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How old is too old to be a patient? Providers weigh in on controversy

By **Joy Daughtery Dickinson**

Should age be a barrier to having outpatient surgery? Not according to recent research and to sources interviewed by *Same-Day Surgery,* some of whom report conducting surgery on centenarians.

"More important that chronological age is physiological age," says **James E. Zins**, MD, chairman of the Department of Plastic Surgery at the Cleveland (OH) Clinic. Zins recently conducted a study that showed when elderly facelift patients are carefully selected, their complication rates are not statistically different from those in a younger control group.[1]

"I have operated on many patients for facelifts who are over 65, operated on patients over 75, and given facelifts to patients over 80, but they were physically

SDS editor wins 1 of 3 national awards won by AHC Media

Same-Day Surgery Executive Editor Joy Daughtery Dickinson has been awarded "Best Blog or Commentary," second place, from the Specialized Information Publishers Association (SIPA) for the Hospital Report blog (http://hospitalreport.blogs.ahcmedia.com).

Dickinson, who has been affiliated with *Same-Day Surgery* newsletter since 1991, has won six awards from SIPA and its predecessor. Dickinson shared the most recent award with AHC Media staff members Russ Underwood, Leslie Hamlin, and Jill Drachenberg, who contribute to the Hospital Report blog. This award was one of three that publisher AHC Media won this year. Other winners were *Hospital Case Management* newsletter (http://bit.ly/1a8gzk1) and *Pediatric Trauma Care: A Clinical Reference for Physicians and Nurses Caring for the Acutely Injured Child*. (http://bit.ly/LaJNxZ). AHC Media has won more SIPA awards, by far, than any other healthcare publisher in the world. We have won more than 100 national awards, including ones from the National Press Club and the Society of Professional Journalists. ■

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healthy patients," Zins says. These patients stay overnight in a hotel next to the surgical facility, and Zins sees them the next morning, he says.

His views on appropriate selection are echoed by **Mark R. Katlic**, MD, MMM, FACS, chairman of the Department of Surgery at Sinai Hospital in Baltimore, MD. Katlic is author of several books and numerous peer-reviewed journal articles on geriatric surgery. "I can tell you I've done outpatient chest surgery, video-assisted, on 100-year-olds," Katlic says. He also is the surgeon-in-chief and director of the Center for Geriatric Surgery at Sinai Hospital. "This is only center for geriatric surgery anywhere in the world to my knowledge," Katlic says.

Outpatient surgery managers would be well-advised to pay attention to what these pioneers have to say. The US Census Bureau predicts number of people over 65 years will double between 2000 and 2050. Zins says, "Probably more important from a surgeon's standpoint is that although patients 65 and older account for 12% of population, they have 40% of the surgical procedures performed in the U.S." Also, the American Society for Aesthetic Plastic Surgery says that more than 700,000 procedures were performed in 2007 on patients over age 65. "That represented a six-fold increase from 1997 to 2007," Zins says.

Research backs up safety

Age is not the key measure in deciding whether elderly patients should have outpatient surgery, research contends.

In a study just published in the *Annals of Surgery*, researchers from Newcastle University in Newcastle upon Tyne, United Kingdom, found that fit older people had a lower risk of dying, recovered better after surgery, and had a shorter stay in hospital than unfit younger people.[2]

Professor **Mike Trenell**, a senior fellow at the National Institute for Health Research at Newcastle University and director of the MoveLab, who led the study, said, "To ensure the best possible outcome after surgery, we have found that it doesn't matter how old you are; it matters how fit you are." The study involved 389 adults who underwent elective liver surgery at the Freeman Hospital in Newcastle upon Tyne over three years. Older people who were described as fit spent the same number of days in hospital as fit younger people.

"This data reinforces how important it is to be physically fit before surgery, no matter how old you are," Trenell says. "We're not talking about being an athlete, but fit enough to ride a bike."[3]

Chris Snowden, consultant anaesthetist at the Newcastle Hospitals NHS Foundation Trust

EXECUTIVE SUMMARY

As the number of aging patients having outpatient surgery continues to increase, patient fitness is more important than chronological age, according to researchers.
- Outpatient surgery programs need to provide more comprehensive preoperative evaluations for geriatrics.
- Consider these evaluations: frailty, mini-COG cognition test, hearing, activities of daily living, nutrition, current medications, fall risk, and risk for pressure ulcers.

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Executive Editor: **Joy Daughtery Dickinson** (404) 262-5410 (joy.dickinson@ahcmedia.com).
Production Editor: **Kristen Ramsey**.
Interim Editorial Director: **Lee Landenberger**.

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

and senior lecturer at Newcastle University, said, "Optimistically, it means that there is an exciting opportunity to improve surgical outcome, across all age groups, but especially in the older person, by improving preoperative fitness."[3]

What geriatric patients need in preop?

While some hospitals have excellent results with elderly surgical patients, those good outcomes aren't uniform across the United States, Katlic says.

