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Comments recorded on cell phone — Patient says staff was mocking him

Just-released safety data raises concerns about OR distractions

By Joy Daughtery Dickinson

A patient underwent a colonoscopy last year, during which he says he was mocked by staff members who said he had syphilis and discussed firing a gun up his rectum, according to Courthouse News Service.[1] On the ride home with his wife, the patient determined that he had accidentally left on his phone after recording postoperative instructions, the news report said. They said they listened in disgust to the recording.

The patient claims that comments from the OR staff included "Oh — Oscar Mike Goss," which is a substitute for the expression OMG, and comments

Special focus this month: How not to get sued

In this month's issue, we discuss some of the most prevalent and disturbing areas of liability and patient safety in outpatient surgery. We tell you a horror story about a patient's phone being left on during a procedure and reportedly capturing the staff's unprofessional comments being made about him. We tell you how to avoid unsafe distractions. Also we address the popular "huddles" and tell you how to conduct them correctly. We cover the top 10 patient safety concerns, with a special focus on reprocessing. We tell you the most common reasons for med/mal lawsuits in surgery. We share information about a new tool to help doctors better identify patients at highest risk for respiratory failure. Steve Earnhart offers his suggestions for improving safety in his monthly column.

We hope you enjoy this special issue of *Same-Day Surgery*.

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on the amount of anesthetic needed. The patient also claims comments were made about his being "a big wimp" and that another physician "would eat him for lunch." He says one staff members said that "after five minutes of talking to you in pre-op, I wanted to punch you in the face and man you up a little bit." Staff members also commented on the patient attending a college that was once a women's college and speculated that the patient was gay, the patient claims.

A staff member also said the patient was a "retard" for looking at an IV placement that he earlier said makes him pass out, he claims. The patient says comments were made regarding an irritation on his penis, and that a medical assistant touched his penis during the procedure. The patient claims the doctors also talked about "misleading and avoiding" him after the procedure. One staff member said she would make a note in the medical record that the patient had hemorrhoids, even though he didn't, the claim says.

The patient seeks $1 million in compensatory damages and $350,000 in punitive damages for defamation, infliction of emotional distress, and illegally disclosing his health records.

Comments made during a surgical procedure can be more than unprofessional or even libelous; they can be a distraction that causes safety issues which negatively impact the patient's outcome, says sources interviewed by *Same-Day Surgery*.

"If there is a negative outcome, and others can argue or show that was due to lack of attention being paid to the procedure or the patient, it can have a liability impact by creating or increasing liability" says **Stephen Trosty**, JD, MHA, ARM, CPHRM, president of Risk Management Consulting in Haslett, MI, and a past president of the American Society for Healthcare Risk Management (ASHRM).

Trosty shares this example: At a medium-sized hospital in Ohio, there was talking and joking in the OR that distracted the anesthesiologist and surgeon, who missed monitoring the patient. The patient had a problem with the anesthesia and ended up in a permanent vegetative state. "This resulted in a horrific patient outcome and a very large judgment against the hospital and physician," Trosty says.

Michelle Feil, MSN, RN, senior patient safety analyst at the Pennsylvania Patient Safety Authority in Plymouth Meeting, PA, says, "When human beings are distracted from a primary task, one of two things will occur: He or she will have a delay in resuming the primary task, or they will commit an error."

EXECUTIVE SUMMARY

A patient who underwent a colonoscopy says he inadvertently left his phone recording during the procedure after he taped postoperative instructions. He reported hearing staff making many inappropriate comments and filed suit.

- Have a policy on cell phones.
- Train employees about distractions in the OR and inappropriate comments about patients and staff. Encourage them to speak up.
- Implement a "sterile OR" in which there is no irrelevant communication during critical phases of surgery. Designate one staff person in the OR to address outside communication from persons or cell phones.

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A leading international researcher on distraction in healthcare says there have been multiple serious safety incidents in United Kingdom ORs in which distraction played a role, including a surgeon doing the wrong anastomosis in a colorectal case and one entirely forgetting to do part of a procedure. "Being distracted was one of many contributing factors in these cases," says **Nick Sevdalis**, PhD, senior lecturer in the Faculty of Medicine, Department of Surgery & Cancer, Imperial College London. "From what we know, I would say extraneous talking (i.e. discussions that have nothing to do with the patient on the table) tend to distract the surgeon and the wider OR team. This may be harmless in most cases, but on occasion reduced concentration and focus can reduce safety checks during cases and thus result in potential increase to risks to the patient."

The Pennsylvania Patient Safety Authority recently released a report that said distraction is a threat to patient safety in the OR.[2] An analysis of reported events from January 2010 through May 2013 found 304 reports of OR events in which distractions and/or interruptions were contributing factors. "The types of events we are seeing most frequently reported to the Pennsylvania Patient Safety Authority that involve distraction in the OR are incorrect counts and specimen handling problems," Feil says. "But there have been reports of distractions contributing to serious events ranging from wrong-side surgery, to failure to notice a significant loss of evoked potential from a patient's arm during spinal surgery, to transfusion of the wrong blood to the wrong patient."

