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INSIDE

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AHC Media

Shootings, other violence on the rise and pose major liability risks

Escaped murderer David Sweat recently was shot and captured after a three-week manhunt in New York. He was taken to Alice Hyde Medical Center in Malone, NY, according to CNN.[1] He later was moved to Albany Medical Center, where vascular surgery specialists and others were involved in his care, CNN said.

The typical patient in outpatient surgery programs does n't usually pose a security risk to staff or other patients, but when a criminal is being treated in the facility, special precautions are essential. Consider this other recent healthcare example: At Inova Fairfax Hospital in Falls Church, VA, a convicted bank robber was being treated and stole a guard's gun. A shot was fired, and he held the guard hostage before fleeing. The prisoner is thought to have carjacked two vehicles after leaving the hospital, and he was captured in a Washington, DC, neighborhood after a nine-hour manhunt involving hundreds of officers.

"THIS IS THE KIND OF THING YOU HOPE NEVER HAPPENS, BUT IF IT DOES, YOU WANT YOUR PEOPLE TO KNOW WHAT TO DO AND HOW TO STAY SAFE."
— GREG BRISON, INOVA FAIRFAX HOSPITAL

The incident prompted a five-hour lockdown of the facility. The facility's preparations for such an event helped minimize the impact, says **Greg Brison**, the hospital's director of emergency management and security.

A key part of that preparation was the workplace violence training required for employees at least once annually. That training includes information specific to responding to shots fired in the healthcare system. Inova Fairfax also works closely with local law enforcement and other emergency responders. In fact,

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it allowed them to use a new patient care center for training before the hospital moved in any patients, and they used a scenario very similar to what later happened.

The hospital had conducted full-scale drills as well as tabletop exercises to test its planning for an active shooter, including a meeting held just the day before the shot was fired. The Inova Fairfax incident illustrates how quickly a violent incident can put thousands of people in jeopardy and disrupt a healthcare facility, Brison notes. No one was injured at the hospital during the incident, and patient care resumed as smoothly as could be expected after a long lockdown. *(For more on the lessons highlighted by the Inova Fairfax prisoner escape, see the story in this issue.)*

"There's no question that our planning and the extensive training for our employees made a difference in the outcome," Brison says. "This is the kind of thing you hope never happens, but if it does, you want your people to know what to do and how to stay safe."

Increasing violence

Healthcare workers are increasingly at risk from violence at work, and their employers face the prospect of huge payouts if they are found negligent for failing to protect employees and patients. Violence in healthcare is not what it used to be, the experts say, and the typical precautions might no longer be enough.

Some level of violence has always been an unfortunate but, seemingly, unavoidable part of providing healthcare services. *(See these stories from the April 2014 issue of* Same-Day Surgery*: "2 incidents raise concerns: How do you protect staff and patients from violence?" "The unlucky 13: Early warning signs of potential violence at work," and "Informed consent can play part in violence.")* However, the type of violence facing healthcare organizations is changing, as evidenced by a recent report in *The Journal of the American Medical Association (JAMA)*. The *JAMA* article indicates that healthcare shootings are becoming increasingly prevalent, with "active shooter incidents" increasing from nine per year from 2000 to 2005, to an average of 16.7 per year from 2006 to 2011. *(A portion of the article is available online at http://tinyurl.com/q8xopy2.)*

When surgeon Michael J. Davidson, MD, was fatally shot on the premises of the Brigham and Women's Hospital in Boston on Jan. 20, 2015, there had been 14 active shooter incidents in U.S. hospitals in the previous year. Fifteen people died in those incidents. "This reality and its potential amplification by

EXECUTIVE SUMMARY

Shootings and other violence in healthcare facilities are increasing, which is prompting administrators to take another look at their security. Experts caution that priorities sometimes are misplaced and that failing to protect employees can lead to significant liability.

- A violent incident at a Virginia hospital proved the value of extensive preparations for such an emergency.
- The number of shootings at hospitals has increased significantly.

copycats has reignited the debate over the adequacy of current and future hospital security arrangements," the *JAMA* report says.

Bureau of Labor Statistics data show that healthcare workers are at higher risk of workplace violence than other U.S. workers. The rate of nonfatal occupational injuries and illnesses involving days away from work for healthcare/social assistance workers was 15.1 per 10,000 full-time workers in 2012, compared to 4.0 for private industry overall.

Keep prisoners restrained

The increase in shooting incidents is prompting more healthcare facilities to conduct active shooter drills, says **Ben Scaglione**, director of security in healthcare for G4S Secure Solutions, a security company based in Jupiter, FL.

Healthcare facilities should reassess how they handle inmate prisoners, he says. Handcuffs and other restraints can be a thorny issue, with clinicians sometimes insisting that a patient be released at least temporarily during treatment.

"It's a lack of understanding. Clinical staff want the best for their patient, but the bottom line is they are prisoners and they need to be shackled," Scaglione says. "Clinical staff need to understand that a shackled prisoner needs to stay that way. I saw a case years ago where a prisoner should have been shackled and wasn't, and he was able to leave his room and sexually assault a female patient down the hall."

In addition to potential civil liability, managers should remember the risk from running afoul of expectations from the Occupational Safety and Health Administration regarding workplace violence, says **John Ivins**, JD, a partner and leader of the Health Care Practice at Hirschler Fleischer in Richmond, VA. In 2011, OSHA issued *Enforcement Procedures for Investigating or Inspecting Workplace Violence Incidents*, document number CPL 02-01-052, to guide inspectors. Ivins suggests that managers should study the document to assess compliance with OSHA's requirements. *(See Resource below for information on updated guidelines.)* Failure to protect employees from workplace violence can result in a general duty clause citation from OSHA, which Ivins calls "serious, significant, and costly."

REFERENCE

1. Feyerick D, Field A, Ford D, CNN. *David Sweat shot and captured alive after New York manhunt.* June 28, 2015. Accessed at http://cnn.it/1RG7sbs.

RESOURCE

The Occupational Safety and Health Administration has updated ***Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers***. Web: http://tinyurl.com/ohwgnoe. ■

Bank robber lockdown holds lessons

Outpatient surgery managers can study the recent lockdown at Inova Fairfax Hospital in Falls Church, VA, involving an escaped bank robber for lessons that might improve their own emergency planning. The incident affirmed the value of much of the facility's planning, but it also highlighted some needs that had not been considered, says **Greg Brison**, the hospital's director of emergency management and security.

Brison notes that some of the lessons from the experience can apply to many emergency situations, not just an active shooter. He offers this advice gleaned from the facility's experience with a shot fired and five-hour lockdown:

• Provide access and information to local law enforcement ahead of time.

During an emergency, it might be difficult for anyone to meet police officers at the front door, let them in, and then guide them through the facility. Provide a way for police to gain entry on their own, such as keys or key cards, along with detailed floor plans they can use on arrival.

• Standardize how you name entryways.

Inova Fairfax has numbered all entry points, starting with the main entrance as Door 1 and then working around the building clockwise with sequential numbers. The number is marked prominently on the entryway. This system will improve communication with police who can be told to go to Door 5, for example, rather than having them struggle to find "the west wing entrance near radiology."

