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INSIDE

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Staff morale low? Before spending money, hear what employees want

5 top predictors of satisfaction listed for hospitals, ASCs

(Editor's note: In the first part of a two-part series on raising staff morale, we offer you the latest research on what surgery center and hospital employees want. In next month's issue, we give you seven suggestions from your peers.)

Want to make your employees happy? Surprisingly, it's probably going to take something that is free, readily accessible, and easy to add: "Communication, communication, communication," says **Mel Thompson**, president and chief executive officer of Data Management & Research, a Franklin, TN-based research firm specializing in health care quality and satisfaction surveys. Thompson's firm presented employee satisfaction data for surgery centers and hospitals at the recent annual meeting of the Federated Ambulatory Surgery Association (FASA).

The problem of low morale is widespread. In the 2001 *Same-Day Surgery* Reader Survey results, 13.6% of respondents ranked low morale in their department/facility as the No. 1 item with which they were dissatisfied in

Proposal: Eliminate most off-campus surgery centers from EMTALA regulations

Under a proposed rule for new Emergency Medical Treatment and Labor Act (EMTALA) regulations from the Baltimore-based Centers for Medicare & Medicaid Services (CMS), most off-campus hospital surgery centers would no longer fall under EMTALA. EMTALA has never applied to surgery centers that are certified by Medicare as freestanding.

"Under the 5/9/02 proposal, hospital-based surgical facilities would be subject to EMTALA only if located on the main hospital campus and treated by Medicare as a department of the hospital, or located off-campus of the main hospital and qualifying as a 'dedicated emergency department [ED],'" says **Eric Zimmerman,** JD, MBA, an attorney at McDermott, Will & Emery in Washington, DC.

(Continued on page 94)

EXECUTIVE SUMMARY

Communication is the key to improving staff morale, says the CEO of a firm that surveyed surgery center and hospital employees on satisfaction.

- The top five predictors of surgery center employee satisfaction were, in descending order of importance: morale/yourself; overall service; value of my work to the surgery center; pay for job; and support of supervisor.
- The top five predictors in hospitals were, in descending order of importance: morale/others; overall service; sense of belonging; the work itself; and communication.

their jobs. It was the fourth highest specific reason mentioned, with the impact of cost-cutting, heavy workload, and staffing making up the top three.

Administrators often are good at making sure operations are efficient and quality care is being provided, but that mission isn't always articulated to employees, Thompson maintains. "You can have the best technical abilities around, but it may not be communicated," he says.

Administrators should be the creators and champions of the facility's mission, Thompson advises. "They can be great operators, but if they don't do the other, employees don't get a sense of belonging, of being a part of something that's quality, and understanding their role in carrying out the cause," he says. "They just become an assembly-line worker, and people didn't get into health care for that purpose." Without a "champion of the cause," recognition doesn't matter, because people don't know what they're being recognized for, Thompson maintains.

Keep employees informed about how well the surgery center is performing, advises **Marlene Brunswick**, RN, director of nurses at Findlay (OH) Surgery Center. "I think people like to know what's going on, good or bad," she says.

Findlay's managers share whether the center has a record-breaking month and indicate where the volume increases and decreases have been. Brunswick also gives her staff a questionnaire once a year with questions about benefits they'd like added. "There's no guarantee [it will be added], but they give feedback," she says.

Brunswick also conducts an annual educational needs assessment. "If there is something people want more information about, I try to get sales reps in, to present a new piece of equipment or machines, or whatever it might be, to keep them educationally informed," she says.

Thompson's firm analyzed 750 responses to an employee satisfaction survey conducted in 43 ambulatory surgery centers (ASCs). **(See article on hospital survey results, p. 87.)** Here are the top five item predictors of employee satisfaction, in descending order of importance:

• **Morale/yourself.** "When people are thinking of morale, they're thinking of things such as their sense of belonging, the work itself, communication, and customer service — how well it's being provided," Thompson says. "We want to be a part of an organization that really is providing quality of care, and my morale is affected by how we're doing that."

El Camino Surgery Center in Mountain View, CA, has improved its employees "sense of belonging" with a staff appreciation week. Each work team has one day to provide a surprise for the staff. Previous surprises have included fondue, a cowboy-themed barbecue, and a make-your-own-sundae party.

"Instead of always focusing on 'what's management going to do,' it gets employees and teams involved," says **Julie Butner**, executive director. At the FASA meeting's session on employee satisfaction, Butner heard frustrated participants asking, "What can I do for morale?" Her response: "I've learned to go to the staff and ask, 'What's the problem? What can we do?' Get them involved in solutions and creating fun," she suggests.

Physicians who work at the center have noted the high morale among staff, Butner says. "It's a great satisfier for me," she says.

• **Overall service.** This item is the perception of overall quality that the entire surgery center provides, Thompson says. For example, if you have a physician who is one of only a few performing a particular procedure in the country, tell your entire staff so they can share in the pride, he suggests.

"Even if you're not working on it, you're a part of it by being there," Thompson adds.

• **Value of my work to the surgery center.** This

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includes how well it's communicated that an individual employee is playing an important role, Thompson says. "For example, is it communicated that you know your role and how it fits into the scheme of providing overall quality?" he asks.

During Nurses' Week, managers at Northern Ohio Surgical Center in Sandusky encourage the business office to observe surgery, says **Lauralee S. Krabill**, RN, CNOR, MBA, administrator.

"I think it improves teamwork," Krabill says. "The business staff have an idea, when they send out a bill, what the patients experience."

Some things are more important than gifts, emphasizes **Sue Nowell**, RN, nursing manager at Bay Area Surgery Center in Corpus Christ, TX. "I really believe that with appreciation expressed by patients and the surgeon owners, the staff feel the work they do is appreciated," Nowell says.

When patients make a positive comment about a particular staff member in the satisfaction survey, Nowell posts the comment for everyone to see. "The thank-yous are probably the No. 1 thing [helping staff satisfaction] and feeling that they can communicate with administrators and owners," she says.

For employees to feel their work is valued by the surgery center, it's important to recognize all employees, not just individuals, Thompson says.

Findlay Surgery Center provides $50 gift certificates for a restaurant, gasoline, or groceries to everyone on staff when the center exceeds its previous high case volume per month, which is currently 408 cases, Brunswick says. It's important to include temporary and PRN staff in such recognition, she says. "PRN staff are so valuable when you are busy," Brunswick says.

