Same-Day Surgery®

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

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IN THIS ISSUE

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What are your options when patients show up without an escort to drive?

Study shows accidents can occur — take steps to avoid liability

An outpatient surgery patient shows up without an escort to drive him home. Despite the nurse's insistence, the patient indicates he doesn't have anyone who can escort him. There is no cab or public transportation available. Reluctantly, the case continues, and the patient drives himself home.

A recent study indicates the results of this practice can be devastating.[1] The authors discuss two malpractice cases of patients who were discharged without an escort after ambulatory surgery procedures. Both patients drove themselves, had accidents, and sustained serious injuries. **(See details, p. 76.)**

The authors recommend that patients not be discharged without an escort regardless of whether the patient receives general anesthesia, regional anesthesia, monitored anesthesia, or sedation. "Driving after ambulatory surgery cannot be considered safe, and caregivers need to

EXECUTIVE SUMMARY

When patients show up without anyone to drive them home, ambulatory surgery programs are left with the potential for patients to injure themselves and others, and possible liability for the facility. Patients should have an escort, regardless of the type of anesthesia.

- Tell the patient during every communication to bring a valid driver, and confirm the driver at registration by copying the driver's license and putting the copy in the patient's chart.
- If the patient has no escort, determine if someone, perhaps from the patient's religious organization, can assist. If patients leave in a cab or drive themselves home, use a statement of discharge against medical advice.
- Consider canceling the procedure to avoid liability. If you have documentation that the patient was informed, you might be justified in billing the patient directly for lost OR time and physician time.

verify a safe ride home," they say.

Think it can't happen in your facility? One survey indicated that 11% of anesthesiologists would be willing to anesthetize patients without an escort.[2]

Anesthesia providers may wrongly think that short-acting anesthetics will wear off by discharge, or that the amount of sedation isn't enough to affect the patient's psychomotor function, the authors say. Actually, psychomotor impairment and cognitive deficits are common postoperatively, they say.[3-6]

Educate surgeons, anesthesiologists, and nurses on the importance of escorts, the authors advise.

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Even after very short procedures, most patients aren't fully recovered by discharge, they say, citing other references.[7-9] "Home readiness is not equivalent to street fitness," they say.

The accidents detailed in the study that fact, says **Stephen Trosty**, JD, MHA, CPHRM, risk management consultant in Haslett, MI. When someone is injured in such a case, the facility may be sued, he warns. The liability would be similar to a bartender who continues to serve patrons who have had too much to drink, then the patrons drive home and injure or kill themselves or others. "There have been cases in which liability has come back to the bartender and, in some cases, even to the bar," Trosty says.

The effect of an anesthetic is somewhat comparable to that of too much alcohol in the patients may be groggy, he says. "There's a reduced ability to react quickly, to recognize that there may be a problem that needs to be reacted to, and sometimes a reduced ability to stay awake," Trosty says.

Additionally, discharge without an escort is contrary to guidelines issued by professional bodies such as the American Society for Anesthesiologists, the authors say. These national guidelines don't distinguish between sedation, regional anesthesia, and general anesthesia, they point out. In all cases, a patient shouldn't drive for 24 hours after ambulatory surgery, the authors say.

The Association of periOperative Registered Nurses (AORN) has issued a revised 2008 recommended practice for monitored sedation that says the pre-op assessment should include verification of a responsible adult caregiver to escort the patient home.

Follow these four tips

Consider these suggestions to ensure patient safety and avoid liability regarding patient escorts:

• In the preoperative registration process, verify that the patient has a driver.

At the preoperative visit or during the preoperative call, tell patients that they need to bring a licensed driver with them, Trosty advises. Verify the name and contact information for that person, sources advise. Tell patients that without an escort, they won't be allowed to drive home and they'll have to stay at the facility until the anesthetic has worn off, Trosty advises.

Another option is to tell patients and document that if they don't have an escort, they will be sent home by cab and expected to pay for it and arrange transportation back to pick up their

cars, Trosty says. "Can you enforce it? Maybe yes, maybe no, but at least you can show the patient was informed," he says.

While most ambulatory surgery programs ask for the names of escorts and their phone numbers, Trosty suggests that you consider going a step further and asking for the driver's license of the escort, which can be copied for the patient record as a means of ensuring the escort is a valid driver. If the patient doesn't have an escort, ask him if there is someone he can call, Trosty suggests. "Tell them that unless someone comes, they won't be discharged," he says.

Document every time you give patients this information, Trosty emphasizes. "The more times you can demonstration the patient given information, the stronger position you'll be in," he says.

Inquire about an escort at every opportunity, advises **Mary Ogg**, MSN, RN, CNOR, perioperative nursing specialist in the Center for Nursing Practice at AORN. "It's just continual asking," Ogg says.

• **Offer suggestions for an escort**.

Nurses need to be creative about helping patients find a ride, Ogg says. An elderly patient may be living alone and have no family in the area. Ask if the patient might have a neighbor or religious organization that would assist, she says.

"Lots of churches have people on call to help with rides," Ogg says. "They might also be able to stay overnight as a caregiver."

A private duty nurse might be another option, she adds.

