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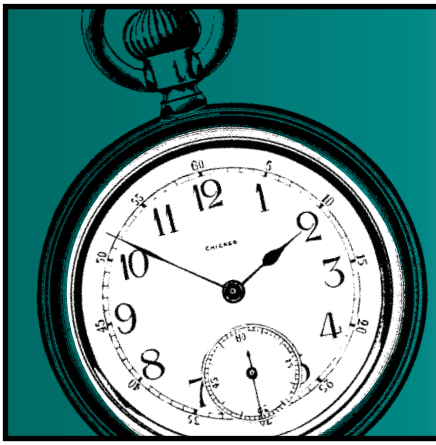

Same-Day Surgery®

Covering Hospitals, Surgery Centers, and Offices for More than 25 Years

THOMSON
AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

JUNE 2003
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Take action now before drugs cause a tragedy at your facility

Recent incidents and study raise tough question: What can you do?

(Editor's note: In this first part of a two-part series on drug-impaired employees, we give you suggestions on how to avoid employee theft of narcotics. In next month's issue, we'll discuss the characteristics of drug-impaired employees and give you resources for helping them.)

A medical student graduates from an anesthesiology training program, gets married, and wins a coveted position with a major medical center. Six months later, he's found dead in a hospital restroom from an overdose of drugs taken from the operating room.[1]

A manager at a surgery center is indicted on charges of tampering with and illegally obtaining Demerol. The indictment charges that the manager, a licensed practical nurse, knew that the drug would be used in surgical procedures, but siphoned the drug from its containers and replaced it with a saline solution.[2] He was caught when a pharmacist noticed that a physician's signature on a Drug Enforcement Administration (DEA) order form

EXECUTIVE SUMMARY

Recent tragedies, an arrest, and a study have brought new attention to drug-impaired surgical staff. Consider these suggestions:

- Perform thorough background checks before hiring, and be alert to unexplained periods of unemployment or erratic job histories.
- Educate yourselves and your staff on chemical dependency. Know signs and symptoms of addiction.
- Track incidents of ineffective patient medication, including pain control medications, sleeping medications, and anxiety prescriptions.
- Consider random drug testing of employees.
- Have strict accounting of narcotics, particularly wastage. Perform spot checks.

didn't appear authentic, according to the center's administrator.

Last summer, an anesthesiology resident drove off a sea wall, built to prevent erosion by the sea, with an intravenous line inserted in his arm and several hospital-grade narcotics in his car. He was put on leave pending the outcome of an inpatient treatment program.[1] Earlier this year, there were two accidental overdoses in Harris County, TX, within two months; one was a 34-year-old RN, and one was a 41-year-old anesthesiologist.[1]

Drug abuse cases involving outpatient surgery providers, particularly anesthesia providers, are not isolated. Experts point to the fact that anesthesia providers often have easy access to drugs. A survey by Duke University in Durham, NC, of 133 U.S. anesthesiology training programs found 1.6% of anesthesiology residents and 1% of anesthesiology faculty members abuse operating room drugs.[3]

"Anesthesia, as far as I know, is the only field in which accidental suicide is one of the hazards of our work," says **Saundra Hudson**, CRNA, peer assistance advisor for the Park Ridge, IL-based American Association of Nurse Anesthetists.

The recent reports of an indictment and fatal overdoses have raised troubling questions in same-day surgery settings across the country. How can managers prevent their employees from stealing drugs? And what can be done to detect and assist impaired employees? Consider these suggestions from experts in the field:

• Watch employees closely.

Managers play a key role in preventing theft of drugs, says **David Horvath**, PhD, RN, CD, clinical services coordinator at National Health Care Associates in Lynbrook, NY, and president of the Blaine, WA-based Consortium of Behavioral Health Nurses and Associates.

One critical step is thorough background checks before hiring and feeling satisfied with answers on interviews for unexplained periods of unemployment, erratic job histories, etc., he says.

Other key steps include adequately supervising employees and maintaining good relationships with workers so they'll tell you if something is wrong, Horvath says.

Keep in mind that addiction can happen to anyone, says **Teri Kersting**, administrator at the Kansas surgery center where the manager was arrested on Demerol charges. "It is usually someone you least expect," she adds.

If convicted, the manager faces a maximum sentence of 10 years in prison, without parole, for tampering with Demerol, and a maximum of four years for each of seven counts of illegally obtaining a controlled substance. He is no longer working for the center. The incident was reported in the media, but no patients called with concerns, Kersting reports. "We were very fortunate the way it all turned out," she says.

• Educate yourselves and your staff on chemical dependency.

Learn as much about chemical dependency as possible, experts advise. **(See *Same-Day Surgery*'s award-winning coverage in the October 2001 issue, p. 109, and November 2001 issue, p. 126.)** Most importantly, understand that chemical dependency is a disease, Horvath says.

