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August 2013: Vol. 37, No. 8
Pages 85-96

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How can you reduce anxiety meds, plus increase satisfaction? Calm your patients

By Joy Daughtery Dickinson

Ambulatory surgery programs traditionally calmed patients by providing anti-anxiety medications and perhaps offering a tour ahead of time for pediatric patients. However, with the current focus on patient satisfaction and the need to eliminate unnecessary medications and their corresponding costs, many programs are going the extra mile by providing calming environments and amenities such as live music, videos, and even flowers and spa robes! Even the traditional tours have become more elaborate by allowing children to don gowns and ride gurneys through all of the departments they will visit on surgery day, including the OR.

Providers are finding that such changes pay off with increased patient satisfaction scores and, in some cases, less anxiety medication, reduced pain, and quicker recovery time. *(For information on the importance of design, amenities, and the type of staff you hire, see story, p. 88.)*

Research at the University of Kentucky (UK), Lexington found that music

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exposure during and after surgery at its hospitals resulted in patients who were less anxious before the procedure and who recovered more quickly and satisfactorily.[1] They also required less medication for sedation and were more satisfied with their medical experience. Calm, slow, gentle music produced the most positive results and facilitated relaxation and pain reduction.

In outpatient surgery at UK Lexington, music is primarily used preoperatively. Some of those patients also come in for wound care, which is an area that has seen significant positive results with music therapy, says **Lori Gooding**, PhD, MT-BC, director of music therapy and lead author of the research. "The amount of time spent in wound care visits goes by much more quickly," Gooding says. Through music, "we decrease patients' perception of pain and anxiety, which allows staff to more effectively do their jobs." UK Lexington offers several playlists and lets patients choose one based on their tastes, she says. The playlists cover many genres of music, Gooding says. Music therapists usually play the music live with guitars and sing. If there are any infection control concerns, recorded music can be played.

When the music therapists have the opportunity, they encourage patients to practice listening to music and relaxing before the surgery. Patients can perform breathing exercises to music or use guided imagery to relax. To address anxiety, patients are distracted with musical activities such as playing drums, singing, and rewriting songs into parodies. These activities help with anxiety because "for humans, it's difficult to focus on two things at same time," Gooding says.

The approach is winning over fans. One parent commented that she previously had the perception that UK staff members were lacking empathy, but she saw that the music therapy calmed her child. It changed her perception of the overall facility, Gooding says. "That's the goal: to provide patient/family-centered care," she says.

Videos cut anxiety at induction

Another medium, videos, has had a positive impact art IWK Health Centre in Halifax, Nova Scotia. A study showed allowing children to watch a video immediately before day surgery was helpful in reducing their anxiety during anesthesia induction.[2] The videos shown by the hospital are pre-screened and selected based on what programs the children watch

EXECUTIVE SUMMARY

Ambulatory surgery programs are decreasing anxiety and improving patient satisfaction by focusing their efforts on calming patients before surgery. One facility interviewed by *Same-Day Surgery* reports satisfaction scores in the 97-98th percentile nationally.

- That facility provides a "spa-like" environment with natural lighting, heavy robes, artwork, and flowers.
- Another facility provides a book that includes pictures of the areas children will visit on the day of surgery and the people they will meet.
- Another facility goes beyond the traditional preop tour by putting patients in gowns and taking them to every area they will visit on the day of surgery. They are wheeled into the OR on a gurney.

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.)

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at home. The videos are approved by the patient's parent, and many are taken from YouTube.

The children can watch part of the videos in the preop area, but when they are wheeled into the OR, screens there also are showing the video. Children continue to watch the videos through anesthesia inductions. The screens had been installed previously to help residents and other surgeons view surgical cases.

Their experience is backed by other recently published research. That study showed that letting children watch a favorite cartoon was found to be an effective and safe way to reduce anxiety before anesthesia and surgery. Anxiety was rated low or absent for 43% of children who watched cartoons, compared to 23% of those who brought a toy and 7% with neither treatment.[3]

At IWK Health Centre, the results from showing videos to children were "striking," says **Jill Chorney**, PhD, psychologist at IWK Health Centre and assistant professor at Dalhousie University, also in Halifax. One-fourth of the children in the video group showed no distress at induction, compared only 5% of children in the group who didn't see the video. Also, children who watched the video shown no change in anxiety when moving from the preop area to the OR, but children who didn't watch the video had a significant increase in anxiety as they entered the OR, Chorney says.

She does offer this caveat, however: It takes time to talk to the patients about what video they want to see and to get the video set up, Chorney says. For that reason, the hospital now offers a limited list of choices. Another warning: "It's not the answer for every kid," Chorney says. For some children, the electronic stimulation can be overwhelming, and those children prepare better in a quiet environment, she says.

Finger Lakes Surgery Center in Geneva, NY, prepares children by offering a monthly tour that allows them to don hospital gowns, wear a head covering, and travel through all of the patient care areas of the center, including a ride to the OR on a gurney, according to a news story.[4] The "trial run" includes transferring children from the gurney to the operating room table, where the child is allows to try on an oxygen mask and have other procedures explained.

The Kids Tour is held at the end of the center's workday, but the center is flexible about scheduling tours other times. The purpose is to help children and their parents feel prepared and relaxed before the day of surgery.

Unity Point Health Methodist in Peoria, IL, has made some changes that are allowing fewer children to be medicated for anxiety before they head to the operating room. Medication now is given in "rare instances," says **Juli Zerwer**, RNC, registered nurse in preop phase 2 recovery. "Before, we were having to give a lot of medication just to get them back through the door," Zerwer says.

Patient satisfaction scores have improved from about 85% to 100% over a three-month period, she says. The hospital has been able to maintain satisfaction scores above 95%, Zerwer says.

One reason for their success is allowing children to read a book in print or electronic format that has photographs of the facility where they will be treated and the staff who will be taking care of them. The "Let's Get Ready for Surgery at Methodist" was made internally in collaboration with a child life specialist, marketing representative, and a photographer. "It's important that when we educate our patients for surgery, they see who they will see [the day of surgery], the equipment they will see, and the environment they will see," Zerwer says. "When the 'sleep doctor' walks in the room, they know what they will do. There are no surprises."

The book is given by the surgeon's office to the patients when the procedure is scheduled so they can read it at home The book also is available on the hospital web site *(http://bit.ly/19dQzAL)*.

Satisfaction rates up, medication is down

The hospital helps children feel more at ease by limiting the people who come in contact with children, Zerwer says. "There's not four or five people trying to get them ready," she says. Also, they work at a pace that allows children to understand what is happening, Zerwer adds. Preoperative tours also are available in which children are allowed to touch equipment and ask questions.

