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Surgical Errors, Retained Sponges Remain Major Problems

As recent data show, surgical mistakes, especially retention of sponges and other objects, remain a big problem in the operating room.¹⁻⁴

“Unintended retention of foreign bodies remains the most frequently reported [surgical] sentinel event for the past three years,” says **Victoria M. Steelman**, PhD, RN, CNOR, associate professor emeritus at the University of Iowa College of Nursing. Patient falls are the other sentinel event, either first or second in frequency between 2018 and 2020.¹

Steelman has conducted several studies on retained objects, including one of 308 sentinel events involving unintentionally retained surgical objects. That retrospective review revealed many surgical instruments were retained, followed by catheters and drains, needles and blades, and packing material.²

Typically, sponges are the most commonly retained object, followed by instruments. These items are left most often in the abdomen or vagina. “The variety of items retained and the number

of contributing factors demonstrate the complexity of the issue and [the difficulty of] resolving it,” Steelman notes.

Investigators found most retained instruments were orthopedic. “The most frequently retained single instrument was a uterine manipulator, commonly used in ambulatory surgery,” Steelman reports.

Overall, retention of objects occurs in about one out of every 1,000 to 8,000 surgeries, depending on the study and the type of procedure examined. In one 2008 study of all potential or actual retained foreign objects in surgery reported to a sentinel event phone line or to a website from 2003 to 2006, investigators found there were 68 reported events out of 191,168 operations. This means a potential retained foreign object defect rate of 0.356 per 1,000 patients, and half of these were near-misses. That amounted to a true defect rate of one in 5,500 operations.^{2,3,5,6}

When objects are retained in surgery, the outcomes are serious, including



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reoperation, a prolonged hospital stay, infection or sepsis, fistula/bowel obstructions, visceral perforation, and death.^{2,5}

“The stress and strain on surgical systems is enormous. The risk to healthcare providers and to patients at time of surgery is considerable,” says **Mary Brindle**, MD, MPH, director of the Safe Surgery/Safe Systems program at Ariadne Labs.

The World Health Organization (WHO) created a surgical safety checklist in 2009 after WHO recognized the high rate of morbidity and mortality associated with surgery. Brindle was part of a multinational panel that made recommendations for using WHO’s surgical safety checklist during the COVID-19 pandemic. They identified 15 ways surgery centers could adapt procedures and policies during the pandemic.⁷

“What degree of error do we accept? What is an acceptable rate of death?” Brindle asks. “For example, before we had sterility in surgery, before we understood that sterilizing instruments was important, the mortality rate in amputation was 50%. But at that time, people understood that was the price you pay.”

It took decades for the public commitment to sterility to catch

up with the science. People argued about the necessity of sterility, since germs were invisible, and surgical research was in its infancy. “What we accept as the likelihood of dying after surgery changes decade by decade,” Brindle says. “When WHO’s checklist was implemented, the surgical mortality rate was 1.5%, and then it went down to 0.8%.”

Surgical errors can harm patients, and take an emotional toll on staff. It is important for surgery centers to create policies and procedures and train on how to handle and prevent adverse events.

“We felt it was important to examine how different surgeons cope with [surgical] errors,” says **Jonathan D’Angelo**, PhD, MAEd, assistant professor of surgery and medical education, colon and rectal surgery, at the Mayo Clinic. “It’s an area that’s important, but there’s not robust research on it. Those surgeons who recover from mistakes will have better outcomes.”

Mistakes occur, but to prevent them it is critical to study how surgeons cope after a bad outcome. This field needs more input from a psychological perspective.

“There is no robust curriculum at this point in terms of how we teach trainees on how to handle errors from a psychological perspective,”

EXECUTIVE SUMMARY

Surgical errors, including the retention of sponges and other objects, have remained a problem in operating rooms for centuries, despite evolving policies and technology.

- Retention of foreign objects occurs in about one out of every 1,000 to 8,000 procedures, depending on the study and type of procedure examined.
- One investigation revealed sponges and surgical instruments are the most commonly retained foreign objects.
- Mistakes can occur even with new technology, such as data matrix tags and built-in tracking chips.

D'Angelo explains. "Whereas in sports psychology, there are psychologists to help athletes who have trouble with the errors they make, and there is robust research on how athletes deal with error."

Some of this research could benefit surgeons, perhaps by the dissemination of information about coping techniques that can enhance surgery practice. "When surgeons take a step back upon an error, and take time for a breath ... it's associated with better overall effectiveness," D'Angelo explains.

D'Angelo and colleagues distributed an electronic survey to surgical faculty and trainees at several Midwestern academic institutions. Questions centered around themes of coping methods. Researchers found 55% of respondents reported stopping and taking a step back to think as an intraoperative coping technique. Forty-nine percent said they focused on calming themselves to ameliorate their own stress response.⁸

"The other thing in coping strategies is those who postoperatively report withdrawing from interaction from work and at home after an error tend to report lower overall coping effectiveness," D'Angelo says. "We left withdrawing up to interpretation in the study, but we think the reader believes it meant [surgeons] did not communicate about the error, but remained silent."

Another interesting finding was the gender differences in coping methods. "I think it's important for surgeons to be aware of that, especially if they're training other surgeons," D'Angelo says. "In the paper, we discuss how, historically, surgery has been a male-dominated profession, and there still are studies that suggest female surgeons have higher rates of burnout and are

subject to bias. We found that males rated their overall coping strategy as more effective than female surgeons rated theirs."

