Same-Day Surgery®

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

THOMSON™
AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

Financial Disclosure:
Author Sheryl Jackson, Senior Managing Editor Joy Dickinson, Editorial Group Head Glen Harris, Consulting Editor Mark Mayo, and Board Member and Columnist Stephen W. Earnhart report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

JANUARY 2006
VOL. 30, NO. 1 • (pages 1-12)

In light of 2 criminal cases, how do you ensure employees don't abuse patients?

Use background checks to find out about applicant's history

An anesthesiologist is charged with three counts of criminal sexual conduct after two patients say he assaulted them while they were awaiting outpatient surgery.[1]

A surgical tech living illegally in this country is convicted of using a digital camera to secretly take photographs of a partially dressed semiconscious patient who had gone to a hospital for surgery after a miscarriage. The tech pleaded guilty early in 2005 to charges that he videotaped under the skirt of an 11-year-old girl at a clothing store. After that arrest, investigators seized his camera, which contained images of the hospital patient.[2] The victim has filed a civil lawsuit against the hospital.[3]

The issue in such cases is not only whether the employee has committed criminal activity or a civil action, but also the potential liability of the hospital, surgery center, or physician's office where they worked,

EXECUTIVE SUMMARY

An anesthesiologist recently was charged with criminal sexual conduct involving two patients waiting outpatient surgery. A surgical tech was convicted of using a digital camera to secretly take photos of a partially dressed semiconscious patient who had gone to a hospital for surgery after a miscarriage. To avoid such problems:

- You can perform background checks for job applicants including criminal checks, checks with the state medical board for physicians, credit checks for those positions that involve handling money, and a check of The National Practitioner Data Bank for professionals.
- Obtain references from previous employers, and ensure that all time periods in an applicant's employment history are accounted for.
- Ensure applicants are who they claim to be. Fingerprints are accurate, but costly to process.
- Don't single out individuals, and follow your state laws.

says **Stephen Trosty**, JD, MHA, CPHRM, director of risk management and continuing medical education at American Physicians Assurance Corp. in East Lansing, MI.

"If they can't show they have done an adequate background check, there's a good chance they could be held liable for these," he says.

On the downside, background checks are expensive and identify only criminal records, says **Waldene K. Drake**, RN, MBA, vice president of risk management at Cooperative of American Physicians-Mutual Protection Trust (CAP-MPT) in Los Angeles.

Several years ago, Florida enacted a law to deter employee abuse of patients by adding a requirement for licensed hospitals and surgery centers. The law forbids, except when emergency circumstances require otherwise, that a staff member be with a patient in the recovery room unless the staff member is authorized to do so and is in the company of at least one other person. However, a facility is exempt from the two-person requirement if it has live visual observation, electronic observation, or any other reasonable measure taken to ensure patient protection and privacy.[4]

A background check is another way to deter employee abuse, say experts interviewed by *Same-Day Surgery*. Before you start conducting these, have relevant policies and procedures in place, Trosty advises. "For example, if you will look at conviction records, you should have a specific policy outlining what you will do relative to the nature and seriousness of any offenses/convictions — e.g., misdemeanor vs. felony, nonviolent vs. violent misdemeanor," he says. "Also, you need to decide if you will look at all offenses/convictions or only those that occurred within a set time limit — e.g., within the last five years or last 10 years."

Avoid charges of discrimination in conducting criminal background checks by doing them for all applicants or by doing them for all applicants for jobs where they may be left alone with patients for extended periods of time, he says. You may want to consider these background checks for those working with pediatric or geriatric patients who may be unattended, Trosty says.

If you examine arrest records in addition to convictions, you probably should weigh only arrests that are related to employment, to the job responsibilities, and to a person's honesty and ethical behavior as it relates to the proposed responsibilities and patient interaction, Trosty says. "It's important to know your state's laws regarding this and adhere to them," he emphasizes. Keep in mind that some states require criminal background checks and may list crimes that would exclude hiring, sources say.

What else should you look for?

In many states, the state medical board's web site will list any paid malpractice claims or medical board actions against physicians, Drake says. "Sexual issues may be seen there if there has been an action taken," she says.

Same-Day Surgery® (ISSN 0190-5066) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Same-Day Surgery®**, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (ahc.customerservice@thomson.com). Hours of operation: 8:30 a.m. to 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $495. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $83 each. (GST registration number R128870672.)

Thomson American Health Consultants (AHC) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Thomson American Health Consultants is an approved provider by the California Board of Registered Nursing (provider #CEP10864). This activity is approved for 20 nursing contact hours.

Thomson American Health Consultants is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Thomson American Health Consultants designates this educational activity for a maximum of 20 Category 1 credits toward the AMA Physician's Recognition Award. Each physician should claim only those credits that he/she actually spent in the activity.

It is in effect for 24 months from the date of the publication.

This CME activity is intended for outpatient surgeons, surgery center managers, and other clinicians.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

This publication does not receive commercial support.

Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Glen Harris**, (404) 262-5461, (glenharris@thomson.com).
Senior Managing Editor: **Joy Daughtery Dickinson**, (229) 551-9195, (joy.dickinson@thomson.com).
Senior Production Editor: **Nancy McCreary**.

THOMSON
AMERICAN HEALTH CONSULTANTS

Editorial Questions

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

For professionals who require license or certification, check with the appropriate entity to ensure there have been no actions taken against them, such as loss of license or certification, Trosty advises. The National Practitioner Data Bank (www.npdb-hipdb. com) also provides information on licensure, clinical privileges, professional society membership, and exclusions from Medicare and Medicaid.

At HealthSouth Aurora (CO) Surgery Center, "Though our credentialing process, all the physicians, all their backgrounds are checked closely through the databank," says **Rosalie Bodenhamer**, MA/MSN, administrator.

At Harmony Ambulatory Surgery Center in Fort Collins, CO, a background check includes a criminal check, a check with the Department of Health and Human Services for Medicare/Medicaid fraud and abuse, a Social Security number verification, and an education/degree verification, depending on the position that the applicant is applying for, says **Rebecca R. Craig**, RN, CNOR, CASC, administrator.

Should you ask for references?

Ensure whoever handles the hiring is obtaining references, Trosty says. Ask employees to sign a permission form that allows you to contact their former employers, he suggests. Subsequently, you can find out if applicants have even been suspended from a job or terminated, he says.

