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INSIDE

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Bullying Among Nurses, Other Healthcare Workers Harms Workplace Culture

Research shows that bullying among nurses is commonplace, destructive both to the physical and emotional health of nurses who are bullied, and detrimental to the cultural health of workplaces.

"Bullying is pervasive in healthcare settings," says **Lynda Olender**, PhD, RN, ANP, NEA-BC, distinguished lecturer and coordinator of the DNP doctoral program and the Nursing Administration Leadership Program at Hunter-Bellevue School of Nursing, City Universities of New York.

A cross-sectional study of licensed registered nurses revealed that 40% of nurses were bullied. Those who were bullied were more likely to score lower on overall health and mental health questionnaires.[1]

Workplace bullying is like a computer virus that penetrates an otherwise safe environment and causes great harm to employees and the organization, says **Brenda Burk**, MSN, RN, NEA-BC, who frequently travels across the United States to speak on this topic. "When I started researching bullying in 2012, I didn't see anyone at conferences addressing the topic," she says. "People didn't talk about it. It was an accepted phenomenon."

A few years later, the health industry started paying more attention to the problem. For example, in 2016, The Joint Commission issued a quick safety notice about bullying in healthcare. The Joint Commission defined bullying as abusive conduct that might involve verbal abuse, threatening, intimidating, or humiliating nonverbal behaviors, and work interference, including sabotage and preventing someone from completing his or her work. *(Editor's Note: Read more at: http://bit.ly/2BFm7W6.)*

The safety notice suggests several tactics for battling bullying behavior, including: establishing a culture and safety system that does not tolerate bullying, supporting targets of bullies and confronting bullies, educating team members on appropriate professional

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behaviors, holding everyone accountable for modeling desirable behaviors, and developing policies and processes that address bullying, reduce fear of retaliation, respond to witnesses of bullying, and institute disciplinary actions.

Additionally, the Civility Toolkit *(https://bit.ly/2NqnufY)*, a project created by members of the Robert Wood Johnson Foundation Executive Nurse Fellows program in 2012, also offers resources to help prevent bullying in the workplace. A workplace bullying assessment lists risk factors related to organizational change and asks questions such as *Has there been a technological change or a pending change?* or *Has there been management change or a pending change?*

Addressing workplace bullying has reached the mainstream, and larger organizations might follow The Joint Commission's recommendations. But smaller healthcare organizations sometimes lack preventive measures, despite the evidence that prevention works, Olender notes.

The more researchers learn about bullying and its effects on the healthcare workforce, the more evidence is accumulated, showing that bullying poses a danger to both individual employees and the overall organization.

For instance, in a study about a questionnaire administered to all registered nurses in one regional healthcare system, investigators found that nurses who were bullied and witnessed bullying were less likely to experience psychological safety and competence development. They also were more likely to be disengaged. Researchers recommended that nurse managers and staff nurses work together to establish safe environments to discuss bullying.[2]

According to the Occupational Safety and Health Administration and the American Nurses Association, more than half of registered nurses and nursing students report episodes of verbal abuse. *(Editor's Note: Read more at: http://bit.ly/2RCQE0F.)* Often, bullies are other nurses, who might not even be aware of their own bullying behavior. Burk was speaking about nurse bullying at a small nursing leadership seminar when she noticed an audience member who looked visibly uncomfortable.

"She didn't raise her hand to ask a question, so I went up to her afterward and said, *'Did you have a question? I could see that you had something you wanted to say,'"* Burk recalls. "She said to me, *'I'm a bully, and I didn't know it. Everything you were talking about, I do. I'm going to go back to my boss and apologize because I didn't know that's who I am.'* That's why I do this ... to help people change their behavior."