Also, women reported focusing on calming techniques when making a mistake, and men reported making ergonomic adjustments. Neither were associated with overall coping effectiveness. "Only those who stopped to think rated their coping effectiveness as higher," D'Angelo adds.

While more evidence-based techniques for surgeons are needed, there already are plenty of evidence-based policies and procedures that surgery centers could follow. "We know how to prevent retained sponges," Steelman says. "Yet, the evidence-based measures are not employed universally."

For example, the technology of radiofrequency (RF) sponge detection could eliminate retained sponges. Although surgery centers may choose not to use the safety feature because of cost, comprehensive analyses have shown there is a cost savings when used.

"Sponges have an RF chip," Steelman explains. "At the end of the procedure, the patient is scanned to determine if a chip is in the patient. If it is, the wound is explored again, and the sponge is removed before the patient leaves the operating room."

Technology that is well-researched and well-designed can help, but leaders should acknowledge this is a longstanding and complex problem that cannot be entirely solved through policies, education, and technology.

"You have to engineer the safety into the system, like airlines," says **Robert R. Cima**, MD, MA, professor of surgery and medical director of the hospital practice for the Mayo Clinic. "You don't rely on the good will of people; you focus on leadership,

teamwork, policies and procedures, and technology." ■

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Retained Surgical Objects: The Centuries-Long Search for Solutions

Retention of sponges and other items in surgery is a problem that has not been solved despite centuries of work.

The problem of retained sponges was reported as early as the beginning of the modern era of surgery, in the mid-1880s, when ether was first available, says **Robert R. Cima**, MD, MA, professor of surgery and medical director of the hospital practice at the Mayo Clinic. “It’s been a continuing problem,” he says. “We talk about prevention now, and it was the same thing 100 years ago.”

Early 20th century surgeons tried to establish best practices to prevent retention foreign objects. They used rudimentary technology to help them with this quest, and yet it has proven elusive.

Harry Sturgeon Crossen, a surgeon, and his son David Frederic Crossen, a lawyer, published a definitive analysis on retained surgical foreign bodies in 1940. The book included a table with quality improvement suggestions, along with suggestions for counting sponges and putting tracers on them.¹

There is no simple or single answer to eliminating all surgical instances of retained foreign objects because the problem is multifactorial and requires a multipronged solution.^{1,2} Technology, staff training, and procedure guides can help. But the problem of

retained foreign objects continues, even in operating rooms that have instituted a safety strategy.

“We’ve used technology in our ORs for over a decade, and we have a process. It has significantly reduced [the problem], but it hasn’t eliminated them,” Cima says. “It’s about training, leadership, and getting staff to buy in to [following best practices]. We need a cultural approach to managing these issues.”

The 21st century development of data matrix tags and built-in tracking chips appear to hold potential for turning retained sponges into a never event. But even with this help, people still will make mistakes.

“I’m in the process with my colleagues of writing up a 10-year experience of using the [tags] technology,” Cima explains. “It significantly reduced [retained sponges], but it hasn’t eliminated it because you still have humans in the system. They may not use the technology appropriately.”

That is the drawback when a facility chooses to invest in technology as an extra safety precaution. Many hospitals and surgery centers may not consider retained sponges to be a problem that requires a technological fix. “Should there be a mandate to use technology?” Cima asks. “Do we consider it a problem? Or, how much of a problem do we need it to be before people adopt change?”

To solve the problem of retained foreign objects, surgery centers need to take a multidisciplinary team approach.

In an earlier study, Cima and colleagues found a health system was averaging one surgical retained foreign object every 16 days. After an intervention, the average interval changed to one event every 69 days.²

The intervention focused on the multidisciplinary team conducting a defect analysis and policy review, followed by raising awareness and improving communication, resulting in better monitoring and control.

“It’s about maintaining their skill set and awareness and building it into a seamless system of how you deliver the care,” Cima explains. “If you rely only on education, then you will educate someone, and six months later you have to re-educate them.” ■

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COVID-19-Era Safety Tips That Could Last After the Pandemic

Surgical safety policies and procedures needed some adaptation during the COVID-19 pandemic. Some of those modifications may carry on in practice well after the pandemic ends.

Consider the World Health Organization (WHO) surgical safety checklist, which has helped professionals prevent errors, injuries, and deaths since its creation in 2009. Recently, a panel of researchers published a paper with updates for the WHO list, recommendations to guide surgeons into a new era, to help them improve safety during this pandemic — and possibly future, similar emergencies.¹

“We’re working with the WHO and will, hopefully, be engaging with them when the 2009 checklist is updated,” says **Mary Brindle**, MD, MPH, paper co-author and director of the Safe Surgery/Safe Systems program at Ariadne Labs.

The WHO checklist started with 19 items, a simple, one-page document that could improve surgical team communication and care consistency. It was studied in eight cities globally. Before implementing checklist recommendations, data from 3,733 surgical patients showed a death rate of 1.5%. After surgeons adopted the recommendations, the rate declined to 0.8%. Inpatient complications declined from 11% to 7%.²

“The WHO checklist is a standard part of surgical procedures in operating rooms,” Brindle says. “In Canada, it’s a requirement for centers to use the checklist.”

The tool lists recommendations in three columns: Before induction of anesthesia, before skin incision, and before patient leaves operating room.³ The first column lists questions such

as “Is the site marked?” The second and third columns include action items, such as this one in the “before skin incision” column: “Confirm the patient’s name, procedure, and where the incision will be made.”

The paper by Brindle and colleagues is an update on these procedures for the 2020s. They provided eight consensus recommendations for modifications to content and seven recommendations for handling the implementation.

