INSIDE

BECKER'S

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10 Areas of Focus for Maintaining a Sterile Field in an ASC

By Kathleen Bernicky, RN, BSN, Director of Clinical Operations for Regent Surgical Health

Surgical infections are a leading cause of patient morbidity and mortality in the United States. Adherence to the principles of asepsis is the foundation of surgical site infection prevention, and it should never be circumvented to save time or money. A sterile field should be prepared and maintained for every surgical patient. A sterile field is a specific area that is considered free of microorganisms. Maintaining a sterile field is not an easy task because there are many chances for a breach in sterility during set-up and maintenance of the sterile area.

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Preventing Healthcare-Associated Infections: Q&A With Wava Truscott of Kimberly-Clark Health Care

By Rachel Fields

Wava Truscott, PhD, MBA, Director of Medical Science & Education for Kimberly-Clark Health Care, discusses healthcare-associated infection prevention.

Q: Who is most vulnerable to contracting a healthcare-associated infection and why?

Wava Truscott, PhD, MBA: All patients entering any healthcare

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8 Steps to "Chase Zero" With Wrong-Site Surgery

By Rachel Fields

Wrong site/side surgery is a serious concern in the healthcare industry: Based on state data, Joint Commission officials estimate the problem occurs 40 times a week in U.S. hospitals and clinics. Linda Groah, MSN, RN, CNOR, NEA-BC, FAAN, executive director and CEO of AORN, discusses eight strategies to "chase zero" when it comes to wrong-site surgery — aiming to make it a "never event" at your facility.

1. Start from the top. If OR team members are going to take wrong-site/side surgery seriously, the message needs to start in the C-suite, Ms. Groah says. "There has to be a concept at the very top that patient safety is number one at the institution," she says. This means the topic should be discussed in whatever method the CEO uses to communicate with the whole hospital — town-hall meetings, regular emails, video chats, etc. "If the CEO really believes and puts forward the message of preventing wrong-site surgery as part of their strategy, everyone else will understand the importance of it," she says.

2. Involve all the stakeholders. Ms. Groah says there are three main

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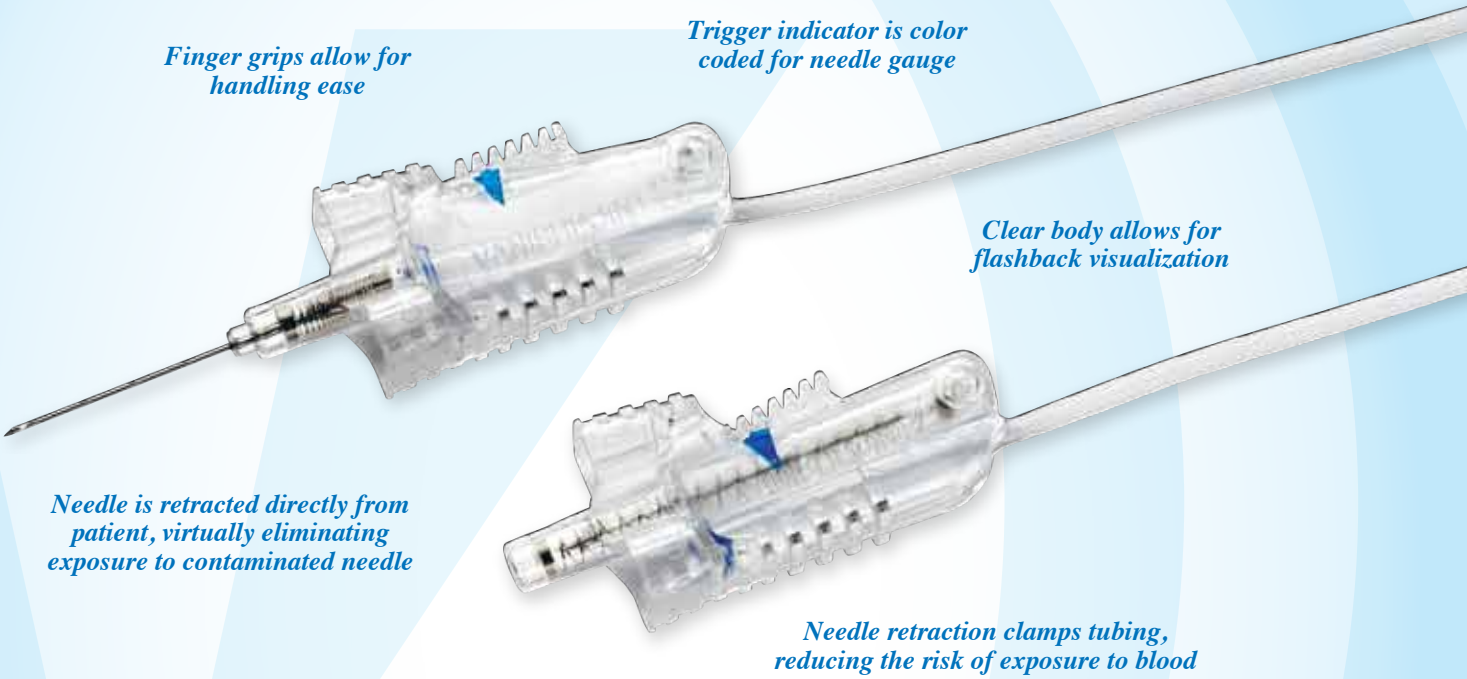

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FEATURES

10 Areas of Focus for Maintaining a Sterile Field in an ASC **(continued from page 1)**

AORN and The Association of Surgical Technologist have developed Recommended Standards of Practice for creating and maintaining a sterile field. It is the responsibility of the healthcare facility to develop, approve and implement policies and procedures, as well as educate staff on these procedures. The entire surgical team has a responsibility to provide and maintain a safe environment for patient care.

Ongoing education is critical and will create a higher level of awareness. Putting the topic on monthly department meeting agendas will keep it front and center. It's also important to encourage staff to speak up when they have a concern or have witnessed a breach in sterility. ASC administrators should perform periodic audits, identify areas for improvement and share the results with the staff in order to educate the surgical team.

10 Areas of Focus for Maintaining a Sterile Field

1. Involve all team members. The entire surgical team — the circulator, the scrub, the surgeon and the anesthesiologist — are responsible for monitoring the sterile field and speaking up if a breach of sterility occurs. It needs to be a team effort.

2. Follow the same practices every day. Establishing routines and expectations for opening and setting up the sterile field is helpful. The team should be mindful of what they are doing. It's easy for staff members to be distracted by conversations with their colleagues, which take their attention away from the task of correctly opening and preparing a sterile field.

3. Reduce conversation in the sterile field. AORN suggests that conversations in the presence of a sterile field should be kept to a minimum to reduce the spread of droplets. Air contains microorganisms on airborne particles, such as respiratory droplets. The primary source of airborne bacteria is healthcare personnel.

4. Inspect instruments and trays for tears. The sterile wrapped instruments and trays should be purposely inspected for small tears that would compromise sterility before opening and placing the instruments on the field. Staff members often skip this step.

5. Include a sterilization indicator with each item/tray. Each sterile item or tray of sterile items must include a sterilization indicator. The indicator must be inspected before opening to note whether the indicator color has changed to the appropriate color for the indicator type. This will verify that the sterilization process was completed. It's helpful if the staff member opening the instruments verbalizes the indicator results.

6. Be sure the item is sterile before using it. It's either sterile or it's not. If in doubt, don't use it.

7. Face the sterile field at all times. The scrub person and the OR team should never turn their back to the sterile field. The fronts of sterile gowns are considered sterile from the chest to the level of the sterile field. The sterile area of the gown front extends to the level of the sterile field because most scrubbed personnel work adjacent to a sterile bed and/or table. Gown sleeves are considered sterile from two inches above the elbow to the cuff, circumferentially.

8. Reduce the number and movement of OR team members as much as possible. The number and movement of individuals involved in a surgical procedure should be kept to a minimum per AORN's "Recommended practices for traffic patterns in the periopera-

tive practice setting." Bacterial shedding increases with activity, and air currents can pick up contaminated particles shed from patients, personnel and drapes and distribute them to sterile areas.