Also show appreciation for your physicians' private scrubs and other staff who come with them to the surgery center, she advises. Her center hosts parties in December and in the spring, and includes those staff.

"They're free help to us," she points out. "We don't have to pay for salaries, but they add a lot to our center. That helps our staffing."

• **Pay for job.** It is unusual for pay to show up as a predictor of employee satisfaction, Thompson says. "Usually pay only shows up on a location-by-location basis when other key drivers are really a problem," he says.

• **Support of supervisor.** The supervisor's support is important because surgery centers are smaller than many other health care facilities, and employees' perceptions regarding satisfaction and how they feel about their supervisors are interconnected, Thompson says. "The supervisor may be the communicator and everything else," he says.

What's the most important thing for a supervisor to do? Krabill suggests: "To truly listen to [employees'] concerns, their issues. If it at all possible, make changes."

[Editor's note: For more help, go to www.samedaysurgery.com. In our Forum, you can share solutions to staff morale or work ethic problems. You'll need your subscriber number from your mailing label, which is your user name. Your password is sds (lowercase) plus your subscriber number.] ■

SOURCES

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What makes staff happy in the hospital setting?

Data Management & Research, a Franklin, TN-based research firm specializing in health care quality and satisfaction surveys, surveyed 17,000 employees, including hospital-based outpatient surgery employees, at 58 hospitals. Here are the top five item predictors of employee satisfaction:

• **Morale/others.** It isn't clear why the morale of others showed up in the hospital survey results, while the morale of the individual scores

SOURCES

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highest in the surgery center pilot study, says **Mel Thompson**, president and chief executive officer of Data Management & Research.

"The assumption is that in a large setting, your morale may not have as much effect on you as what you see happening to everyone," he says. "Size may be the difference."

• **Overall service.** This item concerns the quality of care offered by the hospital, Thompson says. The intent is for there to be a general perception by the staff of quality overall service, he explains. "This item is influenced by morale, communication, customer service perceptions, and technical ability of the staff," Thompson says.

• **Sense of belonging.** "In a hospital, you could get lost in the mix," Thompson says.

Communication is a key part of this factor, he says. "I need to know that what I do is truly contributing to this organization and the quality of care I provide." To feel that, employees need recognition, Thompson adds.

At The Surgical Center at Lake Norman, based in Mooresville, NC, and part of Lake Norman Regional Medical Center, each employee receives a gift, such as a canvas chair, duffel bag, sweatshirt, golf umbrella, or a Wal-Mart gift certificate, during Hospital Week, says **Mary Jane Sutton**, RN, MSN, clinical director at The Surgical Center. Other events held that week include a tea, a dinner for employees receiving service awards, and a picnic. Sutton gives cards to her entire staff on Feb. 14 and Nurses' Day, and she adds a bookmark.

"It's the little things that don't cost very much, but they do make a difference," Sutton says. "They really do appreciate it."

• **The work itself.** This item relates to the particular duties of the hospital staff employee, Thompson says. It is different from the "value of my work," which showed up as a surgery center predictor, he says. The "value" predictor is related to staff members considering themselves important to the organization, Thompson explains.

• **Communication.** At the hospital level, it's not just communication by the supervisor that matters, but communication by the high administration level, Thompson says.

At Northwest Community Healthcare, the Day Surgery Center in Arlington Heights, IL, found that a daily report sheet enhanced interdepartmental communication. The sheet lists sick calls, any equipment issues, general announcements, and social announcements. "We leave it on the bulletin board for several weeks, so part-time staff can see when they come in. Then they go into a book," says **Meaghan Reshoft**, RN, MBA, director of the Day Surgery Center.

"If someone is on vacation, then [that person] can come back and see what was going on the week before," Reshoft explains. ■

Same-Day Surgery Manager

How to organize your operating environment

By **Stephen W. Earnhart**, MS
President and CEO
Earnhart & Associates
Dallas

Have you noticed the advertisements for closet organizers — everywhere? There are infomercials about them, one store has an annual sale on them, and Home Depot and Lowe's, to name only two, have aisles dedicated to hooks, hangers, clear boxes, labels, shoe holders, sweater chests, and hundreds of other items designed to help us organize our closets.

I organized my closets a couple of years ago because I dreaded looking at the mess. Nor could I find clothes that I knew I had. After I organized my closet, I did my drawers as well because the result was so gratifying — instant access to things I didn't know were there. Now imagine if you

could do that with your operating room environment. Whether you are a freestanding ambulatory surgery center (ASC) or a hospital operating department, the results will be the same: control over your department via organization.

As a firm, we do many operation and process audits, which are basically scorecards and report cards about your hospital or ASC and how to "fix" common problems we uncover. However, in the course of those audits, we request many items from the client in preparation for our visit, and therein lies the tale. We have had several clients tell us that just putting that information together made them realize how unorganized their department really was. They knew they had the information, but didn't have ready access to it. So, let's start with organizing your operating room.

First, focus on the things that really matter and that you will use. I am a huge advocate of delegation. You have great staff working for you, so let them assist you in this process.

The most important place to start and the one that will yield the greatest information is your benchmarks. Make a list of everything you think you should benchmark for your top 10 procedures. Have a staff member sit down with the "operative report" and fill in the blanks with those benchmarks. Most of them are in there. Next, organize your findings by age group, by specialties, and by surgeon. This is much easier than it sounds (especially if someone does it for you).

Give each member of your nursing staff 10 preference cards. Tell them to update them in the computer. (I hope you are using your computer for charging and inventory control.) Print out clean, easy-to-read, updated cards. Take those new, unembarrassing cards and put them beside the op-notes for your surgeon to verify for you. (I know. I know. But you can at least try and make a note that you attempted it.)

Next, tackle your personnel files. If your human resources department does this for you — great! Move on. If not, take all the folders with Post-it notes, margin notes, and loose paper inside them and standardize the contents of each folder in the same manner. Print out the list of employees with a quick update note for yourself that includes date of hire, date of review, inservices, etc. Here is a little trick: Put a random date for each staff member for a "You are doing a great job!" meeting. This is a quick five-minute meeting in your office to let that staff member know how much you appreciate his or her help. We should do this all the time, but we get busy, it slips from our memory, and we wonder why people feel unappreciated. This is a great perk for becoming organized.

After that, organize the equipment sitting in your hallways and empty rooms. If you are a hospital-based program, chances are high that you can find someplace other than your department to hide these rarely used "must have" items. For the square footage-impaired ASCs, rent an off-site storage shed that is environmentally controlled and make a detailed inventory of what you put in there.