Nurse-on-nurse bullying includes eye-rolling, sarcasm, belittling people, verbal abuse, exclusion from the group, unfair assignments, people deliberately not helping each other, continual criticism, betraying confidence, and sabotage, Burk explains. Bullying can negatively affect staff health, morale, and job performance, research shows. For instance, a study of Taiwan nurses and their exposure to workplace violence, including psychological and verbal harm that affected 60% of nurses exposed to workplace violence, revealed that workplace bullying affected nurses' health more than external workplace violence.[3]

Burk's passion for educating the healthcare community about bullying is driven partly by her own experience. "I started talking about bullying because I was bullied," Burk shares. After some positive experiences as a nurse and receiving

promotions repeatedly until she was in a senior leadership position, Burk found herself at the mercy of a new boss, whose first words were, *"You are not good enough to do this job."*

"For 18 months, she picked on me and picked on everything I did. I couldn't do anything right," Burk says. "She'd call me to her office and say that doctors were complaining about everything in the operating room. When I asked for specifics — which doctors and what they're complaining about — she said, *'I can't betray their confidence because they wouldn't confide in me again.'"*

These encounters left Burk feeling awful. She wanted to improve her work performance, but she could not fix something if she did not know what was wrong. It was not until Burk finally decided to quit that she learned the truth: There was nothing she could have done to prevent the abusive behavior. "I finally handed in my resignation because I couldn't do it anymore. [The boss] said, *'I'm surprised it has taken you this long,'"* Burk recalls. The woman had purposely bullied her to force her to leave the job.

Surgery centers and other healthcare organizations need to be alert to bullying among staff members and between management and staff. Ignoring the problem can create a toxic work environment. "Why is it so bad? It's because you are destroying your nursing staff," Burk explains. "There are a lot of physical ailments that occur with bullying. You have hypertension, ulcers, headaches, anxiety, depression, gastrointestinal stuff."

Patient safety also could be at risk because nurses and other staff are not capable of working on their best behavior when they are under this type of stress. "It's also a negative for your healthcare organization because you will have the increased costs of a staff revolving door," Burk notes. "You will have a lack of teamwork."

A surgery center that develops a reputation for unhappy staff due to bullying will find that fewer people are interested in jobs at the facility. The solution is prevention and zero-tolerance policies. "You have to call in people and establish healthy relationships with them so that you can talk to them when there's a problem," Burk says. "They need to become familiar with your code of conduct."

For instance, a manager should educate staff about the ramifications of bullying behavior. Managers should be cognizant of their own staff interactions to ensure they do not roll their eyes or reveal other dismissive signs, Burk adds.

One evidence-based initiative to reduce workplace bullying for nurses, called the 'BE NICE Champion' program, taught RNs to intervene when they observed bullying, using stand-by, support, speak up, and sequester tactics. The program resulted in nurses feeling more confident to

EXECUTIVE SUMMARY

Bullying in healthcare settings is ubiquitous, particularly episodes involving nurses, according to research and government data. Ambulatory surgery centers (ASCs) and other organizations can reduce workplace bullying by focusing on what creates a culture that allows bullying to flourish.

- In 2016, The Joint Commission issued a quick safety notice about bullying in healthcare, defining it as abusive conduct that might involve verbal, threatening, intimidating, or humiliating nonverbal behaviors, and work interference.
- More than half of registered nurses and nursing students say they have been verbally abused, according to data from the Occupational Safety and Health Administration and the American Nurses Association.
- Creating a culture of caring can help an ASC stop bullying and prevent the long-term workplace effects of poor staff morale and high turnover rates.

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intervene and respond when they witnessed bullying in the workplace.[4]

Researchers at James Madison University conducted a pilot study of a program to reduce nurse-to-nurse incivility. They found that the intervention raised nurses' awareness of the problem and resulted in incivility decreasing over time.[5] Olender has helped healthcare facilities reduce bullying by creating a culture of caring.

"I find that managers hate to address bullying," she says, noting that when managers witness bullying but ignore it, those managers are part of the problem. "Then, the person is being bullied by not just one person, but the agency itself. Typically, people who have been victimized will leave the agency." The solution is for the organization to set up a culture of caring. A group of employees can work together on the initiative. Just starting work on such an initiative could lead to positive change, Olender offers. "When you empower the staff to make decisions and come up with initiatives to improve their environment, then there's much less bullying." ■

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Your ASC Is Bully-Free? Think Again

Identifying bullying between nurses and others in a healthcare setting is not as simple as recognizing bullying on high school dramedies. Such behavior in healthcare can be less visible and ambiguous to observers and even to those experiencing it — at least at first.

