SAME-DAY SURGERY

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INSIDE

Surgery Centers Could Play Lead Role in Healthcare Transparency

Surgery centers could lead the way in healthcare transparency. Typically, these facilities are the most efficient, safe, and affordable option for procedures, and their prices could be competitive beyond their local borders.

The entire healthcare system would benefit from more transparency for consumers and between businesses, says **Niall Brennan**, president and CEO, Health Care Cost Institute in Washington, DC.

"The healthcare system desperately needs transparency," Brennan says. "When people think of transparency, they frequently think of it is a business-to-consumer type of transparency, about patients knowing more about the price of a specific service. I think it's important to remember that business-to-business transparency in healthcare is just as important."

The healthcare industry's complex web of nondisclosure agreements and proprietary price negotiations stand in the way of cost transparency, he notes.

"Frequently, employers don't have a good picture of how much care costs and what they and their employees have to pay," Brennan explains. "They are shocked to find out the costs on those rare occasions when information does get out."

The industry's value-based transformation is making transparency more imperative. "We're moving from a volume-based model to a relationship among stakeholders, pharma, medical device companies, and all other stakeholders," says **Ferris Taylor**, MBA, executive director, HealthCare Executive Group. "We're moving toward the consumer's experience. They pay for what they get, as opposed to paying for the encounter, which has created in healthcare an unsustainable cost situation."

Taylor argues that instead of lowering healthcare costs, the Affordable Care Act led to much higher premiums and deductibles. "It should have been called the Accessible Care Act because we have 20 million more people who have insurance," he adds. "But just because they have insurance does not mean they can afford it." Within that context, it is unsurprising that costs and

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transparency are key issues in the healthcare world, he says. Taylor uses calculators as an analogy for what should be happening with medical costs vs. the reality. Four decades ago, Taylor bought a hand calculator for his nuclear physics class. It cost him $400 and included four basic functions.

"Today, similar functionality is the size and shape of a business card, and it has solar charging and costs around 30 cents," he says. "It's a giveaway at conferences."

Technology in healthcare also has continued to improve, but consumers are not seeing much of the cost benefits of that improvement, Taylor explains. "Rather than see $400 become 30 cents, it goes in the other direction," he says. "The quality goes up, but the price also goes up."

Transparency could help reverse this trend, and it can work, despite obstacles. Some ambulatory surgery centers (ASCs) have led the way in offering pricing transparency, proving that transparency, however challenging, can be achieved. For example, Monterey Peninsula Surgery Center – Ryan Ranch in Monterey, CA, has listed self-pay prices on its website for several years, says **Tom Wilson**, CEO of the Monterey Peninsula Surgery Centers.

"The prices are discounted off the commercial rates because we collect money up front," Wilson says. "We want consumers to have knowledge and information to make an informed decision."

Elective surgeries are a major consumer purchase, and patients should be fully informed about the cost, he says.

"Society will spend more money on a total hip replacement than on a car, but when people buy a car, they check the gas mileage [and] crash data," Wilson observes. "When you have a total hip replacement, you don't have [access to] the batting average of the surgeon or the infection rate or other information. We make that information as transparent as possible so consumers can make an informed decision."

One reason why there are fewer ASCs and other healthcare organizations providing online prices and cost transparency is because medical consumers have had competing interests in what they want from their providers. "The users of healthcare do not necessarily

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Healthcare transparency is gaining public support, but still faces multiple obstacles to becoming a broad reality across the industry. Some surgery centers are leading the way in making costs and outcomes transparent through their websites.

- Healthcare costs continue rising rapidly despite the Affordable Care Act's emphasis on affordability and accessibility.
- Surgery centers benefit from cost-cutting and efficiency goals, which contribute to a trend of moving site of care to more convenient and cost-effective venues. These include moving a surgery from inpatient to outpatient.
- Surgery centers often specialize, which makes their infrastructure more efficient and contributes to cost-cutting and transparency.

care about cost; they want to go to the best surgeon," says **Michael S. Sherman**, MD, MBA, MS, senior vice president and chief medical officer at Harvard Pilgrim Health Care in Wellesley, MA.

Healthcare plans also focused more on quality and other factors, although this, too, is changing. Accessibility, cost, and quality all are important, Sherman says.

"More and more, our contracting strategy is to identify the highest value and most capable providers, using incentives and plans to encourage people to use those facilities and physicians," Sherman says. "Most notably, there is a large trend toward moving site of care to more convenient and cost-effective venues, which might mean moving a surgery from inpatient to outpatient."

Harvard Pilgrim, which is a non-profit entity without shareholders, is making this change when it is appropriate and convenient. The company's goal is to maintain a 1% to 2% margin and keep premiums affordable, Sherman explains.

"There is a growing recognition that everyone pays for healthcare through insurance. If we're not efficient in choosing high-value providers, then premiums go up," he says.

For-profit payers might not have the same incentive to keep premiums low, but they also are changing, Sherman notes.

"What the larger, for-profit insurers are doing is diversifying to things other than insurance," he explains. "You have CVS merging with Aetna, all looking for revenue from other models, as they recognize public concerns and business dynamics."

CVS is putting what is essentially a primary care center in their pharmacies, and Walmart has been moving in the same direction, Taylor observes. These new models for primary care are in response to patients' needs for not only convenience but also lower costs. Consumer cost is more than premium costs, Taylor explains.

"If a mother of three children has one child who needs medical care because of an injury, it's not just the cost of going to the hospital that impacts that family," he says. The cost of diverting time away from busy schedules to rush a sick child to the doctor or hospital also is a factor.

"To have a more cost-effective environment, you must save on the deductible and overall cost and copays and also keep other aspects of your life in place," Taylor says.

There also are societal and media pressures calling for more healthcare cost transparency. For example, major news organizations have published stories highlighting outrageous medical bills. Other articles showed how predatory some healthcare providers have become in bill collecting.

