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INSIDE

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Patient Surveys Are About to Get a Lot More Complicated

The form is rather lengthy — and there are no e-form options

A Hickory, NC, surgery center's experience with patient satisfaction surveys is fairly typical. The organization sends an automatic email link to patients after discharge. Those who respond answer 10-12 questions, ending with the question, "Would you recommend this facility?" The whole process could take five to 10 minutes.

"All the results are calculated and sent back to us on a monthly and quarterly basis. They're summarized into the quarterly report, too," says **Kathy Kelly**, RN, MSN, CNOR, administrator of Viewmont Surgery Center in Hickory.

This soon will change. The Centers for Medicare & Medicaid Services (CMS) is requiring ambulatory surgery centers (ASCs), as of Jan. 1, 2018, to conduct patient experience surveys either on paper or by phone, or a combination of both. They must use one of 21 CMS-certified vendors, and an electronic option is not yet available. Each survey contains 37 questions required by CMS, and each ASC can add up to 15 of their own. As of late May, the deadline was intact, although it could be postponed or cancelled by CMS. ASCs must report quality of care data for standardized measures to receive the full annual update to their ASC annual payment rate.

> CMS IS REQUIRING ASCS, AS OF JAN. 1, 2018, TO CONDUCT PATIENT EXPERIENCE SURVEYS EITHER ON PAPER OR BY PHONE, OR A COMBINATION OF BOTH.

It's called the OAS CAHPS, which stands for the Outpatient and

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Ambulatory Surgery Survey and the Consumer Assessment of Healthcare Providers and Systems. HHS began developing the survey in 2012 and provided opportunities for ASCs and others to comment on the proposed rule. The ASC Quality Collaboration, which spearheads measure development activities for the industry, was involved throughout the survey development process. The collaboration proposed ways to shorten the survey and make its administration less burdensome for facilities, says **Kara Newbury**, JD, regulatory counsel for the Ambulatory Surgery Center Association (ASCA) of Alexandria, VA.

"The ASC QC and ASCA are aligned in our desire to promote a patient satisfaction survey that provides meaningful data to patients, ASCs, and CMS," Newbury says.

A 37-question survey would be a very long survey to fill out by mail or to answer by phone, she adds.

"Most facilities currently use a patient satisfaction form that is much shorter than this, and they probably include questions more specifically geared toward patient satisfaction — as opposed to patient experience," Newbury says. "Some people don't understand the difference between the two, but there are different ways those questions are written."

Experience and satisfaction are not the same, as CMS notes in CAHPS.

"Patient experience surveys sometimes are mistaken for customer satisfaction surveys," Newbury says. "Patient experience surveys focus on how patients experienced or perceived key aspects of their care, not on how satisfied they were with their care."

For instance, a patient satisfaction survey might ask patients to rate their pre-op nurse on a scale of one to five. A patient experience survey might ask patients whether or how they experienced critical aspects of health care, including communication with their doctors, understanding their medication instructions, and the coordination of their healthcare needs. "They do not focus on amenities," Newbury says.

The focus on patient experience might work well, but ASCs have reason to worry about the survey's length and lack of an electronic option. People are so accustomed to the convenience of electronic surveys that a paper or telephone survey might not deliver the same response rate. Plus, an electronic survey would be less costly to ASCs, Newbury notes.

The OAS CAHPS Survey — for both mail and telephone

EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services (CMS) will require ambulatory surgery centers (ASCs) to conduct patient experience surveys through certified vendors, as of Jan. 1, 2018.

- Each survey contains 37 required questions, with up to 15 optional questions set by the center.
- The approved modes of delivering surveys are paper and telephone calls, or a combination of the two.
- The Ambulatory Surgery Center Association has asked CMS to delay implementation and provide an electronic survey option.

administration — is available in English, Spanish, and Chinese, according to the protocols and guidelines manual on the OAS CAHPS website.

Hospital outpatient and ambulatory surgery sites are not permitted to translate the survey into other languages, but CMS will provide additional translations over time, Newbury says.

If patients being surveyed are concerned about the confidentiality and privacy of their information and responses, survey vendors can reassure them that no responses are linked to an individual patient and participation in the survey will not affect the care or health care benefits they receive, according to the confidentiality and data security section of CMS' OAS CAHPS' protocols and guidelines manual.

CMS was concerned that some patients would not have email or the skills needed to access an electronic form, she notes.