And recorded cell phone conversations aren't the only potential problem. Some surgical patients have reported being alert to everything being said and done in the OR but being paralyzed so they can't move or respond, sources says. (For more on this topic, see "Media and lawsuits put spotlight on awareness in outpatient surgery," *Same-Day Surgery*, June 2007, p. 65.)

How to avoid OR distractions

To address OR distractions, consider these strategies:

• Have a policy on cell phones.

A member of the staff should remind all patients that cell phones must be turned off, Trosty says.

"This should occur when the patient arrives and is registered and again before the patients go into surgery," he says. "It should be verified before surgery."

Have a policy that no cell phones are allowed in the OR, and ensure that all cell phones are given to the person who is with the patient, Trosty says. "This can become part of the checklist that occurs prior to surgery," he says. "This provides several opportunities to state the policy and to help ensure that it is adhered to."

This policy also should apply to staff members, physicians, and vendors, says **Mark Mayo**, executive director of the ASC Association of Illinois and principal, Mark Mayo Health Care Consultants in Round Lake, IL. Mayo says, "What is more important: a call to your broker or checking your e-mails, or taking care of our patients? What if a transient change in the patient's condition is recorded, but the anesthetist missed it because he/she was on the phone?"

• Examine where interruptions are coming from.

Determine what clinical staff outside the OR are interrupting and distracting the surgical team during procedures, Feil advises. She suggests you ask these questions: "Are these interruptions due to OR scheduling problems? Are they related to clinical concerns with other patients in the hospital?"

"Whatever can be done to limit clinically irrelevant communication with the OR team during procedures would improve patient safety," Feil says.

Considering channeling OR visitors to one OR team member, such as a senior nurse circulator, Sevdalis advises. "The circulator could filter the importance and urgency of a request, so that the rest of the team does not get unnecessarily distracted," he says. "The same applies to phones and pagers: They can be left outside the OR and handled by a team member so that they do not interrupt the team during a case."

• Train employees and discuss disciplinary repercussions.

Because it is nearly impossible to stop irrelevant talk in the OR, consider exercising discipline provided for in your policy, Trosty suggests.

"If this is done and people know you are serious and there will be consequences if does occur, it might increase chances for compliance and an end to discussions," he says.

Train staff about why it is important not to talk in the OR, explain what your policy says, and discuss what the results will be if the policy is violated, Trosty says. "This should be documented in each person's employee or contract file," he says.

Emphasizes the quality-of-care issues and the potential impact, Trosty suggests. Discuss the risk issues, including the liability concerns, he says. "It should be stressed and included in training that certain types of discussions are never to occur, regardless of where the people might be," Trosty says. "It should be known and stressed and staff should be educated to the fact that there are specific topics and issues regarding not only patients but also other staff that are completely unacceptable."

Such training can help avoid comments such as the ones reported in the colonoscopy case, sources say. Regarding that case, Feil says, "This is inappropriate small talk taken to the extreme."

Such comments are not only distracting, but also demeaning and degrading to patients, she says. 'We owe it to our patients to treat them with the utmost respect and dignity, and to conduct ourselves professionally, focusing on the procedure at hand and avoiding all potential distraction," Feil says. "There is a sacred trust that should not be violated when patients have placed their very lives in our hands when undergoing anesthesia." (For more tips, see suggestion for mimicking a "sterile cockpit," see below, and advice from the TeamSTEPPS program, see at right.)

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2. Feil M. Distractions in the operating room. Pennsylvania Patient Safety Authority. Accessed at http://bit.ly/SIdpOd.

RESOURCE

• To access the free Pennsylvania Patient Safety Authority report "Distractions in the Operating Room," go to http://bit.ly/SIdpOd. ■

Implement protocol for `sterile OR'

"Surgical teams have seen successful reductions in distractions and improved workflow after implementing a `sterile cockpit' protocol during critical phases of operations," says **Michelle Feil**, MSN, RN, senior patient safety analyst at the Pennsylvania Patient Safety Authority in Plymouth Meeting, PA.

This concept has been borrowed from the aviation field. All communication in the cockpit is restricted to information that is necessary for handling the plane during critical phases, such as takeoff and landing, Feil says. "For surgical teams, these critical phases need to be identified by the team," she says.

Critical phases for the OR team have been defined as briefing, time-out, and debriefing, according to the Pennsylvania report. However, the critical phases might vary according to the procedure and the staff member's responsibilities, Feil says. "For instance, induction may be a critical phase for an anesthesia provider, nerve dissection or creation of an anastomosis may be a critical phase for the surgeon, and surgical counts or specimen labeling may be critical phases for nurses," she says.

