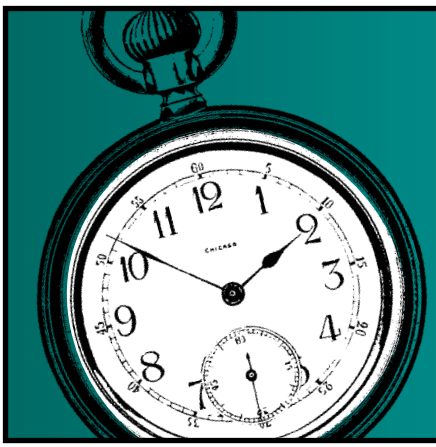

Same-Day Surgery®

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

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IN THIS ISSUE

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You can save a lot of money buying from on-line auctions, but is it a good idea?

Responses mixed to purchasing supplies, devices from web

The next time you need to purchase a laser, how would you like to pay $8,000 for a used one instead of $30,000 or $50,000-$100,000 to purchase a new one? Those were the options faced by one ophthalmologist who turned to the Internet when he needed a CO_2 laser.

"It was used, but the seller stated that it had limited use," recalls **Paul N. Rosenberg**, MD, ophthalmologist at Ocusight Eye Care Center in Webster, NY, and clinical assistant professor of ophthalmology and plastic surgery at the University of Rochester (NY) School of Medicine and Dentistry. "I was interested in this particular laser because I already own the exact model that I use in one of my offices and was familiar with it."

The used laser was missing one additional feature, worth $5,000 at the time a new one had been purchased by Rosenberg about nine years previously. Interestingly, at the time Rosenberg purchased his used laser at www.OpticalAuctions.com, he was using a used laser, the same brand and model as the one on-line, on consignment from a vendor. "They wanted

EXECUTIVE SUMMARY

While some providers tout the cost savings from buying items from on-line auctions, government sources and others urge caution.

- Ensure the item is approved for sale in the United States.
- Try to verify the source of the device, ask what parts of the device were refurbished, whether all parts meet the specifications of the original equipment manufacturer, and whether the work is covered by a warranty.
- Put the payment into an escrow account until you can verify that the product is as it was represented.
- Know that you probably won't find out about product warnings and recalls. With new items, you may not receive training materials, product literature, and warranties.

$30,000 for the used laser, which I felt was grossly overpriced," he says. The used one he purchased on-line worked well for about six months, then needed a repair on the laser tube for about $4,000-$5,000, Rosenberg says. "Despite this unexpected repair, we only had a total of about $12,000-$13,000 invested in the laser, which was much less than the cost of a new one, which can run $50,000-$100,000 depending on the make and model," he says.

Some on-line auctions do not charge fees for items listed for sale or items sold. They typically use a buyer-and-seller rating system.

Some health care providers use on-line auctions to get rid of surplus supplies and equipment. "Surplus has always been problem for hospital facilities," says **Jim Stewart**, president of The Granite Group, which buys and sells health care surplus equipment and supplies from its offices in Huntington Beach, CA. "Sooner or later, they realize it's taking up a lot of space that can be used in productive manner." Also, it saves managers from going into "panic mode" when it's time for an accreditation survey or regulatory inspection, Stewart says. His company pays from hundreds to thousands of dollars to remove surplus from a health care facility, he says. "Many facilities are uninformed of the level of surplus they really have, and what the costs are in storing or trying to preserve these items for later," Stewart says. "This is the old-school thinking and is a burden in today's health care financial environment."

While equipment from The Granite Group is sold as-is, purchasers are buying items that are refurbished at a substantially lower cost than through conventional used/refurbished medical equipment dealers or original equipment manufacturers, he maintains. Buyers can save as much as 80%-90% off the price of supplies and equipment, Stewart says.

How to protect yourself

While some health care experts warn about the perils of buying items at on-line auctions **(see story, p. 40)**, outpatient surgery managers who want to purchase items on-line may be able to protect themselves to a degree by following these suggestions:

- **Know your equipment/supplies.**

Purchasers shouldn't go on a "fishing expedition," Rosenberg advises. "They should have a sense of the going price ahead of time because if there is an eBay-type auction, it is easy to get caught up in the excitement of the chase and overbid," he warns.

Pay attention to labels, the Food and Drug Administration (FDA) warns. "If the instructions are in many languages or if measurements are in S.I. (metric) units, the product may be intended for sale in another country, not the U.S.," the agency advises. "This can mean the product does not meet U.S. requirements and may be of inferior quality."[1]

The agency suggests that you ask the seller, "Has the FDA cleared or approved this product for sale in the United States?" Also, beware of sites that do not include an address and telephone

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

in the United States, the agency warns.[1]

• Ask questions.

Feel free to e-mail sellers and ask questions, but realize that the web sites don't monitor sellers to ensure they are answering questions honestly.

When Rosenberg was interested in buying a used laser on-line, he called the seller, a private ophthalmologist. "I questioned him quite closely about its condition and the number of cases it was used on, Rosenberg says. "While he offered no warranty beyond that it was working, I felt comfortable and wasn't worried that another physician would cheat me, so to speak."

Given the high price of most of the items, it would be best if buyers speak directly to the sellers or least have some communication with them, Rosenberg advises. If buying used instruments, it is usually last year's model, he says. "The seller is getting rid of it either because there is a newer model to which they are upgrading, or the technology is changing and they want to unload it, or it doesn't do what they want it to," Rosenberg says. Also, it may be that the seller jumped on the bandwagon and no longer wants to offer a particular service, he says. Such a seller wants to recoup as much of their cost as they can, he says.

"So, you may be getting technology that is not the newest or greatest but therefore, you will pay less, so that everyone is happy," Rosenberg says. "That doesn't mean that the technology is invalid."

The seller told Rosenberg he was auctioning the laser because he wasn't using it. "Perhaps he was uncomfortable with the use of it or wanted a higher-end laser," he says. "Either way, it didn't matter to me as long as it worked because I already owned the same laser and was very pleased with its performance, especially for the value."

Anyone buying devices on the Internet has to be aware that some of the goods may be stolen, expired, or otherwise in unusable condition, says a spokesperson for The Office of Compliance at the Center for Devices and Radiological Health in Rockville, MD. "The buyers can protect themselves by trying to verify the source of the device, asking what parts of the device were refurbished, whether all parts meet the specifications of the original equipment manufacturer, and whether the work is covered by a warranty," says the spokesperson, who asked not to be identified.

When buying from a hospital, ask for a copy of the maintenance and repair record on the device, sources suggest.

