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Same-Day Surgery®

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INSIDE

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Y2K testing: Will it save your equipment or destroy it?

Some experts advise you not to test most items

If you test your equipment and information systems to ensure they are year 2000 (Y2K) compatible, will it give you peace of mind or drive you to the brink of mental breakdown?

One hospital tried to test an entire operating room and ambulatory surgery center by shutting it down on a Friday night, says **William McDonough**, MPAH, ARM, FASHRM, vice president and national health care risk management practice leader for Johnson & Higgins National Health Group in Boston. The tests went fine over the weekend, and it opened for business on Monday morning. However, an infection control nurse did a routine check and found a significant number of bugs and mold in the OR.

The problem? The hospital had shut down the heating and air conditioning system during the test, and the normally stable OR temperatures fluctuated. "They had to close the OR and ambulatory surgery center for nine days, and their CEO was very upset," McDonough says. The hospital learned its lesson the hard way: "Always include the infection control

EXECUTIVE SUMMARY

Same-day surgery managers are debating whether to test their equipment for year 2000 compatibility and examining what role the manufacturer should play. Consider these suggestions:

- Don't test if you have good compliance information from your manufacturer, one agency suggests.
- Obtain advice from legal advisors, risk managers, clinical engineers, information systems staff, key clinicians, and top administrators before making a decision.
- If you are going to test, try to obtain formal testing procedures from the manufacturer.
- Have a backup plan in the event that the testing shuts down the equipment.

Sample Provider Y2K Readiness Checklist

Please note: This checklist is intended as a supplemental guide in helping you determine your Y2K readiness. Consider using this along with other diagnostic and reference tools you have obtained for this venture. The purpose of this checklist is to aid you in determining your Y2K readiness. This information is not intended to be all-inclusive. The Health Care Financing Administration will not assume any responsibility for your Y2K compliance.

- ✔ **Bank debit/credit card expiration dates:** Y2K Ready ☐ Not Y2K Ready ☐
- ✔ **Banking interface:** Y2K Ready ☐ Not Y2K Ready ☐
- ✔ **Building access cards:** Y2K Ready ☐ Not Y2K Ready ☐
- ✔ **Claim forms and other forms:** Y2K Ready ☐ Not Y2K Ready ☐
- ✔ **Clocks:** Y2K Ready ☐ Not Y2K Ready ☐
- ✔ **Computer hardware (list):** Y2K Ready ☐ Not Y2K Ready ☐
- ✔ **Custom applications (list):** Y2K Ready ☐ Not Y2K Ready ☐
- ✔ **Diagnostic equipment (list):** Y2K Ready ☐ Not Y2K Ready ☐
- ✔ **Elevators:** Y2K Ready ☐ Not Y2K Ready ☐
- ✔ **Fire alarm:** Y2K Ready ☐ Not Y2K Ready ☐
- ✔ **Insurance/pharmacy coverage dates:** Y2K Ready ☐ Not Y2K Ready ☐
- ✔ **Membership cards:** Y2K Ready ☐ Not Y2K Ready ☐
- ✔ **Medical devices (list):** Y2K Ready ☐ Not Y2K Ready ☐
- ✔ **Monitoring equipment (list):** Y2K Ready ☐ Not Y2K Ready ☐
- ✔ **Smoke alarm:** Y2K Ready ☐ Not Y2K Ready ☐
- ✔ **Telephone system:** Y2K Ready ☐ Not Y2K Ready ☐
- ✔ **Spreadsheets:** Y2K Ready ☐ Not Y2K Ready ☐
- ✔ **Treatment equipment (list):** Y2K Ready ☐ Not Y2K Ready ☐
- ✔ **Safety vaults:** Y2K Ready ☐ Not Y2K Ready ☐

Source: Health Care Financing Administration, Baltimore.

nurse in plans like this," McDonough says. "It's an example of how far reaching the Y2K problem can be."

The potential exists for broad consequences from Y2K testing, warns **Tony Montagnolo**, vice president for technology planning at ECRI, a nonprofit research agency providing information and technical assistance to the health care community, based in Plymouth Meeting, PA. "What I suggest is to have a year 2000 committee with risk management, biomedical engineering, operational people, and clinical people," Montagnolo says. "Do some broad-based communication with any staff that might be around that particular device or area so you can become aware of any 'downstream' consequences." **(For more information on Y2K issues, see *Same-Day Surgery*, September 1998, p. 113, and October 1998, p. 131.)**

Some same-day surgery managers want to test all of their equipment, even if they've received compliance information from the manufacturers. Others are testing only when they can't obtain the compliance information or when they think the compliance information is inadequate. Which procedure is correct?