Small talk is inevitable, and it even can help improve teamwork and job satisfaction, Feil acknowledges. "But it is up to each individual member of the team to make sure that they are not creating a situation in which they themselves will be distracted, and that they are not distracting others," she says.

Nick Sevdalis, PhD, senior lecturer in the Faculty of Medicine, Department of Surgery & Cancer, Imperial College London, says that for interventions such as a "sterile OR" to be successful, you must have buy-in from the OR staff "and an active effort to change a 'culture of distractions,' for lack of better term." ■

TeamSTEPPS offers help with distractions

The TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety) program offers two steps to prevent and handle OR distractions, says **Michelle Feil**, MSN, RN, senior patient safety analyst at the Pennsylvania Patient Safety Authority in Plymouth Meeting, PA.

TeamSTEPPS is a teamwork system designed for healthcare professionals by the Agency for Healthcare Research and Quality (AHRQ) that is an evidence-based teamwork system to improve communication and teamwork skills among healthcare professionals in order to improve patient safety.

The first TeamSTEPPS step that addresses distractions is cross-monitoring, or "watching each other's back," Feil says. "It is monitoring the behavior of other team members and providing feedback to ensure that procedures are being followed appropriately," she says. Team members help each other maintain focus on the primary task in the face of distraction, Feil says.

The second skill is advocacy and assertion, or "speaking up" about patient safety concerns, she says, "especially when the leader or other members of the team have failed to recognize the concern or do not believe the concern to be valid."

Team members are empowered to speak up when they recognize a distraction or interruption is impairing performance, Feil says. (For more information on TeamSTEPPS, see "Facility cuts falls 88% and med errors 30%," *Same-Day Surgery*, September 2012, p. 99.) ■

Huddles getting popular, but use them correctly

Managers and clinicians are finding that huddles are an effective way to improve patient safety and identify deficiencies, but there is little guidance on how to conduct them. Experienced huddlers say a formal plan for the huddle will yield more valuable results.

A huddle is a gathering of involved and interested personnel soon after a patient safety event to discuss what happened, why it happened, and how the problem might be prevented. They have been used for all manner of patient safety issues, and Nationwide Children's Hospital (NCH) in Columbus, OH, has found them to be especially effective with medication events, says **Shelly Morvay**, PharmD, medication safety pharmacist at the hospital.

Huddles helped decrease the absolute number of harmful adverse drug events (ADEs) by 74%, and the ADE rate per 1,000 dispensed doses decreased by 85%, Morvay says. ADEs are defined as injuries resulting from medical care involving medication use.

NCH has conducted more than 800 medication event huddles over three years and identified more than 3,000 improvements. ADEs accounted for about two-thirds of reported patient harm at NCH.

The quick-investigation huddle tool was proposed as a means to engage frontline staff in identifying process improvements that might contribute to ADE elimination, Morvay says.

Perioperative areas involved

In March 2010, NCH piloted the medication event huddle process in its critical care units, and in 2011, it introduced the process to all inpatient units and some ambulatory clinics. Subsequently, NCH has spread the process to ADEs that occur anywhere in the organization, including all ambulatory clinics, the emergency department, perioperative areas, and interventional radiology.

NCH's success with the huddles yielded some information about what makes them productive. Responding the ADE quickly was a prime concern; the 30-minute medication event huddles were initiated and scheduled within 24 hours whenever an ADE was identified. The essential components of the huddle included:

- an explanation by the core huddle team leader of the huddle process;
- simulation of the ADE using the actual electronic medical record, infusion pump, pharmacy labels, and other equipment or supplies;
- review of a standard list of questions to identify environmental or practice factors that might have contributed;
- assignment of identified interventions or "tests of change" to appropriate participants;
- follow-up communication about "tests of change" via email;
- encouragement to speak with colleagues about the specific ADE and huddle experience.

In addition, the medication event huddles were used as an opportunity to promote a culture of safety, increase involvement of frontline staff, and speed improvement efforts, says Clinical Coordinator **Dorcas Lewe**, RN, MS, who worked closely with Morvay on the huddles. Morvay and Lewe estimate that medication event huddles require a minimum of 0.5 full-time equivalent (FTE) nurses to review the ADEs, schedule the huddles, and follow up on completion of recommendations. While huddles do not replace a formal root cause analysis (RCA) or daily safety walkarounds by leaders, they do enable a more rapid identification of the cause and subsequent intervention, they say.

Huddles should be conducted by a core group of interdisciplinary representatives, Morvay says. The other people in the huddle should include frontline staff who were involved with the incident or are familiar with it, along with unit leaders. Staff members are reminded that the huddle is a brainstorming session and not intended to single out any person as responsible for the event.