On the day of surgery, children are offered diversions including a computer pad with games, movies on DVDs, and a play room. Children are given choices; for example, they are allowed to select a surgical hat from among several made by volunteers. They also can choose how they want to travel from the prep room to the surgical suite. Options include walking, riding in a wheelchair, or driving a battery-operated child-size Hummer or pink Fisher-Price car. One "huge" satisfier for parents is reuniting them with their children as soon as possible after surgery, Zerwer says. The discharge education is handled before surgery, when parents are not as distracted, she says.

"The whole [pediatric process] deals with education, being prepared, making them feel they're part of decision-making, and building that trust," Zerwer says.

REFERENCES

1. Gooding L, Swezey S, Zwischenberger JB. Using music interventions in perioperative care. *South Med J* 2012; 105(9): 486-490. Doi: 10.1097/SMJ.0b013e318264450c.
2. Mifflin KA, Hackmann T, Chorney JM Streamed video clips to reduce anxiety in dhildren during inhaled induction of anesthesia. *Anesth Analg* 2012; 115:1,162-1,167. Doi:10.1213/ANE.0b013e31824d5224.
3. Lee J, Lee J, Lim H, et al. Cartoon distraction alleviates anxiety in children during induction of anesthesia. *Anesth Analg* 2012; 115:1.168–1,173.
4. Clark Porter S. A tour to ease fears: Trial run-through lets kids see what surgery will entail. Finger Lakes Times. June 16, 2013. Accessed at http://bit.ly/1bN5ZLD.) ■

Patients won over with design and amenities

Patients can become anxious for even the most minor procedures, as outpatient surgery employees know. In comparison, a spa setting is inviting, and part of the reason is the environment and the amenities. Now outpatient surgery providers are finding that if they can provide a similarly inviting environment, it reduces patient anxiety and increases satisfaction.

Franciscan Point Surgery Center, part of Franciscan Saint Anthony Health, both in Crown Point, IN, is an example of an outpatient surgery program that has created such a peaceful environment. "From the moment you hit the door, it's very spacious," says **Judith DeMario**, RN, nurse manager for the surgery center. "There's warm lighting, warm colors and artwork," she says. "It doesn't feel very clinical."

Natural lighting is used in the waiting room, hallways, and the OR suites. Walls are painted in "calming" earth tones. Having no overhead paging also contributes to the spa-like setting, DeMario says.

Pediatric patients have a special area designed for them with a child-sized table, low bookshelf, and their own TV.

Patients have private bays preop (and postop), decorated with artwork, where they sit in attractive recliners to have their IVs started. Most patients walk into the procedure rooms instead of being taken on gurneys. In phase 2 recovery, patients face high windows, instead of each other.

The "spa" environment extends to amenities at the surgery center. For example, patients are given a heavy robe to use while at the center. The robes, which cost about $70 each, are embroidered with the name of the surgery center's owner. Additionally, patients in recovery select a carnation from a large multi-colored bouquet delivered weekly, which costs the surgery center about $35 per bouquet.

Another "plus" for the center is a card sent to patients that is signed by each staff person who helped take care of them. All of these amenities have allowed the center to gain Press Ganey patient satisfaction scores that put them in the 97-98 percentile nationally. "It's from an amazing collaboration of patients and staff," DeMario says.

Dolls used for comfort and education

At Children's West Surgery Center in Knoxville, TN, amenities include handmade comfort dolls on which children can draw, according to a news story.[1] The dolls are provided by a local Kiwanis group. The dolls are "stuffed" by an Alzheimers unit at a local facility.

Playing with the dolls helps children to relax, the staff members say. Also, they use the dolls to explain where on the child's body the surgery will be performed. To distract the children, anesthesia staff members also interact with the dolls.

At Finger Lakes Surgery Center in Geneva, NY, children doing a preop tour are given a popsicle plus a stuffed bear, provided by local colleges, a news story says.[2] They also are encouraged to bring the teddy bear back on the day of surgery along with a DVD to watch before and after surgery. A group that serves individuals with disabilities provides coloring books and crayons to distract the children.

On the day of surgery, nurses often dress the teddy bears in caps and masks and put bandages on them. Such efforts help the children to not be so anxious, staff say.

Having the right staff is key to helping patients relax, say sources interviewed by *Same-Day Surgery*.

At Franciscan Point Surgery Center, "they are clearly experts at customer service," DeMario says. Being able to make an emotional connection with patients, by talking in quiet, calming tones, for example, is as important a quality as having a good clinical background, she says.

"They're more than just comforting," DeMario says. "They make the experience a [positive] emotional one for patients."

REFERENCES

1. James A. Volunteers make dolls for kids facing surgery. Knoxville News Sentinel. Jan. 1, 2013. Accessed at http://bit.ly/10fPsQ8.
2. Clark Porter S. A tour to ease fears: Trial run-through lets kids

see what surgery will entail. Finger Lakes Times. June 16, 2013. Accessed at http://bit.ly/1bN5ZLD.) ■

UCLA's therapy dogs aid in outpatient surgery

Dog program is showcased in PBS documentary

Several four-legged volunteers with the People-Animal Connection (PAC) program at Ronald Reagan UCLA Medical Center and their human counterparts starred in an episode of a PBS television show, "Shelter Me: Let's Go Home." *(Web: http://shelterme.tv)*

The docu-series celebrates shelter pets with positive and uplifting stories about people's lives being improved when they adopt a shelter pet. The show followed a handful of human/dog teams with UCLA's animal-assisted therapy PAC program as they volunteered at the hospital.

All of the dogs featured were adopted from shelters and now bring comfort to outpatient surgery patients, their families, the staff, and other hospitalized patients. To watch a trailer of the episode, go to http://bit.ly/YVUkn8.

"Our animal-assisted therapy dogs truly provide a sense of healing and comfort that no medicine can offer," said **Erin Rice**, the director of UCLA's PAC program. "The show will help raise awareness about the real impact dogs can have on our hospitalized patients, and we hope viewers will be moved by the program."

One patient's mother, who works for Reagan UCLA Medical Center as a grant writer, shared her experience with the PAC program in outpatient surgery:[1]

"While in recovery, my son received a visit from Dixie, a member of the Doggie Brigade, and was given a stuffed animal that he ended up naming after the dog who had visited him. Including the dog's handler, we were helped by three volunteers during the 4-5 hours we were at the hospital. I also cannot say enough about the volunteers with whom we interacted that day; it was clear that they, too, are proud to be a part of Akron Children's Hospital. My son left healthier than he had arrived, but he also left with a feeling about Akron Children's: He felt special, and for that, I will always be a grateful parent and a proud employee of Akron Children's Hospital."

UCLA's PAC is an animal-assisted therapy program in which trained volunteers and their dogs visit patients to provide a more humane environment for patients, family, and staff and to help in the patient recovery process. Started in 1994 with one canine team, PAC has grown to more than 70 teams that visit more than 40 diverse units of the hospital and more than 900 patients each month.

