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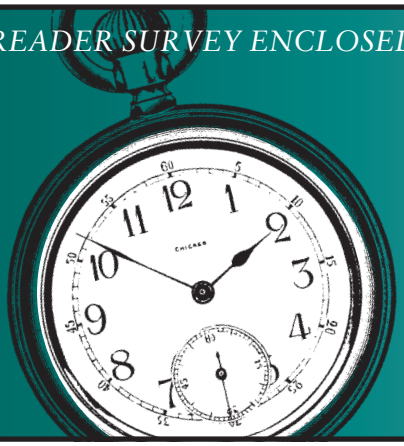

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How to handle a complaint of sexual harassment by staff

Recent cases raise awareness of manager's role

[Editor's note: This issue of Same-Day Surgery features a special focus on sexual harassment, bullying, and other intimidating behavior. In terms of sexual harassment, we focus on recent cases among ambulatory staff and what lessons are to be learned. In our stories on bullying and intimidating behavior, we focus on accreditation requirements as well as practical solutions developed by health care providers.]

A pain center holds a holiday party. Afterward, while the group is waiting for a limousine ride to a nightclub, a receptionist claims one of the physicians patted her read end. At the club, the physician forcefully grabbed her, injuring her arm, to try to get her to dance with him, then screamed when she refused, she says. She filed a police report. The receptionist says she was afraid to return to work afterward and notified her supervisor several times. When she did return a few days later after the physician left for a trip, she was fired for failing to show up for work. She claims she was sexually harassed and has sued the center.

In another case, a surgical tech claims that an anesthesiologist showed up

EXECUTIVE SUMMARY

Managers can be held liable for not preventing sexual harassment, even from outside vendors.

- In addition to having a policy that allows reporting with no fear of retribution, establish a zero tolerance atmosphere for sexual harassment by staying engaged with your staff.
- Provide ongoing education. Ensure you and your staff know what constitutes sexual harassment.
- Investigate all complaints, even when there are no witnesses.

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a work visibly intoxicated and referred to the tech as his boyfriend. The tech says the doctor asked if he could kiss him, and then kissed him even after he refused. The anesthesiologist also fondled him and made remarks that were vulgar, the tech claims. He said he reported the incident to supervisors, and nothing was done. A sexual harassment lawsuit is being field against the surgery center and the anesthesia group.

"Assuming the assertions of improper conduct are true, both cases illustrate how physicians can exploit their organizational power and authority to engage in unwanted and inappropriate behavior," says **Paul B. Hofmann**, DrPH, FACHE, president of the Hofmann Healthcare Group in Moraga, CA, which consults on ethical issues in health care and specializes in performance improvement efforts. "Furthermore, if evidence is presented that management knew or should have known that either of these physicians exhibited a previous pattern of unacceptable behavior and such conduct was permitted, then their organizations will have significant legal exposure."

Such incidents might not be isolated. In Fiscal Year 2009, there were 12,696 sexual harassment cases filed with the Equal Employment Opportunity Commission.[1] Complaints in health care settings seem to be more common than in other environments, says **Elizabeth G. Russell,** JD, partner at Kreig DeVault in Indianapolis, IN. "There seems to be more sexual banter in that environment," Russell says. "I think it's just because they deal with bodies all the time, they get desensitized to it. It's much more prevalent than in the office setting."

Simply having a policy might not be sufficient to stop sexual harassment, Hofmann says. "Some victims feel so intimidated and vulnerable that they are reluctant to notify their supervisor, another member of management, or the human resources department, particularly when they fear retaliation and/or lack confidence in obtaining a prompt and appropriate response," he says.

There is strict liability for employers if there is adverse employment action as a result of sex harassment by a supervisor to a subordinate, according to Russell. "The question is did the employer know or was it so patently obviously that the employer should have known," she says. If all middle managers know, and no one told the decision makers, that situation puts the facility at risk, Russell says. "That's why it is so important to educate your managers about what is and isn't sexual harassment, and they need to report anything that they think constitutes sex harassment so employers can investigate and help remediate the situation." *(For information on what sexual harassment is and isn't, see story, p. 51.)*

Employers are also responsible for the actions of non-employees, such as consultants, contractors, or vendors, who harass employees if the employer or its supervisors knew or should have

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Associate Publisher: Coles McKagen (404) 262-5420 (coles.mckagen@ahcmedia.com).
Senior Managing Editor: Joy Daughtery Dickinson (229) 551-9195 (joy.dickinson@ahcmedia.com).
Director of Marketing: Schandale Kornegay.
Production Editor: Ami Sutaria.

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

known of the conduct and failed to take immediate corrective action, Russell says. "Employers are responsible for providing a harassment-free work environment," she says.

How do you stop if from starting?

Provide zero tolerance for sexual harassment by engaging your employees, advises **Col. Keith Essen**, RN, MSN, MSS, deputy commander of nursing at Madigan Army Medical Center in Tacoma, WA. Essen spoke on disruptive staff at the recent annual Congress of the Association of periOperative Registered Nurses (AORN).

For example, consider an employee who tells a joke that's not conspicuously bad, but it sets the wrong tone, Essen says. "If [the manager] ignores it, that give tacit approval for that behavior to persist, and all of sudden it can go up to the next notch," he says.

Managers also must establish and implement appropriate policies and procedures to facilitate the timely reporting of unacceptable behavior, including provisions that encourage such reporting without fear of retribution, Hofmann says. Essen agrees. "You must have a system that allows a person to go against the power gradient," he says.

Managers also must conduct periodic educational programs to ensure that all staff members are aware of what constitutes sexual harassment and how to address it, Hoffman says.

Essen agrees and adds, "if you don't educate, if you don't perpetually intervene, you don't get the drift that goes into disaster."

Education itself is a form of intervention, Essen maintains. "It enlightens people," he says. "They have to be sensitized, and resensitized, and resensitized, to keep people focused and vigilant. That's the key thing."

Take all allegations of sexual harassment seriously and support immediate and fair investigations of these complaints, Hofmann advises. Don't dismiss complaints by taking the accused party's word without an investigation, Russell agrees. "A lot of people think, where there's smoke, there's fire," she says. If you're receiving a number of complaints about a member of your staff, investigate even if there are no witnesses, she says.

