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IN THIS ISSUE

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Has the patient given informed consent?
Outpatient surgery staff is last line of defense

The patient is ready for surgery, or so the surgeon says. However, the circulating nurse says the patient is asking about the risks of the surgery and appears to be confused about what procedure is being done. Now the nurse is questioning whether this patient gave informed consent.

"That's been a dilemma for nurses for a very long time," says **Ramona Conner**, RN, MSN, CNOR, perioperative nursing specialist at the Center for Nursing Practice at the Association of periOperative Registered Nurses (AORN). The perioperative nurse is responsible for ensuring informed consent has been obtained and that it's appropriately signed and on the patient's record prior to surgery, Conner says. "The circulating RN is the last guardian, the last one to check it," she says.

So what's an outpatient surgery manager to do in this situation? If necessary, the nurse should delay administering of preoperative meds (if ordered) until the physician is located to answer any issues or unresolved questions the patient still has, says **Waldene K. Drake**, RN, MBA, vice president of risk management and patient safety at Cooperative of

EXECUTIVE SUMMARY

Informed consent, if handled incorrectly, can result in liability for the surgeon or surgery facility.

- When possible, informed consent should take place before the day of surgery. If the day of surgery first visit is unavoidable, the surgeon still must handle the informed consent, and it must be done before the patient is sedated.
- Patients should not be offered guarantees regarding their outcomes.
- To gauge a patient's comprehension and literacy, nurses can ask, "Is there any more information you need before having this procedure?"
- Your program's policy on informed consent should discuss the right of the nurse or supervisor to delay surgery and preoperative medications when a patient has verbalized concerns.

American Physicians-Mutual Protection Trust (CAP-MPT) in Los Angeles. Your policy on informed consent should discuss the right of the nurse/supervisor to delay surgery and preoperative medications when a patient has verbalized concerns, she says.

The repercussions of not doing so can be severe. The Physician Insurers Association of America says that 15% of all surgical claims involve allegations of failure to obtain informed consent or failure to clarify elements of informed consent.

In 41% of all closed claims that include those allegations, the patients receive payments, the association says.

However, it's a significant liability for surgery center or hospital staff members who aren't surgeons to try to provide the informed consent discussion, says **Anne M. Menke**, RN, PhD, risk manager at the Ophthalmic Mutual Insurance Co. in San Francisco. "In some states, it's illegal, because they're practicing medicine," she says. "They're increasing their liability if they try to explain what's going to be happening and why." Instead, the staff should be making certain that the patient understands what's being done and has had a discussion with the surgeon, she says.

Informed consent cannot be delegated to anyone else by the surgeon, Menke says. "Everyone has role in helping educate the patient about his condition and the proposed treatment of medication or surgery, but only the surgeon has the knowledge requirement to obtain an informed consent," she says. Menke points to a recent malpractice lawsuit in which a $3 million dollar verdict was obtained by a patient who, among other claims, said there was no personal discussion of the eye procedure with the surgeons, although the patient did sign an informed consent.[1] Some outpatient surgery programs put language into their medical staff bylaws that require surgeons to obtain informed consent in their offices prior to surgery. While the surgeon should discuss the benefits and risks of the procedure, the outpatient surgery program should have a separate consent form that the patient signs giving consent to be treated at the facility, sources say. The facility consent should state that the patient has met with the surgeon and discussed the need for and the potential risks of the surgery, sources say.

Often patients have been informed about the risks and benefits of the procedure in the surgeon's office, but they might not have absorbed all of the information given to them and they might not have understood what they were told, Conner says. "Sometimes they feel more comfortable asking an RN until they really clearly understand," she says.

Outpatient surgery practitioners face some particular challenges with informed consent because they often offer procedures that traditionally have been performed in hospitals, says **Lewis A. Lefko**, partner with Haynes and Boone, a Dallas-based law firm. Patients having these procedures often question why their case is being handled differently. Another challenge is that because patients are going home after surgery, practitioners need to discuss the nature of the risks so that patients under-

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stand what postoperative problems might develop, he says.

Some outpatient surgery programs face the additional challenge of serving patients who live a long distance away and can't be seen until the day of surgery.

Those patients can be sent the informed consent document ahead to time to read and ask questions, Menke says. The morning of surgery, before patients are sedated, the surgeon personally should obtain the patient's informed consent, she says. However, some patients who had an informed consent discussion on the day of surgery have later sued and argued that they were forced to have the procedure and didn't have time to consider the benefits and risks, Menke warns.

It's important for physicians to convey that they are genuinely concerned about their patients, Lefko says. "That's why I prefer informed consent between physician and patient take place in physician's office, rather than when a patient is being rolled into OR," he says. "Surgery centers and hospitals are pretty intimidating."

Keep in mind that informed consent can't be obtained from a patient who is sedated, Menke says. However, if the patient simply has dilated eyes, a family member of staff member may read the consent form to the patient, and then the patient can sign it. That person's name and relationship to the patient should be documented on the form, she adds.

Additionally, when a patient's surgery unexpectedly changes after the case has started, a modified informed consent may need to be obtained from a relative who has been informed of the situation, sources say. In such a situation, the informed consent should be separately documented.

3 tips for a better informed consent

Keep these additional tips in mind involving informed consent:

• **Ensure patients understand there are no guarantees.**

Patients need to understand the procedure and how it relates to the condition they have, Lefko says.

"Make sure that they understand the benefits and risk so that if a positive outcome doesn't occur, that they don't blame the physicians," Lefko says. "They need to understand that there is a risk with all medication treatment, and there are no guarantees."

• **Be attuned to health literacy problems.**

Literacy experts estimate that more than half of people being given medical information don't understand it, Lefko says. "Patients, because of their culture, background, the information being given, or their grasp of the English language, may have trouble understanding the health terms," he says. For cues, look to body language or a lack of questions, Lefko suggests. Say, "Can you tell me in your own words what we just discussed," or "Can you tell me what you understand," he adds.

Some nurses ask patients, "Is there any more information you need before having this procedure?" Drake says. "I think that succinctly keys the nurse into how well this patient was prepared by the physician," she says.

Health care has gotten significantly more technical, Lefko points out. "Terms are not easy to understand, and not everyone understands medications and what they do," he says. 'They don't always understand the setting, such as an ambulatory surgery center." Provide care that takes into consideration the culture of the individual and

Nagging questions on informed consent

When the Centers for Medicare & Medicaid Services (CMS) issued its interpretive guidelines in 2005 on informed consent for hospitals, it required them to list all staff members who would be assisting with the procedure. Many facilities, particularly teaching hospitals, have protested that such information isn't known when the patient signs the informed consent, which is often days or weeks before the procedure.

CMS has indicated that it is reviewing this requirement, and some managers of hospital outpatient surgery departments have assumed that they are not required to list these staff until a final determination is made, sources say. However, CMS officials have indicated that its surveyors are requiring facilities to meet this requirement, sources says. There is one exception, however; facilities are not required to list any residents who are assisting the physician, sources say.

Another area of confusion with the interpretive guidelines is whether there is a need for a separate anesthesia consent form, says **Lewis A. Lefko**, partner with Haynes and Boone, a law firm in Dallas.

While CMS is requiring anesthesia providers to participate in the informed consent process, the agency isn't requiring a separate written consent form, Lefko says. ■

their ability to understand English, Lefko advises.

