

Inside RASC



Rockford Ambulatory
SURGERY CENTER



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Learning a Thing or Two from Athletes

Cross-training of employees improves RASC's overall 'fitness.'

"Having staff members with a strong knowledge of fellow employees' jobs ensures that the surgeons and patients remain satisfied."



Every business experiences staffing inefficiencies from time to time. Hours or days when a particular department does not need some full-time employees or adequate numbers are lacking due to vacations on top of unexpected absences.

"We try to operate with the optimal staffing level to control costs," offers Dr. Steve Gunderson, CEO and medical director.

Nevertheless, the surgery center is not immune to temporary overstaffing or, worse, understaffing.

"The worst thing we can do is inform the surgeon that he or she has to reschedule procedures because we can't staff an OR," Dr. Gunderson says. "The second worse thing is inconveniencing the patients. They may have taken off work and possibly arranged with family or friends to accompany them or furnish transportation."

Rather than populate affected areas with part-time or contract employees who could be told to punch off the clock when circumstances change, the surgery center cross-trains

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Total Care Inside and Out

Circulating nurses observe the surgery and surgical team from a broad perspective.

Operating room patients under anesthesia or sedation are least able to make decisions in their best interest. As advocates for the patient, circulating nurses help surgical team members create and maintain a safe and comfortable environment in the OR at a time when the patient is basically powerless.

Circulating nurses work inside the OR but outside the sterile operating field. "Circulating" throughout the nonsterile area, they apply their education in patient assessment, identification of nursing diagnoses, planning, implementation and evaluation. Key responsibilities include monitoring patient care, assisting the surgical team, preserving the room's sterility and performing instrument and sponge counts.

Circulating nurses facilitate the safe transfer of patients to and from the OR bed. They are responsible for positioning of the patient using proper body alignment and body mechanics. In addition, they maintain the patient's skin integrity and ensure that clothing and bedding are clean and dry.

The goal is to keep the operating field totally sterile during surgery. Although circulating

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Scheduling Tips:
Precertification many times the job of treating physician



History & Physical:
Timely and correct documentation key to successful procedure



What's New:
MyoSure system gives doctors and patients more choices

Cross-training *Continued from cover*

employees to tackle different responsibilities.

“Coverage is easily handled when staff members go on vacation, leaves of absence or even the times they are out to lunch,” says Mary Beth Barich, RN, director of perioperative services. “An operating room nurse, for example, could lend another pair of hands in a crowded recovery room when the OR is empty.”

In sports, cross-training reduces injury and allows exercisers to achieve a high degree of fitness. Similarly, cross-training keeps the surgery center’s personnel and customers —

“Coverage is easily handled when staff members go on vacation, leaves of absence or even the times they are out to lunch.”

both internal and external — in tip-top shape. Mary Beth supervises the 3-year-old program. She explains that cross-training alleviates a burden for everyone.

“Having staff members with a strong knowledge of fellow employees’ jobs ensures that the surgeons and patients remain satisfied,” Mary

Beth says. “It also fosters job security and employee motivation by giving people valuable, diversified work experience.”

Staff members receive cross-training tailored to their individual interests. Each trainee is assigned a mentor. The mentor delivers formal orientation to a different job area.

Cross-training of perioperative nurses cuts across all departments. Currently, two preoperative nurses and one postoperative nurse are cross-training to assume OR responsibilities.

“This is ideal for procedures that call for extra registered nurses in the room,” Mary Beth says, citing cataract surgery as a perfect example. “One nurse cannot physically

perform the multiplicity of tasks and responsibilities that cataract surgery entails.”

“We do not rush the process,” Mary Beth says. “We want our staff to feel comfortable. No one expects them to grasp their new roles immediately. If they feel they need more time, we allow more time.”



Left to right: Perioperative registered nurses Kris Theisen, Lori Vibnanek, Nicole Reyes, Gina Hartman

Approaches to Infection Control

Minimizing the risks of health care-associated MRSA.

Methicillin-resistant *Staphylococcus aureus* (MRSA) is a type of staph bacteria that is resistant to methicillin and other more common antibiotics, such as oxacillin, penicillin and amoxicillin. *Staphylococcus aureus* bacteria live on the surface of people’s skin and inside the nose. MRSA will normally cause skin infections, but it also can cause potentially life-threatening infections, including pneumonia.

The primary mode of transmission of MRSA is by direct contact, usually with another person’s hands.

Because MRSA infection can be fatal, rigorous infection control practices at Rockford Ambulatory Surgery Center are aimed at determining MRSA status. Any patient with a history of MRSA must submit two negative nasal cultures a minimum of 48 hours apart and within the month prior to surgery. Patients who test positive for MRSA may not receive their surgery on the designated day. Instead, we refer them for treatment to eliminate MRSA before surgery can occur at RASC.