"Hopefully you have a requirement that for anyone hired, you have a minimum of two to three references from places they actually worked and from individuals they actually worked for," he says. "That means you're getting, as best as you can, the most accurate and up-to-date information from institutions or surgery centers where they most recently worked."

On the downside, unless the employee has a criminal record, most employers will not share anything negative, Drake warns. "This is usually in fear of litigation from the employee," she says.

To address this problem, request a copy of the job applicant's last one or two performance reviews/evaluations as part of hiring process, Trosty advises. If an applicant was discharged from the armed forces, also request a copy of Form DD-214, he suggests. "This form verifies discharge status and also may include information about a person's performance, any disciplinary action, and/or any psychiatric testing."

In terms of an applicant's employment history, ensure all time periods are accounted for, Trosty advises. While some applicants may have legitimate reasons, such as being pregnant or staying home to raise children, you want to know if applicants took time off because of legal problems or substance abuse problems, he says.

Consider verifying applicant's identity to be certain the person is who they claim to be, Trosty advises. Fingerprints are probably the most accurate means of verification but can be costly to process, involve cooperation of law enforcement, you must be certain that your state permits obtaining them, and you need to obtain them for all employees or all classes of employees, he says. "Do not use selectively," Trosty emphasizes.

Have a process, as well as written policies and procedures, of what checks should be done prior to making a job offer, he says. "Ideally, a job offer should not be made until all verification is completed and a background check has been done."

If a manager thinks he or she has to make an offer before this process is completed, it definitely should be contingent on a successful and positive completion of the process, he says. "This should be clearly set forth in a written letter to the applicant so that there is no misunderstanding or miscommunication regarding this issue."

All of these steps could help you if you end up in court, where traditionally, plaintiff's lawyers tried to make employers 100% responsible for everything their employees did, Trosty says. "Now courts, realistically, can't expect that, but they can expect an adequate and comprehensive background check would have been done, both in terms of clinical skills and abilities, education, licensing, but also in terms of character and personality," he says. For example, outpatient surgery managers can show that they have verified certification and licensing, talked to former employers, and discussed unexplained breaks in employment, Trosty says.

Additionally, you need to have appropriate

SOURCE

For more information on avoiding patient abuse by employees, contact:

- **Stephen Trosty**, JD, MHA, CPHRM, Director, Risk Management and Continuing Medical Education, American Physicians Assurance Corp., East Lansing, MI. Phone: (800) 748-0465, ext. 6808. Fax: (517) 332-0262. E-mail: strosty@apassurance.com.

policies and procedures included in your orientation and revisited on a regular basis as part of inservicing, he says. **(See additional tips, below.)**

"If you have that all in place, you can argue you've done everything humanly possible," Trosty says.

References

1. Detroit Free Press. In Court: Anesthesiologist accused of assaulting patients. Web: www.freep.com/apps/pbcs.dll/article?AID=/20051121/NEWS05/511210329/1001/NEWS.
2. Bird B. Aide deported after secretly taking photos of female patient. *Chicago Sun-Times.* Nov. 19, 2005. Web: www.suntimes.com/output/news/cst-nws-edward19.html.
3. Rozek D. *Chicago Sun-Times.* Hospital staffer admits taking pictures of undressed patient. Sept. 27, 2005. Web: www.suntimes.com/output/news/cst-nws-hosp27.html.
4. The 2005 Florida Statutes. Title XXIX Public Health. Chapter 395 Hospital Licensing and Regulation. Web: www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=CH0395/SEC0197.HTM&Title=->2005->CH0395->Section%200197#0395.0197. ■

Take these steps to cut liability risk

When staff act suspicious, take action

When an employee is reported to be acting suspiciously around partially clothed and/or semi-conscious patients, investigate and interview the patient and/or the employee reporting the suspicious actions, as well as the employee accused, experts suggest.

"Once you're put on notice, you can't ignore it," says **Stephen Trosty**, JD, MHA, CPHRM, director of risk management and continuing medical education at American Physicians Assurance Corp. in East Lansing, MI.

At HealthSouth Aurora (CO) Surgery Center, "We want to have a safe environment," says **Rosalie Bodenhamer**, MA/MSN, administrator. "If there are any reported problems, such as harassment or any inappropriate behavior, we follow through and correct it immediately."

Waldene K. Drake, RN, MBA, vice president of risk management at Cooperative of American Physicians-Mutual Protection Trust (CAP-MPT) in Los Angeles, says, "If serious enough, I would get the facility's attorney involved to guide me." Interviewing the suspicious employee with the attorney may make the counseling session nondiscoverable, she adds.

If possible, determine if other employees have noticed inappropriate activity either at the time reported or in prior incidents, Trosty says. However, it is important to keep the employee's name confidential, he says. If a patient is reported to have been involved, you may want to ask the patient whether he/she is concerned or whether anything inappropriate may have happened.

Depending upon the amount of verifying evidence you obtain, you may need to temporarily suspend an employee or move them into a position where they don't have ready access to patients or where another employee is always in the room with them, he says.

However, there my be legal implications to removing the employee from duty if there is not sufficient evidence and it is a "she said/he said"-type of situation, Drake warns. "With the attorney's guidance, I may even put a write-up about the incident in the employee's file so I could prove that action/investigation was initiated should a further incident take place," she says. "It would provide a defense as well as grounds for disciplinary action or termination, if necessary in the future."

If the allegation proves to be true, you have an obligation to notify a professional's licensing board, Trosty says. If major action is taken, such as an employee's license being suspended or taken away, you are obligated to report that information to The National Practitioner Data Bank (www.npdb-hipdb.com), he emphasizes.

Consider these additional steps to avoid staff abuse of patients:

• Ensure your employees are legal citizens.

To avoid potential liability by employing someone who isn't a legal U.S. citizen, you may want to ask all applicants if they are U.S. citizens, and if they aren't, ask their status, advises Trosty. Avoid an appearance of discriminating against particularly individuals, such as persons of Latin extraction, he warns.

At Harmony Ambulatory Surgery Center in Fort Collins, CO, new employees must fill out an ID9 form for tax purposes their first day and provide appropriate documentation, says **Rebecca R. Craig**, RN, CNOR, CASC, administrator.

• Perform a credit check for business office applicants.

At HealthSouth Aurora (CO) Surgery Center, a credit check is performed for all people seeking positions as business staff or in any other positions that handle money, says **Rosalie Bodenhamer**, MA/MSN, administrator.

"It's amazing that a lot of people do have credit problems," she says.