9. Keep the OR door closed. Leaving the OR door open or frequent opening of the door will interrupt the air exchange system. The OR suite will also lose negative pressure. allowing airborne contaminates in.

10. Monitor the field in case of delay. In the event a case is delayed, the only way to assure sterility is for the field to be constantly monitored. Covering a sterile field and then uncovering it increases the chances for contamination as you remove the cover.

Education is critical to empowering ASC staff members. It gives them the knowledge they need to provide safe patient care. Ongoing education helps to develop surgical consciousness or awareness.

The responsibility of the facility's leadership team is to create a culture of safety so staff members feel free to speak up when they witness a possible or definite interruption in sterility or any patient safety issue. Many staff members are afraid to say something due to repercussions from an angry surgeon or surgical team. Changing gloves, gowns or the sterile field can delay the procedure or surgery for a few minutes, but staff should always be encouraged to speak up and do the right thing. ■

Preventing Healthcare-Associated Infections: Q&A With Wava Truscott of Kimberly-Clark Health Care

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environment are vulnerable to infections, due to injury and/or a compromised immune system. Their normal barriers to infection are focused on healing injuries, preventing invasion of foreign bodies, or have become less effective due to malnutrition, natural aging or diseases like diabetes. According to the Centers for Disease Control and Prevention, approximately 1.7 million hospital patients contract an HAI each year in the United States. That means that 1 in 20 individuals walking into a facility seeking help for a medical concern become infected while they are there.

Q: What are the different ways in which an infection, more specifically an HAI, can be transferred?

WT: Staff, sick patients, visitors and contaminated objects are primary sources for transferring infections. Microorganisms are deposited on surfaces within aerosol droplets from coughing, sneezing and contaminated humidifiers, or by touch transfer from contaminated hands, clothing and instruments. These contaminated surfaces and objects can subsequently play a role in the transfer of pathogens onto other surfaces, the hands of healthcare providers and the hands of patients.

Q: What are some preventative measures that can be taken to reduce the risk of HAI exposure?

WT: Proper use of personal protective equipment, thorough hand hygiene by patients, residents and staff, comprehensive environmental cleaning, meticulous instrument sterilization practices and frequent disinfection of potentially contaminated surfaces all significantly reduce the risk of patients acquiring an infection. To expand:

- According to the CDC, the most important factor for infection prevention within the hospital setting is hand hygiene. Hand hygiene policies should include mandatory use of an alcohol-based rub or soap and water by staff and visitors before and after any contact with patients or potentially contaminated surfaces.
- Easy access to PPE, including gloves, masks and gowns, makes compliance with appropriate protection much more likely. Policies need to be posted reminding staff and visitors of appropriate PPE to be worn depending on the patient's level of vulnerability and possible infectious status.
- Proper surface disinfection begins with choosing an Environmental Protection Agency-approved disinfecting agent. For example, sodium hypochlorite at the appropriate concentration and pH is commonly chosen to address Clostridium difficile concerns. However, especially in the case of C. difficile contamination, the EPA first requires cleaning to remove feces and other organic substance that could physically or chemically interfere with the effectiveness of the disinfectant. Following are important considerations:
- Research has shown that the act of cleaning can actually contribute to transmission of organisms if one is not cognizant of the critical nature of such a seemingly easy task. For example, use of the old open bucket "dip-and-squeeze" method can leave pathogens alive and infectious, floating in the cleaning solution. Each dip of the contaminated rag increases the number of microorganisms in the bucket, and can be spread to each subsequent surface and room. A closed-bucket wiper dispensing system solves this problem easily by eliminating the need to re-dip wipers, preventing associated cross-contamination.
- If the disinfectant is applied inadequately or inappropriately, there is the potential for not killing the pathogens. For example, few institutions understand that many disinfectants are rendered inadequate if a cotton rag or paper wipe is used to spread the disinfectant, due to the pathogen-killing molecules actually binding to cotton and paper fibers. This decreases the effectiveness of the disinfectant due to its decreased concentration. For example, Schultz (2009) demonstrated over 75 percent loss of chlorine concentration in a hypochlorite disinfectant when it was in contact with paper wipes for just 10 minutes. Compatible wipes, usually composed of polypropylene, are critical for ensuring appropriate concentration of the disinfectant is consistently delivered to the target surface. In situations where cleaner-disinfectant combination solutions can be used, the importance of a closed container system that dispenses compatible non-binding wipes are similarly essential.
- Healthcare facilities need to be especially mindful of "high-touch areas," which include frequently visited locations and points of contact such as television buttons, light switches and door handles, making certain that they are routinely disinfected.

Q: What can healthcare professionals and patients do to educate themselves further about HAI prevention?

WT: Healthcare professionals should continually update themselves on developments and compliance requirements related to HAI prevention. Clinicians and environmental services supervisors should provide regular education programs for employees, as well as comprehensive offerings for staff as turnover occurs or untrained, temporary employees are utilized.

- Continuous education around infection prevention practices is vital to ensuring excellent patient care. Kimberly-Clark Health Care has a number of complimentary accredited educational webinars specifically for ASCs archived at https://www.excellentiagroup.com/complimentary-webinar, and additional complimentary online courses available at http://en.haiwatch.com/ClinicalEducation.aspx.
- The Heart of Healthcare campaign, created by Kimberly-Clark Professional and the Association for the Healthcare Environment, features educational materials for environmental services professionals on HAI prevention including a toolkit that supervisors can use to demonstrate the importance of infection prevention within the healthcare setting and to provide key steps employees can take to reduce these risks. Because routine and thorough surface disinfec-

tion is a critical and mandatory facet of infection control, the professionals in environmental services play a key role in prevention efforts within healthcare facilities.

- The Kimberly-Clark HAI Patient Education Program includes in-depth information on infection prevention for patients and their families through a dedicated patient education website, toolkit and support of community events. Additionally, Kimberly-Clark provides HAI prevention resources and training to clinicians and healthcare organizations through the website HAI Watch.
- Healthcare professionals and patients who have worked to reduce HAIs in the healthcare setting are now being recognized by the annual HAI WATCHDOG Awards. The program, sponsored by Kimberly-Clark Health Care, recognizes these efforts and awards educational grants to those working to prevent HAIs in their facilities and also provides a forum for healthcare providers to share infection prevention best practices. ■

Contact Rachel Fields at rfields@beckershealthcare.com.

3 Quality Improvement Projects at UC Davis Medical Center

By Sabrina Rodak

UC Davis Medical Center in Sacramento, Calif., participates in the Delivery System Reform Incentive Program, a five-year pay-for-performance initiative in which California public hospital systems aim to meet benchmarks related to healthcare access, quality and safety outcomes. The program is part of the Section 1115 Medicaid Waiver in California, an initiative that began in November 2010 to help the state's public hospital systems prepare for and implement health reform in 2014. Allan D. Siefkin, MD, CMO of UC Davis Medical Center, describes three of the 14 projects the hospital is implementing under DSRIP.

1. Patient-centered medical home. UC Davis has been developing a patient-centered medical home for about three years. The hospital focuses on transfers of care, chronic disease management and coordination of care practices. To create a PCMH, the hospital has also extended its electronic health records to its physician groups so all providers are connected and can easily access patients' information. The hospital is currently approximately 96 percent paperless, according to Dr. Siefkin. He says the EHRs facilitate not only communication, but also standardization because the EHRs include standardized order sets and direct electronic communication between patients and their team of providers. "The ability to communicate and to share information [electronically] has empowered the quality and safety process," he says.

2. Disease registries. UC Davis is also building disease registries, which include outcome measures such as the number of readmissions and the rate of complications. The disease registries focus on vulnerable populations, such as those with diabetes, as a strategy to help manage population health.

3. Sepsis improvement. UC Davis is in its second year of an initiative to reduce mortality from sepsis. The hospital built into its EHR the ability to screen patients' vital signs, such as pulse, blood pressure and heart rate, for signs of sepsis. If a vital sign indicates the patient is at risk for sepsis, the EHR automatically sends an inquiry to the nurse responsible for the patient. If the patient has no other reason for the abnormal vital sign, the nurse conducts a preseptic workup, draws a blood lactate level, communicates with the physician and applies a sepsis resuscitation bundle.

