INSIDE

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ASC CMS Quality Measure Reporting: Why, What, When, Where & How

By Ann O'Neill, RN, MBA|HCM, Director of Clinical Operations for Regent Surgical Health

The following article was written by Ann O'Neill, RN, MBA/HCM, director of clinical operations for Regent Surgical Health.

By now, almost everyone in the ASC industry is aware of the new CMS quality measure reporting requirements. What you might like to know is why, what, when, where, and how data is to be collected and reported. Some of those questions will be answered here; however, CMS has not

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Back to the Basics: 6 Core Concepts for Patient Safety & Quality Control

By Laura Miller

To construct a truly outstanding patient-safety and quality control program, hospitals must first have a strong quality foundation. Many hospitals attempt to launch sophisticated initiatives and find they are unable to build upon their poor structural foundation and are surprised when their initiative fails; instead, these hospitals should go back to the basics and focus on the core elements of quality and process improvement, says Joseph Cappiello, chief operating officer of Healthcare Facilities Accreditation Program.

"You don't have to be big hospital with significant resources to do a really good job with quality and patient safety initiatives," he says. "There are so many small critical access and community-based medical centers that are doing outstanding work in the quality setting. What you really need is committed leadership supporting staff that are confident in that

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8 Strategies to Prevent Wrong-Site Surgery

Seven years after the Joint Commission first unveiled mandatory rules to prevent operations on the wrong patient or body part, researchers and experts say the problem of wrong-site surgery has not improved. Based on state data, Joint Commission officials estimate that wrong-site surgery occurs 40 times a week in U.S. hospitals and clinics, with 93 cases of wrong-site surgery reported to the accrediting organization in 2010.

The results of wrong-site surgery can be devastating for patient, physician and facility alike, hence the push by accrediting and patient safety organizations to make this issue a "never" event. Linda Groah, MSN, RN, CNOR, NEA-BC, FAAN, executive director and CEO of AORN, discusses eight strategies to prevent wrong-site surgery at your facility.

1. Validate information on side and site the night before surgery. Ms. Groah says the evening before surgery, a staff member should validate the information needed for the next morning. This prevents last-minute panics and gives the patient a chance to confirm the surgical details. "Many hospitals will actually do a telephone interview the night before with the patient just to confirm the instructions, so they know the patient will be ready for surgery the next day," she says.

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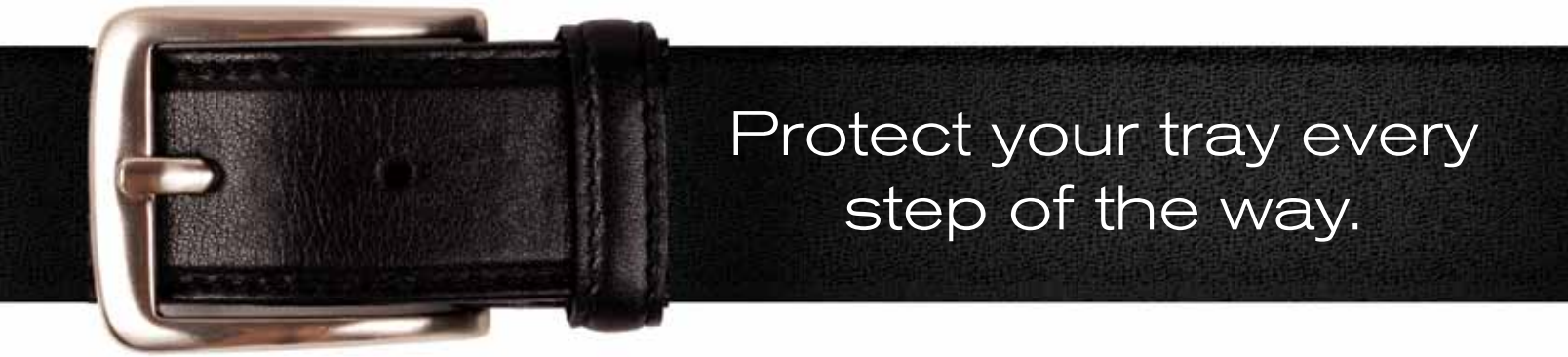

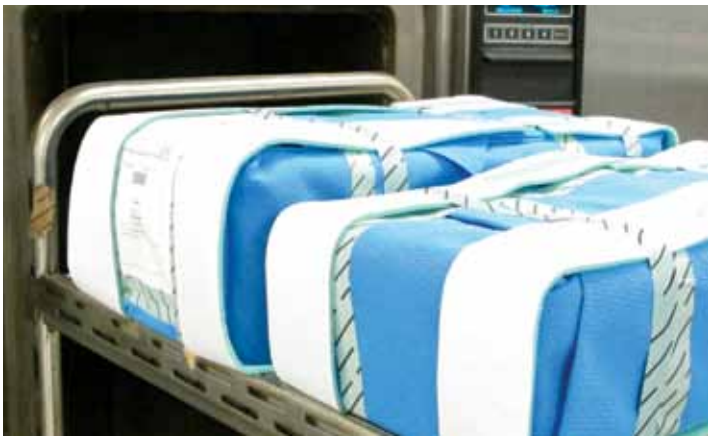

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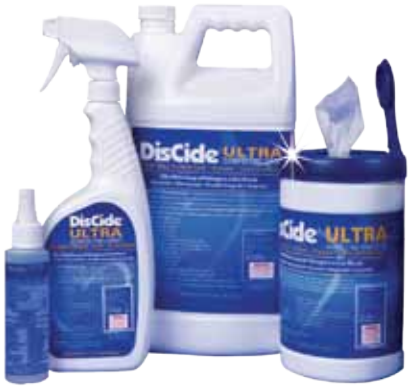

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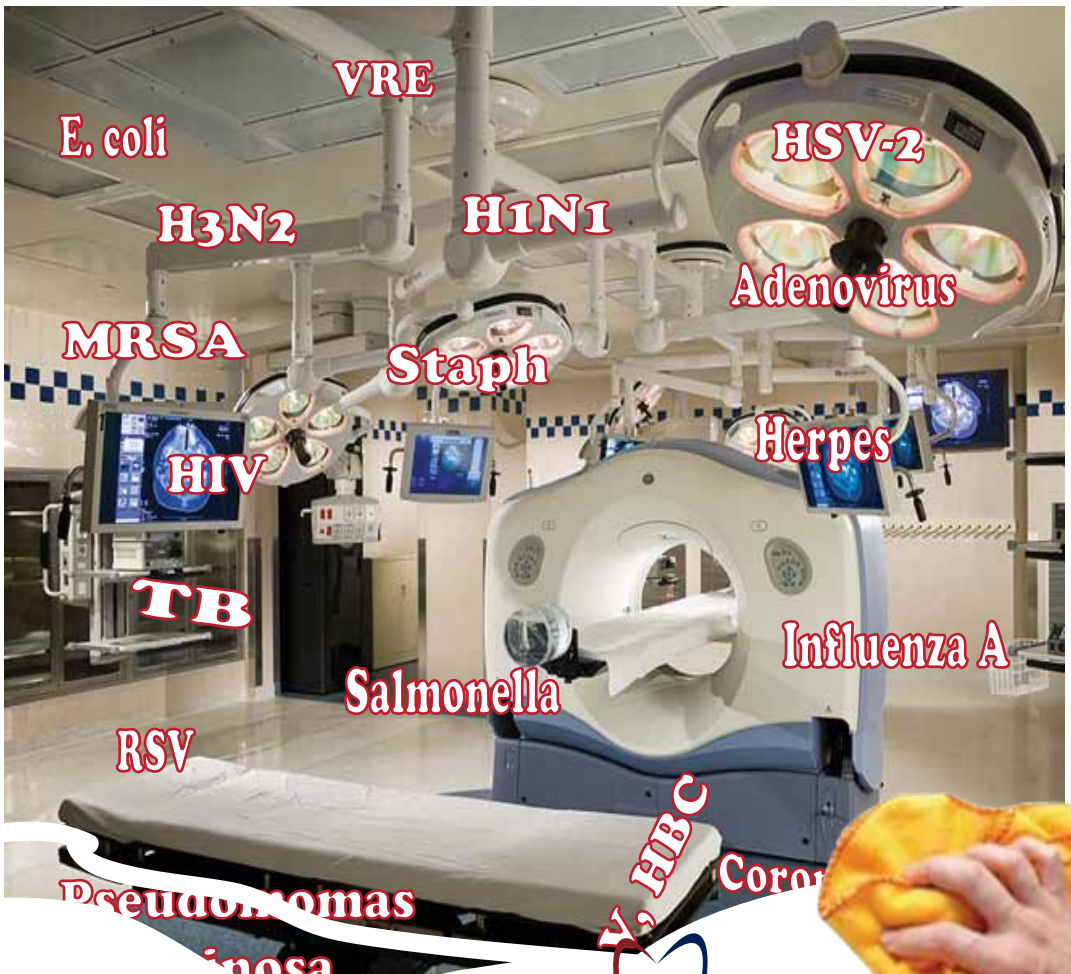

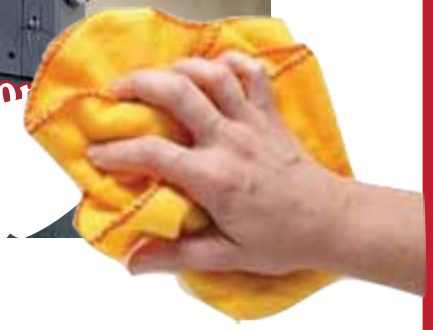

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FEATURES

ASC CMS Quality Measure Reporting: Why, What, When, Where & How
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yet published all the detail that will be needed for full participation in reporting by ASCs.

Why:

Simply stated, the driver for monitoring, measuring, and analyzing these quality measures is to improve patient outcomes. It is an industry-wide approach to advance patient safety. CMS will be using quality measures as a leverage to control healthcare reimbursement.

