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OCTOBER 2007
VOL. 31, NO. 10 • (pages 113-124)

Wrong-site surgery is No. 1 among sentinel events — Are you at risk?

For the fist time since The Joint Commission began keeping records of sentinel events in 1996, wrong-site surgery has reached the No. 1 position over patient suicide in terms of cumulative data. There have been 552 reports of wrong-site surgery, yet it is viewed as an event that often is underreported.

Additionally, The Joint Commission says that in its 2006 surveys, 30% of hospitals, 28% of ambulatory organizations, and 16% of office-based surgeons failed to follow the *Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery*. **(For more information, see "Wrong-site protocol is more than one year old, but problems mount," *Same-Day Surgery*, November 2005, p. 121.)**

In Rhode Island, the state health department recently intervened with an immediate compliance order after a hospital reported its second wrong-site surgery in a year and its third in six years.[1] State officials ordered the hospital to hire a consultant and to have two physicians identify the correct surgical site before each procedure. The action came after a neurosurgeon operated on the wrong side of a patient's head July 30. The hospital suspended the surgeon, and the health department ordered him to stop performing surgery and undergo an evaluation.

A preliminary investigation indicated the surgical team did not take a

EXECUTIVE SUMMARY

Wrong-site surgery now ranks as No. 1 in terms of accumulated data on sentinel events reported to The Joint Commission.

- Have a preoperative verification process. The provider who will do the procedure should mark the operative site. The surgical team should take a timeout immediately before the procedure to confirm patient identity, procedure, and operative site.
- The timeout policy should be proscriptive enough to ensure compliance. Managers should track compliance and make staff aware of the tracking.

"timeout" before beginning the procedure to double-check the correct location and other critical information, according to **Bruce W. McIntyre**, JD, a lawyer for the state Board of Medical Licensure and Discipline, which conducted a preliminary investigation of the doctor's actions.[2]

The surgeon had incomplete paperwork and relied on his memory, according to a Health Department investigation.[3] A nurse practitioner employed by the surgeon did not record which side needed surgery in the patient's medical history nor on the consent form signed by a relative, according to a published report.[3] When a circulating nurse in the OR pointed out that the information was missing, the surgeon wrote the side where he would operate, which was wrong, on the consent form, the report said. The 86-year-old man who underwent the surgery died the next month, and the medical examiner's office is trying to determine whether the surgical error contributed to his death, according to the report. A representative from the hospital's parent company said she believed someone in the OR had questioned whether the correct side was being cut, but the surgeon was confident he was right.[3]

At two recent meetings of The Joint Commission Professional Technical Advisory Committee (PTAC), members have commented that it is alarming that correct site surgery continues to be a problem.

While the increased number of wrong-site surgery sentinel events may be due to better awareness and reporting, the fact is that there continue to be wrong-site surgeries, and they can be avoided, sources say. "Regardless [of the reasons], it is not acceptable that the errors are still occurring," says **Bonnie G. Denholm**, RN, MS, CNOR, perioperative nursing specialist at the Center for Nursing Practice at AORN and a member of PTAC.

Compliance is the key problem, says **David Wong**, MD, MSc, FRCS(C), chairman of the Patient Safety Committee for the North American Spine Society and past chair of the Patient Safety Committee for the American Academy of Orthopaedic Surgeons in Chicago. "So we still get physicians saying, 'I'm on top of this; it's never going to happen to me. This is another extra step I have to make in pre-op protocol. I don't have time, and I don't see the value,'" Wong says.

And the problem isn't limited to surgeons, says **Kate Moses**, RN, CNOR, CPHQ, a representative from the Association of periOperative Registered Nurses (AORN) to PTAC and chair-elect of AORN's Ambulatory Specialty Assembly. Moses also is a quality management nurse at Medical Arts Surgery Centers (MASC) in Miami.

"Members of the team do not all take the time out process seriously," she says. "They appear to have an 'It won't happen to me,' or 'It doesn't apply to my role' attitude. Not everyone is made to pay attention and participate."

The No. 1 problem? Lack of effective communication, Moses says.

The Joint Commission reported that in nearly 80% of wrong-site surgeries reviewed from 1995 to 2005, communication was identified as a root cause.[4] For example, whether through experience

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

Subscriber Information

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

Subscription rates: U.S.A., one year (12 issues), $495. Add $9.95 for shipping & handling. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $83 each. (GST registration number R128870672.)

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or lack of organizational/administrative support, members of the surgical team may not feel empowered to stop processes from moving forward when there is a discrepancy in the procedure at any point where a verification should be taking place, especially during the timeout, Moses says.

There are many other facets to the problem, she says. "Having reviewed policies from several organizations, many are not specific enough — too many holes in the 'Swiss cheese,' so to speak," Moses says. "They allow too much leeway for errors to occur." For example, policies may not demand that a site be part of the consent when applicable, the operating physician may not be mandated to mark the site, and site marking itself may be ambiguous and inconsistent, she says.

"Many facilities have 'timeout' policies/procedures, but they are not proscriptive enough to ensure compliance, and many facilities do not track compliance and make staff aware of the results of the tracking," Moses says. "It only becomes an issue when an event occurs."

Additionally, managers at some nonaccredited organizations may choose not to comply with national safety initiatives, including the universal protocol, she says.

Take these steps

So what is the solution?

Managers, surgeons, and staff must see the value of avoiding wrong-site surgery, sources say. "I think the big thing is that while it's a rare complication, it's a catastrophic one for patients and medical providers involved," Wong says. **(For more information, see "You never forget a wrong-site surgery," *SDS*, December 2005, p. 138.)**

Earlier this year, the World Health Organization's (WHO) Collaborating Centre for Patient Safety Solutions released nine solutions to prevent health care errors that included wrong-site surgery. WHO officials say a major contributing factor to these types of errors is the lack of a standardized preoperative process. Their recommendation? A preoperative verification process; marking of the operative site by the provider who will do the procedure; and having the team involved in the procedure take a timeout immediately before starting the procedure to confirm patient identity, procedure, and operative site.

