

Ambulatory Quality & Compliance Insider

The Accreditation and Safety Resource for ASCs

The Needlestick Safety and Prevention Act at the 10-year mark

In November, on the eve of the 10th anniversary of the signing of the Needlestick Safety and Prevention Act (NSPA)—that was November 6, 2000—AQCI's sister publication **Medical Environment Update (MEU)** had the opportunity to conduct a telephone interview with **Karen Daley, PhD, MPH, RN, FAAN**, president of the American Nurses Association (ANA), who played an instrumental role in making needlestick prevention measures the law in U.S. healthcare.

Daley reflected on the significance of the NSPA then and its continuing importance today in protecting healthcare workers from exposures to such life-threatening diseases as hepatitis B, hepatitis C, and HIV. She also offered her opinion on what current healthcare workplace safety concerns might benefit from the same energy and advocacy that resulted in the passage of the NSPA 10 years ago.

Here's what she had to say:

MEU: What are the elements of the NSPA that make it unique among occupational safety and health legislation and of particular importance to nurses?

KD: Requiring employers or healthcare facilities to involve those directly in the delivery of care—in most cases, the nursing staff—for the evaluation and selection of safety devices is the first unique aspect of the law. Data shows—especially the numbers coming from the Massachusetts Department of Health, which requires the recording of all needlestick and sharps injuries—that nurses represent a significant percentage of needlesticks recorded by

occupation. It is appropriate that those who use safety devices the most, and those who are most at

risk to incur injuries, should have the greatest input in evaluating and selecting safety devices for their workplace.

That way, devices that take excessive training can be eliminated in favor of devices which are easier to adapt to. A needle with a safety feature that takes two days to master probably shouldn't pass evaluation. Likewise, safety needles which take two hands to engage are significantly behind with regard to design innovation.

Obviously, it's better to put the purchase decision in the hands of users than the person who fills out the inventory order.

The other unique element of the act was to require evaluations on a continuing basis and make it part of the exposure control plan required by OSHA. It is not that you can evaluate safety devices once and be done with it. The rate of innovation from the first generation of safety devices to the third and even fourth generation is amazing.

"There is much more awareness now about preventing injuries."

—Karen Daley, PhD,
MPH, RN, FAAN

IN THIS ISSUE

p. 4 Planning the eradication of HAIs

A new white paper makes the case for eliminating healthcare-associated infections.

p. 6 Index

Find a list of AQCI articles from 2010.

p. 8 The Joint Commission's most-cited ambulatory standards

The accreditor reveals the top surveyor concerns for the first half of 2010.

HCP Pro

10-year mark

< continued from p. 1

MEU: I understand a needlestick exposure significantly changed your personal and professional life. Would the NSPA have prevented your exposure?

KD: I know there is much more awareness now about preventing injuries than when my injury occurred.

I visit patient care areas where sharps containers are easily accessible and at eye level, which is the correct height for wall-mounted units.

I know there are some settings that lag behind in acceptance—for example, ambulatory settings and home healthcare, in comparison to hospital settings, which

have more resources to devote to preventing needlesticks and sharps injuries. Nurses should not have to settle for a lower degree of protection because of the setting in which they choose to practice. That is one area where we can continue to look for improvement.

MEU: What was it like to practice in the pre-NSPA days? Did you know then that there were measures and technology to prevent such injuries?

KD: I didn't know how much information and technology was available and how little of it was being used. It was a learning process for me. Back then, too many hospitals were using no prevention technology.

At a recent press briefing hosted by the ANA, Jordan Barab, deputy assistant secretary of labor for OSHA, made the point that we have had 10 years of technological innovation in safety devices, and we should not accept first-generation measures when better third- and fourth-generation solutions are available. Those devices shouldn't even be on the market, he said.

In 10 years, devices have become obsolete and less safe relative to newly introduced products, which is why continuous evaluation so important.

MEU: Do you remember where you were and what you were doing when the act became law?

KD: Actually, I was in the Oval Office with President Clinton for the signing. I have one of the pens he used to sign the act into law. I never use it, but I take good care of it.

MEU: What were your feelings at that time?

