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

March 2011: Vol. 35, No. 3
Pages 25-32

IN THIS ISSUE

Enclosed in this issue:
SDS Accreditation Update: What surveyors are focusing on in 2011; Safety and quality award winner

Financial Disclosure:
Senior Managing Editor **Joy Dickinson**, Executive Editor **Coles McKagen**, Board Member and Nurse Planner **Kay Ball**, and Board Member and Columnist **Stephen W. Earnhart**, and **Frank W. Ling**, MD, guest author, 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.

AHC Media LLC

Should sleep-deprived surgeons inform patients of their condition?

A medical student is participating in a complicated abdominal surgery by holding a retractor. He was up all night the previous night. He falls asleep and slides down to the floor. A nurse drags the student out of the way, and a resident takes over the retractor.

This story was recounted by an anonymous physician in a recent CNN story[1] discussing an editorial published in *The New England Journal of Medicine* suggesting that sleep-fatigued surgeons should disclose their condition to patients. Negative outcomes associated with sleep deprivation happen more often than falling asleep, said **Charles A. Czeisler**, PhD, MD, FRCP, chief of the Division of Sleep Medicine at the Brigham and Women's Hospital in Boston, Massachusetts, and professor of sleep medicine at Harvard Medical School.[1] Czeisler co-authored the editorial with **Michael Nurok**, MD, PhD, an anesthesiologist and intensive care physician at the Hospital for Special Surgery, New York City, and medical ethicist.

Facilities "have a responsibility to minimize the chances that patients are going to be cared for by sleep-deprived clinicians," and elective surgery is the place to start, the authors said. In fact, in the editorial, Nurok and Czeisler argue that sleep-deprived physicians should not be permitted to proceed with an elective surgery without a patient's informed, written consent acknowledging the surgeon's condition.[2] Sleep-deprived physicians should be required to inform patients of the potential hazards that can come

EXECUTIVE SUMMARY

A recent editorial in *The New England Journal of Medicine* suggests that sleep-deprived surgeons should disclosure their condition to patients as part of the informed consent process.

- This disclosure could be an interim step until facilities develop policies and procedures addressing surgeon fatigue, the authors say.
- Surgeons are professionals and are trained to know if they are too exhausted to perform a simple procedure, says the president of the American College of Surgeons.

with this impairment, they maintain. If patients opt to proceed as planned, the informed consent form should be signed on the day of the procedure in front of a witness, they wrote. Patients should be given the opportunity to go ahead with the procedure, proceed with a different physician if possible, or reschedule, according to the editorial.

CNN points to one survey in which 80% of patients who were to undergo elective surgery said that if their doctor was sleep-deprived, they would request a different doctor.[1]

"Elective surgery is the low hanging fruit because there is no urgency to doing it and it can be rescheduled, ideally as a priority with institutional support," Nurok says. "It's a nice place to start to think about policy approaches."

The problem already is being addressed in some areas. For example, some busy practices prohibit scheduling surgeries for physicians on post-call days. "A lot of institutions are not going to be able to take that leap immediately, so as an interim step, we believe that patients need to be informed," Nurok says.

Keep in mind that certain specialties, including neurosurgery and cardiac surgery, might receive a lot of routine night calls, says **Jeffrey M. Rothschild**, MD, MPH, assistant professor of medicine, Harvard Medical School, Physician, Department of Medicine, Division of General Medicine, Brigham and Women's Hospital, Boston.

"I think in cases where they got less than four to six hours of sleep, patients should be informed," Rothschild says. (*For more on disclosure, see story, p. 27.)*

Additionally, many healthcare facilities require employees to report suspected physician impairment, which would include exhaustion, sources point out. Many question whether employees are willing to report physicians in such cases, however. Concerns about sleep-fatigued surgeons have gotten the attention of the Sleep Research Society and the American Academy of Sleep Medicine, which say legislation is needed.

The downside to disclosure

Nurok notes that changing practices goes against the culture of surgery which says that you work when you're fatigued, but he says facilities are rethinking this culture.[1] Also, many surgeons believe that the training enables them to perform at the top of their game despite stresses such as fatigue, Nurok says.[1]

L.D. Britt, MD, MPH, FACS, president of the American College of Surgeons, says, "People have to realize, surgeons are professionals." Britt maintains that surgeon fatigue is not a frequent problem. "I don't know of a case where the surgeon is so fatigued, there's been a mistake in surgery. I haven't seen it personally as a major problem." *(For information about liability, see story, p. 28.)*

Britt points to the difference between "fatigued"

Same-Day Surgery® (ISSN 0190-5066) is published monthly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road, NE, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Same-Day Surgery®, P.O. Box 740059, Atlanta, GA 30374.

SUBSCRIBER INFORMATION

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m. to 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $499. Add $17.95 for shipping & handling. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are $83 each. (GST registration number R128870672.)

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 16.5 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 16.5 Contact Hours.

AHC Media is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AHC Media designates this educational activity for a maximum of 20 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This activity is intended for outpatient surgeons, surgery center managers, and other clinicians. It is in effect for 24 months after the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Executive Editor: **Coles McKagen** (404) 262-5420 (coles.mckagen@ahcmedia.com).
Senior Managing Editor: **Joy Daughtery Dickinson** (229) 551-9195 (joy.dickinson@ahcmedia.com).
Production Editor: **Neill L. Kimball**.

