



AORN

SURGICAL CONFERENCE & EXPO 2014

March 30 - April 2, 2014
Chicago, IL

SESSION NAME Ambulatory Supplement for AORN Perioperative Standards and Recommended Practices

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SESSION NUMBER 0001

DATE/TIME Sunday, March 30, 2014, 8-9am

REPEAT SESSIONS 0111, 0167

REPEAT DATE/TIME Sunday, March 30, 2014, 10:30-11:30am
Monday, March 31, 2014, 7-8am

CONTACT HOURS (CH) 1.0

SESSION OVERVIEW:

The fastest growing segment of the AORN membership is ambulatory surgery center (ASC) registered nurses. In many states ASCs outnumber hospitals. In order to meet the needs of its members and because of the unique challenges freestanding ASCs have, AORN now has an Ambulatory Division with a specific ambulatory focus on AORN Standards and Recommended Practices (RPs). Though AORN RPs are applicable to all procedural areas in both inpatient and outpatient settings, how they are put into practice varies. Because ASCs should follow the same evidenced-based recommended practices, their considerations were incorporated into the 2014 AORN RPs. Ease of use and navigation of a detailed manual were considered when developing these RPs. In order to best use the 2014 RPs with specific ambulatory information, an educational component is needed. This session will include a guide to the use of ambulatory implications. Case studies will be incorporated into this presentation.

OBJECTIVES:

1. Identify the need for Ambulatory Interpretive guidelines in AORN Standards and Recommended Practices.
2. Describe how AORN Standards and Recommended Practices with Ambulatory Interpretive Guidelines can be used in an ambulatory setting.
3. Discuss the challenges of Ambulatory Surgery Centers in interpreting perioperative Recommended Practices.



SPEAKER BIOGRAPHIES:

Jan Davidson, MSN, RN, CNOR, CASC, has been involved in nursing and physician education in various roles throughout her career. In addition to her years of perioperative experience, she has been employed in professional liability, risk management, and patient safety roles. This has provided her the opportunity to offer education to both nurses and physicians on a variety of clinical and ethical issues. Jan was the clinical director of a start-up free-standing ambulatory surgery center where her role included management of the clinical staff, staff education and training, risk management, and infection prevention. Jan serves as the staff liaison to the Joint Commission's Ambulatory Professional Technical Advisory Committee (PTAC) and is an AORN representative on the ASC Quality Collaboration Committee. She was most recently appointed as a member of the Technical Expert Panel (TEP) with the Agency for Healthcare Research and Quality (AHRQ) along with other health care professionals nationwide who will provide guidance on nationally implementing the adoption of both clinical and safety culture interventions. She is on the board of directors for the Accreditation Association for Ambulatory Healthcare (AAAHC), as well as a patient safety coalition and public awareness campaign in Denver called Think About it Colorado. Jan is also an ambulatory surgery center surveyor for AAAHC. She is currently a staff member at AORN where her role is Director of the Ambulatory Division. She is an active member of AORN, ASCA, and ASHRM.

Terri D. Link, MPH, BSN, CNOR, CIC, is currently Ambulatory Education Specialist at AORN. She has over 15 years in ambulatory surgery experience and prior to working at AORN was perioperative patient safety specialist at University of Colorado Hospital. While at University of Colorado Hospital Terri interned with the infection prevention department while completing her MPH. Terri obtained her diploma in nursing at Clarkson in Omaha, Nebraska, her BSN from Regis University, Denver, Colorado, and her MPH in 2008 from the University of Northern Colorado. Terri is an ambulatory liaison to the Recommended Practice Advisory Board and partners with Nursing Practice in developing the ambulatory supplement for AORN Standards and Recommended Practices. Terri is board certified in infection control (CIC).