"We encourage them to be honest about what they think occurred," Lewe says. "They are always informed about the huddles by their managers so that it is coming from someone they know. It's not a call from administration."

Managers know that they are free to forward the huddle invitation to anyone else that might contribute useful information, Lewe says. After the brainstorming in the huddle, any necessary interventions are assigned to specific huddle attendees.

EXECUTIVE SUMMARY
Huddles are used by many providers to improve safety, but there are few guides for how to conduct them. A specific format will improve the results of the huddle.
•Conduct the huddle soon after the event.
•Have a specific format that is used for all huddles.
•One facility reports using huddles to reduce harmful adverse drug events (ADEs) by 74%.

Huddles empower staff

Risk Manager **Carol McGlone**, RN, says the huddles have become a valuable asset in the hospital's overall patient safety program. One of the benefits is that huddles produce useful information much faster than a full RCA, which comes later.

"We have seen over time that staff will report an incident or a near-miss and suggest a huddle is appropriate, rather than waiting for leadership to call a huddle. This is true of events that do not involve medication safety, so that tells me that the staff see the value of huddles and appreciate the opportunity to give input," McGlone says. She participates in some huddles at NCH and collaborates closely with the quality improvement department and clinical leaders.

NCH conducts medication safety huddles once or twice per weekday, as warranted, Lewe says. The hospital uses certain criteria to determine when a huddle is appropriate, but staff members are free to request a huddle even when those criteria aren't met, she says. The criteria for calling a huddle include the need for intervention or additional monitoring, severity of an event, and incidents involving high alert medications or specific focus areas such as medication reconciliation. A huddle also is called when there is a misstep or near-miss when implementing a new policy.

A summary of the information gleaned from the huddle is shared through Microsoft's Sharepoint software to everyone who attended the huddle and those who were invited but could not come. Any huddle attendee who was assigned an intervention also receives a recap of the action needed and when it should be completed, along with frequent reminders until it is done.

The huddle soon will be implemented in the hospital's employee safety program, McGlone says.

At South Nassau Communities Hospital in Oceanside, NY, huddles are used routinely for everything from planning the day on a unit to serious adverse events, says **Ruth Ragusa**, RN, vice president of organizational effectiveness. She has found that the timing for a huddle must be tailored to the individual event. Some should be held as soon as possible, before people forget the important details, while others might be delayed for a day.

"With some incidents, the staff are still dealing with it, and you can't pull them away from patient care," she says. "We also try to let the staff diffuse their feelings about it, because sometimes it can be upsetting to them and they need a breather before you ask them to recount the incident." ■

Reprocessing included in top 10 patient safety list

Atlanta incident shows potential for mistakes

In 2013, letters were sent to more than 450 patients who had received colonoscopies at an Atlanta surgery center since 2011 warning them that they might be at risk for several diseases because staff weren't soaking the instruments in high-level disinfectant.[1]

One of the physicians observed the staff and then asked how they cleaned the instruments, and the missing step was identified.[2] The problem was discovered by a doctor who observed the cleaning practices at Piedmont West and questioned the staff. The center's health care system attributed the problem to communication and management oversight that were lacking.

The center voluntarily reported the action to the state health department. It set up a special phone line for affected patients to call. It sent letters to more than 450 potentially impacted patients and offered testing for hepatitis B, hepatitis C, and human immunodeficiency virus (HIV), and physician counseling at no cost. It identified the risk of transmission as less than one in 1 million and said no patients had reported problems.

Several patients are exposed to endoscopes that undergo improper sanitization every year, according to the Centers for Disease Control and Prevention.[2] Between 2004 and 2009, more than 10,000 patients received colonoscopies with improperly cleaned equipment at several Veterans Administration facilities.[2]

ECRI Institute recently listed "inadequate reprocessing of endoscopes and surgical instruments" in its first list of the top 10 patient safety concerns for healthcare organizations. The list also includes drug shortages, retained devices and unretrieved fragments, and inadequate monitoring for respiratory depression in patients taking opioids.

"The biggest challenge facing the ambulatory setting is that very frequently there are pressures for high volume and quick turnaround," says **Gail Horvath**, MSN, RN, CNOR, CRCST, patient safety analyst/consultant III, Patient Safety Risk and Quality (PSRQ) patient safety, ECRI Institute, a Plymouth Meeting, PA-based nonprofit organization that examines which medical procedures, devices, drugs, and processes enable improved patient care. If procedures are too rushed, critical steps in the process can be overlooked or omitted, Horvath says.

Another potential problem area is that surgical instruments are much more complex in the past; they have more channels and moving pieces, Horvath says. These

complex instruments are more difficult to clean, she says. "Often, staff doesn't have availability of manufacturer recommendations or instructions for use," she says. "They can be unaware of certain steps that need to be taken."

If the cleaning or reprocessing isn't done correctly, it increases the risk for patient infection, Horvath says.