For instance, bullying behavior includes frequent eye rolling and sighing, says **Brenda Burk**, MSN, RN, NEA-BC, a frequent speaker about nurse bullying at national conferences. "It causes a negative environment, which can result in employees leaving because why would they want to work in a place where people are nasty to them and roll their eyes and are sarcastic?"

Bullying also could be continual criticism that is focused on the individual and not offered as constructive feedback on what the employee needs to correct. A coworker or supervisor who points out everything the person does wrong without ever offering positive feedback is engaging in bullying behavior, Burk says. The nurse experiencing the drip-drip-drip of criticism will become fearful at the job, wanting to avoid any contact with other staff. This is a patient safety issue for cases where the fearful nurse is new and supposed to be learning from more experienced staff.

"If the nurse thinks, *'I don't want to watch them work because they'll criticize me, and if I make a little mistake, they'll jump on me,'* then that's unfortunate. That's when a nurse can make mistakes," Burk explains.

Another subtle form of bullying involves exclusion. If an employee walks into the break room and everyone there stops talking, the employee will feel excluded from the group.

Negative behaviors such as these can lead to sabotage, which is particularly insidious. "It's very easy if I'm teaching you something to leave out a step," Burk says. "You don't [learn] that step, and then I can come in as the hero when you can't do it."

For example, Burk heard of a new scrub tech who was learning from an experienced scrub tech. The experienced employee told the newbie how to prepare for a surgery. When the new scrub tech was in the operating room, the surgeon held out a hand, but the new scrub tech did not have the instrument ready. The mentor, who was observing the new scrub tech at work, ran out of the room to grab what the surgeon needed. This led to a delay in surgery, which frustrated the surgeon. The woman who experienced this humiliation explained how it made her feel.

"She kind of realized she was being set up for failure," Burk says. "If you ask the person doing the training, she'd say, *'Oh, I forgot to tell you.'* There are many excuses." Because of the potential for sabotage, as well as

simply poor instruction, surgery centers should identify employees who want to provide staff training and will do a good job of it, Burk offers.

Spreading rumors also is a type of bullying. This is one behavior other nurses and leaders should shut down quickly.

Burk suggests confronting those spreading rumors, saying, *"You know it is nonsense. Let's not talk about her. It's really not nice. We wouldn't want someone talking about us."*

Manipulation is another form of bullying. For example, a nurse might not like orthopedic assignments and manipulates someone else to take those cases. "Or, they'll irritate the charge nurse to get out of work," Burk adds. Manipulators are clever and might push the charge nurse's buttons to the point where the charge nurse quickly dismisses the manipulator and pulls somebody else in the room. ASC directors can monitor for bullying behaviors and create a culture where all employees (especially recent hires) feel comfortable reporting bullying episodes. "I tell all new hires, *'This is an OR. Sometimes, people are not nice to one another, but I want to know when it happens. So come back and tell me,'"* Burk says. ■

Staff Should Lead Culture of Caring Initiative

One of the most effective ways to prevent bullying is to create a culture of caring in a healthcare setting, including ASCs. This process calls for identifying key stakeholders and asking them to work on creating a healthy work environment initiative. The goal is to establish a culture of regard in which staff treat each other positively.

First steps include establishing a code of conduct, establishing competencies, setting clear expectations, and making management available and accessible to staff. **Lynda Olender**, PhD, RN, ANP, offers some other tips for creating a culture of caring and regard among staff members in the ASC:

• **Set up shared governance.** ASCs could start projects of shared governance in which employees could brainstorm ideas and solutions while collaborating with managers. Olender recommends asking group members questions such as *What are the things you would like and appreciate?* and *What are the things you most appreciate while working here?* For instance, the group might desire fostering more teamwork through recognizing employees' birthdays or baby showers. These are events people look forward to attending, which can lead to a more positive environment.

"This type of project would be well worth it to organizations in terms of employee retention and satisfaction," Olender says. "If employees are unhappy, their lives are stressful. They lose sleep and have more injuries. They feel disgruntled toward the agency and leadership."

Instead of focusing on the ASC's growth and quality improvement, leaders who find this type of unhappy culture have to spend time combatting negative behavior.

