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INSIDE

AUGUST 2001

VOL. 25, NO. 8 (pages 85-96)

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You can impress patients and save money without using a magic wand

Steal ideas from your peers for improving patient privacy, cutting costs

A patient walks into a surgery center that is beautifully decorated with local artwork. She changes out of her clothes in an admission bathroom, which has lockers for her clothes and shoes. She uses a key to secure the locker. She is told that after surgery, she will be able to access her clothing and dress in a discharge bathroom on the other side of the lockers. She goes to a cubicle, where she undergoes her preoperative interview in privacy with the anesthesiologist. Her husband remains in the cubicle with her until the time of surgery. After the procedure, she goes to a private room, where she remains until she is discharged that evening. Before she leaves the center, a nurse hands her a medication that was pulled from a dispensing machine in the center.

Although this scenario sounds a little futuristic, it actually incorporates ideas that already are being used at surgery centers around the country. **(For information on the prescription-dispensing machine, see next month's *Same-Day Surgery*.)** In addition, managers also have developed some innovative cost-sharing ideas. **(See story on cutting expenses, p. 87.)** Consider these suggestions:

• **Display local art.** When the Chesapeake Surgery Center in Salisbury, MD, was built, administrator **Joseph Walters**, PA-C, wanted to use art to decorate the center. In his work as an accreditation surveyor, Walters had seen a surgery center display local artists' work. He contacted a local art institute and gallery, which has an "art-at-work" program that allows

EXECUTIVE SUMMARY

Same-day surgery programs are using these cutting-edge ideas to improve patient satisfaction and reduce costs:

- displaying work by local artists for a nominal fee;
- letting patients store their clothing in double-sided lockers that they access on one side before surgery and the other side after surgery;
- using cubicles or private rooms to enhance patient privacy.

artists to display their work at businesses, which pay a nominal fee.

The institute's representatives examined the walls and spaces at the surgery center to determine where the art should be placed. No art was placed in the operating rooms, where blood or other fluids could damage the works. The artist's names and the cost of the works are displayed on placards below the pieces. The displayed art includes sculpture, photography, and paintings.

When a patient or staff member is interested in purchasing a piece, the center's managers simply notify the art institute. "We have contacted the art institute for at least two patients in the waiting room who became interested in buying pieces while they've been here," Walters says.

When the art is sold, the institute replaces it with other pieces. Art that isn't sold is replaced after six months.

• **Use double-sided lockers for patients.** Chesapeake Surgery Center has custom-made wooden patient lockers that are double-sided. The cost was comparable to traditional metal lockers, Walters says.

The lockers create a separating wall between the admission bathroom and the discharge bathroom. Patients change out of their clothes in the admission bathroom and put them into a locker, which locks with a key. Family members or friends keep the key if they are staying inside the facility during surgery. Otherwise, the key is put on the patient's chart. After surgery, patients go to a discharge bathroom on the other side of the lockers and use their key to open the locker containing their clothes.

"In other places, you'd have to wait for someone to get out of a bathroom, or someone has to get your clothes out of a locker, or patients have to wait somewhere," Walters says. "We tried to minimize the amount of walking patients or family members have to do. And nothing gets lost."

If Walters had the opportunity to redo the lockers, which are 1 foot by 1 foot, he would make them bigger so patients could put their clothes and shoes in the same locker, he says. On the positive side, the lockers allowed Walters to put the two bathrooms next to each other, which allowed the plumbing fixtures to be in one place.

He recommends that surgery programs keep an extra set of locker keys for the rare case when a friend or family member loses one.

• **Use cubicles for preoperative patients.** When Palo Alto (CA) Surgecenter was built, it was designed with cubicles for its preoperative patients. The 8-foot by 10-foot cubicles have floor-to-ceiling walls on three sides and a curtain across the front.

What's the advantage? Privacy, says **Lorraine Pucher-Petersen**, RN, former director of nursing at the center. "That was the No. 1 intent when we designed them that way."

When patients meet their anesthesiologists on the day of surgery, they can have the preoperative interview in private. An additional advantage is that staff can have the supplies for each patient in the pre-op cubicle, Pucher-Petersen says.

A chair is located in the cubicle, which allows a family member or friend to wait with each patient. "We think we'd make them a little larger next time to allow for another person," Pucher-Petersen says. "Or if we decided to administer sedation preoperatively, we could monitor patients. It would allow more flexibility."

• **Use private rooms in the place of the post-anesthesia care unit (PACU).** Indiana Surgery Center is a network of freestanding surgery centers in central Indiana that offers 23-hour care. Patients use their private rooms in the place of

SOURCES

For more information on innovative ideas for improving patient satisfaction and cutting costs, contact:

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COMING IN FUTURE MONTHS

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PACU, as well as preoperatively. While private rooms aren't unusual for 23-hour patients, about 90% of Indiana Surgery Center's don't stay that long, says **Amy Glover**, RN, BSN, CNOR, administrator. "But even if patients don't spend the night and just stay until 8 or 9, it's a long stay," she says.