Elderly patients need a more comprehensive preoperative evaluation, he says. The American College of Surgeons and The American Geriatrics Society developed a list of recommended preoperative tests for geriatric patients. *(See resources at end of this story. For more information, see "Preop guidelines published for geriatric surgery patients,"* Same-Day Surgery, *December 2012.)*

The theme is to treat each geriatric patient as an individual, Katlic says. "Not every 80-year-old is the same," he says. "Some can't walk to mailbox, while others can play a vigorous game of tennis."

At The Sinai Center for Geriatric Surgery, clinical coordinators and a full-time nurse practitioner perform a 20-minute evaluation that includes the following:

• **Mini-COG cognition test.** Patients are asked to remember three words, and they are asked to draw the hands of a clock. "That's a test of brain function," Katlic says.

Patients who fail the mini-COG test are at risk for postop delirium, he says. In those cases, nurses and social services staff are alerted that the patients should be watched closely after surgery to see if they have delirium. Also, they might need rehabilitation after the surgery rather than returning home, Katlic says.

At the Center for Geriatric Surgery, 20% of geriatric patients have failed the cognition test, he points out. "We wouldn't have known that if we hadn't done that simple test," Katlic says.

• **Frailty.** This evaluation includes hand grip strength and gait walking speed, as well as questions about energy level and unintended weight loss, Katlic says.

It's important to notify patients if they are hard of hearing, Katlic says. "We're trying to facilitate better care of these people in the hopes we'll get shorter length of stay and better surgical results," he says.

Other areas that are assessed include hearing, activities of daily living, nutrition, current medications, fall risk, and even risk for pressure ulcers, Katlic says. "You wouldn't do on every person coming in, but on the elderly, you don't want to miss anything," he says. The risk factors, along with the medical illness, are used to determine a Charlson Commorbidity [Index] score.

The geriatric center also performs a specialized evaluation for the primary caregiver. The burden placed on the patient's caregiver is assessed before the operation and at some point after to determine if the operation made the burden less or more, Katlic says.

That evaluation includes 20 questions, such as "Do you ever feel you don't want to have friends over because of your loved one?" The responses include "always," "sometimes," and "never." Such evaluations of patients and caregivers are becoming increasingly important as the amount of surgery performed on aging patients increases, Katlic says.

"It's the greatest force affecting healthcare in our lifetime: aging patients," he says. "Cancer, cataract, prostate disease, almost everything is more likely, the older you get. We all need to be geriatric surgeons."

REFERENCES

1. Martén E, Langevin CJ, Kaswan S, et al. The safety of rhytidectomy in the elderly. *Plast Reconstr Surg* 2011; 127(6):2455-63; doi: 10.1097/PRS.0b013e3182131da9.
2. Snowden CP, Prentis J, Jacques B, et al. Cardiorespiratory fitness predicts mortality and hospital length of stay after major elective surgery in older people. *Annals Surg* 2013; 257(6):999-1004; doi: 10.1097/SLA.0b013e31828dbac2.
3. Newcastle University. Fit for surgery? June 11, 2013. Accessed at http://bit.ly/16clFYl.

RESOURCES

• The American College of Surgeons National Surgical Quality Improvement Program and The American Geriatrics Society have a free B***est Practice Guidelines: Optimal Preoperative Assessment of the Geriatric Surgical Patient.*** Web: http://bit.ly/RnJPaF.
• The American Geriatrics Society has a free ***Geriatrics for Specialty Residents Toolkit.*** Web: http://bit.ly/15bxWMo.
• **Sinai Center for Geriatric Surgery.** Web: http://bit.ly/1b8O9Ym. ■

Proposed pay for HOPDs, ASCs announced for 2014

The Centers for Medicare and Medicaid Services (CMS) has proposed a 1.4% inflation update factor for ambulatory surgery centers (ASCs) in 2014 and a 2.5% inflation update factor for hospital outpatient departments (HOPDs). However, with the production reduction for ASCs and HOPDs, and the additional reduction for HOPDs, mandated by the Affordable

Care Act (ACA), the effective update is 0.9% for ASCs and 1.8% for HOPDs.

The proposed payment rule for 2014 disappoints leaders of the ASC Association (ASCA) due to what they say is "continued inequitable treatment of ASCs." ASCA leaders say that using the Consumer Price Index for All Urban Consumers (CPI-U) to update ASC rates is "inappropriate." Hospitals are updated using the Hospital Market Basket, which ASCA leaders feel is more appropriate for ASCs. "The result is that under the proposal, the rates paid to ASCs and HOPDs will continue the troubling trend of diverging in 2014," the ASCA said in a released statement.

William Prentice, CEO of the ASCA, said, "The Centers for Medicare & Medicaid Services' failure to take any action to address the growing discrepancy between ASC and hospital outpatient department payments in this proposed rule demonstrates why enactment of the Ambulatory Surgical Center Quality and Access Act of 2013 (S. 1137/H.R. 2500) is so important. If we can't get a regulatory fix for this problem, we need to continue to pursue a solution in Congress."

These additional changes were included in the proposal:

• Four additional quality measures proposed for ASCs.