• Know that sellers fall under different regulations.

The Office of Compliance reports an increase in inquiries regarding the buying and selling of refurbished devices on the Internet, a spokesman says. The FDA does not require re-marketers of used or as-is devices to comply with the requirements of the various medical device regulations, says the spokesperson. "For example, they are not required to register their establishment with FDA or comply with the quality systems regulation," he says.

• Safeguard yourself.

Some dealers do offer warranties on refurbished items, says **Peter Goldenberg**, president and CEO of Concepts In Sight, which operates www.Optical Auctions.com from its base in Boynton Beach, FL. Also, his company places the buyer's funds into their escrow account until the buyer receives the items and verifies it is what was advertised.

"The important thing here is to question everything beforehand," Goldenberg says.

Reference

1. Center for Devices and Radiological Health. Buying medical devices online. Accessed at: www.fda.gov/cdrh/consumer/buyingmeddevonline.html. ■

SOURCES/RESOURCE

For more information on buying and selling on-line, contact:

- **Peter Goldenberg**, President and CEO, Concepts In Sight, 12180 Dunhill Drive, Boynton Beach, FL 33437. Phone: (561) 752-3638, Fax: (561) 423-753. E-mail: info@opticalauctions.com. Web: www.OpticalAuctions.com.
- **Jim Keller**, Vice President, Health Technology Evaluation and Safety, ECRI, 5200 Butler Pike, Plymouth Meeting, PA 19462-1298. Telephone: (610) 825-6000, ext. 5279.
- **Paul N. Rosenberg**, MD, Ocusight Eye Care Center, Webster, NY. Phone: (585) 872-1300. E-mail: pnrmd_ocusight@yahoo.com.
- **Jim Stewart**, President, The Granite Group, 21561 Surveyor Circle, Huntington Beach, CA 92646. E-mail: jds@granite-grp.com. Web: www.granite-grp.com.

For information on devices that have been cleared or approved for marketing in the United States, go to http://www.fda.gov/cdrh/databases.html and select the Pre-market Notification (510ks) database or Pre-Market Approval database.

Think twice before buying from auctions

'For me, it is a liability issue'

When considering purchasing items from on-line auctions, buyer beware, says **Deb Ulmer**, MSN, RN, nurse administrator at Lake Mary (FL) Surgery Center.

"I prefer to have a warranty on refurbished items and be able to put a face to the product," she says. "For me, it is a liability issue."

Indeed, some health care providers have found themselves involved with legal issues when purchasing on-line. A medical clinic in Arizona bought a pacemaker on eBay and implanted it in a patient. It later was determined that the pacemaker had been stolen.[1]

The Food and Drug Administration (FDA) offers the following consumer warning:

"Buying on-line offers privacy, convenience, and potential cost savings, but personal data given by the consumer can be misused by unscrupulous dealers. While the Internet offers many quality medical devices from legitimate sites, it also offers medical devices that don't work and some that may even harm you or your family. Some web sites sell medical devices for unapproved uses, or they sell medical devices that have not been cleared or approved by FDA. Other web sites sell prescription medical devices without asking for a prescription. Some foreign web sites sell medical devices to customers in the United States where the medical devices have not been cleared or approved for sale."[2]

Generally, it's not a good idea to buy items at an on-line auction, says **Jim Keller**, vice president of health technology evaluation and safety at ECRI, a nonprofit health services research agency in Plymouth Meeting, PA. "If you take a step back, you realize that there aren't the same levels of controls, assuming it's not a legitimate manufacturer selling on eBay," he says. "Individuals [who sell on-line] really are the largest concern."

There are a "whole range of risks," he warns. For example, once single-use devices are shipped from manufacturers, how can you be sure how they were handled and resterilized? With individuals, what kinds of controls are in place? If the item is used, what kind of condition is it in? What kind of guarantee of condition are you receiving, and who will provide support once you receive the item? Should a problem come up with device after it's provided to you, how to you learn about product warnings? "You won't be informed of that," Keller warns.

For used items, you don't know what type of sterilization and refurbishments have been done, he points out. And items advertised as new aren't risk-free, he advises. For example, ask if you will receive the training materials, product literature, and warranties, Keller says. Also, you probably won't be alerted to recall notices, he adds.

Even some reprocessors are shying away from on-line auctions. One did a three-month experiment selling devices such as pulse oximeter sensors through eBay in 2004. ClearMedical of Bellevue, WA, found that there was demand, but in general, hospitals don't prefer to order their routine types of devices on the Internet, says **Mike Blume**, vice president of sales for ClearMedical. "Calling the vendor directly or the distributor is where 99% of the activity is," he adds.

While he says that on-line selling doesn't make sense for his company now, there may be other useful purposes. "eBay is great for hospitals to sell their equipment, and it's a great place for dealers to sell their equipment," he says.

References

1. Klein A. Used medical devices being sold on eBay. *Washington Post.* Dec. 22, 2005:D01. Accessed at www.washingtonpost.com/wp-dyn/content/article/2005/12/21/AR2005122102078.html.
2. Center for Devices and Radiological Health. Buying medical devices online. Accessed at: www.fda.gov/cdrh/consumer/buyingmeddevonline.html. ■

Ticket to satisfaction: Personal movie players

Movies distract, reduce anxiety for family members

Your front desk staff members have to be courteous, friendly, and patient, even when they are asked, "How is my family member doing?" for the 10th time in a two-hour period.

Televisions in the lobby and magazines don't always provide enough entertainment to keep family members from anxiously watching the clock. One outpatient surgery program has found that personal DVD players with movies chosen from a library of movie titles at the facility have

EXECUTIVE SUMMARY

A program that provides personal DVD players with headsets to family members in waiting rooms can be one way to reduce the anxiety of waiting for a loved one to come out of surgery.

- Two sets of headphones enable two family members to watch the same movie.
- Headsets mean no noise to annoy others waiting in the area.
- Movies must be current and appropriate for audience and setting, with comedies and light dramas most popular.
- Storage space requirements and staff time needed to run program should be minimal.

made the wait more enjoyable and less stressful for many people.

Being able to choose a movie and watch it without disturbing other people in the waiting room is ideal for same-day surgery, says **Cathy Boyer**, director of guest relations for Riddle Memorial Hospital in Philadelphia. "Feedback from family members and staff members has been positive."

Because family members are so engrossed in their movies, time passes more quickly, she explains. "Staff members report that there are fewer visits to the receptionist to check on patients because they are able to take their mind off their family members' surgery," Boyer adds.