Consider these suggestions from experts interviewed by *SDS*:

❒ **Consider not testing.**

"From our perspective, we've not advocated strongly user testing for year 2000," Montagnolo says.

The reason? Testing may take time and money away from other higher Y2K priorities, such as obtaining compliance information and developing contingency plans, ECRI says in its position statement.

And here's some additional reasons: The basic type of Y2K testing — a date roll-up — isn't likely to detect subtle problems that might occur only under certain circumstances, such as logging an

COMING IN FUTURE MONTHS

- ■ When the surveyor wants information that's not in standards
- ■ Therapeutic touch and same-day surgery
- ■ Is it OK to use LPNs in your program?
- ■ Meeting the unique needs of older patients
- ■ Screening for high-risk patients and procedures

error code, ECRI maintains. More detailed tests may be beyond your program's capability, the agency advises.

You might need specialized test procedures from the manufacturers, but they may be unwilling to supply these procedures. If the manufacturer does the testing, they might charge you, ECRI warns. Some manufacturers prohibit testing of their products, so you could void the warranty if you do so, the agency advises. You also risk damaging the device if you test it, ECRI says.

ECRI suggests you obtain advice from several sources, including legal advisors, risk managers, clinical engineers, information systems staff, key clinicians, and top administrators before making a decision about whether to test. **(See story, at right.)**

Consider testing in these situations

Testing may be appropriate under certain circumstances, ECRI maintains. For example, when devices are interfaced as a system, they may not be Y2K compliant, even if the devices are compliant individually. In same-day surgery, an example of an interfaced device would be a video colonoscope interfaced to a video processor and monitor. Input and output date formats may differ, so obtain this information from the manufacturer, ECRI suggests. If the formats are different, test the devices as a system, the agency adds.

Also, if you don't have good compliance information from the manufacturer, consider testing, Montagnolo advises. "Clearly, if you do testing, check with the manufacturer and find out if you do what you plan to do, is there the potential for a problem," he emphasizes.

Don't test devices connected to patients, he advises. "That seems obvious, but with things being networked, you may not realize it."

Be wary about outside testing. Companies will claim high degrees of failures after they perform testing, Montagnolo says. "Often what they've done is found problems that manufacturers already have found."

Some groups, including the Health Care Financing Administration (HCFA), suggest that your shouldn't rely on someone else's word when it comes to Y2K testing. On Jan. 12, HCFA sent a letter with the following advice: "Do not assume that a system or a program is Y2K ready just because someone said it is," says **Nancy-Ann Min DeParle**, JD, MA, administrator. "Test to make sure." **(See Sample Provider Y2K Readiness Checklist, p. 30.)**

Health system decides to test everything

At least one health care system isn't taking the manufacturer's word for it when it comes to the year 2000 (Y2K) compatibility of its equipment.

The legal department for Catholic Healthcare West, a San Francisco-based system of 46 acute care facilities, says all critical medical devices should be tested. Period.

Jack Beebe is director of medical devices and facility control equipment at Catholic Healthcare West Year 2000, a project management office set up to address Y2K issues.

"If you look at the information provided by most of the manufacturers, on their Web sites or to the FDA, they tell you device is compliant or noncompliant, or it's compliant with minor implications or effects," Beebe says. "There's no description of minor effects."

Thousands of devices at risk

Beebe's office has tested more than 15,000 devices, and he says 2,700 are at risk. For example, one sterilizer manufacturer states all its equipment is Y2K compliant. However, there is a problem with the load record that prints at the end of every sterilization cycle. That record must be kept for accreditation and infection control purposes.

"That date and time will be incorrect after year 2000," Beebe says. "We're going to have to make a manual intervention and new policy, and probably have two people sign off on the correct date on load records. This is one of those things: It doesn't affect the functionality of the sterilizer, but it does affect the people that run it."

He offers this additional piece of advice: Make sure you check the backup batteries on medical devices. "We've found thousands of devices in which backup batteries are dead."

Backup batteries frequently have not been replaced on a regular schedule, Beebe explains. "The date and time are incorrect because of the lack of a backup battery." ■

Track your test plans and outputs in case a problem occurs later, HCFA suggests.