Art Zwerling, CRNA, MS, MSN, PA-C, FAAPM,

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program director of the Pennsylvania Hospital School of Nurse Anesthesia in Philadelphia, says, "People need to inservice their staffs about the incidents and regular occurrence of chemical dependability, accept is as an occupational risk that goes along with what they do, and recognize earlier signs and symptoms, so we don't find colleagues dead with syringes in their arms in the call room." Zwerling is coordinator of Anesthetists in Recovery (AIR) and a member of the American Association of Nurse Anesthetists' Peer Assistance Advisors Committee.

• **Track ineffective patient medication.**

There may not be a discrepancy if staff are careful to document appropriately, Horvath warns. In that case, be alert to patients who report situations such as inadequate pain control, sleep problems despite prescriptions, and anxiety even though they have taken prescribed sedatives. "The staff may be giving them placebos or something else," he adds.

One recent disturbing trend is for staff or addicted relatives of patients to steal Duragesic fentanyl transdermal system patches (Janssen Pharmaceutica Products, Titusville, NJ) for time-released pain control off patients' skin and put the patches on themselves, Horvath says.

• **Consider random drug testing.**

Elna Jacks of Knoxville, TN, the mother of the anesthesiologist who died of an overdose, says she can never excuse the choices her son made. "[But] they drug screen in Wal-Mart, from the door greeters to the floor sweepers," she says. "A person who has your life in his hands is not drug tested? What does the medical system need to do so another beautiful person does not die for this reason?"[1]

In the Duke study, 61% of department chairs indicated that they would approve of random urine screens of anesthesia providers.[3]

"I personally believe that all anesthesia providers should be having random [urine drug screenings] given the risks," Zwerling says.

Kersting's facility has not performed random drug testing in the past, she says. "This may be added to our policy and procedures in the future," Kersting says.

But the test is just one piece of information, emphasizes **Connie C. Mele**, MSN, RN, CS, CARN-AP, Mecklenburg County program administrator for substance abuse services in Charlotte, NC. "If employees test positive, they then should be referred to the company's EAP [employee assistance program], or if the company does not have one, to a therapist in town who specializes in alcohol and drug problems for a thorough psychosocial assessment," Mele says.

If the employee is found to have an addiction, then proceed with treatment instead of firing the employee, she advises. "Addiction is an extremely treatable disease," Mele emphasizes.

• **Have strict accounting of narcotics.**

Experts are quick to point out that outpatient surgery providers often have poor accountability of drugs, particularly with the waste of narcotics.

One lesson Kersting passes on to other managers: "Always be aware of staff, and have checks and balances in place for procedures on anything to do with the narcotics logs and counts."

Horvath advises spot checks.

Be on the alert for an amount of drugs requested that is disproportionate to the usual dosage and requests for unusual drugs with vague or bizarre explanations about their use, Zwerling adds.

"Particularly in perioperative services, anesthesia, PACU, and recovery, there should be a strict enforced policy including waste of narcotics — how they are signed out and handled," he says. "There needs to a shift-to-shift count, and there needs to be the ability to check waste by refractometry."

Tighter controls and limited access to narcotics are key, Hudson says. For example, in one surgery center, preoperative nurses were signing out drugs for anesthesia, but anesthesia providers could obtain drugs as well, "so there were drugs everywhere," she says.

Drugs shouldn't be transferred between units, Hudson advises. Also, for facilities that have a pharmacy, send drugs back to the pharmacy to be wasted so that pharmacists can conduct random checks on syringes, she says.

Mele says, "The idea of sending drugs to the pharmacy to be wasted is one method to prevent nurses who have addiction problems from having access to those drugs. The precautionary factor is that there are some pharmacists who also have addiction problems."

Freestanding centers are particularly vulnerable to drug-impaired employees because staff members become so close and trust each other, Hudson warns. "It's not OK, at the start of a case, to put a signature where the narcotics wastage is," she says. "You wait, even if it's your brother."

Mele says, "I believe that the best preventative techniques are random reviews of narcotic sign-out sheets, looking for patterns of high usage and wastage by particular staff, patients who complain

SOURCES AND RESOURCE

HCPro of Marblehead, MA, is offering a 90-minute audioconference titled **Drug Theft in Health Care: Real-World Strategies for Prevention and Regulatory Compliance**, 1 p.m. Eastern time, June 18, 2003. The conference will include coverage of health care-specific regulations, laws, and accreditation standards relating to drug theft, as well as questions and answers. The cost is $234 for one phone line. To subscribe, call (800) 650-6787. The speakers are Donald Bogardus, author of *Drug Diversion in Health Care: A Guide to Identification and Prevention*, and Thomas Taylor, vice president and general counsel for Gundersen Lutheran, a health care network in La Crosse, WI.