Certain health systems have sued patients for emergency and other care, sending some into bankruptcy, and the patients sometimes are their own employees. *(Editor's Note: For more on health systems suing patients and employees, please read this article published in the August 2019 issue of our sister publication,* Hospital Access Management*: http://bit.ly/2JsQtz4.)*

"Frankly, I think it leads to an industry that is maybe losing its moral compass a little bit," Brennan says. "And it's definitely at the forefront of the national consciousness right now."

Surprise billing problems are worsening, including anesthesia bills, he adds.

"We've been struggling with this for 10 to 20 years, and there are no magic solutions," Brennan says. "I don't think we need a single-payer system, but we need a single-rater system and a flat rate for all services across different hospitals and payers." *(Editor's Note: For information on balance billing, please read this article from the October 2019 issue of our sister publication,* Hospital Access Management*: http://bit.ly/2JrB0iT.)*

Surgery centers are in the middle of the current healthcare transformation.

"ASCs are a very cost-effective alternative to things that, traditionally, have been done in the hospital," Taylor says.

One factor in ASCs' favor is that most centers specialize, limiting their procedures to areas of expertise. Their overall infrastructure is more efficient, and surgeons can focus on performing procedures at which they excel and leave other procedures to hospitals, Taylor adds.

"You can look at your total cost, and you've simplified this system to the point that you can say, 'In this one area, I can tell you what my costs are, and I can be transparent,'" he says.

Surgery centers have contained some expenses, making it possible to calculate their costs, create bundled payment plans, and be transparent and cost-effective. Monterey Peninsula Surgery Center – Ryan Ranch has bundled some procedures since 2002, making it one of the first ASCs to take this step, Wilson says. In 2012, a major payer asked the ASC to expand their number of bundled cases; today, there are 72 bundles at Ryan Ranch.

Once a surgery center determines costs and offers bundled payments to payers, it is not a huge leap to make prices transparent.

"We started doing the bundles in 2002, but just put our prices up on

the website four years ago," Wilson explains. "We've always quoted prices to patients on what it will cost to do the surgery."

What most people in the United States recognize is that the current healthcare system is unsustainable, Taylor acknowledges. Costs cannot continue to double every decade. Increasingly, people might have insurance, but still struggle with access to care. "We're still focused on accessibility and haven't addressed the cost of healthcare, which is too costly," Taylor says. "I applaud surgery centers for saying, 'I'm going to take this little part and do it really well financially.'" ■

Risk Management Techniques Can Help With Monitoring

Risk management requires more than reporting incidents and adverse events. It is a broader process of monitoring compliance and safety that requires multidisciplinary tools and activities.

"You can teach your staff to monitor what's important, and it helps to put together a simple but thorough checklist," says **Sandra Jones**, MBA, MSM, CPHRM, LHRM, CHCQM, CASC, FHFMA, chief executive officer of Ambulatory Strategies, Inc., in Dade City, FL.

With checklists, employees can monitor one another, taking turns. For instance, after teaching staff about safe medication practices, one person could be the monitor for a period, and then another person will take over. Employees will use a safe medication checklist (which should include definitions and specific instructions) to ensure everyone follows safe practices, she suggests. "The person doing monitoring would make sure that once someone opens a multidose vial, they label it with a beyond-use date," Jones says.

There are a few ways to improve risk management in surgery centers:

• **Develop checklists.** "We set up a 10-point checklist to use as a monitoring tool," Jones says. "It has enough definitions that staff know what to look for."

Checklists, used as monitoring tools, reinforce learning through monitoring, she says. Employees can take turns using checklists, following the workflow and dividing checklist monitoring by floor sections.

"Have one person be responsible for section A in October, and then they're at section C in November, and they're responsible for monitoring that area for multidose vials and outdated cabinets," Jones offers.

• **Train staff with specific instructions.** "Train staff to look at how they're cleaning things between patients," Jones says. "I've seen checklists that are not thorough enough. They say that all areas are wiped down, but that doesn't tell the person who is doing the checking enough information."

Instead, the checklist should include specific action items, including: check that all handrails are wiped down, wipe down all surfaces, use sanitary and disinfection wipes according to manufacturer's instructions for use, use enough wipes to keep surface visibly wet, and wipe the monitor.

"The wipes are wet cloths pulled from a canister, and the canister tells you how to use it," Jones says. "That's the kind of detail that should be on the checklist."

If the instructions are for one wipe to be used to clean and one to disinfect, then it is a mistake for an employee to use one wipe to clean and disinfect.

"Put those details on the checklist so everyone learns not to use just one wipe," Jones adds.

• **Ask staff to report all risks.** "Encourage your staff to report to the risk manager not only the adverse events, but also the near misses, the process failures, and workarounds," Jones says.

Risk managers want to know everything that could have been an

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Risk management should encompass a broad process of reporting adverse events and incidents, monitoring compliance and safety, and initiating quality improvement projects and activities.

- Employees can use checklists to monitor each other for compliance with infection prevention and other standards.
- Encourage staff to report adverse events and all near misses, process failures, and workarounds to the risk manager.
- Surgery centers should create a culture of safety that makes it safe for employees to report problems and does not punish people for owning up to mistakes.

adverse event. They want to know about incidents that almost created patient or employee harm.

"By encouraging staff to let you know of [near misses], you can trend these incidents to show that something is happening more often than people thought," Jones explains.

Using those additional data, risk managers could say the surgery center needs to create a better policy, create more steps, and give more training because twice in the past month, someone caught a problem before it happened, Jones says.

"That's great that it was caught, but what did we do that almost caused the problem?"

These near misses also are great opportunities to reinforce the use of checklists and monitoring. Checks and balances should occur in real time as employees are engaged in their day-to-day tasks.

"You want to do the checklist when it should be done and do it every step of the way," Jones says. "Maybe someone had to do a workaround because a supply wasn't available or a teammate wasn't available. If your staff is educated in how to help you know of these issues, then you can start looking at whether the problems are because of education or staffing changes."

