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IN THIS ISSUE

- Should you consider investing in robotics? . . . cover
- Focus on patients at highest risk of falls 28
- Volunteers help cut falls by 46% 28
- ***Same-Day Surgery Manager*:** Brave steps for you to take for 2012. 31
- Tips for writing your strategic plan 32
- U.S. surgeons, patients don't discuss end-of-life wishes . . 33

Enclosed in this issue:

- ***SDS Accreditation Update:*** Tips for acing your Medicare survey; What to do when you disagree with surveyor; Meeting standards for strategic plan

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AHC Media

Robots: A wise investment, or a luxury you can avoid? Consider these issues

ECRI Institute says they should be on your watch list

The ECRI Institute has said robotics should be on your radar for 2012, according to its top 10 watch list for CEOs, CFOs, and COOs[1] *(See complete list, p. 27.)* The list included one chapter with the provocative title, "Are costly robot wars coming to your operating room?

If the interviews conducted by *Same-Day Surgery* are any indication, the answer is yes. However, the field is not without its problems.

"OR scheduling and workflow problems are reported frequently in new surgical robot programs," says **Robert Bense**, clinical manager at ECRI Institute. The reason? Physician learning curves vary widely, Bense says. Factors include the clinical specialty, prior surgical experience, and procedure types, he says. "In most case, they are facility-specific issues that improve as the program matures and surgical teams gain experience," Bense says.

To address the problem head on, create a team of surgeons, nurses, anesthesiologists, and managers who discuss ways of limiting and standardizing operative time, suggests **Hiep T. Nguyen**, MD, FAAP, The Rose Zimmerman Mandell chair in innovative urological technol-

EXECUTIVE SUMMARY

ECRI Institute says that robotics should be one of the top 10 areas that healthcare leaders watch in 2012.

- Experts debate whether there are improvements in care and outcomes that justify the cost.
- Physician learning curves can create OR scheduling and workflow problems. At the beginning, you might want to bring in experienced surgeons to perform part of the procedure.
- Establish credentialing criteria that include training from the manufacturer, a set number of proctored cases, a set number of cases to be reviewed once the surgeon is operating on his or her own, and a minimal number of cases per year.

ogy, associate professor in surgery (urology), at Harvard Medical School and director of robotic surgery at the Research and Training Center, Department of Urology, Children's Hospital Boston, all in Boston

"Egos will be hurt, but surgeons need to work with others to help decrease the learning curve time when they are learning," Nguyen says. "This can be accomplished by bringing in other surgeons who are more experienced to do part of the procedure with the eventual goal of transition to doing the entire case without assistance."

Surgeons must accept that procedures can be done with graduated responsibility, he says. "It is a learning process and will take time, but this process is lessened with cooperation and understanding of the process," Nguyen says.

Keep in mind that the robot is not a replacement, says **Randy Fagin**, MD, chief administrative officer, Texas Institute for Robotic Surgery, Austin, and senior medical advisor for training, Intuitive Surgical, Sunnyvale, CA. Intuitive Surgical develops, manufactures, and markets robotic technologies, including the da Vinci Surgical System. "The robot is not a replacement for surgical skill," Fagin says. "It is an enabling technology, an amazing tool, with which surgeons can do things they couldn't normally do, but it is not a replacement for skill."

There is no one standard for training, but "equipment training from the manufacturer along with proctored, peer-to-peer, physician training is the most common method," Bense says. Intuitive has robotic simulators that simply require a computer interface for a surgeon to improve efficiency at a console, Fagin says. "That's a huge step forward in allowing surgeons to improve skill before there's a live patient there," he says.

Surgeons must reach proficiency, but the number of cases needed to reach that level isn't clear cut, sources say. According to the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) and the Minimally Invasive Robotic Association, surgeons can receive credentials only from the institution where they wish to perform procedures, based on surgical proficiency, not on the number of procedures performed, Bense says. "Recommended proficiency levels for robot-assisted procedures can range from a few dozen cases to several hundred cases, depending on the type of procedure and surgical specialty group referenced," he says.

Ultimately, it's up to individual facilities to develop credentialing guidelines and standards for robotic surgery, Bense adds. Typically those criteria include training from the manufacturer, a set number of proctored cases, a set num-

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Editorial Questions

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ber of cases to be reviewed once the surgeon is operating on his or her own, and a minimal number of cases per year to maintain the credentialing status, Fagin says.

Is the cost worth it?

One major roadblock standing in the way of robotics being applied in many outpatient surgery settings is the initial investment, especially considering that DRG reimbursement is the same whether the procedure is performed with a robot or not. Some payers are willing to use a robotic modifier billing code that pays 20-40% higher, Nguyen says.

He adds, however, "The cost of the system is the major limitation for allowing it to have widespread application and usage."

This roadblock potentially could create a technology gap between freestanding surgery centers and hospitals, some sources say. However, this roadblock might not be permanent, Bense says. "This could change in the future, as more hospitals acquire robots, more robot-assisted procedures are developed, and per-procedure costs are reduced," he says.

Also, robotics could be used more often for less complex procedures specifically for training, for example, to allow surgeons to become skilled at performing basic procedures before they attempt more complicated ones, Bense says. "In some markets, a shift like this could put pressure on outpatient surgery centers to acquire robotic technology in order to remain competitive."

Fagin maintains that once surgeons become proficient on the system, he has seen improved productivity as compared to the open or laparoscopic equivalent. Nguyen concurs.

So does robotics improve care and long-term outcomes, and are robots worth the cost?

Nguyen says, "From the patients' side, yes. From the surgeon's side, yes. From the managers' side, no. The value added includes ease of surgery, less pain, shorter recovery, etc., but the bottom line is cost."

Not everyone is convinced about improved outcomes. "At present, there is little definitive evidence that robot-assisted surgery is superior to traditional laparoscopic surgery for most applications, and no significant improvements in patient care and/or long-term outcomes have been clearly demonstrated thus far," Bense says. "Proponents of robotic surgery, however, believe that utilization will continue to increase and more tangible benefits will begin to emerge."

According to Fagin, many studies already have shown that robotic procedures have less pain, shorter hospital stays, and less blood loss as compared to the equivalent open procedure. He adds, "As surgeons continue to advance, surgeons become more proficient, robotics will continue to expand into many more areas," he says.

Also, the cost news about robotics isn't all bad, Fagin is quick to add. "We've seen at our own institute, robotic hysterectomy vs. lap hysterectomy, when you look at the case from a purely financially standpoint, our contribution margin is better for robotics," he says. *(For more on this topic, see "Which is better: open, laparoscopic, or robotic?"* Same-Day Surgery*, January 2012, p. 9.)*

REFERENCE

1. ECRI Institute. ECRI Institute's Top 10 C-Suite Watch List: Hospital Technology Issues for 2012. 2012; Plymouth Meeting, PA. ■

Top technologies to watch in 2012

Experts at ECRI Institute in Plymouth Meeting, PA, compiled a Top 10 list of important technologies and technology-related issues that hospital and health system leaders should pay close attention to this year.