For more on addressing addiction, contact:

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of not getting relief from their pain medication, and staff who have changed dramatically in the last several months in appearance, personality, and productivity."

Be watchful, and maintain that watchfulness, Hudson says. "It's not doing anyone any favors to not be vigilant," she says.

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Surprise! The team's here for your JCAHO survey

Unannounced triennial surveys start in 2006

Just as we all count on the seasons changing each year, same-day surgery managers have always been able to count on the triennial crush of work to prepare for the accreditation survey. Intense review of policies, procedures, employee training records, physician re-certifications, and other processes, as well as making sure employees are prepared to answer surveyor questions, have always been a part of preparing for a survey.

Same-day surgery programs accredited by the Joint Commission on Accreditation of Healthcare Organizations will no longer be able to prepare for a specific survey date in the next few years because the Joint Commission will conduct all regular accreditation surveys on an unannounced basis beginning in January 2006.

This move is a logical next step in the Shared Vision-New Pathways accreditation process that begins in January 2004, according to **Stephen C. Anderson**, RN, MBA, consultant for Joint Commission Resources and chief executive officer for Healthcare Information Access in Seattle. **(For more information on the new process, see "JCAHO is turning your world upside down with *you* reporting deficiencies," *Same-Day Surgery,* December 2002, p. 145.)**

"If you are completing the Periodic Performance Review, previously called the self-assessment, then your same-day surgery program should be in a state of continual survey readiness," Anderson says**. (See "On-line tool makes self-assessment easy to access," *SDS Accreditation Update*, supplement to April 2003 *SDS*, p. 1.)**

EXECUTIVE SUMMARY

The Joint Commission on the Accreditation of Healthcare Organizations announced plans to move to all unannounced triennial surveys in 2006 as the next step in the new survey process.

- Hospitals can volunteer to participate in pilot testing in 2004.
- Other organizations can volunteer for participation in the pilot test in 2005.
- Unannounced surveys will demonstrate that an organization is in continual compliance with standards on a day-to-day basis.

Susan Cunningham, MS, ED, administrator for quality at Children's Memorial Hospital in Chicago, says her facility volunteered to participate in the pilot test of unannounced surveys because it gives them the opportunity to show that they are always in compliance with Joint Commission standards. "When you know the date of the survey, the survey is really just a snapshot in time of your organization," she says. "The unannounced survey gives you a chance to show that you truly are meeting the standards on a day-to-day basis."

Pilot testing of unannounced surveys will begin in 2004 with 100 hospitals that have volunteered to participate. In 2005, Joint Commission will continue to conduct unannounced surveys on a limited basis for all types of accredited organizations; subsequently, the transition to all unannounced surveys will take place in 2006.

At this time, the Accreditation Association for Ambulatory Health Care (AAAHC) in Wilmette, IL, does not have plans to move to all unannounced accreditation surveys, says **John Burke**, PhD, executive director of AAAHC. "There are several issues that must be considered when determining whether unannounced surveys make sense for the types of organizations AAAHC accredits," he says. One of these issues is the fact that AAAHC surveyors observe actual procedures, Burke adds. "In the ambulatory environment, surgeries may not be scheduled each and every day," he explains.

Making sure the surveyor is on site on a day during which procedures are scheduled is important to maintain the integrity of the survey process, Burke says.

Whether or not your facility is scheduled to participate in the Joint Commission's pilot testing, or even if you know you won't experience an unannounced survey until 2006, there are some things you should do now to ensure readiness, says Cunningham. Set up an ongoing team to monitor standards and any standards changes that occur, and oversee any development of new policies or practices that the standards will require, she adds.

"We have a Joint Commission guidance team comprised of key leaders in a wide range of departments who are responsible for staying up to date on different chapters in the standards manual," she says. Team members also routinely go on "rounds" throughout the organization to ask to see various items or observe employees to see if departments are compliant with standards on a day-to-day basis, she explains. By continuously reviewing compliance within departments, you can ensure that everyone is ready for an unannounced survey, Cunningham says.

Another tip to ensure readiness is for managers and supervisors to query and quiz staff members on a regular basis, Anderson says.

"We are accustomed to concentrating all our efforts to make sure employees know what to do in case of a fire into a short time frame, but then when a surveyors asks someone the question, the employee panics and freezes," he says. "We've made sure they have the information, but we haven't made sure that they are comfortable being asked the question."

