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Covering Hospitals, Surgery Centers, and Offices for More than 30 Years

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IN THIS ISSUE

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What will your staff members do when violence erupts in your workplace?

Recent incident, state actions raise awareness: You need policies

(Editor's note: This is the first part of a two-part series on workplace violence. This month, we tell you about a recent activity and how you should manage this problem. We also give you a checklist, sample policies, and advice on how to handle layoffs. Next month, we'll give you warning signs, advice on when to call the police, and an extensive list of resources.)

It's an incident every outpatient surgery manager prays they'll never have to face. An unemployed anesthesiologist in Florida has been arrested after police report he threatened former co-workers at a hospital and broke windows at two other medical facilities, according to a media report.[1] The hospital had an injunction that prohibited his presence at the facility, according to the report. He faces two charges of criminal mischief, one charge of aggravated stalking, and one charge of resisting arrest without violence, it said. Another newspaper reported the men's restroom at the hospital was vandalized in a manner similar to vandalism against the anesthesiologist's former co-workers.[2] He was

EXECUTIVE SUMMARY

Workplace violence is inevitable in our culture, experts say, and you must be prepared.

- Communicate openly about upcoming changes, the facility's financial position, any downsizing, who will be affected, and how decisions will be made.
- Train staff on early warning signs of workplace violence and appropriate ways to respond.
- Have a written layoff policy. If possible, offer assistance, including severance, job counseling and placement services, and extended benefits such as an employee assistance program (EAP). Keep the conversation short, and have the employee escorted off the property.

being held without bail, the media reported.[1]

"This was a situation that was clearly escalating; and, in these situations, it is important to take the situation very seriously and bring in resources as needed," says **Corinne Peek-Asa**, PhD, professor of occupational and environmental health and director of the Injury Prevention Research Center, University of Iowa, Iowa City. "The action of the hospital may have helped this situation from becoming worse over time," Peek-Asa says.

This situation serves as a reminder of the importance of thoroughly researching a potential employee's history, says **W. Barry Nixon**, SPHR, executive director of the National Institute for the Prevention of Workplace Violence, Lake Forest, CA. Such scenarios potentially can be avoided "with a really good background check," he says.

The bottom line? You must expect and be prepared for violence, experts say. Nixon points out that there was a 13% increase in workplace violence homicides from 2006 to 2007, according to the Department of Labor/Bureau of Labor Statistics. While violent events in health care often go unreported, states are moving to change that tradition. Oregon's hospitals and surgery centers are implementing violence tracking programs. The Workplace Violence Prevention Law for Healthcare requires periodic security and safety assessments, regular training, and an assault prevention program. Since January 2009, hospitals and surgery centers have been required to report their workplace violence data on all assaults. ***(Editor's note: See workplace violence checklist from the federal government on p. 35. This checklist is part of U.S. OSHA's* Guideline for Preventing Workplace Violence in Healthcare,** ***which can be found at www.osha.gov/SLTC/etools/hospital/hazards/workplaceviolence/ checklist.html.)***

Since January 2008, New Jersey has had a Violence Prevention in Healthcare Facilities Act, which requires hospitals and surgery centers to take steps to reduce the hazard of workplace violence. New Jersey is the third state, after California and Washington, to enact a law that specifically addresses workplace violence in hospitals. The law requires facilities to set up a committee of managers and frontline workers to conduct an "annual comprehensive risk assessment" and to develop a violence prevention plan. NJ facilities also are required to conduct annual training, including techniques to de-escalate violent behavior, to respond to violence, and to report violent incidents.

At some facilities, such as Providence Health and Services facilities in Portland, OR, every employee completes an annual module on workplace violence with their environment of care training. The initial course lasts eight hours, and the annual refresher is a four-hour course. Employees learn how to recognize warning signs, calm agitated persons, and de-escalate potentially violent behavior. If they are unable to diffuse the situation, employees learn how to protect themselves and the violent person with physical intervention. They then work with the person to respectfully diffuse the event.

The key pieces of an effective workplace

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Editorial Questions

Questions or comments? Call **Joy Daughtery Dickinson** at (229) 551-9195.