KD: It's still emotional when I think about it. It was gratifying to know that we—and I'm not just talking about the ANA here, but others such as the healthcare unions, the hospital associations, leadership in the Department of Health and Human Services, and, of course, our congressional supporters—this collection of stakeholders had come together to make it an incredible day.

There were not very many in attendance in the Oval Office, maybe 15–20 people, and I remember President Clinton taking time to speak with each one of us. I knew

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then that his level of commitment was sincere, equal to ours. It wasn't just a routine piece of legislation he was signing, but rather that he was celebrating with us because that legislation was the right thing to do. It was a special day.

MEU: During the advocacy efforts for the NSPA, was there opposition? What were the main points of contention? How valid was it, knowing what you know now?

KD: I can actually sum that up with one word: cost. That was no more unusual then than it would be now. And I appreciated congressional concern about the cost to their constituents.

We spent time explaining how in healthcare especially, concentrating the prevention effort on the front end, no matter how costly it appears, would pay dividends on the back end, and the country would recoup its investment.

The reality was that this legislation was the right thing to do, and it would eventually pay for itself in improved safety and fewer consequences from contaminated needles. Furthermore, we stressed that efforts to improve safety in the healthcare work environment will be appreciated. Nurses notice things like that.

MEU: What issues today concerning occupational health and safety for nurses could use the same advocacy energy, legislation even, as the NSPA?

KD: No question about it, there are two issues right now. The first is safe patient handling—the whole issue of eliminating manual patient lifting. We have outstanding data and the technology available to show, similar to the needlestick act, that the investment will pay off—in some cases as quickly as three to four years. We have the medical evidence and the business model to move on this issue. Nurses know that, and again, nurses will notice and appreciate when employers make efforts to protect them.

The other issue out there—and it has not consistently attracted attention outside of the healthcare profession—is workplace violence prevention.

I've personally known nurses who have been assaulted, and the escalation of incidents is probably the result

of a combination of societal pressures and economic causes that will bring it to a critical stage. It's a concern for all types of healthcare settings, especially emergency departments and psychiatric settings, but also ambulatory settings such as clinics and medical practices.

I hope that soon Congress will be able to listen to both issues and take action. There is also the idea of an infectious disease standard on which OSHA is gathering information and stakeholder input. Clearly the whole issue of infectious diseases and its impact on workers in healthcare is one that I welcome, and we should pay attention to it.

MEU: What could nurses do in the advocacy arena or in daily practice to make sure the goals of the NSPA continue to protect members of the profession today?

KD: Stay involved with the issues so as to take care of your own health so you can provide the best care to your patients. That means using the safety devices that are available, and if they are ineffective, get involved in the evaluation process so you can advocate for newer and more effective replacements. ■

Data for better OSHA compliance

Top 10 medical practice OSHA fines by standard

Of the \$81,822 issued to medical practices in fiscal year (FY) 2010, 76% involved bloodborne pathogens violations.

OSHA standard	FY 2010 fines
1. Bloodborne Pathogens	\$61,852
2. Hazard Communication	\$3,515
3. Vehicle-Mounted Platforms	\$3,500
4. Medical Services and First Aid	\$1,875
5. Maintenance, Safeguards, and Operational Features for Exit Routes	\$1,700
6. Respiratory Protection	\$1,395
7. Portable Fire Extinguishers	\$1,050
8. Asbestos	\$1,000
9. Eye and Face Protection	\$1,000
10. Personal Protective Equipment, general	\$835

Source: OSHA statistics and data Web page (www.osha.gov/oshstats/index.html). Accessed November 3, 2010.

White paper calls for elimination of HAIs

National infection control association experts team up to create a framework for prevention

It may not be the first white paper to call for the elimination of healthcare-associated infections (HAI), but never before have so many national infection prevention organizations teamed up to develop a collaborative approach to eliminating infections from the healthcare environment.

The November issue of *Infection Control and Hospital Epidemiology* featured a white paper entitled “Moving

“There has certainly been a lot of talk at the national level about eliminating infections, and if you were to go back 10 years ago, we never talked about elimination; we talked about reduction.”

—Linda R. Greene, RN, MPS, CIC

Toward Elimination of Healthcare-Associated Infections: A Call to Action.”