The primary reason for the patient rooms is patient privacy and comfort, Glover says. "We feel the private rooms enable that far more than larger, traditional rooms with beds separated by curtains," she says.

The cost of the rooms is low, Glover says. The rooms are small with a hand sink, a window, a bed, and piped-in oxygen. Some have private half-baths. The décor and furniture resemble a hotel more than a health care facility, Glover says. Patients appreciate the privacy of the rooms, she says. "With all the questions patients and families are asked before and after surgery, other patients aren't put in a position of hearing that," she says.

When building private rooms, don't use a layout that resembles a hospital corridor with rooms off both sides, Glover suggests. That type of layout is noisy and creates a lot of traffic, she warns. Also, there's a tendency for visitors to look inside open doors, she says. Instead, lay out the rooms with private hallways that lead to a "pod" of four to five rooms, she suggests.

[Editor's note: Do you have an innovative idea you'd like to share with your peers? Contact Joy Daughtery Dickinson, Senior Managing Editor, Same-Day Surgery, P.O. Box 740056, Atlanta, GA 30374. Telephone: (229) 377-8044. Fax: (229) 377-9144. E-mail: joy.dickinson@ahcpub.com.] ■

EXECUTIVE SUMMARY

Chesapeake Surgery Center in Salisbury, MD, is using these innovative ideas to cut costs:

- Volunteers and students provide clerical and computer work.
- A dollar bill on the biohazardous trash receptacle and a penny on the receptacle for other trash remind staff of the difference in the disposal expense.
- An agreement is being finalized with the local prison to wash the center's linens.

How can you save money? Use volunteers, students

Center also cuts laundry, waste disposal costs

Chesapeake Surgery Center in Salisbury, MD, has just started a volunteer program, and it hit the jackpot: One of the three volunteers who have signed up is a retired nurse who worked in a postanesthesia care unit. That nurse will serve refreshments in the discharge area and help patients to their cars. Another volunteer is a young woman who wanted tasks to do two days a week. That volunteer performs clerical work, but she has expressed interest in working in the supply room and cleaning instruments, which would require training.

"She came just at the right time . . . because we no longer needed two full-time people at the admission desk, and one of the ladies left," says **Joseph Walters**, PA-C, administrator. "It was advantageous to us not to have to replace her when the volunteer was able to pick up the slack two days a week."

The tasks are delegated to volunteers according to their expressed interests and comfort level matched to their experience and/or education, Walters says. "So far, this has worked," he says.

One advantage of using volunteers is that they want to be there, and the quality of work often reflects that enthusiasm, he points out. One potential disadvantage is that it might be difficult to "discipline" or counsel volunteers whose work is not up to standard, Walters says. "However, one could not leave volunteers to their own means without any follow-up of their work," he says. Also, managers must emphasize patient confidentiality when bringing in volunteers, Walters emphasizes.

The center also employs high school students during the summer and college students in the evening to perform mundane tasks, such as purging record files and updating files in the computer. "[Those tasks] are repetitive in nature, but require amounts of time that regular clerical staff cannot allot," he says. "Both of these workers are happy with short hours, minimum pay, and they do not need benefits because they are usually covered by their parents."

Consider these other innovative ideas for saving money:

• **Put your money where your trash is.** Walters found an innovative way to reduce the amount and cost of biohazardous waste disposal. On the top of the biohazardous waste trash receptacle, he

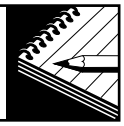
placed a dollar bill. On the top of the trash can where all other waste goes, he placed a penny.

The penny trash container is "cheap trash," Walters says. "The dollar trash can cost $50 a box to dispose of," he says. "The dollar bill gets people's attention."

• **Have inmates wash your laundry.** Walters has been working on a solution to the high cost of washing laundry at his surgery center. Recent guidelines from the Occupational Safety and Health Administration (OSHA) allow facilities to wash their own laundry, as long as special detergent is used, he points out.

Walters has initiated discussions with his local correctional institution, which already washes 3,000 sheets and blankets for inmates every week. He asked whether they would be willing to wash the surgery center's 250 sheets and blankets on a weekly basis. The details are being finalized, but the prison contact expressed interest if the center provided the detergent and transported the laundry. The prison's fee would be paid to the inmates' welfare fund that provides money after their incarceration ends. "If we buy the special detergent, and they get OSHA training for infectious waste and wear gloves, they should have no problem," Walters says. ■

GUEST COLUMN



Fire in a patient's throat leads to death, settlement

By **Jan Gorrie**, Esq.
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An 83-year-old retired farmer went in for day surgery to remove a cancerous lesion from a vocal cord. The anesthesiologist left after initiation, and a certified registered nurse anesthetist (CRNA) was in charge. **(For an update on the rule requiring physician supervision of CRNAs, see box, p. 89.)** The anesthesia team, combining a higher-than-required concentration of oxygen and a failure to properly operate a laser-resistant tube, started a fire in the patient's trachea. Whether the patient initially recovered from his injuries was in dispute, but complications led to his death and a $2.1 million settlement.

