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RELIAS MEDIA

COVID-19 Pandemic Closes Many Surgery Centers

American life began to shut down as COVID-19 spread across the globe. By the end of March, the options for U.S. surgery centers were bleak: postpone all elective procedures, or step up extreme infection prevention actions.

The American College of Surgeons created a newsletter with COVID-19 guidelines, including how to prepare for the potential need to operate on a COVID-19 patient. *(Read more at: https://bit.ly/2y66I2h.)* For surgery centers, especially hospital-based outpatient departments, stopping elective procedures meant they could free up personal protective equipment (PPE) and other resources that were in scarce supply.

The Association of periOperative Registered Nurses (AORN) created a COVID-19 toolkit and published it on Feb. 14, well before cities and states had started to cope with the pandemic. *(Read more at: https://bit.ly/2WCfsY9.)*

"We anticipated global medical supply shortages related to decreased production in China," says **Erin Kyle**, DNP, RN, CNOR, NEA-BC, editor in chief, Guidelines for Perioperative Practice, AORN. "At the time we assembled the toolkit, the spread of the virus was very limited outside of China, but we kept a very close pulse on what medical experts had to say about the potential for and likelihood of a pandemic."

The American Association of Nurse Anesthetists (AANA) also provides online information about how nurses can care for patients with COVID-19. *(Read more at: https://bit.ly/2UxCqNn.)* For example, the AANA recommends nurses use the N95 mask as protection against infection from a known or suspected patient with COVID-19. Clinical anesthesia personnel should be a priority in the issuance of N95 masks.

Some hospitals and surgery centers chose to stop elective procedures soon after the virus began to spread in the United States. "We and others are delaying elective procedures so we have maximal resources available for what will be for most centers a surge that exceeds capacity," says **Greg Poland**, MD, professor of medicine and infectious

Financial Disclosure: Nurse Planner **Kay Ball**, PhD, RN, CNOR, CMLSO, FAAN (Nurse Planner), reports she is on the speakers bureau for AORN and Ethicon USA and is a consultant for Mobile Instrument Service and Repair. Editor **Jonathan Springston**, Editor **Jill Drachenberg**, Author **Melinda Young**, Author **Stephen W. Earnhart**, RN, CRNA, MA, Physician Editor **Steven A. Gunderson**, DO, FACA, DABA, CASC, RN, CRNA, MA, Consulting Editor **Mark Mayo**, CASC, Editorial Group Manager **Leslie Coplin**, and Accreditations Manager **Amy M. Johnson**, MSN, RN, CPN, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

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AUTHOR: Melinda Young
EDITOR: Jonathan Springston
EDITOR: Jill Drachenberg
EDITORIAL GROUP MANAGER: Leslie Coplin
ACCREDITATIONS MANAGER: Amy M. Johnson, MSN, RN, CPN

diseases at the Mayo Clinic and director of Mayo Vaccine Research Group. "You don't want to use up precious resources for things that can easily be delayed. That's where each facility will have to make their own decision."

The more surgery centers decrease interactions and increase the capacity of the medical system to handle testing evaluation and treatment, the better off the United States will be, Poland adds.

Hospitals in the early outbreak areas of the pandemic began to struggle to obtain as many N95 respirators and PPE as they needed.

"Access to N95 respirators went into short supply almost immediately, and we haven't figured out how that happened," says **Paul Biddinger**, MD, MGH endowed chair in emergency preparedness, director of the Center for Disaster Medicine, and vice chairman for emergency preparedness in the department of emergency medicine at Massachusetts General Hospital in Boston.

Biddinger spoke to journalists and others at an Accumen/WIRB-Copernicus Group web conference on March 13. "Manufacturers are trying to distribute to hospitals and not let anyone buy out the market as happened with H1N1 in 2009," Biddinger said. "Gowns [and] masks are also hard to find." In some surgery centers that decided to stop elective surgeries, leaders told surgeons that only tier 1 lifesaving procedures would be performed. Other operations would be reviewed on a case-by-case basis, says **Joseph Abboud**, MD, senior vice president of clinical affairs at the Rothman Orthopaedic Institute in Philadelphia. Abboud says Rothman chose to end elective procedures.

"We follow the guidelines," he adds. "Certain procedures can be done, which are considered urgent or emergent, and others are deferred to a later date or rescheduled."

Surgery center staff call patients, move their appointments, and ask them to wait a month to reschedule, Abboud says. "If they're in a post-op period, we say, 'Let's recircle in two weeks,'" he adds.