Infection and injury to patients are bad for the patient, bad for the provider and bad for the industry. Many agencies have been trying to address these issues for years. Some of the pioneering agencies that have influenced the development of the newly required measures include: CMS, CDC, the Agency for Healthcare Research and Quality, the Indian Health Service, the Food and Drug Administration, National Quality Forum, National Healthcare Safety Network, ASC Quality Collaboration, the Word Health Organization and The Surgical Care Improvement Project national quality partnership of organizations.

Hospitals were the first providers required by CMS to report quality measures or face financial sanctions for non-participation. However, with the Tax Relief and Health Care Act of 2006, Congress gave permission to CMS to create a required ASC quality measure reporting system that is tied to reimbursement. The Act also allows CMS to impose a payment penalty of up to 2 percent for any ASC that fails to submit the required data.

Objective measurement is the only way to evaluate clinical performance of an organization's people and processes. Comparing to industry benchmarks helps us to set internal goals for improvement. Measuring against past performance gives an indication of whether or not we have sustained improvement. Addressing the concerns raised by the statistics helps us to maintain quality. CMS has not established benchmarks for the quality measures. ASCs only need to report measures in this first phase and are not required to meet a designated goal. As we move further into pay for performance we might anticipate that the next step will be a requirement to meet defined goals. These goals will likely be based on new benchmarks established from the ASC data submitted through this new reporting system.

What and when:

There are five initial patient specific quality measures to be reported in CY2012. An additional two facility practice measures must be monitored in CY2012 and reported in CY2013. CMS payment sanctions could begin in CY2014 based on compliance with reporting and the timing of reporting. One more measure is already planned to start in CY2014. Additional measures can be added and/or modified by CMS each year along with further changes to payment determination.

The following table depicts each measure, its definition and its timing.

Measure (Rate = # instances / total population included in measure)	Start Date of Tracking	Start Date of Reporting	Start Date of Penalties
Patient Burns	**October 1, 2012**	**October 1, 2012**	**CY2014**
Definition: Unintended tissue injury caused by any of the six recognized mechanisms: scalds, contact, fire, chemical, electrical or radiation			
Patient Falls	**October 1, 2012**	**October 1, 2012**	**CY2014**
Definition: a sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object			
Wrong Site/Wrong side/Wrong Patient/Wrong Procedure/Wrong Implant	**October 1, 2012**	**October 1, 2012**	**CY2014**
Definition: Not in accordance with intended site, side, patient, procedure or implant.			
Hospital Transfer/Admission	**October 1, 2012**	**October 1, 2012**	**CY2014**
Definition: Patients who are transferred or directly admitted to the hospital upon their discharge from the ASC, not those admitted or seen in the emergency department after they have been discharged.			
Prophylactic IV Antibiotic within one hour of procedure	**October 1, 2012**	**October 1, 2012**	**CY2014**
Definition: An antibiotic ordered and given intravenously with the intent of reducing the probability of an infection related to an invasive procedure within one hour of surgery start time (two hours for vancomycin or fluoroquinolones), or tourniquet application for certain orthopedic cases. For purposes of this measure, the following antibiotics are considered prophylaxis for surgical site infections: Ampicillin/sulbactam,Aztreonam, Cefazolin, Cefmetazole, Cefotetan, Cefoxitin, Cefuroxime, Ciprofloxacin, Clindamycin, Ertapenem, Erythromycin, Gatifloxacin, Gentamicin, Levofloxacin,Metronidazole, Moxifloxacin, Neomycin and Vancomycin.			
Patient Safety Checklist in Use	**January 1, 2012-December 31, 2012**	**July 1 thru August 15, 2012**	**CY2015**
Definition: A documented checklist used in the three distinct patient care phases of pre-procedure/pre-anesthesia, prior to start of surgery (the surgical "time-out"), and the immediate post procedure before leaving the procedure room; containing pertinent information to ascertain patient risk, patient identification, correct procedure, equipment readiness, anticipated critical events, post procedure team debriefing reviewing events and identifying issues, and anything relevant to that individual patient, the specific procedure, or the individual facility. (CMS required implementation of this procedure effective 1/1/2012.) *Sample checklists are available from WHO and various surgery related professional organizations.			
Facility Volume Data on Selected Procedures	**January 1, 2012-December 31, 2012**	**July 1 thru August 15, 2013**	**CY2015**
Definition: To be determined by CMS			
Influenza Vaccination Coverage among Healthcare Personnel Rate	**October 1, 2014**	**October 1, 2014 - March 31, 2015**	**CY2016**
Definition: Influenza vaccination rate of all employees and credentialed healthcare providers working in a facility (number employees and providers vaccinated/total number employees and providers).			

Where and how:

Where and how to report your quality data remains ill defined. What we do know is that patient specific measures will be reported utilizing a different method than the facility-wide measures. Patient specific measures will first have to be reported using quality data codes when submitting a claim to CMS. It is expected that CMS will determine what the codes are and the exact mechanism that should be used to describe the quality measures sometime in the second quarter of 2012.

It is also anticipated that CMS will require reporting of the non-patient specific measures via the QualityNet website, beginning in 2013. The details for ASC registration have not been released.

For the initial reporting in 2012, only Medicare patients receiving Medicare allowed procedures are included in the reporting requirements for the patient specific measures. Starting in 2013, all patients treated in an ASC are included in the reported population for the patient specific measures. ■

Learn more about Regent Surgical Health at www.regentsurgicalhealth.com.

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Back to the Basics: 6 Core Concepts for Patient Safety & Quality Control **(continued from page 1)**

leadership and fully engaged in the program. Top level patient safety and quality programs are not exclusive to large university-based medical centers. Amazing things are being done by smaller and remote centers every day."

Here, Mr. Cappiello discusses the core concepts that serve as a basis for strong patient safety programs.

1. Keep physician credentials updated. Credentialing and privileging are the fundamental building blocks of quality. While the vast majority of hospitals have been vigilant on these issues, some situations continue to be troublesome. Hospitals often work with surgeons who don't perform many cases at their facility. If this is the case, you want to make sure their credentials are up to date and their privileges reflect their current competency when they do bring cases into your hospital, says Mr. Cappiello.

"There is a growing trend of the use of contract physicians — especially anesthesiologists and emergency medicine physicians," says Mr. Cappiello. "Make sure that new physicians who come to practice at the facility are adequately credentialed and privileged. Sometimes with the odd hours and emergency shift work, these physicians may slip under the radar and not be updated with their credentials and privileges."

In addition, make sure you stay aware of the performance of aging physicians, and be prepared to discuss with them when might be the right time to "hang up the shingle."

"You need to collect data to ensure older physicians still have an adequate skill set for the privileges they are being granted," says Mr. Cappiello. "That can be a very politically and emotionally sensitive issue to discuss with physicians who have been engaged in your medical center and great supporters for many years. Medical centers have to keep a keen eye on this because with age frequently comes the erosion of skills."

2. Hire and maintain competent staff members. Maintaining staff competency goes hand in glove with updating credentialing and privileging. When there is an explosion of new equipment, techniques, drugs and disease protocol — as we see in healthcare today — it's important to keep staff training up-to-date on these changes.

"Unfortunately, when hospitals have to make cutbacks because of declining reimbursements or other budgetary issues, the first of these casualties is often education and training," says Mr. Cappiello. "You have to be cautious of eliminating education programs because it raises the issue of staff competency."

When staff members aren't comfortable or knowledgeable in new processes or protocols, the level of patient care suffers. Training staff members appropriately gives them the confidence to administer drugs or follow protocols that maximizes patient safety.

3. Give clinicians the appropriate tools. Hospital leaders must understand what staff members need to be engaged and focused in their work. Actively engaged staff members are focused on the goal of improving patient safety and delivering the best possible patient care.

"One of the challenges of leadership is to understand what it takes to support staff members so they can stay focused on the patients they serve and interact with each day," says Mr. Cappiello. "There must be a trust and faith in the leadership that they understand that challenges that staff face each day and that they will do the right thing, by their actions, to support staff. Staff must be adequately trained and be provided adequate mentoring and supervision. Both must understand the complexities of providing high quality safe care and both must strive to create the most optimal settings and environment to complete their job safely and effectively."

For example, the nurse who is preparing medications should have a designated quiet space to focus on preparing each patient's dose. If an extra space isn't available, the nurses could be given a vest or some other means to signify they shouldn't be disturbed until they are finished. This is but one strategy or example that shows how leadership and staff come together to address issues that have a direct impact on safety and quality of care.

4. Hospital leaders should keep a critical eye on themselves. Hospital leaders oftentimes walk a fine line between being encouraging and critical when they become involved in quality or clinical improvement programs, says Mr. Cappiello. Leaders must set the tone and model the behavior they expect from staff when issues arise.

"Everyone looks to see what leadership does and how they respond to issues — that behavior sets the tone," says Mr. Cappiello. "Leadership behavior is the surest way for staff to understand the priorities of the organization and how they themselves should act. What we need more of in healthcare are leaders who are unafraid to be critical of themselves and the organization they lead. Leaders with the courage to be critical, send a clear message to staff that they should be doing the same — looking for opportunities to improve and having the courage to bring those ideas forward."

Leaders must have an early warning and recognition system for issues of risk and respond quickly and appropriately to mitigate that risk wherever possible. They must also ensure there are fail-safe systems in place so the right patient is treated at the right time in the right setting. "I think all of this leads to the real business of improving the healthcare delivery systems," he says.

5. Tighten the processes for delivering patient care. The route medication takes from the physician writing the order to the administration by the nurse could be tightened in most institutions to reduce the possibility of errors. Our systems of care delivery are many, varied and usually very complex. Medication ordering, administration

and delivery systems are but one example. Despite the attention given to this system, the multiple checks and balances, the electronic innovations, medication errors still occur and sometimes with tragic consequences.