Some ambulatory surgery programs prefer a ride service where drivers have basic training such as bringing blankets and pills to make the ride more comfortable, driving directly to the patient's house, handling an emergency by calling 911, and assisting patients with mobility into the house.

• Have patients sign a waiver of discharge against medical advice.

Cab rides are an option when there is not an escort, Chung and the other authors suggest.

Nurses should escort the patients to the cabs to ensure that they don't drive themselves, the author says. They also suggest that patients sign a statement of discharge against medical advice. This statement allows the facility to provide written information about why the discharge could be hazardous and what the consequences may be, the authors say.

The signed statement is necessary if patients are driving themselves home, Trosty says. "It becomes important at that time that the patient understand the risks imposed by their driving home and that there is acknowledgement that they assume this risk," he says. The statement should indicate the patient had been told ahead of time about the necessity of having someone to drive them home and that they voluntarily ignored the advice, "something indicating prior knowledge as opposed to hearing it for first time when they got there," Trosty says. "The patient can't come back and say, 'No one told me that.'"

• Consider canceling the surgery.

At Toronto (Canada) Western Hospital, when there is absolutely no escort, the case is canceled, says **Frances Chung**, MD, of University Health Network and professor of anesthesia, Department of Anesthesia at University of Toronto. Chung is the lead author of the recent study.

Don't proceed with the case if you know the patient is intending to drive home, she advises. "Medically and legally, you may be in a bind somewhat," Chung says.

There are some instances in which the lesser of the evils is to cancel because if patient should get into an accident, and the staff members know he or she shouldn't drive, a claim may be made against the facility that costs more ultimately than a cancellation, Trosty says. If you've had the patient sign a statement agreeing to have an escort, you might have recourse to bill the patient directly for the lost expenses, including OR time and physician's time, he adds.

When there is high potential for injury, the stronger the need for more patient information and documentation and, "the stronger the case to require patient to do these things or to hold them there long enough to make sure the anesthetic is worn off," Trosty says.

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SOURCES

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Two cases show dangers when patients drive home

Two cases from the Canadian Medical Protective Association, a mutual defense organization for 95% of Canadian physicians, illustrate the danger of patients driving home after ambulatory surgery[1]:

• **A 44-year-old man was a healthy American Society of Anesthesiologist Classification 1 (ASA I) patient with no medical history, no mental illness, no history of alcohol use, or history of a motor vehicle accident.** He did have a history of occasional use of marijuana. During the initial consultation for an arthroscopy, the surgeon informed the patient that he would have to arrange transportation home on the day of the procedure and that an adult would be required to accompany him home.

On the day of the procedure, the patient presented without an escort and said a friend who had agreed to accompany him was now unavailable. The nursing staff reaffirmed the need for a safe means of transportation home, but the patient was anxious to proceed with surgery. The surgeon and the anesthesiologist were informed, and both decided that the procedure could be performed under local anesthesia. Intraoperatively, he became agitated and required sedation. He was given midazolam 2 mg IV and fentanyl 50 mcg IV as well as increments of propofol to a total dose of 50 mg IV. He remained conscious and alert at all times.

In the post-anesthesia care unit (PACU), he was able to eat and walk before he was allowed to leave. While driving himself home, the patient had an accident by driving off the road. This accident left him quadriplegic. In court, the patient stated that he stopped off the road to doze for a short time and resumed driving shortly before the accident. No evidence of alcohol or drug use was noted by the police. The anesthesiologist was found by the court to be negligent in allowing the patient to drive home after sedation, and the orthopedic surgeon was not found guilty.

• **In the second case, a 35-year-old woman was scheduled to undergo dilation and curettage for an early pregnancy under local anesthesia.** She was a healthy ASA 1 patient with no medical history, no mental illness, no history of alcohol use, and no history of a motor vehicle accident.

On the day of surgery, the prearranged sitter did not arrive to take care of her young children. The husband had to stay home to attend to the children. The patient arrived for her surgery by herself, and she was upset and crying. The gynecologist ordered oral lorazepam 1 mg as a pre-medication.

The patient underwent a dilation and curettage under local anesthesia with no other medication. In the PACU, a PACU nurse who knew her personally offered her a ride home. The patient refused and drove home alone. Subsequently, she had a car accident with serious injury. She sued the gynecologist who performed the surgery and the pre-op nurse who gave her the pre-medication (not the PACU nurse). The gynecologist and the nurse were found to be negligent for allowing the patient to drive herself home after sedation. A second car was involved in the accident, and the injured parties in the second car also sued and were compensated.

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Same-Day Surgery Manager

Hospitals fighting back while ASCs struggle

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

I've been in the business of surgery for the past 24 years. Years before that, I was in a clinical role in the OR. I try to stay ahead of the curve; that's my job. Trends are developing out there that you need to be aware of in your workplace.

In the early years of surgery centers, I would team up with business-minded surgeons who were frustrated with the supposed inefficiencies in the local hospital. Hi-ho, hi-ho, it's off to work they would go, as they built their own ambulatory surgery centers (ASCs) and became more efficient. The fact that they could make a nice profit from them clearly played a role in that process. Life was good for everyone. Well, almost everyone.