Also, deal promptly with the findings of any investigation, Hofmann says. The safety of your staff, and your patients, might depend on it, Essen says. "Dealing with the milieu of health care, anything that corrodes or suppress communication ultimately becomes a danger to the patient," he says. *[A copy of a sexual harassment policy is enclosed with the online issue of Same-Day Surgery. For assistance, contact customer services at (800) 688-2421 or customerservice@ahcmedia.com.]*

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What behavior is sexual harassment?

There are two types of sexual harassment.

One is quid pro quo, which typically involves a supervisor or a subordinate. "In this case, 'if you do this sexual favor for me, I will advance your career,'" says **Elizabeth G. Russell**, JD, partner with Kreig DeVault, Indianapolis, IN. Alternatively, it can be a situation in which "I will do something to hurt your career" if you don't participate, Russell says.

The other situation is a hostile work environment, which is much more common, Russell says. "It's an environment where an employee feels so uncomfortable in performing her job that because of actions or attitudes taken toward her, it interferes with her ability to do her job," she says. Such actions can include Internet communication, texting, and forwarding or posting intimidating jokes, photos, or stories, sources say.

Sexual harassment can be caused by a male or female, Russell says.

Sexual harassment is not stray remarks or an occasional off-color joke, Russell says. "Those don't rise to the level of sexual harassment," she says. It has to be pervasive, and it has to be repetitive, Russell says. "I think the courts recognize that there may be some horse play, some joking that may be offensive to some, but it doesn't rise to level of interfering with someone's ability to do the job."

Any touching, however, is much more likely to be defined as sexual harassment, Russell says. ■

Bullying takes toll on staff and patients

Joint Commission: Zero tolerance for intimidation

Compared with carcinogenic chemicals and infectious diseases, workplace bullying might seem like more of an annoyance than a health risk. Yet bullying is a hazard in health care that is linked with poor outcomes for employees and patients alike. Workplaces that allow bullying and intimidation suffer from low satisfaction ratings as well as injuries and poorer patient care.

Concern about bullying was strong enough to inspire new performance requirements in the leadership standards of The Joint Commission. As of 2009, accredited hospitals and surgery centers must have a code of conduct that defines "acceptable and disruptive and inappropriate behaviors" and must have a process for dealing with the inappropriate behaviors. *(For more information, see the following stories in the October 2008* SDS Accreditation Update, *"Are you prepared to address 'health care road rage'? Jan. 1 deadline is looming for TJC," p. 1, "Steps to developing a code of conduct," p. 2, and "Why does surgery setting lead to more outbursts?" p. 3.)*

The standards apply to managers and employees alike, as well as to physicians. They are an important aspect of the leadership standard that calls for hospital leaders to create a culture of safety, says Joint Commission senior vice president **Paul Schyve**, MD.

Intimidating behavior "destroys the culture of safety," he says. "If you want to have consistent safety, you need to have a culture of safety. There is a cycle of being able to report [errors], to talk about things, to trust that it won't be held against you, but in fact will be used to make improvements."

The Joint Commission's strong stance is bolstered by recent studies that reveal the impact of workplace bullying. For example, researchers at the University of Illinois at Chicago found that higher levels of workplace harassment were associated with illness, injury, and assault. Other stress factors, such as not having as much decision-making latitude, did not have the same link.[1]

"Sometimes you're going to feel overwhelmed or not have enough time, but you don't expect someone to yell at you or swear at you," explains **Kathleen Rospenda**, PhD, associate professor of psychology at the University of Illinois at Chicago.

Bullying does not differ by gender; men are as likely to be bullied as women, studies show. But unskilled employees and those who work with clients or patients, including health care workers, face higher rates of bullying, one study showed.[2]

The stress in health care, particularly coupled with staffing constraints, might set the stage for intimidation and retaliation, says **Evie Bain**, RN, MEd, COHN-S, FAAOHN, associate director and coordinator of the Health and Safety Division of the Massachusetts Nurses Association in Canton. "It's part of the whole violence spectrum we see in health care," Bain says.

The bottom line: When a physician blows up at a nurse or a supervisor belittles an employee, it is not just a clash of personalities or a reaction to a stressful day. **Loraleigh Keashly**, PhD, associate professor in the department of communication at Wayne State University in Detroit, says, "We argue that workplace bullying is a systemic issue, not a purely personal one." Keashly has researched workplace bullying and directs a graduate program in dispute resolution.

The Joint Commission requires accredited organizations to educate health care workers at all levels and to adopt a "zero-tolerance" stance toward the worst behaviors. *(For suggestions from The Joint Commission, see story, p. 55.)*

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The ins and outs of bullying at work

Bullying often stems from a power play: a more powerful person acting aggressive or asserting his or her control over someone else. But co-workers also can intimidate.

"If you look at the statistics, the studies have tended to show that it's more likely to come from somebody higher in the hierarchy," says **Paul Schyve**, MD, senior vice president of The Joint

Commission. "But it's actually widespread across all levels, including from nurse to nurse. Any time it occurs, no matter what the relation is, [bullying] will decrease the trust of the culture."

Bullying and intimidation are widespread. Based on research literature, 10-14% of the working population in the United States was exposed to workplace bullying in the past 12 months, says **Loraleigh Keashly**, PhD, associate professor in the Department of Communication at Wayne State University in Detroit. Even those who are not the direct target of the aggression are negatively affected, Keashly adds.

Meanwhile, failing to act to stop aggression or harassment in the workplace just leads to more of the same, she says. "I think some people start taking on these behaviors because there are no consequences and it's permitted," Keashly says.

Changing the organization's culture isn't easy. That's why The Joint Commission released the new performance standards about 18 months before they became effective. Now when surveyors visit hospitals, they look for the written code of conduct, and they ask employees if they feel they can speak up about concerns, errors, or near-misses without fear of retribution, says Schyve.

The Joint Commission does receive complaints. "We continue to have reports of intimidating behavior," says Schyve. "Changing the culture in this way is not something that happens overnight."

There are effective steps that can be taken, by staff and leaders at health care organizations. Keashly learned of one surgical unit that addressed rising hostility and tension. Anyone on the surgical team could yell out, "Tempo!" Everyone then would tone down their behavior. "It's a very gentle way of letting someone know that everyone needs to stop and look at their behavior, because we're heading on the wrong track," says Keashly.