Mary J. Ogg, MSN, RN, CNOR, is a perioperative nursing specialist at AORN where her responsibilities include providing professional, technical, and management consultative services regarding perioperative nursing practice to AORN members, specialty assemblies, the Board of Directors, national committees, and health care organizations. She is responsible for creating products and education materials that support the perioperative professional's safe workplace practice. Mary managed the development of AORN tool kits for sharps safety, surgical smoke evacuation, workplace safety, and safe patient handling and movement in the perioperative setting. She has authored several recommended practices, including Managing the Patient Receiving Moderate Sedation/Analgesia Recommended Practice, Electrosurgery, and Lasers, and Sharps Safety in the Perioperative Setting. Mary has authored "Clinical Issues" columns and other articles published in AORN Journal and other professional publications. Mary has practiced in multiple settings, including hospital based ORs, ambulatory surgery centers, and office-based OR in management and clinical practice roles. Prior to employment at AORN, Mary was the ambulatory surgical services manager at Inova Surgery Center in Falls Church, Virginia. Mary has worked as a staff nurse and RN first assistant in California, Maryland, Virginia, Florida, Hawaii, Kentucky, New Mexico, and Colorado. Mary graduated with a diploma in nursing from Jewish Hospital School of Nursing in Cincinnati, Ohio, and is certified as a CNOR. She holds bachelor's in health science from Chapman University in Orange, California; and a masters in science in nursing administration from George Mason University, Fairfax, Virginia.



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FACULTY DISCLOSURE:

Jan Davidson: 7. No conflict.

Terri Link: 7. No conflict

Mary Ogg: 7. No conflict

AORN Ambulatory Division

- 38% of AORN's 45,000 members work in an ambulatory surgery environment
- Ambulatory Surgery Division launched in January 2013
- We clearly understand the needs of free-standing ASCs/office-based surgery centers are much different than our peers in acute care facilities

Ambulatory Specific Content

- At the request of our ambulatory members, specific ambulatory content was added to the *AORN Perioperative Standards and Recommended Practices* which specifically address the unique challenges of an ASC

Ambulatory Specifics





- All recommended practices were reviewed by ASC experts for ambulatory-specifics
- Additional content was identified for seven of the Recommended Practices
- Ambulatory RP information was developed using an interdepartmental approach (Ambulatory Surgery Division & Nursing Practice Department)
- Ambulatory supplemental information was reviewed by outside ambulatory practitioners.

Ambulatory-Specifics


- Ambulatory Supplements have been written to provide additional considerations for the perioperative RN working in a free-standing ASC or physician office-based surgery center
- Supplemental information is designated within the text of the RP to indicate there is additional ASC-specific information in the ambulatory supplement following the actual document

Finding the Ambulatory Supplements

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* Documents appearing in *gray* for the first time in 2014 and new/revised items published electronically in 2013.

 *Indicates that an Ambulatory Supplement is available for the preceding topic.*

RP: Transmissible Infections

and other health care providers. State, federal, and professional guidelines and strategies should be followed to determine the need for work restrictions for health care personnel with bloodborne infections.^{60,61}

Restricting activities of personnel who have transmissible infections reduces transmission between providers and patients depending on the mode of transmission and epidemiology of the disease.⁶² Infections that may require restrictions from providing direct patient care, entering the patient's environment, or handling instruments or devices that may be used during a surgical or invasive procedure include:

- viral respiratory infections (eg, influenza, respiratory syncytial virus).⁶³
- keratoconjunctivitis or purulent conjunctivitis caused by other microorganisms.⁶⁴
- acute gastrointestinal illnesses (ie, vomiting or diarrhea with or without nausea, fever, or abdominal pain).^{65,67}
- diphtheria (ie, identification as an asymptomatic carrier).⁶⁸
- exudative lesions that cannot be contained (eg, scabies, impetigo, smallpox).^{69,70,71}
- herpes simplex infections of the fingers or hands (ie, herpetic whitlow).⁷²
- pediculosis.⁷³
- scabies.⁷⁴ and
- meningococcal infection (ie, until 24 hours after the start of effective therapy).⁷⁵

Work restrictions for health care personnel with bloodborne infections who provide direct patient care depend on several factors, including circulating viral burden and category of clinical activities.⁶⁰

IX.a. An employee health nurse, infection preventionist, or physician should assess any health care provider with an infection, exudative lesions, or nonintact skin before he or she is allowed to return to work providing direct patient care or handling medical devices that are used in surgical or other invasive procedures. *[Recommended for Practice]*

Medical clearance is necessary before health care providers who have an infection, exudative lesions, or nonintact skin can return to work with patients or other health care providers.⁶⁴

IX.b. Health care personnel should report exposures as soon as they occur and infections as soon as the disease process is noted. *[Recommended for Practice]*