Because Boyer's facility is part of a pilot project, Careflix, the Philadelphia-based company that developed the service, is handling distribution of the DVDs throughout the hospital as they are requested. Even without the help from the vendor, managing the program in a same-day surgery program will be simple, she predicts.

"You do need a small, lockable cabinet to hold the DVD players and the movies, but it doesn't require a great deal of space," Boyer explains. "The receptionist for same-day surgery can explain the program with the help of brochures provided by the vendor, and the family member simply signs a checkout sheet for the movie, headset, and player," she points out.

The players are designed to handle two headsets at once, so two members of the family can watch at the same time, Boyer adds.

While hospitals that make the program available to inpatients and other departments might want to charge for use of the equipment to cover staff costs, Careflix CEO **Jonathan Bebo** does not recommend that same-day surgery programs charge for the service. "The financial benefits to a same-day surgery program are larger if the service is provided for free," he says. "Patient satisfaction and positive word-of-mouth advertising for the facility will outweigh the low cost of this service," he says.

Costs for starting the program vary according to size of the same-day surgery program, but most programs only would need three players with headsets and the start-up library, says Bebo. "This would mean an initial investment of $995 and a monthly subscription fee of $95," he says. The subscription fee charged by his company covers repair or replacement of DVD players, technical support, and updates to the movie library each month, he says.

The initial library consists of about 20-25 movies and four to five new releases are added monthly, says Bebo. "The same-day surgery program keeps all of their movies so that the library continues to grow," he says. "Staff training is minimal, and we provide that as well."

Movies for the program are chosen carefully, points out Bebo. "We tailor movies provided to each facility on the demographics of the facility," he says. "For example, a same-day surgery program with an older population will have classics such as *Casablanca* or *Gone with the Wind* available," he explains. "We also like to include comedies such as *Patch Adams,* and we make sure the movies are medically sensitive and will not be upsetting to family members as they wait," he says. Movies or shows of varying lengths are offered so family members can choose a video that will be completed in the time that they will wait, Bebo adds.

Staff members also appreciate the convenience of checking out a movie as they head home, says Boyer. "Staff members can sign for a movie then

SOURCES

For more information about movies in the waiting room, contact:

- **Jonathan Bebo**, Chief Executive Officer, Careflix, 2121 Market St., Suite 522, Philadelphia, PA 19103. Telephone: (267) 346-2326. E-mail: bebo@careflix.com. Web: www.careflix.com.
- **Cathy Boyer**, Director, Guest Relations, Riddle Memorial Hospital, 1068 W. Baltimore Pike, Media, PA 19063. Telephone: (610) 566-9400, ext. 3686. E-mail: cboyer@riddlehospital.org.

return it a few days later," she says. If the movie is lost or destroyed, staff members are responsible for the replacement cost, she adds.

At this time, Bebo says he is not aware of another company offering this service specifically to health care facilities or to other businesses. While a same-day surgery program could set this up without the help of a vendor such as his company, the program would have to be ready to handle maintenance, repair, and replacement of equipment as well as updates to the movie library on a regular basis, Bebo points out.

The main benefit of a program such as this is improved patient satisfaction, says Boyer. "Improved patient satisfaction is an important focus of all health care performance improvement programs and accreditation agencies," she says. "This type of service is an easy, inexpensive way to make time in a waiting room less stressful for our patients' family members and improve their satisfaction with our service." ■

Argon plasma coagulation minimizes risk of injury

Lack of electrical current means no accidental burns

One of the most frightening aspects of injuries caused by stray electrosurgical current is that almost 70% of these injuries are undetected during surgery and 25% of patients with undetected burns during surgery die, even after aggressive treatment once the injury is discovered.[1] The threat of injury to patients is causing same-day surgery managers to look at a new product that does not use electric current to cauterize tissue.

Safety is the key benefit of the PlasmaJet, says **Denis F. Branson**, MD, a plastic surgeon in Fayetteville, NY. "Because electrical current is not used to cauterize, there is no danger of current traveling through jewelry or a pacemaker," he points out. "There is no need for a grounding pad, either."

The PlasmaJet uses a high-energy jet of pure argon plasma to coagulate, says **Pia Johansson**, RN, MBA, clinical service manager for PlasmaJet manufacturer PlasmaSurgical in Alva, FL. "Electrodes heat the plasma, which is then directed at the incision site to coagulate the blood," Johansson says. "No electrical current passes to the patient, just the heated plasma," she explains.

EXECUTIVE SUMMARY

One way to improve patient safety during surgery is to minimize the risk of electrosurgical burns. A new product that cauterizes using superheated argon plasma is an effective tool for cautery that minimizes risk to the patient, according to surgeons who have used the device.

- No electrical current enters the patient, so there is no risk of electrosurgical burns or arcing.
- Postoperative pain is reduced due to minimized damage to surrounding nerves.
- Fluid buildup is less than with traditional cautery, so drains are not needed as frequently.
- There is less postoperative bleeding or oozing.

Other benefits of neutral plasma coagulation include no direct contact of the handpiece with the tissue, so there is no danger of tissue adhering to the handpiece, and a very low gas flow that minimizes the risk of embolism and overpressure, Johansson points out. "The heated plasma also coagulates the tissues in successive layers, as opposed to top layer only, that produces a more effective barrier to further bleeding," she adds.

Branson has found that the neutral plasma coagulation effectively seals lymphatic vessels and prevents fluid buildup in the incision site. "This means that my breast reduction patients have less need for drains, and that means less patient education and quicker recovery," he adds.

Another unanticipated benefit of neutral plasma coagulation discovered by Branson is less pain after surgery. "Because this process does not cause any damage to nerves as electrosurgical cauteries can cause, patients report less postoperative pain," he says. "This means patients return to normal activities sooner."

Other procedures in which he has used neutral plasma coagulation with the same results include breast augmentation, abdominoplasty, and post-bariatric abdominal contouring, says Branson. The benefits of neutral plasma coagulation seen in plastic surgery procedures will be seen in general and laparoscopic surgery as well, Johansson says.

There is a short learning curve to use the PlasmaJet, but no special courses are needed, says Branson. "It does require a slight change in technique because you do keep the handpiece further away from the bleeding vessel, and you do have to learn to judge what settings work best for your patient and your technique," he says.

SOURCE

For more information, contact:

- **Pia Johansson**, RN, MBA, Clinical Services Manager, PlasmaSurgical, 5450 Lee St., Suite No. 1, Lehigh Acres, FL 33971. Telephone: (877) 775-2762 or (239) 369-5915. Fax: (239) 369-5918. E-mail: pjohansson@plasmasurgical.com. Web: www.plasmasurgical.com.