"I disagree with that," Newbury says. "I have data from [some older] members. It doesn't matter the age group. The success rate for electronic forms is pretty good."

Viewmont Surgery Center's survey response rate has trended upward to about 35% this past year, Kelly says. "I definitely think that response rate would go down if the form was longer."

The trouble is that CMS is requiring ASCs that perform 240 Medicare cases per year to collect 300 completed surveys. If their response rate is low, this means they'll need to survey many more patients than they might otherwise survey. They can survey any patient, including non-Medicare patients. And if the facility does not think it's possible to achieve 300 completed surveys, it must survey all eligible patients, Newbury notes.

ASCA sent a letter, signed by ASCA CEO Bill Prentice, to U.S. Secretary of Health and Human Services (HHS) Tom Price, MD, on April 21, requesting relief from the regulatory burden associated with the OAS CAHPS.

"While we strongly support quality reporting, we fear that the cost and administration burdens associated with this survey may discourage ASCs from participating in the Medicare program," the letter reads.

ASC also asked Price to consider adding an electronic survey option to the paper and phone methods approved by CMS. The new rule would cost the average ASC about $6,000, Newbury says.

"Once an electronic option is approved, this will significantly cut down on the costs for our facilities, and provide more actionable data since the number of patients surveyed can be increased exponentially," the letter reads.

ASCs might be more willing to collect more than the minimum number of completed surveys required if the cost per survey were not as high as it is with the telephone and paper surveys, Newbury says.

"ASCA has been advocating for many different things with regards to the survey, but specifically for the survey to be made shorter," she says. "And we've advocated for an electronic option."

At the very least, ASCA hopes HHS will delay the survey's implementation.

"We believe that Secretary Price, being an orthopedic surgeon by background, understands the burden this could place on our facilities," Newbury says. "We are optimistic that we might get some reprieve, whether it be a short delay, or they re-evaluate the length of the survey, or they allow an electronic option."

One positive change related to the OAS CAHPS is that ASCs will be able to compare themselves to hospital outpatient departments, since everyone will be using the same survey, says **Kathy Wilson**, RN, MHA, vice president of quality for AmSurg.

"That's something we have not been able to do before," Wilson says.

AmSurg participated in a CMS pilot of the new survey in 2014. The organization already had been using paper surveys, so that wasn't an issue, Wilson says.

"We are able to talk to patients and say they may receive a survey, and it's important to us to gather that information from them," she says. "Sometimes, if you connect with patients ahead of time and tell them why it's important to you, they may be more apt to fill it out."

CMS voluntarily collected data with 100 facilities, and the overall response rate was 39%, Newbury says.

"The results were higher than I would think you would get with such a cumbersome long form," she adds.

Vendors will handle most of the work necessary to make the surveys successful. But ASCs will need an information technology expert to help with the initial task of uploading the file to the survey vendor. The patient lists can be submitted electronically, but there is some work necessary to get the reports built, Wilson says.

"You have to meet file specifications that come from the survey vendor, and you have to build a report out of a billing system to meet those filing specifications," she explains. "An IT person, working with the billing vendor, can bridge the billing vendor with the survey vendor."

Some ASCs will take the rest of 2017 to find a survey vendor and get started on a voluntary, pilot basis with the change. Others will wait and see if HHS will announce a delay to

implementation, Newbury says.

All ASCs should at least explore the new survey process and learn what they can do before committing to a vendor, she adds.

"The questions asked in the new survey are vastly different, so learning how patients are going to respond to the questions in this survey might take some time," she says.

"We're very supportive of quality reporting, and we're not opposed to some sort of survey that will allow patients to compare across sites of service," Newbury says. "We're just not sure — given lengths and modes of operation — whether this is the appropriate tool." ■

Recent Hospital Kidnapping by Gunman Highlights Need for Active Shooter Plan

In mid-May, a prisoner in a hospital ED in Geneva, IL, overpowered a guard, grabbed his gun, and held two nurses hostage. He was shot and killed after negotiations failed and a SWAT team moved in.

The nurses were unharmed physically, but emotionally distraught, according to a report.[1]

The wrong thing for an ASC team to think after reading about this type of incident is "it can't happen here," active shooter training specialists say.

When security and risk consultant **Lee Eaves** of Nashville, TN, recently spoke to a group of ASC directors and staff about how to prevent active shooting incidents, he was shocked at how many people said their ASCs had treated people in criminal custody.