Background: The patient had been diagnosed as having a cancerous lesion on a vocal cord, and his physician recommended laser surgery. During the procedure, which was performed on an outpatient basis, the surgical and anesthesia team used a Z-Xomed laser-resistant tube, but failed to follow the manufacturer's recommendation to place wet pledgets around the cuff. The error, combined with a higher-than-recommended concentration of oxygen, caused a fire in the patient's trachea. The fire was long and hot enough to melt the patient's endotracheal tube. Suffering from burns and inhalation injuries, he soon died.

In addition to claiming the medical team failed to properly operate the laser, the plaintiff maintained that the anesthesiology team used an improper oxygen preparation with nitrous oxide as the anesthetic agent.[1] The plaintiff maintained that the combination of the misuse of the equipment and high concentration level of oxygen started the fire. The plaintiff also alleged that once the fire started, the physicians failed to act timely and properly by either turning off the oxygen or crimping the line to limit the supply of fire-fueling oxygen. In conclusion, the plaintiff claimed that the misuse of equipment and failure to appropriately manage the accident once it occurred caused severe inhalation injury resulting in the subsequent development of acute respiratory distress syndrome and multiorgan failure, which lead to the patient's death.

The defendants contended they acted properly and denied using inappropriate concentrations of anesthetic agents. Additionally, they claimed the decedent died from unrelated hemorrhagic pancreatitis, which occurred after his trachea had healed. The physicians settled prior to trial for $2.1 million.

Hospitals, surgery centers, and physician offices are full of things that can and do ignite. As this scenarios illustrates, health care professionals must handle flammable and caustic materials with extreme caution and care; otherwise, they and their patients might be unintentionally burned.

This case demonstrates the need for the adequate training of staff and appropriate credentialing of professionals.

"Training in the use of new equipment is critical, regardless of whether it is being used on an inpatient or outpatient basis," says **Ellen L. Barton**, JD, CPCU, risk management consultant, of Phoenix, MD. "While manufacturers clearly have a responsibility to provide instructions and

New rule is coming on supervision of CRNAs

The rule developed by the Clinton administration eliminating the requirement for physician supervision of certified registered nurse anesthetists (CRNAs) has been rejected by the Bush administration, which is going to issue a new rule by the end of the year, according to national anesthesia groups.

The new rule will keep the previous requirement for physician supervision, but it will allow state governors to dismiss the requirement under the following conditions:

- The state boards of medicine and nursing are consulted.
- The state law permits CRNAs to work without physician supervision.
- The governor demonstrates that it is in the best interests of the citizens of the state that the CRNAs work without physician supervision.

Addition, the new rule calls for the Department of Health and Human Services to conduct a study of patient outcomes based on different states' practices involving supervision of nurse anesthetists. ■

training, health care practitioners also have a responsibility to acquire the appropriate proficiency and experience to be able to operate any new equipment without causing harm."

All staff assisting in a procedure should be trained in the management of the use the equipment as well as the management of a malfunction or operational error, Barton says. "And, as may have been the case in this scenario, staff training in the outpatient setting may be even more critical than the inpatient setting simply because of the lack of additional resources, such as a designated rescue team," she says. "Staff have a right to such training and a duty to refrain from assisting in such procedures or using new equipment if [they do] not feel equipped to handle any contingency."

A related issue is the credentialing of the practitioners performing various specialty procedures and using the specialized requisite equipment, Barton says. "Just as every hospital traditionally uses established credentialing criteria — education, training, experience, and references — for basic clinical privileges, the same should hold true for stand-alone outpatient facilities," she says.

Regardless of location, it is equally important to continuously update the list of each practitioner's specific privileges, particularly as new technology and equipment enter the market place, Barton says. "Credentialing should be specific as to what the physician is able to perform and the exact equipment to be used in each of the procedures," she says.

The training provided to staff was not sufficient in this case since the fire seemingly burned out of control, Barton says. "Whether this was because of the manufacturer's specifications or the trainees is uncertain," she says. Although it isn't known whether claims were brought against the equipment manufacturer, it is likely that the manufacturer's instructions for using the laser were clear and available to the health care providers, she says.

"To avoid such allegations in the future, a facility's credentials committee must develop and apply appropriate criteria to the awarding of privileges and make sure that their own staff are familiar with the equipment being used," Barton says. "In addition, and perhaps fortunate for future patients, various payers also are starting to require such credentialing of professional prior to their reimbursing for services."

Reference

1. *Helen Durston, Individually and o/b/o the Estate of Everett Durston, deceased, et al. v. Rio Grand Surgery Center Associates, L/O., d/b/a Rio Grande Surgery Center, Michael J. Gossett, CRNA, Jaime Gumucio Viancos, MD, and Keith A. Picou, MD,* Hidalgo County (TX) District Court, Case No. C-2957-98-C. ■

Same-Day Surgery Manager

7 areas to address when you open a satellite

By **Stephen W. Earnhart**, MS
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Last month, we discussed the reasons and advantages of opening a satellite facility to accommodate your growing surgical list, combat cramped quarters, or attract new users. This month we will discuss how to develop that satellite and

the changes in case loads and income that, we hope, will occur. **(To get a copy of last month's article, see editor's note at the end of this article.)**

First, make sure your reasons for expansion are based upon sound logic and need. Avoid the ego-driven desire to take over the world.