Through monitoring, risk managers can ensure that all processes are smooth and all steps are followed. They can see that obstacles and problems are not fixed at the last minute, which can lead to staff injuries.

• **Make improvements continuous.** Using monitoring checklists to also collect data on mistakes and workflow issues can help surgery centers develop quality improvement projects. In fact, the data should help the center maintain an atmosphere of continuous quality improvement.

"If I ever have someone tell me they can't figure out what to do on a quality improvement/process assurance [QI/PA] project, I wonder how many checklists they've ever worked on because I don't think anyone could find something that doesn't need to be fixed," Jones says.

Often, there are too many issues and processes that need to be improved, she adds.

"Work with your staff without pointing fingers," Jones advises. "Look at processes that need to be improved, and then you have a QI/PA project." Perhaps the monitor checked 27 open, multidose vials, and found that four were still on the anesthesia cart after the patient left the room.

"You say, 'Here's what we can look for, here's the gap in performance we found, and here's what we can do about it,'" Jones explains. "Educate, monitor, and then look in a few months to see if the changes worked."

• **Involve staff.** Surgery center risk managers have to engage staff and teach them to be the eyes and ears of the center. The risk manager cannot be the only enforcer, Jones cautions.

"They have to know how to alert the risk manager when something needs to be addressed," she says. "Have a culture of safety, not just ratting on someone, not making someone look bad or pointing fingers."

Encourage people to speak up when they find it necessary to do something that is against protocol. It is better to hear about these lapses before they cause harm.

"The staff needs to be comfortable that they won't be punished [for reporting]," Jones says. "Help create a system that is safe for them and the patient." ■

AORN Offers Safe Patient Handling Guidance

Nearly half of occupational injuries among perioperative nurses are musculoskeletal, often related to lifting and moving patients, according to the Association of periOperative Registered Nurses (AORN).

Root causes of these patient handling injuries include too few staff members required to transfer a patient, lagging technology that could make patient transfers safer, and poor planning.[1] In one survey of 116 OR nurses from eight hospitals, two-thirds reported suffering from musculoskeletal problems, says **Mary Ogg**, MSN, RN, CNOR, senior perioperative practice specialist for AORN. The same survey also showed that about 53% of respondents reported pain in the lumbar region and 38% experienced pain in the cervical region. Also, OR nurses' musculoskeletal problems are one of the most common causes of long-term absence from work.[2]

Since AORN developed its first safe patient handling guidance statement 15 years ago, the challenges in moving patients have only grown bigger. Obesity among patients is one of the chief challenges. The percentage of adults who are obese is around 40% in the United States.[3]

"Safe patient handling is more important today than it was 10 to 15 years ago because none of our patients are getting any smaller," Ogg says. "That same patient who might have weighed 170 pounds 20 years ago now might weigh 270 pounds. When we had a 200-pound patient then, we

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Perioperative nurses often sustain musculoskeletal injuries from lifting and moving patients. This is a problem that poses even more risks in a society with an obesity epidemic.

- Injuries among nurses and other staff can occur when too few people try to transfer a patient and from a facility's lack of assistive technology to help with moving patients.
- The Association of periOperative Registered Nurses offers guidelines and tools to help surgery centers with improving patient handling and make it safer.
- When building a new ASC or renovating operating rooms, architects could design them with assistive patient handling devices in mind.

thought the person was huge; today, we think that's a smaller patient."

AORN's most recent safe handling and movement guideline offers suggestions for how ORs can improve staff and patient safety during transfers.[4]

The guideline calls for creating a culture of safety, including incorporating ergonomic design principles to provide a safe environment. ORs should select, install, incorporate, and maintain safe patient handling technology in the perioperative setting.

Also, be sure to educate and train staff on safe patient handling techniques and equipment use. To ensure continuous safety, establish a comprehensive quality assurance and performance improvement program to evaluate safe handling practices. Without assistive technology, it is unsafe for staff to handle patients who are morbidly obese, Ogg says. There are more modern solutions, such as hovercraft-like machines, to more old school devices, such as ceiling lifts attached to a sling and boom-mounted lifts. ORs also can use beds that can be modified with automatic lifting and other table functions.

"There are a few things out there to help," Ogg observes. "Many nurses think they only need these devices to move bariatric patients, but, in reality, we should use them for all patients."

When ASCs are built, they could be designed with assistive patient handling devices in mind, Ogg says.

"This is especially helpful in outpatient ambulatory surgery centers because you tend to not have a lot of staff for moving patients," she notes. "It's great to have these assistive technologies available to make it easier for everyone so they don't experience a neck or back or shoulder injury."

Despite the benefits of technological solutions and other safe patient handling measures, not enough surgery centers and ORs have adopted them, Ogg laments.

"We have a long way to go; the OR is the last frontier for getting these in place," she says. "Hospitals may have this technology in place [on nursing floors], but they haven't gained too much popularity in ORs yet." ■

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How to Make Performance Evaluations Useful for Everyone

Mention the annual job performance evaluation, and chances are everyone will run in the opposite direction. Many employees and managers dislike them. But they must be conducted, so why not do them well? "Performance evaluations are done sort of haphazard," says **Ann Geier**, MS, RN, CNOR, CASC, chief nursing officer, Surgical Information Systems, LLC in Alpharetta, GA. "There's a lack of training for managers on training evaluations. The forms are usually poorly designed, and it's very subjective, just a matter of opinion."

Geier offers a few suggestions for improving the performance

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Performance evaluations should be conducted throughout the year and in a thoughtful way that increases their usefulness and helps staff improve their work skills.

- One approach is to ask employees for a self-evaluation that includes a list of their three work goals and three personal goals.
- Use findings and the employee's goals from the previous year's evaluation to compare with the current year to see if performance has improved and the employee's goals were met.
- Goals for administrators can include taking the Certified Administrator Surgery Center exam, participating in a state association, writing professional articles, and speaking at national meetings.

evaluation process and making it useful as part of a surgery center's mission to deliver high-quality care:

• **Make performance reviews a year-long process.** Some surgery centers will conduct all employee reviews at the start of each new year or on a predetermined date. While there might be some appeal to setting aside time once a year for these, it is not necessarily the most efficient or best way to handle the annual review process.