If managers and supervisors always are asking the questions, employees get used to answering them and there is no panic, he adds. "Don't call these questions 'mock surveys,' because we want to move away from the mode of preparing for the test and concentrate on continual readiness," says Anderson. Also, use this process as a way to identify educational needs, he adds. "If a manager asks different questions throughout a two- to three-week period, he or she can identify areas in which employee knowledge is weak, provide education, then move on," Anderson says. ■

SOURCES

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Take steps to prevent spread of SARS cases

If you don't assess patients preoperatively for severe acute respiratory syndrome (SARS), you run the risk of spreading the potentially fatal disease in your facility, infectious disease experts warn. At press time, there were 332 "suspect" and "probable" SARS cases, but there had been no deaths in the United States, according to the Centers for Disease Control and Prevention (CDC). At least one of the cases is a health care worker

EXECUTIVE SUMMARY

If a patient presents with respiratory symptoms, outpatient surgery programs can take steps to prevent the spread of what may be severe acute respiratory syndrome (SARS):

- Isolate potentially affected patients early. Wear N95 masks, gowns, gloves, and eyewear if the patient is coughing.
- Clean and disinfect all areas in which the patient is placed. Minimize the handling of linen.
- When transporting an affected patient, place a surgical mask on the patient and a blanket over his or her arms and hands.
- If health care workers report fever or respiratory symptoms after unprotected exposure to SARS patients, they should report to the person responsible for employee health or infection control and be excluded from duty for 10 days.

who provided care to a reported probable SARS patient, according to the CDC. Worldwide, there were 7,296 cases, including 526 deaths, according to the World Health Organization (WHO).

Notify the surgeon if a patient is positive for SARS symptoms, says **Joan Blanchard**, RN, MSS, CNOR, CIC, perioperative nursing specialist at the Center for Nursing Practice at the Association of periOperative Registered Nurses (AORN) in Denver. SARS symptoms include fever greater than 100.5° F (38° C), as well as chills and rigors; one or more clinical findings of respiratory illness (for example, runny nose, cough, shortness of breath, difficulty breathing, hypoxia, or X-ray findings of pneumonia); myalgia or diarrhea; and travel to southeast Asia, or close contact with someone who has suspected symptoms of SARS. People with SARS have a history of travel to southeast Asia, including Hong Kong, Guangdong Province, China, Vietnam, Thailand, and Singapore. They develop fever and flulike symptoms within 10 days of exposure. Experts theorize that SARS is caused by a novel coronavirus. Consider Blanchard's suggestions for preventing your staff and patients from contracting SARS:[1]

• Follow all transmission-based precautions, including droplet, airborne, and contact. (See "Recommended practices for standard and transmission-based precautions in the perioperative practice setting," in *Standards, Recommended Practices, and Guidelines.* Denver: AORN; 2003.) The typical incubation period for SARS is two to seven days, but it can be one to 12 days, Blanchard says.

• Isolate potentially affected patients early. Patients who have SARS symptoms, traveled to affected areas, or are in close contact with someone who has SARS should be isolated or quarantined, she says. "Even if you suspect it, until you've done an assessment and know for sure, it's best to isolate them," Blanchard says.

Place a surgical mask on the patient immediately, she advises. "Putting a surgical mask on them would stop the droplets," she says.

For facilities that have negative airflow rooms, escort the patient immediately to that area, she says. If your facility doesn't have a negative airflow room, the physician and probably the anesthesiologist should be notified, she suggests. The patient can be moved to a hospital or instructed to see his or her primary care physician, Blanchard advises. "Moving them out of center as quickly as possible is the best option," she says.

When a potential SARS patients is identified, restrict visitors in the perioperative area, she adds.

• When a potential SARS case is identified, perioperative staff members should wear N95 (respiratory protective device) masks, gowns, gloves, and eyewear if the patient is coughing.

Wear a surgical mask if an N95 mask is unavailable, Blanchard adds.

• Clean and disinfect all areas in which the patient is placed.

"Coronavirus 229E, one of the strains isolated from a SARS patient, may survive on a surface for up to three hours," she says.[1] Blanchard suggests you refer to "Recommended practices for environmental cleaning in the surgical practice setting," in *Standards, Recommended Practices, and Guidelines* (Denver: AORN; 2003).

• Minimize the handling of linen, because this step prevents aerosolization of the pathogens.

"One of the things you don't want to do is unnecessarily moving that linen or triaging it," Blanchard says. "You don't want to move that linen from out of that bag."

• When transporting an affected patient, place a surgical mask on the patient and a blanket over his or her arms and hands to prevent contact with surfaces in the environment.

• Practice proper hand hygiene.

SOURCE

For more information on SARS, contact:

- **Joan Blanchard**, RN, MSS, CNOR, CIC, Perioperative Nursing Specialist, Center for Nursing Practice, Association of periOperative Registered Nurses, Denver. E-mail: jblanchard@aorn.org.

Wash your hands with warm water and soap after removing gloves and between patients, Blanchard suggests. "Alcohol preparation may be used if hands are not visibly soiled or there is no sink available," she says.[1]

• If health care workers report to work with fever or respiratory symptoms after any unprotected exposure to SARS patients, they should report to the staff responsible for employee health or infection control and be excluded from duty for 10 days.