Some states are getting involved. The Florida Board of Medicine has enacted a "pause rule" that requires the surgical team to pause before a procedure to confirm the side, site, patient identify, and surgery/procedures. **(To view the rule, go to www.doh.state.fl.us/mqa/medical/info_pauserule.pdf.)**

A comprehensive policy should follow the guidelines of the universal protocol and have the buy-in and support of all members of the surgical team, as well as administration, Moses says. Mandatory compliance with such a policy has proven to be the best method of turning a sentinel event into a near-miss, she says. "Unfortunately, there is still the human factor involved, and we may never be able to eliminate the errors completely," she says.

Continue educating your staff, Moses advises. "Support your staff by empowering them to say, 'STOP!' when discrepancies are identified," she says. Use tools such as the correct site surgery tool kit offered by AORN, Moses advises. **(To access the tool kit, go to www.aorn.org/PracticeResources/ToolKits/CorrectSiteSurgeryToolKit.)**

"Hopefully, with guidelines that AORN has provided those of us in the ambulatory setting, and accreditation and regulatory standards, we can minimize the risks," she says.

SOURCE/RESOURCE

For more information on wrong-site surgery, contact:

- **Kate Moses**, RN, CNOR, CPHQ, Quality Management Nurse, Medical Arts Surgery Centers (MASC), 8940 N. Kendall Drive, No. 201E, Miami, FL 33176. Phone: (786) 596-7556. E-mail: KateM@baptisthealth.net.

A wrong-site, wrong-procedure, and wrong-person universal protocol has been required by the Joint Commission on Accreditation of Healthcare Organizations since July 2004. For access to the universal protocol, a free one-hour audio conference on wrong-site surgery and a synopsis of the *Second Wrong Site Surgery Summit* held June 21, 2007, go to www.jointcommission.org/AccreditationPrograms/07_calls.htm. For more information about wrong-site surgery from the Joint Commission International Center for Patient Safety, including copies of the *Sentinel Event Alert* on wrong-site surgery, go to www.jcipatientsafety.org/22813.

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Proposed conditions would take extra time

CMS: ASCs would need an extra 55 hours a year

Do you and your staff have an extra 55 hours a year? That's the amount of time the Centers for Medicare & Medicaid Services (CMS) estimates that you and your ambulatory surgery center (ASC) staff would spend complying with new and revised Conditions for Coverage (CfC) for ASCs.

The breakdown of the time estimate is as follows: four hours to develop a disaster preparedness plan, at least 40 hours to develop a Quality Assurance Performance Improvement (QAPI) plan, one hour to adhere to new patient rights requirements, and 12.5 hours to investigate patient complaints and develop and send out notices about the complaints to people in authority in the ASC, the state, and local bodies having jurisdiction, as well as the state survey agency if warranted.

CMS is proposed to update the ASC Conditions for Coverage (CfC) to reflect contemporary standards of practice in the ASC community, as well as recommendations from the inspector general. The new requirements will ensure quality services in ASC, according to CMS.

However, some leaders in the field think CMS has added requirements that won't improve outcomes or patient safety.

One example is a requirement that patients disrobe or wait in a private place, says **Kathy Bryant**, president of the Federated Ambulatory Surgery Association.

"I think common sense says, 'OK, it's not to improve patient outcomes or safety, but it's nice for patients,'" she says. "But I've never been to an ASC where patients disrobe in the middle of waiting room."

Much of the wording in the proposed changes, such as the term "private space," is subject to interpretation, Bryant says. "As long as CMS interprets that to mean that curtains around the area are fine, there may not be a problem," she says. If they say it must be soundproof and viewproof, that would be a problem, Bryant adds. "We want to make sure definitions aren't adding burdens."

Other industry leaders are more optimistic, such as **Craig Jeffries**, executive director of the American Association of Ambulatory Surgery Centers (AAASC). AAASC is "delighted" that CMS has proposed improvements in the CfC that reflect standards of practice that most ASCs, already address, Jeffries said in a prepared statement. "Establishing these new requirements in regulatory rules should eliminate many of the regulatory oversight concerns raised by those who opposed further expansion of the list of procedures that Medicare allows to be performed in an ASC," he said.

The proposed CfCs include three new conditions:

- **Patient rights.**

ASCs would be required to provide patients with verbal and written notices of their rights and responsibilities prior to providing care. Some ASCs already may have interpreters to be certain that patients who don't understand English fully understand their rights and responsibilities. For those who don't, telephone services can be purchased for about $2 per minute, according to CMS. The agency estimates that 3% of cases might need such services, and that an average of 15 minutes might be needed per patient.

Also, each ASC would be required to establish an advance directive policy. Generic advance directives forms in English and Spanish are available

EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services (CMS) has proposed new and revised Conditions for Coverage for surgery centers.

- ASCs would be required to notify patients of their rights, including patients who don't understand English.
- ASCs would be required to prevent, control, and investigate infections and communicable diseases, and take action that results in improvements for problem areas. They would have to designate an infection control officer.
- Documentation of the history and physical would be required to be in the patient's chart before a procedure began.
- Physicians or qualified practitioners who performed the surgery would be required to be available until the discharge order was signed.

from state agency web sites and other sources, CMS says.

As part of the patent rights CfC, CMS emphasizes that access to patient information and clinical records is permitted only with the written consent of the patient or representatives, or as allowed by law. All ASCs would be required to comply with the Health Insurance Portability and Accountability Act (the HIPAA privacy rule).

The CfC would require ASCs to document and investigate written and verbal grievances made by patients or their representatives. These grievances may include mistreatment; neglect; theft of personal property; and verbal, mental, sexual, or physical abuse. The ASC would be required to report allegations to a person in the ASC, at the state level, and local bodies that have jurisdiction, and the state survey agency, if warranted. The grievance process should specify time frames for reviewing and responding to the grievance, CMS proposes. Also, certain information would have to be documented, including how it was addressed, the steps during the investigation, written notice to the patient or representative of the decision, including the name of an ASC contact person, the results of the grievance process, and the date the process was completed.

ASCs may have to investigate complaints from about 1% of patients due to allegations of mistreatment and neglect, for example, CMS estimates.

• Infection control.