Using this method, UC Davis has already reduced all sepsis mortality from 17 percent to 11 percent and has reduced severe sepsis mortality from 30 percent to 23 percent, according to Dr. Siefkin. One of the reasons for the initiative's success is because UC Davis used the EHR not only to gather and file information, but also to apply the information in real situations. "This is one example of how we use the EHR to improve care. Having information doesn't do any good if you don't turn around and use it," he says. ■

Contact Sabrina Rodak at srodak@beckershealthcare.com.

8 Steps to "Chase Zero" With Wrong-Site Surgery **(continued from page 1)**

groups of providers who actually touch the patient: nurses, surgeons and anesthesiologists. All three groups have to agree on the format for double-checking the correct side and site of surgery. Ms. Groah says most surgical facilities use a version of the World Health Organization, Joint Commission or CMS recommendations around using a surgical checklist.

She says the lists are often modified to fit hospital needs; for example, a pediatric hospital would need to add special precautions for young patients, while hospitals with extensive use of laser and electrosurgery machines might add checklist issues about fire protection. Ms. Groah says the process of customizing the surgical checklist for a facility should involve the OR director, the head of nursing, the chief of surgery and the chief of anesthesia.

3. Educate all OR members together. Ms. Groah recommends holding an education session about wrong site/side surgery that includes all OR team members. One of the biggest roadblocks to successful prevention of wrong site/side surgery is a lack of collaboration in the OR, she says. In many cases, the surgeon will go ahead with the case without stopping to check the side and site of surgery, and other providers do not feel comfortable interrupting the process.

She says every member of the OR — the surgeons, anesthesia providers and nurses — should sit down together and discuss the benefits of the checklist. She recommends providing literature on the effectiveness of using a surgical checklist, as well as going through role-playing exercises to get providers used to checking in with each other. She says some hospitals have taken extra measures to make sure the surgical checklist is visible. For example, some facilities color-code their checklists to show which staff members are responsible for which tasks. Other facilities post the checklist on an electronic board on the wall of the OR, so that everyone can see each step as it is completed.

4. Ask the surgeon to take the lead. Ms. Groah says the surgeon should start the checklist process by getting the attention of all OR members and saying, "Let's go through the checklist." All the OR team members should then introduce themselves to encourage collaboration and show who's responsible for the care of the patient.

Once everyone has been introduced, the circulating nurse should go down the checklist and complete every precautionary task, including double-checking the side and site of surgery. Every person in the OR should have their complete attention focused on the checklist, to make sure no miscommunications occur.

6. Institute a number of "double checks" to ensure the right side/site is understood. Prior to surgery, the facility should institute a series of "double checks" to make sure everyone is on the same page about the side and site of surgery. "It starts in the surgeon's office, when the patient and the surgeon agree to surgery," Ms Groah says. "At that point in time, they'll say, 'We're going to operate on your left hip,' and that's the way the procedure is scheduled when the surgeon fills out a form or calls the scheduling office."

She says the patient will then sign a consent form prior to surgery, which can occur either during the office visit or during a pre-op visit within two weeks before surgery. The consent form should clearly say where the surgery will occur on the patient. The surgeon would then make a note in the chart before surgery and mark the side and site on the patient during pre-op, when the patient can participate. The circulating nurse would check the consent form and the OR schedule when she checks the patient in after pre-op. In the pre-op area,

7. Install "secret shoppers" to check up on OR compliance. Once you have educated your OR team members about the surgical checklist process, you need to know if they're complying with the policy. Ms. Groah says the best way to do this is to assign a "secret shopper" to make rounds and observe team members on a regular basis.

"Nobody knows the person is observing the protocol for the checklist," Ms. Groah says. "The advantage to the concept is that if you're being watched, you're going to do it the right way." If team members don't know they're being watched, they'll give a more accurate portrayal of what happens in the OR on a daily basis.

8. Debrief after surgery to go over "near misses" and "good catches." Ms. Groah says it's important to reserve some time after surgery to review everything that happened. In the debriefing, people have the opportunity to talk about instances when a wrong site/side surgery could have happened, but didn't. This provides a learning opportunity for the next surgery, because "near misses" will probably be avoided in the future if the staff members understand why they happened. ■

Contact Rachel Fields at rfields@beckershealthcare.com.

7 Fundamentals for Maintaining Safe and Effective Sterile Processing Departments

By Jaimie Oh

Marcia Patrick, RN, MSN, CIC, an infection prevention consultant and a member of the Association for Professionals in Infection Control and Epidemiology's board of directors, discusses six fundamentals for maintaining a safe and effective sterile processing department in ambulatory surgery centers.

1. Evaluate each product before purchase. Ms. Patrick says a new instrument or machine "may seem like the best thing since sliced bread," but administrators should calculate how the equipment will impact efficiency prior to purchase.

"Before an ASC purchases anything that requires sterilization or [deep] high-level disinfection, administrators need to carefully measure cleaning time. One instrument may take five hours to clean, and in a busy operating room, that's just not practical," she says. "In addition to top-level evaluation, administrators should also receive input on individual purchases from staff members."

2. Schedule education for staff members. After evaluating and purchasing a product, administrators and infection control leaders should be educated on sterilization and disinfection by company representatives. Ms. Patrick suggests double-checking that the representative's information is consistent with the manufacturer's recommendations. "Representatives may not necessarily have the background to totally understand the processing of a particular product, so we just want to be sure that what he or she is teaching is consistent with the manufacturer's instructions."

3. Keep the manufacturer's recommendations handy. With the explosion of new types of medical instruments, devices and equipment, ASCs must keep a current copy of the manufacturer's recommendations for sterilization and disinfection for each item. This may mean creating a printed log of the manufacturer's recommendations or uploading that text into a computer. ASCs can also print instructions for each phase and post them around the reprocessing department.

"If the primary processing staff member happens to be on vacation, it's important that the back-up staff member is able access those materials and become familiar with the reprocessing of a device," Ms. Patrick says.

4. Lay out the processing area in an efficient and safe manner. Simple things, like the physical lay-out of the processing area, can hamper reprocessing and waste time. Ms. Patrick says ASCs can solve this dilemma by labeling each phase of the reprocessing area. This way, clean instruments are never crossed over to dirty areas and infected with bacteria. The flow of instruments should be uni-directional and start with soiled receiving, then cleaning and rising, then high-level disinfection or sterilization.

"Any staff member who walks into the reprocessing department should be able to know what phase of cleaning that instrument is in, whether it is still soiled, has gone through cleaning/washing or has gone through drying and is ready to be placed in the autoclave," Ms. Patrick says.

5. Properly maintain:
Sterilizers. The machines that sterilize instruments and other devices need to be cleaned too. Racks inside desktop sterilizers should be removed and the sterilizer cleaned at least monthly. Ms. Patrick says ASCs should run spore tests to ensure sterilization is occurring.

High level disinfection products. Although the manufacturer's recommendations will explain how often to change the liquid chemicals for high level disinfection, ASC staff should also "dip stick" the liquids before each use so that the liquids retain the correct potency for killing bacteria.

Ms. Patrick says the supply purchasing and reprocessing departments should communicate regularly to prevent an infection outbreak. "ASC reprocessing departments want to make sure they are aware of which [sterilization of high level disinfection] product they are using because sometimes the purchasing department will substitute items for cost savings," she says. "Although the cost savings is beneficial to the ASC, if different processing times are not followed, it can lead to devastating results for patients."

6. Avoid immediate-use steam sterilization. Immediate-use steam sterilization, formerly known as flash sterilization, should not replace a full sterilization cycle, Ms. Patrick says. In fact, nursing advocacy and accrediting bodies, including APIC, the Association of periOperative Register Nurses and AAAHC, say healthcare facilities should have a sufficient number of devices and instruments prepared for anticipated surgical volumes, rather than relying on immediate-use steam sterilization. However, ASCs do not need to prepare trays for every procedure.

"If an ASC, for example, has 10 cases for one day, they need to have four to six sets so they have enough instrumentation to efficiently complete each procedure and allow for enough time to conduct a full-cycle processing in between cases," Ms. Patrick says.

7. Don the proper personal protective equipment. ASCs must ensure their employees, including those working in reprocessing departments, are adequately protecting themselves against infection. Personal protective equipment, such as waterproof gowns, aprons, gloves and masks, can reduce the risk of bacterial transmission. "Sometimes, healthcare workers don't perceive the risk," Ms. Patrick says. ■

Contact Jaimie Oh at joh@beckershealthcare.com.

