Rockford Ambulatory SURGERY CENTER

Inside RASC

Volume 3, Issue 2

Surgery Recovery at RASC a Proven Success

The goal of postoperative care is to ensure a safe recovery without complications, promote patient well-being and prepare the patient to return home safely.

Before surgery, patients learn about the procedure and prepare for the healing process at home. But what happens immediately after the surgeon has finished has a huge impact on patient satisfaction.

Care given during the initial postoperative period lasts from the instant the patient enters the recovery room until discharge from the surgery center. The length of this phase depends on the type of surgery, amount of anesthesia, patient's medical condition and other contributing factors. Some can be controlled; others cannot.

Postoperative Department RNs (from left) Judy Young, Rita Reese, Lisa Bender and Shelley Sheffield prove there's a lighter side to serious medical professionals.

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Putting the Healed Foot Forward

Staff podiatrists help patients lead active lives.

The great Renaissance artist Leonardo da Vinci called the foot a "masterpiece of engineering and a work of art." That masterpiece undergoes quite a workout from Americans as a group, even when they are not playing or exercising.

Although jobs in the United States have grown less physically strenuous, physical activity still characterizes Americans' leisure hours. That fact, combined with an aging population, makes the need for foot care all the more apparent.

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Common Foot Disorders Treated

A **bunion** is an enlargement of bone or tissue around the joint at the base of the big toe. The condition can cause the big toe to turn in toward the second toe. Bunions can be painful and limit motion. A bunionectomy can improve the foot's form and increase ease of wearing shoes.

There are more than 100 surgeries for bunions. Surgeons sometimes perform multiple procedures at the same time. Surgery generally involves an incision in the top or side of the big toe joint and the removal or realignment of soft tissue and bone. Severely deformed joints often require stabilization with tiny wires, stitches, screws or plates. Implant insertion of all or part of an artificial joint may be called for.

Hammer toe is a joint deformity causing the second, third or fourth toe to bend in a shape resembling a hammer. The condition typically results from wearing poorly fitting shoes. Muscle, nerve and joint damage may be the root cause. Several surgical options, with the patient under local or spinal anesthesia, are available when other treatments have failed to achieve results. Corrections can be made with changes to soft tissue or the bone.

Heel spur surgery is usually only considered after employing conservative treatment options without success. Endoscopic plantar fasciotomy is the first way to eliminate pain. The surgeon detaches the plantar fascia ligament from the heel bone, relieving stress and pain and allowing new fascia tissue to develop in the space that was created. In other procedures, only a portion of the ligament is detached. The surgeon may decide to remove the spur itself. This procedure seeks to minimize pain by preventing the bone fragment from further damaging tissue around the heel.

Did You Know?

In January 2011, the American Podiatric Medical Association (APMA) publicly launched the Today's Podiatrist campaign to educate the public, medical professionals and students about podiatry education and training.

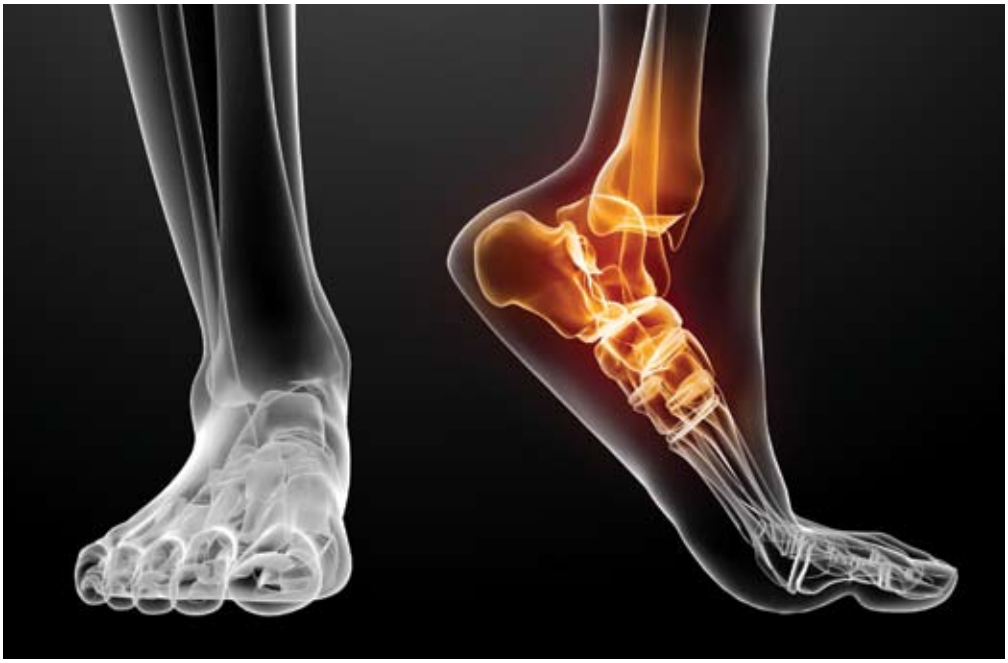
Healed Foot Forward *Continued from cover*