Meetings with patients are handled via telemedicine, but this also poses challenges. "Telemedicine capabilities are there, but were not expected to be scaled at this level," Abboud says. "We were not expecting this large of an increase, this quickly."

At Columbus Laser & Cataract Center in Westerville, OH, the situation continued to evolve through March. "We're waiting to hear guidance from the government in the next couple of days of what businesses and healthcare providers should

EXECUTIVE SUMMARY

The COVID-19 pandemic led many surgery centers to close and surgeons to put off elective surgeries.

- Hospitals in the early outbreak areas of the pandemic began to struggle to obtain as many N95 respirators and personal protective equipment as they needed.
- Nationwide, cities and states enacted social distancing measures in an attempt to slow the virus' spread and keep hospitals from experiencing patient surges that outpaced their available beds and other supplies.

do," says **Danielle Bartholomew**, OD, human resources manager and optometrist. "In the meantime, we sent out messages to patients to let them know if they're immunocompromised, have health concerns, or are showing any kind of illness to stay home and reschedule all elective surgeries."

The center communicated through a text messaging system that also is used to send notifications and appointment confirmations. "We had some patients who chose to reschedule surgery at a later time," Bartholomew says. "We've started to discuss how we're going to implement our employees being able to do things from home." Columbus Laser also told staff to use their paid time off if they needed to stay home due to child care or health concerns, since schools were closed. "That's something we need to reassess on a weekly basis," Bartholomew says.

While the center still operated under the shadow of the pandemic, staff implemented extra infection procedures, such as wiping the exam lane completely before each patient and disinfecting the lobby frequently throughout the day. Staff also removed magazines and any items people might share. "We placed a notification on the door, telling people if they have any symptoms — coughing or flu-like symptoms or a cold — we would like them to reschedule an appointment," Bartholomew says.

Menomonee Falls Ambulatory Surgery Center in Menomonee Falls, WI, closed all but one of tis four ambulatory surgery centers (ASCs) in early March, says **Dianne Appleby**, RN, BSN, MBA, director of the ASC. "We are part of a healthcare system that owns the four ASCs," Appleby explains. "The one center is open now only to cases that would be deemed non-elective."

The center that is remaining open follows all federal, state, and accrediting body regulations related to infection control, Appleby says. "In light of the current pandemic, we are tracking and following information from various sites as it relates to shortages of personal protective equipment," she explains. "Our staff have been directed to follow the normal process for letting us know if they are ill." To screen patients for COVID-19, ASCs should ask patients questions and explain which symptoms to look for, she adds.

The social distancing measures enacted in March in many cities and states were designed to slow the virus' spread in hopes of keeping surge demand for hospital beds lower than they would if nothing changed, Biddinger observed. "If we can defer visits, it is extremely important and decreases consumption of resources," he said. "We're seeing decreases in available workforce; either physicians, RNs, or others who have exposure to patients with suspected COVID-19, are quarantined for 14 days."

This cuts into the available health care workforce at a time when greater numbers of healthcare professionals are needed. "There is a lot of healthcare fear, a lot of fatigue," Biddinger acknowledged. "In my own hospital, we've had a command center activated since late January, and I'm running six weeks-plus in emergency response mode, running 16-hour days. That takes a toll on frontline staff."

While hospitals in some cities prepared early for the pandemic, the federal government lagged. "Problems with [viral] testing in the United States is well-documented and frustrating for everyone involved in this response," Biddinger noted. "It's extraordinary to look and see how different the U.S. is for testing, compared with anywhere in the world. There were 23 tests per 3 million people in the United States, the lowest in any industrialized country."

Without adequate testing, the United States could not know how much disease there is and how widespread it is. "There's especially a need for testing in inpatient care at hospitals," Biddinger said. "Without tests, healthcare workers have to treat every patient with symptoms as if they have the disease. This means they are using more PPEs and putting more people at risk."

The lack of proper testing also makes it harder for physicians to make optimal decisions about which patients to admit to the hospital. "Policies, health systems, and offices will change, depending on how things play out in the next few weeks," Abboud notes. "Some things are life-altering if you don't address them in a timely fashion."