The byline included experts from the leading infection prevention associa-

tions, including APIC, the CDC, the Society of Healthcare Epidemiology of America (SHEA), the Infectious Diseases Society of America (IDSA), the Division of Healthcare Quality Promotion, the Pediatric Infectious Diseases Society, the Association of State and Territorial Health Officials, and the Council of State and Territorial Epidemiologists.

It’s the national collaboration that makes this call to action unique, says **Linda R. Greene, RN, MPS, CIC**, APIC board member and director of infection prevention and control at Rochester (NY) General Health System.

“If you look at the white paper and you look at all the organizations that had a part in writing that, it is very collaborative with a great deal of consensus among the experts in infection prevention,” Greene says. “So it’s not just an APIC paper, or it’s not just a CDC or a SHEA paper, but it’s all of these organizations. These are really influential groups that came together as a team and as a group and said, ‘We believe in this, and these are what

we think are the key actions that need to be taken.’ So it’s really a very impressive step forward.”

Experts in the field hope that collaboration catapults infection prevention into the next level, bringing together efforts from staff and leadership.

“Progress towards the elimination of HAIs is real,” Denise Cardo, MD, director of the CDC’s Division of Healthcare Quality Promotion and lead author of the white paper, said in a press release. “Now is the time to build on this momentum and investment made at the federal, state, and local levels. We have the opportunity to expand the successes highlighted at the recent Fifth Decennial International Conference on HAIs to all healthcare settings, including outpatient surgery centers, long-term care facilities, and dialysis clinics.”

The pillars of elimination

In the white paper, the authors explain the four pillars of elimination, which were derived from previous success in preventing HAIs:

► Adherence to evidence-based best practices.

This is something that every infection preventionist (IP) has heard countless times. In this case, the authors point to the recommendations laid out in the CDC’s Healthcare Infection Control Practices Advisory Committee (HICPAC) infection control guidelines, SHEA and IDSA’s “Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals,” and APIC’s Elimination Guides.

“What I will tell you is all three of those are very important,” Greene says. “First of all, the HICPAC guidelines are certainly related to the strength of the evidence; the SHEA compendium gives you advice on what you should do; and finally, the APIC Elimination Guides really are the how-to. It is the nuts and bolts for the infection preventionist. All three of those are certainly very, very important in terms of evidence-based practices, and each one has a different purpose.”

► **Aligning financial incentives.** Financial incentives through CMS reimbursement have already taken effect. Other incentives related to public reporting have also gone into effect on a state-by-state level. Experts call for a streamlined approach that effectively collects data and fairly rewards those facilities that successfully eliminate infections.

“You have to crawl before you can walk,” Greene says. “You need to start with those things that are important. They are high volume, they are high risk, and they have potential for complications. You begin to look at those intensely, because if you focus on everything at once, nothing gets done. Then you begin to look at some of the lessons you have learned, and then you apply those lessons to more and more populations. So I think in terms of public reporting, that’s what we’re doing.”

► **Filling knowledge gaps.** In order to prevent infections, IPs need to have a better understanding of why they occur. This means funding for more studies that discover potential interventions, understanding the epidemiology of infections, developing additional evidence-based practices, and then tracking the real-world outcome of these interventions.

► **Collecting data.** This final pillar is important to track and maintain progress on, especially within infection prevention. Thorough data collection allows

hospitals to easily identify weaknesses in addition to highlighting successes and performance improvement. These data can also provide the public a glimpse of the measures hospitals are taking to eliminate HAIs.

A changing attitude

This paper represents one of the biggest changes in infection prevention in the past decade, says Greene.

“There has certainly been a lot of talk at the national level about eliminating infections, and if you were to go back 10 years ago, we never talked about elimination; we talked about reduction,” she says.

Ten years ago, HAIs were viewed as part of “the cost of doing business.” Now the widespread attitude is that the prevention and elimination of infections is possible and encouraged.

There are ICUs that have eliminated central line-associated bloodstream infections and sustained that rate for long periods of time, something IPs would have never even thought about 10 years ago.