For more information on SARS, visit www.who.int or call your local or state public health department, Blanchard suggests. **(See *Same-Day Surgery*, May 2003, p. 49.)**

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Same-Day Surgery Manager

Don't ignore the gorilla in the room: Poor morale

By **Stephen W. Earnhart**, MS
President and CEO
Earnhart & Associates
Dallas

When I bought a boat, I was looking for a retreat, a place to escape from the world's problems. Well, the idea of having a retreat never worked. What did happen was 9/11 and everything that followed through the Iraqi War and this SARS [severe acute respiratory syndrome] mess.

We all are just a little bit off right now. Many outpatient surgery managers give me similar comments: Things are not like they used to be. The fun is gone. I just don't care anymore. We have a morale issue here, ladies and gentlemen. In fact, 20% of respondents to last year's *Same-Day Surgery* Reader Survey said that morale is their most challenging problem, which means morale tied with documentation/paperwork as the second biggest challenge overall. (Recruiting staff ranked No. 1.)

I share many of the same emotions. And yes, things are not like they used to be, but the fun is not gone, and we still do care. It is OK to feel like this — to a point. I had a surgeon yell at me last week. It was a misunderstanding, actually. He thought I was the pathologist. (If he knew I was a consultant, he might have stabbed me!) However, the fact that he yelled at me is not the important thing. The important thing is, I yelled back! I'm not meek by nature, but in my profession, it is not a good idea to yell at anyone — especially someone who pays the bills.

But doesn't it seem as if everyone is just a bit short fused right now? I think it is healthy to admit it and openly discuss it in staff meetings. There is an expression that says, "When you have an 800 pound gorilla in the room with you, you had best not ignore it." Well, we have that gorilla in the operating room right now, and it needs to be addressed. I know that there are many other issues out there right now, such as the HIPAA regulation. (There must be something else my tax dollars can be spent on besides the Health Insurance Portability and Accountability Act of 1996.) But the fact is that morale is much more important in our facilities than we give it credit for. Poor morale leads very quickly into apathy, and apathy leads to carelessness and mistakes.

What can we do about it? Plenty! First, talk about it. Open up a staff meeting with the statement that, "This is not fun for me anymore! Does anyone else feel like that?" I think you will be surprised. Often just getting the issue out in the open and addressing it can be enough.

This might be a great time to repaint the facility or department with a bright color. If that isn't feasible, just paint the lounge. Splurge on things you haven't in the past. Walk around with a pocket full of movie tickets to a comedy showing at the local movie house. Have a joke contest at the next staff meeting and announce that the employee with the best joke will receive $10. Have an "applause meter" or a version of the *Gong Show* to judge the jokes. It is time to lighten up — without taking our eyes off the bottom line.

(Editor's note: Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Contact Earnhart at 5905 Tree Shadow Place, Suite 1200, Dallas, TX 75252. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.) ■

Waiting times are top improvement opportunities

Similar problems in freestanding programs

(Editor's note: This is the second in a two-part series that looks at patient satisfaction scores for freestanding and hospital-based same-day surgery programs. Last month, we looked at overall scores and key issues for all same-day surgery programs. This month, we will look at areas of greatest opportunity for improvement for each type of program.)

EXECUTIVE SUMMARY

An analysis of patient satisfaction data performed by Press Ganey Associates shows that waiting times, privacy, waiting room comfort, employee courtesy, and education are areas in which same-day surgery programs can improve.

- Reduce waiting times by scheduling pre-op visits.
- Make ancillary services personnel part of same-day surgery staff to better monitor staff courtesy.
- Freestanding centers can provide a snack area for waiting family members.
- Designate one nurse to communicate with family throughout the surgical process.

Waiting room comfort, waiting times in various departments, privacy, and staff courtesy are areas in which all same-day surgery programs, freestanding and hospital-based, need to improve, according to an analysis of patient satisfaction data performed exclusively for *Same-Day Surgery* by Press Ganey Associates, a health care satisfaction research and improvement company based in South Bend, IN.

As part of the analysis, Press Ganey also produced a priority index for each of the three categories of same-day surgery programs.

"We look at each question's mean score and the question's correlation with overall satisfaction to produce the priority index," says **Deirdre E. Mylod**, PhD, manager of research and development for Press Ganey. "Questions that appear high on the list would be considered high priorities for improvement because they are both low in score and high in importance to patients." **(See priority index for improvement, below.)**

Concern for privacy only showed up on the priority index for hospital-based programs. "Privacy is a big issue, and we learned a lot after opening our first same-day surgery unit at one hospital," says **Mary Nash**, RN, CNOR, director of the surgical services line at Gwinnett Hospital System in Lawrenceville, GA. "In our same-day surgery department that is attached to the hospital, we have side walls in our recovery area, but always have to make sure that the front curtains are pulled shut and that we talk quietly with the patient."