AHC Media LLC

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

and "exhausted." "No one wants an exhausted surgeon," he says. However, most surgeons don't receive eight hours of sleep at night. "Should I tell all patients I didn't get a good night's sleep even though I have good outcomes?" Britt asks.

Disclosing sleep fatigue "will be confusing and troubling for patient and surgeon," he says. "Some cases I easily can do fatigued," he says. Other, more complex cases could not be performed well, Britt says. "Surgeons should make that call, and they do."

Mandatory disclosure is "unwarranted," he wrote with Carlos A. Pellegrini, MD, FACS, chairman of the college's board of regents, in an accompanying comment to Nurok's editorial. Surgeons are likely to view the proposal for disclosing fatigue as "oppressive and insidious," they wrote. "Many other factors — including marital difficulties, an ill child, financial worries, and so on — negatively affect performance. Are we going to demand full disclosure of these problems as well?"

Instead, surgeons should be trained to understand the relationship between fatigue and their mental and physical capabilities, Britt and Pellegrini wrote. They should use this knowledge to decide whether to disclose their condition, reschedule the operations, or seek assistance, they wrote.

However, people who are sleep-deprived are often not able to accurately assess their degree of self-impairment, according to Nurok. He compared asking surgeons to decide whether they're fit to perform elective surgery after having been up all night to a bartender asking drunks whether they can drive home safely.[1] However, Nurok acknowledges that "there's not a cookie cutter answer."

"We're hoping we've started a debate and interest in policy around this," he says. Elective surgery should be leaders in this area, Nurok says. "It doesn't have to be done," he says. "There's no urgency. And the situation can be optimized." *(For recent research on surgeons and sleep fatigue, see abstract and commentary, p. 28.)*

REFERENCES

1. Watkins T. Researchers urge doctors to disclose sleep fatigue before surgery. Dec. 29, 2010. Accessed at http://www.cnn.com/2010/HEALTH/12/29/sleepy.surgeons.
2. Nurok M, Czeisler CA, Lehmann LS. Sleep deprivation, elective surgical procedures, and informed consent. *N Engl J Med* 2010;363:2577-2579. ■

What are the cons of fatigue disclosure?

Might be 'burdensome' and 'damaging'

Adding the surgeon's sleep fatigue to informed consent "might prove burdensome to patients and physicians and damaging to the patient-physician relationship," acknowledge the authors of a recent editorial in *The New England Journal of Medicine* proposing that approach as an interim measure to address the problem of surgeons' sleep fatigue.[1]

The editorial authors identify several barriers that might make informed consent and surgery rescheduling unpopular with patients and physicians. Patients might have made logistical provisions for their surgery and might be unhappy if they have to reorganize their schedule again. Clinicians might lose cases to colleagues and thus income. Departments and institutions might lose income if patients reschedule and seek treatment elsewhere.

However, the costs might be offset by improved surgical outcomes, says **Michael Nurok**, MD, PhD, an anesthesiologist and intensive care physician at the Hospital for Special Surgery, New York City, and medical ethicist. Nurok adds, "You may save money if you have zero complications."

Adding sleep fatigue to the informed consent may be necessary until institutions take the responsibility for ensuring that patients rarely face such dilemmas, the authors maintain.

"This is where the biggest impact is, and it is the most efficient way to deal with this problem: Create a policy around it," Nurok says. The real answer? The "institutions should say to a surgeon, `on your post-call day, we're not going to allow you to schedule routine procedures,'" he says.

Nurok acknowledges that such a policy could be more challenging for a rural facility where there are no other surgeons in the area and where surgeons most often do not get called in overnight. However, policies could be targeted for elective cases on post-call days in busy, urban centers, Nurok suggests.

REFERENCE

1. Nurok M, Czeisler CA, Lehmann LS. Sleep deprivation, elective surgical procedures, and informed consent. *N Engl J Med* 2010;363:2577-2579. ■

Is there liability with sleep fatigue?

There is the possibility of liability when surgeons perform more surgery "than common sense would dictate that they can do," says **Steven Levin**, lawyer and founding partner, Levin & Perconti, Chicago.

"From my viewpoint as representing patients, if an injury occurs, and if it's related to a doctor operating when he's too tired to operate, there will be unquestionably a large settlement or verdict," Levin says.

The law holds all professionals to a standard of reasonableness, he says.

The facility might be liable if managers and/or administrators had a reason to know that the surgeon was operating in a less-than-optimal state, he says. Liability could arise if they observed that the surgeon appeared to be tired or if the surgeon had poor record of complications that wasn't otherwise explained, Levin says.

"Just like a truck driver shouldn't drive and endanger people when he is too tired, a surgeon shouldn't operate when he is too tired," Levin says. ■

Are complications related to sleep the prior night?

Abstract & Commentary

By **Frank W. Ling, MD,** Clinical Professor, Department of Obstetrics and Gynecology, Vanderbilt University School of Medicine, Nashville, is Associate Editor for *OB/GYN Clinical Alert*, also published by AHC Media.