• Have procedures for employees to report unusual behavior of other staff.

The facility should have policies that make it easy for employees to report unusual or inappropriate behavior of other staff, says Drake. "This may be the facility's only 'early warning,'" she says. "Small facilities, however, may be lax in this area, as it seems too time-intensive."

• Ensure professional employees maintain current licenses.

Ensure your professional employees maintain their current licenses, Drake says. "Don't leave it up to the employees," she warns. "A facility needs a mechanism to check the licensing boards themselves."

Loss of a license may be an early warning of an employee problem, Drake adds.

• Take extra precaution with temporary employees.

At HealthSouth, all applicants for internal temporary positions undergo a criminal background check, just as applicants for full-time positions do, says Bodenhamer.

One of the best defenses for a surgery program is to have a contract with a temporary hiring agency that says that the agency has checked the employee's licensure and references and, perhaps, even performed a background check prior to contracting out that employee to the facility, Drake says. "A background check would be good for temp employees as employees with problems may 'hide out' by working through temp agencies — especially those that are not careful about references/history — rather than at hospitals/facilities with strong [human resources] policies, she says.

Regarding having an agency perform the background check, Trosty says, "Courts and others are saying that you can do that, but there is an obligation to make sure the agency is reputable and is following appropriate procedures."

When an outside agency performs background checks, review your contact to find out what specific information the agency will ask for, what information will result in a more in-depth examination, what sources the agency will use in its review (e.g., licensing boards, prior employers, and/or The National Practitioner Data Bank), and whether the search will include other states in an effort to identify individuals who might move from place to place because of past employment problems, Trosty says. "Make sure you're comfortable it is adequate and sufficient," he says. ■

Boost patient satisfaction: Keep families informed

Liaisons keep everyone up-to-date and informed

(Editor's note: This is the first of a two-part series that looks at improving communications with family members of patients. This month, we look at nurse liaisons that are responsible for updating family members. Next month we will evaluate different technological ways to keep family members updated.)

What staff position can be described as beneficial to your outpatient surgery program by 82% of your surgeons, 93% of your RN circulators, and 99% of your PACU staff, and 100% of your preop staff? And by the way, this same staff person also is described as very beneficial by 88% of your patients.

These are the results of a survey conducted by Lexington Medical Center in West Columbia, SC, two months after implementing a clinical nurse liaison program in the surgery department.

"Many family members express their appreciation for the information provided by the clinical nurse liaison both at the time of surgery and in follow-up surveys," says **Maureen Spangler**, RN, CNOR, director of perioperative services at the hospital. "We've found that a real bond develops between families with lengthy surgeries and the liaison," she adds.

While most outpatient surgeries are not lengthy,

EXECUTIVE SUMMARY

Keeping families informed as their family member undergoes surgery is one way to make everyone's job easier and keep patient satisfaction scores high. Nurse liaisons that are responsible for checking on patients and talking to family members while they wait is one approach.

- Make liaisons' visits to the waiting rooms frequent so that family members don't feel forgotten.
- Hire knowledgeable nurses who can communicate well with people from a wide range of races, socioeconomic levels, and educational backgrounds.
- Give family members information that lets them know how the patient is doing, where patient is in the surgical process, and when they can expect to see the patient.

some orthopedic procedures can last longer than other outpatient procedures, Spangler adds. "Surgeons also appreciate having a RN to be able to communicate with regarding information they wish to be relayed to families."

For example, having the liaison tell the family that the procedure is starting late due to previous procedures running long will keep family members less anxious and they won't assume the worst when the surgeon takes longer than expected to complete the procedure, she explains.

Kingston General Hospital in Kingston, Ontario, Canada, uses a combination of technology and nurse liaisons to keep families informed, says **Lorraine Osborne**, RN, CPN[C], perioperative clinical educator. "Our electronic board in the waiting room can give general information that shows the patient moving from pre-op to the operating room to recovery, and family members appreciate that information, but the real comfort is hearing from the nurse liaison and being able to ask questions."

While Canadian surgery departments do not have to meet Health Insurance Portability and Accountability Act (HIPAA) privacy requirements, patients are identified only by a combination of letters that the family knows so that the patient's privacy is protected, Osborne explains.

The responsibility for nurse liaison rotates among certain staff members, with Osborne, as department educator, being the default liaison when no one else is available. "We have several nurses who handle the responsibility for two days to one week at a time," she says. "They keep family members for outpatient and inpatient surgical patients up to date on where their family member is and what is happening."

At Lexington Medical Center, there are two RNs handling the position, says Spangler. One works each day for a 12-hour shift, she says. "One RN works 36 hours a week and the other works 24 hours a week, and they each cover for the other when one wants time off," she explains.

The surgeries start at 8 a.m., so the nurse liaison starts rounds about 8:45 a.m., explains Osborne. "The liaison goes from area to area and into operating rooms to check on patients and find out where they are and how soon they will move to the next area," she says. "Then the liaison goes to the waiting room and talks with families to let them know how things are progressing," Osborne says.

Rounds and talking with family members continue throughout the day, she says. "We try to go to the waiting room every two hours — more if a family member is especially anxious," Osborne adds.

At Lexington Medical Center, there is no set schedule; instead, the nurse liaison is continuously in contact with surgical staff and family members, says Spangler. "Information is provided at the request of the family or at the start of the visit to prevent issues or alleviate anxiety," she says.

Due to the high volume in their department, there is no set routine for a time the liaison will speak to a family. "It truly is a continuous process as these nurses are very proactive — making sure they can spend as much time as necessary with the families," Spangler says.

The most important thing to remember about a nurse liaison's schedule is that he or she shouldn't disappear for long periods of time, says Osborne. "The frequent visits to the waiting room, even to see other families, lets people know that the liaison is still checking on all patients," she adds.

Be discreet, give general info

Nurse liaisons at Lexington Medical keep a written record of the times the patient enters each area and of the patient's condition, says Spangler. This record enables the liaison to keep track of the patients and give family members information that keeps them from becoming anxious, she adds.

Information at Kingston and Lexington is given in the waiting room but privacy is always kept in mind. "The information is usually given in a discreet manner, directly to the family without other families being able to hear what is said," says Spangler. "If there is a problem with the patient or if the information is very personal or sensitive or needs to confidential, then the conference room is used."

