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INSIDE

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ASCs Can Use QAPI Projects to Help Patient Safety, Processes

Any surgery center can start today

Before delving into quality assurance and performance improvement (QAPI) projects, some people might view them as mysterious, enigmatic puzzles. But they're not. The quality improvement process can be straightforward and simple. One way to envision QAPI is to see it as a process for ambulatory surgery center (ASC) leaders to continually strive for improvements in surgery center operations.

"One of my goals in working with centers is to get them to see that quality improvement is a culture," says **Yvonne Visbeen**, BSN, RN, senior clinical director at AmSurg in Nashville, TN. "We're trying to improve everything we do with the goal of providing really safe, high-quality care in a cost-effective way."

> "WE'RE TRYING TO IMPROVE EVERYTHING WE DO WITH THE GOAL OF PROVIDING REALLY SAFE, HIGH-QUALITY CARE IN A COST-EFFECTIVE WAY."

Accreditation organizations and other surveyors are interested in ASCs' quality improvement projects because this shows that the site takes patient safety and quality care seriously. One of the first items surveyors ask to see is a site's QAPI plan, says **Jan Allison**, RN, CHSP, senior director of regulatory at AmSurg and a national speaker about QAPI.

Surgery center leaders should look at the big picture as they tackle QAPI projects, suggests **Carolanne Reho**, MHA, BSN, RN, CNOR, senior director of clinical services at AmSurg. Reho sometimes speaks at national surgery center conferences about QAPI and quality improvement.

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As a surveyor for the Accreditation Association for Ambulatory Health Care (AAAHC), Reho often is asked what should be the center's focus of study.

"Choosing a topic is very challenging for people because they're so used to problem-solving on a daily basis that they don't see the things they are dealing with or know how to track and trend events," Reho explains. "A lot of times there are things they do a lot or see a lot, and these are right there in front of them, but it's hard for them to focus on these things because they see them every day."

According to Allison, a successful QAPI plan will include procedures for data collection, identifying problems, and creating steps for improvement with follow-up. Two important questions:

- Are we meeting the standard of care?
- Are we always looking to improve?

"I'd look at how robust it is, whether it's compliant with expectations, compare it to the requirements, and look at indicators and what is being monitored," Allison says. "Having a robust QAPI program is something everybody needs to do; it's what drives patient safety."

Surgery centers with QAPI programs will examine data to see which processes need improvement to keep patients safe and to prevent harm. "That's the whole purpose," Allison adds.

QAPI is a continual process of studying data, analyzing what the information shows, making changes based on this information, and then monitoring to make sure improvements are sustained, Visbeen says. Quality improvement teams should include staff from every area of the center, Visbeen adds. *(See story on how to establish QAPI, page 27.)*

"Sometimes, a facility has a feeling of where a problem is, but it's not something they're measuring," Allison says. "They can collect data on those areas to see if there's an opportunity for improvement."

For example, a surgery center might have a great record when it comes to wrong-site surgeries; internal data might show zero mistakes in this area. But this doesn't mean that the center should not bother to create a QAPI plan for this issue.

"Maybe, the surgery center realizes they don't perform a time-out process well," Allison says. "And they open up the risk of having a wrong-site mistake when they don't do it well, so they realize they need to improve their time-out process."

A QAPI plan can be implemented proactively. Administrators don't have to implement a plan that is reactive to data that identify problems, Allison adds.

EXECUTIVE SUMMARY

Quality assurance and performance improvement (QAPI) projects are a way to work toward every surgery center's goal of providing safe, cost-effective, high-quality care.

- Surveyors typically ask to see a site's QAPI plan.
- QAPI is a continual process of studying data and analyzing the information.
- It's about acting proactively to prevent problems.

"That's what performance improvement is — you're proactive in preventing the problem from occurring," Allison says.

Finding areas to improve should not be an issue for any healthcare organization.

"There are so many different and great areas that people can look at," Reho says. "In my experience, centers that have embraced QAPI are very successful and see the benefit of looking at appropriate topics for themselves, and when they see an improvement take place, it's so rewarding and so important."

When ASCs first tackle QAPI projects, one step is to talk with staff.

"Ask them what quality means to them," Allison suggests. "Sometimes, people don't understand; they can grumble about things going on, but not necessarily understand that by addressing it, there could be an opportunity to improve it."

Employees will know which processes and areas are problematic. They might help leaders generate ideas for projects. A surgery center's nurses play a large role in quality improvement because of their hands-on patient care, Allison notes.

"QAPI is monitoring to see if we're doing what we're supposed to do," she adds. "Are we doing best practices? Do we have an opportunity to improve? And, what is our data telling us?" ■

A Blueprint for Starting the QAPI Process

Start by looking at the big picture

Surgery center administrators might find that initiating a quality improvement process is daunting and time-consuming. However, the process can reveal much about the ASC, its staff, and its operations. The key is to examine the big picture, including asking employees which problems should be the first ones tackled under a QAPI program, says **Carolanne Reho**, MHA, BSN, RN, CNOR, senior director of clinical services at AmSurg.

"I often tell surgery centers to rely on the expertise and experience of their staff to help them choose a topic," Reho says. "There's a lot of cumulative experience in people who work at surgery centers."

ASC directors should reach out to their employees, asking them about challenges they face and engaging them in the QAPI process, she adds.

"Get people to talk about their jobs on a very basic level," Reho suggests. "Ask them if there are things that inhibit them from doing their jobs well. Are there things that make them more efficient at their jobs?"

Engaging staff to use their expertise to identify areas for improvement is an important part of the process, she adds.

The following are some additional suggestions and strategies for starting a QAPI program:

• **Bring physicians on board.** "First and foremost, you need physician support," says **Yvonne Visbeen**, BSN, RN, senior clinical director at AmSurg. "Some centers have a lot of physician involvement, and this leads to a thriving program. When physicians are not involved, it can be hard because directors have to drive the process by themselves."