Despite earlier concerns, HCFA assures providers they will be ready on Jan. 1, 2000, to process claims. If you aren't already using compliant electronic claim formats, the agency suggests you consider testing your electronic data interchanges (EDI) with one or more payers, including Medicare. "This will ensure that your payer can accept your EDI transactions, especially claims," Min DeParle says.

❒ **Get the vendor involved, if possible.**

Dave Hall, senior consultant at ACS Technology Solutions, a provider of information technology services, software solutions, and Y2K project services, based in Oak Brook, IL, says, "In our experience, the ideal case is to have the vendor or your service provider develop formal testing procedures and have them accomplished in conjunction with a clinical engineer or whoever does the maintenance of your equipment."

Think of this testing as an "add-on" to the acceptance test or functional test that the manufacturer normally performs for new equipment, Hall explains. He acknowledges that in a significant numbers of cases, vendors won't do the testing or tell you how to do it yourself.

Would it be easier to buy new equipment?

Of the approximately 50% of equipment or systems with Y2K impacts, "realistically, you may have to decide whether it's worth testing to you, if the vendor won't tell you how," Hall says. "We've run into cases in which it's easier to buy a new piece of equipment rather than figure out how to test, especially with older equipment and/or complicated equipment, especially if you don't have all the manufacturer's documentation."

For example, if you don't know the microcode, line by line, it will be resource-intensive to develop tests, he warns. "So it's basically an exercise in risk management. How much risk are you willing to take vs. how long it will take you to catch everything?"

❒ **Evaluate what the manufacturer tells you about your equipment.**

Be careful about accepting a vendor's certification, Hall warns. "Normally it will say, 'You will use equipment this way with this kinds of inputs and this kind of date formatting.' Also must use it hooked up to other Y2K-ready equipment. Otherwise, they don't guarantee anything." Read

Conference to target cost and quality in SDS

Experts will share their proven ideas for managing successful same-day surgery services, including addressing the millennium bug, at Balancing Cost and Quality: The Secrets of Successful Ambulatory Surgery Programs, to be held March 14-16 in Atlanta. The conference is sponsored by American Health Consultants, publisher of *Same-Day Surgery*.

The timely topics offer something for every same-day surgery manager, whether your program is hospital-based, freestanding, or office-based. Speakers will address issues including:

- interpreting financial information;
- monitoring quality trends and their impact on finances;
- improving physician, employee, and patient relations;
- recruiting and retaining physicians;
- handling contracts with managed care and vendors;
- addressing sentinel events;
- understanding new federal regulations;
- implementing ambulatory patient classifications;
- following construction requirements;
- adding pain management services;
- using creative marketing strategies;
- cross-training successfully;
- improving patient satisfaction;
- leasing employees;
- reprocessing single-use devices legally and ethically;
- surviving change;
- discharging patients quickly.

Each session sets aside time for you and your peers to ask the experts your most burning questions. Twenty contact hours of continuing education will be offered.

The conference fee includes a kick-off cocktail party to network with speakers and other registrants, continental breakfasts, lunches, a course manual, and a form exchange for those in attendance.

For more information, contact American Health Consultants, Customer Service, P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421 or (404) 262-7436. Fax: (800) 284-3291. E-mail: customerservice@ahcpub.com. ■

ECRI addresses Y2K in phone seminar series

ECRI, a nonprofit research agency based in Plymouth Meeting, PA, has developed a series of interactive telephone seminars to provide a forum so that health care facilities and experts on year 2000 (Y2K) topics can share their perspectives. Two seminars have been held. Five more are scheduled for 1999, and each will address a different Y2K concern.

The seminars will be from 1 p.m. to 2:30 p.m. Eastern time on the following dates; topics may be subject to change:

- March 10 — Y2K Contingency Planning.
- April 14 — Y2K Remediation: What to Do about Noncompliant Devices.
- May 12 — The Many Legal Issues of Y2K.
- Oct. 13 — Y2K Staff Awareness and Media Relations.
- Nov. 10 — It's a Quarter to Midnight: Are you Ready for Y2K?

The cost for each seminar will be $109 for members of ECRI programs and $129 for nonmembers. This fee allows the connection of one telephone line from your site. Anyone within your organization can listen on that line and participate.

To register, contact ECRI's Communications Department, 5200 Butler Pike, Plymouth Meeting, PA 19462. Telephone: (610) 825-6000 Ext. 5888. Fax: (610) 834-1275. E-mail: info@ecri.org. ■

the certification closely, he suggests.