Spangler says the type of information given to family members is general and includes:

— reasons for delays preoperatively;
— condition of patient during surgery;
— response to anesthesia;
— progress of surgery;
— condition of patient in post-op ambulatory care unit (PACU);
— explanation of what the physician told the family;
— explanations of hospital routines;
— post-op instructions and teaching.

Kingston's nurse liaison program started in January 2005 and after some minor adjustments in June, the program is going well and is appreciated by family members and staff, says Osborne.

"Because we perform inpatient and outpatient procedures in the same department, we found that

SOURCES

For more information about nurse liaisons, contact:

- **Lorraine Osborne**, RN, CPN[C], Perioperative Clinical Educator, Kingston General Hospital, 76 Stuart St., Kingston, Ontario, Canada K7L 2V7. Telephone: (613) 549-6666, ext. 4396. E-mail: osbornel@kgh.kari.net.
- **Maureen Spangler**, RN, CNOR, Director, Perioperative Services, Lexington Medical Center, 2720 Sunset Blvd., West Columbia, SC 29169. Telephone: (803) 791-2363. Fax: (803) 939-4561. E-mail: mdspangler@lexhealth.org.

some of our outpatient family members were getting too many visits at first," she says.

Outpatient procedures usually aren't lengthy, so getting one or two visits from the liaisons was enough, Osborne says. "Now, we adjust the number of times we talk with family members based on their need for information."

Spangler and Osborne use only RNs for the nurse liaison position at this time because they believe that an RN's clinical knowledge is important as the liaison answers questions. "We are evaluating the use of LPNs or OR techs to handle the position with proper training, and in time, we may move that way to address staffing needs," says Osborne. **(For tips on hiring the right person as a nurse liaison, see article, below.)**

Family members often are fearful, and they usually feel powerless, says Osborne. "Sometimes, it helps to have the nurse liaison come to them and explain that it will be a while before the patient is out of the operating room so they should go get some breakfast and take care of themselves."

They don't know what to do, so they feel as though need the staff's permission to leave the waiting room, Osborne says. "With the liaison looking out for them, they know they won't miss any information," she adds. ■

Nurse liaison must communicate well

Translate 'medicalese' into plain talk

Nurse liaisons can quickly become a highly appreciated member of your staff, say experts interviewed by *Same-Day Surgery*.

"The staff in the pre-op area see the nurse liaison's interaction with patients and families as having a calming effect on the patient and family members, especially when there are delays, and [post-anesthesia care unit] nurses are relieved that the family is being taken care of so they can concentrate solely on the patient's needs," explains **Maureen Spangler**, RN, CNOR, director of perioperative services at Lexington Medical Center in West Columbia, SC.

A nurse liaison is only beneficial if the right person is in the position, and not all RNs are right for a nurse liaison position, she warns. Excellent communication skills are essential, she points out. After excellent communication skills and solid perioperative knowledge, the next most important quality the clinical nurse liaison must have is the ability to work with people, including patients, families, nursing staff, volunteers, and physicians," Spangler says. "The nurse liaison must also be able to work under pressure and multitask."

The nurse liaison must be able to explain everything to the family members in everyday terms, says **Lorraine Osborne**, RN, CPN[C], perioperative clinical educator of Kingston General Hospital in Kingston, Ontario, Canada. "The liaison also should be comfortable talking to all types of people and able to deal with people who are very emotional," she adds. Liaisons should also be able to communication with people from a wide range of backgrounds, races, and socioeconomic levels, she adds.

Make sure your liaisons have the resources they need to do their job, suggests Spangler. "Give the liaisons the authority to use service recovery items such as gift baskets, meal tickets, or gift certificates when appropriate," she says. "It is a stressful role, and we have allowed them to identify ideas for service recovery based upon their own experiences."

For example, nurse liaisons were given beepers they can distribute to families if family members want to leave the facility, Osborne says. Another suggestion from the nurse liaisons was a cell phone for each nurse so they would be available at any time in any location, she explains. "They also make their cell phones available for patients or families to use if they need to make phone calls."

Don't forget to offer education to liaisons that is pertinent to their position. "We had the nurses work with guest services for two weeks prior to beginning their role," explains Spangler. In addition to reviewing communications skills, nurses also spent time learning how to identify and handle the

different ways in which people react to stress, she says.

"Some people withdraw and others become aggressive, so it's important for the liaison to recognize these behaviors as stress-induced and talk with them in a manner that relieves the stress without taking their behavior personally," she explains. ■

Adopt a written anti-harassment policy

(Editor's note: In this second part of a two-part series on physician harassment, we discuss having a written anti-harassment policy, and we tell you how to handle repeated offenses. In last month's issue, we discussed steps to avoid liability.)

When you update your policies to address sexual harassment, change them to prohibit *all* forms of unlawful harassment, advises **Brian A. Lapps Jr.**, JD, member at Waller Lansden in Nashville, TN. Lapps, along with **E. Brent Hill**, JD, also a member at Waller Lansden, spoke at the most recent annual meeting of the Federated Ambulatory Surgery Association.

In the policy, explain how to report perceived abuse, Lapps says. The failure to have a policy that is posted and provided to employees it good evidence that the employer is not serious about complying with the law, he says.

Follow that policy and train managers, Lapps says. Although nonemployee doctors probably will not want to attend in-depth training, they should at least be provided a copy of the ASC's policies so that the ASC can credibly argue that it did what it could to prevent discrimination, he and Hill explained at their presentation.[1]

Disseminate policies to doctors, Lapps advises. "If doctors have never been given a policy, it can be used against the center to show that it does not care about the policy," he says.

Make it a part of your credentialing application and reapplication that the physician agrees to comply with the facility's policies and procedures, he says. "If a company can get doctors to agree to follow policies, lawsuits can sometimes be avoided," Lapps says. "Where the doctors choose not to follow a policy, the center can at least prove that it used its best efforts to protect its employees."

Have your position written into your physician bylaws, "so everyone knows up front it won't be tolerated," advises **Anita S. Lambert-Gale**, RN, MES, vice president of clinical operations at HealthMark Partners in Nashville, TN. By doing that, managers always can go back to them and say, "You're violating your own bylaws," she says.

When defending a lawsuit, it is almost worse to have a policy and not to follow it than not to have a policy at all, Lapps says. "Ignoring a policy can be used as proof that the employer does not care about its employees."

The policy should identify more than one person who can receive a complaint, in case the person who is designated to receive complaints is part of the problem, he says. "If there is a corporate compliance hotline available, this is usually a good mechanism for receiving complaints," Lapps says.

