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Put Reprocessing Compliance on This Year's To-do List

The goal is to improve safety

Reprocessing problems can cause surgery centers major headaches during surveys or worse problems when infections occur. They also can result in illness and death, media attention, and federal investigations.

Endoscope reprocessing has been in the news in recent years, including in 2015 when there was an outbreak of carbapenem-resistant Enterobacteriaceae (CRE) at a UCLA medical center, says **Laura Schneider**, RN, CGRN, CASC, senior director of clinical services at AmSurg in Dallas.

The CRE outbreak at the Ronald Reagan Medical Center in 2015 resulted in two deaths, seven illnesses, and was attributed to inadequately sterilized endoscopes. Earlier, inadequate cleaning procedures of duodenoscopes are suspected of causing an outbreak of superbugs at two hospitals in Highlands County in Florida in 2009. That outbreak killed 15 people and affected 70 patients. National media focus on cases like these can grab people's attention. But some worry that there are many more infections that are not reported because of inadequate surveillance, undiscovered breaches, infections with long incubation periods, and for other reasons, Schneider notes.

"Statistics show that the rate of infection from endoscopy is low statistically," she says. "So, it's hard to connect the dots when there are infections connected to endoscopic procedures."

For instance, patients who contract hepatitis or HIV will recall the procedures they underwent that exposed them to blood. But patients who receive a colonoscopy months earlier will not think to connect their bacterial illness to that procedure, she explains. Schneider speaks about reprocessing at national conferences and she oversees surveys, audits, and credentialing for 16 ambulatory surgery centers (ASCs) in Texas and Oklahoma.

The cleaning process for scopes is extremely complex. ASCs must pay close attention and follow all standards and

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manufacturer's instructions for use to ensure it's performed adequately, she says. Reprocessing medical devices and sterilizing equipment cannot fall short of standards, despite the time and space constraints.

"The challenge with surgery centers is they typically don't have a lot of training and education in reprocessing," says **Michele McKinley**, LVN, CMQ/QE, CQA, senior clinical education specialist at STERIS.

Sometimes, scrub techs clean, but they haven't been trained to conduct the actual process, McKinley notes.

"Surgery centers have to follow the same guidelines as health centers, but they might not have the resources to identify where they might be out of compliance," McKinley says.

Schneider and McKinley suggest ASCs take these actions to improve their reprocessing and instrument cleaning processes:

• **Assign a point person to oversee reprocessing.** Someone in a surgery center should oversee reprocessing, ensure guidelines are followed, and make sure training is adequate with competencies. The ASC's infection control expert or a supervisor might handle training and quality assurance regarding reprocessing. The focus would be on consistency and competency to ensure training was a success. In some organizations, a group could be assigned to the task, Schneider suggests.

"The person who oversees scope processing and education can be a center leader, an administrator, or an infection control professional," Schneider says.

There is discussion whether endoscope reprocessors should be certified, although only a few states require certification. One well-designed certification program is the Certification Board for Sterile Processing (CBSP), she notes.

"Several of us took the exam to see if we could recommend it, and we all agreed the exam was excellent and covered all of the essential principles of endoscope reprocessing," Schneider adds.

The certification exam contained questions that were not just about reprocessing and following manufacturer's instructions, but also about using critical thinking skills, she adds.

• **Develop site-specific training and processes.** "Each of my centers use different machine chemicals, different scopes, and they have different automated endoscope reprocessors [AERs], so I can't develop one education program for all of my centers,"

EXECUTIVE SUMMARY

Surgery centers that fail to pay close attention to their reprocessing processes could end up causing dangerous — even fatal — infections.

- Although the rate of infection from endoscopy is low, it's likely that some infections related to reprocessing problems are not reported because patients do not attribute their illness to a procedure they might have undergone several weeks earlier.
- One best practice in reprocessing is to create site-specific training and policies.
- Another strategy is to follow federal and/or other expert guidelines on reprocessing.

Schneider laments. To develop training, examine all scope equipment, their manuals, and nationally accepted guidelines. Then, create a step-by-step process for reprocessing with their specific equipment, Schneider suggests. Everyone who will be reprocessing equipment needs training, whether the employee is a sterile processing technician or an operating room tech, McKinley says.