“Will you ever be able to completely eliminate all healthcare-acquired infections so that you never have them? No,” Greene says. “But when you have this mentality of elimination, what you’re basically doing is saying, ‘You know what, if we get one, it’s not just the cost of doing business. We want to look at it intensely, and

> *continued on p. 6*

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White paper

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we want to review the case, and we want to learn from opportunities.’ ”

Collaborating at all levels

There is also a change in attitudes concerning collaboration at the state, local, and facility levels. Although hospitals are constantly in competition with one another, in some cases infection prevention has become a team effort, even between hospital systems. This point is highlighted in the white paper as a major factor of eliminating HAIs.

“Eliminating HAIs requires working as a team,” Cardo said in the release. “Collaboration among groups, including public health officials and providers, healthcare facilities,

legislators, and consumers, is necessary to bring this goal to reality and increase patient safety.”

Going forward, competition needs to take a backseat in favor of establishing the best possible prevention methods.

“We have moved past competition and into collaboration, and one of the things that we have learned is one person cannot do it alone, one organization cannot do it alone, and one group cannot do it alone,” Greene says. “But particularly in infection prevention and healthcare epidemiology it is a major move because we have really realized this is a team sport, if you want to use the word ‘sport.’ It’s all about team, it’s all about collaboration, and it’s all about learning from each other and moving forward in a very cohesive manner.” ■

Ambulatory Quality & Compliance Insider 2010 index

AAAH accreditation

AAAH revises infection control/safety standards. Feb., p. 6.

Facilities and environment

Chemical spill cleanup procedure checklist. March, p. 5.

Dealing with chemical spills. March, p. 5.

Evaluating decontamination procedures prior to sterilization. April, p. 5.

MSDS compliance checklist. Aug., p. 5.

The paper chase of MSDS compliance. Aug., p. 5.

FDA

FDA classifications. July, p. 5.

FDA warning forces alternative equipment sterilization methods. March, p. 1.

SUD reprocessing: Balancing cost savings, patient safety. July, p. 4.

Infection control

Acinetobacter is on the rise in medical facilities. April, p. 3.

Alternative methods to the STERIS System 1. March, p. 3.

CDC updates guidelines on CAUTI prevention. April, p. 7.

Choosing a vendor. July, p. 6.

Conduct at least annual audits of sterilizers. March, p. 2.

The cost associated with better technology. Oct., p. 8.

Establishing healthy competition. June, p. 6.

A growing problem. Sept., p. 8.

Implementing the hierarchy of controls. Feb., p. 4.

Improving hand hygiene compliance rates with marketing, accountability, and incentives. June, p. 5.

iPhone app attempts to streamline hand hygiene tracking. Aug., p. 8.

Isolation precautions with space constraints. May, p. 6.

Legionella tool. Sept., p. 6.

More money devoted to IC surveys for ASCs. March, p. 6.

New campaign focuses on UTI reduction. Oct., p. 7.

New concerns arise with drug-resistant organisms.

April, p. 1.

New Jersey law requires ASCs to report infection rates.

March, p. 8.

New preoperative skin preparations to reduce SSIs.
May, p. 4.

NIOSH reviews potential acid exposures. March, p. 4.

Observer bias may be affecting your hand hygiene rates.
Dec., p. 4.

Oncology clinic prevents H1N1 with aggressive policies.
May, p. 6.

Proving your good faith. Feb., p. 3.

Regulatory focus on sterilization practices. March, p. 6.

Study confirms *C. diff* travels through the air. Sept., p. 7.

Study looks at parenteral nutrition and its effect on
bloodstream infections. Feb., p. 7.

Updated *C. diff* guidelines focus on tracking infections,
diagnosis, treatment, and cleaning. July, p. 7.

Waterborne illnesses can fly under the radar.
Sept., p. 4.

Where do you start? Sept., p. 5.

Medicare

Q&A: CMS infection control requirements, common pitfalls, and best practices for compliance. Dec., p. 8.

OSHA

Be prepared for your next OSHA inspection. Dec., p. 7.

Bookmarking your way to OSHA compliance. Dec., p. 6.

Breaking down the OSHA directive on N95s. Feb., p. 1.

Evaluating the possibility of an OSHA infectious diseases
standard. Aug., p. 1.

Getting physicians trained on Occupational Safety and
Health Administration bloodborne pathogens. Nov., p. 1.

