assessment performance improvement committee meeting minutes as well."

Some states require an effective risk management program to obtain a facility license. Some states, like Florida, even require facilities have a licensed healthcare risk manager.

"It's imperative that the governing body be aware of the state requirements," says Ms. Hiatt. "A lot of times the state requirements are even more stringent than accreditation or Medicare."

As for accreditation organizations, they typically require ASCs to develop and maintain a risk management program that is "appropriate to the organization," she says. This means the program is comprehensive and designed to protect the organization against degrees of loss. While specific requirements will vary based on the accreditation agency, at a minimum the program must aim to protect lives and the welfare of the organization's patients and employees.

Medicare's Conditions for Coverage are even more stringent than the accreditation agencies. Medicare "requires some specific documentation about how the organization uses the information [it] gathers through the risk management program to improve patient outcomes and reduce medical errors," says Ms. Hiatt.

2. Identify system and provider weaknesses before an adverse event occurs. "An effective risk management program is an organization's first line of defense in identifying a weakness or system failure before it occurs and in mitigating or reducing any loss after it occurs," says Ms. Hiatt.

One example she cites is informed consent. While the requirements of informed consent vary some by state, she says, it's important for all ASCs to understand that informed consent is more than just a piece of paper. "It's a process," she says. "That piece of paper demonstrates that the patient has completed that process [and met] certain elements that are required with informed consent."

However, errors with the informed consent document are not uncommon, she says. For example, a procedure might be scheduled for the right eye but the documentation may reference the left eye. Usually, such an error is identified in the preoperative area, but occasionally it's missed.

"I've seen situations of adverse patient outcomes accompanied by incorrect or insufficient informed consent," Ms. Hiatt says. "When a provider is sued, and this documentation is missing or incorrect, the implications for defending the case are significant."

When staff members catch these errors, they should report them as "variances" to the ASC's risk manager (or risk management committee) so the problem can be identified and addressed, staff can be educated, and the ASC can move into a monitoring period where the process leading to the error can be improved and fixed before an adverse outcome happens.

"You'd be surprised how widespread and prevalent this system failure is because organizations fail to identify and address problems," says Ms. Hiatt.

3. Mitigation or reduction of potential loss after an event has occurred. Sooner or later, all providers, if they practice long enough, will likely face a significant adverse patient outcome, says Ms. Hiatt. "An effective risk management program is the provider's first line of defense," she says. "If you follow the principles of risk management, you can mitigate collateral losses following an adverse event."

If an adverse event occurs, Ms. Hiatt says the patient's medical record is a critical component if any litigation were to follow. She advises clients to keep all staff members connected to the event in the facility until the risk manager reviews the chart to make sure it's complete and no forms or documentation is missing.

"I encourage risk managers to number the pages of the medical record and initial each page so they know the medical record is complete when they view it in the future," she says. "If it's an electronic medical record, the complete medical record should be printed and secured so all access to the record is restricted."

She also advises providers notify their malpractice insurer as soon as an adverse event occurs. "The timing of that step is imperative because most malpractice policies have a timely notice provision," Ms. Hiatt says. "That defines the timeframe within which the event has to be reported in order to trigger the insurer's responsibility to defend and cover the provider."

Many providers take a wait-and-see approach to learn if any litigation comes out of the event rather than contact their malpractice carrier immediately, which is why they must be reminded that if they fail to report within that window of time, neither their defense nor the subsequent damages are covered, she says.

4. Provides a framework to gather data that can be used to improve patient outcomes. "When people think of risk management, they usually think of incidence reports, but risk management is more than that," Ms. Hiatt says. "It's patient satisfaction surveys, patient grievance complaints, and infection investigation tools, just to name a few, and all of these tools are only effective if the organization provides the required education to employees when they

are hired and annually thereafter." Educating the organization's employees regarding risk management is also an accreditation requirement.

An effective risk management program can provide ample opportunities for meaningful quality improvement studies which positively impact patient outcomes and captures another aspect of accreditation and Medicare requirements.

"If there's an open culture that encourages employees [to] record any type of event that varies from the organization's policies and procedures or expected outcomes, then tracking these recorded events can help you identify topics for future studies," she says. "If the organization is telling employees to report anything that isn't right or deviates from what it wants to happen, then it can gather and track event information to be used to formulate future studies."

For example, if a survey reveals patients are unhappy with the quality of a surgeon's explanation prior to surgery, then this is an area to consider for a quality improvement study. "Doing this is a way to reduce risk because if a patient is not satisfied with the explanation they receive before or after surgery, then they're more likely to be unhappy with other aspects of their care or surgical outcome," Ms. Hiatt says.

She says most organizations are not using patient satisfaction surveys to their best advantage. "Most organizations are pleased if they have really high scores. If they have really high scores, either they're not asking the right questions or they're not asking enough in-depth questions. I always encourage organizations to keep asking questions until they discover a problem because it helps them reduce their risk," she says.

If a surgery center is Medicare-certified, CMS will require the organization to track adverse patient events and examine their causes. Ms. Hiatt suggests ASCs perform this task using a surgeon outcomes reporting tool each month by asking its surgeons to fill out a form which identifies patients who experienced complications and what the complications were. Completing this form satisfies Medicare's risk management requirement, she says.

