



Same-Day Surgery

Covering Hospitals, Surgery Centers, and Offices for More than 30 Years

— 2007 SDS Reader Survey, SDS Accreditation Update, Patient Safety Alert



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Georgia hospital hit by F3 tornado — post-op patients, others evacuated

OR conducts immediate procedure, then patients triaged in hallway

Many outpatient surgery managers are prepared, at least to some extent, to respond to a disaster in their communities, but what do you do when your facility *is* the disaster?

The new operating room director at Sumter Regional Hospital was at home after 9 p.m. March 1, 2007, when the F3 tornado struck Americus, GA. Although **Midge Schuster**, RN, BSN, had no power, she received a call from an out-of-town friend who had seen on the news that the hospital had been severely damaged and that all nurses and physicians in the area were requested to report. Although Schuster lives about a five-minute drive from the hospital, it took her 45 minutes to arrive there. **Susie Fussell**, BSN, RNC, VP of nursing at Sumter Regional, had the same experience. "We were weaving through debris, streets lights, street signs all hanging down, and power lines," she recalls. "It was just unbelievable."

The area surrounding the hospital had been devastated, and two people died in a residence directly behind one of the hospital buildings. When Schuster finally arrived, she went in through the emergency department, which was the only lighted area on the exterior, she says. "My first sight

EXECUTIVE SUMMARY

When an F3 tornado severely damaged a hospital in Americus, GA, all patients had to be evacuated, including five patients who had undergone surgery that day.

- Fifty-three patients were evacuated by area ambulances and a school bus.
- The OR staff conducted an immediate amputation of a finger. The OR director helped direct triage and arranged medications for post-op patients who were in pain from being moved.
- The hospital advises others to have an internal evacuation plan, two-way radios, a megaphone to direct staff and volunteers, and additional security.

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was that the ED doors were blown wide open, and there was debris all in the hospital," Schuster says. Branches, dirt, grass, and leaves had been thrown through the air into the facility, she says.

The hospital had declared a Level 3 disaster and was being evacuated, due to the instability of the building. The hospital had one side that was collapsing; additionally, it had lost part of the roof, had many windows blown out, and was flooding. Seventy-five cars in the parking lot were toppled on top of each other.

The surgical hall was lined with five patients

just out of surgery that day, but no cases were going on when the tornado hit. In the hall's other direction, the wall was leaning at a 45-degree angle, Fussell says. "I thought, 'Oh my God, this place is coming down,'" she recalls. "I said, 'We've got to get these people out of here.'"

Triage ended up in OR hallway

Triage was relocated a couple of times as the building became increasingly unstable. Ultimately triage ended up being conducted in the OR hallway flowing into the ED. This part of the building was protected by being partially below ground level. Staff members were calm and comforted patients, Fussell says. "We were in ankle-deep water, with water pouring over our heads and down stairwells," Fussell says. In the middle of those dismal circumstances, staff members were carrying inpatients down stairwells on mattresses, she says. "Everybody was all business."

Schuster went immediately to the OR, which is her disaster station. When she walked in, emergency patients and inpatients already were triaged and lined down the hallways and into the OR. In the OR, all the rooms were flooded, but there was one functional OR and one cystoscopy room, she says. Because Fussell and the ED staff were warned about the tornado a few minutes before it hit, all patients were moved into interior hallways and away from windows. Subsequently, there were few serious injuries inside the facility from the tornado. There was one immediate surgery that had to be performed on a visitor who needed a finger amputated due to a door that had slammed on it. Schuster started that procedure but was able to phase in other nurses as they arrived.

Schuster worked as the "leg person" of triage to line up all the patients and get them evacuated. Anyone with a strong back joined members of the fire department and emergency medical services in moving patients, Fussell says. Post-op inpatients on the third floor were of a particular concern because they had just completed surgery that day, she says. Those patients needed pain medications after they were moved to triage. Amazingly, the pharmacy operated during the evacuation. The staff used the old-fashioned "runner" system to obtain medications, Fussell says.

Schuster obtained supplies, managed the hospitalist physician who was overseeing the triage, and matched up patients with hard copies of their records before they were evacuated. All the patients had a nurse at their side, and many had

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Editorial Questions

Questions or comments?
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at (229) 551-9195.

a physician there as well.

Many staff and area physicians showed up, with their identification badges on, to assist. "We had to know who was in there," Fussell says. Area ambulances responded, as well as a school bus for ambulatory patients, and 53 patients were evacuated to area hospitals. Because the hospital has not fully implemented an electronic records system, staff members were able to send hard copies of the patients' records with them. Two people stood outside the door where patients were being evacuated, and they verified arm-bands, patients' names, their chief diagnoses, and where they were going. Because power was out, that information was recorded manually with pen and paper. The evacuation took about three hours.

Here's what they learned

As in any disaster, there were lessons learned. One is to be prepared for the unthinkable — that your facility will be hit by a disaster — by developing an internal evacuation plan, advises **Schelly Murray, RN, BSN**, nurse manager and ER clinical coordinator.

Another lesson involves the internal wireless phones and cell phones. They were working initially, but most eventually were unusable, Fussell says. "Two-way radios would have been most useful," Murray says. Additionally, Murray had difficulty supervising the triage and patient flow because she was constantly bombarded with questions. "There was so much help on top of me, it was difficult to organize," she says. Additionally, she struggled to make her voice heard and to get people's attention above the noise and chaos. Murray says, "We needed a megaphone."

The hospital could have used additional security, Fussell acknowledges. "Everyone wanted to help and was coming in to help," she says. Murray was faced with directing patients *and* volunteers. "Eventually, we put volunteers in a waiting room and told them to await instructions," she says.

The police were shorthanded in trying to keep roads clear and manage traffic, Fussell says. When Murray requested help so that she could direct the triage and patient flow, the police requested backup help from the Department of Natural Resources (DNR), who sent a game warden. "He stood behind me to keep people away from me," Murray says. People couldn't hear Murray to follow her instructions, she says. "That

was one of the biggest obstacles," Murray says. The game warden, who was more than 6 feet tall, repeated Murray's instructions over her head when she couldn't be heard.