❒ **If necessary, develop your own formal testing procedure.**

Have a formal test procedure before you turn any system's date forward, Hall advises. Turning the date forward may "freeze up" the equipment or cause the software license to become expired, which will require going to the vendor to have the equipment made operational.

A formal test procedure should include exactly what you're going to do, your expected results, and a process for making the equipment operational in the event that you run into problems, he says.

"I've seen people turn dates forward, watch the equipment lock up, and they have to get the vendor to give them — sometimes for extra money — the key to unlock software, or the system has become a boat anchor," he says.

[Editor's note: Has your facility developed a contingency plan for Jan. 1, 2000? If so, Same-Day Surgery *would like to hear about it. Contact Joy Daughtery Dickinson, Managing Editor. Telephone: (912) 377-8044. Fax: (912) 377-9144. E-mail: joy.daughtery @medec.com.]* ■

SOURCES

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New Procedures

Gastrointestinal repair brings in new patients

(Editor's note: This is the fourth story in a four-part series highlighting innovative outpatient surgery procedures. In the previous three issues, we've covered cosmetic procedures, pain management procedures, and sentinel node biopsy.)

New equipment that measures contractility of the esophagus, tests that measure stomach acidity, and a surgeon's agreement to perform the procedure at the center were the main reasons Fremont (CA) Surgery Center began offering laparoscopic paraesophageal hernia repair with Nissen fundoplication.

"We have a very active gastrointestinal [GI] department, and we perform about 150 GI procedures per month," explains **Debbie Mack**, RN, MSN, director of nursing at the freestanding center. Manometry equipment that can measure the contractility of the esophagus combined with pH testing to determine the acidity of the stomach enables physicians to more accurately diagnose esophageal hernias, says Mack.

A general surgeon in the area who has a great deal of experience with laparoscopic hernia repair agreed to perform the procedure if the patient was appropriate for outpatient laparoscopic surgery.

EXECUTIVE SUMMARY

Laparoscopic paraesophageal hernia repair with Nissen fundoplication is an attractive alternative to open laparotomy for patients with esophageal hernias.

- The procedure is ideal as a 23-hour stay and requires little additional equipment or staff training for most programs, some experts say.
- Reimbursement varies from managed care contract to contract. Same-day surgery managers report that reimbursement generally covers costs at first, then produces profit as volume increases.

"We've been performing this procedure for four months, and it is always a 23-hour stay," says Mack.

At this time, her center is doing two to three laparoscopic Nissens each month, and reimbursement just covers costs. "As we increase the number of these procedures we perform each month, we should begin to make a profit," she adds.

At Promina DeKalb Medical Center's day surgery center in Decatur, GA, the volume of six or eight Nissens per month is not only covering costs, but also generating a small profit, says **Gwen H. Lyons**, RN, CNOR, assistant director of surgical services. The hospital-based program has been performing the outpatient procedure since 1994.

Your facility's mix of managed care contracts will determine whether the procedure generates a profit, especially at the beginning, Mack explains. Her program has some contracts that reimburse below cost, but there are others that reimburse more than the center's cost; thus, Mack decided it was financially feasible to proceed with the service. Mack and Lyons suggest evaluating reimbursement levels from your current managed care contracts when you evaluate offering the procedure.

Any same-day surgery program that already is offering laparoscopic cholecystectomies should need very little new equipment, staffing, or training to offer the procedure, say surgery center managers.

As with any laparoscopic GI procedure, you must be prepared and equipped to perform an open laparotomy even though only 4% to 5% of laparoscopic hernia repairs require opening, says **Jeffrey Ponsky**, MD, director of minimally invasive and endoscopic surgery at the Cleveland Clinic Foundation. Freestanding surgery centers will need procedures in place to transport and admit the patient into a hospital postoperatively.

Two essential pieces of equipment include esophageal dilators and ultrasonic shears or scalpel, says Ponsky. The ultrasonic shears (available from U.S. Surgical in Norwalk, CT, and Ethicon in Somerville, NJ) cut and cauterize using ultrasonic energy rather than heat.

At a cost of $30,000, the ultrasonic equipment can be expensive for a center just beginning to build the laparoscopic hernia repair business, says Mack. Her center takes advantage of a program offered by U.S. Surgical that allows her to borrow the equipment on an as-needed basis. Surgery program managers can check with their manufacturers' representatives to see if similar programs are offered in their area, she suggests.