Early self-reporting of exposures and infections helps prevent transmission to patients and other health care providers. Health care providers can be encouraged to self-report exposures or infections when facility policies are designed to prevent judgment or penalty (eg, loss of wages, benefits, job status) for self-reporting.^{76,77}

IX.c. The health care organization should have a written policy regarding health care personnel who have a potentially transmissible infection. The policy should establish responsibility for

reporting the condition, work restrictions, and guidelines for clearing the employee for work after an illness that required a restriction.^{60,62} *[Recommended for Practice]*

Recommendation X

Perioperative personnel should receive initial and ongoing education and competency validation of their understanding of the principles of infection prevention and the performance of standard, contact, droplet, and airborne precautions for prevention of transmissible infections and MDRs.⁶⁰

Education and competency validation are prerequisites for ensuring standard and transmission-based precautions are understood and followed.⁶⁰ Ongoing development of knowledge and skills and documentation of personnel participation is a regulatory and accreditation requirement for both hospitals and ambulatory settings.^{78,79}

Initial and ongoing education on infection prevention practices facilitates the development of knowledge, skills, and attitudes that affect safe patient care. Periodic education programs provide the opportunity to reinforce the principles of infection prevention, the necessary precautions to take when providing care to a patient who has a transmissible infection (eg, standard, contact, droplet, airborne), and the actions to take when a health care provider has a transmissible infection.

Competency validation measures individual performance; provides a mechanism for documentation; and verifies that perioperative personnel have an understanding of infection prevention, MDRs, and facility policies. Every nurse is personally accountable for maintaining competency validation.⁸⁰

There are no universally accepted or mandated ways to perform or validate competency, and strategies differ between states. Some states mandate specific topics that affect public health (eg, bioterrorism) or that are specific to certain areas of nursing. The goal of competency strategies are to reassure the public that nurses have the knowledge, skills, and judgment to provide safe and effective care.⁸¹

X.a. Education, training, and competency validation should address:

- standard precautions;
- contact precautions;
- airborne precautions;
- droplet precautions;
- MDRs;
- procedures for transporting patients who require infection precautions;
- use of NIOS or powered air-purifying respirators;
- bloodborne pathogens;
- double gloving;
- sharps safety; and
- perioperative considerations to prevent central line-associated blood stream infections, catheter-associated urinary tract infections,

Ambulatory Supplement: Recommended Practices for Prevention of Transmissible Infections

Recommendation III

Droplet precautions should be used throughout the perioperative environment (ie, preoperative, intraoperative, postoperative) when providing care to patients who are known or suspected to be infected with microorganisms that can be transmitted by large droplets.⁶²

III.a. The facility should screen individuals for infectious agents (eg, influenza, pertussis) transmitted by droplets. At identification of infected individuals before their admission to the ambulatory surgery center (ASC) may prevent infection transmission.⁶²

Recommendation IV

Airborne precautions should be used when providing care to patients who are known or suspected to be infected with microorganisms that can be transmitted by the airborne route.

IV.b. Elective surgery should be postponed for patients who have suspected or confirmed (tuberculosis) TB until the patient is determined to be noninfectious. If surgery cannot be postponed, perioperative personnel should follow airborne precautions and consult with an infection preventionist.

IV.c. Personnel in an ASC that provides care to patients with confirmed or suspected TB should follow recommendation IV.

IV.d. Unless the facility has the capability of establishing a negative pressure room, patients with suspected or confirmed cases of TB should be transferred to or re-scheduled at a facility with a negative pressure room. A negative pressure airborne infection isolation room and a respiratory protection program are needed for airborne infection isolation. Airborne infection isolation is needed for any patient with suspected or confirmed active pulmonary TB.^{64,65}

Recommendation X

Perioperative personnel should receive initial and ongoing education and competency validation of their understanding of the principles of infection prevention and the performance of standard, contact, droplet, and airborne precautions for prevention of transmissible infections and [multidrug-resistant organisms] MDRs.

X.a. An ASC that is certified by the Centers for Medicare & Medicaid Services (CMS) must des-

ignate a staff member trained in infection prevention to lead the facility's infection prevention program.⁶⁰

Interpretive Guidelines: §416.51(b)(1)

The ASC must designate in writing, a qualified licensed health care professional who will lead the facility's infection control program. The ASC must determine that the individual has had training in the principles and methods of infection control.

