June 2012: Vol. 36, No. 6
Pages 61-68

IN THIS ISSUE

Enclosed in this issue:

- ***Same-Day Surgery Accreditation Update:*** Trouble areas in Joint Commission surveys; How to comply with medical record standard; Wrong-site surgeries tool cut those errors by 63% in preop and 51% in OR; Free patient safety posters

Financial Disclosure:
Executive Editor **Joy Dickinson**, Board Member and Nurse Planner **Kay Ball**, and Board Member and Columnist **Stephen W. Earnhart** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. **Mark Mayo**, Consulting Editor, reports that he is director of ambulatory services, Ambulatory Surgical Care Facility, Aurora, IL. **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

Is there sexism among surgeons? Some answer with emphatic 'yes'

(Editor's note: Have you experienced sexism in your position? Or do you know of a good way to avoid this problem creeping up in your program? Contact Joy Dickinson, Executive Editor, at joy.dickinson@ahcmedia.com.)

It started with an attempt at humor by the then president-elect of the American College of Surgeons. He wrote an editorial for last year's Valentine's Day publication for members that attempted to take a humorous look at male/female relationships. The editorial, which later was retracted by the college, said that semen was a mood enhancer for women and referred to a study of female college students and said those who had unprotected sex were less depressed than those whose partners used condoms.

The article resulted in strong negative responses from some of the college's female members, among others. The author met with the college's board and apologized, but his editorial still resulted in his resignation from his posts as editor in chief of the college's newspaper and president-elect. Beyond the initial controversy, the editorial led to discussion of whether female surgeons — about 10% of the college's members — are considered equals in a male-dominated field. One anonymous online commenter, who identified herself as a female surgeon, said, "Women surgeons have always been and CONTINUE TO BE treated deplorably by some of their male counterparts (particularly the very old men…) female surgeons receive inappropriate and harassing verbal and physical attention."

The charge of sexism seems to be backed up by a white paper about disruptive physician behavior based on a survey of 840 physicians by the American College of Physician Executives (ACPE).[1] *(See results from that survey, as well as a discussion of the need for policies, p. 63.)* Among the respondents, 73% were male, and 27% were female. One respondent reported being a witness to

Next month: How not to get sued in outpatient surgery

Next month's issue of *Same-Day Surgery* is one of the most awaited issues of the year: avoiding liability in outpatient surgery. We'll discuss trends and new pitfalls. We'll also give you step-by-step instructions from your peers about how to avoid them. Don't miss this special issue of *Same-Day Surgery*!

the "creation of an intolerable work environment for a female physician by a male colleague who was condescending, bullying, and refused to acknowledge her supervisory role in the practice."

One blogger for *The New York Times* commented that while women make up about 50% of medical school students, less than one-third go into surgery, which she attributed in part to the perception of male discrimination.[2] This trend is backed by just-released research that found women who expressed intent at the time of medical school graduation to become certified in surgery were more likely than men who had similar intentions at graduation to become certified by boards other than the the American Board of Surgery. Study author **Dorothy A. Andriole**, MD, FACS, Washington University School of Medicine, St. Louis, said, "That women were more likely than men to leave the surgery workforce to pursue certification in other specialties is an issue worthy of attention by the profession and the American College of Surgeons, which seeks to recruit and retain women surgeons as fellows in the organization."

The blogger for *The New York Times* said research indicates that more than half of female surgeons, once they are practicing, report feeling demeaned, and she said about one-third report they have been the object of inappropriate remarks that were sexist. Some female surgeons are afraid to complain, said one chairwoman of surgery quoted by the blogger.

One study found that female surgeons "are more vulnerable to discrimination, both obvious and covert."[4] The same study said female surgeons are subject to a glass ceiling in terms of pay and leadership, and the authors cited manifestations of sexism in the medical environment as one of the three major causes.

Policies and education

What's the solution to avoiding sexism in your outpatient surgery program?

"Clear and well-communicated expectations of employees are the first step," says **J.E. (Betsy) Tuttle-Newhall**, MD, FACS, professor of surgery, Saint Louis University, division chief of abdominal transplantation, Cardinal Glennon Medical Center, both in St. Louis, MO. "Education about what constitutes boorish behavior at time of hire, and ongoing education regarding sexism and other forms of discrimination is essential to prevent and address any issues that may arise."

Hospitals and surgery centers accredited by The Joint Commission must have a code of conduct that

EXECUTIVE SUMMARY

Some female surgeons report being not treated as equals by their fellow physicians.
- Have policies and a code of conduct in place, educate new staff with your expectations, and conduct a non-conflicted investigation of any complaints.
- Be proactive by asking staff members if they have any concerns in this area.

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 105109, Atlanta, GA 30348.