In another case, nurses created a "code white." If a nurse was being mistreated by a physician, a nurse would call out a "code white," and the location on the address system and available nurses would gather to observe. Their presence alone would support the nurse who was being intimidated and would put the physician on notice to moderate his or her behavior. *(For more steps to address bullying and intimidation, see story, right.)*

Veterans Affairs is taking a systemic approach to improving civility through its program called CREW (Civility, Respect, and Engagement in the Workplace). (*For a profile of the CREW system,* *see story, p. 54.)* "An organization can have a profound influence on the quality of the working environment," says Keashly.

Take 4 steps to stop bullying, intimidation

Managers should take the following steps address bullying and intimidation in the workplace:

• Look for indications of human resource problems.

A department with unusually high levels of sick leave or turnover might warrant a closer look, says **Loraleigh Keashly**, PhD, associate professor in the Department of Communication at Wayne State University in Detroit. Job satisfaction surveys might be one way to monitor the workplace climate, Keashly adds.

• Allow for informal feedback.

Ideally, employees work with a team approach and feel comfortable airing their concerns. For example, some departments might begin a shift with a short "huddle" in which employees can raise issues. But informal mechanisms also are valuable, says Keashly. That includes peer advisers or ombudsmen, who can be a conduit to management and can provide confidentiality to the employee bringing the concern. Some health systems have contracted with outside providers, such as EthicsPoint of Lake Oswego, OR (www.ethicspoint.com), to provide a confidential reporting hotline.

• Be prepared to take action, when necessary.

The policy should apply to all members of the health care team, from physicians to nurses to managers, says **Paul Schyve**, MD, senior vice president of The Joint Commission. "Sometimes there's a tendency to take more severe action against a nurse than against a physician who is bringing in patients," Schyve says. "For this to really be a culture in which there is trust, it needs to be just. 'Just' means you need to treat people equally."

• Take a proactive approach.

Don't just respond to problems when they arise, but actively seek to build a collaborative atmosphere that encourages openness, says Schyve.

"If you're trying to create a culture of safety, you as the leaders need to really be on top of this issue," he says. ■

Joining the CREW builds civility at VA

Culture change being better outcomes

You can't just mandate a civil workplace. You have to build one.

That is what the Veterans Affairs (VA) health system is doing, one unit at a time. Today, more than 750 units at 150 facilities have adopted Civility, Respect, and Engagement in the Workplace (CREW), a program that is supported by psychologists and specialists in culture change at the VA's National Center for Organization Development in Cincinnati.

CREW pays off in better outcomes, says **Linda Belton**, FACHE, director of organizational health at the Veterans Health Administration in Ann Arbor, MI. "The higher the level of civility in your work unit, the lower your sick leave . . . [and you have] lower EEOC [Equal Employment Opportunity Commission] complaints, higher employee satisfaction, higher patient satisfaction," Belton says. Units are also more likely to meet their performance requirements and be safer, she says.

CREW began in 2005 with a pilot project involving eight units at eight facilities. "It's really engaged around the people you work with every day," says Belton.

It begins with a commitment of support from hospital leaders, in writing. The facility conducts an assessment, which includes a short Civility Scale given to the unit's members. *(See Civility Scale, right.)* The items are rated on a 5-point scale from strongly disagree (1) to strongly agree (5).

Facilitators or "champions" from the unit attend face-to-face training sessions and provide monthly updates via phone calls and written reports. The unit also has regular CREW meetings, which are a critical aspect of the program, says Belton. "[Employees] are asked their opinions. They're given a platform, sometimes for the first time in their employment," she says. "We talk about having honest conversations where you can say the difficult things that need to be said."

In one unit, for example, a physician aired a gripe about how long it took nurses to retrieve an EKG machine when a patient was crashing. The physicians envisioned nurses walking slowly despite the dire need. A nurse explained that they literally ran across the multi-acre campus to borrow the machine from the emergency department. As a result of the conversation, the unit requested the purchase of an EKG machine, which was approved.

No one had ever realized that solving the problem would be that easy, says Belton.

CREW does not specifically address intimidation and bullying; its focus is on the positive. "We visualize what civil behavior is and that's what we go for," she says.

There are some cases in which an individual is causing problems on a unit. That must be dealt with through human resources procedures, Belton says.

CREW simply sets the stage for a workplace that values respectfulness. "If you can create that environment where people have honest conversa-

Civility Scale

Rate the following items on a 5-point scale from strongly disagree (1) to strongly agree (5):

- ☐ Respect: People treat each other with respect in my workgroup.
- ☐ Cooperation: A spirit of cooperation and teamwork exists in my workgroup.
- ☐ Conflict resolution: Disputes or conflicts are resolved fairly in my workgroup.
- ☐ Co-worker personal interest: The people I work with take a personal interest in me.
- ☐ Co-worker reliability: The people I work with can be relied on when I need help.
- ☐ Antidiscrimination: This organization does not tolerate discrimination.
- ☐ Value differences: Differences among individuals are respected and valued in my workgroup.
- ☐ Supervisor diversity acceptance: Managers/supervisors/team leaders work well with employees of different backgrounds in my workgroup.

Source: Veterans Health Administration in Ann Arbor, MI.

tions, some level of trust and respect one another, then they're less likely to engage in bullying and they're less likely to permit bullying to occur," she says. "A healthy organization is a place where patients want to come to receive care and employees want to work."

Attaining a culture change by working with one unit at a time might seem like a long, slow process. But eventually, the entire organization has a new climate, Belton says. "When you have a certain percentage of your work units participating in CREW, that becomes a tipping point," she says. "Satisfaction and other metrics go up all around the facility." ■

Joint Commission offers advice on action steps

16 tips on intimidating behavior

[Editor's note: While the Accreditation Association for Ambulatory Health Care (AAAHC) does not have standards specifically related to bullying/intimidating behavior, this issue falls under their general administration and governance standards.]

The Joint Commission suggests accredited organizations take actions to address the issue of bullying and intimidation:

• Educate all team members — both physicians and nonphysician staff — on appropriate professional behavior defined by the organization's code of conduct. The code and education should emphasize respect. Include training in basic business etiquette (particularly phone skills) and people skills.

• Hold all team members accountable for modeling desirable behaviors. Enforce the code consistently and equitably among all staff regardless of seniority or clinical discipline. Enforce it in a positive fashion through reinforcement as well as punishment.