"A lot of companies do it on a calendar year basis where everyone's evaluation is due on the same day," Geier observes. "If you have 50 employees to evaluate at one time, it opens a whole slew of issues."

When performance reviews are conducted at the same time each year, they might start off strong, but fall off toward the end, she notes.

"You will get tired of doing them and go through them quickly," Geier says. "By the time you get to the last eight or 10, you're hardly looking at what you're reading and are not paying attention to the actual evaluation."

The better process is to stagger evaluations, perhaps handling them on the anniversary of employees' hiring dates. Also, Geier recommends managers keep notes on employees' performance throughout the year. When there are issues or opportunities for praise, managers should notify employees in real time.

"There shouldn't be surprises," Geier says. "If you give bad news at the evaluation, then that's your fault; there should be feedback all year."

• **Empower employees to participate.** "I empower employees to remind me a month ahead of their work anniversary that my evaluation is due," Geier says. "When I schedule time for an employee's evaluation in my calendar, that says to the employee that this is important." One of Geier's first steps is to hand employees a self-evaluation to complete.

"What's important to me about the self-evaluation are the employee's goals," she says. "What are the employee's three work goals and three personal goals?"

Employees bring their self-evaluations with them to the performance evaluation meeting. The manager's evaluation is completed before the manager sees the self-evaluation. One way to make performance evaluations useful is to compare the employee's self-evaluation with the supervisor's evaluation and to discuss any differences in the meeting with the employee, Geier says.

Also, Geier compares the employee's professional goals from the previous year's evaluation with the goals the employee met in the past year. The idea is to see if the employee succeeded in achieving those goals, she explains.

"If employees didn't succeed, I ask, 'Where did I let them down?,' not 'Where did they fail?'" she says.

For example, if one of an employee's goals is to become a certified infection preventionist, but the employee never earned this certification, Geier would consider how she, as the supervisor, never did anything to help the employee sign up for classes for certification. "I have a different take on evaluations, but I take them very seriously," Geier says.

Another approach for making employees comfortable during the performance evaluation meeting is to ask the employee to sit at a right angle to the supervisor, Geier explains.

"If you sit straight across from one another, it's a power play," she says. "If you face them, then it's you against them, and it's not collaborative."

But when the pair sit at right angles to each other, it creates an environment open to dialogue, Geier adds. Meeting at a round table also can be effective. "It removes that barrier between management and employees," Geier says.

• **Keep it personal, confidential, and fair.** When supervisors hold performance evaluation meetings, they should keep the meetings private, confidential, and behind closed doors. A 'do not disturb' sign could be placed on the door to prevent interruptions.

"Make the encounter comfortable, and give the evaluation to the employee to read," Geier says.

Supervisors should explain their findings and scoring on the evaluation

form. If each performance item is scored from a one (poor) to three (meeting expectations) to five (best), a supervisor should let employees know a little about how those numbers are determined. A performance indicator about wearing OR clothing might only receive a score of three. "You can meet that expectation, and you can't exceed it," Geier explains. "Some employees think their performance is perfect and they should get all fives. I have to explain to them that in some situations, you can never achieve a five. You either do it or don't do it."

Any scores of one or five should include a comment explanation. "If it's a five on a performance item related to working with the patient and family, it can be a comment, saying, 'You excel in conversations with the family,'" Geier says. "Then, you can use an example about how one family was upset about something while waiting in the waiting room, and the employee gave the family a restaurant gift card."

If a score is a one or two on the attendance performance indicator, then the comment might note that the worker had been late three days out of 20 days in March, Geier adds. Any performance reviews that include ones and twos, indicating poor performance, should not be a surprise to the employee. These problems should have been discussed with the worker when they occurred, Geier notes.

• Discuss findings and set goals. "We should be in agreement on the evaluation, and if not, let's discuss it," Geier says. "'I rated you this, and you rated yourself this, so let's discuss it.'"

Geier focuses on the employee's goals and helps them provide specific actions they'd like to take. For example, an employee might set a personal goal of creating a better work-life balance. The supervisor can ask the employee to specify what might need to change for the worker to meet this goal.

"We can discuss it, and the employee might say, 'I'd like to leave on time every day,'" Geier says. "An employee might make it a personal goal to take vacations because the person had been carrying the vacation days over from one year to the next."

Another worker might make a professional goal to become a certified infection preventionist, so the supervisor can suggest they talk about that after the evaluation is complete. Geier once encouraged a business manager to take coding classes to become a certified coder. The employee did this and became certified.

It is the supervisors' role to help employees grow professionally through setting goals that stretch their skills.

For administrators, Geier suggests they set four goals: Take the Certified Administrator Surgery Center exam, be an active participant in a state association and serve on a committee, write an article for a national publication with a surgery center focus, and speak at a national meeting.

"Their immediate response to being asked to speak is to say, 'I can't do that,' but I say, 'You can do that, and I'll help you do that,'" Geier says.

• Make process positive. "Set up your employees and managers to succeed," Geier says. "It's a positive experience." Clear communication helps with creating a positive environment. Supervisors should explain how pay raises resulting from the performance evaluation results are determined. If there's a cap on the percentage of increase, explain what that percentage is and who is eligible for the maximum.

"Not everyone is at a 5% increase level," Geier notes. "You have great employees that meet all expectations and do their job well, but they won't get to the next level. Then, you've got employees who have initiative and volunteer to do extra projects, and they deserve a bigger increase."

Geier shows employees she cares about their professional development, even to the point where she will help them move up to a position outside of her own organization.