"What can you do to minimize the risk?" Eaves says. "You probably should have a VIP program and use that program to have prisoners go through the back entrance or a secluded elevator, keeping them out of the main lobby and out of sight of other patients within the center."

If law enforcement brings an inmate to an ASC for surgery, another strategy is to be alert for the number of security officers escorting that person. If only one security officer arrives with the inmate, then an ASC director should ask that the surgery be rescheduled until a second officer is available as well, says Eaves, who worked for the Secret Service for 10 years, corporate security for five years, and also has worked as a flight paramedic.

"If someone in custody presents themselves for glaucoma or cataract surgery and they're six-foot-seven and 300 pounds, and you don't feel security is adequate, make a phone call and request more security," he says. "If you don't feel comfortable with the situation, then make sure law enforcement has provided adequate support staff to ensure the ASC is safe and security is maintained."

Active shooting incidents happen, on average, once a day in the United States. Healthcare settings, schools, churches, and other public places are vulnerable targets. Most active shooters are men with a history of mental instability.[2]

Several things make ASCs a potential target for gunmen, such as stashes of pain medication someone might desire to steal, says **Ken Alexandrow**, founder of Agape Tactical, an organization that educates and trains individuals, families, churches, and businesses in self-protection.

Another issue, which is a possibility for any employer, is that a member of the staff is involved in a romantic relationship with someone who is violent. A third possibility is that a disgruntled patient or former employee would seek revenge for perceived wrongs.

Eaves and Alexandrow offer the following suggestions for how ASCs might prepare for and prevent an active shooter event:

• **Prevention is the answer.** In cases like the incident of a prisoner kidnapping nurses, the only good solution is prevention, Eaves says.

EXECUTIVE SUMMARY

ASCs and other healthcare organizations are vulnerable to active shooter scenarios, so they should prepare for these by learning prevention strategies.

- To minimize risk, any inmate who arrives at an ASC for surgery should be treated according to VIP processes, entering through a back door.
- ASCs should create an open communication environment, encouraging staff to speak up if they have domestic issues that could spill over into the workplace.
- ASCs should take all threatening emails, calls, or letters seriously and monitor the person's social media behavior.

"Mitigating the threat on the front end is the only thing you can do," he explains. "And the way to do that is by having adequate guards and limiting movements."

There are times when surgery centers are asked to treat inmates. When this occurs, they should keep in mind that some prisoners will see this as an opportunity to escape. So in planning for this event, ASCs should create a special plan or enact their VIP plan, Eaves says.

For instance, a VIP plan might require certain patients enter through a back or side door so they do not have to be seen in the lobby. The inmate also should enter that way. Surgery centers also should make certain the inmate's facility does not tell the patient in advance where the surgery will take place. This could prevent the inmate collaborating with an outside contact to escape.

The foundation of active shooter prevention rests on three pillars: deter, detect, deny.

"Deterrent is largely psychological," Alexandrow says. "If someone wants to attack a building, but there are security controls like a buzzer to get in and cameras, you deter them before they even try."

Detection involves putting in place early warning systems, including cameras or security guards, that detect an active shooter before the person enters the building, Alexandrow explains.

A threatening email or letter also can be detected and red flagged.

Denial is up to the individual industry or business, but it can involve hiring armed guards or equipping certain staff with weapons.

"Some doctors are arming themselves, and they are well-trained, taking training multiple times a year," Alexandrow says. "Their weapon is always accessible within a few steps."

Also, professionals can teach staff how to fight back by throwing chairs, books, clipboards, bottles of water, or anything they can reach, Alexandrow says.

"Throw and distract the shooter until you can neutralize the threat," he suggests.

• Develop an open communication culture. Domestic violence accounts for a sizeable number of active shooter situations. An angry, estranged husband or boyfriend seeks out the woman and kills other people in the process.

Employers must know when an employee is going through a difficult divorce or has experienced domestic violence. The best way to be aware is to create an open communication culture in which employees feel safe sharing this kind of information, Alexandrow says.

An ASC's policies and procedures should state that reporting information like this will not cause workers to lose their jobs, he says.

"One of the most important things you can do is eliminate the gossip and have an open, inviting environment to say, 'I want to talk to you about this,'" Eaves says.

ASC directors or human resource departments should tell staff that if they experience domestic violence, stalking, or threats of violence, they need to speak with a designated ASC person about it. "If they keep that information to themselves, then the business can't prepare for it," Alexandrow says.