Synopsis: The complication rate for procedures performed by attending surgeons and obstetricians was not greater among those who worked overnight.

Source: Rothschild JM, et al. Risks of complications by attending physicians after performing nighttime procedures. *JAMA* 2009;302:1565-1572.

Conducted in a 700-plus bed tertiary care, urban academic teaching hospital with a trauma center and referral center for high-risk obstetrics, this retrospective cohort study involved the procedures of 86 surgeons and 134 OB/GYNs between 1999 and 2008.

Cases performed between midnight and 6 a.m. were considered "overnight," and "sleep opportunity" was defined as the time between the end of the overnight procedure and the start of the first scheduled morning procedure. The study was conducted to see if sleep opportunities correlated with surgical complications among attending surgeons and OB/GYNs. The complication rates among post-nighttime procedures were compared with those of controls. Also, complication rates in post-nighttime procedures performed by physicians with more than six-hour sleep opportunities were compared to those performed by physicians who had sleep opportunities of six hours or less. Nearly a thousand obstetrical and more than 900 surgical cases were identified as post-nighttime, and these were compared to almost 4,000 obstetrical and more than 3,500 surgical control cases.

There were complications in 101 post-nighttime cases (5.4%) and 365 control procedures (4.9%; odds ratio [OR], 1.09; 98% confidence interval [CI], 0.84-1.41). Among the post-nighttime complications, they occurred in 6.2% of cases in which the sleep opportunity was six hours or less compared to 3.4% of cases where the sleep opportunity exceeded six hours (OR, 1.72; 95% CI, 1.02-2.89). In addition, complication rates in post-nighttime procedures performed after working more than 12 hours was higher, but not significantly, than after working 12 hours or less (6.5% vs 4.3%; OR, 1.47; 95% CI, 0.96-2.27).

Commentary

The conclusions of this article, from one single study site, are that there were not higher complication rates for surgeons and gynecologic surgeons who had worked overnight, although the complication rates were slightly higher among the post-nighttime procedures done if sleep opportunities were less than six hours. Surgeons did have a higher complication rate if sleep opportunities were limited, though the rate was not increased for OB/GYN attendings.

Is that reassuring? It can be, particularly if you're one of those surgeons who works inconsistent and unpredictable hours. Throughout our training, the issue of long hours and sleep deprivation has always been there, particularly with the implied concern that daytime activity could

be adversely affected by nighttime emergencies/unscheduled procedures. On the other hand, if you are someone looking to debunk these data, one can simply (and correctly) point out that this was only one study site, it was retrospective in nature, and the outcome measures were not defined appropriately. It was also done at a tertiary care facility, which certainly could be very different from community hospitals that most physicians utilize in their respective practices. Nevertheless, there is not a statistical difference in the surgical complication rates whether or not the surgeon had done other procedures the night before.

Likewise, much more study is needed before being able to determine the critical amount of rest/sleep that a surgeon needs to avoid increasing the complication rates after a nighttime procedure. Prospective data are needed. There might not be, in fact, a specific number of hours of rest that is needed. That is unlikely to stop boards, commissions, governmental agencies, etc., from declaring that certain guidelines must be in place to protect the welfare of patients. In fact, who can argue with regulations that protect the patient? We're all practicing this business called medicine for that primary reason, i.e., the patient. The controversy arises when the good intentions of those making the rules run into the good intentions of those trying to render quality health care.

The results of the 2003 decision by the Accreditation Council for Graduate Medical Education to limit resident duty hours to 80 hours per week have yet to be fully appreciated. Since that time, further tweaking has occurred, with more refinements to defining how those hours may be counted. Even greater reductions are in play, with first year residents being limited differently than upper level trainees. On the other hand, the topic of hours of attending physicians has not been addressed, with this article adding to the discussion. I raise the topic of resident duty hours because it is germane to practitioners as they look at their newly graduated younger colleagues and how they practice. Some might adapt well to an unregulated practice pattern with unlimited practice hours. Others either might choose not to adapt or find that the rigors of such a schedule are stressful and/or difficult to manage.

Of greater importance are patient safety topics that we can all do something about. First, we all can have back-up plans for what we do. Self-awareness of fatigue also plays a critical role. It's OK to be tired and admit to it. It has been reported that fatigue played a role in up to 16% of preventable adverse events in one study.[1] Another study came to different conclusions for cardiac surgeons who performed procedures within a 24-hour period after an overnight case. In that study, there was no difference between surgeons who were or were not sleep-deprived.[2]

Perhaps a series of questions could cause each of us to consider this controversy:

Does the practice routinely avoid scheduling elective surgery the day after someone has been on call the night before?

- Is the possibility of delaying elective surgery appropriately utilized (recognizing the inconvenience and stress on the patient and families)?
- Do attending physicians factor in monetary reward (i.e., surgical fees) as they decide if an elective procedure should be rescheduled? Are older, more experienced physicians more or less susceptible than residents to the effects of fatigue?
- Are we taking full advantage of "hospitalists" to minimize the risk of overnight emergency procedures adversely affecting the surgeon the next morning?
- Do we have back-up providers available to step in should surgeons find that fatigue is affecting them?
- Have we adequately educated ourselves on the topics related to sleep deprivation?
- Do we use caffeine appropriately (as opposed to inappropriately) as a stimulant to combat fatigue?