"I'm asked all the time, 'Why do you do that?' I say, 'Because, you're going to lose them anyway; they'll find something else to do, so we help each other, and it never stops,'" Geier explains. "It's paying it forward, and at some point, I'll have to retire. I am training my replacement, somebody to return to take my place. I hope it's somebody who has the motivation and love for this industry that I have." ■

Tips for Effective and Efficient Scope Cleaning

Infections attributed to contaminated scopes have made headlines and cost healthcare organizations and scope manufacturers millions of dollars over the past few years.

This makes scope cleaning an important best practice and quality improvement project for surgery centers. It is among the reasons why The Endoscopy Center of Encinitas, CA, focused on this process improvement, says **Jill Smith**, RN, infection preventionist of The Endoscopy Center. After implementing quality improvement process changes, the center improved its proper cleaning compliance rate to 98%.

"We had been looking at different areas where we felt we could do a better job," Smith says. "With GI procedures, it's always changing, like the national reports on duodenoscopes and people having infections and the difficulties in cleaning them. We thought this is where we needed to get educated and see what we could improve."

The surgery center launched quality improvement/quality assurance processes, looking at procedure room cleaning, scope cleaning, and reprocessing.

"We took it a step further and said, 'How can we do a doublecheck on cleaning processes of our scopes?'" Smith says. "We put our scopes in a processor, but how well are we manually cleaning these scopes?"

This question launched a study and has resulted in the surgery center collecting several years of data. The information led to continuous process changes.

"We made huge changes, and it was eye-opening in the scope cleaning. We have had really great success with that," Smith reports. The changes led to the center's proper cleaning compliance rate increasing from 86% to 98%. "We continue to enjoy a success rate of 98% to 100% now that the process has become second nature," Smith says.

Another outcome was that the room turnover time has improved. It once ranged from six minutes to 19 minutes. Under the streamlined, uniform approach to the cleaning process, it is consistently six to eight minutes, Smith adds.

What follows are the best practice steps The Endoscopy Center has taken to achieve positive outcomes:

• **Collect direct observational data.** "We watched the room turnovers to see how people were doing it, and we were surprised at how different the rooms would look, depending on who did the turnover," Smith says. "Some went above and beyond."

They also observed contact times and dwell times to see if employees adhered to manufacturers' instructions for use, waiting the full two minutes (if that was specified), Smith adds. "Any kind of disinfection or wipe or product has to stay wet for a certain amount of time for it to kill what it says it will," she observes. "If you wipe it and then put something down on the surface or if the surface doesn't stay wet, then you're not getting disinfectant qualities, according to the manufacturer's instructions."

Direct observation worked well. It included observing whether staff wore personal protective equipment as required and whether they completed checklists daily (including signing off on logs). "We decided it needed to be streamlined," Smith says. "We had a meeting and talked about the times of disinfectants, high and low surfaces, and we developed a flow that starts at the door and goes counterclockwise."

Leaders also developed a checklist and used a timer. "We don't do it anymore, but we also added a timer so when you wipe, you hit the timer, which was set for two minutes to make sure we were being conscientious of the dwell time," Smith explains. "We instituted that change, and have gone back and remeasured and made tweaks, as necessary."

• **Develop a checklist.** As part of quality assurance, Smith presented the observation data to the staff and asked what they thought about it and what they would think of a change. She used staff feedback to develop

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Preventing infections through better facility and scope-cleaning practices takes a concerted effort on the part of surgery centers. Leaders must make this a quality improvement project, and develop and train staff to follow best practices.

- Direct observation of whether staff wears personal protective equipment, completes checklists daily, and signs off on logs can help.
- Sample checklist items on the endoscopy cleaning log for the post-anesthesia care unit include examining privacy curtains for visible soil.
- One helpful change is to hire additional staff to give technicians more time for scope cleaning and to streamline the process.

a checklist. Before rolling out the checklist, Smith asked staff to assess it, asking them how useful it was.

"You can't make change in a bubble," she explains. "If you want to make a change, you have to have people who are invested in it."

There are three checklists. Now, the cleaning process is automatic, and the checklists are available for new staff to use.

"We also use an end-of-the-day terminal cleaning checklist, and they sign it off every day," Smith says. "Someone looks at this checklist and confirms these things were done."

Some sample checklist items on the endoscopy cleaning log for the post anesthesia care unit include: glucometer and thermometer cleaned after each use at end of day, all high-touch areas cleaned properly, and privacy curtains examined for visible soil and professionally cleaned as needed.

The endoscopy cleaning log also lists standards instructions, such as: dwell time is three minutes; high-touch areas include, but are not limited to, computer keyboards, side rails, phones, carts, door handles, call light, and clipboards; and all patient care area floors are properly wet-mopped at the end of the day by contracted services provider.

• Implement new processes and monitor progress. After implementing the tool, Smith conducted observations over the first month, sometimes one or two per week. She also conducted 10 to 12 spot checks in the first month.

"Then, I took my direct observations to see if the checklist was being used," she says. "We took that data, looked at it, and saw whether it was working and whether we were seeing more compliance." Smith studied employees' routines and looked for processes to tweak. This observational monitoring occurred monthly at first. Now, Smith conducts these on a quarterly basis and also checks the logs each month.

"I try to get five to 10 observations in a quarter of different people doing turnover in the recovery room to make sure we're on the same page," Smith says. "If we have a new hire, it's part of their orientation to make sure they understand it."

As nurse managers work, they can secretly observe room turnovers, Smith says.

"I don't just stand there with a clipboard and say, 'Ready, go,'" she says. "I do a secret shopper observation."

Infection prevention and best practices in cleaning and disinfecting are continual quality improvement projects.

"Every year, when I write my infection control plan, it's a hot button. My staff knows it's always going to be this way," Smith explains. "When working in a procedure room where we are dealing with infectious fluids, we have to be mindful and be committed as staff and administration."

• Make changes as needed. Quality improvement processes need to be evaluated continuously and changed when necessary.