"Once our volume increases, I may be able to justify purchasing the equipment, but not now," she explains.

Patient volume increasing

Patients who previously had to live with their conditions because they didn't like the alternative of major surgery that requires a hospital stay are beginning to request the laparoscopic procedure, says Lyon.

Most patients with paraesophageal hernias are candidates for the surgery, but there are some exceptions, says Ponsky. The procedure is difficult to perform on a very obese patient because of the length of the trocars and instruments. Also, patients with upper abdominal scarring from multiple previous surgeries may not be appropriate because the scarring limits laparoscopic accessibility.

Also, "patients with pulmonary or coagulation difficulties are not good candidates for the laparoscopic procedure," he adds.

Training requirements for the surgery center staff are not extensive, says Mack. "We basically had our staff observe a procedure prior to assisting during a procedure."

The staff should be oriented to the instruments, positioning of the patient, and the procedure by the physician, suggests Ponsky. "Everyone should also observe a procedure before assisting," he adds.

Managers at DeKalb Medical Center's outpatient surgery center not only visited other centers at which the procedure was performed, but nurses were sent to training courses offered

SOURCES

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by vendors who supply the equipment used for the procedure.

"Visit other surgery centers," Lyons suggests. "There is nothing more valuable than to see what works for other people. Site visits help you plan and prepare more effectively." ■

Perioperative pathway ensures consistent care

"It's too confusing."

"There's too much paperwork."

"Each time I learn how to do it this way, it gets changed."

Change is difficult enough in a health care setting, but if you think you've had a tough time developing pathways, imagine developing five perioperative pathways for use in a same-day surgery program, condensing the five pathways to three, then reducing the three to one perioperative pathway that is used not only in day surgery, but also in endoscopy and inpatient surgery.

Those were the challenges for the day surgery staff at North Colorado Medical Center in Greeley. Pathways have been used at the hospital since 1992, but in 1994, all units were expected to use pathways to chart patient care, explains **Becky S. Winter**, RN, BSN, surgical services resource nurse and outcomes coordinator at the center.

"We based our original five pathways on the type of anesthesia used for the patient's procedure," she says. The program received an award for the first five pathways in the "Pick a Path" contest conducted by *Hospital Case Management* newsletter, published by American Health Consultants, publisher of *Same-Day Surgery*. The first five pathways were:

- ❒ monitored anesthesia care for eye patients;
- ❒ adult general monitored anesthesia care;
- ❒ pediatric monitored anesthesia care;
- ❒ intravenous conscious sedation;
- ❒ local anesthesia.

After four years, the staff reduced the number of pathways to three to address adult, pediatric, and IV conscious sedation.

"Five pathways was cumbersome, and they all looked the same on the first pages," says Winter. "We had many cases of nurses who began charting on a pathway, only to discover halfway through it that it was the wrong pathway form."

In January 1999, the staff developed one pathway that can be used for day surgery, endoscopy, and inpatient surgery. Winter formed a pathway implementation team composed of all nursing units that might use the form. Physician input came from a representative of the anesthesia department and a review of the pathway by all members of the department. **(See related story, p. 36.)**

The multidisciplinary team ensured that everyone supported the form from the beginning, says **Thelma M. Taylor**, RN, BSN, staff nurse in the ambulatory care department and a member of the team. "We were asking some department staff members, such as endoscopy, to completely change the way they had been charting," she says. "We knew it wouldn't be an easy process, so we wanted them involved at the beginning."

EXECUTIVE SUMMARY

Not only do pathways provide a consistent, easy way to chart a patient's recovery, but the pathway development process gives staff a chance to review and evaluate standards of care already in place. The keys to successful perioperative pathway development and implementation at North Colorado Medical Center in Greeley include:

- development by a multidisciplinary team;
- thorough review of medical literature, policies, and procedures.

Use your form during review to avoid reprints

Even when you make sure your proposed pathway undergoes extensive review, some errors don't get caught until hundreds of printed pathways are delivered and put into the patients' charts, says **Becky S. Winter**, RN, BSN, surgical services resource nurse and outcomes coordinator at North Colorado Medical Center in Greeley, CO.

Draft copies of the perioperative pathway, developed by day surgery and fine-tuned for use throughout the hospital, were sent to the anesthesiologists for their review during the development process. The physicians liked the pathway because they didn't have to recopy information from other forms, says Winter. A problem did occur, however, when the form was put into use.