"I started my career as an operating tech and found that you don't get a lot of training in processing or sterile processing," McKinley explains. "There are courses staff can take to learn about sterile processing."

Also, the ASC can develop training by following existing guidelines.

"We didn't want to reinvent the wheel, so we went to manufacturers of each piece of equipment or product and looked at their educational materials first," Schneider recalls. According to Schneider, training should be detailed, explaining each necessary cleaning action, including these steps:

- Check for leaks before washing the scope;
- Flush by hand or with a pump;
- Clean with enzymatic detergent, following specific manufacturer's instructions.

"A lot of people think of it as soap — like dishwashing liquid — and so they add more enzymatic detergent," Schneider notes. "I ask how much they added because there are specific instructions to add one ounce per gallon, and if you add too much it can cause a buildup on the scope and contribute to bacterial growth. It can be detrimental if you don't follow enzymatic detergent instructions." Additionally, Schneider recommends disinfecting water bottles connected to scopes and maintaining a temperature range and time for soaking. This latter tip can be tricky. In Schneider's 30 years as a gastrointestinal nurse, she followed the guidelines of keeping the high-level disinfectant (HLD) at room temperature.

"And then, all of a sudden, they changed their instructions to say a minimum of 68 degrees," Schneider recalls. "The room temperature in scope reprocessing areas is usually set lower. Because staff are wearing gowns and masks and are hot, the room temperature could be 67 degrees or less."

When Schneider called the scope manufacturer to clarify if the HLD had to be 68 degrees or could be room temperature, the company told her that it must be at least 68 degrees.

"I said, 'We can't get it to 68 degrees,' and they said, 'Other facilities have put in heating pads,'" she recalls.

Heating pads didn't work, so Schneider's site used terrarium heaters that are waterproof and can be placed underneath the container or floating aquarium heaters and permit the water temperature to be measured and adjusted.

• Create consistency to avoid common errors. The CDC offers a reprocessing toolkit for ASCs (http://bit.ly/2HyoNpR). Other toolkits and information also are available. (*See story on reprocessing guidelines, p. 40.*)

ASC directors should be a little cautious about which guidelines they'll use to ensure consistency and quality of reprocessing. Consider that different guidelines might offer conflicting suggestions. Or, the guidelines might contain recommendations that are impractical in an ambulatory surgery setting, Schneider notes. For example, one set of guidelines could recommend surgery centers use disposable valves, which would add $7 to the cost of each procedure, Schneider says.

"An ASC can't add $7 to each procedure — that's ridiculous," Schneider says. "So, why don't we just read the cleaning instructions and clean the valves correctly?" Inconsistent reprocessing behavior can lead to common errors that might affect patient safety. Here are a few such errors, according to Schneider:

- Improper cleaning;
- Improper leak testing;
- Not following enzymatic instructions for use;
- Equipment not maintained correctly, such as flushing device and AER;
- Lack of documentation of expiration dates;
- Re-use of single-use items, including sponges and brushes;
- Failure to document patient and scope numbers;
- Different reprocessing method after treating HIV or hepatitis patients;
- General infection control practices are not followed;
- There's no verification of the AER cycle printout with scope after each cycle.

• Focus on patient safety. "Our main goal in anything we do in sterile processing is patient safety," McKinley

says. Those who are dedicated and passionate about patient safety should handle reprocessing.

"I would look for someone who works hard," McKinley adds. "When I hire somebody for sterile processing, the first thing I tell them is, 'If you don't want to work hard, don't take this job — you can't skate by with this.'"

ASCs renovate or invest in new construction as their services and practices expand. These construction changes also should make administrators focus on improving patient safety by creating adequate space for reprocessing and cleaning equipment. The room needs appropriate ventilation and negative air pressure, if cleaning involves decontamination, McKinley says.

"Do you have space to house a lot of equipment and trays needed for total joint and other new procedures and to wash equipment effectively," she asks. "Part of the challenge with anything in medicine is that you want to add new procedures, but people don't think about the space or supporting sterile processing and what needs to be done to accommodate that. It may mean increasing the space and ventilation, and it's costly."