5. Reduce number, type and severity of adverse events. While no program will prevent every adverse event, the number of events can be reduced if the organization is fully engaged, recognizes the protection afforded to it through risk management, and actively encourages its employees participate in risk management.

"Risk management should not be something that is done to the organization but rather something that's done by the organization," Ms. Hiatt says. "The attitude and approach to risk management by leadership makes all the difference in how effective the program is and to what degree employees provide input."

Any organization that knows its strengths and exposes and corrects its weaknesses will be better prepared to handle the challenges of providing quality care. "Not to mention the demonstrable value by improving the organization's outcomes as we move toward a payment system that rewards organizations which produce the highest quality patient outcomes," she says. ■

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6 Steps to Reduce Surgical Site Infections in Surgery Centers

By Rachel Fields

Peggy SaBell, RN, MS, CIC, regional director of infection prevention for Kaiser Permanente in Denver, Colo., and spokesperson for the Association for Prevention in Infection Control, shares six ways surgery centers can reduce surgical site infections.

1. Work to eliminate complacency. Surgery centers generally see fewer complications and surgical site infections than hospitals — a trend that can be both a blessing and a curse, Ms. SaBell says. If surgery centers assume that surgical site infections will be a once-in-a-blue-moon occurrence in their facilities, they will probably fail to install a surveillance program to identify infections when they occur. "If we don't have a really good surveillance program in place, we don't actually know what's happening to our patients postoperatively," Ms. SaBell says. "That contributes to a sense of complacency that says, 'We don't have to do anything differently.'"

She says the first step in reducing surgical site infections in the ASC setting is to target that sense of complacency. Surgery centers should adopt the same "target zero" approach to surgical site infections that many hospitals have installed: Anything more than zero surgical site infections is unacceptable. This means re-educating providers on infection control practices and then holding them accountable for their actions. Providers are more likely to comply with infection control policies if ASC leadership develops clear expectations and emphasizes those expectations in writing, meetings and daily discussions. "It's about changing the culture," Ms. SaBell says. "In our ASC, we have signs outside each of our pre-operative areas that say 'Foam In, Foam Out,'" she says. "Our staff is talking about it and they are proud of what they're doing."

2. Look at outcomes and processes for every adverse event. Every time your surgery center experiences an adverse event, staff members should discuss the processes that might have contributed to the event and the outcomes involved, Ms. SaBell says. "Every time we find out about a surgical site infection, some sort of investigation needs to be done," she says. "What happened on that day? Were we behind or rushed? What risk factors contributed to the infection?"

Once you identify the factors that contributed to the surgical site infection, write them down in a report and meet to discuss how those problems can be fixed. If your surgery center staff failed to wash their hands because they were rushed, talk about how you can improve efficiency in other areas to leave enough time for hand-washing. If no one knew the patient had a condition that made him more likely to acquire an surgical site infection, work to improve your pre-op phone call or visit so risk factors can be identified in the future.

3. Develop relationships with hospital and primary care providers. Unlike hospitals, where patients are likely to return to the same facility with a surgical site infection, surgery centers may not know an adverse event has occurred unless they follow up. Ms. SaBell recommends developing relationships with hospital infection prevention personnel and primary care providers in the community, if possible. A surgery center in a large city may have trouble developing relationships with every primary care provider, but ASCs in smaller communities should reach out and make sure their contact information is available to local practitioners. These contacts can alert ASC leadership when they see a patient who acquired a surgical site infection at the surgery center.

"We really have to be proactive and develop relationships with hospital infection preventionists so that they call us when they see [one of our patients] on their admit list," Ms. SaBell says. She also encourages surgery center administrators to join their local APIC chapter, which can extend their network of contacts and increase the likelihood they will hear about surgical site infections when they happen.

4. Make sure your systems encourage good practices. Surgery centers should "get back to basics" when it comes to infection prevention, Ms. SaBell says. This means ensuring proper hand-washing techniques, time-outs in the operating room, appropriate aseptic techniques and other basic policies that providers should already know. The key is making sure that your surgery center's systems encourage providers to make the right decisions. "Does the housekeeping staff have appropriate and safe cleaning products, or are the products so noxious that they can't stand to use them?" Ms. SaBell says. "Is it too difficult for staff to get things properly cleaned and sterilized because we're pushing them or we haven't got enough instruments?"

Sit down with staff and ask how infection prevention systems could be improved. They may speak up and say they need more time, better equipment, clearer instructions or more physician involvement. Once you hear their feedback, follow up promptly with a plan and begin implementing the plan as soon as possible.

5. Flatten the OR hierarchy. Nurses and other providers may feel hesitant to speak up when they notice a physician breaking aseptic technique, Ms. SaBell says. Hospitals and surgery centers should try to break away from traditional notions of operating room hierarchy by encouraging staff members to speak up when they notice a patient safety issue, she says. "It's very similar to what the airline industry has done," she says. "Any of the personnel on the flight can speak up about a problem because they are on equal footing with the chief pilot when it comes to safety issues." She says in order to effectively "flatten" the OR hierarchy, ASC leadership should speak honestly with ASC staff about their relationships with the center surgeons. "Staff members are asked to be very honest and tell us which surgeons and anesthesiologists they do not feel comfortable discussing [patient safety] with," she says.