"We now have electronic medical records, electronic ordering, and checks and balances done electronically," says Mr. Cappiello. "But there is also a human element in all of our delivery systems. As we think about how to improve care delivery, we have to look at both the electronic or automated systems as well as the human factors and how they interface. We have to look at them separately, how they come together as a system and how they constantly interface."

We continue to have clinicians and staff in denial. They believe that their own careful attention to detail and the fact that they haven't made an error in the past will somehow ensure that will not commit an error in the future. These clinicians do what they can to avoid the protocols advised by their colleagues or outside quality groups or simply go through the motions with the belief that these activities are an intrusion and an imposition.

"That's a bad attitude to take," says Mr. Cappiello. "You're first mistake can be your next patient. What we are trying to do is provide both risk assessment and risk prevention to minimize the setting and opportunities for those errors to occur."

6. Engage patients in safety initiatives. Healthcare providers engage patients in their care for a variety of reasons, including the desire to improve HCAHP scores and create a patient-centeredness in the facility. "Beyond that, I believe that knowledgeable patients make care safer," says Mr. Cappiello. "If they understand what is being done and why it's being done, they have the opportunity to be invested in their own care. The more engaged the patient and family members are, the better their experience will be but more importantly, the safe their care will be."

Patients should be encouraged to ask questions about their medications and treatments, what to expect from those medications and why they are undergoing those treatments. "An environment that encourages patient involvement and allows a patient to actively participate in their own care, increases their knowledge to where they become care partners not just patients, The end result of that, I strongly believe, are patients and family members who help the staff create a safe and supportive environment," says Mr. Cappiello." ■

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8 Strategies to Prevent Wrong-Site Surgery
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In some cases, the patient may be frustrated with having to give the same information multiple times, but Ms. Groah says the provider should simply reassure the patient that repetition is necessary. "The answer is that these are measures of safety we put into place to make sure your surgical procedure proceeds uneventfully," she says.

2. Pre-operatively, make sure all documents agree on the side and site of surgery. Prior to surgery, a staff member should look at all documents related to the surgery to make sure the information about the surgical site matches up. She says the staff member would check the informed consent form, signed by the patient, as well as the procedure on the typed schedule and the physician's note written pre-operatively about the procedure. Any inconsistencies should prompt a conversation with the physician and the patient about the correct site of surgery and best way to proceed.

3. Require the surgeon performing the procedure to mark the site. After some discussion on this topic, CMS and the Joint Commission decided that the surgeon performing the procedure should be the one to physically mark the surgical site with his or her initials or an X.

"The person performing the procedure basically has the responsibility and accountability for the patient and for the procedure that's being done," Ms. Groah says. "They're being held accountable to do the procedure and should be the one that actually partners with the patient to mark the side and site." Ms. Groah says studies have shown that instances of wrong-site surgery do increase significantly when the site is marked by a provider other than the surgeon performing the procedure.

4. Institute "red rules" that allow any staff member to stop the surgical process. During the time-out prior to surgery, team members confirm the side and site of surgery (preferably with the patient) and the surgeon marks the location. "The critical thing here is that everything stops and everything is focused on the patient and what you're about to do," Ms. Groah says. She says if there is any hesitance from a team member, the surgical process should stop — a policy she calls "red rules."

"Red rules mean that anybody on the team, when they see something that's not consistent with standards of practice, has the authority to call the 'red rule' and stop whatever's happening until it's resolved." She says it's important to instill the culture of "red rules" in the OR during safety training. Physicians and other providers should be reminded that no one is allowed to ignore the red rules per facility policy.

5. Train all staff members on the use of a surgical checklist. Every operating room should utilize a surgical checklist to prevent errors such as wrong-site surgery, Ms. Groah says. The concept of surgical checklists originated with the airline industry, which introduced checklists for use before flights after a number of accidents caused by human error. "There are so many significant things that need to be done pre-procedure and prior to incision — there are so many steps," Ms. Groah says. "Forgetting any one of those could lead to a disastrous outcome."

She says the circulating nurse is generally assigned the work of checking off items on the checklist, during which time everything in the OR should stop. She says OR team members should undergo orientation on how to use checklists, and hospital administration should encourage staff to take the checklists seriously. "There are some people who take the checklist and check it off and get cavalier about it rather than actually going through the process," she says. She says every facility should have a no-tolerance policy for this attitude: "I had the opportunity to work with a chief of surgery who said, 'If you don't use the checklist appropriately, you don't want to operate here,'" she says.

6. Involve the patient in marking the side and site. Ideally, Ms. Groah says the patient should be kept awake during the checklist process to confirm the correct side and site of surgery. The patient will likely feel more confident in the facility's safety if they are involved in confirming the correct surgical location.

7. Share incidents with wrong-site surgery throughout the facility. Ms. Groah says some staff members may not appreciate the significance of preventing wrong-site surgery because they have never experienced a surgical error. She says while it's not necessary to point fingers at those who make mistakes, the facility should share instances of wrong-site surgery or other surgical errors throughout the hospital to emphasize the importance of safety policies.

"If there is an unusual occurrence and a wrong-site surgery, the drilldown on that critical event can be pretty devastating," she says. "It's important to share those significant events — not necessarily who did it, but how the patients were mixed up or how the wrong-site surgery was performed — to prevent it from happening in the future."

8. Sample random procedures to determine checklist compliance. Instituting a policy around wrong-site surgery is relatively useless if no one follows it. To make sure your staff members are using their checklists, asking the surgeon to mark? the site and involving the patient in the process, Ms. Groah recommends choosing random procedures and observing the pre-operative time-out. She says this information should be tracked over time to determine whether compliance is improving and how that compliance relates to surgical error rates. ■

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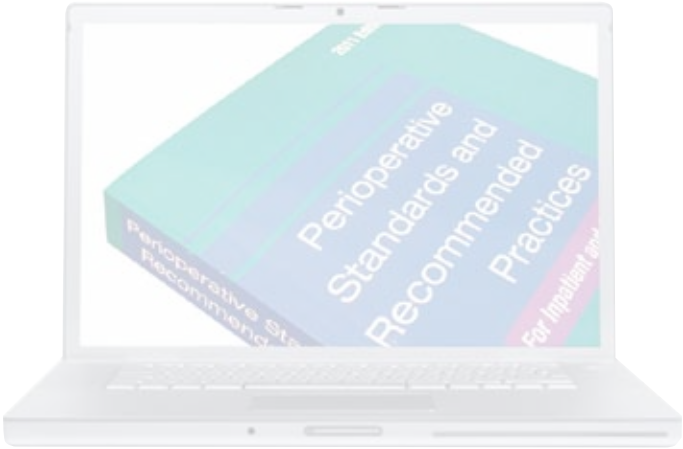

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8 Guiding Principles on Crafting a Sound Safety Program

By Jaimie Oh

Most, if not all, hospitals and health systems have some version of a safety program in place that emphasizes patient, workplace and environmental safety, says Lillee Gelinas, MSN, RN, FAAN, vice president and chief nursing officer at VHA Inc., a nationwide network of more than 1,400 not-for-profit hospitals that work together to improve their clinical and economic performance. Ms. Gelinas says the difficulty in creating a safety program is not in the educational aspect. "In the healthcare industry, we don't lack evidence, ideas or the white papers necessary to produce safety education. What I have seen the industry lack is execution skill," Ms. Gelinas says.

Here are eight principles that can guide healthcare providers in successfully executing a culture of safety through sound educational programs at their respective organizations.

Levels of impact

Ms. Gelinas says a successful healthcare safety program must be able to transcend three impact levels, each necessitating different educational and assessment approaches.

Personal-level impact. Hospitals must launch a safety approach with programs that ensure each employee learns and adopts the necessary personal skills and competencies to promote patient safety. Each employee should possess several key personal skills, including courage, engagement and a strong understanding of one's own beliefs and values. For instance, an employee who sees a surgeon who has not washed his or her hands should have the courage to stop that surgeon from starting a procedure.

"If a true culture of safety is in place, there's already an expectation that an employee will feel safe and confident in calling out their colleagues' shortcomings," Ms. Gelinas says.

There are a variety of ways to assess each employee's personal perception and impact on patient safety. One strategy employed by VHA hospital leaders includes a time assessment. How many minutes a day are employees unnecessarily spending on their cell phones, as opposed to documenting? Or engaging in direct patient care? It takes time to be safe, to listen and talk to patients about their healthcare and to comfort them. This time assessment helps individual practitioners see firsthand how their multitasking may or may not be in line with the healthcare organization's mission for patient safety, Ms. Gelinas explains.

Unit-level impact. Ms. Gelinas says the individual-level of a patient safety culture should naturally progress into department- or unit-level safety. The Agency for Healthcare Research and Quality administers a survey that allows hospitals and health systems to assess how the culture of patient safety is played out in individual units, such as pediatrics or obstetrics. The survey covers very specific aspects of patient safety culture, which can be particularly useful. For instance, staff members of a particular hospital unit may report a great teamwork environment but also some breakdowns in communication, which can prove detrimental to safety.

To view AHRQ's survey on patient safety culture and distribute it within your own healthcare organization, click here.

Organization-level impact. Leaders must ensure programs that support a safety culture have an organization-level impact. This hinges on administrators' ability to create cohesive and comprehensive missions related to safety. Ms. Gelinas says achieving enterprise-wide safety is not possible without engaging the frontline staff in safety. .

"Once we've assessed the personal, departmental, and organizational expectations related to safety, hospital leaders can begin to craft programs and strategies that close all the knowledge gaps," she says.

Cultural pillars

Although safety approaches must be delivered on all three impact levels, programs must also take into account a wide variety of cultural factors that can make or break the success of an organization's safety goals.