• Security should know where prisoner patients are at all times.

It is not enough for security to know that an inmate is in a certain unit. Security should know exactly what room, and staff members should notify security whenever the patient is moved somewhere else.

• Serve only finger food to prisoners.

Even plastic eating utensils can become effective weapons, so prisoner

patients should be designated for only meals that require no utensils, such as a sandwich. Any staff members delivering meals should know of this restriction so they don't routinely include a utensil packet or comply when the prisoner asks for one. If you decide to provide utensils, you must have a strict accounting of them afterward.

• Use high visibility clothing for prisoners.

As a result of the prisoner escape, Inova Fairfax will no longer provide standard hospital gowns for anyone under police custody. Those patients now wear bright orange gowns to make them easier to spot if they escape and also to serve as a warning to staff that this person could be hostile.

• Enable after-hours security officers to access security video.

It is common for night-time security officers to be limited in their access to security camera recordings, and it frequently requires a manager to come in to the facility and to obtain them. When a violent person still might be on the campus, security officers must be able to gain access to those recordings without delay so they and local police can identify and track the person.

• Have backup command centers.

For much of the lockdown, Inova Fairfax leaders could not get to their command center because it was in an area of the hospital not yet cleared by police. They now are establishing a backup command center on the opposite end of the building, with the same communication capabilities and resources such as job action sheets.

• Arrange police escorts for necessary clinical care.

Even in a lockdown, patients might have a clinical emergency. The staff members responsible for those patients cannot remain in place as they are supposed to during a lockdown, so police should be prepared to escort them and guard them as they work. This system is best accomplished by discussing the need with police ahead of time so they can have adequate personnel on hand.

• Arrange for off-site parking.

Parking might seem a mundane issue when people are in jeopardy, but it quickly became a problem that threatened to hinder the response of staff and local law enforcement. The Inova Fairfax shooting happened at 3 a.m., and the hospital's shift change is 6:30 a.m. Additionally, outpatients begin arriving soon after, so about 2,000 people and cars were arriving while the hospital campus still was locked down.

Inova Fairfax is developing a plan for designated parking areas in an emergency and a method for notifying those coming to the facility. The plan also will include a way to ferry critical staff to the facility from those off-site parking areas.

• Prepare for media arriving at your campus and other areas.

The plan should call for public relations staff and security officers to be on hand, not just at the hospital campus, but also at any other area where staff members are likely to congregate after evacuation. Reporters will go to those areas to interview staff, so public relations representatives should be there also to help control the public message. Any designated off-site parking area for incoming staff and patients must have media relations and security present.

Another precaution includes handcuffing the patient to the OR table, says **Mark Mayo**, CASC, executive director of Golf Surgical Center in Des Plaines, IL. Even if sedated, "some prisoners may be ongoing drug users who have a higher tolerance to medications," Mayo says. Other items to consider include limiting advance notice, in the event the prisoner wants to notify someone on the outside of the facility to try to arrange an escape, and allowing a police escort to be posted just outside the procedure room.

"Staff need to be trained and understand that prisoners, who may look and act normally, should still be considered dangerous," Mayo says.

Cases with gunshot wounds need extra care, he says. "In many cases of gunshot wounds there is … a need for a proper 'chain-of-evidence' handoff so that any retrieved bullet can be used by law enforcement and the courts in any ongoing criminal investigation," Mayo says. ■

Participants in ASC pilot study share safety changes

Are you looking for ideas to improve your facility's patient safety culture? Would you like to compare your safety culture to that of other ambulatory surgery centers (ASCs)? Your wishes are granted, thanks to the recent pilot study involving the AHRQ *Ambulatory Surgery Center Survey on Patient Safety Culture*. The pilot study was held to refine the survey and share the results with ambulatory surgery centers.

The pilot study results were presented recently by the Agency for Healthcare Research and Quality and pilot study participants in a webinar.[1] In 2014, more than 1,800 staff in 59 ASCs participated in the pilot test of

the survey. The survey participants included a wide range of ASCs. A quarter of the ASCs were hospital-affiliated. Seventeen percent of ASCs were considered single specialty or nonsurgical centers, with areas such as ophthalmology, dermatology, or pain management. Forty-three percent had three or fewer OR/procedure rooms; 15% had seven or more.

The survey was developed for everyone working in the ASC, including full- and part-time employees, per diem employees, contract staff members, and doctors who worked at least four times a month at the ASC and who also had been working at the ASC for at least six months. Respondents also included nurses, certified registered nurse anesthetists, physician assistants, nurse practitioners, technicians, and management, administrative, clerical, and business staff.

Based on survey results, the area showing the most room for improvement was "Staffing, Work Pressure and Pace," which measures whether staff members feel rushed, don't have enough time to properly prepare for procedures, and don't have enough staff members to handle the workload. Specifically, when staff were asked whether they felt pressure to do tasks that they hadn't been trained to do, 72% answered positively. When asked if they felt rushed when taking care of patients, 58% responded positively. *(To see all the areas that were surveyed, go to http://1.usa.gov/1haAK75.)*

Participants in the pilot test have taken the results and responded with changes. Two facilities shared the following changes:

• They assigned recovery nurses to specific rooms to improve communication between physicians and staff.

EXECUTIVE SUMMARY

The participants in the pilot study of the AHRQ *Ambulatory Surgery Survey on Patient Safety Culture* were able to compare themselves with peers and find areas for improvement.

• The area showing the most room for improvement was "Staffing, Work Pressure and Pace." This area measures the extent to which staff members don't feel rushed, whether they have enough time to properly prepare for procedures, and whether there are enough staff members to handle the workload.

• Changes were made by participating centers to address staff concerns about better communication, staffing, training, and speaking up.

• The survey tools are available for any surgery center to use. AHRQ also offers a *Hospital Survey on Patient Safety Culture* and one on *Medical Office Survey on Patient Safety Culture*.

The first area Idaho Endoscopy Center in Boise, ID, addressed was "Communication Openness," in which their result was 73% positive versus 85% for all of the pilot ASCs. "…[W]e found that lack of effective communication was the reoccurring concern expressed by staff," said **Erin Brown**, RN, director of nursing services at the Center and at Digestive Health Clinic in Boise.

Based on this information, the facility assigned recovery nurses to specific rooms each day to help improve face-to-face communication with physicians, facilitate continuity of care, and validate staff concerns. Previously, nurses rotated as needed and were not assigned to specific recovery rooms, Brown said. With the new system, "[t]he nurse can then discuss intraop concerns, plan of care, and have an open discussion regarding patient issues with the provider," she said. "And an example of an intraop concern would be if the recovery nurse has a question regarding the patient's response to sedation, it can be addressed with the physician at this time, thus validating the nurse's concerns."

• They trained certified medical assistants to remove patient IVs prior to discharge.

Brown's center also focused on "Staffing, Work Pressure and Pace," for which their result was 55% positive versus 76% for all ASCs in the pilot study. The facility was going through a staffing transition, and staff members thought the facility didn't have enough nursing staff to handle the workload. "Staff also felt rushed when taking care of patients," Brown said. "And nurses felt there were areas where certified medical assistants could help more, but were not yet trained."