From a surgery center's financial and operational perspective, the pandemic's impact is unprecedented and unpredictable. "No one has planned for anything like this from a cash flow perspective," Abboud notes. "Postponing elective procedures can be done for a short period of time, but for a long period of time, it will be problematic." ■

COMING IN FUTURE MONTHS

- Reopening a surgery center after the COVID-19 pandemic
- Handling supply shortages in the COVID-19 era
- Study highlights trends in ambulatory laminectomy
- Outpatient arteriovenous fistula surgery outcomes

AORN Offers Perioperative Nurses Guidance on COVID-19

The Association of periOperative Registered Nurses (AORN) created a toolkit about COVID-19 to inform and assist perioperative nurses during the pandemic.

"We knew there would be questions that needed answers. We wanted to anticipate what perioperative clinicians may ask and provide those answers in a timely manner," says **Erin Kyle**, DNP, RN, CNOR, editor in chief, Guidelines for Perioperative Practice, AORN. "With so much misinformation and conflicting information coming from different sources, we knew that providing reliable information from reputable sources would be an imperative."

When the toolkit was launched in mid-February, it served as a repository for news releases and situation updates from the Centers for Disease Control and Prevention (CDC).

"It also provided resources intended to inform clinicians who face shortages of supplies like surgical masks, gowns, and drapes," Kyle says. "Before our board of directors made the difficult, but wise, decision to cancel our annual Global Conference and Expo, we used the toolkit to inform members and exhibitors about what precautions we and the expo venue were taking to keep them safe while attending the meeting. It now includes information that has become available from other societies and medical journals for the most up-to-date and reliable information about the spread of COVID-19 and how healthcare workers can protect themselves by selecting and using personal protective equipment [PPE] properly."

For example, the toolkit provides a link to Nebraska Medicine's Biocontainment Unit webpage, which includes resources written by national experts on communicable disease containment and treatment.

The toolkit also contains links to a Strategic National Stockpile fact sheet and information from the World Health Organization and the Association for Professionals in Infection Control and Epidemiology. This information would apply to any respiratory communicable disease. *(Read more at: https://bit.ly/2WCfsY9.)*

"We hope that perioperative nurses use the resources we have assembled to inform interdisciplinary decisions about how to respond to COVID-19 in their communities and healthcare organizations," Kyle says. "For example, places where the outbreak has led to municipalities declaring states of emergency, the response is different than those places where the outbreak has not yet reached. Specific patient populations may also require different responses within a healthcare organization. Those organizations whose services are focused on the most fragile and vulnerable to the disease may require different practices than those that serve less vulnerable populations."

The toolkit provides resources for evidence-based decision-making at the facility level. Perioperative nurses will persevere and be leaders during these trying times, Kyle predicts.

"Perioperative RNs are known for their ability to remain calm under pressure, focusing all efforts on patient care," she says. "We do this as part of an interdisciplinary team every day." The toolkit recommends perioperative nurses lead the way in practicing common-sense prevention measures, as outlined by the CDC, including these:

- Avoid close contact with people who are sick.
- Avoid touching eyes, nose, and mouth with unwashed hands.
- Wash hands often with soap and water for at least 20 seconds, especially after eating, blowing your nose, coughing, sneezing, or going to the bathroom.
- Use hand sanitizer that is at least 60% alcohol whenever soap and water are not available.
- Stay home when sick.
- Cover coughs and sneezes with a tissue and throw it in the trash.• Clean and disinfect frequently touched objects and surfaces with household cleaning agents.

Perioperative nurses and others in healthcare should follow the CDC's recommendations regarding PPE use. *(Read more at: https://bit.ly/3boBL7E.)*

"Use only what you need for each patient," Kyle says. "Plan ahead. Have a contingency plan for obtaining supplies from alternative vendors. Consider reusables when possible, and work with the materials management department to define this contingency plan before a shortage situation arises at your facility."

The CDC offers information about PPE, including what standards to consider as well as best practices in using gowns, gloves, and respirators, such as an N95 filtering facepiece respirator. *(Read more at this link: https://bit.ly/2WF4qRV.)*

The pandemic affects people in different ways, but it can be especially frightening to frontline medical staff because of the greater risk of infection. While this is understandable, it is important to learn more about COVID-19 to prevent panic. "Fear and panic are wasted energy," Kyle says. "We, as

healthcare professionals, should spend our energy seeking out reliable information and focusing on what we can do to protect ourselves, our communities, and our patients from the detrimental effects of this pandemic." Finally, the advice from AORN to perioperative nurses boils down a simple but powerful message: "Do what we do best: Remain calm, and take care of the problem," Kyle adds. ■

Research Highlights Disparate Outcomes for Black Surgery Patients

Numerous studies in recent years highlighted differences between black and white surgery patients. Investigators have researched different surgeries as well as patients' outcomes and access. They all came to the same conclusion: Black patients fare worse.