A simple printing error throughout the form divided time into 20-minute segments rather than 15-minute segments. Although the printed form was reviewed and approved by the physicians, none tried to actually use it. Thus, the problem wasn't discovered until after implementation. Winter suggests that anyone reviewing a form try to use it as part of the review.

Another format revision occurred when anesthesiologists tried to copy their portion of the trifold form so they would have the information in their own records. "A trifold form doesn't photocopy easily, so we changed to a single page format and we made the anesthesiologist's page a two-part self-copying form. Once they fill in their information, they simply pull their copy off the back," Winter explains.

After dedicating one page to the anesthesiologist's record and adding the operating room record as part of the pathway form, the move from the trifold form to a single page format creates an 11-page pathway for the chart, but instead of being more cumbersome, it is easier to use, she says. Not only does it flow well, but it is less expensive to produce, Winter says. The trifold form required heavier paper and a larger press to produce it. The lower cost of producing 8½- by 11-inch single pages will save $16,000 per year, says Winter.

An added benefit is a decreased turnaround printing time when supplies run low: from two weeks for the trifold to two days for the single page. ■

The biggest change was the move to charting by exception, says Taylor.

"In nursing school, we are taught that if we wrote it in the chart, we did it," she explains. "The most often asked question when switching to pathways on which we only write something when the patient's recovery doesn't follow the pathway is 'Is it legal?'"

Inservice education conducted by Winter and the education department alleviated nurses' fears and explained the use of the forms. Posters showed the old and new forms. Highlighted areas showed the location of similar information and areas that contained new information such as vital sign parameters.

During the pathway development process, the team found some inconsistencies among units. "Our research to develop our pathways showed that vital signs should be monitored [intraoperatively] every five to 15 minutes or based on medication titration, but we discovered that endoscopy patients were not monitored at this frequency," says Winter.

Visiting policies for the postanesthesia care units (PACU) were different in inpatient and outpatient surgery. "This was confusing to families who had experience with both units," she adds. "Our day surgery program did not have written policies, but we routinely allowed the families of pediatric patients to come back to the PACU and we did not limit the number of visitors."

The inpatient surgery PACU did limit the number of family members to one at a time for pediatric patients. "We now have written policy regarding number of visits that applies to both units," Winter says.

Pre-op phone calls to endoscopy patients were improved as a result of pathway implementation. Prior to use of the pathway, staff members making the calls told patients what time to arrive, what dietary restrictions should be followed, and to plan for a driver, says Winter. "If the patient asked questions about the procedure, he or she was referred to the physician," she says.

Now, the pathway enables the endoscopy staff to answer questions and review a care plan because the prompts are in the pathway, she says.

The pathway development process also caused the rewrite of the protocol for IV conscious sedation. "The standard time in the recovery room used to be one hour, but some IV conscious sedation patients are ready to leave sooner," she explains. Recovery room nurses now base the decision to release the patient on specific criteria.

SOURCES

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You can make the pathway development process smoother and less time-consuming by gathering as much up-to-date information related to the care that the pathway addresses.

Do your research upfront, says Winter. She reviewed standards from accrediting organizations and professional organizations, current medical and nursing textbooks, and the policies and procedures of her own organization.

"Make sure you reference everything you put into your pathway," she adds. "For example, on your vital signs parameters, footnote exactly which source was used for the parameters." This note will save you time and effort if the parameter is questioned, she explains. ■

Same-Day Surgery Manager

Hospital pitfalls with joint ventures

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

My company has been putting hospital and physicians into a joint venture in ambulatory surgery centers (ASCs) for well over a dozen years. Consequently, we have learned a few things that never change.

We are all familiar with the expression "hospital bureaucracy" and "hospital mentality." Well, often, there is truth to those terms. With the big rush for hospitals to build freestanding surgery centers, and an even greater rush to do them with their physician staff, I thought I would offer a few tips to help others avoid the mistakes many hospitals currently are making today.

• **Setting expectations.** If you talk about doing something with your surgical staff and discussed it with them, you have set the expectation that something is going to happen. I don't know how many times we have heard the expression, "They [the hospital] talk, and talk, and talk about doing an ASC. We got tired of waiting and are doing it ourselves."

Schedule on a time line

The key here is to move forward as quickly as you can or tell the physicians why you cannot do it as quickly as they may want. Put together a "time line" for them so they can see progress or understand the lack of it.