Some states, including California, require annual sexual harassment training. "Even where not required by law, the training of managers avoids many problems," he points out.

Reference

1. Lapps BA, Hill EB. *Dealing with the Problem Employee and Physician.* Federated Ambulatory Surgery Association Program Syllabus; 2005. ■

Don't simply ignore repeated offenses

Facilities address inappropriate conduct, harassment

With repeated offenses on physician harassment of staff, consider sending a formal letter saying a physician's behavior is not acceptable, suggests **Anita S. Lambert-Gale**, RN, MES, vice president of clinical operations at Nashville, TN-based HealthMark Partners, which co-owns and manages surgery centers with physicians and hospitals.

At a center managed by HealthMark Partners, when a physician's behavior is referred a second time to a center's medical advisory committee, an investigatory committee is appointed to investigate the claims. They usually meet with the offending physician, remind the physician of the policy for nonretaliatory action, and make a recommendation to the committee. "Usually, if it's gotten this serious, we'll get legal counsel involved," Lambert-Gale says. The committee tells the physicians that if they don't change, they risk losing privileges.

Michael Burnett, BSN, RN, clinical manger of the Adena Health Pavilion Surgery Center in

Chillicothe, OH, previously worked at a facility where a physician made inappropriate sexual comments to a female staff nurse. He says the physician had a reputation for making such comments at that institution and previous ones. "We suspended the physician's privileges for one year and then made him reapply," he says. The physician was able to obtain his privileges back, Burnett says.

As his current health system, two physicians have been released and are not permitted to return due to inappropriate conduct and harassment, including throwing instruments, he says. "It's part of the organization culture, and it's just not tolerated at the facility I'm at now," Burnett says. "We're a shared governance model; nurses have strong input." Also, having a medical director who will not tolerate abuse is a strong deterrent to physician harassment of staff, sources say.

When managers take a strong stand, it pays off with your staff, says **Brian A. Lapps Jr.**, JD, along with **E. Brent Hill**, JD, both members at Waller Lansden in Nashville, TN, spoke at this year's annual meeting of the Federated Ambulatory Surgery Association.

"By being proactive and paying attention to employee-related issues, particularly issues related to unlawful harassment, an [ambulatory surgery center] can provide an attractive workplace to its employees, better retain qualified employees, and avoid expensive litigation," Lapps said.[1]

Reference

1. Lapps BA, Hill EB. *Dealing with the Problem Employee and Physician.* Federated Ambulatory Surgery Association Program Syllabus; 2005. ■

Same-Day Surgery Manager

Boost your staff's morale with these ideas

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

Always eager to please, I have some ideas that might perk up your staff's morale.

Why do most of us not have maids that come in and clean our home? Too expensive, most of us would say. Others may say it is not necessary, but generally we would rather do it ourselves and save that money for other occasions, right?

I fly a lot and usually use Southwest Airlines. Being a frequent traveler, I observe things while in the air. The flight attendants make countless trips up and down the aisles collecting trash. Then, while people like me are getting off the plane, they go through the plane as if they are possessed, straightening the magazines, putting away pillows, folding blankets, and doing a dozen other similar tasks.

It impressed me that these staff members didn't cry out that "turning over the plane" (clue: turning over *the operating room*) was offensive to them. Or that it was below them. The fact was (after interviewing a number of them) that it was part of their job: To assist their employer do a better job of being *on time*.

Further, they added (and tying all of this together for you) that the airline saves money on a cleaning crew and the associates' hassle of dealing with incomplete or spotty cleaning and customer complaints. "You know, it is just easier to do it ourselves" is the common reply I got back. I found out that the savings for Southwest is in the millions of dollars per year — all of which goes back into employee benefits. Why can't we do that in our departments and centers? Many centers already do their own cleaning and save money, but the vast majority do not. Why not get our staff members to clean the facility and put that savings into a fund for parties, cash distributions, or trips?

You may not want to do the sterile areas, as there are fairly complicated cleaning steps and routines and products required there, but as far as the rest of the department of facility — why not?! Those who think this task is below them or not in their job description do not have to participate nor share in the booty. I did some research on this matter and discovered that the average freestanding center can save about $20,000 to $30,000 per year. The average time it would take to clean the average center is about an extra 10 minutes per day per employee. Come on, give it a try. What do you have to lose?

Here is another radical Earnhart idea. When your cases for the day are complete, send your staff home with full pay.

They probably are budgeted to work all day anyway, so you won't be losing money on the

deal, but you will be making all of your surgeons and anesthesia happy that your staff are so efficient. You probably will need to rotate some of the staff for the work they do after cases, but for the most part, you can send them home.

See how fast your surgical schedule really can move. Back in my days of doing anesthesia, I was able to leave when my patient caseload was complete. I hauled butt to help turnover those rooms and get my patients into the OR and then back to PACU. It works. Do a one-month trial. Yes, there are details you would need to work out, but you can make it happen. ■

SOURCE/RESOURCE

For more information on the guidelines, contact:
- **Constance Hill**, MD, Clinical Professor of Anesthesiology, Department of Anesthesiology, State University of New York Downstate, 450 Clarkson Ave., Box 6, Brooklyn, NY 11203. E-mail: chill@downstate.edu.

The guidelines are available on the web at www.asahq.org. Click on "Clinical Information" on the left, then "Practice Parameters" on the right. Practice Guidelines for the Perioperative Management of Patients with Obstructive Sleep Apnea."

What do you need for sleep apnea patients?

New guidelines address outpatient cases

According to new practice guidelines from the American Society of Anesthesiologists, when patients are at increased perioperative risk from obstructive sleep apnea (OSA), the facility should have emergency difficult airway equipment, respiratory care equipment [nebulizers, continuous positive airway pressure (CPAP) equipment, and ventilators], radiology facilities (for portable X-rays), and clinical laboratory facilities (for blood gases and electrolytes).

"Perhaps a patient that would have severe OSA would not be an ideal patient to do in a free-standing center where you don't have those facilities," says **Constance Hill**, MD, clinical professor of anesthesiology at State University of New York (SUNY) Downstate, Brooklyn.

The capabilities of the outpatient facility are just one of nine factors for outpatient surgery programs to consider when deciding whether outpatient surgery should be performed on a patient with OSA, according to the guidelines. The other factors are: sleep apnea status, anatomic and physiologic abnormalities, nature of surgery, type of anesthesia, need for postoperative opioids, patient age, adequacy of post-discharge observation, and status of coexisting diseases, they say. For example, determine if "they have diseases that are impacting on organ systems, particularly cardiovascular pulmonary systems," she advises.