• Develop and implement policies and procedures/processes appropriate for the organization that address.

• Allow "zero tolerance" for intimidating and/or disruptive behaviors. Zero tolerance is especially important with the most egregious instances of disruptive behavior such as assault and other criminal acts. Incorporate the zero-tolerance policy into medical staff bylaws and employment agreements as well as administrative policies.

• Develop medical staff policies regarding intimidating and/or disruptive behaviors of physicians within a health care organization that are complementary and supportive of the policies that are present in the organization for nonphysician staff.

• Reduce fear of intimidation or retribution and protect those who report or cooperate in the investigation of intimidating, disruptive, and other unprofessional behavior. Nonretaliation clauses should be included in all policy statements that address disruptive behaviors.

• Respond to patients and/or their families who are involved in or witness intimidating and/or disruptive behaviors. The response should include hearing and empathizing with their concerns, thanking them for sharing those concerns, and apologizing.

• Determine how and when to begin disciplinary actions such as suspension, termination, loss of clinical privileges, and reports to professional licensure bodies.

• Develop an organizational process for addressing intimidating and disruptive behaviors that solicits and integrates substantial input from an interprofessional team including representation of medical and nursing staff, administrators, and other employees.

• Provide skills-based training and coaching for all leaders and managers in relationship-building and collaborative practice, including skills for giving feedback on unprofessional behavior, and conflict resolution. Cultural assessment tools also can be used to measure whether attitudes change over time.

• Develop and implement a system for assessing staff perceptions of the seriousness and extent of instances of unprofessional behaviors and the risk of harm to patients.

• Develop and implement a reporting/surveillance system (possibly anonymous) for detecting unprofessional behavior. Include ombuds services and patient advocates, both of which provide important feedback from patients and families who might experience intimidating or disruptive behavior from health professionals. Monitor system effectiveness through regular surveys, focus groups, peer and team member evaluations, or other methods. Have multiple and specific strategies to learn whether intimidating or disruptive behaviors exist or recur, such as through direct inquiries at routine intervals with staff, supervi-

sors, and peers.

• Support surveillance with tiered, nonconfrontational interventional strategies, starting with informal "cup of coffee" conversations directly addressing the problem and moving toward detailed action plans and progressive discipline, if patterns persist. These interventions initially should be nonadversarial in nature, with the focus on building trust, placing accountability on and rehabilitating the offending individual, and protecting patient safety. Make use of mediators and conflict coaches when professional dispute resolution skills are needed.

• Conduct all interventions within the context of an organizational commitment to the health and well-being of all staff, with adequate resources to support individuals whose behavior is caused or influenced by physical or mental health pathologies.

• Encourage interprofessional dialogues across a variety of forums as a proactive way of addressing ongoing conflicts, overcoming them, and moving forward through improved collaboration and communication.

• Document all attempts to address intimidating and disruptive behaviors. ■

Marketing director boosts volume 8%

(Editor's note: This is the second part of a two-part series on the benefits of a marketing director for a surgery center. In this issue, we tell you about the benefits of having a full-time director with a marketing background. In last month's issue, we told you about the successes of a former RN who increased referrals while working part-time as the marketing director.)

Despite a difficult economy, Lakeland (FL) Surgical & Diagnostic Center (LSDC) has managed to steadily increase its case volume 8% annually with the help of a full-time marketing director. The ambulatory surgery center (ASC) also has received national recognition for its patient satisfaction scores.

David G. Daniel, FACHE, CEO, says he understand that many surgery centers consider having a full-time marketing director to be a luxury that can be afforded only by the largest, busiest, and most profitable centers. "However, even if we were much smaller, I would still highly recommend at least a part-time person dedicated to the marketing role, since keeping the physicians and their office staff content and informed is absolutely critical to the uninterrupted patient flow to your facility, as well as the patient satisfaction follow-up, community involvement, and all the other small, but very significant, marketing and promotion activities which would be overlooked and not done, if it was not for a dedicated marketing professional's attention," Daniel says. "Dedicated marketing in an ASC always pays for itself through physician and patient satisfaction, increased volume, and enhanced community exposure."

Jill Daly, the center's director of marketing, came to the center from a position as marketing director at a local hospital. "She intimately knows, understands, and appreciates all the local health care leaders and the inter-relational politics, which is invaluable," Daniel says. "Because she is a marketing professional and not a clinician who is trying to do marketing 'on the side,' she brings much more to the table in exactly how to approach this task in order to get the best results."

However, if you can only arrange for a part-time clinician to do part-time marketing, "that is still much better than having no marketing at all, and trying to 'wing it' by the seat of your pants," Daniel says. "You really get what you pay for here."

Daly's responsibilities include:

• Marketing to physicians and local employers.

Daly says, "The biggest key is knowing your competition, knowing your community, and building those relationships with physicians and group practices."

Her relationship with referring physicians is so strong that they even offer testimonials on the center's web site (www.lsdc.net). "It is great for first-time patients who are visiting our site and read that their physician is so pleased with our facility, the quality of care their patients receive, and our

EXECUTIVE SUMMARY

Lakeland (FL) Surgical & Diagnostic Center has increased its case volume 8% annually and received national recognition for its patient satisfaction, with the help of a full-time marketing director.

• The marketing director is the liaison with the physicians' offices to ensure they know about changes and new services.

• The center sends each patient a preprinted thank-you card with signatures of every staff member who cared for that patient.

efficiency, which in turn, puts the patients' minds at ease," Daly says.

She also is responsible for marketing to local employers thorough employee health fairs. Daly gives out brochures about the facility, and her booth provides a special clinical focuses during times such as breast cancer awareness month (October) and colon cancer awareness month (March).

• Communicating regularly with physician offices.

Daly works closely with the referring physicians' offices to ensure there are no communication breakdowns, Daniel says.

"She meets periodically with all the physician office staff to answer any questions that they may have or address any problems or concerns regarding getting their patients scheduled and properly served by the LSDC," he says. "Without a marketing director concentrating her time and attention on the needs and desires of our physicians and office staff, communication breakdowns would occur and patient volume would surely suffer."

Her responsibilities ensure that the office staff have the paperwork, tools, and knowledge of the center for a "seamless appointment schedule" when referring patients, Daniel says.