To avoid problems, know that properly cleaned, sterile surgical instruments "are the first step in patient safety in any patient area," she says. Ensure you have qualified people performing the cleaning and disinfection of scopes, Horvath advises. Two states now require national certification, and many states have introduced legislation that would require national certification, she points out.

Include the staff members who perform the sterilization in your device purchasing decisions, Horvath says. Including them will help ensure you have proper equipment that can be cleaned and sterilized according to the manufacturers' instructions, she says.

Finally, give them time, Horvath says. "Ensure that adequate time is allowed for them to be properly processed prior to returning instrument or scope to patient use," she says.

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RESOURCES

- ECRI Institute's Top 10 Patient Safety Concerns for Healthcare Organizations (Full Report). Web: www.ecri.org/EmailResources/PSRQ/Top10/Top10PSRQ.pdf.
- ECRI Institute's Top 10 Patient Safety Concerns Poster. Web: www.ecri.org/EmailResources/PSRQ/Top10/Top10PSRQ_Poster.pdf. ■

Tool helps predict respiratory failure

A new prediction tool can help doctors better identify patients who are at highest risk for respiratory failure after surgery and therefore prevent the often deadly condition, suggest data from a large multi-center study published in the May issue of *Anesthesiology*.

Affecting nearly 200,000 Americans a year, acute respiratory distress syndrome (ARDS) is a sudden failure of the lungs caused by several issues ranging from smoke inhalation to pneumonia or blood infection. High-risk patients can develop ARDS after surgery. ARDS is difficult to treat once it develops and is fatal at least 20% of the time.

"It's well-documented that those who develop this syndrome stay in intensive care longer and in the hospital longer, and the impact of the syndrome can persist for many years," said **Daryl J. Kor**, MD, lead author of the study and associate professor of anesthesiology at Mayo Clinic, Rochester, MN.

Doctors might be able to take measures during surgery to prevent the condition, such as using blood products conservatively, restricting the volume of fluids administered, and using different methods to ventilate the lungs. However, only about 3% of patients considered at risk actually develop ARDS, and testing preventative measures is costly, time-consuming, and might be less than ideal for patients not at high risk. Therefore, researchers in this study focused on identifying patients most likely to develop ARDS after surgery.

"It's certainly true in this case that an ounce of prevention is worth a pound of cure," Kor said. "But our ability to predict who is at risk has been limited. By identifying those who are at highest risk with better accuracy, we can begin to take steps toward preventing this dangerous and costly surgical complication."

The prediction tool could help doctors assign risk levels to patients by determining if they have one or more of the following predictors identified as most associated with the development of ARDS:

- blood infection (sepsis);
- liver disease;
- high-risk surgery on the heart or aorta;
- emergency surgery;
- admission from a location other than home (such as a nursing home or other hospital);
- an increased respiratory rate;
- two measures that show the patient has lower-than-normal oxygen levels in the blood.

The more factors that apply to the patient, the greater the risk of developing ARDS and the more important it is to use preventive measures, Kor said.

In the study, researchers performed a secondary analysis of data from a trial at 22 medical centers, identifying 1,562 patients who prior to surgery were considered at risk for ARDS. Of those, 117 (7.5%) developed ARDS. Based on their findings, researchers revised an existing prediction tool (used for ARDS prediction in a patients undergoing elective surgery) so it was far more effective at identifying patients who were at greatest risk for ARDS after a wide variety of surgical procedures.

The findings might alter the way patients at high risk of the syndrome are cared for in the operating room,

Kor says. "For example, we may be a bit more conservative in the way we transfuse blood products," he says. "We may also ventilate their lungs in a little different way than we might if their risk score was low." ■

Same-Day Surgery Manager

Protect yourself and your patients

By Stephen W. Earnhart, MS
CEO
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Austin, TX

I have always been fearful of making a big mistake that is going to cause pain or injury to others. I've had nightmares about it. As a nurse, a CRNA, and a consultant in the wonderful world of healthcare, my fear is probably not pathologically paranoid, but perhaps it is just a healthy fear of screwing up something that will hurt others.

Safety must be a priority. In my world, I look for three things to be successful in the operating room (OR) environment, regardless of whether the OR is hospital-based or in an ambulatory surgery center or surgeon's office. They are:

- Is it a safe environment for patients and staff?
- Will we provide a positive experience for patients and staff?
- Is it increasingly profitable?

Increasingly The Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC), and American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) are focusing on patient safety and outcomes, with good reason. Our goal is the betterment of our patients and not adding burden by mistakes or oversight. It's lofty idealism, I know, but it's doable.

