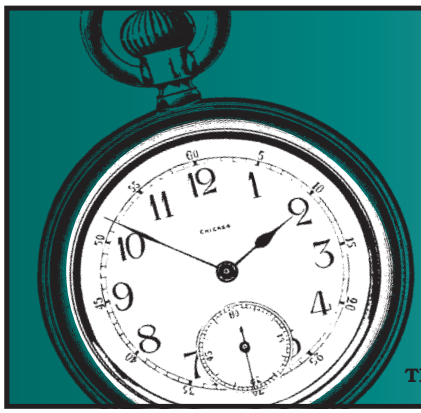

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With new protocols, patients come out of the OR nearly discharge-ready

By **Joy Daughtery Dickinson**

Surgery providers, outpatient and inpatient, are finding that the use of enhanced recovery pathways are allowing their patients to come out of the OR nearly "discharge-ready."

"Using a pathway which includes evidence-based practices with excellent outcomes is key," says **Terri Link**, MPH, BSN, CNOR, CIC, ambulatory education specialist in the Ambulatory Surgery Division of the Association of periOperative Registered Nurses (AORN). "Quality, safety, and efficiency are what insurance companies are looking for and are what is best for our patients."

However, some facilities have been slow to change their practice, says sources interviewed by *Same-Day Surgery*. Staff and surgeons might be reluctant to buy in, warns **Robert Cima**, MD, colorectal surgeon and chair of the Surgical Quality Subcommittee at Mayo Clinic in Rochester, MN, and medical director of surgical outcomes research at Mayo's Robert D. and Patricia E. Kern Center for the Science of Health Care Delivery. The difficulty comes if different providers use different protocols, Cima says. "Some say you can drink [after midnight], some say not, and the nurse on the preadmit unit must sort through who's who and what the rules are," he says.

The reasons for slow acceptance vary, says **Traci L. Hedrick**, MD, assistant professor of surgery in Section of Colon and Rectal Surgery at the

EXECUTIVE SUMMARY

Enhanced recovery protocols are allowing providers to discharge patients more quickly without additional complications or readmissions.
- A multimodal approach to medications helps avoid side effects that increase length of stay.
- Electronic medical records allow quicker documentation.
- Nurses must be comfortable with using clinical-based discharge criteria rather than time-based criteria.

University of Virginia in Charlottesville. "As surgeons, we don't want to do anything we think may be changing practice without strong evidence," Hedrick says. "Sometimes we're too reluctant to change. Sometimes it stops us from being innovative." Hedrick is one of those who is convinced that there is strong evidence. For elective colorectal resections at her facility, they reduce IV fluids and use early feeding, early ambulation, and elimination of IV narcotics, as well as "very active and engaged" patient participation. As a result, they have seen a 30% reduction in length of stay, while complications have been cut in half, from 30% to 15%. Readmissions have been reduced from 18% to 8%. Additionally, "just about every single response improved significantly" on their patient satisfaction scores, Hedrick says. Also, direct patient costs have been reduced about $6,500 per patient, she says.

What's different?

For inpatients and outpatients, the key is to change routines so that patients can go home earlier, but not with increased complications or a greater likelihood of readmissions. This issue is especially important as the Centers for Medicare and Medicaid Services is tracking quality measures, and ultimately Medicare payment will be impacted by these quality measures.

The process must start with having the right patient and the right expectation by the patient, Cima says. "For example, someone who's a chronic narcotic user won't tolerate a procedure like someone who is not," he says.

The key to enhanced recovery protocols is using a multimodal approach to medications by using medications from different classes of compounds, says **Rebecca S. Twersky**, MD, MPH, professor and vice-chair for research, Department of Anesthesiology, at State University of New York (SUNY) Downstate and medical director, Ambulatory Surgery Unit, SUNY Downstate Medical Center and at Bay Ridge, both in Brooklyn. The goal is that by using different medications, providers will minimize the side effects for any individual medication, Twersky says. While some providers have been taking this approach for years, now providers are using even more non-opioids in the place of opioids, she says. Those non-opioids include IV acetaminophen, IV ibuprofen, and IV ketorolac, coupled with nerve blocks or regional anesthesia preop or postop. "We're using them pretty much on everybody so we can avoid opioids in the recovery period," Twersky says.

The result? "Patients are experiencing smoother postop courses in the recovery area," Twersky says. The patients appear to have less need for opioids, she says. "We haven't used morphine in our recovery room for quite a while," Twersky says.

Cima's protocol includes pre-emptive analgesia, Cima says. Before his patients even go into the

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Enhanced Recovery Pathway for Colorectal Surgery

- An evidence-based, multimodal program to reduce postoperative stress responses and organ dysfunction so patients recover more quickly, easily, and naturally.
- Key tenet is that improving patient health before surgery results in faster, less traumatic recovery.
- Avoids traditional preoperative fasting and bowel cleansing.
- Allows patients to eat and drink shortly after surgery.
- Pre-emptively treats pain and nausea before surgery.
- Avoids fluid and sodium overload during and after surgery.
- Limits use of intravenous narcotics postoperatively.
- Benefits include shorter hospital stays, improved outcomes, and fewer long-term complications.

Source: Mayo Clinic, Rochester, MN.

OR, they're given Cox-2 inhibitors (Gabapentin) and acetaminophen. Also, "we're strong users of regional anesthetics as a supplement to general anesthesia," he says. They also use a local anesthetic at the end of the procedure and occasionally a long-acting anesthetic. "As soon as the patient is in recovery, we give oral pain medicine," Cima says. As a result, for colectomies, the length of stay has improved from 7% of patients leaving postop day two to 44% of patients leaving on that day. Complications have lessened, and readmissions are unchanged, Cima says. *(See his enhanced recovery protocol, above.)*

Appropriate pain management is always important, but even more so in ambulatory surgery when patients are discharged earlier, Link says. "Regional blocks are common and an effective way to manage postoperative pain," she says. "Less narcotics are used and, as a result, the risk of nausea and vomiting postoperatively is less." *(To see how anesthesia changes helpeimprove length of stay for pediatric knee surgeries, see story, p. 109.)*

Twersky says because monitored anesthesia care (MAC) is much more prevalent now in ambulatory units than general anesthesia, "patients indeed are discharge-ready fairly rapidly." Nurses are another key component, she says. "The nursing staff has developed a comfort level and recognized fast tracking a patient doesn't compromise their safety and the ability to educate the patient and family postop," Twersky says.