Your supply room is a mess. Hire someone to put up more shelves. Buy those plastic office supply lockers that Office Depot sells, and line your walls with them. Inventory what you put in there, print it, tape it to the door of each container, and make your staff update it.

Create a list of where things are. Print the list onto a rolling file of cards that you can buy in office stores, and put those cards everywhere. Don't make staff members wait until they get into the computer to look for it and then go find it.

These are just a few suggestions. Send me yours, and I will pass them on.

(Editor's note: Earnhart and Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management.

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Using informed consent forms vs. progress notes

While not required, forms ensure accuracy

If it's not documented, it didn't happen. That applies to informed consent as well as all other activities associated with same-day surgery.

Even though obtaining informed consent is a responsibility of the surgeon, all same-day surgery managers should make sure the consent is documented in a manner that clearly meets accreditation, state, and federal guidelines, says **Jean S. Clark,** RHIA, director of health information services at CareAlliance Health Services in Charleston, SC.

Although there is no requirement that a separate form be used to document informed consent,

EXECUTIVE SUMMARY

It is the same-day surgery program's responsibility to make sure the consent is documented. While a form with signatures is not required, many programs offer informed consent forms to ensure accurate documentation.

- Specific procedure forms can list risks, complications, and options available for the procedure directly on the form.
- Most programs require a witness to the patient's signature.
- Verbal consents from family members can be given over the telephone if two RNs are listening and sign the form as witnesses.

the best way to ensure documentation is to use a form, she says.

"Relying on physicians to document the informed consent in the progress notes doesn't work," Clark says. "We've conducted chart reviews to see if it happens on a regular basis, and it doesn't."

About three years ago, Clark's hospital gathered the variety of informed consent forms that were being used throughout the facility and pared the number to three forms. "We have a surgical consent that includes anesthesia and blood transfusion consents, a surgical and anesthesia consent that does not include blood transfusion, and a consent form for medical patients receiving blood," Clark says. "We've chosen not to include specifics about the risk of surgical procedures on the form because we wanted to keep the form to one page to make it easy for the patient to read."

The form includes language that indicates the physician explained the risks, benefits, and options for treatment, she says.

Informed consent forms that contain a description of risks for specific procedures are the direction taken by Hanover (PA) Hospital. "We have one general consent form and 40 specific consent forms that have been developed at the physicians' requests," says **Pamela Owens**, RHIA, director of health information management at the facility. **(See Informed Consent for Stone Manipulation, inserted in this issue.)** "Our hospital attorney designed a template that includes the terms and language we needed, then we add the risks and complications that are specific to the procedure," she explains.

The surgeons who perform the procedure for which the consent form is designed are involved in the review and approval of the final form, Owens adds.

Although there are no requirements for a form or for signatures on the form, both Owens' and Clark's facilities require a signature from the patient, a witness, and the physician.

"Our legal counsel recommends that the signatures be obtained as further proof that risks, complications, and options were explained," Owens says.

Clark says physicians at her facility have to sign the informed consent form before they go into the operating room. "The patient signs the form during the admitting process on the day of surgery after the admitting nurse has verified that the physician discussed risks and options," she says. "If the patient says the surgeon did not discuss these things, the physician is called to the admitting area and asked to talk with the patient."

Because Owens' facility offers specific procedure forms as well as a general informed consent form, packets are sent to the physicians' offices so the forms can be completed prior to the day of surgery and sent over to the same-day surgery program. "If a form is not completed at the physician's office, we have the patient sign the general consent form during the admission process," she says.

There are some instances that require going ahead with a procedure even though the patient has not signed the informed consent, Clark says. "If the patient is not alert, not able to communicate, or not competent to give informed consent, we'll contact family members or guardians by telephone," she explains. "If we have to rely upon a verbal consent, we have two RNs on the line talking with the family member.

"Two RNs are necessary since the family member giving the consent will not be signing the form. The second RN is an extra witness to the consent in case questions are asked about the validity of the consent later," Clark says. Both RNs sign the consent form as witnesses, she adds.

Although most people complain about extra paperwork, there have been no complaints about informed consent forms, Clark says.

SOURCES

For more about informed consent, contact:

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"The forms have made it easier for the physicians," she says. "It is one less piece of documentation that they have to remember to include in their progress notes, and we can be sure the medical record is complete." **(For more information, see "Have your patients truly given informed consent?" *Same-Day Surgery*, April 2001, p. 45.)** ■

Pre-op procedures: Check all women for pregnancy?

SDS programs differ on need for global testing

Test for pregnancy in all cases? In some cases? Who makes the decision? These are just a few of the questions faced by outpatient surgery managers who are looking at pregnancy testing policies in terms of cost savings and patient safety.

A survey conducted by The SurgiCenter of Baltimore in Owings Mill, MD, shows that 57% of the 171 respondents do routinely test all females of childbearing age for pregnancy; 81% of the respondents use a urine test to obtain results, and 83.5% conduct the test on the day of surgery.

The survey was conducted as part of the same-day surgery program's evaluation of its own pregnancy testing policy, says **Jerry Henderson**, executive director of the program.

"Our policy was ambiguous and subjective because it gave nurses and anesthesiologists the responsibility of determining a need for the test," she explains.

Although the center excluded women who had undergone hysterectomies or were menopausal, other factors such as different birth control methods and a partner's vasectomy were not applied consistently to determine which patients required a pregnancy test, she says. After receiving the survey responses, input from physicians, and feedback from the nursing staff, the policy was changed to require a pregnancy test for all women of childbearing age, Henderson says.

Jane A. Kusler-Jensen, RN, MBA, CNOR, chair-elect of the Association of periOperative Registered Nurses' Ambulatory Surgery Specialty Assembly (AORN) and director of surgical services for Aurora BayCare Medical Center in Green Bay, WI, has worked in same-day surgery programs that do not require a pregnancy test for all women.

"The decision would be made by the surgeon on a case-by-case basis," she says. The pre-op nurse and the anesthesiologist would ask all patients about the possibility of pregnancy, Kusler-Jensen explains. "If the patient was hesitant to answer, or indicated that there might be a possibility, the anesthesiologist would order the test," she adds. It was a very collegial decision, based on everyone's level of comfort, she says.

Kusler-Jensen's facility used a blood test, and results could be turned around in less than an hour by a laboratory next to the surgery center.

Henderson's program relies on a urine test that can be read by the program's nurses. "The key is to reassure surgeons that testing all women will not delay the start of their procedures and will ensure patient safety," she says.