It's clear that ASCs will continue to expand their procedures and surgeries, which means these types of design issues related to patient safety are paramount, McKinley adds. ■

Where to Find Reprocessing Guidelines

There are many downloadable tools available online

When an ASC begins revamping its reprocessing program, a good place to start is with guidelines that can be found easily. Here are some suggestions for where to start:

• Follow the manufacturer's guidelines. "Every one of our centers is different and has different equipment, but the bottom line is they all have to follow manufacturer's instructions," says **Laura Schneider**, RN, CGRN, CASC, senior director of clinical services at AmSurg in Dallas.

ASCs must base reprocessing education on the instruction manuals, as well as other guidelines. Scope manufacturers also provide useful education online.

"New endoscopes come with two manuals, including an operation manual and a reprocessing manual," Schneider says. "The reprocessing manual is complicated and over 100 pages, so many people don't even look at it." But the manual also contains more easily digestible sections. Schneider suggests designating someone to read and follow the manual, section by section. ASCs also should check manufacturers' websites regularly for updates and alerts. Sometimes, manufacturers post letters about whether a particular cleaning agent should be used on their devices.

• Know regulatory and other guidelines. ASCs can download infection control and reprocessing guidelines from federal agencies or professional organizations, such as the Society of Gastroenterology Nurses and Associates (SGNA).

SGNA recommends surgery centers follow these nine steps for endoscope reprocessing:[1]

1. Precleaning begins in the procedure room right after the insertion tube is removed from the patient;
2. Leak testing detects damage to the endoscope's interior or exterior;
3. Manual cleaning is needed before automated or manual disinfection;
4. Rinse after manual cleaning;
5. Visual inspection, which warrants its own step and could be considered a time out or safety stop, is necessary to verify the endoscope is at least visually clean;
6. High-level disinfection is the standard for reprocessing endoscopes; This includes using automated reprocessing that circulates fluids through all endoscope channels with equal pressure and without trapping air;
7. Rinse after high-level disinfection;
8. Dry and purge all channels with air until dry;
9. Store endoscopes in an area that's clean, well-ventilated, and dust-free to keep them dry and free of microbial contamination.

Other resources include a 12-page reprocessing report by the Healthcare Infection Control Practices Advisory Committee (HICPAC), which is a federal advisory committee to the CDC. The report's seven steps are similar to other guidelines, but also add visual inspection, storage, and documentation.[2] Surgery sites should maintain adherence documentation to each step each time an endoscope is reprocessed. It's necessary for quality assurance purposes and for patient tracing, according to the HICPAC report.

The FDA also offers advice about reprocessing medical devices with specific guidance on validation methods and labeling.[3] The FDA's guidance includes tips on effective cleaning, including:

- minimizing the soil transfer from one patient to another or between uses in a single patient;

- preventing accumulation of residual soil throughout the product's use life;

- allowing for successful, subsequent disinfection/sterilization steps. "Always follow the guidelines," says **Michele McKinley**, LVN, CMQ/QE, CQA, senior clinical education specialist at STERIS. "I recommend that all staff should know the guidelines."

When an ASC's reprocessing is investigated, the inspector won't ask management to describe the process. Instead, they'll approach frontline staff and ask them to demonstrate the process, McKinley warns. "I tell people to teach reprocessing as part of continuing education," McKinley says. "Do one guideline a week and focus on the manufacturer's instructions for use each week. That way, the employee is continually learning about the guidelines and instructions for use." ■

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Helping New Nurses Thrive in ASC Setting

Improve recruitment, retention through better training

As ASCs compete with hospitals, physician offices, and other providers for nurses, they also might consider new nurse graduates.

"Our workforce is changing, and we have to look at things very differently," says **Deena Gilland**, MSN, RN, NEA-BC, vice president and chief nursing officer at Emory Ambulatory Care in Atlanta. "Our newer generation of nurses has a lot of interest in ambulatory settings; they come in thinking about care across the continuum. Those of us who graduated years ago were more narrowly focused in our thoughts."

ASCs and other ambulatory settings need RNs who are skilled and knowledgeable about ambulatory care, says **June Levine**, MSN, BSN, RN, patient-centered medical home director at Southside Coalition of Community Health Centers in Los Angeles. Levine has helped develop a residency program for nurses in ambulatory settings. (*See story on strategies to prepare new nurses for ASC work, p. 44.*)

"The RN workforce needs to be built up in numbers, quality, and in leadership skills," Levine says. "The numbers are irrelevant if they're not qualified or if they don't know how to lead."