These pathways all segway into the concept of the perioperative surgical home where anesthesiologists collaborate with other professionals to provide a patient-centered perioperative surgical care system designed to improve efficiency, be cost effective, enhance value, and focus on safety.

Another change for many patients has been a provision for them to drink up to about four hours before surgery. The drink is supposed to help with gastric emptying and improve sugar control, Cima says. Patients are instructed they can have clear drinks, with no creamer, through the night and up to four hours before the procedure, he says.

The end result of these enhanced recovery protocols, when handled appropriately, is happy patients, say our sources.

"Patient satisfaction is key," Link says. Patients expect to have pain control, no nausea and vomiting, and no complications or readmissions, she says. "Great outcomes do not happen by chance," she says. "Having proven pathways of care which are safe, cost saving, and with great outcomes and satisfied patients are the goal." *(For more information on the components of a successful enhanced recovery protocol, see story, below.)* ■

Follow these steps to enhanced recovery

When seeking enhanced patient recovery in ambulatory surgery, being prepared is key, according to sources interviewed by *Same-Day Surgery*.

Selecting the right patient, then preparing them with calls and, in some cases, visits to the home to assess for safety are important, says **Terri Link**, MPH, BSN, CNOR, CIC, ambulatory education specialist in the Ambulatory Surgery Division of the Association of periOperative Registered Nurses (AORN).

"Clear discharge criteria using evidence-based practice along with follow-up after discharge, including postop phone calls and surgeon office visits, are necessary to intervene and prevent complications," Link says. A plan/pathway of care can

ensure the patient recovers at home rather than a longer stay that might put the patient at risk for a hospital-acquired infection, she says.

Consider these specific suggestions:

• Use of electronic medical records (EMRs).

When fast-tracking patients began several years ago, patients might have felt hurried because nurses hadn't finished the paperwork, says **Rebecca S. Twersky**, MD, MPH, professor and vice-chair for research, Department of Anesthesiology, State University of New York (SUNY) Downstate, and medical director, Ambulatory Surgery Unit, SUNY Downstate Medical Center and at Bay Ridge, both in Brooklyn.

"Now with electronic records, it's not as cumbersome for document milestones to be met to be discharge-ready," Twersky says. "I think with the nursing staff's continued commitment to patient education and to the families, the overall experience will be reviewed as favorable and positive."

• Nurses' comfort with using clinical-based discharge criteria.

Nurses have accepted the move away from time-based discharge criteria, Twersky says. Much of the success falls to having excellent nurses in the postop care unit (PACU) and the step-down areas, she says. "If everyone is on board with treating common side effects, engaging patients and family in the recovery, that would be a path for a successful recovery protocol without increasing complications or readmissions," Twersky says. ■

Electronic reminders might help prevent SSIs

The use of electronic reminders such as text messages, emails, or voicemails is highly effective at getting surgical patients to adhere to a preadmission antiseptic showering regimen known to help reduce risk of surgical site infections (SSIs), according to a first-of-its-kind study published in the August issue of the *Journal of the American College of Surgeons*.

Each year approximately 400,000 SSIs occur and lead to a death rate approaching nearly 100,000, according to data cited by the study authors. To help reduce the risk of these dangerous infections, clinicians recommend that surgical patients take antiseptic showers with chlorhexidine gluconate (CHG) 24-48 hours before admission. CHG is beneficial because it reduces the microbial burden on the surface of the skin and, thereby, the risk of intraoperative wound contamination. *(For more information on this topic, see these stories in the March 2013* Same-Day Surgery*:"Want to get a jump start on preventing infections? Have patients do the prep work," p. 25, and "SSIs reduced 60% for colorectal patients," p. 27.)*

"SSI risk reduction really involves a holistic approach, and the preadmission shower is an important component of that comprehensive prevention program. So if a patient excludes one of the components in this process, the benefit of the surgical care could be affected," said lead study author **Charles E. Edmiston**, PhD, professor of surgery and hospital epidemiologist, Medical College of Wisconsin, Milwaukee.

"In general, getting patients to comply with this preadmission cleansing strategy is a challenge throughout healthcare," Edmiston said. "While patients want to be compliant, they will often forget to fulfill this preadmission requirement, so that's why we looked to new technology for a solution. When you use a prompt like texting or emailing, you make the patient an intimate partner in the healthcare process."

For the study, researchers recruited 80 healthy volunteers who were randomized to one of four skin-antiseptic showering groups. Electronic alerts were sent as voicemails, text messages, or emails, with text messages being the most popular method (80%) among volunteers. Volunteers were randomized to taking two (Group A) or three showers (Group B). Group A1 and group B1 were prompted to shower by an electronic alert reminder, while Groups A2 and B2 did not receive an electronic prompt.

The participants were instructed to return to the laboratory within three hours after their last shower to have their skin-surface concentrations of CHG analyzed at five sites on their bodies. Researchers measured compliance by looking at skin-surface concentrations of CHG in all 80 individuals who were assigned to take the antiseptic showers.

The analysis showed that CHG skin-surface concentrations were significantly higher in groups A1 and B1 (patients who received alerts) compared with groups A2 and B2 (patients who did not get reminders). In a comparative analysis between groups A1 and A2, there was a 66% reduction in the composite mean concentration of CHG on the skin surface in patients who were not

alerted to shower (group A2) compared with those who received electronic reminders (group A1). Furthermore, in the groups that showered three times, there was a 67% reduction in the composite mean skin-surface concentration of CHG in patients who were not alerted before showering (group B2) compared with those who received electronic alerts (group B1).

The researchers conclude that the patients who did not receive digital communications reminding them to shower were significantly less compliant with preadmission orders compared with those who received the electronic reminders. These study findings have great ramifications not only for this preadmission strategy and its potential impact on SSI risk reduction, but also for other preadmission orders.

"I think a study like this provides us with a tremendous opportunity to empower patients because it clearly makes them an intimate partner in the whole healthcare experience," Edmiston said. "It's reminding them that they are not a passive player but rather an active participant in an important risk-reduction strategy that, if successfully completed, can contribute to an improved clinical outcome."