"When the foot hurts, your whole body hurts" is a statement that instills pride in their profession among podiatric physicians and surgeons. Podiatry is to the foot what ophthalmology is to the eye or dentistry to the tooth. Whether referred to as podiatrist, doctor of podiatric medicine or DPM, this specialist is thoroughly trained to diagnose and treat diseases and injuries that impair the foot, ankle and lower leg.

Within the field of podiatry, practitioners can focus on different specialty areas, including surgery, sports medicine, biomechanics, geriatrics, pediatrics, orthopedics and primary care. Podiatrists in an ambulatory surgery setting alleviate conditions resulting from disorders of soft tissue, muscles, bones and joints. They remedy toenail deformities, bunions, corns and calluses. Patients suffering from job- and sports-related foot ailments are seen by podiatrists as well. Annually, surgeons at RASC perform several hundred podiatry procedures, including bunionectomies, ankle arthroscopies and exostectomies (removal of the bony bump on the toe joint).

The following staff physicians serve patients at Rockford Ambulatory Surgery Center. They rely on the most current technology available to relieve pain and improve foot and ankle function.

William J. Bush, DPM
Flavio Cordano, DPM
Tina Entwistle, DPM
Joseph T. Fanara, DPM
Paul A. Galluzzo, DPM
Heath Hoffman, DPM
Kelly R. Lawler, DPM
John Nielsen, DPM
Dinesh Pandya, DPM
Philip W. Seeber, DPM
Janusz P. Skwark, DPM
Mary C. White, DPM
Kelly J. John, DPM



Scheduling Tips For Podiatry Cases

Surgery nurses, anesthesia providers and surgeons live by the surgery schedule. The schedule specifies the correct procedure at the correct time. It allots the accurate amount of time for the procedure. It accounts for the availability of equipment, instruments and any special requests for the surgery.

To accommodate all cases and their equipment needs, the Scheduling Department records when a surgeon plans to use special equipment that other physicians at the center share. For example, knowing precisely who will need a laser or mini C-arm (an imaging device for podiatric and orthopedic applications) ensures that everything is in place when patients arrive.

In addition, the materials management staff must know in advance of the date of surgery about special implants, bone screws, bone putty or bone graft materials not normally stocked at the center or in short supply. Materials staff can make calls to locate equipment, talk to vendor representatives and, hopefully, avoid overnight shipping.

Surgery Recovery *Continued from cover*

Patients who receive only a local anesthesia are transferred by cart to a recovery room with operating room nursing staff. The surgeon gives patients postoperative orders regarding weight-bearing activities. Anyone receiving general anesthesia is transferred lying on a gurney to a recovery room accompanied by the anesthesia provider and the RN circulator.

Rockford Ambulatory Surgery Center splits postoperative care into two stages. The center is equipped with stage one and stage two recovery rooms (also called postanesthesia care units or PACUs for short).

It takes only moments for the patient to surrender to anesthesia. Eliminating anesthesia from the body's tissues, on the other hand, takes time. The most acute postoperative care occurs in the first stage while the patient is still under significant influence of preoperative medications and intraoperative anesthesia.

The patient moves to a stage two recovery unit once the patient is alert and able to communicate verbally, the major effects of anesthesia have worn off and vital signs have stabilized. Patients should exhibit improvement in key areas that were checked in phase one, such as respiration and muscle strength. Skin color and condition are considered during this phase, too.

On average, a patient stays in the PACU approximately one hour. During the second stage, the recovery room RN provides expert counseling and education services — for instance, the proper use of crutches — for patients going home after their surgeries. The nurse explains the importance of caring for wounds, adhering to medication regimes and getting plenty of rest.

Dedicated to Minimizing Complications

The surgery center has 21 recovery beds. Eight beds are in Stage I PACU, and 13 are in the Stage II PACU area. We maintain a ratio of one nurse to two patients in the stage one area. Nurses care for up to five patients in stage two. Management of the Postoperative Department's six registered nurses rests with Dee Stokes, RN, a 17-year veteran of RASC. As charge nurse, Dee oversees scheduling and makes certain that department staff abide by surgery center policy. In addition, she coordinates patient safety measures.