Rely upon trained interpreters rather than family members, sources suggest. An outpatient surgery program cannot rely upon the interpretive skills of a third party if they are not professional or certified interpreters with a health care background or experience, sources say. Such interpreters are needed to accurately answer questions and convey concerns of a patient, which is critical to the informed consent process, they say.

• Know who developed an informed consent form before you adopt it.

Before grabbing any type of informed consent form to copy, know who developed it and who commented on it, Lefko suggests. Several states, such as Texas, have medical disclosure panels that develop such forms, he says. **[English and Spanish copies of the Texas informed consent form are available with the on-line edition of the November 2006 issue of *Same-Day Surgery*. Go to www.ahcpub.com. For assistance, contact customer service at customerservice@ahcmedia.com or (800) 699-2421. For access to more consent forms, see resource box, below.]**

"You can fill those in, but the form doesn't keep you from having discussion," Lefko emphasizes. Also, keep in mind that different physicians may use different techniques, such as laparoscopic vs. an open approach, so the risks may be different, Drake says.

The form can help prepare patients for potential complications, Menke says. "That's also an important piece of informed consent: Patients are important members of the health care team," she says. "If they are better informed, they are better able to make their surgery go as good as possible."

SOURCES/RESOURCE

For more information on informed consent, contact:

- **Lewis A. Lefko**, Partner, Haynes and Boone, 901 Main, Suite 3100, Dallas, TX 75202. Phone: (214) 651-5608. Fax: (214) 200-0424. E-mail: lew.lefko@haynesboone.com. Web: www.haynesboone.com.
- **Anne M. Menke**, RN, PhD, Risk Manager, Ophthalmic Mutual Insurance Company, 655 Beach St., San Francisco, CA 94109-1336. Phone: (800) 562-6642, ext. 651. Fax: (415) 771-1810. E-mail: amenke@omic.com.

More consent forms, including a general consent form, are available from the Ophthalmic Mutual Insurance Company. Go to www.omic.com. Click on "Informed Consent Documents."

Reference

1. New York jury issues $3 million verdict in medical malpractice case. *LexisNexis Mealey's Personal Injury Report* Aug. 10, 2006; 3. Accessed at www.mealeys.com/free%20views/per.htm#_New_York_Jury> citing *Gropack v. Eric D. Donnenfeld, MD.* ■

Surgeons less likely to disclose errors

Study says surgeons provide fewer details

A recent study suggests that compared to medical physicians, surgeons disclose less information about their errors.[1] Nineteen percent of surgical specialists said they would explicitly mention the error to patients; in comparison, 58% of medical specialists said they would do so.

In the survey, mailed to medical and surgical physicians in the United States and Canada, participants received one of our scenarios depicting serious errors. The errors varied by specialty (medical and surgical) and by how obvious the error would be to the patient if not disclosed. Five questions measured what respondents would disclose using scripted statements.

In addition to suggesting that surgeons disclose less information to avoid an explicit apology for the error, the study indicates that surgeons tend to provide fewer details about preventing recurrences of errors, despite their greater reported willingness to disclose errors, says **Thomas William Mayo**, JD, director of the Maguire Center for Ethics and Public Responsibility; associate professor at the Southern Methodist University/Dedman School of Law; adjunct associate professor of internal medicine at The University of Texas Southwestern Medical School; and counsel for Haynes and Boone; all in Dallas.

Respondents disclosed more information if they had positive disclosure attitudes, felt responsible for the error, had prior positive disclosure experiences, and were Canadian. "For a surgery manager, this [study] suggests the need to encourage surgeons to discuss their disclosure practices explicitly, to develop institutional guidelines for appropriate disclosure, and to consider training — when that is available — to improve interpersonal

interactions, including communications about surgical error," Mayo says. "The time has arrived to consider the skillful disclosure of error as an essential aspect of high-quality patient care."

The disclosure of medical errors may be required under some circumstances, but it is a good idea under all circumstances, Mayo maintains. "Skillful and sensitive disclosure can enhance the trust relationship between physician and patient, or at least help prevent the loss of trust that may otherwise result when a serious error has occurred," he says.

Honesty is one component of disclosure, but it is not the only one, Mayo says. "The timing of the disclosure, the amount of information disclosed, the use of blame-shifting language, and the apparent willingness to continue to provide honest, helpful support as more information becomes available — these are all elements of effective, patient-oriented disclosure," Mayo says. ■

Streams of water, balloons offer back pain relief

New techniques offer minimally invasive option

What do a stream of water, a balloon, and a titanium implant have in common? They are all components of new techniques to treat different conditions that cause back pain, and they all can be performed in an outpatient surgery setting.

After conservative treatments such as epidurals, massage, physical therapy, and acupuncture have not relieved back and leg pain caused by a herniated disc, the next step does not have to be major back surgery, says **Didier Demesmin**, MD, a pain management specialist in Milltown, NJ. Hydrodiscectomy is an outpatient procedure that s performed under local anesthesia. "When you remove some of the nuclear material from the disc, you can reduce the amount of pressure that is causing the disc to herniate," he explains.

Using the Hydrocision SpineJet Hydrodiscectomy System (Hydrocision; Billerica, MA), Demesmin removes the nuclear material with a high-pressure stream of water. **(To obtain more information on the system, see resource box, p. 115.)** "It takes about three minutes to remove 20% of the nuclear material to reduce the herniation," he says.

Hydrodiscectomy takes about 30 minutes to perform, and discharge is usually one to 1½ hours after the procedure is complete. "There is some soreness where the tool went through muscle in the back, but the patient is usually free of any pain or soreness associated with the herniated disc and the procedure in one to two weeks," says Demesmin.

With proper patient selection **(See story on patient selection, p. 114)**, the success rate for hydrodiscectomy is between 70% and 80% for total relief, says Demesmin. "Even patients who experience a 50% reduction in pain appreciate the procedure because it does enable them to reduce narcotic medication they may be taking, and it is an improvement," he says.

Patients like reducing the use of narcotics to control pain for many reasons, including the cost-savings, says Demesmin. Reimbursement is not a problem for the procedure, so it is a win-win for the patient, he adds. **(For more information on reimbursement and costs, see p. 115.)**

The benefit of hydrodiscectomy over other procedures to reduce nuclear material in the disc is the use of water, which does not conduct heat and does not exclude older patients from the procedure, says Demesmin. "As people age, their discs degenerate and lose moisture content," he says. "Other discectomy procedures rely upon a certain amount of moisture in the disc to properly and safely work, but hydrodiscectomy can be performed on patients of all ages."

While hydrodiscectomy cannot be used for patients whose back pain is caused by lumbar spinal stenosis (LSS), the X Stop Interspinous Process Decompression System is the first technique available for treatment of the condition that is

EXECUTIVE SUMMARY

Minimally invasive procedures that can relieve back pain on an outpatient basis are now available.

- Hydrodiscectomy uses a high-pressure stream of water inserted into a herniated disc to reduce the amount of nuclear material, which reduces the pressure on the disc wall. The success rate for hydrodiscectomy (total relief of pain) is 70%-80%.
- Balloons inserted into a fracture of the spine can correct the deformity caused by the fracture, which enables the surgeon to cement the bone to stabilize it and relieve pain. Ninety-eight percent of balloon kyphoplasty patients experience total or near total relief of pain.
- X STOP procedure resolves pain in patients with lumbar spinal stenosis by positioning the spine so that pressure is not placed on nerves.

caused by a narrowing in the lumbar spinal canal that carries nerves to the legs. **(For more information on the X Stop, see resource box, p. 115.)** As the space shrinks, the nerves that go through it are squeezed, causing pain in the back, legs, and buttocks.