Surgery centers need to be aware that disparities exist, says **Robert White**, MD, assistant attending anesthesiologist, Weill Cornell Medicine.

"Doctors aren't aware of disparities or aware that they, their team, and hospital could be contributing to the disparities," he observes. "People are blind to their biases that could impact treatment."

Surgeons, like everyone, carry biases, which can influence patient care, says **Charles G. Rickert**, MD, PhD, a surgical resident at Massachusetts General Hospital in Boston.

"A lot of these biases are not the result of deliberate negative attitudes toward a certain group or certain set of people. They're influenced by the media around us and the population we grew up around," Rickert says.

Rickert and colleagues at Massachusetts General Hospital founded a community health collaborative in 2016 to evaluate and improve patient care. Its goals included increasing awareness in the department about social determinants of health and healthcare disparities.[1] They used implicit association testing to assess biases. It uses a set of tasks performed on a keyboard and records responses, Rickert explains.

"It's not a perfect test, but the idea is that if you associate certain terms together faster than other terms, then that suggests an unappreciated association in your mind," he says. This association could suggest positive or negative biases regarding a particular racial group.

Research also shows striking disparities in access to elective surgical procedures. The authors of a study of shoulder arthroplasty utilization examined more than 250,000 primary shoulder arthroplasties performed between 2005 and 2011. They found black patients constituted slightly less than 4% of cases.[2]

The findings revealed significant racial disparity at both national and institutional levels, which exists despite similar rates of osteoarthritis in both white and black patients. Over the study's six-year period, the percentage of cases involving black patients increased slightly from 3.9% to 4.5%, says **Joseph Abboud**, MD, a study co-author and senior vice president of clinical affairs at the Rothman Orthopaedic Institute in Philadelphia. Black Americans represented about 15% of the total U.S. population during the study period. Even with the increase Abboud and colleagues observed, the disparity still was significant.

One hypothesis for the disparity is that people often choose elective surgeries based on word-of-mouth referrals. A friend, neighbor, or family member undergoes surgery. It goes well, and the person tells others about it, making it more likely they might seek the same procedure, Abboud explains.

If someone does not know anyone who has been exposed to shoulder replacement, then he or she might prefer to live with shoulder pain

EXECUTIVE SUMMARY

Recent studies show that racial disparities affect access to surgery and outcomes across the United States.

- Surgeons and other healthcare professionals carry biases they might not acknowledge, which can contribute to racial disparities.
- A study of shoulder arthroplasty utilization revealed that black patients constituted slightly less than 4% of cases, about one-fourth of their overall proportion of the U.S. population.
- Another study revealed black patients were 8% more likely than white patients to experience spine surgery-specific complications and 14% more likely to experience general postoperative complications.

rather than expose themselves to an operation for which he or she has no personal knowledge, Abboud continues. Another factor could be that people are more comfortable seeing doctors of similar ethnicity, race, and gender, but there are no data to support that, Abboud adds.

Other research showed black patients experience worse outcomes after surgery vs. white patients. For example, in a study of 267,976 patient discharge records for inpatient lumbar spine surgery, White and colleagues found black race was a social determinant of health and outcomes.[3] The study revealed black patients were 8% more likely than white patients to experience spine surgery-specific complications and 14% more likely to experience general postoperative complications. Black patients also stayed in facilities longer after surgery, paid more money, and were at higher risk for 30-day and 90-day readmissions.

Initially, these investigators were going to examine insurance policies and the differences between Medicare and Medicaid and the safety net among different populations, says **Dima El Halawani Aladdin**, MD, a study co-author and a resident in anesthesiology at Washington University in St. Louis. "When we had all the data in front of us, we said, 'No, we need to change our major questions and talk about this,'" she says.

One factor concerned presurgery health. According to the data observed, black patients were more likely to be obese, diabetic, and suffer from heart disease prior to surgery, El Halawani Aladdin notes. Researchers took these factors, including demographics, comorbidities, hospital characteristics, surgical approaches, and state and year of surgery, into account. Nevertheless, they still found disparities when comparing patients with similar presurgery health.

The authors of a study published in 2018 found that African American children are more likely to die within 30 days after surgery compared with white children.[4] "Risk of death was two times higher for African American children compared with white children," says **Oguz Akbilgic**, PhD, MS, a study co-author and associate professor, department of health informatics and data science, Loyola University in Chicago. "Our goal was to provide more evidence to surgeons about which children are at higher risk and which are at lower risk. We developed a model that provided high accuracy."