5 Best Practices for Central Sterile Processing

By Sabrina Rodak


Alecia Cooper

Central sterile processing plays a key role in hospitals' infection prevention efforts, particularly in relation to surgery patients. Failing to follow the appropriate sterile processing standards can result in infections, which increases costs and causes harm to patients. Alecia Cooper, RN, BS, MBA, CNOR, senior nursing consultant at Surgical Directions, and Valeria McAfee, MBA-HCM, a central sterile processing consultant for Surgical Directions, share five best practices for sterile processing.

1. Ensure proper training. One of the most important elements in central sterile processing is employees' training. Ms. Cooper suggests requiring certification for sterile processing staff to ensure everyone is educated on correct practices. Currently, many staff members get on-the-job training; while this training is not bad, it needs to be supplemented with a formal certification course, according to Ms. Cooper. Furthermore, education should be ongoing so staff stay updated on current guidelines.

In addition to knowing the facts of how to sterilize, staff should also understand why sterilization is important, according to Ms. McAfee. "If they understand why they need to make sure there's no bioburden and that [instruments] are properly functioning, it enhances the quality of work that the sterile processing person does," she says.

2. Adhere to evidence-based standards. Sterile processing employees should follow standards set by professional organizations such as the Association for the Advancement of Medical Instrumentation and The Joint Commission, according to Ms. McAfee.

3. Follow the manufacturer's recommendations. Instruments should be sterilized according to the manufacturer's recommendation. Because different instruments may have different manufacturers and different instructions, Ms. McAfee suggests sending the manufacturer's recommendation with each instrument that comes into the sterile processing department.

4. Build a strong working relationship with OR staff. Sterile processing staff and operating room staff need to work together to ensure proper sterilization and to learn from each other. "It has to be a collaborative team effort, because the OR [team] is your defense in surgery — they are the ones who will recognize something they feel might not be properly sterilized," Ms. McAfee says. "They need to give feedback to the central sterile processing area, [which can] take the information and say 'How can we make this better? What did we do wrong and how can we improve?'"

Feedback from the central sterile processing department to the OR can assist both parties in recognizing opportunities for improvement, such as ensuring at the end of a surgical procedure that dirty instruments are sprayed or covered with a damp towel at the point of use before being transported back to sterile processing. This practice prevents the bioburden from drying on the instruments and allows ease of cleaning the instruments, according to Ms. McAfee. Open communication between sterile processing and the OR is essential for sharing this type of information. "When there's not a collaborative working relationship, you are not enabled to make the kind of changes that are needed for improving patient care," Ms. Cooper says.

5. Cross-train staff. One of the best ways to promote collaboration among OR and sterile processing staff is to schedule rotations in which staff members rotate into other departments, according to Ms. Cooper. For example, an OR staff member would work in the sterile processing department for a day, and vice versa. This practice allows staff to better understand the practices and challenges in each department.

Ms. Cooper suggests beginning the rotation as part of new employees' orientation to emphasize the importance of the OR-sterile processing relationships. Hospitals should then schedule rotations throughout the year to continue cross-training. ■

Contact Sabrina Rodak at srodak@beckershealthcare.com.

5 Quick Tips for Benchmarking Quality Data in Surgery Centers

By Sabrina Rodak

Measuring and tracking patient care processes and outcomes is essential for determining a surgery center's quality performance and identifying areas for improvement. Scott Trimas, MD, FACS, a facial plastic surgeon and otolaryngologist in Florida who serves as a surveyor for the Accreditation Association for Ambulatory Health Care and a consultant for its subsidiary, Healthcare Consultants International, shares five quick tips for benchmarking quality data in ambulatory surgery centers.

1. Establish systems for tracking data. "The most important quality and patient safety metrics include establishing appropriate monitoring systems for tracking data in an organized and standardized fashion," Dr. Trimas says. "These should have some clinical relevance and look at outcomes, adverse incidents and other results of care, and address infections, risk issues, etc."

2. Track benchmarking data in a standardized timeframe. Dr. Trimas says benchmarking data should be tracked quarterly, semi-annually or annually at a minimum, depending on the size of the organization.

3. Delegate benchmarking responsibility to a quality improvement committee. A QI committee typically leads benchmarking efforts, according to Dr. Trimas. The committee can use the benchmarked data to adapt quality and safety initiatives and measure their effectiveness.

4. Benchmark on local, state and national levels. ASCs can find benchmarking data from many sources, including peer-reviewed journals, Gallup for patient satisfaction and the AAAHC Institute for Quality Improvement. Dr. Trimas says ASCs can also "compare with other surgery centers or facilities in the network where data in the aggregate can be used to compare to [their] center."

5. Use data to drive quality improvement. Dr. Trimas says a new requirement of AAAHC will be that at least one of a center's quality improvement studies be based on the results of benchmarking data. Benchmarking can thus help drive overall quality and patient safety at a facility. ■

Contact Sabrina Rodak at srodak@beckershealthcare.com.

How Low-Level Disinfection Prevents HAIs, Failed Inspections and Morale Issues: 8 Points From EquipSystems' Carl Runge and Chris Wilkerson

By Rachel Fields

Cleanliness is next to godliness in a surgical facility; patients demand it, regulatory bodies require it and physicians and staff members expect it. But despite the best efforts of hospitals across the country, many facilities don't understand how to properly clean patient care equipment to prevent healthcare-associated infections. Carl Runge and Chris Wilkerson of EquipSystems discuss why regularly scheduled 'deep cleans' are necessary for hospitals to prevent infections, patient satisfaction issues and regulatory hurdles.

1. Responsibility for deep cleaning can slip through the cracks. Mr. Runge likes to say that hospital equipment is "used by everyone, owned by no one and impacts everything." He gives the example of a stretcher that moves from the emergency department to the operating room to PACU, then back to the patient floor and patient transfer area. The stretcher might move five times a day on a daily basis. The movement of this equipment means that no one feels particularly attached to or responsible for it. "It's tough to go into a department and say, 'Because you use stretchers, you're responsible for every stretcher in the hospital,'" Mr. Runge says. "It doesn't compute."

He says many hospital administrators assume that deep evidenced based cleaning is covered by the hospital's environmental services department — a myth, and a dangerous one. "We do a deep evidence based cleaning of the hospital's patient care equipment, which is generally not covered by the environmental services department," Mr. Runge says. "They're usually focused on other areas." He says this can spell problems for a facility, when every department assumes another department is responsible for cleaning.

2. Joint Commission requires cleaning and low-level disinfection of equipment. Mr. Runge and Mr. Wilkerson say the importance of cleaning and low level disinfection is evident in the Joint Commission's hospital standards. According to the Joint Commission's Elements of Performance, Joint Commission-accredited hospitals are required to perform "intermediate and low-level disinfection and sterilization of medical equipment, devices and supplies." "Hospitals need to deliver on this and prove that it's being done," Mr. Runge says. "Facilities have realized recently that their in-house teams are able to do the daily cleaning, but they're not able to effectively document the evidenced-based cleaning and disinfection on a regular basis and prove that it was done."

He says when a regulatory agency, such as the Joint Commission, pays a visit to the hospital, they'll check the hospital's cleaning policies and procedures as well as the hospital's history of implementation. Having a clear policy is the first step; the second is to schedule regular low-level disinfections and record their occurrence in order to fulfill regulatory reporting standards.

3. You can't disinfect a surface that isn't clean. Mr. Runge and Mr. Wilkerson say EquipSystems' service is complementary to the in-house cleans that happen during daily cleaning and disinfecting because regular terminal cleaning improves the effectiveness of low-level disinfection. "When staff members clean an operating room, they do a wipe-down of the surfaces," Mr. Runge says. "You can't disinfect a surface that's not clean."

He says there has been a lot of hype in the infection control industry about UV technology and hydrogen peroxide, which he says are both valuable tools if you perform a cleaning prior to utilizing the low-level disinfection these technologies provide. "Some hospital leaders think [UV technology and hydrogen peroxide technology] are an effective way to disinfect and clean a room, but you can't use that technology until the surface is clean," he says.