This honeymoon lasted several years — decades, actually. Then the paradigm began to shift. Insurance companies began to realize that the surgeons and ASCs were doing *too* well. It was time to start ratcheting down the reimbursement. It became increasingly more difficult for surgery centers to obtain good payer contracts — if they could get a contract for reimbursement at all! The sky started to fall.

Everyone started looking for a safe haven. What good is an efficient surgery center if you can't get paid? Granted, many surgery centers don't care about profits (LOL!) as long as they have an efficient place to do their cases. But seriously, time also is profit. As long as they don't have to keep putting money into their efficient operation, many are content just to build equity and rake in the precious saved minutes.

During that time, it was obvious that surgery centers needed an ally. Who better to help obtain commercial and managed care contracts — good contracts — than the hitherto shunned local hospital? Strange bedfellows those two made! As a company, we loved it! Hospitals that wanted to joint venture with local surgeons contacted us. They were of the mindset that it was better to lose half of the surgery cases to the surgeons by joining them than it was to lose all of their cases by not. The surgeons were OK in sharing the revenue with the hospitals because they now were in a better position to pick up more revenue.

It has been a blissful period. Everyone was busy making deals, making money, and enjoying new relationships. Nurses have been learning more about the business. Hospitals were starting to understand their surgical partners a little better and were applying that knowledge in making their inpatient surgeries more efficient. With their needs met, surgeons have started relaxing a bit. They aren't feeling paranoid now that they have achieved their goal of getting their cases done in a reasonable time and they aren't being stressed out about it.

Can you hear the distant thunder? The gathering storm? Listen . . .

Welcome everyone to 2008! Even the people with their heads buried deepest in the sand have to think, "What the heck?"

Suddenly, China and Japan have decided to start building things. The price and availability of steel — the main structure of a surgery center — has skyrocketed in price and become more difficult to obtain as the Asian countries eat up it up like candy. Hurricanes and gas prices have driven up the cost of construction for surgery centers from $120 per square foot to more than $300 and higher, and that does not even include the cost of the land and building. Overnight, everything costs more. The surgeons have to spend more to build their centers — and they have to borrow more! (Anyone see what else is coming?)

Then a one-two punch lands! The subprime real estate market has gone to hell. Not only is it more difficult to get a loan to construct a $5 million surgery center, but many surgeons are not able to get a loan to begin with. Owners of the buildings where surgery centers reside are less willing to build unless the surgeons collectively become responsible for the cost of the building in the event the centers don't succeed. Many surgeons and their joint-venture hospital partners are starting to think twice about this situation.

Did I forget to mention that reimbursement for surgery centers got pushed back on its butt? Cases that once were profitable in a surgery center aren't anymore. *Talk* about a nightmare.

Hospitals have begun to fight back. Armored with all the above, they no longer are willing to sit back and take a minority interest in a for-profit

surgery center, at decreased reimbursement, with surgeons who can no longer really afford to do it anyway. They are putting their foot down with a collectively thunder and saying, "No!" Hospitals are building their own cost-effective and efficient outpatient departments (HOPDs) that surgeons are very welcome to use but not have ownership in. The hospitals are having those centers professionally managed and are teaching their staff to become a lower-cost provider of surgical services, not only to the surgeons, but to the hospital itself.

You know what? It's working. Half of our business now is centered on management of HOPDs and it's growing. Talk about going full circle.

The irony of all of this change is that the cost of surgery still is high and, with fewer surgery centers being built, more patients will use hospital-based centers at a significantly higher price.

Sometimes you just gotta shake your head.

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

Make your web site accessible for elderly

Outpatient surgery providers are increasingly using web pages as a means to educate patients; however, how should you design and organize your web page so that it is accessible and easily navigated by older patients? Consider these suggestions from **Kay Ball**, RN, MSA, CNOR, FAAN, perioperative consultant and educator for K&D Medical in Lewis Center, OH:

• **Make the text easy to read.**

Your web site should comply with the Dottie Older Adult-Friendly Web Design Guidelines. **[Those guidelines are available with the online version of *Same-Day Surgery*. For assistance, contact customer service at customservice@ahcmedia.com or (800) 688-2421.]** For example, the text size should be at least 12 point. The typeface should not be condensed. Boldface type may help the elderly to read the text easier, as does double-spacing of the text, Ball says.

All capital letters used only for headings makes the text easier to follow, she says. Left-justified text is more appealing to the older adult, Ball says. Contrast between the page color and the print color allows for easier reading, she says.

• **Organize the text in a simple format.**

Present information about surgical procedures, the surgeons, and facilities in a manner that is sensitive to older adults who may process information more slowly than younger ones, Ball says.

Text should be simple, with short sentences. A glossary of technical terms is helpful, particularly if the more technical words have a hyperlink to the definition. Another option is to have the word hyperlinked to another web site for more information.

The sections that divide each web page should be short and organized into consistent and logical formats. For example, the hip replacement and knee replacement information should consistently discuss why joint replacement is performed; what a healthy joint vs. a problem joint is; a description of the prosthesis; how to make appointments; and expectations before surgery, on the day of surgery, and during rehabilitation.