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 enduring material for a maximum of 20 *AMA PRA Category 1 Credits™*. Physicians should claim only the 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.

Senior Vice President/Group Publisher: **Donald R. Johnston**.
Executive Editor: **Joy Daughtery Dickinson** (229) 551-9195 (joy.dickinson@ahcmedia.com).
Production Editor: **Kristen Ramsey**.

AHC Media

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

defines "acceptable and disruptive and inappropriate behaviors," and they must have a process for dealing with the inappropriate behaviors.

The Joint Commission requires accredited organizations to educate healthcare workers at all levels and to adopt a "zero-tolerance" stance toward the worst behaviors.

"However, discrimination for any reason can be dangerous to the patients cared for, disrupts team building, and adversely affects the business and work environment of the system," Tuttle-Newhall says. For that reason, "Each facility should have their own policies and procedures, but should certainly hold people accountable for their behavior." That accountability should include firing physicians, when necessary, for repeated behavior violations, she says.

Awareness of the problem of sexism is needed, says **Susan L. Orloff**, MD, FACS, professor of surgery, chief, Division of Abdominal Organ Transplantation, adjunct professor, Department of Microbiology & Immunology, Oregon Health & Science University, chief, Portland VA Medical Center Transplant Program, all in Portland. "There has to be an open mind from leadership as well as a willingness to accept feedback from their employees to know whether a problem exists in their institutions," Orloff says.

Be proactive, she advises. Orloff says that rather than waiting for staff members to report a problem, ask them: Has this happened to you? Are there any issues surrounding this problem that you'd like to discuss?

"There has to be awareness, acceptance, and a willingness to receive feedback, and then desire for change," she says.

REFERENCE

1. MacDonald O. Disruptive Physician Behavior. May 15, 2011. Accessed at http://bit.ly/j2mlcR.
2. Chen PW. Sexism Charges Divide Surgeons' Group. April 15, 2011. Accessed at http://nyti.ms/ikpEay.
3. Andriole DA, Jeffe DB. Certification by the American Board of Surgery among US medical school graduates. *JACS* 2012; 214(5):806-815.
4. Zhuge Y, Kaufman J, Simeone D, et al. Is there still a glass ceiling for women in academic surgery? *Annals of Surgery* 2011; 253(4)637-643. Doi: 10.1097/SLA.0b013e3182111120.

RESOURCE

The Association of Women Surgeons has a "Code of Ethics" available at http://bit.ly/IakgD5. ■

Properly investigate reported incidences

Mechanisms for reporting and investigating sexist behavior among physicians are necessary, say sources interviewed by *Same-Day Surgery*.

In a survey conducted by the American College of Physician Executives (ACPE), 20% of female respondents said they strongly disagreed that their facility has a clear, well-enforced policy on disruptive behavior, compared to 11% of male physicians.[1] Only 17% of females strongly agreed that there was a structured method to report incidences of disruptive behavior, while 27% of males strongly agreed. Females who were surveyed reported that they were less comfortable than males with reporting and confronting incidences of disruptive behavior. The females also said they were less likely to feel well-prepared to deal with such incidents.

A female surgeon or other staff person who has been offended by sexist remarks or behavior must be willing to report the offense, says **Susan L. Orloff**, MD, FACS, professor of surgery, chief, Division of Abdominal Organ Transplantation, adjunct professor, Department of Microbiology & Immunology, Oregon Health & Science University, chief, Portland VA Medical Center Transplant Program, all in Portland. "If it's not reported, it doesn't exist," Orloff says.

A reporting system must be established, and there must be non-conflicted investigation of any complaint, says **J.E. (Betsy)Tuttle-Newhall**, MD, FACS, professor of surgery, St Louis University, division chief, abdominal transplantation, Cardinal Glennon Medical Center, both in St. Louis.

"I think education is a key part of prevention and also when an incident happens that is intolerable," Tuttle-Newhall says. "There must be accountability and full disclosure of the incident with a 'debriefing' so that the entire staff understands what happened, why it was wrong, and how the organization plans to move ahead."

The leaders of an organization "must follow through on any issues with honesty and full transparency and have a no-tolerance policy for any discrimination, whether it is related to gender, race, or sexual orientation," Tuttle-Hall says. "Some discriminatory behavior can be classified under the 'disruptive behavior' category for physi-

cians, and there are anger management programs, sensitivity trainings, etc." *(For resources to address disruptive physicians, go to http://scr.bi/nBz2u.)*

In terms of setting expectations, "it should come down from the top," Orloff says.

The persons responsible for the daily running and steering of the organization must lead, Tuttle-Newhall says. "This means holding people to the expectations of their employment, any code of conduct or behavior within the facility, making sure the surgeons and physicians follow the professional guidelines and behavior guidelines that ensure safe patient care, and compliance with national standards," she says.