Ultimately, the researchers are striving to develop a standardized process in which surgical patients take preadmission showers in a methodical way and achieve an overall improvement in outcomes. Additional research is needed to determine if electronic alert reminders and better compliance translate into lower SSI rates, Edmiston said. ■

Give options: Register online or at kiosk

Patients accustomed to using self-service kiosks at airport check-in counters and placing online retail orders likely wonder why they have to stand in line to give demographic and insurance information to a registrar verbally.

"There are many self-service options available in patient access, and more are emerging. It's an exciting time for patient access technology," says **Amber J. Harris**, administrative director of patient-centered access at Integris Health in Oklahoma City, OK.

Sandra J. Wolfskill, FHFMA, director of healthcare finance policy at the Healthcare Financial Management Association (HFMA), says self-service options "ease backlogs in the registration area, and in the case of online options, allow patients to interact with the hospital at their convenience." Wolfskill also is director of HFMA's revenue cycle Measure Apply Perform (MAP) initiatives.

Executive Summary

A growing number of outpatient surgery providers offer "self-service" options with online registration or kiosks. Registration times decreased by almost 50% after kiosks were implemented at five of Integris Health's hospitals.
- You can use kiosks for pre-registered patients.
- Have support staff available to help patients.
- Consider committing to kiosks as the primary arrival mechanism for all scheduled patients.

Wolfskill says that the options patients expect are "generational in nature. It varies from 20-somethings who expect mobile access and processing, to retirees with time to come in early and chat with the registration staff."

She estimates that about 20% of hospitals offer some type of online pre-registration. "This is a viable option for many patient access areas, as long as appropriate encryption and security are provided," says Wolfskill. "Some details may require staff intervention, such as electronic insurance verification or billing codes that are captured during registration."

Kiosks are especially useful for patients who have been pre-registered for services, according to Wolfskill. Payments are processed electronically from the kiosk and applied to the account, the patient's armband and arrival paperwork are printed, a staff member bands the patient, and the patient is directed to the service area.

"Since the patient's information has already been validated and updated, the arrival process involves simply checking in, confirming identity, and paying any agreed-upon amount," Wolfskill explains.

Registration time cut almost 50%

Registration times decreased by almost 50% after kiosks were implemented in the main registration area and surgery centers at five of Integris Health's hospitals.

"We are building a new registration area at Integris Baptist Medical Center, and it fully incorporates kiosks into the registration experience," reports Harris. "We use them as an express registration option for pre-registered patients."

Integris Health plans to implement an online patient portal for registration once the hospital converts to a new Epic system, she reports.

Patients adjusted quickly to the kiosks. "They are exposed to increasing self-service technology in other industries," notes Harris. "We asked patients if they wanted to try our kiosks. We didn't force anyone to use them and still don't."

All patients using the kiosks are presented with a quick survey at the end about their registration experiences. "Of patients surveyed, 96% said they liked the kiosks, and 87% said the process was easier than a traditional registration," reports Harris.

Do this before implementation

Before implementing kiosks in registration areas, Wolfskill says to take these steps:

• Have support personnel available to help patients use the kiosks.

Without appropriate support, some patients will become frustrated or unable to complete the process.

"Even the airlines, who pioneered the extensive use of kiosks, have personnel standing by to help the moment a passenger looks lost or confused," says Wolfskill.

• Commit to kiosks as the primary arrival mechanism for all scheduled patients.

Staff members can provide information on kiosks to patients during the pre-registration process, make announcements to the community, post signs about the kiosks, and provide handouts on the kiosks in registration areas.

"Otherwise, the unscheduled arrival area becomes backlogged with people who do not want to use the kiosks," Wolfskill says.

Moving toward self-service

At Emory University Hospital in Atlanta, the Information Services Department is working on ways to use technology to add self-service options to patient access areas. A related goal is to minimize the need for patient contact with patient access employees at time of service, says **Pete Kraus**, CHAM, CPAR, FHAM, business analyst for patient financial services. "With respect to elective services, it all begins at scheduling," he says.

This process involves gathering data needed to pre-register, pre-certify, determine medical necessity, determine whether the patient's status is inpatient or outpatient, and determine financial need and the patient's ability to pay. All these items must be completed as a prerequisite to scheduling, says Kraus.

Kraus recently discussed the feasibility of patients completing the Medicare Secondary Payer Questionnaire using a kiosk or as part of online registration. "Given current complexities, we're not sure it will ever be doable, but we can and do collect the information during preadmission calls," says Kraus.

In coming years, once the patient presents, there could be little left for patient access to do except obtain signatures. "Perhaps we'll eventually embrace technology to have consent obtained in advance," says Kraus. "Very little of this is current reality. But each step we take is designed to move us in that direction." ■

Drug approved to treat malignant hyperthermia

Can be prepared in less than 1 minute by 1 person

The Food and Drug Administration (FDA) has approved Ryanodex (dantrolene sodium) from Eagle Pharmaceuticals in Woodcliff Lake, NJ, for injectable suspension indicated for the treatment of malignant hyperthermia (MH). Ryanodex can be prepared and administered in less than one minute by a single healthcare practitioner.

MH is an inherited and potentially fatal disorder triggered by certain anesthesia agents in genetically susceptible individuals. The FDA had designated Ryanodex as an orphan drug in August 2013. At press time, Eagle said it has been informed by the FDA that it will learn over the next few weeks if it has been granted the seven-year orphan drug market exclusivity.

"When a patient experiences malignant hyperthermia during surgery, it is a life-threatening emergency requiring immediate treatment including the administration of the 'antidote' drug dantrolene sodium," said **Henry Rosenberg**, MD, CPE, a founder and president of the Malignant Hyperthermia Association of the United States (MHAUS). "The ability for healthcare professionals in hospitals and surgery centers to more quickly prepare and administer this new formulation of the antidote dantrolene sodium is expected

to bring the crisis under control more rapidly and prevent severe complications from MH."

Ryanodex is the first significant enhancement to MH treatment options in more than three decades, and it has been reformulated to improve performance in managing MH. The product has the potential to become a new standard of care for the treatment of malignant hyperthermia because it enables anesthesiologists to deliver a therapeutic dose of the only antidote for MH (dantrolene sodium) in a much more expedient manner than possible with existing formulations of IV dantrolene sodium.