If your staff feels uncomfortable raising issues with your physicians, involve a respected physician leader in "flattening" the hierarchy, Ms. SaBell says. The physician champion can approach his or her colleagues and respectfully talk to them about listening to staff concerns and improving infection control practices. "Getting a physician champion makes such a difference," she says. "Having those tough conversations is easier on a colleague-to-colleague level."

6. Improve patient education. Make sure patients understand what they have to do before and after surgery to prevent a surgical site infection, Ms. SaBell says. Develop a thorough, easy-to-read sheet of preoperative instructions and ask your surgeon's office to distribute it to patients before surgery. The sheet should include instructions on showering before surgery, wearing freshly laundered clothes and stopping medications as appropriate.

Surgery centers should take some time on the day of surgery to educate patients about postoperative practices as well. Ms. SaBell recommends talking to patients before surgery, as patients may be recovering from anesthesia after surgery and will likely be sleepy and anxious to get home. "I think the most important thing is to educate them about hand hygiene and the importance of washing their hands before and after touching their dressing," she says. She also recommends giving the patient literature on the signs and symptoms of infection and asking them to call if they notice a possible infection. ■

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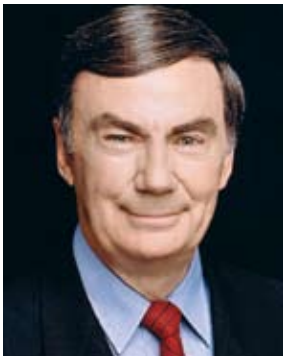

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5 Current Trends in Patient Safety

By Jeff Terry of GE Healthcare Performance Solutions, Patricia Daughenbaugh, RN, MSN, MBA, of GE Healthcare Performance Solutions Clinical Excellence consulting practice, and Kathy Martin, MBA, of GE Patient Safety Organization

The noise about patient safety has never been louder or less coherent.

In April we were told that, "adverse events occur 10 to 100 times more frequently than previously estimated."[1] This after the Office of Inspector General found in December that more than one in four Medicare beneficiaries suffered an adverse event while in hospital.[2] In short, the problem is real, widespread, growing and expensive.

There is also no shortage of good news. A series of efforts inspired by Peter Pronovost's CUSP and Universal Protocol have reduced central line-associated blood stream infections (CBLASI) in the United States by 63 percent since 2008.[3] In England, the National Health System reduced MRSA by 57 percent between 2003 and 2008.[4] There are dozens of similar successes within health systems and hospitals.

So, whether you believe harm to patients is decreasing or climbing, here are five trends we're watching closely.

1. Patient Safety Organizations. PSOs were launched in 2009 and within just one year 100 had been listed by AHRQ. Within two years, 17 had delisted because they could not perform the basic function of PSOs. But, the promise and potential of PSOs remains real and significant. Why? Because only inside a PSO can providers share real stories from the tip of the spear of healthcare delivery without fear of discovery or reprisal. We believe this is transformational because big improvements in safety are about learning. That learning can best take place within PSOs. (*Full disclosure:* GE is so convinced of the potential of PSOs that we created the GE PSO. The GE PSO emphasizes insights, community and tools to improve.)

2. Implement a Just Culture. Policies that decree behavior change usually fail. Actions taken against those who do harm often backfire. What to do? We find that many organizations are embracing methodologies like Team STEPPS and philosophies like Just Culture. Just Culture, from Outcome Engineering, seeks to create a learning culture that balances transparency and accountability. In a Just Culture, the organization focuses on behaviors that lead to harm rather than bad outcomes. Doing so seems to make great sense but is difficult to operationalize. More often than not, where we see big success, we find organizations that have embraced the Just Culture movement.

3. Re-examine policies and procedures. Too often, there is a gap between an organization's policies and its reality. For example, we met one hospital which sought to reduce problems of patient misidentification by requiring that four identifiers be examined when labeling a specimen for the lab. The result, of course, was that the staff ignored this requirement and continued to examine two. The larger problem was that this served to normalize deviance, weakening the authority of all policies and procedures in the institution. Another example is hand hygiene compliance. Too many organizations use the secret shopper approach to report greater than 80 percent compliance. Automated measurement finds actual compliance between 30 percent and 50 percent. This begs the question: What is the value of policies that mandate 100 percent compliance when, in practice, it's procedurally possible or acceptable to behave otherwise?

4. Test-drive simulation. Healthcare has lagged other sophisticated industries in the use of simulation. That may be changing. New applications of simulation seem everywhere. Simulation centers train physicians and nurses and teams. Surgical simulators train and test surgeons. Simulation models test new hospital designs before they are built. In short, the sophistication of simulation is beginning to catch up with the complexity of healthcare delivery. For example, at St. Luke's in Houston and Mount Sinai in New York, GE is working with the operators to create simulation models that can be "played forward" to provide the staff with "weather forecasts." These provide the staff with the status of each bed, bay and OR tomorrow so they can make better, non-intuitive decisions today. That matters.