“The ambulatory surgery environment is unique for infection control,” notes Dr. Steve Gunderson, CEO and medical director. “By nature, surgical center patients are healthy, and they spend less time here, lowering the risk of acquiring a nosocomial infection, like MRSA. Appropriate infection control measures further reduce the risk of transmission.”

History & Physical: Cornerstone of a Medical Visit

Of the preparations that need to be accomplished before the day of surgery, few are as important as documenting the patient’s health and surgical history and physical assessment.

The extent of a preoperative evaluation will depend upon the patient’s medical condition, proposed surgical procedure and type of anesthesia. The history and physical are the foundation for providing clearance for surgery and anesthesia.

In accordance with state and federal regulations and surgery center policy, Rockford Ambulatory Surgery Center requires that each patient have a history and physical

completed by a physician no more than 30 days prior to the scheduled date of surgery. If the H & P was done more than 24 hours before the surgery, the patient upon admission must receive a brief presurgical assessment.

A complete medical history would include surgical history, family history, hospitalizations, immunizations, current medications, allergies, assessment of tobacco and alcohol use, any possible toxic exposures and history of the present illness. Coronary artery disease, history of a myocardial infarction, poorly controlled hypertension, symptomatic arrhythmias, endocrine disorders, respiratory problems and diabetes controlled by

medication are just a few examples.

A detailed medication and drug history with the names and dosages of current medications also is very important. Patients may be taking over-the-counter and herbal or nutritional products that have been shown to affect the surgery and response to anesthesia.

The presurgical assessment on the day of surgery identifies any omissions, additions to medical history or changes in physical condition (such as a cold, fever, breathing problems or chest pains) since the procedure was scheduled that could cause a last-minute cancellation.

Not Just Technical Work Anyone Can Do

Perioperative nurses help patients come through surgery in good shape.

Surgery is a complex endeavor, requiring a large support team to run smoothly and successfully. As a member of the surgical team, the perioperative registered nurse plans and directs nursing care for patients before, during and immediately following surgery.

“Perioperative nurses care for the patient as a whole.”

Perioperative nurses coordinate care with the surgeon, anesthesia provider, surgical technologist and other assistive personnel.

Perioperative nurses ensure that all medical information about known allergies, consent forms and diagnostic tests is documented and accessible to the surgical team before the start of surgery. They are one of the team members responsible for making sure the correct patient goes into the operating room for the correct surgery. They also serve as nurse liaisons between the operating room and patients’ families to render support and communication.

“Perioperative nurses care for the patient as a whole being, taking into account physiological, psychological, sociocultural and spiritual issues,” explains Mary Beth Barich, RN, director of perioperative services. “Clinical

competency and outstanding organizational and interpersonal skills are essential.”

Fundamental nursing skills are the foundation for perioperative nurses; however, their education continues beyond the basic nursing programs. Before pursuing training to work in the perioperative arena, a candidate attends nursing school and receives licensure as a registered nurse.

“Core nursing values — knowledge, skill and judgment — form the basis of the quality of care that surgical patients have relied on and can expect,” Mary Beth says.



*Mary Beth Barich, RN,
director of perioperative services*

Circulating Nurses Continued from cover

nurses do not need to be sterile, they wear face masks, contain their hair under surgical caps and follow other measures to avoid compromising the clean conditions in the OR. Should a break in sterility or technique occur, corrective action is taken. For example, if touching a nonsterile person, instrument, or area contaminates a sterile team member, that individual must step out of the sterile field and scrub in again before resuming the surgery.

Circulating nurses also connect the people in the sterile field with the nonsterile area. They

can open an autoclaved package so that someone in the operating field can access the sterile tool inside. Additionally, they adjust the OR lights, prepare labels and remain with the patient during induction of anesthesia.

After surgery, circulating nurses provide equipment for transporting the patient and supply any equipment needed for airway maintenance during transport of the patient. They send for the next patient in a timely manner and prepare for subsequent procedures.



Left to right: Perioperative registered nurses Ineta Henry, Jan Stringer, Stacy Durack, Becky Kunz

Scheduling Tips

Failing to Precertify Can Cost a Lot of Money

Not all health insurance companies and health plans require medical precertification for outpatient surgeries. Still, many do. And the treating physician bears primary responsibility for obtaining precertification. Failure to do so may result in nonpayment of claims after submission.

Medical precertification, also referred to as prenotification or preauthorization, is the process of confirming patient eligibility and determining the medical necessity and appropriateness of a physician’s treatment plan. Insurers say precertification helps control health care costs and limit unnecessary medical procedures.

Physicians can consult precertification lists that health insurance companies maintain for specific procedures to determine what is applicable. Likewise, the surgery center stays current with insurance companies and procedures requiring precertification.

Health insurance companies ask for basic patient data, medical procedure codes, diagnosis and expected charge amounts, among other information. Precertification is complete when the health insurer approves coverage for a planned procedure. The surgery center verifies with the insurance company that precertification has been obtained prior to a patient’s admission.