The topic of patient safety in the operating room would not be complete without touching on a couple of other topics. What effect has the surgical "time out" made? You can be your own judge. Maybe it's not a bad thing, even if it seems as though it shouldn't be necessary.

What about patient safety elsewhere? I'd like for each of you to think about your practice. Answer these questions to see how things stack up within an environment that you, as the practitioner, have a greater degree of control:

- Do we have foolproof tracking mechanisms for all lab tests drawn?
- Do we have a system to notify patient of all abnormal results?
- Are providers responsible for signing off on all test results?
- Are phone calls logged and answered in a timely fashion?
- Does the office have appropriate protocols in

place in case of cardiac arrest or adverse patient outcomes?

• If procedures such as hysteroscopy or loop electrosurgical excision procedure (LEEP) are done in the office, are the same safety measures taken in the hospital operating rooms utilized in the office?

What we do in our respective daily activities should be based on good medicine first, but with a healthy dose of patient safety in mind at every turn. Let's lead the way and show the government, insurers, and anyone who wants to watch us that physicians take this topic seriously.

REFERENCES

1. Gawande AA, Zinner MJ, Studdert DM, et al. Analysis of errors reported by surgeons at three teaching hospitals. *Surgery* 2003;133:614-621.
2. Ellman PI, Law MG, Tache-Leon C, et al. Sleep deprivation does not affect operative results in cardiac surgery. *Ann Thorac Surg* 2004;78:906-911. ■

Checks and balances keep denials low

Care managers assess patients in PACU

By taking a proactive approach to patient status and instituting a series of checks and balances, Good Samaritan Hospital in Dayton, OH, keeps denials at a minimum.

The 577-bed hospital requires physician offices to fill out a pre-admission form that includes patient status before a patient can be scheduled for surgery, according to **Teresa I. Gonzalvo**, RN, MPA, CPHQ, LNC, director of integrated care management.

"We have many access points and have created standardized admissions procedures with a goal of getting patient status right the first time and diminishing the errors. Every patient who is admitted to the hospital is reviewed by a case manager for admission status, regardless of their access point or payer," Gonzalvo says.

The case management department worked with the surgery schedulers, the director of surgery, and the nurse manager of the post-anesthesia care unit (PACU) to develop a system for making sure patient status is correct before and after surgical procedures. The pre-admission form that physician offices must fill out before scheduling patients for surgery includes a list of the appropriate choices for patient status after surgery including inpatient, outpatient, or post-procedure recovery, along with the CPT codes.

"Physician office staff must fax that form with all the information completed before they can schedule the surgery," says Gonzalvo.

Once a patient is transferred to the post-anesthesia care unit (PACU) after surgery, the nurse checks to make sure the status is still accurate. If the patient's stay in the PACU exceeds the expected post-procedure recovery period, the nurse brings it to the attention of the surgeon.

The unit-based case managers take turns rotating through the PACU between 2 p.m. and 4 p.m. to determine admission status for patients who are in recovery following surgery. If the unit case manager who is assigned recovery room responsibility has a big caseload on his or her regular unit for that particular day, another unit case manager or the manager takes over the process, Gonzalvo says.

The case managers assess which patients potentially might stay overnight and whether they are meeting observation or inpatient criteria.

If the patient had a procedure with the option of inpatient, outpatient, or post-procedure recovery, the case manager reviews the record for medical necessity and calls the surgeon or attending physician if he or she thinks the order does not place the patient in the appropriate status, Gonzalvo says. If the case manager and the admitting physician can't agree on a patient status, the medical director for case management intervenes.

"It's more efficient to get these patients admitted in the right status if someone goes to the recovery area, rather than trying to manage the admission status when the patients get to the floor," Gonzalvo says.

The team created a user-friendly manual for Medicare's Inpatient Only list to ensure that patients who receive surgical procedures on the list are admitted to the hospital as inpatients. Surgery schedulers use the manual as a reference to determine if patients should be admitted as inpatients. The case managers re-evaluate the patient status while they are in the recovery room. The medical record has patient status as a required field and includes order sets specific to the procedures on the Inpatient Only list. If a procedure is on the Inpatient Only list, the physician does not have the option to order any other status, Gonzalvo says. ■

Same-Day Surgery Manager

Don't fall behind: Stay updated on surgery trends

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

Being a person of a self-assessed "up" mentality, I notice trends that give me pause. Consider the following:

• **Social networking.**

It has hit healthcare full on. My web site is loaded with Twitter, Facebook, and blog. I am forced to "tweet" things because it is where our industry is headed. (If you want a laugh during the day, check out our tweeter page, "SurgeryInc,").

It took me a while to figure out the underlying importance of it. It is beyond networking. It gives those of us in business the opportunity to reach peers that before could be reached only through costly media sources. That is a distinct advantage. As a cautionary note though, it can bite you with a disgruntled employee!

Find a way to use it to meet your needs. It is out there and inexpensive. Use the technology that is rapidly absorbing us.