This directional change among new nurses is positive, and surgery centers should take advantage of the interest new graduates show in their work setting. In large urban areas, there's huge growth and a great need for experienced nurses in ambulatory care. The current supply and pipeline is not enough to meet the need, so something has to change, Levine adds.

"My question was: 'Why are we not taking new graduates in ambulatory care,'" Gilland recalls. "I looked at the literature, and there is some evidence that new graduates can thrive in ambulatory care."

Gilland answered that question two years ago with a plan to build a pipeline from nursing school to ambulatory settings, including ASCs. After one year of planning,

EXECUTIVE SUMMARY

New nurse graduates could be a great solution to filling staff needs at ASCs. However, surgery centers should start by establishing thorough training programs.

- Increasingly, new nursing graduates show an interest in working in ambulatory settings, including ASCs.
- Residency programs can provide structured, consistent training for new nurses.
- Preceptors can work with new nurses, guiding and supporting them as they gain confidence and stronger work experience.

in March 2017 the first group of 11 new nursing graduates found jobs in a formal residency program for ambulatory settings. Five new nurses chose surgery centers. At the one-year mark, Gilland could see that the program worked well. The resident nurses received the support and training they needed to succeed in their roles, and the program has continued to enroll new nursing graduates.

The program worked so well that Gilland cites that as one of the lessons learned.

"When we first started this, my goal was, literally, to enroll one new graduate," she explains. "My lesson learned was that there was a lot more interest in ambulatory care than I'd ever anticipated."

How It Works

• **Prepare well.** "We worked on this a year before we started the residency program," Gilland says. "We were very intentional, taking our time, because we wanted new nurses to flourish."

The first step was to build ambulatory curriculum at the Emory's nursing school. There, students learn not only how important nursing care is in an ambulatory setting, but also about population health.

"No matter how much we planned, we didn't think we planned early enough," Gilland notes.

For the next round of nursing graduates, planning began the day after the first group became residents.

"There are 250 nursing students a year taking an ambulatory care course," Gilland says. Students rotate through ASCs, clinics, and other ambulatory sites. "As senior students, they can help in a surgery center with patient education," she says. "They do a full PACU, pre-op assessments, and medicate patients."

• **Build curriculum.** "We decided to use the Vizient nurse residency program," Gilland says. "I told Vizient what I'd like to do for ambulatory care, and they were very excited about that, partnering with us to do that."

The Vizient/American Association of Colleges of Nursing Nurse Residency Program claims on its website that it maintains a first-year nurse retention rate of 95%.[1] The residency curriculum that Gilland helped develop includes a monthly didactic classroom meeting. These classes cover communication skills, occupational injury, evidence-based practice, and other topics. The program requires all residents to complete an evidence-based practice project.

"Residents identify a problem or issue in their area, like in an ASC, and then they work with their mentor to address the problem," Gilland explains.

They make a change and collect data after the change. Residents also can present their projects.

"Two of our residents will present their projects at the program graduation," Gilland adds.

Sample Items From Residency Competency Tool

Both residency program nurses and their preceptors complete the four-page Emory Clinic of Atlanta ASC BSN Residency Competency Assessment and Validation Tool. The new nurses and their preceptors complete the self-assessment part, judging the new nurse's skills according to these three levels: Level 1 (limited experience and knowledge, competent in basic skills, has theory base, is task-oriented), Level 3 (acceptable competency and proficiency, minimum of one year experience and knowledge), and Level 5 (mastery experience, knowledge, competency; able to teach and supervise others). Below are some expected nursing competencies:

• **Pre-op Patient Assessment**: Patient identification, correct surgical site, H&P (less than 30 days), consent (dated and timed), allergies documented, DVT assessment.

• **Physician Orders**: Sign off, read back and verify for verbal order, physician signature and date for standing order.

• **Emergency Protocol**: Defibrillator, crash cart location, Pediatric cart if applicable, Jump bag location (if applicable), AED (if applicable), malignant hyperthermia supplies, emergency number (for your site).

• **Documentation**: Pre-assessment, pre-op, post-op, post-op phone calls.