Because patients don't feel like they are in a private area when curtains are involved, the freestanding center that was built on the campus of another system hospital has small rooms with doors in the recovery area, Nash says. "We also included a private consulting room for physicians to talk with family members before the patient arrives in recovery," she adds.

Waiting times in X-ray, EKG, and registration were areas of improvement identified for all types of same-day surgery programs. The only employee group identified as needing to improve courtesy was X-ray techs.

Wait times always are a concern, admits **Jackie Scott**, RN, CAPA, performance improvement coordinator for surgical services at Gwinnett Hospital

Areas that need improvement to raise patient satisfaction scores

The following areas are the highest priorities, in descending order, for improvement for same-day surgery programs based on analysis of Press Ganey Associates in South Bend, IN, patient satisfaction data performed exclusively for *Same-Day Surgery*. These areas are important because they rank low in actual patient satisfaction scores but are high in importance to patients.

Hospital-based programs:

1. waiting time in X-ray;
2. waiting time in EKG;
3. courtesy of X-ray technician;
4. comfort of family waiting room;
5. staff concern for privacy.

Hospital-owned programs that are off site:

1. décor and cheerfulness of center;
2. comfort of family waiting room;
3. instructions regarding preparation prior to surgery;
4. courtesy of X-ray technician;
5. waiting time in X-ray.

Freestanding, independent programs:

1. waiting time in X-ray;
2. comfort of family waiting room;
3. waiting time in EKG;
4. (tie) comfort of main waiting room;
4. (tie) waiting time for registration.

System. Her same-day surgery programs have reduced wait times by scheduling pre-op visits several days to two weeks prior to scheduled surgery and by adding staff to handle pre-op testing.

"In addition to reducing waiting times, we've found that we don't get complaints about staff courtesy when the employee is a part of the same-day surgery staff," Scott says. When an ancillary employees are a true "part of the same-day surgery team," they view same-day surgery patients as their patients and are more committed to making sure they have a good experience, she adds. **(For more information about addressing wait times and employee courtesy, see story, below right.)**

Instructions about preparation prior to the surgery is an area in which hospital-owned freestanding centers can improve, according the Press Ganey data.

"We don't hear a lot of complaints about lack of preparation for our patients because we do bring them in for a pre-op visit," says Nash. "We also ask that a family member come with the patient so we can give instructions to both." Nurses also call patients one to two days prior to surgery to make sure they don't have any questions, she adds. The combination of face-to-face and telephone contact along with written instructions means better prepared patients, she explains.

Keeping patients and family members informed throughout the entire process is important, adds Scott. "When the OR circulator goes to get the patient, he or she tells the family member how long the entire surgery should take," she says.

Although the surgeon may have given a timeframe, the surgeon doesn't always take into account the time for preparation or recovery, she says. During surgery, it is the same nurse who calls the waiting room to update the family members on the patient, especially if the procedure is running longer than anticipated, she explains.

The same-day surgery staff at Gwinnett Hospital System go one extra step to make sure patients don't feel as if they are sent home before they are fully prepared for discharge.

"We tell patients why they are clinically ready for discharge and then ask them if they feel ready to go home," says Nash.

Because the surgical experience leaves patients feeling as if they have no control, this is one way to give them some control and make them feel that they are prepared to go home, she explains. Patients rarely choose to stay longer, she adds.

Comfort of waiting rooms showed up on the Press Ganey priority index for all types of same-day surgery programs. The comfort of waiting rooms is always a key area to address for patient satisfaction, says **Vickie Axsom-Brown**, a same-day surgery consultant with Practice Resources in Anderson, SC. Axsom-Brown and Scott suggest that same-day surgery managers look closely at issues such as separate waiting areas for different ages, televisions, snack areas, and current reading material. **(For more tips, see p. 70.)**

The most important step in improving patient satisfaction is to focus on the patient's need, says Scott. While same-day surgery staff members focus on clinical issues to provide good patient care, patients and their family members will not notice the level of training, the type of equipment, or the infection control procedures, she points out.

"I don't care about the amount or variety of the reading material in our waiting rooms, but our patients do, so we make sure we have current magazines that appeal to all types of people," Scott says. ■

SOURCES

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Communication, pre-op visits reduce complaints

"Why am I waiting so long?" It's one comment that staff members always can expect to hear from patients and family members, say experts interviewed by *Same-Day Surgery.*

"Long waits always show up on patient satisfaction surveys as complaints," says **Jackie Scott**, RN, CAPA, performance improvement coordinator for surgical services at Gwinnett Hospital System in Lawrenceville, GA. "We've cut down on our wait times by scheduling same-day surgery patients for pre-op interviews, at which

time we perform any lab work or X-rays that are needed." **(For more information on pre-op visits, see "53% cancellation rate cut to less than 20%," *Same-Day Surgery*, November 2002, p. 138.)**

To make sure they can handle the pre-op interview schedule, additional staff was added to conduct the interviews, draw blood, and perform EKGs within the same-day surgery area, she says.