Openness. Every healthcare organization, no matter the size, should have an open-door policy in place, Ms. Gelinas says. Such a policy helps foster a culture of openness and encourages employees to believe there is no such thing as a "non-discussable" issue. This applies to employees and patients. A VHA hospital in North Carolina ensures that a patient advocate is present at all meetings so patient and families' interests are always taken into account.

"Everyone must be able to discuss anything, at anytime, related to any issue, and know they are working in a safe environment, where they won't be ridiculed or pigeon-holed," she says.

Respect. Although the importance of collegial respect may be common sense, it cannot be reiterated enough. Ms. Gelinas urges every healthcare organization to establish a zero-tolerance policy for bullying in any shape or form, electronically or verbally. That collegial respect must be extended to patients and families.

With the rapid boom of social networking, she adds, healthcare organizations may find it helpful to institute a social media policy to prevent the risk of harm to employees and patients through this medium. The American Nurses Association offers nurses social media guidelines comprised of tips and principles that promote awareness of the potential harm from online behavior.

Program creation

Once the cultural and impact factors have been accounted for, healthcare organizations can begin working to create a sound infrastructure to assure a "safe" organization.

Timeliness. Safety programs must be updated on a regular basis to keep up with changes published in medical literature and industry standards. Ms. Gelinas says most safety programs don't have to undergo major changes frequently — 80 percent of most programs have a long shelf-life — but there is still the 20 percent that must be updated and reworked to stay ahead of the curve.

Adaptability. Considering the diverse range of roles and learning styles of each employee, hospitals must ensure that their safety programs are crafted and altered to cater to each audience, whether it is the environmental services department or executive administration. Diligently crafting safety programs this way will ensure each employee fully grasps the safety education appropriate for his or her role.

"You can't just design a one-hour program for everyone," Ms. Gelinas says. "The program may have to be administered through a number of venues, such as face-to-face meetings, in a large classroom or via webinars and conference calls. In this day and age, you need multiple ways to reach out and engage people in the learning process. One size does not fit all."

Assessments. Regular assessments of healthcare employees' skills and knowledge will be critical, as it will allow an individual to evaluate his or her own competency. One example is a 360 safety assessment, completed by peers, subordinates and supervisors. This approach evaluates the staff members' strengths and weakness in the context of maintaining safety and helps evaluate the safety program's effectiveness, Ms. Gelinas says.

"A hospital can have all the topics and tactics in the world, but alone, they won't spur change," she says. ■

Ambulatory Surgery Center Infection Prevention: A Necessary Evil or a Dose of Fun?

By Libby F. Chinnes, RN, BSN, CIC, Owner and Infection Control Consultant, IC Solutions in Mt. Pleasant, S.C.

On May 18, 2009, the Centers for Medicare & Medicaid Services (CMS) conditions for coverage for ambulatory surgery centers (ASCs) became effective for facilities that receive Medicare/Medicaid reimbursement.[1] Among many standards, CMS cites the need to educate patients, visitors, and staff regarding infections, communicable diseases, and methods of prevention in the ASC and in the community.

The *Infection Control Surveyor Worksheet* includes questions related to how the staff receives training (i.e., methods); which staff members receive training (e.g., medical, nursing, other direct care staff, staff responsible for onsite disinfection and sterilization, environmental services staff, and others); frequency of the training (e.g., on-hire, annually, as needed); whether the training is the same or different for all categories of staff; and whether there is documentation of training for all staff.[2]

CMS is also concerned about the training administered to the infection preventionist (IP). In fact, one of the standards requires that the ASC have a licensed healthcare professional who is designated and qualified through training to lead the center's infection prevention and control program. The IP may be an employee or contracted consultant; he/she may be certified in infection prevention and control or not. However, if the designated infection prevention professional is not certified, there must be documentation regarding the training he/she has received specific to this role.

Even though failure to comply with these standards will lead to deficiencies and citations during a CMS audit, the most critical issue relates to the fact that untrained staff may have more opportunities for transmitting infection unknowingly to the patients entrusted to their care. Training does not have to be an arduous ordeal. Look for creative ways to transmit the information (and not the organisms).

Infection prevention orientation training for staff may be the same as training for patient care staff. However, the IP will probably need to address busy physicians separately. Providing physicians with a summary of your orientation information (in bulleted format) and administering a post test trainees submit for credit would be a quick, fun way to engage and interest trainees. Environmental services staff and other contractors may need a special orientation on infection prevention in your facility — what hospital disinfectants do you use, how do you clean a blood spill, to what schedules do your staff adhere? Adult learners want interesting issues presented that apply directly to their jobs. Real life scenarios often hold the learner's interest well.[3]

A little effort goes a long way

What have colleagues chosen to do for inservice training at other facilities? Tap into their knowledge to get ideas. You don't have to be creative; you just need to be a good "copier."

As a staff member, would you want to see the same video on infection prevention and control every year? The answer is probably "no."

Instead of showing the same stale video, consider creating a poster presentation on review of bloodborne pathogens, tuberculosis, and other infection prevention topics of interest to your staff.

When was the last time the staff and physicians have received a review of safe injection practices? Safe injection practices —in addition to respiratory hygiene and cough etiquette — are now a routine part of the Centers for Disease Control and Prevention's standard precautions. Try designing a crossword puzzle on this subject to keep the information fun and fresh.

Consider offering a self-instructional computer-based training module for staff. This may be more convenient for all; be sure to make yourself available, as per the Occupational Safety and Health Administration standards, during this time in case any questions arise. It may also be beneficial to present infection prevention case scenarios in small groups, potentially using some brief instances of role playing. It could cultivate a lively group discussion and enhance problem-solving skills by working as a team.

Think outside of the box

Although complex tasks — such as high-level disinfection and sterilization — may be assigned to one or two specific staff members, these activities may lend themselves to training through return demonstration and competencies. Give thought to who could perform these duties and supervise this area if the assigned staff members were out for a period of time. Do additional nursing staff members need to be competent in this area? If the answer is "yes," consider developing a checklist of necessary skills or a carefully structured train-the-trainer program for a large group of staff.

Many IPs have adapted games such as Jeopardy, Survivor, and Wheel of Fortune to be infection prevention-themed. Adults enjoy learning in a nonthreatening environment and sharing some of their own life experiences. Mix up the learning activities as much as possible to allow for broader participation and engagement. Instead of leading all of the teaching activities, bring in a consultant or an infectious disease physician to talk to the staff and physicians during influenza season. Take the time to develop a "Room Full of Errors" with a manikin or make use of the Association for peri-Operative Nurses cartoon "What's Wrong with This Picture" that allow the learner to detect breaks in sterile technique and safety issues.

Incorporate food, door prizes, and other incentives in the educational efforts, whenever possible. Providing treats during a brown bag lunch is a great way to break the ice and encourage staff to relax and enjoy their learning experiences. And don't forget: "just because we taught them, it does not mean they learned!" IPs should evaluate their educational programs and also ask staff to evaluate their own learning to determine overall effectiveness. Make education participatory and enjoyable — not just a requirement. Our patients' safety depends on it. ■

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Learn, Apply, Share: Kaiser Permanente's 3-Step Strategy for Healthcare Quality Improvement

By Sabrina Rodak

Many hospitals and health systems are turning their attention to quality to improve patient care and avoid financial penalties for issues such as preventable readmissions and infections. While the Patient Protection and Affordable Care Act has brought the issue to the forefront with the creation of Partnership for Patients and other initiatives, many organizations have been pursuing high quality for several years.

In 2005, Oakland, Calif.-based Kaiser Permanente partnered with the Institute for Healthcare Improvement to become a top performer in quality. Kaiser Permanente studied high-quality organizations and devised a multi-pronged strategy for improvement, which it will present in May at the 2012 Quality Institute for Healthcare in Anaheim, Calif. Lisa Schilling, RN, MPH, vice president of healthcare performance improvement at Kaiser Permanente, explains how the organization followed three steps to improve quality.

Strategy

After studying various organizations, Kaiser Permanente identified six common capabilities among high-quality institutions:

- Leadership alignment
- Knowledge of the system
- Measurement of improvement
- Sharing best practices
- Training
- Involvement of the entire organization

The three underlying strategies to achieving these capabilities were learning, applying and sharing. The organization needed to learn new skills in process improvement, apply them to real care delivery systems and then share the results and effective practices with others across the organization for rapid adoption. In addition, part of the share strategy is to share and learn with outside organizations to develop new practices and models of care as well as adapt those to their organizations.

1. Learn. "We learned from other industries that the development of expertise requires developing skills in everyone from leadership to frontline staff and needs to be a multi-year strategy," Ms. Schilling says. When applying improvement techniques, Kaiser Permanente used a variety of tools instead of adopting one single approach that includes a model for improvement and Lean Six Sigma. This broader philosophy allows staff and leaders to use the tools that are most appropriate for a given situation. "After our benchmarking visits, we found that it's far more important that culturally we want to focus on performance [rather] than the methodology and tools used," Ms. Schilling says. "We don't want to teach people a new language around improvement; we want to teach [them] how to focus on designing care around the person so they can bring the tools [they need] to make that care better."

2. Apply. In order to achieve the desired results through training, Kaiser Permanente established a system that supported the learner's application of knowledge directly in the care delivery setting. "We also adapted the master black belt approach to our system and teamed the individual with each medical center to assist our students in applying their learning to improve care delivery and service," Ms. Schilling says. Kaiser Permanente hired experts with 20 to 30 years of experience in improvement to mentor staff and leaders on improvement strategies. Building knowledge through expert mentors helped embed quality improvement in the culture of the organization and accelerate the rate of learning and change in strategic implementation.