The effort began with an open call for nominations throughout ECRI Institute. The list of 30 technologies and related issues that were submitted were circulated among key ECRI Institute thought leaders, who individually ranked their Top 10 choices. A ratings consensus panel helped reach agreement.

The final list is:

- Robotic-assisted surgery
- Minimally invasive bariatric surgery
- Electronic health records
- Digital breast tomosynthesis
- New CT radiation reduction technologies
- Transcatheter heart valve implantation

- New cardiac stent developments
- Ultrahigh-field-strength MRI systems
- Personalized therapeutic vaccines for cancer
- Proton beam radiation therapy ■

Target those most at risk of falls, but others too

Fall prevention efforts usually target those thought most likely to fall, but does that leave the other patients at risk if no one is paying attention to their potential for falling? A special focus on high risk patients doesn't have to shortchange others, says **Pamela E. Toto**, PhD, OTR/L, BCG, FAOTA, an occupational therapist at the School of Health and Rehabilitation Sciences at the University of Pittsburgh in Pennsylvania.

Beginning Oct. 1, 2012, ambulatory surgery centers (ASCs) will be required to submit data on five quality measures to avoid a payment adjustment in 2014. They are patient fall; patient burn; wrong site, side, patient, procedure, or implant; hospital admission/transfer; and prophylactic IV antibiotic timing. The Centers for Medicare and Medicaid Services (CMS) has the statutory authority to apply a 2% penalty on ASC payments.

The highest risk patients should always get more attention to prevent falls, even when everyone else is still at risk to some degree, Toto says. *(For information on those who are at most risk for falling, see "Study Identifies Patients at Risk for In-Hospital Falls,"* Same-Day Surgery Weekly Alert*, Dec, 8, 2011. To sign up for this free weekly ezine, go to www.ahcmedia.com. In the left column, at the bottom, select "Free Alerts.")*

"If you look at the literature, I could make the argument that the majority of people in the hospital are at risk for falls," Toto says. "I could go to a nursing home and tell you that 100% of the patients are at risk for falls. But you can make them into high, medium, and low risks relative to that particular population, and that can still be useful in directing your efforts."

The extra attention to high-risk patients is justified by the data that identifies risk factors, Toto says. That focused attention doesn't mean that other patients don't need the basic fall prevention efforts that can apply to anyone, such as keeping the room free of clutter and providing grab bars, she says. "We know, however, that certain patients at risk in certain ways or in certain conditions. If we know that a patient has urge incontinence, she is going to be in a hurry when she gets up, and that situation puts her at risk more than a patient without that condition," Toto says. "It's appropriate to provide more assistance and more education about that scenario even if you don't address that with everyone."

Healthcare providers are using increased knowledge about the risk factors for falls to prevent accidents in more practical and patient-friendly ways, Toto says. Rather than trying to keep patients in bed to avoid falls, the traditional approach, more hospitals are providing assistance to patients when they want to get up.

"It's not about limiting their ability to move, but rather providing them a safer way to move," Toto says.

SOURCES

• **Pamela E. Toto**, PhD, OTR/L, BCG, FAOTA, Department of Occupational Therapy, School of Health and Rehabilitation Sciences, University of Pittsburgh (PA). Telephone: (412) 383-6612. E-mail: pet3@pitt.edu. ■

Volunteer program cuts falls 46%

Some of the best ways to prevent falls require personal, hands-on attention to individual patients, but hospitals don't have enough staff to provide as much of that tending as they

EXECUTIVE SUMMARY

A hospital program that relies on volunteers to check up on patient at risk for falls has reduced falls by 46%. The program costs virtually nothing and has proven successful for several years.

• Volunteers visit patients to assess the situation for fall dangers.
• They also verify that the bed or chair alarm is activated.
• Staff members are held accountable for deficiencies in the fall protocol.

would like. One hospital has found that volunteers are eager to do the job, and it has cut falls by a whopping 46% as a result.

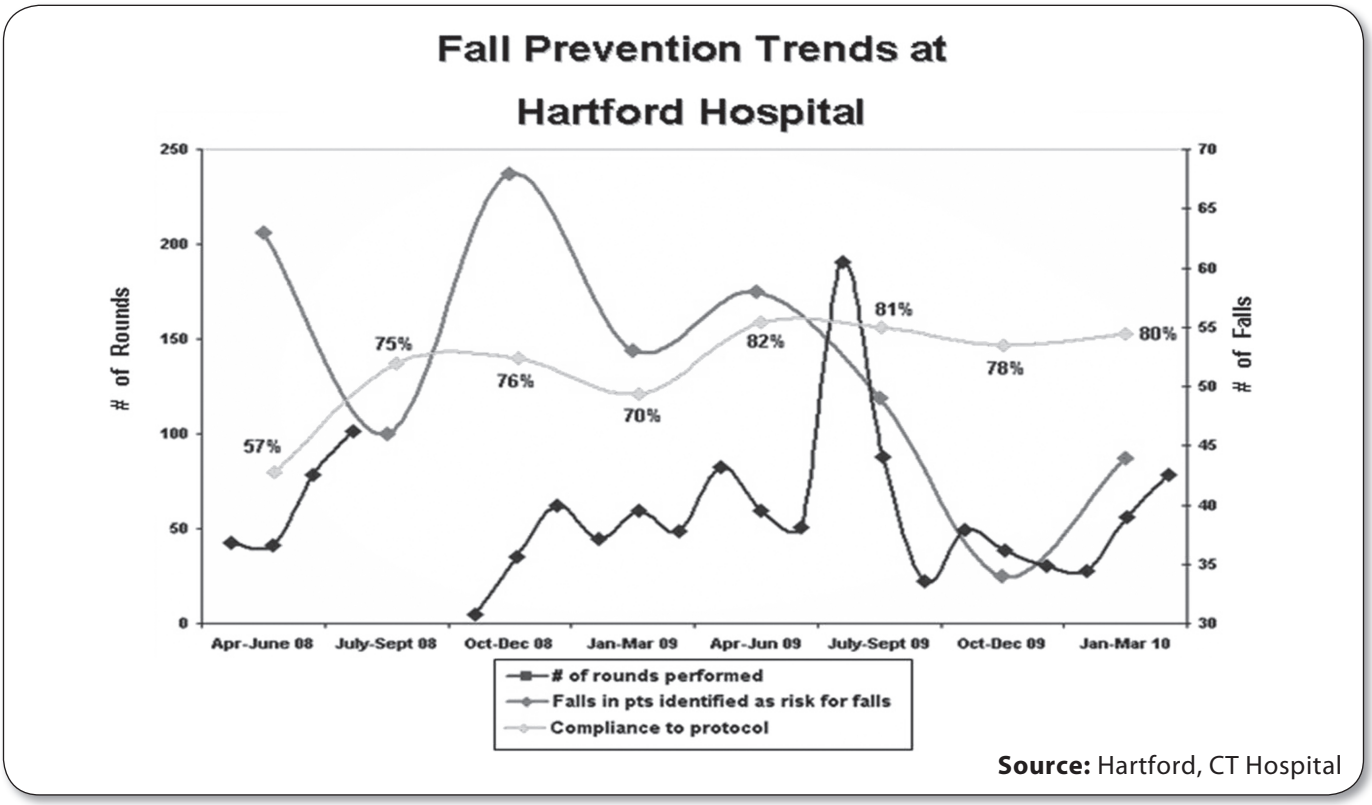
Overall compliance with fall-prevention protocol has improved significantly since the initiation of the program in April 2008, says **Christine Waszynski**, APRN, a geriatric nurse practitioner and clinical nurse specialist in the geriatrics program at Hartford (CT) Hospital. The volunteer program, which costs the hospital virtually nothing, started out with only two volunteers from a local job corps academy and has grown to 16 volunteers.