Investigators also found that the prevalence of preoperative risk factors associated with death after surgery was significantly higher for African American children. "We looked at social determinants of health, and we basically looked at socioeconomic status of children. We tried to adjust them by demography," Akbilgic says.

These factors were relevant to the results. For example, when investigators looked at a particular city (Memphis, TN), they found that most of the African American population lived in poor-quality neighborhoods. Further, African American children there carried more risk factors and were at a higher risk of death after surgery, Akbilgic says.

The authors used information from a national database of about 250,000 surgeries, but there was no in-depth information on the socioeconomic status of the children, Akbilgic says.

"We can assess by surgical risk factors, but there is much more information we need, and we don't have these data," he laments. "Maybe there are certain risk factors in how people are raised, their food intake, and what they're provided as growing children. This impacts how fit they are before surgery."

The study's findings show surgeons need to pay more attention to risks among minority patients, Akbilgic says. "If surgeons know that African American children may be at higher risk for the same risk conditions, then they would be more prepared," he adds.

Race also plays a role in where people choose to undergo elective surgery, according to a recently published investigation.[5] The authors found that white people who live in the Bronx were more likely than racial minorities to travel to Manhattan for elective surgical care. This was true regardless of insurance type.

"The purpose behind that study was to examine racial segregation within healthcare," says **Numa Pompilio Perez**, MD, a study co-author and general surgery resident, Massachusetts General Hospital. "Our take was to not look at outcomes. We wanted to look at where people choose to have surgery."

Research into racial disparities in surgery do not demonstrate explicit racism, which is low, Perez notes. Surgeons try to treat patients the same, but there are subconscious processes, flawed science, and structural barriers that ultimately cause harm, he adds. ■

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Achieving Racial Equity in Surgery Starts with Personal Mindset

Healthcare professionals often are unaware of their own gender, racial, cultural, or religious biases, which can play a role in inequity and disparate outcomes. One tactic surgery centers could employ to raise awareness about these biases is through the Implicit Association Test (IAT), which was designed by several scientists who formed Project Implicit. *(Learn more online at: https://bit.ly/33HYBoh.)* The IAT evaluates potential implicit associations between different terms, says **Charles G. Rickert**, MD, PhD, a surgical resident at Massachusetts General Hospital in Boston. "You can use different terms to look at whether or not there are associations between positive or negative terms with one racial group, or if you associate faster positive terms with a depiction of someone who is Caucasian," Rickert explains.

Rickert was the lead author of a paper about surgeons' biases.[1] He and his colleagues highlighted the efforts of faculty and residents at Massachusetts General Hospital's department of surgery to form a community health collaborative in 2016 for the purpose of improving community outreach and increasing awareness about social determinants of health.

The collaborative designed a project that administered the IAT to physician faculty and residents. "The purpose of the study was to initiate the conversation among physicians in our department at Mass General," says **Numa Pompilio Perez**, MD, a study co-author and general surgery resident at Massachusetts General. "We want to have conversations that we don't always have about social determinants of health and healthcare disparities. You forget these issues are front and center from the patient's perspective." The IAT is a useful assessment that can be a catalyst for self-reflection and raise awareness of implicit biases. However, it also is uncomfortable to take, Rickert notes. "The reaction a lot of people have when doing the [IAT] is they feel bad," he says. "They take the test and see that they have a moderate bias in one way or another. They think, 'Oh gosh, that's awful.'" The surgery department's findings highlighted some interesting differences between people who demonstrated more implicit bias and those who did not. Physicians with more implicit bias tended to say that race and social determinants of health had less bearing on outcomes than those with less implicit bias, Perez reports. "Whereas people who said issues of racial disparities had a bigger weight when it came to surgical outcomes tended to be people who had lower levels of implicit bias," he adds.

Everyone has biases, and these do not make us bad people, Rickert notes. What is important is to become aware of these biases and learn to avoid making comments or engaging in interactions that reflect bias toward patients of particular cultures or races, he adds.

