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Are you among those who don't always label containers on a sterile field?

With new patient safety goals, Joint Commission will watch meds closely

The ramifications for not labeling medications on the sterile field can be severe for patients and for providers, due to liability and now, a new National Patient Safety Goal from the Joint Commission on Accreditation of Healthcare Organizations.

Here's just one example: A patient being treated in a hospital-based physician's office sustained severe burns to his genitals when the physician, believing vinegar was in an unlabeled bottle, mistakenly applied TBQ (a cationic germicidal detergent with a pH of 13) to bleach a wart to improve visibility.[1]

Incidents such as this one have gotten the attention of the Joint Commission. The just-announced 2006 patient safety goals require hospitals, ambulatory care facilities, and office-based surgery facilities to label all medications, medication containers (such as syringes, medicine cups, and basins) and other solutions on and off the sterile field in perioperative and other procedural settings. **(For more on the safety goals,**

EXECUTIVE SUMMARY

A 2006 National Patient Safety Goal requires all surgery providers to label all medications, medication containers, and other solutions on and off the sterile field.

- A recent study indicates that less than half of hospitals always label such medications on the sterile field even when just one product or solution is present.
- Provide labels and require staff to label one medication at a time. Solutions also are medications.
- Medications should be confirmed by circulating staff, scrub staff, physicians, and any relief staff. Discard unlabeled medications.
- Walk around your facility, including the endoscopy and pain management areas, to ensure policies are followed. Publicize tragic mix-ups to encourage compliance.

see "Joint Commission's 2006 National Patient Safety Goals address communications and medication safety," *SDS Accreditation Update*, inserted in this issue, p. 1.)

Less than half (41%) of hospitals always label such medications on the sterile field even when just one product or solution is present, according to a recent study conducted by the Institute for Safe Medication Practices (ISMP) in Huntingdon Valley, PA.[1] Eighteen percent do not label medications and solutions on the sterile field at all, and another 42% apply labels inconsistently, ISMP says.

". . . Surprisingly, this rather basic safety measure is not widely implemented in hospitals," the institute says. "This is particularly disturbing because patients undergoing a surgical procedure cannot intervene on their own behalf. They are typically sedated or anesthetized and, thus, feel more vulnerable to errors at this time."

Based on a six-year analysis of all perioperative medication errors by the United States Pharmacopeia (USP) in Rockville, MD, most errors occur in the OR sterile fields, says **Rodney Hicks**, MSN, MPA, ARNP, research coordinator for the Center for the Advancement of Patient Safety (CAPS) at USP.

"We know that absence of labeling occurs when meds are removed from their original containers and introduced into the sterile field," he says. The move involves collaboration between the circulating nurse and the scrub person, Hicks points out. "We have several incidences of [errors] where things were not labeled," he says.

Why is this happening? "I give you the short answer: normalization of deviance in risk," says **Betsy Hugenberg**, BSN, MSA, RN, CIC, senior health care consultant with AIG Consultants, Healthcare Management Division, in Atlanta.

Outpatient surgery managers set up policies, build in safety features, and take extra steps to make sure their staffs are following best practices for patient safety, Hugenberg points out. "But it's human nature for policies to be degraded over time and shortcuts to be taken and policies worked around," she explains. **(See what administrators can do to help ensure safety, p. 77.)**

Health care providers often are given tremendous workloads and are being asked to handle increasingly growing caseloads, while throughput is rushed, Hugenberg adds.

"They want to do a crisp and smart job, and they find workarounds to get it done, but these can fail," she says.

It's the manager's responsibility to set up processes that won't impede patient safety, Hugenberg emphasizes. The Association of periOperative Registered Nurses (AORN) in Denver and ISMP have helpful material, she says. **(See resource box, p. 75, for how to obtain materials.)**

"I think that's one of the key things: Compare and contrast what your facility has against those published items," Hugenberg says. "Amend

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Editorial Questions

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

[policies] if you need to tune up something," she notes.

Consider the following recommendations from ISMP, most of which are mentioned in the AORN's *Guidance Statement: Safe Medication Practices in the Perioperative Practice Settings.*[1]*

• **Provide labels.**

Purchase sterile markers, blank labels, and pre-printed labels prepared by the facility or commercially available that can be opened onto the sterile field during all procedures, ISMP advises. **(For information on commercially available labels, see resource box, at right.)**

Some nurses have improvised by using sterile marking pens and sterile strips of tape to label containers, Hugenberg says. "You can't hold nurses back when they need to improvise," she says.

Prepare surgical packs ahead of time with sterile markers, blank labels, and pre-printed labels for all anticipated medications and solutions for the case, ISMP suggests.

• **Require labels.**

Even if only one medication or solution is involved, require labels on all medications, medication containers (syringes, medicine cups, and basins), or other solutions on and off the sterile field, ISMP advises.

Require labels on all solutions, chemicals, and reagents, including formalin, saline, Lugol's solution, and radio contrast media, that are used in the perioperative settings, the institute says.

Many providers don't think of irrigation fluid as a medication, but it is, says **Sharon Giarrizzo-Wilson**, RN, MS, CNOR, perioperative nursing specialist at the Center for Nursing Practice at AORN. **(See article on confirming labels, p. 76.)**

• **Differentiate look-alike products.**

If drug or solution names are similar, use capital letters on the labels to differentiate them, or highlight/circle the distinguishing information on the label, ISMP advises.

"When possible, purchase skin antiseptic products in prepackaged swabs or sponges to clearly differentiate them from medications or other solutions and eliminate the risk of accidental injection," the institute says.

If you are using multiple solutions, you might have multiple containers of the same size and shape, Hicks warns. Labeling is the only thing to help you differentiate, he adds.

Clear medicine and irrigation can be confused, Giarrizzo-Wilson warns.

• **Label one at a time.**

Individually verify each medication and complete its preparation for administration, delivery to the sterile field, and labeling on the field before another medication is prepared, ISMP advises.

"Verify any medication listed on the physician's preference list with the physician before delivery to the sterile field, labeling, and/or administration," the institute adds.

The advantage of this system is that you don't have several items that you're going to put a label

RESOURCES

At press time, the Association of periOperative Registered Nurses' (AORN's) 2004 Guidance Statement on "Safe Medication Practices in Perioperative Practice Settings" was the most recent one posted on the web site at www.aorn.org/about/positions/pdf/7f-safemeds-2004.pdf.