AORN addresses the pregnancy issue by recommending that all women of childbearing age be asked about the possibility of pregnancy and that a urine test should be performed preoperatively if they indicate there is a possibility[1], says **Ellen O'Connor,** RN, CNOR, chair of the membership committee of AORN's Ambulatory Surgery Specialty Assembly and staff nurse at the Women's OR of Huntsville (AL) Hospital.

"Our hospital tests all women of childbearing age in our pre-op holding area with a urine specimen, and the nurse reads this result unless we have a specific order written by a physician that it is not necessary," she explains. "Our policy is the same for both in- and outpatient."

If you do test for pregnancy, be prepared to handle unexpected positive results, Kusler-Jensen suggests. Be sure that you know who will tell the patient about the pregnancy and whether the surgery will be cancelled, she explains. "In one center, we had two instances of teen-agers who had an idea that they might be pregnant but had

EXECUTIVE SUMMARY

While there is no consensus about the need to test all, or just some, women for pregnancy prior to outpatient surgery, many programs are taking a close look at what their policies state.

- In a recent survey by The SurgiCenter of Baltimore, 57% of respondents do test all women of childbearing age for pregnancy prior to surgery.
- Urine specimens are used most often for the pregnancy tests.
- It is important that surgeons know that the pregnancy tests will not delay surgery.
- SDS programs need to have procedures in place to handle situations in which the pregnancy test is positive.

SOURCES

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not verified their suspicions," she says.

Both times, the surgeon cancelled the procedures, which were elective, and offered to talk to the girl's mother. Be prepared with referrals to agencies that offer social support for the patient if necessary, she adds.

You also should be prepared to handle the financial aspect of the pregnancy test if you require it for all women, Henderson says.

"Insurance will usually pay for a test if it is part of an overall lab workup prior to the surgery day, but might refuse to pay for a test performed the morning of surgery in the surgery center," she says. "We've made the decision that we will continue to perform the pregnancy tests on everyone, even without reimbursement. No matter how much a pregnancy test costs, it will be less than the cost of a lawsuit if a baby is harmed by anesthesia during surgery."

Reference

1. Association of PeriOperative Registered Nurses. *Ambulatory Surgery Principles and Practices: Standards and Recommended Practices for Ambulatory Surgery*. Denver; 2001. ■

8.5 million cosmetic procedures done in 2001

Women, baby boomers make up most patients

The past stigma that was associated with use of cosmetic surgery to improve appearance has decreased dramatically. Fifty-five percent of Americans approve of cosmetic surgery, with 34% of women and 19% of men saying that they would consider cosmetic surgery now or in the future, according to a 2002 consumer survey conducted by the American Society for Aesthetic Plastic Surgery (ASAPS) in Los Alamitos, CA.

Not only are Americans saying that they approve of cosmetic surgery, but they are actually seeking the procedures, according to the 2001 ASAPS physician survey. Nearly 8.5 million cosmetic surgical and nonsurgical procedures were performed in 2001, a 48% increase over the previous year's total of 5.7 million.

The five most popular surgical procedures in 2001 were lipoplasty (385,390), eyelid surgery (246,338), breast augmentation (216,754), rhinoplasty (177,422), and facelift (117,034).

While women still account for the majority of the procedures (88%), men had more than 1 million cosmetic procedures that represented 12% of the total, an increase over the 11% represented by men's procedures in 2000. The top three surgical cosmetic procedures for men were lipoplasty, rhinoplasty, and blepharoplasty or eyelid surgery.

Baby boomers, ages 35-50, had 44% of all cosmetic procedures. "The younger age group of patients typically undergo breast augmentation, liposuction, and rhinoplasty," says **Malcolm D. Paul**, MD, president of ASAPS. "The safety of these procedures, particularly the validation of the safety of augmentation mammoplasty and liposuction, have caused the increase in these numbers."

Plastic surgeons expect to see a continued increase in the numbers of procedures due to the number of baby boomers who want to "look as good as they feel," Paul says. Public acceptance of cosmetic surgery, safety of the procedures, and new procedures that are effective but less traumatic than conventional procedures are factors that will contribute to a continued increase, he adds.

EXECUTIVE SUMMARY

Americans underwent over 8.5 million cosmetic procedures in 2001, a 48% increase over the previous year's total of 5.7 million.

- Baby boomers, ages 35-55, represented 44% of all cosmetic surgeries.
- The five most popular surgeries were lipoplasty (385,390), eyelid surgery (246,338), breast augmentation (216,754), rhinoplasty (177,422), and facelift (117,034).
- Men represented 12% of all procedures, up from 11% in 2000.

SOURCES

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To obtain a free copy of the results of the 2001 American Society for Aesthetic Plastic Surgery (ASAPS) survey, contact:
- **ASAPS Communications Office**, 36 W. 44th St., Suite 630, New York, NY 10036. Telephone: (212) 921-0500. Fax: (212) 921-0011. E-mail: media@surgery.org. Results of the survey, along with downloadable graphs and spreadsheets, can be seen at www.surgery.org.

Some of the newer procedures include endoscopic brow lifts, power-assisted suction lipectomy that is less traumatic than traditional lipectomy, and minimal incision necklifts and facelifts, Paul says. **(See "Mini-facelifts offer quick recovery, attract patients," *Same-Day Surgery,* March 2002, p. 36.)**

Another new method for cosmetic surgery is the lipoplasty-only breast reduction, says **James Baker Jr.,** MD, of Winter Park, FL, chair of the ASAPS Breast Surgery Committee. Breast reduction surgeries increased by 28%, from 90,042 in 2000 to 114,926 in 2001, and Baker expects that number to continue increasing as the benefits of lipoplasty breast reduction become more well known.

Because breast tissue is predominantly fatty tissue, it is ideal for lipoplasty, Baker says. Patient selection is important because the greater the amount of fatty tissue in the breast, the easier it is to shape and the better the results will be, he explains. "Perimenopausal and menopausal women have breasts that are mostly fat, so they are the best candidates," Baker adds.

Women who want a small-to-moderate reduction in breast size also are good candidates, he says. "A large, droopy breast for which the patient wants a significant reduction is not appropriate," he says. If you try to remove too much fat, it is harder to maintain an appropriate shape, and the nipple moves too much out of its normal position, Baker explains. "The best results are obtained with women who want to decrease their bra size by no more than one or two cups," he adds.