After administering IAT, researchers found the surgery department was similar to the rest of the country in its level of bias. "We would all like to think we'll be perfectly unbiased, but

it was good for everyone to see where we are and that there is a need to institute efforts to diminish those implicit biases as much as possible," Rickert says. Experts on racial disparities offer these suggestions on how to reduce inequities:

• **Generate a baseline understanding of staff's biases.** "The first step is to be aware of the problem and acknowledge it," says **Dima El Halawani Aladdin**, MD, a resident in anesthesiology at Washington University in St. Louis. "Don't turn a blind eye." Using the IAT, surgery centers can show staff and physicians how everyone has some biases based on race and other demographics. "It generates discussion," Rickert says.

The next step is to know the patient population and be mindful of the staff's biases and patients' biases. "Say you're a plastic surgery office in a metropolitan area. Your cliental happens to be primarily Caucasian, and you say this is a population that is looking for this type of surgery," Rickert offers. "But when you look at the community, you see there is a wide variety of patients in the area."

The reason the surgery center sees mostly Caucasian patients could be related to how the center advertises, he notes. "Maybe you are advertising in only certain newspapers and magazines," Rickert says. "Are you getting most of your referrals from primary care providers in certain cloistered portions of the city?"

• **Know the historical context for minorities.** As strange as it might seem to those graduating from medical schools in the 21st century, there is long-standing false information about black patients. For example, not long ago, there were those who believed black patients did not experience pain or nausea as acutely as white patients, Perez says.

"These were all preconceived notions that people came to believe," he notes. "The [false] science that generated some of these results and got propagated through many years came from one generation teaching it to the next."

Another example of false science that leads to racial bias is the formula that determines how well a patient's kidneys are working, Perez says.[2]

"To this day, they give you a correction if a patient is black. With that correction, the patient's GFR [glomerular filtration rate] function tends to appear better," he explains. "Because of that correction, African American patients are referred later for dialysis. This has been propagated generation after generation because of a paper from the 1960s that was based on flawed science."

• **Address trust issues.** "When I was digging into the literature and reading about many different studies that look at racial healthcare disparities, one of the things I read is that black patients — because of everything they've been through — said they've lost trust in the whole healthcare system," El Halawani Aladdin says. "It's not a matter of what's happening right now, but everything they've been through over all those years. That's why some black patients seek treatment late in the course of disease."

• **Put rules in place to foster discussions about biases.** Employers should set clear expectations and behaviors. "I don't mean that all offices need to be super-PC [politically correct] environments," Rickert explains. "But it's important for workplaces to say, 'Our mission here is to provide wonderful care to all patients, regardless of socioeconomic, racial, income, and other differences.'" Then, once a month, hold meetings on this topic. "You're not looking to criticize people, but [allowing] everyone to discuss it and have a recap of what's going on in the office," Rickert offers. "Make sure you're making the facility as welcoming an environment as possible." ■

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Racial Disparities Affect Where Patients Undergo Surgery

The authors of a recently published paper found racial segregation affects patients' selection of where to undergo elective, same-day surgery.[1]

Researchers compared two boroughs in New York City: Manhattan and the Bronx. Although the two communities are adjacent, they are markedly different, according to **Numa Pompilio Perez**, MD, a study co-author and general surgery resident, Massachusetts General Hospital in Boston.

"Manhattan is the richest borough in New York City, and the Bronx is the poorest," Perez says. "Manhattan has the majority of academic medical centers and more top-rated hospitals."

Perez and colleagues examined elective cardiothoracic, colorectal, general, and vascular surgeries. White patients who lived in the Bronx were significantly more likely than black patients to undergo elective surgery in Manhattan operating rooms.

"After adjusting for age and race, putting it all together with a comorbidity score, and adjusting for everything, we saw that whites are 2.7 times more likely than blacks to leave the Bronx and get their care in Manhattan," Perez reports.

Investigators stratified data by race to see if differences persisted when they looked at only Medicare patients, for whom care is supposed to be equal.

"Medicare is everywhere, and there should be no difference in access," Perez argues. "But even for people who had Medicare, whites were two times more likely than blacks to leave the Bronx and get their care in Manhattan."

Perez and colleagues compared these findings to the 1950s and 1960s when white Americans began leaving cities for the suburbs to separate from other populations.

"This kind of movement, and these choices of where you get your surgery, are reminiscent of that," Perez offers. "They're concerning because we could potentially end up with a healthcare system where whites get their care in one place and blacks and others get their care in another place."

"HOW DO THESE RACIAL MINORITIES FEEL WHEN THEY COME TO YOUR DOOR?"

While the authors shed light on the trend, they could not find a definitive answer for why white patients choose to undergo surgery in Manhattan and black patients do not.

