***Introducing the AHRQ Ambulatory Surgery Center Survey on Patient Safety Culture***
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## Speakers

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Scott Smith, PhD, Senior Study Director, AHRQ Surveys on Patient Safety Culture, Westat, Rockville, MD (Moderator and Presenter)

Erin Brown, RN, Director of Nursing Services, Digestive Health Clinic and Idaho Endoscopy Center, Boise, ID

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## Presentation

**Scott Smith**

***Smith (opening), Slide 1***
Good afternoon, and welcome to our Webcast entitled, "Introducing the AHRQ Ambulatory Surgery Center Survey on Patient Safety Culture." My name is Scott Smith, and I'll be the moderator for today's Webcast. We're very excited about today's topic and glad to see you share our enthusiasm.

***Smith (opening), Slide 2***
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***Smith (opening), Slide 3***
I want to give you a brief overview of today's speakers on the call. Jim Battles is the Project Officer for the Agency for Healthcare Research and Quality, or AHRQ, Safety Program for Ambulatory Surgery. He joined AHRQ as Senior Service Fellow for Patient Safety in 2000 and serves as Senior Content Specialist in Patient Safety for AHRQ's patient safety initiatives. Dr. Battles is an internationally recognized expert in the area of patient safety and has authored numerous articles and book chapters in the past several years. Today he'll provide a background and overview of the Ambulatory Surgery Center Survey on Patient Safety Culture.

Erin Brown is a Registered Nurse and the Director of Nursing Services for Digestive Health Clinic and Idaho Endoscopy Center in Boise, Idaho. Erin will describe how her center implemented several changes based on their survey results, including assigning recovery nurses to specific rooms in order to improve communication between physicians and staff.

And Terry Tinsley is also a Registered Nurse and Clinical Nurse Manager for Underwood Surgery Center in Orlando, Florida. Terry will describe how her center implemented several changes based on their survey results, including starting quarterly meetings between the medical director and physicians in order to talk about more timely patient safety concerns.

And, as I mentioned earlier, my name is Scott Smith, and I'm a Senior Study Director at Westat, a research firm based here in Rockville, Maryland. I was Lead Analyst and Project Manager for this project.

***Smith (opening), Slide 4***
Before we begin the presentations I'd like to introduce you to our Webcast console. All the components on the console can be resized to fit your entire browser window, moved and minimized into the menu dock at the bottom of the console. If the slides are too small, click on the lower right-hand corner of the slide window and drag your mouse down to make it larger.

We're pleased to offer closed captioning, as well. To access the closed captioning, please click on the icon called Closed Captioning that is at the bottom of your screen view. After you click on the icon, a new window will display the captioning.

I'd also like to remind you that if you experience any technical problems you may click on the question mark button at the bottom of the screen to access the Help Guide. You can also click on the Q&A icon at the bottom of your screen to contact us with your question. Our technical staff will work with you to resolve any issues.

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***Smith (opening), Slide 5***
Now, today's slides are available for download by clicking on the icon at the bottom left of your screen that says Download Slides. This will generate the PDF version of the presentation that you can download and save as desired. We also have additional resources available for you to access under the Resources icon. Here you'll find a link to the Ambulatory Surgery Center Survey on Patient Safety Culture Web site, where you can download the survey, items and composites and the User's Guide. There is also a PDF version of the 2014 Pilot Study Results which we'll be discussing during today's Webcast.

***Battles, Slide 6***
Now that we've reviewed the console I'm going to turn it over to Jim to give a brief background on AHRQ's Ambulatory Surgery Survey on Patient Safety Culture. Jim?

**Jim Battles**

***Battles, Slide 7***
Great. Thank you very much, Scott, and I want to welcome you all to this conference call on our latest edition to AHRQ's family of Patient Safety Culture Surveys. As some of you know, our premier -- can you back that one -- back it up, Scott? -- is our Hospital Survey on Patient Safety Culture. We also have our Nursing Home Patient Safety Culture, the Medical Office Survey Culture and Community Pharmacy. And so you can see if you haven't looked at the others this is available on our Web site.

***Battles, Slide 8***
Next slide. Well, the issue of ambulatory surgery is quite prevalent, as there are more than 5,300 ambulatory surgery centers that service more than 25 million procedures as of 2014, and nearly two-thirds of all surgeries performed are performed in ambulatory surgery centers. So clearly this is an important locus of care for the surgical patients.

***Battles, Slide 9***
Next slide, Scott. Thank you. So the majority of ASCs are single specialties, and they are partially or completely owned by physicians. However, there's a growing tendency among ASCs that are owned or managed by multifacility chains, so this is a growing aspect of the care provided.

***Battles, Slide 10***
And so on average, the preventable patient safety events are low. However, there is a significant variability across outpatient surgery facilities in their rates. And so if you could look at the 30-day venous thromboembolism, it's 0 to 3.4 percent, 30-day admission rates 0 to 7.7. And what's very interesting is the 30-day emergency room visits. This is one of our most telling. But the rates are 0 to 22.8 percent. So there is variability, and there is a need to begin to look at issues around patient safety in ambulatory surgery centers. Next slide.