"Adding the extra staff eliminated the need for patients to go into the main hospital departments for these tests and gives us more control over scheduling," she explains. "We don't routinely order X-rays, so very few of our patients must have them done."

Although not all patients can make it to a pre-op interview prior to their surgery day, 70% to 80% of all same-day surgery patients at the hospital-based and freestanding center at Gwinnett Hospital System do come in for pre-op interview and testing, says **Mary Nash**, RN, CNOR, director of the surgical services line at Gwinnett Hospital System.

Freestanding centers have a special challenge when it comes to addressing wait times for ancillary services, says **Vicki Axsom-Brown**, a same-day surgery consultant with Practice Resources in Anderson, SC. "Most freestanding centers don't have X-ray, lab, or EKG in their building, so patients have to go to another location for pre-procedure tests," she says.

Even if you send patients elsewhere, don't think that you won't have to deal with complaints about these areas, she cautions. A same-day surgery manager can't pass the buck and tell the patient that because diagnostic services are offered elsewhere, there's nothing that can be done to improve service, she says.

A same-day surgery center should address the process of handling patient complaints in its agreement with the ancillary service partner, says Axsom-Brown. "Keep the lines of communication open between yourself and your partners and suggest ways you can expedite the solution to any fixable problem," she says. "For example, if patients complain about long waits, call your partner and ask if there are certain times of the day that are busier for them and offer to schedule your patients at a different time."

The only employee group that shows up in the South Bend, IN-based Press Ganey Associates' priority index as an area for improvement is courtesy of X-ray technicians. "Handle complaints about

Just how old are your waiting room magazines?

Same-day surgery staff members point with pride to their turnover times, numbers of procedures handled during a day, and outstanding clinical outcomes, but patients and their family members notice things such as waiting room reading material, noisy children, and their own hunger.

There are ways to reduce complaints about waiting rooms and improve your patient satisfaction scores, says **Jackie Scott**, RN, CAPA, performance improvement coordinator for surgical services at Gwinnett Hospital System in Lawrenceville, GA. First, make sure you have plenty of current reading material that appeals to a wide range of people, she suggests.

The next thing you can do is to look at your patient population, recommends **Vicki Axsom-Brown**, a same-day surgery consultant with Practice Resources in Anderson, SC. If your center handles all ages of patients, including pediatrics, be sure to remember that older patients don't want to hear loud children or see children running around a waiting room, says Axsom-Brown. One freestanding center at which she worked, Medicus Surgery Center in Anderson, SC, set up separate pediatric and adult waiting areas, she says.

"Although there was a large window on the wall between the two areas, the pediatric waiting area was basically a soundproof playroom filled with toys and activities that were safe for all ages," Axsom-Brown explains. Not only did the adult patients appreciate the quieter waiting room, but parents of the pediatric patients appreciated the diversion the playroom offered their children as they waited, she adds.

Patients at freestanding centers don't have the option of running to the hospital cafeteria for a snack or a drink, so Axsom-Brown suggests setting up a small area with coffee, water, juices, and small snacks such as cookies or crackers. "You don't want a full-size vending area in a small waiting room, but you can provide some drinks and snacks on an honor system," she says.

Just post prices and ask people to pay by putting money in a box or piggy bank on the counter, she suggests. Pay attention to the location and number of televisions in your waiting room as well, suggests **Mary Nash**, RN, CNOR, director of the surgical services line at Gwinnett Hospital System.

"We place televisions in areas with separate seating so people have the option of watching or not watching," she says. If possible, have more than one television so people have a choice of the type of programming they can watch, she adds. ■

employee courtesy the same way you handle complaints about waiting times," Axsom-Brown suggests. Contact the partner or department providing the service and pass along the patient comments, she says. "Also, ask your partner to pass along any comments about your service or employees that your patients may make while at the ancillary service provider," she adds.

Patients may make comments to someone outside your surgery program that they may not feel comfortable making directly to your own employees, she explains. Having the communication about patient complaints go both ways helps both your same-day surgery program and the ancillary service provider, Axsom-Brown adds.

If possible, make the lab, EKG, or X-ray tech a part of your staff to ensure patients see a friendly, courteous person, suggests Nash. Not only do the ancillary staff members receive the same customer service-focused orientation to the department, but they feel more accountable because they are part of the department, she says. "Since we don't routinely order X-rays, we don't have an X-ray tech on staff, but the lab and EKG personnel are a part of the same-day surgery staff," she says.