Volunteers are particularly well suited to ensuring compliance with fall prevention protocols, Waszynski says. Many of the volunteers are teens who can be shy about interacting with patients in a way that requires them to strike up a conversation, but Hartford's Fall Prevention-Safety Monitor Volunteer Program provides them a specific set of factors to check with each patient. *(For a video showing how the program works, go to http://vimeo.com/user7284985/videos and choose the video titled Safety Volunteer Program at Hartford Hospital. For more on the results of the program and tips for replicating it, see the stories on p. 30 and p. 31.)*

The program was developed to monitor and increase staff compliance with fall-prevention protocol measures, reduce patient falls, and increase involvement of patient and family in creating and maintaining a safe environment, Waszynski says. Volunteers are recruited and trained specifically for the program after completing the standard mandatory volunteer orientation. "We teach them to look for measures that should be in place for patients who are at risk for falls, and they correct any oversights they might find," Waszynski says. "They also remind patients and families about the risk of falling and their role in fall prevention."

The volunteers visit all patients who have been designated as a fall risk, which can include up to 80% of patients on some units. On each visit, the volunteer introduces himself or herself to the patient and family, and the volunteer explains that the purpose of the visit is to help reduce falls and keep the patient safe.

Using the hospital's fall safety screening tool, the volunteer confirms that the patient is at risk and then checks to see that all aspects of the fall prevention protocol are being followed. *[A copy of that screening tool is included in the online issue of* Same-Day Surgery. *For assistance, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]* That



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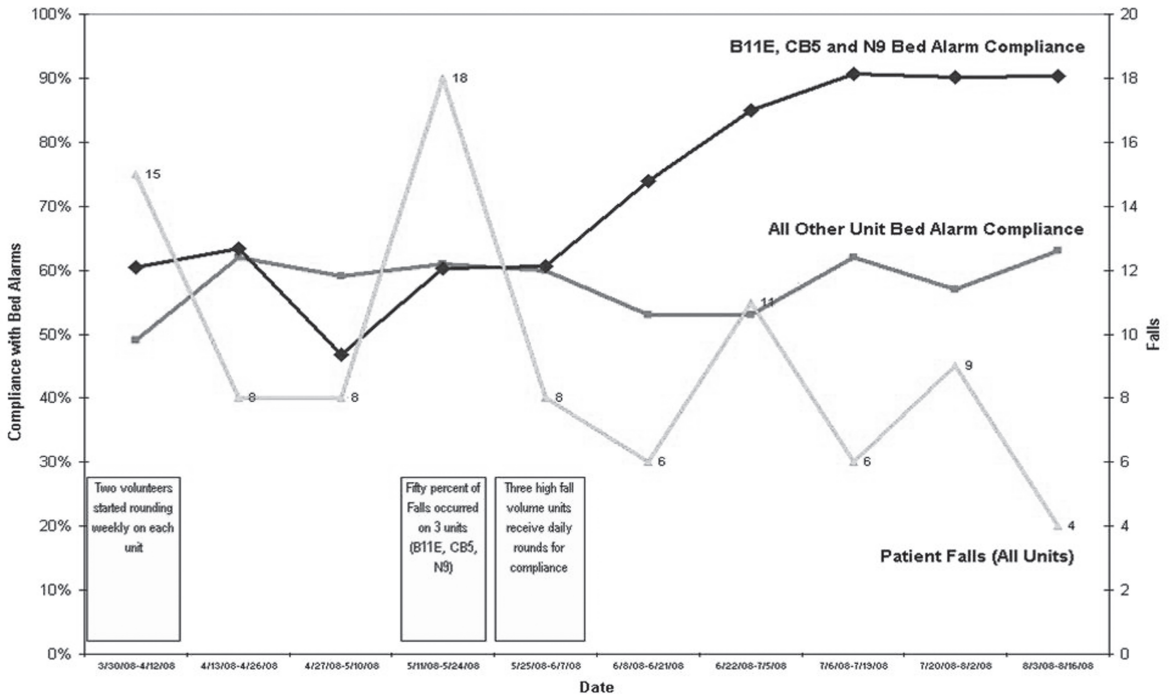

Source: Hartford, CT Hospital

includes verifying that the patient is wearing the hospital's green fall risk bracelet, there is a green triangle on the door, and the bed or chair alarm is activated. The volunteer also scans the room for fall hazards and improves safety however necessary, such as moving the phone to within the patient's reach, removing clutter, and making sure the patient knows how to call for assistance.

Each bedside check is recorded by the volunteer. At the end of the volunteer's shift, the results are reviewed with the unit's nurse manager or charge nurse. The findings also are sent to the fall-prevention team coordinator, who compiles the results for each unit monthly and presents them as a graph depicting compliance over time.

"We've used this program to help us change culture. When we started this program, the culture was 'patients fall, and there's nothing we can do about it,'" Waszynski says. "Our compliance with fall prevention was 50% at best. By talking about this all the time and using our volunteers, now our compliance is about 90%."