There are ways to obtain physician buy-in. "Doctors are very data-driven, and they're competitive," Visbeen notes. ASCs can engage physicians in the QAPI process if administrators can present physicians with data about any quality improvement topic, whether it's patient satisfaction or what one supply costs vs. another, she adds. For physicians who own a portion of the ASC, this works especially well, Visbeen offers.

"You can say, 'We'd like to do a study to see if we like this supply from this manufacturer as well as the one we use, but we'll save $5 per item,' and the physicians will be on board," Visbeen says.

• **Form a quality improvement team.** An ASC's quality improvement team should include staff from all areas, Visbeen says.

"Everyone has their own world they work in, but if you have a QI team, it could bring people together," she says. "You're hopefully building connections between this team and how it might affect someone else down the road."

ASC directors might look for employees with skills that would help a quality improvement team. For instance, there might be a staff member who is skilled at creating Excel spreadsheets and graphs, which could be used in data analyses.

"You want to tap people where their interests are, and that means you must know your staff," Visbeen suggests. "Hold meetings and say, 'I'm thinking of doing some quality improvement in this area, and I need some help.' Start with small

things, something that staff can take ownership in."

Initial projects might affect employees' daily workflow, and the ASC director can look for volunteers who are willing to study the issue and find solutions.

• **Educate with visuals.** ASCs might post visual representations of QAPI initiatives throughout the center. For instance, posters could list patient satisfaction survey results.

"If everyone congregates in the lunch room, put posters in a place people are walking by," Visbeen suggests. "If I walk into a center and ask any employee what the surgery center is doing with quality improvement, the employee should be able to tell me. But 90% of employees cannot identify a quality improvement project because, one, we're not including them in QI, and, two, we're not giving them any visual cues."

Hanging posters and other visuals in the surgery center will educate staff about QAPI in a way that expands its reach. "Even if they're not involved in QAPI, they are aware of it because they see it on the bulletin board," Visbeen adds.

• **Identify variations in practice.** "This is something any surgery center can do," Reho says. "If it's a big topic, you could focus on smaller aspects of it."

For instance, the surgery center might tackle the big topic of patient safety and quality in anesthesia care, breaking it down into the smaller issue of post-op nausea and vomiting.

"An ASC might have three different anesthesia providers managing these patients," Reho says. "You can use peer review in this process, tracking these specific providers' patients and their rate of post-op nausea and vomiting."

The ASC then tracks nausea and vomiting cases over a two-month period and compares patient rates of this problem across the three physicians.

"See if there's a trend," Reho suggests. "Maybe one doctor [treats] a majority of the patients with post-op nausea and vomiting."

When surgery center administrators track a trend by provider and procedure, they are focusing on the problem and its possible cause. Administrators can study these data even more by examining:

- What agents are used?
- What type of procedure have the patients undergone?

"You've started with the big, general topic and then focused on that until you get more specific items to track," Reho says. "Once we track and trend specific items, we can look at ways to effect change."

A potential finding might be that one specific inhalation agent resulted in a greater proportion of patients with post-op nausea and vomiting. The ASC director discusses this finding with the quality improvement team, and the team proposes a solution to implement and monitor.

• **Build on small successes.** "You can use data to present to physicians and to champion quality improvement every day," Visbeen says. "Get away from thinking it needs to be a long and involved study; look at something that is a daily problem."

For example, a small QAPI project might focus on discharge instructions. Visbeen recalls one discharge instruction quality improvement initiative. Patients said in a survey they didn't feel that certain discharge items were adequately addressed.

"So, we gave surgery centers instructions on what the discharge instructions should say, and we suggested they ask staff, 'How can we help patients understand discharge instructions before they leave the facility?'" Visbeen recalls.

Some centers solved the problem with laminated discharge instructions. Staff handed these instructions to patients pre-procedure. This gave patients time to ask questions prior to the procedure.

"Start discharge teaching before [patients] walk in the door," Visbeen says. "That's been valuable in improving patient satisfaction."

An additional solution is to place a poster in the consultation area where patients wait to speak with physicians. "It's a visual cue for them and family members," she says. "The poster lists the things patients should be aware of [and] the reasons they should call their doctor."

• **Network with other surgery centers.** ASC directors might attend state meetings or conferences and ask their peers how they addressed QAPI needs.

"Networking at a local level is extremely helpful," Reho says. "For our corporation, we can facilitate

EXECUTIVE SUMMARY

The key to successfully launching quality improvement projects is to study the big picture by asking employees which problems to tackle first.

- Another important step is to get physicians on board with the QAPI process.
- Form a quality improvement team and educate staff with visual aids.
- Look for variations in practice, singling out small QAPI steps that can be taken first.

networking and link up people."

Solo ASCs must be resourceful. Attending meetings and events with other ASC leaders is a good place to start. An ASC director can collect email addresses and phone numbers from other ASC directors and then contact them when an issue or question arises.

"Reach out to people who are doing the same job you're doing," Reho says.

The Ambulatory Surgery Center Association (ASCA) is another resource for networking and peer information.

"ASCA has a daily blog, sent by email," Reho says. "People ask questions about their processes and whether anyone else deals with these same issues." ■

A Patient-centered QAPI Project

Patient experience is a good area to mine for a QAPI project in an ASC.

"Based on a lot of feedback I see in patient satisfaction surveys, waiting room time is a huge complaint, universally," says **Carolanne Reho**, MHA, BSN, RN, CNOR, senior director of clinical services at AmSurg.

Patients often are anxious or nervous before their procedures. Families worry while waiting for their loved ones during surgery. It's important for ASC staff to be mindful of their feelings and to communicate what's going on when procedures are delayed, she says.

"In surgery centers, frequent communication is vital," Reho says.

Someone might let patients know when there's a delay.

"A physician or nurse or receptionist could go out and give a brief update," Reho says. "Acknowledging the wait is vital. It shows that you understand that they've been sitting there, waiting, and their time is valuable."

There also should be follow-up. If someone has just told a patient that they'll be ready to go back in five minutes, but this is delayed, give the patient an update.

"Consistency is important with communication," Reho says. "Anytime there's a wrinkle in that process, where communication lapses, that's when people get upset; they feel their time is disrespected or their concerns are disregarded."