"X Stop is the closest thing to a no-risk procedure for these patients as possible with any type of surgery," says **James F. Zucherman**, MD, an orthopedic surgeon in San Francisco and inventor of the procedure. Typically, LSS patients are treated with nonoperative treatments such as steroid injections, which has a success rate of less than 13%, he says. The next step to treat LSS has been fusion of the spine to stabilize it and prevent further narrowing. "The benefit of the X Stop procedure is that we can stabilize the spine without removing tissue or eliminating any other treatment in the future," he says.

In the X Stop procedure, a titanium metal implant is placed between the spinous processes of the vertebrae in the patient's lower back, says Zucherman. "It is designed to be a permanent implant without attaching to the bones or ligaments," he explains. The implant positions the spine so that the spinal canal is not squeezing the nerves, he adds.

You must screen patients carefully

Ensuring good outcomes for any procedure means making sure that the procedure is the right treatment for the patient's condition, and patient screening for back pain treatments is essential for success, says **Didier Demesmin**, MD, a pain management specialist in Milltown, NJ.

When using hydrodiscectomy to treat back pain, make sure that the patient's back pain is caused by a herniated disc and not spinal stenosis or fractures, he emphasizes. Good candidates for the procedure also must have at least 50% of their disc height, no infections, and no slippage of discs. "Once these other causes and conditions have been ruled out, hydrodiscectomy is a good choice," Demesmin says.

Most patients who are candidates for X Stop Interspinous Process Decompression System are older than the age of 50 with pain in the buttocks and legs that makes it difficult to stand and walk, says **Arya Shamie**, MD, a spine surgeon at Santa Monica-University of California at Los Angeles Medical Center. Not all patients with these symptoms are appropriate for the procedure, he explains. Patients with severe osteoporosis are not candidates for X Stop because the implant can cause a fracture when placed against weakened bones, and patients with more than two levels affected by lumbar spinal stenosis (LSS) are not candidates, either, Shamie says. "Also, if the patient does not get relief from the pain when sitting, he or she is not a candidate," he adds.

While balloon kyphoplasty is a very successful treatment for patients with spinal fractures as a result of osteoporosis, there are some patients who should not undergo the procedure, says **B. Christoph Meyer**, MD, an orthopedic surgeon in Houston. Patients who are not good candidates for balloon kyphoplasty have underlying infections that can spread into the area in which you inject the cement, or they have medical conditions that increase the risk of anesthesia, he says. ■

Balloons and cement treat fractures

While a herniated disc can cause severe pain, spinal fractures in an osteoporosis patient not only mean persistent pain, but few realistic treatment options as well. Treatment for spinal fractures related to osteoporosis typically have been treated by bed rest, medication, and bracing, but this approach does not offer relief from continuing pain and deformity of the spine caused by the fracture.

B. Christoph Meyer, MD, an orthopedic surgeon in Houston, says vertebroplasty is a procedure that has been around for a while, and it does relieve pain when cement is placed in the bone to stabilize it. The disadvantage of vertebroplasty is that the deformity caused by the fracture is not addressed, and the cement freezes the deformity so that it cannot be corrected, he explains.

"Balloon kyphoplasty allows me to use a minimally invasive procedure to insert a balloon into the space where the fracture occurred, inflate the balloon to partially correct the deformity, and then cement the bone to stabilize it," says Meyer. "Ninety-eight percent of my patients have total or near total pain relief following balloon kyphoplasty."

His patients are very satisfied with the results of the procedure, and one way that Meyer knows about this satisfaction is the patient's reaction if they suffer a fracture in another part of their spine. "About 15% of my patients will have additional fractures because osteoporosis puts them at risk," he says. "While they are hesitant or anxious the first time I suggest balloon kyphoplasty, when they come to me with another fracture, they are the ones who suggest the procedure." ■

New treatments for the back cut costs

The ability to go home within 23 hours, the reduced need for anesthesia, and fewer potential complications all add up to less expensive procedures for treatment back pain when you evaluate hydrodiscectomy, X Stop, and balloon kyphoplasty.

The cost of hydrodiscectomy is about $1,100 per tool, but the tool can be used two or three times on the same patient if more than one disc is herniated, says **Didier Demesmin**, MD, a pain management specialist in Milltown, NJ. "This procedure is very attractive to insurance companies, and reimbursement is not a problem if you select the patients carefully and perform a post-procedure MRI to prove the disc reduction," he says.

Local anesthesia with oral sedation to reduce anxiety is used because he does not want the patient asleep during the procedure. "Patients can give me feedback to let me know what sensations they feel so that I can make sure I am addressing the problem," Demesmin explains. "I do recommend that an anesthesiologist be available in case the patient needs deeper analgesia."

At this time, the majority of Demesmin's patients do require intravenous sedation that requires monitoring. "When the tool pierces the muscle, patients who are anxious tend to move, which makes it difficult to get a clear picture of where the tool is heading," he explains. The deeper analgesia relaxes the patient so that movement is limited but allows the patient to remain conscious, he adds.

The X Stop procedure enables patients to go home the day of surgery or to be held in a 23-hour stay unit, says **Arya Shamie**, MD, a spine surgeon at Santa Monica-University of California at Los Angeles Medical Center. The Centers for Medicare and Medicaid services recently approved a $4,400 add-on to reimburse hospitals the extra cost of new technology, he says. "Not only is this procedure one-third to one-half the cost of a laminectomy, but there is also no lengthy stay, and the patient does not have to be exposed to the risks of general anesthesia."

Balloon kyphoplasty can be performed under local or general anesthesia, and **B. Christoph Meyer**, MD, an orthopedic surgeon in Houston, uses conscious sedation for 25%-30% of his patients. "In general, the procedure lasts 30 minutes for each level you are treating," he says.

"Right now, I would do almost every balloon kyphoplasty on an outpatient basis, but Medicare reimbursement of this procedure as an outpatient procedure does not cover the hospital's costs," Meyer points out. Although about 20% of his patients do go home on the same day of the procedure, he does book it as an inpatient procedure, he adds.

Meyer does expect Medicare reimbursement policies to include balloon kyphoplasty as an outpatient procedure as more procedures are performed and the financial benefit of performing the procedure as an outpatient procedure are more thoroughly documented. Private insurance companies are more likely to cover the procedure as outpatient, he adds. ■

SOURCES/RESOURCES

For more information about back procedures, contact:

- **Didier Demesmin**, MD, Accucare Pain Medicine, 440 S. Main St., Milltown, NJ 08850. Telephone: (866) 322-6500 or (732) 967-1001. Web: www.accucarepainmedicine.com.
- **B. Christoph Meyer**, MD, 8200 Wednesbury Lane, Suite 360, Houston, TX 77074. Telephone: (713) 484-6200. Fax: (713) 773-0905. Web: www.spinehouston.com.
- **James Zucherman**, MD, One Shrader St., No. 450, San Francisco, CA 94117. Telephone: (415) 750-4877. E-mail: yaquai@aol.com.