Malignant hyperthermia is an inherited genetic disorder found in an estimated one out of 2,000 people. MH crisis situations are triggered by commonly used general anesthetics and the paralyzing agent, succinylcholine, and result in a biochemical chain reaction response in the skeletal muscles of susceptible individuals. General signs of MH crisis include increased heart rate, greatly increased body metabolism, muscle rigidity, and/or fever that may exceed 110 degrees Fahrenheit along with muscle breakdown. MH crisis mortality is extremely high without immediate recognition and treatment with the antidote, dantrolene sodium.

MHAUS provides information and resources to medical and lay communities through conferences, educational materials, ID tags, a 24-hour MH Hotline (800-644-9737), and the MHAUS website: http://www.mhaus.org. ■

Deaths rise with shift to outpatient urology

As hospitals have shifted common urological surgeries from inpatient procedures to outpatient, potentially preventable deaths have increased following complications. These were the primary findings of a study led by researchers at Henry Ford Hospital in Detroit.

The researchers initially expected that improved mortality rates recently documented for surgery overall also would apply to commonly performed urologic surgeries. The opposite turned out to be true. The research paper has been published online by *BJUI*, the official journal of the British Association of Urological Surgeons. The study included researchers at Harvard Medical School in Boston, the University of Montreal Health Center in Quebec, Canada, Yale University's Department of Urology in New Haven, CT, and the Harvard School of Public Health in Boston.

The study also identified older, sicker, minority patients and those with public insurance as more likely to die after a potentially recognizable or preventable complication. "These high-risk patients are ideal targets for new healthcare initiatives aimed at improving process and results," said **Jesse D. Sammon**, DO, a researcher at Henry Ford's Vattikuti Urology Institute and lead author of the study. "Urologic surgeons and support staff need a heightened awareness of the early signs of complications to prevent such deaths, particularly as our patient population becomes older and has more chronic medical conditions."

The study focused on a measure of hospital quality and safety called Failure to Rescue (FTR), derived from the Institute of Medicine's landmark 1999 report *To Err is Human*, which highlighted significant concerns for patient safety in American hospitals. "Failure to rescue describes the inability of a provider or institution to recognize key complications and intervene before mortality," Sammon explained. "While comparison of overall complications and mortality rates penalizes hospitals treating sicker patients and more complex cases, FTR rates may be a more accurate way to assess safety and quality of care."

Using the Nationwide Inpatient Sample, the largest all-payer inpatient healthcare database in the United States, the researchers identified all patients discharged after urologic surgery between 1998 and 2010. This pool of more than 7.7 million surgeries was analyzed for overall and FTR mortality as well as changes in mortality rates. The researchers determined that while admissions for urologic surgery and overall mortality decreased slightly, deaths attributable to FTR increased 5% every year during the study period.

The researchers also identified each patient's age, race, and insurance status, including private insurance, Medicare, Medicaid, and self-pay. In addition, the severity of each patient's illness was determined based on co-morbidity. They found that the number of inpatient urologic surgeries dropped during the study period and surmised this was due to a major shift to outpatient procedures.

Sammon said that compared to other medical specialties, "these findings also raise the possibility that the care of urologic surgical patients is suffering from inadequate or poorly applied patient safety measures."

"It's worrisome," he continues, "that the odds

of FTR-related deaths have risen over time for the most common types of urologic surgeries including ureteral stenting, treatment of enlarged prostate, bladder biopsies, removal of a diseased kidney, and others." ■

Anethetists' hand hygiene indicates low compliance

Anesthesia providers are missing opportunities to clean their hands during surgical procedures, according to a study published in the July issue of the *American Journal of Infection Control*, the official publication of the Association for Professionals in Infection Control and Epidemiology (APIC).

In the study, researchers at Dartmouth-Hitchcock Medical Center used video observation to map patterns of anesthesia provider hand contact with anesthesia work environment surfaces to assess hand hygiene compliance. Researchers observed an average of 149 hand hygiene opportunities per hour of anesthesia time. Hand hygiene compliance was lowest during the first and last 20-minute time periods. The low hand hygiene compliance rates at case start and case end corresponded with sharp peaks in bacterial contamination of the 20 most frequently touched objects during these same time periods.

According to the study, conducted at Dartmouth-Hitchcock Medical Center, anesthesia providers were least likely to perform hand hygiene immediately before patient contact and after contact with the patient's environment. They were most likely to perform hand hygiene after potential exposure to body fluids.

The World Healthcare Organization (WHO) specifies five moments for hand hygiene to reduce the risk of healthcare-associated infection: before touching a patient, before a clean procedure, after exposure to body fluids, after touching a patient, and after touching a patient's surroundings.

"This work adds to the body of evidence pertaining to intraoperative bacterial transmission because it identifies targets for improved frequency and quality of environmental cleaning as well as important periods for hand hygiene compliance, namely induction and emergence from general anesthesia," state the authors.

The study points out that complete compliance with hand hygiene guidelines that are established for non-operating room environments would consume more than the 60 minutes available in each hour of anesthesia time, "a fact that identifies a need to create more practical – but still effective – methods of controlling bacterial transmission in anesthesia work environments," the authors write. "New methods to reduce bacterial contamination of the anesthesia work environment are needed to prevent healthcare-associated infections."

Infections that occur after surgery are one of the most common types of healthcare-associated infections. According to the Centers for Disease Control and Prevention, there are approximately 157,000 surgical site infections each year. To access the study, go to http://bit.ly/1x6oHKN. *(For ideas on how anesthetists can reduce infections, see "Wearing 2 sets of gloves cuts contamination,"* Same-Day Surgery, *August 2014, p. 86.)* ■

Tool integrates caregivers into the discharge plan

The Project RED (Re-Engineered Discharge) toolkit has added a tool to help hospitals integrate family caregivers into the discharge plan so they can be partners in improving transitions and reducing readmissions, according to the American Hospital Association.

The new toolkit chapter structures working with family caregivers into five steps: identifying the family caregiver, assessing the family caregiver's needs, integrating the family caregiver's needs into the after-hospital care plan, sharing family caregiver information with the next setting of care, and providing telephone reinforcement of the discharge plan. Developed by researchers at Boston Medical Center, the toolkit includes 12 actions facilities can implement to ensure effective transition at discharge.