All dogs must pass a thorough veterinary exam and behavioral screening process to be accepted into the program. Screenings are offered once a year for each campus. The PAC program is supported solely by donations.

REFERENCE

1. Guiley K. Another special day at Children's. Akron Children's Hospital. Feb. 25, 2013. Accessed at http://bit.ly/XF0PO9.

SOURCE

• **Erin Rice**, Director, People-Animal Connection (PAC) Program, Ronald Reagan UCLA Medical Center, Los Angeles. Phone: (310) 267-8184. Web: www.uclahealth.org/PAC. ■

Consider these lessons from case of jailed surgeon

Documentation was put in the hot seat

(Editor's note: This is the second part of a two-part series on avoiding liability with documentation. This month, we cover the lessons that can be learned from the case of a surgeon who was charged and jailed regarding mistakes he made in the medical record that did not impact billing. Last month we discussed the specifics of the case.)

To avoid liability in outpatient surgery, ensure that providers' documentation is complete and readable, say sources interviewed by Same-Day Surgery.

"It is imperative that the documentation is legible, thorough, and factual," says **Leilani Kicklighter**, RN, ARM, MBA, CHSP, CPHRM, LHRM, of The Kicklighter Group, which is a Tamarac, FL-based consulting group that specializes in risk management, patient safety, infection prevention, and loss prevention in ambulatory settings.

This advice is timely considering the case of a surgeon jailed after mistakes were found in the operative report that did make a difference in the billing. **John Natale**, MD, of Chicago, a cardiothoracic and vascular surgeon, went to federal prison on charges related to operations on several patients performed nearly 10

years ago. Natale was acquitted of all fraud charges, but he was convicted on two counts of making false statements. Natale and the Association of American Physicians and Surgeons asked the Court of Appeals for the Seventh Circuit to reverse the conviction, but the conviction was upheld on June 11, 2013.

"It is a shame this case rose to the level it did; however, if physicians/surgeons follow the rules of full, thorough, legible, timely documentation and dictation with medical necessity included for all tests, treatments, procedures, and medication, they should find it easier for them in the long run," Kicklighter says.

Such documentation is imperative, Kicklighter says. "In discussions with physicians about legibility of — or lack of — handwriting, often it is commented that they get to interpret what they wrote," she says. "In a court action or other legal action, it is the jury who makes that interpretation."

In today's environment, legibility is important should records be requested for a Recovery Audit Contractor (RAC) audit or other governmental review, Kicklighter says. "In many instances, if the documentation justifying medical necessity are not legible, it is considered by some to not be documented," she says. "In other instances, when a record is requested for patient care, the next caregiver may not be able to read the entries that could result in a mis- or missed-diagnosis, or a delay in or duplicate care if tests are repeated."

Legibility will become less of an issue with conversion to electronic health records, but legible handwritten signatures still are important, Kicklighter says. "Signatures that are scribbles and undecipherable may be much easier to forge," she adds.

Consider these other suggestions:

• Have thorough documentation.

One of the first steps in a lawsuit is to request and review the medical record, Kicklighter points out.

"A thoroughly documented record may reflect that all tests and treatments, based on full medical and social history and physical exam, differential diagnoses, critical thinking thought-process steps, and medical justification for preliminary and final conclusions regarding treatment and diagnosis/diagnoses goes a long way to support compliance with the standard of care," she says. "When there are no omissions in the documentation in the steps of the process, often there is nowhere to assert a claim of omission or commission as a basis for a malpractice suit."

Documentation of the practice record in an office is just as important as in a hospital or ambulatory surgery center, Kicklighter adds.

• Ensure the documentation is accurate.

The surgeon's signature on a dictated surgical/procedure report indicates that the facts in the report have been validated and authenticated, Kicklighter says.

"There have been times when "L," left, and "R," right, have been incorrect, words misspelled, or blanks in the report that have not been corrected by the surgeon," she says. Such issues can be trouble, particularly if there is a lawsuit, Kicklighter says.

Another problem occurs when someone other than the surgeon who performed the procedure dictates the report, she says. "In these situations the surgeon who performed the procedure must take special care to carefully review the typed report to verify the specifics of that specific patient are detailed correctly," Kicklighter says.

• Accurate coding is a necessity.

Usually the government doesn't prosecute miscoding, particularly if it is unintended, as it was in the Natale case, says **Stephen Trosty**, JD, MHA, CPHRM, ARM, president of Risk Management Consulting Corp., in Haslett, MI.

"This [case] becomes even more absurd, and highly questionable, if this physician did not routinely miscode cases and this is an anomaly for him," Trosty says. "It definitely seems to run contrary to the intent of Medicare and the accompanying regulations as it relates to the imposition of fines, requiring the paying back or inappropriate reimbursement, or the loss of the right to receive Medicare reimbursement." ■

Same-Day Surgery Manager

Answers to 6 questions that puzzle *SDS* readers

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

Question: Our facility will not buy us lunch! Is that not the cheapest thing you have heard? Most of us work through our lunch break anyway and are so busy turning over the rooms that we don't have the luxury of going someplace to get something to eat. We do, like, 40 cases a day here, so it is not like they don't have the money. We

are too embarrassed to keep asking the vendors to bring us food. My question is: How many places do you know where the surgical facility will buy the staff lunch on busy days? Please include the address if they are in the Denver area! *(Editor's note: The reader didn't identify whether the employer was a hospital or freestanding center.)*

Answer: First, thank you for the LOL! Our clients are about 50/50 hospitals and surgery centers, and I can tell you that I don't know of any hospital that we work with that will pay for staff lunches. I don't think it is because they are cheap. I think it is more of the fact that they have many employees, and it would not be right for them to do for one what they cannot do for another. If you are in a surgery center, I cannot think of a surgery center that will not buy lunch for staff on busy days! There are exceptions, but they are rare. As far as the vendors bringing lunch in, most of them actually have budgets to do that, so don't feel bad about asking them.

Question: Why is our hospital charging us to park? It is sometimes $6 to $10 per day! I don't understand why we are paying parking fees. Anyone else out there doing this?

Answer: I agree with you! I don't understand why patients who are paying thousands of dollars per day are charged to park at hospitals. I feel the same about staff. If I had to pay to park to go to the food store or mall, I would find another store. I do know that many hospitals hire outside firms that run their parking garages or spaces. They don't come cheap either. But still, I agree with you, that if you have to recoup those fees, add a little more to the bill to make up for it rather than hourly parking fees.

Question: You said in a recent column that electronic medical records need to be implemented in every center. You never said how. I have only two other people in my business office, and there is no way we can scan hundreds, if not thousands of patient records. Who is going to do that?!