After the evacuation was complete, approximately six men from the DNR performed a final check of every room on every floor to ensure no one was left behind.

Surgeons, cases are relocating

The tornado not only devastated the hospital, but also destroyed several surgeons' offices. They are relocating, as needed, to other locations, including other doctors' offices.

In terms of the hospital, Schuster initially feared that everything in the OR might be lost, due to water damage. "I could visually see anesthesia machines with water dripping down on them," she says. After she was able to walk through the unit a few days later, she realized that most instruments and many double-wrapped supplies were in good condition. "The central supply area and the core [used for storage] didn't receive direct water damage," she says.

In the immediate future, Schuster is meeting with two area hospitals to discuss the possibility of continuing surgical cases at their sites. Also, the hospital is considering setting up a temporary two-room OR in Americus, but that facility would take four weeks to set up, sources say.

In hindsight, the hospital staff responded wonderfully to the disaster, Fussell says.

Even though the hospital had never drilled for an internal disaster, every staff person knew his or her role, sources say. Previous disaster drills were a significant help, they add. Murray says, "They gave us a game plan on how to evacuate internally, because they were about handling massive amounts of patients."

Fussell agrees. "They might have not done it just by the book, but they knew someone had to track every patient as they were transferred, and they knew all hands had to be on deck to evacuate," she says. "We practice and we practice all the time, I'm telling you. When you get so panicked and in the midst of chaos, it takes that practice, because it becomes what you do instinctively."

(Editor's note: To see photos of the tornado damage, go to www.sumterregional.org and click on the hyperlink for the disaster photos.) ■

What will you do if disaster hits your ORs?

SDS programs share lessons from quake, tornado

When two outpatient surgery departments faced disaster in the past year, they learned just how important it is to participate in disaster drills and to come together as a team when a crisis hits.

There was no warning when an earthquake hit Hawaii at about 7:10 a.m. on Oct. 15. Because the quake hit on a Sunday, no outpatient surgery procedures were in progress at Kona Community Hospital in Kealahou. The 6.7 magnitude quake caused a couple of dozen injuries but no fatalities. However, the quake caused damage to all three ORs, including fallen ceiling tiles, cracked walls, along with dust and debris, says **Dawn Brewer**, RN, BSN, CNOR, nurse manager of surgical services. Total damage to the hospital was estimated at \$5 million, which included staff overtime and lost surgeries.

The surgery staff learned how important teamwork is. "A lot of our surgical staff came in within an hour and were helping to clean the OR and do everything to get it fully operational," Brewer says. The work paid off. In less than one hour, one OR was fully functional for emergencies. However, the others were closed to elective surgeries for nine days, she says.

Staff called each patient and rescheduled elective surgeries, Brewer says. Staff continued to show up for work during the following nine days, Brewer says. "If they were not needed in the unit, they went elsewhere to help with the cleanup and getting the rest of the hospital up

and running," she says. Initially, only 10% of the hospital was operational.

For future disasters, Brewer says it would be helpful to have a list of persons in the community who might be able to help in a time of disaster. "They could be community volunteers or others that might be available when an emergency hits," she says.

Once the ORs were ready for elective surgery, the public relations staff provided that information to area radio stations and print media. The medical staff services office informed physicians.

The twice-a-year disaster preparedness exercises, which the outpatient surgery area participated in, were helpful in preparing for the earthquake, Brewer says. In fact, the hospital has just completed a drill about three weeks before the disaster. Participating in the drills helped the staff be clear about who would be on the response team and who would be the coordinator in an emergency, Brewer says. "It's helpful to do that every year, so you're not running around in a panic at the time of a true emergency," she says.

Include your insurance agent in your drills, to determine what services they may be able to provide in a disaster, sources suggest.

A recent study from The Joint Commission found that community-based preparation for — and response to — disasters requires more effective communication and planning among health care providers and other responders.¹ The study also found that national benchmarks are needed to measure and promote emergency preparedness planning.

Tornado hits in the middle of a drill

Sumner Regional Medical Center in Gallatin, TN, learned about the importance of disaster drills in April 2006 when a tornado came through the community in the midst of a drill that had been planned for two years.

Because of the drill, ham radios had been activated, and those radio operators reported a tornado was moving through the state. The drill immediately was suspended.

Mark Schultz, director of safety at Sumner Regional Medical Center, saw a TV report that indicated with an arrow where the tornado was headed. "The tip of the arrow was where the hospital is," he says. The hospital immediately called a Code Yellow (tornado), locked down the facility, and moved patients to center corridors. There

EXECUTIVE SUMMARY

Two outpatient surgery programs learned lessons when an earthquake and a tornado hit unexpectedly.

- Have your entire staff assist with whatever tasks may be necessary, including cleaning the ORs, running medications and other supplies, and treating minor injuries.
- Hold annual preparedness exercises so your staff will know which people hold what responsibilities.
- You may need help from your community in terms of volunteers to help with cleaning and recovery or delivery of linens, supplies, and food.

were approximately 10 patients in the same-day surgery (SDS) preparation/discharge area and ORs when staff received word of the impending tornado, says **Debbie Harper**, RN, staff nurse. In the prep area, "we pulled patients out of rooms with windows and put them in hallways or rooms where there were no windows," Harper says.

One outpatient surgery procedure was being finished when staff received word about the tornado, says **Tricia Place**, RN-C, staff nurse in the operating room. The staff were thankful that the surgery was being conducted in one of the inside ORs with no windows, Place says. The surgery was finished, and the patient was taken to a recovery room, she says.

About four minutes later, Schultz heard a police officer on the radio say, "There it is." Schultz went out the back door and saw the tornado, which came within 1¼ miles of the hospital. The Category 3 tornado hit the ground for 20 minutes and caused about 35 injuries and seven fatalities.

The disaster drills were helpful in that they indicated to the same-day surgery area what kinds of supplies they might need in an actual disaster, Harper says. Ironically, the supplies for the drill had been moved out of the area when the drill was canceled, and they had to be brought back after the tornado, Harper says.

No one was allowed to be discharged for several hours until the tornado warning was canceled and it was determined that the roads were safe for travel, she says. "There was a lot of damage in our town," Harper says.