A supervisor or HR director could meet with the employee and ask, "I don't want to pry into your life, but are you OK? Is there anything you want to talk with someone about?" Eaves suggests. "It's OK to pull someone aside and say, 'Are you OK? Is there anything I can do for you?' That can be the discussion and open the door to their talking."

• Monitor pre-attack behavior. If an ASC receives an ominous or threatening email or letter from an unhappy patient or angry ex-employee, the organization should take it seriously and monitor the person's social media behavior, Eaves says.

"So many times there is pre-attack behavior, stalking or threatening behavior on social media," Eaves says. "So many times, we see the news and see underlying mental health issues, or there is someone with a high emotional load."

Emotional load is like a bridge that has a certain weight limit. If someone puts on more weight than the bridge can hold, it will crumble, he says.

"I don't believe you one day wake up and by lunch, you're an active shooter," Eaves says. "What does happen is a person goes through a divorce and then tremendous financial strain; they've lost their support system, lost a loved one, and feel like a failure."

The ASC's outstanding surgery bill could be the final emotional load that breaks a person.

Employers might feel it is "big brother" behavior to monitor social media, but it's acceptable to do so when there's a potential threat.

"We might look at Facebook or social media that is open to the public. A simple Google search for someone's name can [turn up] quite a bit of information," Eaves says.

Small organizations that cannot afford to hire staff to monitor social media accounts can hire outside professionals to do so. That's what large corporations do on a regular basis, he says.

Security experts can monitor behavior of threatening individuals and suggest a course of action. For

instance, if the threat came from an unhappy client, the answer might be to forgive the person's medical bill, making the threat disappear, he suggests.

• **Teach staff to recognize precursors to an attack.** After a major shooting tragedy, police and media usually find that there were warning signs that no one caught. For example, a jealous romantic partner might say something like this verbally or by text: "If I can't have you, then no one else can," Alexandrow says.

"That's one of the most common phrases, but we can't overlook it anymore," he adds.

Other precursors include stalking or excessive texting. The partner or spouse might show up at the workplace uninvited.

"The thought is, 'I'm going to catch you cheating on me with the doctor or someone,'" Alexandrow says.

"In my 26 years of law enforcement, the most violent cases were domestics because it's passionate," he notes. "When a woman is stabbed 16 times, we don't look for a stranger; we look for the husband or boyfriend."

Staff could explain to employees that common phrases can take on a different meaning depending on how they're said.

"Someone says, 'I love you, and I can't live without you,'" Alexandrow explains. "That's a common phrase, but if you hear in their voice that creepy factor, you might hear the person's meaning: 'I can't live, and I might take you with me.'" ■

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Data Collection with Benchmarking Provides Great Quality Improvement Opportunity

Technology makes it easier, affordable

Quality improvement projects in ASCs have not always benefited from data collection and benchmarking. Not so many years ago, small healthcare organizations could not afford the manpower and platform resources necessary for data collection and comparison.

Fortunately, technology has made it possible for ASCs to extract and analyze data efficiently and quickly.

"By extracting data, we were able to see how we were performing," says **Michelle George**, RN, MSN, CASC, group director of clinical services for Surgical Care Affiliates of Deerfield, IL.

"Initially, we were doing internal benchmarking, looking at our own performance from year to year," she says. "External benchmarking is the next level of saying, 'I'm doing pretty good. How do I look in comparison to the ASC down the road?'"

Data collection and benchmarking are the first steps of a strategy that helps organizations either maintain their current performance or drive it to the next level, George says.

The Ambulatory Surgery Care Association (ASCA), state associations, and ASC Quality Collaboration efforts have helped ASCs compare their own performance to their peers.

"They've helped put together data warehouses where 1,500-plus facilities participate, and you get a broad picture of how you are doing," George says.

It also makes networking possible.

"Once you know how you're doing compared to the rest of the world, then that allows you to say, 'How are they doing? What are they doing? And who can I call?'" she says. "Once you can do networking with the organization, it gives your data pool credibility; the larger the number, the more confidence you have, and you can network with peers and facilities like yours."

George suggests ASCs take the following steps:

1. Find your key performance indicators.

These are metrics that are most important to a facility's patients, physicians, and owners. They might include:

• What are the turnaround times?

• Do your first cases of the day start on time?

• What do patient outcomes look like?

• Are there medication errors?

• Are there surgical site infections?

• Are patients falling?

"Once you establish a baseline of what your performance metrics would be, then you have a sense of how you are doing with them," George says.