Workplace Violence Checklist

(Editor's note: This checklist is part of U.S. OSHA's Guideline for Preventing Workplace Violence in Healthcare, *which can be found at www.osha.gov/SLTC/ etools/hospital/hazards/workplace violence/checklist. html.)*

Designated competent and responsible observers can readily make periodic inspections to identify and evaluate workplace security hazards and threats of workplace violence. These inspections should be scheduled on a regular basis; when new, previously unidentified security hazards are recognized; when occupational deaths, injuries, or threats of injury occur; when a safety, health, and security program is established; and whenever workplace security conditions warrant an inspection.

Periodic inspections for security hazards include identifying and evaluating potential workplace security hazards and changes in employee work practices that may lead to compromising security. Please use the following checklist to identify and evaluate workplace security hazards. Every "true" answer indicates a potential risk for serious hazards:

True or False?

__ This industry frequently confronts violent behavior and assaults of staff.
__Violence has occurred on the premises or in conducting business.
__ Customers, clients, or co-workers assault, threaten, yell, push, or verbally abuse employees or use racial or sexual remarks.
__ Employees are NOT required to report incidents or threats of violence, regardless of injury or severity, to employer.
__ Employees have NOT been trained by the employer to recognize and handle threatening, aggressive, or violent behavior.
__ Violence is accepted as "part of the job" by some managers, supervisors, and/or employees.
__ Access and freedom of movement within the workplace are NOT restricted to those persons who have a legitimate reason for being there.
__ The workplace security system is inadequate — i.e., door locks malfunction, windows are not secure, and there are no physical barriers or containment systems.
__ Employees or staff members have been assaulted, threatened, or verbally abused by clients and patients.
__ Medical and counseling services have NOT been offered to employees who have been assaulted.
__ Alarm systems such as panic alarm buttons, silent alarms, or personal electronic alarm systems are NOT being used for prompt security assistance.
__ There is no regular training provided on correct response to alarm sounding.
__ Alarm systems are NOT tested on a monthly basis to assure correct function.
__ Security guards are NOT employed at the workplace.
__ Closed-circuit cameras and mirrors are NOT used to monitor dangerous areas.
__ Metal detectors are NOT available or NOT used in the facility.
__ Employees have NOT been trained to recognize and control hostile and escalating aggressive behaviors, and to manage assaultive behavior.
__ Employees CANNOT adjust work schedules to use the "Buddy System" for visits to clients in areas where they feel threatened.
__ Cellular phones or other communication devices are NOT made available to field staff to enable them to request aid.
__ Vehicles are NOT maintained on a regular basis to ensure reliability and safety.
__ Employees work where assistance is NOT quickly available. ■

violence prevention program include administrative policies and procedures, training, and environmental control, Peek-Asa says.

"Effective workplace violence prevention programs include policies and procedures that clearly state what the expectations for good conduct are, and what the consequences for violent actions or threats of violent actions — physical or psychological — are," she says.

Clearly define every employee's role, disseminate these policies to all employees, and provide training, Peek-Asa says. "The business should have grievance procedures so that problems are identified early and dealt with in a fair manner," she says. Develop and practice a protocol for threat assessment, Peek-Asa says.

Have a zero-tolerance policy for violence at work, and make it prominent in your handbook, suggests **Sandy Seay**, PhD, president of Seay Management Consultants, a human resources management consulting firm in Orlando, FL. **(See sample workplace violence policy, p. 36.)** Seay is scheduled to speak on "Lateral Violence, Problem Employees & Other Challenging Staffing Issues"

Workplace Violence — Zero Tolerance Policy

The Surgery Center has adopted a Zero Tolerance Policy for workplace violence. Consistent with this policy, acts or threats of physical violence, including intimidation, harassment, and/or coercion, that involve or affect the Surgery Center or that occur on Surgery Center property will not be tolerated. Examples of workplace violence include, but are not limited to, the following:

- All threats or acts of violence occurring on Surgery Center premises, regardless of the relationship between the Surgery Center and the parties involved in the incident.
- All threats or acts of violence occurring off the Surgery Center's premises involving someone who is acting in the capacity of a representative of the Surgery Center.
- All threats or acts of violence occurring off the Surgery Center's premises involving an employee of the Surgery Center if the threats or acts affect the legitimate interests of the Surgery Center.
- Every employee and every person on Surgery Center property is encouraged to report incidents of threats or acts of physical violence of which he or she is aware. The report should be made to your supervisor or any member of management.

Source: Seay Management Consultants, Orlando, FL.

at this month's ASC Association meeting.