SOURCE

• **Christine Waszynski**, APRN, Geriatric Nurse Practitioner, Geriatric Clinical Nurse Specialist, Geriatrics Program, Hartford (CT) Hospital. Telephone: (860) 545-5630. E-mail: cwaszyn@harthosp.org. ■

More rounding means better fall compliance

Two years of the Fall Prevention — Safety Monitor Volunteer Program at Hartford (CT) Hospital has yielded significant results, says **Christine Waszynski**, APRN, a geriatric nurse practitioner and clinical nurse specialist in the geriatrics program. *(See the charts, above and on p. 29.)* In addition to reducing falls 46%, analysis of the bed check results shows these findings:

• **There is a relationship between the frequency of volunteer rounding and the degree of staff compliance.** The more often the volunteers visit, the better the staff complies with the fall prevention protocol.

• **Nurses welcome the volunteers, seeing them as an extra set of hands to help with monitoring they don't have enough time to complete.** Volunteers report that nurses thank them for helping keep patients safe and helping

them do their jobs better.

• **Staff members report that the volunteer rounding helps remind them to follow the fall prevention protocol at all times.** Units even had unofficial competitions to see who could achieve 100% compliance more than the others. Staff members sometimes use the volunteers' checklist to conduct their own fall safety rounds.

• The program receives high marks from volunteers, patients, and family members. Volunteers can see the results of their work and feel appreciated by the staff. Patients and family members are thankful that the hospital is looking out for the patient's safety. ■

Clinical champion is a must for falls program

Who wouldn't want to replicate a falls prevention program that cuts falls 46%? If you want the same results, here are some tips from **Christine Waszynski**, APRN, a geriatric nurse practitioner and clinical nurse specialist in the geriatrics program who works with the Fall Prevention-Safety Monitor Volunteer Program at Hartford (CT) Hospital:

• **You must have a clinical champion.**

The program can't be run solely out of volunteer services. A clinical professional from the fall prevention team needs to work closely with the volunteer coordinator to train the volunteers, monitor their work, and make good use of the data they collect.

• **Give the volunteers concrete, specific instructions.**

Don't educate them about fall prevention and then tell them to visit patients to look for fall hazards. Provide a checklist with precise items to inspect, correct, and talk to the patient about. The volunteers will be much more comfortable with their roles and more effective.

• **Involve the nursing department.**

Part of the program involves providing feedback to the nursing staff and holding staff accountable for deficiencies found by the volunteers. To ensure that the volunteer program is seen as an aid to the nursing staff rather than anything punitive, the nursing department needs to be on board from the start. ■

Same-Day Surgery Manager

Questions and answers to help you survive 2012

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

Can you believe that 2012 is almost 25% over! It just started, for heaven's sake! Myself, I'm still struggling with issues from 2011.

One of the great things I enjoy about writing this column is the wonderful feedback I get after each column. I received quite a bit of feedback from the January 2012 column on revamping surgery in the outpatient area. I think I hit a nerve. If you didn't get a chance to read it, go back and grab your issue. I had comments from several hospital CEOs and owners of GI and pain centers, as well as staff members who work with them. They already are noticing the trend. For help in this area, read on.

Question: We are a GI center only, and while we have had some decline in the volume of cases over the past year and a half, we are financially struggling with volume that we used to flourish with. Our center is up for sale by our owners. How can that happen, and so quickly? We don't see the "numbers" (as the docs call them), but we feel the void and the insecurity.

Answer: Surprisingly, with a number of single-specialty facilities at the tipping point (an event of a previously rare phenomenon becoming rapidly and dramatically more common), it comes on quickly with the decline in even a small reduction in cases being performed. The reason those decreased cases are so dramatic is that those last few hundred cases per year are the ones that generate the profit and lead to financial success.

Question: I have heard that there are opportunities for recruiting cash-paying patients from other countries to hospitals and even surgery

centers in the United States. Is that true, and is that an option for our hospital?

Answer: Yes, and many hospitals and surgery centers are doing just that. You need to stand out, however, to be successful. You need to have a unique procedure that you perform, such as bariatric procedures, penile implants, cardiac, transplants, etc., to be attractive to international patient will to travel to the United States for surgery that is technically difficult or unavailable in their country. These patients want state-of-the-art facilities and first class service when they arrive. The vast majority of hospitals and surgery centers cannot live up to those standards. *(To read about one facility that caters to international patients, see "Consider your options for recovery care — Services range from hotels to home health,"* Same-Day Surgery*, May 2011, p. 50.)*

Question: Our hospital has never laid off staff before. In the last few months, they have started aggressively reducing personnel. Is this just the beginning?

Answer: Unfortunately, it is just the beginning. I have spoken about and written about so often over the past few years the need for individual growth and achievement within your respective organization. You need to stand out in the crowd, or you will stand out with the crowd.

Question: Our surgery center has started "flexing" (rolling reduction in hours for staff) staff this year. We have never done this before, and it is demoralizing to us all and, quite honestly, scary. Have you heard of others doing this, or are we the only ones?

Answer: First, you and everyone reading this need to get out and interact with your peers, either online or through local and national conferences, so you will not feel so isolated. Yes, it is going on in many facilities, including hospital surgical departments, and it is everywhere. In a way, it is not such a bad thing, unless you need every one of those 40 hours per week. It allows the facility to reduce everyone's hours just a bit during slow periods to avoid terminating staff.

While it is troublesome to all, it is better than a reduction in staff. I always tell "flexed staff" that this is the perfect time to take courses at your local college to perfect your skills and desirability to your employer. As nurses and techs, we have always been (or felt) we were a protected class. Not anymore. You need to look sharp and be sharp.

Question: Several of our surgeons have become employees of the hospital. I didn't know that could even happen, but obviously it does. They no longer do late elective cases or seem to "bust our butts" on turnaround times and starting on time. It doesn't seem like this is the way to be more productive. Is it just me?

Answer: No, not just you. We see it too. Hospitals' physician employment jumped 32% from 2,000 previously to roughly 212,000 physicians in 2010, according to the AHA Hospital Statistics, 2012 Edition. That number means hospitals employ almost 20% of all physicians, notes a Hospitals & Health Networks Daily article. That trend is going to continue, and I predict that we will continue to see a reduction in productivity that you so accurately described.

So, with all the above going on, I have a motto on my web site and all of my e-mails that says: "Audentes Fortuna luvat." ("Fortune favors the brave.") Consider it. *[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. Twitter: @SurgeryInc.]* ■

Surgery stays on track with strategic plan

Planning process covers critical points

At Ohio State University Medical Center in Columbus, there is a standard eight-step process for writing strategic plans.

It includes coming up with a mission, vision, and values; an internal and external analysis; setting goals and objectives; creating an action plan; and performance metrics to measure the plan, explains **Daniel Like**, MHA, chief operating officer of ambulatory services at Ohio State. *(See order of steps for strategic planning process on p. 33.)*

Therefore, when a strategic plan was put in place for a hospital-based ambulatory surgery center (ASC) several years ago, this content was followed by the planning committee that included a facilitator from the planning department, surgical leadership, the chief medical offi-

cer, key health system hospital administrators, and representatives from nursing and marketing.