• **Electronic medical records (EMRs).**

I cannot find enough ways to fit EMR into conversations in the lounge. It is staying, and you need to find the money and time (oh the time!) to implement it. The field of vendors is shrinking.

More surgeon's offices are using it, and if you don't have it yet, you will. You should start planning for it. Medicare is going to require it shortly.

• **Smartphones with cameras and camcorders.**

These smartphones are scary in the surgical department. The potential for abuse is high, but I don't know a realistic way to remove it. We are becoming a distracted nation. I am sure someone can Tweet or blog a solution.

• **Bariatric surgery.**

Once the savior for many surgical programs, I am nervous about the introduction of this service into new locations. I am not saying the bubble has burst, but pharmaceutical treatments are becoming a real competitor to surgery. Do your homework on this one.

• **Bariatric furniture in your waiting rooms.**

A must for 40% of your waiting room.

• **Surgeons with attitudes.**

I have noticed a real change in staff treatment toward difficult surgeons. They are not tolerating them like in the past. Finally they are being told to leave their bad moods at the door and get past it while they are in the operating room. Being respectful, but firm with this type of surgeon is long overdue!

• **Anesthesia cooperation.**

Anesthesia cooperation with your surgical program has turned the corner. I have observed a serious change of attitude with anesthesia becoming more responsive to the challenges we are all facing. If you have noticed it, let them know.

• **Personal recognition.**

Personal recognition is so critical to all of our sense of self-worth. Going out of our way to recognize and tell staff members you appreciate the job they are doing should become muscle memory to us all.

Now get out there and "poke" someone.

[Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management.] ■

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 activity with the June issue, you must complete the evaluation form provided and return it in the reply envelope provided to receive a letter of credit. When your evaluation is received, a letter will be mailed to you.

COMING IN FUTURE MONTHS

■ Can you prevent staff from dating patients?

■ Avoiding provider abuse of patients

■ Survival strategies for drug shortage

■ Tips for using a third-party negotiator

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.

9. Where is the best place to start with a policy for sleep-deprived surgeons, according to the authors of a recent editorial in *The New England Journal of Medicine* (Nurok M, et al. 2010;363:2577-2579)?
A. Neurosurgery
B. Cardiac surgery
C. Elective Surgery

10. How does Good Samaritan Hospital take a proactive approach to patient status that reduces denials?
A. Physician offices are required to fill out a pre-admission form that includes patient status (inpatient, outpatient, or post-procedure recovery) before a patient can be scheduled for surgery.
B. Physician offices are called to confirm patient status on the day before surgery.
C. Physician offices send a confirmation of the patient's status with the patient on the day of surgery.

11. What are some of the reasons to convert to electronic medical records, according to Stephen W. Earnhart, MS, CEO of Earnhart & Associates?
A. More surgeon's offices are using it.
B. Medicare is going to require it shortly.
C. A and B
D. None of the above

12. How have video cameras benefited CoxHealth?
A. Prevent or identify criminals in car break-ins, thefts of patient items within the facility, narcotic thefts, and internal thefts of employees.
B. Helped recover a set of wedding rings that a family member had taken home for a patient.
C. Helped identify that an outside contractor had damaged equipment in the ambulatory surgery center.
D. All of the above

Answers: 9. C; 10. A; 11. C; 12. D

SDS ACCREDITATION UPDATE

Covering Compliance with The Joint Commission and AAAHC Standards

Will you be caught off guard at your survey? — Focus on infection control, patient safety

Outpatient surgery managers going through accreditation by The Joint Commission and Accreditation Association for Ambulatory Health Care (AAAHC) say the surveyors are targeting two primary areas.

Kate Moses, RN, CNOR, CPHQ, quality management coordinator at Medical Arts Surgery Centers (MASC) in Miami, went through extensive three-day Joint Commission surveys at both of her centers. "Certainly their main focus was patient safety and infection control issues," Moses says. Also, because they were deemed status surveys, the Medicare standards played a significant role, says Moses, who also is chair of the Ambulatory Surgery Specialty Assembly, Association of peri-Operative Registered Nurses, Denver.

The Conditions for Coverage for ambulatory surgery centers that took effect in May 2009 have been the focus of recent Joint Commission surveys at two Titan Health Corp. facilities, says **Roseanne M. Ottaggio**, MSN, RN, CDE, CASC, regional vice president, based in New Jersey, for Titan. Titan is a national surgery center developer and operator based out of Sacramento, CA. Surveyors asked questions based on Medicare's Infection Control Surveyor Worksheet. "The facilities completed the survey prior to the JC survey to help prepare for the site visit," Ottaggio says. *[The worksheet was included in the online June 2010 issue of* Same-Day Surgery. *For assistance, contact customer service at (800) 688-2421 or customerservice@ahcmedia.com.]* Two of the most challenging standards were identification of risk for infection and reducing those risks, Ottaggio says.

Surveyors wanted to see their procedures for handwashing, she says. They looked at how the facilities were cleaning the ORs and induction bays. Also, as part of the patient tracer, surveyors watched handwashing and glove use.