ASCs would be required to prevent, control, and investigate infections and communicable diseases, and take action that results in improvements for problem areas. The sanitary environment standard would be expanded to include use of infection control standards of practice as guidelines in the ASC infection control program. While CMS would not dictate any specific set of infection control guidelines, officials "strongly encourage" ASCs to use guidelines published by the Centers for Disease Control and Infection (CDC), the Association of Practitioners in Infection Control (APIC), and The Joint Commission as references.

ASCs would be required to designate a qualified professional, such as a registered nurse, as the infection control officer. That officer would investigate and resolve incidents. That person would need continuing education in infection control on at least an annual basis, CMS says. CMS estimates that facilities would spend about $500 annually on infection control training for that person that would include an approximate four-hour course.

"I don't think having an infection control officer is harmful," Bryant says. ASCs often already have someone who deals with clinical issues, including infection control, she says. "Everyone knows who it is that does that," Bryant says. "If they have to have on a chart they are on an infection control officer, it's not a big deal."

The infection control program would be required to follow a plan of action to identify problems and correct and prevent them, when necessary. ASCs would be required to establish hand hygiene policies. These policies would include antiseptic agents used, scrubbing technique, duration of the scrub, condition of the hands, and techniques for drying and gloving.

ASCs would be required to create and implement policies and procedures for instrument cleaning and maintenance of sterilization equipment.

• Patient admission, assessment, and discharge.

CMS proposes that each patient have a history and physical not more than 30 days before the date of surgery by a physician or other qualified practitioners. The history and physical would be required to be in the patient's medical record

CMS Proposes Definition Changes

The Centers for Medicare & Medicaid Services (CMS) has proposed to revise the definitions of ambulatory surgery center (ASC) and overnight stay:

- **ASC.** Any distinct entity that operates exclusively for the purpose of providing surgical services to patient no requiring an overnight stay following the surgical service, has an agreement with CMS to participate Medicare as an ASC, and meets the conditions set forth in subparts B and C of this part. (The proposed rule can be seen at www.cms.hhs.gov/CFCsAndCoPs/Downloads/ambsurgreg.pdf.)
- **Overnight stay.** For purposes of ASC CfCs, overnight stay would meant the patient's recovery requires active monitoring by qualified medical personnel, regardless of whether is it provided in the ASC, beyond 11:59 of the day on which the surgical procedure was performed. Accordingly, ASCs that are Medicare-certified may not keep patients beyond 11:59 p.m. of the day on which the surgical procedure was performed.

Source: Centers for Medicare & Medicaid Services. Medicare and Medicaid programs, ambulatory surgical centers, conditions for coverage, proposed rule (CMS-3887-P). 2007; Baltimore.

Revisions proposed for 3 conditions

The Centers for Medicare & Medicaid Services (CMS) has proposed revising three Conditions for Coverage (CfCs) for ambulatory surgery centers (ASCs):

• Evaluation of Quality [renamed Quality Assurance Performance Improvement (QAPI)]

The QAPI program would be required to include an ongoing program to demonstrate measurable improvement in outcomes and improve patient safety by using quality indicators or performance measures. Consider using QAPI programs already used by other health care entities, CMS advises. CMS lists the Institute for Quality Improvement (www.aaahc.org) as one example.

ASCs would be required to implement improvements in its performance as identified through the QAPI program. ASCs would be required to collect information in four areas: adverse patient events, infection control, process of care, and services furnished in the ASC. ASCs should focus on high-risk, high-volume, and problem-prone areas. Examples listed include patients with minimal support at home, surgery on patients with concurrent health issues, and those who diagnosis and care may be unique to the ASC. The number and scope of projects must reflect the scope and complexity of the ASC's services, CMS says.

CMS is accepting comments regarding the extent to which ASCs are using quality measure, the data source (claims data and chart abstraction), the extent to which data are electronic, how the measures were developed, and why they are appropriate for Medicare patients in ASCs. The annual Medicare payments update can be reduced for centers that fail to comply. *(Editor's note: The annual payment update factor for hospitals in 2009 and subsequent years will be reduced by 2 percentage points for hospitals that don't report quality measures.)*

• Governing body and management.

New language requires the governing body to assume responsibility for the QAPI program and a disaster management plan.

ASCs would be required to maintain disaster plans that address fire, natural disaster, failure of equipment, or other events. ASCs would be required to coordinate with state and local agencies and seek their advice on developing the plan. The plan would need to be reviewed annually.

ASC staff would be required to demonstrate through annuals drills and written evaluations their ability to manage emergencies likely to occur in their geographic area. ASCs would be required to have a written evaluation of every drill and immediately implement any corrections to its plan.

• Laboratory and radiologic services.

ASC s would be required to meet the requirements of the CfCs for portable X-ray supplies if the ASC furnishes these services directly. CMS also proposes that radiologic services furnished under arrangement would be performed by an organization that is certified by Medicare as a supplier of portable X-ray services.

The laboratory requirements would not change. ■

before the procedure is started.

CMS proposes several items that must be included in the pre-surgical assessment, including an updated entry for examining any changes in the patient's condition since the most recent history and physical, documentation addressing the patient's physical and mental capacity to undergo the surgery, and documentation of any allergies. The post-surgical assessment would require that a through assessment of the patient's condition is documented, and that any post-surgical needs are addressed and included in the discharge notes.

The ASC would be required to provide each patient with written discharge instructions. The ASC would ensure all patients have the "best possible" transition to home and that all post-surgical needs would be met. The discharge instructions should include physician coverage information regarding emergency care for any postoperative adverse effects.

CMS proposes that each patient have a discharge order signed by the physician or practitioner who performed the procedure. The discharge order would indicate that the patient has been evaluated for anesthesia and medical recovery.

"We believe it is imperative . . . that a physician or the qualified practitioner who performed the surgery or procedure be available to provide assistance in the ASC if needed, until all patients have been given a signed discharge order by the aforementioned practitioner," CMS says. "We believe this would eliminate any confusion with respect to the level of care and the ability of the ASC to respond to a patient emergency before the patient is discharged."