The advantage of breast reduction lipoplasty is that it is minimally invasive, Baker says. "There are tiny incisions that are made in the crease of the breast, and the patient is up and following her normal schedule the next day," he explains. This compares to conventional breast reduction that requires suture removal the following week and seven to 10 days before the women returns to a normal schedule, he adds.

Operating room time is significantly less. One hour or less is required for lipoplasty vs. three hours for the traditional surgery, which means less time under general anesthesia for the patient, Baker says. Many times, a surgeon also will have a woman undergoing traditional breast reduction spend one night in the hospital, he adds.

One point that Baker makes about tools for the surgery is "a surgeon must use a rounded, blunt tip cannula to avoid disturbing breast tissue."

Another benefit of breast reduction lipoplasty is that it does not leave any scar tissue or other type of mass that might distort future mammograms, Baker says.

As with most cosmetic procedures, breast reduction surgery is most often a self-pay procedure, he says. "Occasionally, if the woman has experienced severe neck pain or lower back pain and a certain amount of breast tissue has to be removed, an insurance company will cover the procedure." Baker sees an increase in the number of women seeking breast reduction lipoplasty. "Because it is most often a self-pay, the lower cost of lipoplasty breast reduction, as a result of less OR time and no hospital stay, and quicker recovery, will appeal to many women," he says. ■

AAAHC, JCAHO sign recognition agreement

An agreement signed by the Accreditation Association for Ambulatory Health Care (AAAHC) in Wilmette, IL, and the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, allows the ambulatory care, including same-day surgery, components of

(Continued on page 95)

(Continued from cover)

For the first time, CMS gives a description of a "dedicated ED," says **Robert A. Bitterman**, MD, JD, FACEP, director of risk management and managed care for the department of emergency medicine at Carolinas Medical Center in Charlotte, NC. "This is new. It means that if you hold yourself out as offering emergency or urgent services, CMS is going to call you a real ED," Bitterman says.

However, other types of facilities, such as off-campus surgery centers, radiology clinics, mammography clinics, primary care clinics, and rehab centers, where patients come in for scheduled visits and aren't seeking emergency care, would no longer fall under EMTALA. "They really backpedaled on that, which is very good for hospitals," he says. "The change eliminates a whole bunch of the off-campus rules, but EMTALA never should have reached that far in the first place."

Off-campus sites that face a patient with an emergency condition now could use existing emergency medical system protocols instead of contacting the ED, says **Charlotte Yeh**, MD, FACEP, medical director for Medicare policy at the Hingham, MA-based National Heritage Insurance Co. CMS has begun to distinguish who is asking for emergency care and who isn't, Yeh says. If it's clear that someone is coming in for a scheduled visit and there is no emergency medical condition, then obligations under EMTALA will end at that point, she adds.

"This explains something that people had trouble grasping," Yeh says. Much of the anxiety about EMTALA requirements stemmed from confusion over which sites fall under EMTALA and which don't, she says. Yeh offers the following summary of the two new definitions that address this:

• The "dedicated ED."

— A specially equipped and staffed area of the hospital is used a significant portion of the time for initial evaluation and treatment of outpatients with emergency medical conditions.

— This may be an on-campus or off-campus department of the hospital.

— This includes not only the ED, but other hospital departments (such as labor and delivery or psychiatric units), which are held out to the public as places to come for urgent, nonappointment visits.

• Hospital property.

— This includes parking lot, sidewalk, driveway.

— This excludes areas and structures that are within 250 yards of the main hospital building, but are *not* part of the hospital (e.g., physician offices, entities with separate Medicare provider numbers, restaurants, shops, other nonmedical facilities).

The proposed rule was published in the May 9, 2002, *Federal Register*. The deadline for comments is July 8, 2002. A final rule will be published later this year and is expected to become effective Oct. 1, 2002. ■

EMTALA SOURCES AND RESOURCES

For more about the proposed rule, contact:

- **Robert A. Bitterman**, MD, JD, FACEP, Department of Emergency Medicine, Carolinas Medical Center, P.O. Box 32861, Charlotte, NC 28232-2861. Telephone: (704) 355-5291. Fax: (704) 355-8356. E-mail: rbitterman@carolinas.org.
- **Charlotte S. Yeh**, MD, FACEP, Medical Director, Medicare Policy, National Heritage Insurance Co., 75 Sgt. William Terry Drive, Hingham, MA 02043. Telephone: (781) 741-3122. Fax: (781) 741-3211. E-mail: charlotte.yeh@eds.com.
- **Eric Zimmerman**, McDermott, Will & Emery, 600 13th St. N.W., Washington, DC 20005. Telephone: (202) 756-8148. Fax: (202) 756-8087. E-mail: ezimmerman@mwe.com. Web: www.mwe.com.

The proposed rule is *Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates*. Comments from the public will be accepted until July 8, 2002. Refer to file code CMS-1159-P. No faxed comments will be accepted. Mail written comments (an original and three copies) to:

• Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1203-P, P.O. Box 8010, Baltimore, MD 21244-1850.

To order a copy of the *Federal Register* with the proposed rule, contact New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954. Specify the date requested (May 9, 2002).

Credit card orders also can be placed by calling the order desk at (202) 512-1800 or by faxing to (202) 512-2250. The cost for each copy is $9. The *Federal Register* is available at many libraries and on the web: www.access.gpo.gov/nara/index.html.

Joint Commission-surveyed organizations to use AAAHC accreditation decision to satisfy Joint Commission accreditation requirements.

This agreement means that AAAHC-accredited same-day surgery programs do not have to undergo a Joint Commission survey even if the rest of the hospital is undergoing a survey.

This agreement is the result of the Joint Commission Cooperative Accreditation Initiative program that recognizes the decisions of other accreditation bodies. Accrediting organizations that can participate have requirements similar to those of the Joint Commission: survey cycle of three years or less; extensive survey and accreditation decision processes; standards development processes; and procedures for training and monitoring of surveyors. ■

Certified administrator exam set for Sept. 28

The Board of Ambulatory Surgery Certification (BASC) will administer the first certified administrator surgery center (CASC) examination on Sept. 28, 2002, in St. Louis. The board was developed by the Federated Ambulatory Surgery Association (FASA).

The exam will have five equally weighted sections: delivery of patient care, quality management, human resources, financial and business development, and regulatory and legal issues.

You do not have to be a member of FASA or be a surgery center administrator to take the exam. The application for the exam will be available at the aboutcasc.org web site, which at press time was scheduled to be up by the end of June, according to **Sarah Silberstein**, FASA deputy executive director.