For more information on back pain products and techniques, contact:

- **Hydrodiscectomy:** HydroCision, 22 Linnell Circle, Suite 102, Billerica, MA 01821. Telephone: (888) 747-7470 or (978) 474-9300. Fax: (978) 600-5037. E-mail: info@hydrocision.com. Web: www.hydrocision.com. To find information on hydrodiscectomy, choose "products" on the top navigational bar, then scroll down to "hydrodiscectomy system."
- **X Stop:** St. Francis Medical Technologies, 960 Atlantic Ave, Suite 102, Alameda, CA 94501. Telephone: (510) 337-2600. E-mail: info@sfmt.com. Web: www.sfmt.com. To find information about X Stop, choose "LSS Fact Sheet" on left navigational bar. You also can choose "patient information" on top bar, then choose "The X Stop System" on the left navigational bar.
- **Balloon Kyphoplasty:** Kyphon, 1221 Crossman Ave., Sunnyvale, CA 94089. Telephone: (408) 548-6500. Fax: (408) 548-6501. Web: www.kyphon.com. To find information on balloon kyphoplasty, choose "Healthcare Professionals" on top navigational bar, then select "Balloon Kyphoplasty" on left navigational bar.

Liposuction, exercise, and nutrition = good outcomes

Illinois surgeon offers formal follow-up program

With more than 450,000 procedures performed in 2005,[1] liposuction remains the most frequently chosen cosmetic procedure in the United States. With this many patients looking for a surgeon and with the number of surgeons from whom they can choose, it is important to find a way to differentiate your liposuction services from others.

The Lipo Lifestyle Program, developed and introduced in his Chicago-area practice by E**dward Lack**, MD, formalizes the advice given by many surgeons to patients who elect to undergo liposuction procedures. "I have always stressed the importance of nutrition and exercise to achieve the maximum benefit of liposuction," he says. "In the past 10 years, I've noticed that there is a significant difference in outcomes between patients who do follow surgery with regular exercise and good nutrition and the outcomes of patients who don't follow a regular exercise program."

After years of recommending exercise and offering nutrition advice to patients, Lack developed a formal program that combines the surgery with follow-up care designed to ensure the best results. Patients who undergo liposuction with him receive a package of eight sessions with a trainer to be used for the first month following surgery and a complimentary visit with a nutritional counselor. "There is no extra charge for these items, but we emphasize that regular exercise will improve the results of their surgery," says Lack.

"I also have my patients walk four miles each day beginning the day after surgery and lasting a minimum of 30 days," he says. "Not only does this get the patient started on a program of exercise to keep them fit, but it also reduces the amount of pain medication they need following surgery." Lack does allow patients to break up the four-mile daily walking distance into two walks.

The nutritionist and trainer that are part of the Lipo Lifestyle Program are two people Lack found as he was recovering from pancreatic cancer. "Both nutrition and exercise were important to my recovery, and I saw that my liposuction patients would benefit from professional advice in these areas," he explains.

Lifestyle programs are common in bariatric surgery practices, but Lack is not aware of another program geared toward liposuction patients. "If a physician does want to begin such a program, I'd suggest starting on an informal basis to make sure you are comfortable with recommending exercise the day after surgery," he suggests. It also is important to choose the other members of your team carefully, Lack adds.

Valerie Rivelli, business manager for Lack's practice, says, "The people you select as your trainer and nutritionist have to present the same message that you are presenting to your patients." Make sure you screen them carefully and that they have several years of experience, she suggests. The experience requirement for the Chicago program is a minimum of 10 years to ensure that they have experience working with a lot of different people and that they have developed a good reputation in their fields, she says. Staying up-to-date on the latest in their fields and being comfortable working with all types of patients are also important to look for in your team members, she adds.

Space & coordinator needed for success

Once you've found a nutritionist, you need a room for the consultation, Rivelli says.

Currently, the nutritionist doesn't have a set schedule, she says. Instead, she comes in when she's scheduled to see a patient, Rivelli says. The surgery office coordinates the patient's schedule and the nutritionist's schedule to arrange the consultation. "When we have more patients in the program, we will look at specific days for the

EXECUTIVE SUMMARY

As office-based surgery practices look to differentiate their services in the marketplace, new programs that address more than the procedure itself may be beneficial. A Lipo Lifestyle Program, developed by a Chicago cosmetic plastic surgeon, offers patients a follow-up plan that includes nutritional advisement and a month of sessions with a trainer who will develop an exercise program for the patient.

- Choose nutritionist and trainer carefully to ensure they represent your program the way you expect it to be.
- Plan space for nutritional counseling, and handle the scheduling.
- Be sure staff members know and understand the program.
- Designate a program coordinator to oversee details of program.

SOURCE

For more information about the Lipo Lifestyle Program, contact:

- **Edward Lack**, MD, MetropolitanMD, 2350 Ravine Way, Suite 400, Glenview, IL 60025. Telephone: (847) 832-6700. Web: www.metropolitanmds.com.

nutritionist to be in the office," Rivelli explains.

Patients go to the gym at which the trainer works for the exercise part of the program, she adds.

You also need to designate a program coordinator to oversee the management, scheduling, and marketing of the program, suggests Rivelli. At this time, the coordinator's position is incorporated into another staff person's job, but as the program grows, it may require a full-time person.

In terms of marketing, they use direct mail, community presentations, and fliers distributed through the office, says Rivelli. "At this time, the new patients we are seeing heard about us through other patients," she points out.

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Because liposuction is an elective procedure for which patients pay from their own pockets, it is important to make sure that your package pricing is not higher than your competitor's pricing for liposuction only, warns Rivelli. "We negotiated fees with the trainer and nutritionist that we pay out of the price we charge the patient," she explains. "We see it as an important part of offering a service to the patient and believe that it will benefit the program in the long run."

The most important part of putting a lifestyle program in place is educating your staff members, says Lack. Not only do they need to know about the program, but also staff members and the surgeon need to be involved in maintaining their own healthy lifestyles, he says. "A surgeon's advice to a patient to exercise and eat well sounds very hollow if it is obvious that the surgeon doesn't follow that advice," he points out.

The knowledge of all staff members is also critical, adds Rivelli. "A patient may be walking down the hall after talking with the surgeon and even if they asked questions during their discussion with the doctor, they will still ask staff members if the program really works," she says. Patients will ask how it works, if it will cost more, and if it really makes a difference in outcomes, Rivelli explains. "Staff members need to be familiar with the program to be able to answer confidently and reassure the patient."

With no other cosmetic surgeon offering the combination of liposuction and a lifestyle program, Lack is seeing patients who choose his practice because of the package. Rivelli says, "They want the best outcomes and believe that this will help them."

Reference

1. *2005 Cosmetic Surgery National Data Bank Statistics.* American Society for Aesthetic Plastic Surgery. Los Alamitos, CA; 2005. ■

Same-Day Surgery Manager

A tale of two managers — Where is the grass greener?

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

It could happen anywhere. After three days of torrential rains in Atlanta, Mary Jo finally was able to drop off her car at the car wash. As she walked into the office of the car wash, a woman was opening her briefcase and pulling out a recent copy of *Same-Day Surgery*.

Mary Jo asked, "Do you manage an outpatient surgery program?"

"Yes," she said, "How did you know?"

Mary Jo pointed to the newsletter. "Me, too."

The woman extended her hand, "I'm Vonda."

"Mary Jo. Nice to meet you." Their hands shook.

There was a short silence.

"Where do you work?"

"At the surgery center on Peachtree Circle. You?"