There also is a different look to the tissue as it coagulates as compared to electrosurgical cautery, Branson says. "While the tissue may appear black, the argon plasma is not injuring the tissue," he explains.

The price for the PlasmaJet console ranges from $30,000-$35,000, says Johansson. The disposable handpieces are $295 each, but the price may vary according to volume ordered, she says.

The price is reasonable for the patient safety benefits as well as the patient comfort, says Branson. While the overall costs are not significantly different from electrosurgical equipment, the handpieces are higher than electrocautery handpieces, he says. The trade-off for the slightly higher costs is the reduced need for drains, lower levels of postoperative pain, and increased level of patient safety, he adds.

"Overall, I can be more effective because the risk and concern about injury to adjacent tissues and organs is reduced," he says. "Not only do I have more control over the coagulation process, but I know that my patient is going to recover more quickly."

Reference

1. Werner C. Guarding against an unseen killer: Stray electrosurgical burns. *Healthcare Purchasing News* 2002; 26:28. ■

Panel: Insurers favor more costly back pain treatments

CMS doubles rate for less invasive procedure

Insurance companies favor fusion surgery over back pain management therapies, according to a recent panel of orthopedic surgeons, interventional radiologists, physiatrists, and pain management specialists from academic centers. Yet fusion surgery often is more than 10 times costlier than other methods of managing chronic discogenic lower back pain.

The panel discussed and examined pain management strategies from medical specialties that routinely work with patients suffering from chronic lower back pain. Participants in the panel discussion included pain management specialists, spine surgeons, interventional radiologists and physiatrists from various institutions such as the Albany (NY) Medical College, the Cleveland Clinic, Columbia University in New York City, Johns Hopkins Hospital in Baltimore, Rush Presbyterian-St. Luke's Medical Center in Chicago, Mayo Clinic in Jacksonville, FL, Cedars-Sinai Institute for Spinal Disorders in Los Angeles, and Stanford University Medical Center in Palo Alto, CA.The panel was conducted by MedPanel in Cambridge, MA, an on-line medical market research company.

The discussion was sponsored by the American Society of Interventional Pain Physicians (ASIPP) and Smith & Nephew Endoscopy.

In discussing their treatment options for patients with chronic discogenic lower back pain, panelists agreed that the first course of treatment always should be physical therapy and/or chiropractic, muscle relaxants and nonsteroidal anti-inflammatory drugs (NSAIDs). If the patient doesn't respond to these treatments in four to six weeks, most of the panelists agreed that minimally invasive procedures should be considered. Panelists also agree that the last treatment to consider is fusion surgery, which fuses two or more damaged discs together to reduce or eliminate pain. But this also can cause potential complications such as nerve damage and treatment failure.

The panel of physicians concluded that there is a bias toward the higher-cost fusion surgery option. This bias is the result of several factors — in particular, insurance companies opting to pay for more invasive treatments, rather than minimally invasive or pain management procedures, even though those pain management protocols and procedures are considerably less expensive and may be more clinically relevant.

Intradiscal electrothermal therapy (IDET) costs about $7,000, but only between 5,000 and 7,000 of these procedures are performed each year. IDET is sold by Smith & Nephew Endoscopy, but the procedure has not caught on though it is substantially less expensive, less invasive, and reversible, unlike a fusion surgery. The IDET procedure is for those who have failed a program of aggressive nonoperative therapy. During the procedure, controlled levels of thermal heat are applied to the affected disc to

contract and thicken the collagen fibers within the disc wall, potentially closing the cracks and tears and cauterizing the tiny nerve endings that cause the pain.

One positive sign for IDET is the recent news that the Centers for Medicare & Medicaid Services (CMS) has increased reimbursement for the procedure, placing it in a more appropriate Ambulatory Payment Classification (APC). The new reimbursement classification appears in the final rule for the Medicare Hospital Outpatient Prospective Payment System for 2006. Under the reclassification, CMS will reimburse $1,424.50 for the procedure in 2006, in place of the 2005 payment level of $622.43. Medicare does not pay for this procedure in a surgery center, according to Smith & Nephew.

'Huge financial incentive' for fusion procedure

David Kloth, MD, president of ASIPP and an interventional pain physician at Danbury (CT) Hospital attributed some of the low numbers of IDET and other less invasive surgical procedures being performed to the fact that surgeons can make up to nearly $40,000 for a single-fusion operation. "There is a huge financial incentive for surgeons not to see [IDET] done on a routine basis," he said.

However, Kloth noted that surgeons also may be less likely to refer patients for IDET because they are not familiar with it, and he acknowledged that the minimally invasive procedure is not for everyone. "I will tell you that the patients I see who have disc problems, more times than not I have to turn them away from these minimally invasive surgeries because they're not a candidate because of their specific anatomy."

Kloth said initially, perhaps some minimally invasive techniques such as IDET were first done on patients who perhaps were not good candidates for the procedures, but over the last six or seven years, "we've certainly refined [the population], and it's much better." He defined a "good" candidate for IDET as someone with good disc height (70% or greater), no instability, no significant modic endplate changes, and no sizeable disc herniations.

Obviously, the cost of an IDET procedure vs. a lumbar fusion also is an issue that needs to be debated, and Kloth said he remains puzzled as to why more insurance carriers aren't covering a procedure that costs nearly 10 times less than its more radical surgical cousin.

"Even if you take some of the worst [IDET] studies," he said, "it's still got a 50% success rate, so if 50% of the people get better without needing a $50,000 operation, it's not hard to run those statistics and say, 'Wait a minute, you would save millions of dollars if you did this on a cohort of patients.'" Kloth pointed out that "even if you fail at IDET, you can always go to fusion; [whereas,] if you fail a fusion, you're really up the creek," which typically means having to do another fusion procedure at another level of the spine or having a spinal stimulation device implanted.

Kloth said he believes that patients should definitely get a second opinion before having a fusion done, and adds that he thinks insurance companies, who are known for their desire to keep costs to a minimum, will come around to the notion that trying out the less costly alternative first might be better for the bottom line.

"I think what you're going to see five years from now are that the insurance companies are actually going to mandate a pain-management evaluation before you have a lumbar fusion," he predicted.