Interpretive Guidelines: §416.51(b)(1) in Centers for Medicare & Medicaid Services, State Operations Manual Appendix A—Survey Protocol, Repeal and Interpretive Guidelines for Hospitals, Rev. 07/2012.

III.a. Ambulatory surgery center personnel, including:

- medical personnel,
- nursing personnel,
- personnel responsible for on-site sterilization/high-level disinfection processes, and
- environmental services personnel should receive infection prevention education.⁶⁰

III.b. Infection prevention education should be conducted:

- upon hire,
- annually, and
- periodically as needed.⁶⁰

Recommendation XI

Documentation should reflect activities related to infection prevention.

XI.a. A CMS-certified facility's infection prevention program must document the process of consideration, selection, and implementation of a nationally recognized infection control guideline,⁶⁴ such as the AORN Perioperative Standards and Recommended Practices.⁶⁶

XI.b. Supporting documentation for the surgical site infection tracking and surveillance program should be maintained.⁶⁴

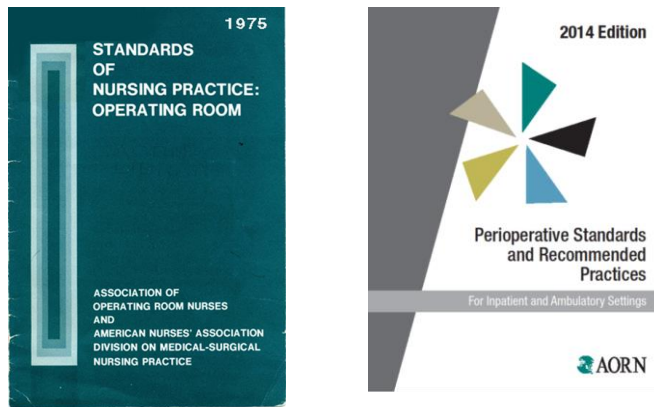
XI.c. Infection prevention education records should be maintained for all personnel.⁶⁰

Recommendation XII

Policies and procedures for the prevention and control of transmissible infections and MDRs should be developed, reviewed periodically, revised as necessary, and readily available within the practice setting.



Recommended Practices



Recommended Practices

- Applicable to all procedural areas in both inpatient and outpatient settings
- ASCs should follow same evidenced-based standards and recommended practices
- Facility policies and procedures reflect variations in practice settings and how the recommendations are implemented
- ASC considerations were incorporated into the Recommended Practices for 2014

Introduction

- The following Recommended Practices for Prevention of Transmissible Infections have been **approved** by the AORN **Recommended Practices Advisory Board**.
- They were presented as **proposed** recommendations for comments by members and others.
- These recommended practices are intended as achievable recommendations representing what is believed to be an **optimal level of practice**.

Purpose

- **Why** is this recommended practice important?
- Description of the **intent** and **scope** of the document

Example

These recommended practices are intended to guide perioperative RNs in implementing standard precautions and transmission-based precautions (i.e., contact, droplet, airborne) to prevent infection in the perioperative practice setting.

Evidence Review

How was the **literature searched**?

- What **databases** were used?
- What **search terms** were used?

Example

A medical librarian conducted a systematic review of MEDLINE®, CINAHL®, Scopus®, and the Cochrane Database of Systematic Reviews for meta-analyses, randomized and nonrandomized trials and studies, systematic and nonsystematic reviews, guidelines, case reports, and opinion documents and letters.

Recommendation

- Broad “**should**” statements in a bold font
- “**Must**” statements if it is a regulatory requirement
- Designated by a Roman numeral (**I**)
- **Rationale**

Examples

Recommendation IV (Transmissible Infections)

- Airborne precautions **should** be used when providing care to patients who are known or suspected to be infected with microorganisms that can be transmitted by the airborne route.