CMS is proposing the following measures, which will affect payment in CY 2016, with data collection beginning in CY 2014:

▸ complications within 30 days following cataract surgery requiring additional surgical procedures;

▸ endoscopy/polyp surveillance: appropriate follow-up interval for normal colonoscopy in average risk patients;

▸ endoscopy/polyp surveillance: colonoscopy interval for patients with a history of adenomatous polyps — avoidance of inappropriate use;

▸ cataracts: improvement in patient's visual function within 90 days following cataract surgery.

• Small facility quality reporting exemption proposed for ASCs.

CMS has proposed a minimum case threshold to exempt smaller facilities where program implementation can be overly burdensome. They have selected 240 Medicare claims per year because 10% of ASCs have fewer than 240 Medicare claims per year, so this policy would exempt only those ASCs with the fewest number of Medicare claims, the ASCA says.

• No new procedures proposed for ASCs.

The agency has not proposed to add any procedures to the ASC list of payable procedures for 2014.

• Ending the direct supervision enforcement delay for critical access hospitals and small rural hospitals on Dec. 31 proposed.

This item was strongly opposed by the American Hospital Association (AHA).

• Creating 29 comprehensive ambulatory payment classifications (APCs) to replace existing device-dependent APCs proposed.

Additionally, without congressional action, the Physician Fee Schedule rule would reduce Medicare physician payments by an estimated 24.4% on Jan. 1, the AHA says.

Comments are due to CMS by Sept. 6, and final rules are expected by Nov. 1, according to the AHA. The proposed rule appeared in the July 19, 2013, Federal Register and can be downloaded from the Federal Register at http://1.usa.gov/14H179J. ■

Stop risky EMR practices before a med/mal suit

It's an 'evolving area of risk exposure'

Providers are increasingly becoming aware that in many cases, electronic medical record (EMR) documentation creates legal risks that didn't exist with paper charting.

"EMR is an evolving area of risk exposure," says **Richard E. Moses**, DO, JD, a Philadelphia-based gastroenterologist, risk management and compliance consultant, and adjunct assistant clinical professor at the Temple University schools of medicine and law. "As more healthcare providers move to EMR charting, we are going to see new areas of risk and theories of liability emerging." For example, copying and pasting portions of a progress note has the potential to carry an error throughout the patient's chart and medical record.

Current EMRs are not designed as physician workflow tools, but as a data repository tool that evolved from hospital billing systems, according to **Luke Sato**, MD, chief medical officer and senior vice president of CRICO, the Cambridge-MA based patient safety and medical professional liability company serving the Harvard medical community. "Doctors are overwhelmed with information, time constraints, and the pressures of seeing 20 to 30 patients a day," says Sato. "The result is a huge potential risk that, in the average eight-minute patient/physician encounter, something is bound to be missed."

EMRs increase this risk to some extent, says Sato, because doctors have to comb through the EMR to search for information needed to care for their patients.

Defense is complicated

EMRs often complicate defense against medical malpractice allegations, according to CRICO's recent analysis of more than 40 claims occurring in 2007-2012 involving an EMR. When a physician is sued, the insurer receives a printout of the entire medical record, but this record is a poor representation of the actual information the doctor used to make a decision, Sato explains.

"You can't make judgments on the physicians' cognitive or decision-making capabilities, because the paper record is not an accurate representation of how that information was seen by the physician in the EMR," says Sato. "That is the biggest challenge right now in defending physicians dealing with errors related to today's EMRs."

EHRs can hinder physician defendants from demonstrating that the standard of care was met, says **Ron Sterling**, CPA, president of Sterling Solutions, a Silver Spring, MD-based firm that guides medical practices in the use of technology, and author of Keys to EMR/EHR Success (Greenbranch Publishing; Phoenix, MD; second edition, 2010). "Unfortunately, inadequate use of EHRs can undermine the ability of the physician to show that proper care was provided," he says. "The biggest risk is that that information entered in the system will tell a story different from the physician's actions, when the computer records are examined in the course of discovery."

Physicians have to take a carefully planned approach to EHR use, argues Sterling. "Indeed, they literally need to make sure that their charts are properly maintained on a daily basis," he says. Consider these practices to reduce legal risks involving EMRs:

• Validate, correct, or update data automatically filled by the system when using templates.

Kathy Ferris, ARM, CPHRM, a healthcare risk management consultant at Physicians Insurance in Seattle, says, "If the data is not validated or updated consistently, the result can be a series of encounters that appear to be exactly the same." When the chart is reviewed, it might appear as though the physician or organization didn't pay attention to the patient and cared more about administrative efficiency than the individual patient. "This can contribute to clinical decision-making based on bad information and may also call into question whether or not the care being billed for is appropriate," Ferris says.

• Don't assume previous providers validated the patient's history.

Electronic information can be copied easily from one record to another or from one encounter to another, but this step creates a risk of copying incorrect information that might be used for future clinical decision-making, says Ferris.