AORN has other resources for members and nonmembers. To order these resources, contact AORN, 2170 S. Parker Road, Suite 300, Denver, CO 80231-5711. Phone: (800) 755-2676, ext. 1. Web: www.aorn.org. (Under "What's New, click on "Medication Tool Kit.")

- **Safe Medication Administration Toolkit.** Includes videos, a computerized graphic presentation, and a pocket reference that provides calculations conversions. Provides 4.8 contact hours. Hard copies of the kit are being mailed to AORN members who are managers and educators, plus 4,500 CEOs, COOs, and risk managers. AORN members who don't receive a kit (staff nurses) in the mail can download/view the components free on the web site or purchase the hard copy of the kit for $25, including shipping and handling. Nonmembers can purchase for kit for $100, including shipping and handling.
- **Dietary herbal interaction poster.** Free for members on the web site. Nonmembers can purchase for $20, including shipping and handling.

To obtain a copy of a medication safety alert from the Institute for Safe Medication Practices, go to www.ismp.org/MSAarticles/loud.htm.

To obtain pre-printed sterile labels, contact:

- **Health Care Logistics**, P.O. Box 25, Circleville, OH 43113-0025. Phone: (800) 848-1633 or (740) 477-3755. Fax: (800) 447-2923 or (740) 477-2923. E-mail: sales@HealthCareLogistics.com. Web: www.HealthCareLogistics.com. Three hundred pre-printed sterile labels (item 16071) are available for $425 plus shipping and handling.

on "in just a minute," Hugenberg continues.

"Then you get distracted," she adds.

For example, while the circulator is trying to calculate a medication dose, something happens on the sterile field that requires the nurse to stop and attend to a need, Giarrizzo-Wilson says. "The most critical priority obviously will take precedent," she says.

• **Discard unlabeled medications.**

Don't assume that you know what is contained in an unlabeled syringe, cup, or basin, ISMP warns. "Discard any unlabeled solution or medication found in the perioperative area [including the sterile field], and report the event as a hazardous condition," the institute says. "Nothing should leave the hand unless it is labeled."[1]

James A. Yates, MD, surgeon at Plastic Surgery Center in Camp Hill, PA, has a rule that if there is a syringe filled with unidentified fluid on the surgical table, it is thrown out, even if the nurse verbally identifies it.

"One of the main concerns in surgery, especially outpatient surgery, is cost savings," Yates points out. "Many times a nurse says, 'I know what that is, and if you throw it away, you'll lose money.' But if you don't throw it away, you may lose a life."

When changing policies, avoid resistance from your physicians and staff by making it clear that you're changing policies based on best practices from professional groups, Hugenberg says.

"Spin it positively," she advises. "When patient safety is your goal, it's hard to argue."

SOURCES

For more information about labeling medications on the sterile field, contact:

- **Center for Nursing Practice**, AORN, Denver. Phone: (800) 755-2676. E-mail: consult@aorn.org. Web: www.aorn.org.
- **Rodney Hicks**, MSN, MPA, ARNP, Research Coordinator, Center for the Advancement of Patient Safety (CAPS), United States Pharmacopeia, Rockville, MD. E-mail: rh@usp.org.
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- **James A. Yates**, MD, Surgeon, Plastic Surgery Center, 205 Grandview Ave., Suite 401, Camp Hill, PA 17011-1714. Phone: (717) 763-7814. Fax: (717) 763-4918. E-mail: jay5plas@msn.com.

Reference

1. Institute for Safe Medication Practice. Loud wake-up call: Unlabeled containers lead to patient's death. *ISMP Medication Safety Alert!* Dec. 2, 2004. Web site: www.ismp.org/MSAarticles/loud.htm.

Confirm medications as well as their labels

To avoid medication errors, the scrub person and the circulating nurse should concurrently verify all medications and solutions visually and verbally by reading the product name, strength, and dosage from the labels, advises the Institute for Safe Medication Practices (ISMP) in Huntingdon Valley, PA.[1]

If there is no scrub person, the circulating nurse should verify the medication/solution with the person performing the procedure, the institute says. Keep all original medication and solution containers in the room for reference until the procedure is concluded, ISMP suggests.

Always reinforce the five Rs of medication safety: the right patient, right medication, right dose, right time, and right route, says **Sharon Giarrizzo-Wilson**, RN, MS, CNOR, perioperative nursing specialist at the Center for Nursing Practice at the Association of periOperative Registered Nurses (AORN) in Denver.

"The scrub persons, once they see the medications, need to label everything: the container it's going into, syringes that will be used to draw for delivery for surgeons, or any other transfer device the scrub person will use to transfer medications to the surgeon," she advises.

Providers may see a manufacturer label on a vial but may not read it, Giarrizzo-Wilson warns. "We need to use active communication and not assume we're getting what we think we're supposed to have," she says.

Surgeons should watch the circulating nurse take the syringe, withdraw the solution, and transfer it to the scrub nurses, says **James A. Yates**, MD, surgeon at the Plastic Surgery Center in Camp Hill, PA.

"My rule, which I instituted years ago, is that I must see the vials," he says. Yates doesn't permit

his staff to throw away the vials after the medications have been distributed to the scrub nurse.

"I say, 'Show me the jars,'" he notes. "Even if they have labeled them, at least I have a second backup."

Be sure to check the label for concentration of medications such as epinephrine, he emphasizes. A concentration of 1:1,000 may mistakenly be drawn up as 1:100. "1:100 can cause severe cardiac problems depending on the quantities used vs. 1:1,000, which only permits vasoconstriction or reduced blood loss," Yates says.

At shift change or relief for breaks, require the entering and exiting staff to concurrently note and verify all medications and their labels on the sterile field, ISMP advises.

As ambulatory surgery programs tackle longer and more difficult cases, they may find that OR staff need to relieved for meals, meetings, or emergency calls. Establish workplace controls "to make sure that the patient is protected," emphasizes Giarrizzo-Wilson.

Reference

1. Institute for Safe Medication Practice. Loud wake-up call: Unlabeled containers lead to patient's death. *ISMP Medication Safety Alert!* Dec. 2, 2004. Web site: www.ismp.org/MSAarticles/loud.htm. ■

How can administrators ensure medication safety?