“THE CHECKLIST WILL WORK FOR THEM, WHERE THEY ARE, AND THESE THINGS CAN BE TAILORED TO A PARTICULAR OPERATING ROOM OR FACILITY.”

“We have this pre-existing tool that can be adapted to address the issues around airborne infection prevention,” Brindle says. “Especially in places where the vaccine will not come anytime soon, we can use this tool to protect patients and surgical team members. The [new] recommendations are what we would add to the checklist and what we would change in terms of content and how to use the checklist. During a pandemic, one of the things you should be thinking about is making sure people in a surgical

team understand the things that are important in protecting patients and team members.”

What follows are some sample items from these recent consensus recommendations:

• **Review patient’s COVID-19 test results, symptoms, and risk factors.** “If a patient has high risk for COVID or has a COVID-positive test, how likely is it this patient could be a risk to the team members, and should the patient have surgery today?” Brindle asks.

• **Review the plan for intubation.** When patients need a tube to help them breathe during surgery, there is potential for coughing and materials blocking their airway, which could be spewed into the field.

Surgery centers need their safety plans to include actions to take in the event a patient has COVID-19 or is at risk for contracting the disease. The plan might include making sure there are no extra staff in the operating room during intubation.

“Make sure people understand for each case they’re doing what that risk is to them and what they should do in their practice to protect themselves from their patients,” Brindle suggests. “We tried to not be too prescriptive, saying, ‘You need to do all of these things.’ Part of this paper is to allow people to feel like the checklist will work for them, where they are, and these things can be tailored to a particular operating room or facility.”

• **Review aerosolization risks.** “How likely is the patient to produce a lot of aerosols?” Brindle asks.

For instance, if the procedure moves through the patient’s nose to access the brain, then it would be much more likely to produce aerosols than a procedure on the patient’s in-

grown toenail. “The back of the nose is a place really high in COVID virus if the patient is positive,” Brindle notes. “The [brain] surgery may create a large amount of aerosol that could form clouds around the team.”

- **Ensure in-room availability of all necessary equipment.** This recommendation is designed to minimize the number of times people enter or leave the operating room. “Part of what keeps people safe in the hospital is that the OR doors are closed,” Brindle says.

The goal during the pandemic is to reduce opportunities for aerosols to spread to and from the OR. “You also want to make sure you don’t have extra equipment in the room, where the virus gets on top of it, sitting on top of surfaces,” Brindle says. “Make sure [staff] don’t open the door and bring extra people in the room.”

- **Discuss handling, packaging, and transport of lab specimens.** “This is one where we had a lot of

discussion about it and how much risk there is for people touching specimens that have come from COVID patients,” Brindle says. “So much of what we know about the virus is evolving. If there is highly infected tissue, you would want to be more careful about it.”

- **Confirm postoperative bed availability.** “Where does the patient go to recover, and what is their exposure to other patients?” Brindle asks. “If we take a tube out of your throat, you will cough a lot. Would you be in close proximity to other people and put them at risk?”

The surgery center or HOPD might mitigate this risk with good air exchange and ventilation. “Many places, even in hospitals with good air exchange, avoid putting the post-op patient with COVID in the same general post-op care units as other patients,” Brindle observes.

- **Sign out before extubation.** “One of the high-risk periods for

transmission is when the tube is being removed,” Brindle says.

To reduce risk, policies should direct staff to leave the room unless they are needed. Surgery leaders should engage in discussions about other plans that would lower risk at extubation. ■

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Best Practices for Handling Adverse Events

Consider the patient who was scheduled to undergo a procedure to remove kidney stones from the right side. The surgeon performed the procedure on the left side by mistake — and still found a kidney stone, which the surgeon removed.

In recovery, the patient complained about persistent pain on the right side. The nursing staff could not understand why. When a nurse contacted the surgeon, he realized the mistake. Eventually, the patient underwent another procedure to remove the kidney stone on the right side.

Fortunately, the surgery site had a plan in place for handling errors, and they quickly communicated the

problem to the patient in a way that helped maintain confidence.

Mistakes and near-miss errors occur in every healthcare setting. With proper planning, surgery professionals can minimize adverse events and react appropriately if they do occur to prevent the situation from spiraling out of control.

Sandra Jones, CASC, CPHRM, CHCQM, chief executive officer of Ambulatory Strategies, Inc. in Dade City, FL, outlines tactics to help surgery professionals create the right atmosphere:

- **Create a safe space.** The first step is to create a nonjudgmental atmosphere in the surgery center. If a mistake occurs, staff should feel safe about timely reporting.

“The report is a way to look at what was going on at the time of the event and to look at the systems or processes in place,” Jones says. “It’s not to point fingers or find fault with anybody; the emphasis on the system is important.” Employees should not be afraid to report problems. They should not try to cover up mistakes. Instead, staff should be fastidious when reporting information about an error. No one should speculate.

- **Make a plan.** When adverse events occur, staff should know who to report to and how, along with understanding expectations on timeliness. If it is a severe adverse event, sequester equipment, do not throw out trash, and do not empty any syringes.

Explain who speaks to the patient and who has to make the report. Identify what staff members have to do to resolve grievances or complaints. Script a reply to patients who may be voicing a complaint that could turn into a malpractice issue.

When planning, consider government regulations. For example, some states require a physician tell a patient about an adverse event, even if the physician was not involved. “Some states don’t say who needs to tell, but the patient needs to be aware of the adverse event,” Jones says.

National organizations are valuable resources when creating these plans. For instance, the Agency for Healthcare Research and Quality offers modules, videos, sample forms, and PowerPoint presentations on how to deal with communication of errors and patient safety.