Answer: Rarely does that staff do it. It is far too time-consuming, and it distracts from normal operations. Many facilities hire outside companies to do it over weekends and evenings. There are ultra high-speed scanners out there that can scan incredibly fast that you can rent to get caught up.

Question: We had a patient come into our center last week with a dog. I love animals, but not in the operating room! She said her pet was an "emotional support animal" (ESA), and she had documents stating such. She told us we were required to let her bring her pet into the facility and even into the operating room when she had her augmentation procedure. She said it was an ADA (Americans with Disabilities Act) requirement that we had to comply with. Have you ever heard of this?

Answer: Yes, I've heard of it. An ESA certificate is valid. You can take you pet on planes, and some hotels honor the certification. But, unlike other animal certifications, such as seeing eye dogs, you cannot bring your pet into a place of business that will not allow pets in the first place — the operating room or even your center being examples. You are right to deny the pet.

Question: Our hospital is going to build a surgery center about five miles from where we are now. They are not going to allow the surgeons to invest in it like the one across the street. Why would they do this?

Answer: By not allowing physician investment in the center, the hospital can receive hospital reimbursement rates, which can be as high as 40-50% higher than a joint-ventured facility. They also don't have to share the revenue with the surgeons. Hospitals have learned over that past 30 years that freestanding surgery centers are more efficient, both in time and dollars, than hospitals. There are many reasons why a hospital would want to build its own surgery center. They are looking for a lower-cost facility to perform outpatient surgery. It's as simple as that! A freestanding surgery center is much less expensive to build than expanding current hospital operating rooms.

Question: Our surgery center is now on Facebook and other social media sites. I fail to find the rationale for this. Is there any value in this?

Answer: I like the social media phenomenon that is pulsating around us. I think it is dynamic, exciting, and will continue to grow and influence many aspects of our lives, including being a driver in healthcare decision-making for patients. Social media has the ability to draw together, or polarize, diverse groups with shared interest. But surgery…? I scratch my head and wonder why some surgery facilities have a "like us" tab on their website. Why would I "like" it? Maybe some of our readers can give feedback to us based on their experiences. *[Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Earnhart & Associates' address is 238 S. Egret Bay Blvd., Suite 285, Houston, TX 77573-2682. Phone: (512) 297.7575. Fax: (512) 233.2979. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.]* ■

Critical issue: Oversight of robotic surgery

(Editor's note: In this second part of a two-part series, we discuss how facilities can manage risks that come with cutting-edge technology. Last month we discussed the details in the case of a surgeon investigated for his robotic surgeries and how the facility became involved.)

In the case involving allegations of unprofessional conduct against a Colorado surgeon, the use of a robotic surgery arm might be only a distraction, say two malpractice attorneys. No matter what equipment was used, the real issue might be whether the facility adequately credentialed him and required him to meet the same performance standards as any other surgeon, with or without the robot.

Warren Kortz, MD, of Denver is under investigation for 14 robotic surgeries with poor outcomes or adverse events. The Colorado Board of Medical Examiners has charged Kortz with 14 counts of unprofessional conduct after failed procedures with the robotic surgery arm owned by Porter Adventist Hospital in Denver. According to the complaint filed by the board, from 2008 to 2010 Kortz cut and tore blood vessels, left sponges and other instruments inside patients after closing, injured patients through improper padding and positioning, subjected some to overly long surgeries, and had to abort kidney donations because of mistakes. The board also alleges that Kortz failed to properly document some of those problems. The state is asking an administrative judge to suspend Kortz's license to practice medicine.

Porter Adventist Hospital in Denver could be held liable if the plaintiff shows that the surgeon was insufficiently trained or skilled on the robotic device, because the hospital allowed him to operate there, explains **Daniel P. Slayden**, JD, a partner with the law firm of Hinshaw & Culbertson in Joliet, IL. Moreover, the hospital marketed the robotic surgery and included Kortz in the marketing efforts. A plaintiff could claim that the hospital gave the doctor a pass on surgical outcomes that would raise a red flag with other doctors because he was generating significant revenue for the hospital, Slayden says.

The hospital is more likely to be drawn into such a case when the state has no liability cap, explains **Rodney K. Adams**, JD, a shareholder with the law firm of LeClairRyan in Richmond, VA. The plaintiff will look to the deeper pockets of the hospital and allege negligent credentialing, failure to have a safe environment, and similar issues. "In Virginia, for instance, most physicians are insured to the cap, and so the plaintiff doesn't need four or five defendants," he says. *(For information on how to comply with credentialing accreditation standards, see* SDS Accreditation Update, *p. 1, enclosed in this issue.)*

Although some facts are not known about the Denver case, Slayden notes that it does highlight a particular risk of working with new technology. Like lasers 20 years ago, robotic surgery is now a cutting-edge, high-tech treatment option that can draw in more patients to the hospital, but Slayden cautions that managers must apply the same patient safety standards.

"Patients with choices will decide where they want to be treated based on marketing that shows the latest, most up-to-date technology in use," Slayden says. "But what standards are you setting for your physicians so you can be comfortable that they are properly trained and skilled? It can be a grey area, because if it is new technology, the only training might come from the company that makes the device, and they certainly want doctors to be certified so they can sell the product."

Adams notes that patients can drive the use of such technology and physicians will want to respond. The equipment can cost millions of dollars, so facilities sometimes are heavily incentivized to market the technology and look the other way if outcomes are not good, he says.

Watch for any tendency among administrators and clinical leaders to accept lower quality or more threats to patient safety when cutting-edge technology is used, Slayden says. "Those temptations will always come up with any new technology. That's the nature of the beast," Slayden says. "Your job has to be to hold the line on what is an acceptable record and not change that because your doctor or your hospital really wants to use this device."

But expect some push back on that, Adams cautions. "That's going to create some tension with the marketing department. We saw the same thing with bariatric surgery, when so many hospitals wanted to get into that field because it is very lucrative and there's a big demand for it," Adams says. "A lot of hospitals have since gotten out of it because bariatric surgery requires a lot of training and brings some real challenges for the facility and a high complication rate. The marketing department and the accountants might have wanted to keep it, but someone had to step in and say this isn't the best thing for us to offer." ■

Video monitor system helps ensure a timeout

The North Shore — LIJ Health System in Forest Hills, NY, is expanding a first-of-its-kind video monitoring system used to measure hand-washing compliance at North Shore University Hospital in Manhasset, NY, by introducing cameras in operating rooms at Forest Hills (NY) Hospital. The pilot program provides hospitals with real-time feedback in their ORs and marks the first time in the United States that remote video auditing (RVA) has been used in a surgical setting, according to North Shore — LIJ.