The guidelines contain significant recommendations for the preoperative evaluation of OSA patients, for postoperative management, and for selection of appropriate patient/procedure/anesthesia combinations that are suitable for outpatient care.

"These patients should not be discharged from the recovery area to an unmonitored setting (i.e., home or unmonitored hospital bed) until they are no longer at risk for postoperative respiratory depression," according to the guidelines.[1] "Because of their propensity to develop airway obstruction or central respiratory depression, this may require a longer stay as compared to non-OSA patients undergoing similar procedures." Outpatient surgery staff can document whether their postoperative respiratory function is adequate by observing patients in an unstimulated environment, preferably while they appear to be asleep, to establish that they are able to maintain their baseline oxygen saturation while breathing room air, the guidelines suggest.

In compiling the guidelines, the ASA used a panel of expert consultants to examine which surgical procedures could be performed safely on OSA patients as outpatients. While there was disagreement regarding some procedures, the

COMING IN FUTURE MONTHS

- ■ Changing anesthetics to reduce complications and costs
- ■ What are states telling consumers about care at your facility?
- ■ Another procedure moves outpatient — what you need to know
- ■ Update on national legislation that affects you

Consultant Opinions Regarding Procedures That May Be Performed Safely on Outpatients at Increased Perioperative Risk from Obstructive Sleep Apnea

Type of Surgery/Anesthesia	Consultant Opinion
Superficial Surgery/Local or Regional Anesthesia	Agree
Superficial Surgery/General Anesthesia	Equivocal*
Airway Surgery [Adult, e.g., uvulopalatopharyngoplasty (UPPP)]	Disagree
Tonsillectomy in Children Less than 3 Years Old	Disagree
Tonsillectomy in Children Greater than 3 Years Old	Equivocal*
Minor Orthopedic Surgery/Local or Regional Anesthesia	Agree
Gynecologic Laparoscopy	Equivocal*
Laparoscopic Surgery, Upper Abdomen	Disagree
Lithotripsy	Agree

* Equivocal: Qualitative data are not adequate to permit inference of a relationship between an intervention and an outcome and 1) there is insufficient quantitative information; or 2) aggregated comparative studies have found no significant differences among groups or conditions.

Source: American Society of Anesthesiologists Task Force on Perioperative Management of Patient with Obstructive Sleep Apnea. *Practice Guidelines for the Perioperative Management of Patients with Obstructive Sleep Apnea.* Park Ridge, IL; 2005.

consultants agreed that superficial surgery with local or regional anesthesia, minor orthopedic surgery with local or regional anesthesia, and lithotripsy could be safely performed outpatient on patients with OSA. **(For complete list of procedures, see table, above.)**

While the practice guidelines serve a valuable function, these recommendations are based almost entirely on expert opinion, as there is very little relevant literature, says **David O. Warner**, MD, professor of anesthesiology at the Mayo Clinic College of Medicine in Rochester, MN. "Indeed, the assumption that these patients are at increased risk for perioperative complications is exactly that — an assumption that has not yet been rigorously tested," Warner says.

The few studies are primarily retrospective using clinical information systems, and they are equivocal, he says. For example, Warner points to study he co-authored that was not included in the literature review in the practice guideline but is relevant to the question of whether patients with OSA can be safely managed as outpatients.[2] His study found that the preoperative diagnosis of OSA was not a risk factor for unanticipated hospital admission or for other adverse events among patients undergoing outpatient surgical procedures in a tertiary referral center.

"The question of what factors may preclude outpatient surgery in patients with OSA thus still is very much open, and the practice guideline appropriately does not provide definitive recommendations," Warner says. "Further research studies are urgently needed to determine whether patients with OSA are at increased risk for perioperative complications, and, if so, what characteristics may be predictive of such risk."

References

1. American Society of Anesthesiologists Task Force on Perioperative Management of Patient with Obstructive Sleep Apnea. *Practice Guidelines for the Perioperative Management of Patients with Obstructive Sleep Apnea*. Park Ridge, IL; 2005.
2. Sabers C, Plevak DJ, Schroeder DR, et al. The diagnosis of obstructive sleep apnea as a risk factor for unanticipated admissions in outpatient surgery. *Anesth Analg* 2003; 96:1,328-1,335. ■

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 **June** issue, you must complete the evaluation form provided 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. ■

CMS adds 32 codes, cuts 10 from ASC list

The Centers for Medicare & Medicaid Services (CMS) has changed the Medicare list of procedures approved to be performed in ambulatory surgery centers, according to the Federated Ambulatory Surgery Association.

CMS is adding 32 codes and deleting 10. These changes are based on revisions from the American Medical Association to the 2006 Current Procedure Terminology (CPT) codes. They were effective Jan. 1, 2006.

To view a copy of the transmittal, go to: www.fasa.org/october21cmstransmittal.pdf. ■

CE/CME *questions*

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

1. While she currently only uses RNs for the nurse liaison position, what other personnel is Lorraine Osborne, RN, CPN[C], perioperative clinical educator at Kingston General Hospital, evaluating as potential employees to fill the liaison role?

A. LPNs and OR techs
B. Receptionist and volunteers
C. OR techs and volunteers
D. Lab techs and social workers

2. Why have nurse liaisons found cell phones to be a useful tool in their job, according to Maureen Spangler, RN, CNOR, director of perioperative services at Lexington Medical Center?

A. They can lend their phones to family members who need to make a call.
B. They don't have to stay in or near the waiting rooms.
C. They can be reached easily anyplace in the hospital.
D. A & C

3. Why were Association for the Accreditation of Ambulatory Health Care surveyors happy with the privileging protocol for his facility, according to John M. Powell, chief executive officer of the Orthopedic Surgical Center of the North Shore?

A. The privilege list for all surgeons was comprehensive.
B. Privileges are based upon procedures surgeons can perform at the hospital.
C. Privileges are granted only to board-certified surgeons.
D. Privileges granted were specific to his facility.

4. What are two sentinel events for which organizations cited communications problems as a root cause, according to Richard Croteau, MD, executive director for patient safety initiatives for the Joint Commission on the Accreditation of Healthcare Organizations?