CMS has not specifically required a physician to be on site while there are patients in the ASC. "However, when the discharge order is signed, the patient would be expected to be discharged, that is, physically leave the ASC facility within a

SOURCES

For more information on proposed changes to the Conditions for Coverage, contact the following people in the Office of Clinical Standards and Quality at CMS:

- **Joan A. Brooks**, Health Insurance Specialist, Clinical Standards Group. Phone: (410) 786-5526.
- **Steve Miller**, Director of Non-Institutional Quality Standards. Phone: (410) 786-6656.
- Jacqueline Morgan, Health Insurance Specialist, Clinical Standards Group. Phone: (410) 786-4282.
- **Rachael Weinstein**, Director, Clinical Standards Group. Phone: (410) 786-6775.

reasonable amount of time," which CMS defined as 15-30 minutes. **(For a list of proposed definition changes, see p. 117. For a list of proposed revisions to CfCs, see story, p. 118.)**

For those ASC managers who may be concerned about the proposed changes, keep in mind that CMS has been working on these proposals for more than a decade, and it's uncertain when the final rule will be published, Bryant says.

In the meantime, share your concerns with your associations, she advises. "We need to know how to comment," Bryant says.

Comments on the proposed rule will be accepted through Oct. 30. The proposed rule can be seen at www.cms.hhs.gov/CFCsAndCoPs/Downloads/ambsurgreg.pdf. A final rule will be issued later this year. In commenting, refer to file code CMS-3887-P. Comments may be submitted electronically at www. cms.hhs.gov/eRulemaking. ■

Assess anticoagulants to meet new requirement

Policy should address precautions for blood thinners

Compliance with The Joint Commission's National Patient Safety Goal (NPSG) 3 in 2008 will require accredited organizations to pay close attention to their assessment and monitoring of patients who are on anticoagulation therapy.

With one death every day and approximately 1.3 million people injured annually due to medication errors,[1] it is no surprise that reducing the risk of patient injury due to medication error is a safety goal for the Joint Commission.

While Goal 3, "Improve the safety of using medications," always has been a safety goal, it is regularly reviewed and requirements for meeting the goal are adjusted as needed, says **Peter B. Angood**, MD, vice president and chief patient safety officer for The Joint Commission. The 2008 addition to Goal 3 is requirement 3E, which states that organizations must "reduce the likelihood of patient harm associated with the use of anticoagulation therapy."

"This topic [anticoagulation therapy] has surfaced in our Sentinel Events Advisory Group's reviews quickly in the past couple of years," says Angood. Anticoagulation therapy can be safe for patients "if they are monitored carefully by their primary care doctor to make sure that the correct dose is taken," he says. While surgeons and outpatient surgery center staff do not have responsibility for initial implementation of the therapy or for long-term monitoring, it is critical that they be aware of the patient's use of anticoagulants, he says.

One difference in requirement 3E's implementation from previous years' new goals is a specific timetable for implementation, says Angood. "In past years, we have identified a goal and given organizations one year to prepare for implementation," he says. The one-year timeframe gave organizations a sense that there was no need to do anything for one year, Angood admits. The checkpoints outlined in the rationale for requirement 3E calls for assignment of leadership responsibility by April 1, 2008; implementation work plan in place by July 1, 2008; pilot testing in at least one clinical unit by Oct. 1, 2008; and full implementation by Jan. 1, 2009. "These checkpoints should help organizations better prepare for full implementation," he adds.

EXECUTIVE SUMMARY

Although outpatient surgery programs regularly ask patients to identify the medications they take, the newest requirement for The Joint Commission's National Patient Safety Goal 3 has surgery programs looking specifically at anticoagulant use to reduce risk of patient harm.

- Assess use of and specific type of anticoagulant used by patients to determine when patient should discontinue medication prior to surgery and resume medication following surgery.
- Educate staff as to increased risk of bleeding for patients who are on anticoagulant therapy.
- Increase patient education regarding resumption of anticoagulant therapy following surgery.

Many outpatient surgery programs can incorporate the identification of anticoagulant use in their initial pre-op assessments or at whatever point staff members begin to gather information on the medications that patients are using, says Angood. In addition to identifying the patient's use of anticoagulants, the outpatient surgery staff should have specific protocols to follow to manage the patient preoperatively, he adds. These protocols may require stopping the medication at a certain point before surgery, if it can be done safely, he says. Surgery programs also must include specific patient education upon discharge to make sure that patients know when to resume the anticoagulation therapy, he points out.

Checklist highlights blood thinners

Staff members at Manatee Surgical Center in Bradenton, FL, are ready for the new patient safety goal, says **Linda M. Nash**, MBA, CASC, LHRM, administrator of the center. "We addressed anticoagulation therapy this year because we noticed an increasing number of patients using a lot of different types of anticoagulation therapies," she says. With the variety of therapies, Nash and her staff noticed that not all patients even realized they were on anticoagulation therapy, she says.

The pre-anesthetic form that is completed on the day of surgery was redesigned to list specific anticoagulation therapies for patients to select, says Nash. It was important to identify the specific medications to make sure patients remembered to tell them about the blood thinners, she says. **[A copy of the surgery center's pre-anesthetic evaluation is available with the online edition of the September 2007 issue of *Same-Day Surgery*. Go to www.ahcmedia.com. For assistance, contact customer service at customerservice@ahcmedia.com or (800) 699-2421.]** "The form is given to patients in the physician's office at the time surgery is scheduled," she points out. This gives the physician or the physician's staff a chance to talk to the patients about when to stop their anticoagulation therapy, then the surgery center staff verify the use of blood thinners when the preoperative call is made, she says.

In addition to making sure that they identify patients who are using blood thinners, Nash's staff created a list of each surgeon's specific needs regarding the stopping and restarting of anticoagulants, says Nash. "This list is posted on every clipboard in pre-op so that no matter which patient's chart is being reviewed, the nurse knows what that patient's surgeon requires with anticoagulants," she says.

It is not possible to develop just one list for all surgeons unless your center performs only one type of procedure, points out Nash. "The protocol for cataract surgery usually doesn't require the patient to stop taking his or her anticoagulant because the procedure is clean," she says. "On the other hand, a patient undergoing a colonoscopy during which polyps might be removed will be asked to discontinue blood thinners prior to the procedure."