For example, Smith's center was using a product with a long dwell time. Employees were not keeping the surface wet for as long as the instructions advised.

"They didn't know they had to keep it wet for five minutes," she says. "We knew that long dwell time wouldn't work when we were turning over rooms as soon as possible."

The solution was to change the wipe to wetter products with far shorter dwell times. But even this change took time to perfect. Leaders found that one-minute wipes were hard on some material and incompatible with the equipment, Smith recalls.

"We had to switch to something less caustic to equipment in the room," she says. "Now, we're using a two-minute prep, but have bigger wipes that are wetter and cover the surface better."

This change is monitored and reviewed continuously. "We make it part of our yearly compliance when we do our annual education," Smith says.

Another process change involved the endoscopy cart. Previously, the focus was on cleaning the dirty endoscopy cart. This has changed. Now, the surgery center's focus is on looking at the room holistically for cleaning and decontamination.

"If you have a dirty door handle and no one wiped it, and you touch it before going to a patient, the potential for infection is high," Smith explains. "We know better and can do better, and that's what we did."

Changes often require more resources. In The Endoscopy Center's case, this meant administrators added another tech to allow more time for scope cleaning and to streamline the process. The center added more work to scope cleaning, which includes a channel check, extra checks and balances, and increasing scope cleaning time.

"We separated the tasks," Smith says. "Instead of [putting the cleaning] all on the technician, it's split between the nurse and tech."

Nurses come into a room and perform an environmental cleaning. They own responsibility for the room to make sure the cleaning happens. After completing the initial cleaning and waiting for the dwell time, the nurse collects medication and reviews the patient's history. Then, the tech comes into the room and prepares

the new scope and equipment for the next case, Smith explains. Before, the cleaning was left mostly to the technicians, who would say they did not have enough time. Physicians believed the cleaning process took too long. "We realized that someone had to take ownership, so we figured out a new, streamlined process and tried it," Smith says. "There was some grumbling in the beginning, and it was bumpy at times."

But after the new process was first studied and then implemented and remeasured, staff began to see its benefits.

"It works very well now," Smith reports. "No nurses quit over this change, and it helped us more as a team because we worked on it as a team." ■

SDS Manager

The Captain of the Ship Doctrine

By Stephen W. Earnhart, RN, CRNA, MA
CEO, Earnhart & Associates, Austin, TX

There is a little-known phase in our industry and operating arena called, "The Captain of the Ship Doctrine." It is intimately important to understand because it can explain some quirks of our surgeons and perhaps improve your day-to-day dealings with them.

This doctrine came from the Supreme Court of Pennsylvania in 1949 when it ruled that: "... it can readily be understood that in the course of an operation in the operating room of a hospital, and until the surgeon leaves that room at the conclusion of the operation ... he is in the same complete charge of those who are present and assisting him as in the captain of a ship over all on board, and that such supreme control is indeed essential in view of the high degree of protection to which an anesthetized, unconscious patient is entitled ..."

Many older surgeons are strong believers in this doctrine and demand it be followed by every member in the operating room, whether they are aware of it or not. I know that from a legal standpoint, courts will uphold this doctrine. If something goes wrong in the OR, regardless of who is at fault, the surgeon is always the point person and culpable.

If you follow this doctrine, the surgeon is responsible for the temperature in the room. AORN standards cite 68-72 degrees, but the surgeon can override that for certain procedures if they so choose.

Many operating surgeons like music played in the room. Anesthesia often may not be crazy about the choice of music or the volume, but it is not their say. It is the captain's choice.

Those are just two examples of many. You can probably list dozens more. Often, there can be clashes between certain regulations (state and federal) that override a surgeon's preference, but short of that, the surgeon is the boss. My own experience with the issue is that there are some surgeons who will push this to the limit, but the vast majority know their bounds and stay reasonable, not letting it go to their head. ■

(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.)

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.

COMING IN FUTURE MONTHS

- Joint program produces positive outcomes in ASC
- Transitional pain service nurses can be big help in OR
- Reduce same-day cancellations by following these tips
- Digital surgery can improve surgeon education

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.

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CME/CE QUESTIONS

1. **What is a good argument in favor of conducting performance reviews annually at the employee's hiring anniversary?**
   a. When reviews are conducted at the same time, it is likely performance reviews will suffer in quality after dozens of employees' reviews are completed within the same period.
   b. The precise hiring anniversary is the best time for a review because it sends the message that the employer celebrates the worker.
   c. Employees are more excited about going through their reviews on their anniversary date.
   d. Typically, employers choose Jan. 1 as their annual performance review date, which is a busy time for surgery center managers.

2. **Which is an example of how surgery centers can improve patient handling and movement?**
   a. Create a patriarchal culture.
   b. Direct technicians and perioperative nurses to develop an action plan.
   c. Select, install, incorporate, and maintain safe patient handling technology in the perioperative setting.
   d. Set patient criteria to a weight limit of 250 pounds.

3. **Transparency in healthcare has not become a trend, but some other trends could be pushing the industry, including ambulatory surgery centers, in that direction. Which describes one of those trends?**
   a. The industry is moving from a volume-based model to a fee-for-service model.
   b. Media and societal attention have unveiled some of the exorbitant unexpected and hidden costs of medical care.
   c. Consumers are beginning to control the cost experience of healthcare.
   d. Payers are rebelling against rising healthcare costs.

4. **Which is a good example of a detail that should be included in an infection prevention checklist?**
   a. Keep surgery center clean and disinfected.
   b. Infection preventionists should monitor staff.
   c. Check staff for signs of antimicrobial-resistant infections.
   d. Use enough wipes to keep surface visibly wet.