"When he was in the preop holding area, and the patient was getting moved out, he asked, `What happens here in the room now that the patient's gone?' He wanted to hear we were wiping everything down before the next patient was brought into that bay," Ottaggio says.

In the OR, surveyors were watching for sterile technique. "They wanted to see that people had gloves on if they were touching the patient or coming into contact with anything," she says. "When removing gloves, they wanted to know, were they washing their hands."

Surveyors also wanted to see the sterile processing area. "They watched them clean the instruments after a case and get reprocessed," Ottaggio says. "They wanted to see what we were doing in terms of documentation. They wanted to know if a tray didn't pass sterilization, what would happen."

At OA Centers for Orthopaedics in Portland,

EXECUTIVE SUMMARY

Accreditation surveyors are focusing on infection control and patient safety standards.

- Perform a walkthrough or mock survey.
- Ensure employees are washing their hands any time they take off gloves.
- Expect a focus on medication safety and the life safety code. Perform a monthly safety check. (Checklist is enclosed with online issue.)

Financial Disclosure:
Senior Managing Editor **Joy Dickinson**, Executive Editor **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.

ME, which recently went through AAAHC accreditation, surveyors verified that the centers had good staff training so staff understood the policies and procedures in infection control, says **Lynn Shorty**, BSN, RN, director of patient services.

At Tucson (AZ) Orthopaedic Surgery Center, which recently went through a AAAHC survey, handwashing was "a real point of emphasis" for surveyors, says **Stuart Katz**, FACHE, CASC, executive director. "It was one of those things that both AAAHC and folks from the state licensing department looked at every time they saw someone with a patient," Katz says. They wanted to know whether staff washed their hands before they saw a patient and when they were done, "every time they took off gloves," he says.

Katz said the managers had talked with staff "ad nauseam" about it. "It seems to have sunk in," he says.

Staff should expect to be asked about the policy on handwashing. "It's a case of they need to be articulate on the policy," he says. They also need to know the policy is being followed and where to find the policy if someone wants to see it, Katz says. "That's how they check to see how information is disseminated from the top to the bottom, or the bottom to the top," he says. The emphasis on vertical communication was echoed by other sources interviewed by Same-Day Surgery.

Surveyors ask about patient safety

At MASC, surveyors asked a large number of questions about medication management and safety, including single-dose vials, labeling, and administration of medications, Moses says.

In Tucson, the surveyor was focused on the life safety code. "He was checking for fire penetrations, proper signage, generator testing," Katz says.

Two staff members at his center perform a monthly safety check with a checklist that examines items such as the fire sprinkler system, ceiling penetration, lighted exit signs, and fire extinguishers. *[That checklist is included with the online issue of* Same-Day Surgery. *For assistance, contact customer service at customerservice@ahcmedia.com or (800) 688-2411.]*

Surveyors are looking beyond the surface, Moses advises. "Surveillance and monitoring of safety and compliance are important, but they are very tuned into what you do with that data and how you improve or maintain compliance," she says. "Frontline staff need to be able to speak to their roles and to address patient safety." Use reinforcement and repetition to help them reach the place where they are comfortable discussing those issues, Moses advises. ■

Warnings: Surveyors look at previous surveys

If you had a previous accreditation, know that your surveyors will be looking at them before they visit your facility again.

"If you don't incorporate some of their suggestions, you have to be prepared to explain why," says **Lynn Shorty**, BSN, RN, director of patient services at OA Centers for Orthopaedics in Portland, ME.

For example, Shorty is expecting to be challenged at her next survey because surveyors want her to increase chart review in terms of frequency and number. "It would be an administrative nightmare at the level they are requesting," she says. "We are meeting the requirement, but they would like us to bump it up a notch."

Shorty says she might have to say she can't do it at the volume they're recommending. "I will convince them why our process is just as effective," she says.

You can challenge a surveyor, says **Kate Moses**, RN, CNOR, CPHQ, quality management coordinator at Medical Arts Surgery Centers (MASC) in Miami. "At one center the surveyor called into question the use of fanny packs for anesthesia's controlled drug supplies," Moses says. Her center performed a quick failure mode exercise that proved keeping the medications in a fanny pack worn by the anesthesia professional didn't alter the drugs' stability or efficacy. "This won praise from the surveyor," Moses says.

Consider these other suggestions:

- **Read the standards.**

Read the manual thoroughly and contact the accreditation group if you have questions about interpretation and specific requirements , says **Debra Stinchcomb**, RN, BSN, CASC, consultant with Progressive Surgical Solutions in San Diego, which provides consulting services to ambulatory surgery centers. Stinchcomb also is vice chair on the Ambulatory Professional Technical Advisory Committee (PTAC) for The Joint Commission.

The accrediting groups "are very receptive and will spend as much time as needed with clients,"

Stinchcomb says.

Know that there are symbols in the manuals to assist with compliance, she says. For example, in The Joint Commission's ambulatory manual, a D with a circle around it indicates that something must be in writing. "There is also a list of items that must be documented, Stinchcomb says.

• Perform a walkthrough or a mock survey.