Such tools are increasingly important, as the Centers for Medicare & Medicaid Services (CMS) is increasing its emphasis on discharge planning and has developed a worksheet for surveyors to use to determine if hospitals are in compliance with the Conditions of Participation (CoPs). CMS has added categories of patients who might need discharge planning and included same-day surgery patients. *(For more information, see "Hospitals: Beef up discharge planning,"* Same-Day Surgery, *August 2014, p. 81.)*

To access the toolkit, go to bu.edu/fammed/projectred/toolkit.html. The new toolkit chapter is available at http://bit.ly/1pmA6WB. ■

Surgical collaborative saves $75 million

Ten hospitals and their ambulatory surgery centers (ASCs) in the Tennessee Surgical Quality Collaborative (TSQC) have reduced surgical complications by 19.7% since 2009, resulting in at least 533 lives saved and $75.2 million in reduced costs, according to new results presented at the recent national conference of the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP).

The hospital collaborative was formed in 2008 as a partnership of the Tennessee chapter of the American College of Surgeons and the Tennessee Hospital Association's (THA) Center for Patient Safety, with support from Blue Cross Blue Shield's Tennessee Health Foundation. ACS NSQIP is a nationally validated, risk-adjusted, outcomes-based program to measure and improve the quality of surgical care in hospitals. The program provides a prospective, peer-controlled, validated database of preoperative to 30-day surgical outcomes based on clinical data. Through the ACS NSQIP program, TSQC hospitals collected clinical 30-day outcomes data from 10 participating hospitals to examine and identify trends in and evaluate best practices. Between 2009 and 2012, participating hospitals collected data on more than 55,000 surgical procedures, and researchers examined rates of 17 types of surgical complications.

Compared with complication rates in 2009, participating hospitals in 2012 achieved 19.7% fewer postoperative occurrences ($p < 0.001$), and the postoperative mortality rate dropped 31.5% ($p < 0.001$). Hospitals prevented an estimated 3.75 deaths per 1,000 surgical procedures and avoided $75.2 million in excess costs. The collaborative saw improvements in 13 of the 17 types of complications, and nine improved significantly ($p < .05$). The areas of most improvement included all types of surgical site infections, pneumonia, and urinary tract infections, which all dropped by approximately one-third.

"Our results show not only have Tennessee hospitals improved care, but we've been able to sustain those improvements over time," said **Brian Daley**, MD, MBA, FACS, lead author of the study and professor of surgery and chief of the Division of Trauma and Critical Care at the University of Tennessee Medical Center, Knoxville. "Our collaborative approach and use of robust clinical outcomes data through ACS NSQIP is an effective model for quality improvement across our state and nationally."

An earlier study based on TSQC data was published in the *Journal of the American College of Surgeons* in 2012. It showed the 10 TSQC members reduced complication rates and saved more than $8 million in excess costs from 2009 to 2010. This study shows TSQC facilities continued to improve after the program was launched. In 2012, the collaborative expanded and now includes 22 Tennessee hospitals and their ASCs.

Oscar Guillamondegui, MD, MPH, FACS, chair of TSQC's leadership committee, said, "Participation in an ACS NSQIP collaborative is helping Tennessee hospitals accelerate their improvements by sharing data, comparing results, and evaluating best practices among peers." Guillamondegui is an associate professor of surgery at Vanderbilt University Medical Center in Nashville, TN.

Craig A. Becker, THA president, said, "The TSQC has helped align the efforts of hospitals and surgeons around quality improvement, which supports the THA board's commitment toward zero incidents of preventable harm in our state's hospitals. This collaborative is an excellent example of how the hospital association, physicians, hospitals, and payers can work together to improve care using clinically valid measures in a cooperative way." ■

Regional anesthesia touted for pediatric knees

Study: As much as 98% was done outpatient

A recent study of femoral nerve block shows that it leads to less opioid use and allows most patients to go home within hours of surgery. As many as 98% of all pediatric knee surgeries performed at Nationwide Children's Hospital in Columbus, OH, were done in an outpatient setting as a result of this method.

"Our goal with this technique is to reduce pain, which improves patient outcomes and patient satisfaction," said **Tarun Bhalla**, MD, director of acute pain and regional anesthesia at Nationwide Children's and a co-author of the study. Bhalla also is director of the pediatric regional anesthesia fellowship at Nationwide Children's and a faculty member at The Ohio State University College of

Medicine, also in Columbus.

"We also use fewer pain medicines intraoperatively as well as postoperatively, so we could really avoid a lot of the side effects that come along with them," he said. "We're localizing our numbing medicine to the area where the incision is being made to keep the coverage localized."

The anesthetic blocks pain for up to 12 hours in some cases, which significantly reduces postoperative pain. Following surgery, patients have a catheter that runs to the surgical site. The catheter is connected to an exterior pump that delivers anesthetic to the area for up to three days after surgery, while the patient is at home.

The study also showed for patients who did require hospitalization spent fewer days inpatient as a result of ultrasound-guided regional anesthesia. "With a significant reduction of inpatient stays, patients are going home within a couple hours after coming out of surgery and they have an easier recovery," Bhalla said. "I think the quality of recovery is much better because the patients are so much more comfortable at home and not surrounded by the sounds of hospital machines."

For the study, which was published in the June issue of the *Journal of Pediatric Orthopedics*, researchers reviewed records of 376 patients age 7 to 18 years old who underwent arthroscopic knee surgery at Nationwide Children's between July 2008 and July 2011. Of these patients, 131 received a femoral nerve block in addition to general anesthesia, while 245 received general anesthesia alone. Patients who received the combined anesthesia reported less pain, required less pain medication after surgery, and had shorter hospital stays when compared to patients who had general anesthesia alone. This includes 98% of ACL reconstructions, which are one of the most painful of all procedures evaluated in the study.

Kevin E. Klingele, MD, chief of orthopedics at Nationwide Children's and a co-author of the study, said, "It's a safe procedure that's markedly improved our ability to perform outpatient surgical services and, in fact, it's become very rare for us to have any overnight stays for knee reconstruction."