While some have argued that the IDET's success rate is not very good and has not been borne out long-term in studies, Kloth said from personal experience he believes that the right candidates can benefit from it. He pointed out that while some private insurers still will not pay for it, workers' compensation in Connecticut, where he practices, routinely pays for these surgeries because "they know my return-to-work rate with the treatments that I do with these aggressive minimally invasive surgeries is 75%. Historically, fusion success return to work is 25%." ■

Same-Day Surgery Manager

When to cut the cord with a management company

Also: Moving up, moonlighting, and other issues

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

Question: Our surgery center has a management

contract with a well-known surgery center management company. Our board is considering terminating that contract because everything is running well at the center, and they don't want to pay the high fees per month (6% of net collected revenue). My thoughts, as the administrator, are that I like having the resources in place with the group. When should we terminate an agreement with them?

Answer: There are a number of valid reasons why a center might consider terminating a management agreement, but because "everything is running well" is not one of them. I would argue that things are running well *because* of the agreement in place that you described. However, there a valid reasons to terminate:

- The fees are too high. Often a center will enter into a management agreement when they first start out and not realize they will be paying as much as they are.
- They are not pleased with the work effort of the team.
- The center is just not "running well."
- The contract in place was too long and should come to a peaceful closure.

All of these can be negotiated with the management company and almost always can be resolved.

Question: Our hospital is searching for a replacement for our operating room department head. She has been here for 15 years and is leaving for another position. The hospital has spent a ton of money to advertise for her position and interviewed nine candidates. I am one of those candidates, and I am getting upset that they do not see the merit in me. I have been a loyal assistant to her for 10 years. I do not understand why they did not give the position to me to begin with and save all this time and money. Everyone says I am qualified. Is this common?

Answer: You want to be hired by the hospital because you are the best candidate, not because everyone *thinks* you are. It is very common for the hospital to do what they are doing to "find out what is out there" and to see what qualifications other candidates might have. This also is a good time for them to understand more the requirements of the position. You want them to do this so you will be hired as the best candidate — not the only candidate. (P.S. She got the job three weeks later at a pay rate higher than her predecessor!)

Question: There are a number of us who work at the hospital that have been approached by the surgery center across the street to work per diem with them. Most of us work four 10-hour shifts and can fill in at the center. They (the surgery center managers) are willing to pay us more money than the hospital for per-diem work. This sounds good to all of us who are looking to work another day per week. However, the hospital is telling us that they would "frown" very much on any employee that moonlights at the center. We plan on doing it anyway, but we were curious as to your thoughts.

Answer: There is actually more to this story than the above question reflects. All of the nurses above were paid a large sign-on bonus just eight months before this became an issue. The hospital administrators' position is that they do not want the staff working an additional eight to 16 hours per week and then being too tired to fulfill their obligations to the hospital.

I think the biggest issue here is that the hospital is upset with the surgeons who left to build the ASC to begin with, and now they are upset that the same surgeons are "cherry-picking" their staff. The hospital administrators think that the nurses working there would be disloyal to the hospital.

I told the nursing staff that I agreed with the hospital on this issue and that if the nurses were looking for additional work hours, they should give the hospital the first option. They did approach the hospital and are working more hours in the hospital operating room and postoperative care unit (with overtime), and everyone seems happy with the outcome. Well, almost everyone.

Question: I need to have our surgery center, which is a joint venture with a hospital, accredited by an agency. Since we are associated with a hospital, do we have to go with the Joint Commission [on Accreditation of Healthcare Organizations]?

Answer: No. You can go with the Joint Commission, American Association for Accreditation of Ambulatory Surgery Facilities (AAASF), or Accreditation Association for Ambulatory Health Care (AAAHC). They are all acceptable by payers and are recognized as having deemed status by the Department of Health and Human Services.

[Editor's note: Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Contact Earnhart at 3112 Windsor Road, Suite A-242, Austin, TX 78703. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.] ■

Bariatric surgery available to more Medicare patients

Outpatient surgery programs will be able to offer the outpatient lap band procedure to Medicare beneficiaries following an announcement that the procedure now is covered by the Centers for Medicare & Medicaid Services (CMS).

On Feb. 21, 2006, CMS announced the establishment of a national coverage policy that will standardize coverage for all Medicare contractors and expanded the types of bariatric surgery that are covered.

CMS will cover open and laparoscopic gastric bypass, and open and laparoscopic biliopancreatic diversion with a duodenal switch, but the new policy also covers lap band surgery, which is used in outpatient settings, says **Harvey Sugerman**, MD, professor emeritus of surgery at Virginia Commonwealth University in Richmond and immediate past president of the American Society for Bariatric Surgery (ASBS). **(For information on the lap band procedure in outpatient setting, see *Same-Day Surgery*, August 2005, p. 89.)**

Coverage also will be easier to determine because this is a national coverage policy, says Sugerman. CMS' prior policy restricted coverage of bariatric surgery to procedures that were necessary to correct an illness that was caused by, or aggravated by, the patient's obesity. While patients still must have a body mass index $\geq$ 35 and have at least one comorbidity related to obesity, the nationally standardized guidelines will eliminate coverage decisions that varied from region to region, he points out. Previously, regional Medicare contractors set their own coverage parameters, and it was difficult for surgeons and surgery programs to predict reimbursement, he says.

Because Medicare reimbursement is determined after a procedure is complete, there have been many instances in which a surgeon proceeded with the procedure, expecting reimbursement based upon his or her interpretation of coverage policies, only to find out that the regional Medicare contractor denied payment to the surgeon and the hospital, Sugerman explains. "A standardized, national policy will make it more likely that the surgeon and the surgery program know that the surgery will be covered."

Another component of the CMS policy is that coverage will only be provided if the surgery is performed at an ASBS/Surgical Review Corp. (SRC) Center of Excellence or an American College of Surgeons Level One Center of Excellence.

For a center to receive an ASBS/SRC Center of Excellence designation, the hospital or institution must perform at least 125 bariatric surgeries per year collectively and the surgeon must have performed at least 125 bariatric surgeries himself or herself, and perform at least 50 per year. The center also must report long-term patient outcomes and have an on-site inspection to verify all data. In addition, the center must have a dedicated multidisciplinary bariatric team that includes surgeons, nurses, medical consultants, nutritionists, psychologists, and exercise physiologists.

The Center of Excellence is an important provision to ensure quality patient care, Sugerman says. "At this time, ASBS has several outpatient surgery programs going through our Outpatient Centers of Excellence program, so we will have those programs accredited within the next six months," he says. (For more information about the ASBS/SRC Center of Excellence program, visit www.surgicalreview.org.)