5. Focus on usability. Several decades ago, aviation demonstrated that "safety" is bigger than a single device, cockpit or plane. "Safety" requires a minimum level of standardization between devices. Simply put, we all assume that pulling back on an airplane's yoke causes the nose of the plane to move up. To achieve this and other standardization, aviation organized Commercial Aviation Safety Teams with representation from pilots, airlines, manufacturers and regulators. We face the same challenge in healthcare. For example, if a defibrillator is perfectly safe unto itself, but works differently than the defibrillator in the next OR, it is inherently unsafe. Leaders in healthcare, including Peter Pronovost, are urging healthcare to follow aviation and adopt new approaches to improve usability, standardization and safety.

Patient safety remains one of our great challenges and opportunities. These and other trends may finally demonstrate that safety is getting better, and not worse. ■

Learn more about GE Healthcare Performance Solutions at http://performancesolutions.gehealthcare.com and the GE Patient Safety Organization at www.gehealthcare.com/promo/pso.

[1] David C Classen, et al., "Global trigger tool" shows that adverse events in hospitals may be ten times greater than previously measured," Health Affairs (Project Hope) 30, no. 4 (April 2011): 581-589

[2] Daniel Levinson, "Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries" (Department of Health and Human Services Office of the Inspector General, November 2010

[3] Health Aff April 2011 vol. 30 no. 4 628-634, Pronovost et al.

[4] Harutyunyah, UK MRSA Cut in Half. Sep 26, 2008, www.emaxhealth.com/2/39/24997.html

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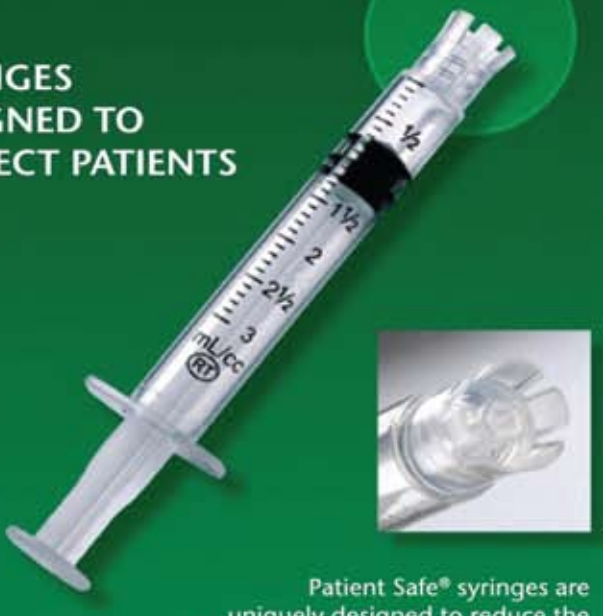

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Loaner Instrumentation Checklist: 10 Steps to Follow

By Rob Kurtz

Ambulatory surgery centers, like most facilities, cannot typically afford to purchase all of the instruments needed for the wide-range of procedures they perform. This, coupled with changing technology and a lack of storage space, leads most ASCs to employ the use of loaner instrumentation.

The use of loaner instrumentation presents many challenges for surgery centers, says Rose Seavey, RN, BS, MBA, CNOR, CRCST, CSPDT, president/CEO of Seavey Healthcare Consulting and formerly the director of the sterile processing department at The Children's Hospital of Denver. "You don't always get those instruments in enough time to appropriately reprocess them, and you should avoid the use of immediate-use sterilization," she says. "In addition, for those [staff members] who are going to be scrubbing — whether it's a technician or a nurse — if they've never seen those instruments before, it can present challenges to efficiency and safe patient care."

Ms. Seavey recently worked with the International Association of Central Service Materiel Management on a management of loaner instrumentation position paper. Included in the position paper is a checklist which Ms. Seavey developed. "It's a quick, down and dirty checklist [ASCs] should use any time they have loaner instruments."

Ms. Seavey discusses the nine steps in the checklist and adds a final step to complete the "before and after" cycle of receiving and returning loaner instrumentation.

1. Sterile processing is notified of loaners prior to receiving them. The first step is to inform your sterile processing department or the staff member who is overseeing sterile processing that you will be receiving loaner instrumentation and what is included in the delivery. "It's important so they can plan their day, so they know that it's coming," Ms. Seavey says. "But the most important piece of it is that they can make sure they have the manufacturer's instructions for use so that they know ahead of time that they are able to follow those instructions. For instance, if the instructions say [the instrument] must be cleaned in an ultrasonic cleaner, then you have to have an ultrasonic cleaner or else you're not going to be able to clean those items correctly."

2. Instruments are received in facility at least two working days (48 hours) for existing loaner sets and three working days (72 hours) for new sets before scheduled case. Receiving the instruments 2-3 days in advance provides time to identify problems, properly clean the instruments and run biological indicators if there's an implant

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and have those results available before the instruments are used. "For new sets, the recommendation is 72 hours because for the person in the operating room who is going to be scrubbing the case, it would be nice for them to have an in-service and be familiar with the instrumentation before they open it up to do the case," Ms. Seavey says. "It's not just an efficiency issue but also a patient safety issue."

3. Inventory list is provided/available. "When we're borrowing instruments, we're not borrowing forks, knifes and spoons, which is what I call the routine, everyday instruments," she says. "They're complicated instruments and they're usually coming in multiple instrument trays, and often they're things we're not familiar with. You need not only an instrument list but ideally you should have illustrations or pictures because sometimes if you just have an inventory list with a lot number, you don't know what the instruments are used for."