• **Focus on communication and feedback.** Similar to an old-fashioned phone tree, a communication network asks employees to speak with a small group of other staff until plans and ideas are communicated to everyone and feedback is obtained, Olender explains.

ASCs might hold a focus group to ask people to identify what they most appreciate about the agency and what tactics they think are necessary to produce even more positive results. The key is to keep these sessions from becoming negative. Leaders might use the word "appreciate" and steer people away from negative inquiries and comments. "People get excited about what's working well in the workplace and what they appreciate about each other," Olender says.

Even when an organization has experienced noticeable problems with bullying and staff might have

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legitimate grievances, it is best for leaders to use positive wording and framing. "You might walk into that room and cut it with a knife," Olender says. "But I have learned that you have to go on the positive or you will find yourself in a very unhappy situation."

For instance, Olender starts with a discussion of prevention approaches and how to establish a healthy work environment and culture of caring. "If there is a report about bullying [in the ASC], you have to address that immediately, and you have to establish mutual goals," Olender says. "A manager has the right to expect people to get along and treat each other with respect. You don't have to love everybody you work with, but you have to be able to work with them effectively."

• **Create contagious impact.** ASC managers can take actions that prevent bullying, including developing mentorships that rely on willing and proficient staff.

This takes more time than just assigning whoever seems available to take on the role. Avoid using employees who are disgruntled or close to retirement who are no longer invested in the facility's future.

"Set up a tone for how mentoring occurs," Olender says. "Elevate it to an important job rather than something extra the precept has to do."

ASC directors might assess what is working well and figure out how to get more of the same, Olender offers.

"Don't leave it to the preceptor to figure out," she stresses. "Ask them questions about what they think would be the most helpful for the new person." ■

When Obtaining Informed Consent, Focus on Everyone's Role in the Process

Surgeons know that obtaining acceptable informed consent from patients requires more than asking for a signature at the bottom of a form. What they might misunderstand is what the role is for the nurse and other healthcare providers (other than physicians) in the informed consent process.

"Sometimes, there is confusion [among] the public, attorneys, and other healthcare providers as to what is the role of the surgery center nurse or staff member with regard to informed consent," says **William A. Miller**, JD, partner and chair of Higgs Fletcher & Mack LLP in San Diego. "They are generally not required by law to obtain informed consent. That is the role of the physician."

Generally, it is the physician's responsibility to diagnose, determine a treatment plan, and make recommendations to patients about the treatment plan. Physicians should ensure patients are fully educated about the procedures to be performed, along with risks and benefits. "The role of the surgery center staff is more of a witness when the informed consent form is signed at the surgery center," Miller says.

Another issue is the notion that informed consent is synonymous with the informed consent form. Instead, providers should focus on the informed consent process, not just the signature.

"People tend to focus on the form that needs to be signed rather than on the process itself," says **Debra Stinchcomb**, MBA, BSN, RN, CASC, senior consultant for Progressive Surgical Solutions in Fayetteville, AR, and former president of the Arkansas Ambulatory Surgery Association. "It's important for patients to understand exactly what they're having done. Informed consent should start with the surgeon in his or her office. Explain why the person needs surgery, any alternatives available vs. surgery, and any risks and benefits that the surgery is going to bring."

Informed consent in the surgeon's office also might include the physical therapist informing the patient of necessary therapy after surgery or information from other providers.

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Obtaining patients' informed consent is the physician's responsibility, but the process is more than just a signature on a page.

- Surgery center staff are witnesses who confirm the informed consent form has been signed.
- Typically, the informed consent process communicates the time the patient will spend in recovery, potential adverse events, and what types of activities patients can handle as they recover.
- When patients do not have mental competence and consent capacity, then a legal guardian or a person with durable power of attorney must sign an informed consent form on their behalf.

The informed consent process typically covers the time the patient will spend in recovery, potential adverse events, and what types of activities patients can handle as they recover. Patients should receive this information before they schedule the procedure. Then, on the day of surgery, the surgery center needs to ensure the patient has been fully informed, Stinchcomb says. "That's where the consent form comes in, but the entire process is not just the form," she adds.