To ensure medication safety in your program, perform regular safety rounds in perioperative areas to observe labeling procedures, promote consistency, and inquire about barriers to implementing this safety practice, advises the Institute for Safe Medication Practices (ISMP) in Huntingdon Valley, PA.

Administrators should not neglect back rooms such as pain management and endoscopy, advises **Betsy Hugenberg**, BSN, MSA, RN, CIC, senior health care consultant with AIG Consultants, Healthcare Management Division, in Atlanta. "Make sure what you think is going on, is," she stresses.

Insurers have indicated to Hugenberg that sometimes there are nonlabeled medications in the pain management areas. Programs often have prepackaged trays that have wells to be filled with fluids for injections. Managers should ensure medications are monitored and when they're drawn up, they're labeled and not left unattended, Hugenberg says. She knows of two instances in which radiographic contrast was confused with other solutions (a skin prep solution and an injectable anesthetic). In one of those instances, the incorrect medication was injected under the patient's skin, she says.

Tell memorable stories to perioperative staff about tragic mix-ups that have occurred in other facilities when medications and solutions were unlabeled on the sterile field to help motivate practice changes, ISMP advises. A multidisciplinary perioperative safety team that includes nurses, technicians, pharmacists, and physicians also might help to improve consistent labeling, the institute says.

Janice Izlar, certified registered nurse anesthetist at Georgia Institute for Plastic Surgery in Savannah, says, "As a patient advocate, I have posted every article I have read about this potential danger in our facility, and it has been discussed during inservice meetings to heighten awareness of the dangers." ■

Save your program money: Shop at department stores

Center saves thousands on equipment

Many of us thinking about shopping at discount department stores or office supply stores when we want to save money on household items, but one surgery center saved thousands by hitting these same stories to purchase medical equipment.

The Lake Mary (FL) Surgery Center was recognized by the Federated Ambulatory Surgery Association at its most recent conference for a poster that illustrated the cost savings.

When the Lake Mary center opened in 2004, it was small (three ORs, with only two being used), had a large number of specialties, and had a limited budget. And, as it is with all freestanding surgery centers, Lake Mary faced frozen Medicare rates.

"Everything continues to rise except reimbursement," says **Deb Ulmer**, MSN, RN, nurse administrator.

"The hardest thing as a nurse administrator and for my staff is that we have to provide a

service, accommodate the physicians, and provide high-quality care with a limited budget," she notes.

To find ways to save, Ulmer relied on her experience, as well as her staff's, and common sense. "My grandma used to say, 'There's more than one way to skin a cat,'" she says.

Ulmer says the price markup is phenomenal whenever equipment or supplies are labeled as "medical." And much of the equipment, such as a crash cart, are required by law. "But it doesn't say in the regulation that it has to be bought through a medical magazine," she points out.

Build it yourself

Lake Mary needed an A-frame accessory cart, but the cost was going to be $2,623.50. One of Ulmer's staff said, "I can build this." Ulmer purchased the supplies from Home Depot, and the staff member built it from sight. Total cost, including his supplies and his time, was $61, she says.

Instead of paying $450.50 for a medical suture cart, Ulmer found a supply cart at Corporate Express, an office supply center, for $120. **(For information on the stores Ulmer used, see resource box, above right.)**

The office supply cart comes in various sizes and has four or five shelves and a back, she says. "It's the same cart," Ulmer says.

Instead of paying $743 for an anesthesia chair, Ulmer spent $121 for a chair at an office supply store. Like the anesthesia chair, the less-expensive chair was taller, with a wide back and bottom and no arms.

Before purchasing, be certain that an office supply chair will meet your state regulations, Ulmer advises. In Florida, the chair couldn't be made of a flammable material, such as fabric, and it had to be made of material that could be wiped clean.

For task chairs used outside the patient care area, Ulmer spent $49.50 each at Office Depot instead of $288.68 each for the medical version. These chairs don't have to meet the same state regulations because they're used outside the patient care areas, she points out.

Rather than spend more than $900 for a crash cart alone, Ulmer obtained a metal Sears tool cart for $272, including the oxygen holder, dividers, and bins. The bins, purchased at Wal-Mart, were $1 for 10 instead of $30.10 for two cases. The center purchased tackle box inserts for $6 each at Target and used them as dividers on the crash cart. Otherwise, the price would have been of $30.58 for two cases. The staff person who handled oxygen gave Ulmer an oxygen holder, and she paid a handyman to weld it to the cart, she says.

In her 20 years of experience, Ulmer has used a crash cart only once, and that was to pace a patient. "So why spend the money on that stuff?" she asks. "We tried to take those items that were not having as much use and still provide services you need to take care of patients."

In other cost savings, Ulmer purchased a bedside stand at Target for $30, compared to $308.85 for the medical version. An orthopedics weights set was designed and made by a local welder for $31, compared to $595 for the medical version.

A wire rack for the storage area costs $79 at Sam's Club; in comparison, the medical version ranges from $430 to $500. OR back tables were purchased at Sam's club for $99; a medical version costs $495.

Many of these cost-saving ideas came out of brainstorming sessions with her staff, Ulmer says. "It's much better to bring 10 heads to the table vs. one individual," she says. "If you think you know it all, you're in trouble."

Lake Mary has saved thousands of dollars by thinking out of the box, Ulmer says. "ASCs need to think like this," she advises.

Purchase the generic brand, Ulmer says. "It

SOURCE/RESOURCES

For more information, contact:

- **Deb Ulmer**, MSN, RN, Nurse Administrator, Lake Mary Surgery Center, 460 St. Charles Court, Lake Mary, FL 32746. Phone: (407) 585-0260. Fax: (407) 585-0264. E-mail: debulmer@lakemaryasc.com.

For information on discount supplies, contact:

- **Corporate Express**, One Environmental Way, Broomfield, CO 80021. Phone: (888) 238-6329 or (303) 664-2000. Web: www.cexp.com.
- **Home Depot**, Atlanta. Phone: (800) 553-3199. Web: www.homedepot.com.
- **Office Depot**, Delray Beach, FL. Phone: (800) 463-3768. Web: www.officedepot.com.
- **Sam's Club Member Service**, 608 S.W. Eighth St., Bentonville, AR 72716. Phone: (888) 746-7726. Web: www.samsclub.com.
- **Sears**, Hoffman Estates, IL. Phone: (800) 349-4358. E-mail: order@sears.com. Web: www.sears.com.

works the same, fits the state requirements at *half* the price," she adds.

