

# PROMOTING PATIENT SAFETY

By Kris Ellis

**T**o thrive in today's marketplace, ambulatory surgery centers (ASCs) must excel in many areas, from clinical competence to business efficiency. The foundation on which every aspect of a facility's operations rests, however, is patient safety. Promotion of this vital principle must penetrate every level of the successful ASC.

"It all comes down to the culture of the organization," says Richard Croteau, MD, executive director for patient safety initiatives for the Joint Commission International Center for Patient Safety. "We recognize that different organizations have different cultures, and it's heavily dependent on the leadership and the message that's sent and how patient safety is seen in the context of all of the operations. What we're looking for are organizations in which safety is the primary consideration in everything that's done; it's not seen as someone's job to 'do' patient safety, but rather that's what the organization focuses on in everything it does."

Croteau notes that this effort involves constant vigilance and awareness that adverse events may happen at any time. "Looking for what can go wrong, trying to anticipate it and head it off before it happens, and always looking to protect the patients from the inevitable mistakes that will be made, because people are people; we all make mistakes. It's the culture, it's the attitudes, and it's the behaviors of people that act out on that culture. We've been studying this very closely as we study adverse events that are reported to us, and that continues to come through as kind of the bottom line, the ultimate root cause of all of this, and so we're going to be addressing that in our standards; there will be more in our standards relating to the culture of the organization — how to measure it, how to improve it, what the dif-

ferent attributes of a safe culture are."

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)'s National Patient Safety Goals (NPSGs) are designed to highlight problematic areas in healthcare and describe expert-based solutions to them. "The basic principle behind the Safety Goals — and this goes back to when the concept was first approved by the board of commissioners — is to focus on a relatively small number of topics, with specific requirements, and work with organizations on those topics before moving on to other things, expanding the list and so on," Croteau explains. "The mandate we have is to annually review the National Patient Safety Goals and make recommendations to our board, whether to keep what we have, add to it, move certain things out of the safety goals, perhaps into the standards, and so on. To do that, we have a panel of experts on patient safety, systems engineering, etc.; that's the group that we refer to as the Sentinel Event Advisory Group (SEAG)."

This group meets several times annually to review and prioritize the list of topics and decide what should even be considered in terms of new topics and requirements. Any additions then go up for field review. "We post that information, potential goals and requirements, on our Web site, available to anyone who wants to comment on it," Croteau continues. "What we're looking for, specifically, is information on what the impact would be if a particular

requirement were implemented; whether it's seen as cost effective, what the impact would be, what the burden would be, and how practical it would be for the different types of organizations we accredit. We bring that information back to the advisory group and they formulate their recommendations which then go to our board for their review and modification, if they wish to, and approval."

New NPSGs were added for 2006, some of which presented challenges to some ambulatory organizations. "There's a new requirement under the goal for improving communication that deals with hand-off communications," Croteau says. "That's been a challenge, largely to understand exactly what the expectation is there, particularly in the ambulatory setting. I think it's a little clearer in the inpatient setting, where patients move from one unit to another, from one service to another, and so on. One of the factors that's different for ambulatory as compared to acute care is the time factor; in acute care, the information, the hand-off if you will, has to be done, basically, in real-time. If you're talking about ambulatory surgery, that's similar to the hospital environment, where you're talking about the pre-op team handing off to the OR team, handing off the post-anesthesia unit. There, the information has to be provided literally face-to-face. If it's more protracted, such as from one clinic visit to the next, then there are other options. The one specific requirement we have in terms of the

process itself is that there always has to be an opportunity for the person who's receiving the patient to ask questions and get answers."

In its NPSGs implementation expectations, JCAHO defines the following attributes of effective hand-off communications:<sup>1</sup>

- Hand-offs include up-to-date information regarding the patient's/client's/resident's care, treatment and services, condition, and any recent or anticipated changes
- Interruptions during hand-offs should be limited to minimize the possibility that information be conveyed or would be forgotten
- Hand-offs require a process for verification of the received information, including repeat-back or readback, as appropriate
- The receiver of the hand-off information has an opportunity to review relevant patient/client/resident historical data, which may include previous care, treatment, and services

Croteau also mentions Goal 3D, which involves medication labeling. "It's interesting because that's not a new requirement; that's been in place for a long time, the expectation that medications should be labeled. The problem is that hasn't always been the behavior in procedural settings; people have gotten into

a rather casual habit of pouring medications into open cups or drawing them into syringes but not labeling them. That's dangerous, and we've seen some really tragic events resulting from that, so that was the reason for putting in the safety goals — it's not a new expectation; it's just to put a spotlight on it. That's probably the only thing that makes the safety goals different from the standards, is there's a lot brighter light shining on them to get people's attention."