Physicians and others might provide an informed consent form, but it is important that ASCs create their own facility consent form in which the procedure is described. This form should include a statement that reads, *"I have been given information about my diagnosis about this procedure and any risks, benefits, and alternatives,"* Stinchcomb notes.

Surgery centers can run into legal problems when patients believe the informed consent process was inadequate in some aspect. For example, one case involved a plaintiff who claimed brain damage post-surgery and wanted $15 million in damages, Miller says.

"The patient claimed to have consented to only a certain type of procedure being performed and further claimed the patient would not have gone through with surgery if the particular procedure was not performed," he explains. "The physician contended the issue had been discussed with the patient preoperatively, and there was no agreement the surgery would proceed only if the particular procedure was performed." The physician contended the particular procedure could be performed, but only if the physician concluded it was clinically necessary, Miller adds.

Conditional consent also could look like this hypothetical example: A patient visits an orthopedist and says, *"My knee really hurts, and I'm willing to undergo knee surgery, but will only agree to have a knee replacement procedure."* In response, the doctor says, *"OK, I think you are an appropriate candidate for total knee replacement."* But then right after starting the procedure, the doctor said, *"I don't think the knee looks that bad, so I'll only debride the cartilage."*

In this scenario, Miller says the patient could sue the doctor, claiming that the patient's consent was conditioned on the surgeon performing the total knee replacement procedure, not anything less than that. "The patient might say, *'Had I known you would only do something less than total knee replacement, I wouldn't have had surgery and anesthesia. Now, when I need a total knee replacement surgery in the future, I'll have to go through a second surgery with all of its risks,'"* Miller explains.

In other cases, patients might sue surgery centers claiming that the informed consent process was inadequate because they did not receive enough information, Miller offers. "If a patient wasn't given enough information, then the claim generally is a claim for negligence. "If, on the other hand, I consented to procedure A, and you proceeded to procedure B, and you never obtained my consent in the first place for procedure B, then that's a battery claim."

For example, there could be a medical battery claim if a patient consented to surgery on his right knee but the surgeon performed surgery on the left knee. Typically, ASCs direct a pre-op nurse or someone in the registration area to handle informed consent and ask patients to sign the form.

However, there are some circumstances when the person handling the consent form should stop the process. For instance, if the person handling the consent form believes the patient has cognitive issues, the process should not continue. "Whoever notices that the patient is confused should notify nursing staff, the medical director, and surgeon," Stinchcomb advises.

When patients do not exhibit mental competence or consent capacity, then a legal guardian or a person with durable power of attorney must sign an informed consent form on their behalf, Miller says. Since ASC procedures are elective surgeries, there is no emergency issue at stake. A delay until a medical guardian is available would be the answer.

"Make sure you have the right person making those decisions," Stinchcomb cautions. "I have had some cases where people call us and say, *'We had someone transfer from the skilled nursing facility, and we don't have a medical power of attorney, so what can we do?'* I say, *'You have to send them back and wait until you have [permission from] a power of attorney or a court-appointed guardian.'"*

It is inconvenient to postpone surgery, but sometimes this is the prudent choice. ASCs should cancel a case where the patient's decision-making capacity is questioned and there is no patient representative authorized to sign an informed consent form on the patient's behalf, Miller recommends.

"You're better off canceling the case than having the case go forward and risking an unfortunate complication and the question of whether the person had the competency to provide informed consent," Miller explains. "Someone suing would say, *'This is not an emergent procedure; it's elective, and there would have been no harm to see if that person was competent.'"*

Surgery centers also should pay attention to language barriers that

might affect the patient's informed consent. "At the physician's office, if patients say they don't speak English, and the doctor doesn't have a translator, then how could the physician obtain a meaningful informed consent?" Miller asks. "Patients could have a family member translate, but most states require you to have a translation service available for the patient."

If there is a complication during surgery, and the ASC and surgeon relied on a patient's family member to translate, then it raises questions about the adequacy of the informed consent process.

"Who does a jury believe — a family member, who after the fact says they were not informed of all of these risks, or the nurse, who says they clearly understood it and communicated to me they understood it?" Miller says.