4. FDA-cleared manufacturer written instructions are available for cleaning, packaging and sterilization processes. The FDA clearance is the only way you can ensure the processes have been validated. "You need the FDA-cleared instructions because those have been validated to be efficacious for cleaning as well as sterilization," Ms. Seavey says. "It's not just the cleaning instructions but you also need the sterilization instructions. They've been validated so following these precise steps will ensure efficient sterilization."

5. Inventory and quality check is completed. Performing the inventory and quality check to make sure nothing is broken or missing is not only a patient safety issue but also a financial issue. "You don't want it to get up to the OR and find you have an instrument missing that's vital to the case and then you can't do the case," she says. "Also, if you're doing an inventory before, and inventory after (see step #10), then you're assured you're sending back what you received and the vendors are not going to come back and say 'this screwdriver is missing' and charge you for it."

6. Multiple trays are numbered and labeled (with patient and surgeon). This labeling system allows you to keep track of the similar items you received. "You might get a loaner set of instruments with five trays it, so then you should label it tray one of five, tray two of five, etc., and then ideally on that it should have the patient's name and surgeon's name on it," Ms. Seavey says.

7. Trays do not exceed 25 pounds. This is the national limit recommendation from AAMI and AORN. "That came about because of OSHA regulations: problems with ergonomic issues as well as sterilization and drying issues," she says.

8. All instruments are in good condition, with no rusting or pitting. "You want to make sure that the instruments don't have any discoloration or rust," Ms. Seavey says. "The instruments might be completely there but then maybe you have pliers, a screwdriver or retractor that's rusted — you don't want to use that on the patient. If there is [an instrument in poor condition], you can note that when you send it back to the vendor. There's a financial issue there."

9. Container is in good condition, with no rusting, tape, residue, etc. If the instrumentation comes in a rigid container, you should check to ensure there are no cracks or dents in it, she says. If you discover any cracks or dents, the container may have been dropped on the way to your facility and now you may not be able to maintain the sterility of the instrumentation. You also want to check the container for damage so you can inform the vendor about the problem and avoid a repair charge.

10. Perform inventory prior to returning instrumentation. "This is more of a financial issue, making sure you're sending back what you received and checking to make sure nothing was broken on your watch," Ms. Seavey says. ■

Learn more about Seavey Healthcare Consulting at www.seaveyhealthcareconsulting.com.

Why You Should Test Your Surgical Instrument Washer Weekly

By Matt Smith, Marketing Analyst, Healthmark Industries Co.

Conducting weekly tests to ensure your instrument washer is functioning properly has become increasingly important over the years. New guidelines from AORN (*Recommended Practices for Cleaning and Care of Surgical Instruments and Powered Equipment*, Section XXII.a) and AAMI (*Comprehensive Guide to Steam Sterilization and Sterility Assurance in Health Care Facilities*, ST79:2010) call for weekly testing (preferably daily, according to AAMI) of the automated instrument washer.

Testing cleaning efficacy is one of the most important steps to the surgical instrument sterilization process since instruments cannot be effectively sterilized unless all surfaces are properly cleaned.

Here are some simple steps to follow when using a suitable challenge device to test your surgical instrument washer:

- Empty previous cycle.
- Secure one test per level in the center of a tray.
- Compare the test to the interpretation guide.
- Record results on log sheet.
- If less than optimal results are obtained immediately report results.

Some other factors such as improper water temperature, incorrect cleaning solution (concentration, etc.), exposure time and proper spray action, to list a few, can also affect the quality of cleaning. There are water quality and temperature tests designed to monitor these key parameters of cleaning. ■

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6 Steps to Prevent Wrong-Site Surgery

By Rachel Fields

In June, the Joint Commission Center for Transforming Healthcare reported that despite intense efforts to curb wrong-site surgery, the adverse event still occurs approximately 40 times a week nationwide. Wrong-site surgery — which includes wrong procedure, wrong patient, wrong side and wrong site — was the third most common sentinel event reported in 2010. Linda Groah, CEO of AORN, discussed six ways hospitals and ambulatory surgery centers can prevent-wrong site surgery.

1. Lead a campaign around wrong-site surgery throughout the facility. Ms. Groah recommends hospitals and surgery centers push for wrong-site surgery prevention by holding a campaign that involves every level of the facility. "When I talk about patient safety from the CEO perspective, it has to permeate the organization from the top down," she says. This means that administration should bring up wrong-site surgery at staff meetings, participate in safety rounds and note progress toward wrong-site surgery prevention in employee newsletters, CEO blogs or on the facility intranet.

Facilities can support wrong-site surgery prevention with the rest of the healthcare industry by participating in National Time Out Day, a June 15 holiday that aims to remind the entire surgical team of the importance of time-outs before surgery. Of course, prevention efforts should not start and end on June 15; administration should roll wrong-site surgery prevention into overall patient safety goals throughout the year.