The center leaders trained the certified medical assistants to remove patient IVs prior to discharge, especially when there was a shortage of nursing staff. "And this task is within the CMA's scope of practice," Brown said.

The medical assistants enjoyed learning a new skill and taking on a new task, she said. "Furthermore, the team dynamic with this change contributes to the overall balance of patient flow and solidifies the importance of patient safety," Brown said.

• They added ongoing staff

training and additional drills.

In the "Response to Mistakes" area, Brown's center scored 78% positive versus 82% for the pilot study ASCs. Breaking down the result "showed areas for improvement related to 'Staff Training/Response to Mistakes' as a learning opportunity instead of blame, and enhancing communication between staff members when patient safety problems occur," Brown said.

The center added ongoing staff training and additional drills to develop staff confidence in performing tasks, she said. "Additional drills included more disaster drills, event of patient transfer, and more incapacitated provider drills," Brown said. "In regard to staff training, we covered areas of IV insertion, conscious sedation, scope reprocessing, and overall infection control. Training is also reinforced in our monthly company newsletter that is distributed to all staff."

• They implemented a new surgical procedure checklist.

The survey process indicated that 40% of the staff at Underwood Surgery Center in Orlando, FL, didn't feel comfortable speaking up.

"[I]f you don't feel like the doctor is encouraging you to speak up, then that is definitely a problem," said **Terry Tinsley**, RN, clinical nurse manager. Physicians were surprised that the employees felt somewhat intimidated, Tinsley said, "and it does start with the doctor in the room, with a culture of feeling safe to speak up."

A new surgical procedure checklist has everyone involved with the case say his or her name at the beginning of the procedure. Sometimes there are vendor representatives in the room or X-ray technicians whom everyone doesn't know, Tinsley pointed out, but "even if you know the people for a long time, it just helps to open your mouth and get a good feeling of being able to speak up."

The process also includes having the physician say, "Is there anyone who has any safety issues?" Also, signs in the rooms remind staff members to speak up, especially if they need to voice a concern, Tinsley said. "It's important that all staff feels a freedom and encouragement to speak up during the procedure," she said.

The medical director has become a champion of this effort and meets with the other physician partners quarterly, Tinsley said. The director explains to the physicians that staff members might feel intimidated and that physicians need to say out loud that staff members can speak up, Tinsley said.

"It's a work in progress, but we are doing much better than we have before," she said.

• They give treats to staff.

Staff members are rewarded when they share a safety concern, such as an expired medication, or when they share an idea, Tinsley said. Treats have included candy, movie tickets, and candles.

"[W]e just want to encourage them to bring it to us and to share their ideas, because it's very important that everyone feels a part of making this a very safe environment for our patients," Tinsley said.

REFERENCE

1. Agency for Healthcare Research and Quality. *Introducing the AHRQ* Ambulatory Surgery Center Survey on Patient Safety Culture. July 15, 2015. Accessed at http://bit.ly/1IOrXUF.

SOURCES/RESOURCES

- **Agency for Healthcare Research and Quality.** Patient safety resources including tools and training. Web: http://1.usa.gov/1eQ7MI1.
- **ASC Survey on Patient Safety Culture web site.** Download the survey, the user's guide, and the pilot study results. The results provide breakouts by multispecialty versus single specialty, not hospital-affiliated versus hospital-affiliated, number of surgery/procedure rooms, and staff positions. A *Data Entry and Analysis Tool* is an Excel file that has tabs and macros. This tool helps to administer the survey on paper, because it allows the center to take respondent data and put it into the tool. It automatically generates charts and statistics of results. Web: http://1.usa.gov/1IGj5dC.
- AHRQ also offers a ***Hospital Survey on Patient Safety Culture*** at http://1.usa.gov/1mzyvVQand a ***Medical Office Survey on Patient Safety Culture*** at http://1.usa.gov/1Df3PIk. ■

Proposed Medicare payment rates released

In the 2016 proposed payment rule for ambulatory surgery centers (ASCs) and hospital outpatient departments (HOPDs), the Centers for Medicare & Medicaid Services (CMS) is proposing a 1.1% effective rate update for ASCs.

"If the proposed rule were to be finalized as drafted, ASCs would see an effective update of 1.1% — a combination of a 1.7% inflation update based on CMS's estimation

of the change in Consumer Price Index for All Urban Consumers (CPI-U) and a productivity reduction mandated by the Affordable Care Act of 0.6 percentage points," the ASC Association (ASCA) said in a statement. "However, CMS does not take into account sequestration in its proposed rule. This statutory 2% reduction remains in effect until at least 2024 unless Congress acts."

ASCA CEO **Bill Prentice** said, "Unfortunately, the proposed rule and continued use of the CPI-U to update ASC reimbursements offers more evidence of CMS' unwillingness to recognize that the agency must do more to actively promote ASCs as a high quality, efficient provider of outpatient care for America's seniors if we are to survive and thrive in the future."

For HOPDs, the effective rate update would be 1.9%, ASCA said. Under the rule, there would be a net decrease in outpatient prospective payment system (OPPS) payments of 0.2%, according to the American Hospital Association (AHA). "This net decrease largely results from a proposed 2.0 percentage point cut intended to account for CMS's overestimation of the amount of packaged laboratory payments under the OPPS for laboratory tests that were previously paid under the Clinical Laboratory Fee Schedule," the AHA said.

AHA Executive Vice President **Rick Pollack** expressed disappointment with the negative update and said the AHA was "dismayed that miscalculations by the actuaries are resulting in penalties to hospitals and the patients they care for." He urged CMS to reevaluate the actuaries' estimates.

The conversion factor would be $44.605 for ASCs and $73.929 for HOPDs.

In addition, CMS proposes to alter its two-midnight policy so that certain hospital inpatient services that do not cross two midnights might be appropriate for payment under Medicare Part A if a physician determines and documents in the patient's medical record that the patient requires reasonable and necessary admission to the hospital as an inpatient, the AHA says. A fact sheet about the two-midnight rule can be downloaded at http://go.cms.gov/1R5vlhF.

Pollack called the proposals a "good first step" and said hospitals "appreciate today's proposal to maintain the certainty that patient stays of two midnights or longer are appropriate as inpatient cases." However, he expressed dismay that CMS did not propose to withdraw the 0.2% cut, and he urged the agency to extend the partial enforcement delay beyond Sept. 30.

> "... THE AGENCY MUST DO MORE TO ACTIVELY PROMOTE ASCs AS A HIGH QUALITY, EFFICIENT PROVIDER OF OUTPATIENT CARE FOR AMERICA'S SENIORS IF WE ARE TO SURVIVE AND THRIVE..."