Getting real with OSHA violation data. Oct., p. 1.

OSHA inspection checklist. Dec., p. 7.

The problem of physician training. Nov., p. 3.

Quick look at frequent and expensive Occupational
Safety and Health Administration fines,
July 2009 to June 2010. Oct., p. 4.

Safety officer online resource list. Dec., p. 6.

Quality improvement

Changing the way we interpret Surgical Care Improvement Project measures. Oct., p. 5.

Use a Lean approach to improve efficiency. Jan.,
p. 5.

Staff safety

Choosing safety despite your manufacturers' options.
May, p. 1.

Common P-listed medical wastes. Nov., p. 8.

Determining hazard severity. Sept., p. 3.

Disposing of extra costs in regulated medical waste
contracts. Dec., p. 2.

Disposing of multidose and single-dose vials. Nov., p. 6.

Distinguishing the disgruntled from the dangerous.
July, p. 1.

Doing your own thing, regulated medical waste-wise.
Dec., p. 3.

The dos and don'ts of safety discipline. Jan., p. 3.

The four tiers of selecting safety devices. May, p. 3.

Glove safety is literally in your hands. June, p. 7.

Healthcare worker medical glove checklist. June, p. 8.

How to respond to threatening calls, suspicious packages.
Jan., p. 4.

Looking back in order to look forward. Aug., p. 4.

New pharmaceutical disposal guidelines on the way.
Nov., p. 6.

Risk assessments: The catch-all for hazard analysis.
Sept., p. 1.

Safety discipline: Successfully approaching violators.
Jan., p. 1.

Staying clear of whistleblower infractions. Feb., p. 5.

Study: Universal gloving could be viable alternative for
contact precautions. Aug., p. 6.

Taking the guesswork out of regulated medical waste.
Dec., p. 1.

Vaccination

Implementing mandatory flu shots: Two systems share
their stories. June, p. 1.

The legal and ethical side of mandatory vaccinations.
June, p. 3.

Vaccination in the form of a patch. Nov., p. 4.

When is the patch available? Nov., p. 5. ■

Privileging, medication storage top list of most-cited Joint Commission standards

Surveyor concerns with privileging, medication storage, infection control, and waived testing are among The Joint Commission's top ambulatory standards compliance issues for the first half of 2010.

The list identifies the Joint Commission standards and National Patient Safety Goals and Universal Protocol™ requirements that were most cited by surveyors from January 1, 2010, to June 30, 2010, according to the September *Joint Commission Perspectives*.

The list includes the following:

- HR.02.01.03 (most cited at 48%), which requires ambulatory facilities to grant initial, renewed, and revised clinical privileges to healthcare practitioners
- MM.03.01.01 (25%), requiring safe medication storage
- IC.01.03.01 (23%), which requires facilities to identify the risks for infection
- WT.05.01.01 (23%), requiring facilities to maintain waived testing records
- IC.02.02.01 (22%), which requires facilities to reduce the infection risk associated with medical equipment, devices, and supplies

Other standards on the list cover surgical timeouts, other waived testing issues, medication labeling, and verification of staff qualifications, according to the *Joint Commission Perspectives* article.

List highlights major problems

The Joint Commission's list illustrates problem areas for many ASCs, says **Troy Lair**, president and CEO of The Compliance Doctor, LLC, in Los Angeles.

"The quality of patient care is very problematic, and the list covers the majority of the main problems with ambulatory care," Lair says.

Lack of adequate staff training appears to be the underlying concern behind the issues found by Joint

Commission surveyors, says **Dawn Q. McLane, RN, MSA, CASC, CNOR**, chief development officer at Nikitas Resource Group in Broomfield, CO.

"All centers are struggling with having people trained, and they need to have binders put together on how to properly sterilize and clean the equipment," McLane says.

Lair says he is unsure why these standards continue to be problem areas. He notes that these are basic functions of all surgery centers that staff should be performing properly from the start.

"There needs to be more attention given to detail," Lair says. "Goals should be set every day, and people shouldn't leave until they are done," he says. "Managers need to be more effective."

McLane believes that many ASC staff do not have the time or resources to properly comply with accreditation requirements. ■

Illustration by
David Harbaugh