- **Identify a good communicator.** When an adverse event happens, the best person to speak with the patient is someone leaders have identified as a great communicator. This person could be a physician, nurse, director, or anyone with excellent communication skills and who can gain people’s trust.

“You can practice scenarios and choose the person who will have that conversation, and it might not be an administrator or director,” Jones

explains. “It could be someone who is a super communicator and who can defuse anger and frustration.”

Good communicators gain confidence by telling patients what the facility plans to do about it.

EXPLAIN WHO SPEAKS TO THE PATIENT AND WHO HAS TO MAKE THE REPORT. IDENTIFY WHAT STAFF MEMBERS HAVE TO DO TO RESOLVE COMPLAINTS.

“Usually, you will know who is the communicator because she’s that person who will coach underperforming staff members without hurting their feelings,” Jones observes. “These are people who have good communication skills, good listening skills, and know how to approach a difficult subject.”

- **Know when to contact a malpractice carrier.** If there is a serious adverse event, the big question is

whether malpractice insurance carriers need to be notified and involved.

“Do they need to help guide discussions?” Jones asks. “An investigation may have to include a malpractice attorney. What is discussed can be part of client-attorney protected information.”

The internal investigation should include an analysis and a search for the root cause. When digging deep into root causes, follow the Five Whys rule: “You keep asking ‘why’ until there are no more whys, and you can see what you need to do to not go down the wrong path again,” Jones explains.

- **Assess track records.** Risk management includes collecting data on near-misses and anything that was not planned or is out of the ordinary.

Surgery leaders could collect information about each member of the team’s track record with errors and assess whether there are people with more frequent mistakes.

“I know one surgery center that believed one physician was bipolar, and when he was off his medication he had more complications. There was a discussion on how to control that,” Jones recalls. “You should look at complications and transfers to the hospital and medication errors. Look at the stuff the staff is indicating about how that person has some health issues that are leading to

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increased complications or injuries. Your staff need to be reassured that they can speak up.”

• **Track medication errors.** If the patient is allergic to a drug that was administered, the physician may give the patient a different medication to counter the reaction.

“Tell the patient, ‘We gave you this drug, so if you have any symptoms, alert us right away,’” Jones says. “Or, they could say, ‘We’ll keep you here a little longer.’” Regardless, both the patient and family need to be informed of such an event.

• **Determine solutions.** Perhaps the solution is simple — for instance, adding a barrier (e.g., a time-out before the first surgical cut). This ensures no one makes a cut until everyone confirms the correct part of the body.

Regardless, if staff believe there is a problem or potential issue, they need to speak up. “Your staff needs to be aware that it’s their duty to provide safe care. If an intervention needs to occur, then they shouldn’t hide that information,” Jones says.

• **Focus on systemic fixes.**

There are several ways to solve any problem. The weakest one is to educate the staff member involved in the adverse event and tell him or her to do it right the next time.

“If you have a systemic problem, the mistake will be repeated because it’s not just one person’s problem,” Jones explains. “Look to see what can keep you from going down the wrong road. For some situations, it may be to write a better policy and to educate the staff; for others, it could be to establish another barrier.”

Think of barriers as safety features, like how a microwave will not start unless the door is closed. “Your car won’t go into gear until your foot is on the brakes, and your seatbelt rings until you fasten it,” Jones says.

In an ambulatory surgery center, a good example is eye shields. Perhaps surgeons are working only on one eye. Before the operation, staff might ask the patient to identify which eye is undergoing the procedure, and check that response

against information in the chart.

“Then, [staff] say, ‘I’ll put this shield over your right eye so it won’t be in the way when we work on your left eye. Then, you can take the eye shield home and put it over your left eye to protect it when you sleep,’” Jones offers.

Through a combination of questions, verbal cues, and fact-checking, this surgery center is ensuring the patient undergoes the right procedure on the proper eye.

Any surgery center can establish their own barriers. These can be creative solutions. For example, Jones knows of an orthopedic surgeon who once performed surgery on the wrong knee.

After that experience, he established a rule of putting a compression stocking on the nonoperative knee of every knee surgery patient.

“The compression stocking confirms that the surgeon is operating on the correct knee,” Jones says. “Even if the patient is turned over, the surgeon is not going to cut through a compression stocking.” ■

Study Suggests Perianesthesia Nursing Can Be Standardized Globally

A survey about education and the role of postanesthesia care unit (PACU) nurses in 11 countries revealed a wide variation in how the profession was viewed and treated. There was little international standardization in education and professional guidelines.¹

“We believe anesthesia nursing training is very important and something we need to highlight and discuss,” says **Karuna Dahlberg**, PhD, RN, CCN, study co-author and associate senior lecturer at the

Örebro University School of Health Sciences in Sweden.

International discussions between nurse educators, leaders, and others led to questions about PACU nursing challenges and about requirements and practices in different countries for educating people entering this nursing specialty area. The survey went to PACU nurses in places with membership in the International Collaboration of PeriAnaesthesia Nurses, Inc. (ICPAN). Dahlberg and colleagues observed respondents

saw the same issues with patients, but believed their training and educational experiences to be diverse.

The authors grew curious about international diversity in training and education of PACU nurses and set out on a strategic plan involving creating collaborative, global advanced practice, says **Joni M. Brady**, BNP, PMGT-BC, CAPA, study co-author and chair of the ICPAN board of directors. “Where education was concerned, only one country [in the study] has

a certification for perianesthesia nursing, and that is the United States,” Brady says. “Three countries have a formal education process to become a perianesthesia nurse and to be called a PACU nurse.”