RVA ensures that members of the surgical teams take a timeout before they begin a procedure. The cameras also are being used to alert hospital cleaning crew when a surgery is nearing completion and the pre-operation area when a room is ready for the next case, which helps reduce the time it takes to prepare the OR for the next surgery. To reduce the risk of infections, the monitoring system also confirms whether ORs have been cleaned thoroughly and properly, both between cases and overnight.

The system observes every OR once per minute. It evaluates and sends email/text alerts typically within 2-4 minutes of observing a timeout. It does not does not listen to the timeouts, but the hospital leaders do listen into the rooms separately from the system (on a sampled basis), and they provide real-time feedback if the timeout isn't being verbalized correctly.

The program was designed and implemented by North Shore — LIJ's anesthesiology provider, North American Partners (NAPA), in partnership with Mount Kisco, NY-based Arrowsight, a developer and third-party provider of RVA services and software.

The program was initiated in March 2013 in eight ORs at North Shore — LIJ's Forest Hills Hospital. "The initial focus at Forest Hills has been on monitoring for surgical timeout compliance, and within just one week of receiving real-time performance feedback, our operating room teams achieved nearly perfect scores," said **Rita Merceica**, RN, the hospital's executive director.

Given the success of the program at Forest Hills, **John DiCapua**, MD, chair of anesthesiology at North Shore — LIJ, said the monitoring system would be installed in June 2013 in more than 20 ORs at another North Shore — LIJ hospital. "We are very excited to bring this important innovation to additional surgical suites," DiCapua said. "We believe that third-party RVA can provide our hospitals with strong, sustainable tools to improve patient safety and perioperative efficiencies."

DiCapua said he expects the pilot projects to be completed by the end of this year and plans on submitting an academic study for publication in 2014.

The introduction of video monitoring in ORs follows its ongoing, successful use in the medical and surgical intensive care units at North Shore University Hospital (NSUH) in Manhasset, NY. A 2011 study published in Clinical Infectious Diseases Medical Journal covered the video monitoring in an article titled "Using high-technology to enforce low-technology safety measures: the use of third-party remote video auditing (RVA) and real-time feedback in healthcare." NSUH demonstrated that the use of a third-party RVA system rapidly improved and sustained hand hygiene rates to nearly 90% in less than four weeks. *(Editor's note: To access the abstract, go to http://bit.ly/uDzj8w.)* ■

AORN releases RPs on sharps safety

The Association of perioperative Registered Nurses (AORN) has released a new "Recommended Practices for Sharps Safety," which replaces the "Guidance Statement: Sharps Injury Prevention in the Perioperative Setting" issued in 2005.

Surveillance data indicates that sharps injuries continue to increase in surgical settings, says **Mary J. Ogg**, MSN, RN, CNOR, perioperative nursing specialist at AORN. Half a million healthcare workers receive these injuries each year, Ogg says.

Sharps injuries have been linked to the occupational transmission of the hepatitis B virus (HBV), hepatitis C virus (HCV), & HIV, Ogg says. And healthcare workers aren't the only ones at risk. There have been 132 cases documented in which healthcare providers transmitted HBV, HCV, or HIV to patients. "Sharps injuries carry a heavy emotional and economic burden," Ogg says. "Recognizing the increased risk to surgical patients and the perioperative team for a bloodborne pathogens exposure from sharps injuries, AORN transitioned the guidance statement to a recommended practice."

The recommended practice is based on the Occupational Safety and Health Administration's (OSHA's) "Bloodborne Pathogen Standard 29CFR 1910.1030 Hierarchy of Controls." It addresses elimination of the hazard, engineering controls, workplace

controls, administrative controls, and the wearing of proper personal protective equipment (PPE).

Sections of this RP that have the highest level of evidence, such as Cochrane reviews, randomized controlled trails, and regulatory requirements, and make the most impact in reducing sharps injuries include double gloving, use of blunt tip suture needles, use of the neutral zone, and elimination of sharps objects, Ogg says. Double gloving can reduce the potential for injury by 87%, and blunt tip suture needles can reduce the potential by 54%, she says.

"An important recommendation for the ambulatory surgery setting is establishing a written bloodborne pathogens exposure control plan that is reviewed and updated annually," Ogg says. "The ambulatory surgery center must establish a process for selecting and evaluating sharps safety devices as part of the exposure control plan. The interventions that a surgery center can implement now to improve sharps safety are double gloving and using a neutral or safe zone for passing sharps."

RESOURCE

The 2013 edition of "Perioperative Standards and Recommended Practices" is available at http://bit.ly/1atxegg in a variety of formats. A PDF of the single chapter "Recommended Practices for Sharps Safety" is available for $70. ■

Equal pay discussed for ASC procedures

MedPAC submits report to Congress

The Medicare Payment Advisory Commission's (MedPAC's) June report to Congress includes a chapter reviewing several proposals to expand site-neutral payments, the American Hospital Association (AHA) reported. The report discusses equalizing payments for certain surgical services commonly furnished in ambulatory surgical centers, which would reduce hospital payments for 12 surgical ambulatory payment classifications (APCs) by $590 million, the AHA said.

Another proposal would expand the site-neutral policy to 66 additional APCs, which would reduce hospital payments by another $900 million, the organization said. MedPAC expects to continue discussing the proposals in the fall, the AHA said.

"AHA believes that it was premature and ill-advised for MedPAC to include a site-neutral payment policy chapter in its report," said **Joanna Kim**, AHA vice president for payment policy. "Given the complexity involved in crafting a site-neutral payment policy, we believe that a more robust analysis of impact should have been conducted before this issue was committed to a published chapter."

The potential cuts could have a significant impact, Kim said. "Although MedPAC staff did not provide exact estimates, based on the information provided, the impact of implementing site-neutral payments as described in the chapter would likely be well over $2 billion in a single year, reducing payments to the chronically underfunded Medicare outpatient system by 5.5%, and reducing hospitals' Medicare outpatient margins from negative 11% to negative 17%, all else being equal," she said.

To access the report, go to http://www.medpac.gov/documents/Jun13_EntireReport.pdf. ■

New guidelines set for patient safety

Washington State surgeons recently announced standardized guidelines for preoperative care in the form of pre-surgical checklists and tools available to all surgeons to use in their offices or by patients at home to ensure that the health of patients is optimized before surgery.

The Strong for Surgery checklists assess whether patients have modifiable risks for surgery and then offer a set of interventions to reduce the risk before hospitalization. They address four target areas: nutritional support to prevent infections, reducing cigarette smoking, reviewing and coordinating potentially dangerous medications, and improving diabetes care before surgery.

Nearly one-third of hospitalized patients experience adverse events related to their care, and far too often these events are preventable. While quality improvement initiatives have made surgery safer and have achieved improved outcomes, they usually focus on the care of patients once they enter the hospital. Strong for Surgery provides the opportunity for early intervention to reduce risks prior to hospitalization.