To identify a patient experience quality improvement project, the ASC could conduct a time study, tracking the time patients and families wait.

"It would be wise to engage the clinical staff about how long people have been waiting, and it's wise to also talk with the front office staff, looking at the [check-in] process," she says.

Ask staff these questions:

- Do you know how long someone has been sitting and waiting to be called up?
- Does your area receive a lot of complaints about patients waiting a long time?

"Engage people at the front line of receiving patients, and help them realize that from the moment a patient walks in the door, the patient's experience at the surgery center begins," Reho says. "We need to be mindful of their experience."

It's also important to emphasize to front office staff that their experience in dealing with patients is just as important as the experience of the people in the back office, Reho notes.

"This validates the importance of their position and their being the face of the surgery center," she adds.

Technology can help with this process.

"One of my surgery centers is ophthalmology, and most of their surgeries are cataract procedures, which are fast procedures with a lot of patient turnover," Reho says.

To improve the patient experience and help the center run more efficiently, the ASC maintains an electronic sign-in board. Patients walk in the door of the center, and their time is noted on the board. This electronic sign-in creates a signal to the front door receptionist, and begins a time clock on each patient's waiting time.

"They can see in real time how long the patient has been in the facility," Reho says.

The electronic system also gives the pre-op nurse information that the patient is ready to be brought back. If there is any holdup, the staff can communicate with the patient about it.

"It makes them more efficient, in general," she says. "They've seen a decrease in wait times in doing that process because it heightens their awareness."

Also, patient satisfaction surveys show that patients are happier with this system, although they're only aware of the sign-in board and not of the system's communication to other areas of the ASC.

"That one simple motion of their signing in gives the entire team the beginning of a communication pattern, which has helped them a lot," Reho adds. ■

Make Board Meetings More Efficient With Improved Agenda

Use a consent agenda first

It's rare to find someone who enjoys spending hours in a board meeting. Yet, ASC governing boards must meet regularly for oversight. The solution is to create a more efficient meeting agenda.

"Every surgery center board has to have meetings, minutes, and requirements, so the question is 'How can we improve the board agenda?'" says **John Goehle**, MBA, CPA, CASC, chief operating officer at Ambulatory Healthcare Strategies in Rochester, NY. In 2015, Goehle wrote a book on governing board agendas, titled, *Ambulatory Surgery Center Governance — A Guide for Ambulatory Surgery Center Owners & Governing Body Members*. If the agenda is designed well, most board meetings can be completed within 45 minutes or less, he says.

The following are ways ASCs can improve their board meeting agendas and shorten meetings:

• Make use of a consent agenda. A consent agenda is when several agenda items are batched together for one vote. They are the noncontroversial items, which do not require any discussion. These might include:

- approval of previous board meeting minutes;
- review of financial statements;
- approval of a policy manual;
- approval of administrator reappointments;
- approval of the formulary;
- approval of policies and procedures.

"You put those things under the consent agenda, and before the meeting starts, people can say, 'I don't want that in the consent agenda. Let's pull that out and have a discussion,'" Goehle says.

The meeting facilitator can say, "In front of you is a consent agenda. Does anyone have any objections to approving it?" If everyone agrees, then the consent agenda is approved.

The whole idea of the consent agenda is to avoid engaging in long conversations about items on which everyone already agrees and to expedite the meeting by holding one vote rather than multiple votes, Goehle adds.

• Break down important meeting elements. Put the most important items on the agenda that are within the board's responsibility first.

"Put front and center quality improvement and risk management as one of the first things you talk about," Goehle suggests.

ASC boards should review the quality improvement meeting minutes and focus only on the areas that require board action or discussion.

"For example, say during the quarter you had five incidents and four of those incidents were just things that happened, such as somebody was transferred to the hospital prior to surgery because of new onset cardiac issues," Goehle says.

In those cases, investigations found that the ASC had no effect on those incidents. They just happened, and so there would be no change to policy and procedures because of them.

"No one has to be disciplined or fired," Goehle says. "So, you don't want to talk about that during board meetings because nothing happened with those four incidents."

But suppose the fifth incident was a fall that injured the patient.

"During the investigation by the QI committee, it was discovered there was no policy with regard to risk assessment, so the QI committee recommended a change in policy to have a fall risk assessment program," he explains. "Only the governing board can approve that policy, so this is something the board has to discuss."

• Set expectations from the start of the meeting. "I'm usually the meeting facilitator, and what I would try to do is gently say, 'We have a very tight agenda today,'" Goehle says.

EXECUTIVE SUMMARY

The board meeting agenda holds the key to running meetings more efficiently and with fewer discussions going off the tracks.

- Surgery center boards can use a consent agenda to expedite votes on noncontroversial and minor items, including approval of previous meeting minutes.
- The most important items on the agenda should be put ahead of items for which no discussion or action are expected.
- Present financial statements in a way that emphasizes the important items and de-emphasizes trivial ones.

"'There's information in a packet that I've provided to you, and I'd be happy to talk with you after the meeting, but I'd really like us to focus on things that have a discussion and/or decision point.'"

For most organizations, the person who will keep the meeting on track is the administrator who created the agenda and is actively involved in meetings. Administrators can ask experienced facilitators to run the meeting, too, he adds.

• Not all financial statements require a discussion and vote.

Administrators might ask governing board members for feedback about each quarter's financial statement prior to the meeting, Goehle says. The administrator could ask, "Are there any things we need to discuss for the board meeting, or should I include it in the consent agenda?" Anytime a financial report is not included in the consent agenda, it becomes an important agenda item for discussion. Goehle has learned from experience with a board meeting that went off track that it's wise to present financial reports in a way that reduces sidebar discussions and facilitates discussions.

"Several years ago, I put together a financial statement that showed a percentage over budget," he recalls. "During the board meeting, one person went through the items and picked out things that were way over budget. One line item was 200% over budget."

The board member perseverated on that single item, leading the board into a 15-minute discussion about how to handle that one item. But the line item was a water fountain that had a $75 budget and a $200 expense.