[Editor's note: Do you have a cost-saving tip to share with your peers? Contact: Joy Daughtery Dickinson, Senior Managing Editor, Same-Day Surgery. *Phone: (229) 551-9195. Fax: (229) 551-0539. E-mail: joy.dickinson@thomson.com.]* ■

By end of year, GAO to complete ASC report

FASA president offers Medicare update

The Centers for Medicare & Medicaid Services (CMS) is required by law to implement a new payment system for ambulatory surgery centers (ASCs) by Jan. 1, 2008.

CMS is directed to consider a report from the General Accounting Office (GAO) on ASC payment. The report was due Jan. 1, 2005, but is expected to be completed toward the end of 2005, said **Kathy Bryant**, executive vice president of the Federated Ambulatory Surgery Association (FASA) at the group's annual meeting.

The survey will compare relative costs of hospital outpatient departments and ASCs and determine whether ambulatory payment classifications (APCs) will work for ASC procedures. About 400 surgery centers will be surveyed, according to Bryant.

GAO will request:

- an income statement;
- a list of procedures performed in the last year;
- the number of procedures by Current Procedural Terminology (CPT) code (not just Medicare).

Additionally, GAO will ask how much the center spent on areas such as entertainment and lobbying, Bryant said.

Many centers are asking if they have to participate in the survey, Bryant said. The GAO says yes.

FASA's lawyer **Ronald L. Wisor** with Arent Fox in Washington, DC, says that the answer appears to be no; but if you don't, the agency could subpoena your existing records.

The Office of Inspector General (OIG) also is studying ASCs more closely by looking at appropriate physician coding, billing services, and enrollment applications, Bryant said.

The OIG contends that in a sampling of claims for three carriers, physicians incorrectly checked where the procedure was performed 70% to 80% of the time. Send a memo to your physicians reminding them to use different site of service codes for procedures performed in the ASC, she suggested.

In terms of billing services, the OIG is examining whether ASCs are getting better reimbursement with those services and, if so, whether that increase is due to better billing practices or fraudulent billing, Bryant said.

ASCs also need to check to see if their Medicare enrollment application is up to date; for example, determine if the address is current, she explained.

According to a CMS spokesperson, centers should check with the Medicare contractor that processes their claims to update or check the enrollment application.

In other news:

- **Overnight care.**

CMS previously sent a letter to state surveyors saying, "An ASC that routinely provides overnight recovery stays, regardless of payment source, may no longer meet the regulatory definition of an ASC and will jeopardize its Medicare certification."

FASA receives two or three calls a week asking the status of this statement, Bryant said. The interpretation is in effect, she said, but CMS has said a clarification is forthcoming.

- **Update ASC conditions of coverage.**

The ASC conditions of participation have changed little since they were implemented in the mid-1980s, Bryant reported. CMS intends to issue a proposed rule late in 2005 to update the conditions of participation, she said.

- **Performing non-ASC list procedures.**

In a previous letter on overnight care to state surveyors, CMS said surveyors should verify that "Medicare patients are scheduled only for procedures on the CMS-approved list."

The interpretation is in effect, but CMS has told FASA that a clarification is forthcoming, Bryant said. **(For more information, see, "Should ASCs be cited for non-list procedures?"** ***Same-Day Surgery,*** **July 2004, p. 81.)**

- **New technology intraocular lenses (IOLs).**

ASCs were paid an extra $50 for IOLs designated as "new technology IOLs" by CMS. The designation was good for five years. CMS recently declined to expand the ASC list to include more IOLs.

The new technology IOL designation for those previously given that label expired May 18, 2005, and the payment reverted to $150, Bryant said.

• **CPT 66711, Ciliary body destruction, cyclophotocoagulation, endoscopic.**

CPT 66711 inadvertently was not added to the ASC list. The code is being paid retroactive to Jan. 1, 2005, Bryant said. Centers that have not been automatically retroactively paid by their Medicare carrier can resubmit claims for cases done after Jan. 1 for payment. ■

Purchase of presbyopia-correcting IOL clarified

Medicare beneficiaries can purchase presbyopia-correcting intraocular lenses (IOLs), under a new ruling from the Centers for Medicare & Medicaid Services (CMS).

Previously, outpatient surgery providers generally have not offered beneficiaries presbyopia-correcting IOLs because the costs substantially exceed Medicare's payment.

The ruling clarifies that a beneficiary may request insertion of a presbyopia-correcting IOL in place of a conventional IOL following cataract surgery.

In this case, the presbyopia-correcting IOL device and associated services for fitting one lens are considered partially covered by Medicare.

The beneficiary is responsible for payment of that part of the charge for the presbyopia-correcting IOL and associated services that exceed the charge for insertion of a conventional IOL following cataract surgery.

For more information, go to the CMS web site at www.cms.hhs.gov/rulings and click on "CMS Ruling 05-01." ■

RESOURCES

For more information, contact:

- **Eyeonics**, 6 Journey, Suite 125, Aliso Viejo, CA 92656. Phone: (949) 916-9352. Fax: (949) 916-9359. E-mail: Contact@eyeonics.com. Web: www.eyeonics.com. The crystalens costs $825.
- **Alcon**, 6201 South Freeway, Fort Worth, TX 76134. Phone: (800) 862 5266. E-mail: web master@alconlabs.com. Web: alconinc.com. AcrySof ReStor costs $895.
- **Advanced Medical Optics**, 1700 E. St. Andrew Place, Santa Ana, CA 92705. Phone: (714) 247-8200. Fax: (714) 247-8672. Web: www.amo-inc.com. ReZoom is $895.

Same-Day Surgery Manager

What doctors are saying and why they are leaving

Hospitals have been slow to respond to surgeons

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

Like the rest of the operating room world, I began my career in the not-for-profit hospital environment. I was around in the early days of surgery centers; and for a number of reasons, I made the switch to the for-profit world of surgery centers. I have learned much.