There are medical translation services available that could handle any language and dialect. Since these are elective procedures and not emergency situations, the surgeon should delay the case until a translator is available, Miller adds. Surgery centers must provide quality care in their work and also should provide optimal informed consent. "In my experience of 29 years of doing healthcare law, I know that ambulatory surgery centers are doing the best they can for their patients, and they want to provide excellent care," Miller says. "Informed consent is one way to help minimize the perception that you don't provide thorough care. It minimizes the risk of being sued." ■

Tips to Improve Informed Consent Process

ASCs can ensure best practices in the informed consent process through knowing state laws and ensuring patients fully understand the procedure, along with its risks and expected outcomes.

Patients need to know what is required, which takes more than just signing a consent form, says **Debra Stinchcomb**, MBA, BSN, RN, CASC, who offers a few tips for improving the informed consent process:

• **Witnesses.** The person who signs the informed consent document as a witness is documenting that the patient or guardian signed the form, *not* providing informed consent.

"It's the surgeon's responsibility to provide informed consent. The witness only verifies that the signature is that individual's," Stinchcomb explains. "If there are any questions from patients, the entire process needs to stop, and the surgeon needs to come out and answer the questions." The surgery needs to wait until the surgeon can answer the patient's last-minute questions. Usually, patients are well-informed by the time they make it to the day of surgery. But ASC staff should know that any confusion on the patient's part is a red flag to stop the process. "Make sure you get those questions answered before moving forward," Stinchcomb adds.

• **Guardianship.** Stinchcomb says some states have passed laws that allow an emancipated minor who is not of the legal age of 18 to still sign consent for themselves. More often, there are cases of elderly patients who become confused periodically, and a family member needs to have a medical power of attorney and documentation, showing that family member can make medical decisions for the patient, Stinchcomb explains.

• **Time limits.** In some states, procedures are time-limited, meaning the procedure cannot be performed for a set number of hours after the patient has signed the informed consent form. An example of this would be tubal ligation or sterilization in which a patient has to wait 24 hours after signing consent, Stinchcomb says. "States that have time limits on procedures really want people to think about it," she notes.

• **Readability.** Informed consent forms should be written in language patients can understand easily with one exception: "When it comes to the actual procedure, that should be written in medical jargon," Stinchcomb says. "The main reason for that is due to the time-out in the operating room where everyone stops to make sure they're doing the right procedure on the right patient. They'll need to compare the consent form with what they're doing."

If the consent form describes the surgery one way, and the actual name for the procedure is something different, it might cause confusion or hold up the process.

• **Language.** When patients are not fluent in English, the informed

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consent process needs to include language interpretation, either with a professional fluent in the patient's language or with the help of an interpretation hotline. When necessary, consent forms also should be in the patient's language.

ASCs are responsible for ensuring patients can read and understand post-op instructions, consent forms, and other relevant information, Stinchcomb says.

• **Documentation and storage.** "The informed consent form should be kept within the medical record and retained for as long as that state requires a site to retain medical records," Stinchcomb says. "In some states, that might be seven years; in others it's 10 or 15. You should understand your state's regulations." ■

Follow These Tips to Ensure All Loaned Instrument Tray Processes Are Up to Date

With technology continually evolving and new manufacturer's instructions for use (IFU) to follow, ASC staff might need a refresher course on best practices in cleaning and sterilizing loaned instrument trays.

Sometimes, ASCs have to clean, sterilize, and turn around these loaned trays quickly, says **Delores O'Connell**, LPN, CRCST, CIS, clinical education specialist at STERIS Corporation in Mentor, OH. O'Connell speaks about operating room cleaning and sterilization processes at national surgery center conferences.

There is more time to prepare instrument trays when an ASC owns the instruments, but organizations have less control over when a vendor will deliver a loaned instrument tray. It might arrive soon before the surgery for which it is needed. Still, the tray will need to be cleaned and sterilized before use, even if the last user already performed the same process. "Sometimes, there are multiple instrument trays for one patient," O'Connell notes.