"The dollar amount involved was very small," Goehle says. "But because I had showed the percentage over budget for each line item, I misdirected the governing body to look at this. They should have spent time discussing how the supply costs were $30,000 over budget for the month."

The $30,000 was a smaller percentage over budget, but the dollar amount made it more important. The answer to this one might have been that revenue was up by $200,000, so the ASC had handled more cases in the past month, which would also lead to more use of supplies, Goehle adds. Instead of focusing on line items that mattered and needed explanation, the board began to discuss how someone could monitor the water fountain for a few days.

> "EVERY SURGERY CENTER BOARD HAS TO HAVE MEETINGS, MINUTES, AND REQUIREMENTS, SO THE QUESTION IS 'HOW CAN WE IMPROVE THE BOARD AGENDA?'"

"It was funny, after a while," Goehle says.

The financial report does not need micro details, and meeting time was wasted because of how the information was presented.

"It was my fault in the first place," Goehle admits. "A good administrator will know how to present information in a way that will help them make these decisions."

• Present operational reports as brief dialogue. ASCs can ask the medical director, administrator, and business office manager to present reports, if applicable. The reports should be sent with the advance packet to board members so the information does not have to be repeated aloud.

"During the meeting, the administrator and medical director will say, 'The report is in there, and I'd like to highlight these items,'" Goehle says. "This should take no more than two minutes."

For example, an administrator's report might go like this: "I've hired two more people. We have some staff members on maternity leave right now, and we need to consider a pay raise at this meeting."

Most surgery centers might not include written reports with the agenda packet. In these cases, centers should keep the oral report short. The best strategy is to begin the reports with noncontroversial items that require no votes and to end it with items that need a decision point, Goehle adds.

"The board meetings are meant for a dialogue, talking about everything that happened over the last three months," Goehle says. "But people will sit around and look at their cellphones when we want them to focus on those issues that require dialogue."

If there are any policy changes that are noncontroversial, these do not need to be discussed, he adds.

• Handle controversial issues expediently. ASC administrators or facilitators might learn how to introduce controversial topics cautiously. The idea is to avoid wasting time. Here's one strategy for beginning the report: "I have a total of five incidents — four we don't need to speak about. They were all

preoperative transfers to the hospital, and there were no issues with those. The fifth was an injury to a patient. We investigated it and found it was from a fall, and we need a fall prevention policy," Goehle suggests.

The administrator could continue by saying that a fall prevention policy proposal is in the agenda packet and ask if anyone has any questions or issues to raise, he adds.

"The administrator focuses on everyone and gets them back on track, asking, 'Is there any discussion?' and 'Can we approve these policies and move on?'" he says.

• Pay attention to the meeting minutes. "The wrong way to do minutes is to expect the administrative assistant to write these things up," Goehle says. "These minutes are legal documents that are very important."

He also recommends that ASCs avoid making audio tapes of sessions. Administrators or a designated minutes' expert can document the minutes by hand or in an electronic document, following a template that is well-structured. The important thing to remember with meeting minutes is that if something is not documented in the minutes, then it's as if it never happened.

"So, if we didn't document that you approved the new fall prevention policy, then it never happened," Goehle says.

For votes, they're indicated by writing, "approved by the governing body." If it wasn't unanimous, then add, "with one (or 2, 3, etc.) dissent."

For ASCs with very small boards of one or two people, meeting minutes still are a good way to document the actions that are made, even if someone is just meeting with him- or herself. Board meeting minutes are not protected from disclosure in court cases, Goehle notes.

"The minutes reflect how the governing body carried out its responsibility," he says. "One important thing is you don't want them to be only one page long."

It's also important to thoroughly document every vote and item on the agenda while ensuring such documentation is not worded in a way that could cause legal problems later, especially when the board is discussing protected information, such as privacy issues, he adds.

• Focus on key points in improving board meetings. Goehle recommends that boards keep the following main points in mind:

1. Make sure meetings focus on items the board must decide.
2. Make sure meeting minutes reflect every action that was taken and include some background information that makes sense of the action.
3. Keep meeting minutes specific, but without extraneous details.
4. Focus on the discussion, not the background information, at meetings, because the board should know the background details. ■

How to Succeed at Succession Planning

Identify potential leaders first

ASC administrators might notice how difficult it is to fill perioperative nursing jobs. There are competing interests for bachelor's degree nurses, and perioperative nursing has not been a priority in many schools. One researcher studying this issue has found that this is a problem throughout the surgery center nursing pipeline. Too few new nurses specialize in surgery, which leads to too few nurses who are qualified to climb the management ladder.

"One of the reasons I became interested in this topic was I was seeing within my own facility longer and longer times to fill perioperative staff nurse positions, as well as leader positions," says **Donna Doyle**, DNP, RN, CNOR, administrative director for surgery and anesthesia at OhioHealth in Columbus. Doyle has researched surgery nurse training, jobs, and leadership roles and plans to present data at the Association of periOperative Registered Nurses (AORN) Global Surgical Conference & Expo 2018 later this month in New Orleans.

"The first thing impacting the nursing shortage is that many nursing programs no longer have rotations in perioperative nursing," Doyle says. "So, when nurses graduate, they're no longer imprinted on working in the perioperative specialty."

Nursing students rarely complete their education to work in an operating room. But they might be interested if they participated in a surgery suite rotation.

"We think they should put a perioperative rotation in the curriculum for BSN degrees," Doyle says. "But in reality, they only have so much time, and every specialty

believes theirs should be part of that program."

At the other end of the spectrum, experienced surgery center nurses and nurse leaders are retiring. The average age of perioperative nurses is older than in other specialties. These are the baby boomers, many of whom have been working in surgery centers for 20 years.

"That's a lot of critical thinking and skill sets walking out the door with them," Doyle says. "When you talk about the pipeline, and you have all of these folks leaving, and you don't have a front-end pipeline bringing in those individuals, you have a deficit in that area."

It's a domino effect, she says. "If you don't have a full pipeline, then it can impact your ability to staff your operating room, and it leads to an access issue."