The first step after you have determined (for all the right reasons) to develop a satellite center is to perform a feasibility analysis. If you are a small group, you probably can perform an abbreviated study that addresses the capitalization issues such as the cost of equipment for the new center, the cost of leaseholds, and how will you pay for them. Then you need to determine what your potential return on your new investment will be by dividing the cash cost of the new project by your profits. Chances are you will need your accountant to handle that part of the transaction. If you are expanding into virgin territory and are going to joint venture the new center with outside investors, hospitals, or other physician groups, you should entertain a more comprehensive study that can be used in the syndication process and that meets state Securities and Exchange Commission regulations.

Be prepared for negative recommendation

After you have performed your analysis, some of you had better put the brakes on right now. Virtually 45% of all the feasibility work we do returns a negative recommendation to move forward. If it doesn't work, don't force it and think it will get better after you have spent your time and money. Some of the smartest people out there realize that you do not want to chase bad money with good. If it doesn't work today, it might in another year or two, or if you add new partners to the equation or significantly increase your surgical output. Be sensible. It is better to walk away from a good deal than to do a bad one.

If the recommendation is positive, examine these areas:

• **Location.** Remember: location, location, location. Usually the ideal place for a surgical facility is near the perceived existing medical community — usually within eyeshot of a hospital. There are many successful centers in the middle of a corn field, but if you have the option, go for the former. It is far easier to attract new investors and users in that type of a location.

• **Size and scope.** On average, an ambulatory surgery center can accommodate between 1,000 and 1,500 cases per year per operating room. If you have identified 4,000 cases (not procedures), you should build your center with about three to four operating rooms. Depending upon your specialty mix, you can go lower or higher. Square footage of your satellite center is important because you are paying by the square foot! Be conservative. It seems as if everyone is overbuilding the size of surgery centers. Future expansion is important, but you need to pay for your space now. Do not overbuild. There are many three- and four-OR centers out there that are smaller than 10,000 square feet. Avoid the trap of building a center that is too large. Most consultants and architects will try to increase the size of your center. Be strong.

• **Partnerships.** Do not delude yourself into thinking "if you build it, they will come." Those days are long gone. Do not build a center thinking that other surgeons will beat a path to your door when it opens; they will not. Therefore, financially it must stand on its own merit. If you are trying to bring new investors into the satellite center, then modify your partnership agreements to allow your current investors in the original center to invest in the satellite as well. However, offer as much equity in the satellite center to make it worth the investment for the new investor group.

• **Passive investors.** You may have passive investors in the existing center who would like to sell their shares and buy into the new center. The usual reasons are because it is closer to their home, they have better posting opportunity, or a better block time, or whatever. This is a good time to clean house from an investor standpoint. Be smarter this time!

• **Shifting cases.** Do not plan to shift cases from the original center to the new facility. All business in the satellite needs to be new business. A common argument is that now patients from *that* part of town do not have to drive all the way over *here* for surgery. Unless the existing center is very strong, and you can afford to shift cases, don't sacrifice one for the other.

• **Staffing.** You should be building your satellite because you are "maxed" out in the existing center. If you can afford to shift staff to the satellite, then chances are you really are not maxed out at all. Plan on a separate clinical staff, but seriously consider a common administrator and business office manager. You would be hard-pressed to have a common nurse manager, but you could save some money and try it.

• **Training.** While your center is under construction, train your key staff members in your

existing center so you can hit the road running.

Learn from your mistakes. There is not a center out there that cannot be improved. Make sure you incorporate the good and eliminate the bad in the new center.

(Editor's note: Earnhart and Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Earnhart can be reached at 5905 Tree Shadow Place, Suite 1200, Dallas, TX 75252. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.

For a copy of last month's article, contact the customer service department at: customerservice@ahcpub.com.) ■

CDC draft guidelines say no artificial nails

OR technician reported to have infected 3 patients

In the wake of a published study that an operating room technician who wore artificial nails infected three laminectomy patients with *Candida albican*,[1] the Centers for Disease Control and Prevention (CDC) in Atlanta has drafted hand hygiene guidelines that recommend health care workers should not wear artificial nails. This will be the first time CDC has made such a recommendation for all health care workers with patient contact.

In the three cases involving infection transmitted by artificial nails at Stamford (CT) Hospital, the mean time from the surgery to diagnosis was 54 days. The OR technician had scrubbed on all three cases and had worn artificial nails during the procedures. *Candida albicans* was isolated from her throat; the technician was treated with fluconazole and removed from duty.