Be sure to address patient education and restart of anticoagulants, suggests Angood. "A surgery center should educate the patient about the right time to restart medications and should review the proper dosage and timing of the medication," he adds.

Staff education also is important, says Nash. "Not all anticoagulants can be started immediately after surgery, so staff members need to understand what medications and what situations require different protocols," she says. For example, if a patient underwent a colonoscopy but had no polyps removed, it is fine to start anticoagulants immediately, she says. If, however, polyps are removed during the procedure, the nurse needs to verify how long the patient should remain off anticoagulant therapy, she adds.

Requirement 3E is the only new addition to The Joint Commission National Patient Safety Goals for ambulatory and office-based surgery programs for a reason, points out Angood. "We are aware that new goals or new requirements create a need for our accredited organizations to re-evaluate systems and procedures," he says. "Our field review demonstrates that organizations are coming up to speed on the goals, so we eased off on the number of new goals that organizations must address in 2008."

RESOURCE

To see a copy of the 2008 National Patient Safety Goals and implementation expectations, go to www.jointcommission.org. Select "Patient Safety" on the top navigational bar, then choose "National Patient Safety Goals." Select "Ambulatory Care and Office-Based Surgery" or "Hospital" to see the goals. Links to the appropriate manual chapters that describe the rationales and implementation expectations are at the top of the page.

Reference

1. Food and Drug Administration. Medication errors. Accessed at www.fda.gov/cder/handbook/mederror.htm. ■

It's 'yes' for artificial nails, but not in the OR

AORN, CDC prohibit them on all surg personnel

You have switched from razors to clippers to remove hair, you developed strict, scientifically based protocols for administration of prophylactic antibiotics, and your staff scrub their hands in the proper manner. Although all of these steps reduce the risk of infection in the operating room, have you checked your staff's nails?

Although artificial nails are popular and attractive, they should not be worn by any staff member in an operating room, whether they circulate or scrub in for the procedure, says **Carol Petersen**, RN, MAOM, CNOR, perioperative nursing specialist at the Center for Nursing Practice, Association of periOperative Registered Nurses (AORN) in Denver. AORN's recommended practice for surgical hand asepsis states that "artificial nails should not be worn, and nails should be kept short, clean, and healthy,"[1] she adds.

Artificial nails are defined by AORN as any nail other than a person's natural nail, Petersen points out. This includes acrylic or gel overlays that are bonded to the natural nail, she says. Even though the material is bonded to the nail, there is always a chance for a gap between the natural nail and the overlay so there is an opportunity for microorganisms to develop, she adds.

In addition to AORN recommendations regarding artificial nails, the Centers for Disease Control and Prevention also say health care personnel who care for high-risk patients, such as personnel in intensive care units or operating rooms, should not wear artificial nails and that natural nails should not be more than ¼-inch long, Petersen says.

Outpatient surgery staff members at Columbia St. Mary's Hospital in Milwaukee are not allowed to wear artificial nails, and the policy is clearly spelled out in the hand hygiene policy, says **Jane Kusler-Jensen**, RN, BSN, MBA, CNOR, director of perioperative services at the hospital. Although the hand hygiene policies are being reviewed, overall, everyone is happy with the requirements, she says. "We don't allow artificial nails of any type, and we only allow nail polish if it's in good condition." Nail polish is in good condition if there are no chips, she says. "It is hard to keep nail polish in good condition in the operating room because the mechanical hand scrub required for the operating room staff is hard on polish as well as artificial nails and creates openings for bacteria," Kusler-Jensen points out.

EXECUTIVE SUMMARY

Artificial nails, including acrylic and gel overlays, are more popular than ever, but that popularity doesn't change the increased risk of spreading infection in the operating room. The Association of periOperative Registered Nurses and the Centers for Disease Control and Prevention recommend that no personnel in the surgery area wear artificial nails.

- Clearly written, evidence-based policies regarding hand hygiene should specifically address artificial nails as well as use of nail polish.
- Emphasize patient safety to staff members in all hand hygiene education.
- Monitor staff members' adherence to hand hygiene policies including those for artificial nails.

Use staff audits to monitor hand hygiene

One part of the hand hygiene policy review is a hand hygiene audit that will be conducted throughout the hospital as well as all surgery areas, reports Kusler-Jensen. "We've just finished the pilot project in the surgery department that tested our audit tool, and after evaluating the tool and the data, we'll roll it out to all areas of the hospital," she says.

Operating room coordinators and supervisors conducted the audit by having 50 staff members complete a questionnaire and by observing scrub techniques of all staff members in the operating rooms, Kusler-Jensen explains. "Once we collect the data, we'll use the information to update or enhance our policies and to educate staff members about potential weaknesses in hand hygiene practices," she says.

Although Kusler-Jensen admits that staff members in some units of the hospital are resistant to a ban on all artificial nails, surgery staff members usually don't complain. "Most surgical nurses started surgery at a young age, and they've grown up with the expectation that artificial nails and nail polish are not allowed," she says.

The key to development, implementation, and acceptance of a good hand hygiene policy that addresses nails is to make sure the policy is based

RESOURCE

To see a full copy of the Centers for Disease Control and Prevention hand hygiene guidelines, go to www.cdc.gov/handhygiene.

on up-to-date, evidence-based practice, recommends Kusler-Jensen. "Remember that the patient's safety is more important than the appearance of someone's nails," she says.

Reference

1. Association of periOperative Registered Nurses. Recommended practices for surgical hand antisepsis/hand scrubs. *Standards, Recommended Practices, and Guidelines.* Denver, CO: 2007; pp. 565-573. ■

You are invited — ASCs open doors to public

Open houses offer marketing opportunities

(Editor's note: This is the first of a two-part series on sponsoring community events and open houses. In this month's issue, we cover open houses. In next month's issue, we will give suggestions for handling the media.)

Balloons, cookies and punch, tours, and free health screenings are just a few of the ways that outpatient surgery programs can make open house events fun and appealing to the community. Although the Federated Ambulatory Surgery Association (FASA) promotes Aug. 15 as National ASC Day and encourages outpatient surgery programs to invite the community to their facility, outpatient surgery managers often find themselves planning open houses or community events for a variety of reasons.