The outpatient surgery prep/discharge area became an overflow treatment area for the emergency department (ED), she says. SDS staff treated fractures, extremities, cuts, and contusions, Harper says. "It wasn't our norm." Most of those patients were treated and released, she adds.

The typical admitting routine didn't work well in a disaster situation, Harper says. She hopes that future disaster planning will address patient flow and patient identification, she says. "We were down to a staff of three in our department, and they were having to send us people from throughout the hospital to help," Harper says. Also, in the midst of a disaster situation, it can be difficult to take the time to find a job for everyone, she adds. "It let us know that next time we could be better coordinated on using our help," Harper says.

The OR staff provided help to the ED and to the SDS treatment area, Place says. The staff also

RESOURCE

The Joint Commission and Joint Commission Resources recently cosponsored a conference on emergency preparedness that included a profile on the Gallatin, TN, tornado. For presentations and more information from the conference, go to www.jcrinc.com/14226.

became supply runners for medications that were needed in different areas, she says.

Do you use just-in-time delivery?

Disaster preparedness is a two-way street, and it's important that the hospital managers understand what they will require from the community, says **Louise Kuhny**, RN, MPH, MBA, CIC, associate director of standards interpretation at The Joint Commission.

"If disaster lasts more than a few days, [providers] that utilize just-in-time delivery of linens, supplies, and foods might need some of the things from the community if they can't get them from their regular suppliers," Kuhny says.

Additionally, you may want to have contracts in place for cleaning and glass boarding, sources suggest. Also, consider having a contract with a contractor who knows the layout and the needs of your facility, they advise.

It's essential to set up effective communication strategies before disaster occurs, Kuhny says. Internally, communicate the plan to the members of your staff so they understand their roles, she advises. Also, communicate planned improvements internally after an exercise. For example, managers may determine during an exercise that they are unable to easily identify the number of beds available and to locate patients. "That would be an improvement that needs to be communicated in terms of the people responsible for beds and the people responsible for caring for patients," she says.

Make sure your disaster exercises are meaningful, she emphasizes. "They make a difference," Kuhny says. "You learn from them. They're not just done to meet the requirements."

Reference

1. Braum BI, Vineman NV, Finn NL, et al. Integrating Hospitals into Community Emergency Preparedness Planning. *Ann Intern Med* 2006; 144:799-811. Web: www.annals.org/cgi/content/full/144/11/799. ■

Intranet keeps staff updated on news, policies

Easy access, limitless space proves tool effective

(Editor's note: This is the second part of a two-part series that examines the use of computers and networks to communicate with employees and physician offices. Last month, we looked at how an outpatient surgery program can use the Internet to tie physician offices into the scheduling system. This month, we evaluate the use of an intranet to communicate with employees.)

Using the Internet to promote communications between physician offices and outpatient surgery programs is a good way to connect with your surgeons, but have you considered using an intranet to communicate with employees?

"Our intranet was up and running the day we opened the surgery center in 2003," says **John J. Goehle**, MBA, CASC, former administrator of Brighton Surgery Center in Brighton, NY. "I knew we would have a lot of information to share with employees throughout the first months, so I knew we needed an accessible, easy-to-update communications tool," he explains.

While the Internet is accessible by anyone, an intranet is a network that is accessible by only a specific group of people, in this case, the employees of Brighton Surgery Center, Goehle explains. The 65 Brighton Surgery Center employees access the intranet by using a computer within the center to access the surgery center web site, then choose "administrator" to go to a page that asks for a login and password, says Goehle. From that point, employees can see the company calendar with meetings, special events, and parties that are scheduled, staff meeting notes that are posted for departmental meetings, and staff news updates. "At first, I updated the staff news section on a daily basis, but now it is updated every few months," he says. Not only was there a greater need for constant updates when the surgery center first opened but by posting new information each day, he ensured that even employees who were not computer-savvy were getting in the habit of checking the site daily for information, he says.

In addition to ongoing communications, the intranet also has a module that contains all of the policies and procedures for the surgery center, says Goehle. "This is extremely helpful because it is

searchable, so if you are looking for policies that relate to admissions, you can search for the word "admissions" and have all of the applicable policies appear," he says. The Association for Accreditation of Ambulatory Health Care (AAAHC) surveyor liked this system because it is easy to find policies, Goehle says.

Another module on the intranet contains staff training in video and audio formats and links staff members to policies that relate to the training session, says Goehle. "At this time there is no automatic documentation of training feature, but the system does print out a form the employee can give to the supervisor," he adds.

Accounts payable records and contracts also are accessible on the intranet, but only to select employees who need access to those items, says Goehle. At this time, employees cannot access the intranet from outside the surgery center, but the administrators are examining how to safely allow outside access, especially for investors, says Goehle. "There are a lot of possible uses for our intranet, but we have to make sure our information stays protected," he adds.

One use of the intranet that did not work as well as anticipated is the computerized communication log for nurses, admits Goehle. "The idea that nurses could complete or access the logs from any computer is a good idea as opposed to the nurse looking for the paper copy of the log," he says. "The problem is that it is a more complicated system to use and requires more training than we've been able to provide at this time."

If you are interested in setting up an intranet for employee communications, look for a web designer who is familiar with content management systems, which is a subset of web site design, suggests Goehle. "The top products, Mambo [www.mambo-server.com] and Joomla [www.joomla.org] are free, but if you don't have the information technology expertise on staff, it is necessary to pay for help," he says. Because he enjoys setting up web sites and is

SOURCE

For more information about using an intranet for employee communications, contact:

- **John J. Goehle**, MBA, CASC, Vice President of Finance, Surgery Consultants of America, Riverwalk Building., Fourth Floor, 8540 College Park, Fort Myers, FL 33919. Telephone: (585) 594-1167. E-mail: JJG@surgecon.com.

knowledgeable, Goehle designed the intranet site for his center. "It is unusual for a surgery center to have someone on staff with the knowledge and the time to do this," he admits.