SDS ACCREDITATION UPDATE

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

A Closer Look at the Most Common Surgery Center Survey Issues

Infection control top finding in sweeping new report

Infection prevention and documentation were among the top reasons why surgery centers, in various ambulatory settings, were found deficient in accreditation surveys, according to the *2019 AAAHC Quality Roadmap* report.[1]

"The areas with high deficiencies tend to be those that are relatively complex, such as safe injection practices, including storage and handling of single-dose vs. multi-dose medications, immediate use, labeling, and medication disposal," says **Naomi Kuznets**, PhD, vice president and senior director, Accreditation Association for Ambulatory Health Care (AAAHC) Institute for Quality Improvement.

Some high-deficiency standards appear year to year in AAAHC's annual quality roadmap report, but surgery centers are improving in a few areas. "We are seeing lower overall deficiency rates with certain standards, such as conducting quality improvement studies and scenario-based drills," Kuznets reports.

Infection prevention and life safety code standards are among the most common noncompliant standards for accredited ambulatory health organizations and office-based surgery practices, according to The Joint Commission.[2] Surgery center administrators might not be familiar with the latest requirements and updates to the life safety standards related to building and fire protection systems, says **Pearl S. Darling**, MBA, executive director, ambulatory care services, The Joint Commission.

Until 2018, life safety code standards were not one of the top four challenging standards, Darling notes. Deficiencies related to safe injection practices could be resolved through targeted quality improvement practices, Kuznets offers.

"Some of the organizations' staff are either unfamiliar with how to conduct quality improvement activities, or they lack an understanding of why the AAAHC requires certain components, such as specifying measurable goals, which provide clear information about whether the goal is achieved," Kuznets explains.

AAAHC standards require attention to details, such as credentialing and privileging. This includes the use of peer review information. "Another factor relates to issues with the provider and/or staff familiarity and experience," Kuznets continues. "Some employees have only completed desktop emergency drills vs. scenario-based ones, as required. Technology and experience also can be associated with standards' deficiencies."

For instance, electronic health records that do not require documentation of allergies beyond listing them fail to meet the AAAHC's standards, which require descriptions of allergy reactions and severity, Kuznets adds.

Kuznets and Darling describe some of the other common deficiency findings and how to prevent these problems:

• **Infection control and prevention programs.** Surgery centers should create an infection control and prevention program that reduces the risk of infections through staff education and active surveillance.

This should be a frequent area for quality improvement projects, yet it is one of the most common deficiency areas in surveys by both AAAHC and The Joint Commission.

AAAHC's 2019 report revealed that more than 30% of Medicare Deemed Status (MDS) ambulatory surgery centers failed to meet standards with their infection prevention programs. For office-based surgery sites, more than 15% had that deficit. For both, this was the most common finding. For non-MDS sites, this also was on the list of top deficits.[1]

The Joint Commission's infection prevention and control standard often is a problem for sites because there is a lack of training and education for staff responsible

for maintaining these equipment, devices, and supplies, Darling says. Also, surgery centers sometimes fail to follow the manufacturer's instructions for use. A best practice solution is to ensure the organization owns the manufacturer's instructions for use on all supplies, equipment, and devices, Darling suggests. "Conduct process checks on your sterilization procedures and ensure staff is educated on processes approved by leaders and evidence-based guidelines or best practices," she adds.

• **Credentialing and privileging are incomplete.** Surgery center organizations grant privileges for healthcare professionals to practice for a specified period. These individuals must be legally and professionally qualified for the privilege.

While Joint Commission surveyors have found that surgery centers have improved in credentialing and privileging, AAAHC surveyors often come across surgery centers where the credentialing process is inadequate.

"One area that often gets overlooked is checking annual items that can expire, such as medical licenses: DEA, BCLS, ACLS, and any others that are required by an organization," Kuznets says. "Another issue is when privileges are requested that are outside the scope of the ambulatory surgery center. The requested privileges should be included on the list that has been approved by the governing body."

Surgery centers should include allied healthcare providers and supervisor activities in their credentialing and privileging, Kuznets says. "They must ensure that credentialing and privileging information is up to date," she says. "Peer review information should be used for credentialing and privileging."

This includes directing each center and provider to align their scopes of practice and documenting the governing board's work on privileging. Part of the credentialing process is clinical-based peer review, another component that is missing frequently, Kuznets observes.

"Peer review should be determined by the providers, including how often and what is to be reviewed," she explains. "It should be based on clinical practice guidelines that are relevant to patient care."

Other items that should be included in peer review are adverse events and transfers, along with provider behavior (if needed), Kuznets adds.

The exact wording of specific findings in the AAAHC 2019 report include (but are not limited to): "Credentialing files did not contain written requests or approvals for specific procedures," "Peer review was not conducted for allied health or contracted providers," and "Privileges granted for procedures were outside the scope of the center's procedures."[1]

"Routine peer review should occur on a predetermined schedule and should be completed by like peers," Kuznets recommends. "Adverse events and transfers should also be reviewed as determined by the organization's risk management team, and results of the peer review should be included in the provider's recredentialing."

• **Safe anesthesia services.** In MDS ambulatory surgery centers, the third leading deficiency involves creating a safe environment for anesthesia services. More than one out of four sites were deficient in this area.[1]

"Safe injection practices include more than 'one needle, one syringe, one time,'" Kuznets explains.

Safe injection practices also must include details about where to store medication as well as proper labeling and disposal. Other needed information should include how to draw certain medications and how to use medication within specified time frames.

This standard relates to providing adequate space, supplies, and equipment. There must be written policies for safe use of injectables as well as single-use syringes and needles. A log should be kept for preventive maintenance, and all equipment should be maintained and tested according to manufacturer's instructions.

"Part of this problem involves how providers deliver medication," Kuznets notes. Mistakes can include using single-dose vials as multiple-dose vials, not labeling syringes for use, improper storage of medication on anesthesia carts, and pre-spiking IV bags, she adds.

Other specific deficiencies noted in the 2019 AAAHC report include (but are not limited to): "Not treating a multidose medication opened and drawn in a patient treatment area as a single-dose vial," "IV hub not sterilized each time anesthesia administered," and "Single-use eye drops used on multiple patients."[1]

"Although knowledge of safe injection practices is slowly

EXECUTIVE SUMMARY

Some of the most common deficiency findings by accreditation organizations include problems in the areas of infection control, documentation, safe injection practices, and medication disposal and storage issues.