• **Be realistic.** Do not build a six-room surgery center for 3,000 cases per year. You are not going to fill it overnight, and you and every investor will pay for each square foot that isn't utilized. Use the following as a rule of thumb: One well-managed operating room can handle between 850 to 1,500 cases per year per operating room. Obviously, if all your cases are short and uncomplicated vs. long and detailed, it would be a different situation. Remember that most pain management cases don't even need an operating room; they can be done in the recovery room.

Conversely, don't build a three-OR center for 5,000 cases. Yes, it will probably be profitable, but it is going to cause problems later when your investors don't have posting time. Define the size and the scope of your project as well as you can early. It is a major expense driver for your investors.

• **Don't do your own equipment planning.** Equipment planning for a surgery center is an art and a thankless, detail-oriented, time-consuming, horrible job! Even if it goes absolutely perfect — and it will not — it is expected. Leave this job to the professional equipment planners. We don't even do it; we hire others to do this chore. If you are asked to "put together the equipment list" for a surgery center, run away, very fast.

• **Let the facility purchase its own supplies.** Many hospitals think they have the best prices in town when it comes to disposable goods. Truth is, most surgery centers get better, significantly

better pricing. If a not-for-profit hospital were to purchase supplies for its for-profit surgery center, it would have to take the higher cost supplies and then mark them up before it could sell them to the center. Hardly a profitable situation for the ASC.

Further, if the hospital marks up the supplies, it is now, theoretically, making a profit on the transaction. That doesn't work either. Just giving the supplies to the facility is enticement to the physicians — and on it goes. Bottom line: Get a surgical tech or RN to do all the purchasing for the facility. It is much less complicated, and techs and RNs do a better job.

• **Don't staff the center like the hospital.** As a consultant, this issue is right up there with why you don't want 6 a.m. meetings. (Think about it.) We spend too much time trying to convince hospital management (usually OR directors) that you do not need the same staffing levels in an ASC for the same number of cases as you do in the hospital. Smaller areas, healthier patients, and hand-picked, highly motivated, and high-energy personnel work better in smaller numbers.

The best way to deflate a good surgery center is to overwhelm it with people. Start small and add up. Never go the other way around, if you can avoid it.

• **Keep meetings small and short.** What is the deal with all these meetings? I won't go there, but be mindful that the smaller the group and the shorter the meeting, the more you will get accomplished. Enough said. Some things cannot be changed.

• **Don't manage your own center.** This is especially true if you have a joint venture with the doctors. You, as the hospital, just cannot win here. You will have to face the investors every month at the profit and loss meetings and explain each line item to your physicians. Do you really want to try and tell them why you are paying $135 for an intraocular lens that the rest of the world is paying $50? Try to explain why you are over budget on payroll, and you have three managers to run a four-room surgery center.

These are things to think about. There are many more areas that you need to consider. Let me know if you want to hear more.

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ACCREDITATION TIP

Competence: 'The shot heard round the world'

It's the one topic that the Joint Commission on Accreditation of Healthcare Organization receives hundreds of phone calls, letters, and e-mails about.

It's competence — also known as "The shot heard round the world," says **Ann Kobs**, MS, RN, former director of the department of standards and current sentinel event specialist for the Joint Commission. Competence is covered in the Management of Human Resources section of the standards manual.

What is the biggest misconception? Seventy-five-page checklists are necessary, Kobs says.

"No. 1, long before we said the word competence, didn't you have a job description?" she asks. "We never asked for checklists. However, if you want to continue checking them, go for it. My question is, why would you bother to check someone who has performed very well on the job all year long, or all two years?"

Perform performance appraisals at intervals, she suggests. "I mean, why would you then put them through a skills lab of putting down an NG tube and taking a blood pressure? If they can't do that, why are they working?"

You have several options, and one of the options is observation in daily work," Kobs says. "In the absence of error, competence can be assumed. That cuts out all that paperwork."

EXECUTIVE SUMMARY

According to accreditation groups, the competence standards have generated significantly more paperwork and concern than necessary.

- Base the performance evaluation on the job description.
- Ensure employees have experience, as required, and can demonstrate age-specific competence. Lengthy age-specific criteria check sheets are unnecessary.
- Document orientation for all new employees.
- Have the same expectations for agency personnel as you have for your own staff.