While teaching employees how to use the intranet is simple, it is important to make sure you have several employees who are responsible for updating sections of the intranet, suggests Goehle. If you want your intranet to be useful as a communications tool, it requires more than one person to stay on top of the information, he says.

Employee input on content is solicited, and several good suggestions have enhanced the content, says Goehle. "The most surprising suggestion, which has resulted in the most popular section of the intranet, was a recipe section," he says. "Employees routinely posted copies of recipes from parties, staff dinners, or get-togethers in the employee lounge, but it was awkward for employees to copy the recipes. Now, the recipe is on the intranet for everyone to see and print out if interested." ■

CMS revises guidelines on informed consent

List those performing specific significant tasks

Under newly revised interpretive guidelines from the Centers for Medicare & Medicaid Services (CMS) for informed consent, hospitals are required to list all people performing "specific significant surgical tasks." According to at least one legal expert, ambulatory surgery centers (ASCs) also should follow this guideline, which that expert says will be the new standard of care.

The previous interpretive guidelines had raised

the ire of many outpatient surgery providers because they required providers to list all persons performing parts of the procedure, including closing of a wound. "The issue, particularly with teaching hospitals, was that a resident may be asked to close or do a portion of the procedure, and that may or may not have been identified during the informed consent process because residents may be floating around ORs," says **Lew A. Lefko**, partner at Haynes and Boone in Dallas.

The revised guidelines say significant tasks include "harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues," but wound closure is not listed and apparently is exempted, Lefko says. "That gives teaching hospitals a little leeway," he says.

The revised guidelines also seem to contain a loophole with some added language: "We recognized that at the time of the surgery, unforeseen circumstances may require changing which individual practitioners actually are involved in conducting the surgery."

The interpretive guidelines for surgery centers involving informed consent have not changed. ASCs must simply document properly executed informed consent. However, surgery centers should follow the hospital guidelines and document who is conducting significant tasks as part of informed consent, Lefko says. "For professional liability reasons, you don't want to do different informed consent in the ASC than in the hospital," he says.

CMS letter supports alcohol-based skin preps

In other news, CMS has issued a letter to all state surveyors supporting the use of alcohol-based skin preps in surgical settings.

The letter says the following fire risk reduction measures are appropriate:

- **Use skin prep solutions that are packaged to ensure controlled delivery to the patient in unit dose applicators, swabs, or other similar applicators; and provide clear and explicit manufacturer/supplier instructions and warnings.** "These instructions for use should be carefully followed," CMS says.
- **Ensure that the alcohol-based skin prep solution does not soak into the patient's hair or linens.** "Sterile towels should be placed to absorb drips and runs during application and should then be removed from the anesthetizing location prior to draping the patient," CMS says.
- **Ensure that the alcohol-based skin prep**

EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services (CMS) has revised its guidance on informed consent and alcohol-based skin preps.

- Hospitals must list all people performing specific *significant* surgical tasks. Closing a wound is not listed. One legal expert says this guideline is the standard of care that surgery centers also should follow.
- CMS has stated support for the use of alcohol-based skin preps.

solution is completely dry prior to draping. "This may take a few minutes or more, depending on the amount and location of the solution," CMS says. "The prepped area should be inspected to confirm it is dry prior to draping."

• **Verify that all of the above has occurred prior to starting the surgical procedure.** "This can be done, for example, as part of a standardized preoperative 'timeout' used to verify other essential information to minimize the risk of medical errors during the procedure," CMS says.

Hospitals that use alcohol-based skin preparations in anesthetizing locations should establish appropriate policies and procedures to reduce the risk of fire, CMS says. "They should also document the implementation of these policies and procedures in the patient's medical record."

According to the Association for Professionals in Infection Control and Epidemiology, the support of skin preps removes the risk of individual states banning their use, following such action in Pennsylvania and Nebraska.

(Editor's note: To view the letter sent Jan. 12, 2007 to CMS Surveyors, go to www.premierinc.com/quality-safety/tools-services/safety/topics/hand_hygiene/downloads/01a-sclletter-07-11.pdf. For more information on this topic, see "Alcohol-based skin preps receive NFPA approval," Same-Day Surgery, October 2005, p. 119.) ■

Same-Day Surgery Manager



Capital equipment process made simple

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

While we need to budget for new equipment in the surgical suites, we don't necessarily need to spend it. With already escalating costs for energy and labor, any area where we can save money or "capital" is wise planning.

Capital usually is any single piece of equipment

that is more than a certain amount of money, typically a single item in excess of \$1,000. A new sterilizer would be a capital equipment purchase, while a new minor instrument tray would not. Little known fact: The word "capital" is in reference to the U.S. capital, which is synonymous with the spending of money.

The biggest reasons for purchasing capital equipment are to replace existing equipment that is no longer functional or has become obsolete or . . . one or more of your surgeons went to a trade show.

How do you budget for capital equipment? Well, it is a bit confusing. Hospitals do it differently from surgery centers. Hospitals usually have a complicated method that entails looking at the useful life of existing equipment and taking into account how much money they have in the kitty to distribute to the various hospital departments: emergency department, med-surg, ORs, etc. It usually is so complex and difficult to understand that it is often easier for the surgeons to build their own surgery center and not have to worry about it.

Surgery centers are more schizophrenic about the process by buying capital equipment only for the surgeons who treat the staff the best.

Occasionally, both systems need to buy something for the facility. So if you ever get in a situation where you cannot get away with "smoke and mirrors" or popularity contests, you might need to consider this scenario.

New equipment (not replacement equipment) needs to be justified before you *should* purchase it. Let's consider this situation: Your plastic surgeon (who wants everything) approaches you to buy a new CO₂ laser that can obliterate eyebrows faster than the one that is sitting unused in the storage closet. The price is \$45,000. What you need to do is to find out how many *new patients* this equipment will bring to the facility. Then you need to determine the fee you can charge for this new procedure. Add in labor, supplies, and recovery time expenses. Subtract your expenses, and find out what your profit margin is on this new procedure made possible by the laser. Let's use the following numbers:

- Facility fee = \$800.
- Expenses (including labor) = \$300.

Thus, not counting your fixed overhead expenses, you have a potential profit of \$500 per case.