2. Implement a checklist. Ms. Groah says AORN has seen strong improvements in wrong-site surgery prevention in facilities that implement a checklist. "The use of a checklist actually identifies everything that needs to be done for the patient pre-operatively, including marking the side and site of the surgery," she says. She indicated that generally, the operating room circulating nurse is in charge of the checklist, though the surgeon or lead provider is responsible for marking the site and side of surgery. Since operating rooms can be noisy and distracting environments, she says some organizations enlarge the poster and attach it to the wall so that every provider can watch the circulating nurse check off the essential steps.

Ms. Groah adds that wrong-site marking is part of the Joint Commission's Universal Protocol requirement. "This is one way to actually get across to people that if you don't do this, there are ramifications from the perspective of regulations." AORN provides a checklist in two versions — a PDF and a customizable word document that providers can tweak based on the type of case. For example, a cardiac case might include different steps than a seven-minute cataract surgery. The AORN list is color-coded and designates which steps are Joint Commission criteria, World Health Organization criteria and SCIP measures required by CMS.

3. Watch for miscommunication during hand-offs. Ms. Groah says a checklist can also help providers communicate during patient hand-offs. "I might go on my lunch break, and the nurse that is relieving me may assume that something has been done," she says. A checklist will let the next provider know that the site of surgery has not been checked prior to incision.

4. Involve the patient in marking the site and side. Ms. Groah recommends providers talk to the patient before marking the site and side of surgery. This might mean saying, "Ms. Jones, we're going to be operating on your left knee today, and I'm going to mark it now. Is that correct?" She says some physicians will put more responsibility on the patient by asking, "Which knee am I going to do today?" to make sure the patient doesn't simply agree with the physician's assessment because they are intimidated. The difference between these two questions depends on the patient's level of education and cognition, she says.

5. Think outside the operating room. Ms. Groah indicates that some facilities concentrate their wrong-site prevention efforts on the operating room and forget about other areas of the hospital. "Wrong-site surgery does not only occur in the operating room," she says. "There are chest tubes and surgical procedures that are done in the intensive care unit, emergency room and other departments, and interestingly enough, they frequently think they don't have to abide by wrong-site surgery protocols." She says organizations should encourage prevention efforts throughout the facility, taking time to emphasize that departments where surgery does not traditionally occur are not exempt.

6. Involve every team member — physicians included. Some providers may be hesitant to implement a time-out or a checklist because they feel impervious to errors. Physicians might say, "I have been operating for 25 years, and I've never performed a wrong-site surgery," Ms. Groah says. In these cases, hospitals and ASCs should present data on the rates of wrong-site surgery and allow staff members to give testimonials about their experiences with adverse events.

These testimonials and statistics can give administration some leverage in pushing for a campaign. Ms. Groah cited a statistic that showed over 90 percent of physicians said they would want their surgical team to use a checklist if they were undergoing surgery themselves — a much higher percentage than said they used a checklist while performing surgery. ■

Learn more about AORN at www.aorn.org and the comprehensive surgical checklist at www.aorn.org/PracticeResources/ToolKits/CorrectSiteSurgeryToolKit/Comprehensivechecklist/.

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Infection Prevention in the Outpatient Setting: Q&A With CDC's Dr. Melissa Schaefer

By Rob Kurtz

The Centers for Disease Control and Prevention has released the Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care. *Melissa Schaefer, MD, medical officer in CDC's Division of Healthcare Quality Promotion, discusses how outpatient facilities can maximize the benefits of the guide and CDC's increasing focus on outpatient care.*

Q: What are CDC's objectives with this new guide?

Dr. Melissa Schaefer: Our main objective is to ensure that patients receive safe care every time they visit an outpatient facility. The Guide, and its accompanying checklist, is a way for us to package our existing evidence-based infection prevention guidelines and make them available, in a convenient package, to outpatient settings.

Q: Why release the guide now?

MS: We're seeing the transition of healthcare to settings outside of the hospital. We're also continuing to see outbreaks and patient notifications from lapses in infection control and people not following Standard Precautions (*Note:* For examples of recent outbreaks and patient notification events, visit www.cdc.gov/HAI/settings/outpatient/outbreaks-patient-notifications.html).

CDC has a number of evidence-based infection prevention guidelines that are readily available through our website, but I think a lot of people believe they only apply to hospitals and, perhaps, other settings aren't looking at them or using them as they were intended. We felt like this was an important opportunity to remind outpatient settings of these resources and the minimum infection prevention expectations for safe care - the things they should already know and should already be doing.

Q: What are the key takeaways from this guide for outpatient facilities?

MS: The bottom line is we want them to make infection prevention a priority in their facility and make it easy for the staff to do the right thing.

To help with this, we developed an infection prevention checklist to accompany the Guide. We divided the checklist into two distinct sections. Section one is geared for the facility administrator and addresses key infection prevention policies, procedures, resources and training they should have in their facility. Section two is targeted toward the frontline healthcare personnel and lists the infection prevention practices that they should be implementing in their day-to-day activities in the facility.

It's important to note that this Guide is not just targeting ambulatory surgery centers. It's for all outpatient facilities. Patients deserve safe care anywhere healthcare is provided and bad things can happen anywhere providers are not following Standard Precautions.

Q: Would you say the CDC is starting to look more closely at outpatient settings?

MS: I do think we are paying more attention to settings outside of the hospital. That's a reflection of the fact that those settings are where the majority of healthcare is being provided.