2. Identify a benchmarking organization and networking options.

"Identify the organization that can provide the external comparisons for you," George says. "If you want to look at on-time starts and turnaround times, those are efficiency metrics. So you find an organization that has those benchmarking metrics."

For instance, ASCA's benchmarking program is very comprehensive and includes operational efficiencies, as well as financial metrics and patient outcomes, she says.

"There are two good ways to determine if there are networking opportunities," George explains.

"First, talk to the benchmarking organization and ask them whether they provide training and assistance for participants so they can reach out to other folks," she adds. "Also, ask whether they host opportunities to meet and talk to other people, and ask them about their program and services."

3. Determine how to collect data.

"You may not be Excel-savvy, so do you need someone on your team to help you with that?" George asks.

Other questions to ask include:

- How do you submit data?
- How do you get data back?
- How do you present data to your audiences, such as the governing body, medical executive committee, and others?
- What do those reports look like?

"Some reports are data-rich," she says.

An organization's governing body and others will look at data and provide feedback on where the surgery center's priorities should be.

Another decision involves how to disclose data results. Besides sharing the information internally, there is some information that a facility might want to share with their customers. Some information must be reported through Medicare's Quality Reporting Program, George notes, while there might be some data that the organization will want to share. For example, if the surgery center has a 95% patient satisfaction rate, then the ASC might want to put that number on its website.

"Presenting performance results with a pictogram, graphic, or visual representative tells the story better than something narrative," George suggests. "Graphic reports provide the ability to do a side-by-side comparison, if you want to do that."

4. Use data to drive the performance improvement program.

"Hopefully, no one stops before this juncture," George says.

Ask the following quality improvement questions:

- What are we doing?
- How did we do it?
- What kind of results did we get from it?

"Quality committees are a great way to look at this data. They look at it and ask, 'How are we doing compared with the rest of the folks?'" she explains. "Also, 'If we're not doing as well and we want to be better than anyone else, how do we get there?'"

This is the start of a performance improvement or quality improvement project. An ASC performance improvement team decides to hardwire a process that is working or try a new strategy and roll it out to staff.

"Or maybe they work on something for a while and can't budget the numbers," George says. "So they try a number of things, and if they haven't gotten the desired results, they might seek additional clinical best practices from their external networks."

George offers this example of patient falls to show how the data-driven performance improvement process might work: "It's a patient harm event that no ASC wants to see, and many facilities can go years and years without one patient fall," she says. "Other facilities may have as many as four to six falls in a year. Your goal should be zero falls."

Let's say some patients have fallen at an ASC. The organization tried several changes that did not work. The ASC decides to identify the root cause of the falls to see why they're continuing to happen.

The quality committee reviews data and discovers that most of the falls occurred in the patient recovery room when patients awoke from the anesthesia and tried to dress or use the restroom.

"So, you have isolated the problem

EXECUTIVE SUMMARY

Quality improvement projects can benefit from data collection and benchmarking. Small surgery centers now can afford the resources necessary to make these happen.

- Internal benchmarking lets an organization see how it's performing year to year.
- External benchmarking lets an organization compare itself to peers.
- Benchmarking services also can include opportunities to network with peers and learn from their processes and experiences.

to your recovery area," George says. "Now that you have that level of insight into the problem, you know patients should not be getting dressed alone."

One solution would be to require a member of the staff to be available to assist the patient as needed.

"That's how you drive performance," George says. "Write a policy and educate the entire team that patients cannot get dressed or go to the restroom without an attendee or escort."

Once an organization executes these changes, the falls stop and the problem is solved, she adds.

"Then you continue to monitor falls within the recovery area, and you should see your baseline return to zero," she says.

The take-home message is for ASCs to determine what they want to measure, identify a benchmark source, determine how they'll communicate their results, and make sure they're sharing information broadly with leaders in the facility, George says.

"The more people know about it, the more engaged they are in helping you achieve your results," George says. ■

Better Communication Between Staff Can Help Prevent Medical Mistakes

Acronym tools help define processes

Worst-case surgery scenario: Surgery begins, goes well, and the patient is wheeled into recovery. Later, the ASC learns the patient underwent the procedure at the wrong surgical site.

Wrong site, wrong procedure, and wrong patient surgery problems consistently have an underlying factor: poor communication between healthcare professionals, according to the Patient Safety Network (PSNet) of the federal Agency for Healthcare Research and Quality (AHRQ). *(More information on PSNet can be found at: http://bit.ly/2pPdNiR.)*

"There are lots of ways for a breakdown in communication," says **Ann Shimek**, MSN, BSN, RN, CASC, senior vice president of clinical operations at United Surgical Partners International (USPI), based in Addison, TX.