How many cases can you do? The surgeon tells you he/she can bring you 500 cases per year if you get the laser for him/her. Next, you need to reduce his/her expectations of new cases just a bit. Let's reduce it by, oh, say 400 cases. So you

now have a potential new market of 100 cases per year with revenue of \$80,000, expenses of \$30,000, and profits of about \$50,000. One of your goals is to pay off any new equipment in less than five years. Using this scenario, you actually could pay it off in one year. So it passes the financial test.

The next thing you need to do is test the market that your plastic surgeon claims is so rich with people who have unruly eyebrows who are willing to pay \$800 to have them fried off. First, you do a literature search to learn all about this quirk of nature. Next, contact the manufacturer or sales rep that is selling the machine. Find out who else is using this machine for this procedure. Contact them and ask them how they are doing. Discuss it with your payers to see if it is reimbursable. (Yeah, right!) Lastly, take your findings and present them to your board or finance committee. If you are uncertain that there really is a market for this affliction, then tell the board that you are unable to substantiate the volume numbers and let them make the decision.

Bottom line, don't be so risk adverse that you pass up new revenue by not buying the necessary equipment. Just make sure you are as informed as you can be before you do.

[Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Contact Earnhart at 1000 Westbank Drive, Suite 5B, Austin, TX 78746. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.] ■

From fighter pilots to lap procedures

3D system is portable, less costly than robotic

Three-dimensional technology that the military created to help fighter pilots in air combat is now being used by outpatient surgeons to perform complex laparoscopic cases, and at about one-tenth the price of the da Vinci Surgical robotic system (Intuitive Surgical, Santa Monica, CA). The 3Di Digital Vision System, available from Viking Systems in San Diego, also has the advantage of being portable and thus can be shared among facilities.

The three-dimensional aspect of the system is what makes a difference to surgeons, says **Lonna**

Williams, senior vice president of commercial operations. "You have the ability to have that [depth] perception while you perform lap surgery," she says. "Your natural vision is restored."

At Hoag Hospital in Newport Beach, CA, "Viking provides the surgeon a greater field of vision in minimally invasive surgery, which is an advantage for both the MD and the patient," says **Carole Metcalf**, RN, CNOR, CRNFA, director of perioperative services. Hoag is one of about 60 hospitals in the United States and 40 more worldwide using the Viking system.

The Viking system includes the head-mounted display, a 300-watt xenon light source, a 3D digital stereo camera, stereoscopes, a digital video recorder, a central data-processing unit, and a 23-inch flat-panel LCD monitor and cart. The head-mounted display offers surgeons a three-dimensional video image of the inside of the patient's body. The cameras are inserted into patients via the laparoscope. The system can be used with any procedures that use a 10-mm endoscope.

The system costs approximately \$150,000. In comparison, the da Vinci system costs about \$1.2 to \$1.6 million, according to a company spokesperson. Also, the da Vinci has an annual maintenance fee of about \$100,000-\$140,000 and the total cost of instruments and accessories used per case is about \$1,500.

No twisting your head

The Viking system provides an ergonomic benefit, says **Don Tucker**, CEO of Viking. The image goes directly into the eye of the surgeons as opposed to surgeons having to stare at monitors across the rooms, which may require them to twist their heads.

Also the system has the ability to bring secondary information into the surgeons' field of view, Tucker says. For example, surgeons can see a fluoroscopic scan or diagnostic material in their head-mounted display, similar to a "picture-in-picture" capability of some TVs. That information can be brought in using voice technology.

Hoag is using the system in some of the more complex laparoscopic procedures, including some gynecological and general cases, Metcalf says. "If you're doing fine tissue dissection or if dissections involve a nerve or delicate structure, then the enhanced vision is helpful," Metcalf says.

Surgeons who are trained to perform laparoscopic procedures need only a few minutes to become comfortable with the head-mounted

display, Williams says. At Hoag, Viking officials provided in-house training for staff and physicians, Metcalf says. "They provided structured inservices, with hands-on opportunity to learn the equipment, and individual case support" she says. Viking representatives also attended department meetings and offered individual support to physicians in private meetings.

The challenge was having adequate support staff who were comfortable with the system and able to assist physicians, Metcalf says. Staff set up the system, monitor it, and adjust it as needed she says. "[They] must be familiar with the system, Metcalf says. "We have 18 operating rooms and a lot of staff, so we chose to train some key staff members thoroughly, and they are 'super-users,' so to speak." ■

Should you buy surgeons a PlayStation 3?

Study links video games, laparoscopic skills

Surgeons who are skilled at video games also are more skilled at laparoscopic surgery, according to a just-released study published in the February issue of *Archives of Surgery*.¹

However, before you invest in the latest version of PlayStation 3 for your surgeon's lounge, consider these caveats from **Myriam J. Curet**, MD, FACS, professor of surgery, associate residency program director, and associate dean for medical education, Stanford School of Medicine, Stanford (CA) University, who wrote a critique of the study:²

- The study was small (12 surgeons and 21 surgical residents).
- While the authors suggest that video game playing should be included in laparoscopic skill training, their data indicate that it is *past* playing that actually improves laparoscopic skills.
- The authors didn't identify what years of playing will improve laparoscopic skills. "If those skills are best developed from the ages of 8 to 15 years, then video game play during residence is fruitless," Curet said.²
- The study doesn't indicate that good scores on the Rosser Top Gun Laparoscopic Skills and Suturing Program (Top Gun), which was used for the study, decrease deaths, increase patient safety, or are tied to competency. Superb judgment, great interpersonal skills, and outstanding communica-

tion skills may make a better physician than someone who has high Top Gun scores, Curet says.²

Curet said, however, that there is a lesson to be learned: "We should consider using video games as another tool to help surgeons reach competency."

References

1. Rosser JC, Lynch PJ, Cuddihy L, et al. The impact of video games on training surgeons in the 21st Century. *Arch Surg* 2007; 142(2):181-186.
2. Curet MJ. Invited critique. *Arch Surg* 2007; 142(1):186. ■

Minnesota lists 24 outpatient adverse events

The Minnesota Department of Health has released its third annual report, *Adverse Health Events in Minnesota*. The report, containing events from a 12-month period starting October 2005, showed 154 total adverse events.