Access will be a crucial issue in the next decade. It will become a crisis for ASCs if there are not successful succession planning strategies underway.

"Succession planning strategies have to be developed now before the crisis becomes greater and to avert a crisis of phenomenal proportions down the road," Doyle says. "Perioperative leaders come from the ranks of staff nurses, so it's imperative that you have a succession plan."

Doyle suggests ASCs and others use the following strategies to prevent succession problems:

• Develop partnerships with colleges. Doyle approached a professor at a local college, Otterbein University, to develop a perioperative elective so students could rotate within the operating room.

"We've had that in place for several years, and it's been very effective," Doyle says. "We have hired several individuals from the program."

The program started with six to eight students, and several were hired after they graduated, she adds.

• Mentor millennials and other new nurses. "Assign a buddy system to help guide them," Doyle says. "Those mentoring relationships continue long after they finish their orientation."

"SUCCESSION PLANNING STRATEGIES HAVE TO BE DEVELOPED NOW BEFORE THE CRISIS BECOMES GREATER AND TO AVERT A CRISIS OF PHENOMENAL PROPORTIONS DOWN THE ROAD."

New nurses will rely on their mentors to guide them and help them develop. They also benefit from a socialization perspective, Doyle adds.

"Every clinical area has its own culture, and the culture of the operating room is no different," she notes. "Trying to socialize new nurses into the environment is just as important as teaching them the competencies and skills they need in order to be successful, and this helps to retain them."

To make the buddy system work, ASCs should pair new nurses with someone who is willing to show them the ropes. The mentor might be someone with at least a few years of experience working in an ASC, Doyle suggests.

• Work to retain millennials and other staff. "Retention is absolutely imperative," Doyle says. "Millennials want to be involved; they want to contribute, and many times the culture of the operating room is one in which people have a tendency to say, 'Have you put in your time? You have to pay your dues before you start to contribute.'"

But this won't work well with new nurses. A better retention strategy is to find out what is important to these new nurses, whether they're millennials or another generation, she says.

"If you can't provide what's important to them, then the likelihood of their finding another place to work is much higher," Doyle says.

"Perioperative leaders come from the ranks of staff nurses, so it's imperative that you have a succession plan," Doyle adds.

• Identify high-performing employees. ASC administrators can find the next leaders among their staff, but only if they know which qualities to identify.

"Look for individuals who have positive attitudes, who are engaged, who are problem-solvers, who communicate and interact well with all team members, including physicians," Doyle says. "These are the people who, many times, ask to be involved in various committees and initiatives in the department."

Target these high-performing individuals early and find out if a leadership role would be a good plan and match for them.

"Once you identify your talent, you have to validate whether or not that individual wants to do that," Doyle says. "You may think this person would be a great manager

or team leader, but that may not be what they want to do."

While there might be employees who perform above average at the skills and tasks of their jobs, they could fall short of leadership potential. One way to screen these individuals is to ask for staff input.

"When people say he or she 'is a good nurse, but…,' it might mean the person is a little caustic in approach or may be passive-aggressive," Doyle says.

Perhaps the potential nurse leader is great, but has a little tardiness issue. It's up to the administrator to determine if that's a short-term problem or a long-term trend.

• Help employees develop career growth plans. One of the best ways to do this is to meet with staff members individually to determine what type of career growth they desire and what are their near- and long-term goals, Doyle suggests.

"We develop individual development plans," she says. "We look at each person's career growth to identify opportunities for this individual."

Opportunities might include attending classes or conferences, or becoming a preceptor. Educational sessions could be offered to new employees or students, or some classes might include learning the skills to become a mentor. ASC administrators also must identify opportunities for advancement for these nurses with leadership potential.

"You must do succession planning and development planning with each person," she says. "You can't just wait to do it until there is a vacancy and then try to figure out how you'll fill it."

Wherever possible, there should be a stair-step progression plan for employees. Career growth planning also helps retain employees.

"When you're working with employees on individual development, they're very engaged," Doyle says. "At our organization, we have year-long classes for new or aspiring leaders."

The organization has found that when supervisors are engaged with employees in their career planning, the probability of success is much greater, she adds.

> "WHEN YOU'RE WORKING WITH EMPLOYEES ON INDIVIDUAL DEVELOPMENT, THEY'RE VERY ENGAGED. AT OUR ORGANIZATION, WE HAVE YEAR-LONG CLASSES FOR NEW OR ASPIRING LEADERS."

• Find out what employees want from the job. Doyle sets up one-on-one, 30-minute meetings with employees to talk about their future development.

"During that meeting, I explain why I'm talking with them, and I give them a little background and straight out ask them where they see themselves," Doyle says. "Where do you see yourself in a year, five years? Where do you want to be?"

These open-ended conversations have led to Doyle discovering that one nurse, who showed leadership potential, really aspired to be an RN first assistant. She didn't know how to get started in achieving this goal and was unsure of what it would entail, but Doyle could help her.

"If your organization has tuition reimbursement, then you might encourage some employees to go back to school as part of their development plan," she says. "So now you are investing, whether it's sitting and talking with them about their career growth or offering tuition reimbursement."

Organizations can protect themselves from wasting this kind of benefit by asking employees to sign a form, saying they agree to stay a year after completing the class.

• Provide follow-up. "As a leader, you need to be out there and visible," Doyle says. "You're interacting with your staff, and part of that interaction is to just touch base."

The best practice is to follow up on employees' individual development plans on a quarterly basis, asking, "How is it going? You said you were going back to school, how is that going? Is there anything else you need from me? How can I help you?" Doyle suggests.

Encouragement goes a long way. It's important to put this process into perspective. "There is always the reality and what is possible," Doyle notes. "What I tell managers is to not focus on how it's always been done, but to look at what are the possibilities and how you can make it work. Sometimes, you just can't make it work, and you have to consider the business needs of the organization first, but there is a trade-off."

If one plan won't work, maybe some other plan that is nearly as desirable will work. When the employee's desired goals won't work within an organization, it's important to be honest and clear about why these won't work.