In 2010, The Joint Commission approved the reinstatement of a requirement prohibiting discrimination for medical staff membership and clinical privileges. The requirement was deleted in 2003 because it was thought to be covered elsewhere in the manual, but that proved to not be fully accurate. An element of performance (EP) was added to Medical Staff (MS) standards MS.06.01.07, which addresses the granting of privileges, and MS.07.01.01, which addresses appointment to the medical staff. The requirements apply to hospitals.

REFERENCE

1. MacDonald O. Disruptive Physician Behavior. May 15, 2011. Accessed at http://bit.ly/j2mlcR. ■

Proposal released for quality reporting

The Centers for Medicare & Medicaid Services (CMS) has released proposed guidelines for Medicare's new ASC quality reporting program, available by the Ambulatory Surgery Center Association (ASCA) on ASCA Connect at http://bit.ly/K6OM1O. According to the ASCA, the proposal provides the following information:

- Using quality data codes on a claim will indicate that a facility is part of the quality reporting program. No additional action is required.
- Any ASC that is a Medicare-participating facility as of Jan. 1, 2012, will need to begin reporting Oct. 1, 2012, to be eligible for the full Medicare payment update in 2014. Those that are designated as open by Oct. 1, 2012, will need to begin reporting Jan. 1, 2013. Although CMS has not clearly indicated how this schedule will affect ASCs that open in the future, ASCs that open by October of a given year could expect to be required to begin reporting on Jan. 1 of the next year. ASCA will seek clarification on this point.
- The proposal sets a completeness threshold of 50%, which means ASCs will be considered successful reporters and won't face financial penalties if 50% of Medicare claims contain quality data codes. This threshold will increase in the future.
- CMS will not seek to validate what ASCs report through any means beyond the usual claims validation process Medicare contractors conduct.
- If an ASC believes that CMS has erred in determining that the ASC has failed to adequately report data, that ASC will have access to the same reconsideration process available to hospitals.
- ASCs that are unable to report quality data due to extraordinary circumstances will be able to avail themselves of an extension/waiver process.
- While CMS noted that it is "proposing that any and all quality measure data submitted by [an] ASC" could be made public, the agency did not specify what data it will use for public reporting. ASCA will continue to advocate for CMS to begin by posting on its web site those ASCs participating in the program. This transition would be followed by CMS posting each facility's performance on the measures.
- ASCs will be required to designate a QualityNet administrator to serve as a point of contact between the ASC and the QualityNet web site. ASCs will use this site to report data on their use of a safe surgery checklist and the surgical volume they manage beginning in summer 2013. ASCs will need to have a QualityNet administrator in place by then. ASCs should allow two weeks to complete registering a QualityNet administrator.

CMS also released the manual for the quality reporting program. According to the ASCA, the manual indicates that ASCs that used a safe surgery checklist based on accepted standards of practice at any time during 2012 can answer "yes" when they report whether they used a safe surgery checklist during the year. Previously, CMS had indicated that ASCs would be able to answer "yes" only if they had a safe surgery checklist in place on Jan. 1, 2012.

For more information, go to http://bit.ly/Kb9hKd. To download the manual for the ASC quality reporting program, go to http://bit.ly/IBQ5eh. ASCA will be offering free webinars about quality reporting. Register at ascassociation.org/webinars. ■

Same-Day Surgery Manager

Solutions that work for difficult staffing issues

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

I receive some interesting questions as a result of *Same-Day Surgery* newsletter. Some are funny, others serious; there are a few sad ones, and some are outrageous. I tried this month to pick ones that I think might be universal to all surgery providers. I hope you agree.

Question: I (director of surgical services at a hospital) am having a very difficult time with several of my staff members. They have formed a 'clique' and are very passive-aggressive with myself and the rest of the staff, and they are making it close to impossible to have a cohesive team. They have done a great job sucking up to the surgeons (who think they walk on water!) and are very close to being completely insubordinate to my authority. I cannot fire them for many different reasons, but I also cannot continue to deal with this on a daily basis. Any ideas?

Answer: What you describe is not at all uncommon. Many staff members form alliances at their workplace. Hopefully you are not upset because you might have been left out of that 'clique' and are taking it personally. You shouldn't, because then it becomes an entirely different problem!

My approach and advice to you is to address the issue head-on! Meet with the members of this group, and let them know your concerns. What you want to do is establish constructive communication. Is any member of that group actually involved in activities at the hospital other than just working there; i.e. on any committees, outreach programs to surgeons offices, patient pre-or post op calls, etc.? (You probably can see where I'm headed here). I have always maintained that every member of every staff needs to have more than just a job that they go to. Surgical departments, for the most part, are relatively small and easy to get staff involved in. Are their jobs threatened, or are you facing cutbacks that have them scared for their positions? Fight or flight; it is real!