Recommendation I (Sharps Safety)

- Health care facilities **must** establish a written bloodborne pathogens exposure control plan

Rationale

- **Why?**
- Summary of **evidence** that supports the recommendation

Example

- Airborne transmission can occur when small particles that contain infectious agents that remain infective over time and distance are inhaled.
- The use of airborne precautions can help minimize transfer of diseases that are spread by the airborne route (e.g., *Mycobacterium tuberculosis* [TB], rubeola, Varicella zoster)

Intervention

- **Steps** or **actions** needed to complete the recommendation statement
- Designated by a Roman numeral followed by a lower case letter (**I.a**)
- **Evidence** rating
- **Rationale**

Intervention

Example

IV.h. Elective surgery should be postponed for patients who have suspected or confirmed TB until the patient is determined to be noninfectious. If surgery cannot be postponed, perioperative personnel should follow airborne precautions and consult with an infection preventionist. *[1:Strong Evidence]*

Activity

- More **specific** steps or actions needed to complete the intervention statement.
- Designated by a Roman numeral, a lower case letter, and an ordinal number. (**IV.h.1**)

Example

IV.h.1. A single-use, disposable bacterial filter should be placed between the anesthesia circuit and the patient's airway.

References

- Each reference is appraised and scored.
- Scores are noted in brackets after each citation

Example

54. Bassetti S, Bischoff WE, Walter M, et al. Dispersal of *Staphylococcus aureus* into the air associated with a rhinovirus infection. *Infect Control Hosp Epidemiol*. 2005;26(2):196-203. doi:10.1086/502526. [IIB]

Glossary

Specialized terms with their definitions related to the document

Example

Airborne infection isolation: The isolation of patients infected with organisms spread via airborne droplet nuclei < 5 µm in diameter.

Developing Policies & Procedures

Policy

- Use an intervention statement as a basis for your policy statement.
 - II.c. Medications should be stored according to manufacturer's medication storage requirements.
- The “should” becomes a “must” in the policy statement.
 - Medications must be stored according to manufacturer's medication storage requirements.

Procedure

- Use an activity statement as a basis for your procedure statement.
 - VI.d.1. Goggles should fit snugly, especially at the corners of the eye and across the brow, be indirectly vented, and have anti-fog properties.
- The “should” becomes a “must” in the procedure.
 - Goggles must fit snugly, especially at the corners of the eye and across the brow, be indirectly vented, and have anti-fog properties.

Using the Recommended Practices

- Index
 - Search for a specific topic (eg, restricted area)
 - Updated & improved
 - Located at the end of the book
- Implementation articles
 - *AORN Journal*
- Webinars
 - Highlights new and changed content
 - Recoded and available on the website
- Recommended Practices Summaries
 - *AORN Journal*
 - Highlights important points

Medication Safety

- Contracted pharmacy services
- Ordering, procuring, and administration of medications in an ASC
- Safe injection practices
- Compounding medications
- Tracking of controlled substances



RP: Medication Safety

the medication concentrations that are acceptable for use in critical care settings.²⁸ Newly released medications present risk for error because nurses are less likely to be familiar with them and information often cannot be found in printed medication references.²⁹

- 1c. Pharmacists should be available for consultation with members of the perioperative team in all facilities, including ambulatory surgery centers and office-based surgery facilities, and at each phase of the medication use process.²⁸

Errors may be more likely to occur when medication products and dosing strengths are available without pharmacist review. Collaboration between pharmacists and members of the perioperative team to determine special considerations for medications (eg, temperature ranges for medication storage, disposal of medications) or patient conditions (eg, medication reconciliation, allergies, weight-based dosing, side effect management) decreases the opportunity for medication errors.

Recommendation II

Medications, chemicals, reagents, and related supplies should be procured and stored in a manner that facilitates safe and efficient delivery to the patient.

Medication errors have been traced back to procurement, the first phase of the medication use process.¹ Risk for errors at this phase can be reduced by making proactive decisions about unit-of-use versus multidose containers, shelf life, and the general supply chain (ie, medication availability, delivery, and protection during transit from the wholesaler to the end user).⁴

- II.a. The health care organization's medication management plan should incorporate considerations for procurement including, but not limited to, ³⁰
- obtaining medications from manufacturers or suppliers with established quality programs;³⁰
 - developing procedures for current or potential product shortages, discontinuations, and

method for identifying potentially contaminated syringes because some had gone through three distribution steps before reaching the end user and others bore the name of a subsidiary company to the original manufacturer.²⁴

Errors at the procurement phase have been reported when medications that are received are not verified with what was ordered before they are stocked. The Pennsylvania Patient Safety Authority reports two circumstances involving errors in stocking 1,000 mL bags of IV solutions. One involved 1,000 mL of sterile water for injection that was mistakenly dispensed and stored on a dialysis unit instead of 0.9% saline solution. The other involved a wholesaler who mistakenly delivered 1,000 mL of sterile water for injection instead of 5% dextrose solution.³¹

- II.a.1. Medications in perioperative storage areas should be rotated based on the expiration date indicated on the medication label.