CMS has proposed that all web-based measures in the ASC Quality Reporting Program be reported by May 15 each year. Currently, the deadline for ASC-8 (Influenza Vaccination Coverage among Healthcare Personnel) is May 15, although the deadline was extended only for 2015. (*See "ASC-8 reporting deadline moved,"* Same-Day Surgery, *August 2015.)*

According to CMS, aligning the dates "would allow for earlier public reporting of measure data and reduce the administrative burden for ASCs associated with tracking multiple submission deadlines for these measures."

The deadline for the following quality measures this year is Sept. 30, based on information from ASCA:

- ASC-6, Safe Surgery Checklist Use;
- ASC-7, ASC Facility Volume Data on Selected ASC Surgical Procedures;
- ASC-9, Endoscopy/Poly Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients;
- ASC-10, Endoscopy/Poly Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use.

For more information on the extension, go to http://bit.ly/1g5LgvJ.

CMS is not proposing to add any new measures to the ASC Quality Reporting Program for the coming year.

The agency is proposing to use Quality Improvement Organizations to conduct first-line medical reviews of most patient status claims rather than Medicare administrative contractors or recovery audit contractors, which would focus only on those hospitals with consistently high denial rates. "However, CMS

does not propose to reverse the 0.2% payment cut associated with the two-midnight policy," the AHA said.

To access the rule, go to http://bit.ly/1H0tZx1. Comments will be accepted until 5 p.m. ET on Aug. 31, 2015.

Download a fact sheet at http://go.cms.gov/1R5EHde. ■

11 new procedures proposed for ASCs in 2016

The Centers for Medicare and Medicaid Services (CMS) has proposed to add 11 new procedures to the ASC list of payable procedures:

• 0171T, Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar, single level;

• 0172T, Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar, each additional level;

• 57120, Colpocleisis (Le Fort type);

• 57310, Closure of urethrovaginal fistula;

• 58260, Vaginal hysterectomy, for uterus 250 g or less J8;

• 58262, Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s);

• 58543, Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;

• 58544, Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s);

• 58553, Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g;

• 58554, Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s);

• 58573, Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s). ■

Comments solicited on office-based cataract surgery

In its proposed 2016 Medicare fee schedule regulation, the Centers for Medicare and Medicaid Services (CMS) is soliciting information regarding the advisability of paying for cataract surgery in the office-based surgical suite, according to the Outpatient Ophthalmic Surgery Society (OOSS).

CMS cites several perceived advantages in implementing such a policy, including patient convenience, flexibility in scheduling surgery, and lower Medicare expenditures. For more information, go to http://bit.ly/1MvNwd6.

CMS is not formally proposing implementation of a program for office-based cataract surgery, but it is simply seeking feedback, the OOSS said. "OOSS believes that the concept of office-based cataract surgery raises a number of patient health and safety issues as well as other concerns, and we will address these in formal comments to CMS," the Society said. ■

SDS Manager

How to address management company complaints

By ***Stephen W. Earnhart****, MS*
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Last month we talked about why hospitals and surgery centers are looking for outside management companies to help ensure they are the best that they can be.

Having an outside professional manage your staff and services is a neato, hip, and cool solution! Yay! Problem solved! … Or is it just beginning?

Here are some common issues we have uncovered from facilities that are professionally managed by experts. They are in no particular order of importance because each facility has its own order of pet peeves.

1. When representatives of the management company visit the facility, they spend most of their time on the phone with some other facility and don't interact with the staff where they are. (Huge complaint!)

2. Seemingly irrelevant people from the management company come through the facility and appear to offer nothing meaningful, and then we get stuck with large travel expenses for them.

3. With all this "talent" on board, why do we, the staff, still have to do all the work with payer negotiations,

third-party vendors, and personnel issues that we were told their HR staff would handle?

4. We don't understand why, when their "regional directors" come to town, we go to eat at the fanciest of restaurants – and pick up the check, but when budgeting for staff meals in the budget, they always eliminate those.

5. The docs used to complain about how "inept" we were. Now they complain about the ineptness of the management company.

6. It seems like they are never around during holidays or toward the end of the year. We are told that the management company is "restricting travel" toward the end of the year, so they can get their bonuses.

7. According to the docs, their quarterly distributions are lower than they were before the management company was hired.

8. We get lots of calls from potential clients for the management company wanting to know if they should hire them. The reality is that if they get more clients, we get less time with them than we do now!

9. It seems like the conferences and CEUs we were told we could expect just never seem to materialize.

10. It seems like the vice presidents or regional directors have a short life span with these companies. It seems like when you get used to them, they move on, and you get another one to train.

So what do you do? It almost seems as if some facilities go from the frying pan right into the fire. Clearly, if you can self-manage your facility, you are better off, but some just cannot. The larger hospitals and ASCs can hire the staff to deal with the regulatory nightmares and long list of "stuff that just needs to be done by people that I don't have." For most of us, however, there just isn't enough staff to do it, or do it right. So if you MUST hire a management company, consider the following requirements:

1. Short-term contract. Most management companies will not do less than a 10-year agreement. Period. Try to keep your initial contract to five years or less. If it works out, great! Many of them do, but if it doesn't, there is a light at the end of the tunnel when they leave.

2. Insist upon meeting the person who is going to oversee your facility! You don't want to get the new kid in the company who is using you as his/her learning curve.

3. Ensure the contract gives you the opportunity to approve replacement of your "regional director." Ask to see the resume. Ask to call the references.

4. Your contract should require them to justify any people visiting your facility BEFORE they incur travel expenses that you are going to pay after they leave.

5. Finally, have a bullet list of exactly what services they provide. They often will drop names and services they bring to the table, but you never hear about them again.

[Earnhart & Associates is a consulting firm specializing in outpatient surgery development and management. Earnhart & Associates' address is 5114 Balcones Woods Drive, Suite 307-203 Austin, TX. 78759. Phone: (512) 297-7575. Fax: (512) 233-2979. Email: searnhart@earnhart.com. Web: www.earnhart.com.] ■

Warning! Smartphone recordings could be a liability risk for your facility

Smartphones are everywhere, and it has become increasingly common for patients to record their encounters with clinicians, usually so they can review the medication instructions or other information that they might not remember clearly. Patients also find it useful to share the recording with spouses or caregivers so they have a clear understanding of what transpired.

Those recordings could be a liability risk. Much like the 1990s controversy over whether to allow videotapes of childbirth, some legal experts caution that the recording could be used against the clinicians in a malpractice case. But not everyone agrees that the risk outweighs the positive aspects.

A jury recently awarded a patient $500,000 after he accidentally recorded clinicians making disparaging remarks about him during surgery. He had hit "record" on his smartphone before surgery so he could review the post-op instructions, but he forgot to turn off the phone. It was with his personal belongings underneath the surgery table. *(See the story in this issue for more details and a link to the audio of the recording.)*

Video recordings can be misleading if they don't capture the entire interaction perfectly, which no smartphone can, says **David M. Walsh IV**, JD, partner with the law firm of Chamblee Ryan in Dallas. The recording might have audio of the doctor giving instructions to the patient, for example, but it might

EXECUTIVE SUMMARY

More patients are using smartphones to record their interactions with clinicians. Allowing such recordings could place the hospital and clinicians at risk of a malpractice lawsuit.