4. Many facilities lack adequate policies for facility cleaning. Mr. Runge says while many facilities are starting to create infection control policies, a good number of hospitals are still lacking. "Infection control officers should be writing in standards that say they have to properly clean and disinfect all surfaces that patients have contacted with some sort of frequency," he says. Every hospital should have a policy on low-level disinfection of patient care equipment — how often it occurs, who is in charge of it, and how it is recorded.

"Some facilities are doing it on a quarterly basis, and every facility can choose how often they want to do it, but the bottom line is that they need to deliver it and prove it's being done," he says. Mr. Runge and Mr. Wilkerson say EquipSystems recommends deep cleaning on a quarterly basis for high-use areas such as operating rooms, emergency rooms, ICUs and dialysis sections. Other areas of the hospital that don't see as much traffic can perform a deep cleaning on a semi-annual or annual basis, he says.

5. Regular deep cleaning encourages staff to keep equipment clean on a daily basis. Scheduling regular deep cleaning can also affect employee satisfaction and discipline, as it pertains to keeping the facility clean. Mr. Runge and Mr. Wilkerson compare it to the detail cleaning of your car "If I have your car detailed, you're willing to put in a little more effort to keep it up between visits," he says. "If something looks really clean, people are willing to wipe it down a little bit more." He says this motivation will lead to a more thorough cleaning process on a regular basis — in the same five minutes they would spend to wipe down the

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surface, the employee will really work to remove infection because they have a standard in mind for how it should look.

He says regular deep cleaning also affects employee satisfaction, which in turn affects work ethic. "We've done customer satisfaction surveys, and we've found that people are just more willing to work in a place that they know has been cared for," he says. He says the day after EquipSystems' cleaning, employees often come in and remark that the equipment looks new. "It's tough to measure, but there's definitely an effect there," he says.

6. Clean facilities boost patient satisfaction — and therefore profits. Cleanliness is key to high patient satisfaction scores, which increasingly inform whether patients choose a facility for their procedures. In the era of consumer information, patients are less reliant on their physicians to choose a hospital for them — instead, they'll go online, do their own research, and compare patient satisfaction rates among hospitals. This means that patient satisfaction has a significant effect on facility profits; happy patients mean more volume, and more volume means more money. Mr. Runge says cleanliness has such a drastic effect on satisfaction because most patients cannot judge every detail of their care with a professional eye.

"A simplified version of how people evaluate quality of care is: Was the staff nice to you? Was the food good? Was the place clean?" he says. "Beyond that, it's very difficult for the typical patient to say, 'I got the best hip replacement I've ever seen.'" He says if a patient sees that a wheelchair has been covered up with a sheet to hide the dirt, that's a bad sign. A disordered hospital looks more prone to infection and disease, and patients will remember if they felt unsafe.

7. There is no "magic bullet solution" for infection control. Mr. Runge wants to emphasize that there is no "magic bullet solution" for cleaning a healthcare facility. Instead, it takes collaboration from different providers and processes to get the best outcome. "There are so many different parties involved in taking care of the patient that it has to be a very integrated approach," he says. "I see claims made by companies, that they'll save you certain amounts of money. You have to understand that there's a lot of training involved, and we advertise more of a piece of the puzzle than a solution."

8. HAIs can be financially crippling for a facility. Mr. Runge recalls a particularly affecting infection control advertisement he saw in a magazine. The page was almost completely black, with a stage light illuminating a bed table. The page said, "Don't let this piece of equipment be the most expensive decision you ever made." He says healthcare-associated infections can be crippling to a facility's finances, particularly after regulatory changes covering reimbursement for HAIs. ■

Contact Rachel Fields at rfields@beckershealthcare.com

Quality Outcomes Reporting Expected to Cause 'Major Changes' in ASC Marketplace

By Rachel Fields

The introduction of mandatory quality reporting for ambulatory surgery centers is expected to cause "major changes in the ASC marketplace," according to a *HealthLeaders Media* report.

Starting Oct. 1, 2012, a new CMS rule created through healthcare reform will require Medicare-eligible ASCs to submit reports on five quality measures or face a 2 percent payment reduction. The initial five quality metrics are the number of 1) patient burns; 2) patient falls; 3) surgeries that are wrong site, wrong side, wrong patient, wrong procedure, or wrong implant; 4) surgeries requiring a hospital transfer or admission; and 5) the number of patients who did not receive an IV antibiotic within one or two hours before incision.

A year after the implementation date, the list will include facility volume for some gastrointestinal, eye, nervous system, musculoskeletal, skin and genito-urinary codes. The year after that, the list expands further to include the percentage of healthcare personnel who receive influenza vaccinations.

"I believe the pay-for-reporting quality metrics will be good for our industry because it will raise the bar for all ASCs," said David Covert, CEO of Phoenix-based Banner Surgery Centers, which is part of Banner Health and has 10 surgery centers in Arizona, Colorado and Nevada. ■

Contact Rachel Fields at rfields@beckershealthcare.com.

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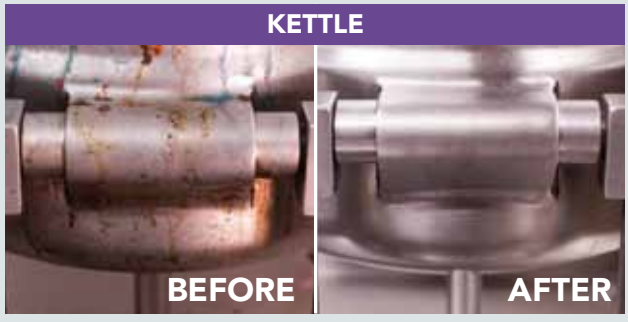

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5 Essential Aspects of Fluid Waste Management in a Surgical Facility

By Rachel Fields

Disposing of fluid waste in a surgical facility seems like an obvious task — and yet many surgical facilities botch the process, endangering employees through potential exposure to infection. According to Teresa Clouse, RN, CNOR, clinical consultant for Bemis Health Care, the process is relatively simple.

First, the employee must always wear personnel protective equipment during the disposal process, no matter the method used. She says the facility should ideally use a fluid waste management system that protects the employee through a number of safeguards. With a management system, the employee generally takes the canister of fluid to a closed system that engages the equipment to prevent exposure to the staff member. The canister is then emptied, and the employee can rinse it, remove it and place it in regular trash. The fluid is then discarded through the sewer system, in keeping with EPA recommendations.

Here she discusses several important aspects of fluid waste management in a surgical facility, including its impact on accreditation, finances and employee satisfaction.

1. Fluid waste management is essential to limit exposure to infection. Fluid waste management limits employees' exposure to infectious fluid waste, Ms. Clouse says. She says many facilities in the United States are still disposing of fluid waste by dumping it down a hopper or a sink — a process that exposes the employee to dangerous infectious material that could splash back from the sink. She says the process of dumping fluid waste down a sink is also bad for the environment. "We want to keep this stuff out of landfills and put it where it's supposed to go, which is in the sewer system," she says.

She says a fluid waste management system, which protects the employee from infection and then discards the fluid waste into the proper location, is essential for employee safety and satisfaction as well as accreditation.

2. Accrediting bodies are looking more closely at fluid waste management. Unlike federal definitions under RCRA, the Joint Commission considers infectious fluid materials hazardous, and has developed a number of criteria for surgical facilities dealing with fluid waste. The use, handling and disposal of hazardous materials and waste must follow applicable local, state and federal regulations under Joint Commission standards, and hospitals must develop written plans that state exactly how they handle fluid waste. OSHA notes that waste should be placed in containers that are closable; made to contain all contents and prevent leakage of fluids during handling, storage, transport, or shipping; properly labeled; and closed prior to removal to prevent spilling.

"The Joint Commission is definitely looking at fluid waste management more closely, as well as the AAAHC," Ms. Clouse says. She says according to Joint Commission guidelines, hospitals and other surgical facilities must create a written plan that follows state guidelines as to how to identify, evaluate and inventory hazardous materials and used or generated waste. Failing to follow regulatory guidelines can have severe financial consequences for surgical facilities, as a failed survey may necessitate hiring a consultant, revamping programs and re-training employees.