Medication storage areas that are organized to avoid outdated items helps to reduce the risk of administering expired medications to patients. Medications that are stored on emergency or special procedure carts may not be used frequently and have increased risk of becoming outdated before they are used. Rotating low volume medications back through a central or regional pharmacy or through vendor agreements may save money in spite of potential restocking fees and also reduces potential environmental pharmaceutical waste.

- II.a.2. Processes should be implemented when stocked medications are not available because of shortages, discontinuations, or recalls. Processes should include, but not be limited to,
- removing recalled items from storage and returning them to the appropriate location,
 - procuring substitutions, and
 - communicating to licensed independent

Ambulatory Supplement: Recommended Practices for Medication Safety

Recommendation I

A multidisciplinary team approach for medication management and the prevention of medication errors should be used throughout the phases of perioperative care.

- 1.a.i. The medication safety committee should include key stakeholders (e.g., nurses, physicians, anesthesia professionals, pharmacists, risk management personnel, purchasing personnel, administrators) who participate in the medication use process. If an on-site pharmacist is not available, the organization should contract with a pharmacist to provide consultative services. The contracted pharmacist should be a member of the organization's committee that has oversight responsibility for medication safety.⁴⁵

Recommendation II

Medications, chemicals, reagents, and related supplies should be procured and stored in a manner that facilitates safe and efficient delivery to the patient.

- II.a. The health care organization's medication management plan should incorporate considerations for procurement including, but not limited to, obtaining medications from manufacturers or suppliers with established quality programs. Assessment criteria should be used to select a compounding pharmacy (Table 11).⁴⁶
- II.g. Medications should be procured in limited varieties of concentrations and dosages and standardized in all perioperative medication storage areas. Epinephrine in concentrations of 1:1,000 is a high-alert medication that has been reported to cause harm when it is not diluted.⁴⁷ Warning labels may help to reduce confusion when a high-alert medication requires dilution, but it may be more effective to store the vials in the pharmacy to reduce the risk of error.⁴⁸ High-alert medication vials that require dilution should be secured from unauthorized access if there is no pharmacy. Prescription pads should be secured, not pre-signed and/or postdated.⁴⁹

Recommendation V

Pharmacists should be actively involved in diagnosing aspects of perioperative medication use across all perioperative settings.

- V.a. Pharmacists should review medication orders before administration. In perioperative settings, this review should include standing orders (e.g., preference cards).⁵⁰ Centers for Medicare & Medicaid Services (CMS)-certified facilities must meet CMS requirements for pharmaceutical services.⁴³

§416.48 Condition for Coverage: Pharmaceutical Services

The [Ambulatory surgery center] ASC must provide drugs and biologicals in a safe and effective manner, in accordance with accepted professional practice, and under the direction of an individual designated responsible for pharmaceutical services.

§416.48(b)(1)(ii) Change: Pharmaceutical Services. In: Centers for Medicare & Medicaid Services. State Operations Manual Appendix I—Criteria for Surgery Ambulatory Surgery Center. Rev. 05/2013.