The implementation expectations surrounding Goal 3D note the following points:<sup>2</sup>

- Labeling occurs when any medication or solution is transferred from the original packaging to another container
- Labels include drug name, strength, amount (if not apparent), expiration date when not used within 24 hours, and expiration time when expiration occurs in less than 24 hours
- Labels can be developed by the facility, or are available commercially; sterile labels can be purchased
- Any medications or solutions found unlabeled should be discarded immediately
- At shift change or break relief, all medications and solutions (and their labels) both on and off the sterile field should be

reviewed by entering and exiting personnel

"There's another goal that wasn't really new for this year because we introduced it last year, but last year the requirement was to plan and develop a process for medication reconciliation," Croteau continues. "This year the expectation is that it will be fully implemented, and that's been a real challenge for organizations, and I assume it's no less a challenge for ambulatory care organizations." Goal 8 focuses on accurately and completely reconciling medications across the continuum of care.<sup>2</sup> This involves implementation of a standardized method for creating an accurate list of medications when patients enter a facility. The medication list should be communicated between service providers within the facility and checked for accuracy.

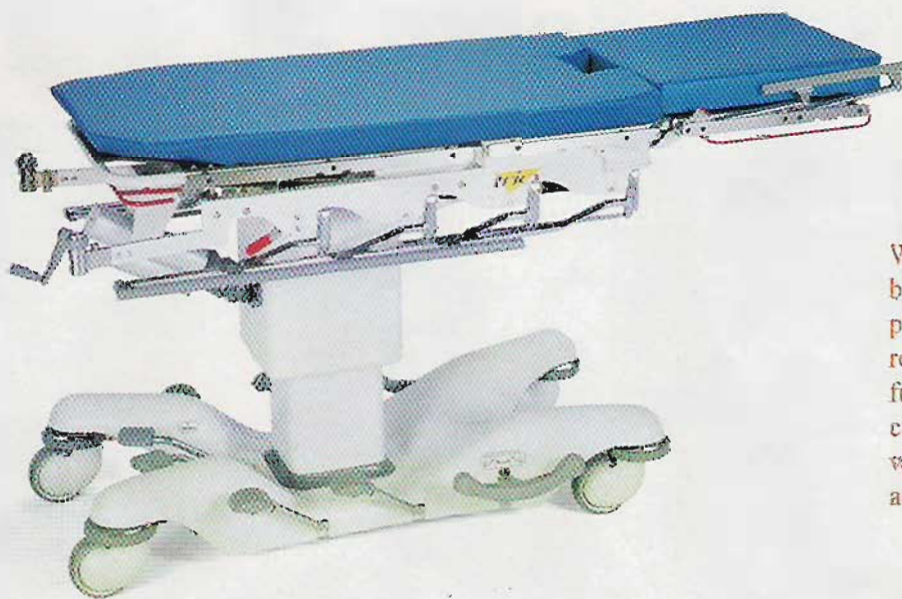
Croteau also cites dangerous abbreviations as an ongoing issue. "We're making gradual headway with that," he says. Goal 2B calls for a list of abbreviations, acronyms, and symbols to be made that are not to be used throughout the facility. The Joint Commission's official "do not use" list specifies potential problems with certain abbreviations as well as suitable alternatives.<sup>3</sup>

In terms of inherent challenges to the ambu-

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latory setting, Croteau cites limited exposure time with the patient. "In the acute care setting, there's certainly a lot more going on, and a lot more complexity, so there are other barriers to getting things done, but at least they will typically have contact with the patient for a period of several days or so. Obviously that's not true in the ambulatory setting. The time factor is certainly a significant barrier."

Croteau stresses that the way in which facilities approach implementation of NPSGs oftentimes determines how successful they will be in doing so. "When you talk about something like medication reconciliation, people who look at that and say, 'Oh boy, here's another Joint Commission requirement that we have to add on to what we're doing,' if they look at it as another add-on, that's going to be a problem. The better way to come into compliance with this is to integrate that into your existing process, not to make it just a separate task and assign it to someone; it's really got to be handled more as a team activity like everything else."

For facilities seeking assistance with NPSGs, JCAHO resources do exist. "If it's a matter of understanding what the requirements are; interpretation or clarification of

the requirements, our Standards Interpretation Group does that — you can contact them by phone or email to get clarification," Croteau points out. "If it's advice on how to implement something in a specific organization, there are a variety of ways that we deal with this through our subsidiary Joint Commission Resources; we have many publications that deal with different aspects of the safety goals, we provide education programs, field education — that means custom education programs for particular organizations or groups of organizations — and Joint Commission Resources provides consultation services as well. These are all things that are available for a fee; the interpretation aspect is free, but the rest of it is buying a publication or getting consultation service. There are plenty of consultants out there; we have one as a subsidiary."