Having audio or video capabilities can enhance a web site and help the patient fully understand the text message, Ball says.

• **Make the site easy to navigate.**

Navigation features are extremely important for a web site often used by the older adult, Ball says.

For example, provide a single mouse click to access information, she says. Also, offer consistency in the text format, Ball says. Have each page labeled with the same headings and footers. Clicking on an option within the header or footer can help the user move around the web site quickly while homogeny is maintained. Ball suggests that the footer information be available as a second line within the heading so that information won't be missed.

Use the navigation word "top" used within the text to easily move the user back to the beginning of the page. No pull-down menus are ideal because older adults often find them difficult to navigate, Ball says.

• **Include site maps, contacts, and a search mechanism.**

Site maps are helpful to outline how the web site is organized. Relevant links to other sites on the Internet make a web site more valuable and dependable. If you offer technical information, any further information and reference materials would be extremely valuable, Ball says. This increases the reliability of the web site because other explanations are offered, she adds.

Provide contact information for each web site section so that the reader can talk to a person or

e-mail a contact for more information.

A search mechanism for the Internet, using key words or menu choices, makes a web site more user-friendly and functional, Ball says. If you provide information in portable document format (PDF), a link to download free Adobe software allows easy access (www.adobe.com), she says. ■

Institute for QI releases benchmarks

Cataract, colonoscopy, and knee arthroscopy targeted

The AAAAHC Institute for Quality Improvement (IQI) has released the clinical versions of three benchmarking study reports: cataract extraction with lens insertion, colonoscopy, and knee arthroscopy with meniscectomy.

Clinical reports include data on factors such as outcomes, complications, and patient satisfaction, as well as operative techniques, anesthesia and policies and procedures that improve efficiency and reduce patient wait times. Here are the results:

• **Cataract surgery.**

Intraoperative anesthetic techniques include topical (42%), peribulbar block (24%), retrobulbar block (26%).

Individuals insured by Medicare were less likely to receive high-tech replacement lenses that also correct presbyopia (15%) compared to non-Medicare-eligible patients who received the corrective reading lens (28%).

Two weeks following surgery, 95% of patients said their vision had changed for the better. Almost all patients (99%) said they understood the procedure and what was going to happen to them, were comfortable during and after the procedure, and would recommend the procedure to friends or family members with cataracts. The vast majority (97%) said they were able to return to their activities of daily living within one week, with 76% reporting resumption of activities within two days.

• **Colonoscopy.**

In 94% of cases, a time was given for visualization of the cecum. In 80% of the cases, the time from cecum visualization to the end of the procedure was six minutes or more.The average time from the visualization of the cecum to the end of the procedure (by organization) ranged from four to 18 minutes, with a median of nine minutes. The 2002 U.S. Multi-Society Task Force on Colorectal Cancer recommended that the withdrawal phase for colonoscopy should average at least six to 10 minutes.

Only 2% of patients reported "almost severe" or "severe discomfort" during the procedure itself; however 15% reported discomfort with bowel preparation techniques prior to the procedure. Of those who reported significant discomfort with the bowel preparation, 8% said they would not have the procedure again.

• **Knee Arthroscopy with Meniscectomy.**

Almost half (45%) of procedures were performed due to traumatic injury, and 55% were due to degenerative disease.

Average discharge time ranged from about 94 minutes for patients receiving epidural/spinal anesthesia to 66 minutes with local anesthesia and IV sedation.

Of 576 patients who remembered their procedures, 97.7% said they were comfortable during the surgery. All but 35 (5%) indicated they had begun walking at the time they were surveyed (within seven days of the procedure).

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

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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.

1. According to the authors of a recent study *(Anes Analg* 2008; 106:817-820), what types of anesthesia are permissible for patients to be discharged without an escort?

A. Not general anesthesia, regional anesthesia, monitored anesthesia, or sedation.
B. Only for sedation.
C. Only for sedation and monitored anesthesia.
D. Only for sedation, monitored anesthesia, and regional anesthesia.

2. How can you verify that the patient has a valid driver to escort them home, according to Stephen Trosty, JD, MHA, CPHRM?

A. Ask for a copy of the driver's license, and make a copy for the patient record.
B. Take a photo of the escort, and make a copy for the patient record.
C. Have the escort sign the discharge instructions, and make a copy for the patient record.
D. Require the escort to attend the preoperative screening.

3. What size should the text be on your web site in order to be user-friendly for elderly patients, according to Kay Ball, RN, MSA, CNOR, FAAN?

A. At least 10 point.
B. At least 12 point.
C. At least 14 point.
D. At least 16 point.

4. Which is true regarding patient flow tracers conducted by surveyors from The Joint Commission?

A. Surveyors will not ask staff direct questions about patient flow unless a problem is clearly identified.
B. Surveyors will want to know what barriers were identified, but organizations are not required to show what actions were taken as a result.
C. If surveyors see patients waiting in ED hallways, this will be considered as noncompliance with the patient flow standards.
D. Surveyors will want to know how any identified problems with patient flow have been mitigated.