3. Training for fluid waste management programs is limited. Ms. Clouse says training for a fluid waste management system is relatively simple and requires little time on the part of the organization. The training should require a few hours of in-service for employees and should simply cover how to use the new system, who should be in charge and why the change is being made. She says generally, surgical facilities delay implementation because of the time and effort required to get employees accustomed to the new processes.

"Nurses don't like change — and I know, because I've been one for a long time," she says. "Especially with OR procedures, they get stuck in their ways. But once they see that it is for their protection, is environmentally safe and is good for the environment, then it's simple and we usually don't have any resistance."

4. All employees should be trained — regardless of seniority or time spent using the equipment. Ms. Clouse recommends training all employees on a new fluid waste management system, especially in an ambulatory surgery center. "When I do the in-services, I generally teach everybody in the facility, especially in facilities where everybody does every job," she says. "It improves efficiency when everyone knows how to use a system, from the director all the way down."

5. Several options are available on the market. Bemis is not the only manufacturer of fluid waste management systems, and Ms. Clouse recommends trialing a few systems to determine which works best for your facility. Staff may have preferences about ease of setup, disposal and reprocessing, as well as noise level, cost of product and allocation of space in the facility.

Different companies have different methods for handling fluid waste; for example, some products create a dam on the floor to hold back and quietly suction waste fluid, while others are placed inside a suction canister to transform fluid into a solid mass for disposal. The options should fit with your facility's particular fluid needs, which will frequently be driven by the amount of fluid produced due to procedure type and physician technique. ■

Contact Rachel Fields at rfields@beckershealthcare.com.

10 Changes to Quality Reporting Programs

By Jaimie Oh

CMS issued a rule recently that will update Medicare payment policies and rates for inpatient stays in acute-care hospitals under the Inpatient Prospective Payment System and hospitals paid under the Long-Term Care Hospitals Prospective Payment System in fiscal year 2013.

In addition to payment updates for inpatient services to Medicare beneficiaries, the rule includes several important changes to federal quality reporting programs:

Hospital inpatient quality reporting program

- The final rule reduces the number of measures in the inpatient quality reporting program from 72 to 59 for the FY 2015 payment determination and 60 for the FY 2016 payment determination.
- CMS is reducing the annual random validation sample from 800 hospitals to 400 hospitals. CMS is also reducing the targeted sample to up to 200 hospitals by using specific targeting criteria.

New quality reporting programs

- CMS has created new quality reporting programs for two types of hospitals that are exempt from payment under the IPPS — inpatient psychiatric facilities and cancer hospitals.
- CMS finalized an initial set of five quality measures and program requirements for reporting in FY 2013 by cancer hospitals and an initial set of six "process of care" measures for reporting in FY 2013 for inpatient psychiatric facilities.

Hospital value-based purchasing program

- The IPPS final rule also establishes several operational policies for FY 2013, including when hospitals will receive total performance scores. In addition, a 1 percent reduction to base-operating diagnosis-related group amounts will be applied for FY 2013 discharges.
- Value-based incentive payments will be made beginning in January 2013 with respect to discharges occurring in FY 2013.
- CMS also finalized several policies for the FY 2015 hospital value-based purchasing program, including new measures and finalized performance standards.

CMS has also finalized several requirements for the ASC quality reporting program under the calendar year 2012 Outpatient Prospective Payment System/ASC final rule:

ASC quality reporting program

- CMS finalized new administrative, data completeness and extraordinary circumstance waivers or extension request requirements, as well as a reconsideration process, for the ASC quality reporting program.
- ASCs that fail to report quality data or to comply with these requirements will incur a 2 percentage point reduction in their payment update, starting in CY 2014. Data collection for CY 2014 payment determination will begin Oct. 1, 2012.

Hospital-acquired conditions list

- CMS added "Surgical Site Infection Following Cardiac Implantable Electronic Device" and "Iatrogenic Pneumothorax with Venous Catheterization" to the HAC payment provision for FY 2013. ■

Contact Jaimie Oh at joh@beckershealthcare.com.

Harvard Researchers: Global Payments Improve Healthcare Quality

By Jaimie Oh

Research results out of Harvard Medical School suggest that global payments could lower healthcare spending while improving healthcare quality.

Researchers from Harvard Medical School's Department of Health Care Policy analyzed two years of claims data from Blue Cross Blue Shield of Massachusetts's Alternative Quality Contract, a global budget program in which 11 healthcare providers were given a budget for episodes of care. This model is in stark contrast to the traditional fee-for-service model.

The researchers found AQC providers spent 3.3 percent less than fee-for-service groups in the second year. Similarly, AQC providers saw increased cost savings over time, from 6.3 percent in the first year to 9.9 percent in the second year. The researchers also found quality improvements in chronic care management, adult preventive care and pediatric care within the AQC program grew in the second year.

"Moving away from fee-for-service models is high on the agenda of those looking to establish a fiscally sustainable, efficient healthcare system," said Michael Chernew, professor of healthcare policy at Harvard Medical School and senior author on the study. "It is likely that this type of new payment model will grow rapidly in coming years in the nation as a whole, and particularly in Massachusetts. By analyzing this program, we're studying the future before it gets here." ■

Contact Jaimie Oh at joh@beckershealthcare.com.

10 Common Roadblocks to Achieving Surgery Center Accreditation

By Taryn Tawoda

Donna Tiberi, RN, a standards interpretation staff member with the Healthcare Facilities Accreditation Program, discusses 10 common roadblocks observed during the surveying process of achieving ambulatory surgery center accreditation.

1. Credentialing and privileging. The educational background and training of all physicians must be verified before granting privileges, says Ms. Tiberi. The surgery center also should not assume that hospital privileges qualify the physician to perform procedures in the ambulatory setting. "Sometimes people forget about this," she says. "For example, organizations will grant privileges for GI services, but the ASC must clearly delineate the specific privileges approved for the GI practitioner to perform in the ASC setting. You can't take a hospital list of approved privileges and approve the same privileges for the ASC setting."

2. Primary source verification. The ASC's leadership must conduct a primary source verification of the physician's background through the American Medical Association, American Board of Medical Specialties, American Osteopathic Association, Educational Commission for Foreign Medical Graduates or Federation of State Medical Boards, says Ms Tiberi. The American Academy of Physician Assistants and National Commission on Certification of Physician Assistants can be consulted for physician assistants.

3. Obtain professional references. An ambulatory surgery center should request at minimum at least three professional references confirming the physician's experience, qualifications, character and judgment, says Ms. Tiberi. The references should attest that the physician worked at a particular hospital, completed a residency and performed specific procedures. "This is usually done in the form of a letter and verifies that the physician is trained, qualified, and competent," says Ms. Tiberi.

4. Patient emergency situations preparation. ASCs must have the appropriate staff, equipment and medications to respond to a patient emergency situation. A surgery center may sometimes assume that they stock appropriate supplies and medications, but that is not always the case, says Ms. Tiberi. "Some of the ASCs believe they're prepared for emergency situations, but actually they don't have the necessary pediatric equipment, such as EG intubation, blood pressure cuff sizes, pediatric unit dose medication, or nurses who are competent to respond to a patient emergency, such as advanced cardiac life support (ACLS) certification or pediatric advanced life support (PALS)," she says. "ASCs need to ensure they are prepared to stabilize their patients until the ASC can transfer the patient to the closest hospital or hospital of agreement."

Although ASCs may carry the necessary emergency equipment, they may not stock the required dosages of crucial medications, such as the mandatory Dantrolene to treat malignant hypothermia. "Some organizations don't carry the medication because it's expensive," says Ms. Tiberi. "The ASC must have all 36 vials available to address that emergency situation."

5. Hand hygiene guidelines. Infection control training and education for the ASC is vital, Ms. Tiberi says. "The ASC must follow current hand hygiene practice guidelines such as the CDC or WHO guidelines. During survey, the surveyors will be observing staff hand hygiene and protocols and may interview the staff," she says. Staff must be educated on hand hygiene guidelines and follow them consistently.

6. ASC equipment sterilization and disinfecting. The ASC should clean and sterilize all equipment in accordance with CDC HICPAC guidelines. If the ASC contracts with an outside vendor to perform sterilization for their equipment, it must ensure that its contract agreement follows CDC HICPAC sterilization guidelines, says Ms. Tiberi.