There are a few best practices when it comes to processing loaned instrument trays:

• **Check manufacturer's IFUs.** Read outlines on how the instruments should be cleaned and sterilized and check for any packaging considerations. As loaned instrument trays are sent from one facility to the next and subjected to various risks during transportation, an ASC must clean and sterilize these trays after they arrive, O'Connell says.

"You don't know where it's been and what it's been subjected to during transportation. You don't know what the previous place's processes were," she says. "For instance, I've seen loaned instrument trays arrive via an open pickup truck."

• **Match manufacturer's IFU with mechanical washing.** "Make sure you have the proper chemistries and proper cycle," O'Connell says. "You go from the instructions for use for the machine and match them."

Most instructions for use are generic, but some include specific details — watch for those. For instance, some instrument sets contain plates, screws, and wires, and the IFUs indicate that no lubricant is to be used during the wash cycle.

• **If the ASC uses chemical integrators, insert these during assembly process.** Some surgery centers use integrators that monitor sterile trays to ensure they meet all the critical parameters, including time, temperature, and steam quality. These tools are small sticks that use the words "pass" or "fail." If there is a problem with one of the parameters, the tool will say "fail" when the packaging is opened. Operating room staff will need to reprocess the tray.

O'Connell says the integrators should be placed on opposite corners

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on each pan. "On the first level, I would place it on the upper left and lower right corners; on the second level, I'd place it on the upper right and lower left, and then move it back and forth on each level. At the top, you can have at least one in the middle so the team can see it as soon as they open it."

Even the integrators will include their own manufacturer's instructions for use. ASCs should follow those instructions when available.

• Match manufacturer's IFU to packaging. After the mechanical or manual instrument washing, the next steps are inspection and packaging in rigid sterilization containers or sterilization wraps. ASCs need to check manufacturer's instructions to ensure these steps match. Inspection ensures there is no hidden debris before the instruments are packaged in a sterile barrier that prevents recontamination before the tools are ready for use, O'Connell explains.

• Clean and inspect after using instrument tray. After the tray is used, staff wash and inspect the tools. There is no point in sterile packaging as the vendor receiving the returned items will re-inspect and verify that all critical components are returned, O'Connell says.

Some surgery centers have begun to take an additional step: using technology that photographs the instrument tray when it arrives from the vendor, places a barcode on it, and tracks it. This electronic instrument management system helps surgery centers keep track of the loaned instruments and devices, creating an electronic inventory that can be compared to what is assembled after use and before the instrument tray is returned to the vendor. ASCs can ensure that they have returned the tray in the same condition as when they received it, O'Connell says. "This is something that's been needed a long time," she adds. "It closes the loopholes of what was in the tray and what it looked like."

ASCs should provide instrument cleaning and reprocessing training based on federal regulatory standards and monitor staff practices and habits to continually update and refine training. "You will have new employees entering the field, newly certified, or, depending on the state, it can be on-the-job training for sterile processing," O'Connell says. "We have to make sure everyone is following best practices and guidelines." ■

SDS Manager

Tidbits, Tips, and Tricks

How hiring managers and job applicants define 'the right fit'

By Stephen W. Earnhart, RN, CRNA, MA
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Austin, TX

Anyone reading this has been hired to perform a job, has hired others to work a job, or both. It is expensive to find the right person with the appropriate skills who is right for the position and company culture.

Typically, all a hiring manager has available are applicants' résumés for screening. After identifying half a dozen worthy candidates (if you are lucky), the hiring manager screens applicants via phone conversations and on-site interviews. The whole process is tedious, time-consuming, and expensive. If you are applying for a job, it is a roll of the dice to see if you fit into a position with a company.

What if you could significantly increase the odds of finding the right individual before expending so much time and resources? Maybe you are the applicant; what if you could know you would be successful in the job before you are hired? Both hiring managers and applicants have certain expectations regarding job openings, but how do either determine what constitutes "the right fit?" Is it meeting the culture of the position

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.

offered? It is just as stressful for the applicant to realize *"This is not the right job for me"* as it is for managers trying to figure out how to move a person who is a bad fit for a role after the fact.

Many companies offer these short pre-employment tests for potential new hires. These tests help both hiring managers and applicants understand if someone is right for a job opening. I have started using this approach and swear by it. Google the phrase "culture testing hiring process." Such a search should return results for various testing options, as well as articles written by authors weighing the pros and cons of the approach.