EXECUTIVE SUMMARY

Open houses allow outpatient surgery programs to show off new facilities, introduce new services, and create a positive public image.

- Schedule the event at a time when visitors won't interfere with scheduled surgeries and patient privacy.
- Plan time to clean rooms and equipment used during tours.
- Coach staff members on how to conduct tours and answer questions.

"We did hold an open house on National ASC day in 2006, and it was very successful," recalls **Mindy Vieck**, facility administrator at Vincennes (IN) Surgery Center. About 100 people attended Vieck's event to enjoy refreshments, hand massages by a licensed massage therapist, blood pressure and blood sugar screenings, and an assortment of door prizes such as tickets to local sporting events. "Staff members took people on a tour of our pre-op and recovery areas and one procedure room," Vieck says. Operating rooms were not included in the tour so that the staff would not have to sterilize the rooms, she adds.

The staff at Corvallis (OR) Clinic Surgery Center did allow tours through the operating rooms, but they picked the days and times carefully to allow time for sterilization, says **Judy Corwin**, director of marketing and public relations for the Corvallis Clinic. "Our open house was a big deal because it was our grand opening, and we are the first free-standing multispecialty surgery center in the area," she says. It was important to let physicians, their office staffs, and members of the community see that the facility was capable of offering the same outpatient surgery services a hospital surgery department can offer, she explains.

They actually held three open houses or tours, says Corwin. The first tour was for retired physicians who had been supportive of the development of the center before their retirement. The second open house and tour focused on the office staff members of referring physicians. The third open house and tour was for the general public and community and business leaders.

"Our first two events were held before we performed any procedures so we did not have to worry about maintaining a sterile area," she says. "The community event was after we had performed some procedures in order to meet requirements for state and Medicare accreditation," Corwin says. Not only did the timing enable them to tell members of the community that they were accredited, but it also enabled the surgery center to be up and running full speed immediately after the community event, she explains. The community event was held on a Friday from 4 to 6 p.m. This timing gave the staff the weekend to clean the operating room areas, she explains.

When planning tours of the facility, don't assume staff members know how to conduct tours, suggests Corwin.

"Our surgery center director spent a great deal of time coaching staff members on the messages we wanted to convey, what items to point out, what questions to expect, and how to answer questions," she says. The primary message throughout the tours was the center's emphasis on exceptional service from the first pre-op call through every step of the process, she says. "We know that people are anxious about surgery, so we try to answer all questions to alleviate their anxiety," she adds.

"Staff members were also trained to give a tour of the entire center and explain all activities that occur in each department, regardless of where they work," explains Corwin. Staff members learned the purpose of different equipment, how long patients stayed in certain areas, and what services are provided by the center, she says. To make sure everyone could answer questions, mock tours of the center were conducted during the weeks leading up to the open house, she adds.

If reporters attend the events, make sure that specific staff members are available to work with the media to help them get the information they need, she adds.

Because the main attraction at Corwin's events was the new facility, the main focus was on tours and answering questions from people attending the open houses. At most open houses, there is a need to offer something to attract guests, says **Pam Wrobleski**, CRNA, administrator of Southwestern Ambulatory Surgery Center in Pittsburgh. Wrobleski's center uses open houses to promote the physicians on staff by offering screenings by different physicians. "Our podiatrists offer foot and ankle screenings, our ophthalmologists offer eye screenings, and other physicians offer skin cancer screenings, hemocult tests, or other screenings that get their name into the community," she says.

They also offer tours, so they schedule the open house at a time when they can block out time so that there are no cases going on, says Wrobleski. "We usually have a light schedule in the morning, then no cases in the afternoon, to make sure that we respect our patients' privacy," she explains. Visitors wear shoe covers and hats, and a cleaning crew is available to clean immediately after the open house, she says.

Because Wrobleski's facility is part of a larger medical office complex, there are frequent joint open houses with other medical offices, she says. "We have holiday open houses with refreshments, and every Halloween the entire complex offers a safe trick or treat program in which children visit the different offices," she says. All of these events are important because they make your facility a part of the community, she adds.

Be sure to allow enough time to plan your event, suggests Vieck. "We started planning our open house 45 days prior to the event," she says. This gave staff time to plan the screenings, send fliers to physician offices, and place advertisements in the newspaper, she says.

"The FASA open house planning kit also is a useful tool that saves you a lot of time," suggests Wrobleski. Sample ads, press releases, and checklists help you avoid the time it takes to create something from scratch, she explains. **(For a free copy of the FASA open house planning kit, go to www.fasa.org/ascopenhouse.)**

Although Vieck did not plan a general open house for National ASC Day in 2007, she is continuing events to invite the community to her facility. "We are now planning events that promote one specialty at a time," she explains. They recently sponsored an evening seminar on female

CNE/CME instructions

Physicians and nurses participate in this CNE/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. ■

COMING IN FUTURE MONTHS

- Results of 2007 *Same-Day Surgery* Salary Survey
- A device that educates and entertains patients
- Media visits: How to get the coverage you want
- What's the advantage of exhibiting a 40-foot colon?
- Innovative ideas to retain experienced nurses

incontinence that featured urologists, Vieck says. "It attracted 30 people and did generate some immediate new business for the physicians," she says. **[Editor's note: Have you had a successful community event? Tell your peers! Contact Joy Daughtery Dickinson, senior managing editor. Phone: (229) 551-9195. E-mail: joy.dickinson@ahcmedia.com.]** ■

CNE/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. How do staff members at Manatee Surgical Center know each surgeon's preferences regarding patients on anticoagulation therapy, according to Linda M. Nash, MBA, CASC, LHRM?
A. Nurses call the physician's office when patient is admitted.
B. The surgery center has one standard protocol for patients admitted to the center.
C. A list with each surgeon's instructions is attached to clipboards in the pre-op area.
D. The patient tells the nurse what instructions the physician gave him or her.

14. What surgery department staff members can wear artificial nails without compromising patient safety, according to Carol Petersen, RN, MAOM, CNOR?
A. Surgical techs
B. Circulators
C. Anyone if proper hand hygiene techniques are followed and gloves are used
D. No operating room staff member

15. What is one factor to consider when planning the day and time of your community event, according to Judy Corwin?
A. Allow time to resterilize areas used during tours.
B. Transportation issues for people who want to attend.
C. Media deadlines.
D. Other events in the community.