In a recent case reviewed by Ferris, multiple providers cared for a single patient, and each allowed the history information to automatically fill without adequately reviewing it with the patient. "Significant inaccuracies were contained in the history because one provider, trying to be efficient, had copied history from a different patient record and failed to make patient-specific changes," says Ferris. "Fortunately, the patient had not suffered a medical injury caused by the inaccurate information."

• Use free-text entry in addition to system tools.

"This can strengthen documentation of the history of the physician-patient partnership that defines quality care," says Ferris.

If physicians rely too heavily on templates and preformatted lists, discussions and clinical details unique to individual patients might become lost. "Free text entry in available fields or notes can document clinical decision-making more clearly than a time stamp followed by a preformatted order," she underscores.

• Be sure that use of drop-down menus, default information, macros, and templates don't lead you to inadvertently document interventions that weren't performed.

"The philosophy has changed from 'If it's not documented, you didn't do it," to 'You documented it, but did you do it?'" says Moses.

Use of prepopulated templates can create inaccuracies in the record, such as failing to document certain abnormalities, documentation of abnormalities that do not exist, or creating conflicts between different entries, he warns.

Providers need to read the chart after it's created and make any corrections as appropriate, advises Moses.

"Providers don't always read what they've typed, dictated, or clicked on," he says. "Ultimately, you are responsible for that note."

EXECUTIVE SUMMARY

Electronic medical record (EMR) documentation creates some legal risks that didn't exist with paper charting. Information that doesn't accurately represent patient encounters is more easily added to the medical record. To reduce risks, have your staff do the following:

- Correct or update data automatically filled by the system.
- Validate patient history documented by previous providers.
- Use free-text entry in addition to system tools.

RESOURCE

• **CRICO**, the patient safety and medical professional liability company serving the Harvard medical community, has produced a video on how electronic medical records can be embedded into the physician workflow in a manner that would improve healthcare, with a dramatization based on real malpractice cases. To view the video, go to: www.rmf.harvard.edu/EMR. ■

New clinical guideline: pediatric ear tubes

A multidisciplinary clinical practice guideline that helps physicians identify children most likely to benefit from tympanostomy tubes, provide the best care before and after surgery, and improve counseling and education for parents was published in a supplement to the July edition of the journal *Otolaryngology — Head and Neck Surgery*. It is the first evidence-based guideline in the United States for tubes, the most common reason for outpatient surgery performed on children in the United States.

"The tympanostomy tube guideline not only helps doctors and parents identify children likely to benefit most from surgery, but importantly identifies those for whom watchful waiting may be a better option," said **Richard M. Rosenfeld**, MD, MPH, chair of the guideline panel.

Research shows that 667,000 tympanostomy tube procedures are performed annually on children under the age of 15. By age 3, nearly 1 in 15 children have tubes.

Despite the frequency of tympanostomy tube surgery, until now there have been no evidence-based recommendations in the United States to assist doctors in identifying the best surgical candidates and their subsequent care. The guideline, covering children aged 6 months to 12 years, was created by a panel that included a pediatric and adult otolaryngologist, otologist/neurotologist, anesthesiologist, audiologist, family physician, behavioral pediatrician, pediatrician, speech/language pathologist, advanced nurse practitioner, physician assistant, resident physician, and consumer advocates. The guideline's authors are Richard M. Rosenfeld, MD, MPH, Seth R. Schwartz, MD, MPH, Melissa A. Pynnonen, MD, MSc, David E. Tunkel, MD, Heather M. Hussey, MPH, Jeffrey S. Fichera, PA-C, Alison M. Grimes, AuD, Jesse M. Hackell, MD, FAAP, Melody F. Harrison, PhD, Helen Haskell, MA, David S. Haynes,

Significant Points in Tympanostomy Tube Guideline

• Many children with otitis media with effusion, or OME in the middle ear get better on their own, especially when the fluid is present for less than three months.

• Children with persistent OME for three months or longer should get an age-appropriate hearing test.

• Tympanostomy tubes should be offered to children with hearing difficulties and OME in both ears for at least three months, because the fluid usually persists and inserting tubes will improve hearing and quality of life.

• Tympanostomy tubes may be offered to children with OME, lasting at least three months in one or both ears, and symptoms that are likely attributable to OME, including balance (vestibular) problems, poor school performance, behavioral problems, ear discomfort, or reduced quality of life.

• Tympanostomy tubes should not be performed in children with recurrent (frequent) ear infections (AOM) who do not have middle-ear effusion (fluid behind the eardrum). In contrast, tubes should be offered when middle-ear effusion is present because the tubes will prevent most future AOM episodes and will allow episodes that do occur to be treated more safely, with ear drops instead of oral antibiotics.

• Tympanostomy tubes may be offered to children who are at-risk for developmental difficulties when OME is present in one or both ears and is unlikely to resolve quickly. This includes children with permanent hearing loss, speech/language delays or disorders, autism-spectrum disorder, Down syndrome, craniofacial disorders, cleft palate, and/or developmental delay.

• Ear infections that occur in children with tympanostomy tubes should be treated with topical antibiotic ear drops only, not with oral (systemic) antibiotics, since drops are more effective and have fewer side effects.