Who is the Original Author?

We are constantly amused when we see policies and procedures at a facility we are working with that has our name on it or the name of someone with whom the facility has no relationship. Who really started your marketing plan? Who is the original author of the article you are reading? There are various online tools that can help organizations identify plagiarism. Conduct research to see if one of these tools is right for your organization. It might surprise you to find out where information originated.

Payer Contracts

Are your payer contracts up to date? Have you submitted your updated "charges" each year to all your payers? You are getting the short end on reimbursement if you have not. Payer contracting, like certification, is an ongoing process.

There are services available that can compare your payer contracts, rates, reimbursement, missed charges, incomplete insurance submissions, and average filing against other similar organizations. These are companies that provide this audit service for free. Again, this is another service worth researching online to see what is right for your organization.

Benchmarking

This is essential to effective and efficient operations at your facility. Lately, we have visited some surgery facilities whose leaders think they are doing well until they compare themselves with their peers and realize they are missing the mark in some critical areas. Again, many (if not most) benchmarks for our industry are available online for free. Even if you just secretly check out yours against others, it is still good information to know. ■

(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. Instagram: Earnhart.Associates.)

ASCA Continues Working With Congress on Colorectal Cancer Screening Legislation

A resolution regarding colorectal cancer screening that stalled in a House committee in May 2018 remains important, according to the Ambulatory Surgery Center Association (ASCA), which is working with the new Congress to keep the legislation alive.

"For the 116th Congress, we will once again work with [a] larger coalition to pursue the most effective solution to ensuring patient access to screening colonoscopies that save lives," says **Heather Falen Ashby**, director of government affairs for ASCA.

The Removing Barriers to Colorectal Cancer Screening Act of 2017 would waive Medicare coinsurance requirements involving colorectal cancer screening tests, regardless of whether the code billed was for a diagnosis or procedure.

Ashby explains that under current law, Medicare waives coinsurance and deductibles for screening colonoscopies as a preventive procedure.

However, when a surgeon discovers and removes a polyp, the procedure is reclassified as therapeutic for Medicare billing purposes. Thus, patients have to pay the coinsurance. This is an unexpected cost for Medicare beneficiaries, which might deter patients from undergoing the screening procedure.

The ASCA calls on Congress to pass legislation closing this loophole and helping reduce colorectal cancer.

According to the CDC, colorectal cancer is the second-leading cause of cancer-related death among men and women.

Much more information about the disease, including screening tests, is available through the CDC online at: https://bit.ly/2hNyIeN. ■

SAME-DAY SURGERY

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CME/CE QUESTIONS

1. **Surgery centers could establish a culture of caring and regard to reduce the risk of bullying affecting their facilities. Which of the following is a recommended approach?**

   a. Make management available and accessible to staff.
   b. Establish weekly staff lunches and monthly culture of caring workshops.
   c. Set up a "bullying jar" in which each time an anonymous note accuses someone of bullying, that employee must pay a dollar to the jar.
   d. Ask staff to sign an anti-bullying pledge.

2. **Which of the following is one of The Joint Commission's listed tactics to battle bullying?**

   a. Establish a Let's Be Civil initiative.
   b. Support people reporting sexual harassment.
   c. Enact a zero-tolerance policy, including sanctions ranging to dismissal, for any act of bullying.
   d. Hold everyone accountable for modeling desirable behaviors.

3. **When a surgeon's informed consent process is inadequate, what is one of the chief risks?**

   a. The patient might decide to not sign the informed consent form.
   b. The surgeon and surgery center could run into legal problems that might result in a lawsuit if something goes wrong during surgery.
   c. The Joint Commission could survey the surgery center and cite the facility.
   d. The patient might report the surgery center to the FDA.

4. **What should surgery centers always do before cleaning and sterilizing loaned instrument trays?**

   a. Open the sterile package containing the instruments.
   b. Check the manufacturer's instructions for use.
   c. Ensure reprocessing equipment temperatures are set correctly.
   d. Check indicators for evidence of a breach.