Nash looks for people with "the right personality" to provide good customer service. "Sometimes, we hire the right personality for the job and teach the skills they need," she says. ■

CE/CME instructions

Physicians and nurses participate in this CE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answers listed in the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. **This concludes the CE/CME semester. For your convenience, all this semester's questions are enclosed in this issue. After completing this activity, you must complete the evaluation form and return it in the reply envelope to receive a certificate of completion.** When your evaluation is received, a certificate will be mailed to you. ■

Gynecare surgical gel removed from market

Gynecare Worldwide, a division of Ethicon of Somerville, NJ, has voluntarily withdrawn Gynecare Intergel Adhesion Prevention Solution from the market and is urging customers to immediately stop using this product. Pain and repeat operations have been reported among women who received it during gynecological operations, according to the Food and Drug Administration (FDA). Three deaths have been reported; however, "the deaths cannot be conclusively tied to the Intergel," according to an FDA spokesperson.

This product is intended to be used in open, conservative gynecological surgery to reduce postsurgical adhesions. But Gynecare has received about 103 complaints worldwide of pain, internal scarring, and repeat surgeries, FDA officials said. They said there were 72 reports from the United States, which the FDA still is evaluating.

Intergel products and samples should be returned to Gynecare. Questions about returning these products can be answered by Gynecare sales representatives or the customer hotline at (800) 551-7683. Further information can be found at www.fda.gov/medwatch/safety/2003/Intergel.pdf. The FDA also is investigating and will update this web page as information becomes available. ■

Free webcast targets wrong-site surgery

The Northern Michigan Operating Room Education Network will offer a free webcast on wrong-site or wrong-body part surgery from 5 p.m. to 7:30 p.m. Eastern time, June 2, 2003.

The webcast will define wrong site surgery and discuss contributing factors, legal implications, and preventive techniques and strategies. The program offers 2.8 contact hours. To register, go to www.nmoreducationnetwork.net. ■

COMING IN FUTURE MONTHS

- New safe practices announced for surgery
- Resource to obtain average costs for procedures
- Product reduces bacteria in wounds
- International Association for Ambulatory Surgery meeting coverage
- Tips from facilities surveyed in last six months

CE/CME objectives

After reading this issue you will be able to:

- Identify why freestanding centers may be vulnerable to drug-impaired employees. (See "*Take action now before drugs cause a tragedy at your facility"* in this issue.)
- List what activity or tool will help you make sure you are ready for an unannounced regular accreditation survey. (See "*Surprise! The team's here for your JCAHO survey.")*
- Identify one step you should take immediately if you suspect a patient has severe acute respiratory syndrome (SARS). (See "*Take steps to prevent spread of SARS cases.")*
- Identify one way that the same-day surgery staff at Gwinnett Hospital System makes sure patients are prepared to go home after surgery. (See *"Waiting times are top improvement opportunities.")*

CE/CME *questions*

If you have any questions about this testing method, please contact customer service at (800) 688-2421 or by e-mail at customerservice@ahcpub.com.

21. Why are freestanding centers particularly vulnerable to drug-impaired employees, according to Saundra Hudson, CRNA, peer assistance advisor for the American Association of Nurse Anesthetists?
    A. because they don't have a pharmacy
    B. because the staff members become so close and trust each other
    C. because they can't afford expensive devices to perform spot checking
    D. because they frequently aren't accredited.

22. Use of what activity or tool will help you make sure you are ready for an unannounced regular accreditation survey by the Joint Commission on the Accreditation of Healthcare Organizations, according to Stephen C. Anderson, RN, MBA, consultant for Joint Commission Resources and chief executive officer for Healthcare Information Access?
    A. accreditation newsletters
    B. the Periodic Performance Review (Joint Commission self-assessment)
    C. networking with other same-day surgery managers
    D. a checklist of policies

23. If you suspect a patient has severe acute respiratory syndrome (SARS), what should you do immediately, according to Joan Blanchard, RN, MSS, CNOR, CIC, perioperative nursing specialist at the Center for Nursing Practice at the Association of periOperative Registered Nurses?
    A. Place a surgical mask on the patient.
    B. Find the surgeon.
    C. Escort the patient out of the facility.
    D. Call the patient's primary care physician.

24. What is one way same-day surgery staff at Gwinnett Hospital System make sure patients are prepared to go home after surgery, according to Mary Nash, RN, CNOR, director of the surgical services line?
    A. Nurses check with family members.
    B. Nurses check with billing to make sure all information is complete.
    C. Nurses ask patients if they feel ready to leave after they are clinically recovered enough for discharge.
    D. Nurses follow specified time frame for recovery of each case.

Answer Key: 21.B; 22.B; 23.A; 24.C