"Also ban weapons at work, and define what you mean by 'weapon,'" he says. "You don't want people coming to work with guns or long knives." However, keep in mind that some states, such as Florida and Georgia, allow employees to bring guns to a work location if they have a license and if the guns are kept locked in a personal vehicle, Seay adds. **(See sample weapons policy, p. 37.)**

Environmental control issues include good entrance and exit control, lighting, and visibility, Peek-Asa says. "Identify areas that might be vulnerable, and consider remediation such as access control or surveillance," she says.

The key to handling violence is to realize that it is not a rare situation, Seay says. "We have to expect it and prepare for it," he says.

Dawn Q. McLane, RN, MSA, CASC, CNOR, chief development officer of the Nikitis Resource Group, a Broomfield, CO-based company that specializes in surgery center development, management, and consulting, adds, "We take for granted that our workplaces are safe, and we take precautions to attempt to ensure that they are; however, we are living in extraordinary times." **(For more information on how to handle layoffs, see below. For more information on potential violence in the workplace, see "Are you prepared to address 'health care road rage'? Jan. 1 deadline is looming for TJC," "Steps to developing a code of conduct," and "Why does surgery setting lead to more outbursts?" *Same-Day Surgery*, October 2008, supplement, pp. 1-4.)**

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1. Abel J. Threats, violence, and vandalism. Tampa doctor accused of damaging medical centers. *St. Petersburg Times,* Feb. 3, 2009. Accessed at www.tampabay.com/news/publicsafety/crime/article972747.ece.
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Advice on how to handle layoffs

In these tough economic times, when people are losing their jobs, communication is the key to prevent worker-on-worker violence, says **Corinne Peek-Asa**, PhD, professor of occupational and environmental health and director, Injury Prevention Research Center, at the University of Iowa, Iowa City.

"Businesses with a good work culture, open communication, fair policies and procedures, and workplace violence policies will likely be ready to handle downsizing and layoffs," she says.

Keep employees informed of changes, the program's current financial position and, if there will be downsizing, who will be affected and how the decisions will be made, she suggests. "With good communication, perceptions of unfairness will be diminished," Peek-Asa says.

With the current scarcity of jobs, people might feel more anxious about finding another position, says **Dawn Q. McLane**, RN, MSA, CASC, CNOR, chief development officer of the Nikitis Resource Group, a Broomfield, CO-based company that

Weapons at Work

Employees are not allowed to have weapons such as knives, guns, or rifles in their possession while at work, unless these weapons are necessary to perform the job — such as security guard — and unless authorized in advance by management in writing. "Possession" is defined to mean in lockers or tool boxes, in an employee's personal possession, or anywhere else on company property, except as outlined below. (For Florida, Georgia, and some other states, there is an exception for maintaining guns in a locked personal vehicle, for those persons who are properly licensed.) Employees who violate this policy will be subject to immediate dismissal.

Source: Seay Management Consultants, Orlando, FL.

specializes in surgery center development, management, and consulting. "This added stress has the potential to create a heightened emotional response, which, in some people, may result in a more violent reaction than it ordinarily would," McLane says.

Have a written layoff policy to ensure there is consistent guidance to managers and those leading the layoff process, says **W. Barry Nixon**, SPHR, executive director of the National Institute for the Prevention of Workplace Violence in Lake Forest, CA. Ensure that all people who will address terminated employees are trained in recognizing the early warning signs of potential workplace violence, appropriate ways to respond to upset or agitated employees (those who arrive angry), and that policies and practices have been tuned to treat employees in a respectful manner, Nixon says. "There are numerous examples of disgruntled employees being triggered toward violence by a sharp-tongued disability clerk or payroll reps," he says.

"Consistent practices are a critical element of the layoff process, Nixon says. "People will never be happy with getting laid off," he says. "However, what sets off the perception of injustice is where there are inconsistent applications of the policy and/or unfair decisions."

It's best to handle a termination at the end of the day, says **Sandy Seay**, PhD, president of Seay Management Consultants, a human resources management consulting firm in Orlando, FL. "That gives employees prone to violence less opportunity at the location to engage in violence," he says.

While some experts suggest terminating employees on a Friday, Nixon suggests you avoid that day. "This is convenient for the organization because it most likely parallels the pay period and is the end of the week; however, it is the worse time to terminate an employee because they have no avenues available to them to refocus on the future, but instead have the whole weekend to brew over 'how awful it is that you terminated them' and to conjure up all kinds of things," he says.