16. What does Ann Purvis, RN, BSN, CNOR, recommend that all outpatient surgery programs have to ensure that any staff member can greet and assist a surveyor?
A. A policy requiring senior management to return to the office as soon as a surveyor arrives.
B. Clearly labeled documentation in notebooks placed in a central location that is accessible to whoever is senior manager in the center at the time.
C. Blocking all dates when senior managers might be out of the office.
D. Multiple copies of standards and documentation in different offices.

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

SDS ACCREDITATION UPDATE

Covering Compliance with Joint Commission and AAAHC Standards

Medication safety tops list of surveyors' focus

Reconciliation, labeling, prescribing, and tracking required

Patient safety goals and all standards related to patient safety top the list of items focused upon by The Joint Commission surveyors, according to outpatient managers surveyed during recent months.

Medication safety is a key focus, says **Lynn Burgett**, RN, BSN, administrator of Lakeshore Surgery Center in Fort Gratiot, MI. One area that has presented a challenge for Burgett's center is the National Patient Safety Goal requiring reconciliation of medications at admission and upon discharge, she admits. "We have struggled with different ways to comply with this goal's requirements but had not successfully addressed it at the time of our survey," she says.

During the survey, Burgett and her staff presented the surveyor with several ideas that they were considering, and the surveyor offered suggestions, she says. "We now have a one-sheet carbon copy form that collects all of the medication information that we need prior to surgery and at discharge," she says. Information includes the name, dose, and frequency of medications, as well as instructions for the patient regarding stopping and restarting specific medications, she explains. **(For more information about the form and how to access it, see story on p. 3.)** One copy of the form is given to the patient at discharge so the patient has a complete list of medications, including any medications prescribed on the day of surgery, she adds. Experts also recommend that a copy of the medication form be sent to the surgeon so that he or she is aware of medications given by the anesthesiologist after the surgeon has left the surgery area. This helps the surgeon in case of complications that require admission or telephone consultation with the patient the night of surgery or the next day.

Labeling medications that are drawn into a syringe for use in a procedure was a focus of the surveyor at North Texas Surgery Center in Dallas, says **Melody Heatherley**, PhD, RN, CNOR, CASC, director of nursing. "The surveyor checked all medication in the pre-op, PACU, and the OR to make sure that they were clearly labeled with the name of the medication as well as the date drawn," she says. Other Joint Commission requirements for the label include

EXECUTIVE SUMMARY

Surveyors continue to focus upon National Patient Safety Goals from The Joint Commission as key areas for surveys. Outpatient surgery programs surveyed during recent months report that medication safety is a key focus.

- Specific medication reconciliation forms can help staff members identify medications, dose, frequency, and patient instructions prior to surgery.
- All syringes must be labeled, even if the physician draws the medication immediately prior to a procedure.
- Copies of prescriptions for controlled substances should be kept in the patient's chart to protect the surgery program and physician in the event of alteration of the prescription.

Financial Disclosure:
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 Magna Health Systems and a consultant for DayOne Health.

quantity and dosage, she adds.

Although Heatherley's nursing staff members are aware of the need to label all medications, the toughest part of ensuring compliance with this requirement is with the anesthesiologists, she says. "Our anesthesiologists will draw medication for an eye block to be performed in the pre-op area, then place the syringe in their pockets as they walk to the patients," she says. Because they have just drawn the medication and are heading straight to the patient, they often don't take time to label the syringe, she admits. "Changing this behavior will take time and continuous education," she says.

In addition to reminders at medical staff meetings, Heatherley will routinely ask an anesthesiologist if the syringe in his or her pocket is labeled. "The one-on-one monitoring is important, because I remind them that this is not a rule I implemented, it is a requirement for our accreditation," she says. "I also focus on medication labeling in all of our mock surveys that involve all staff members, including physicians."

Even if the physician is not walking from one location to another, labeling is required, points out Burgett. "The nursing staff labels everything in the OR, but our surveyor observed one of our anesthesiologists performing a pain management procedure," she says. The physician had a circulator in the room, but no other nursing staff. "He drew the medication for the procedure with the patient in the room, then immediately started the procedure," Burgett says. The surveyor pointed out that labeling the syringe still was necessary, she adds.

Sample meds must be tracked

The emphasis on medication safety extends to sample medications and prescriptions, points out **Marion Benson**, vice president and executive director of Good Shepherd Ambulatory Surgical Center in Longview, TX. "The surveyor asked if we had sample medications or if we dispensed medications," she says. The policies that related to documentation of inventory, expiration dates, and order writing for these medications were reviewed, Benson says.

"We were surprised to find out that the complimentary eye bags that our ophthalmologists asked us to give their patients were considered medications," says Burgett. The bags, which are given to the physicians by pharmaceutical companies, contain items that a cataract patient needs following surgery such as eyedrops, patch, and eye shield, she explains. "The bags also have a pocket on the outside that we use to hold the card that contains information on the implant the patient received," Burgett adds.

Because the bags contain prescription eyedrops, the surveyor pointed out that they are considered medications and that the surgery center staff must log every bag received, verify and document expiration dates, and track distribution of each bag, she recalls. "Even if the drops are over-the-counter medications, it is still necessary for a staff person to check expiration dates and track distribution," Burgett points out. "We were distributing the bags as a convenience for both the patient and physician, but we've changed our practice since the survey," she says. Now, the eye bags are given to the patient in the physician's office prior to surgery, and her staff reminds the patient to use the eye drops at discharge, she adds.

Copy controlled substance prescriptions

Another tip from Burgett's surveyor is extra protection for the surgery program as well as the physician. "He recommended that we make a photocopy of every prescription for controlled substances that we give to patients and include that copy in the chart," she says. "Because prescriptions for controlled substances have been altered to obtain additional refills or increased number of pills, the copy in the chart proves the dose, frequency, and number of refills ordered by the physician."