The three countries with a formal education process are Ireland, the Netherlands, and Australia. Their programs range from six months to 15 months after the person becomes a registered nurse (RN), Dahlberg says. Certification in the United States occurs through the American Board of Perianesthesia Nursing Certification. There are certificates for post-surgery nurses and ambulatory post-surgery nurses.

“You can be a nurse and work in the PACU, and certification is not required,” says **Jan Odom-Forren**, PhD, RN, CPAN, FASPAN, FAAN, study co-author and associate professor at the University of Kentucky College of Nursing. “I have a CPAN [certification], and I’d want someone with a CPAN working in an ambulatory unit because it shows they’re interested in staying up to date on important pieces of education and requirements.”

Another difference involves the work setting and who works in the PACU. “In the United States, whether in a freestanding surgery center or a hospital, you have perianesthesia nurses working in the PACU, and they may or may not

have assistants to help them,” Odom-Forren says.

Nurse anesthetists and intensive care nurses in Sweden, most of whom have earned some sort of higher education, work in the PACU, says **Ulrica Nilsson**, PhD, RNA, study co-author and professor of nursing at the Karolinska Institutet.

“In Sweden, we struggle to have a specific education to become a PACU nurse, so this is an important paper for us,” says Nilsson, a professor of perioperative medicine and intensive care at Karolinska University Hospital in Stockholm. “There is not a specific education you need to work in the PACU. We want to have this education as you have in the U.S. and as they have in Australia.”

Perianesthesia nursing is not recognized as a specific specialty in Sweden and some other countries, Dahlberg says, “but we’re working on it.”

“Ulrica, Karuna, and I want to emphasize the specific competence a nurse needs to work in the PACU,” says **Maria Jaensson**, PhD, RNA, study co-author and associate professor at the Örebro University School of Health Sciences. “You may be skilled to work as a nurse, but not in high-quality PACU care.”

At international forums, before this study, Brady and other nurse leaders would hear that PACU nurses’ work was not recognized

as a specialized practice. “Some organizations had perianesthesia lumped under critical care,” Brady explains. “A big piece of the goal of this study was advocacy for nurses to be recognized as a specialized group with specialized knowledge.”

Perianesthesia nurses offer critical skills for patient safety. “We’re an important part of the room,” Brady says. “A big piece is to say we’re very important for outcomes, safety, and professional [goals], and we’re a vital part of the team.”

Regardless of education or certification, it is important for a PACU nurse to know about anesthetic agents and how that medication works with other medication patients are taking.

“PACU nurses should know how the patient was preoperatively, which anesthetic medications they had, how that impacts their care, and [how that] affects the PACU,” Odom-Forren says.

It also is important for PACU nurses to know about specific surgical procedures and their risks of complication and mobilization.

“They need knowledge about anesthesia and surgery and knowledge about other problems patients can have,” Nilsson says. “The care is quite complex, and the care is very short. When the patient comes to the care unit, you must think about the next level of care.”

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PACU nurses must be alert to potential severe complications. “The PACU nursing curriculum should have education on how to follow up these patients and implement this in clinical practice,” Nilsson offers.

In the ambulatory surgery setting especially, PACU nurses need to be considerate of patients’ social determinants of health.

“Who will help the patient at home after surgery? Is the patient homeless?” Brady asks. “We face, in the United States, many challenges now with food insecurity, and nurses have to think about these, in addition to all of the clinical pieces.”

Although it was not part of the study, the researchers and global nursing leaders also have discussed how PACU nurses are coping with the toll of the COVID-19 pandemic.

“In meeting with both my board and the 11 members of the Global Advisory Council, everyone is really struggling with this pandemic, except New Zealand, where they have a strong female leader,” Brady says. “What I’m hearing is a lot of exhaustion and leadership issues.”

For instance, many PACU nurses have been moved to different units during pandemic surges, creating stress and moral distress.

“They are seen as an easy grab for bringing into COVID intensive care units,” Brady explains. “We have a crucial care skill base, and it’s seen as appropriate to send us over to the critical care unit.”

PACU nurses often are moved to new units and offered no support. “One colleague in London told me he was pulled to the critical care unit, and no one helped him or even showed him where the supplies were,” Brady says. “We worry about their mental health and stress levels. When you’re put in a situation that is unfamiliar and in crisis mode, where does that leave you in your own practice?”

It also is a stressful time for nursing students and nurse educators. “We want to educate skilled nurses with different competencies, and we had to turn education to a digital mode,” Jaensson explains. “It’s stressful to put nurses [in healthcare facilities] because they are concerned for their own safety and for their families at home, and they need to study and educate themselves.”

There are plenty of students applying to nursing school internationally, but it is a challenge to give them a clinical practice with quality, and the clinical teachers are

strained and working too much. The same trend is happening in the United States.

“We have more students applying to nursing school than we can take,” Odom-Forren says. “All of us in education are trying to figure out the best way to educate students.”

For instance, clinical setting simulation can help provide experience without too much stress on a healthcare system that is already too stressed because of the pandemic.

“Organizational support is imperative right now, and organizations need to think about everything they can do to support their nurses,” Odom-Forren says.

One example is to help nursing staff with child care support, which became critically scarce during the pandemic’s surges and shutdowns. Another tactic is to give nurses a day off to prevent exhaustion. ■

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SDS Manager

Building or Remodeling an ASC

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

Our company works with 15 to 20 ASC clients per year. Most clients build their ASC from the ground up, but some have remodeled or expanded existing facilities. Ninety percent of our facilities are state-licensed and Medicare-certified. The rest are office-based

ASCs or some type of ASC hybrid. There are some commonalities with our projects that might help others who are considering building a new facility or expanding an existing facility.