While this study looked specifically at arthroscopic knee surgery, regional anesthesia is also becoming more widely used in orthopedic procedures in the shoulder, elbow, and wrist and in other surgical procedures in the abdomen. Regional anesthesia is being used in cardiac and urological surgeries as well.

Bhalla said, "Ultrasound-guided regional anesthesia is being used more regularly in pediatric patients, and more often in younger and younger patients. One of the most significant side effects of opioid use in infants is depressed respiratory function, which leads many infants to require intubation. Reducing the need for narcotics helps the infants come off ventilation more quickly."

"Since 2010, we have significantly increased the number of blocks we are doing and now perform 150 and 200 a month," said Bhalla, who travels around the country and the world teaching other medical centers how to do these procedures in pediatric patients. "Of course, it's reduced cost to patients and families, reduced cost to insurance companies. So, it really is a whole benefit for the community and improves the experience for our patients." ■

Same-Day Surgery Manager

`Don't confuse me with the facts!'

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

I received a huge response from readers regarding the last column of "What have you done for me, today?" It always makes me feel good when I hit a topic that you can relate to.

Based upon a number of your comments, I wrote this month's column. It could have been titled "Perception is Reality." But truly, what we perceive is our reality, as we have nothing else to base it on except what we can see, touch, sense, etc.

For example, consider the surgeons' perceptions about turnover time between cases. If they leave the operating room at 9:15, and they don't enter the room again until the next patient is asleep at 10:20, the turnover of that room, to them, is 65 minutes. Don't confuse them by saying, "Yes, but…" It doesn't work. How do you dispel it? Difficult to do, unless you all agree on what "turnover time" is versus "patient-out-and-patient-in

time" (which is really more accurate). Once you define it, post it daily, weekly, etc. until you drive home your point.

Another complaint is late start on cases. The perception is that the surgeon is waiting in the room, arm in the air, gowned, gloved, and ready to go, except no patient, anesthesia, staff, equipment, or open supplies. Often the reality is that the lab work is late, the patient is late, anesthesia is tied up in another room, the surgeon is not there, and on it goes.

All of us have done studies on why cases are late starting. Everything just mentioned is on that list, except for those who perceive it is always because of the "other person." Post the reasons for late starts in the locker room or lounge. Pull no punches, and call it as it is. As we will get to in a minute, there is a reason to dispel false perception of reality!

Consider these other perceptions:

• **"I'm not getting the hours I was promised."** I can almost guarantee that complaint is based upon one paycheck and not every pay period. Show them the facts.

• **"There is nothing for me to do."** Have staff read minutes of last several staff meetings where you are looking for volunteers to do different things.

• **"Our benefits are horrible."** Get a comparable benefits plan from another facility and show them how well they really have it.

Don't let people get away with believing things that are just not true. It can become divisive and seriously injure morale and overall attitude. What we see all too often is surgeons who wish to leave a hospital or surgery center for another home because of false perceptions. Don't let that happen!

One thing I enjoy is letting surgeons know that their cost per case is high. Of course their perception is that it is not. Price their preference cards and show them what their actual (or factual) cost really is. Compare it with another surgeon doing the same procedure with lower cost. There's no reason why you can't vent a bit yourself. Who knows? It just might tone things down a bit.

[Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Contact Earnhart & Associates at 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.]

Get ready: Deadline set for ICD-10 conversion

The Department of Health and Human Services (HHS) has issued a rule finalizing Oct. 1, 2015, as the new compliance date for the transition to ICD-10, the latest revision of the International Classification of Diseases.

For more information, visit the web site administered by the Centers for Medicare and Medicaid Services at http://www.cms.gov/ICD10. ■

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.

1. Read and study the activity, using the provided references for further research.
2. Scan the QR code below or 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 emailed to you instantly. ■

COMING IN FUTURE MONTHS

■ Debate: CRNAs versus anesthesiologists

■ Work with surgeons' office on discharge plans

■ Hackers target healthcare: Protect data

■ Improving efficiency: Ideas from your peers

CNE/CME QUESTIONS

1. For colectomies performed at the Mayo Clinic, enhanced recovery protocols have changed the length of stay from 7% of patients leaving postop day two to what, according to Robert Cima, MD, colorectal surgeon and chair of the Surgical Quality Subcommittee?
A. 14% of patients leaving postop day two
B. 24% of patients leaving postop day two
C. 34% of patient leaving postop day two
D. 44% of patients leaving postop day two

2. The Food and Drug Administration has approved Ryanodex (dantrolene sodium) for injectable suspension indicated for the treatment of malignant hyperthermia (MH). What are its advantages?
A. Ryanodex can be prepared and administered in less than one minute by a single healthcare practitioner.
B. Ryanodex can be prepared and administered in less than three minutes by a single healthcare practitioner.
C. Ryanodex can be prepared and administered in less than five minutes by two healthcare practitioners.
D. Ryanodex can be prepared and administered in less than seven minutes by two healthcare practitioners.

3. In a study of hand hygiene compliance by anesthesia providers at Dartmouth-Hitchcock Medical Center, when was the lowest compliance?
A. During the first 20-minute time period.
B. During the last 20-minute time period.
C. During the first and last 20-minute time periods.
D. None of the above.

4. What impact did the use of electronic reminders such as text messages, emails, or voicemails have on adherence to a preadmission antiseptic showering regimen known to help reduce risk of surgical site infections, according to study results published in the *Journal of the American College of Surgeons*?
A. The patients who did not receive digital communications reminding them to shower were significantly less compliant with preadmission orders.
B. The patients who did not receive digital communications reminding them to shower were somewhat less compliant with preadmission orders.
C. The electronic reminders had no impact.

SDS ACCREDITATION UPDATE

Covering Compliance with TJC, AAAHC, AAAASF, and Medicare Standards

Want to avoid accreditation survey citations? Follow this protocol step by step

Four providers were arrested for selling fake cosmetic injections. Their arrests and subsequent release had been documented in the local newspaper. The ambulatory surgery center recredentialed them a month later, with no discussion, or at least that was the finding of accreditation surveyors at the exit interview.