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

SDS ACCREDITATION UPDATE

Covering Compliance with Joint Commission and AAAHC Standards

Surgery managers must prepare for changes to Joint Commission leadership standards

Ambulatory surgery managers in hospitals, surgery centers, and offices face new requirements in 2009 under a revised chapter of leadership standards from The Joint Commission (TJC).

"The focus is on accountability for the quality and safety of care," says **Sue Dill Calloway**, MSN, JD, RN, director of hospital patient safety at OHIC Insurance Co./The Doctors Company, Columbus, OH.

Go through the standards individually to determine compliance, Calloway advises. "This might take a little more time than you thought, so I encourage the leadership team to get started right away," she says. **(To access the standards, go to www.jointcommission.org. Under "Standards," click on "Pre-Publication Standards.")**

This also will help prepare you for the leadership session that lasts about one hour. **(For questions you may be asked about patient flow at this meeting, see story, p. 2.)**

EXECUTIVE SUMMARY

New and revised leadership standards for 2009 focus on quality and safety of care.

- Regularly assess the culture of safety, and take action on the results. Hospitals must use a validated survey.
- Create a code of conduct on what is acceptable/unacceptable behavior and a process for managing it. Designate someone to manage conflict.
- Communicate regularly about performance improvement, safety incidents, safety solutions, population-specific issues, and input from those populations.
- Identity the information and knowledge that leaders need, and provide access to information and training.

Assess culture of safety

One of the biggest challenges for outpatient surgery managers will be the requirement to regularly assess the organization's culture of safety, says **Maureen Carr**, project director, Division of Standards and Survey Methods at TJC.

Offices and surgery centers are asked to assess the culture and take action on the results, she says. Hospital-based programs are required to use a validated tool for a regular assessment. **(For more on hospital-only requirements, see story, p. 2.)** Tools can include surveys or focus groups, for example, Carr says. The Agency for Healthcare Research and Quality has developed a free survey. **(To access survey, go to www.ahrq.gov/qual/hospculture/hospdim.htm.)**

Focus on staff perceptions, Carr says. You can examine how often safety issues are reported within the organization, for example, she says.

Another challenge for all providers is complying with the leadership standards related to disruptive behavior, Carr says. This standard address this behavior by any staff person or board member, she emphasizes. "We're asking organizations

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Some changes are for hospitals only

Under new leadership standards from The Joint Commission (TJC) that take affect in 2009, only hospitals will be required to focus on conflict that may affect safety and quality.

Senior leaders must create a process for conflict management, says **Maureen Carr**, project director, Division of Standards and Survey Methods at TJC.

The organization needs to identify a skilled person who can help in the conflict management process, says **Sue Dill Calloway,** MSN, JD, RN, director of hospital patient safety at OHIC Insurance Co./The Doctors Company, Columbus, OH. These people can be from within the organization, such as human resource management, or from people outside the organization, Calloway says.

A designated person can meet with the involved parties and work to manage or resolve the conflict, Carr says. "We realize that conflict sometimes isn't resolved, but they need to make sure safety and quality are not harmed," she says.

Learn conflict resolution

Conflict management skills can be obtained through experience, education, and training, Calloway says. "Many places offer conflict resolution classes," she says.

If the organization chooses to train its leaders, it may offer training to key individuals or bring in experts to teach conflict management skills, Calloway says. "Most [facilities] will probably decide to offer a course on conflict management to their senior leaders and department managers," she says.

Hospitals leaders also are required to identify their shared and unique accountabilities to the organization, Carr says. For example, the medical staff are responsible for overseeing the quality of care, she says. Management is responsible for hiring competent staff.

The governing body needs to provide resources, Carr says. "That's their accountability," she points out. ■

to create a code of conduct on what is acceptable and unacceptable behavior, and a process for managing it," Carr says.

The code of conduct should stipulate that staff people speak with each other and behave in a manner that isn't threatening or intimidating, she says. It should explain acceptable and unacceptable behavior, says Calloway. "Facilities can't accept disruptive behavior anymore," she says. "There needs to be a process so if it occurs, I have a channel to report it to so the matter gets taken care of." Educate your staff on this code, Calloway advises.

More new requirements

Leaders will be required to communicate regarding issues of safety and quality, Carr says.

"They should be talking regularly about [performance improvement] activities, any reported safety incidents, solutions that they have come to on safety issues, issues that might be specific to specific populations they service, and input from those populations," she says.

The organization also must identify the kinds of knowledge and information that leaders need to function well. "For example, leaders must be oriented to the mission, safety and quality goals, the decision-making processes within the organization, how budgetary and financial issues are addressed, issues of their population served, and accountabilities of leaders within the organization," Carr explains.

The governing bodies must provide leaders with access to information and training in areas where they need skills and expertise. "That can be an in-house briefing," Carr says. "For example, a person may be unfamiliar with financial issues, and you may want to go over basic principles." ■

Patient flow getting increased scrutiny

Scheduling issues with the operating room. Your facility failing to grow in response to the needs of the community.

These are some of the many factors — some controllable, others not — that can wreak havoc with patient flow at your organization.