Registration also is available by contacting the BASC office at (703) 836-4871. A detailed content outline will be available through the web site (aboutcasc.org) and the BASC Office, Silberstein says. The cost for taking the examination is $750.

"The CASC credential benefits the industry by providing a mechanism for determining whether those serving or seeking positions as administrator have the necessary knowledge," Silberstein says. "It also establishes to the health care community that ambulatory surgery center are a separate and distinct category of health care entities." ■

Anesthesia section gets major changes for AAAHC

Standards related to anesthesia services undergo major revisions in the 2002 edition of the Wilmette, IL-based Accreditation Association for Ambulatory Health Care's (AAAHC) *Accreditation Handbook for Ambulatory Health Care.*

"The new anesthesia standards are far more detailed, with comprehensive definitions of differing levels of anesthesia," says **C. William Hanke**, MD, president of AAAHC. "This enables organizations to better determine which standards are applicable to them, depending on the level of

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anesthesia or sedation they are administering," he adds. Other sections that have been revised include governance, quality of care provided, quality management and improvement, and employee and occupational health services.

The handbook is available by contacting AAAHC, 3201 Old Glenview Road, Suite 300, Wilmette, IL 60091. Telephone: (847) 853-6060. Fax: (847) 853-9028. Web: www.aaahc.org. ■

Correction

In a story in the May 2002 issue of *Same-Day Surgery*, we mistakenly indicated that a recall notice from Olympus America did not include model numbers. The model numbers were included. ■

CE/CME *questions*

After reading this issue, the CE/CME participant will:

- Explain ways to document informed consent. (See "*Using informed consent forms vs. progress notes.")*
- Know what policies address pregnancy tests for women of childbearing age. (See **"***Pre-op procedures: Check all women for pregnancy?")*
- Identify the most popular surgical cosmetic procedures in 2001. (See "*8.5 million cosmetic procedures performed in 2001.")*

Please save your monthly issues with the CE/CME questions in order to take the two semester tests in June and December. A Scantron form will be inserted in those issues, but the questions will not be repeated.

1. In surveys conducted by Data Management & Research, what was the top predictor of employee satisfaction in the surgery center and hospital settings?
   A. morale/yourself and morale/others
   B. pay
   C. quality of equipment
   D. lack of staff shortages
   E. the supervisor

2. How can a same-day surgery program manager ensure accurate documentation of a verbal informed consent when the patient is unable to give consent and a family member is contacted, according to Jean S. Clark**,** RHIA, director of health information services at CareAlliance Health Services?
   A. Have two RNs involved in the telephone conversation, and have them both sign the form.
   B. Ask the surgeon and the surgeon's nurse to contact the family for consent.
   C. Rely upon the family members to contact the admissions nurse to give consent.
   D. Require the family member to sign the consent.
   E. Have the phone call monitored by the surgeon and the family attorney.

3. What percentage of respondents to a survey conducted by The SurgiCenter of Baltimore routinely test all females of childbearing age for pregnancy?
   A. 12%
   B. 27%
   C. 42%
   D. 57%
   E. 72%

4. The most popular cosmetic surgery procedure in 2001, according to a survey by the American Society of Aesthetic Plastic Surgeons, was:
   A. rhinoplasty.
   B. breast augmentation.
   C. eyelid lift.
   D. facelift.
   E. lipoplasty.

Informed Consent for Stone Manipulation and Stent Insertion

It is very important to your doctor that you be involved in any and all decisions concerning procedures, which you need to have. Giving your "informed consent" is a matter to be taken very seriously. Only sign this form when you understand the procedure(s), the risks, the alternatives, the risks of those alternatives, and all of your questions have been answered.

_____ _____

Patient's initials Date

I, _____, hereby authorize Dr. _____ and any associates, or assistants deemed appropriate by my physician to be present and/or to perform a ureteroscopic stone manipulation and stent insertion.

The doctor has explained the benefits of the procedure to me. However, I understand there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of the procedure. I also authorize the administration of sedation and/or anesthesia as may be deemed advisable or necessary for my comfort, well-being, and safety.

The doctor has explained to me that there are risks and possible undesirable consequences associated with any procedure including, **but are not limited to,** blood loss, transfusion reactions, infection, heart complications, blood clots, loss of use of body part, neurological injury, or death. I understand that if I need blood or blood products, these carry a risk of contracting HIV/AIDS, hepatitis, or other diseases.

The doctor has also explained to me that there are risks and possible undesirable consequences of ureteroscopic stone manipulation and stent insertion. They include, **but are not limited to,** pain, bleeding, infection, ureteral or renal perforation, and failure to retrieve the stone.

In permitting my doctor to perform the procedure, I understand that unforeseen conditions may necessitate change or extension of the original procedure or performance of a different procedure from what was explained to me. I, therefore, authorize and request that the above-named physician, his/her assistants, or designees perform such procedure as is necessary and desirable in the exercise of his/her professional judgment.

The reasonable alternative(s) to the procedure, as well as the risks to the alternatives, have been explained to me. These alternatives include, **but are not limited to,** no treatment, continued conservative management, and ESWL (extracorporeal shock wave lithotripsy).

I hereby authorize Hanover Hospital to utilize or dispose of removed tissues, parts, or organs resulting from the procedure authorized above. I consent to allowing a surgical equipment representative to be present during my procedure at the physician's discretion. I consent and give authorization for the photographing or videotaping of my procedure for medical education purposes, provided my identity is discretely protected.

Any questions I had regarding the procedure have been answered to my satisfaction.

_____ _____ _____ _____

Date Time Signature of patient/authorized individual Relationship of authorized individual

WITNESS:

☐ The Patient/authorized individual has read the form or had it read to him/her.
☐ The Patient/authorized individual expresses understanding of the form.
☐ The Patient/authorized individual has no questions.

_____ _____ _____

Date Time Signature of witness

CERTIFICATION OF PHYSICIAN: I certify that prior to the procedure(s) I discussed and explained the facts, risks, and alternatives of the procedure(s) described in this consent form with the individual granting consent.

_____ _____ _____

Date Time Signature of physician

MR# 552 06/2000

Source: Hanover (PA) Hospital.

PATIENT SAFETY ALERT™

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Poor supervision can contribute to a higher rate of errors

When focusing on systems, don't forget human factor

The current focus on systems when exploring the cause of medical errors overlooks one important fact: People still are interacting with those systems.