Accurate information necessary

When a patient is sent to the surgery center for treatment, it is imperative that we receive accurate patient information (with correct spelling and up-to-date address), along with proper diagnosis and procedure codes. We rely on the accuracy of these codes. Claims may be reviewed or denied for a discrepancy between the precertified service and the subsequently submitted claim code.

Did You Know?



RASC has 20 perioperative nurses, eight of whom work as OR “circulators.”

More Choices, More Options

Multiple endometrial ablation techniques bring this outpatient alternative to more patients than ever.

Every year, more than 2.5 million women in the United States visit a gynecologist because of menorrhagia (excessive uterine bleeding). This ailment can drain a woman's energy and her confidence.



"A broad spectrum of techniques has been developed to avoid major surgery with simpler outpatient alternatives."

Many women end up having a hysterectomy. In fact, upwards of one-third of American women undergo hysterectomies by age 60.

"A broad spectrum of techniques has been developed to avoid major surgery with simpler outpatient alternatives," points out Dr. Steve Gunderson, CEO and medical director.

"Naturally, we want to provide minimally invasive therapy when possible, with a resulting positive impact on quality of life."

Hysteroscopic surgery

Hysteroscopic surgery involves placing a small telescope into the opening in the cervix. The physician can view the uterine cavity to detect polyps, fibroids, hyperplasia or cancer. Very

thin instruments inserted into channels of the hysteroscope remove scar tissues, polyps and small fibroid tumors without difficulty.

Hysteroscopic endometrial ablation

There are several ways to destroy the endometrium (inner lining of the uterus), such as radiofrequency, hot saline water, microwaves and extreme cold. Hysteroscopic endometrial ablation destroys the endometrium by employing a hysteroscope together with a device that heats up, freezes or lasers the endometrial lining. The patient's normal activity can resume within two or three days. A major study found that, two years after the procedure, about 85 percent of women reported that it solved their bleeding, pain or other menstrual problem.

Hydrothermal endometrial ablation

Hydrothermal endometrial ablation is essentially a diagnostic hysteroscopy with additional capabilities. The Boston Scientific Hydro ThermAblator® System that gynecologists use at RASC incorporates a special computer-controlled pump and water heater. Because the fluid circulates freely throughout the uterine cavity, the cavity's shape does not affect the results. Once the proper temperature is reached, the heated saline solution circulates for 10 minutes. The surgeon watches the endometrial lining change from red to white as it is cauterized. The solution then cools for about a minute, and the loose material from the lining is removed.

Did You Know?



An estimated 600,000 hysterectomies are performed annually in the United States.

NovaSure® radiofrequency ablation

A product of Hologic Inc., NovaSure is a quick and simple radiofrequency treatment. The doctor inserts a slender wand through the cervix into the uterus. The doctor extends a triangular mesh array through the wand, where it expands to conform to the dimensions of the uterine cavity. Radiofrequency energy is delivered into the uterus for approximately 90 seconds. The energy and heat destroy the endometrial tissue; suction is applied to remove it. The triangular mesh array slowly retracts, and the wand is removed from the uterus.

Gynecare Thermachoice® balloon ablation

Thermachoice is a uterine balloon therapy. The doctor inserts a small silicone balloon attached to a catheter into the uterus. The balloon fills with fluid and inflates to the contours of the uterus. The fluid is gently heated and circulated while the uterus lining is treated. When the treatment is completed, all the fluid is withdrawn from the balloon and the catheter is removed. In most cases, patients can return to normal activities the next day.

What's New

MyoSure™ System Simplifies Fibroid Removal

Uterine fibroids affect up to 70 percent of all reproductive age women, according to the National Institutes of Health. Hysteroscopic myomectomy currently represents the standard minimally invasive surgical procedure for treating submucous fibroids. Rockford Ambulatory Surgery Center recently began trial testing MyoSure, a new hysteroscopic morcellator from Interlace Medical.

MyoSure removes fibroids without incision and preserves the form and function of the uterus. A mechanical drive assembly connected to a drive cable and associated control box on one end and a shaft on the other end make up the

MyoSure system. The MyoSure device is inserted through the hysteroscope. The shaft is equipped with an open channel that houses an oscillating blade. When the side channel is exposed to target tissue and the motor is activated, the oscillating blade cuts the tissue within the channel. The tissue travels down the center of the shaft via suction and is trapped in a vacuum container.

"The morcellator is an important instrument for tissue retrieval in myomectomy," says Mary Beth Barich, RN, director of perioperative services. "Having the MyoSure system is a win/win situation for the doctors, patients and our

facility. The doctors can offer their patients an incision-less procedure using a simpler, quicker technique that is easy to learn and perform."

Did You Know?



Fibroids of the uterus (leiomyomata) vary in size and number and are more prevalent in African-American women. Many women do not know they have fibroids, which may remain undetected until symptoms develop.