Of the 154 events in the most recent report, 129 involved inpatients, one didn't involve a patient, and 24 involved outpatients in various settings, including hospitals and surgery centers. The 24 outpatient adverse events include:

- 12 wrong-site surgeries/invasive procedures;
- five retained foreign objects;
- four wrong procedures;
- one medication error;
- one wrong patient;
- one intra-/post-op death.

"The intent is for surgery centers to implement best practices that have resulted from this reporting system in order to eliminate 'never' events," says **Traci Albers**, MBA, president of the Minnesota Ambulatory Surgery Center Association and executive director of High Pointe Surgery Center in Lake Elmo.

The information from the report helps staff understand why errors occur and what can be done to prevent them, Albers says. For example, it has been helpful to understand why wrong-site surgeries continue to occur in facilities, she says. "We are learning that it is a number of contributing factors," Albers says. "Surgery centers have implemented the nationally accepted safety recommendations, but are discovering that our processes must be more defined and more focus needs to occur during the timeout prior to the procedure."

The full report is available at www.health.state.mn.us/patientsafety. Under "Spotlight," click on

“Adverse Health Events in Minnesota Report, January 2007.” ■

New resource lists ASCs by district

The American Association of Ambulatory Surgery Centers (AAASC) has developed a list of ambulatory surgery centers (ASCs) by states and by congressional districts.

This resource is designed to help surgery centers advocate issues before Congress. The state-specific directory identifies the congressional district and members of Congress for each Medicare-approved ASC in every state. To access the web site, go to www.aaasc.org. Under “State Associations,” click on “State Advocacy,” then click on the hyperlink for “Directory of ASCs in each U.S. Congressional District.” ■

Cuts proposed for ASCs, hospitals

In President Bush’ proposed budget, the inflation increase for ambulatory surgery centers (ASCs) and hospital outpatient departments (HOPDs) has been decreased by 0.065 percentage points starting in 2010 for surgery centers and 2008 for HOPDs.

Rich Umbdenstock, president of the American Hospital Association, said in a prepared statement, “The proposed budget includes a tidal wave of cuts that will inflict real damage on hospitals’ ability to care for patients. America needs policies that shore up these programs, not damage them further.”

Kathy Bryant, president of the Federated Ambulatory Surgery Association (FASA), is concerned. “The very first year we are scheduled to get an update, the president is proposing taking

part of that away,” says Bryant, referring to the six-year freeze thus far in inflation updates for ASCs.

The American Association of Ambulatory Surgery Centers (AAASC) opposes anything less than a full inflation update for ASCs, says **Craig Jeffries**, Esq., executive director. “Our grass-roots advocacy with physician-led ASCs is laser-focused on the implementation of a new ASC Medicare payment system and achieving a payment rate as close to 75% [of the hospital outpatient rate] as possible,” Jeffries says. “The president’s Medicare budget is a distraction with little traction in the Democratic Congress.”

A copy of the proposed budget is available at www.hhs.gov/budget/08budget/2008BudgetInBrief.pdf. ■

Lenses to correct astigmatism allowed

The Centers for Medicare & Medicaid Services (CMS) has agreed to allow astigmatism-correcting lenses as an option for Medicare beneficiaries, according to the Federated Ambulatory Surgery Association (FASA).

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

■ New federal regulation affects your everyday practice

■ Should you invest in bedside communication system?

■ Preparing for changes to Medicare payment system

■ How to decide what tasks you should outsource

■ Reducing anxiety in your pediatric patients

The lenses will be paid as standard intraocular lenses (IOLs) with any additional fees for the lens the responsibility of the patient, FASA says. For a copy of the ruling, go to www.fasa.org/docs/astigmatism.pdf. ■

CE/CME questions

- **Identify** clinical, managerial, regulatory, or social issues relating to ambulatory surgery care.
 - **Describe** how current issues in ambulatory surgery affect clinical and management practices.
 - **Incorporate** practical solutions to ambulatory surgery issues and concerns into daily practices.
13. What section of the Brighton Surgery Center intranet is the most popular among employees, according to John J. Goehle, MBA, CASC?
 - A. Staff meeting notes
 - B. Staff recipes
 - C. Policies and procedures
 - D. News updates
 14. What was the challenge of using the 3Di Digital Vision System, according to Carole Metcalf, RN, CNOR, CRNFA?
 - A. Developing in-house training for staff.
 - B. Having adequate support staff who were comfortable with the system and able to assist physicians
 - C. Having physicians become accustomed to wearing the goggles.
 - D. Having physicians become accustomed to the three-dimensional aspect of the surgery.
 15. What other information, in addition to patient name, procedure and site, should be addressed in a pre-surgical briefing, according to Fabrizio Michelassi, MD?
 - A. Patient allergies
 - B. Special equipment needed for surgery
 - C. Medication administered prior to surgery
 - D. All of the above
 16. What did Veronica Aston-Rickenbach, RN, do when patient satisfaction surveys showed an increase in complaints about wait times?
 - A. Checked with staff members to see if patients were waiting too long.
 - B. Reported the fact to the board of directors as something to watch.
 - C. Conducted a time analysis study.
 - D. Ignored complaint as something that could not be changed.

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

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ACCREDITATION UPDATE

Covering Compliance with Joint Commission and AAAHC Standards

Expand your mandated pre-procedure timeout to enhance patient safety efforts in the OR

Pre-surgical briefings should include allergies, medications, and more

A decrease in the perceived risk of wrong-site surgery and an improvement in collaboration among members of the operating room team improved significantly following the introduction of a standardized operating room briefing for all surgical procedures performed at Johns Hopkins Medical Institutions in Baltimore.

The study shows that following the implementation of briefings, 91.5% of the staff agreed that “surgery and anesthesia worked together as a well-coordinated team,” an improvement over the 67.9% of staff members that agreed with this statement prior to briefings. More than 64% of staff agreed that “a preoperative discussion increased my awareness of the surgical site and side being operated on” following the briefings, compared to 52.4% that agreed prior to the regular use of briefings.¹

The Joint Commission identifies communication breakdowns as the most common root cause

of wrong-site surgeries, says **Martin Makary, MD, MPH**, director of the Johns Hopkins Center for Surgical Outcomes and lead author of the study. “Our research indicates that operating room personnel see pre-surgical briefings as a useful tool to help prevent such errors,” he says.