While not going as far as to say checklists aren't necessary, **Beth Derby**, RN, MBA, a surveyor for the Accreditation Association for Ambulatory Health Care (AAAHC) in Skokie, IL, and executive vice president for Health Resources International (HRI) in West Hartford, CT, says the job description can be the same document as the performance review checklist. HRI is involved in the ownership, development, and management of surgery centers in the United States. The company is developing ambulatory projects in many overseas markets.

The job description should be concise, fairly complete, and include age-specific competence requirements where indicated, Derby says. The performance review tool should indicate that the employee was observed and monitored demonstrating competence. Be sure the performance evaluation tool includes specifics, she advises.

If a nurse, for example, is expected to be familiar with many pieces of equipment, the evaluation form might say, "good knowledge of all appropriate equipment."

"If the nurse is required to discharge patients from the postanesthesia care unit, and the patient population includes infants, is that nurse successfully completing her duties, or does she need to have a colleague evaluate all of her pediatric patients? Her supervisor should be aware of the staff nurse's capabilities and demonstrated competency in caring for the patient population in the facility," Derby says.

This is how evaluation, monitoring, and supervising measures age-specific competency, she says.

Watch out for these areas that can trip you up during surveys, say representatives of the accrediting groups:

• **Age-specific competence.** Between January and June 1998, 23.4% of facilities surveyed received a score of 3, 4, or 5 for HR.5: Staff ability to meet performance expectations.

"People have generated more paper over that than anything I've ever seen," Kobs says. "If you have a statement in the job description that says, 'This employee performs well providing age-specific care to the elderly. Yes or No?' That's enough."

Derby says that a lengthy age-specific criteria check sheet is unnecessary. She emphasizes, however, that in a program in which segments of the population have special needs — for example, the elderly or very young — the staff should have documented experience and be able to demonstrate the ability to take care of those patients.

• **Orientation of new employees.** AAAHC suggests that orientation forms usually should be maintained in employee files; however, they can be held by the supervisor to use as a reference when evaluating performance or developing new education programs, Derby says. One of the important factors to consider in orienting staff is to ensure consistency in general knowledge of the facility and its policies and procedures, she says.

The Joint Commission requires orientation documentation for personnel hired after Jan. 1, 1993. The surveyors don't care where you keep the files, Kobs says. "It's a matter of whether you can come up with the information when the surveyor says, 'How [do] you measure competence?' and 'We'd like the file of a new staff nurse hired within the past three months.' Can you go find one?"

• **Data reported to governing body.** Between January and June 1998, 5.3% of facilities being surveyed by the Joint Commission received a score of 3, 4, or 5 for HR 4.3: Aggregate data reported to the governing body.

"HR 4.3 talks about you have to report to the governing body on the human resources that you

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have," Kobs says. "It appears that even the surveyors don't read the end of the sentence because it says, 'for purposes of identifying educational needs.'" That's the key piece, she maintains. In what areas do you need to plan education? Look at your performance appraisal or your competence model to answer that question.

AAAHC, in its standard on governance, includes characteristics that require the governing board to establish and delegate responsibility for the policies on continuing education of the staff.

Additionally, there is a standard on professional improvement that "strives to improve the professional competence and skill, as well as the quality of performance of the health care practitioner and other professional personnel it employs."

• **Agency personnel.** You must have the same expectations for agency personnel as you have for your own staff, surveyors say.

"And they must be proved competent before they work," Kobs says. "They have to have an orientation and any other requirements you may see fit to put in." ■

• **1999 Society of American Gastrointestinal Endoscopic Surgeons Meeting** — March 24-27, San Antonio. Contact: SAGES, 2716 Ocean Park Blvd., Suite 3000, Santa Monica, CA 90405. Telephone: (310) 314-2404. Fax: (310 314-2585. E-mail:sagesmail@aol.com. Web site: http://www.sages.org/. ■

Correction

In the January 1999 issue of *Same-Day Surgery*, an article on cosmetic procedures should have listed $300 as an example of the charge for laser hair removal instead of the average charge.

The typical charges for other cosmetic procedures listed in that issue were taken from the World Wide Web, not Candela Corp.'s research department.

SDS regrets the errors. ■

CE objectives

After reading each issue of *Same-Day Surgery*, the reader will be able to do the following:

• Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care and management. **(See "Gastrointestinal repair brings in new patients.")**

• Describe how those issues affect nursing service delivery or management of a facility.

• Cite practical solutions to problems or integrate information into their daily practices, according to advice from nationally recognized ambulatory surgery experts. **(See "Perioperative pathway ensures consistent care" and "Competence: 'The shot heard round the world.'")** ■