A. Falls and wrong-site surgery
B. Delay in treatment and operative/post-op complication
C. Anesthesia events and fire
D. Suicide and medication error

Answers: 1. A; 2. D; 3. D; 4. B.

SDS ACCREDITATION UPDATE

Covering Compliance with Joint Commission and AAAHC Standards

Delays, postoperative complications rank high in percentage of sentinel events

Joint Commission looks at reasons and recommendations for prevention

Although outpatient surgery managers often focus on avoiding wrong-site surgery, they should be equally concerned about delays in treatment and operative/post-op complications, which together cause sentinel events that are reported more often than wrong-site surgery.

Wrong-site surgery leads the list of sentinel events recorded by the Joint Commission on Accreditation of Health Care Organizations for freestanding ambulatory care organizations since January 2001, with 32.5% of reported events related to wrong-site surgery. However, delay in treatment (19.5% of reported events) and operative/post-op complication (15.6% of reported events) occur frequently enough that outpatient surgery programs should pay close attention, says **Richard Croteau,** MD, executive director for patient safety initiatives for the Joint Commission.

These statistics reflect only the cases reported voluntarily to the Joint Commission, but there are various states that mandate reporting of sentinel events, Croteau points out. Even though the states' programs are mandatory, there is never 100% reporting, he adds. However, state statistics can give an outpatient surgery manager another source of information with which to evaluate their program.

"The Joint Commission is working with a number of states to help develop their reporting systems, and we are working toward a system of sharing information," he says. There are a number of issues related to privacy and comparison of data that will make this effort a long-term project, he adds.

Although more than half of the sentinel events related to delays in treatment were reported to the Joint Commission by emergency departments, outpatient surgery programs did report delays in treatment as causes for sentinel events, says Croteau.

"In a surgery setting, a delay in treatment that would result in a sentinel event is most likely a delay in diagnosing and treating a condition such as a venous thrombosis that creates a complication after surgery," he explains.

Other reasons for delayed treatment include delayed test results (15%), physician availability (13%), delayed administration of ordered care (13%), and patient left unattended (4%). "There were multiple root causes for the delays in treatment, but most organizations [84%] cited a breakdown in communications between physicians and staff as a key root cause," Croteau adds.

Incomplete communications is identified as a root cause of operative/postoperative complications by two-thirds of the organizations who reported sentinel events in this category.

Communication breakdowns are key reasons for sentinel events, he adds. This is one area addressed by the Joint Commission's 2006 National Patient Safety Goal that requires outpatient surgery programs to develop a standard process to ensure communication as a patient moves from one area of care to another, he says.

As more outpatient surgery programs develop handoff communications protocols, the root causes of some of these sentinel events will be addressed, explains Croteau.

A trifold document used by the staff at River View Surgery Center in Lancaster, OH ensures

SOURCES/RESOURCE

For more information about sentinel events, contact:
- **Richard Croteau**, MD, Executive Director, Patient Safety Initiatives, Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Blvd, Oakbrook Terrace, IL 60181. Phone: (630) 792-5776. Fax: (630) 792-5005. E-mail: rcroteau@jcaho.org.
- **Patti Moore**, RN, Director, River View Surgery Center, 2401 N. Columbus St., Lancaster, OH 43130. Phone: (740) 681-2700. E-mail: pmoore @mchs.com.

communication between staff members as the patient moves from one area to another, says **Patti Moore**, RN, director of the center.

"This document is used when the pre-admission nurse makes her first call to the patient to gather information over the phone," she says.

Because the pre-admission call is made 24-72 hours prior to surgery, the nurse is able to pass along any information to the anesthesiologist and pre-op nurse well ahead of the day of surgery so that potential problems, such as an illness or a medication, that might delay surgery can be identified in time to reschedule without disrupting the center's schedule. "In addition to the pre-admission call, we also call patients the day before their surgery to verify the information obtained in the pre-admission call and to go over any pre-op instructions and information such as arrival time," Moore adds.

"This form has sections for each staff member who will care for the patient to complete," says Moore.

'Always a chance to ask questions'

As the patient moves from one area to another, staff members not only give a verbal report of the patient's condition and care, but they also refer to the written notes on the form, she adds. Because each staff member signs and dates notes made in the document, if there are questions for someone other than the staff member directly transferring the patient, nurses know who to contact if the notes are not clear. "There is always a chance to ask questions if someone has them," she explains.

The operative/postoperative category includes a jumble of complications and procedures, but there are several procedures that are routinely performed in an outpatient surgery setting that resulted in complications, says Croteau. The types of procedure and complication involved in the sentinel events include: massive fluid overload from absorption of irrigation fluids during gynecological procedures, endoscopic procedures that resulted in perforation of adjacent organs, and burns from electrocautery.

In addition to breakdown in communications, other reasons cited by organizations filing sentinel events related to operative/post-op complications include incomplete preoperative assessment, deficiencies in credentialing and privileging, inconsistent postoperative monitoring, and failure to question inappropriate orders.

Standardization of orders is one way that River View Surgery Center staff has addressed communication between physicians and staff members. They developed templates for their history and physicals, pre-surgical orders, operative records, discharge forms, and post-op instructions, says Moore. "The physician simply points and clicks on the appropriate information for the patient, and the information is printed out for the chart and for the patient," she says. "By making the forms and the information consistent, staff members don't have to ask physicians what they meant by a vague order, and they don't have to make assumptions as to what the physician intended." ■

Emergency preparedness standards, others change

AAAHC clarifies number, type of emergency drills

Emergency preparedness becomes a more important part of the accreditation survey, according to revisions made to the Accreditation Association for Ambulatory Health Care's 2006 standards.

Emergency preparedness is raised to full letter standards in the Environment of Care chapter, and more specific requirements are spelled out, says **Stephen Kaufman**, RN, senior director of accreditation at the AAAHC. "This change is not a reflection of the hurricane season we just experienced, but is a natural progression of the changes we have been making throughout recent years," he explains.

In fact, the changes related to emergency preparedness had been proposed prior to the hurricane season as a result of feedback from accredited organizations, Kaufman says. "Managers have told

us that they want more clarity and more direction as to the type of plans, drills, and training that are required to meet these standards," he adds.

AAAHC requires a minimum of four drills that test the entire emergency preparedness plan — not just fire drills, says Kaufman. "Because Medicare requires an Medicare-certified organization to conduct four fire drills each year, the organizations for which we conduct a combined Medicare certification and AAAHC accreditation survey will need to conduct a minimum of seven drills during the year: four fire and three other types of emergency drills," he explains.