Midweek terminations are better because the employee can immediately apply for unemployment, start putting in applications at other firms, talk to counselors, handle other business matters, and take other positive steps, he says. "The key is to shape your termination/layoff policy from the viewpoint of the impacted person, not from the viewpoint of what is easy for the organization," Nixon says.

All aspects of the termination process should be tuned to treat people with dignity and respect, he says. It also is a good idea to offer terminated employees some type of assistance package that can include severance, job counseling and placement services, and extended benefits such as EAP, Nixon says. "It helps to soothe the pain," he says.

Always alert security staff that you are terminating or laying off an employee, Seay advises. "It's always better to escort employees off the premise rather than just let them go," he says. Otherwise, they might destroy property on their way out, warns Seay, who knows of one employee who destroyed thousands of dollars of computer equipment after being terminated.

Always have a witness in the room with you when you're delivering layoff or dismissal news, Seay advises. The conversations should be short, he says. "There's an old saying, 'The more you say, the more you pay.'"

Have a prearranged sentence or paragraph that you'll use to deliver the news, Seay says. Resist the temptation to explain, he says.

Clearly communicate what the expectations are, and explain that these are policy-based and not just for the single individual, Peek-Asa says. For example, is the employee expected to remain off of the business property? Usually this step is advised as a policy, Peek-Asa says. When is the employee expected to have his or her personal items removed? Usually right away, she says.

"It is also important to communicate what is available to the employee, such as any training opportunities, if a reference letter be provided, and information about employment resources within the business and in the community," Peek-Asa says. ■

Who knows best? Probably your staff

Employees' ideas improve efficiency

Sometimes the best ideas for improving your efficiency might be right under your nose. At two surgery programs, staff members have suggested ideas that, when implemented, resulted in better patient flow and reduced costs.

At San Luis Valley Regional Medical Center in Alamosa, CO, the front office person sits within an office that is separated from the pre-op area by a door. "It is a fire door, so it cannot be left open," says **Angela Blankinship**, RN, CASC, director of surgical services.

When patients checked in, staff attempted calling the pre-op nurse to notify her that she had a patient, she says. "If they are busy with other patients, the nurse can't answer the phone, Blankinship says. The staff considered pagers, but the nurses didn't like that idea. "The front desk person can't leave her desk to run and tell them they have a patient," she adds.

The solution? One of the nurses went to a local discount store and bought a wireless doorbell. The cost of this item is about $15. The staff selected the doorbell tone. "Occasionally, one of the anesthesia providers changes the tone just to keep things lively," Blankinship says.

The staff simply plugged the doorbell into a wall socket in the pre-op area, Blankinship says. "We placed the actual door bell button on the receptionist's keyboard with double-sided sticky tape," she says. When the receptionist completes her registration process, she rings the doorbell. The nurses know there is a patient, and they come and pick them up, Blankinship says.

"It has really helped by keeping the receptionist in her office and improved timely patient flow," she says.

At Bald Mountain Surgical Center in Lake Orion, MI, the staff regularly meet at the end of busy days to determine what they can change to boost efficiency, says **Annette Bak-Lopez**, MSN, administrator.

"It keeps everyone engaged in process, looking to always improve processes," she says.

As a group, staffers determine the most effective time frame for bringing in patients to start the pre-op process so there wasn't a too-long wait, she says. Another potential problem is that the center has a small waiting room that they don't want overflowing with visitors, Bak-Lopez adds. The staff determined that with minor procedures such as cataracts and colonoscopies, the patient immediately could go back to the recovery room, where the surgeon could speak with them, she says. "That improved the flow process," Bak-Lopez says.

Other changes included making up linen packs ahead of time and using recliner chairs as much as possible in order to free up patient carts for transport.

Another dilemma solved by staff at San Luis Valley involved overstocking of surgical screws, with a corresponding rise in costs.

To ensure that there were enough screws, materials management received an order for the screws from the central supply department (CS), and the CS technician opened the packages and placed the screws in a special compartment, Blankinship says. The screws were then available for restocking, she says. "As you can imagine, we accumulated more screws that we could possible use," she says. There were no par levels, and the overstocking continued, she says. "The techs just didn't consider that the screws were an investment," Blankinship says.

With tighter reimbursement margins, this overstocking created a dilemma, she says. "We need to save every possible penny," she explains.

The materials management staffer came up with a solution, Blankinship says. After reviewing the financial reports with the materials management staff person, she developed a system using a large file box; index cards; and a two-copy, no-carbon-required (NCR) sheet that she uses when ordering and restocking screws.