"This is a win-win-win situation for Medicare, obesity patients, and health care providers," says Sugerman. "Many Medicare patients who undergo bariatric procedures are younger than 65 but are on Medicare due to disability related to obesity," he says. "By making the surgery available to more patients, we will not only see a drop in the health care bills as these patients are better able to deal with other conditions such as diabetes, pulmonary dysfunction, or arthritis, but we will also see more of them return to work and moving off Medicare."

The final decision CMS memorandum can be found at: www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=160. ■

CMS approves $50 added fee for new IOL

Bill patient after subtracting normal lens allowance

The Centers for Medicare & Medicaid Services (CMS) has announced the approval of a new class of New Technology Intraocular Lenses (NTIOL) that is eligible for an additional $50 payment when the lens is provided in a surgery center. The payment adjustment is in effect Feb. 27, 2006, and is valid for five years.

CMS approved a request from Advanced

Medical Optics that Tecnis Models Z9000, Z9001, and ZA9003 be given NTIOL status. Advanced Medical Optics provided data that the Tecnis IOL compensates for corneal spherical aberrations and improves vision, according to CMS. The new class of NTIOLs is referred to as Reduced Spherical Aberration.

Medicare suggests that surgery providers use a written notice to notify patients that the eyeglass/contact replacement part is excluded from Medicare and, thus, the patient will be billed for that amount. The normal lens allowance should be subtracted from the charge, or it is considered a form of double billing. Medicare pays for the IOL as part of the facility fee.

Since the NTIOL process began in 1999, CMS has approved two NTIOL classes. The Multifocal Corrective IOLs and Toric classes were created in 2000 and expired in 2005. CMS stopped paying the additional $50 NTIOL payment for these classes in May 2005.

[Editor's note: For more information, go to www.cms.hhs.gov/apps/media/press/release.asp?Counter=1762. The notice was published in the Federal Register *on Jan. 27, 2006. To access that notice, go to www.gpoaccess.gov/fr/index.html. For more information, contact Michael Lyman at CMS. Telephone: (410) 786-6938.]* ■

CDC to conduct survey on outpatient surgery

For the first time since 1996, the Centers for Disease Control and Prevention (CDC) will conduct the National Survey of Ambulatory Surgery (NSAS).

The survey was halted after 1996 due to a lack of resources, but it will resume in 2006 to fill the gap in information about surgical procedures that are increasingly being performed in an outpatient setting. The new survey will provide detailed information on a national level.

The NSAS gathers data on surgery in freestanding ambulatory surgery centers as well as hospital outpatient settings. Surgery centers and hospitals are selected randomly across the country, and individual patients are selected randomly within surgery centers and hospitals. Data are abstracted from patient records on characteristics such as sex, age, race and ethnicity, type of payer, diagnoses, procedures, type and duration of anesthesia, and symptoms during and after surgery.

The identity of surgery centers, hospitals, and patients sampled for the NSAS are held in strict confidence by CDC, but de-identified data are available to researchers.

While only one in 10 surgery centers or hospitals will be sampled for the NSAS, it is vital for all sampled facilities to participate, according to CDC researchers. A high participation rate ensures better estimates of ambulatory surgery, and a low rate weakens the data.

The CDC contracts with the U.S. Census Bureau so ambulatory surgery programs that are selected for the survey will be contacted by the Census Bureau during the summer of 2006. Participating centers will abstract approximately 12 records for each month in 2006. If for any reason a center cannot do the sampling and abstracting itself, then a trained Census Bureau staff member will be available to abstract the records, but the preferred method is for surgery program staff members to abstract the data from

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. ■

COMING IN FUTURE MONTHS

- Tips for reducing surgical site infections
- Preparing for new accreditation standards
- Ideas for improving OR efficiency
- Family presence during scope procedures — the pros and cons
- How to know if your patients understand their discharge instructions

the center's medical records, because they are most familiar with their records and better able to provide data of the highest quality.

For more information about the NSAS, go to www.cdc.gov/nchs/nsas.htm and click on the link for "National Survey of Ambulatory Surgery" in the center of the page. ■

Random unannounced surveys end in 2007

Although the Joint Commission on Accreditation of Healthcare Organizations previously announced that random unannounced surveys would continue through 2008, the date for the end of random unannounced surveys has been changed to Dec. 31, 2007, says **Mark Forstneger**, spokesperson for the Joint Commission.

The Joint Commission conducts unannounced surveys on a 5% random sample of accredited organizations every year to ensure that demonstrate that organizations remain in compliance with Joint Commission standards throughout the three-year accreditation cycle. Random unannounced surveys are conducted nine to 30 months following the organization's accreditation date.

All Joint Commission surveys are unannounced as of Jan. 1, 2006. ■

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.

13. What benefits does a service to provide personal DVD players and a choice of movies to family members in your waiting area give a same-day surgery program, according to Cathy Boyer?
A. Less anxious family members who ask staff members to check on patients less often.
B. New source of income for same-day surgery program.
C. Greater patient satisfaction because experience for patient and family members is improved.
D. A and C

14. How does the use of argon plasma coagulation decrease the need for patient education for some of his patients, according to plastic surgeon Denis F. Branson, MD?
A. The procedures are finished more quickly.
B. He doesn't have to explain the method he uses to coagulate blood.
C. He doesn't have to teach how to care for drains in the incision site.
D. Insurance companies don't require the patient education.

15. What is the ideal number of members for an effective rapid response team, according to Kathy D. Duncan, RN?
A. Four people, including a physician
B. Two people, including a respiratory therapist
C. There's no specific number as long as expertise in critical patient assessment is present.
D. The number depends upon the time of day the team is covering the hospital.

16. Under a new Medicare coverage policy, which of the following procedures are covered?
A. Open and laparoscopic gastric bypass
B. Open and laparoscopic biliopancreatic diversion with a duodenal switch
C. Lap band surgery
D. All of the above

Answers: 13. D; 14. C; 15. C; 16. D.

SDS ACCREDITATION UPDATE

Covering Compliance with Joint Commission and AAAHC Standards

Rapid response teams are not just for inpatient units

Education, support from RRTs part of patient safety culture

Rapid response teams are a strategy that relies on a team called to a patient's bedside to investigate potential problems that might lead to a Code Blue, and this strategy is proving effective in reducing patient deaths.

Rapid response teams are one component of a total patient safety culture that the Joint Commission on Accreditation of Healthcare Organizations is considering for inclusion in the 2007 National Patient Safety Goals for hospitals.

This strategy works great for inpatients and critical care patients, but do rapid response teams apply to the outpatient surgery setting? Absolutely, according to experts interviewed by *Same-Day Surgery*.