With the addition of a new patient flow tracer

for 2008, surveyors from The Joint Commission (TJC) will use tracer methodology to look for "patient backflow" that creates congestion in the surgical areas, as well as the EDs and critical care units (CCUs).

"This often results in treatment delays, medical errors, and unsafe practices," says **Michelle H. Pelling**, MBA, RN, president of The Propell Group in Newberg, OR, a consulting group specializing in health care performance improvement and TJC accreditation.

According to **Pat Adamski**, RN, MS, MBA, director of The Joint Commission's Standards Interpretation Group, surveyors will require organizations "to really take a serious look at this. We expect them to do a thorough assessment of flow, and determine any issues that may impact their ability to provide quality and timely care."

Surveyors to examine flow

Since the tracer will determine how well the organization is complying with the patient flow standard LD.3.15, surveyors won't merely ask questions during the leadership interview — they'll want to review actual processes. Staff should be able to answer the questions: "How have you improved patient flow?" or "What has the hospital done to remove barriers to patient flow?" says Pelling.

Surveyors will identify patients who experienced backflow during their hospital stay, even if it didn't affect the care they received, by reviewing medical records, interviewing staff members involved in patient care, and visiting different units and departments throughout the hospital.

Patient flow tracers won't necessarily be done during every survey; it will depend on what surveyors see on-site. A surveyor may decide to do a patient flow tracer because they identify a delay in treatment during another tracer, or because they see patients backed up in the hallways. "Those kinds of things could set off a red flag in the surveyor's mind to do a patient flow tracer to see what they can learn," says Adamski.

What surveyors will ask

During the leadership interview, surveyors may ask about the process for identifying barriers to patient flow, results from data collection, how the medical staff have been involved, and actions taken to lessen the impact of patient backflow. "We don't say, 'You have to be at this level.' We say you have to identify what your problems are and be actively working on them," says Adamski.

Use data to evaluate flow

Patient flow is a "network of queues" throughout the hospital that need to be studied and then improved wherever possible, says **Kirk Jensen**, MD, chief medical officer for Best Practices, a Fairfax, VA-based consulting group specializing in physician leadership and management. Jensen also is a faculty member of the Institute for Healthcare Improvement and served on the expert panel for Urgent Matters, a Robert Wood Johnson Foundation initiative aimed at helping hospitals eliminate ED crowding and congestion.

Performance improvement teams should monitor the relevant metrics to create a "road map" of the patient's journey, identify where waits are occurring, and then work to improve or eliminate those waits, says Jensen. Surveyors will want to see your data on four specific areas: available supply of patient bed space, the efficiency of patient care treatment in service areas, the safety of patient care treatment in service areas, and support services that affect flow.

"Organizations can develop their own indicators, as long as those four areas are addressed," says Adamski.

However, data are not enough on their own; surveyors will want to see what's been done. If the data have revealed problems, expect to field questions from surveyors about the process improvement plan in place to mitigate those.

Avoid this pitfall

A common pitfall: Organizations have all of the required data in hand, but aren't analyzing them properly.

"The person in charge may have left unexpectedly, and no one picked up the ball. Or you may fix a problem and think you've got it resolved, and then the dam breaks loose in another area," says Adamski. "You need an ongoing PI process to constantly re-evaluate the situation, put fixes in place, and follow through to make sure they hold up."

Since the patient flow tracer is new this year, it should be practiced internally, says Pelling. She recommends tracking a sample of patients from the time they enter the facility until they reach their initial destination, and then following them

until discharge. "This can be done both concurrently and retrospectively," says Pelling. "Track the time from when each order was written to the time it was executed. Establish a reasonable time goal for each stage."

Benchmark with other organizations

Benchmark with other organizations to compare your performance, which will give you a "high-level view" of the process, says Pelling. "If there are delays at any point, follow up by drilling down to determine the cause. Evaluate whether they are isolated incidents or problems that occur frequently," she says. "If it's the latter, evaluate the potential causes and establish plans to improve."

Pelling recommends collecting data to evaluate how efficiently care, treatment, and services are being provided, such as time of the physician's order to the time of discharge. Collect data on length of stay, recommends Jensen.

Diane Jacobsen, MPH, CPHQ, director of the Institute for Healthcare Improvement's initiative on Improving Flow through Acute Care Settings, also recommends measuring the length of stay. "There are guidelines as to what the normal length of stay should be for some diagnoses, and if it is very long for a certain patient population, it provides an opportunity to understand why some of the delays might be occurring," says Jacobsen.

"Data are helpful and important, but collecting large amounts of data should not become the only thing that we do," adds Jacobsen. "You need a big picture understanding of the measures and also the chronic bottlenecks that affect those measures."

Collaboration is needed

Improving patient flow requires a number of "puzzle pieces" to come together, with the involvement of physicians and staff.

Physicians are key players in the process, since the assessment of whether a patient is ready for discharge often is delayed due to surgery schedules and unexpected patient crises, says Pelling.

Frontline staff are the group that "can make or break you," says Adamski. "If they know you are working to move through patients quicker, they may see it as creating more work for them," she says. "But in reality, if you correct a lot of these flow issues, it should help the staff as well."