In the file box, screws are filed by their part number, Blankinship says. Screws are filed without removing them from their package prior to being restocked in trays. "The CS tech can look into the filing system, remove the screw they

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- Advice: Get the best performance from your staff

need, and both the CS tech and materials management can visualize their stock quantities," Blankinship says. "This also helps her if she does find that she is overstocked, as now we can return the screws if needed," because they are in the original package, she says.

"We have saved to date about $3,000, and we have been using the system about three months," Blankinship reports.

The NCR form is organized, comprehensive, and clear, Blankinship says. The second copy goes to the billing department, she says. The form is organized to not only help her control stock, but provide the billing person a legible accounting of the particular screws used," Blankinship says. It is not part of the medical record, Blankinship says. *(Editor's note: An implant log also could be used to be certain that the costs of chargeable items are captured every time.)*

Will they always choose to use the NCR form? Probably not, Blankinship says. "It is an added expense," she says. However, it was value-added in that it allowed materials management to gain control of this small particular problem, Blankinship says.

"It was delightful from a director's point of view to see her take pride in her actions, come up with a plan, execute the plan and she now is re-evaluating her processes with her entire department, developing a true 'Lean Six Sigma' [performance improvement] style of thinking," she says.

The end result? "She is excited, and that is contagious to all other aspects of our team," Blankinship says. Now, employees volunteer ideas, she adds. "It usually starts with, 'Hey, I was thinking. . . it may not work . . . but, could we . . .?' How very cool is *that?"* ■

CNE/CME instructions

Physicians and nurses participate in this CNE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answers listed in the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing this semester's activity with the **June** issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

Same-Day Surgery Manager

Economy, surgery, and salaries — Oh, my!

By **Stephen W. Earnhart**, MS
CEO
Earnhart & Associates
Austin, TX

When people lose their jobs, they often lose their health benefits as well. Since the majority of surgery is outpatient, and the bulk of that outpatient surgery is elective or can be delayed, it is not surprising that surgery in some areas is significantly down. Here are some of my ideas to cut personnel costs:

- **Cut hours, not people.** More than ever, your staff need their jobs. Reducing your hours of operations can save many staff members. This can spread the loss over all of your staff instead of letting individuals go.
- **Reduce days of service.** It is better to close your schedule to elective cases on one day and have a full rest of the week than it is to having staff sitting around for long times between cases.
- **Encourage staff to take one or two vacation days per month off** until conditions improve, and they will improve!
- **Obviously, do not fill open positions.**
- **Try to supplement other areas of the hospital, surgery center, or physician practices that do not have service reduction issues.** A nurse is a nurse and can work anywhere! Techs and front staff people have skills they can apply to other parts of health care. Encourage your surgeons to consider them to fill in gaps or opportunities in their practices.
- **Look for areas within your department that you can replace your surgical staff with, such as housekeeping.** I cleaned out dog cages for years, and it didn't hurt me! While they might not be the most glorious positions, it keeps the cash flowing.
- **Sending staff members to surgeon's offices to tout your services.** This is a good way to convince your boss the value of keeping your people together.
- **Talk to your surgeons!** Let them know what

is going on, and encourage them to bring cases from other facilities to yours. Uh-oh. Maybe someone at those "other facilities" might be asking their docs to do the same thing right now!

• **Ask for volunteers to take a leave of absence.** We all hate those people that are always saying, "I don't really *need* to work, you know." Put them on the spot and out the door.

• **If you absolutely, categorically, have no choice and have to let staff go, do it by seniority:** Last in, first out. It isn't fair, but what is?

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

CNE/CME *questions*

- **Identify** clinical, managerial, regulatory, or social issues relating to ambulatory surgery care.
- **Describe** how current issues in ambulatory surgery affect clinical and management practices.
- **Incorporate** practical solutions to ambulatory surgery issues and concerns into daily practices.

13. What is the key to workplace violence prevention programs, according to Corinne Peek-Asa, PhD?
A. Administrative policies and procedures
B. Training
C. Environmental control
D. All of the above

14. Why are midweek terminations better than Friday terminations, according to W. Barry Nixon, SPHR,?
A. The employee can immediately apply for unemployment, start putting in applications at other firms, talk to counselors, handle other business matters, and take other positive steps.
B. They line up with most payroll schedules.
C. Suicides are more common on weekends.
D. None of the above

15. How did San Luis Valley Regional Medical Center decide to notify preoperative nurses that a patient is ready?
A. Pagers.
B. Leave the door open so the nurse could be called.
C. Wireless doorbell.
D. The front desk person walks to the back to notify the nurse.