- A recent verdict involved a patient who recorded clinicians making disparaging remarks during surgery.
- Some physicians encourage the recordings to improve patient understanding and compliance.
- Recordings are unlikely to be a complete record of the encounter.

not capture the patient nodding to indicate comprehension, or it might not show what written material was provided.

Lawyer: Don't do it

Walsh advises not allowing patients to record encounters with clinicians.

"Unless it is something very specific and limited, like a doctor telling you how to take a certain medication, I would suggest not allowing them to be recording you," Walsh says. "If they want to record you generally, the entire encounter, that tells me they don't trust you for some reason, and that would make me suspicious of their motivation."

Some clinicians see more benefit than risk in allowing patients to record their encounters. **Randall W. Porter**, MD, a surgeon with Barrow Neurological Associates in Phoenix, AZ, encourages his patients to record their interactions. He was prompted in part by his father's experience with prostate cancer. Although his father had a PhD in economics and his mother was a nurse, Porter could tell that they recalled only part of what was said when talking with a clinician.

"A lot of factors go into that: information overload, emotionally charged discussions, age, hearing loss, medications," Porter says. "I figured if I would have liked to have a recording for my own father, why not offer it to my own patients?"

Porter eventually went a step further and started recording patient encounters himself and offering the patient a copy. He has developed a recording system called the Medical Memory, which uses a computer tablet. Patients create an account on the tablet, which is then placed on a stand in the examination room. The doctor starts and stops the recording, after which a copy is automatically sent to the patient. The cost of the system varies according to a practice's needs, but an office utilizing two systems for clinic, rounding, and discharge is charged about $300 a month, which includes the hardware. *(More information is available online at http://www.themedicalmemory.com.)*

"We've done over 4,000 patients with about 20 providers using it, and we've never had a legal issue, no 'gotcha' moment," Porter says. ■

Anesthesiologist ordered to pay $500,000 after patient's smartphone records insults

A Virginia jury ordered an anesthesiologist and her practice to pay a patient $500,000 for disparaging remarks made during surgery and a false diagnosis on his chart. The man might never have known about the offenses if he had not accidentally recorded the encounter on his smartphone. *(For more information, see "Comments during procedure recorded on cell phone — Patient says staff members were mocking him,"* Same-Day Surgery, *July 2014.)*

The comments were made by anesthesiologist Tiffany M. Ingham, MD, an employee of the Aisthesis anesthesia practice in Bethesda, MD, which the jury ruled should pay $50,000 of the $200,000 in punitive damages it awarded. Court records tell a story that illustrates how smartphone recordings can expose healthcare providers to significant liability.

The patient was preparing for a colonoscopy in a Reston, VA,

COMING IN FUTURE MONTHS

- Ensuring staff don't violate HIPAA
- Could you be required to videotape patients?
- New requirements for nurse anesthetists
- Will public data mean more litigation?

surgical center when he started a recording on his smartphone so he could capture the physician's instructions to him. His phone was put in his personal belongings in a bag underneath the surgical table, still recording throughout the entire procedure, court records indicate. When he reviewed the recording, he was shocked to hear the surgical team insulting him, mocking him, and falsifying a diagnosis. These are some of the comments on the recording:

• A medical assistant noted the man had a rash, and the anesthesiologist warned her not to touch it. She cautioned the assistant that she might get "some syphilis on your arm or something."

She added, "It's probably tuberculosis in the penis, so you'll be all right." Others in the room laughed at the remark. The gastroenterologist said, "As long as it's not Ebola, you'll be fine." The anesthesiologist joked "It's penis Ebola," which prompted more laughter.

• The gastroenterologist told the medical assistant that she should speak to the patient after surgery and lie to the patient about the doctor having been there.

"Just tell him Dr. Shah said everything, and you just don't remember it," he said. The anesthesiologist then suggested that the doctor have a "fake page" go off as an excuse not to talk to the patient. She said she has used fake pages previously.

• Again debating who would have to talk to the patient after the procedure, the anesthesiologist said, "Round and round we go, wheel of annoying patients we go. Where it lands nobody knows." *(The audio recording is available at http://tinyurl.com/og37fez.)* ■

Program aims to improve geriatric surgical care

The American College of Surgeons (ACS), with the John A. Hartford Foundation in New York City, will conduct a four-year initiative that it says will lead to improved care of older surgical patients through a standards and verification program for hospitals.

The leaders for this initiative are Clifford Y. Ko, MD, FACS, director of the ACS Division of Research and Optimal Patient Care, and Ronnie Rosenthal, MD, FACS, chair of the ACS Geriatric Surgery Task Force and chief of surgery at the VA Connecticut Healthcare System in West Haven. The grant amount awarded by the Foundation for the program is $2.9 million.

One of the forces behind this initiative is America's expanding geriatric population. The U.S. Census Bureau reports that more people were 65 years and older in 2010 than in any previous census. Moreover, the largest percentage point increase for the "oldest-old population" (starting at age 85) over the previous two decades was concentrated in the 90- to 94-year-old age group, which increased from 25% of the oldest-old group in 1990 to 26.2% in 2000 and 26.4% in 2010.[1]

"More than ever, 80-, 90-, and even 100-year-olds are undergoing surgery, and that trend will only grow," said **Terry Fulmer**, PhD, RN, FAAN, president of the John A. Hartford Foundation. "This important partnership between the John A. Hartford Foundation and the American College of Surgeons to develop standards, and then verify that hospitals can deliver optimal geriatric surgical care, will save lives, improve outcomes, and reduce harm for older adults across the country."

Quality geriatric surgical care is an area of prime consideration to the ACS, the organization states. ACS published guidelines with the American Geriatrics Society in the *Journal of the American College of Surgeons* for the perioperative care of elderly patients.[2]

REFERENCES

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2. Chow WB, Rosenthal RA, Merkow RP, et al. Optimal preoperative assessment of the geriatric surgical patient: A best practices guideline from the American College of Surgeons National Surgical Quality Improvement Program and the American Geriatrics Society. *J Am Coll Surg.* 2012; 215(4):453-466. ■

CNE/CME OBJECTIVES

After reading *Same-Day Surgery,* the participant will be able to:

- identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care;
- identifiy how current issues in ambulatory surgery affect clinical and management practices;
- incorporate practical solutions to ambulatory surgery issues and concerns into daily practices.

SAME-DAY SURGERY

CNE/CME INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.
2. Scan the QR code to the right or log on to the AHCMedia.com site to take a post-test. Go to "My Account" to view your available CE activities. First-time users will register on the site using the subscriber number on their mailing label, invoice, or renewal notice.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the test, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. A credit letter will be e-mailed to you instantly.

CNE/CME QUESTIONS

1. What does Greg Brison, director of emergency management and security at Inova Fairfax Hospital, advise regarding clinical care that must go on during a lockdown?

A. You should arrange in advance to have police officers available to escort and guard clinicians.
B. The care should be provided only if staff do not have to move from their shelter-in-place position.
C. Patients needing care should be transported out of the building.
D. Clinicians should proceed with providing care and call for help if needed.