3. Share. After applying quality improvement strategies, Kaiser Permanente shared the results and effective practices with others in the organization so they could learn from each other and avoid needing to reinvent solutions that had already been tested in other areas of the organization. Particularly for an organization the size of Kaiser Permanente, which has 37 hospitals and more than 500 medical offices, communicating quality improvement experiences across the organization can save a significant amount of time and resources by reusing a successful technique for multiple areas. In addition, Kaiser Permanente has engaged in strategic partnerships and networks to continue learning with others around the world. ■

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10 Tips to Go Above and Beyond in a Surgery Center Accreditation Survey

By Rachel Fields

Preparing an ambulatory surgery center for an accreditation survey can be nerve-wracking, with so much paperwork to present and so many regulations to double-check. Sandy Berreth, administrator of Brainerd Lakes Surgery Center in Baxter, Minn., and a surveyor for the AAAHC, identifies 10 ways she has seen ASC administrators go "above and beyond" to impress a surveyor.

1. Present the most current standards handbook upfront. Ms. Berreth says she is always surprised by the number of surgery center administrators who don't own the current standards handbook for their accrediting body. "If your accreditation is for 2011, you're going to be accredited with the 2011 standards, not the 2009 or 2008 standards," she says. In an organization that wants to start preparing for accreditation now, that means purchasing a copy of the 2012 accreditation standards. She says while the majority of standards do not change from year to year, small changes can make the difference between a positive and negative outcome for a surveyed center. For instance, between 2008 and 2009, the AAAHC added a chapter on infection control standards to its handbook.

Ms. Berreth says when she walks into a center to start a survey, she usually says upfront, "Why

don't you grab your handbook so that when we discuss standards, we'll be able to refer to your book?" She says if the surgery center administrator returns with a standards book that is two or three years old, that sets off a red flag in her mind. Make sure you have a copy of the most current standards handbook easily accessible in your surgery center so you're prepared to answer any questions about your compliance when the time comes.

2. Create a three-ring binder that demonstrates adherence to regulations. Ms. Berreth says she is always impressed when she walks into a center and the administrator hands her a three-ring binder containing a list of policies and procedures that follow the accrediting body standards "right down the line." She personally owns a three-ring binder divided into 13 sections. In each section, she has a list of the surgery center's policies, how they correspond with accrediting body regulations and how she can validate that the surgery center follows the standards.

For example, AAAHC regulations mandate that surgery center patients are treated with respect, consideration and dignity. The binder might list the regulation and then demonstrate that the surgery center enforces this policy by listing the ASC's methods: conducting patient satisfaction surveys, posting the policy in a clear place in the surgery center and rewarding staff with incentives for excellent customer service.

3. Include a table of contents in your binders. Make sure your ASC surveyor can find all the required information quickly by adding a table of contents to each binder, Ms. Berreth says. "If you don't have a table of contents, it makes it very, very difficult to pull out the policies we need to look at," she says. Including a table of contents will save you from rooting through several binders to find one sentence of information on your center.

4. Demonstrate that all your decisions go through the ASC board. Your surgery center should be able to demonstrate through meeting minutes that all decisions in the ASC go through board approval before implementation, Ms. Berreth says.

"If the administrator has the authority to make decisions in the surgery center, you have to have somewhere in your minutes that the board gives full authority to the administrator to conduct business," she says. She says this can be considered "the number one rule" for ASC accreditation since the release of the 2009 Conditions for Coverage by CMS. You must be able to demonstrate you take thorough minutes at your board meetings and save them for future reference.

5. Lay out 2-3 current quality improvement studies. Quality improvement studies don't need to be snazzy, but they do need to be current, Ms. Berreth says. Take two or three current quality improvement studies and present your process in an easy-to-read format. Include your goal at the beginning of the study and your results, including the data you collected along the way. If you take the time to present this information in an attractive, understandable format, your surveyor will appreciate it, Ms. Berreth says.

6. Know the answers to simple questions by heart. Brush up on simple, expected surveyor questions before the survey to show you've taken the time to prepare, Ms. Berreth says. For example, the surveyor will probably ask how many quality improvement studies you conducted this year, last year and the year before that. Don't stand there trying to count up the number of studies in your head; count them before the surveyor arrives so you can rattle off your answers professionally. You should also know the kind of benchmarking your surgery center performs and your most recent internal benchmarks for staff hours per case, days in A/R and other common ASC statistics.

7. Set up a space for the surveyor to work. If your survey is scheduled for a specific date — or you have a 90-day window when you know the survey will occur — you should be able to set aside some space for the surveyor to work. "You should always be able to prepare a space that's ready in less than five minutes," Ms. Berreth says.

This could mean the administrator's office or an unused office or empty conference room. The important thing is to make sure the surveyor has access to peace and quiet, as well as several outlets and Internet access. "Expect that your surveyor is going to be on the Internet, and expect that they're going to need to plug in their computer," she says. While free Wi-Fi is not necessarily a "must" for surgery centers, it certainly helps a surveyor feel comfortable.

Ms. Berreth says the surveyor will also need a space to change into scrubs, as well as an unused pair of scrubs to conduct the clinical aspects of the survey. For surgery centers that don't have extra scrubs lying around, she recommends purchasing a pair of extra large scrubs for surveyor use. "Small women can fit into extra large scrubs, but large men can't fit into small scrubs," she says.

8. Involve a physician who cares about the survey. Nothing impresses an ASC surveyor quite like a physician who really cares about the survey process, Ms. Berreth says. Don't panic and think you need to involve your whole physician staff or your most well-known providers — she says one is enough to demonstrate teamwork at the center. Talk to your most involved physician before the survey date (if you know the date in advance) and ask him or her to come by the center to help answer questions.

9. Keep information brief — but know where to get more if needed. Every surveyor is different: Some will want to see every detail of your policies and procedures, and others will only want enough to demonstrate you meet standards. Keep everyone on the surveyor spectrum happy by presenting information in an abridged form, and letting the surveyor know you can bring more information if necessary. "During your 90-day window, whittle down what's important and put it in manageable binders," Ms. Berreth says. "You can always take the surveyor into your office and open up your built-in closet and say, 'Okay, now which organizational documents did you want?'"

10. Prepare a list of physicians and staff. Your surveyor will need to see some of your credentialing folders and personnel files, Ms. Berreth says. To make this process easier, prepare a list of all your physicians and a separate list of all your clinical and business office staff. You should also have a list of all contracted services. You can give this list to the surveyor and then provide credentialing information and personnel files based on the employees they select to review. For example, for contracted services, the surveyor may look at your list and then ask to see your laundry contracts specifically. ■

Sounding the Alarm: 6 Strategies to Reduce & Prevent Alarm Fatigue

By Sabrina Rodak

Alarm fatigue — when clinicians fail to respond to alarms due to overexposure — is a serious condition that can have fatal consequences for patients. In fact, the ECRI Institute named alarms the most hazardous health technology for 2012. In October 2011, several organizations, including the Association for the Advancement of Medical Instrumentation, The Joint Commission, the ECRI Institute and the American College of Clinical Engineering, held a medical device alarms summit to address alarm fatigue and identify ways to prevent and eliminate it.

Shawn O'Connell, MS, RN, a member of the AAMI Medical Device Alarm Committee and Director of clinical value marketing at medical device manufacturer B. Braun Medical, shares the top causes of alarm fatigue and strategies to prevent it.

Causes

The sheer number of alarms clinicians must respond to is one of the main causes of alarm fatigue. Data reported at the medical device alarms conference showed there can be as many as 300 or more alarms per shift, Ms. O'Connell says. Compounding this issue is that many alarms are not clinically relevant for the patient. "There are more and more devices with more and more types of alarms, but not all of them have clinical significance," Ms. O'Connell says. "An alarm may not be telling something about a patient, but it may be about the device, or it may not require action on the part of the clinician."

Cardiac monitors are among the top alarm-producing devices, according to Ms. O'Connell. It monitors multiple parameters beyond heart rate, such as the occurrence of abnormal beats and ST-Segment elevation, which can signal an impending heart attack. In addition to sounding an alarm to warn clinicians of a physiological problem, the cardiac monitor may also sound because of electrode interference. For example, heart rate alarms can occur when a patient rolls over in bed or scratches an electrode, when electrodes are not changed frequently or if there is electrical interference from other equipment. "A restless patient is one of the most challenging because [he or she] is constantly moving, grabbing [his or her] clothes, setting of the alarms constantly," Ms. O'Connell says. "It may prompt clinicians to set very broad alarm limits or turn some alarms off."

When confronted with an overwhelming number of alarms, clinicians may not respond promptly, turn some alarms off or broaden monitoring parameters. These actions can cause physicians, nurses and staff to miss a critical change in the patient, which may lead to harm or death. In fact, the FDA reported there were 566 alarm-related deaths in the United States between 2005 and 2008.

The number of alarms does not affect only clinicians, however. Alarms' loud volume can lead to sleep deprivation of patients, which can in turn affect the patients' mental and physical state. Alarms' effect on patients is particularly challenging in the neonatal intensive care unit, where too much visual and audio stimulation can be "incredibly detrimental," Ms. O'Connell says.

Solutions

Ms. O'Connell provides six short- and long-term strategies to reduce alarm fatigue.

1. Gain leadership support. The organization's leaders need to recognize alarm fatigue as an important issue and support efforts to remedy the problem.

2. Use a team approach. Ms. O'Connell suggests gathering key clinical leaders in the organization to discuss and prioritize the top alarm-related challenges. These leaders can provide insight into which devices produce excessive alarms and which alarms may be clinically insignificant.

3. Establish alarm policies. Establishing alarm policies is a key step in mitigating the risk of alarm fatigue. Ms. O'Connell suggests starting broadly, such as requiring certain alarms always be on and alarm responses documented. "It's a big undertaking because there are so many devices that can produce alarms. You should start with ones that have the most potential to cause patient harm if not addressed: cardiac monitors, infusion pumps, respiratory monitors, [anything] that can alert you to a life-threatening change," she says.

An alarm policy should address the need for alarms in different areas of the hospital. For instance, some alarms in the ICU may not be necessary in less acute areas. The policies should also leave room for clinical judgment, Ms. O'Connell says.