We're seeing procedures, previously only done in hospitals, being performed in doctors' offices. No matter where you have a procedure performed, the same standards should apply and the same infection prevention practices should be followed.

Q: What would the CDC like outpatient facilities to be doing and focusing on when it comes to infection prevention?

MS: It goes back to making infection prevention a priority. This includes having at least one individual, with infection prevention training, who is providing infection prevention oversight and expertise for the facility. It's one of the things we highlight in the guide — to have that leader and that resource available.

The rest of the Guide really focuses on Standard Precautions and the basics — the minimums that should be done. When we've seen these outbreaks and notifications, they are from providers not following Standard Precautions.

Q: Are you interested in hearing from facilities about the guide and the CDC's efforts?

MS: We would definitely be interested to see the feedback that comes from this and find out how it's being implemented.

One of the resources the CDC has is the "Safe Healthcare" blog (hosted at http://blogs.cdc.gov/safehealthcare/). We have a blog about the Guide and the checklist which has a comments box where people can leave their feedback (hosted at http://blogs.cdc.gov/safehealthcare/?p=1742. We also have CDC-INFO (hosted at www.cdc.gov/cdc-info) which can also be used to address questions about CDC guidance or materials.

Finally, healthcare personnel should also work with their professional organizations. We encourage professional organizations to package and distribute these materials to their members. ■

Contact Rob Kurtz at rob@beckersasc.com.

10 Things to Know About Waste Management and Preventing Surgical Site Infections

By Rob Kurtz

Linda R. Greene, RN, MPS, CIC, director, infection prevention and control for the Rochester (N.Y.) General Health System and APIC board member, discusses 10 things for organizations to know about surgical waste removal systems, and steps to take to prevent bloodborne pathogen transmission to healthcare workers and physicians and surgical site infections for patients.

1. Closed containers most common waste removal system. The typical approach for waste removal after a surgical case is the use of closed (suctioned) containers to hold and move the waste. These containers are typically emptied into a disposable sewer system, and oftentimes that is performed in a decontamination area.

"You have large containers full of blood and body fluid and then somebody would empty them," says Ms. Greene. "One of the things you find is it's easy to use and inexpensive. The downside is oftentimes it can put people at risk as there's always the potential for spilling and other issues."

2. Waste solidification effective, but expensive. Another option many organizations use for waste removal is waste solidification. In this process, an enzyme is used to turn liquid waste into solid waste, which is then placed into red bag or regulated waste.

"The positive [to this process] is it's fairly efficient," Ms. Greene says. "The negative for an approach like that is those containers are heavy as you've taken a huge container of liquid and made it into a solid. It becomes heavy. It goes into your red bag trash and you now pay by the poundage (or bag) to have the trash removed."

3. Direct-to-drain units growing in popularity. A third approach organizations can consider for waste removal that is garnering more users is a direct-to-drain unit. This is a closed system that suctions out waste and sends it to a central place where it would, essentially, automatically go down a drain using an organization's pumping system, Ms. Greene says.

"These systems are becoming popular, although the initial investment is somewhat expensive," she says. "The waste goes to the docking system and then it's automatically offloaded into your waste management system. It's almost like a plumbing system, in that kind of a simplistic view."

4. Research waste removal system options. Each of these waste removal options has its pros and cons, and organizations should weigh them before investing in one over another or moving forward with a change in system. Not only should cost and efficiency be considered, but organizations will also want to consider the potential for exposure to bloodborne pathogens when handling waste, Ms. Greene says.

5. Regardless of the system used, personnel need protective equipment and safety education. None of the three systems can ensure staff members will not be exposed to bloodborne pathogens during the waste removal process. It is therefore critical for organizations to educate staff members on the proper way to remove waste using the system in a manner most likely to reduce the potential for exposure and to always have protective equipment available, such as a gown, mask, goggles and gloves, Ms. Greene says.

6. Don't neglect goggle use. Goggle use is particularly important for organizations using the closed container waste removal system. "One of the things we find is oftentimes people fail to wear goggles, but splashing and splattering is likely [with containers]," she says. "[Staff members] need to make sure they're being very careful when opening the containers."

7. Use of drains in patients presents infection risks. After a surgical case, physicians will often use drains to prevent the accumulation

of fluid underneath the skin. "After you have surgery, there's going to be bleeding around the area [of the incision(s)] and what you don't want is all of that bleeding to occur underneath the skin — you want to have that removed," Ms. Greene says.

The downside of drains from an infection prevention perspective is they provide a direct pathway to an area that is typically sterile. "My skin is my first layer of protection," she says. "If I have surgery, I have some sutures, so I have a little bit of an open wound that allows bacteria to enter. Now you put in a drain and I have almost a direct pipeline into an area that is normally considered more of a sterile area. This can present a risk of infection."

In addition, Ms. Greene says some of the current literature says drains may increase the need for blood transfusions, and there is literature that says patients who require blood transfusion are at a higher risk of infection. "A lot of things that used to part and parcel of medical care, they're really being reexamined," she says.

8. Prolonged use of drains presents additional challenges. "The longer a drain is left in place, there's much more risk of contamination," says Ms. Greene. "As we look at all of these things which are really related to fluid management from a removal perspective, there are definitely practices needed to address the risk of infection."