• **Test Equipment for Safe and Proper Functioning**: Overhead lights, electric equipment, suction equipment, mechanical equipment, OR furniture, oxygen and nitrous tank levels, check integrity of tourniquet cuff, proper handling/transporting of sterilized instruments, assessing sterilized package integrity and expiration date prior to opening.

• **Create and Maintain a Sterile Field**: Maintains adequate distance when passing sterile field, reports any break in sterile technique with proper follow-up, opens sterile supplies to field without contamination after verifying sterile indicators and dates. ■

• **Obtain buy-in.** Directors and nurse managers at Emory's seven surgery centers had to decide if their unit was ready for a new graduate. There would need to be a preceptor and a buy-in culture for the residency program, Gilland says.

"So, directors would talk with their staff and providers, saying, 'We want to bring a new graduate into this environment. What do you think?'" she says. "Everybody had to have buy-in."

Some ASCs decided the program was not a good fit for them, maybe because of their size or for other reasons. But those who decided to hire new nurse residents were very engaged with the process, she says.

"We wanted the program to be successful and keep going, so we had to have current staff buy-in," Gilland adds.

• **Train preceptors.** The Emory residency program includes boot camp training for preceptors, covering their roles as educators, coaches, advocates, and role models, Gilland says.

"When talking about communication, we brought in experts from the patient and family experience department to talk about building tools," she explains. "Most new graduates are millennials, and so we focus on that piece about how to best communicate with them."

The boot camp occurs over one day, and 70 nurses volunteered for the first one.

"We also talk about how to handle challenging situations," she says. "And we have an interactive part with real-life scenarios, asking how they would handle those."

Lastly, preceptor training focuses on how to ease a recent nursing school graduate into the role of an autonomous nurse. "How do you let go? You have to begin with the end in mind," Gilland says. "So, how do you nurture them and then step back from that? You want this person to be a successful surgery center nurse."

• **Provide structure.** The residency program offers curriculum that reflects each nursing setting. Nurse leaders and an education coordinator wrote a checklist and skills for the first 16 weeks of the residency program. They developed an onboarding process and an orientation.

"Nurse leaders and ASC leaders decided they wanted new grads to be well-rounded and have experiences in all areas," Gilland says. "They can have experience in the surgery center's operating room and touch on all of the other areas, too."

This helps new nurses understand the entire ASC workflow, but it also gives them an idea of which area in which they would most like to work. A program supervisor makes sure preceptors are ready to take on the role, and she checks on them to make sure they are checking in with their residents weekly.

"It's written into the preceptor structure that there are weekly check-ins and that preceptors know what their residents' goals are for the week," Gilland says.

The residency program also includes a competency assessment and validation tool that is completed by the orientee and the preceptor. (*See sample competency assessment, p. 42.*)

Preceptors and residents complete a list of skills and competencies that were built into the program. The goal was to help the new graduates become independent.

By the time the new graduate has been on the job for four months, they might be ready for more autonomy and less preceptor oversight.

"The program is very structured with a lot of rigor to make sure they're practicing safely and have the skills they need," Gilland says. "We have weekly sheets to show the competencies they're working with and the goals set for the next week."

• **Complete the follow-up.** For the last eight or so months of the residency year, preceptors and orientees engage in sit-down meetings to go over skills and goals. These meetings are not necessarily weekly, as they were for the first few months.

"The preceptor lets them work on their own, and checks in with them, but not at as frequent intervals," Gilland explains. "The preceptor is there as a resource, but not to work as intensely side by side with them."

The goal is to help the new nurses flourish and grow, she adds.

• **Tweak program.** After the first group of nursing graduates entered the residency program, the program team decided to make changes for the next round. They planned to add simulation lab work.

"New nurses might learn about codes by having a mock code blue," Gilland says. "They'd practice in the simulation lab to be part of the team."

As nurses graduate from the residency program, Gilland will continue collecting information about their retention rates and career growth, hoping the metrics will confirm what she's heard anecdotally about the residents.

"Everyone who works with them thinks they're doing great work as part of the team," she says. ■

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The Challenge of Improving the Nursing Hiring Pipeline

Make it work by tailoring training

Surgery centers and others in ambulatory healthcare always try to find the best nursing staff. As the most experienced nurses retire over the next decade, improving the nursing hiring pipeline becomes a challenge.