Physicians, staff, anesthesiologists, and the scheduler must communicate about the patient during the multiple handoffs, Shimek says.

A technique that confirms communication that is thorough and can improve handoffs is ISBAR, which is:

I – Introduction, identify;

S – Situation: describe the situation;

B – Background: share the background, including allergies and medical history;

A – Assessment;

R – Recommendation.

"ISBAR is a way to confirm you're meeting all those components to ensure we're doing the appropriate handoff," Shimek says. "It improves care and reduces medical errors."

ISBAR can be used at every stage of patient-ASC interaction. For example, if the patient is sleeping too long in the recovery room, the nurse can give the physician an update on the patient's status. The update should provide a full picture of the patient's situation, she explains.

Most medical errors could have been averted through communication. For instance, a medication was ordered and it never arrived in time for a procedure. This backorder issue becomes a problem if it hasn't been communicated to the surgical team before the patient arrives, which might lead to a surgery delay. This would be a communication error, Shimek says.

Communication and a tool like ISBAR also are useful when contacting patients.

"We must make sure we identify what's important to the patient and their family so we can provide patient-centered care and make sure the patient experience is the best we can make it," Shimek explains.

Another communication tool that can be used when speaking with patients is AIDET:

A – Acknowledge the patient, greet by name, and make eye contact.

I – Introduce yourself and explain what you're going to do. "A nurse could say, 'I've been doing this for 15 years, and you're going to be in good care because I care about my patients," Shimek says. "It takes introduction to the next level, making the patient feel comfortable."

D – Duration: How long will surgery last? How long before the patient learns pathology results? "One of the biggest complaints we hear is how we make patients wait," she says.

"Everyone is challenged, so make sure we set those expectations with the patient about how long they're going to be."

E – Explanation: "Explain what you're going to be doing, the steps you'll take, and who comes in next," Shimek says. "Make sure they have a good understanding of what you're doing and why."

T – Thank you: Thank patients for entrusting their care to your facility, saying, "We value you and appreciate your coming here."

Communication that follows AIDET can take place at any time.

"When you're the pre-op nurse and setting expectations, you can do it," Shimek says. "When the nurse comes in for the IV, she can say, 'This will take a few minutes, and I'll use lidocaine.'"

The idea is to explain well enough that patients have a full understanding of the process. It might take having someone sit down with the patient, looking the patient in the eyes, and walking the person through the process — rather than just starting the IV, slamming it in, and walking away, she adds.

Following the AIDET method can provide for a much different provider-patient experience, and it helps to ensure the facility is providing excellent service, as well as quality, Shimek says.

"Everybody should be doing this," she notes. "That way, we're making sure the patient is at the center of our communication."

A third acronym tool is CUS. This one is useful to remember when someone in an ASC sees something wrong in processes or witnesses an error. CUS represents:

C – Concern: Employees might say they are concerned that they have seen something that doesn't look right. This often is all it takes to get the physician or supervisor's attention, Shimek notes. But if they don't see results, they proceed to the next step.

U – Uncomfortable: "Say, 'I'm uncomfortable,'" she suggests. Using the word "uncomfortable" is less threatening to the listener than saying, "You're making a big mistake" or "You're doing that wrong."

S – Safety: If expressing concern and discomfort are not grabbing attention and resulting in a change, then the person who witnessed the issue should say, "This is a safety issue." They also can add that the process should be stopped to check the medication or correct whatever error the person witnessed, Shimek says.

> "IT STARTS WITH THE CULTURE AT THE FACILITY, WHERE WE NEED TO MAKE SURE EVERYONE FEELS THEY ARE SUPPORTED."

"It's uncomfortable speaking up. People think they're right, and you think, 'Maybe I'm wrong,'" she explains. "Everybody in an organization needs to be empowered to speak up anytime about anything that might be wrong."

Not speaking up can result in tragedy, whereas there should be no recrimination or embarrassment for speaking up and not being correct.

"Maybe it was the right medication dosage," Shimek says. "We thank the person for speaking up, saying, 'We have the right medication, but thank you.'"

CUS was developed to give healthcare employees a practical way to intervene when they witness a problem. "If you say you are concerned, it sounds different than saying, 'You're giving the wrong medicine,'" Shimek says. "The receiver's reaction might be 'Oh, wait. Let me look. Let me check.' It's easier on both ends and not so uncomfortable."