4. Choose technology wisely. Organizations need to carefully consider a technology's alarm systems before purchase. "There are dozens of different alarm configurations, some may be unique so one supplier can differentiate itself from another; there might not necessarily be strong clinical evidence to support the clinical significance of the alarm," Ms. O'Connell says.

5. Work with suppliers. Healthcare organizations should work with the supplier when acquiring new equipment, according to Ms. O'Connell. "Work collaboratively with the supplier to truly understand the logic behind all the alarm."

6. Conduct additional research. Very little research on alarm fatigue exists, which makes establishing policies and standards more difficult. The paucity of research on this topic may be due to a general unawareness of its importance. Alarm fatigue garnered attention only when incidents of alarm-related death were highly publicized, Ms. O'Connell says. In addition, alarm fatigue research is not as high-profile as studies in other areas, such as infection control. Its relatively low status in the research arena may be partly responsible for the difficulty getting funding for the research and attracting researchers.

However, research is needed to identify alarms that are clinically significant, how alarms should be set and what the most effective alarm sounds are, among other issues. "There are still a lot of unanswered questions," Ms. O'Connell says. "It's hard to make concrete recommendations for change without research." ■

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When Your ASC Needs "Immediate Corrective Action": How to Form a Plan of Correction for Medicare

By Chris McMenemy, vice president of Ortmann Healthcare Consultants

The following article was written by Chris McMenemy, vice president of Ortmann Healthcare Consultants.

So Medicare paid you a surprise visit and the result, unfortunately, was a Plan of Correction. Although you most likely are feeling a great deal of panic, take a few deep breaths and get busy. You and your ASC can survive the process, and maybe you'll be a little bit better in the end.

First of all, don't beat yourself up. You are not alone — not the first and not the last to be told to take immediate corrective action. With some hard work and important self-examination, you will be able to write an acceptable plan that will keep your ASC in business.

Medicare inspections are always unannounced. The only way to be truly prepared is to always be prepared. That means you must be up-to-date on all Medicare regulations. One great help that I've found is to read the Interpretative Guidelines that are used by Medicare to train surveyors. This document gives much more detail than the federal regulations and is a great tool for surveyor readiness.

What is a Plan of Correction?

So what is a Plan of Correction? It is a document that lists any problems (deficiencies) the surveyor finds in the way the ASC is operated. And panic is an understandable emotion, as the ASC has 10 days (counting weekend days) to respond to the POC with a plan to correct the deficient practices or risk losing Medicare certification. The more problems that are noted by the surveyor, the more work will be required in writing the Plan.

If the POC is not received back within 10 days, steps will be taken by Medicare to terminate your certification. And although you may appeal the POC's findings, you are not entitled to a hearing prior to termination, so it may be quite some time before you would be able to bill for Medicare patients as the hearing process progresses. It's also important that you write and implement a good plan because the surveyors will re-survey your ASC, and they will expect that the deficiencies have been satisfactorily corrected. If not, your center could still lose its certification. Serious business? You bet!

During the survey, don't be afraid to ask questions. Make sure you understand exactly how the surveyor believes a regulation is not being met. That information is invaluable when it comes time to respond to the plan. You will also receive more information once the actual Plan is received, but speaking directly to the surveyor is always helpful. Often during a discussion, the surveyor will understand better your process and in the end not mark a deficiency on a particular item.

How to Respond to the Plan of Correction

Once you receive the plan, you most likely will feel overwhelmed, but break it down into individual pieces and get busy! This is a "drop everything" time for a few people in your ASC. You must put sufficient time and effort into this response; that may mean canceling a few procedures or bringing in extra staff so that others can dedicate their time to the response.

For each citation, you need to respond to five components. When I have assisted with writing a POC, I actually number each component and use an outline form in the response for multi-answer components: 1 a. 1 b. 1c., etc. Briefly, the components require the response to:

1) Identify how corrective items were accomplished for any patients who were affected by the deficiency;

2) Describe how the corrections will protect patients in the future;

3) Describe the measures that will be put in place to ensure the deficiency will not re-occur;

4) Identify how the ASC will monitor its correction to ensure the solutions are sustained and do not reoccur; and

5) State the date the corrective action will be completed.

Components 3 and 4 are important as in answering those items, you have the crux of the plan. For instance, if the Plan stated that the ASC failed to ensure each patient had a pre-surgical assessment completed that included an examination for any changes in the patient's condition since their most recent H&P, numbers 3 and 4 might read as follows.

3) The following actions will be taken to ensure the deficient practice will not re-occur:

a) Policy #10017 History & Physical has been updated to include the need for documentation that the H&P is to be reviewed for all procedures during the pre-surgical assessment

b) Provider & staff training will take place to ensure all are aware of the H&P update requirements

c) The patient chart record has been updated for easier documentation and physicians will receive training on the use of the updated record.

4) The Center Director is responsible for ensuring this correction is achieved and sustained. The following will be utilized:

a) Policy #10017 History & Physical will be presented for discussion and approval to the Quality Committee and Governing Board.

b) The revised patient chart record will be presented for discussion and approval to the Quality Committee and Governing Board.

c) All patient charts will be reviewed for compliance with this standard for a period of three months. Results will be reported to the Quality Committee.

Respond to each deficiency with an answer for each required component with specific information and the plan will be completed. Then, make sure you have done everything that you said you would do. I usually include changes to policies and forms in the POC as attachments to the plan. Make a checklist of all documents and training that need to be completed to assist in keeping track of everything that is to be completed.

Although you may not be happy to have a Plan of Correction in your life, it is something that with hard work, you can complete. The discussions that will take place with your staff and physicians can actually be beneficial to the ASC as a whole. I hope you never need to complete a POC for your ASC, but if you find yourself faced with a Plan, don't panic: Roll up your sleeves and get to work, and keep your Medicare certification in tact. It's worth it in the long run. ■

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The CASC Exam: An Individual's Story

By Vivek Taparia, administrator of The Center for Ambulatory Surgery at Swedish Covenant

The following story is written by Vivek Taparia, administrator for The Center for Ambulatory Surgery at Swedish Covenant, a Regent Surgical Health ASC.

Can you define the following: "Deemed status, Safe Harbor Laws, Dantrium, FMLA, Certificates of Need, and Methicillin resistant Staphylococcus Aureus"?

When I first joined the ASC industry in 2009, I felt like I had traveled to a country where I did not speak the language. The above are all examples of words that surfaced in conversations and I had no idea what they meant. For the next three years, I served as a director on the management team of Regent Surgical Health, and during our management calls, I wrote down all the words and concepts I did not understand. I followed up with my colleagues with questions to fill the gaps in my knowledge, but I found that my inquiries would only take me so far. I realized that I could use additional academic training in the various subjects required to be successful in the ASC industry. Given my financial services background, I had a high level of comfort in the accounting and financial aspects of ASC management. However, I lacked knowledge in the clinical, business office, human resources, legal and regulatory aspects of the ASC industry.

To my pleasant surprise, I learned at the 2010 ASC Industry Conference in Anaheim that there exists a credential called the CASC (Certified Administrator Surgery Center), that tests for a comprehensive understanding of the skills and knowledge an ASC administrator requires. However, those who pursue the CASC are not only administrators, but are also medical directors, DONs, BOMs and all those involved in the professional management of ASCs.

At the same time, I became increasingly involved in the operational aspects of running a surgery center through the case costing initiatives I had been implementing at Regent. The more exposure I received to ASC operations, the more excited I became about taking the CASC exam and pursuing an ASC administrator position. Not only would the CASC exam help consolidate my industry knowledge; it would potentially position me for an administrator position one day. I decided to take the test!

The ASC Association has review workshops for the CASC exam every year in conjunction with their annual conference, which will be held this year in Dallas. These courses are posted online, so the first action I took to prepare for the exam was to download these workshops. While taking these courses, it occurred to me that my lack of knowledge was okay. The courses were catered toward individuals with diverse professional experiences. The clinical modules were focused on those without clinical backgrounds. The regulatory and legal aspects of the courses were focused on individuals without background in those aspects of the ASC industry. After all, those who are leaders in the ASC industry come from all types of backgrounds ranging from financial to clinical to legal. I believe what these leaders have in common is a desire to make an impact on patient care and a continuous thirst to learn.

I studied for the exam for about two months. The exam is offered twice a year; I took the test at the Becker's ASC Conference in October 2011. The hotel room was packed with test takers, and I sat next to an RN from Minnesota who wanted to increase her knowledge in non-clinical areas. The test lasted around four hours and I was one of the last people sitting in my seat when the proctor said "pencils down." I had no idea how I did, but I got a favorable letter in the mail several weeks later!

Shortly after taking the CASC exam, I decided to interview for the administrator position at Regent's latest de novo ASC in partnership with Swedish Covenant Hospital on the north side of Chicago. I am not sure if the CASC credential helped me get the Administrator position, but it certainly gave me great confidence that I am ready for this next phase of my career.

For those who have an interest in pursuing the CASC credential, I recommend taking the review course online or attending the review course offered by the ASC Association. Feel free to contact me if you have questions about the process. ■

Learn more about Regent Surgical Health at www.regentsurgicalhealth.com.

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What to Expect From AAAHC's Longer Accreditation Terms: Q&A With Marci Ramahi

By Abby Callard

The AAAHC recently eliminated the six-month and one-year accreditation terms, and the change affects ASCs applying for accreditation after March 1. Marci Ramahi is the accreditation services manager and served as the staff liaison to the task force that recommended the change.

Q: What was behind the decision to discontinue the shorter accreditation terms?

Marci Ramahi: AAAHC wanted to simplify the accreditation decisions and focus on a process that would assist organizations in improving patient care. Shorter terms had allowed AAAHC to return to an organization to assess its corrective actions or sustained compliance, but the interim surveys will accomplish the same goal.

Q: How will this change the accreditation process?