Daly is in a physician's office every 2-3 days, she says. She also attends monthly staff meetings at those group practices. "If we've had any changes in paperwork or referral process, I'm the liaison to let them know what changes have happened and what they need to do to ensure it won't interrupt their referral process," Daly says. "I tell them about any changes with managed care contracts." She also helps copy any forms they need.

• Focusing on patient satisfaction.

Daly performs a weekly review of patient satisfaction surveys and follows up patient comments with phone calls and personal letters as needed.

The center also sends preprinted thank-you notes to each patient with signatures of every staff person who cared for them. "It speaks volumes having thank you notes," Daly says. "You'll be out in public and you'll hear, 'can you believe they sent me a thank you card for visiting their facility?'" The idea has been so successful that their competitors have adopted the idea.

"Our best marketing tool is our patients," Daly says. "When they leave satisfied, they will tell neighbors and loved ones, which is what I hear continually."

Daly posts quarterly results from the patient satisfaction surveys and also posts comments when patients recognize specific staff members and physicians. "Employees really enjoying seeing what our patients say about us, and it gives them a feeling of accomplishment, that what we do as an organization truly matters," she says.

Her efforts have paid off. In September 2009, the center received one of 23 Apex Quality Award for Healthcare Excellence given nationally by CTQ Solutions in Branford, CT. The award is given for consistently achieving the highest level of excellence in patient satisfaction.

• Recognize outstanding employees.

Daly oversees the employee recognition program, called the STAR (Special Thanks And Recognition) program that awards employees who go above and beyond the normal scope of duties.

Staff receive a point in areas such as perfect attendance, service on a committee, submission of a cost-saving ideas or safety suggestions, completion of a degree or certification, teamwork beyond their normal scope of responsibility, or internal/external customer service. Staff can be recognized by employees, physicians, patients, or family members of patients. At quarterly staff meetings, everyone who has been recognized is entered into a drawing for items such as restaurant gift cards, logo apparel, and umbrellas. Three names are drawn at each meeting. Employees also can track their points and use them to purchase these items.

Such programs help boost the staff's morale and the center's image, Daly maintains. "Know your community," she says. "Know what keeps your physicians, staff, and patients happy and satisfied."

Marketing in today's ASC is not a "fluff" job that should be considered a luxury, Daniel says. "It is integral to the success and viability of your organization and will pay off in big dividends, if used and employed appropriately," he says. "The return on investment is huge, and unfortunately not fully appreciated, understood and utilized." ■

SAME-DAY SURGERY MANAGER

'May you live in interesting times'

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

The euphemistic statement "may you live in interesting times" is believed to be an ancient

Chinese curse. There is another one that I also think is interesting: "May you come to the attention of those in authority." To me, that statement is probably just as scary as the "interesting times!" Sounds like an IRS audit doesn't it?

Speaking of mixed meanings.... everyone who reads this will be affected by the new health care reform bill signed in March. I suppose, like most, you just don't know how. But it will be interesting.

As best I can tell, no one actually has read it or fully understands all the implications, individually and career-wise. In the meantime, life goes on. For at the least the next several years, nothing is going to change for any of us. But that doesn't mean that we can put our heads in the sand. Read on!

When the government gets as intrusive in anything as it is going to get with health care, one can always expect more paperwork. While there might not be immediate changes, extra reports and data collection are always a threat. Start gearing up for that eventuality

Much of the employer/employee insurance requirements focus on the "more than 50 employees" rule, which simply put, says starting in 2014, our new boss will fine the employer for not providing health care insurance for employees if you have 50 or more employees. This means that if you are the 51st employee added to your new job, well... you might want to be careful. I predict that many small businesses will make sure they reduce to that threshold.

Clearly reimbursement is not going to increase. Paperwork and significantly higher health insurance is going to force most businesses -- us included -- to be more efficient in what we do. Strongly consider finding out just how efficient you are now, and look at ways to tighten up. (Editor's note: For a special package of cost-cutting ideas, see the January 2010 issue of Same-Day Surgery.) Reconsider keeping those employees whom you cannot figure out where they are and what they do. Be realistic; you all have them!

For hospitals, be prepared to address your surgeon issues about decreasing reimbursement for their professional fees. Since it became obvious that the health care reform bill was going to pass in mid-March, our phones have been ringing off the hook with surgeons thinking they need to become investors in existing surgery centers or develop their own. As a hospital outpatient department, you do not have the luxury of financial incentives to counter the ASC industry, so you need to really tout your efficiencies and other services. This would not be a good time to have idle employees and long turnover times between cases!

If you are an existing surgery center with surgeon investors, you really need to tighten your belts and weigh your options. Ninety-five percent of the calls we have received in the past month are from surgeons who cannot buy into an existing surgery center because there are no more shares available. This situation is forcing most of them to start a new one. A strong strategy will be to free up as much ownership opportunity as possible to new surgeons or to those who have been hounding you for more equity. Construction costs, surprisingly, are low right now due to the struggling economy, so this is a good time for many of your potential investors to develop their own center. Don't let them!

So ... an interesting time is upon all of us. Never one for the status quo, I will admit to rubbing my hands together with glee at the opportunity to make a difference in this exciting new era of health care. What was it that Forrest Gump said? "Life is like a box of chocolates...?" Open the box and enjoy the ride! *[Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Contact Earnhart at 13492 Research Blvd., Suite 120-258, Austin, TX 78750-2254. E-mail: searnhart@earnhart.com. Web: www.earnhart.com. Tweet address: Earnhart_EAI.]* ■

Economy sparks interest in device reprocessing

Most outpatient surgery providers would like to do business in a way that is good for the environment, but it certainly is a plus when going green also delivers cost-savings. That is precisely what many hospitals have found to be the case with the reprocessing of medical devices.

Phoenix-based Banner Health, for example, saved more than $2 million by reprocessing medical devices last year, and it pocketed an additional $30,000 in savings in waste-removal avoidance, according to Sarah Remington, Banner Health's environmental compliance coordinator.

"We were able to avert about 62,000 pounds of waste," Remington says.

While Banner Health has been reprocessing medical devices for a decade, many hospitals are effectively leaving cash on the table by not hav-

EXECUTIVE SUMMARY

Phoenix, AZ-based Banner Health saved more than $2 million dollars last year by reprocessing medical devices. The approach also saved the health system an additional $30,000 in waste removal costs. Industry experts say some large hospitals can save millions of dollars by reprocessing devices, but implementing such a program requires commitment and compliance.