2. What were some of the lessons learned from a recent lockdown at Inova Fairfax Hospital involving a bank robber who escaped?

A. Provide access and information to local law enforcement ahead of time.
B. Standardize how you name entryways.
C. Use high visibility clothing for prisoners.
D. Prepare for media arriving at your campus and other areas.
E. All of the above

3. In the pilot study for the AHRQ *Ambulatory Surgery Center Survey on Patient Safety Culture*, which area showed the most room for improvement at ASCs?

A. Staffing, Work Pressure and Pace
B. Communication Openness
C. Response to Mistakes

4. In the case involving comments made by anesthesiologist Tiffany M. Ingham, MD, during surgery, what part of the jury award does her employer have to pay?

A. $50,000 of the $200,000 in punitive damages
B. All of the $200,000 in punitive damages
C. $100,000 of the $200,000 in punitive damages
D. None of the punitive damages

SDS ACCREDITATION UPDATE

Covering Compliance with TJC, AAAHC, AAAASF, and Medicare Standards

Outpatient surgery managers are in a tough place regarding how to handle multiple-dose vials

CMS changes wording to states, and surveyors are taking note

When it comes to the sensitive issue of using one vial on one patient, do you feel as if you're in a no-win position? If so, you're not alone.

"On one hand is the need to adhere to DEA [Drug Enforcement Administration] and CMS guidelines, and on the other hand the cost and the waste costs associated with 'one patient/one-vial' standards, means that we are clearly wasting a valuable and limited-supply medication that could cause other patients to be denied care," says **Mark Mayo**, CASC, executive director of Golf Surgical Center in Des Plaines, IL.

Ambulatory surgery centers have the additional challenge that short-supply medications go first to hospitals "where inpatient needs trump any elective outpatient need," Mayo says. "Patient care can be compromised when less effective medications must be substituted."

> "PATIENT CARE CAN BE COMPROMISED WHEN LESS EFFECTIVE MEDICATIONS MUST BE SUBSTITUTED."

Cost is also an issue, he says. "Manufacturers must, out of supply-cost necessity, charge significantly more for true single dose vials, ampules, which will drive the cost per patient higher," Mayo says.

He acknowledges the other side of the issue. "… [T]here is always some increased risk of incorrect draw procedures, mislabeling, and even contamination or dilution caused by illegal diversion of some open medications — a drug-dependent person could easily draw out from a bottle and replace it with water or another possibly contaminated liquid — and possible failure to adhere to strict standards," says Mayo, referring to standards such as those to check the vial, disinfect the stopper, label drawn syringes, and always verify both the manufacturer's expiration date and the 28-day expiration date. There can be failure to have proper storage under control, such as medications being locked away, and failure to have enhanced quality surveillance in which managers look for any patterns of cross-contamination, illness, injury, or apparent lack of potency due to possible illegal drug diversion.

"Obviously, the ideal is for the provider to open sealed medication, draw, label if not immediately used, administer, and discard unused portion, so there is no possibility of error or distortion of the medication," Mayo says. However, he and others acknowledge that providers "are wasting most of the drug order to achieve absolute safe control, which could still be subject to illegal diversion should a drawn syringe be switched out by a drug-abusing staffer." Mayo also adds that manufacturer-labeled uses must be followed. If it says "For single patient use," that is how it must be administered, he says, and unused portions must be wasted.

On top of all of these concerns, there is updated guidance from CMS and increased interest from surveyors.

Jan Allison, RN, CHSP, of Washington, OK,

Financial Disclosure:

Executive Editor Joy Dickinson and Board Member and Nurse Planner Kay Ball report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Mark Mayo reports that he is executive director of Golf Surgical Center and executive director and a retained consultant of the ASC Association of Illinois. Physician Reviewer Kirby Scott, DO, discloses that he is a consultant, stockholder, and on the speakers bureau for Entellus Medical.

EXECUTIVE SUMMARY

Outpatient surgery providers face new scrutiny from CMS and accreditation surveyors regarding the handling of multiple-dose vials.

- Dedicate a multi-dose vial to a single patient whenever possible.
- Some facilities, on a case-by-case basis, opt to make a judgment in the best interest of patients, while considering the drug entity, the emergent status of need, and whether alternative drugs exist, in collaboration with the medical director and/or the anesthesia provider.

director of accreditation and survey readiness for Surgical Care Affiliates, says, "The proper use of multi-dose vials is one of the key infection control practices monitored by surveyors since misuse of medication vials was identified as a significant cause of outbreaks of infectious diseases in patients throughout the healthcare industry."

Subsequently surveyors have increased their awareness of the additional steps needed to ensure multi-dose vials aren't contaminated when used for more than one patient, Allison says. "As surveyors have more recently become better educated, they have been placing more focus on these additional steps," she says.

In a letter from CMS to its state survey agency directors, the agency spells out changes to the *Ambulatory Surgical Center Infection Control Surveyor Worksheet* and its *Manual Instructions*. The changes to instructions to surveyors for injection practices includes an "unable to observe" selection, in addition to "yes" and "no." The instructions say the following:

"If 'unable to observe' is selected, please clarify in the surveyor notes box why it was not observed and attempt to assess by means of interview or documentation review. NOTE: Some types of infection control breaches, including some specific to medication administration practices, pose a risk of bloodborne pathogen transmission that warrant engagement of public health authorities. When management review confirms that a survey has identified evidence of one or more of the breaches described in Survey & Certification (S&C): 14-36-All, in addition to taking appropriate enforcement action to ensure the deficient Medicare practices are corrected, the State Agency should also make the responsible State public health authority aware of the identified breach."

The instructions include the following (new wording is in italics):

- "B. Syringes are used for only one patient *(this includes manufactured prefilled syringes)*.
- "C. The rubber septum on a medication, *whether unopened or previously accessed,* vial is disinfected with alcohol prior to piercing.
- *"H. The ASC has voluntarily adopted a policy that medications labeled for multi-dose use for multiple patients are nevertheless only used for one patient. (Note: a "No" answer to question H. does not indicate a breach in infection control practices and does not result in a citation. However, a "No" response to either or both of the related questions I and J should be cited).*
- *"J. Multi-dose medication vials used for more than one patient are stored appropriately and do not enter the immediate patient care area (e.g., operating room, anesthesia carts)." (To access all of the changes, go to http://go.cms.gov/1D9wRcO.)*

"In an ambulatory surgery center, the immediate patient treatment area is defined in the preoperative and postoperative units as the patient bedside, but in the operating room or procedure room, this involves the entire space," Allison says. The reason for this practice is to prevent someone inadvertently contaminating the vial through contact, direct or indirect, with surfaces or equipment that could be contaminated, she says. "So this can make it particularly challenging during a procedure when the anesthesia provider accesses a multi-dose vial for a patient in the operating or procedure room and can no longer use that vial for multiple patients," Allison says. "The medication vial must be dedicated to that patient only." Have a significant amount of medication left in the vial? It ends up being wasted, she says.