The managers at the center knew they had spent three hours at a board meeting discussing the arrests and that they had held off making a decision while more information was obtained. However, none of this action was reflected in the board minutes, according to **John J. Goehle**, MBA, CASC, CPA, chief operating officer of Rochester, NY-based Ambulatory Healthcare Strategies, which offers management consulting for surgery centers and office-based surgery practices. Goehle, who is also a surveyor for the Accreditation Association for Ambulatory Health Care (AAAHC), spoke on accreditation at this year's annual meeting of the Ambulatory Surgery Center Association (ASCA).

In another incident at a different facility, a "young, naïve person" had been hired to perform credentialing. One physician had a 70-page report from the National Practitioner Data Bank. He had lost his license in three states, and there was no documentation that he ever got it back.

"She thought she just had to run the report and put it in the folder," Goehle says. The facility caught the mistake before any damage was done and before a survey team arrived to examine the credentialing documents, however, he says.

In yet another situation, surveyors showed up when the medical director was out of the country and the nurse manager, who lived in another part of the state, had not returned back to work on Monday. "It extended the survey for an additional day," Goehle says. "It didn't get things off on the right foot."

Major gaffes during an accreditation survey can be avoided by using a survey protocol, Goehle advises. Provide it to your staff, especially at the front desk, he says. The protocol should outline steps to follow, who to call, and what to do when administrators can't be reached, Goehle says.

"It eliminates uncertainty and demonstrates organization," he says.

Here are the steps Goehle recommends in his protocol:

- Surveyors usually will show up between 7:45 and 8 a.m. There might be one to three surveyors, although there might be more if there are trainees. The Life Safety Code surveyor might not show up with the regular survey team.
- When they arrive, the receptionist should do the following:
  - o Inspect their credentials and take their business cards.
  - o Immediately page the following to the front: administrator and nursing director.
  - o Immediately call the following to tell them the surveyors are on-site: (list names). The facility should list any other persons, such as consultants who might live a long distance from the facility.
- The administrator or nursing director will take surveyors to the conference room. Make sure

Financial Disclosure:
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the room is clean and devoid of any files. Ask them to take a seat, and show them where they can get coffee.

• They will want to do an entrance conference within 15 minutes of arrival. The administrator, nursing director, and medical director should attend, if they are available. Take notes, especially about what they want you to gather for them.

• Provide them immediately at the end of the entrance conference with the following: policy and procedure manual, board minutes, QI minutes, medical staff bylaws, corporate governance documents (bylaws, certificate of incorporation, etc.), operating certificate, Medicare approval letter, and as-built design for the facility (for the life safety surveyor).

• At the end of the conference, they will want to take a quick tour of the facility. Make sure someone accompanies them and introduce them to your staff members as they move throughout the facility.

Mark Mayo, executive director of the ASC Association of Illinois and principal of Mark Mayo Consultants in Round Lake, IL, says, that "wherever possible, staff should accompany the surveyors and staff should take notes of any issues raised by the surveyors or any special requests such as a copy of a specific policy."

• If the survey is being performed by AAAHC, you must provide lunch for any full day of survey. Get a menu and make sure this is done before 10 a.m. so that it is available for them at noon (unless they instruct otherwise). If the Centers for Medicare and Medicaid Services (CMS) or the state is performing the survey, you will NOT be allowed to provide or purchase lunch for the surveyors. They usually will leave during lunch.

• During the opening conference, they will tell you how to select medical records, employee records, and credential files. Expect the following:

o **Medical records.** They will want all complications and transfers and a random sample that they will select for you. They will usually request at least 20 records. Several of the records will need to be Medicare patients. Gather the charts, and get them to the surveyors within 15 minutes.

o **Employee records.** They will select from a list that you must provide of all employee names. They also often will select certain employees that they meet during the day or who are performing procedures. Get these files to them within 15 minutes.

o **Credential files.** They will select from a list you must provide them of credentialed providers. They also most likely will select all or some of the providers on-site during the survey. Provide these files to them within 15 minutes.

EXECUTIVE SUMMARY

A survey protocol is a useful tool for being organized and prepared for accreditation surveys. It should include the following steos:

• Provide the front desk staff members with a list of who to contact when surveyors arrive and what to do if administrators can't be reached.

• At the end of the entrance conference, immediately provide surveyors with your policy and procedure manual, board minutes, QI minutes, medical staff bylaws, corporate governance documents (bylaws, certificate of incorporation, etc.), operating certificate, Medicare approval letter, and as-built design for the facility (for the life safety surveyor).

• Expect to be asked to pull at least 20 medical records, plus employee records and credential files. Take these items to surveyors within 15 minutes of the entrance conference.

• One of the surveyors (usually a nurse or a doctor) will perform the clinical walk-through. This step will take several hours. Dedicate one staff person to accompany this individual (most likely the nurse manager). They will want to follow a patient through his or her visit and accompany him or her into the operating room. They usually will not stay for the whole procedure. The patient tracer should be arranged immediately after the surveyor arrives, Goehle says. The reason is that the surveyors typically want to watch the patient from the time of check-in at the front desk until they are put in a wheelchair and wheeled out, he says. Tell the surveyor about the timing, Goehle advises.

"Often, you get to talking, and the patient we want to look at, they're already checked in, so you get off cycle. You have to choose another patient," he says.

Staff members can obtain cooperation and permission from the surveyor to observe, Mayo says. "This is not required under Medicare but is always a proper touch," he says. "Some facilities also inform the patient that a nurse or physician who is conducting the survey may observe this case."

• Make sure someone is available to go through the files that they are reviewing as they review them. (Some surveyors will not permit this person to be there, but most will.)

Mayo suggests that staff members keep a list of the files (patients, employees, and physicians) submitted to the surveyor. "In case of an issue or concern, it is easier to reference back later on," he says.

• If the medical director is available, they will probably want to spend about 15 minutes talking to him or her about various issues.

• The review of QI and infection control most likely will occur during the first afternoon or early on the second day.

• As the survey progresses, surveyors will provide continuous feedback as to their findings. Make sure that each person who receives the feedback writes it down.

• They usually will complete the first day at about 5 to 6 p.m. If they are AAAHC surveyors, they will go back to their hotel and work for another 2-3 hours on compiling their findings.

• Expect that you all will have to spend several hours at the facility to debrief on the findings of the day and to make whatever changes you can overnight to address issues that can be immediately fixed. For example, AAAHC surveyors might instruct managers that they need a policy in a specific area or suggest revising the wording in a policy.