Wrong-site surgery represents the second-highest percentage (13%) of sentinel events reported to The Joint Commission, and the most frequently identified root cause for wrong-site surgery is communications. While communication was identified as the root cause in 70% of wrong-site surgeries reported in 2005, this is a drop from almost 80% for wrong-site surgeries reported between 1995 and 2004.

One reason for that decrease is the increasing use of pre-surgical briefings, suggests **Fabrizio Michelassi, MD**, chairman of the Department of Surgery at New York-Presbyterian-Weill Cornell Medical Center. “We’ve been doing a pre-surgical briefing for a couple of years now, and we cover more than just the surgical site and side,” he says.

Confirming the patient’s identity, procedure, and site begins before the patient enters the operating room, points out Michelassi. “In the preoperative area, the site is marked and confirmed by the patient, then as the patient enters the operating room, the nurses verify name, procedure, and site, with the patient before anesthesia is administered,” he explains. “Our third and final check is performed once the patient is asleep and just before

EXECUTIVE SUMMARY

Although the pre-procedure timeout is recognized as an important activity to prevent wrong site surgery, some programs are expanding the timeouts to include more than patient name, procedure, and site.

- Staff members believe that pre-surgical briefings improve staff collaboration and communication.
- This information should be shared in the briefing: medication administration including prophylactic antibiotics, availability of equipment or blood if needed, and patient allergies.
- Checklists on the chart or a whiteboard system in the OR can effectively document the briefing.

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Author Sheryl Jackson, Senior Managing Editor Joy Dickinson, Associate Publisher Coles McKagen, and Board Member and Nurse Planner Kay Ball report no consultant, stockholder, speaker’s bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Mark Mayo reports that he is an employee of Symbion Healthcare.

the procedure begins." Although timeouts are required by accreditation organizations prior to any surgical procedure, Michelassi's surgery program covers more than the basic required information, he says.

All members of the operating team must be present and listening during the pre-surgical briefing, says Michelassi. In addition to patient name, procedure, and site, the team also hears reports on antibiotics or heparin that have been administered, allergies, and special equipment that is needed, to confirm that the equipment is in the room, he says.

Standardize briefings

It is important that all staff members follow the same process for all surgical procedures, Makary says. The standardized OR briefing program has been Hopkins' policy since June 2006, he says. The two-minute briefing at Hopkins addresses the information the Michelassi's meetings cover, but they begin with each member of the OR team stating their name and role. When staff members leave and are replaced by another staff member during the procedure, the new staff member introduces him or herself and restates his or her role, he adds.

"Before the new policy was implemented, many surgeons would walk into the OR and start working without a conversation of any kind and without even knowing the names of the nurses and other staff who were assisting them," he says.

Documentation of the timeout or pre-surgical briefing can be accomplished by notations on a checklist in the chart or, as in the case of Strong Memorial Hospital in Rochester, NY, on a specially designed white board. The board, from Davis International, Fairport, NY, not only helps staff members cover all items, but it stays visible to all team members throughout the procedure. **(See resource box, right, for information.)**

Ivelisse Vicente, RN, BSN, perioperative nursing safety officer for Strong Health says, "Our surgical pause takes place after the patient is prepped and draped and just before the incision is made. Our pause board contains sections to identify name, procedure, site, antibiotics, beta-blockers, available implants, additional equipment, patient position, blood availability, allergies, and other issues related to safety," she says. Red tags indicate the items that have not yet been discussed, and then green tags are flipped over by the circulator once the item is covered in the surgical pause, she says.

While staff members now like having the

information visible throughout the procedure, staff members were resistant at first and viewed the board and the pre-surgical pause as something else to do and fill out, admits **Dan Nowak**, RN, MS, associate director of perioperative services at Strong Memorial. Once staff members realized that the board is filled out prior to the pause and that the pause takes less than two minutes, everyone saw the value of the process, he adds.

The surveyor for Strong Memorial's most recent accreditation survey was so impressed with the surgical pause board that he is submitting it as a best practice to share with other health care organizations, says Nowak.

While the pause board is well received and appreciated by surveyors and staff members, it is still a work in progress, admits Vicente. "We are redesigning it to include an area that enables us to list the times that we administer prophylactic antibiotics or other medications," she says. They

RESOURCES

For information on the Perioperative Checklist SliderBoard, contact:

- **Davis International**, 388 Maison Road, Suite 1A, Fairport, NY 14410. Telephone: (585) 421-8175, ext. 103. Fax: (585) 421-8707. E-mail: jimd@davisint.com. All orders can be customized to fit each outpatient surgery program's needs, but costs are generally \$300 per 2-foot by 3-foot board and \$250 for 12-inch by 18-inch board.

For other information, tips and tools for prevention of wrong-site surgery, go to:

- The Institute for Clinical Systems Improvement, a Minnesota quality improvement organization, offers **a free protocol for site verification**. The recently revised protocol has algorithms for preoperative, intraoperative, and bedside site verification. To download the protocol, go to www.icsi.org and select "Guidelines and More" from top navigational bar. Select "Other Health Care Conditions" and scroll down to "Safe Site Protocol for All Invasive High-Risk or Surgical Procedures (Protocol)." Choose the "+Show Additional Materials" link to display options for the summary as well as documents.
- **Institute for Healthcare Improvement** offers a variety of free tools related to surgical safety issues. Go to www.ihl.org. Click on "topics," and select "patient safety." Choose "safety: general" and "tools." Scroll down to find "General Tools." A list of available tools includes "Procedural Pause Audit Tool."

want to keep the process simple and easy to implement, but also be willing to update the process, Vincente adds.

The pre-surgical briefing is a simple concept, Michelassi says. The timeout is mandated by accreditation organizations, but it is very easy to take the basics of the mandated timeout and expand upon it to make it better and make surgery safer, he says. "It is effective because it is often the only time that all members of the operating team have a chance to be together and talk about the patient as a group," Michelassi says.