MR: For most organizations, there will be no change. Previously, when an organization received a one-year or six-month term, they would need to provide what corrective actions were taken to correct deficiencies cited during the survey. With the policy effective this year, the AAAHC will receive an organization's plans for implementing its improvement actions shortly after the survey and before its full completion, providing an increased level of oversight by AAAHC.

Q: What about facilities that received six-month or one-year accreditation in the past?

MR: Organizations that received six-month and one-year terms under the application of the old policy will need to re-apply for the re-survey. However, the new policy will be applied for the decision generated from the re-survey.

Q: What was the original reason behind the short periods?

MR: The shorter terms were to allow AAAHC to assess an organization's compliance with the standards when there were indications that sustained compliance with the standards should be assessed. AAAHC feels this oversight can be accomplished through plans for improvement and interim surveys.

Q: What was the stigma attached to organizations with shorter accreditation periods?

MR: While an accreditation term of six months or one year could be seen positively since the organizations achieved accreditation, AAAHC heard from organizations that some other entities, such as insurance companies, did not view the accreditation achievement in quite the same light. For example, a newly operational organization that had an Early Option Survey would need to have a re-survey in six months or one year so its track record of activities could be assessed. The need for the re-survey was not intended to be punitive or indicate that there was concern for patient care. ■

Learn more about AAAHC at www.aaahc.org.

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Best Practices for Proper Care of the Morbidly Obese in Surgery Centers

By Anne Dean, RN, BSN, LRM, CEO and co-founder of The ADA Group.

As America's waistband expands more and more, we are seeing patients who qualify for the classification of the morbidly obese being admitted to the surgery centers for their procedures. This practice will, most probably, *not* go away, but will become even more popular. The question emerges as to whether or not the average ambulatory surgery center is prepared to take care of such patients. From what this author has seen, unless the center performs bariatric surgery, neither the available equipment nor the staff/staffing are usually adequate to provide safe care of the patient.

In the past, leaders in the surgery centers designated a pound limit for admission to the center (e.g., patients over 350 pounds would not be admitted for procedures). This figure was primarily selected based upon the poundage limit of stretchers and OR tables. There was not, on the whole, a conversation about other equipment (exception being a lift) needed in order to care for this type of patient. There was an assumption that any patient weighing 350 pounds was obese; however, just as America's waistband has expanded, so has our height. We are seeing many more patients in ASCs who are 6'6" tall and taller. Those patients may not, in fact, be classified as obese. This distinction has forced us to begin evaluating a patient's level of obesity based on his body mass index. Today the designation of obesity can only be made by performing a BMI.

In many centers, neither the patient's weight nor BMI is made known until the day before the procedure when the schedule is sent to the operating room supervisor. This practice does not allow adequate preparatory time to plan for a safe environment for these patients. Rather, this information must be collected at the time the patient is scheduled. Collect the patient's height and weight as a matter of course during the scheduling process, then calculate the BMI. Calculation of the BMI is accomplished by taking the weight in kilograms divided by height in millimeters squared (kg/m^2). The following classifications should be followed:

- < 18.5 — Underweight
- 18.5-24.9 — Normal
- 25.0-29.9 — Overweight
- 30.0-39.9 — Obese
- >40.0 — Morbidly obese

Instruct the scheduling secretary to notify the OR supervisor of any BMI greater than 35 immediately so that proper preparatory actions and processes can be put in place.

For preoperative care:

- The scheduling secretary calculates the BMI and alerts the OR supervisor if BMI is > 35
- The BMI is posted on the surgery schedule if >35.
- The preoperative RN completes the nursing assessment following the nursing care plan for patients who are morbidly obese and the assessment tool for patients who are morbidly obese.
- The preoperative nurse places the inflatable patient transfer pad on the preop bed and collects the appropriate sized blood pressure cuff, patient gown bed linens and extra large sequential compression devices for each leg.
- The anesthesia providers assess the patient in the preoperative area to include the lungs, oral airway and history of obstructive sleep apnea. The anesthesia provider determines the presence of all required specialty equipment to meet the special needs of the morbidly obese to include intubation equipment and CPAP or BIPAP, as appropriate, head cradle and elevation wedge.
- The preoperative RN assesses lung sounds, vital signs, oxygen saturation, presence of edema and information regarding sleep habits such as snoring, daytime sleepiness and other symptoms of OSA,
- The preoperative RN performs postoperative teaching in the preop area, teaching the patient regarding deep breathing, leg exercises, incentive spirometry, CPAP or BIPAP (bileval positive airway pressure).

Note: The preoperative RN should interview the patient regarding reflux/GERD and should alert anesthesia where the patient admits to this condition. Determine with the patient to what degree he is able to lay flat. Advise anesthesia of this response.

Intraoperative care:

- The anesthesia provider pre-oxygenates the patient. Provide two anesthesia providers where a difficult airway is anticipated.
- The anesthesia provider positions the patient's head using a head cradle and an elevation wedge being especially aware of the patient's needs regarding the presence of GERD/reflux while awake and the impact of this condition on the patient's comfort as well as the hazard it imposes regarding the possibility of aspiration. The need for the elevation wedge is evident.
- The circulator procures extra drapes to adequately create the sterile field while protecting the patient from the possibility of "pooling" of prep and/or irrigation solutions especially in skin folds.
- The circulator gathers extra large equipment as needed, such as bariatric instrumentation for retractors.
- Extra large stepstools are provided for additional staff to prevent leaning across or onto the patient.
- Provide pads, positioning and protective devices to prevent pressure points and assess these areas frequently.
- Position hands such that maximum protection is allowed.
- If patient is to be in the lithotomy position, check prior to the day of surgery with the surgeon to determine the acceptability of available stirrups (e.g., candy cane vs. boot)..
- The patient in lithotomy position will require special attention to fluid volume shifts and ventilation changes presenting in this position.
- Select anesthesia based on procedure to be performed utilizing regional or local whenever possible. Ketorolac is recommended.
- Deflate the inflatable patient transfer device once the patient is on the table.
- Prior to draping, check again for pooling making sure crevices are dry.
- If intubated, following the procedure the anesthesia provider should delay extubation as long as possible.
- Reinflate the patient transfer device for transferring the patient from the OR table to the stretcher bed.
- Advise the PACU that the patient is about to be transported from the OR.
- The anesthesia provider and circulating RN transport the patient to the PACU with oxygen.
- If possible due to the procedure performed, transport the patient with the head of the bed elevated to 30-45 degrees in order to relieve the intra-abdominal pressure on the lungs.
- If extubated, transport the patient with a nasal or oral airway in place.

Postoperative care:

- Maintenance of the airway is a special challenge in the post-anesthetic morbidly obese patient and should be monitored closely.

- Have CPAP or BIPAP ready for immediate use in the PACU.
- Maintain the elevation of the head of the recovery bed.
- Make sure emergency airway equipment is immediately available.
- Limit narcotic and sedative use and use ketorolac when possible.
- Use nebulized breathing treatments as needed.
- Observe patient for conditions and complications associated with severe obesity after surgery to include:
  - congestive heart failure
  - deep vein thrombosis
  - myocardial infarction
  - pulmonary embolism
  - respiratory depression
  - rhabdomyolysis (deep muscle damage)
  - skin breakdown
- Initiate standard postoperative care

Care of the morbidly obese in the PACU and discharge area requires a one-on-one staffing ratio until the patient is ready for discharge. It is crucial that this patient be rigorously monitored. Deep breathing/breathing treatments and leg exercises are crucial. Getting the patient up and out of the recovery bed to a chair as quickly as his condition allows is vital to his successful recovery. Repetitive education regarding breathing and leg exercises at home is critical. Provide demonstrations and demand the patient return the demonstration. Make sure he or she applies his CPAP device properly. Solicit the patient's return explanation regarding the prevention of DVT (and the care person's explanation, too). Remember that this patient's size in of itself is an obstacle in moving his or her body to the extent needed. The nurse providing postoperative instructions must ensure the patient's level of understanding is such that the patient will "move the mountain" in order to best provide the best outcome possible for his or her care. The need to limit pain medication may further inhibit activity and limit compliance. Be firm. Explain possible complications and the degree that inadequate ventilation and exercise contribute to these even to the point of pneumonia and blood clots that could, potentially, be fatal.

In providing the best possible patient education, the nurse caring for these patients must be aware of the underlying emotional needs as well as the obvious physical that are present. The patient may be defensive about his or her weight. The patient may, even, be in denial of the extent of the problem. The patient may be embarrassed, but, certainly sensitive about the issue. Protect his or her privacy. Provide as much privacy during the assessment and teaching phases of his care as the physical plant restrictions allow. Plan this out prior to the patient's admission. Is there space anywhere that can be commandeered to provide these special needs? This patient needs staff support.

How do you provide staff support of the morbidly obese patient when literature and studies abound regarding the stigma and bigotry that exists regarding such patients? Start now with providing staff education. Have round table discussions on the subject. Contact local eating disorder clinics or bariatric centers for expert guest speakers. Given the staffing constraints that exist in most surgery centers, nevertheless, select and assign staff members carefully when planning the patient's care. Just as there are considerations in making other staffing assignments due to religious beliefs, etc., so these may exist among your staff members regarding weight and the morbidly obese. Staff members should be assessed as to whether such pre-conceived convictions can be set aside to provide the degree of support these patients need.

Care of the staff person must also be planned and implemented when caring for the morbidly obese. Injury is a very real hazard, whether a back injury from moving the patient or an injury sustained trying to prevent a patient from falling or working with lifting devices, etc. Determine how best to mitigate such circumstances.

Finally, calculate the costs of providing care to the morbidly obese patient in the ASC. If your center does not routinely provide care to bariatric patients, what are all the direct and indirect costs you will be incurring compared to the reimbursement you will be receiving? ■

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Is It True You Can't Use Multiple Dose Vials Anymore?