"Make sure they know the 'why' behind it," Doyle advises. ■

Do Your Numbers Match?

A closer look at profit and loss statements, insurance contracts, and supply costs

By Stephen W. Earnhart, MS
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Austin, TX

When it comes to profit and loss statements, all too often we find that what we think the numbers are in a surgical area or freestanding center are not that way in the books, which an accountant or bookkeeper prepares. It is a big deal, regardless of awareness.

Case in point: We are conducting an evaluation for a client that involves re-syndication of their surgery center. It involves some number-crunching, analysis of "things," and generally coming to an understanding of how the facility is performing. Per everyone, including the owners and those who wish to buy in, everything is great.

However, upon looking at the books, it's not so good. There are major errors and omissions from what the facility thought vs. what the numbers show. This had a big impact on new surgeons joining the facility and even existing partners wanting out. The administrator, business office manager, owner, or someone else must check what you report against what is reported in the books every month. In this case, it had been more than a year since that happened, and the accountant had just been recording what was inaccurately reported each month. The inaccuracies grew. Any discrepancy between actual and posted must be discussed and rectified before any month is closed out.

• **Insurance contracts.** Many facilities have so-so insurance contracts. A few have great contracts. But most have lousy little contracts because they are typically created "in house" by those who don't know what they are doing.

Regardless of where you fall in this mix, many are getting shortchanged because what you think you are getting when the case is posted is not what you are getting reimbursed. This is usually your fault. Insurance contracts change all the time. It is a group effort to stay on top of those changes and record it in your billing system. Many do not. When you get reimbursed $2,112 for a procedure when you thought you would receive $2,885, most don't notice the discrepancy.

Every reimbursement for each patient must be checked against what you have contracted. Many don't have the time, desire, or personnel to do that, so most don't. Nevertheless, what you are missing could easily support one new hire to only check for variances.

• **Supply costs.** There is an accepted protocol for the ordering and payment of supplies. One person orders the supplies. Another person confirms the delivery and matches the items on the invoice against what was ordered and the contracted price. A third person approves payment, and the invoice is sent to the fourth person, who cuts the check. Ninety-nine percent of the time, that fourth person rarely examines that invoice before he or she signs the check. Any deviation in this protocol is a set-up to be ripped off, and chances are high that you have been, will be, or currently are.

We all love our vendors, and they are very helpful for most of us, but our local and trusted vendors have several people stacked up behind them on every transaction we make with them. Honest mistakes happen, contracts get messed up, quotas may not be accurate, and backordered items may not have been paid. These issues are not rare; they are everyday occurrences that people are just too busy to investigate further.

Is there a good solution? Probably not, but the one way to deal with all these issues is very simple: profit-sharing. Let everyone pay for these mistakes/oversights, not just the owners. Very quickly, motivated staff will go the extra mile.

If that isn't an option, then use diligence. Let everyone know what must be done and then make sure it is. That will help for a while because tracking the "numbers," like credentialing and accreditation, is an ongoing, daily activity that never ends.

Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Earnhart & Associates can be reached at 5114 Balcones Woods Drive, Suite 307-203, Austin, TX 78759. Phone: (512) 297-7575. Fax: (512) 233-2979. Email: searnhart@earnhart.com Web: www.earnhart.com. ■

SAME-DAY SURGERY

CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.

2. Log on to AHCMedia.com then select My Account to take a post-test. *First-time users must register on the site.*

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After completing the test, a credit letter will be emailed to you instantly.

5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

CE QUESTIONS

1. **A successful quality assurance and performance improvement (QAPI) plan includes:**

   a. data collection.
   b. identifying problems.
   c. creating an improvement plan.
   d. All of the above

2. **One strategy for initiating QAPI projects is to focus on the problem and its potential cause. Surgery centers can do this more effectively by:**

   a. starting with small process problems and following these to learn more about general problems.
   b. asking patients to select the top three problems they see in the surgery center.
   c. drilling down into data and studying comparison details.
   d. None of the above

3. **Which of the following items would not be included in a consent agenda?**

   a. Approval of an increase in the annual budget
   b. Review of a financial statement
   c. Approval of previous board meeting minutes
   d. Approval of administrator reappointments

4. **Succession planning strategies should begin when nursing or other healthcare staffing issues become critical in a surgery center's region.**

   a. True
   b. False

CE OBJECTIVES

After reading *Same-Day Surgery,* the participant will be able to:

- identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care;
- identify how current issues in ambulatory surgery affect clinical and management practices;
- incorporate practical solutions to ambulatory surgery issues and concerns into daily practices.

SDS ACCREDITATION UPDATE

Covering Compliance with TJC, AAAHC, AAAASF, and Medicare Standards

How ASCs Can Avoid OSHA Citations

Satisfy National Fire Protection Association and Life Safety codes

Surgery center staff must conduct research about and work proactively to comply with all federal, state, and local requirements, as well as accreditation standards. If attention to the Life Safety codes is lax, ambulatory surgery centers (ASCs) might experience code problems related to the National Fire Protection Association (NFPA) codes or Occupational Safety and Health Administration (OSHA) regulations.

One of OSHA's common questions when it finds a violation during a survey is, "Did you know about your violation?" The next question is, "Should you have known about your violation?" says **Thomas Salamone**, vice president of the Long Island Healthcare Life Safety Association in Ronkonkoma, NY. The association conducts audits to help organizations prepare for a department of health inspection. "They refer to this as a general duty clause," Salamone says.

To avoid OSHA and other citations, Salamone says ASCs might pay attention to the following 10 areas:

1. Bloodborne pathogens. Common citations are for failure to maintain a written exposure plan, failure to complete an annual review of the written exposure plan, and failure to conduct a safer medical device assessment, Salamone explains.

ASCs should develop — or adapt from other sources — an exposure plan. They can start with a template and customize it for their own facility, Salamone offers.

"I had one facility that used an exposure plan from another facility, and the sad part was they didn't go through the document and change it, so the name of the other surgery center was on their plan, and that became a real nightmare," Salamone recalls. "I said, 'If you use another facility's plan, then retype it or do a word search.'"