Reference

1. Makary MA, Mukherjee, BA, Sexton JB. Operating room briefings and wrong-site surgery. *J Amer College Surg* 2007; 204:236-243. ■

Evaluate results of patient surveys carefully

Look for trends, conduct studies to verify data

A well-managed and carefully-monitored patient satisfaction improvement project is one reason that staff members at The Urologic Surgical Center in Lancaster, PA, received good marks and positive comments from their surveyor in January 2007.

"We are a small, single-specialty surgical center, so it's not a very complicated survey," says **Veronica Aston-Rickenbach**, RN, nurse manager of the center. "The surveyor did use the tracer method to follow patients through their surgical day, but our staff members were well prepared and ready to answer questions," she says. Aston-Rickenbach also was prepared with performance improvement studies.

One of the ongoing performance improvement projects that the surveyor reviewed for the surgery program is patient satisfaction. "We give a patient satisfaction survey to every patient before they leave," explains Aston-Rickenbach. "Patients can either complete them in the office or mail them back to us."

By offering patients a chance to complete the survey in the office, Aston-Rickenbach's return rate is 50%. "I review every survey and track the results to report to our board of directors," she says.

Every negative response is investigated by Aston-Rickenbach, and trends are reviewed to

make sure that there is no ongoing problem at the center, she says. "It is important to investigate trends as well as individual responses to get a true picture of complaints," she says.

Other sources recommend that staff members reply to patients who express dissatisfaction so that they know their complaint is taken seriously. Thank-you notes to patients who return surveys and sharing copies of positive surveys with physicians are two other ways to use patient surveys to strengthen relationships, sources say.

Waiting times a problem

While patients rate her center's service positively, the one area that constantly results in some negative responses is waiting times, admits Aston-Rickenbach. The perception of how long is too long varies widely from patient to patient, she admits.

"It's important to remember that some patients consider a five-minute wait too long, while other patients don't think that anything is wrong with a 25-minute wait," Aston-Rickenbach says.

"When reviewing patient satisfaction trends, I have to evaluate the problem and determine if there is anything that can be done to improve," she says. When patient surveys did show a slight increase in complaints about waiting time, Aston-Rickenbach conducted a time analysis study in which the time interval between the patient's arrival and the time the patient was seen were measured. "We found that our waiting times were not unreasonable" she says. Waiting times were often less than 20 minutes, she adds.

To address patient's concerns about waiting, the center's staff are quick to apology to patients and their family members for any waits, says Aston-Rickenbach. "We explain the reason for the wait, such as an earlier procedure took longer than expected, so that they know the reason is related to patient care," she says. "If we know that a physician is running well behind schedule, we inform the patient and ask if they'd prefer to reschedule their appointment." Printed information that explains what patients can expect during the visit also can explain why there may be delays on some days, sources add.

In this world of fast food, high-speed Internet, and overnight delivery of packages, Aston-Rickenbach does not expect complaints of wait times to completely disappear, but "we must look carefully at the results of patient surveys and find ways to address concerns, even if we can't eliminate the waiting completely," she says. ■

Joint Commission changes its name

The unwieldy name of Joint Commission on the Accreditation of Healthcare Organizations no longer exists. As of January 2007, the accreditation association's name was changed to The Joint Commission.

Along with the name change comes new logos for The Joint Commission and its affiliate Joint Commission Resources (JCR). The Joint Commission web site is www.jointcommission.org. ■

Health care literacy gap is addressed

What did the doctor say? *Improving health literacy to protect patient safety* is a free white paper offered by The Joint Commission that explores the use of medical terms in communications with patients and the challenges that this use creates for patients. The paper emphasizes that what may be very clear to the physician is not always clear to the patient. The Joint Commission report on strategies for addressing health literacy and protecting patient safety contains 35 specific recommendations that cover a wide range of important improvement opportunities including:

- sensitization, education, and training of clinicians and health care organization leaders and staff regarding health literacy issues and patient-centered communications;
- development of patient-friendly navigational aids in health care facilities;
- enhanced training and use of interpreters for patients;
- redesign of informed consent forms and the informed consent process;
- development of insurance enrollment forms and benefits explanations that are "client-centered";
- use of established patient communication methods such as "teach-back";
- expanded adaptation and use of adult learning centers to meet patient health literacy needs;
- development of patient self-management skills;
- health care organization assessment of the literacy levels and language needs of the communities they serve;

- design of public health interventions that are audience-centered and can be communicated in the context of the lives of the target population;
- integration of the patient communication priority into emerging physician pay-for-performance programs;
- provision of medical liability insurance discounts for physicians who apply patient-centered communication techniques.

(Editor's note: To download a copy of the paper, go www.jointcommission.org and select "public policy" from the top navigational bar. On the Public Policy homepage, select "'What Did the Doctor Say?': Improving Health Literacy to Protect Patient Safety." Another free tool to improve communications with patients can be found at www.ihl.org. Select "topics" then "patient safety," then choose "safety: general" and "tools." Scroll down to find "General Tools." A list of available tools includes "Tips for Safer Surgery," a tip sheet for surgical patients to use to improve communications with their health care providers.) ■

Federal agency satisfied with association firewall

The investigative arm of Congress reported that The Joint Commission and its not-for-profit educational and consulting affiliate, Joint Commission Resources (JCR), have made progress in the past several years to prevent improper sharing of facility-specific information, though continued monitoring is warranted.

Three members of Congress, including Rep. Pete Stark (D-CA), the new chairman of the Ways and Means Health Subcommittee, requested the Government Accountability Office's (GAO's) report to help determine whether the relationship between The Joint Commission and JCR represents a conflict of interest that affects the accrediting process. The report follows a 2004 GAO report that identified flaws in The Joint Commission's hospital accreditation survey process.

"Ensuring the independence of the Joint Commission's accreditation process is vitally important," according to the GAO's new report. "To prevent the improper sharing of facility-specific information, it would be prudent for the Joint Commission and JCR to continue to assess the firewall and other related mechanisms." ■