"Even among Manhattan residents, racial minorities were more likely to leave Manhattan and go to the Bronx, so it was bidirectional," Perez says.

One theory is that Bronx hospitals seemed more welcoming to racial minorities because there are more minorities on staff, Perez suggests.

"We may say that our doors are open to anyone who wants to come in," he adds. "How do these racial minorities feel when they come to your door?"

Perez suggests asking several questions: If all patients see are paintings of illustrious white founders, how does that make them feel as African Americans? If a patient is Hispanic, is there a single interpreter around? How does it make a minority patient feel if the things that patient needs are considered an afterthought? Are facilities staffed with any healthcare providers who look like minority patients?

"There are decisions a healthcare organization can make when they are staffing, decorating, and figuring out the necessary resources to make a population feel welcome," Perez says. "We are not closing our doors to racial minorities, but we're failing to do certain things that make them feel welcome."

When hospitals and surgery centers choose new locations, they might also consider satellite locations in minority communities. Although there are financial and other considerations, organizations still can make decisions to structure their geographical footprint in their area and to appeal more to minority patients. Provide help with payer information and make people feel welcome.

"People make choices, and go to the hospital system where they feel more welcome and feel like they belong," Perez says. "Then, one family tells the next person about their experience." ■

REFERENCE

1. Perez NP, Stapleton SM, Tabrizi MB, et al. The impact of race on choice of location for elective surgical care in New York City. *Am J Surg* 2020; Jan 24. pii: S0002-9610(20)30044-1. doi: 10.1016/j.amjsurg.2020.01.033. [Epub ahead of print].

Surgery Centers Can Improve Patient Record Documentation

From a nursing perspective, medical recordkeeping is more about risk management than it is about complying with regulations.

"I tell nurses to go back to what they learned in nursing school," says **Debra L. Stinchcomb**, MBA, BSN, RN, CASC, senior consultant, Progressive Surgical Solutions of Fayetteville, AR. "No matter if you graduated in 1981 or last year, the rules have not changed. I should be able to take a medical record from any surgery center and do a timeline. That medical record should tell me a story of that patient, the episode of care."

The record also should reflect answers to these questions: When was the patient admitted? When did the patient go to preop? What orders were implemented in preop? "If a surgery center ever goes to court, then that's what the plaintiff's attorney does — set up a timeline," says Stinchcomb, who serves as chair of the quality committee of the Ambulatory Surgery Center Association. "It's important to make sure the medical record does that."

Sometimes, deficits in documentation are related to the physician's orders. "The physician's orders should tell nurses what to do, and those orders should be signed, dated, and timed by the physician," she says. "The nurses need to note those orders, and they should also sign, date, and time."

When nurses sign and put a date and time on the order, it needs to be a time that is after the surgeon signed and timed it, Stinchcomb stresses.

"A lot of times, we see nurses filling in a time for physicians, which they should not do. Or, nurses will note those orders before the physician signs them, and they should not do that."

That is one area of deficiency, and it is more of a risk issue than a regulatory issue, Stinchcomb offers.

"Nurses need to make sure they don't prepopulate forms," she cautions. "We see this more often in electronic medical records [EMRs] than on paper, but they shouldn't prepopulate it at all because you never know what is going to happen with the patient."

Even if 99.9% of patients experience no issues, there will be that one case that is a problem. "If you prepopulated that chart, then it will be picked up in court, and it will decrease the credibility of the nurse," Stinchcomb warns.

Lawyers will ask what else the nurse changed in the documentation. They will explain to the jury that the nurse wrote down what happened to the patient before it happened, such as saying the patient was transferred to the PACU with no incident. In reality, the patient experienced a problem, and was transferred to the hospital.

"They shouldn't go back and change it," Stinchcomb says. "It's a double-edged sword. If they make an error, then mark out the error. But once you document, you should not change it."

Surgery center nurses move fast, and it is easy to forget something. It is acceptable to put in a late entry, per the facility's policy. The key takeaway is to document correctly. Specifically, any activities that regulations require a physician must be handled by a physician. "The operative report must say everything that was done during the surgery," Stinchcomb says.

Electronic documentation is faster than paper documentation, and it makes charting efficient. "I would encourage centers to maybe evaluate their paper or electronic record every couple of years to see if there is a way to make it more efficient," Stinchcomb says. "Whichever process you have in place, try to make it flow better."

Whether an organization operates one surgery center or 20, review documentation every year or two to see if the process still works and whether any improvements could be made. Another tactic to improve documentation is to offer workshops.