Assuming the owner has conducted a financial feasibility

analysis and the numbers work, the following are important considerations when building a new center or remodeling/expanding an existing facility:

- **Design.** Most ASC floorplans begin on a surgeon’s scratch pad. They morph into the finished

product with help from outside consultants and qualified architects.

The Life Safety Code requirements for an ASC, at the state and federal levels of government, are not suggestions, they are mandates. Just because an architect friend designed a house does not qualify that person to build a surgery center.

Hire only an experienced architect who understands state regulations and CMS codes and who has built or remodeled many ASCs. The finished product does not have to win an award (although many architects will try, at the owner's expense). Still, the finished facility must be able to sail through rigorous inspections.

- **Size of the ASC.** Our experience shows hospitals overbuild, and independent surgeons underbuild ASCs. Never assume that if you build it, surgeons will fill it. Stick to the plan.

- **Mechanical, Electrical, and Plumbing (MEP).** Typically, MEP planning is handled by a firm the qualified architect recommends. This firm determines the size and the location of the drainage from the selected sterilizer, to the placement of wiring.

Do not guess or put off these decisions. Construction cannot begin until this process is finished and approved.

- **Equipment.** Selecting the equipment does not mean the surgeon knows what OR lights she wants or which surgical table. Surgeons may think, "We do not need an equipment planner; I know what we need."

But this is one of the more frequent reasons some ASCs open late or have to settle for less than what owners wanted — waiting on backorders. Most consultants offer a room-by-room list of equipment

needs. However, knowing what the center needs and purchasing it a fair price and receiving it on time are completely different.

- **Realistic expectations.** It often takes longer than it should, but remember all the government agencies and private sector firms involved. Their schedules are beyond your control. A well-planned timeline will eliminate much of this stress.

As construction proceeds, the owner or others might consider changes along the way, such as:

- **Separate ASC lounge for surgeons.** These are expensive and remove the ability of all staff to mingle and resolve any immediate issues that arise.

- **Salvation Army furniture.** Do not make a bad first impression with patients by buying cheap furniture. It makes patients wonder if the center cut corners in other, more important areas.

- **Washer and dryer.** Employees may not smell it, but others can when they visit. The requirements for this equipment are explicit. It is cheaper to send out linen for cleaning, or go disposable.

- **Hire for experience.** Do not hire the nurse from the hospital who circulates cases to set up the surgery center. ASCs are big business, and they need highly specialized and

experienced administrators and nurse managers.

Throughout the entire process, meet often with the hired team to review every aspect of the project. Do not assume everyone is doing what they should and when. The architect, project manager, and equipment planner should meet, at a minimum, of once a month.

Go to the work site as often as possible to watch what is happening. Question everything. If something remains unclear, conduct more research.

We love everything about surgery centers. The process of remodeling or building new ASCs is exciting and fulfilling for everyone. For most, it is a once-in-a-lifetime experience, so make it enjoyable.

A well-planned facility can produce decades of profits, happy patients, dedicated staff, and a sense of accomplishment and fulfillment. Enjoy the trip. ■

(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.



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CME/CE QUESTIONS

1. **Which surgical-related sentinel event has been the most common for the past three years?**
 - a. Wrong site surgery
 - b. Unintended retention of a foreign object
 - c. Post-op complications
 - d. Wrong procedure
2. **To solve the problem of retained foreign objects, surgery centers should:**
 - a. use technological solutions
 - b. revise policies and procedures.
 - c. create a multidisciplinary team.
 - d. provide regular team education.
3. **What surgical tool/intervention was associated with the death rate of surgical patients dropping by half globally?**
 - a. The College of Nursing Faculty Tool Kit
 - b. The World Health Organization Surgical Safety Checklist
 - c. The Prevention of Perioperative Pressure Injury Tool Kit
 - d. The American Surgical Association Safety List
4. **Directing a staff member to communicate with patients affected by surgical adverse events is one good technique for reducing these events. Which staff member should handle these communications?**
 - a. Unless local regulations say otherwise, this could be someone of any job title with the best communication skills.
 - b. The surgeon who commits an error must be the one handling these communications.
 - c. Nurses are the best candidates, especially those who work in the PACU.
 - d. The surgery center administrator should handle this task.

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SDS ACCREDITATION UPDATE

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

The AAAHC Antimicrobial Stewardship Toolkit, Explained

Revised guide includes details about how COVID-19 could derail existing programs

Updated tactics for combating antimicrobial resistance are featured in the stewardship toolkit published earlier this year by the Accreditation Association for Ambulatory Health Care (AAAHC).¹

The toolkit provides some specific, evidence-based guidelines on how surgery centers and other ambulatory sites can prevent the spread of microbial-resistant infections.

“When it comes to surgical care considerations, what [try] to encapsulate and provide a brief overview of where the use of antibiotics, according to evidence, could be reduced or eliminated,” says **Belle Lerner**, MA, director of research at the AAAHC Institute for Quality Improvement. “We list certain types of procedures where we found this to be true in doing our research. These include cataract surgery, dental implants, hand surgery, and dermatological surgery.”

Antimicrobial stewardship is an important part of drug management in an ambulatory surgery center (ASC). “As ambulatory surgery centers are usually independently owned, cost is a major issue with ASCs,” says **Cheryl Pistone**, RN, MA, MBA, clinical director of AAAHC. “Drug management is always a factor at an ASC, and doing it well is important.”