"We hired an external consultant to look at our plan for opportunities for improvement," says Like.

During the initial planning, the team determined that the surgery center should be diverse because reimbursement for a particular service line could change and a single specialty surgery center could be financially risky. The service lines at the medical center includes a balance of ophthalmology; ear, nose and throat (ENT); plastic surgery; and hand surgery.

"As reimbursement changes across those service lines, we are balanced in our approach," says Like.

Keep plan up-to-date

Strategic plans are not documents that can be tucked away in a file and forgotten. They must be monitored and updated. *(To learn what accreditation agencies require in regard to strategic plans, see article in* Same-Day Surgery Accreditation *Update supplement included in this issue of* Same-Day Surgery.*)*

To stay abreast of the reimbursement changes being considered by legislators, stay connected to state and national associations, experts advise. Subsequently, use the information to plan ahead. At Ohio State Medical Center, there is a reimbursement specialist that helps departments project certain scenarios that might result with reimbursement changes and develop ways to adapt to the changes.

To forecast surgery volume, look at how many physicians are in each service; how many surgeries they can complete based on the number of surgical days in a particular year; the demographics of your service area; and the market, Like says. Some states collect data on hospital outpatient surgery and ASC procedures that can be used. Also helpful is membership in an organization that has a significant number of forecasting tools, such as the Health Care Advisory Board, with headquarters in Washington, DC.

Before a strategic plan is put in place at Ohio State, performance indicators are identified and then tracked. Twice a year, scorecards based on the core metrics are reviewed. However, a significant amount of data that is easy to track is reviewed on a monthly basis such as case volumes by service, financials, turnover times between cases, and patient satisfaction scores. Problems are swiftly identified.

"We have a formal presentation of our performance indicators twice a year, but track them more frequently," explains Like. ■

Medical center has eight-step process

The Ohio State University Medical Center in Columbus has an eight-step strategic planning process that includes the following:

- **Strategy formulation.**
  1. Identify mission, vision and values.
  2. Perform external competition and market analysis.
  3. Perform internal analysis of resources and capabilities.
- **Strategy translation.**
  4. Identify goals and objectives.
  5. Identify priorities based on goals.
- **Strategy execution.**
  6. Develop action plans.
- **Monitor and review.**
  7. Monitor strategic indicators, and conduct performance tracking.
  8. Perform annual review of assumptions, trends, and goals. ■

Surgeons don't discuss end-of-life care

According to a recent survey,[1] published in the *Annals of Surgery*, many U.S. surgeons fail to discuss their patients' wishes in case a risky operation goes awry, and even more say that they would not operate if patients limited what could be done to keep them alive. The survey indicates that the restrictions are being debated among doctors.

Margaret Schwarze, MD, an assistant professor at the University of Wisconsin School of Medicine and Public Health, Madison, WI, who was one of the survey's authors, said that reportedly, "[surgeons] feel the advance directive basically ties their hands behind their back, and they're not given the tools to get them through the surgery."

The survey's authors asked 912 surgeons who regularly perform risky operations 14 questions on how they discuss a patient's advance directives and whether the directives influence their decision to operate. More than four out of every five surgeons discussed which forms of life support the patients would like to limit. But only about half asked specifically about the patient's advance directive, which can include restricting the use of feeding tubes and ventilators to keep a person alive.

"I think some surgeons just don't discuss advance directives because they think it's so irrelevant," Schwarze added.

The Centers for Medicare and Medicaid Services (CMS) requires ambulatory surgery centers to ask patients about advance directives before their surgery procedure. More than half the surgeons said they would not operate if an advance directive limited what could be done to keep a patient alive after surgery.

The researchers said such instructions also can cause tension between the surgeon and the patient because it shows the patient might be unwilling to accept the therapies that come with high-risk operations. The study also found that heart surgeons appeared to be much more likely than brain surgeons to decline an operation.

REFERENCE

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Military hospital advances medicine

Facility in Germany treats wounded soldiers

At Landstuhl Regional Medical Center, a military hospital operated by the Army and the Defense Department in Landstuhl, Germany, medical-surgical teams save the lives every day of warriors wounded in Afghanistan and, until recently, saved troops wounded in Iraq. But that's only part of their success.

Here, a side benefit of providing care from the point of injury in the war zone to what doctors call "definitive care," care given to manage a patient's condition, has been to advance the practice of military medicine and, ultimately, the practice of medicine everywhere.

For medical teams at Landstuhl, the brutality of combat and the urgent need to respond to the wounded have yielded advances in en-route lung bypass, whole-blood transfusion, and even combat tourniquets that can be applied with one hand and in the dark.

"Ten years ago, we had to stabilize [patients] before we could move them," said Army Col. (Dr.) **Jeffrey B. Clark**, commander of the Landstuhl Regional Medical Center. "Now what our Air Force can do is basically put an intensive care unit in the back of a C-17 with a critical-care air-transport team so we can continue to stabilize while we are moving."

The critical-care team program is part of the Air Force aeromedical evacuation system. A team consists of a critical care physician, a critical care nurse, and a respiratory therapist, along with supplies and equipment.

Over the past 70 years, and especially over the past 10, a combination of evolving surgical capabilities, technology-intensive critical care, and long-range air transport have pushed medical-surgical capability far forward. This effort saves lives and helps to reduce the load on teams at Landstuhl, whose staff since 2004 has treated nearly 66,000 patients from Iraq and Afghanistan and military personnel and their families stationed in Germany.

From the United States, 48 visiting civilian trauma surgeons rotate in to Landstuhl for two weeks at a time from hospitals at Johns Hopkins University in Baltimore, the University of Cincinnati in Ohio, the Oregon Science and Health University in Portland, and others. Landstuhl is the only hospital outside the United States designated a Level I Trauma Center by the American College of Surgeons. Its survival rate for trauma patients is 99.5%.

"About 14,000 of the 60-some thousand were actual battle injuries," Clark said. "We have returned to duty about 20 to 21% of those who have come to us from Iraq or Afghanistan, which is huge."

Every week, every critically ill patient is discussed on a video teleconference that spans nine time zones on three continents. Attendees include NATO colleagues such as the Medical Emergency Response Team (MERT), the British paramedic units that have physicians on the helicopter teams, the forward surgical team, the

three combat support hospitals and Landstuhl, partners on the East Coast and San Antonio, and the Air Force Aeromedical Evacuation service, said Air Force Maj. (Dr.) **David H. Zonies**, Landstuhl's trauma director.

"Everyone discusses their care that's provided along the continuum," he added.

Military innovations adapted by civilians

The broad influence of Landstuhl's medical-surgical innovations is seen 25 to 30 times a day, every time a patient undergoes surgery in an operating room, Zonies said.