"I HAD ONE FACILITY THAT USED AN EXPOSURE PLAN FROM ANOTHER FACILITY, AND THE SAD PART WAS THEY DIDN'T GO THROUGH THE DOCUMENT AND CHANGE IT, SO THE NAME OF THE OTHER SURGERY CENTER WAS ON THEIR PLAN, AND THAT BECAME A REAL NIGHTMARE."

OSHA also might cite ASCs for failure to train employees about handling sharps, blood products, or other infectious material. The training must be competency-based.

"What I usually recommend is to develop a questionnaire of 10 questions with the goal that employees demonstrate a 90% competency level," Salamone says.

The questionnaire, if administered during one-on-one instruction, can include open-ended questions. If it's in a classroom, it could be written and include multiple choice and true-false questions. Other problems might include failure to use needleless devices, improper placement of sharps containers, or maintenance of sharps containers.

"Make sure the sharps containers do not go above the fill line," Salamone warns. "Let's say you have

a surgery center that takes care of children. You want to make sure that container is not within their reach. Some centers put it right by the exam table, and when you turn your back on the child, they might go through it."

2. Hazard communication. Common citations are failure to maintain a written program that outlines the flammables, corrosives, and hazards encountered in the workplace. Other citations include:

- failure to maintain training;
- failure to maintain labeling;
- failure to maintain a safety data sheet.

"In the old days, these were referred to as material data sheets," Salamone says. "Now, these are referred to as safety data sheets to make it more global. They know what safety data sheets are anywhere in the world."

A written exposure program for bloodborne pathogens is an inventory of flammables, corrosives, and hazards. It includes the necessary personal protective equipment.

"You have to notice what the hazardous materials are and have precautions in place," Salamone says.

Labeling problems can occur when someone transfers chemicals from one container to another without labeling the new container.

"There's an exception if you transfer chemicals from one container to another and it doesn't leave your possession," Salamone notes. "But if you don't label it and put it in a room, you don't know who could walk in and use it."

The label must include a NFPA diamond that shows whether the chemical is flammable and corrosive, he adds.

3. Respiratory protection. As with the others, failure to create a written program is a top citation. Others are failure to:

- provide a medical evaluation to determine the employees' ability to use a respirator;
- provide respirators;
- ensure the use of tight-fitting face pieces or fit-testing;
- identify and evaluate respiratory hazards.

"You want to make sure the respirator fits the face," Salamone says. "Make sure it's tight-fitting." All these actions should be performed and then put in writing. "If it's not in writing, then it didn't happen," Salamone adds.

> "NURSES ARE GREAT AT PROVIDING NURSING, BUT THEY DON'T KNOW HOW TO MAKE POPCORN. THERE ARE A LOT OF RECORDS OF FIRES IN MICROWAVES THAT ARE BEING USED FOR POPCORN."

4. Electrical safety. ASC directors can start by checking extension cords and wires. Other common problems involve:

- open junction boxes: "Sometimes you find an electrical box above the ceiling, and the cover is missing," Salamone says.
- unsecured electrical panels: All electrical panels must be secured, labeled, and unobstructed, Salamone stresses.
- improper ground fault circuit interrupters: "If you have an electrical receptacle within six feet of a water source, they must have GFCI," Salamone notes.
- improper electrical receptacles: "Are they properly inspected, tested, and maintained?" Salamone asks. "This is really important because a lot of facilities don't know the code requirement, so they'll have a policy that says, 'I inspect all receptacles once a year.' But how do you prove that? And, two, is it required?"

Consider this an issue for all policies and procedures: If an ASC puts an action in its policy and the action is not in code or required by a regulatory or accreditation organization, then the ASC has increased the requirement, Salamone explains.

"For example, the code says you only need to test and maintain certain receptacles, but if you put in the word 'all,' then you've increased the code," he adds.

"Many of the violations in surgery centers, with respect to the department of health and the feds, are very expensive," Salamone says. "They mainly deal with electrical and fire safety."

One new code concerns the proper electrical protection for wet procedure locations. This means that if ASCs are conducting procedures that cause a wet environment and there's a risk of pooling water in the surgery center, then the centers must use either GFCIs or line isolation monitors.

"The code allows either, but the line isolation monitors are much more reliable," Salamone offers. "GFCIs sometimes fail prematurely, and you don't want that to happen on that table."

Other items that can create safety problems are space heaters and microwaves.

"Nurses are great at providing nursing, but they don't know how to make popcorn," he says. "There are a lot of records of fires in microwaves that are being used for popcorn."

The simplest solution is to ban popcorn from the center's

microwave. This prohibition should be put in writing, preferably on the door of the microwave.

5. Asbestos. ASCs must perform an exposure assessment and identification, depending on the age of the facility. The assessment will identify areas that contain asbestos or the potential for asbestos. Facilities built within the past two decades should not contain asbestos. In facilities built in the middle part of the 20th century, asbestos could exist. There's a problem when asbestos becomes friable, meaning it has been disturbed, Salamone notes.

"OSHA says that if you don't know if it's asbestos or not, you have to assume it is, and you need to have written plans and policies in place for identifying and handling asbestos," he adds.

6. Egress routes. The Life Safety Code calls for facilities to install adequate aisles with a clear width. Also, all exits must be maintained and not locked for exiting. Deadbolts are not allowed.

"Unfortunately, in this world, we lock a lot of exits, but we have to lock them [to keep strangers from entering] and not from coming out of the building," Salamone says. "Make sure you have proper maintenance of the ingress and egress of your facility."

Use the Life Safety Code for compliance, following its rules on keeping exit routes free and unobstructed, Salamone adds.

7. Recordkeeping. Two big deficiencies include failure to comply with OSHA 300A and 301 forms for recording injuries and illnesses and failing to enter information within seven calendar days and posting records when necessary, Salamone says.

"They have to post, by Feb. 1 of every year, their OSHA logs," he says. "They have to be posted in an area where all employees can see them."