Root cause analyses of medical errors show that even when staff witnessed a problem, they sometimes felt too intimidated to speak up. Or they might fear retaliation, Shimek explains.

"It starts with the culture at the facility, where we need to make sure everyone feels they are supported," she says. "We are very efficient. Doctors want us to move quickly, so we need to balance that with patient safety."

Other methods for improving communication include creating a communication board for staff. It might contain updates and changes in policies and regulations. ASCs also can hold a daily huddle in which one person from each department comes together to talk about how surgeries went that day: What went well? Where are there opportunities for improvement?

"Then we look back and see if we have the right equipment and right supplies," Shimek says. "A responsibility of the team that meets during the daily huddle is to take information and communicate it back to their staff."

All these methods to improve communication hinge on the surgery center's culture, she notes.

"It's about building that culture where everyone feels empowered to speak up," she says. "If you don't have that, then none of this will be successful." ■

Study Shows How ASCs Can Cut Cancellations in Half

One site: 16.8% to 8.8%

Cancellations at a pediatric ASC dropped from a rate of 16.8% to 8.8% three months after the ASC made changes that included educating staff and implementing a call log, call script, and checklist, according to a new study.[1]

The study found that directing preoperative nurses to call patients or their guardians on two separate days improved communication and preoperative screening.[1]

"It's an ongoing effort to try to keep cancellation rates down," says **Virginia C. Muckler**, DNP, CRNA, CHSE, National League for Nursing Simulation leader and an assistant professor and clinical education coordinator at the Duke University Nurse Anesthesia Program in Durham, NC.

The study, which involved a pediatric ASC, found that uniformity in the message helped with the project's success.

The call log includes the procedure, who called the family, and additional tracking items.

"Pre-op nurses use the log and document their pre-op assessments and instructions," Muckler says. "They ask if the parent/guardian has questions, and they notify them that there will be a follow-up phone call one or two days before the day of surgery."

The log is handwritten, and there is an assessment checklist. Nurses also worked from a script of uniform questions to ask patients. "The script is to make sure items of importance are pretty standard," Muckler says. "We verify that the surgeon and type of surgery planned are correct."

"We make sure the parent or guardian knows where to arrive on the day of surgery," she adds. "They tell them they need appropriate identification and an insurance card, and they make sure they advised them about symptoms."

If the patient has a fever, there is a question about symptoms and medication. Also, parents and guardians can bring in a comfort item for the child, including a teddy bear or blanket, Muckler says.

Before each surgery, ASC staff will call twice. The first call will be a week or two before surgery, and the second call will be one or two days before surgery. "They start calling at two days prior to surgery in case they are unsuccessful in reaching someone," Muckler says.

By insisting on uniformity in pre-op calls and questions, the surgery center identified things that otherwise might have been forgotten. These could be instructions that are specific to a particular type of surgical procedure. Without a checklist and script, it's easy for people to forget to discuss something important.

"Nurses often run the pre-op clinics and are not trained to the specific job they are being asked to do," Muckler says. "That's no fault of the nurses; it's a system issue."

On-the-job training is a vital part of nursing education.

When Muckler was working on a research project involving nurses, she found that most learned how to perform their jobs through trial by fire.

"They said, 'I got chewed out a lot,'" she recalls. "I knew we had a problem then."

The script proved to be very helpful, and the checklist helped standardize the routine, Muckler says.

There is another benefit to the consistent messaging and repeated calls: Patients and their families are more likely to remember what they need to do.

"I think providing them with some follow-up and reiterating these important points were important, also, in lowering cancellations," Muckler says.

Train staff on new processes like logging calls, documenting what occurred, using scripts, and following up with a second call, she suggests. These training sessions can occur at department meetings or in lunchtime learning sessions.

But it's important the training is followed by monitoring and data collection, she says. For instance, a surgery center should compare surgery cancellation rates pre-training and post-training. They can collect data on patients' stated reasons for cancellation.

For example, sometimes surgeries have to be rescheduled by the family because of a personal or work event. Other times, the surgeon has to reschedule. There are rare occasions when the family did not follow the food and medication instructions, and surgery is postponed for this reason, Muckler says.

After the process was implemented, families were better informed about the surgery, and cancellations declined, she adds.