"Strong for Surgery takes the idea of checklists and moves them to where decisions are being made before the patient gets to the hospital," says **Tom Varghese**, MD, who is leading Strong for Surgery. Varghese is an associate professor in the Department of Surgery at the University of Washington and the director of the thoracic sur-

gery program at Harborview Medical Center, both in Seattle Putting the checklist in every doctor's office across the state takes the focus of surgical safety beyond the operating room. Surgical preparedness now becomes part of the basic conversation about planning for surgery, and the patient shares in that process. It empowers patients."

Strong for Surgery is a public health campaign that engages doctors, nurses, other clinical staff, and, most importantly, patients and their families to make Strong for Surgery checklisting universal. Free Implementation Guides to assist hospitals, centers and doctor's offices in successfully implementing the Strong for Surgery checklists are available on the website at www.strongforsurgery.org. The Implementation Guide contains all of the Strong for Surgery checklists and all of the accompanying resources, references, forms, and other supporting materials. *(Click on "Clinicians, Learn More About Optimizing Health Prior to Surgery," then on the left side of the page, select "Request the Implementation Guide.")* There is a specific section on the website for patients, so that individuals may download the checklists and bring them to their doctor's office to ensure that any areas of concern are reviewed and addressed. ■

Alternatives listed for compliance hotlines

The compliance hotline operated through the Ambulatory Surgery Center Association has been discontinued due to an increased cost of the program that the association did not want to pass on to its members. However, ambulatory surgery providers can consider these other providers of compliance hotlines, also referred to as ethics hotlines, employee hotlines, or whistleblower hotlines:

• **Compliance Resource Center in Alexandria, VA.** Confidential compliance communication through telephone and web-based reporting. Telephone: (703) 683-9600 Extension 405. Email: info@complianceresource.com. Web: https://www.complianceresource.com.

• **InTouch in Minneapolis.** This company offers hotlines of all types, from basic Sarbanes-Oxley compliance lines to more robust feedback systems. Telephone: (612) 926-7988. Email: info@getintouch.com. Web: http://getintouch.com/solutions.

• **Lighthouse Services in Blue Bell, PA.** The sole focus of the business is compliance and ethics hotlines, and the program includes internal control and fraud reports, human resource complaints, and ethics and compliance violations. Telephone: (215) 884-6150. Email: info@lighthouse-services.com. Web: http://www.lighthouse-services.com/index.html.

• **NAVEX Global in Lake Oswego, OR.** All reports — whether via anonymous hotline/helpline, custom web portal ,or manager open-door report form— are captured in a central repository to support investigation, remediation, reporting, and trend analysis. Telephone: (866) 297-0224. Web: http://www.navexglobal.com. ■

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

■ Should age be a barrier to having outpatient surgery?

■ When is an experienced RN ready for the OR?

■ Online communication and risks for patient privacy

■ What is involved in changing accrediting agencies?

CNE/CME QUESTIONS

1. Research at the University of Kentucky, Lexington has found that music exposure during and after surgery at its hospitals resulted in patients who were what?
   A. Less anxious before the procedure
   B. Recovered more quickly and satisfactorily
   C. Required less medication for sedation
   D. Were more satisfied with their medical experience
   E. All of the above

2. What amenities have helped Franciscan Point Surgery Center achieve Press Ganey patient satisfaction scores in the 97-98 percentile nationally?
   A. Patients are given a heavy embroidered robe to wear
   B. Patients select a carnation from a multi-colored bouquet
   C. Patients receive a card signed by each member of the staff
   D. All of the above

3. What is the advice of Leilani Kicklighter, RN, ARM, MBA, CHSP, CPHRM, LHRM, of The Kicklighter Group, regarding someone other than the surgeon who performed the procedure dictating the report?
   A. No one other than the surgeon should dictate the report.
   B. The surgeon who performed the procedure must take special care to carefully review the typed report to verify the specifics of that specific patient are detailed correctly.

4. How has remove video auditing (RVA) been used at the North Shore — LIJ Health System?
   A. Ensures that members of the surgical teams take a timeout before they begin a procedure
   B. To alert hospital cleaning crew when a surgery is nearing completion
   C. To alert the pre-operation area when a room is ready for the next case
   D. To confirm whether ORs have been cleaned thoroughly and properly, both between cases and overnight
   E. All of the above

SDS ACCREDITATION UPDATE

Covering Compliance with The Joint Commission, AAAHC, and Medicare Standards

Avoid most common areas of noncompliance with tips from The Joint Commission and AAAHC

Half of ambulatory organizations undergoing accreditation by The Joint Commission are out of compliance with the standard on credentialing and privileging (HR.02.01.03). The biggest reason? Noncompliance with Element of Performance (EP) 3, which requires the organization to document training specific to the privileges being requested.

"What they're doing wrong is they're not using primary sources," says **Michael Kulczycki**, executive director if the Ambulatory Health Care Accreditation Program at The Joint Commission. Ambulatory organizations may mistakenly accept a copy, rather than looking directly on the web, for example, to obtain a certificate of completion or confirm an educational degree. The prime source documentation must be in the credentialing file.

Also, EP15 specifies that when you're granting initial privileges to a licensed independent practitioner (MD or DO, for example), you must review that practitioner's information at the National Practitioner Data Bank (http://www.npdb-hipdb.hrsa.gov).

EXECUTIVE SUMMARY

Credentialing and privileging, as well as quality improvement, are areas where accredited organizations struggle with compliance.

- Use primary sources, review the National Practitioner Data Bank, and tell physicians that privileges are time-limited.
- The Accreditation Association for Ambulatory Health Care (AAAHC) requires you to review your QI program annually. The Joint Commission requires that at least annually, the leaders provide governance with written reports on all system or process failures, number and type of sentinel events, and all actions taken to improve safety.
- AAAHC spells out 10 elements that must be included in QI studies. *(See list, p. 3.)* The Joint Commission has a performance improvement standard (PI.01.01.01) and elements of performance identifying expected and suggested data collection.

Providers must review the data bank when renewing privileges also, Kulczycki says. Also, once the organization has reviewed the data bank, the leaders must evaluate whether they are going to grant privileges, he says. *(For more details, see resource in blog listed on p. 2.)*

The Accreditation Association for Ambulatory Health Care (AAAHC) says organization frequently neglect to tell physicians that the privileges are time-limited, says **Steven Gunderson**, DO, chief exececutive officer and medical director of the Rockford (IL) Ambulatory Surgery Center. Gunderson is a AAAHC surveyor and a member of the AAAHC Accreditation Committee. Organizations usually give surgical privileges for two or three years, depending on what their state allows, Gunderson says. "What we find is that they give privileges, they send a letter saying 'you're on staff,' but they don't know the privileges are for a limited time and they have to reapply." That information must be in the letter or in the governing minutes, he says. *(For more on complying, see "Credentialing is a problem — Here's how to comply,"* SDS Accreditation Update *supplement, November 2010, p. 3.)*

Consider these other suggestions for complying with problematic standards:

- **Safely store medications.**

Medication must be stored in accordance with manufacturer recommendations, which means that if refrigerator storage is required, the facility must comply, Kulczycki says. Alarms and records that the

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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.

refrigerator has maintained the proper temperature also are essential elements.