"In the outpatient surgery department at the hospital right down the road," she said as she pointed in the general direction of the hospital.

"Want to compare jobs?" asked Mary Jo, grinning like she was getting ready to do something wicked.

Looking around, Vonda said conspiratorially, "Yeah, but let's keep it between us."

There was a brief silence until one of the nurses spoke up.

"What is the best thing about your job?"

"The people. Definitely the people. It's like we all have a common bond. And, I will admit, challenges from the competition, if you know what I mean." She laughed. "It's like we all have to work harder now."

"Same with us. It's really changed with all the stuff happening in the industry." She was reflective. "But I still wouldn't work any other place."

"Me too. Our biggest issue right now is being more time efficient. They are really on us to get cases started on time and reduce turnover time. Sometimes I think we push the limit on what we can do."

"I know what you mean. But that's really what it is going to take to keep the surgeons working there. But it's not as 'patient-focused' anymore. I miss that."

There was a moment's silence again as they both reminisced.

"Maybe we all need to learn that, the efficiency thing. Seems like that is what everyone, including the patients, want."

The other woman nodded knowingly, "How's the pay?"

"Ah, never enough! But they are trying to come up with incentives that are starting to make sense to everyone. I think we are finally starting to come around to realizing this is a business that, like it or not, revolves around more than just good patient care."

"What about anesthesia? We are having a tough time getting them for cases now that there are all these different locations."

"Yeah, I know. They keep getting pulled in all directions. They complain about it to the docs all the time. Doesn't seem to be much of a solution, however."

The other woman nodded.

"Do you like it? I mean, do you ever think about leaving and coming over to us?"

"No. I mean, yes! I love it. I just couldn't work in your environment. There is nothing wrong with it, it just . . . isn't for me." She leaned over and whispered, "But we do talk about you guys all the time. Sometimes we think you guys are deliberately making it tough for all of us."

She nodded, "Yeah, I know what you mean. We talk about you guys, too, like how you can stand working in that place."

Question: Where does Mary Jo work? *[Editor's note: Please send your response and your reasons for choosing that response to Earnhart at searnhart@earnhart.com. 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.]* ■

Clinical guideline on nausea posted on-line

The American Society of PeriAnesthesia Nurses has produced an evidence-based, multidisciplinary, multimodal approach to preventing and treating postoperative nausea and vomiting (PONV).

The clinical guideline was developed by a panel of 18 experts who reviewed and analyzed published evidence related to PONV prevention and management. The guideline's recommendations address identification of risk factors, traditional treatment modalities such as pharmacology, hydration and NPO status, and complementary treatment modalities such as acustimulation and aromatherapy.

To see a copy of the guideline go to www.aspan.org. Under the "Clinical Practice" heading on the top navigational bar, select "PONV/PDNV guideline." At the bottom of the page, click on "PONV/PDNV Guidelines." ■

COMING IN FUTURE MONTHS

- Risk managers share ways to reduce liability in outpatient surgery
- How can you ensure your clinical competency program is top notch?
- An easy way to reduce anxiety and lower blood pressure, heart rates
- New resource to help your accreditation survey go more smoothly

Center finds way to make holidays more meaningful

Staff boost morale, image with idea

Want to boost staff morale and your community image with one effort? Consider this inspired idea from the staff at AtlantiCare Surgery Center in Egg Harbor Township, NJ.

As the December holidays approached last year, a few members of the staff decided not to exchange gifts with each other. Instead, they thought of helping needy families in their area. The idea spread through the staff members who, along with some physicians affiliated with the center, decided to help four local families. The staff previously had been involved in charitable giving by shipping more than 70 boxes of supplies and clothing to a former employee who was working at a hospital on the Gulf Coast that had been depleted by the 2004 hurricanes. "We already were in a gift-giving mode, and we expanded it to the holiday time," says **Francine Daley**, RN, CNOR, director of nursing.

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The staff organized the effort and contacted a local charitable group to find needy families. At meetings, staff had the opportunity to select family members by age groups. One mother had requested only food for her family, but the surgery center staff went beyond that request and contributed gifts and clothing, as well as holiday dinners, for all the families. Some of the

CE/CME instructions

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

SOURCE

For more information on helping needy families, contact:

- **Francine Daley**, RN, CNOR, Director of Nursing, AtlantiCare Surgery Center, Egg Harbor Township, NJ. Phone: (609) 407-2200. E-mail: fdaley@atlanticare.org.

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.

17. What is one requirement to be a good candidate for hydrodiscectomy, according to Didier Demesmin, MD?
A. No history of herniated discs
B. Minimal back pain
C. An active infection
D. At least 50% of normal disc height for the herniated disc

18. Which of the following procedures my be appropriate for patients with spinal fractures due to osteoporosis if there is no underlying infection, according to B. Christoph Meyer, MD?
A. Balloon kyphoplasty
B. X Stop
C. Hydrodiscectomy
D. None of the above

19. What test must be performed following a hydrodiscectomy to ensure reimbursement, according to Didier Demesmin, MD?
A. X-Ray
B. Range of motion test
C. MRI
D. Standard lab work

20. What is one benefit of developing a Lipo Lifestyle Program, according to Valerie Rivelli, business manager of MetropolitanMD?
A. The ability to charge higher prices for liposuction
B. Increased insurance reimbursement
C. A way to differentiate the surgery practice and attract new patients
D. An opportunity to increase staff responsibilities

Answers: 17. D; 18. A; 19. C; 20. C.

families choose to pick up the items at the surgery center, which gave staff members the opportunity to meet them, Daley says. "It gave them a better connection and a spirit of giving at Christmas time," she says.

The event was a morale booster for staff, Daley says. "I think that gave them more of a focus of working together as a team and providing something for people in need rather than just exchanging gifts among each other," she says. 'It brought everyone together with one goal."

Additionally, the center received positive publicity from the local newspaper and the newsletter distributed to AtlantiCare organizations. ■

Correction

In the August 2006 issue of *Same-Day Surgery*, a quote referring to endoscopy programs should have identified them as "diagnostic-oriented." Endoscopy programs are considered surgical programs by the Joint Commission on Accreditation of Healthcare Organizations. ■

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	(4)	Other Classes Mailed Through the USPS	33	42
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	(2)	In-County as Stated on Form 3541	1	1
	(3)	Other Classes Mailed Through the USPS	0	0
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f. Total Free Distribution *(Sum of 15d and 15e)*			50	50
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I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including multiple damages and civil penalties).

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PS Form **3526**, September 1999 *(Reverse)*

Joint Commission revises look-alike/sound-alike list

For the first time in several years, the Joint Commission on Accreditation of Health Care Organizations has revised the look-alike/sound-alike drug list.

In addition to identifying pairs or groups of medications that easily can be confused, the list identifies potential complications and strategies to avoid confusion. Medication pairs added to the list for surgery programs are: hydroxyzine and hydralazine, metformin and metronidazole, and Oxy-Contin and oxycodone. Medication pairs deleted from the list are: cisplatin and caroplatin, fentanyl and sufentanil, lantus and lente, and taxol and taxotere.

Ambulatory and office-based surgery program managers can view the list at www.jointcommission.org. Go to "Patient safety" on top navigation bar and select "National Patient Safety Goals." On right-hand side of page, look under "Resources" and select "Look-alike/sound-alike drug list." ■

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Avoid hiring woes by keeping your current good employees

Educational opportunities, meaningful bonuses appreciated by staff

"The best offense is a good defense" is often said by athletic coaches, but the same concept applies to recruitment and retention of employees. While many managers look carefully at how their outpatient surgery programs recruit new employees, it is just as important to look carefully at what you are doing to retain the good employees you have now, say experts interviewed by *Same-Day Surgery*.