• Children with tubes can usually swim or bathe without earplugs, headbands, or other precautions.

SOURCE: The American Academy of Otolaryngology — Head and Neck Surgery. ■

MD, Tae W. Kim, MD, Denis C. Lafreniere, MD, Katie LeBlanc, MTS, MA, Wendy L. Mackey, APRN, James L. Netterville, MD, Mary E. Pipan, MD, Nikhila P. Raol, MD, and Kenneth G. Schellhase, MD, MPH.

The guideline can be found at http://www.entnet.org/guide_lines/Tubes.cfm. *(See significant points, p. 102.)* ■

About $12,000 raised for same-day surgery room

Fundraiser targets those who send holiday cards

Looking for a quick and easy way to raise money? The auxiliary for Covenant Hospital Plainview (TX) raised about $12,000 for the purchase of equipment and conversion of hospital space into a same-day surgery room. The fundraiser was simply asking local residents to donate money during the holidays to the auxiliary.

The fundraiser is a 43-year tradition and has raised more than $250,000 total.

"When it was initially started, local people, instead of spending money on postage and cards, they give that money to the auxiliary," said Auxiliary President Janice Posey. "And that's how it still is," added **Rose Ann Bailey**, president-elect of the auxiliary. "At 45 cents a crack on postage, that adds up."

Every year since its inception, the auxiliary has raised more funds than the year before, Posey said. Close to $12,000 from the 2011 event was used for the purchase of equipment and conversion of hospital space into a holding area for preoperative work for same-day surgery patients. Previously, individual hospital rooms were serving outpatient surgery needs. The room being renovated for outpatient use was once designated as an ICU area and most recently has been used for storage. Funds raised have been used by the hospital to purchase gurneys, chairs, curtains, flooring, and other renovation costs.

The hospital, on average, performs 60 outpatient surgeries per week. **Carol Terrell**, director of Covenant Hospital Plainview Foundation, said, "Our hospital is outgrowing the facility. There are days we are at capacity and need extra room."

People are eager to participate

While there is no set amount to donate, the average donation is $25.

Posey said, "Because of the increase in the price of postage over the past few years, people seem to be eager to send the money they would spend on postage and Christmas cards to the auxiliary for this fundraiser."

Working with the local media to publicize the fundraiser helps it to be successful, Posey said. A newspaper articles written from a press release included information on how to participate.

To participate in the annual fundraiser, a cut-off date for donations to be received is set for early December. Four 2/5 page ads run once a week for four weeks leading up to the deadline.

When the event is completed, a two-page color ad of a holiday card lists the names of all those who contributed. There are two levels of donors: Contributors are those that make donations up to $50, and angels are those who contribute $50 or more. The cost was about $2,500 for all of the advertising. The only other expense is for stationary and postage for a mailout letter that explains the fundraiser and solicits donations of any amount. About 500 letters go to previous donors and new residents to the city of Plainview. *(See the letter with the online issue of* Same-Day Surgery *at www.ahcmedia.com. For assistance, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.)* ■

NPSG on clinical alarms will start with phase one

As of Jan. 1, 2014, hospitals and critical access hospitals will be expected to begin phase one of a new National Patient Safety Goal (NPSG) on clinical alarm safety (NPSG.06.01.01).[1]

The new goal will be implemented in two phases. Phase one begins Jan. 1, 2014, when hospital leaders will be required to establish alarm safety as an organizational priority and identify the most important alarms to manage based on their own internal situations. Phase two begins Jan. 1, 2016, when hospital leaders will be expected to develop and implement specific components of policies and procedures, and to educate staff in the organization about alarm system management.

The Joint Commission will publish the phase one and two requirements at the same time in order to provide complete information about the ultimate requirements of the NPSG. However, the proposed phase two requirements might be enhanced before they are implemented in 2016, according to The Joint Commission. These changes could arise from hospitals' experience with phase one requirements

as well as emerging evidence about best practices. The Joint Commission is aware of efforts underway that will support the implementation of phase two requirements. For example, the Association for the Advancement of Medical Instrumentation's (AAMI) Healthcare Technology Safety Institute (HTSI) is engaged in activities that promote safe alarm system management, including:

- conducting a survey and study of hospital practices in setting alarm parameters;
- posting literature on the HTSI website (http://www.aami.org/htsi) about best practices on alarm system management. This literature is reviewed by a best practices work group;
- offering webinars on safe alarm management (http://www.aami.org/htsi/alarms/index.html).

If any changes to the phase two requirements are made, accredited hospitals will be notified through field review and Perspectives.

The ECRI Institute website (https://www.ecri.org) contains useful information on safely managing alarm systems. In addition, The Joint Commission published a Sentinel Event Alert on clinical alarm management in April. The alert contains suggestions for assessing and managing risks associated with alarms, and complements the expectations of the new NPSG. *(For more information, see "Teen's death, $6 million settlement put the spotlight on alarm fatigue,"* Same-Day Surgery, *June 2013, p. 61.)* Additional Joint Commission resources on the topic include two Take 5 podcasts (http://bit.ly/152imVq) and the replay of a webinar held in May (http://www.jointcommission.org/alarm_safety_webinar).