Laurie A. Dorr, RN, CNOR, RNFA, compliance specialist/clinical educator/infection control officer at OA Centers for Orthopaedics, says, "I would say getting ready for survey, it's helpful if you do a walkthrough of facility before from a surveyor's side." For example, are hallways cluttered? Are items in open closets neat and tidy? "There are things you walk by every day that you don't necessarily open and look at," Dorr says.

Surveyors will pull out hydrogen peroxide in a closet and look at the expiration date, Shorty warns. "You have to go through with almost a microscope to make sure and go through your workspace with a keener eye than a surveyor would," she says.

Mock surveys can be performed by the facility, a consultant, or the accreditation group. Stinchcomb says, "This is the best way to determine areas that need improvement as well as to ensure them of survey readiness."

• Receive and share ideas with your surveyors.

Surveys can be a give-and-take process in terms of idea sharing, says **Stuart Katz**, FACHE, CASC, executive director. Tucson (AZ) Orthopaedic Surgery Center.

For example, his surveyor liked the way his staff conduct drills and document them, Katz says. The director of nursing and Katz assign staff responsibility for the drills. "The staff figures out the scenario, runs the drill, runs the critique, and writes it up," he says. The advantage? "You get buy-in from the staff," Katz says.

Another area that made an impression on his surveyor was that checklists are placed in applicable work areas. For example, the checklist for spore testing of sterilizers is kept in the sterilization area. The checklist is completed in the work area, then added to the record books in a central location. "The thinking is that is should all be centralized," which can be a problem, Katz says. While the checklists need to be in a central location when they're completed, staff doesn't always remember to go get the sheet when it needs to be completed. Having the checklist in the area addresses that problem.

His surveyor shared her interesting tickler system. Her system is taken from the area of the manual for the Accreditation Association for Ambulatory Health Care (AAHC) where it explains requirements for the board. She puts those items on a page that is never published. When compiling the agenda for her next quarterly board meeting, she puts 25% of those items on the agenda. The same items are discussed at the same quarterly meeting every year. This system allows her to continuously check off items and ensure they are completed. "We've never seen it done that way, Katz says.

Ask your surveyors questions, says **Roseanne M. Ottaggio**, MSN, RN, CDE, CASC, regional vice president, based in New Jersey, for Titan Health Corp. "You requested and are paying them to be there, and it should be a learning and collaborative effort," Ottaggio says. "I found the surveyors are very knowledgeable and willing to share how to improve different areas."

Lastly, continuously prepare, sources advise.

"We tend to be always working toward Joint Commission and [Medicare] compliance," Moses says. "We have ongoing initiatives with staff and physicians to keep us in the ever-ready mode." *(See a survey "don't," below.)* ■

Don't overwhelm with documentation

OA Centers for Orthopaedics in Portland, ME, learned the hard way that trying to be helpful to surveyors can backfire.

"I remember the first time years ago, we thought we would be one step ahead by bringing all documentation into one room, so they wouldn't have to ask for anything," says **Lynn Shorty**, BSN, RN, director of patient services. "They were overwhelmed by the volume of materials we had for them to review."

Now the staff wait until surveyors ask for information, and then they provide it to them. Also, organizing the information, such as personnel folders, can help surveyors, Shorty says. Because her centers have many employees with longevity, those folders are fairly thick, she says. "It can be helpful to have a table of contents for each personnel file so that each file is organized in the same way," Shorty says. "Instead of going through the contents, they could look at the summary sheet." ■

Anesthesiologist wins safety and quality award

John H. Eichhorn, MD, anesthesiologist at UK Chandler Medical Center and professor at the University of Kentucky, both in Lexington, has been named a recipient in the annual John M. Eisenberg Patient Safety and Quality Awards from the National Quality Forum (NQF) and The Joint Commission.

Eichhorn is recognized for improving the quality of anesthesia care and patient safety through the development and application of practice standards and protocols. His contributions led to dramatic and sustained reductions in catastrophic intraoperative anesthesia accidents, as well as improved anesthesia patient safety and quality of care overall, according to The Joint Commission and NQF.

In the nomination letter, Joseph Conigliaro, MD, director of the Center for Excellence in Quality and Safety at University of Kentucky Medical Center said Eichhorn "created and implemented the concept of mandatory clinical 'standards of practice' (above and beyond, and distinct from, 'statements,' `recommendations,' and 'guidelines') as quality improvement instruments, a strategy that proved to have enormous impact. This approach permanently changed anesthesia practice and has had a significant positive influence on the safety of patients anesthetized in the U.S. (and much of the developed world) over the last 20 years."

Eichhorn was described as a leader in the anesthesia patient safety movement. "Dr. Eichhorn pioneered, researched, and popularized the concept of 'safety monitoring' — the intense integration of behavior and technology through the application of mandatory practice standards," Conigliaro said. "The principles embodied in these standards have been widely credited with producing a dramatic decrease in catastrophic intraoperative anesthesia accidents." In an interview with *Same-Day Surgery*, Eichhorn said the risk of having a catastrophic intraoperative anesthesia accident is less than 1 in 350,000 and might be as remote as 1 in 500,000. "People don't understand that the risk of the average person getting killed in a wreck is about 1 in 6,000 to 1 in 7,000," he said. "It's vastly safer to have anesthetic than to ride in a car for a year."