• Buy-in throughout the organization is key to the implementation of a successful program.

• Reprocessed devices typically cost about half that of new devices.

ing such a program in place or by not fully realizing all the savings that they could be achieving, according to commentary in the March 2010 issue of *Academic Medicine*.[1] In that piece, the authors maintain that health care facilities have been slow to adopt the reprocessing of medical equipment because of misconceptions regarding safety as well as the process involved with recycling medical devices. The article noted that in 2002, only about one-quarter of U.S. hospitals reprocessed at least one type of single-use device (SUD), but it further noted that the current economic squeeze is prompting many more providers to consider reprocessing medical equipment because these devices cost roughly half as much as new medical devices.

The Association of Medical Device Reprocessors (AMDR), based in Washington, DC, concurs and indicates that in 2010, more than two-thirds of all U.S. hospitals are reprocessing at least some of the medical devices that they use. "We are serving over 4,500 individual facilities," explains **Daniel Vukelich**, Esq., the president of AMDR.

An average-sized hospital can achieve savings in the area of $500,000 per year from the reprocessing of medical equipment, Vukelich says.

Stringent standards answer safety concerns

While some facilities formerly performed their own reprocessing, more stringent Food and Drug Administration (FDA) oversight of reprocessed medical equipment, implemented in 2002, made in-house reprocessing impractical, says Vukelich. However, such standards have gone a long way toward alleviating concerns about safety.

Winning over surgeons and other clinicians can be a challenge, however.

In fact, with her background as an operating room nurse, **Dee Whittington**, RN, BSN, CNOR, a clinical supply manager at Banner Health, was a "doubter" about reprocessed devices until she toured a reprocessing facility and witnessed firsthand how the equipment is broken down into parts, sterilized, and scrutinized. "We are taught that 'single use' means 'single use,'" Whittington says. "So it really took an impressive display for [the reprocessing facility] to not only change my mind, but make me an advocate by the time I was done with the tour."

Mergers and acquisitions within the reprocessing industry have drastically reduced the number of reprocessing companies. Today, Vukelich notes that just two companies, Ascent Healthcare Solutions, based in Phoenix, and SterilMed, based in Minneapolis, handle about 95% of all third-party reprocessing in the United States.

Between 10% and 50% of the medical reprocessing business involves devices that have been taken out of their packaging but have never been used.

REFERENCE

1. Kwakye G, Pronovost P, Makary M, et al. A call to go green in health care by reprocessing medical equipment. *Acad Med* 2010; 85:398-400. ■

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.

COMING IN FUTURE MONTHS

- ASC infection control under attack – How to fight back
- Do workers infected with HIV or hepatitis pose a risk?
- Profitable new ambulatory surgery procedures
- Latest benchmarks for ambulatory surgery

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.

17. Is the following statement true or false? Employers are also responsible for the actions of non-employees, such as consultants, contractors, or vendors, who harass employees if the employer or its supervisors knew or should have known of the conduct and failed to take immediate corrective action, according to Elizabeth G. Russell, JD, partner at Kreig DeVault.
A. True
B. False

18. Which of the following could be considered sexual harassment, according to Russell?
A. Stray remarks or occasional off-color jokes.
B. Behavior that is pervasive and repetitive.
C. Horse play or joking that might be offensive to some staff.
D. All of the above.
E. None of the above.

19. Researchers at the University of Illinois at Chicago found that higher levels of workplace harassment were associated with which of the following?
A. Illness
B. Injury
C. Assault
D. All of the above
E. None of the above.

20. What convinced Dee Whittington, RN, BSN, CNOR, a clinical supply manager and former OR nurse at Banner Health, to have devices from her facility reprocessed?
A. She read the reports on this issue from the Government Accountability Office (GAO).
B. She contacted other facilities that were reprocessing.
C. She toured a reprocessing facility and witnessed firsthand how the equipment is broken down into parts, sterilized, and scrutinized.

Answers: 17. A. 18. B 19. D 20. C.

SDS ACCREDITATION UPDATE

Covering Compliance with The Joint Commission and AAAHC Standards

Biggest problem area for surgery centers? Maintaining records for waived testing

Last year, the highest area of noncompliance for ambulatory surgery centers accredited by The Joint Commission was Waived Testing 05.01.01, the organization maintains records for waived testing. It was the highest area of noncompliance for surgery centers. Eighteen percent of all ambulatory surgery centers were found noncompliant.

Element of Performance (EP) 3 says that the quantitative test result reports in the clinical record for waived testing are accompanied by normal values specific to the test, method (machine), and the population.

"For example, blood sugars would be accompanied by normal values specific to that test," says **Virginia McCollum**, MSN, RN, associate director of the Standards Interpretation Group at The Joint Commission.

There is a difference in the normal values for an adult population and a pediatric population, McCollum points out. "This [type of information] needs to be documented on the same page as the test result, or located somewhere within the permanent clinical records," she says.

Semi-qualitative results, such as urine macroscopic and urine dipstick, are not required to comply.

Surgery centers might be using references ranges for their labs, McCollum says. Reference ranges have to be specific to the machine and the test being performed, she says. For example, the reference range for a glucometer might not be the same as the reference range for another lab, she says.

Machines can be bought and sold, or replaced, McCollum says, but the reference ranges have to be specific to the machine being used. Usually the normal values can be placed in parenthesis on the report sheet, she says. "The solution is to do that where they record the waived testing," McCollum says.

You can add such information to your common tests, such as blood sugars, she says. "Once they put it on the form they use, they never have to think about it again," McCollum says.

This information has to be available in the record, she says. "But five years from now, you don't know `normal' for that machine at the time you did the test," she says. When blood is sent to a reference lab, the reply always has a reference

EXECUTIVE SUMMARY

In 2009, the two highest areas for ambulatory surgery center noncompliance with The Joint Commission requirements were maintaining records on waived testing (18%) and labeling medications (14%).

- Normal values must be specific to the test, method (machine), and the population.
- When labeling medications, there are no exceptions when the products are easily recognizable, when only one product is used,
- The only exception is when the medication is drawn up and given directly to the physician or patient with no interruptions.