Many facilities post these notices by the punch clocks. The logs list how many people were hurt and the number of lost work days.

8. Eye wash stations. In terms of OSHA citations, eye wash stations are hot, becoming the most cited item in recent months, Salamone says.

"UNFORTUNATELY, IN THIS WORLD, WE LOCK A LOT OF EXITS, BUT WE HAVE TO LOCK THEM [TO KEEP STRANGERS FROM ENTERING] AND NOT FROM COMING OUT OF THE BUILDING. MAKE SURE YOU HAVE PROPER MAINTENANCE OF THE INGRESS AND EGRESS OF YOUR FACILITY."

"They're on their way up, being cited so much," he says. "Basically speaking, you have an eye wash station wherever corrosives and caustic chemicals are used. They have to be proper, and eyes have to be plumbed with tepid water."

OSHA requires facilities to make a bottle available for eye washing. It must hold at least six gallons.

"What I find is people put these squeeze bottles in the eye wash stations, and they don't hold six gallons," Salamone explains. "Are they located where they need to be? Are they properly located? Are they high off the floor?"

The stations should be situated so that staff can put their heads in there and flush their eyes with water. There should be 0.4 gallons of water per minute for 15 minutes, which is six gallons total, Salamone says.

"Sometimes when I'm doing an audit, I point out which items are corrosive," he says. "The problem is people often don't know what is corrosive and caustic. The easiest way to find out is to go to the safety data sheet and look at the chemicals."

9. Portable fire extinguishers. To comply with NFPA codes, ASCs must maintain fire extinguishers and store them in proper locations.

"You're supposed to do a monthly visual inspection and then an annual maintenance," Salamone says. "The monthly inspection can be done in house — you just need someone who is knowledgeable about what to look for."

Salamone has trained maintenance staff to perform monthly fire extinguisher inspections. "They need to heft the fire extinguisher, picking it up to see if it feels like it's full," he explains.

10. Automatic sprinkler systems. Proper placement and maintenance is required for NFPA and Life Safety Code compliance.

"The problem is that people are not educated in those codes," Salamone says. "Maybe sprinklers are not located with respect to their area of coverage and location."

Also, the ASC should perform a fire protection audit, studying the number of sprinkler heads per room and how those heads are spaced.

"If rooms are used as office space or an exam room, the sprinkler head spacing would be less than if they were placed in a storage room," Salamone explains. "For light hazard sprinklers, you need 225 square feet; for ordinary hazard sprinklers, you need 130 square-foot spacing." ■

Which Compliance Issues Might ASCs Focus on for 2018?

Emergency preparedness among top issues

Same-Day Surgery asked for more information about compliance and regulations in 2018 in a Q&A with **Gina Throneberry**, RN, MBA, CASC, CNOR, director of education and clinical affairs at the Ambulatory Surgery Center Association (ASCA) in Alexandria, VA. Throneberry also serves as the executive director of the Board of Ambulatory Surgery Certification (BASC).

Throneberry offered the following answers to written questions about what kind of changes ASCs might encounter this year.

SDS: Which regulatory compliance issues should every ASC focus on in 2018? What are some areas of compliance that ASCs find most problematic?

Throneberry: ASCs must make certain they are compliant with all the regulatory requirements that apply to them all the time, but compliance is especially challenging when new regulations and other changes occur. In November 2017, for example, Medicare began enforcing new emergency preparedness requirements. ASCs must review these requirements along with their facility's policies to make sure they comply.

A lot has changed in sterilization and infection prevention recently, as well. ASCs should routinely review Medicare's ASC Infection Control Surveyor Worksheet and make sure they are doing all they can when it comes to following best practices in sterilization, instrument reprocessing, hand hygiene, safe injection practices, and everything else related to preventing infections in their ASC.

In October 2018, licensed healthcare professionals working in ASCs will be able to obtain a certification that will allow them to demonstrate their understanding of the skills and knowledge required to fill the role of an infection preventionist in an ASC. The new certification program, Certified Ambulatory Infection Preventionist (CAIP), will be offered by the BASC and will indicate an individual's commitment to ensuring they are current on proper infection practices in the ASC setting. For more information, go to: www.aboutcaip.org.

> "AS MEDICARE'S ASC QUALITY REPORTING PROGRAM CONTINUES TO EVOLVE, WE CAN EXPECT THAT SOME MEASURES WILL BE ADDED, AND OTHERS WILL BE TAKEN AWAY."

Another area that ASCs must study closely this year is their compliance with the new Life Safety Code requirements Medicare put in place recently. ASCA's annual meeting in Boston, April 11-14, will include an intensive, two-part pre-meeting workshop on this issue, and the main program will include multiple sessions on infection prevention and emergency management.

SDS: What are some strategies for ASCs to avoid future reductions in their Medicare reimbursements?

Throneberry: For Medicare's ASC quality reporting program, facilities must remember that the data for ASC-9, ASC-10, ASC-13, and ASC-14 are reported via QualityNet. To report and access the data for these measures, ASCs must employ an active security administrator. ASC management experts highly recommend employing two active security administrators in case of staff turnover at a facility. To keep their ASC's account active, the active security administrator must remember to log in to the secure portal every 60 days. For ASC-8, ASCs report this data in the CDC's National Healthcare Safety Network (NHSN). Of the 221 facilities that are subject to a 2% reduction in their 2018 payments, 95 of those failed to report their data in NHSN. It is important for the user of the Secure Access Management Services account to log in within a 12-month period, or their account will be deactivated.

SDS: What are some of the future changes that you anticipate might occur?

Throneberry: As Medicare's ASC quality reporting program continues to evolve, we can expect that some measures will be added, and others will be taken away. Two measures that are currently under consideration for addition are Ambulatory Breast Procedure Surgical Site Infection Outcome Measure and Facility-Level Quality Measures of Unplanned Hospital Visits within 7 Days after Selected Ambulatory Surgical Center Procedures (general surgery). Beginning in 2018, ASCs will no longer have to report data on three measures: ASC-5, ASC-6, and ASC-7. ■