16. How can you reduce personnel costs, according to Stephen W. Earnhart, MS?
A. Cut hours, not people.
B. Reduce days of service.
C. Encourage staff to take one or two vacation days per month off until conditions improve.
D. All of the above

Answers: 13. D 14. A. 15. C 16. D.

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SDS ACCREDITATION UPDATE

Covering Compliance with The Joint Commission and AAAHC Standards

What requirements from The Joint Commission must your program meet for informed consent?

When developing a policy on informed consent, you must use accreditation standards, as well as state law and the Hospital Conditions of Participation (CoPs) or Ambulatory Surgery Conditions for Coverage, says **Sue Dill Calloway**, RN, Esq., BSN, MSN, JD, director of hospital patient safety at The Doctors Co./OHIC Insurance Co., Columbus, OH.

Dill Calloway recently spoke on "Informed Consent: CMS, The Joint Commission, and Other Standards Every Healthcare Provider Should Know" in an audio conference sponsored by AHC Media, which publishes *Same-Day Surgery*. **(For information on ordering the audio conference CD or MP3 download, see resource box, p. 2.)** There are differences in consent requirements by CMS for hospitals and critical access hospitals, she points out.

The Joint Commission (TJC) uses the same informed consent standards for ambulatory and hospital-based programs, except that for ambulatory programs, the Elements of Performance (EP) 4 and 5 in the Ethics, Rights, and Responsibilities section RI.01.03.01. do not apply. EP4 policy describes the process to be followed: The surgeon talks to the patient; the consent form is signed, if the surgery is elective, it is sent to hospital, and it is put on the chart before the patient goes to surgery. EP5 describes how to document consent in the medical record: in the progress notes section.

TJC standards say a facility honors the patient's right to give or withhold informed consent. TJC and CMS expect a signed consent form to be on the chart before surgery, unless it's an emergency, Dill Calloway says. As for how long consents are valid, neither the Centers for Medicare & Medicaid Services (CMS) nor TJC specify a time period for the informed consent to be done, she says. Dill Calloway queried 50 hospitals, and most said conduct informed consent within 30 days or within 60 days. "You get to pick," she says. If you receive a consent form that doesn't fit within those parameters, have the patients reaffirm that they've received informed consent, and have them re-sign the form,

EXECUTIVE SUMMARY

Accreditation standards, state law, and Medicare Conditions of Participation/Conditions for Coverage should be used to develop your policy on informed consent.

- The Joint Commission (TJC) uses the same informed consent standards for ambulatory and hospital-based programs, except that for ambulatory programs, the Elements of Performance (EP) 4 and 5 in the Ethics, Rights, and Responsibilities section RI.01.03.01. do not apply.
- TJC-accredited health care facilities must list the procedures performed and whether they require informed consent. Update your list every year.
- TJC EP 12, in RI.01.03.01, says informed consent must include a discussion about any circumstance under which information about the patient must be disclosed or reported.

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SOURCE/RESOURCES

For more information on informed consent, contact:
- **Sue Dill Calloway**, RN, Esq., BSN, MSN, JD, The Doctors Company/ OHIC Insurance Co., 155 E. Broad St., Columbus, OH 43215. Phone: (614) 255-7163.

For consent forms that list the risks, complications, and alternatives of many procedures by the Queensland government in Australia, go to:
- www.health.qld.gov.au/informedconsent/ConsentForms/14025.pdf.
- www.health.qld.gov.au/informedconsent/formsindex.asp.

The CD and MP3 download from the audio conference "Informed Consent: CMS, The Joint Commission, and Other Standards Every Healthcare Provider Should Know" are available for $299 each. Call (800) 688-2421 and mention Priority Code T09312/7758. Or go to www.ahcmedia.com, and on the left side of the page, click on "Audio Conferences." Under "Past Audio Conferences Available on CD," click on the audio conference title.

Dill Calloway suggests. The time period and the policy on expired consent forms should be included in your policies and procedures and followed, she says.

For its part, the Accreditation Association for Ambulatory Health Care (AAAHC) says informed consent of the patient or representative is obtained before the procedure is performed. It also says one consent form can be used for anesthesia and surgery. TJC has gone from requiring an anesthesia consent to now recommending one, but Dill Calloway highly recommends that one is done.