The new NPSG will be published in the Comprehensive Accreditation Manual for Hospitals (CAMH) in the fall and in Update 2 to the CAMH in 2013, and the e-edition will be updated in October.

REFERENCE

1. The Joint Commission. New NPSG on clinical alarm safety: phased implementation in 2014 and 2016. Joint Commission Online June 26, 2013. Accessed at http://bit.ly/14ZFxhD. ■

TJC cuts one word, saves hours of time

The Joint Commission (TJC) has given ambulatory organizations a gift. That gift comes in the form of one word being cut from an element of performance (EP) for a human resource (HR) standard addressing renewed privileges.

In a blog posted by TJC, **Joyce Webb**, project director in the Department of Standards and Survey Methods, said, "A single strike-through in standard HR.02.01.03, EP 3, is going to save our ambulatory customers a lot of work, time and effort."[1] The word "renewed" has been deleted in the following EP: "Before granting initial, renewed or revised privileges, the organization uses primary sources when documenting training specific to the privileges requested."

Cutting out the word "renewed" means ambulatory facilities don't have to go back to the primary source of a specific credential when renewing privileges for an independent licensed practitioner.

TJC recently approved 12 revisions to ambulatory care requirements that take effect Jan. 1, 2014. The revisions are posted on the Prepublication Requirements section of the TJC website (http://bit.ly/185lkYi).

REFERENCE

1. Brown A. "Ambulatory standards revisions make sense." Ambulatory Buzz July 9, 2013. Accessed at http://bit.ly/12W3IwI. ■

Same-Day Surgery Manager

How to overcome failure to communicate

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

I have never had a problem letting people know what I think. Is it a curse or a blessing? I'm not sure. But I do know that the operating room is the last place you want to have failure to communicate intentions and failure to give and receive direction.

We have all observed break-downs in communications at work. It happens within family circles, in business dealings, with friends; it just happens sometimes. Much of it can have to do with the individual's personality. Some of us just don't like confrontation and, therefore, we don't speak up when we need to get our point across. While that's OK, it is not an option in the operating room. With all the changes ahead of

us, we need to realize when and how to communicate effectively.

There are, I'm sure, many great articles on the Internet about effective communications skills, but I doubt there are many on how to be effective communicators in surgery. Like many facilities today, we have many new graduates as staff. I watch them frequently and sometimes hold my breath when I see them hold back when they don't understand something or when they don't speak up if they see a break in technique. When queried, they often say they didn't think it was their place to be critical or outspoken because they are "new." Wrong, of course.

That response got me thinking about how many of us interact in surgery. We have interviewed many surgeons in the course of our business in my company: more than 7,500 and counting. Many of our questions to the surgeons are about staffing and efficiency. I am confident that their comments are sincere and honest. The surgeons often will sing praises about staff, from the front desk to PACU and discharge. When they are critical of staff, it is often because of lapses in communication. Communications is a two-way street, and it needs to be active and not passive. The surgeons often admit they don't let the staff know how they want it done. They just assume that members of the staff know the surgeons' intentions. Few of us are mind readers.

When was your last staff meeting? I don't mean a "huddle" or a "timeout." I mean a real staff meeting with all the members of the team present and not texting. If you are like many facilities, they are far too infrequent. With all that is happening in our field, and with the world's attention on the U.S. healthcare changes now and coming, I cannot imagine an effective and efficient surgical facility that doesn't need to meet weekly (not weakly!) with their staff. I'm referring to a true staff meeting with a written agenda that allows at least 50% of the time allocated to Q&A and feedback from the staff. Remember when we would have surgeons address the staff to go over their procedures and what their needs were? Remember when we had guest speakers address the group? Seriously, when was the last time? "We don't have time for that in our facility," is the response I receive most of the time. If you are too busy for weekly staff meetings, then you, above all others, need staff meetings!

Training your staff to ask questions, to challenge, to solicit feedback is an active and ongoing requirement of our jobs. Listening, observing, having confidence in knowing what you are doing, and encouraging, develop communication skills. Make it happen!
[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.] ■

Checklists can improve patient safety during crises

When doctors, nurses, and other operating room staff follow a written safety checklist to respond when a patient experiences cardiac arrest, severe allergic reaction, bleeding followed by an irregular heartbeat, or other crisis during surgery, they are nearly 75% less likely to miss a critical clinical step, according to a new study funded by the Agency for Healthcare Research and Quality (AHRQ).

While the use of checklists is rapidly becoming a standard of surgical care, the impact of using them during a surgical crisis has been largely untested, according to the study published in the Jan. 17 online and print issue of *The New England Journal of Medicine. (To access the study, go to http://bit.ly/U1EV6m.)* "We know that checklists work to improve safety during routine surgery," said AHRQ Director **Carolyn M. Clancy**, MD. "Now, we have compelling evidence that checklists also can help surgical teams perform better during surgical emergencies."