By Sheldon S. Sones, RPh, FASCP

Occasionally, on an accreditation review, the AORN and ASA position of not using multiple dose vials in the operating room is commented on. At this junction, this is a recommendation — not a regulation.

The assumption/assertion is that use of multiple dose vials in a completely sterile manner is time consuming and prone to non-compliance. Some say that if you use a multiple dose vial, it should be treated as a single dose vial only.

There has been considerable pushback on the AORN position, especially during our nearly two year long experience with unprecedented drug shortages. Some drugs such as insulin and succinylcholine remain primarily as multiple dose vials. While hospital pharmacies with laminar and vertical flow hoods may be capable of preparing single doses from multiple dose vials, ASCs with hoods and sterile technique training are far and few between. Additionally, drugs used in an emergent manner or to titrate a patient would be administered in a more time consuming manner with significant loss of expediency. And what about high cost vaccines?

Common sense prevails: Single patient use vials such as propofol are to be handled appropriately. Any multiple dose vial that has been used in a sterile field, placed on a contaminated surface or used procedural tray or has been used in an emergent procedure should be discarded after use for such purpose.

WHAT NEXT?

The future may well hold for more stringent regulations on the use of multiple dose vials. Manufacturers may have to retool what they bring forth as products, and yet it is difficult to imagine a total prohibition of multiple dose vials, especially with the drug shortage experience we have had. Additionally, the FDA continues to approve multiple dose vials resulting in potential regulatory confusion. Draw out 2 mL of a 20 mL labetalol, which is difficult to find today, and throw out 18 mL? Could be a hard sell. Anesthesia providers should step to the microphone on this one. ■

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Approaching Quality the Sanford Way: A Coordinated Improvement Strategy

By Sabrina Rodak

In 2009, Fargo, N.D.-based MeritCare merged with Sioux Falls, S.D.-based Sanford Health to create an integrated health system that now includes more than 34 hospitals, 116 clinics, 30 long-term care facilities and 1,000 physicians. The system — the largest rural non-profit healthcare system in the United States, operates in seven states. The wide breadth of the organization geographically requires coordinated efforts to reach quality goals. Bruce G. Pitts, MD, CMO of Sanford Health, discusses how leadership, physician alignment and electronic medical records are critical to successfully adopting a single quality strategy.

The Sanford Way paves the path to quality

The Sanford Way is Sanford Health's common performance improvement methodology that is being developed from tools from both former MeritCare and pre-merger Sanford Health (the two merged in 2009). For example, Dr. Pitts designated a chief quality officer for each of the system's three geographic regions to oversee quality, safety and service at a regional level, an idea he borrowed from pre-merger Sanford Health. The health system also uses clinical decision support to encourage best practices, a practice that was more fully developed at MeritCare.

"Both systems had robust approaches. My job is to develop a consistent enterprise-wide approach to quality, safety and performance," Dr. Pitts says. "It's a way to have a common language and a common approach to performance improvement — solving problems, reducing waste and engaging the human spirit."

One tenet of this approach is continuous improvement. While the health system already performs well in readmission rates, risk-adjusted mortality and other quality metrics, Sanford Health is "never satisfied," Dr. Pitts says. The system looks at comparative reports and data from its electronic medical records to identify target areas for continued improvement.

Coordinating care over distance

Sanford Health's ability to adopt strategies and ideas from different areas is one of the benefits of its large geographic reach. "We have an opportunity to try a lot of different approaches to performance improvement across the enterprise and identify what works best for us and our culture," Dr. Pitts says. However, the physical area Sanford Health encompasses creates a challenge in coordinating performance initiatives. To better align practices, Dr. Pitts centralized key performance improvement resources. Sanford Health employees also stay connected over distance through the EMR. "We cover a huge geography that is relatively sparsely populated; our approach has to be different than if we were located in one city. The network approach allows us to communicate improvements across the enterprise in a transparent way and share methodology of how to get there," Dr. Pitts says.

Leading the Sanford Way

Deploying a universal set of tools across a system relies on strong leadership at every level. "Perhaps the most unique aspect of the Sanford Way is its very explicit understanding about the role of leadership," Dr. Pitts says. "So often when people talk about methods [of performance improvement], they focus on tools and data. We're very focused on the role of leadership. Of all the ingredients, that's the most important one."

Sanford Health promotes leadership by offering leadership education, giving future leaders progressively more responsibility and mentoring. In addition to supporting people in formal roles of leadership, Sanford Health encourages informal leaders who may not be in positions of power but are still very influential in the organization. Sanford Health mentors these 'informal" leaders and exposes them to situations in which they can exercise their leadership skills.

Physician alignment drives coordinated care

Integration is key to succeeding with a single performance improvement methodology, says Dr. Pitts. He attributes Sanford Health's current success in quality in part to the system's close alignment with its physicians. This alignment will also help the entire system adopt the Sanford Way. "One of the reasons we do well is because we are an integrated health system. Our affinity and common purpose have driven improvement over the years," Dr. Pitts says.

Sanford Health's physicians are all employed and are members of one practice. They retain close ties to the organization regardless of distance through the EMR, which provides patients' information, and sophisticated video connectivity, which enables physicians to communicate with other clinicians and patients. Sanford Health also established a local and enterprise-wide leadership structure that connects physician to the system. "We are so good at keeping people out of the hospital because our primary care physicians are so well connected to the whole enterprise," Dr. Pitts says.

Leveraging technology

In addition to helping physicians align with the overall system, EMRs help improve patient safety across Sanford Health by ensuring clinicians' access to a patient's file in any part of the system. Dr. Pitts says this capability is important because patients often go to different areas for care: their primary care physician may be located in a different area than their specialist, which may be in a different location than an emergency department they enter, for instance.

To enhance this capability, Sanford Health is currently transitioning its Fargo region facilities from GE Centricity EMRs to Epic EMRs, which facilities in the Sioux Falls region already use. While this transition will be a challenge, having compatible EMRs across the enterprise is critical to deploying a single quality approach, according to Dr. Pitts. ■

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5 Qualities of High-Quality Infection Preventionists

By Jaimie Oh

Infection prevention and control is one of numerous issues in the forefront of healthcare, and healthcare organizations have taken on the challenge through a variety of means, including hiring infection preventionists. But what, one may ask, separates the one-star experts from the five-star experts. Karen Mackie, RN, MA, CIC, infection control manager at Greater Baltimore Medical Center in Towson, Md., explains five must-have qualities of top-tier infection preventionists.

1. Achieves certification in infection control. Certification in infection control is a measure of competence in the infection prevention world, says Ms. Mackie, who herself is certified in infection control. Interested clinicians can only achieve certification through the Certification Board of Infection Control and Epidemiology. In order to prepare, clinicians should consult with a variety of expert resources, including the Association of Professionals in Infection Control, The Joint Commission and the Centers for Disease Control and Prevention, to help prepare for the certification exam.

"If I was a healthcare employer and wanted to hire a specialist to oversee infection control, I would want to hire an individual who is certified," Ms. Mackie says.

Ms. Mackie's point is supported by recent research published in the American Journal of Infection Control. In that study, infection control policies and outcomes from 180 California hospitals showed hospitals with certified infection control professionals had lower rates of MRSA infections than hospitals without such expertise.

2. Develops leadership qualities. While many skill sets, such as computer literacy and research capabilities, are important to have for infection preventionists, none may be more pivotal than leadership. According to Ms. Mackie, leadership qualities include organization, an eye for detail and project management.

"[Infection preventionists] are increasingly being asked to lead projects, so these professionals must be able to bring the right people to the table and lead that group effectively once they're there," she says.

Ms. Mackie adds another key leadership quality is requesting colleagues' input on projects. Constantly dictating what needs to be done without engaging or obtaining buy-in from stakeholders is an obvious red flag that he or she lacks this quality.

"One of my colleagues said, 'We're puzzle solvers, we're detail oriented, we're researchers. We also worry and nag,'" Ms. Mackie says with a laugh. "And I believe that we are. Sometimes people don't want to hear your message about hand hygiene or another compliance issue, but you have to do it; otherwise it won't get done."

3. Builds a strong network of peers working in infection control. Membership or affiliation with local chapters of national professional groups, such as APIC or the Association of periOperative Registered Nurses, not only opens doors for learning opportunities but also gives infection preventionists a way to network with other professionals. Ms. Mackie says failure to network can stunt an infection preventionist's growth, particularly those who work in smaller facilities. For her part, Ms. Mackie found joining the Baltimore chapter of APIC has dramatically expanded her learning opportunities.

"While I have two wonderful colleagues who work with me on infection prevention at GBMC, I realize that infection control professionals can't do it alone. You need to develop that network," she says. "I have developed relationships with other practitioners in the area, and now they're an email or phone call away."

4. Acts on curiosity. Ms. Mackie says one of the most rewarding and enjoyable aspects of specializing in infection control for more than 30 years is the ongoing process of wondering and learning. Great infection preventionists are people who will act on every curiosity and research all possible solutions until a conclusion is met. Answering questions, particularly related to infection control and prevention, is now easier than ever with the advent of the World Wide Web, Ms. Mackie says.

"In this day and age, there are multiple electronic resources. What use to take me a week of searching through journals, I can now do in a few minutes on the Internet," Ms. Mackie says. "If you don't want to or aren't able to keep up with researching infection control, you aren't going to be effective. I go home every day learning something new."

5. Is a patient advocate. While individual nurses may be assigned to deliver bedside care to specific patients, top-notch infection preventionists will be a patient advocate for all. With a heightened sense of accountability for all patients in the hospital, Ms. Mackie says great infection preventionists will make sure every patient receives stellar healthcare and all the right practices, such as hand hygiene and antimicrobial stewardship, are followed.

"From the infection prevention perspective, we can't just advocate for Mrs. Jones or Mr. Smith," Ms. Mackie says. "We advocate for everyone in the more general sense." ■

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