

AORN Delegate Education Report  
Denver, 2010  
Krista Johnson, Delegate

**Fire Safety Program**

Date: Monday, March 15, 2010

PRESENTER (S):

Mr. Scott Aronson - Russell Phillips & Associates

Mr. Dennis Parker – father of surgical fire victim

**Mr. Dennis Parker** began the session describing how his son had died after being injured by an airway fire. He said the best response is prevention. He referenced the National Quality Forum (NQF) 2009 Update which found you should learn from mistakes – both yours and others.

**Mr. Scott Aronson** of Russell Phillips & Associates then spoke to the causes of and response to fires in the Operating Room. He stated the response needs to be intuitive – staff needs to be ready and knowledgeable to respond quickly. A new video is being released by APSF by end of April which focuses on Anesthesia's inherent risks, role and response to fires. Surgical fires are now thought to be 5 times more common than at first believed – numbering 550 – 650 incidents a year. He gave a web site for reference: <http://surgicfire.org/>. He said the following steps would help to decrease the incidence of fires:

- decrease the O2 concentrations to lowest levels needed (<30% usually)
- utilize oxygen blenders
- use of closed circuit systems (cuffed ET tubes, LMA's)
- improve draping techniques to prevent “tenting” of drapes and using “loban” drapes to seal the area from O2.
- instructing patients to NOT use hair spray on day of surgery
- staff who know fire suppression techniques
- improved communication between surgeons and anesthesia providers
- use moist sponges – dry sponges absorb O2
- use the cautery holster, do not lay pencils on drapes
- use bipolar cautery when possible – there have been NO reports of fires with bipolar cautery

At the first sign of a fire, shout: “**FIRE – SHUT OFF THE GASES**”. This statement will alert the team to the situation and be a reminder of the first action to extinguish the fire – removing O2 from the triangle. Staff should practice this statement at annual fire safety in-services. Especially with an airway fire, it is imperative to shut off the gases prior to removing the ET tube, or it just becomes a torch that burns and melts with removal. If it is a small fire on a drape or patient, use the smother and SWEEP technique – do not pat, you could just spread the fire. If you feel unsafe, you need to evacuate. If evacuation becomes necessary, staff needs to know how to unlock the bed manually if the power to the electric bed is unavailable.

## LEAN IN THE PERIOPERATIVE SETTING

### A) LEAN HOSPITALS SEEK TO:

- 1) Specify value in the eyes of the customer
- 2) Identify the value streams
- 3) Make value flow without interruptions
- 4) Let customers pull value
- 5) Pursue perfection

### B) HOSPITALS WILL FAIL AT LEAN IF THEY THINK IT IS:

- 1) A quick-fix solution to problems
- 2) A way to reduce the work force
- 3) A “here today, gone tomorrow” quality method
- 4) A group of tools that can be mastered in a classroom
- 5) A housekeeping or clean-up campaign
- 6) A methodology they should do because “everyone else is doing it”

### C) THE EIGHT DEADLY WASTES

- 1) Over-production
- 2) Waiting
- 3) Transport
- 4) Poor process design
- 5) Underutilized resources and creativity
- 6) Defects
- 7) Motions
- 8) Inventory

### D) LEAN METHODOLOGY TO DRIVE OUT WASTE

- 1) Define value
- 2) Measure value
- 3) Analyze process-flow
- 4) Improve process-pull
- 5) Control process

These are the steps for “Lean Six”. The presenter showed us how they used Lean Six for “operating Turnover Time”. Thank you for the opportunity to serve as your delegate at AORN this year. Jane Pence RN, CNOR

## Safer Surgery: Reducing Complications & Disparities

Speaker: Atul Gawande, MD

Dr. Gawande discussed the need of a comprehensive surgical checklist to be used throughout the surgical process, not just doing a time out. He said this idea will not go over well at first, but suggested we try using it and fixing it to fit our needs. The checklist was described as a tool that is misunderstood but has a great set of values. This checklist is used in the holding area, before induction, at time out, and then before leaving the operating room.

Dr. G. leads the World Health Organization's Safe Surgery Saves Lives initiative. He stated the checklist is now the standard of care in 24 countries. 3500 hospitals in the United States are using a check list. He used as an example a story about a three year old drowning victim who was revived after no cardiac function for nearly 90 minutes. He said the girl was saved by the many steps taken by medical and surgical teams. There were many steps needed to help her along the way to recovery and each step after another was taken in the right direction. However, if one step was missed that little girl today would not be a normal five year old. He stressed how following steps reduces failure.

Another example given was the B-17 bomber. He described how steps taken using a checklist in the cockpit can divert catastrophe. When the bomber was being developed all went well until something was missed prior to takeoff resulting in a crash. It was found that a step missed prior to take off. From this a checklist was developed. He said we too can miss something in the surgical arena if we do not have a checklist to follow because "surgery has become too complex for any one individual to 'fly'". This checklist is about teamwork. It is not for the nurse to be the police, but for the entire team to be involved.

The checklist can be a whiteboard or paper, but verbally going over the points is the key. Dr. G. stated 20% of those using the checklist found it too difficult or long to use. However, 83% stated they wanted a checklist used if they were having surgery.

An example of a Comprehensive Surgical Checklist was made available. Due to space, I am not enclosing a copy. If you wish to see a copy I will have some available at the April meeting or you can contact me at [MaryWismann@aornfw.org](mailto:MaryWismann@aornfw.org). It is another checklist for the nurses in surgery and may be difficult to initiate in the beginning, (like the time out was) but it is coming. There were several posters showing how the checklist is utilized in facilities in the United States. This is another form of safety for our patients and the staff to avoid errors in the operating room. It is coming soon to your operating room.

Thank you for the opportunity to attend Congress this year. Congress always gives me a renewed energy for my return to the operating room. I hear so many new ideas. It offers me a great opportunity to discuss issues with other nurses and find how they handle situations. I hope each and every one of you gets an opportunity to attend a Congress. It is overwhelming, but such a great experience. Thank you.

Mary Wismann

## Are You in Compliance with Best Practices?

### A Guide to Auditing Your SPD

Rose Seavey, RN, BS, MBA, CNOR, ACSP

As summarized by Tracey French

This was a very informative session. It brought all of the key points of sterile processing and put them all in one easy reference page. Some of the new things I already knew, due to the nature of my business, but there was some things I didn't have a clue about. Like OR nurses have AORN Standards, sterile processing folks have AAMI (Association for the Advancement of Medical Instrumentation) Standards and IAHCMM (International Association of Healthcare Central Service Materials Management) [pronounced ish' im] to govern their practice. This audit tool can be used as a checklist to see if your department is doing the things to be compliant. It touches on personnel considerations, facility design considerations, decontamination, packaging, sterilization, sterile storage, and policies and procedures that should be present for a SPD. All of this information came out of the ANSI/AAMI Standards: ST79.

Some of the topics discussed were the placement of the internal indicators in the sets, peel packs: to double or not to double, air exchanges in dirty side, versus clean side versus sterile cores, PPE and of course, TASS and the care of the eye instruments that are mostly involved with this eye infection. The speaker was a bit rushed, but she did have a TON of things to cover. Luckily, this wasn't the first time to hear things like this, so it was easy for me to keep up with the things I didn't know. Very good session!