Financial Disclosure:
Senior Managing Editor Joy Dickinson, Associate Publisher Coles McKagen, and Board Member and Nurse Planner Kay Ball report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.Consulting Editor Mark Mayo reports that he is an Administrative Consultant to USPI Chicago Market. Steven Schwaitzberg, MD, Physician Reviewer, discloses that he is on the speakers bureau for Stryker Corp. and Merck & Co., he is a medical advisor to Surgiquest, and he is a stockholder in Starion Instruments.

range, but that range is related to the way the test is performed, McCollum says. "It's confusing, because it's often similar for the test," she says.

Also, staff should know who reviews the test results, what to do with the results that are out of range, who receives a report about out-of-range results, and what the response should be, sources say.

No. 2 problem? Labeling meds

Fourteen percent of surgery centers were noncompliant with National Patient Safety Goal (NPSG) 03.04.01 label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.

EP 1 clarifies that the NPSG applies in perioperative and other procedures settings, both on and off the sterile field, and applies to medications and solutions that are not immediately administered.

If a medication is prepared or obtained and taken directly to the patient, and it's administered without any break in the process, you don't have to put a label on it, says McCollum.

However, this exception is strictly interpreted to mean no interruptions, says **Elizabeth Norton**, BSN, RN, CNOR, manager of OR patient safety and quality at Children's Hospital Boston. Norton spoke on patient safety at the most recent annual meeting of the Association of periOperative Registered Nurses (AORN). If a clinician gets stopped to have a conversation, or the phone rings, or they get distracted prior to administering a unmarked medication, that would cause a citation from The Joint Commission because that's an interruption, Norton says. In the OR, if a surgeon asks for specific medication that is not already on the sterile field, the medication can be drawn up and verified between the scrub and circulator, then handed to the surgeon for immediate administration to the patient, Norton says. That would be an exception to labeling. "However if there is time, it is always best practice to place the label," she says.

EP 2 clarifies that labeling occurs when any medication or solution is transferred from the original packaging to another container. All containers, including syringes, medicine cups, and basins, must be labeled, McCollum emphasizes.

Labels should include the full name of the medication/solution and the concentration, Norton says. Products that expire in less than 24 hours require expiration date and time, she says.

The Joint Commission has made a change to EP 3.

"Preparation date" was deleted from the list of information to include on medication or solution labels. The corrected EP reads: In perioperative and other procedural settings both on and off the sterile field, medication or solution labels include the following: medication name, strength, quantity, diluents and volume (if not apparent from the container), preparation date, expiration date when not used within 24 hours, expiration time when expiration occurs in less than 24 hours.

Challenges with labeling

There are multiple challenges with labeling, Norton acknowledges. One is compliance with medications that require the date and expiration time on drugs such as Propofol, which expires in six hours.

But in an ambulatory surgery center, if all of the cases are completed in less than six hours, it might not be necessary to label expiration time, she says. The center might opt to not require staff to put the date and time, because the drug will not expire during the procedure, she says.

Another challenge is compliance when only one solution is used and staff might think it is not necessary to label, Norton says. However, the no exceptions rule applies in this situation as well, she says.

A third challenge is staff compliance with the labeling requirement when the solution appears obvious, says Norton.

Sometimes your staff might ask why they have to label a product if it's the only solution that color. "I say no exceptions. When labeling, and you've transferred it, nothing is considered obvious," Norton says. "Everything must be labeled for patient safety. It's a Joint Commission requirement, and there's no getting around that." ■

Tips for meeting national safety goals

Can you prove you are in compliance with National Patient Safety Goals (NPSGs)? Compliance is mandatory for facilities undergoing an accreditation survey by The Joint Commission (TJC), and many surveyors ask for measurement data as proof of compliance, says

Sue Dill Calloway, RN, Esq., BSN, MSN, JD, medical legal consultant in Dublin, OH. Dill Calloway recently spoke on "2010 Joint Commission National Patient Safety Goals and How to Comply" at an audio conference sponsored by AHC Media, publisher of *Same-Day Surgery* and *SDS Accreditation Update*.

Failure to comply with NPSGs will result in a requirement for improvement (RFI), she says. However, TJC states that there are no prescribed requirements for measurement or data collection relative to most of the NPSGs, but you do need to know how you are in compliance, Dill Calloway says. The exception used to be 2C on timely reporting critical tests and results, but that exception was removed in 2010, she says. Performance improvement (PI) standards require data collection related to PI priorities, Dill Calloway adds.

Have policies and procedures for each NPSG, she advises. Additionally, the leadership standards require leaders to set priorities for improving the safety and quality of care, Dill Calloway emphasizes.

Using an alternative approach

Alternative approaches must be at least as effective as the Joint Commission selected approaches.

Complete the "Request for Review of an Alternative Approach" form. *(Editor's note: Go to www.jointcommission.org. Under "Patient Safety," select "National Patient Safety Goals." Under "2010 Additional Resources," select "Request for Review of an Alternative Approach to a National Patient Safety Goal Requirement.")*

If the alternative approach is not accepted, The Joint Commission staff will tell the facility leaders the rationale behind that decision. The leaders then can revise their request if they wish.

Here are some selected NPSGs, with compliance tips:

• Goal on patient identification.

The intent of that goal is to reliably identify the right patient and, second, to match the service or treatment with that patient, Dill Calloway says.

TJC clarified that you have to use patient identifiers when performing other treatments and procedures, she says. For example, you must make sure you have the correct patient for procedures such as moderate sedation, she says.

Compliance can be achieved by matching the patient name and medical record number with the bracelet. Two identifiers on an arm band are more reliable than the memory of another staff member. If your patients wear armbands, they must be attached to the patient and not taped to the bed, Dill Calloway emphasizes.

Bar coding that matches two identifiers is acceptable as long as one is not a room number.

The requirement for two identifiers assumes that there is a process in place on admission and that there are identifiers are attached to the patient, Dill Calloway says. However, you don't have to ask the patient his or her name every time blood is taken, Dill advises.

• Goal on hand hygiene.

The facility must provide an alcohol-based hand rub (ABHR) product, Dill Calloway says. However, the staff aren't required to use it, she says. Staff members may use soap and water.

The Life Safety Code allows installation of ABHR gel dispensers in egress corridors, but it's best to perform hand hygiene in the presence of patients, Dill Calloway says. Performing hand hygiene in front of patients demonstrates to them they you have done it and gets staff members into a good routine, sources say.