Meet with them informally if you can, and do not expect changes overnight. It sounds like they are valuable assets, and you need to find a way to constructively communicate!

Follow up to this issue: The director did meet with the staff members. It turns out it was more of an issue with the director wanting everyone to like her and not the staff members. She became hostile to the group, and the issue quickly escalated. It eventually reached a point at which it came to the attention of members of the Surgical Committee. They felt that the director was not effective and recommended to the hospital administrator that she be replaced. Ouch!

Question: The medical director at our surgery center is too busy to work with us. She is an anesthesiologist and the head of her group of about 40. She is rarely here. When she is, she is always on the phone with the other surgery centers that her group covers, and she is delaying our cases because of it. Her own staff complains about how inconsistent she is and how she turns the place upside down the days she is here. She was appointed by the surgeon board, and they are OK with her, but the rest of us are not. Thoughts?

Answer: The most important thing is that the surgeons are OK with her. Most surgeons do not want chaos in their center — rightly so — and often want to avoid confrontation, so tread lightly. I would recommend that you sit down with her and explain your concerns and not escalate this issue. Ask her how you can help her organize her services better to the center.

FYI: This administrator called me a week after this note. She did meet with her medical director and explained everything. The medical director apologized and recommended that she recommend another member of the anesthesia staff to be the medical director, as she was just too busy to give the center the attention it deserved. That was done, and the board approved the change. Everyone is happy as of this writing. *[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.]* ■

Needlesticks decrease, but challenges remain

In a "call to action," sharps safety experts are targeting gaps in needlestick prevention and seeking to spur a new commitment to make improvements.

"Over the past 25 years, there's been such tremendous success in reducing health care workers' risk of bloodborne pathogens," says **Janine Jagger**, PhD, director of the International Healthcare Worker Safety Center at the University of Virginia in Charlottesville and a pioneer in sharps safety. "It's a question of finding gaps [in compliance] and trying to plug up those gaps."

Sharps safety experts cite several remaining barriers and arising new challenges, including reducing the risks of injuries and blood exposures in the surgical setting:

• Improve sharps safety in the surgical setting.

Sharps injuries in the OR actually rose during the time that injuries from needles and syringes were declining dramatically.

Surgeons have been reluctant to use blunt suture needles or safety scalpels, Jagger says. "It all comes down to getting surgeons on board. If they're not onboard, nothing's going to happen," she says.

Still, hospitals and surgery centers should adopt policies that mandate safety. "Most of the injuries in the OR occur to the OR staff and not to the surgeon," says Jagger. "The surgical equipment that the surgeon chooses has the major effect on the risk of everyone else in the room."

Surgeons should work with nurses and other OR personnel "to develop sharps safety standards and practices that are consistently implemented and followed in all surgical environments," according to the consensus statement. The experts also called on the Occupational Safety and Health Administration (OSHA) to monitor compliance in ORs.

The American College of Surgeons has issued statements encouraging safer practices, including double-gloving, passing instruments in a neutral zone, and using blunt suture needles. The consensus statement gives OR personnel some additional leverage, says Jagger. "It gives them a new opportunity to raise the issue and to focus on its importance," she says.

• Increase use of safety devices in non-hospital settings.

The use of sharps safety devices is commonplace in hospitals, but not as consistent in non-hospital settings such as clinics, physician offices, and home health, some experts maintain. In fact, the needlestick surveillance programs focus on hospitals; much less is known about compliance elsewhere. Market data from device manufacturers indicates less use of safety needles in non-hospital settings. The sharps safety experts recommended more research from the National Institute for Occupational Safety and Health (NIOSH) and special enforcement programs from OSHA.

"There's less compliance because there's less enforcement [in smaller settings]," Jagger says.

• Ensure that frontline workers are involved in selection of safety devices.

The Bloodborne Pathogen Standard requires employers to solicit the input from frontline workers when they select sharps safety devices. Yet it is difficult to keep tabs on the compliance with this provision. The experts note that it is "not consistently" followed. In the consensus statement, the experts said, "At a time when the pressure to reduce healthcare costs is intense, it is important to keep these user-oriented questions at the forefront of device selection."

• Continue innovation in safety design.

When needle safety became law in the United States, device manufacturers responded quickly and developed more effective and innovative designs. Jagger says, "It's really quite amazing. The technology they've brought forward is really good technology."

But even 11 years after the revised Bloodborne Pathogen Standard was released, there are devices for which there is no safety version. "I think that as we bring new information forward about gaps we have, the medical device industry is likely to respond very well again," Jagger says.