Eichhorn served as the secretary of the American Society of Anesthesiologists (ASA) Committee on Standards. This committee formulated national standards for monitoring anesthesia patients. Eichhorn also demonstrated the efficacy of safety monitoring. At the ASA, Eichhorn developed and promulgated guidelines for practice areas including preoperative and postoperative care and anesthesia at remote sites.

Eichhorn convened the International Task Force on Anesthesia Safety. This group published the International Standards for a Safe Practice of Anaesthesia, which were adopted as the official world standards by the World Federated Societies of Anesthesiologists (WFSA). He also participated in the Anaesthesia Working Group, which was part of the WHO Safe Surgery Saves Lives task force. The resulting comprehensive program for safer surgery includes a 19-point "Surgical Safety Checklist" (http://www.who.int/patientsafety/safesurgery/ss_checklist/en/index.html). ■

Joint Commission offers Leading Practice Library

Solutions are ones deemed as successful

The Joint Commission has launched its Leading Practice Library, a complimentary tool available only to Joint Commission-accredited organizations.

The library contains solutions that have been successfully implemented by accredited organizations and reviewed by The Joint Commission. Many topics are applicable to the ambulatory setting, including discard date for medications and contract service criteria evaluation.

Louise Kuhny, RN, MPH, MBA, clinical educator, Accreditation and Certification Operations at the Joint Commission, says, "Many of these are 'turnkey solution' documents that an ambulatory facility can use as is or can modify for its population and services. This is a great timesaver for busy ambulatory professionals."

The library will be updated continuously as new solutions become available. Users can browse through topics, and documents can be cross-referenced to chapters in the accreditation manual. The library includes a tutorial with guided steps on how to use the tool as well as information on how to submit suggestions for new leading practices. Ambulatory care and office-based surgery practices are invited to submit their proven solutions for the library.

The library is accessible via organizations' Joint Commission Connect extranet by clicking "Leading Practice Library." ■

Tucson Orthopaedic Surgical Center
MONTHLY SAFETY/QUALITY REPORT

	YES	NO	ACTION TAKEN
Spill kits in designated locations Formalin Blood			
Staff knowledge of spill kit			
Appropriate PPE for BBP in use			
Staff demonstrated knowledge of PPE **Next training due:**			
Sharps containers emptied when ¾ full / proper disposal			
Red bags for all appropriate contaminated waste			
Leak proof bags for all dirty linen			
Clean linen stored separately from dirty			
Clean linen stored covered and not with other items			
Paper towels in holders and available			
Antibact. soap located at each sink			
Alternative hand washing products available throughout facility			
Aseptic technique being followed			
Sterile trays/supplies are stored according to policy			
Autoclave cleaned per procedure			
Autoclave used per policy/procedure			
Biological indicators performed per policy – minimum weekly			
Cleanliness of facility evident			
Operating rooms cleaned between patients following disinfectant manufacturer recommendations.			
Evidence of terminal cleaning being performed daily by housekeeping			
Masks removed at end of case and not worn dangling			
Soiled shoe covers removed prior to leaving surgical area.			
Staff demonstrates proper technique for gowning and gloving			
PACU monitors dust filters cleaned			
	YES	NO	ACTION TAKEN

Nurse Call system functioning and cords are not frayed			
No electrical wires are exposed			
No electrical outlet covers are missing			
All light bulbs are in working order			
All light covers are clean and free from bugs			
All walls are free from holes, or other damage			
Staff can verbalize the location and purpose of MSDS sheets			
MSDS binder is complete (perform spot check on 2 random chemicals)			
1)Chem. Name:			
2)Chem. Name:			
Staff demonstrates knowledge of Exposure Control Plan and location of information.			
Staff verbalizes knowledge of fire evacuation plan			
Staff observed using proper hand hygiene			
Biohazard containers appropriately labeled			
Appropriate handling of Biohazard products in practice by staff.			
Appropriate surgical attire being worn by staff			
Nothing stored within 6” of floor, or 12” of ceiling			
Eyewash station intact and functional			
No eating, drinking, application of cosmetics in patient care areas.			
All exit signs are illuminated			
Nothing that can be damaged by water is being stored under the sinks			
All egress routes are free from obstruction			
All surfaces are clean and free of dust or spills			
All patients charts are being handled with regard to HIPAA rules			
Fire Extinguishers are checked and signed (all 11) place tally marks for each one signed.			***See Evacuation Egress Route Maps for locations of all fire extinguishers**
THE FOLLOWING LOGS ARE UP TO DATE			

Crash Cart checked daily			
Mo. Crash Cart hands-on insp. Doc.			
Daily defibrillator strip present			
E-tank O2 cylinder checked daily			
Malignant Hyperthermia			
Latex allergy checked			
Autoclave/ spore culture testing			
Refrigerator Temperature			
Medical Gases			
OR #1			
OR #2			
OR #3			
OR #4			
Anesthesia Cart verification			
OR #1			
OR #2			
OR #3			
OR #4			
CLIA Waived Testing- QC			

Comments:

_____

_____

_____

_____

_____

_____

_____

_____ _____

Inspectors Signature **Date**

Source: Tucson (AZ) Orthopaedic Surgery Center.