"There are some strategies proposed, but they're not implemented in a way to get to the outcome that's needed," says **June Levine**, MSN, BSN, RN, patient-centered medical home director at Southside Coalition of Community Health Centers in Los Angeles.

For instance, new nurses rarely learn about ambulatory care as it's not part of most undergraduate nursing studies, she says.

"Many people are asking academic programs to include ambulatory care," she says.

But the academic programs are focused on educating students to pass the RN boards, so they focus most on the topics that will be covered in the tests and on those subjects that are required for nurses to meet the changes in medicine and nursing, she adds. If nursing students are interested in ambulatory medicine, they could take an elective course, but most do not for several reasons.

"One problem that occurs is that a new RN has difficulty finding a job at a hospital, so she sees an ambulatory position open and thinks she could do it for a year," Levine says. "Ambulatory care is not the traditional doctor's office anymore, and they don't understand the pace and issues."

Therefore, any program designed to increase the number of new nurses who go into ambulatory nursing must address early exposure to ambulatory care in nursing schools. Developing an ambulatory nursing residency program is one possible solution. It might not be feasible for every ASC, but there are some smaller steps administrators could take to improve orientation and training of new nurses or training of experienced nurses who are new to ambulatory care, Levine says. Here are some of her suggestions:

• Study existing nurse residency programs. The American Academy of Ambulatory Care Nursing (AAACN) offers an ambulatory nurse residency program.[1] The program is designed to help nurses transition to ambulatory care, whether they are experienced nurses in other specialties or new RN graduates. The program can be customized for an ASC or other settings, and it includes a curriculum guideline, competency assessment, clinical rotation guidelines, checklists, templates, simulation guides, and preceptor and mentor tools.

"It's comprehensive and has connectivity between all of the components new nurses have to do," Levine says. "Curriculum is built around a nursing job's specific specialty area."

• Take small steps toward building better orientation and competencies. When it's not possible or pragmatic to engage in a full nursing residency program, ASCs could take some smaller steps. These would help with transition into a new specialty or transition into practice.

"Sometimes, you might start building toward a residency program because, ultimately, that's what you need," Levine says.

For instance, an ASC could start by training nurses from existing staff to be preceptors for new nurses.

"Traditionally, orientation is two weeks and they expect the new graduate or RN who comes in with experience in acute care, but no experience in ambulatory care, to need less education on the job," Levine explains.

She also recommends ASCs use an existing residency program as a guideline for training new nurses. The program's competency items also could be helpful to assess new staff during the orientation period.

• Vary the orientation or residency program according to staff's experience. While a new nurse graduate could benefit most from a full 12-month residency program, an experienced acute care nurse might perform well in a four- to six-month program, Levine offers.

"They will pick up things quicker and have stronger skills in assessment and follow-up," she says.

The person in charge of the orientation or residency program must retain knowledge about all the competency areas and how to build in preceptor time, simulation time, and class lecture time to suit the needs of each practice area.

• Adjust the program to an ASC's specific needs. When an ASC adopts the AAACN or another residency program, it's important to adjust areas to the surgery center's specific needs.

"You will use the program's roots, but substitute some of the specific details," Levine advises. "For example,

you wouldn't necessarily have an in-depth lecture on diabetes care, but you would make sure the RN asks certain questions and checks on a patient's history and recent labs before the patient goes into a same-day surgery." ■

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Misunderstood Overtime Rules Could Cost ASCs Thousands of Dollars

To reduce future headaches, experts recommend starting by auditing wage practices

Increasingly, healthcare providers are running afoul of federal overtime wage laws. Since 2011, there has been a 30% increase in federal lawsuit filings of all such cases. ASCs can be especially vulnerable because of hourly employees starting their days earlier than scheduled or staying late when procedures run long.

"Healthcare practices are getting targeted in overtime violations," says **Salvatore Puccio**, Esq., partner with Garfunkel Wild in Great Neck, NY. "ASCs, in particular, fall under the same types of issues as hospitals and physician practices. When procedures take longer than anticipated and staff have to stay longer, you run into risks with regard to overtime and record-keeping."

Surgery centers also might violate state and local laws when they are not fully aware of all requirements and rules.