Surgical crises are high-risk events that can be life threatening if clinical teams do not respond appropriately. Failure to rescue surgical patients who experience life-threatening complications has been recognized as the biggest source of variability in surgical death rates among hospitals, the study authors noted. For this randomized controlled trial, investigators simulated multiple operating room crises and assessed the ability of 17 operating room teams from three Boston area hospitals — one teaching hospital and two community hospitals — to adhere to life-saving steps for each simulated crisis.

In half of the crisis scenarios, operating room teams were provided with evidence-based, written checklists. In the other half of crisis scenarios, the teams worked from memory alone. When a checklist was used during a surgical crisis, teams were able to reduce the chances of missing a life-saving step, such as calling for help within 1 minute of a patient experiencing abnormal heart rhythm, by nearly 75%, the researchers said. Examples of simulated surgical emergencies used in the study were air embolism,

severe allergic reaction, irregular heart rhythms associated with bleeding, or an unexplained drop in blood pressure.

Each surgical team consisted of anesthesia staff, operating room nurses, surgical technologists, and a mock surgeon or practicing surgeon. **Atul Gawande**, MD, senior author of the paper, a surgeon at Brigham and Women's Hospital and professor at the Harvard School of Public Health, said, "For decades, we in surgery have believed that surgical crisis situations are too complex for simple checklists to be helpful. This work shows that assumption is wrong. Four years ago, we showed that completing a routine checklist before surgery can substantially reduce the likelihood of a major complication. This new work shows that use of a set of carefully crafted checklists during an operating room crisis also has the potential to markedly improve care and safety."

Hospital staff who participated in the study said the checklists were easy to use, helped them feel more prepared, and that they would use the checklists during actual surgical emergencies. In addition, 97% of participants said they would want checklists to be used for them if a crisis occurred during their own surgery.

The practice of using checklists is borrowed from high-risk industries such as aviation and nuclear power, where checklists have been tested in simulated settings and shown to improve performance during unpredictable crisis events. ■

Anesthesia concerns expanded to adults

As pediatric specialists become increasingly aware that surgical anesthesia might have lasting effects on the developing brains of young children, new research suggests the threat also might apply to adult brains.

Researchers from Cincinnati Children's Hospital Medical Center reported June 5 in the *Annals of Neurology* that testing in laboratory mice shows anesthesia's neurotoxic effects depend on the age of brain neurons, not the age of the animal undergoing anesthesia, as once thought.

Although more research is needed to confirm the study's relevance to humans, the study suggests possible health implications for millions of children and adults who undergo surgical anesthesia annually, according to **Andreas Loepke**, MD, PhD, a physician and researcher in the Department of Anesthesiology. "We demonstrate that anesthesia-induced cell death in neurons is not limited to the immature brain, as previously believed," said Loepke. "Instead, vulnerability seems to target neurons of a certain age and maturational stage. This finding brings us a step closer to understanding the phenomenon's underlying mechanism."

New neurons are generated abundantly in most regions of the very young brain, explaining why previous research has focused on that developmental stage. In a mature brain, neuron formation slows considerably, but extends into later life in the dentate gyrus and olfactory bulb. The dentate gyrus, which helps control learning and memory, is the region Loepke and his research colleagues paid particular attention to in their study. Also collaborating were researchers from the University of Cincinnati College of Medicine and the Children's Hospital of Fudan University, Shanghai, China.

Researchers exposed newborn, juvenile and young adult mice to isoflurane in doses approximating those used in surgical practice. Newborn mice exhibited widespread neuronal loss in forebrain structures — confirming previous research — with no significant impact on the dentate gyrus. However, the effect in juvenile mice was reversed, with minimal neuronal impact in the forebrain regions and significant cell death in the dentate gyrus.

The team then performed extensive studies to discover that age and maturational stage of the affected neurons were the defining characteristics for vulnerability to anesthesia-induced neuronal cell death. The researchers observed similar results in young adult mice as well.

Research over the past 10 years has made it increasingly clear that commonly used anesthetics increase brain cell death in developing animals, which raises concerns from the Food and Drug Administration, clinicians, neuroscientists, and the public. Also, several follow-up studies in children and adults who have undergone surgical anesthesia show a link to learning and memory impairment.

Cautioning against immediate application of the current study's findings to children and adults undergoing anesthesia, Loepke said members of his research team are trying to learn enough about anesthesia's impact on brain chemistry to develop protective therapeutic strategies, in case they are needed. To this end, their next step is to identify specific molecular processes triggered by anesthesia that lead to brain cell death.

"Surgery is often vital to save lives or maintain quality of life and usually cannot be per-

formed without general anesthesia," Loepke said. "Physicians should carefully discuss with patients, parents, and caretakers the risks and benefits of procedures requiring anesthetics, as well as the known risks of not treating certain conditions." The study's abstract can be accessed at http://bit.ly/17rTc3F.