"From the last 10 years, a lot of the evidence that we've gathered has changed not just the practice of military medicine, but has now been completely translated back into civilian practice," Zonies said.

For example, the way patients are resuscitated has changed significantly since 2001, he said. For the past 50 years, the standard practice for storing blood has been to break it up in to components such as red blood cells, platelets and plasma, he points out. When it was time to give stored blood to a patient, "we'd give them a bunch of red cells, and maybe for every four of those we'd give a unit of platelets [and plasma]. That was how it worked," Zonies said. "Well, we noticed that our mortality rate was extremely high doing that, and it was standard practice."

About seven years ago, Army surgeon **Dr. John Holcomb** and Air Force surgeon **Dr. Donald Jenkins**, now both retired, observed that transfusions with 1-to-1 ratios of plasma and platelets to blood cells lowered patient mortality rate by about 15%. They began to use the practice for combat trauma patients, Zonies said. "That is how we changed our guidelines for how we resuscitate all our patients," he said. "We have now taken that evidence back to our civilian counterparts, and they've been able to replicate the same approach in civilian practice, and it has decreased mortality there."

Another life-saving innovation involves a procedure called extracorporeal membrane oxygenation, or just extracorporeal life support. To perform this lung bypass, or cardio-pulmonary bypass, a special team from Landstuhl flies downrange to perform en route as the patient is evacuated from the war zone. The suitcase-sized device takes the patient's blood through an artificial membrane that replaces carbon dioxide with oxygen.

The technology, developed by a team at the University of Regensberg in Deutschland, Germany, about a four-hour drive from Landstuhl, has been around for about 30 years, but only in the past decade, "has it gotten to the point where everyone feels this is a safe modality that truly … improves patient outcomes," Zonies said.

So far, Landstuhl has the only capability in the Defense Department of providing that kind of support, Zonies said. At Landstuhl, the hospital itself is a sprawling complex built in the early 1950s. By 2018, a new hospital that's more contemporary and flexible will replace it, to be called the Kaiserslautern Community Medical Center.

"It's a very special mission," Clark said. "We take a tremendous amount of pride in what we do, and so we consider it a privilege. In many ways, it is so terribly uplifting to take care of wounded warriors, to take care of our own. But … it can wear on you, so we try very hard to look out for each other." ■

CNE/CME INSTRUCTIONS

Physicians and nurses participate in this CNE/ CME program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■

COMING IN FUTURE MONTHS

- What should you be doing with a patient's advance directive?
- Have nursing students perform clinical rotations at your facility
- Center nets top patient satisfaction awards – Here's how
- What reading level should your informed consent forms be?

CNE/CME OBJECTIVES

- **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.

CNE/CME QUESTIONS

1. What is a common problem reported frequently in new surgical robot programs, according to Robert Bense, clinical manager at ECRI Institute.
   A. OR scheduling
   B. Workflow problems
   C. A & B
   D. None of the above

2. In the fall prevention program that reduced falls by 46% at Hartford (CT) Hospital, who is responsible for checking patient rooms to ensure compliance with the fall protocol?
   A. The unit's director of nursing
   B. Physician interns
   C. Volunteers
   D. Family members of patients

3. To forecast surgery volume for a strategic plan, what areas should you consider, according to Daniel Like, MHA, chief operating officer of ambulatory services at Ohio State University Medical Center?
   A. How many physicians are in each service
   B. How many surgeries they can complete based on the number of surgical days in a particular year
   C. The demographics of your service area
   D. The market
   E. All of the above

4. In a study regarding surgeons and end-of-life care, what percentage of surgeons said they would not operate if an advance directive limited what could be done to keep a patient alive after surgery?
   A. 10%
   B. 25%
   C. One-third
   D. More than half

SDS ACCREDITATION UPDATE

Covering Compliance with The Joint Commission and AAAHC Standards

For Medicare survey success, managers must strive for excellence

If ambulatory surgery center (ASC) managers want to ace the Medicare survey, they should make sure staff members understand what will be assessed and current best practices for the standards.

"Compliance with the standards isn't just about passing a survey, but to ensure a high level of quality care is being provided to patients. Once that is ensured, survey success follows," says **Jan Allison**, RN, CHSP, director of accreditation and survey readiness, Clinical Services Team, Surgical Care Affiliates in Birmingham, AL.

Managers should carefully examine surgery center protocols and procedures to make sure they are up to date with the most recent, commonly accepted medical practices, according to **Thomas Hamilton**, director of the Survey and Certification Group for the Office of Clinical Standards and Quality, Centers for Medicare & Medicaid Services (CMS) in Washington, DC. Also make sure staff receives adequate training in infection control, then examine their fidelity of execution, says Hamilton.

"Make sure staff is following the protocols," he adds.

To ensure high quality care is provided patients, assess clinical and quality needs periodically, and also assess also the competency of staff in critical areas, advises **Lee Anne Blackwell**, RN, BSN, EMBA, CNOR, group director of clinical services for Surgical Care Affiliates. Get direct feedback, and conduct competency and performance reviews. "Based on your findings, set up focused training," says Blackwell.

Managers need to perform their own mock surveys on a routine basis to ensure there are no deficiencies in center processes and teammate behaviors, says Allison. When problems are identified, put an action plan in place immediately, she advises. For example, if equipment is not being cleaned appropriately after it is used with patients, go through the cleaning process according to the manufacturer's recommendations.

Although surveyors will observe processes and behaviors in action to ensure safe delivery of patient care, it is still critical to have documentation in place to support ongoing compliance with many of the standards, adds Allison. For example, there needs to be current and complete governing body meeting minutes, policies and program plans, education and training documentation, medical records, credentialing and human resource (HR) files, quality improvement activities, and inspection and maintenance reports.

Keep up on program oversight

Many ASCs struggle during surveys with the quality assessment and performance improvement (QAPI) and infection prevention sections of CMS survey standards, says **Beverly Kirchner**, RN, CNOR, CASC, president of Genesee Associates, a Dallas-based independent consulting business working with ASCs and hospital systems with ASCs to improve quality of care, safety, and regulatory compliance.

Problems occur because they do not maintain the programs on a regular basis or they have done nothing but collect data and cannot show how it was used to improve quality of care, she adds. To maintain survey readiness, review the programs weekly or at

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least monthly, she advises.

Get organized, says Kirchner. "The more you organize your information, the better the survey will go," she explains. She suggests using binders, or some other method, to store data.

Also important are meeting minutes covering all required elements. "I suggest administrators set up a calendar of what month the reports will be discussed at meetings," says Kirchner. *[See Kirchner's sample calendar inserted with the online issue of* SDS Accreditation Update. *For assistance, contact customer service at customerservice@achmedia.com or (800) 688-2421.]* Set up template agendas with the data or information that needs to be reported, so nothing falls through the cracks.