• Enhance education and training.

Teaching hospitals have higher needlestick rates than non-teaching hospitals. That difference indicates a need to improve training, the safety experts said. Failure to activate a safety device also might reflect a lack of training in how to use the device. The Bloodborne Pathogen Standard requires annual training that includes "an opportunity for interactive questions and answers with the person conducting the training session." ■

GOLD STAR Award

David Shapiro, MD awarded by SDS

(Editor's note: As part of the celebration of our 35th anniversary year, Same-Day Surgery *is giving gold star awards to outstanding leaders and innovators in the field. This month marks our first award winner. If you would like to nominate yourself or someone else for this award, contact Joy Daughtery Dickinson. Email: joy.dickinson@ahcmedia.com.)*

David Shapiro, MD, has been named by *Same-Day Surgery* as our first Gold Star award winner. Shapiro is being heralded for his multiple contributions to the ambulatory surgery center (ASC) field through leadership positions and activism at the state and national level. Shapiro serves as president of the Ambulatory Surgery Center Association (ASCA) and the Ambulatory Surgery Foundation (ASF). He also is chair of the Ambulatory Surgery Center Quality Collaboration, which develops, measures, and publically reports national ASC quality data.

Shapiro is an anesthesiologist from Florida who has had extensive experience serving as a department chair, medical director, and board member of several ambulatory surgery centers. In addition, Shapiro has served as the national medical director on behalf of ASC management corporations, prior to establishing his consulting firm, Ambulatory Surgery Co. His consulting practice encompasses areas related to clinical quality and regulatory compliance in the ambulatory surgery arena.

Shapiro is an active participant in surgery center industry activities, and he is a frequent speaker at state and national ambulatory surgery industry functions. He serves on the board of the Florida Society of Ambulatory Surgery Centers (FSASC).

Shapiro also served on the board of a publicly traded medical liability corporation (First Professionals Insurance Co.) and chaired their claims and underwriting committee for several years, until the sale of the company in 2011. Additionally, Shapiro conducts healthcare facility surveys on behalf of AAAHC (Accreditation Association for Ambulatory Health Care) and Medicare.

Same-Day Surgery salutes our first Gold Star winner! ■

Same-Day Surgery publisher launches *Hospital Report* blog

For analysis and discussion of topics important to hospital professionals, check out *Hospital Report*, AHC Media's new free blog at http://hospitalreport.blogs.ahcmedia.com.

Same-Day Surgery's executive editor Joy Daughtery Dickinson contributes. ■

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 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

- Reduce the number of children medicated for anxiety in preop
- Implementing a wellness program for employees
- What you should do to prepare for Medicaid RAC program
- How to reduce throughput in outpatient surgery

CNE/CME QUESTIONS

1. What's the first step to avoiding sexism in your outpatient surgery program, according to J.E. (Betsy) Tuttle-Newhall, MD, FACS, professor of surgery, Saint Louis University, division chief of abdominal transplantation, Cardinal Glennon Medical Center?
   A. An orientation that includes an in-depth discussion of sexism.
   B. Clear and well-communicated expectations of employees.
   C. Thorough background checks.

2. Which of the following was a finding from a survey conducted by the American College of Physician Executives?
   A. 20% of female respondents said they strongly disagreed that their facility has a clear, well-enforced policy on disruptive behavior, compared to 11% of male physicians.
   B. 15% of female respondents said they strongly disagreed that their facility has a clear, well-enforced policy on disruptive behavior, compared to 6% of male physicians.
   C. 10% of female respondents said they strongly disagreed that their facility has a clear, well-enforced policy on disruptive behavior, compared to 3% of male physicians.

3. According to the Ambulatory Surgery Center Association, what indicates that a facility is participating in the quality reporting program from the Centers for Medicare and Medicaid Services (CMS)?
   A. The use of quality data codes on an ASC's claims.
   B. Completion of a form required by CMS.
   C. Contact by email or phone with CMS.

4. Which of the following statements is true regarding needlestick safety?
   A. Sharps injuries, as well as injuries from needles and syringes, have declined dramatically.
   B. Sharps injuries, as well as injuries from needles and syringes, have increased.
   C. Sharps injuries in the OR actually rose during the time that injuries from needles and syringes were declining dramatically.

SDS ACCREDITATION UPDATE

Covering Compliance with The Joint Commission and AAAHC Standards

The top troublesome standards in surveys by The Joint Commission

When examining compliance issues before your survey by The Joint Commission, consider the quote from former president **Ronald Reagan**: "Trust, but verify."