In the past six years, the staff at Harmony Ambulatory Surgery Center in Fort Collins, CO, has grown to accommodate the 8%-11% annual growth in volume of cases handled, but the key to the center's success has been a low turnover rate, says **Rebecca Craig**, RN, CNOR, CASC, administrator of the center.

In the July 2006 issue of *Same-Day Surgery*, 780 salary surveys were mailed to readers, and 10.7% of the readers responded to the survey. Although almost 46% of respondents to the 2006 *Same-Day Surgery* Salary Survey reported no change in their staff size in the past year, slightly more than 42% did report an increase in staff size. While increasing in volume and staff size is exciting, it does pose challenges, she admits.

"We have usually had no problem finding applicants for positions, but the local hospital is opening another trauma facility and is hiring at a higher salary rate than we pay," she says. Craig still receives qualified applicants for her positions, but not as many as she used to receive, she adds.

More than 80% of respondents to the *SDS* Salary Survey reported increases in their salaries that ranged from 1% to more than 21%, with the largest percentage (33.33%) reporting increases of between 4% and 6%. Respondents also reported salaries that ranged from $50,000 per year to more than $130,000 per year, with the largest percentage (22.62%) reporting salaries between $90,000 and $99,000 per year. **(See charts, p. 2.)**

'People move for lifestyle reasons'

While the competitiveness of your salary in the marketplace may affect the number of applicants you attract, salary alone usually is not a reason for people to leave your outpatient surgery program, reports **Laurie J. Wensink**, RN, MBA, MSN, clinical director of perioperative services at Luther Midelfort Hospital in Eau Claire, WI.

"I have found that people move for lifestyle reasons," she says. These reasons may include flexible schedules, a friendlier workplace environment, or an opportunity to grow professionally, Wensink notes. "If you can address employee's needs for these things within your own organization, you will retain good employees."

The most important first step to take once you've hired a new employee is to make him or her feel welcome, suggests Wensink. "I call new employees after they've been hired and given a start date, but before they report to work to tell them how happy I am that they will be joining our staff," she says. "I also tell them the name of the staff member who will greet them on their first day and give them their tour and be available to answer their questions."

After Wensink's call, the "peer" staff member also calls the new employees to welcome them and

answer any questions that new hires are reluctant to ask Wensink. "There are a lot of unwritten cultural rules," says Wensink. For example, new employees may wonder whether staff can take time off for their child's doctor's appointment. "No new employee wants to ask that of the new boss, but everyone is comfortable asking that of a peer," she says.

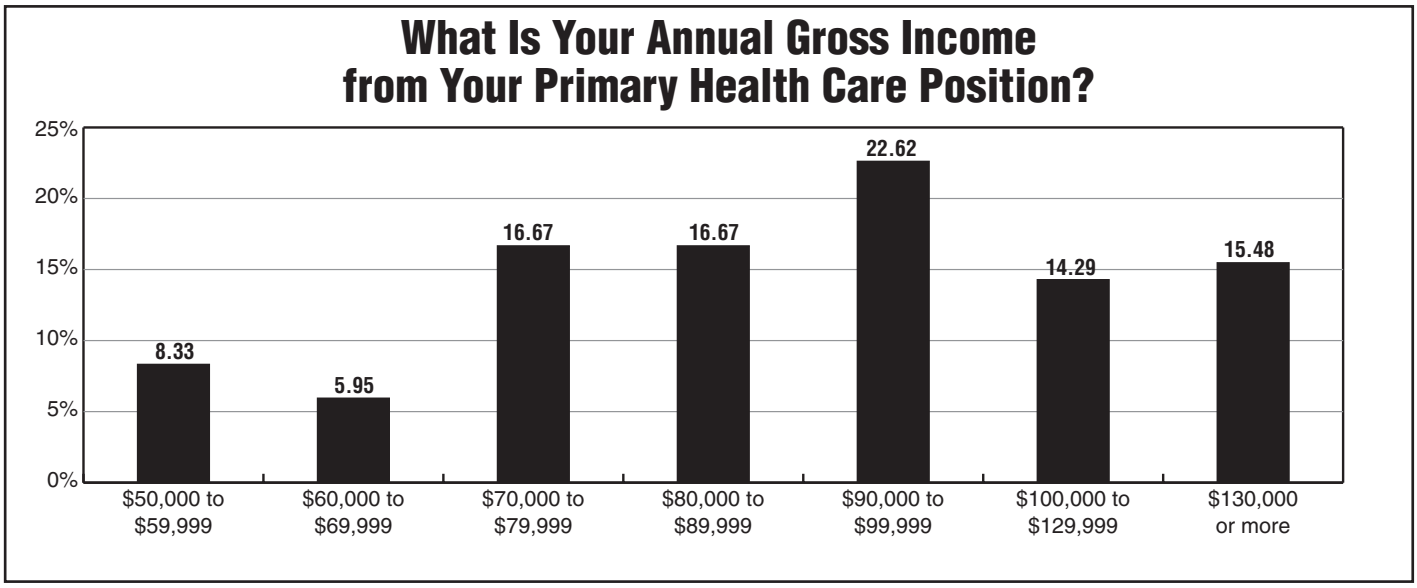
They also make sure the new employee's name is written on a mail slot in the employee lounge, so the staff member can point to it and say, "here's your mailbox," says Wensink. "It's a small thing, but it shows that they are already part of the team," she explains. Wensink also sends an e-mail to all staff members the day before a new employee's first day with a brief introduction of the employee. "It is very reassuring to a new employee to hear people say that they knew he or she was coming and that they are excited to have them join the team," she adds.

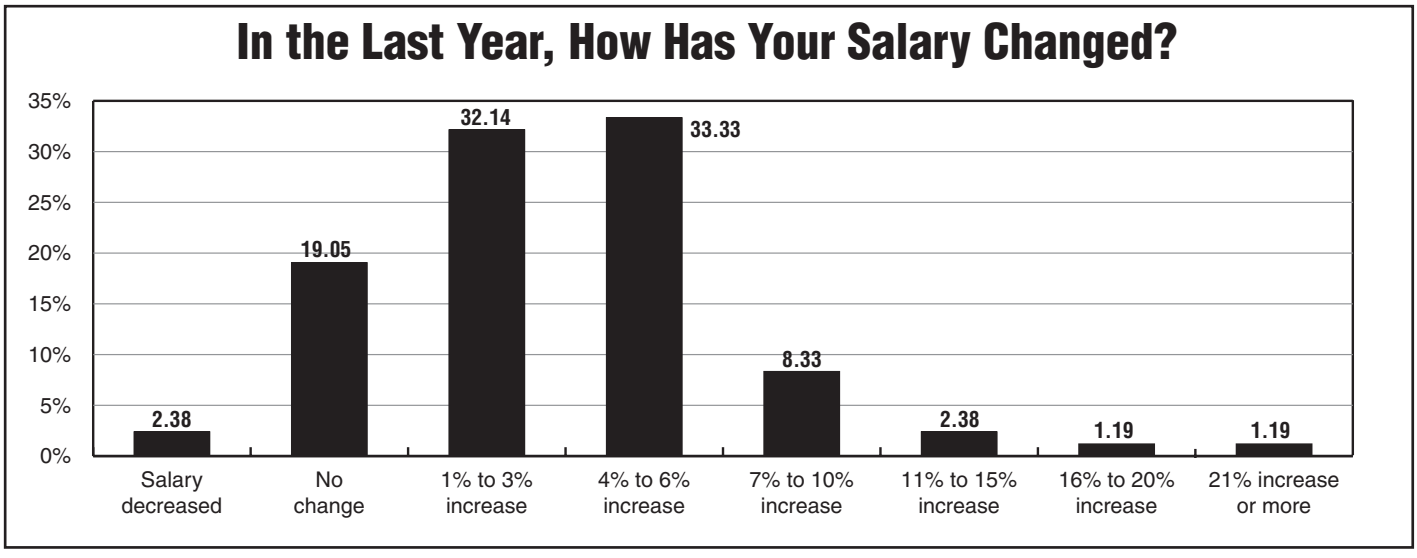
Once the new employee has started employment, make sure that your orientation program is interesting and specific to the job, suggests **Mary P. Malone**, MS, JD, president of Malone Advisory Services, a South Bend, IN-based patient and employee satisfaction consulting firm. Interactive sessions, use of on-line education programs, tours, and a variety of speakers can improve any orientation session, she says.