9. Drains require proper and careful handling. Considering the potential for infection when using drains, Ms. Greene says care providers must ensure sure they are handling drains aseptically. "One needs to be very sure they washed their hands, that they followed very good technique and that the nurse is looking for signs and symptoms of infection when a patient has a drain," she says.

10. Monitor area following drain removal. Drains are typically removed with 24-48 hours, and it is important from an SSI perspective for that area to be monitored closely. "The area should be covered," Ms. Greene says. "There is some definite literature, particularly pertaining to orthopedics, to say an occlusive dressing, a dressing that covers the area like Saran Wrap, should be used to prevent moisture and may be more effective in preventing infection" than other dressings. Some experts recommend three layers of dressing: a non-adhering layer, an absorptive layer and an occlusive dressing. ■

Linda R. Greene, RN, MPS, CIC, is author of APIC's Guide to the Elimination of Orthopedic Surgical Site Infections (www.apic.org/downloads/ortho_guide.pdf), *which details many of the issues discussed in this article. Learn more about APIC at www.apic.org.*

7 Surprising OSHA and Waste Management Rules and Regulations

The Accreditation Association for Ambulatory Health Care (AAAHC) places significant emphasis on organizations meeting OSHA regulations and performing proper waste management. However, these are areas where facilities, including ambulatory surgery centers, frequently struggle, says Scott J. Trimas, MD, FACS, a facial plastic surgeon and otolaryngologist in Florida who serves as a surveyor for AAAHC and consultant for its subsidiary, Healthcare Consultants International.

Dr. Trimas identifies seven OSHA and waste management rules and regulations that organizations may find surprising, although failure to meet them could put a facility in violation of OSHA requirements, and thus subject to thousands of dollars in penalties, out of compliance with AAAHC standards and even simply hurt the bottom line.

1. OSHA requirements can vary by state. While OSHA may be a federal agency with requirements that organizations must meet, states develop and operate their own job safety and health programs, and have the authority to establish their own requirements. AAAHC standards require organizations to have knowledge of and meet federal *and* state guidelines, Dr. Trimas says.

"As a surveyor, I frequently go to an organization and they don't know their state OSHA requirements," he says. "I'd say about one-third of all surgery centers I survey are not familiar with their state OSHA requirements."

2. Copies of hazardous waste manifests must be kept on file. Facilities need to keep copies of the signed manifest provided by the hazardous waste removal vendor following waste removal usually for a period of 5-7 years, depending on the state, according to Dr. Trimas.

3. Organizations need to conduct annual safety device evaluation. A national OSHA requirement, and one Dr. Trimas says many organizations do not meet, is annual testing and evaluation of new safety devices.

"Every year you're supposed to try safer alternatives to your syringes, needles, IV catheters, blades for surgery, etc., and evaluate whether they're useful for your organization," he says. "Probably a third of the organizations don't do that, or they don't document they do it. You have to document it."

4. Biohazardous waste must be kept separate. Biohazardous waste must be kept separate from other waste, and there are often other requirements about where biohazardous waste can be placed and what it can be kept near, which varies by state, Dr. Trimas says.

5. Proper labeling required for biohazardous waste. Biohazardous waste must be labeled as such. "The type of label and what the label needs to indicate vary by state," he says.

6. Surgical fluid waste can often go down the drain. In many states, organizations can dispose of fluid suctioned away during a procedure, such as blood or saline, down their sanitation system. "However, there are some states that don't allow you to do that," says Dr. Trimas. "In these 'green' states, they are afraid it will contaminate their water and they will require you to solidify it."

If your state does not require solidification, it may be cost effective to dump this waste down the sanitation system as opposed to producing more, and expensive, red bag waste.

7. State may allow products with blood on them to go into regular garbage. "If you have gauze that has blood or other patient waste product in it, a lot of times you can throw this in the regular garbage, as long as it's not saturated," Dr. Trimas says. "That varies from state to state as well. In Florida, if we have gauze that has some blood on it from dabbing, if it can't be rung out, then it can be thrown into the regular garbage. If you don't do that and instead fill a whole red bag with things that could go into the regular garbage, that just wastes money." ■

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As you know, some disinfectant's list different kill times for different microorganisms / bugs simply because they can't meet all of the needs of a health care facility in a single product! All they do is to confuse things by claiming 5 minutes this bug, 1 minute for that bug, 30 seconds for this bug and they don't mention the ones they can't kill and it goes on and on and on...

New Opti•Cide³ kills bacteria, viruses, TB, and fungi with a single 3-minute contact time including the tough ones. VRE, MRSA, Norovirus, Pseudomonas, Salmonella, TB, and a multitude of others. It effectively loosens and lifts C. difficile spores for removal from surfaces...

...and, Ready to Use **Opti•Cide³** can be applied to all surfaces including vinyl, aluminum, brass, stainless steel, chrome, painted surfaces and Plexiglas®. It is the perfect cleaner disinfectant for use on all surfaces including cots, monitors, cabinets, and even laptops.

Finally, a product with no mixing, no confusing contact times, no hassles and no confusion! Available in spray, bulk liquid sizes for re-filling spray bottles and convenient wet wipes!

End of Confusion!

Protecting Your Patients
Your Staff
& Your Family

Micro Scientific Industries, Inc.®

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