"In your [facility], when we start going through some of the top scored standards are things that your staff are saying, 'Oh we've got this covered, we're doing this in the new electronic medical record,'" says **Jennifer Cowel**, RN, MHSA, vice president and principal at Patton Healthcare Consulting in Glendale, AZ. "That's wonderful, but at some point you're going to have to stop and ask, 'Let me see our compliance with … let's see the data on …' because sometimes the data does not speak as highly as staff's perception of compliance."

Cowel recently spoke on The Joint Commission's "Top Scored Standards and Other Troublesome Requirements" at a webinar sponsored by AHC Media, publisher of *Same-Day Surgery*. *(For ordering information, see Resource at end of the article.)* She held leadership and management roles for more than 17 years with The Joint Commission.

On Day 1 of the survey, expect the surveyors to visit your OR, visit your ICU (if you are a hospital), then come together at lunch and start sharing notes, she says. "They start forming conclusions pretty early in the survey process about how your survey is going to go," Cowel says.

Focus your time and money on the issues scored high in noncompliance, she says. "So when that survey team comes back after that first couple of tracers in the morning on day one, they're going to be talking, 'Hey, this is an organization that's on top of it. They've heard us, they're listening, and they're really focusing on some of these very challenging issues.'"

New problem areas: Environment of care

For those facilities that haven't been surveyed in a couple of years, one key difference is that most of the top problematic standards are not in the provision of care areas or traditional care areas. Instead, they're in the life safety or environment of care, Cowel says.

"These are the things that had traditionally been scored by the life safety code surveyor, which are now also being scored, during your onsite survey, by the clinical surveyors, by the doctor, the nurse, the administrator," she says.

In 2011, 40% of hospitals surveyed were out of compliance with EC.02.03.05. The hospital maintains fire safety equipment and fire safety building features. The figures for ambulatory and office-based organizations were not released.

Clinicians should be learning more about these standards, learning to identify gaps in these standards, and communicating those gaps to leaders, she says.

On the list for years: Medication storage

Safe medication storage (MM.03.01.01) is another problematic standard, Cowel says.

In 2011, 32% of ambulatory organizations were out of compliance, and 27% of office-based surgery facilities were not in compliance. The hospital non-compliance rate was not released by The Joint Commission.

"This particular standard has been on the list for years, and I would imagine it will be on the list for years," she says.

Financial Disclosure:
Executive Editor **Joy Dickinson** 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.

The Joint Commission has a booster pack available to all accredited organizations free of charge on the extranet that covers challenges and the recommendations for compliance with this standard, Cowel says. "But the largest problem that has been scored in this area has been medication temperatures, and The Joint Commission surveyors are coming around saying, 'Let me see the last month of refrigerator temperatures…' to see gaps in compliance with your own record or your own policy on this area," she says.

When you educate your staff, only keep out one month of a log if you're still using paper, Cowel says. "It is so tempting and so easy if the surveyor is given the last 12 months of logs to sit there and thumb through it while a conversation is going on, and if you show me 12 months of refrigerator logs, there's a guarantee that I'm going to find two dates in the last 12 months that you forgot to record it," she says.

Another problem area is that if the medication refrigerator is out of the proper temperature range, you have to document what you did about it, and the staff members need to able to verbalize what was done. They might say, "Well we turned it down. We checked it again." These steps must be documented on the logs, Cowel emphasizes.

For ambulatory surgery, the question comes up: How do you monitor temperatures on the weekends in areas that are only open Monday through Friday? If the ambulatory area is part of an inpatient facility that says temperatures are checked every day, surveyors will go to your ambulatory areas and ask to see the logs for Saturday and Sunday. Your policy should match your actions, Cowel says.

"In your five-day settings, it is perfectly acceptable to say, 'We capture temperature on days of operation, and we have high-low thermometers that we check back over the weekend to ensure that ours did not go wildly out of range over the weekend. And we have a policy in place on what we're going to do if our temperatures went out of range,'" Cowel says. "For both policy and review, don't forget those areas." *(For information on another problem standard, having a complete medical record, see story, right.)*

RESOURCE

The webinar "Focus on 2012 – TJC top scored standards & other troublesome requirements" includes two tracer tools. One is a department walk-through checklist, and one is an environment of care document review. The price for the webinar and the tools is $350. To order, go to http://bit.ly/HNVKct. ■

A big problem area: Complete medical record

One of the most problematic standards for organizations accredited by The Joint Commission is the requirement for a complete medical record (Record of Care.01.01.01). In 2011, 66% of hospitals were non-compliant with that standard. The non-compliance rates for ambulatory and office-based organizations were not released.

"The biggest issue is timing of entries into the medical record: EP 19," says **Jennifer Cowel**, RN, MHSA, vice president and principal at Patton Healthcare Consulting in Glendale, AZ. "And when you've got still a blended record or a paper copy record, you've got to get all practitioners — doctors, nurses, and anyone else who is entering into the medical record — to time those entries."