"We've seen a number of healthcare agencies get audited and targeted for overtime violations, so what we're trying to do is be preventive with ASCs, instead of reactionary," Puccio explains.

Puccio speaks about employee overtime rules at national conferences. Here are his suggestions for how to stay compliant with overtime and other wage rules:

• **Conduct a self-audit.** "Make sure you're complying with federal and local laws," Puccio says. "Often, there are changes at the state and local levels, and this causes potential problems and issues."

For example, the state of New York is making a change regarding how on-call time is paid. The change will be different from current federal and state requirements. The proposed change would require paying employees for the time they are off duty, but on-call, and not only for the time they spend working if they are called into work. This on-call/but-not-at-work time would be subject to the minimum wage and potential overtime calculations, Puccio explains.

At print time, the exact rules were unknown; however, these new rules are expected to provide greater protections to employees and add additional requirements on employers, according to Puccio.

"For ASCs, this might impact non-exempt employees," he says. "Exempt employees are not paid overtime."

• **Monitor early arrivals and those working through lunch.** One prevalent problem is that hourly nurses might work through their lunch hour because a surgical procedure requires extra time. When this happens, nurses must be paid for that extra work time, Puccio says.

"Some time settings automatically deduct a half hour for lunch, and someone would have to go through it and override it every day if an employee works through lunch," he says.

Pre-shift and post-shift work also must be compensated.

"Where this comes into play is when someone's shift starts at 9 a.m., but the person is required to prep the

EXECUTIVE SUMMARY

Within the past seven years, federal lawsuit filings regarding wage overtime rules have increased by 30%, a trend that should jar surgery centers into taking preventive actions.

- First, conduct a self-audit to ensure the surgery center complies with all federal, state, and local wage and overtime laws.
- Next, check to see whether hourly employees follow the center's rules about when to clock in and clock out, and make certain all overtime — inadvertent or intended — is paid properly.
- Unintended technical wage and overtime violations are common, but they can be prevented by maintaining and storing accurate records.

station and does this at 8:30 or 8:45 a.m.," Puccio says. "What we're seeing in practice is that while there might be a policy in place about paying employees if they come in early, it's not always happening. It's not that the employer is violating the law, but the employees are doing this themselves."

Maybe some employees want to get a jumpstart to their day, so they arrive earlier than their scheduled shift and they don't clock in. They might not ask to be compensated for this extra time.

"So, what happens is you have one disgruntled employee, who says, 'I came in and everybody came in 10 or 15 minutes early,'" Puccio says. "These litigations result in class action lawsuits."

Thus, one person's complaint can result in thousands of dollars in legal fees and fines. ASCs can prevent this by making sure they maintain policies about pre-shift or after-shift work and how it's compensated. Then, administrators must make sure they are enforcing the policy, even if employees are not on board with sticking strictly with their set shift hours. "For example, we were doing a presentation to a nonprofit healthcare facility, and we were hearing that nurses like to come in and do X, Y, and Z," Puccio says. "You have to tell them they can't do that, or they have to clock in and tell you they're clocking in."

Employers also will have to make sure that employees do not arrive early, spend the extra time in the lunch room, but count that as paid work time.

"It's a fine line," he says. "But if someone is working and is needed, then they have to be paid."

• Watch for small wage mistakes and technical violations. Probably 90% of wage infractions are unintentional technical violations, Puccio says.

"The amounts of those errors are usually very small, but the costs of paying attorney fees and penalties are higher," he says. "What you face are back wages and liquidated damages, which are double the back wages, and attorneys' fees."

Mistakes can occur when employees' overtime pay is miscalculated, or when records are not well-kept regarding overtime pay. "You need to maintain good records and maintain them for long periods of time because that's your best defense," Puccio advises.

ASC employers must account for each mistake. If a mistake is systemic, affecting more than a single worker, then there could be a class-wide settlement, ranging from $25,000 to hundreds of thousands of dollars, depending on how many times the mistake had occurred.

"It's a cost you want to avoid if you can and put that money back into your infrastructure and patient care," Puccio says.

To avoid this type of mistake, ask an expert to review the way wages are determined and paid, comparing the ASC's practice to all wage regulations.