Artificial nails promote subungual growth of gram-negative bacilli and yeast, according to the published report. Previous CDC guidelines on surgical site infection "strongly recommended" no artificial nails. **(For more information on surgical site infection guidelines, see *Same Day Surgery*, September 1999, p. 105.)** Recommended Practices from the Association of periOperative Registered Nurses in Denver recommend that OR nurses not wear artificial nails. **(For more information on artificial nails, see *SDS*, April 2000, p. 37.)** Infection control experts urge SDS managers to review the literature and update their policies on artificial nails, as needed.

On another matter, the CDC is drafting a guideline on sterilization of equipment used on patients who have Creutzfeldt-Jakob disease (CJD). The guideline follows reports that instruments used on a CJD patient at Tulane University Hospital and Clinic in New Orleans were subsequently used on eight other patients. **(See *SDS*, April 2001, p. 37.)**

The CDC sterilization guideline may differ somewhat from other existing guidelines, such as that of the World Health Organization in Geneva, Switzerland. The guidelines will try to incorporate the current laboratory and epidemiological science about CJD transmission and provide the users with more flexibility, says **Bill Jarvis**, MD, associate director for program development in the Division of Healthcare Quality Promotion at the CDC. "All nosocomial transmission has been either brain-to-brain inoculation or injection of brain material," Jarvis says.

Reference

1. Parry MF, Grant B, Yukna M, et al. *Clin Infect Dis* 2001; 32:352-357. ■

Staffing is tough task for all surgical units

(Editor's note: In this second part of a two-part series on combining or separating inpatient and outpatient surgery, we explore the staffing challenges. In last month's issue, we discussed the factors that influence your decision to combine or separate units.)

Finding the right people to work in your operating rooms is a challenge, but how do those challenges differ between separate same-day surgery units and units combined with inpatient surgery?

"I have to find staff members who are able to interact with many people in a short period of time and present a caring attitude," says **Peter Mollenholt,** MD, administrative director of DayStay at Oregon Health Sciences University Hospital in Portland, OR, where the same-day surgery services are separate. "My staff also have to recognize that our patients have choices as to where they go, so we have to give good service."

It is easy to recruit for a unit that only handles

same-day surgery because the hours are more predictable, there is no call, and the patients are not ill, he adds.

While the manager of a combined surgical unit doesn't have to worry about hiring different OR staffs for inpatient and outpatient, it is difficult to find nurses who can handle inpatient and outpatient surgery, says **Susan Bales**, RN, MBA, director of surgical and obstetrical services at Promina DeKalb Medical Center in Decatur, GA.

"A nurse who wants to handle inpatient and trauma cases likes the extra money for taking call and likes the slower pace of longer cases," she explains. "A same-day surgery nurse is a high-energy person who likes quick cases, fast turnovers, and no call on weekends."

Because Bales' staff work all types of cases, she says it is difficult to find a "hybrid" nurse who likes both types of surgeries. "I also find that the more experienced operating room nurses are less likely to stay in a combined unit as they burn out," says Bales. "They are more attracted to same-day surgery centers because of the predictable hours and lack of call." ■

One day a week means profits for some programs

Efficient use of resources, lower staff costs help

An efficient use of resources can lead to a profitable same-day surgery program, and one way to be efficient is to make sure that your OR staff move from one case to the next with no or little down time. For at least one same-day surgery center, this efficiency means being open for surgery only four to six days per month.

"Our center in Dedham, MA, does 25 to 35 surgical cases and five to 15 laser cases on the one day per week that it is open. If this center was open four or five days per week, profits would be reduced by 60%," says **Brent Lambert**, MD, chief executive officer of Ambulatory Surgical Centers of America (ASCOA) in Norwell, MA.

The other four days of the week, the only staff working are two administrative workers who handle scheduling, billing, claims, purchasing, and other record-keeping duties, Lambert says. Because salaries are often the highest or one of the highest expenses for a same-day surgery program, having the OR staff work only on a day that they will be busy is a good way to manage costs, he says.

Although there are fixed costs such as rent and equipment expenses that are spread over fewer procedures, these costs do not reduce the profit margin significantly, says Lambert. "We build very functional facilities without a lot of extravagant furnishings or excess space so we keep facility costs down to begin with," he says.

These costs are not as high as personnel costs, which are managed by making sure staff are productive when they are at work, he adds.

John Dunne, CRNA, is administrator of the Cataract and Laser Center in Dedham, MA, which is one of the five New England surgery centers that Dunne manages for ASCOA. "I've managed and worked at surgery centers that were open four and five days per week, but most of the centers I now manage for ASCOA are open no more than five to 10 days per month," he says.

Dunne has no trouble finding staff to work in surgery programs that only open one to two days per week because he negotiates an hourly rate that is equal to or better than the rate offered by local hospitals. "Although we usually work 10 hours on the days we are open, I guarantee a nine-hour workday," he says. "This lets the employees know that they won't come to work, then be sent home without pay a few hours later because we are slow. It makes it easier for them to plan their personal budgets."

There is no guarantee of number of days per month made to employees, but Dunne points out, "We try to look weeks or months ahead at our schedule. If we know one of our surgeons will not be busy one month because of a planned vacation, we'll cut a surgery day as far in advance as possible so the staff members know

EXECUTIVE SUMMARY

While the traditional same-day surgery program is open most days of the week to allow flexible scheduling for physicians and handle a fluctuating volume of cases, some programs limit the number of days for surgery as a way to stay efficient.