What you might be missing

One important note for TJC-accredited health care facilities is that they must list the procedures performed and whether they require informed consent. "We know that some hospitals don't have this," Dill Calloway says. Update your list every year with new procedures for which physicians have received privileges, she says.

Additionally, most providers don't seem to know about EP 12, in RI.01.03.01, that says the informed consent process includes a discussion about any circumstance under which information about the patient must be disclosed or reported. This section refers to laws requiring mandatory reporting to the departments of health, she says. "This could include mandatory reporting requirements for HIV, [tuberculosis], viral meningitis, and other diseases to the [Centers for Disease Control and Prevention] or the state department of health," Dill Calloway says.

Another standard requires the hospital to honor the patient's right to give or withhold informed consent regarding the use of recordings, films, or other images of the patient for purposes other than his or her care. A sample consent form for photos is available from the American Health Information Management Association (AHIMA). *[Editor's note: To access the* Patient Brief: Patient Photography, Videotaping and Other Imaging and Sample Consent for Photography/Videotaping (For Media or Educational Purposes), *go to library. ahima.org. For requirements by DNV Healthcare, see story, below.]* ■

Access standards from DNV Healthcare

DNV Healthcare, which has been approved by the Centers for Medicare & Medicaid Services (CMS) for deemed status, is a little more stringent than CMS, and unlike The Joint Commission, it has no separate standards for critical access hospitals, says **Sue Dill Calloway**, RN, Esq., BSN, MSN, JD, director of hospital patient safety at The Doctors Co./OHIC Insurance Co., Columbus, OH.

DNV's standards are available on its web site, www.dnv.com. The standards are free, but you must register to access them. The informed consent standards are on p. 96 in the Patient Rights section. ■

TJC proposes revisions to align with CMS

In order to line up with Medicare's Conditions of Participation (CoPs), The Joint Commission (TJC) has proposed some wording changes and organization to its hospital standards for 2009.

These proposed changes already are being reviewed by surveyors; however, they won't

Proposed Changes to Hospital Standards

- **Element of Performance (EP) for PC.03.01.03.**
  10. A pre-anesthesia evaluation is completed and documented by an individual qualified to administer anesthesia within 48 hours prior to surgery or a procedure requiring anesthesia.
- **EP for PC.03.01.07.**
  7. A post-anesthesia evaluation is completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia.
  8. The post-anesthesia evaluation for anesthesia recovery is completed in accordance with laws and regulations and policies and procedures that have been approved by the medical staff.
- **EP for PC.01.02.03**
  4. The patient receives a medical history and physical examination no more than 30 days prior to, or within 24 hours after, inpatient admission or registration, but prior to surgery or a procedure requiring anesthesia services. (See also MS.03.01.01, EP 6)
  5. For a medical history and physical examination that was completed within 30 days prior to inpatient admission or registration, an update documenting any changes in the patient's condition is completed within 24 hours after inpatient admission or registration, but prior to surgery or a procedure requiring anesthesia services, whichever comes first. (See also MS.03.01.01, EP 8 and RC.02.01.03, EP 3) ■

impact a hospital's accreditation decision until July 1, 2009.

One change has been to the standards for pre-anesthesia evaluation and post-anesthesia evaluation. "The Joint Commission always required assessment or evaluations pre and post-op, but the time frame is new: 48 hours," says **Mary E. Brockway**, MS, RN, associate director of standards in the Division of Standards and Survey Methods at TJC. **(See proposed new wording, above.)**

Also, some wording has been changed in the history & physical exam (H&P) standards to make it clear that the H&P must be completed prior to registration. Previously language referred to "admission," and because some facilities might not be considered outpatient to be admitted, the wording change was made, Brockway says. **(See proposed new wording, above.)** "[The Centers for Medicare & Medicaid Services] recently updated its language, so we included it," she says. (*Editor's note: To see the changes, go to www.jointcommission.org. Under "Library," click on "What's New on the Website." Then click on "Hospital deeming application: January 2009 Update."*) ■

Joint Commission may draw line in the sand in Nevada

HCV outbreak might lead to requirements

In what might be a prelude to accreditation requirements in Nevada ambulatory care settings, officials from The Joint Commission (TJC) have been meeting with state legislators and working out an agreement to report infection control problems such as the improper needle practices that led to a hepatitis C outbreak last year in Las Vegas.