"When I first started working in an ASC, liability insurance carriers would come to surgery centers and do documentation workshops like I do now," Stinchcomb says. "It never hurts to see if your liability carrier would come out, although they don't do that as much anymore."

For surgery center nurses who use EMRs, they should remember to use drop-down menus and click on "N/A" if there is not another answer, Stinchcomb advises.

"If a surgery center plans to buy a new EMR, then they should review it carefully and have an ASC nurse look at it," she says. "You don't want to buy a practice management product or hospital product. Get an ASC product. As a friend told me: 'Putting a hospital EMR system in an ASC is like shooting a butterfly with a cannonball.'"

Surgery centers also should audit charts as part of their program. "Sometimes, we do chart audits where they're just looking for

completed signatures, and that's not very robust," Stinchcomb says. "Certainly, you need to have those things done, but you should be looking in greater depth." For instance, check whether the physician signed every necessary item in the order. "Look at the medical record, and see which items in the medical record they want to look at on a monthly basis to see whether they can follow that episode of care and pick out any issues," Stinchcomb says. "Develop a medical record audit form, if you don't already have one, and go through the chart to see if you take issue with anything. Then, take steps to correct it." ■

SDS Manager

Orientation Checklist

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

As a Medicare surveyor, I am in many different facilities. One area I always find room for improvement is how new employees are trained and oriented.

It is important (and a requirement) to make sure a proper orientation process is documented and what it entails. The process must provide the date the employee was oriented and identify if that employee can perform in those areas. The employee must review, sign and initial, list their date of hire, list their title, and include the date they received the orientation.

The supervisor also must be named, along with their initials indicating the employee completed the review and any comments for each area reviewed. This orientation should be performed as soon after hire as possible but no later than 30 days.

Questions in this area always concern what should be reviewed. I have seen some strange items on checklists, including "How to tell when Dr. X is in a bad mood." That is not a good checklist for orientation.

Below are the required items to review. There may be other items specific to your facility, but these are a minimum for the Centers for Medicare & Medicaid Services. These change often, so stay abreast of state and Medicare requirements.

- **General Orientation.** Mission statement, goals and objectives, patient rights and responsibilities, abuse and neglect/reporting, advance directives, and facility tour.
- **General Department Polices.** Employee handbook guidelines, quality improvement program, hand hygiene, code call response/emergency codes review/crash cart, reporting patient concerns/grievances, and vendor security.
- **Department Orientation.** Tour of department, introduction to co-workers, conduct and courtesy, restrooms, time recording, lunch/break periods, phone use, and patient identifiers.
- **Training & Education.** Age specific, fire safety (including exits and extinguishers locations), Health Insurance Portability and Accountability Act, corporate compliance, Occupational Safety and Health Administration, emergency preparedness, risk management (including incident reports), infection control, safety program, sharps injury prevention, radiation safety program, laser safety program, general safety and security, bioterrorism, and workplace violence. ■

(Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Address: 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.

SAME-DAY SURGERY

CME/CE INSTRUCTIONS

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

1. Read and study the activity, using the provided references for further research.
2. Log on to **ReliasMedia.com** and click on My Account. First-time users must register on the site. Tests are taken after each issue.
3. Pass the online test with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the test, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be emailed to you.

CME/CE QUESTIONS

1. **What was the main reason many surgeons and centers stopped performing elective procedures as the COVID-19 pandemic spread nationwide?**
   a. They were running out of medication needed for surgery.
   b. They could free up the limited supplies of personal protective equipment and other resources.
   c. They were told to close by state governments.
   d. Surgeons were treating too many pandemic patients to continue with elective procedures.

2. **When documenting physician's orders, nurses should:**
   a. sign and date the order at the same time and date as the physician.
   b. sign, date, and time the order, after the surgeon has already signed, dated, and timed it.
   c. fill in the time and date for the physician.
   d. prepopulate the order and other documentation, leaving only space for the physician's signature.

3. **The authors of a study of shoulder arthroplasty utilization and patient demographics over a six-year period found black patients were underrepresented, constituting which percentage of cases?**
   a. 4%
   b. 7%
   c. 11%
   d. 14%

4. **Which is a good test to identify healthcare professionals' biases regarding race, ethnicity, and other demographics?**
   a. Racial Bias Test
   b. Minnesota Multiphasic Personality Inventory
   c. Implicit Association Test
   d. Checklist for Ethnic Bias