The other drills can be related to medical emergency within the outpatient surgery program, tornadoes or other geographically relevant weather emergencies, power outages, or bomb threats, whatever is appropriate to the individual organization's location and activities, Kaufman says.

Another requirement that has been changed from a subparagraph to a full letter standard is under the Quality of Care section, says Kaufman. The standard that states "the provision of high-quality health care services is demonstrated by at least the following: appropriate, accurate, and complete clinical record entries" has previously been a subparagraph of another standard, he says. "This requirement is so significant that it has been raised to a full letter standard which means that an organization must meet the requirement more fully in order to meet a surveyor's expectations for compliance," he explains.

A change to the wording of the Surgical Services chapter won't affect outpatient surgery program managers, but it will make life easier for office-based practices that perform procedures that require only local and topical anesthetics, says Kaufman. "Primary care offices that sew lacerations with the use of local anesthetics were having to prepare for the survey without knowing how much of the surgical services chapter applied to them," he says. The chapter heading now includes the statement that "some standards may not apply to organizations that only perform minor superficial procedures without anesthesia or under local or topical anesthesia."

While the AAAHC standards don't specify the use of anesthesiologist, certified nurse anesthetist, or registered nurse to administer sedation or other type of anesthesia, a new standard does require the organization to credential and grant privileges to the individuals administering the anesthesia, says Kaufman.

"We recognize that different states define scope of practice for different types of anesthesia providers, so we expect our accredited organizations to grant these privileges in line with the scope of practice allowed in their area," he says. The intention of the new standard is to emphasize AAAHC's current focus on the importance of granting credentials and privileges, he explains. ■

SOURCE/RESOURCE

For more information about Accreditation Association for Ambulatory Health Care's 2006 standards, contact:

- **Stephen Kaufman**, RN, Senior Director of Accreditation, Accreditation Association for Ambulatory Health Care, 3201 Old Glenview Road, Suite 300, Wilmette, IL 60091. Phone: (847) 853-6060. Fax: (847) 853-9028. E-mail: skaufman@aaahc.org.

At press time, the 2006 standards revisions were scheduled to be posted by Jan. 1. To view the revised standards, go to www.aaahc.org and choose "annual standards revisions" on the left navigational bar, then select "2006 standards revisions."

How one agency meets privileging standards

Organizations accredited by the Accreditation Association for Ambulatory Health Care (AAAHC) consistently struggle with the credentialing and the privileging standards, says **Stephen Kaufman**, RN, senior director of accreditation at the AAAHC.

"The documentation of credentials and the granting of privileges must be done in a complete and timely manner," he says. "In addition to showing documentation, the approval of a surgeon's credentials and the granting of privileges must be reflected in the governing board's meeting minutes to fully comply with the standard."

At Orthopedic Surgical Center of the North Shore in Peabody, MA, AAAHC surveyors who visited recently were pleased with the credentialing and privileging process, says **John M. Powell**, chief executive officer. "We handle the credentials verification ourselves by verifying

licenses, contacting medical schools, and obtaining other documentation we need," he says.

They grant privileges based upon what the surgeon is permitted to do according to his or her board certification and training and any state regulations that might apply, explains Powell. The training and experience of the surgeon is only one part of the privileging decision, he adds. "We also look at the specific procedures we are staffed and equipped to handle in our facility, and we look at the type of patient that might need the service," he says. "We don't allow any high-risk patients, and we look carefully at the appropriateness of the procedure for our setting."

They are discussing a spinal procedure with a surgeon who currently is performing all of the surgeries at the hospital, says Powell. While his facility might be able to provide the operating room time, the equipment, and the staff, Powell says he is getting input from all areas to see if they can be sure the patients can be given all of the necessary care in the outpatient surgery facility.

"We don't want to accept these patients, then find ourselves transferring them to the hospital because it is more complicated and requires more care than we anticipated," he adds.

Powell's facility does not base privileges at the surgery center on privileges the surgeon has at other facilities, and that is the right approach, says Kaufman. "An outpatient surgery facility cannot just copy the list of privileges from another facility or a hospital," he says. "The privileges must be granted specifically for the facility, based upon the facility's capabilities." ■

Fixed performance areas listed for random surveys

Although the Joint Commission on Accreditation of Healthcare Organizations begins unannounced surveys for all organizations in 2006, it does not mean that random unannounced surveys will end.

Because random unannounced surveys are one way that the Joint Commission can demonstrate that organizations remain in compliance with Joint Commission standards throughout the three-year accreditation cycle, random unannounced surveys will continue to be performed, even after January 2006.

"The Joint Commission will continue to conduct unannounced surveys on a 5% random sample of accredited organizations every year through 2008," says **Mark Forstneger**, spokesman for the Joint Commission. These random unannounced surveys are conducted nine to 30 months following the organization's accreditation date.

The 2006 fixed performance areas for outpatient surgery programs surveyed as part of a hospital are: assessment and care/service; medication management; patient safety; and the 2006 National Patient Safety Goals that are applicable to services provided.

The 2006 fixed performance areas for outpatient surgery programs surveyed under the ambulatory care standards are: quality improvement expertise and activity, information management, patient safety and the 2006 National Patient Safety Goals that are applicable to services provided by the organization.

In addition to the fixed performance areas, organizations selected for random unannounced surveys will be surveyed on variable components that are specific to the organization being surveyed.

For more information about random unannounced surveys, contact Kevin Hickey, director of the Management Support Unit, Joint Commission, at khickey@jcaho.org. ■

JCR offers do-not-use abbreviation kit

Outpatient surgery managers can get a jump on reminding staff members not to use certain abbreviations with a new toolkit available from Joint Commission Resources (JCR), an affiliate of the Joint Commission on Accreditation of Healthcare Organizations.

The toolkit, "Spell It Out!" is designed to help health care organizations eliminate the use of dangerous medical abbreviations, acronyms, and symbols. The kit includes clipboards, posters, quick reference cards, sticker sheets, and multiclick pens with a window that displays the do-not-use abbreviations.

The complete kit (order code KAB-05BHM) costs $49 plus $10.95 for shipping and handling. To order a kit, call (877) 223-6866 or go to www.jcrinc.com and choose "Online Ordering," Click on "publications and media." In the "Search by Keywords" box, type "Spell it out." Items also can be ordered separately. ■