Legibility also is scored, she says. "If you can't read it, the surveyor can't read it, and a couple people around you can't read it, they will score it out here," Cowel says.

If you are still using a paper record system, and if you are having significant challenges trying to get your practitioners to sign, date, and time all their entries, "consider using that data as part of the ongoing professional practice evaluation of your physician and licensed independent practitioners," she advises. "If you measure it, monitor it, and present it up through the department, that [process], in other organizations, has had a greater degree of success in getting behavior to change."

The Centers for Medicare and Medicaid Services (CMS) allows stamps, but "if you're using stamps in your organization, you can't have them prefilled in with the date or a time stamp even," Cowel says. "You can only do a 'fill-in-the-blank' signature where it's clear that the physicians themselves have signed, dated, and timed each entry in the medical record." ■

New tool addresses wrong-site surgeries

A new targeted solutions tool (TST) from The Joint Commission's Center for Transforming Healthcare to address wrong-site surgeries cut those surgeries by 63% in the preoperative area, 51% in the OR, and 46% in the scheduling area during the testing period. These reductions are significant, considering that there are as many as 40 wrong-site sur-

geries each week.

The Center for Transforming Healthcare tested the safety tool at eight hospitals and ambulatory surgery centers. The tool is meant to be used in addition to the Universal Protocol. It is free to all accredited organizations and can be accessed through the Joint Commission Connect extranet. The tool includes training modules, and videos show good and bad practices. Interactive training materials assess staff learning. The TST provides detailed implementation guides and checklists.

At a recent webinar held about the tool, representatives of Algonquin Road Surgery Center, Lake in the Hills, IL, discussed their experience.

The tool helps facilities identify and measure risks in their processes that can contribute to wrong-site surgery, then reduce them, says **Andrew Ward**, MD, medical director at the center. "You don't want to have the event occur, and then figure out what you can do to keep it from happening," Ward says. "You'd rather do something more while you can, and never have it happen."

Since the tool focuses on scheduling, preoperative, and the OR, facilities can address one area at a time, or all three at once, says **Lori Callahan**, CASC, director of the Algonquin Road facility. "So it was very easy. It didn't take too much on our part," Callahan says.

The TST provides training tools and resources to prepare select staff members to collect observation data. Observations can be collected on paper or input directly into the tool using a tablet device, such as an iPad. Ward says, "Data collection is critical to the project since your focus of improvement stems from the data," he says.

The tool allows advanced data analysis and automatically generated charts and graphs. You can easily share this data with your leaders and staff, Ward says. "After having implemented the tool, we've gained the acceptance and the buy-in from the surgeons, the staff, and the anesthesiologists to increase our percentage and get close to 100% compliance in the operating room, and to drastically improve the compliance in the holding room," he says.

The data helps you zero in on any problem areas, Callahan says. They tell you the rate of defective cases per day, the percent of those cases that contain more than one defect, and a breakdown of results by specialty or surgeon. This data analysis can lead you to the top three or four solutions for your key risk areas, Callahan says. "Why spend time implementing solutions that may not — and probably don't — address your risk areas?" she says. "What we think in leadership is working effectively may not always be working the way we think it's working until you actually have some data that is measurable, and you can print out and actually review with staff."

You'll see improvements as soon as eight weeks, say leaders from Algonquin Road, and most facilities finish the project in 14-16 weeks. "By utilizing the TST, it allowed our employees to become empowered," Callahan says. "It gave them a chance to stand up to the surgeon and actually stop them in a situation that may not be following policies."

The center's biggest improvement? Buy-in from the staff and surgeons at the beginning of cases, Ward says. "Previous to using the tool we would have people working on the Mayo stand, checking gauges, writing things down, and not really paying attention to the timeouts," he says. "Now, however, everybody does stop, everyone listens, and everyone agrees."

Hospital shares its success

Holy Spirit Hospital, in Camp Hill, PA, realized improvement opportunities after testing the TST.

The timeout has been expanded so everyone, including the surgeon, anesthesiologist, and surgical technician, actively participates, according to **Susan McQuade**, RN, associate director of surgical services.

"We are proud of how we handle patient safety, but we wanted to be proactive and develop protocols so we never have a wrong-site surgery," says **Joseph A. Torchia**, MD, senior vice president and chief medical officer at Holy Spirit. "We joined the Center for Transforming Healthcare project because we wanted to put into place an evidence-based best practice that eliminates the possibility of having a wrong site surgery."

For more information on the tool, go to http://bit.ly/IWHfRF. ■

Speak up posters available in English, Spanish

As part of The Joint Commission's Speak Up initiatives for patient safety, the agency is offering colorful posters that feature the characters from the Speak Up videos. The posters can be downloaded for free.