The most important way you can improve orientation is to make it applicable to the individual employee, Malone points out. "Revitalize the traditional orientation to include mentors for new employees," she suggests. "Formalizing a mentor program not only ensures that new employees get skills training they need for their job, but it also recognizes experienced employees for their knowledge and talent," Malone explains.

Tailor program to age, experience, skill

When you evaluate recognition and reward programs to enhance your retention rates, it is important to look at employees' experience and





age, suggests Malone.

"You might have a nurse in her mid-30s with over 15 years of experience and a nurse in her mid 40s who is just entering the profession," she points out. "Each of these employees is looking for something different to stay interested in your organization."

Remember, too, that you need to take into account how long the employee has worked in outpatient surgery, not just health care, suggests Malone. "A nurse with 15 years of experience in a hospital setting is a very different employee than another new employee with 15 years of outpatient surgery experience," she points out. It is very common to have employees move to outpatient surgery from other health care fields, as shown by salary survey respondents who have all worked in health care for 10 or more years, but slightly more than 45% have been in outpatient surgery for less than 10 years. **(See charts, this page.)**

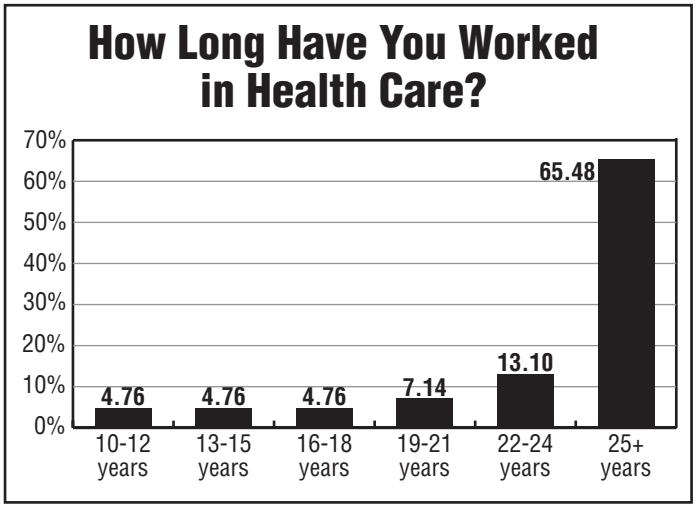
Signing bonuses have become popular in competitive markets, but Wensink questions their value. A signing bonus might make someone choose one job over another, but it doesn't provide an ongoing incentive to stay, she points out.

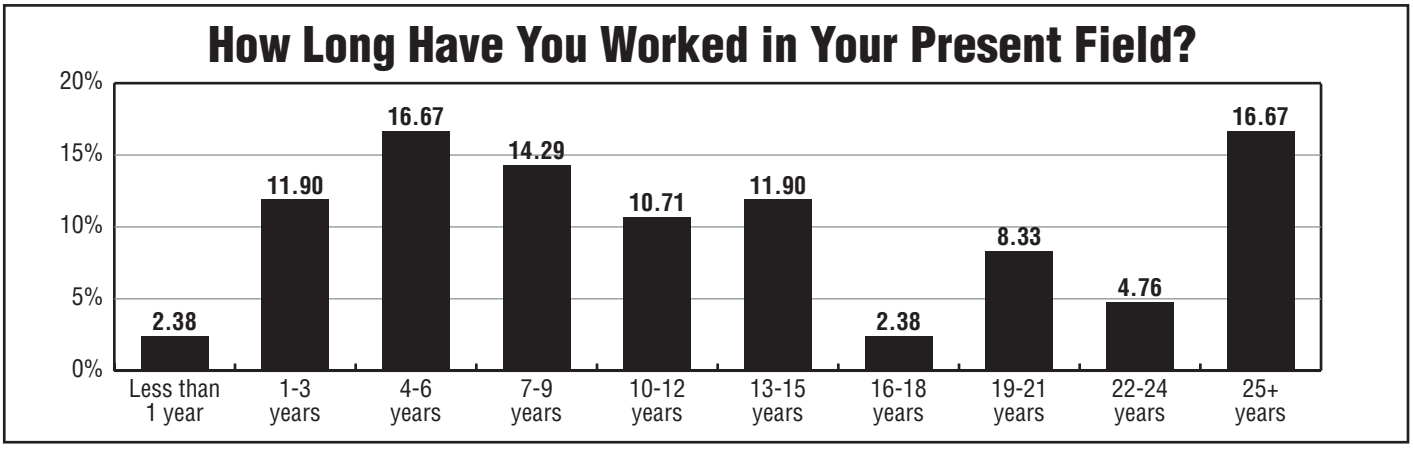
"In a previous hospital in which I worked, the critical care unit was piloting an incentive program that rewarded employees who consistently stepped up to take extra shifts above and beyond the requirements for their FTE level," she says. "Employees were given a $250 bonus each quarter that they pitched in and helped when staffing was tight." The bonus check was sent separately from the paycheck so it was easily recognized as something special, she points out. "I don't know how it could work in outpatient surgery, but I liked the idea of rewarding employees for specific actions that truly helped the unit," she adds.

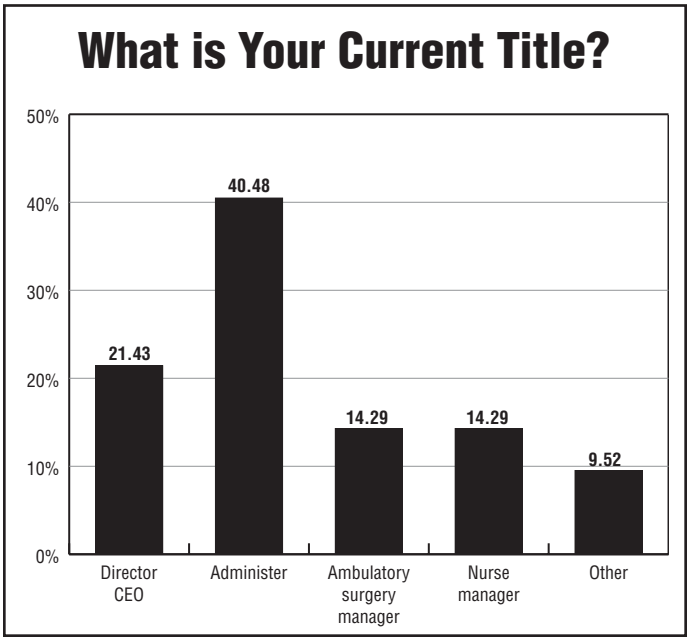
Wensink's current employer offers a different type of monetary recognition. "In addition to an annual cost of living raise, employees can receive between 1% and 4% performance raise that is based on employee evaluations and performance throughout the year," she says. This is another way to let employees know that you have noticed their effort during the year and that you appreciate it, she says.