Interpretive Guidelines: §416.48

The ASC must designate a specific licensed healthcare professional to provide direction to the ASC's pharmaceutical services. That individual must be suitably present when the ASC is open for business, but continuous presence is not required, particularly when the ASC is open for longer periods of time to accommodate the recovery of patients for up to 24 hours. Ideally the ASC should have available a pharmacist who provides oversight or consultation on the ASC's pharmaceutical services, but this is not required by the regulation, unless the ASC is performing activities which under State law may only be performed by a licensed pharmacist. *Alternative language §416.48 in Centers for Medicare & Medicaid Services. State Operations Manual Appendix I—Criteria for Surgery Ambulatory Surgery Center. Rev. 05/2013.*

- V.b. The health care organization should comply with local, state, and federal regulations for pharmacy resources and ensure solutions are prepared according to national standard specified in The United States Pharmacopoeia, Chapter <797>.⁵¹ The CMS regulation does not require a pharmacist to be on site unless an ambulatory

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Compounding Pharmacies

- Drug Quality and Security Act, signed November 2013
- Gives FDA oversight in compounding pharmacies
- Will oversee mass producing pharmacies
- May register with FDA – though not mandatory
- Smaller compounding pharmacies who compound for individual patients will continue to be regulated by state boards of pharmacy

<div style="writing-mode: vertical-rl; transform: rotate(180deg);"> Ambulatory Surgery Patient and Worker Safety </div>	Ambulatory Supplement: Medication Safety
	<p>Table 1: Compounding Pharmacy Assessment Criteria</p> <p>Licenses-Permits</p> <ul style="list-style-type: none"> Is the pharmacy licensed and in good-standing with the state board of pharmacy? Has the pharmacy ever been disciplined for any infractions related to its compounding services? If the pharmacy is in a different state than the purchasing institution, is the pharmacy licensed to dispense/distribute/provide medications in the state as well? What is the license number? Is the permit in good standing? Will the pharmacy become licensed? Has the pharmacy ever been disciplined for any infractions related to its compounding services in those states in which it currently or formerly had a license/permit? If the pharmacy is in a different state than the purchasing institution, is the pharmacist-in-charge or another full-time pharmacist licensed in the state as well? What is the license number? Has the pharmacist ever been disciplined for any infractions related to his/her compounding services? Has the pharmacy demonstrated it meets national quality standards by earning accreditation by the Pharmacy Compounding Accreditation Board (PCAB)? Current accreditation can be verified at http://www.pcab.org Is the pharmacy accredited by any other accrediting bodies? If so, which ones? Are the pharmacist(s) and/or pharmacy staff members of the International Academy of Compounding Pharmacists (IACPS)? Of the American Society of Health-System Pharmacists? <p>Compounding Services Provided</p> <ul style="list-style-type: none"> What types of dosage forms does the pharmacy prepare (eg, injectables, capsules, troches, and liquids, suppositories, topical, ophthalmics, inhalations)? How long has the pharmacy compounded these various dosage forms? Does the pharmacy provide sterile compounding services? At what level of complexity? <p>Internal Controls and Quality Assurance</p> <ul style="list-style-type: none"> Does the pharmacy have written and active standard operating procedures (SOPs) in place for all compounding activities? Does the pharmacy obtain its pharmaceutical ingredients from a US Food and Drug Administration- and Drug Enforcement Agency-licensed pharmaceutical ingredients supplier? How is that documented? Are SOPs in place to demonstrate verification of supplier registration status? Does the pharmacy obtain certificates of analysis (COAs) for all formula ingredients from its supplier? Are these available for verification? Does the pharmacy have an SOP in place in case of a recall? Has the pharmacy had a recall in the last 18 months? Does the pharmacy have an SOP on how a customer can report problems to the pharmacy? Has the pharmacy staff been trained and evaluated in proper aseptic technique, gowning, and cleanroom procedures? What SOPs exist that show performance compliance with these procedures? Does the pharmacy compound sterile preparations? What level of sterile compounding is performed by the pharmacy using the commonly named "low-risk, medium-risk, and/or high-risk" categories? Does the pharmacy comply with current US Pharmacopeia (USP) <797> standards for sterile compounding? How is that compliance documented through SOPs? Does the pharmacy compound nonsterile preparations? Are the preparations simple, medium, and/or complex? Does the pharmacy comply with the current USP <795> standards for nonsterile compounding? How is that compliance documented through SOPs? <p style="text-align: right;">ambisound.com/page...</p>

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Ambulatory Supplement: Transmissible Infections

- Designated facility Infection Preventionist
- Risk assessment
- Screening of patients and family for infectious diseases
- Isolation precautions in a ASC
- Staff education
- Policies and Procedure development
- Surveillance and outbreak investigations



An ASC that is certified by the Centers for Medicare & Medicaid (CMS) must designate a staff member trained in infection prevention to lead the facility's infection prevention program.