In my role now, I have had the opportunity to visit with many of the movers and shakers in this industry. Some are quite colorful and included some prima donna staff, some self-serving directors and management, dedicated nurses and techs, Generation X newbies (they're fun to work with, aren't they?), highly motivated administrators, and about 5,200 surgeons.

When we are putting together a new surgery center, we need to get a feel for what the local surgeons are looking for in the new entity, hence, the surgeon interviews. You should hear what they have to say about the hospital they are considering leaving for their own surgery center.

I will be as polite as I can, but some of this stuff you cannot sugarcoat (or should). We, the hospitals, have a perception problem with our surgical staff. About 90% of Earnhart clients are hospital/physician joint ventures, so I do consider myself to be an authority on this matter and thus able to address the issues forthright.

The outpatient surgery industry exists because hospital operating rooms have missed their target market: the surgeon. We are all tired of hearing that, but it just doesn't seem like it is sinking in.

Even in the past few weeks, we have interviewed another 38 surgeons, and their biggest complaint (again and again) is the (seemingly) lack of respect they receive from the hospital.

It ranges from the administrative "top-down bureaucracy" to slow turnover of rooms, inattentive staff members, "clock-watching" personnel, and just plain "it-is-only-a-job" attitude.

We (the hospitals) have a perception problem that just will not go away with our surgeons. It is broad-based and cuts across all generations of surgeons. The younger ones want more time efficiency and the older, close to retirement, surgeons want to be free of the hassles of fighting for time, space, and equipment.

I really have thought about a solution to the situation and have only come up with one.

The surgeons generally are tolerant about the restrains on inpatient and overnight stay patients, but they are incensed that their outpatient cases get caught up in the quagmire of the overnight, nonelective foray. Probably the greatest reason for this tolerance for the inpatients is the fact that they really do not have other options for this class of patients — yet! They do, however, draw the line with outpatient cases. Why? They have a multitude of other options. There seemingly are surgery centers on every street corner and cash available to build their own if they wish. Why do we continue to hold the door open for them by ignoring their wishes?

Why most hospitals continue to integrate inpatient and outpatient cases surprises me. Most hospitals have options available to segregate these two class of patients (yes, they are different classes), but that old mentality just keeps on hanging on. By ignoring their needs, hospitals eventually will lose these surgeons.

So what options are available? Most hospitals are expanding their operating rooms as surgery is up just about everywhere in the country. If you are looking at new construction, start planning to split inpatient vs. outpatient cases. These patients' needs are different, and the pressure on the surgeons to perform these cases promptly is an issue.

The people having outpatient surgery are expecting to be treated differently. They know what is going on in the industry, and they are tired of working around the needs of the hospital. You need to learn to work around their needs by dedicating staff that are outgoing, customer service-oriented, time-efficient, and attentive to the needs of the surgeons who brought the patients to you to begin with.

While you can share much of the physical OR environment with both classes, you never should share or mix staffing as the two need to be separate in form and function. The outpatient staff have to quickly establish a positive encounter with the patient (and family) and be attuned to getting the case started on time, having a quick turnover, and impressing the surgeons that this is where they need to be. Rarely can one team of staff handle the needs of these radically different customers.

Also, where is the waiting room for these outpatient cases? Few hospitals ever anticipated 70% of their surgery patients coming through the doors the morning of surgery and never planned on having a place for them to wait. Speaking of waiting, shame on you if you require an 11 a.m. outpatient case to be at the hospital by 7 a.m. If you can't adjust the registration process and patient flow to accommodate these patients, they shouldn't be in your facility.

There are ways you can make it happen. Ask your surgeons who are doing cases in a free-standing center what your hospital can do to emulate what that center does. It is not as difficult to change that mentality as you think.

(Editor's note: Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management.) ■

AAASC creates new state advocacy program

The American Association of Ambulatory Surgery Centers (AAASC) has announced a new state advocacy program in collaboration with state associations, corporate ambulatory surgery centers (ASCs), and allied national organizations.

The program will assist surgery centers in states considering measures such as restrictions on physician ownership, provider taxes, and onerous certificate-of-need and licensure requirements. "First and foremost, we want the ASC industry to be well known and well regarded and protected at the state level," says **Craig Jeffries**, Esq., executive director of AAASC.

The program will have an operational plan for grass-roots relationship building between the state ASC association (and its members) with the state elected officials, Jeffries says. "Second, we will identify legislation that would help ASCs and also reinforce the value of ASCs," he says.

This program allows AAASC and state associations to develop a positive, proactive state agenda,

rather than responding to anti-ASC measures, Jeffries says.

"What we're trying to do is create an infrastructure that supports the state association lead and allows us to intervene and help," he says. The new program will be led by Adam Dickson, state advocacy manager for AAASC. ■

[Editor's note: This column addresses specific questions related to implementation of the Health Insurance Portability and Accountability Act (HIPAA). If you have questions, please send them to Sheryl Jackson, Same-Day Surgery, *Thomson American Health Consultants, P.O. Box 740056, Atlanta, GA 30374. Fax: (404) 262-5447. E-mail: sherylsjackson@bellsouth.net.)*

Question: Do policies related to HIPAA compliance have to be kept in a separate policy book?

Answer: No, the HIPAA policies do not need to be in a separate book, says **Robert W. Markette Jr.**, an Indianapolis attorney. The HIPAA documentation standards simply require the provider to document the policies and procedures in written or electronic form, he says.

"If a provider wants to make the HIPAA policies and procedures part of a larger policy manual, that is acceptable," Markette explains. As with the rest of the procedures, it is a good idea to have the manual thoroughly indexed and cross-referenced, he says.

The security rule does require the covered entity to make the security documentation available to those who are responsible for implementing the procedures in it, Markette points out.

Whether you have these policies in a larger manual or a HIPAA-specific manual, providers should be fine as long as they are easily accessible, he says.

Question: What physical safeguards are necessary to comply with the HIPAA security rule?

Answer: As with the rest of the security rule, physical safeguards need to be complex enough to reduce "reasonably anticipated risks" to a "reasonable and appropriate" level, Markette says.

For surgery centers, facility security is a large concern, he adds. Locked doors to rooms with computers that can give access to electronic protected health information (PHI) are essential for times that the surgery center is closed, he says. Physical safeguards also must be taken during normal business hours, Markette says.