Preventing surgery cancellations

is a big issue, and it's something that must be revisited continually with an ongoing program to educate nurses involved in preoperative phone calls, Muckler says.

"There also needs to be an educational component for patients and family members," she adds. "We need to make sure we're educating on both sides." ■

REFERENCE

1. Lee CM, Rodgers C, Oh AK, Muckler VC. Reducing surgery cancellations at a pediatric ambulatory surgery center. *AORN J* 2017;105:384-391.

SDS Manager Promoting from Within

By Stephen W. Earnhart, MS
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I am always surprised when I read something in the news like, "the acting FBI director is in charge until a new director is hired," or the "assistant chief of surgery" will be in charge until the new chief of surgery is appointed.

This seems sort of embarrassing for the one labeled "acting." Isn't the "assistant director" or "assistant chief" in training for the real thing? But what if, when the opportunity finally becomes available, the boss turns around and hires someone else after you performed the job while management looked for another? Where does that leave you? That's a morale killer.

Have you ever heard this one: "The assistant vice president of finance will lead the search for a new vice president of finance." If I were that assistant vice president, I wouldn't look too hard to find that person. I would drag it out and then take the job myself when management gives up looking for someone else. Such a position must mean more money and better bathrooms, right? I'm pretty sure that if you are the "assistant" of anything and you get passed up for the real thing, you need to consider a career change.

In hospitals and surgery centers, nothing says, "This is the place to work because they hire from within." They recognize homegrown talent that has been training as an assistant for years, just to be ready to step up when someone steps down. I am always impressed when I learn that the new department head was the past assistant department head, or that the CEO once scrubbed the floors in the lunchroom and worked up the chain to their current position. "But I like being the 'assistant' because I don't want the responsibilities of being the 'real' person." If you don't want to consider that you eventually might be called on to be the "real thing," then you shouldn't be the assistant to begin with.

Most businesses like ours need a strong mixture of full- and part-time staff because of the wide swings in case load. Sure, not everyone experiences those swings, but most do, and it is nice to be able to draw on a flexible staff during those unpredictable days. Most personnel are part-time for a reason, but those reasons change over time. It is always good to check first from within before going out to find new people.

Consider flex positions: Why do so few organizations not give the option for two part-time people to become one full-time person? We used to routinely combine two people (or three or four) into one full-time position, and it worked beautifully. As a past ASC administrator and hospital OR department head, I would have loved and encouraged the opportunity to employ 40 part-time people in my facility over 15 or 20 full timers. One might think this would create a paperwork nightmare; however, an administrator could take those two or three individuals, by name, and make them responsible for their own schedule. They will be much better at covering themselves and keeping track of their hours than you ever could be. Not only is it more efficient and malleable, but usually part-time staff do not need benefits — another bonus. When one part-timer needs time off for vacation or illness, the others can cover for him or her.

Many businesses and companies advertise on TV or place posters in subways and airports that tout slogans such as "Our Employees Make the Difference," or "Job Satisfaction is Our Goal." Hiring from within, along with offering built-in perks such as flexible staffing options, a 10-hour work day, profit-sharing in ASCs, creative time off with pay, or other ways to make life just a little easier for the front-line professionals that make the rest of us look better and enhance the patient experience, is worth the effort.

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SAME-DAY SURGERY

CME/CE 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. Log on to AHCMedia.com then select My Account to take a post-test. *First-time users must register on the site.*

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 completing the test, a credit letter will be emailed to you instantly.

5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

CME/CE QUESTIONS

1. **The Centers for Medicare & Medicaid Services (CMS) is requiring ambulatory surgery centers (ASCs), as of Jan. 1, 2018, to conduct patient experience surveys either on paper or by phone, or a combination of both. How many questions are on the survey?**

   a. 18
   b. 21
   c. 37
   d. 45

2. **Which of the following is a good strategy for preventing an active shooter situation at an ASC?**

   a. Make certain physicians and/or staff are armed and trained to use handguns when necessary.
   b. Create an open communication policy in which employees can talk about domestic relationship issues that could spill over into the workplace.
   c. Install metal detectors.
   d. None of the above

3. **Which of the following is an important metric to select when collecting data about an ASC's performance?**

   a. What are the turnaround times?
   b. Do your first cases of the day start on time?
   c. What do patient outcomes look like?
   d. All of the above

4. **A good communication technique ASCs could employ to improve communication with patients is AIDET. What does the "D" in AIDET stand for?**

   a. Duration
   b. Development
   c. Describe
   d. Doing