"You can do that pretty quickly after a surveyor has left and have them be acceptable," Goehle says.

• On the second day, surveyors might want to get there early, so be prepared for that possibility. "I like to get in at 7 a.m., but that's not universal," Goehle says.

• For AAAHC surveys, the second day usually has less interaction with the staff as surveyors complete the report and fill in the missing information.

They will wish to complete an exit conference with the staff at approximately noon or 1 p.m. for a 1½-day survey and 3-4 p.m. for a two-day survey. At this conference, the surveyors are obligated to verbally provide their findings. If there is any factually incorrect finding, bring it up during the exit conference and immediately provide them documentation after the conference. Take extensive notes of the exit conference so that you can start taking corrective action.

• Immediately after the conference, they will leave the facility. ■

TJC issues an *Alert* on tubing misconnections

The Joint Commission (TJC) has issued a *Sentinel Event Alert* that addresses the risks of accidental medical tubing misconnections that can cause severe patient injury or death. An example of a potentially fatal misconnections includes a limb cuff inflation device connected to an IV. A 71-year-old woman died postoperatively after a blood pressure cuff was accidentally connected to her IV line, which caused an air embolism, according to the *Sentinel Event Alert*.

The risk for tubing misconnection is high, considering that almost all patients are likely to receive an IV, according to the alert, which is titled "Managing risk during transition to new ISO tubing connector standards."

Accidental tubing misconnections occur because medical tubes with different functions can easily be connected with luer-style connectors that are used to make leak-free connections between medical tubing. The tubing connections also can be rigged using adapters, tubing, or catheters. To prevent dangerous tubing misconnections, the International Organization for Standardization (ISO) has developed new international manufacturing standards for connectors. The standards are being introduced in phases and include engineering specifications for small-bore connectors with an inner diameter of less than 8.5 mm. The new connectors manufactured under the ISO standards will make it nearly impossible to connect tubing delivery systems that serve different functions.

Although connectors manufactured to the new specifications are expected to enter the marketplace this month, the old connectors will remain in use until supplies are depleted. This situation is leading to concerns about the potential for misconnections to still occur. Due to the continuing risks, The Joint Commission urges organizations to be vigilant and begin planning for the transition to the new connectors, which will introduce changes and new risks. Because the old tubing supplies will be in use until they are depleted, temporary adaptors are being introduced to connect the old tubing with the new tubing, and the potential for misconnections still will exist.

The Joint Commission is alerting organizations to prepare for the changes in connectors and to do everything possible during the transitional period to avoid tubing misconnections.

"Organizational leadership is the first line of defense in this transition to the new connectors," says **Mark R. Chassin**, MD, FACP, MPP, MPH, president and CEO, The Joint Commission. "Leaders must assume the responsibility for ensuring the safe adoption of the new standards, and they must empower their employees to not be afraid to speak up if they discover a problem."

The organization doesn't anticipate introducing new accreditation or certification standards related to tubing connectors.

According to the *Sentinel Event Alert*, tubing misconnections probably are under-reported overall, especially when the mistake doesn't result in harm to the patient. When they are reported, it is sometimes under a sentinel event category such as a medication error.

The Joint Commission offers several detailed strategies in preparation for the launch of the new ISO connector standards. The strategies address assessing and managing current risks of injury; assessing and adapting existing systems, processes, and protocols to carefully transition to the new ISO connectors; effective processes and procedures for prevention of misconnections; and implementation of safe practices for administering high-alert medications.

To access the *Alert*, go to http://bit.ly/1nuZWBz.The alert is part of a larger communication effort named Stay Connected. The Stay Connected website, www.StayConnected2014.org, includes a timeline, a question-and-answer section, and other information.

RESOURCES

- An infographic related to the *Alert* is available at http://bit.ly/YVSKJp.
- For a list of relevant TJC standards for hospitals, ambulatory care facilities, and others, go to http://bit.ly/1p5VMQi. ■

AAAHC addresses use of power strips

Training resources for safety officers listed

The Accreditation Association for Ambulatory Health Care (AAAHC) has shared information on two topics that came up at a recent meeting:

• Is it true that the Centers for Medicare and Medicaid Services (CMS) has banned the use of power strips in clinical areas of an ambulatory surgery center (ASC)?

The AAAHC Life Safety Code consultant has confirmed (as has the ASC Association) that this is NOT the case, at least not at the present time. *NFPA 99 [Health Care Facilities Code*, from the National Fire Protection Association in Quincy, MA] has long required "sufficient" receptacles in rooms to avoid the need for extension cords or outlet multipliers. However, CMS has never specifically said extension cords or outlet multipliers are not allowed. (In fact, a separate section of NFPA 99 says certain types of extension cords are allowed.)

Although it is always possible that a current rumor will become a future requirement of CMS (as was the case with humidity monitoring), currently power strips are not disallowed.

Training for risk managers

• Do you have resources for safety officer/risk manager training?

Here is a non-exhaustive list of organizations that provide education on risk management:

o American Society for Healthcare Risk Management (ASHRM) is a membership group of the American Hospital Association representing risk management, patient safety, insurance, law, finance, and other related professions. ASHRM offers an HRM Certificate Program, if you're looking for a structured educational path, and many a la carte educational resources. Web: http://www.ashrm.org.

o **International Association for Healthcare Security & Safety (IAHSS)** is focused more on the physical safety of healthcare environments than on patient safety as it relates to the quality of care. As such, its members are law enforcement and public safety professionals, but the association does provide healthcare safety training options including a certificate of completion program with modules on employee safety, fire safety and Life Safety Code compliance, hazardous materials and waste management, and emergency management. Web: http://iahss.org.

o **Occupational Safety and Health Administration (OSHA)** offers training on a wide array of safety and health topics. Web: https://www.osha.gov/dte/index.html.

o **Institute for Healthcare Improvement (IHI)** is an independent, not-for-profit organization offering a semi-annual weeklong Patient Safety Executive Development Program in Cambridge, MA. Web: http://bit.ly/1oOx5h3 *(Editor's note: AHC Media, publisher of* Same-Day Surgery*, also publishes* Healthcare Risk Management*, which offers continuing education credits. For more information, go to http://bit.ly/MpC6fi.)* ■