"The surgery center manager may determine that a formal access control policy is needed in order to keep track of individuals in the building," he says. A simple policy would include signing in and having guests wear badges, Markette suggests.

If a surgery center has a small number of staff on the surgery center's computers, and these staff members and their computers are not visible or easily accessible from areas where patients and their visitors are located, the center might rely on an even more informal policy where guests sign in and are allowed to proceed to the appropriate room unescorted, he says.

"This less formal policy approach relies upon staff recognizing when nonemployees were in areas they shouldn't be and taking time to escort them out of unauthorized areas," Markette adds.

Question: How can PHI be used in credentialing and peer-review activities without violating any of the HIPAA privacy rules?

Answer: Credentialing and peer review are acceptable uses of PHI, Markette explains.

"Because a same-day surgery program is required to have minutes and records of the credentialing and peer-review process and PHI is part of the process, the inclusion of PHI in the minutes or records is allowed," he says. "The key to HIPAA compliance in this case is to secure the minutes and the documentation in a manner that only allows access to those people who need the information."

For example, the individual in charge of credentialing and peer review can be designated as responsible for ensuring the documentation is secured, Markette suggests. Surgery centers might consider removing PHI from the records, but depending upon the requirements of the peer review and credentialing standards, that may render the documentation useless from a compliance standpoint, he points out.

The short answer to this question is that a same-day surgery program should secure the minutes in the same manner that other forms of PHI are secured, Markette says.

"If these minutes are part of a regular board meeting or other meeting, the full minutes could have the peer-review portion removed with a reference that information was removed for HIPAA

purposes," he suggests. This removal will eliminate the concern that some individual who needs to review the rest of the meeting minutes will not also see the PHI contained in the minutes, says Markette. "At the same time, this process also ensures that the peer-review portion is available in order to prove compliance with peer-review and credentialing requirements," he adds. ■

2 free HIPAA resources available on the web

Two resources that address the security rule of the Health Insurance Portability and Accountability Act (HIPAA) are available on the Internet.

The National Institute of Standards and Technology (NIST) has released a special publication that gives examples of how organizations can meet the requirements of the security rule. The paper, "An Introductory Resource Guide for Implementing the Health Insurance Portability and Accountability Act Security Rule," explains some of the key concepts of HIPAA security, including administrative, technical, and physical controls, as well as general administrative and organizational requirements. The NIST paper is available at www.csrc.nist.gov. Enter the special publication number, "800-66," in the search field to go to the document.

The Centers for Medicare & Medicaid Services has published the third white paper in its HIPAA security series. The paper addresses physical safeguards required by HIPAA and can be found at www.cms.hhs.gov/hipaa/hipaa2/education.

Under "Security Educational Material," choose "Security Standards — Physical Safeguards." The objectives of the white paper include:

- to review each physical safeguard and implementation specification listed in the security rule;
- to discuss physical vulnerabilities and provide examples of physical controls that a covered entity could implement;
- to provide sample questions covered entities may want to consider when implementing physical safeguards.

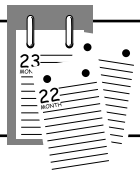
The next paper in the series will cover technical safeguards under the security rule. ■

Federal office addresses HIPAA privacy question

The Office for Civil Rights (OCR) posts answers to frequently asked questions related to the Health Insurance Portability and Accountability Act (HIPAA) privacy rule on its web site: www.hhs.gov/ocr/hipaa. One addition to the frequently asked questions section is a question about sharing protected health information (PHI) with an interpreter. According to OCR, patient authorization is not needed to disclose PHI to an interpreter when:

- The interpreter is part of the provider work force.
- The covered entity engages the services of the interpreter as a business associate.
- The interpreter is a family member, close friend, or other person designated by the patient as the interpreter for a particular health care encounter. ■

CALENDAR



- **July 14-15, 2005**: Joint Commission Accreditation Essentials: Ambulatory Care, Cleveland. Contact: Ohio League for Nursing. Phone: (440) 331-2721. Web: ohioleaguefornursing.org. Click on "OLN News & Events."
- **Sept. 23-24, 2005**: Accreditation Association for Ambulatory Health Care's (AAAHC's) "Achieving Accreditation," Baltimore. Also **Dec. 2-3, 2005**, Las Vegas. Contact AAAHC. Phone: (847) 853-6060. Web: www.aaahc.org.
- **Dec. 2-3, 2005**: AAAHC's "National Quality Forum for Ambulatory Health Care," Las Vegas. Contact AAAHC. Phone: (847) 853-6060. Web: www.aaahciqi.org. ■

COMING IN FUTURE MONTHS

- How to uncover payers' latest plot to pay you less
- Do you have a problem employee? How not to get sued
- How to make sure you make money off new procedures
- Do you use agency care staff? Take steps to reduce liability
- Reducing risk of patient admissions

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. After completing this semester's activity with the December issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. ■

CE/CME objectives

- Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care. (See *Joint Commission's 2006 National Patient Safety Goals address communications and medication safety* and *Competency assessment ranks high in survey* in this issue.)
- Describe how current issues in ambulatory surgery affect clinical and management practices. (See *Are you among those who don't always label containers on a sterile field?* and *HIPAA Q&A.)*
- Incorporate practical solutions to ambulatory surgery issues and concerns into daily practices.

CE/CME *questions*

1. If you only have one medication on the sterile field, should you label it, according to the Institute for Safe Medication Practices?
   A. No
   B. Yes
   C. Only if there is a likelihood of a second medication being introduced into the sterile field
   D. Only if the medication is not a solution

2. What is one physical safeguard that a same-day surgery program can reasonably implement to meet the security rule requirements HIPAA, according to attorney Robert W. Markette Jr.?
   A. Never allow unescorted guests or patients in the facility.
   B. Keep room where computers are located locked when the facility is closed.
   C. Restrict patients and visitors to areas with no computers.
   D. Make sure staff members recognize when a visitor is not authorized in an area and that they are prepared to escort them out of the area.