Sheldon Sones, RPh, FASCP, a pharmacy consultant based in Newington, CT, points to a changing dynamic over recent years. "… [T]he standards are very clear that multiple-dose vials used in patient care areas are to be used for single patients only," Sones says. He says that vials not used in direct patient areas should be dated, and the expiration date should be at 28 days. "Of course, the chronic problem with drug shortages has exacerbated the efforts to remain compliant with the standard and at the same time meet the immediate needs of patients, Sones says. *(See story in this issue on how to handle drug shortages.)*

In the facilities with which Sones consults with, he emphasizes the established standard because of the problems linked to mishandling of multiple-dose vials. "However, there is that delicate balance that we must be sensitive to," he says. The trend is toward a single-dose model for medications within sterile environments and in proximity to patients.

"Certainly, if I was an anesthesia provider, I would be reluctant to use a multiple-dose vial handled by another provider on a previous case or day," Sones says. "I would be taking responsibility for the integrity of the product and could not comfortably do so if the product was not under my direct control from the time of opening." ■

What do you do about multi-dose vials when you have a drug shortage?

Drug shortages are increasing, so outpatient surgery programs must develop strategies for dealing with them, advises **Jan Allison**, RN, CHSP, of Washington, OK, director of accreditation and survey readiness for Surgical Care Affiliates.

"A challenge is determining if the facility is able to establish a process that complies with the guidelines for accessing the multi-dose vial outside the immediate patient care area," Allison says. Don't use the product beyond the designated expiration date, she says. *(See more information about Allison's position in story included in this issue.)*

Sheldon Sones, RPh, FASCP, a pharmacy consultant based in Newington, CT, often is asked what to do about discarding partially used vials if products aren't available or are in short supply.

"I continue to reiterate the standard," Sones says. "Yet what some facilities have opted to do is to, on a case-by-case basis, make a judgment in the best interest of patients considering the drug entity and the emergent status of need, whether alternative drugs exist, in collaboration with the medical director and/or the anesthesia provider." [*See Sones' sample policy enclosed with this month's online issue of* SDS. *For assistance, contact our customer service department at (800) 688-2421 or customer.service@AHCMedia.com. This policy is presented to facilitate discussion.* SDS *doesn't advocate any practice that is in opposition to Drug Enforcement Administration or accreditation standards.]*

Sones points out that some vials that appear to be multiple dose are, in fact, single-dose vials. He points to esmolol (Brevibloc) and metoprolol, as well as configurations of lidocaine, bupivacaine, and propofol.

"On entry into a multiple-dose vial, it should be swabbed with an alcohol swab using friction," Sones says.

Regulations need to change and procedures need to be put into place so valuable medications aren't wasted, says **Mark Mayo**, CASC, executive director of Golf Surgical Center in Des Plaines, IL.

Sones "Option B" policy includes the following wording: "If, in the opinion of medical, clinical, and administrative leadership, multiple dose vials [MDV] must be maintained in the facility and utilized within patient care areas, by consensus conclude that patient access would be denied and thus compromise patient care if MDV drugs in short supply are routinely discarded after each patient use in said patient care areas, the facility may opt to temporarily and judiciously maintain these MDV."

Mayo says, "I suspect that some providers already follow Option B out of necessity, not out of greed, because medication shortages are a real, and weekly, problem in healthcare delivery." ■

Follow these standards, director recommends for outpatient surgery programs

What should outpatient surgery managers do when it comes to multi-dose vials? Adhere to national recognized guidelines, recommends **Jan Allison**, RN, CHSP, of Washington, OK, director of accreditation and survey readiness for Surgical Care Affiliates.

"The identified best practices are most commonly resourced from the Centers for Disease Control and Prevention and the United States Pharmacopeia General Chapter 797," Allison says. The standards are built into government requirements and accreditation standards. "They exist to reduce/prevent the risk of serious disease transmission," she says. Allison says the standards include:

- Dedicate a multi-dose vial to a single patient whenever possible.
- If using a multi-dose vial for more than one patient, do not store or access in the immediate patient treatment area.
- If storing or accessing a multi-dose vial in the immediate patient treatment area, dedicate the vial to that patient only and discard after use.
- Always access the medication in a multi-dose vial with a new, sterile needle and syringe each time.
- Use aseptic technique when accessing multi-dose vials, and ensure the diaphragm of the vial is cleansed appropriately with alcohol or other approved antiseptic.
- Discard the multi-dose vial whenever sterility is compromised or questionable.
- Date and discard an opened or accessed multi-dose vial within 28 days unless the manufacturer specifies a different date for that opened vial.
- Discard an unopened or non-accessed multi-dose vial according to the manufacturer's expiration date. ■

CMS addresses false fingernails and immediate-use sterilization

In a letter from the Centers for Medicare and Medicaid Services (CMS) to state survey agency directors, the agency spells out changes to the *Ambulatory Surgical Center Infection Control Surveyor Worksheet* and its *Manual Instructions* for areas including artificial fingernails and immediate use steam sterilization. New CMS wording on artificial fingernails says, "Personnel providing direct patient care do not wear artificial fingernails and/ or extenders when having direct contact with patients."

Marcia Patrick, MSN, RN, CIC, a surveyor for the Accreditation Association for Ambulatory Health Care and a consultant in infection prevention, based in Tacoma, WA, was "thrilled" to see this change. "That particular piece is long overdue," Patrick says. "We know from studies that people with false nails grow a huge, much broader range of bacteria, as well as many, many more times the number of organisms than short natural nails."

Now facilities have federal clout to put behind regulations prohibiting their use, she says.

CMS also made changes to requirements concerning immediate-use steam sterilization, or what formerly was referred to as "flash" sterilization. "They're very, very specific on how to do that," Patrick says. "That's another very good clarification."

Here are the CMS changes:

Is immediate-use steam sterilization (IUSS) performed on-site? If IUSS is performed, all of the following criteria are met:

• Work practices ensure proper cleaning and decontamination, inspection, and arrangement of the instruments into the recommended sterilizing trays or other containment devices before sterilization.

• Once clean, the item is placed within a container intended for immediate use. The sterilizer cycle and parameters used are selected according to the manufacturers' instructions for use for the device, container, and sterilizer.

• The sterilizer function is monitored with monitors (e.g., mechanical, chemical and biologic) that are approved for the cycle being used.

• The processed item must be transferred immediately, using aseptic technique, from the sterilizer to the actual point of use, the sterile field in an ongoing surgical procedure.

Note: "Immediate use" is defined as the shortest possible time between a sterilized item's removal from the sterilizer and its aseptic transfer to the sterile field. A sterilized item intended for immediate use is not stored for future use, nor held from one case to another. IUSS is not equivalent to "short cycle" sterilization performed in accordance with manufacturers' IFUs. IUSS must not be a routine or frequent practice in the ASC.

Immediate-use steam sterilization is NOT performed on the following devices:

• Implants.

• Post-procedure decontamination of instruments used on patients who may have Creutzfeldt-Jakob disease or similar disorders.

• Devices that have not been validated with the specific cycle employed.

• Single-use devices that are sold sterile.

Is IUSS performed on a routine basis? (A "Yes" answer must be cited as a deficient practice in relation to 42 CFR 416.51(a).