A good antibiotic stewardship program will improve patient care by giving patients the right medications at the right time. A proper program also will prevent staff from prescribing too much medication, which will reduce spending.

The five-page kit includes more than 40 references and a flowchart that condenses information, making it

easier to see evidence-based best practices. The flowchart describes typical protocols for various surgical types, including clean, clean-contaminated, and contaminated. The guide gives answers and recommendations, including specific details on when and how much to dose for a patient before surgery, she adds.

Core elements of the toolkit’s checklist come from CDC data. The main topics related to antimicrobial stewardship are as follows:

- **Make a commitment.** “That includes getting buy-in from stakeholders and leadership and being held accountable,” Lerner says. “One way to do this is through action.”

- **Take positive steps.** “Agree to implement at least one policy related to antimicrobial stewardship,” Lerner says. “Figure out which procedures you are doing at high volume at your facility and see what national clinical guidelines are related to conducting that procedure.”

Those guidelines may include information on antibiotic use. Surgery centers should follow those national recommendations, adopting them as part of the stewardship program.

- **Track and report.** “You don’t know what you’re doing until you track it and see where you are relative to the other providers at the facility,” Lerner says. “Or, you can do external benchmarking to see how other prescribers are practicing.”

When two providers are performing the same procedure, it is important to collect data on each provider’s rate of prescriptions and compare each to national guidelines.

• **Ask experts.** “Rely on expertise within your organization and educate your staff about the antimicrobial stewardship program you are implementing at your facility,” Lerner says. “There should be some expertise at your facility to really set up a proper program.”

The toolkit spells out how to dose antibiotics and which types would work in different situations. It suggests surgery centers consult with an infection preventionist, as needed.

The information also incorporates antimicrobial stewardship activities related to COVID-19.

“It has to do with an awareness issue,” Lerner explains. “There’s a concern that there is an increase in prescribing for patients with mild to moderate disease who are not presenting with a bacterial infection.”

Another issue is related to how the pandemic led to more hospital

admissions, which increased the risk of hospital-acquired infections. This results in higher prescribing of antibiotics.

The AAAHC toolkit contains the latest evidence-based information, but surgery centers should regularly check with the CDC and the World Health Organization for information that can change daily and is always up to date. Using an evidence-based toolkit is useful, but not the most important step in antimicrobial stewardship. Leadership also is needed.

“It’s important to have a champion to implement an antimicrobial stewardship program,” Lerner says. “You’re more likely to have the implementation be successful if you can get a champion.”

The champion can be the infection preventionist, a physician, a nurse, or anyone who can

successfully explain the program and gain traction among staff. “Know who your stakeholders are,” Lerner says. “Creating teams will more likely lead to buy-ins and positive outcomes.”

It also is a good idea to track the procedures the surgery center performs most frequently and tailor antimicrobial stewardship to the organization’s identified needs.

“Look at the national guidelines to see what they say about antibiotics for your procedures and benchmark against your peers,” Lerner says. “This could be a quality improvement project.” ■

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AORN Issues Revised, Evidence-Based Perioperative Pressure Injury Guide

The Association of periOperative Registered Nurses (AORN) has released a revised perioperative pressure injury toolkit, which was built on international guidance from 2019.¹

Ellice Mellinger, MS, BSN, RN, CNOR, senior perioperative education specialist for AORN, and **Lisa Spruce**, DNP, RN, ACNP, CNOR, CNS-CP, ACNS, FAAN, director of evidence-based perioperative practice for AORN explained to *Same-Day Surgery* (SDS) more details about this toolkit.

(Editor’s Note: Mellinger and Spruce provided their answers in

writing. This transcript has been lightly edited for length and clarity.)

SDS: *What are some of the changes in this edition of the toolkit?*

Mellinger: There are perioperative-specific screening tools to assess the level of risk of perioperative pressure injury. Instructions for use are available in the toolkit. Evidence-based, revised educational slide decks are available. A manager or educator can teach their team by accessing the four slide decks from the AORN website.

In addition to great content and images, there are also “speaker notes” to help the instructor. Content includes basic patient positioning in

surgery, pressure points, strategies to prevent perioperative pressure injuries, and risk management concerns related to perioperative pressure injuries.

SDS: *How should perioperative nurses use this toolkit? How could it improve care quality and best practices?*

Mellinger: This toolkit can be a catalyst for changing nursing practices for those nurses who are not aware of the problem. Toolkits are designed so that the nurse and other users can review all the content and choose components that will help them address a specific concern at their facility. This toolkit is designed to help the entire healthcare

facility prevent the surgical patient's risk for perioperative pressure injury.

For administrators, there is information for quality improvement initiatives and a sample poster of another healthcare facility's success in developing a perioperative pressure injury prevention program. The manager, educator, and all perioperative nurses have tools to educate the entire team about safely positioning patients for surgery and strategies to prevent perioperative pressure injuries.

The perioperative nurse can learn about the problem, and is provided assessment, implementation, and evaluation tools for use in clinical practice.

SDS: *What do you believe is the most important part of this toolkit?*

Mellinger: All surgical patients are at risk for perioperative pressure injuries. Surgical patients are vulnerable during surgery. They cannot speak for themselves; they cannot reposition themselves once anesthesia has been administered.

This toolkit provides resources to the perioperative team as well as

healthcare administrations about the problem of perioperative pressure injury and offers solutions to inform the team, prevent harm, and reduce the incidence of perioperative pressure injury events.