Dispensers in egress corridors have some limitations, she says. For example, the corridor must be six feet wide, and the dispensers must be at least four feet apart, she says. Additionally, dispensers can't be placed over power outlets, and they can't hold more than 1.2 liters when they are in rooms and corridors, Dill Calloway says. The same rules apply to alcohol-based foam, she says.

If hands aren't visibly soiled, use an alcohol-

EXECUTIVE SUMMARY

Facilities undergoing accreditation by The Joint Commission (TJC) are required to comply with the National Patient Safety Goals (NPSGs). Although TJC has not prescribed requirements for measurement or data collection, surveyors might ask for data as proof of compliance.

- You may use an alternative approach, which must be submitted in writing.
- You must use patient identifiers when doing other treatment and procedures, such as moderate sedation.
- You must provide an alcohol-based hand rub, and it can be put into egress corridors with some limitations. Staff members aren't required to use that product.

based hand rub in all settings, Dill Calloway says. If hands are visibly soiled or contaminated with protein material, blood, or other body fluids, then use soap and water, she says. Also, use soap and water with patients who have *Clostridium difficile (C. diff)*, Dill Calloway says.

Monitor the volume of ABHR used per 1,000 patient days, she advises. Periodically monitor and record adherence to hand hygiene compliance, and give feedback to staff, she advises. This direct observation is necessary for corrective action, Dill Calloway adds.

Ambulatory surgery providers are making progress with hand hygiene, says **Virginia McCollum**, MSN, RN, associate director of the Standards Interpretation Group at The Joint Commission. In fact, handwashing has dropped to no. 10 on the list of noncompliant areas by ambulatory organizations, McCollum says. "Surgery centers seem to be leading they way in their handwashing practices," she says. *(For a correction to a NPSG, see story below. For information on complying with* Sentinel Even Alerts*, see story, below.)* ■

Joint Commission makes correction to NPSG

The following correction to the 2010 National Patient Safety Goals (NPSGs) is effective immediately and affect the NPSG for ambulatory care, critical access hospitals, hospitals, and office-based surgery organizations. The correction will appear in the July 2010 update to the E-dition and in the print manuals.

In NPSG.07.03.01, Element of Performance (EP) 3, "prevention" was added so that it now reads: Educate patients, and their families as needed, who are infected or colonized with a multidrug-resistant organism about health care-associated infection prevention strategies. ■

What are requirements for Sentinel Event Alerts?

Although providers aren't scored on their compliance with Sentinel Event Alerts, unless they are National Patient Safety Goals or standards, they are an important safety area that should not be ignored, says **Sue Dill Calloway**, RN, Esq., BSN, MSN, JD, medical legal consultant in Dublin, OH.

Dill Calloway advises the following:

- Sign up on The Joint Commission web site to get new ones sent to you. Go to www.jointcommission.org/Library/Newsletters/list_serve.htm.
- Have a committee to review each one as they're released.
- Develop a plan of action to incorporate the recommendations into practice.
- Redesign relevant processes. For example, the Sentinel Event Alert on patient-controlled anesthesia should have resulted in a policy, nurse education, a patient education flier, and labeling of machines. ■

Electronic application available for AAAHC

Application shortened to 14 pages

The Accreditation Association for Ambulatory Health Care (AAAHC) has made an electronic Application for Survey (application.aaahc.org) available to organizations seeking surveys.

"Our new application is not only online; it has been shortened from 91 to 14 pages in response to feedback from accredited organizations requesting a more user-friendly application process," said **John Burke**, PhD, AAAHC executive director. "As a web-based tool, it also represents another initiative for our 'going green' campaign."

With the exception of managed care organizations, all organizations, regardless of accreditation type, will use the new version of the *Application for Survey*. This new version will be used for applications for an initial survey, reaccreditation survey, and Medicare survey. Previously, the application required facilities to submit three paper copies of documents, such as policies and procedures related to AAAHC standards, for review prior to the accreditation survey.

"With the new application, the documents can be uploaded and sent to AAAHC electronically, saving time, trouble, and mailing costs," Burke said.

Organizations that have questions about the revised application should call (847) 853-6060 and ask to speak to an application coordinator. ■

NON-HARASSMENT POLICY

All employees are responsible for ensuring that the workplace is free from harassment. The Company expects its employees to treat each other with respect and it will not tolerate offensive or demeaning behavior at work.

Harassment is an illegal form of discrimination if it is directed at a person based upon his or her race, color, religion, age, sex, national origin, or disability. Harassment is defined as including unwanted, deliberate, or repeated unsolicited comments, slurs, demeaning references, gestures, graphic materials, physical contact, solicitation of favors, advances, or other adverse treatment that creates for another employee an offensive work environment or interferes with his or her ability to perform their job.

If you believe that you or any other employee is being harassed by a co-employee, vendor or any outside third-party at the workplace, you should promptly take the following steps:

1. If you are the victim of the harassment and feel comfortable doing so, politely but firmly confront whoever is doing the harassing. State your feelings about the actions and request that the person cease the harassment.

2. If the harassment is observed by you against a co-employee, is directed toward you and continues after you have confronted the harasser, or if you feel uncomfortable confronting the problem with the harasser directly, then you should notify _____[usually I put Human Resource Director here because they are more trained to handle such complaints]. In the alternative, if the _____[Human Resource Director] is the person doing the harassing, notify _____[put President or V.P. here].

3. All harassment complaints will be taken seriously. An investigation will promptly be conducted and based on the results of its investigation; the Company will take any necessary corrective action. The further action may include disciplinary measures up to and including termination of the harasser. To the extent possible, the investigation will be handled as confidentially as possible. However, in order to do a thorough investigation the alleged harasser and those employees in "need to know" positions will be advised of, and may be asked to participate in, the investigation.

The Company assures you that no adverse action will be taken against you for complaining of harassment or by participating in any harassment investigation.

ACKNOWLEDGEMENT OF RECEIPT:

By: _____ _____
Employee's signature Date

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Source: Elizabeth G. Russell, JD, Partner, Kreig DeVault in Indianapolis, IN. *This prototype policy should not be construed as legal advice or legal opinion on any specific facts or circumstances. The contents are intended for general informational purposes only, and you are urged to consult your own lawyer on any specific legal questions you might have concerning your situation.*