While quarterly meetings formerly were sufficient, it is easier to meet at least bimonthly now to address accreditation changes, she adds. Although it has been more than two years since CMS implemented an improved survey process that promotes better infection control practices, ASCs still struggle with some issues according to the experts.

For example, with infection control, hand hygiene still is problematic, says Allison. "A nurse can perform hand hygiene when she enters the patient's bay, but then she grabs the curtain and pulls it closed, then proceeds to touch the patient," she explains. *(For details on how to better prepare for a survey, see article, right.)*

Hamilton recommends that all ASC managers keep a copy of the article on the results of the initial pilot for new CMS survey practices that appeared in the June 2010 issue of The Journal of the American Medical Association (*JAMA*).[1] "It has useful information in regard to particular types of problems that were identified in that pilot," he explains. *(For a summary of the pilot target areas described in the* JAMA *article, see p. 3. For more information, see "Ambulatory surgery found lacking in proper infection control procedures — Experts offer advice on being prepared for your survey,"* Same-Day Surgery, *June 2010, p. 61.)*

An infection control worksheet for hospital surveys is being tested in several states and is expected to be implemented in federal fiscal year 2012. While surveyors always have looked at infection control in the course of the larger hospital survey, the more comprehensive worksheet will increase the knowledge and sensitivity of the surveyor, says Hamilton.

While this worksheet is a work in progress, it is available for review on the CMS web site. In the meantime, outpatient surgery departments might find the ASC tool quite useful, says Hamilton. *(To access these tools, see resources, at right.)*

In light of the upcoming change in hospital surveys, Kirchner says, "If I were a hospital leader, I would be working with the infection prevention team identifying issues and being proactive in changing practice before a surprise survey."

REFERENCE

1. Schaefer MK, Jhung M, Dahl M, et al. Infection control assessment of ambulatory surgical centers. *JAMA* 2010; 303:2,273-2,279.

RESOURCES

The link to the draft hospital worksheets found on the Centers for Medicare and Medicaid Services' web site: https://www.cms.gov/Surveycertificationgeninfo/downloads/SCLetter12_01.pdf.

The link to the ambulatory surgery center worksheet used by Medicare accreditation surveyors can be found at http://www.cms.gov/manuals/downloads/som107_exhibit_351.pdf ■

A more thorough survey requires preparation

Create a team for complete coverage

In 2012, ambulatory surgery center (ASC) administrators can expect surveyors from the Centers for Medicare and Medicaid Services (CMS) to be very thorough, says **Jan Allison**, RN, CHSP, director of accreditation and survey readiness, Clinical Services Team, Surgical Care Affiliates in Birmingham, AL.

As surveyors become more experienced, they are able to expand their focus. The first year, surveyors focused on infection control and medication safety. While additional standards were assessed, it wasn't until the next year that more focus was placed on some of the new standards, such as ensuring there is a contracted radiologist in place to oversee the radiology services, says Allison.

"Many centers may have the CMS Conditions for Coverage standards covered very well, only to find they neglected ensuring compliance with life safety [requirements]," says Allison. Top issues with life safety are penetrations in smoke barrier walls, lack of appropriate latching of the fire doors, and lack of conducting fire drills each quarter or with no varying scenarios or physician participation. Also it is important to ensure that the location of equipment, carts, and other items does not impede access to the fire exits, she explains.

Team approach best

To prepare effectively for a Medicare survey, select staff for the preparation team from all areas of the ASC to include direct patient care, instrument processing, the environment, quality program, and registration.

"A center should never lean on one person to drive the compliance when all the teammates should be engaged," says Allison.

However administrators should note that the team members will need time to focus on survey preparation outside of their patient care duties. In these tough economic times, it has been challenging for administrators to efficiently allot time to research, documentation, education. competencies, and audits, Allison adds.

All areas must be assessed. For example, infection control practices of the anesthesia providers must be observed such as cleaning medication vials and IV ports with an alcohol swab. "In addition, teammates should be observed to ensure they are referencing the manufacturer's directions for cleaning agents and appropriate disinfection or management of the equipment," says Allison.

Physicians need to understand what constitutes a comprehensive history and physical (H&P) and that every patient must have one regardless of how minor the procedure. Also physicians must understand that the update note does not make an H&P older than 30 days current, says Allison.

Some surgery centers struggle with environment of care standards, says **Beverly Kirchner**, RN, CNOR, CASC, president of Genesee Associates in Dallas, an independent consulting business working with ASCs and hospital systems with ASCs.

"Keeping records on maintenance of equipment and safety checks is important," Kirchner explains. *(To learn how to respond to compliance issues, see article on p. 4.)*

Mock surveys are helpful in preparing; however, someone outside the surgery center should conduct the survey, says Kirchner. Outside eyes are helpful because staff members in the center are comfortable with their processes, which might have flaws, she explains.

"If you are not sure how to meet a CfC [Condition for Coverage] or any other regulations, do not hesitate to contact an organization to help you," advises Kirchner. These organizations might include the state health department, the Centers for Disease Control and Prevention, the Association of peri-Operative Registered Nurses (AORN), American Society of PeriAnesthesia Nurses (ASPAN), and the Occupational Safety and Health Administration (OSHA), she says.

"Network and find peers that complement your skills," adds Kirchner. "Use each other as resources." ■

JAMA article highlights infection control lapses

An article[1] published in *The Journal of the American Medical Association* with the results of the pilot for the new Medicare accreditation survey process provides good background information for administrators at ambulatory surgery centers (ASCs) on types of problems surveyors found, says **Thomas Hamilton**, director of the Survey and Certification Group for the Centers for Medicare and Medicaid Services, Office of Clinical Standards and Quality.

Twenty-eight percent of ASCs participating in the pilot were cited for using medications in single-dose vials for multiple patients. According to the *JAMA* article, two-thirds of the pilot ASCs had lapses in infection control identified during the inspections and 18% of the centers had lapses extending across three or more areas of infection control. Surveyors evaluated the following:

- hand hygiene;
- whether gloves were exchanged before each new task;
- the use of new sterile needles and syringes for each patient and each entry into medication vials that were used for multiple patients;
- the preparation of injections in a clean work area;
- whether single-dose medications were dedicated to one patient;
- the pre-cleaning of equipment prior to sterilization or high-level disinfection;
- whether facilities followed manufacturer instructions for reprocessing equipment and storing after reprocessing;
- whether facilities used disinfectants registered by the Environmental Protection Agency to clean operating and procedure areas between patients;
- whether blood glucose meters were cleaned and disinfected after each use;
- whether spring-loaded lancing penlet devices were used for multiple patients. *[The Association of periOperative Registered Nurses (AORN) has just released a new medication standard. For more information, see* Same-Day Surgery Weekly Alert*, Jan. 19, 2012. To subscribe to this free publication, go to http://bit.ly/pdZ45Z, or contact customerservice@ahcmedia.com or call (800) 688-2421.]*

REFERENCE

1. Schaefer MK, Jhung M, Dahl M, et al. Infection control assessment of ambulatory surgical centers. *JAMA* 2010; 303:2,273-2,279. ■

Back disagreements on findings with fact

During a Medicare accreditation survey, do not argue with the surveyors while they are onsite if you feel their assessment of compliance is inaccurate, advises **Beverly Kirchner**, RN, CNOR, CASC, president of Genesee Associates in Dallas, an independent consulting business working with ambulatory surgery centers (ASCs) and hospital systems with ASCs.