3. From the *SDS Accreditation Update* supplement: What is the most important component of the 2006 National Patient Safety Goal related to communication between caregivers during the handoff of a patient, according to Michael Kulczycki, executive director of the ambulatory accreditation program for the Joint Commission?
   A. That history and physical reports be on the chart
   B. Confirmation of insurance information
   C. Opportunity to ask and answer questions
   D. Use of forms designed by Joint Commission

4. What surveyor request surprised Jill Andrews, RN, BSN, CNOR, administrator of Central Utah Surgical Center during her most recent survey?
   A. The surveyor did not ask to see competency assessments.
   B. The surveyor focused upon competency assessments for OR staff only.
   C. The surveyor asked to see competency assessments for nonclinical staff.
   D. The surveyor asked to see assessments for contract employees.

CE/CME answers

1. B **2. B** **3. C** **4. C**

SDS ACCREDITATION UPDATE

Covering Compliance with Joint Commission and AAAHC Standards

Joint Commission's 2006 National Patient Safety Goals address communications and medication safety

The two new items added to the 2006 National Patient Safety Goals were ones that received the highest marks in the first-ever field review of proposed patient safety goals for outpatient surgery programs.

"There were a significant number of ambulatory care and office-based surgery programs that commented," says **Michael Kulczycki**, executive director of the ambulatory accreditation program for the Joint Commission on the Accreditation of Healthcare Organizations.

In addition to input from the Sentinel Event Advisory Group, the Joint Commission board looked at comments from accredited organizations, he explains.

"While there were a number of other patient safety goals that might have at first glance seemed more important, comments from our accredited organizations showed that the goals related to label medications and ensuring communication between caregivers as more important to patient safety and implementable for all organizations," Kulczycki adds. **(See list of new 2006 National Patient Safety Goal requirements, p. 2.)**

First addition

The first addition to the goals is a requirement that a standardized approach to handoff communications be developed.

"About 80% of all root causes for all sentinel events reported to Joint Commission are related to communications, so this requirement is an important step for all organizations to address patient safety," he says.

"The most important component of this goal is that the communication include an opportunity to ask and respond to questions," Kulczycki notes.

The verbal communication ensures that the staff member who is transferring the patient to another person's care can be sure that the information needed to provide care is given and understood, he adds.

This communication needs to take place throughout the surgical experience as well as through discharge if the patient is referred to another caregiver, such as a physical therapist, Kulczycki points out.

"Our process begins when we make initial contact with the patient," says **Patti Moore**, RN, CNOR, CASC, director of River View Surgery Center in Lancaster, OH.

Document the handoff

"We have a standard, tri-fold form that is used to collect information from the pre-admission call throughout the entire process," she explains.

"There is always a verbal report when the chart is handed to the next person, but sometimes questions come up later," Moore adds.

As the form is passed from department to department, the person completing each section signs and dates the form.

"If staff members have questions that they don't ask when the chart is first handed over, they know who to call to get the answers," she says.

The same-day surgery staff at Greenville (SC) Hospital System also uses standardized forms

JCAHO 2006 National Patient Safety Goals

The following new requirements apply to both hospital-based, freestanding, and office-based outpatient surgery programs. The new requirement or wording is boldfaced.

Goal: Improve the effectiveness of communication among caregivers.

- **Implement a standardized approach to handoff communications, including an opportunity to ask and respond to questions.**

Goal: Improve the safety of using medications.

- **Label all medications, medication containers (e.g., syringes, medicine cups, basins), or other solutions on and off the sterile field in perioperative and other procedural settings.**

Goal: Accurately and completely reconcile medications across the continuum of care.

- **Implement** a process for obtaining and documenting a complete list of the patient's current medications upon the patient's entry to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.

For a complete list of all National Patient Safety Goals, go to www.jcaho.org and choose "accredited organizations" on the top navigational bar, then choose "ambulatory care," "hospitals," or "office-based surgery." Then on the left navigational bar, choose "National Patient Safety Goals" to go to your specific goals.

and a checklist that ensure the collection of information from patients and explanation of information to patients and subsequent caregivers, says **Colleen J. Trask**, RN, MSN, CNOR, director of perioperative services for the hospital.

Keep all documentation with chart

It's important to make sure that as the patient and the chart are handed off, all of the documentation that is supposed to be collected earlier in the process is in the chart, she says.

To address the problem of incomplete charts making their way into the OR, Trask removed the "no" option on some questions on the pre-op checklist.

"For example, the question that asks if the history and physical is present has a box to check "yes" but no other choices," she explains.

"We found that people would check the "no" box, but then do nothing to get the history and physical," Trask points out.

"By not giving a person a chance to check "no" and pass the chart along, we know that we get complete information down the line," she points out.

Some questions related to blood work or X-ray results have an "ordered" box with a spot for the date ordered, but once again, the staff member must follow up to get the results before the chart can be passed along, Trask explains.

"This ensures that the next nurse has the information he or she needs," she says.

Label all meds

The other new requirement for same-day surgery programs states that any medications, medication containers such as syringes or basins, or other solutions in the operating or procedure room be labeled.

"It is important to note that this requirement addresses medications and containers that are both on and off the sterile field and that are in rooms in which any invasive procedure takes place," Kulczycki notes. "This requirement doesn't apply only to operating rooms."

Because the Joint Commission doesn't prescribe specific methods to meet the goals and requirements, labeling doesn't necessarily mean a peel-and-stick label, Kulczycki notes.

"As long as the medications and containers are clearly and correctly identified, the requirement will be met," he adds.

"We use an old-fashioned marker to write the name of a solution in a basin or a medication directly on the disposable cover of the table," Trask continues.

"If there is more than one container of medication or solution, we do put a label on the syringe or basin," she says.

Another safety step is the announcement of which medication is in the syringe as the surgical tech hands it to the surgeon, Trask explains.

"We performed a performance improvement study to see if we should go with pre-printed labels on the back table or if the nurses should

SOURCES/RESOURCE

For more information about the 2006 National Patient Safety Goals, contact:

- **Michael Kulczycki**, Executive Director, Ambulatory Accreditation Program, Joint Commission on the Accreditation of Healthcare Organizations, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Phone: (630) 792-5290. E-mail: kulczycki @jcaho.org.
- To find frequently asked questions and answers, as well as updates to the goals and requirements, go to www.jcaho.org. Click on "Standards FAQs — Ask a Question," then under "Shortcuts," click on "National Patient Safety Goals."