***Battles, Slide 11***
As part of our overall efforts in patient safety, and as part of the National Action Plan for health-associated injuries, as part of the Department, there was a need to focus on ambulatory surgery. So we developed a four-year project to apply the principles of the Comprehensive Unit-based Safety Program that we had done for other HAIs in the ASC environment. And the goal was to implement a surgical checklist-centered quality improvement intervention to reduce surgical site infections, SSIs, and other major complications related to ambulatory surgery while improving teamwork and communication. So that is the focus of AHRQ's Program for Patient Safety in Ambulatory Surgery.

***Scott, Slide 12***
And as part of that there was a need to develop a safety culture instrument specifically for ambulatory surgery centers. And Scott's now going to tell you all about the development and testing of that center. Scott, back to you.

**Scott Smith**

***Smith, Slide 13***
Thank you, Jim. So before I get into the survey development process and the results, I first want to take a moment to talk about patient safety culture and what it is. Simply put, it's the way things are done. You could think of culture as the personality of a group of people or an organization. It's the beliefs, it's the values and the norms that they share. And so it's not what one person thinks, but rather it's what collectively people in an organization think.

And so based on these shared values, culture can be measured by what is rewarded, supported, expected and accepted in an organization. So we certainly know, for example, if shortcuts are things that are tolerated and accepted that they become essentially the norm. And so that's what we're talking about when we talk about culture. It's not exactly what is espoused in policies or procedures, but really it's what is done.

***Smith, Slide 14***
And so for the development of the AHRQ Ambulatory Surgery Center Survey on Patient Safety Culture, we convened a technical expert panel, and they provided input at various times during the survey development process, and we're really grateful for their contributions. You can see that Centers for Medicare & Medicaid Services, universities and various national organizations are all represented here in the panel.

***Smith, Slide 15***
So now I'll take a moment to discuss our survey development process. First we conducted a literature review on patient safety and medical error to understand what some of the issues are facing Medicare-certified ASCs in particular. And then we interviewed experts, surgeons, anesthesiologists and technicians in order to just better understand the setting. Then we identified key areas of patient safety culture and developed survey items to assess those areas.

And then we pretested those items with physicians and staff, and then we obtained input from the technical expert panel. We then finalized the survey and then piloted it in 59 ASCs, and 1,821 staff completed the survey. So then we took those responses and conducted psychometric analyses, which basically looks at the factor structure of the survey items and how well we measured those patient safety culture areas. We also looked at the reliability of the composites, which pretty much looks at what's the average correlation of these items together. Are we measuring what we intended to measure? And so based off these analyses we dropped items that just didn't perform well.

And then we went back to AHRQ and the technical expert panel again to help us decide how to drop further items to make the survey as lean and as effective as possible. And then we finalized the survey. We developed various toolkit materials, and some of which I'll discuss at the end of this Webcast.

***Smith, Slide 16***
So, the final survey assesses eight composites of patient safety culture with 27 items. You'll see that below those eight there are some single-item measures: near-miss documentation and staff overall rating of patient safety. And then we also had three items that measured communication in the procedure/surgery room, which I'll discuss a little bit later.

As you look at these eight composites you'll notice that many of them are quite similar to other composites across the surveys on patient safety culture in other settings. Now, while these items and these -- while these composites are common across the other surveys, the items within these composites are tailored specifically to the ASC setting.

***Smith, Slide 17***
So, here are some background characteristics on our 59 ASCs. We administered the survey via paper, and the ASCs were spread out across 20 states, and we collected the data between May 2014 and August 2014.

And you'll see here that a quarter of the ASCs were hospital affiliated. And what we mean by hospital affiliated is that the ASC was partially or wholly owned by a hospital or hospital system, and these centers, then, could be either on the hospital campus or off the hospital campus, but they were separate structures from the actual hospital. And you'll see as we go through these slides that we really made a concerted effort to get a diverse sample of ASCs, and we tried to recruit ASCs from different ownership arrangements, different sizes and different geographic regions.

***Smith, Slide 18***
So as we were recruiting the ASCs we also focused on the type of procedures and surgeries that they performed. You can see here that the majority of ASCs performed surgeries and nonsurgical procedures. So an example of a surgery would be an arthroscopic surgery of the knee that would require general anesthesia, and a nonsurgical procedure would be an endoscopy that would require mild sedation.

You can also see that 17 percent of ASCs were considered single specialty or nonsurgical centers. And these are ASCs that specialized in areas such as ophthalmology, dermatology or pain management. And the 7 percent of ASCs that were considered single specialty surgical centers, they focused in one specific type of surgery that typically involved general anesthesia, such as orthopedic surgery or plastic surgery, in some cases.

***Smith, Slide 19***
So the average ASC response rate across the 59 ASCs was 77 percent. You see that we had a range of 50 percent to 100 percent. And then the average number of completed surveys for ASC was 31, and the range was 5 to 90.