Postoperative Department staff

Dee Stokes, RN, Charge Nurse
Jennifer Abrahams, RN
Lisa Bender, RN
Peggy Powell, RN
Rita Reese, RN
Shelley Sheffield, RN
Judy Young, RN

Photo at far right: Jennifer Abrahams, RN. Pictured left to right in photo at right: Charge nurse Dee Stokes, RN, and Peggy Powell, RN.

Recovery Starts in the PACU

Stage One Recovery

Awakening from anesthesia: Hearing is the first sense to return following general anesthesia. PACU staff speak in a reassuring tone when talking to the patient.

Assessing patient needs and vital signs: The first priorities upon admission to the stage one PACU are assessment of the openness of the patient's airway, level of consciousness and vital signs.

Report of anesthesia provider: The anesthesiologist or nurse anesthetist reports on the patient's condition, surgery performed, anesthesia administered, estimated blood loss and input of fluids during surgery. The anesthesia provider remains immediately available for consultation and orders until the patient's discharge.

Pain management: Patients typically experience some discomfort as a result of surgery. The effects of anesthesia linger, rendering extended relief from pain. Other forms of pain management augment the diminished effects of anesthesia.

Continuous monitoring: To identify any postoperative complications, the nurse continues to monitor temperature, respiratory rate, pulse, blood pressure and possible nausea or vomiting.

Stage Two Recovery

Maintenance of patient comfort: Some residual effects of anesthesia may or may not be present. If necessary, pain medication administered orally replace intravenous infusions.

Patient instructions: The nurse reviews with the patient the postoperative instructions and medications.

Preparing for discharge: Both the patient and any home care providers should understand all discharge instructions. Travel arrangements for the patient to be taken home are verified.

New to the RASC Team

Our two newest members of the nursing team are both area nursing school graduates and both attached to the Preoperative Department.

Laura Castaneda, RN, started last September and already has carved out a place for herself at the surgery center. Laura came to RASC from SwedishAmerican Hospital, where she had cared for orthopedics/neurology patients since 2007.

Laura completed the registered nursing program at Rock Valley College in 2003. She is in the process of cross-training to provide postanesthesia care in the surgery center's stage two recovery area.

Fluent in Spanish, Laura assists with translating instructions for our Spanish-speaking patients.

"The surgery center has a lot to offer," she says. "The nursing staff all work together very well toward a common goal. Being here presents different challenges and different areas of opportunity compared to a hospital."

For Carlee Koerner, RN, training as a patient care technician served as a stepping stone to becoming a registered nurse. Beginning in 2006, she worked alongside doctors, nurses

Laura Castaneda, RN: "The surgery center is a good environment to work in. The staff members here are very friendly."

and other health-care professionals at SwedishAmerican Hospital, aiding patients with many tasks that they couldn't do for themselves.

Carlee is a 2010 graduate of Saint Anthony College of Nursing. After completing her undergrad studies, she assumed floor nurse duties on an ortho/neuro floor at Swedes.

Carlee is looking forward to receiving cross-training in RASC's Postoperative Department.

"There is a personal connection that develops with patients when you're delivering preoperative and postoperative care," she explains. "On one end, you help patients relax before surgery and prepare them for how the day will progress. On the other end, before patients go home, you provide them with education about caring for themselves. I've always been attracted to that aspect of the profession."

Carlee Koerner, RN: "A personal connection develops with patients when you're caring for their preoperative and postoperative needs."

When CPT Codes Speed Things Up

How to get faster answers to your patients' out-of-pocket-cost queries.

The average medical patient could be forgiven for confusing the CPT (Current Procedural Terminology) code assigned to incising and draining an abscess with a Manhattan zip code. They're the same number: 10060. Nevertheless, patients have a firm grasp of copays and deductible payments.

The surgery center doesn't require the CPT code as part of the scheduling process. Surgery scheduling staff are knowledgeable about the codes related to surgeries and procedures performed here on a regular basis.

From time to time, however, our Scheduling Department fields calls from surgeons' offices asking whether a patient's health plan covers a particular service. It's understandable that patients would want to know their out-of-pocket costs.

In such instances, documenting the CPT code at the outset saves everyone time and effort. Having the right CPT code translates into a fast and accurate financial liability estimate that is passed on to the patient. It reduces follow-up calls back and forth between the surgery center and physician offices.

Patients rely on accurate communication between the physician's office and surgery scheduling specialists like Deb Ballard.

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1016 Featherstone Road | Rockford, Illinois 61107
(815) 226-3300 | www.rockfordambulatory.com