Staff members assigned to disinfect and or sterilize equipment in the ASC must always follow the manufacturer's requirements for maintenance and care. Rapid or "flash" sterilization of equipment is not prohibited, but should not be performed on a routine basis in place of a full sterilization, says Ms. Tiberi. The ASC must maintain a written or electronic log of all sterilized equipment so that the center can track infection rates and or notify any affected patients if a sterilization malfunction is discovered, she says.

7. Wrong site surgery. The ASC is required to conduct a standardized "time out" process before every surgical procedure to ensure that the right patient, right procedure, right equipment, right medications, right surgical marking and the right physician are present. The surgical site is to be marked by the surgeon with a standardized surgical marking.

A "time out" checklist is required to be used to ensure that all of the time out steps are consistently followed, says Ms. Tiberi. "Sometimes the time out process is being performed, but staff fail to document it, or elements of the time out are missing," she says. "When a surveyor is on site, they will review charts to verify that time-out was documented." Ms. Tiberi adds that the verification process should begin from the time a patient is scheduled for a procedure through to the time of surgery. "You always want to ensure that you have the right patient," she says. "You need to follow consistent policies, and procedures."

8. Patient education process. Patients and their families need to understand what is expected and required of them before the patient arrives for their surgery all the way through to the patients discharge, says Ms. Tiberi. "Sometimes a patient is not given a full explanation of their discharge instructions, or information is missing and staff must ensure that the patient understands the instructions which can be accomplished through return demonstration or repeat instructions."

The ASCs must gather and document the complete list of all medications as in prescription, over-the-counter or herbal medications that the patient is currently taking. "This must be documented in the medical record before administering anesthesia or prescribing new drugs," she says. "Sometimes patients don't know or remember what medications they're using. In that case, a family member can provide this information or the patient can bring in their medication bottles with them. Regardless, you must make a good faith effort to collect medication list information."

9. Medication log: all medications taken in and out of the facility. The surgery center should maintain a log for all controlled medication brought into the facility. "These medications are considered controlled substances," says Ms. Tiberi. "Staff are required to ensure that they sign all controlled medications in and out. ASCs must follow state and federal law and regulations for all controlled medications. Usually facilities maintain a medication log to monitor use and administration. Staff must verify controlled medications levels — usually these controlled substances are counted before the start of cases and at the end of the day by two staff members, and all wasted controlled medications have a witnessed signature." Only those employees designated, licensed and authorized by their state law and facility policy may access medication, she says.

10. Waived tests. Facilities performing waived testing — such as blood sugar levels, urine dipstick or urine pregnancy tests — must have an up-to-date clinical laboratory improvement amendments certificate (CLIA certificate), says Ms. Tiberi. All staff members performing waived testing must be competent and trained to perform the facility list of waived tests, she says. ■

4 Tactics to Prepare for an HFAP Accreditation Survey

By Jaimie Oh

The nature of ASCs could make efforts to achieve accreditation more challenging. As smaller healthcare delivery systems with more intimate staffing/governing structures, leaders and employees often serve in multiple positions, juggling numerous responsibilities in addition to patient care. Alexa Simkow, director of surgical services at Botsford Hospital in Farmington Hills, Mich., and accreditation surveyor for Healthcare Facilities Accreditation Program, discusses four tactics to help ASCs achieve accreditation.

1. Gain and maintain a comprehensive understanding of accreditation standards. Ms. Simkow says noncompliance to HFAP standards can most frequently be attributed to failure to read the standards or document action steps to meet the standards. These failures increase the chance of citations during inspections.

"The HFAP standards are incredibly clear and concise. They tell you exactly what you need to do to meet the standard, so it becomes obvious whether or not a facility has even read the standards," she says.

Ms. Simkow says the facilities that really meet and exceed this standard are those that go the extra step to create a manual for accreditation, with supporting documentation outlining action steps for each standard. "It's an excellent way for facilities to show surveyors how they are meeting each and every single standard."

2. Ensure staff members are competent with standards. A keen understanding of HFAP standards requires staff members to develop a deep understanding of why the standards are there in the first place. Ms. Simkow says an immediate red flag during her inspections is when staff members cannot explain why certain processes or policies are in place, such as donning of personal protective equipment or terminal cleaning.

"There is so much to understand [regarding infection control] that ASCs must make it a priority to go one step deeper during staff education," Ms. Simkow says. "The facilities that pass the inspection with flying colors have staff that can tell you, without question, why each infection prevention process is in place."

3. Make quality improvement a standard agenda item during meetings. According to HFAP standards, every quality-related effort, such as quality improvement projects, must be well-documented and taken to the governing body. Ms. Simkow says although ASCs generally do a great job maintaining quality, collecting data and implementing action plans, this detail may be easily overlooked.

"A lot of times, surgery center staff simply forget to get approval from the governing body [on matters related to quality improvement]," she says. "I think this happens because a lot of times, the physicians are already part of the governing body. When the surgeons are engaged as clinicians and discussing quality during the day, those issues are not always taken back to the governing body."

Ms. Simkow says ASCs can prevent this by making quality issues a standard agenda item during governing body meetings.

4. Consider the physical layout of the surgery center. Maintaining high-quality infection prevention and control also requires attention to the physical layout of the surgery center. Consideration of the physical plant should be applied to everything, such as sterilization, disinfection, patient privacy or medication storage.

"For instance, there should be sufficient physical space in reprocessing areas to separate clean instruments from dirty instruments or clean linens from soiled linens," Ms. Simkow says. "Another spacing issue ASCs must consider is accessibility, including whether hand hygiene products are close by."

Ultimately, a culture of patient safety will play the biggest role in achieving compliance with accreditation standards. "A physician surveyor and I recently conducted a survey of an ASC. By the end of it, neither of us could find any deficiencies, and it was because the staff didn't just simply follow the standards — they truly believed their process and procedures were the right thing to do." ■

Contact Jaimie Oh at joh@beckershealthcare.com.

GAO: More Data Needed on Injection Safety in Ambulatory Care Settings

By Jaimie Oh

Data on outbreaks related to unsafe injection practices in ambulatory care settings are limited and may underestimate the full extent of such outbreaks, according to a report by the U.S. Government Accountability Office.

Data collected by the CDC reveals 18 outbreaks of viral hepatitis associated with unsafe injection practices in ambulatory settings from 2001 through 2011. CDC officials and others believe this number does not represent the full scope of outbreaks for a number of reasons, such as infections often being difficult to detect and trace to specific healthcare facilities. The CDC and other officials are also not fully aware of the true costs associated with these types of outbreaks.

In addition, CMS' surveyors have stopped documenting the extent to which ASCs are following safe injection practices after fiscal year 2011, in part because of concerns that collecting these data is a burden to surveyors.

Although HHS has taken some steps to improve safe injection practices, additional targeted outreach is needed for healthcare settings not overseen by CMS. GAO recommends that HHS resume collecting data on unsafe injection practices, use those data for continued monitoring of ASCs and strengthen the targeting efforts of the One and Only Campaign for healthcare settings not overseen by CMS. HHS agreed with GAO's recommendations. ■

Contact Jaimie Oh at joh@beckershealthcare.com.

5 Tips on How to Improve Patient Safety With the Help of Technology

By Michael Wong, Founder, Physician-Patient Alliance for Health & Safety

More than 10 years ago, the Institute of Medicine in its landmark report, "To Err is Human," pointed out that at least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented. IOM therefore called for the building of a safer healthcare delivery system.

In 2009, 10 years after the original IOM report, Consumers Union, the non-profit publisher of Consumer Reports, concluded in its report "To Err is Human - To Delay is Deadly": "Despite a decade of work, we have no reliable evidence that we are better off today. More than 100,000 patients still needlessly die every year in U.S hospitals and healthcare settings."

Implementing change to decrease adverse events and to increase patient safety can be difficult for hospitals and healthcare facilities to implement. But, improvements are possible. Here are five tips to get you started.

1. Focus on what is right for the patient. This leads to better patient care and outcomes and, often, lower costs.

For example, at Riley Hospital for Children in Indiana, Courtney Rowan, MD, a pediatric critical care fellow, and her colleagues looked at how to decrease the number of blood gas measurements required from patients. Their study found that, after continuously monitoring with capnography all mechanically ventilated patients in pediatric ICU, they were able to save almost $1 million over a six-month period.