What can you do today, right now, to protect yourself and your patients, and at the same time, avoid the nastiness of liability if you don't? Consider these suggestions:

- **Use common sense.**

If it doesn't seem right or feel right, go with your gut and question it. If you are working in the surgical environment, you have that sixth sense about what is right. Use it! We have timeouts to force us to look at the basics before we proceed with the case. However, we also need to pause and look at the bigger picture, the 30,000 foot level if you will, and just think about what we are doing.

For example, the patient is being wheeled back into the recovery area, and you notice the patient's arm has slipped, is hanging off the stretcher, and the door is closing. Common sense tells you that the arm could get hung up in the door and cause injury. Another example: The IV line is snagged on the IV pole that is about to be removed as the patient is transferred. Tell someone, or reach out and free it.

- **Read your policies and procedures.**

Boring. Unquestionably boring. I write hundreds of them and hate each one, but they really are there for a reason. As a staffer, you need to have read them and understand them. It's part of your job and continued employment. But when was the last time you did read them?

As I have found out over the years, not every staff member understands that P&Ps change and are updated constantly. So, instead of trying to reach the next level on your phone game, just get the manual and scan the table of contents. If you see something different or not what you expected (a good one is the policy on bullying), read it or at least scan it to get the flavor of what it is about. It is very satisfying to read something and then see it played out in real time.

- **Question things that you don't understand or that don't seem to make sense.**

Don't be obnoxious and make people roll their eyes every time you open your mouth, but as a member of the staff it is your job to make sure what we are all doing is correct. Again, if it doesn't feel right, it probably isn't.

- **Speak up at staff meetings.**

In my world, silence means acceptance. If you don't understand what is being discussed or it is just strange, speak up and let your feelings known. Too many decisions are made without complete understanding of the implications. I promise you, if you don't understand it, others do not as well.

- **See patients as family members.**

It might sound weird, but if you can picture your patients as family members, it often is easier to empathize with them and show compassion as well as job skills.

- **Quit your job.**

Some of you don't like your job anymore, and you are just going through the motions. Believe me, I have been there! I see so much apathy in our workplace that it is frightening. You can rededicate yourself to your career, or move on before you burn out.

What we are doing in surgery requires constant awareness and vigilance. If you can be honest with yourself and admit you are not doing that, then you need to let someone know and get some guidance.

We are fortunate to work in the healthcare industry. It is a much sought after place to have a job and a career. Let's all make it a safer place to work! [Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Earnhart & Associates' address is 5114 Balcones Woods Drive, Suite 307-203, Austin, TX 78759. Phone: (512) 297-7575. Fax: (512) 233-2979. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.] ■

Claims allege failure to monitor surgical patients

A recent malpractice case named an orthopedic surgeon who had prophylactically placed a patient on antibiotics days before performing arthroscopic surgery to clean up scar tissue on the patient's ankle.

"The surgeon failed to appreciate that the patient had developed the early stages of Stevens-Johnson syndrome," says **Nan Gallagher-Auferio**, JD, Esq., an attorney at Kern Augustine Conroy & Schoppmann in Bridgewater, NJ.

The plaintiff alleged that if a proper medical history been obtained and a thorough preoperative examination been performed, the surgery would have been aborted and the patient would have been sent to the hospital for immediate interventions to be performed. "Here, the surgeon putting the patient under general anesthesia only intensified the adverse reaction of the syndrome, and the patient went into multi-organ failure in the lobby of the surgery center. She subsequently died," says Gallagher-Auferio. The case was settled for $550,000.

In another case involving failure to monitor a patient, an anesthesiologist was sued after a patient developed disseminated intravascular coagulopathy in the post-anesthesia care unit (PACU) following removal of a malignant testicle at an outpatient surgery center. The surgeon left the building.

"The anesthesiologist left the building without properly monitoring the patient's postoperative vital signs and failed to respond to multiple pages from the PACU nurses," says Gallagher-Auferio. "The patient later died. The physician's conduct was indefensible."

EXECUTIVE SUMMARY

Common allegations in malpractice claims involving surgical patients are failure to obtain a proper medical history, failure to perform a preoperative examination, and failure to monitor patients postoperatively.
- Conduct preoperative briefings.
- Provide recovery teams with readily available contact information for the surgeons and back-up contacts.

Claims stem from communication lapses

Communication lapses are a frequently cited cause of medical malpractice cases, according to **Cindy Wallace**, CPHRM, senior risk management analyst at ECRI Institute, a Plymouth Meeting, PA-based organization that researches approaches to improving the safety, quality, and cost-effectiveness of patient care.

To protect themselves against these claims, Wallace recommends these practices:

- The surgical team should conduct a preoperative briefing to share information on the patient.

For example, the physician/surgeon and anesthesia provider should review the pre-anesthesia evaluation of the patient to discuss any known risks and the plan to minimize these risks.

- The physician/surgeon should ensure that the recovery team knows how to reach him or her, as well as a back-up contact, in case any questions or concerns arise.
- There should be an established process for handing off the patient from the surgical team to the recovery team.