- Staff costs stay low because salaries and benefits are not paid to operating room staff when they are not working.
- Recruitment of RNs is easier since a part-time surgery program appeals to people who do not want to work full time or take call.
- The profit margin is higher since there is no downtime for staff and equipment on surgery days.

how to plan their time."

In the same way, if Dunne sees a need for an extra day of surgery for a month, he adds it as far in advance as possible. In addition to the comparable hourly rate of pay, employees also like knowing that they won't have to be on call or work weekends, says Dunne.

"We usually have a lot of new mothers working for us or people who are trying to earn some extra money for things like college for their children," he explains. "The key to a good staff for this type of surgery center is to hire savvy people who understand that we are not an assembly-line facility but are a very busy surgery center one day a week."

There are generally five or six RNs, three surgical techs, and two office employees, says Dunne. Health insurance, sick leave, and paid vacation are offered only to the office personnel who work each day of the week, he adds.

A contract for anesthesia services with an anesthesiology group provides an anesthesiologist and one or two certified registered nurse anesthetists on the day of surgery, says Dunne.

The cost of building and equipping a center that will only be open a few days each month is the same as a center that is open a full week, says Lambert. "We design it and equip it to handle a full day of continuous surgery," he says.

For the Dedham center, this design means two ORs and one laser room equipped for ophthalmic procedures, he adds.

Because the Dedham center is owned completely by the surgeons who operate there, the state considers it to be an extension of their offices by says Dunne. This enabled them to open without undergoing any certificate of need approval, which would require that they demonstrate a significant need for additional surgery facilities in the geographic area, he says.

SOURCES

For more information about programs that are open a few days per month, contact:

- **John Dunne**, CRNA, Administrator, Cataract and Laser Center, 333 Elm St., Dedham, MA 02026. Telephone: (508) 878-4977.
- **Brent W. Lambert,** MD, Chief Executive Officer, Ambulatory Surgical Centers of America, 15 Farrar Farm Road, Suite Two, Norwell, MA 02061. Telephone: (781) 659-0422. Fax: (781) 659-0434. E-mail: blambert@ascoa.com.

Patients are not concerned that the center is open only one day per week, says Dunne. "Their doctors tell them they perform surgery on Tuesdays and when they show up, they see a busy, efficient, pleasant surgery center," he says. In fact, he says, "At the end of the day, patients tell us how much they appreciate the pleasant surroundings, friendly staff, and short amount of time they had to spend in the center. That is another by-product of efficiency and good planning." ■

Low costs are not dependent on volume

Cataract study pinpoints factors that do matter

(Editor's note: This is the second part of a two-part series on the second study of Cataract Extraction with Lens Insertion conducted by the Accreditation Association for Ambulatory Health Care Institute's for Quality Improvement. Last month, we looked at pre-procedure time, procedure time, and discharge time. This month, we look at costs.)

The good news identified in the 2000 Cataract Extraction Study is that there is not a high correlation between volume and supply costs, says **Naomi Kuznets**, PhD, managing director of the Wilmette, IL-based Accreditation Association for Ambulatory Health Care's Institute for Quality Improvement, which conducted the study.

"The annual number of cataract extractions for our participants ranged from 150 to 2,500," says Kuznets. The facilities that reported the best prices for lenses as well as narcotics and sedatives were not always the high-volume facilities that might be eligible for volume discounts, she says. In fact, negotiations, relationships with vendors, and standardization played more important roles in containing costs than volume, she adds.

Eighteen same-day surgery programs participated in the study. Same-day surgery managers can use benchmark studies such as this one to perform a quality analysis by comparing practice patterns, cost of supplies, and time per case, experts advise. **(To order study, see resource box, p. 94.)**

In the intraocular lens category, costs ranged from fewer than $40 to almost $160.

"Our lens costs for the study were very high

RESOURCE

A copy of the 2000 Cataract Extraction Study is $40. To order, contact:

- **Accreditation Association for Ambulatory Health Care**, Institute for Quality Improvement, 3201 Old Glenview Road, Suite 300, Wilmette, IL 60091. Telephone: (847) 853-6079. Fax: (847) 853-9028. Web: www.aaahc.org.

[$120] because the study was conducted during a time period that we were evaluating a number of new lenses, including acrylic lenses that cost $80," says **Grace Niedmann**, RN, director of nursing at Opticare Eye Health Center in Waterbury, CT. Now that they are completing their evaluations, Niedmann's physicians will be standardizing their lenses as much as possible to negotiate the best prices, she says.

"We are always tough negotiators," says Niedmann. "We are always open to switching vendors to obtain the best price as long as they offer the lens we want."

Multidose vs. single dose eye drops

The study also looks at the use of multidose vs. single dose eye drops. Traditional hospital practice calls for single dose eye drops, but 94% of the participants use multidose drops, Kuznets says. "Studies show that infection rates do not rise as a result of multidose eye drops,"[1] she says.