To demonstrate to surveyors that impediments to patient flow were mitigated, staff at Virginia Mason Medical Center in Seattle will point to the following, says **Dana Nelson-Peterson**, RN, MN, administrative director of hospital operations:

- Twice-daily "bed flow huddles," with representation from all floors and perioperative services.
- A 9 a.m. standard for physician discharge orders. "This has allowed us to move up the average time of discharge significantly throughout the hospital, creating capacity to absorb the postoperative patients and unplanned admits through the ED," says Nelson-Peterson.
- A daily huddle with perioperative services to review the upcoming three days of OR schedules to ascertain CCU/monitored bed needs and capacity.

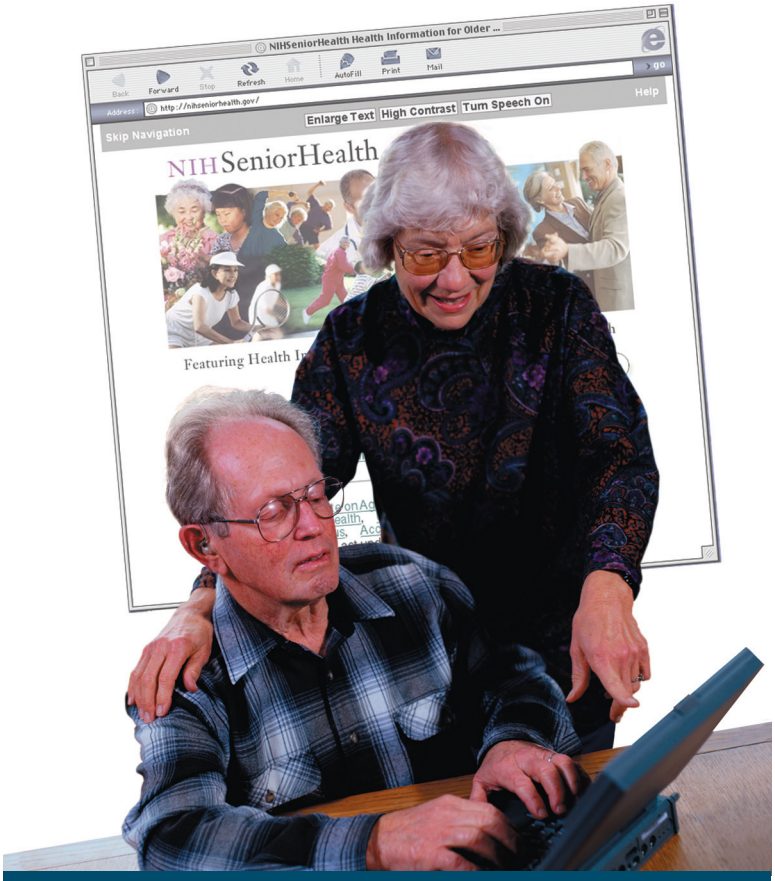
Monthly tracers performed

At Lucile Packard Children's Hospital in Palo Alto, CA, questions about patient flow are incorporated into monthly tracers to increase the ability of staff to articulate what the organization has done. **Vicki Link**, RN, BSN, MBA, director of quality management, says they expect managers and nursing education to perform tracers and provide feedback to staff.

The hospital is having a mock survey done by an independent company and has asked them to do specific tracers for patient flow.

"Since patient progression is such a huge component of our daily procedures, we feel staff will be comfortable with these new tracers," says Link. ■

Making Your Web Site Senior Friendly



A Checklist

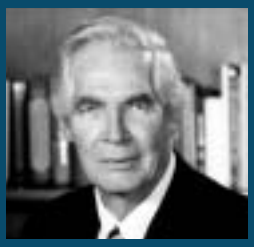
Published by the National Institute on Aging
and the National Library of Medicine

National Institute on Aging

NATIONAL LIBRARY OF MEDICINE

By implementing this Checklist, web designers can help open the Internet to great numbers of people over 60 who want to know more about their health and aging.

Richard J. Hodes, M.D.
Director
National Institute on Aging



"Good information is the best medicine for older adults. Web site designers can help seniors find answers to their medical questions from the comfort of their own home thanks to this Checklist and the Internet."

Donald A.B. Lindberg, M.D.
Director
National Library of Medicine

The goal of this Checklist is to provide research-based guidelines for web site design that, when implemented, will make web sites more accessible to all adults.

People age 60 and older now constitute the fastest growing group of computer users and information seekers on the World Wide Web.[1] They go on line principally to find health information, to plan personal travel and for e-mail.[2] While advanced age is not a hindrance to computer or Internet use, there are normal, gradual age-associated declines in vision and certain cognitive abilities that may limit the use of electronic technology. In the last two decades, the National Institute on Aging has funded a number of basic and applied cognitive aging studies, focus groups and usability tests, and survey research on how age-associated changes affect computer use.[3]

[1] U.S. Department of Commerce, 1999

[2] Morrell, Mayhorn & Bennett, 2000

[3] Research conducted by Elizabeth A. Bosman, Neil Charness, Sara J. Czaja, Katherine V. Echt, Arthur D. Fisk, Catherine L. Kelley, Sherry E. Mead, Roger W. Morrell, Denise C. Park, Wendy A. Rogers, and Joseph Sharit

Web Site Checklist

Designing Readable Text for Older Adults

Changes in vision that occur with age can make it more difficult to read a computer screen. These include reductions in the amount of light that reaches the retina, loss of contrast sensitivity, and loss of the ability to detect fine details.[1] Following the guidelines will improve readability of online text.[2]

Typeface

Use a sans serif typeface, such as Helvetica, that is not condensed. Avoid the use of serif, novelty, and display typefaces.