SOURCES

For more information about accreditation survey experiences, contact:

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In addition to medication safety practices, Heatherley's surveyor also asked about physicians' awareness of their responsibilities in case of a surgical fire. "He wanted to know that if he stopped a surgeon and asked him about his role in a patient fire, the surgeon could answer accurately," she says. The surveyor pointed out that the physician should say: "Remove any burning materials from the patient and help put the fire out by putting the materials on the floor and extinguishing the fire, control any bleeding and prepare patient in case evacuation is necessary, put sterile towels over the surgical site if we need to move the patient, otherwise, finish surgery as quickly as possible and help move the patient." There is no confusion in her center, and physicians do know their responsibilities, she says. "We have a chart posted in the OR that describes everyone's role," she adds. **[A copy of the fire responsibility chart is available with the online edition of the October 2007 issue of *Same-Day Surgery*. Go to www.ahcmedia.com. For assistance, contact customer service at customer service@ahcmedia.com or (800) 699-2421.]**

Physicians must be involved in all patient safety activities, Heatherley says. "Our surveyor wanted to see minutes of the medical executive committee and other medical committee meetings at which we presented quality improvement [QI] studies related to patient safety," she says. This was no problem for Heatherley, because physicians on these committees often will suggest QI studies and participate in the studies, she says.

Reporting trends and ideas for QI studies is not enough, says Heatherley. "Our surveyor wanted to see closure," she says. "He wanted to see how we report the study findings and actions taken to improve performance back to medical staff members." ■

Reconciliation form should show stop, start dates

Indicate who instructed patient to stop medications

Anyone can make a list of medications dictated by a patient, but to fully comply with The Joint Commission's requirement to reconcile medications taken by your patient, your documentation needs to address more than just the name of the medication.

At Lakeshore Surgery Center in Fort Gratiot, MI, the first step in improving the center's ability to reconcile medications was to move away from listing medications within another admission form to designing a separate form to be used just for medication information, says **Lynn Burgett**, RN, BSN, administrator. "Our medication reconciliation form is the result of four or five trials of different forms," she says. "We produced the first form, then as we piloted its use, we gathered comments from nurses who identified space needed for other information," she says. **[A copy of the medication reconciliation form is available with the online edition of the October 2007 issue of *Same-Day Surgery*. Go to www.ahcmedia.com. For assistance, contact customer service at customerservice @ahcmedia.com or (800) 699-2421.]**

The form has space for the name of the prescription or over-the-counter medication taken by the patient as well as any herbal medications, the dose, the frequency, and instructions about stopping and starting the medication, says Burgett. "In the initial version of the form, the column that the nurse completed for the date the patient stopped taking a medication, such as Coumadin [warfarin], just included the date," she says. "Our surveyor pointed out that there was no identification of who instructed the patient to stop taking the medication and therefore, it appeared that the nurse gave these instructions." Now, the column identifies the physician who told the patient to stop taking the medication, she says.

3-4 day leeway

To identify potential risks related to anesthesia and patient medications, Burgett's staff makes pre-op calls three to four days prior to surgery. "This gives us time to identify medications that might pose a problem and talk with the patient's physicians," she says. Her nurses also have a protocol related to medications that has been developed by the center's anesthesiologists, she says. "This protocol enables nurses to talk to patients about what is safe to take on the day of surgery and what is not," she says. The protocol also prompts the nurse to discuss the use of some medications and herbs with a physician, she adds. Although most patients can be reached several days prior to surgery, occasionally nurses will talk with them the night before, she admits. "The only time we have to postpone surgery is if

these patients are taking anticoagulants and have not discontinued their use," she says.

Although the form is simple to use, it does add extra time for the discharge nurse, Burgett points out. "The nurse goes through each medication on the list, explaining what can be restarted on which date," she says. "The discharge nurse also writes the information on any prescriptions given on the day of surgery and explains their use," Burgett says.

Even with the extra time required, the form is very beneficial to staff and patients, says Burgett. "Not only do we make sure we accurately identify medications, but the completed list given to the patient at discharge is a tool they can carry to their physician at the follow-up visit to ensure an accurate list in their physician's chart," she says. ■

A surveyor at your door? Senior managers out?

Make sure other managers know how to find info

One of the first steps to take for a successful survey is to make sure that staff members who know the location of all documents needed by the surveyor are at work when the surveyor arrives.

When a surveyor for the Accreditation Association for Ambulatory Health Care (AAAHC) arrived at one outpatient surgery center to conduct a survey, she was greeted by a lone receptionist. "She told me that the center had no cases scheduled that day, so she was the only staff person, and she asked me to come back another day," says the surveyor, **Betty Bozzuto**, RN, MBA, CASC, executive director of Naugatuck Valley Surgical Center in Waterbury, CT. "I explained that the center had been notified that I was surveying the center on that day, so she needed to call some people to come in to work," she says. Two people did come to meet with Bozzuto, but she points out that their initial absence was a good indication of how ill-prepared they were for the survey.

You always must be ready

Although AAAHC does provide exact survey dates for non-Medicare accreditation surveys, Medicare surveys are completely unannounced, says Bozzuto. Just like The Joint Commission's unannounced surveys, organizations can block certain times of the year if there are special events or activities that will interfere with the surveyor's ability to evaluate the program, she says. However, throughout the rest of the year, you always must be ready, Bozzuto says.

Organize your documents

In addition to having a policy that requires the presence of a management team member in the center at all times, it also is important to organize your documentation in notebooks that are clearly labeled and placed together in one location, suggests **Ann Purvis**, RN, BSN, CNOR, surgical services clinical director and director of nursing at SurgiCenter Services of Pitt in Greenville, SC. Making sure that all levels of management know the location of the notebooks paid off when the surveyor arrived at the time when Purvis, the president of the surgery center, and the quality assurance manager were out of the building at different meetings. "My assistant nursing manager was able to quickly get the books to the surveyors and answer all of the questions," she says.

In addition to organizing information well, Purvis also recommends that outpatient surgery managers involve staff in all areas of survey readiness. "We try to be very transparent in our organization so that everyone knows what is happening in all areas," she says. "This enables any management person from any area to find information and answer questions intelligently." ■

SOURCES

For more information on handling accreditation surveys when your top management is out, contact:

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