"It is very important for an outpatient surgery center that is linked to a hospital to be involved with the rapid response team set up within the hospital," says **Danita R. Turner**, RRT, manager of the respiratory care department at Gwinnett Health System in Lawrenceville, GA. "Our medical response team [MRT] is getting more calls from outpatient departments as we've expanded our educational efforts and as employees are more aware of what we can do to help them," she says.

Gwinnett's MRTs are comprised of one intensive care unit (ICU) supervisor or charge nurse and one respiratory care supervisor. The combination of these two disciplines is important because before the establishment of a MRT, when staff members asked an ICU nurse to assess a patient who appeared to show signs of distress, the nurse often would arrive to discover that the problem was respiratory and a respiratory therapist would have to be called, says **Joanne M. Culvern**, RN, CCRN, manager of the hospital's ICU department. "By having both departments respond, we can make sure that no time is lost in assessing the patient," she explains.

The MRT at Gwinnett does not include a physician in the initial call because there often is no need for one, says Turner. "If we do reach the patient and we determine that a physician is needed, we call one of our hospital-based physicians," she says.

Physicians like the concept of the MRT because there is an established relationship with the ICU nurses and a high level of trust in the nurses' ability to assess and evaluate a patient's condition, reports Turner.

"Many times we don't have to do much more than reassure the nurse who called that he or she is doing the right thing for the patient," points out Turner. "Our primary purpose is to be an extra pair of hands and extra experience to help the nurse who is concerned about a patient," she says. The MRT members do not take over care of the patient but they do assess the condition and recommend a course of action to address the patient's new symptoms, Turner adds.

Size of team not important

Kathy D. Duncan, RN, a faculty member at the Institute for Health Improvement (IHI) in Cambridge, MA, and the key IHI consultant for rapid response teams, isn't aware of a freestanding surgery center that has established a rapid response team. However, Duncan points out that the concept of rapid response is "not about the team as much as the philosophy of rescuing people earlier than a Code Blue situation."

"I've seen large hospitals with large rapid response teams, and I've seen critical access and specialty hospitals with a rapid response 'team'

of one person," says Duncan. A small facility does not need a large team — just a well-qualified person who is experienced in assessing critical patients and is designated as expert backup in a situation in which a nurse needs an extra pair of eyes and a second opinion, she adds. "Because situations in an outpatient surgery program may be related to respiratory distress due to anesthesia, look for someone who can handle respiratory problems," she suggests.

"I encourage outpatient surgery departments within a hospital to make sure they are included in rapid response team coverage and educate staff members about the existence of a team," says Duncan. "It is probably more critical for outpatient departments to increase staff awareness because outpatient staff members are accustomed to healthy patients and routine procedures."

A relatively healthy patient will compensate longer than a chronically ill patient, says Duncan. "This means that a healthy 50-year-old man who comes in for a hernia repair will hold his oxygen saturation level longer and will be able to maintain his respiratory rate longer, even when there is a problem, than a 60-year-old with chronic renal failure," she says.

The decline of the chronically ill person will be much slower and will be noticeable sooner than the decline of the healthy patient because the signs of the healthy patient's decline are subtle, Duncan explains. "Once he demonstrates obvious symptoms of decline, the decline will be fast, and he will be harder to rescue," she adds.

The main benefit of a rapid response team is the increased awareness of patient safety and the emphasis on calling for assistance even when there may not be significant changes in a patient's condition, says Duncan. "Some facilities hand out protocols that list specific parameters that indicate a need to call a rapid response team, and a few just suggest that staff members call if they think something is wrong," she says. "The most effective approach is a combination of both."

The criteria for call Gwinnett's MRT is very broad, but it is printed on a small card that is given to all staff members at educational meetings about the MRT, says Culvern. "We have a set of triggers such as heart rate below 40, abnormally high or low blood pressure, and decreased urine output so that nurses do have some guidelines," she says. "Because every patient's normal rate for different vital signs is different, we did not want a nurse restricted to specific numbers, so we emphasize that if the nurse has a concern, even if the patient's condition is not changing rapidly, the MRT can be called." ***[Editor's note: This card is available online.*** *If you're accessing your online account for the first time, go to www.ahcpub.com. Click on the "Activate Your Subscription" tab in the left-hand column. Then follow the easy steps under "Account Activation." If you already have an on-line subscription, to go www.ahcpub.com. Select the tab labeled "Subscriber Direct Connect to Online Newsletters. Please select an archive." Choose "Same-Day Surgery," and then click "Sign on" from the left-hand column to log in. Once you're signed in, select "2006" and then select the April 2006 issue. For assistance, call Customer Service at (800) 688-2421.]*

With the emphasis on development of a patient safety culture within accreditation organizations, strategies such as rapid response teams will provide a safe, nonpunitive way for nurses to "raise the red flag" and ask for help, says Duncan. "The key is to help the patient before the Code Blue' must be called," she says. ■

SOURCES/RESOURCE

For more information about rapid response teams, contact:

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- **Danita R. Turner**, RRT, Manager, Respiratory Care, Gwinnett Health System, 1000 Medical Center Blvd., Lawrenceville, GA 30045. Telephone: (678) 442-2388. E-mail: drturner@ghsnet.org.

For information on rapid response team development, go to www.ihi.org, choose "topics" on left navigational bar, then click on "improvement" and "move your dot." Then choose, "improvement stories" and scroll down to stories that describe rapid response team development.

Alert addresses medication errors

Reconciliation prevents mistakes

More than 10% of all sentinel events reported by organizations accredited by the Joint Commission on Accreditation of Healthcare

Organizations relate to medication errors, and in ambulatory and office-based surgery organizations the rate is almost 8%.

Miscommunication can be fatal

According to the Joint Commission, in a *Sentinel Event Alert* issued this year, 63% of the medication errors that resulted in death or serious injury were a result of communication breakdowns. Half of the communication breakdowns would have been avoided with effective medication reconciliation, according to the report authors. **(See recommendations, p. 4.)**

Because his surgery center conducts the preoperative evaluation and gathers information on the patient's medications by telephone three days prior to surgery, it is important that the nurse making the call is good at gathering medication information, says **Geoffrey Hibbert**, RN, director of nursing at the Center for Special Surgery in Greenville, SC. "Not only is that first telephone call our chance to make a positive impression on the patient, but we also need to make sure we get the most accurate information," he explains.