Sans Serif: Helvetica
Arial
Univers
News Gothic

Serif: ~~Times New Roman~~

Novelty: ~~Old English Text~~

Display: ~~Bodoni Poster~~

Type Size

Use 12 point or 14 point type size for body text.

12 point: The quick brown fox jumped over the lazy dog.

14 point: The quick brown fox jumped over the lazy dog.

[1] Echt, 2002

[2] Hartley, 1999

Type Weight

Use medium or bold face type.

Helvetica Medium
abcdefghijklmnopqrstuvwxyz
ABCDEFGHIJKLMNOPQRSTUVWXYZ

Helvetica Bold
abcdefghijklmnopqrstuvwxyz
ABCDEFGHIJKLMNOPQRSTUVWXYZ

Capital and Lowercase Letters

Present body text in upper and lowercase letters. Use all capital letters and italics in headlines only. Reserve underlining for links.

Physical Spacing

Double space all body text.

Justification

There are three ways to justify type: left, full, or center justified. Left justified text is optimal for older adults.

This is an example of left justification. Left justification allows an even left margin and an uneven right margin. This is an example of left justification. Left justification allows an even left margin and an uneven right margin. This is an example of left justification.

This is an example of full justification. Full justification refers to text lines that are spaced so that the margins on either side are equal. This is an example of full justification. Full justification refers to text lines that are spaced so that the margins on either side are equal. This is an example of full justification.

This is an example of center justification.
Center justification balances text around a central axis. This is an example of center justification. Center justification balances text around a central axis. This is an example of center justification.

Color

Avoid yellow and blue and green in close proximity. These colors and juxtapositions are difficult for some older adults to discriminate. Ensure that text and graphics are understandable when viewed on a black and white monitor.

Backgrounds

Use dark type or graphics against a light background, or white lettering on a black or dark-colored background. Avoid patterned backgrounds.

Research shows that the ability to perform some mental operations decreases with age. These operations include the ability to simultaneously remember and process new information, to perform complex cognitive tasks, and to comprehend text.[1] Although these changes are not usually dramatic, their presence can interfere with the performance of some daily tasks such as using a computer.[2]

Older adults also process information more slowly than younger adults. There are effective ways to present text to mediate these age-related changes.[2]

Writing the Text

Style

Present information in a clear and familiar way to reduce the number of inferences that must be made. Use positive statements.

Phrasing

Use the active voice.

Simplicity

Write the text in simple language. Provide an online glossary of technical terms.

Organization

Organize the content in a standard format. Break lengthy documents into short sections.

[1] Craik & Salthouse, 2000
[2] Czaja & Sharit, 1998; Morrell, 1997

Illustrations and Photographs

Use text-relevant images only.

Animation, Video and Audio

Use short segments to reduce download time on older computers.

Text Alternatives

Provide text alternatives such as open-captioning or access to a static version of the text for all animation, video, and audio.

Also consider these navigational features when designing a web site for older adults.[1]

Navigation

The organization of the web site should be simple and straightforward. Use explicit step-by-step navigation procedures whenever possible to ensure that people understand what follows next. Carefully label links.

The Mouse

Use single mouse clicks to access information.

Consistent Layout

Use a standard page design and the same symbols and icons throughout. Use the same set of navigation buttons in the same place on each page to move from one web page or section of the web site to another. Label each page in the same location with the name of the web site.

Style and Size of Icons and Buttons

Incorporate text with the icon if possible, and use large buttons that do not require precise mouse movements for activation.

Menus

Use pull down menus sparingly.

[1] Charness, Kelley, Bosman & Mottram, 2001; Rogers & Fisk, 2000; Mead, Batsakes, Fisk, & Mykityshyn, 1999

Increasing the Ease of Navigation

Scrolling

Avoid automatically scrolling text. If manual scrolling is required, incorporate specific scrolling icons on each page.

Backward / Forward Navigation

Incorporate buttons such as Previous Page and Next Page to allow the reader to review or move forward.

Site Maps

Provide a site map to show how the site is organized.

Hyperlinks

Use icons with text as hyperlinks.

Help and Information

Offer a telephone number for those who would prefer to talk to a person or provide an e-mail address for questions or comments.

Solicit unbiased comments from older adults through focus groups, usability testing or other means, to evaluate the accessibility and friendliness of the web site.

NIH Senior Health.gov

For an example of a senior friendly web site that was developed in accordance with these guidelines, log on to **www.nihseniorhealth.gov**. This web site was jointly developed by the National Institute on Aging and the National Library of Medicine.

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