A final change from CMS involves chemical indicators:

A chemical indicator (process indicator) is placed correctly, as described in manufacturer's instructions for use, in the instrument packs in every load. A biological indicator is used at least weekly for each sterilizer and with every load containing implantable items, as evidenced by ASC documentation (i.e., log). ■

Portal addresses environmental challenges

The Joint Commission and the American Society for Healthcare Engineering have launched a Physical Environment Portal to provide free online resources and tools for healthcare facilities to be compliant with the eight most challenging Life Safety and Environment of Care standards. While the portal is primarily geared toward hospitals, several modules will be relevant to ambulatory surgery centers.

The portal will highlight the eight LS/EC standards cited most frequently for non-compliance. Each standard will be highlighted in modules that are two months in length. The first month focuses on the requirements and compliance. The second month focuses on resources to help evaluate the organization's level of compliance. A new module is posted every two months, with the previous ones remaining on the site.

The portal is housed on The Joint Commission website (http://bit.ly/1IpYevE). ■

Option B

Subject: **Multiple Dose Vials**

Policy: The facility is mindful of the standards of best practice regarding the usage of multiple dose vials (MDV) in health care settings, as enunciated by several agencies, such as the CDC. So stated, multiple dose vials are designed for repeated entry for single patients in patient care areas. Throughout the facility, there will be an effort to **minimize the use of MDV except where necessary due to availability limitations.**

Procedure:
1] Multiple Dose Vials (MDV) are those vials so-labeled by the manufacturer
2] Entry into MDV shall be via use of careful technique, including alcohol swabbing of rubber stopper with friction prior to entry.
3] The nurse or physician shall make a physical inspection of the MDV for second and subsequent entries prior to re-entry
4] *When MDV must be maintained in the facility, outside of patient care areas,** the vial is dated with the expiration date which shall be twenty eight (28) days after the initial entry. The vial is deemed "outdated" by the 28-day rule, or, the manufacturer's printed expiration date/ beyond use date, whichever occurs first. When a MDV is opened and accessed in an immediate patient care area, the vial is dedicated for use for that patient only. Any unused medication from said vial is appropriately discarded. If feasible, access to MDV performed outside a direct patient care area, permits application of the 28 day rule, as enunciated in items 3 & 4 above.
5] Medications shall be drawn as close to the time of administration as feasible and within one (1) hour. These shall be properly labeled, including the drug, strength, date, time drawn, and initials of the person preparing syringe. Drugs in syringes that are immediately administered and not placed on a tray or other location, require no labeling if they are the sole preparation being handled at one time.
6] The facility encourages single anesthesia provider use of each MDV, recognizing the inability to attest to prudent management by a previous provider
7] If, in the opinion of medical, clinical, and administrative leadership, multiple dose vials must be maintained in the facility and utilized within patient care areas, by consensus conclude that patient access would be denied and thus compromise patient care if MDV drugs in short supply are routinely discarded after each patient use in said patient care areas, the facility may opt to temporarily and judiciously maintain these MDV.

*** CDC, WHO, and Medicare define patient care area as "operating room, procedure room, and patient examination areas."**

SSS: 06/12 Revised 4/14

Source: Sheldon S. Sones, RPh, FASCP, pharmacy consultant, Newington, CT.

Same-Day Surgery

Confidential Salary Survey

This confidential salary survey is being conducted to gather information for a special report. Watch in coming months for your issue detailing the results of this survey and the overall state of employment in your field.

Instructions: Select your answers by filling in the appropriate bubbles completely. Please answer each question as accurately as possible. If you are unsure of how to answer any question, use your best judgment. Your responses will be strictly confidential. Please do not put your name or any other identifying information on this survey form.

1. What is your current title?

- ◯ A. Director/CEO
- ◯ B. Administrator
- ◯ C. Ambulatory Surgery Manager
- ◯ D. Nurse Manager
- ◯ E. Other _____

2. What is your highest degree?

- ◯ A. LPN
- ◯ B. ADN (2-year)
- ◯ C. Diploma (3-year)
- ◯ D. BSN
- ◯ E. MSN
- ◯ F. MS
- ◯ G. Masters/Other
- ◯ H. PhD
- ◯ I. MD
- ◯ J. Other _____

3. What is your age?

- ◯ A. < 25
- ◯ B. 26-30
- ◯ C. 31-35
- ◯ D. 36-40
- ◯ E. 41-45
- ◯ F. 46-50
- ◯ G. 51-55
- ◯ H. 56-60
- ◯ I. 61-65
- ◯ J. 66+

4. What is your annual gross income from your primary healthcare position?

- ◯ A.< $30,000
- ◯ B. $30,000 - $39,999
- ◯ C. $40,000 - $49,999
- ◯ D. $50,000 - $59,999
- ◯ E. $60,000 - $69,999
- ◯ F. $70,000 - $79,999
- ◯ G. $80,000 - $89,999
- ◯ H. $90,000 - $99,999
- ◯ I. $100,000 - $129,999
- ◯ J. $130,000 or more

5. Where is your facility located?

- ◯ A. Urban area
- ◯ B. Suburban area
- ◯ C. Medium-sized city
- ◯ D. Rural area

6. In the last year, how has your salary changed?

- ◯ A. Salary decreased
- ◯ B. No change
- ◯ C. 1% - 3% increase
- ◯ D. 4% - 6% increase
- ◯ E. 7% - 10% increase
- ◯ F. 11% - 15% increase
- ◯ G. 16% - 20% increase
- ◯ H. 21% increase or more

7. What is the work environment of your employer?

- ◯ A. Hospital-based
- ◯ B. Freestanding, hospital-affiliated
- ◯ C. Freestanding, independent
- ◯ D. Freestanding, part of chain
- ◯ E. Office-based

8. How long have you worked in healthcare?

- ◯ A. Less than 1 year
- ◯ B. 1-3 years
- ◯ C. 4-6 years
- ◯ D. 7-9 years
- ◯ E. 10-12 years
- ◯ F. 13-15 years
- ◯ G. 16-18 years
- ◯ H. 19-21 years
- ◯ I. 22-24 years
- ◯ J. 25+ years

9. In the past year, how has the number of employees in your department changed?

- ◯ A. Increased
- ◯ B. Decreased
- ◯ C. No change

9. If you work in a hospital, what is its size?

- ◯ A. < 100 beds
- ◯ B. 100-200 beds
- ◯ C. 201-300 beds
- ◯ D. 301-400 beds
- ◯ E. 401-500 beds
- ◯ F. 501-600 beds
- ◯ G. 601-800 beds
- ◯ H. 801-1,000 beds
- ◯ I. > 1,000 beds
- ◯ J. I don't work in a hospital

Deadline for Responses: Nov. 2, 2015

Thank you very much for your time. The results of the survey will be reported in an upcoming issue of the newsletter, along with an analysis of the economic state of your field. Please return this form in the enclosed, postage-paid envelope as soon as possible.

If the envelope is not available, mail the form to: AHC Media LLC, P.O. Box 550669, Atlanta, GA 30355.