"There are two things you have to remember," says **Anthony F. Grasha**, PhD, professor of psychology at the University of Cincinnati. "Strong systems build strong people — and vice-versa. You have to work at both ends at the same time. You will be successful in minimizing errors if you can do what's right for the system *and* for the individual."

The other thing you must remember, Grasha says, is the critical role of the supervisor within the system — and the need for supervisors to be well trained in psychosocial skills. "Administrative and technical skills work great for the system, but you need psychosocial skills for employees to perform at their best," he says.

The impact on errors

Grasha has conducted extensive research into the cause of errors, particularly with pharmacists, and he has found a direct link between errors and the way his subjects perceived their supervisors. Those who made fewer errors had a supervisor whom they perceived as helpful in setting task goals and who allowed them appropriate autonomy.

What's the connection? "We've known for a long time that positive nurturing and more democratic approaches work better than micromanaged people, particularly professionals," Grasha says.

"By definition, a professional is someone who's obtained a high standing through independent work. When they then find themselves in a position where someone hovers over them, the net result is it creates tension and stress," he says.

In Grasha's work, the pharmacists who made the fewest mistakes and were most satisfied with their jobs also rated the quality of their supervision higher.

Generally, these pharmacists had supervisors who allowed them to "do their jobs as they saw fit" and worked with them rather than constantly telling them what to do, he explains. Supervisors who made demands for people to meet high performance standards in a more controlling manner (i.e., directing vs. working with people, using negative incentives vs. encouraging) had staff with higher levels of job dissatisfaction — and who also tended to make more mistakes.

"One of the things I've found is that accuracy, productivity, and job satisfaction [form] a triangle, with supervision in the middle of the triangle," he continues. "It affects all of them through the vehicle of stress and tension and mental distractions that make a job less fun. Stress sets up a process where you work faster than you should and take shortcuts, and are mentally distracted at times you should be focused. This leads to errors of commission as well as omission."

This same dynamic works among nurses, physicians, and pharmacy teams. "People who report more problems with their supervision report fewer errors and intercept fewer errors," he observes. "The basic principals apply, the examples just differ; it just so happens the vehicle I've studied has been the pharmacy."

"I don't think we perceive as much of a link between supervision and errors as we could in health care," adds **Judy Smetzer**, RN, vice president of the Institute for Safe Medication Practices (ISMP), based in Huntingdon Valley,

Pharmacy Supervisor Skills Checklist

The following checklist of pharmacy supervisor skills, created by Anthony F. Grasha, PhD, professor of psychology at the University of Cincinnati, can readily be applied to other areas of health care as well:

- ✔ Set clear goals and directions for the work people do.
- ✔ Help establish a climate for excellence and professionalism.
- ✔ Be clear but not overbearing when discussing expectations.
- ✔ Encourage people to enhance their level of performance.
- ✔ Delegate appropriately the freedom to do a job.
- ✔ Be able to "work with people" rather than "always telling them what to do."
- ✔ Ensure that the reasons why something is done are stated clearly.
- ✔ Set high standards for performing tasks.
- ✔ Be able to help people set priorities for completing multiple tasks.
- ✔ Promote critical thinking about how to work effectively.
- ✔ Be able to motivate and get people excited about their jobs.
- ✔ Be able to get people to identify and solve problems as a group.
- ✔ Provide sufficient answers to questions.
- ✔ Be able to fix responsibility for getting tasks accomplished.
- ✔ Hold people accountable for doing their jobs properly.
- ✔ Adjust your supervisory style to accommodate differences among people.
- ✔ Make people feel involved and important.

PA. She says that supervisors who instill fear are likely to have employees who hide errors.

Smetzer notes the example of a nurse in a long-term care facility who received an order from a physician to reduce the dose of warfarin for a patient. However, as an LPN, she was not permitted to accept the order. She also forgot to note the order in the patient's medical record, so the warfarin continued at the same dose.

Later, when the physician called to discontinue the warfarin, the nurse falsified the records to show that the patient had received the lower dose as ordered previously, Smetzer adds. The patient later died, and court records show the death could have been prevented if the nurse had revealed her mistake immediately.

Many work environments are punitive, she says. "Even counseling can be very punitive, depending on how it is carried out," Smetzer explains. "At the lowest end of the scale, perhaps the supervisor goes through all the things that were allowed to happen. And to this day, there are people who are fired for an error if the patient is harmed."

Too much control

Perhaps the supervisors who have the greatest impact on errors are the ones who exercise too much control. Grasha talks in terms of control modes ("I get good performance by controlling you"), as opposed to working with modes ("People do better work if they are committed").

"One of the biggest predictors for making more mistakes on prescription double-checks was micromanagement," he notes.

This can take many forms. The supervisor may give instructions on how to do something you already know how to do. Or he or she can tell you to do something a certain way and then not follow up. "It's their way of saying, 'Here's how I want to control you,'" Grasha explains.

In an interdisciplinary team setting, the team may make a decision about the most appropriate medication to give a patient, then the supervisor comes by and says, "Why did you bother doing that when you could have actually done nothing and waited to see what happens?"

"If you control frontline workers like a parent would a child, there's no room for creativity, autonomy, or teamwork — those skills that can really help curtail errors," Smetzer says. **(What supervisory skills work best? See checklist, at left.)**

Training can help

Proper training of supervisors can help improve staff attitudes, and at the same time, help reduce errors, Smetzer says. "If you look at any health care training program — medicine, nursing, pharmacy — you usually have a course in management. They teach hierarchy and theory but not [psychosocial] skills. There's not a lot of that going on in health care. Some of the best teaching needs to be about how and why we make mistakes."

Smetzer points out the "high-reliability" approach being taken by large organizations outside of the health care industry to produce

good safety records. "Why do the nuclear industry and the chemical industry have lower error rates than we do? They have better training programs," she asserts.

"If you look at what's happening in pharmacy generally, there's no training, no [continuing education] CE offerings," adds Grasha. "People graduate one day, and they're in charge of a pharmacy the next. In the hospital environment, human resource development staff and funding are being cut."

This approach is penny-wise and pound-foolish, he argues. "People need a chance to role-play, to do case studies, to get their hands dirty. It's not the kind of stuff we can learn by just reading," Grasha says. "We need to be coached."

Smetzer says that mentoring also can be effective. "I would think mentorship is the best way to go," she says. "You have people who already have good supervisory skills; usually the staff can tell you who the best supervisors are."