SDS: *To what extent are pressure injuries a problem in the operating room?*

Spruce: The Agency for Healthcare Research and Quality states that more than 2.5 million people in the United States develop pressure injuries every year.² These are associated with longer hospital stays and increased morbidity and mortality. The National Pressure Injury Advisory Panel estimates that pressure injury incidence directly attributable to the operating room ranges between 4% and 45%. Typically, a pressure injury attributable to surgery develops between several hours to three to five days.¹

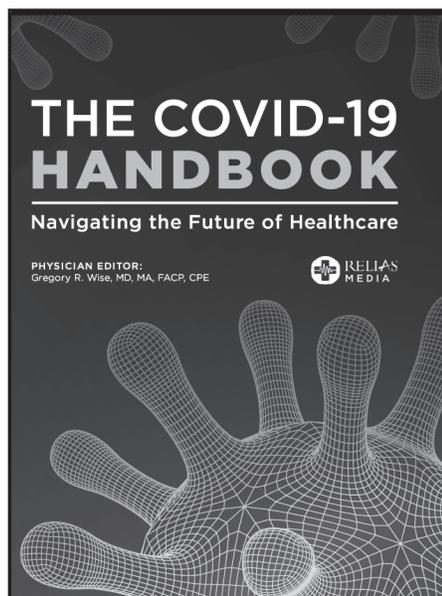
Patients undergoing surgery are at increased risk for a pressure injury because they are immobile, positioned on hard surfaces, are not able to feel pain or discomfort, and

are unable to change their position during surgery. They are immobile during the preoperative period and often remain that way until they are waking up in the recovery room. These risks, along with individual patient factors such as age, comorbidities and nutritional status, all combine to increase a surgical patient's risk of developing a pressure injury.

It is extremely important for perioperative team members to evaluate every patient for the degree of risk for developing a pressure injury and implement preventive strategies. ■

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The COVID-19 Handbook provides a fact-based approach to address multiple aspects of the COVID-19 pandemic, including potential therapeutics, the effect on healthcare workers, and the future of healthcare in a post-COVID world.

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Accreditation Activity Managers Faced Multiple Challenges During COVID-19 Pandemic

Accreditation of surgery centers and other organizations did not end after the COVID-19 pandemic began. But it became more challenging.

Organizations that hold educational conferences had to change the way they manage these programs. Instead of attracting attendees to interesting destinations and providing opportunities for in-person networking, they had to switch all programs to virtual formats. Each had to offer something different from the virtual webinars that were a regular part of many events even before the pandemic.

“When you’re doing an occasional webinar, it’s largely a talking head or slide presentation,” says **Noel Adachi**, MBA, president and chief executive officer of the Accreditation Association for Ambulatory Health Care (AAAHC). “You have to figure out how to leverage the platform to drive more engagement through using Q&As and having knowledgeable faculty who are responsive to the audience. We’ve integrated a lot more Q&As, so there still is responsive access to our faculty, and all faculty are experienced surveyors in the ambulatory space.”

One of the big drawbacks of virtual conferences is the lack of a captive live audience. They may be “attending” the conference while also multitasking. Viewers could be drawn away from a session because of some work- or family-related issue.

“Now, we need to chunk-feed the content into absorbable periods of time so it fits in with the reality of people’s lives,” Adachi observes.

From the perspective of surgery centers, finding time for activities not related to their daily work was more challenging after the initial national shutdown in the early months of the pandemic.

“Just like AAAHC had to postpone onsite surveys, our clients had to postpone a lot of their patient care. Into the first quarter of 2021, they were very busy, catching up with all the patients who delayed their procedures and follow-up care,” Adachi explains.

Creating online educational material requires more creativity, says **Timothy J. Peterson**, MD, AAAHC board chair. “We customize part of the achieving accreditation seminar so they’re interactive,” Peterson says. “We added more detailed structure so workshops will allow people to interact with one another.”

Other changes included the creation of an Ask the Expert session, in which participants can go into small chat rooms to ask questions, one on one, with a faculty expert.

“The good side of having content that’s recorded is that if people are interrupted, we can make content available to them for a month afterward so they can review it for their convenience,” Peterson explains. “Or, if they have three staff members who might benefit from that, they can have them look at it.”

Educational content already was moving toward a model of blended curriculum, but the pandemic accelerated this process.

“Blended does not mean putting on a webinar, but reaching audiences and engaging them virtually,” Adachi says. “With virtual sessions, you can meet the masses. But you also need

to have small group activities so people can talk to each other.”

During Zoom sessions, participants can meet new people and network with peers and colleagues.

“With every live program at AAAHC, people want to know who attended because they want to follow up with that person,” Adachi says. “Having that small group and not just having faculty talking allows us to experience that opportunity.”

While educational programs can work in the online space, accreditation surveys would be more challenging to conduct online. “There are different ways to leverage a virtual survey, but we don’t want virtual to replace on site,” Adachi says. “Virtual contact can augment onsite surveys by allowing more temperature checks and more quality checks through that [pandemic] period.”

This can help accredited organizations strengthen their commitment. “Right now, surveyors are going on site,” Adachi says. “We had a stoppage or significant reduction of onsite surveys during the initial blast of COVID, but we’ve done onsite surveys through the vast majority of the time.”

One of the lessons learned from the pandemic is that more education about and heightened awareness of hand hygiene and wearing masks resulted in large reductions in the number of flu cases and other respiratory infections when compared to other years.

“There is a whole emphasis on infection prevention, education, and these move into the fabric of our organizations and daily lives,” Adachi says. ■