If your program offers bonuses that are tied to the organization's performance, consider giving it more often than annually, recommends Craig. At her center, employees receive a bonus that is directly proportionate to the quarterly distribution given to the investors, she explains. "We base the amount on the wage and FTE status of the employee instead of the number of hours or shifts worked." The bonus is based on FTE rather than hours worked because the center will send people home if they are not needed. People who are sent home due to a slow surgery schedule should not be punished financially, Craig says.

The danger with monetary rewards or recognition is that if the money appears in a check, then the employee forgets that it is a reward for specific performance and assumes that the money will just continue. That is not the case with education, however, points out Wensink. "People will forget that they got a 50-cent per hour bump in pay, but if I tell someone that I appreciate the good job that they do and I'd like to send them to an educational seminar







as a reward, it is a more memorable form of recognition," she says.

The key with using educational seminars or conferences as a reward is to know the areas in which your staff members want to learn more, Wensink adds. "I make it a point to know what my employees short and long-term goals are, then I offer them a chance to progress toward those goals," she says.

Sometimes the educational opportunities won't cost more than giving the nurse a few hours out of the operating room to attend a lecture given by a staff physician, points out Wensink. "The key is to make your offer mean something to that employee," she says. The value of this type of recognition is twofold, Wensink says. Not only does the employee appreciate the educational opportunity, but the employee also appreciates the fact that you did listen to his or her goals, she adds.

Lunches for staff members and holiday giveaways are always welcome, but another reward that means a lot to employees is a day off, says Craig. "We hold a drawing each month," she says. The names of employees who have had no discipline actions during the month are placed in the drawing, and the winner receives an extra day off. "Only 12 people win during the year, but everyone gets excited about the monthly drawing," Craig says.

An important part of retaining employees is that the workplace environment is welcoming and that people enjoy being there, says Craig. Not only does a good environment keep employees at your program, but it also ensures that applicants hear about openings through word-of-mouth, she says.

In Fort Collins, the hospital that is a joint venture partner with Craig's center developed behavior standards for hospital employees. Craig incorporated the standards into her own employee performance evaluations. "Everyone knows up front what is expected, so it is easy to talk with an employee if there is an attitude problem," she explains. Not only do the behavior standards minimize problems but they also reassure all employees that everyone is expected to work as a team, Craig adds. **[A copy of these standards is available with the on-line version of *Same-Day Surgery* at www.ahcmedia.com. For assistance, contact Customer Service at (800) 688-2421 or ahc.customerservice@ahcmedia.com.]**

While it is important for administrators to be open and communicative with employees, remember that the strongest relationship an employee develops is with his or her immediate supervisor, says Malone. More than 61% of the salary survey respondents carry the titles of director, chief executive officer, or administrator, but there are many supervisors within an outpatient surgery program that can affect the organization's retention rate, she explains. **(See chart, p. 4.)** "One mistake that is often made is to promote people for the wrong reasons," she says. Instead of basing promotions on seniority, years of experience, or clinical skills, look for people who can develop strong relationships, Malone suggests.

One way that all levels of management can build relationships with employees is to walk around and ask questions, suggests Craig. Ask the right questions, she emphasizes, such as, "What's working well for you?" Such questions also will lead to suggestions that will improve the employee's ability to do the job, she says. When a nurse said she needed another vital signs monitor and another employee said that they needed chairs for family members in the preoperative and postoperative area, Craig was able to do something to help. "Employees want to have the tools they need to do their job," she points out. "Being able to provide simple things like chairs demonstrates that we do value their contribution and we do listen to their suggestions." ■

RESOURCE

For other information about research and strategies used by other health care organizations to retain employees, go to the Robert Wood Johnson Foundation web site at www.rwjf.org. Choose the "Interest Areas" tab on the top navigational bar and select "nursing." Click on "Publications" or "Research."

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★I smile and introduce myself to customers, both in person and on the phone. Before ending a conversation I ask, "Is there anything else I can do for you?"
★I anticipate my customer's needs.
★I promptly respond to patient call lights, phone calls and customer needs.
★I walk customers to where they want to go.

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We are all responsible for creating a positive experience in our workplace.

★I have the attitude that I am a co-owner of PVHS and reflect this in my actions. I take care of our property and equipment.
★I take responsibility for my attitude and actions. I treat others with dignity and respect; rudeness is not acceptable.
★I am compassionate, caring and cooperative.
★I am supportive and flexible when change occurs.
★I identify opportunities for improvement.
★I take a proactive approach to problem-solving. If a problem is identified, I first ask "What can I do to help resolve the situation?"
★I have a "can do" versus "that's not my job" attitude.

SAFETY

We strive to maintain a safe, accident-free environment.

★I protect myself and others by using appropriate precautions.
★I report concerns, hazards, or faulty equipment.
★I return items to their proper place.
★I take appropriate actions for spills.
★I pick up trash.
★I wash my hands to protect myself and others from infection.

PROFESSIONAL APPEARANCE

We represent PVHS and show respect for customers through our grooming, dress and care of facilities.

★I dress appropriately to promote credibility, safety, and project a professional image to customers.
★I follow the PVHS dress code policy.
★I clean up after myself.
★I keep my work area clean and neat.
★I wear my ID badge where it can be easily read.

COMMUNICATION

We talk, listen, and interact with others in a way that is consistent with our values.

★I communicate in a respectful and professional manner. Non-verbal communication is as important as what I say.
★I listen attentively to others to fully understand their needs before responding, and ask questions when needed.
★I acknowledge others, make eye contact and smile.
★I use proper manners, including please, thank you, and apologies.
★Before I speak, I consider who might be listening and what is appropriate in that situation.
★I have the courage to communicate issues directly and honestly with people. I do not gossip.
★I keep current on organizational information.
★I respond to others in a timely manner.

COMMITMENT TO PVHS TEAM

We rely on fellow employees and they rely on us to accomplish our mission.

★I show respect to all members of the PVHS team: volunteers, employees, managers, medical staff, students and others.
★I help new or less experienced staff feel welcome.
★I promote others by describing them in a positive way.
★I respect the privacy and confidentiality of my co-workers.
★I arrive on time to work and meetings.
★I do the right thing because it is the right thing to do, whether anyone is watching or not.
★I respect the strengths each person brings to the team.

PVHS Vision: *To be a world class health care provider*
PVHS Mission: *To be an independent, non-profit organization and to provide innovative, high quality, comprehensive care that exceeds customer expectations.*
PVHS Values: *Quality, Compassion, Confidentiality, Dignity/Respect, Equality, Integrity*

Source: Poudre Valley Health System, Fort Collins, CO.