- Recently, life safety standards have become one of the top problem areas.
- Targeted quality improvement practices could help resolve problems with safe injection practices.
- Credentialing is another problematic area, as surgery centers often overlook checking annual items that can expire, such as medical licenses.

increasing, more progress needs to be made," Kuznets says.

• Medication reconciliation, allergies. The AAAHC report noted deficiencies related to medication use and reconciliation. For example, a surgery center might not include documentation about which medications they instructed a patient to discontinue prior to a procedure and when, how, or whether the patient should resume the medication.

"Similarly, a new medication may be prescribed for the patient, but documentation on when and how the patient is supposed to use it might be missing," Kuznets says.

Patients need to take a document to the next provider that explains medication reconciliation, discharge medications, and continuation of current medications, she adds. Even surgery centers that do not use electronic health records should be compliant with this standard. "A less complete electronic health record does not excuse incomplete medication reconciliation," Kuznets cautions. Another issue is related to allergies. Some surgery centers fail to consistently document allergy severity and patients' reactions.

"For example, a localized rash is quite different from anaphylaxis," Kuznets observes. "We currently have a toolkit on allergy documentation, and, beginning in 2020, the AAAHC will be offering a benchmarking study on allergy documentation." ■

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Positive Steps to Take to Comply With Standards

Examine underlying factors for deficiencies

The most successful healthcare organizations are run by leaders who champion quality and patient safety.

"They develop and support the policies and procedures that guide frontline staff," says **Pearl S. Darling**, MBA, executive director, ambulatory care services, The Joint Commission.

Successful surgery centers also involve their staff in the entire accreditation process to ensure both understanding and engagement, she adds. Surgery centers that receive notice of accreditation deficiencies should review any systemic issues or underlying factors that could have prevented these deficiencies.

The Joint Commission offers a Robust Process Improvement tool that provides a technique for quickly identifying the root cause of a problem.[1]

Deficiencies in conducting quality improvement (QI) studies remain relatively high, but the overall deficiency in QI programs had declined slightly, says **Naomi Kuznets**, PhD, vice president and senior director, Accreditation Association for Ambulatory Health Care (AAAHC) Institute for Quality Improvement.

"Conducting QI is not intuitive for many providers and staff," she explains. "They lack education on how to do so."

Also, most employees at a surgery center wear multiple hats, and the resources necessary to conduct QI studies are limited, Kuznets adds.

"Governance support and key staff and providers need to be involved," she advises. "The absence of a basic understanding of the process and pitfalls, including poorly described goals and measures that fail to identify key performance factors, and the inability to focus on important issues are also problems."

AAAHC has found that healthcare professionals are better now than in past years about complying with standards related to using emergency equipment and developing a safe evacuation plan, Kuznets notes.

This could be attributed to educational resources, such as AAAHC's emergency drills toolkit and webinars. Healthcare organizations also are more aware of their own vulnerability to natural and man-made disasters due to media coverage of where problems occur, Kuznets observes.

There is an increasing proportion of millennials in the work place who have grown up with more exposure to drills and safety measures than previous generations.

"Also, having increasing resources from the AAAHC may have fostered a better understanding of the importance of ongoing staff development and improvement," Kuznets says.

Surgery centers can follow AAAHC's 1095 Strong practice, which refers to their being prepared all 1,095 days of the accreditation term. "They use systems and tools, such as reminders, prompts, in-services, and other education/resources, to help them work pre-emptively and effectively," Kuznets says. ■

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AORN Releases Updated Guideline Regarding Team Communication

Goal is to prevent patient deaths

Communication breakdowns can be a factor in patients' adverse events, data show.

"Statistics from The Joint Commission identified that 70% of adverse events that are occurring in the surgical environment are caused by breakdowns in communication among healthcare providers," says **Lisa Spruce**, DNP, RN, ACNP, director of evidence-based perioperative practice, Association of periOperative Registered Nurses (AORN). "The latest statistics show that wrong-site surgery and unintended retention of a foreign body continue to be the top events."[1]

AORN developed new communication guidance to help perioperative professionals use communication tools to reduce the incidence of patient safety events. The guideline's chief message is for surgery centers to focus on team communication, using tools to prevent communication breakdowns.

"It is estimated that between 180,000 and 400,000 patient deaths occur annually as a result of medical errors, making it the third leading cause of death," Spruce says.[2] "Every facility needs to focus on patient safety as this number is staggering."

AORN offers several tools that help with team communication, as well as evidence-based protocols to improve patient safety.[3]

"Tools such as a handover process, a briefing process, a surgical safety checklist, and a debriefing process can help perioperative team members to improve patient safety by promoting optimal communication during every phase of the surgical process," Spruce says.

Communication errors can occur through written or verbal means. They can be acts of omission.

"Many factors can impact communication, including distractions, personal relationships, hierarchical cultures, language preferences, culture, and others," Spruce says.

For example, Spruce recalls a case in which a biopsy was performed on the wrong surgical site.

"The cause of that incident was a failure of the perioperative team to conduct a time out to confirm the site prior to proceeding with the procedure," she explains.

The first step in avoiding a communication error and adverse event is to stop thinking that critical patient errors and adverse events will not happen at one's own surgery center.

"As humans, we are all vulnerable to human error and failures in communication," Spruce notes. "Perioperative nurses must speak up when patient safety is in jeopardy." Even if a surgery center uses communication tools, they will not be enough if nurses do not have the courage to speak up, advocate for their use, and stand firmly behind safety measures.

Spruce recommends nurses read *The Silent Treatment*, published in 2011 and authored by representatives from the American Association of Critical-Care Nurses, AORN, and VitalSmarts.

"It examines an especially dangerous kind of communication breakdown: risks that are known, but not talked about."[4] ■

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