"Standardized communication tools, such as the SBAR [Situation-Background-Assessment-Recommendation] briefing tool, should be used to clearly describe the patient's condition and key concerns and recommendations for the patient's recovery," says Wallace.

Want better outcomes? Establish culture of safety

Would you like to have better care, teamwork, communication, workflow, and staff/ patient satisfaction, along with fewer frustrations? These outcomes can be achieved with a culture of safety, says **Ann Shimek**, MSN, RN, CASC, senior vice president, clinical operations at United Surgical Partners International in Addison TX. Shimek spoke on "Establishing a culture of safety in your ASC" at the recent Ambulatory Surgery Center Association (ASCA) annual meeting.

In a culture of safety, every employee has a role in patient safety and can speak up anytime to "stop the line," which means the procedure is stopped. As lessons are learned, they are communicated to the staff to prevent future errors.

A culture of safety is an environment in which safety incidents and errors are discussed openly rather than taking a punitive response, which minimizes reporting, Shimek says. A culture of safety encourages employees to report errors or "good catches" caught before an error occurs without fear of retribution, she says. The focus of blame is on processes, not people.

Shimek suggests these steps to establish such a culture:

• **Create a culture of safety team.**

Include representatives of departments including the business office, preop, and materials management. Encourage the medical director to attend these meetings, Shimek advises. Have the team meet monthly, and buy lunch, she suggests. Have the team members report their progress as well as concerns they are addressing, Shimek says.

Also, designate a culture of safety champion. This person should be passionate about the topic and willing to learn as much as possible, she says. Also, this person should be willing to share their enthusiasm with employees.

• **Educate your staff and doctors.**

In addition to educating employees and physicians, include contract and agency personnel, Shimek says. Perform the education at orientation, and conduct annual competency training. Go over the adverse events that are reported, how to report the events, and the importance of reporting good catches, Shimek says.

"Some centers are having employees sign an attestation that says, 'I agree to support a culture of safety and help avoid wrong-site surgery.'"

• **Encourage staff and physician involvement.**

Dedicate a monthly staff meeting to the culture of safety. Acknowledge and reward staff members for reporting "good catches" made before they reach the patient.

Also, review the culture of safety with the medical director. Report results of your efforts on an ongoing basis to the medical executive committee and the governing board, Shimek advises. Also include the culture of safety as an agenda item at the medical staff meetings, and report your results, she says.

Have a box for anonymous reporting of safety concerns and suggestions on how to improve patient care and outcomes, Shimek says. Review these suggestions on a regular basis with the staff, she says.

• **Have leadership rounding.**

Leaders should round every department at least once a day, and they should vary the times they round, Shimek says. Ask employees and physicians about any safety concerns they have, she says. Make sure staffing is adequate and that they have the tools and resources they need, Shimek says.

• **Have a stop-the-line policy.**

Make sure your employees know they are supported if they want to "stop the line" and question patient safety. Establish a direct phrase that all employees and physicians are educated to use. For example, with a potential wrong medication dose, employees can say, "I need clarification that this is the correct dosage." They can repeat the phrase if needed. If the process is not discontinued immediately, then the employee can call the manager and state, "I have a stop-the-line event."

"If you're not being called, it's not working," Shimek says. "The most key part is that the manager drops everything to support the employee." ■

Study says ASCs more efficient setting

Ambulatory centers perform surgery more efficiently than hospitals and could offer a viable way for the nation keep to pace with a growing demand for outpatient procedures, according to a study published in the May issue of "Health Affairs."

The authors are health economists Elizabeth Munnich of the University of Louisville (KY) and Stephen Parente of the University of Minnesota in Minneapolis. The researchers analyzed Centers for Disease Control and Prevention data for 52,000 surgical visits at 437 facilities over four years. They found that surgery center patients spent 25% less time undergoing outpatient surgery than hospital patients, and they inferred that individual patient costs were $363 to $1,000 lower while their healthcare was just as satisfactory.

Munnich and Parente predict in their study that the number of outpatient surgeries in hospitals alone will continue to climb by 8% to 16% each year through 2021. The Congressional Budget Office has said that in two more years, 25 million more Americans will have health insurance as a result of the Affordable Care Act (ACA). The statistic has raised questions as to how healthcare providers will meet the anticipated surge in demand.

"Ambulatory surgery centers are a high-quality, lower-cost substitute for hospitals as venues for outpatient surgery," Munnich said. "Their increased use may generate substantial cost savings, helping achieve the ACA's goals of reducing the cost and improving the quality of healthcare." ■

Requirement removed for radiologist on staff

ASCs to save $41 million annually

The Centers for Medicare & Medicaid Services (CMS) has removed the provision in the Conditions for Coverage (CfCs) requiring ambulatory surgery centers (ASCs) to have a radiologist on the medical staff, according to the ASC Association (ASCA). CMS estimates that the change will save ASCs $41 million annually.