#### Putting Safety into Practice

Peter Pacik, MD, FACS, has owned and operated Manchester, N.H.-based Plastic Surgery Center, which is accredited by the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), for more than 20 years. "We had very different ways of thinking about surgery back

then," he says. "When I bought the building I'm in now in 1985, it was just natural for me to move into the sphere of outpatient surgery. I immediately set it up as Class C so we could do general anesthesia, and I felt that anybody who worked at the surgery center needed to be ACLS (advanced cardiac life support) certified. That was an immediate requirement — any nurse working with me, and myself, needed to be ACLS certified. Since 1985, we've been certified and re-certified every two years; every staff member and every person in the recovery room is ACLS certified and I feel that is a minimum requirement."

If an emergency were to occur, Pacik made sure that his staff would be prepared by setting up drills with the local ambulance services and EMTs (emergency medical technicians), making sure stretchers fit through his facility's doors, and so on. Employing the services of skilled anesthesia providers has also been an important point. "I've used nurse anesthetists for probably at least 10 years," Pacik continues. "For more difficult problems, we'll have an MD anesthesiologist come down, and if I have any concerns at all, the patient is done in the hospital. That's a judgment call I make personally, and we're very strict on what we'll

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do in the surgery center and what we'll do in the hospital."

In his quest to promote safety, Pacik also does everything possible to guard against potential complications. "We are using the intermittent compression with pulsation stockings," he says. "We're doing that on just about all of our cases; any case that's an hour or more, we're using the stockings, and even though most people would say you don't really need them unless you're doing three hours of surgery, my feeling is that they're in bed prior to the surgery, and then they're on the OR table, and then in bed for another three hours. We encourage patients to flex their muscles, we do the intermittent pulsation, and we also walk our patients into the OR, so we actually get them out of bed, and instead of moving them in on a stretcher, we have them walk in, and they all wear compressive stockings, and those go on in the recovery room." Pacik notes that none of his patients have experienced an episode of deep vein thrombosis (DVT).

Planning and attention to patient safety have paid off for Pacik's facility on the rare occasions when problems did arise. "We had two patients who developed dysrhythmias after we injected the local anesthesia," he recalls. "Both of them went into a fairly serious sequence of events where they developed PVCs (premature ventricular contractions) which led to a bigeminy with an extremely low pulse. That becomes a very serious problem, and I hadn't even started doing the surgery yet — this was just from the local anesthesia. We immediately gave them a bolus of lidocaine — here is where we relied on our ACLS — we had the ambulance actually

wait outside until the patient was completely stabilized, and then we transferred the patient to the OR, and one of them actually went directly to open heart surgery." Pacik notes that both patients had been cleared by their physicians, and both of them had normal EKGs (electrocardiograms) prior to surgery, which underscores the need for diligent planning and preparation for such an event.

Preoperative patient history and testing is another cornerstone of safety for Pacik. "We're very thorough about any other medical event that could create an adverse situation in the OR," he explains. "One example that comes to me is a nurse who had a history of very heavy menstrual periods. We started inquiring about any kind of bleeding disorder; she didn't have a bleeding disorder, but her son once had problems with bleeding when his wisdom teeth were taken out. We decided to do some extensive testing on this patient, and it turned out that she had Von Willebrand's Disease. So she was then given vasopressin by the hematologist prior to surgery, and we were very careful with total control of bleeding during surgery. She still bled a little bit afterward, but nothing too serious. This would have been a disaster had we not made the diagnosis before surgery, because it was a breast enlargement. This is the first patient that I ever operated on with Von Willebrand's Disease and she pulled through just fine. I think part of safety is what you do before the operation. You need to spend the time to ask questions and do a careful medical history and make sure that you look under every rock. I think there are a lot of things we could avoid that way."

Although maximum efficiency is a goal for

any ASC, Pacik maintains a constant focus on performing safe and thorough procedures. "When I do surgery, I'm very methodical and I'm never trying to see how fast I can get through it," he says. "I'm never interested in how many cases I can do in a day; we do two, or a maximum of three in the morning, and we keep most patients who have had general anesthesia in the recovery room for three hours, even if they could go home earlier, just to make sure that they're OK. Their caretaker is required to be there at the time of discharge to receive verbal instructions, so both the patient and the caretaker have the verbal instructions, and everything is written down. In addition, since I started the center, every patient gets my home phone number and every patient gets a post-op phone call the evening of surgery, first from my nurse at about 5 p.m., and then from me around 8 p.m. There's total communication.

Pacik continues, "All in all, from the time they're in the office for the consultation, when we're exploring any potential problems, to the time they go home from surgery, including the first week after the surgery, we're in constant communication with the patients." □

#### References

1. Joint Commission 2006 National Patient Safety Goals Implementation Expectations. [http://www.jcaho.org/NR/rdonlyres/DDE15942-8A19-4674-9F3B-C6AE2477072A/0/06\\_NPSG\\_IE.pdf](http://www.jcaho.org/NR/rdonlyres/DDE15942-8A19-4674-9F3B-C6AE2477072A/0/06_NPSG_IE.pdf)
2. <I>Ibid.</I>
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