For examples of how some organizations have met these goals, contact:

- **Patti Moore**, RN, CNOR, CASC, Director, River View Surgery Center, 2401 N. Columbus St., Lancaster, OH 43130. Phone: (740) 681-2700. E-mail: pmoore@mchs.com.
- **Colleen J. Trask**, RN, MSN, CNOR, Director, Perioperative Services, Greenville Hospital System, 701 Grove Road, Greenville, SC 29605. Phone: (864) 455-3224. E-mail: ctrask@ghs.org.

hand write labels," Moore notes.

While she was concerned about the extra time it takes to hand write labels, Moore says her nurses believe it is safer for one nurse to read the orders, check the label on the medication, then write a label for the syringe, she explains.

"Our policy calls for a second nurse or tech to check the medication and label," Moore adds.

A word change in one requirement also is important to note, Kulczycki says.

"Last year, the first requirement for the goal to reconcile medications across the continuum of care stated that organizations must develop a process to document all medications," he says. "The 2006 goals require same-day surgery programs to implement the process."

Two requirements from the 2005 goals were eliminated, Kulczycki continues.

"The requirement to remove concentrated electrolytes from patient care areas and the requirement to ensure free-flow protection of PCA [patient-controlled analgesia] pumps were removed because our accreditation surveys have shown a high level of compliance and a reduction of risk to patient safety," he adds. ■

Competency assessment ranks high in survey

Providers not documenting competence properly

Meeting the Joint Commission on the Accreditation of Health Care Organizations' standard for competency assessment of staff was a problem for 14% of ambulatory care organizations and 15% of office-based surgery organizations surveyed in 2004, according to Joint Commission statistics.

"Assessing the competence of a staff member means that the organization has set up a process to make sure the staff member demonstrates his or her ability to do the job and maintains competence over a period of time," says **Michael E. Alcenius**, MS, PA, associate director in the Standards Interpretation Group of the Joint Commission.

"While many organizations do have some process to assess competency, the process is not always documented properly," he points out. Hospitals were not cited as having compliance problems.

It is important to understand the difference between a performance evaluation and a competency assessment, Alcenius says.

A performance evaluation that is related to pay raises might be a general statement such as "performs clinical duties according to standards set by the organization," he explains.

A competency assessment will include details such as "is able to start IVs" or "clearly explains follow-up care to patients," Alcenius points out.

"Start a competency checklist by looking at the job description and breaking it down into specific skills needed to meet the job responsibilities," he recommends.

There are different components of a competency assessment, but one key element that a surveyor will expect to see is an evaluation of the staff member's ability to perform his or her tasks for specific populations, Alcenius explains.

"If your same-day surgery program serves primarily geriatric or pediatric patients, the employee must demonstrate a knowledge of the different needs of your particular population," he says. "If you serve a wide range of ages, your employees must be able to demonstrate how to care for pediatric patients, adults, and geriatric patients."

For example, a nurse in a pediatric facility should be able to assess pediatric pain when the patient can't communicate it, Alcenius says. "If your facility serves a wide range of ages, your employees should be able to explain how a geriatric patient may be positioned differently from a healthy 40-year-old patient in order to ensure comfort."

New hires almost always have some sort of documentation of a competency assessment unless the same-day surgery program is so small that orientation and training is done on an informal basis, he adds.

If this is the case with your program, Alcenius recommends that mentors or staff members providing one-on-one orientation use a checklist based upon the job description to indicate demonstrated competencies.

"You also need to make sure that competence is assessed periodically and not just when the person is first hired," he notes.

A surveyor will check to see that not only are you assessing competency for specific populations based on age, gender, language, or type of care, but also that your competency checklist relates to the person's job description, Alcenius continues.

The surveyor also will want to see who is responsible for the assessment and what method is used to perform the assessment, such as written test or demonstration, or a combination of different methods, he says.

"You also need to show that you have a process in place to handle situations in which staff members cannot pass the assessment," Alcenius explains. "Your policy must state what corrective action, education, and retesting will occur."

Every outpatient surgery program must show that competency assessments also are performed for contract employees as well, he says.

"Agencies that provide contract employees usually perform the assessments and make the information available to the same-day surgery program," Alcenius says.

"If you regularly use the same employees, you can also perform your own assessment and keep the documentation in your own files," he points out.

At Central Utah Surgical Center in Provo, one of the biggest surprises in their most recent survey was the surveyor's request to see competency assessments for the nonclinical staff, says **Jill Andrews**, RN, BSN, CNOR, administrator.

"We've always had competency assessments for our clinical staff, but I didn't realize that our receptionists and billing office personnel needed them as well," she says.

"We've assigned team leaders to take the nonclinical job descriptions and develop competency checklists that include items such as answering telephones quickly, posting payments properly, and knowing who to contact for information that they may not have," Andrews notes.

Although there is no specific timeframe set for periodic reviews of competencies, many organizations tie the competency assessment to the annual performance review, according to Alcenius.

"Even if you don't conduct the assessment annually, you must conduct it before the next accreditation survey or upon any changes in the employee's job that might require additional or new skills," he says. ■

SOURCES

For more information about competency assessment, contact:

- **Michael E. Alcenius**, MS, PA, Associate Director, Standards Interpretation Group, Joint Commission on the Accreditation of Healthcare Organizations, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Phone: (630) 792-5900.
- **Jill Andrews**, RN, BSN, CNOR, Administrator, Central Utah Surgical Center, 1067 N. 500 West, Provo, UT 84604. Phone: (801) 374-0354.

For more information about competency assessment requirements:

- **Joint Commission on the Accreditation of Healthcare Organizations.** Go to www.jcaho.org, choose "accredited organizations" from top navigational bar, then click on the type of organization (for example, ambulatory or hospital) standards under which you are accredited. Select "FAQs" on left navigational bar. To submit a specific question not answered by the FAQs, choose "Standards Online Question Submission Form" on the right navigational bar or call (630) 792-5900.
- **Accreditation Association for Ambulatory Health Care.** Go to www.aaahc.org and choose "AAAHC Accreditation Program" on top navigational bar to get general information. For specific questions, contact AAAHC at 3201 Old Glenview Road, Suite 300, Wilmette, IL 60091. Phone: (847) 853-6060. E-mail: info@aaahc.org.