Available posters include:

- Speak Up: Reduce your risk of falling. Web: http://bit.ly/HYui09. Speak Up : Reducir el riesgo de caidas: Web: http://bit.ly/HXworP.
- Speak Up: Prevent the spread of infection. Web:

http://bit.ly/HNYXsB. Speak Up: Prevenir la propagación de infecciones. Web: http://bit.ly/JUAGA7.

• Speak Up: Prevent errors in your care. Web: http://bit.ly/HVDlyb. Speak Up: Evitar errores en su atención médica. Web: http://bit.ly/ItlA6v

• Speak Up: Kid Power, Captain Speak Up. Web: http://bit.ly/JUAkJH. Speak Up: Poder Juvenil, el Capitán Speak Up. Web: http://bit.ly/JkG44z.

• Speak Up: Kid Power, Cara. Web: http://bit.ly/HNYIhl. Speak Up: Poder Juvenil, Cara. Web: http://bit.ly/HYSihO.

• Speak Up: Take Medication Safely. Web: http://bit.ly/J4xhmN. Speak Up: Tomar medicamentos de manera segura. Web: http://bit.ly/I6PrRT.

• Speak Up: At the Doctor's Office. Web: http://bit.ly/JdIhgC. Speak Up: En el consultorio del medico. Web: http://bit.ly/IacWr7. ■

AAAASF announces Medicare survey DVD/CD

The Education Committee of the American Association for the Accreditation of Ambulatory Surgery Facilities (AAAASF) has developed a three-disc DVD/CD package for Medicare certification, titled the "Medicare Accreditation Assistant for Achieving AAAASF Medicare Accreditation/Certification," to assist ambulatory surgery centers with accreditation.

The "Preparing for Medicare Accreditation" DVD is a step-by-step guided tour through the accreditation program. Watching this cutting edge DVD will introduce you to the process and give you a "behind-the-scenes" look at how an application is moved through the AAAASF national office by Medicare accreditation specialists trained to give you personalized attention and assistance.

The "Conducting a Medicare Health Survey" DVD takes you through the inspection process, including how the survey team will conduct the Medicare survey. After watching this DVD, the facility staff will know what to expect. This DVD was designed to serve as a teaching tool for the surveyor training program and inform facilities about the survey process. Due to the dynamic nature of the standards, this interpretive document should be modified in accordance with the most current AAAASF Medicare Standards.

The price of the package is $950. To order, go to http://www.aaaasf.org/pub/AA.htm. For more information, contact Jaime Trevino. Phone: (847) 775-1970. E-mail: jaime@aaaasf.org. ■

Joint Commission targets non-licensed non-staff

The Joint Commission has published the answer to a frequently asked question by hospitals, ambulatory centers, and office-based surgeons related to non-licensed, non-employee individuals. The question is: What are The Joint Commission's expectations regarding non-licensed, non-employee individuals in healthcare organizations, including healthcare industry representatives (HCIRs)?

The Joint Commission says that to maintain safety, you should be aware of who is entering your facility and what their purpose is (EC.02.01.01, EP 7). Also, you need to make sure that responsibilities are assigned for administrative direction of programs, services, sites, and departments (LD.04.01.05, EPs 1 and 3). This requirement includes processes for knowing who is entering the organization and their purpose, The Joint Commission says.

For non-licensed, non-employees who have a direct impact on patient care, there are additional expectations, the agency says. Examples of these individuals are HCIRs in procedure rooms/ORs providing guidance to the surgeon, HCIRs providing training to staff on equipment use, and surgical assistants brought in by surgeons. Additional requirements for these individuals include:

• taking steps to ensure that patient rights are respected, including communication, dignity, personal privacy (RI.01.01.01, EPs 4, 5, and 7), and privacy of health information (IM.02.01.01, EPs 1 and 2);

• obtaining informed consent in accordance with organization policy (RI.01.03.01, EPs 1, 2, and 13);

• implementation of infection control precautions (IC.01.01.01, EP 1);

• implementation of the patient safety program (LD.04.04.05, EP 1);

• For non-employees brought into the organization by licensed independent practitioners, there are two additional requirements regarding qualifications and competence of these individuals (HR.01.02.05, EP 7 and HR.01.07.01, EP 5).

These Joint Commission requirements are the minimum standards organizations should address, the agency emphasizes.

The agency also notes that The Joint Commission does not require credentialing of these individuals; however, some professional organizations are recommending specific credentialing requirements for HCIRs. For more information on what the industry is recommending on credentialing of HCIRs, you may want to contact AdvaMed at website www.advamed.org. ■