The nurses use a no-touch method to administer eye drops, says Niedmann. "They pull the lower lid down and drop the medication from a least one inch from the eye, then they recap the bottle between uses," she explains.

"If an infection is reported one to three days after surgery, we look for something that happened on the day of the surgery that might have caused the infection. But if the infection occurs more than three days after surgery, the cause is usually the patient or family member improperly administering drops."

Patients and their family members are given verbal and written instructions on how to administer drops, she says.

Reference

1. Brudieu E, Duc DL, Masella JJ, et al. Bacterial contamination of multi-dose ocular solutions. A prospective study at the Grenoble Teaching Hospital. *Pathol Biol (Paris)* 1999. 47:1,065-1,070. ■

Joint Commission issues 2 warnings

Alerts address infusions pumps, drug names

Due to concerns about severe consequences, including patient death, the Joint Commission has published *Sentinel Event Alerts* related to look-alike, sound-alike drug names and infusion pumps. **(For information on accessing the publications, see resource box, p. 95.)**

About 15% of the reports to the Medication Errors Reporting Program run by the US Pharmacopeia (USP) in Rockville, MD, involve similar drug names, either written or spoken. One example is epinephrine and ephedrine, says **Diane D. Cousins**, RPh, vice president of practitioner and product experience at US Pharmacopeia. Another problem is that some drugs have similar labels and

packaging, she says. One example is epinephrine and Anzemet (Aventis Pharmaceuticals, Bridgewater, NJ).

If these drugs are mixed up, the consequences could be severe because Anzemet is an antiemetic and epinephrine is a vasoconstrictor that reduces blood flow to a particular area, Cousin says.

To avoid confusion, the person receiving a verbal order for medication should repeat the order to the prescriber, she suggests.

Recommendations on how to reduce medication errors associated with verbal orders have been released recently by the National Coordinating Council for Medication Error Reporting and Prevention. **(See recommendations enclosed in this issue.)** In addition to the confusion created by medications that sound alike, medications may be mixed up because they have similar packaging, Cousins warns. Also medications of similar strength may be confused because they often are stored next to each other, she adds.

"There should be extra effort added to keep these drugs separated where they are known to be a problem," Cousins says. "Put another product between them, or use an actual physical divider so there's some way to differentiate one from another."

Deaths and near-fatal overdoses from infusion pumps also have resulted in a *Sentinel Event Alert* bulletin being published by the Joint Commission. **(See resource box to obtain a copy of the alert, at left.)**

During on-site surveys this year, Joint Commission surveyors will be asking about use of

SOURCES AND RESOURCES

For more information on avoiding medical errors, contact:

- **Kathleen Catalano**, RN, JD, Children's Medical Center of Dallas, 1935 Motor St., Dallas, TX 75235. Telephone: (214) 456-8722. Fax: (214) 456-6081. E-mail: kcatal@childmed.dallas.tx.us.
- **Diane D. Cousins**, RPh, Vice President, Practitioner and Product Experience, US Pharmacopeia, 12601 Twinbrook Parkway, Rockville, MD 20852. Telephone: (301) 816-8215. Fax: (301) 816-8532. E-mail: ddc@usp.org.

The *Sentinel Event Alerts* by the Joint Commission on Accreditation of Healthcare Organizations can be found on-line at www.jcaho.org. (Click on "Patient Safety/Sentinel Events," "Sentinel Event Alert," then "Sentinel Event Alert" again, then scroll down to the May 2001 and Nov. 30, 2000, issues.) You can sign up to receive *Sentinel Event Alert* via e-mail by going to the *Sentinel Event Alert* home page. To get a fax copy of the latest issue of *Sentinel Event Alert*, call the Joint Commission's fax-on-demand line at (630) 792-3885. Press 4. For more information, contact:

- Joint Commission on Accreditation of Healthcare Organizations, Customer Service, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Telephone: (630) 792-5800, between 8 a.m. and 5 p.m. Central Time on weekdays.

In March 2001, the US Pharmacopeia (USP) released *Use Caution, Avoid Confusion*, an updated list highlighting hundreds of confusing drug name sets and identifying more than 750 unique drug names that have been reported to the Medication Errors Reporting program. The list may be accessed from USP's web site at www.usp.org/reporting/review/rev_076.htm.

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This continuing education offering is sponsored by American Health Consultants, which is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing. Provider Number CEP 10864. Approximately 20 nursing contact hours.

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Editorial Questions

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infusion pumps, says **Kathleen Catalano**, RN, JD, rector of administrative projects at Children's Medical Center of Dallas and a former consultant specializing in regulatory compliance.

Here are five recommendations from the USP to avoid adverse outcomes with infusion pumps:

• Identify all pumps with potential for free-flow errors, including those with confusing labeling.

• Sequester / quarantine / phase out the use of unprotected devices.

• Petition the Food and Drug Administration to withhold / withdraw approval of IV pumps that permit free flow.

• Petition manufacturers to stop production and sale of free-flow pumps.