This change was part of a larger pre-published final rule released titled "Medicare and Medicaid Programs: Regulatory Provisions to Promote Program Efficiency,

Transparency, and Burden Reduction." ASCA leaders have long advocated for this change, according to the ASCA. In a released statement, the association said that requiring ASCs to have a radiologist on staff does not make sense given that radiologic services in an ASC generally are limited to intraoperative guidance that does not require interpretation by a radiologist. Additionally, ASCs have reported difficulty in finding radiologists who are willing to be part of their medical staff, the ASCA said.

Instead of requiring a radiologist on staff, the new language, found at §416.49(b)(2), states: "If radiologic services are utilized, the governing body must appoint an individual qualified in accordance with State law and ASC policies who is responsible for assuring that all radiologic services are provided in accordance with the requirements of this section."

William Prentice, chief executive officer of the ASCA, said, "We are pleased that CMS has responded to our request for a common sense policy pertaining to radiological services in ASCs. We look forward to continuing an open dialogue with CMS to identify and remove other burdensome requirements that hinder our ability to serve patients in the most efficient manner possible."

The rule was published on May 12, 2014, and is available at http://bit.ly/1j0IV4K. The relevant portion begins on p. 16. The change becomes effective 60 days after publication. ■

First week after surgery, need for acute care grows

You probably know that among ambulatory surgery center (ASC) patients, it's rare for patients to need to be transferred to a hospital at the time of discharge. However, you might not know that in the first week afterward, the need for hospital-based acute care is nearly 30-fold greater, according to recently published research.[1]

The need for acute care varies across surgery centers, and it might be a meaningful quality benchmark, according to the researchers.

The researchers look at data from the Healthcare Cost and Utilization Project (HCUP) and identified adult patients who underwent a medical procedure or surgery between July 2008 and September 2009 at ASCs in California, Florida, and Nebraska. The primary outcomes were hospital transfer at the time of discharge and hospital-based acute care (emergency department visits or hospital admissions) within seven days. Rates were adjusted for age, sex, and procedure-mix.

The researchers studied 3.8 million patients treated at 1,295 ASCs. At discharge, the hospital transfer rate was 1.1 per 1,000 discharges (95% confidence interval 1.1–1.1). Among patients discharged home, the hospital-based, acute care rate was 31.8 per 1,000 discharges (95% confidence interval 31.6–32.0). Across ASCs, there was not much variation in adjusted hospital transfer rates (median = 1.0/1,000 discharges [25th–75th percentile = 1.0–2.0]), but there was substantial variation in adjusted, hospital-based acute care rates (28.0/1,000 [21.0–39.0]).

REFERENCE:

1. Fox JP, Vashi AA, Ross JS, et al. Hospital-based, acute care after ambulatory surgery center discharge. Surgery 2014; 155(5): 743-753. Web: http://www.surgjournal.com/article/S0039-6060(13)00627-2/abstract. ■

CNE/CME OBJECTIVES & INSTRUCTIONS

After reading *Same-Day Surgery*, the participant will be able to:

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

To earn credit for this activity, please follow these instructions.

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COMING IN FUTURE MONTHS

- Addressing substance abuse among clinicians
- Should you be bidding out your services?
- New price transparency resources
- Form that guides you through adding procedures

CNE/CME QUESTIONS

1. What are the types of events most frequently reported to the Pennsylvania Patient Safety Authority that involve distraction in the OR?
   A. Incorrect counts
   B. Specimen handling problems
   C. A and B
   D. Neither A nor B

2. According to Clinical Coordinator **Dorcas Lewe**, RN, MS, at National Children's Hospital, who should notify staff members of a huddle after a patient safety event?
   A. The CEO or president
   B. The risk manager
   C. The director of human resources
   D. The manager who supervises that person.

3. According to **Gail Horvath**, MSN, RN, CNOR, CRCFT, patient safety analyst/consultant III, Patient Safety Risk and Quality (PSRQ) patient safety, ECRI Institute, what is the first step in patient safety in any patient area?
   A. Having the right employees.
   B. Having the correct training.
   C. Clean, sterile instruments

4. According to research in "Surgery" about patients having surgery at ambulatory surgery centers, how much does the need for hospital-based acute care increase between discharge and one week later?
   A. It stays the same.
   B. It doubles.
   C. It quadruples.
   D. It increases 30-fold.

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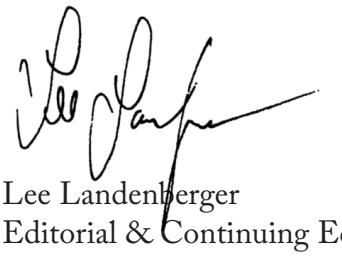

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