(This is a regulatory requirement which makes it a "must" statement.)

Intervention

IV.h. Elective surgery should be postponed for patients who have suspected or confirmed TB until the patient is determined to be noninfectious. If surgery cannot be postponed, perioperative personnel should follow airborne precautions and consult with an infection preventionist. *[Recommended for Practice]*

Amb Personnel in an ASC that provides care to patient with confirmed or suspected TB should follow recommendation IV.

Amb Unless the facility has the capability of establishing a negative pressure room, patients with suspected or confirmed cases of TB should be transferred to or rescheduled at a facility with a negative pressure room.

Transmissible Infections Scenario

- A 66 year-old patient - cataract procedure - patient's first language is Spanish – speaks and understands limited English
- Several family members are in attendance
- Son is acting as interpreter
- The previous day the center attempted to contact the patient to obtain a history but were unsuccessful
- A nurse enters the preop room and introduces herself

Scenario - continued

- While the nurse is interviewing the patient the sister has a coughing spell and the nurse notices blood on her tissue. She asks if she has been sick.
- The son tells the nurse she was being treated in Mexico for tuberculosis though now was feeling much better and thought she no longer needed to take her medication since it was very expensive.
- The son also told the nurse his mother had lived with her sister for many years in Mexico.

Scenario – Discussion Questions

- What should the nurse do first?
- Is isolation appropriate? If so, for whom and what kind?
- Should the surgeon be notified?
- Would the facility guidelines infection prevention program indicate the best response?
- Should the preop nurse consult with the facility Infection Preventionist?
- Would this require notification to the state department of health?

Scenario-Retained Surgical Item

- It is 5:30pm and the ASC is just finishing the last procedure of the day – an excision of a ganglion cyst under local anesthesia.
- The circulating nurse and scrub tech are doing the final count and a sponge is missing. No radiology personnel are on site.
- The surgeon doing the procedure is an orthopedic surgeon who has been credentialed and is privileged to operate and interpret fluoroscopy studies for orthopedic procedures.

Scenario-Discussion Questions

- Should the surgical team call a radiology technician in to do an x-ray?
- If so, should the skin closure be delayed until this occurs?
- Would it be appropriate for the surgeon to take a picture using fluoroscopy to determine the presence of a retained sponge?
- Is it appropriate for the surgeon to read and interpret the fluoroscopic study?

Recommended Practices for Prevention of Retained Surgical Items

Recommendation VI

Standardized measures for investigation and reconciliation of count discrepancies should be taken during the closing count and before the end of surgery. When a discrepancy to the count(s) is identified, the surgical team should carry out steps to locate the missing item.

VI.c.2. If intraoperative imaging is not available, the health care organization should have a policy and procedure describing the actions and communication required between referring and receiving organizations.

pay The ambulatory surgery facility should have a policy and procedure describing actions to take when on-site radiology services are not available to perform a radiograph and interpret the result.

pay A surgeon with perioperative radiologic privileges may consider the use of fluoroscopy to locate the retained item.

pay Fluoroscopy may be used and a preliminary reading obtained by a surgeon with privileges to interpret radiographic studies.⁴³

Recommendation X

Policies and procedures for the prevention of RSIs [retained surgical items] and unretrieved device fragments should be developed, reviewed periodically, revised as necessary, and readily available to the practice setting.

X.a. A multidisciplinary team should establish a policy and procedure for prevention of RSIs.

X.a.4. If intraoperative imaging is not available, the health care organization should have a policy and procedure describing actions necessary and communication required between referring and receiving organizations.

pay Policies and procedures should include circumstances in which the patient should be transferred to the post-anesthesia care unit and a subsequent receiving facility for further radiologic imaging.

Remark
A1. §462.20(b)(4). In: Centers for Medicare & Medicaid Services. *State Operations Manual Appendix A—Survey Protocol, Regulations and Interpretive Guidelines for Hospitals*. Rev 89; 2013. http://www.cms.gov/Regulations-and-Guidance/Guidance/Materials/downloads/som107ap_a_hospitals.pdf. Accessed October 20, 2013.

Evidence-based Reference

- 2014 AORN *Perioperative Standards and Recommended Practices*