• Follow all policies and laws when firing employees. "It's very common that after an employee is terminated for cause, employees go to attorneys, thinking they were discriminated against," Puccio says. "What their attorneys also are doing is inspecting and scrutinizing the pay practices of the employer." ■

SDS Manager

Planning Your Success

By Stephen W. Earnhart, MS
CEO
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Austin, TX

I received an overwhelming response from last month's column about matching numbers regarding profit and loss statements, insurance contracts, and supply costs. Many readers requested even more information about putting everyone on the same page and ensuring financial success, which follows below:

• Daily Huddles. For new administrative and operational staff, it is important to gather the senior management team daily to review the upcoming schedule, assignments, and any issues from the day before. At the very least, this team should include the administrator, nurse manager, OR director, PACU, and medical director. Meetings should be comprehensive but last no longer than 15 minutes. Think of it as a "time out" for management. So many problems can be avoided pre-emptively by adhering to this simple act of communication. I would encourage certain staff members to attend some of these sessions occasionally so they can understand

how the day is planned and how they can contribute. Once you begin holding these huddles, you will be amazed at how you survived without them. And, obviously, this does not replace frequent staff meetings.

• **Staff Assessment.** We see more ASCs using staffing agencies to fill staffing gaps. While there are fine people working for these companies, such agencies are expensive. Using them for more than just an emergency can be counterproductive to most budgets and surgeon relationships. A better option is to increase your own team of per-diem, part-time staff. You will need to use them frequently so they can understand your culture and how you operate. Allow your surgeons to learn who these staffers are by name so the surgeons won't complain about new faces in their room. Surgeons complain about staff turnover frequently, equating new faces to just that. When possible, replace outgoing full-time staff with several part-time personnel to augment your pool.

• **Overtime.** A properly managed surgery center should have zero overtime. Hospitals get a pass because their schedules vary daily (and often hourly), which makes the schedules unpredictable. ASCs do not have that excuse.

• **Budgeting and Planning.** If we were running diet centers or gyms, we would know that we need to increase marketing and staffing for the first of each year when the public decides they need to lose weight and exercise. We do know that our surgical facilities are busier in November and December, as many of our patients have met their insurance deductible. But how many of us plan the rest of the year? Failure to poll your surgeons about their vacation and time-off plans results in frequent staffing problems. You might be overstaffed and see fewer patients than expected because of poor planning. If it is too difficult to get this information from the surgeon, then call their office and ask them when he or she is going to be away.

• **Work Smarter, Not Harder.** There are many service companies that offer solutions to issues that save us time and money in areas in which we do not excel and that could use staff resources unnecessarily. These are areas like scanning and documenting charts and records, verifying patient insurance and deductibles, incorporating the patients' medical records, pre- and post-op phone calls, website updates and maintenance, benchmarks, mock certification surveys, and so many other useful services that are remarkably inexpensive when you hire experts to handle them for you. We work with all these companies and are impressed with their knowledge and services. You owe it to yourself and your facility to explore the options available to all of us now.

• **Your Bottom Line.** Working together, smarter, and educated as a team can make you and your associates successful. There are three things that I require of our facilities and clients:

1. Provide a safe environment for your patients, your staff, and your visitors;
2. Ensure your patients and your staff experience a positive outcome;
3. Be increasingly profitable to fund 1 & 2. ■

Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Earnhart & Associates can be reached at 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.

CME/CE OBJECTIVES

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

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

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- New credentialing program for infection control
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SAME-DAY SURGERY

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CME/CE QUESTIONS

1. **Endoscope reprocessing training should include which of the following cleaning actions?**

   a. Check for leaks before washing the scope.
   b. Flush by hand or with a pump.
   c. Clean with enzymatic detergent, following specific manufacturer's instructions.
   d. All of the above

2. **The Emory Clinic of Atlanta ASC BSN Residency Competency Assessment and Validation Tool includes each of the following competency areas *except*:**

   a. pre-op patient assessment.
   b. psychosocial counseling.
   c. emergency protocol.
   d. create and maintain a sterile field.

3. **Which of the following scenarios could result in noncompliance with wage and overtime laws?**

   a. The employee is late for an 8 a.m. shift and doesn't make up that 15 minutes.
   b. The employee's recent promotion results in a change to exempt status.
   c. The employee's shift and time clock start is at 9 a.m., but the worker comes in at 8:45 a.m. to start prep work.
   d. None of the above