Loepke is also collaborating with researchers from the Pediatric Neuroimaging Research Consortium at Cincinnati Children's Hospital Medical Center to examine anesthesia's impact on children's brain using non-invasive magnetic resonance imaging (MRI) technology. ■

Guidelines address risks with social media

Clinicians should take care in online communications including the electronic posting of information and the exchange of information via computers and phones, says **Lois Snyder Sulmasy**, JD, director of the American College of Physicians' Center for Ethics and Professionalism in Philadelphia.

"What happens online, stays online — forever," she says. A new position paper by the American College of Physicians and the Federation of State Medical Boards provides guidance on the use of social networking, blogging, online forums, cell phone photography, electronic searching, texting, and emailing. *(To view the guidelines, go to http://bit.ly/ZR5Xvt.)*

"Our goal is to help physicians provide the best care to patients and maintain trust in the patient-physician relationship and the medical profession," says Snyder Sulmasy. Potential liability risks for clinicians include confidentiality, privacy and security concerns, risks associated with patient-clinician relationships, informed consent and documentation issues, practice of medicine across state lines, and defamation, she says.

"State medical boards are looking at online activities closely," adds Snyder Sulmasy. "Online activities by physicians is an evolving area, and it could end up the subject of malpractice claims, just as it has become the subject of state medical board disciplinary actions."

A study in the *Annals of Internal Medicine* in January 2013 looked at behaviors such inappropriate contact with patients and use of patient images without consent.[1] It found that these and other online activities would lead board officials to perform investigations. A March 2012 research letter in the Journal of the American Medical Association (JAMA) found that in response to reports of online professionalism violations such as sexual misconduct and misrepresentation of credentials, 71% of state medical boards have held disciplinary proceedings.[2]

"Postings and emails create permanent records that can be forwarded and are discoverable, so attorneys may be looking at this in medical malpractice and other types of litigation," says Snyder Sulmasy.

REFERENCES

1. Greysen SR, Johnson D, Kind T, et al. Online professionalism investigations by state medical boards: First, do no harm. *Ann Intern Med* 2013; 158(2):124-130.
2. Greysen SR, Chretien KC, Kind T, et al. Physician violations of online professionalism and disciplinary actions: A national survey of state medical boards. *JAMA* 2012; 307(11):1141-1142. ■

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

- Avoid problems with look-alike/sound alike meds
- How to draw a line with surgeon volume
- CMC compliance with advance directives
- Best cost-saving tips to survive payer cuts

CNE/CME OBJECTIVES

- **Identify** clinical, managerial, regulatory, or social issues relating to ambulatory surgery care.
- **Describe** how current issues in ambulatory surgery affect clinical and management practices.
- **Incorporate** practical solutions to ambulatory surgery issues and concerns into daily practices.

CNE/CME QUESTIONS

1. At the Center for Geriatric Surgery, what percent of geriatric patients have failed the cognition test?
   A. 5%
   B. 10%
   C. 15%
   D. 20%

2. Which should physicians do to reduce risks with electronic medical record documentation, according to Kathy Ferris, ARM, CPHRM, a healthcare risk management consultant at Physicians Insurance?
   A. Avoid routinely validating patient history documented by previous providers.
   B. Avoid using free-text entry in addition to system tools.
   C. Confirm, correct, or update data automatically filled by the system.
   D. Never switch the coding engine option "off."

3. The auxiliary for Covenant Hospital Plainview (TX) raised about $12,000 for the purchase of equipment and conversion of the hospital space into a same-day surgery room by doing what?
   A. By asking local residents to donate money during the holidays.
   B. By holding a gala.
   C. By asking for donations from motorists at busy intersections.
   D. None of the above.

4. When operating room staff follow a written safety checklist to respond when a patient experiences a crisis during surgery, how much less likely are they to miss a critical clinical step, according to the Agency for Healthcare Research and Quality?
   A. Nearly 25% less likely to miss a critical clinical step
   B. Nearly 50% less likely to miss a critical clinical step
   C. Nearly 75% less likely to miss a critical clinical step

COVENANT HOSPITAL PLAINVIEW AUXILIARY

2601 Dimmitt Road
Plainview, Texas 79072

Dear Friends,

You are invited to celebrate the spirit of Christmas with the volunteers of the Covenant Hospital Plainview Auxiliary by making a donation to our ***43rd Annual Christmas Card Project.***

To residents new in this area and to our project, you may make a donation to this popular and beneficial program in place of buying and mailing Christmas greetings to your local and area friends. Your name will appear on our Christmas Greeting Page in the Plainview Daily Herald on Sunday, December 23, 2012.

The Auxiliary works in cooperation with Covenant Hospital Plainview to provide quality medical and healthcare services to the residents of this area. Your donation will not only express *Holiday Wishes* to your friends but will also help the Auxiliary to support special projects that enhance healthcare.

"Be an Angel"

We honor those who contribute $50 or more by placing their names on our special

Christmas Angel Roll

Please join us with your caring gift by returning your donation in the enclosed envelope by December 7, 2012.

Janice L. Rose, President
Covenant Hospital Plainview Auxiliary

Please make your check payable to: Covenant Hospital Plainview Auxiliary.

PLEASE COMPLETE AND RETURN THIS PORTION

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