Also, medication on the anesthesia cart must be properly labeled, not expired, and, depending on the type of medication, appropriately controlled (locked as needed) and monitored, he says. However, surveyed organizations often find that although medications might have been checked by several persons, there is often a "Joint Commission moment" when the surveyor pulls out the one container of medication that's expired. To avoid this problem, change the person who reviews the medications from time to time.

"If you have clinical person monitoring the medication storage area, to mix it up for one month, pull someone from the front business office, tell them what to look for, and have them do a mock tracer in areas," Kulczycki says. "A fresh set of eyes will bring new perspective."

• Reduce the risk of infections associated with medical equipment.

Noncompliance in this area often can be attributed to surface cleaning of low-level infectious areas, sterilization or spore testing in high-level areas, or expired sterile supplies, Kulczycki says.

"This one in particular is an example that the organization is doing the steps, but maybe the person doing the cleaning doesn't know the specific," Kulczycki says.

For example, the sterilizing solution might require a contact period of a set number of minutes, and the person doing the cleaning might be wiping off the solution right away. The problem sometimes can be traced to supply ordering, Kulczycki says. Members of the staff might change solutions, but they didn't review how the new solution affects the sterilization process in place or train the staff.

• Include detailed allergy documentation in a specific place in every record.

Don't list only the items patients are allergic to, but also list the symptoms they develop.

"For example, the record shows they're allergic to penicillin, but it doesn't say what happens," Gunderson says. "Do they have a rash? Do they go into anaphylactic shock? That's part of the medical record." Such information is essential if, for example, a patient goes into cardiac arrest and has to be transferred to a hospital. "You can't ask the patient," Gunderson says.

• Have a list of look-alike, sound-alike medications.

There should be some mechanisms for the pharmacy to have identified look-alike, sound-alike drugs, Gunderson says. "You don't necessarily have to have a policy, but that's helpful," he says. You should make all staff aware that some drugs look alike and sound alike, and tell them how the facility addresses this potential problem. For example, the facility might choose to segregate those drugs in the pharmacy and the medication cart so it's not easy to grab the wrong drug.

• Avoid the "ventriloquist act."

Educate your staff about the accreditation process, Gunderson says. "It's distressing when you ask, `Have you been involved in the QI process,' and they look like a deer caught in the headlights," he says. "They don't even know what QI is."

Tell your staff what the survey process is about and what to expect in the survey, Gunderson says. At his facility, the leaders put together a newsletter for staff that, on one side of the page, lists standards and, on the other side of page, tells staff members how their facility complies with the standards. "We give examples so staff become familiar with every chapter we will be surveyed on, at least some aspect," Gunderson says. *[To see a copy of a newsletter from Gunderson's facility, access the online issue of* Same-Day Surgery. *For assistance, contact customer service at customerservice@ahcmedia.com or (800) 688-2421. For more tips from Gunderson, see story p. 3.]*

When Joint Commission surveyors are doing patient tracers, they often talk to staff persons who

Hints During the Survey:

- It's OK not to know the answer.
- We are reviewing systems, not individuals.
- Please ask questions. Survey should be interactive and educational.
- Surveyors try to minimize disruptions.
- We will notice things you have never seen.
- If we ask for materials, please obtain ASAP.

Source: Jay Afrow, "Preparing for Joint Commission Accreditation," Ambulatory Surgery Center Association, April 17, 2013.

RESOURCE

• To review a three-part series from The Joint Commission on privileging and credentialing, go to http://www.jointcommission.org/musingsambulatory_patient_safety. On the left side of the page, under "Archives," select "show more." The series ran in November 2011, December 2011, and March 2012. ■

perform activities such as infection control and sterilization. The administrator or quality coordinator is allowed to accompany the surveyor during those discussions. However, "we want to hear form the person doing the job, not the person supervising them or who has a coordination relationship to that area to step in and say, "this is what they're supposed to do," Kulczycki says. Sometimes the supervisor is behind the surveyor mouthing what the staff member should say, he says. "Often, the caregiver knows the answer, and they're perfectly comfortable talking to the surveyor," Kulczycki says.

It's usually the supervisor making the staff worker anxious, not the surveyor, he says. "Surveyors are skilled at making staff comfortable by saying, "Tell me the story about what you did with the patient." *(See boxed list of more hints during a survey, p. 2.)* ■

Are you failing to address these problem areas?

AAAHC surveyor shares top problems with compliance

What's the one area that outpatient surgery programs often have accreditation problems ? QI studies, says **Steven Gunderson**, DO, chief executive officer and medical director of the Rockford (IL) Ambulatory Surgery Center. Gunderson is a AAAHC surveyor and a member of the AAAHC Accreditation Committee.

"That seems to be an issue almost anywhere you go," Gunderson says.

The Accreditation Association for Ambulatory Health Care (AAAHC) requires review of the QI program annually. "Make sure it's addressing those issues you're trying to improve upon and it's doing an adequate job," Gunderson says. There are other areas, including bylaws and patient rights and responsibilities, that are required by AAAHC to be reviewed annually, Gunderson says. The Joint Commission has an element of performance (LD.04.04.05, EP 13) that says at least annually, the leaders provide governance with written reports on all system or process failures, number and type of sentinel events, and all actions taken to improve safety. Make a grid to track the items, and mark off items as you review them, Gunderson advises. *(See sample grid with the March 2012 online issue of* SDS Accreditation Update.*)*

Another problem area is that AAAHC requires your QI project include 10 elements, specified in the standards. *(See box, right.)* "It's in the handbook, but I'm surprised how many times people leave out one of the 10 elements in their study," Gunderson says. If your facility prefers to use another QI methodology, then do 1-2 studies in a three-year accreditation period using the 10 steps, he says. "You'll have a happy surveyor," Gunderson says. "People tend to get upset when you don't use those 10 elements." The Joint Commission doesn't specify the content of QI studies, but it does have a performance improvement standard (PI.01.01.01) and elements of performance

10 Elements of a QI Study

•A statement of the purpose of the QI study that includes a description of the problem and an explanation of why it is significant to the organization

• Identification of the measurable performance goal against which the organization will compare its current performance in the area of study

• A description of the data that will be collected to determine the organization's current performance (i.e., study methodology)

• Evidence of data collection

• Data analysis that describes findings about the frequency, severity, and source(s) of the problem(s)

• A comparison of the organization's performance in the area of study against the previously identified performance goal

• Implementation of corrective action(s) to resolve the identified problem(s)

• Re-measurement (a second round of data collection and analysis as described in AAAHC Standard 5.I,C.4-6) to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement

• If the initial corrective action(s) did not achieve and/or sustain the desired improved performance, implementation of additional corrective action(s) and continued re-measurement until the problem is resolved or is no longer relevant

• Communication of the findings of the quality improvement activities to the governing body and throughout the organization, as appropriate, and incorporation of such findings into the organization's educational activities ("closing the QI loop")

Source: Accreditation Association for Ambulatory Health Care. ■

identifying expected and suggested data collection.