The bottom line is that these important skills can be taught, Grasha says. "A good book on supervision can be helpful, as is taking a management-training course or CE seminar, or beginning company-sponsored work in this area."

One good resource, he adds, is CRM Learning (www.crmlearning.com), which offers a range of educational/training materials.

He also recommends a book by Bill Catlette and Richard Heddon, *Contented Cows Give Better Milk*, which describes companies that attract and keep good people, as well as an article by Amy Edmundson, "Learning about mistakes is easier said than done," in the *Journal of Applied Behavioral Science* (1996; 32:5-28).

The price we pay for failing to train supervisors properly is high indeed, Grasha reminds us. "Organizations put people into positions without much training. They become anxious, and they drop into control mode."

In conclusion, Smetzer offers this caveat about a systems-only approach to errors: "We in health care are very focused on a system-based approach, which we definitely need to be, but with a total emphasis on systems, we can forget about the people, and we need to remember them — not to punish them, but to realize they are the ones who interact with the system. And there are clearly things we can do with people to improve performance."

[For more information, contact:

- ***Judy Smetzer**, RN, Vice President, ISMP, 1800 Byberry Road, Suite 810, Huntingdon Valley, PA 19006. Telephone: (215) 947-7797.*
- ***Anthony F. Grasha**, PhD, Professor of Psychology, University of Cincinnati. Telephone: (513) 556-5543.]*

Recommended readings

- Grasha AF. Pharmacy workload: The causes and confusions behind dispensing errors. *Can Pharm J* 2001; 134(3) 26-35.
- Grasha AF, Schell K. Psychosocial factors, workload and human error in a simulated pharmacy dispensing task. *Percept Mot Skills* 2000; 92:53-71.
- Grasha AF. Into the abyss: Seven principals for identifying the causes of and preventing human error in complex systems. *Am J Health-Syst Pharm* 2000; 57:554-64. ■

Injury prevention model broadens safety scope

Create situations where human error can't happen

Traditional approaches to patient safety that focus exclusively on errors may be missing significant opportunities for improvement, argues a group of researchers from the Injury Research Center at the Medical College of Wisconsin, Milwaukee.

Writing in the April 17, 2002, edition of the *Journal of the American Medical Association (JAMA),* they assert that "The error-oriented approach includes mistakes that do not harm patients such as near-misses."[1] Conversely, they write, "The injury-oriented approach includes patient harm arising from a diagnostic or therapeutic intervention, including those that are not associated with any identifiable error."[1]

What they are proposing is an injury-prevention model, rather than an error-prevention approach. This broadens the approach of identifying medical injuries and developing strategies to prevent them, rather than limiting discussions to the errors that may have been made.

"The main issue related to this approach is not that we are ignoring error, but that we are not making it the sole centerpiece," explains **Stephen W. Hargarten**, MD, MPH, director of the Injury Research Center and one of the paper's authors. "It's similar to what happens when you drive a

car; people make errors in driving. Some don't result in any harm. But if an error does result in a crash, you want to reduce the frequency and the harm of these events. If you do crash, you have a seat belt on and an airbag. This protects you, regardless of how well or how poorly you and others drive. In our case, we are trying to reduce errors, but we recognize that if they are occurring, we should try to reduce the event or reduce our reliance of addressing medical injuries solely by addressing human error."

In summary, the authors assert that by focusing solely on errors, we actually are looking at a relatively small percentage of all medical injuries and missing the majority of them.

A paradigm shift

The paradigm shift of the injury prevention model, Hargarten explains, is that a prevention strategy may circumvent human error by creating a situation where it *can't* happen.

Human error is a challenge in and of itself, he notes, but it can be overcome by technology. "Take needlesticks, for example," he says. "We teach people not to commit the error, but the most complete strategy is to make needles where you really can't stick yourself. This is a very important aspect of our approach."

The injury prevention approach is represented graphically in a table called Haddon's phase-factor matrix, derived from the public health profession's agent-host-environment vector model of injury causation. It was first used in the study of automobile injury, but has proved useful in preventing injuries in a variety of settings.

In its simplest form, it is a two-dimensional chart. Down the left-hand side are three categories:

- Pre-event: Underlying risk factors predisposing to injury.
- Event: What causes an injury to occur? Will an injury result from this event?
- Post-event (outcomes): The final severity is determined here. How severity is minimized or maximized depends on these factors.

Along the top of the matrix are agent, host, vector/vehicle, and environment (with three subsets: physical, social, biological).

In a real-world example, the pre-event may be the reversal of X-ray film, which leads the physician to interpret it incorrectly. The event then could be putting a chest tube in on the wrong side, and the post-event would be the outcome. "A post-event may be that nothing happened," Hargarten explains. "For example, the event may be the prescribing of an incorrect antibiotic."

At present, researchers from the Injury Research Center are conducting studies that implement the injury prevention approach in different settings.

"In applying injury control science to the broad class of issues of medical injuries, we can look at a variety of ways we can have impact using these tools in specific areas like the [emergency department (ED)], ICUs, and so forth," Hargarten says.

How might this unfold in a practical setting in a hospital? "The first and most fundamental part of this is, we are looking at what happens to patients when they enter into, [for example], the ED, and the outcomes of those interactions that are from interventions from a variety of sources — from devices to medications," Hargarten observes. "With these interventions, some outcomes are adverse reactions to medications, or devices put in the wrong place. These are medical injuries, but we do not start trying to identify names and blame."

Rather, he says, they also will look at effects from accepted therapies — for example, reactions to penicillin. "A certain percentage of patients get a reaction," he says, noting they may be asked about an allergy, but respond in the negative. "How do we move forward to reduce this likelihood? Do we want to explore and see if there are other therapies for the same conditions? This is a more productive approach."

Previous studies note that even agreeing that an error took place in a specific case is sometimes difficult to determine. "We are already starting out with the potential for disagreement, but the bottom line for the patient is that there was an adverse reaction, an untoward outcome that no one desires. That's why we should not limit our explorations to those adverse events that occurred as the result of error," Hargarten concludes.

[For more information, contact:

- ***Stephen W. Hargarten**, MD, MPH, Director, The Injury Research Center, Medical College of Wisconsin, 8701 Waterlawn Plank Road, Milwaukee, WI 53226. Telephone: (414) 456-7670.]*

Reference

1. Layde PM, Maas LA, Teret SP, et al. Patient safety efforts should focus on medical injuries. *JAMA* 2002; 287:1,993-1,997. ■