The nurse who handles his pre-op evaluations is an RN with more than 18 years of experience, Hibbert reports. "She asks about prescription medications, vitamins, over-the-counter medications, and herbal supplements," he explains. As she talks to the patients about other medical conditions that may exist, she will ask them what they are taking for that condition, in order to make sure no medications are missing from the list, Hibbert adds. **(For information on herbal supplements, see "Study says patients can take some herbs until 24 hours before surgery," *Same-Day Surgery*, September 2001, p. 97.)**

After talking with the patient, the nurse reviews the list of medications for potential interactions with drugs administered during surgery, makes sure all allergies are noted in the chart, and consults with the anesthesiologist if she has questions about a medication's potential risk for interaction, says Hibbert. Even if the pre-op nurse does not notice any potential problems, the surgeon and the anesthesiologist review the medication list prior to the day of surgery, he says.

"Our medication information is collected on a standardized form that is placed in the same location in every patient's chart," Hibbert points out. This standardization means that staff member at each phase of care do not have to search for the information, he adds.

At University of North Carolina Health Care System in Chapel Hill, an electronic medical record is used to capture all of the preoperative information, including detailed lists of prescription medications, over-the-counter medications, vitamins, and herbal supplements that the patient may be using, says **Larry Mandelkehr**, CPHQ, director of performance improvement. The electronic record and the paper chart that follows the patient through the outpatient surgery process are standardized so that medication information appears in the same place in the chart for all patients, he adds.

Cover medications at discharge

Upon discharge, patients received detailed discharge instructions that explain what new medications are being prescribed, how much to take, when to take, and how to take the medications, explains Mandelkehr.

"The discharge instructions also include when their last dose was administered and when they should take the next dose," he says.

This information is important because patients may not be aware that a pain medication was given to them in the recovery room and that they can take their next dose four hours from that point as opposed to four hours from their discharge time.

"Patients and their caregivers are also given instruction on over-the-counter or herbal supplements they should avoid," says Hibbert. "If a patient is taking a medication that contains acetaminophen, we don't want the patient to take an over-the-counter acetaminophen for a headache, so we explain what is in each medication."

Hibbert's facility will not release a patient until the family caregiver has been given discharge instructions, he says. "Although we prefer that the caregiver be in the facility to take the patient home when we are ready to discharge, it doesn't always happen. If patients have to wait any time, even up to several hours, for a family member to pick them up, we don't let the patient leave until we have presented discharge instructions to the caregiver as well."

Not only do patients get to hear the discharge instructions again, but staff members can be sure that instructions have been given to someone who has not been under anesthesia and is fully alert, he adds.

The key to an effective medication reconciliation process is to involve all areas in the development, suggests Mandelkehr. Physicians, nurses,

pharmacists, and information technology staff members working together will generate a lot of ideas that can be considered, he says. One item that his facility is investigating is software that can be used to identify potential drug interactions at the initial stage of obtaining medication information, he says.

"Technology can't replace the knowledge of our clinicians who gather and review medication information, but it can act as a backup to ensure patient safety," he adds.

When reviewing your reconciliation process, be sure to build a lot of checks and balances, suggests Hibbert. "When something bad happens, it doesn't happen because of one mistake, it happens because a lot of mistakes along the way were made," he says. "We triple- and quadruple-check our records by requiring everyone who comes into contact with the patient to check medications and other items such as surgical site, so that we can catch errors in our information before they affect the patient's safety." ■

SOURCES/RESOURCES

For more information on medication reconciliation, contact:

- **Geoffrey Hibbert**, RN, Director of Nursing, Center for Special Surgery, 209 Patewood Drive, Suite 300, Greenville, SC 29615. Telephone: (864) 527-7700. E-mail: ghibbert @centerforspecialsurgery.com.
- **Larry Mandelkehr**, CPHQ, Director of Performance Improvement, University of North Carolina Health System, 101 Manning Drive, Chapel Hill, NC 27514. Telephone: (919) 966-0488. E-mail: lmandel@unch.unc.edu.

The Institute for Healthcare Improvement web site includes a section on Medication Reconciliation Review, including samples of a reconciliation tracking tool and a medication reconciliation flow sheet. Go to www.ihi.org, click on "topics" on left navigational bar, choose "patient safety," then choose "medication systems." Under "medication systems," click on "tools," then choose "medication reconciliation" to see a list of forms and tools that can be used for medication reconciliation.

To see a full copy of the *Sentinel Event Alert*, go to www.jcaho.org. In the "headline news" section, choose "Sentinel Event Alert, Issue 35: Using medication reconciliation to prevent errors."

JCAHO tips to avoid medication errors

The most recent *Sentinel Event Alert* issued by the Joint Commission on the Accreditation of Healthcare Organizations addresses medication reconciliation and the importance of this process in reducing the risk of medication errors.

To reduce errors related to medication reconciliation, the *Alert* authors' recommendations include[1]:

• putting the list of medications in a highly visible place in the patient's chart and include essential information about dosages, drug schedules, immunizations, and drug allergies;

• reconciling medications at each interface of care, specifically including admission, transfer, and discharge. The patient and responsible physicians, nurses, and pharmacists should be involved in this process;

• providing each patient with a complete list of medications that he or she will take after being discharged from the facility, as well as instructions on how and how long to take any new medications. The patient should be encouraged to carry this list and share it with any caregivers who provide any follow-up care;

• developing clear policies and procedures for each step in the reconciliation process.

As part of its current National Patient Safety Goals, the Joint Commission also requires that each accredited health care organization[1]:

• implement a process for obtaining and documenting a complete list of the patient's current medications upon admission. This process includes a comparison of the medications the organization provides to those on the list. The patient should be asked to describe or confirm any prescription medications, over-the-counter medications, vitamins, herbs, or other supplements that he or she takes;

• communicate a complete list of the patient's medications to the next service provider when the patient is referred or transferred to another setting, service, practitioner, or level of care within or outside the organization.

Reference

1. Joint Commission on the Accreditation of Healthcare Organizations. Using medication reconciliation to prevent errors. *Sentinel Event ALERT* 2006; 35. ■

MEDICAL RESPONSE TEAM

Just call 4420

Anyone can initiate an MRT

WHEN TO ACTIVATE THE MRT TEAM

The most important reason to activate the MRT is when you feel uncomfortable with a patient's situation and you desire an additional clinical opinion. Some <u>examples</u> of reasons to call:

- Respiratory distress, threatened airway, change in breathing
- Acute change in BP or HR
- Acute change in LOC
- Decreased urine output without history of renal dysfunction
- New, repeated or prolonged seizures
- Failure to respond to treatment

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- Failure to respond to treatment

Source: Gwinnett Hospital System, Lawrenceville, GA.