Indeed, the outbreak and a succession of other clusters that have followed nationwide might give TJC a foothold in voluntary accreditation for physician offices and freestanding clinics. TJC recently agreed to alert state public health officials when the accrediting body identifies patient safety breaches at a health care facility, the *Las Vegas Review-Journal* reports.[1]

Oversight sought for surgery centers

Meanwhile, some patient safety advocates are calling for state and federal legislation requiring oversight of ambulatory centers by infection preventionists (IPs) and/or accrediting organizations. The idea of enlisting IPs into oversight roles has been discussed by state lawmakers in Nevada, but there is one snag: A national shortage of IPs.

The issues are resources and work force, says **Marion Kainer**, MD, MPH, FRACP, medical epidemiologist and director of the hospital infections and antimicrobial resistance program at the Tennessee Department of Health in Nashville. "I think these areas would all benefit from having infection preventionists' [oversight]," she says. "I know that these are tough times and resources are limited, but this is basic patient safety. I am sure people would not mind spending an extra two dollars a visit if they could be assured that the most basic infection control measures are taken care of."

Martha Framsted, a spokeswoman for the Nevada's health division, said the state agency has

reached out to 10 other accrediting organizations, according to the news article. Six are coordinating their work with the state's health department, and an agreement is being drafted by the Accreditation Association for Ambulatory Health Care (AAAHC), the *Review-Journal* reported. TJC officials have agreed to share with the health division any patient safety complaints, its survey schedule, and any follow-up information. Also, within two business days of a survey, TJC officials will notify Nevada officials of any immediate threat to patient safety, the newspaper noted.

In addition, the Ambulatory Surgery Center Association's Ambulatory Surgery Foundation has joined with groups such as AAAHC and the Centers for Disease Control and Prevention to promote a safe injection practices coalition. The groups have a web site at www.ONEandONLYcampaign.org.

Reference

1. Wells A. Hepatitis C cases spur accord. *Las Vegas Review-Journal*. Feb. 11, 2009. Accessed at www.lvrj.com/news/39420982.html. ■

Applicants accepted for safety, quality awards

The Joint Commission and the National Quality Forum (NQF) are accepting applications for the 2009 John M. Eisenberg Patient Safety and Quality Awards, which recognize individuals and health care organizations that are making significant contributions in improving the safety and quality of patient care.

Application forms for the John M. Eisenberg Patient Safety and Quality Awards are available at www.jointcommission.org/PatientSafety/EisenbergAward. The deadline for submissions is April 20, 2009.

The awards honor the memory of Eisenberg, a nationally recognized leader in health care quality improvement who advocated for health care, based on a strong foundation of research, that meets the needs and perspectives of patients. Eisenberg, who died in 2002, spearheaded national efforts to reduce medical errors and improve patient safety as director of the Agency for Healthcare Research and Quality.

The John M. Eisenberg Patient Safety and Quality Awards are presented each year, in up to four categories, including individual achievement and project-related achievements in research and innovation in patient safety and quality at the national and local level. Beginning this year, however, nominations will be accepted in the Individual Achievement Category for domestic and international nominees. In addition, a new category has been added for initiatives related to International Patient Safety and Quality.

The accomplishments of award nominees must be focused on one or more of the following: improving patient safety or the quality of health care, leadership in advancing methods for measuring and reporting health care quality, expanding the public's capacity to evaluate the quality and safety of health care, and promoting health care choices based on information about safety and quality.

Awards are not necessarily given in each category every year, and more than one award could be presented in a given category. An award panel of outside experts in patient safety and health care quality select the recipients.

Completed nomination forms may be mailed to the attention of Linda Hanold, director, Department of Quality Measurement and Research, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL 60181. The 2009 awards will be presented at NQF's National Policy Conference Oct. 14-16 in National Harbor, MD. ■

Joint Commission to refine med reconciliation goal

As of Jan. 1, 2009, The Joint Commission (TJC) is evaluating and refining National Patient Safety Goal (NPSG) 8 related to medicine reconciliation. It is taking this step due to the difficulty required for implementation, TJC indicated.

While the goal is being evaluated, survey findings related to the goal will not affect the accreditation decision for hospitals and surgery centers.

Survey findings on the goal will not generate Requirements for Improvement and will not appear on the accreditation report. TJC said in a released statement that "an improved NPSG 8 will be crafted that both supports quality and safety of care and can be more readily implemented by the field in 2010." ■