Another problem occurs when facilities neglect to purchase a new accreditation handbook, he says. "A lot of times they think 'we were surveyed three years ago and did OK, so I'll stick with the book I had then and not spend money for a new book,'" Gunderson says. Over three years, many standards are modified or changed, and some chapters are eliminated or combined. "You don't know what you don't know because you didn't obtain the handbook," Gunderson says.

Facilities also frequently fail to perform a self-assessment, he says. "You should start way ahead of the survey, especially if you're Medicare-surveyed because you have no date, you just have an idea" of when the survey will be, Gunderson says. At his center, about halfway through the three-year accreditation survey period, the leaders start preparing by performing a self-assessment with the most recent handbook. "If you do the self-assessment, you can find out if you have problems with certain standards, then work to correct those problems before the survey occurs," Gunderson says.

These compliance issues aren't "rocket science," he says. "Plan ahead, do the self-assessment, understand the standards, and you won't have any problems." ■

TJC, hospitals identify best measures to prevent SSIs

Working with 17 accredited hospitals to test and trial surgical site infection (SSI) prevention measures, The Joint Commission (TJC) recently issued an implementation guide for its national patient safety goal for hospitals, ambulatory organizations, and office-based surgery on SSIs (NPSG.07.05.01).1

The guide is based on the results from TJC's "SSI Change Project," which focused on identifying effective practices for preventing SSIs. Overall, 23 measures were identified that resulted in at least a 30% reduction in SSI rates for one surgical procedure for at least one year in the participating hospitals.

Surveyors will not be enforcing the specific practices outlined in the document, says **Kelly Podgorny**, DNP, RN, project director in TJC's Division of Healthcare Quality Evaluation and one of the principal authors of the guide.

The Centers for Medicare and Medicaid Services is beginning to refuse covering the cost of additional care related to some SSIs, including orthopedic procedures. While advances have been made in infection control practices, improved operating room ventilation, sterilization methods, barriers, surgical technique, and availability of antimicrobial prophylaxis, SSIs remain a substantial cause of morbidity and have an associated mortality rate of 3%, the Centers for Disease Control and Prevention reports. Of those fatal infections, 75% could be attributed directly to acquiring an SSI, the CDC notes.2

In the TJC guideline, many facilities cited the benefit of having a multidisciplinary SSI team that was responsible for project planning, implementation, and evaluation. Team members included infection preventionists, surgical staff, nurses, surgeons, anesthesia practitioners, pharmacists, and epidemiologists.

The three pediatric hospitals participating in the project determined there was a dearth of pediatric-focused evidence-based practices to reduce SSIs. The pediatric hospitals developed strategies that should be useful for other pediatric settings targeting SSIs.

"We thought that this was an important and unexpected outcome of the SSI Change Project," Podgorny says. "Each pediatric hospital discussed strategies to deal with this barrier and those are addressed and described in the implementation guide."

St. Christopher's Hospital for Children in Philadelphia developed a bundle for pediatric patients that includes a specific focus on postoperative prevention and surveillance after discharge. St. Christopher's implemented the bundle of interventions in February 2011 for spinal fusion surgery patients. "Since then, the hospital has had a 76% reduction in SSI rates and bundle compliance has remained at 100%," The Joint Commission states in the guide. The St. Christopher's pediatric SSI bundle includes a post-op nursing standard of care; designated nursing units for high-risk procedure patients (e.g., spinal fusion surgery); specific dressings and post-op protocols; a nursing teach-back; surgery-specific educational tool for patients and parents; products needed for home care, including how to meet the needs of low socioeconomic families; and early, consistent, scheduled, post-discharge follow-up with the surgeon for early identification of any infection.

REFERENCES

1. Joint Commission. The Joint Commission's Implementation Guide for NPSG.07.05.01 on Surgical Site Infections: The SSI Change Project 2013; Available at: http://ow.ly/m58iD.
23. Centers for Disease Control and Prevention. April 2013 CDC/NHSN Protocol Corrections, Clarification, and Additions. Available at: http://ow.ly/m65zB. ■

RASC
AAAHC
NEWSLETTER

SEPTEMBER 1, 2011
VOL. 4

CHAPTER 3
Administration

An accreditable organization is administered in a manner that ensures high-quality health services and fulfills the organizations goals, and objectives.

Standards

- Enforcing policies and controls to ensure orderly management of the organization
- Protecting the assets of the organization
- Employing qualified management personnel
- Controlling the purchase, maintenance and distribution of equipment
- Establishing lines of authority, accountability and supervision
- Maintaining the confidentiality, security and safety of data on patients
- Maintaining a health information system that collects and reports data as necessary
- Dealing with inquiries from governmental agencies
- Require periodic job evaluations

HOW DOES RASC MEET THESE STANDARDS?

EXAMPLE:
- **FINANCIAL AND CLINICAL POLICIES ARE DEVELOPED BASED UPON "BEST PRACTICES" TO CONTROL AND ENSURE GOOD MANAGEMENT PRACTICES**

EXAMPLE:
- **THE ADMINISTRATIVE STAFF MONITOR ACTIVITIES SUCH AS RISK AND SAFETY TO REDUCE LIABILITY TO THE FACILITY**

EXAMPLE:
- **EACH STAFF MEMBER HAS A JOB DESCRIPTION WITH PERFORMACE REQUIREMENTS & EXPECTATIONS OUTLINED WITHIN**

EXAMPLE:
- **THE FACILITY HAS AN ANNUAL BUDGET THAT ALOTS FUNDS TO PURCHASE AND MAINTAIN EQUIPMENT**

EXAMPLE:
- **THE ORGANIZATION HAS ANNUAL PRIVACY AND SECURITY EDUCATION TO COMPLY WITH HIPAA AND TO PROTECT PATIENT HEALTH INFORMATION**

EXAMPLE:
- **THE ORGANIZATION COMPLIES WITH ALL FEDERAL REQUIREMENTS THAT ALLOW FOR MEDICARE REIMBURSEMENT**

EXAMPLE:
- **EMPLOYEES RECEIVE PERFORMANCE APPRAISALS FROM THEIR SUPERVISOR**