As Dr. Rowan explains, "Every time we draw blood to measure blood gases, we risk putting an infection in the central line. They can be expensive to treat, and add time to the patient's hospital stay."

Dr. Rowan adds, "The money you save is a nice bonus, but we use capnography mainly because it's the right thing to do for patients."

2. Don't be mired in the way things "have always been done." Let technology help you in caring for patients. For example, Anne Miller, RN, an assistant professor at the Center for Research and Innovation in Systems Safety at Vanderbilt University Medical Center in Nashville, Tenn., and her colleagues looked at continuous patient monitoring in acute post-surgical units.

Ms. Miller observes, "One of the things we became very aware of was that, in most post-surgical units, monitoring hasn't really changed since the 1970-1980's. A nurse still typically checks on a patient 15 to 30 minutes immediately post-op, and then again about two to four hours after and then eight hours throughout the day. This involves checking the patient's heart rate, blood pressure, temperature and respiratory rate. At the same time, our patients have changed: They are older on average, have more complex comorbidities and undergo more complex procedures that previously. The problem is that changes in patients' conditions are invisible to nurses still using last century methods and measures. Without oximetry, you can't easily 'see' patients with sleep apnea. Without capnography, you may not be alerted to a patient beginning to experience respiratory depression."

The use of technologies, such as oximetry and capnography, allows patients to be more accurately monitored.

3. Realize that any new technology or technique may have unintended changes to daily routine, but remember that this is better than having an adverse event. Ms. Miller describes some unintended consequences related to implementing new technology. "Implementing new technology inevitably changes the way people work (after all, that's what it's intended to do) but can introduce new and unanticipated problems. For example, in general surgical units, one RN may have four to six patients all with different needs. One of the consequences of continuous monitoring is frequent alarms. Attending to one alarm means that an RN has to stop attending to one patient in order to attend to another. This causes disruptions and discontinuities in care. In this case while solving one problem the monitor has introduced a raft of other problems. So we need to think about this before the technology is implemented."

However, as Tammy Haslar, RN, an oncology advanced practice nurse at St Francis Hospital in Indianapolis, says, caregivers need to make the necessary adjustments and keep in mind the adjustment is preferable to an adverse event.

A few years ago, St Francis was in the process of replacing its IV pumps with "smart" IV PCA pumps. Research into best practice literature and guidelines led them to purchase "smart" pumps with integrated capnography, explained Ms. Haslar.

"Although monitoring all patients using PCA can be seen as 'extra-work,' our facility decided that we could not make the ethical decision of saying which patients should or should not be monitored, and our facility made the decision that all patients with PCA would be monitored with capnography," she said.

4. Ensure changes help caregivers better manage their own daily work days. At St. Francis, the hospital sought to make the implementation of "smart" pumps into nurses' workflow as seamless as possible.

Ms. Haslar explains further the PCA monitoring initiative. "Capnography monitoring for PCA is a nursing intervention and does not require a physician order. We have an educational brochure which is dispensed with each PCA initiation along with the PCA unit and capnography monitor and nasal sampling cannula to provide education for the patient and the families about PCA safety and capnography monitoring," she says.

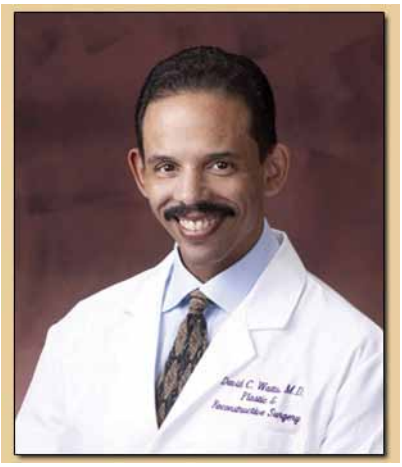
5. Get closer to the patient. Doing so provides answers and this affects the practice habits of healthcare professionals.

"In my opinion, the solutions lie closer to the bedside. For example, real-time monitoring has benefits beyond simple patient monitoring. For the nurses in our study, the major revelation was that their patients had changed and that they needed to be doing things differently. Continuous electronic monitoring gave them feedback about the effectiveness of their actions on these patients," says Ms. Miller. "We need to better understand nurses work – what do nurses do, how do they work, and what pressures lead them to act in certain ways; what problems in their work should the technology solve for nurses (and patients); what are nurses' priorities and how do they make trade-offs when priorities compete."

These are just five tips, and there are undoubtedly many more. However, as Dr. Rowan reminds us, it all starts with what is best for the patient. ■

5 Mistakes to Avoid During Medicare Accreditation

By Taryn Tawoda



David C. Watts, MD, the vice president of education for the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), discusses five mistakes to avoid when pursuing Medicare accreditation in an ambulatory surgery center.

"The process requires incredible vigilance to make sure that everything gets done, but once you have it and you do it, you will have an incredibly safe facility," says Dr. Watts, who also serves as a plastic surgeon at Plastic & Cosmetic Surgery Institute in Vineland, N.J.

Here are some of the mistakes he sees in the Medicare accreditation process:

1. Not complying with federal and state standards. In addition to the federal standards for Medicare accreditation, each of the nine designated regions in the country can interpret the standards differently, says Dr. Watts. "The state can send in Medicare inspectors in addition to your deeming authority on the federal level, and how they interpret the standards may be different," he says. It is therefore important to research the state-specific standards for accreditation prior to the inspection.

For example, the standards for the amount of dantrolene that must be stocked in an ambulatory surgery center differ at the state and federal levels. According to federal standards, the surgery center can have 12 vials in stock but must be able to obtain an additional 24 vials at a location within five minutes of the center, such as at a local hospital. However, according to the standards for region two, which encompasses part of the east coast, a surgery center is required to have all 36 vials stocked in its facility. In this case, the center must comply with whichever standard calls for the higher amount of stocked vials, says Dr. Watts.

"The majority of Medicare facilities don't know this [difference between federal and state standards] exists unless they have some sort of interaction with the state," he says. "But that's important because if you don't know about this ahead of time, there's no way you're going to pass a validation survey performed by State agency surveyors."

2. Unclear documentation for infection control. Infection control meetings address quality infection control topics such as sterilization techniques, hand washing, postoperative infections, protocols for needle sticks and cleaning processes. All clinical staff members must be in attendance and the meeting minutes should be documented, says Dr. Watts. "The meeting minutes have to chronicle exactly what was said and gone over. If there are any problems, you should document what the plan of action is and how you plan to correct it," he says.

3. No formal training in infection control. At least one nurse in the surgery center must have formal training in infection control, such as through a self-paced course offered by the Association of Perioperative Registered Nurses, says Dr. Watts. Without this training, surgery centers are in danger of not passing the inspection.

4. Lack of quality assurance program structure. One of the most common mistakes Dr. Watts has seen as an inspector is the lack of an adequate quality assurance program in surgical facilities. "You want to look at how you're logging in and tracking narcotics, handling disciplinary problems, the advanced directives looked at by patients, the bill of rights looked at by patients — this has to happen on a daily basis for every case," he says. "You want to make sure that documents like pathology reports and x-rays are being signed off on by the physician doing the case. All of this has to be checked."

5. No leader to spot small mistakes. To ensure that small mistakes do not get overlooked at the center, it can be helpful to assign one staff member — typically the supervising nurse — to the role of coordinating the Medicare accreditation process, says Dr. Watts. "It's an involved process, and you want to make sure that everything gets checked," he says. "You need someone to monitor outdated medication and make sure that staff credentials are all up to speed because they're constantly coming up at different times."

Creating a checklist to keep track of various deadlines, including credentialing dates and six-month biomedical equipment inspection requirements, can also be helpful, says Dr. Watts. It is also important to stay vigilant about administrative processes, such as keeping staff members' advanced cardiac life support cards (ACLS) and licenses on file, because a surgery center that lags in meeting these requirements may not achieve Medicare accreditation.

"In the day-to-day process of running a surgery center and taking care of patients, these requirements can get overlooked — but that is what will fail you," says Dr. Watts. "I've failed centers because their paperwork wasn't up to speed and because these deficiencies started adding up." ■

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