• Continue to report errors associated with the use of IV pumps that do not protect against free flow so that accurate frequency and severity of these errors can be assessed.

(Editor's note: The recommendations from USP are reprinted with permission from USP's Practitioner's Reporting News*, Free-Flow IV Pumps, 7/99, www.usp.org/reporting. Copyright 2001. All Rights Reserved.)* ■

CE*questions*

After reading this issue, the continuing education participant will be able to:

• Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care and management.

• Describe how those issues affect nursing service delivery or management of a facility. (See "Fire in a patient's throat leads to death, settlement" and "Staffing is tough task for all surgical units.")

• Cite practical solutions to problems or integrate information into their daily practices, according to advice from nationally recognized ambulatory surgery experts. (See "One day a week means profits for some programs" and "Joint Commission issues 2 warnings.")

5. According to Ellen L. Barton, JD, CPCU, risk management consultant, credentialing should be specific as to:
   A. how many hours of training the physician underwent
   B. how much of the physician's training was hands-on
   C. the credentials and background of the instructors who taught the physician
   D. the exact equipment to be used in each of the procedures

6. Recruiting staff for a surgical unit that handles both inpatient and outpatient procedures is difficult, according to Susan Bales, RN, MBA, director of surgical and obstetrical services at Promina DeKalb Medical Center, because:
   A. You need to recruit a larger number of people.
   B. Salaries are lower.
   C. Not all nurses are comfortable handling both types of surgical cases.
   D. Budget constraints keep staff numbers low.

7. Same-day surgery programs that are only open one or two days per week are more profitable because of a savings in what area, according to Brent Lambert, MD, chief executive officer of Ambulatory Surgical Centers of America?
   A. salaries
   B. utilities
   C. equipment cost
   D. supplies

8. According to US Pharmacopeia, what should be done with IV pumps that do not protect against free flow?
   A. They should continue to be used with close supervision.
   B. They should be sequestered/quarantined/phased out.
   C. They should be returned to the manufacturer.
   D. none of the above

National Coordinating Council for Medication Error Reporting and Prevention

COUNCIL RECOMMENDATIONS

Recommendations to Reduce Medication Errors Associated with Verbal Medication Orders and Prescriptions

Adopted Feb. 20, 2001

Preamble

Confusion over the similarity of drug names accounts for approximately 25% of all reports to the USP Medication Errors Reporting (MER) Program. To reduce confusion pertaining to verbal orders and to further support the Council's mission to minimize medication errors, the following recommendations have been developed.

In these recommendations, verbal orders are prescriptions or medication orders that are communicated as oral, spoken communications between senders and receivers face to face, by telephone, or by other auditory device.

Recommendations

1. Verbal communication of prescription or medication orders should be limited to urgent situations where immediate written or electronic communication is not feasible.

2. Health care organizations* should establish policies and procedures that:
   - Describe limitations or prohibitions on use of verbal orders
   - Provide a mechanism to ensure validity / authenticity of the prescriber
   - List the elements required for inclusion in a complete verbal order
   - Describe situations in which verbal orders may be used
   - List and define the individuals who may send and receive verbal orders
   - Provide guidelines for clear and effective communication of verbal orders.

3. Leaders of health care organizations should promote a culture in which it is acceptable, and strongly encouraged, for staff to question prescribers when there are any questions or disagreements about verbal orders. Questions about verbal orders should be resolved prior to the preparation, dispensing, or administration of the medication.

4. Verbal orders for antineoplastic agents should NOT be permitted under any circumstances. These medications are not administered in emergency or urgent situations, and they have a narrow margin of safety.

5. Elements that should be included in a verbal order include:
   - Name of patient
   - Age and weight of patient, when appropriate
   - Drug name
   - Dosage form (e.g., tablets, capsules, inhalants)
   - Exact strength or concentration
   - Dose, frequency, and route

- Quantity and / or duration
- Purpose or indication (unless disclosure is considered inappropriate by the prescriber)
- Specific instructions for use
- Name of prescriber, and telephone number when appropriate
- Name of individual transmitting the order, if different from the prescriber.

6. The content of verbal orders should be clearly communicated:
   - The name of the drug should be confirmed by any of the following:
     — Spelling
     — Providing both the brand and generic names of the medication
     — Providing the indication for use
   - In order to avoid confusion with spoken numbers, a dose such as 50 mg should be dictated as "fifty milligrams . . . five zero milligrams" to distinguish from "fifteen milligrams . . . one five milligrams."
   - Instructions for use should be provided without abbreviations. For example, "1tab tid" should be communicated as "Take / give one tablet three times daily."

7. The entire verbal order should be repeated back to the prescriber, or the individual transmitting the order, using the principles outlined in these recommendations.

8. All verbal orders should be reduced immediately to writing and signed by the individual receiving the order.

9. Verbal orders should be documented in the patient's medical record, reviewed, and countersigned by the prescriber as soon as possible.

* *Health care organizations include community pharmacies, physicians' offices, hospitals, nursing homes, home care agencies, etc.*