"If you disagree with the way a surveyor judged compliance for a condition of coverage, standard, or regulation, you have the right to appeal," says Kirchner.

Be sure you have all of the facts in hand and proof of compliance to present with your letter of complaint to the head of the organization that surveyed your facility, whether Centers for Medicare and Medicaid Services (CMS), the state health department, The Joint Commission or the Accreditation Association for Ambulatory Health Care (AAAHC). Even if you disagree with the surveyor, you must write a plan of correction, and you must implement the plan as stated.

Once the plan is submitted to CMS, staff at surgery centers must work with the processes for correction. If for some reason the process change does not work, then administrators must be prepared to show through process improvement (PI) that the process did not work and what they have done to ensure compliance to the Condition for Coverage (CfC) for which the center was cited in the survey, says Kirchner.

If the surveyors come back, and you have not done what you said, CMS certification can be terminated, Kirchner warns. ■

Strategic plan necessary for accreditation success

Accrediting agencies do not provide a blueprint for writing a strategic plan. However, The Joint Commission and Accreditation Association for Ambulatory Health Care (AAAHC) expect hospital, ambulatory surgery center (ASC), and office-based surgery administrators to devote time to planning.

"Strategic plans vary from organization to organization. We try not to be prescriptive and say they must have a planning document that includes the following elements," says **Marshall Baker**, MS, FACMPE, immediate past president of AAAHC.

To determine if administrators have conducted long-range planning, a surveyor most likely would read the minutes of board meetings and the planning document, he adds. The surveyor wants to see that the organization dedicated time to determining where it is going, why it is going there, and how it is getting there, explains Baker.

It is meaningless to read in governing body minutes that states an organization talked about plans for the upcoming year. Organizations must commit those plans to writing, but the document can be as simple as a one-page bullet outline with areas broken into headings, such as staffing and services, says Baker.

While solo providers might carry the strategic plan around in their heads, that information is not enough, says **Marsha Wallander**, assistant director of accreditation services at AAAHC. There must be some sort of brief document outlining the strategic plans for the next 3-5 years, which might include adding another physician or expanding to a second procedure room.

The Joint Commission surveyors would not ask per se whether an ASC has a strategic plan. However it can be used to illustrate compliance with the leadership chapter, according to **Michael Kulczycki**, the executive director of the Ambulatory Care Accreditation Program.

AAAHC surveyors want to see that administrators dedicated time to planning and did not just give it lip service. For example, did they make an effort to forecast the future by researching what the future holds for Medicare reimbursements? Or was an analysis of medical staffing completed to determine if any high-volume surgeons might be retiring or leaving? (*See steps for writing a strategic plan, on p. 32 of this issue of* Same-Day Surgery.*)*

At least quarterly, have the strategic plan review on the agenda, because the AAAHC administrative standards require management to follow the strategic plan of the organization, says Baker. In that way, goals can be evaluated. For example, if the goal was to be in three managed care plans by the end of the first quarter but the ASC is only in one, administrators need to determine what prevented them from reaching the goal.

"Strategic planning is a serious activity, a necessary activity, and it is essential to the success of the organization," says Baker. ■

SURGERY CENTER ACTIVITY CALENDAR

Place X in month activity is due. Document date performed.

ACTIVITY		JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
Meetings:													
Anesthesia	Quarterly												
Governing Board	Bimonthly												
Medical Executive	Bimonthly												
Staff	Monthly												
Performance Improvement	Monthly												
PI Reports:													
Infection Control	Quarterly												
Safety	Quarterly												
Pharmacy	Quarterly												
Patient Satisfaction	Quarterly												
Clinical Process,	Quarterly												
Approp. Of Care/Variance	Quarterly												
Inservice/													
Staff	Monthly												
Exposure/Infection Control	Annual												
Fire/Safety Annual	Annual												
Fire Drill	Quarterly												
Disaster/Evacuation Drill	Quarterly												
Haz Com/Utilities/Equip	Annual												
Laser Safety	Annual												
ACLS	Q2 years												
CPR	Q2 years												

Source: Genesee Associates, Dallas.

SURGERY CENTER ACTIVITY CALENDAR

Place X in month activity is due. Document date performed.

ACTIVITY		JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
Preventative Maintenance													
Anes. Systems	Quarterly												
Autoclaves (Steam)	Quarterly												
Copier	Annual												
Elec. Generator PM	Quarterly												
Elec. Generator Tested with load	Monthly												
w/o load	Weekly												
Elec. Equip. (Biomed PM)	Semiannual												
Fire Alarm Tested	Quarterly												
Fire Alarm PM	Annual												
Fire Extinguisher PM	Annual												
HVAC, and Hepa Filter	Quarterly												
Air Intk Filters Change	Monthly												
Laser Systems PM	Annual												
Med.Gas trace gas leak test	Quarterly												
Medical Gas (levels)	Weekly												
Medical Gas Lines/ Manifold	Annual												
Security Alarm Tested	Quarterly												
Sprinkler System PM	Annual												
Vacuum Pump	Quarterly												
X-Ray Equipment (PM)	Annual												
Physicist Check	Annual												
Dosimeter/Badges QC	Quarterly												
Apron leak	Annual												

Source: Genesee Associates, Dallas.

Safety Volunteer Check List: Visiting all patients with triangles

Date:
Time:
Name of person rounding:
Unit:
Who was this form **reviewed** with? (circle one) Nurse Manager Resource nurse Other_____

					Questions pertaining to bed				Questions pertaining in chair		
Room # Bed #	Name of care team RN PCA	Is Green bracelet on?	Are personal items within reach?	Is call bell in reach?	Is bed alarm on?	Red-red cable?	Circled cable plugged in?	Bed plugged into red outlet?	If in chair… use of wrap-around or seat belt?	If in chair… Is the chair alarm on?	If chair alarm is on, is it plugged into the wall?

Equipment issues:

Other comments:

Source: Hartford (CT) Hospital.