***Smith, Slide 20***
Now, in terms of size, we measured size by number of operating or procedure rooms, and we had a good mix of both small and large centers. Forty-three percent, in fact, had three or fewer operating/procedure rooms. You can also see that nine ASCs, or 15 percent, had seven or more. And also noted there is that

the largest proportions of ASCs came from the Pacific region, which included states Alaska, California, Hawaii, Oregon and Washington.

***Smith, Slide 21***
So now we've talked about ASCs, and now we'll go down to the staff position level and talk about who actually responded to the survey. When we developed this survey we developed it for everyone in the ASC, including full- and part-time employees, per diem employees, contract staff members or doctors that worked at least four times a month at the ASC that had also been working at the ASC for at least six months. We felt that was a good time frame where they would have a good idea of how to report on the culture within that center. And our respondents included not just doctors and nurses, as you can see here, but also certified or registered nurse anesthetists, physician assistants, nurse practitioners, technicians, management staff, administrative, clerical and business staff, as well.

***Smith, Slide 22***
So these are the results for the 59 ASCs that participated in the pilot study. You can see that these were particularly high, and you'll notice that we measure culture with a percent positive, or a positive response. And you can find detailed information about how percent positive scores were calculated in the Pilot Study Preliminary Comparative Results document, which is posted on AHRQ's Web site.

When we looked at other surveys on patient safety culture we'll see that often the preliminary results from a pilot study tend to be very positive, but that they actually go down in later years when we have a larger number of facilities participating and submitting data to a comparative database. So, while these are initially high in a larger sense, it's also important to keep that in mind and recognize that one possible reason why these composites are so high initially is that the facilities or centers willing to participate are likely more open to this kind of survey, more interested in patient safety culture, and on the cutting edge of improvement and efficiency.

So, that being said, the most positive composite of patient safety culture was Organizational Learning-Continuous Improvement. And the items within this composite measure the extent to which the facility actively looks for ways to improve patient safety and makes changes to ensure that problems do not occur.

***Smith, Slide 23***
And the area with the most room for improvement was Staffing, Work Pressure and Pace, at 76 percent positive. And this composite is measuring the extent to which staff do not feel rushed, they have enough time to properly prepare for procedures, and there are enough staff to handle the workload.

***Smith, Slide 24***
So now that we've talked about the composites we'll go dig a little deeper and look at the individual items of the survey at the composite level. The composite items that were top performing both came from the Communication About Patient Information composite. You can see, with 96 percent positive, important patient care information is clearly communicated across areas in this facility. The next highest one, at 95 percent positive, within this facility we do a good job communicating information that affects patient care.

***Smith, Slide 25***
The two bottom-performing items were from Staff Training and the Staffing, Work Pressure and Pace composites. You can see that at 72 percent positive staff feel pressured to do tasks that they haven't been trained to do. And then at 58 percent positive staff responded that they felt rushed when taking care of patients.

***Smith, Slide 26***
So at the end of the survey we had an open-ended comment section, and when we got the data we took some time to analyze and code those comments, and we found that many of the comments were in line with areas of the patient safety culture that we were trying to measure in the composites. For example, the comment, "Handoff report between RNs has improved with face-to-face report given," that aligns under the Communication About Patient Information composite. And in that same vein, "Sometimes I feel

some of the doctors are all about how fast you can turn over the OR, or operating room, and I feel pressured if I am not going as fast as they want me to," well, that certainly falls under the Staffing, Work Pressure and Pace composite.

***Smith, Slide 27***
So besides the composites items, we had a single item that measured the overall rating on patient safety. And you can see here that 87 percent respondents, on average, across the pilot sites gave their ASC an overall rating on patient safety of excellent or very good, with just 10 percent good, 2 percent fair and 0 percent poor.

***Smith, Slide 28***
We also had a single item that measured the frequency about near-miss documentation. And a near miss is when something happens that could've harmed the patient but it doesn't, perhaps out of luck or perhaps just because it was an error that wasn't particularly severe. Now, on average across sites, 88 percent of respondents answered that always or most of the time when something happens that could've harmed the patient but does not it was documented in an incident or occurrence report. And you can see that just 8 percent said sometimes, 3 percent said rarely and 1 percent said never.

***Smith, Slide 29***
So now we get to the three items that had to do with communication in the surgery/procedure room. And these are related to AHRQ's efforts that Jim mentioned earlier in the Webcast about implementing a surgical safety checklist in ASCs across the United States. Now, only physicians and staff who were typically in the room during surgeries, procedures or treatments answered these items. So these are only people that are really in the room at the time when these tasks should be or could be taking place. And these items are measured on a frequency scale from never to always.

And so you can see here on average across the pilot ASCs 92 percent of respondents reported that team members had stopped most of the time or always to discuss the overall plan of what was to be done with the patient. And you can see then that only 65 percent reported that just before the start of procedures doctors encouraged all team members most of the time or always to speak up at any time if they had any concerns. And this was the poorest performing item of the three.

And then in the middle, approximately three-quarters of staff said most of the time or always immediately after procedures team members discussed any concerns for patient recovery.

***Smith, Slide 30***
So we looked at the results in terms of ASC characteristics, and we found that hospital-affiliated ASCs were more positive than ASCs not affiliated with hospitals at the Response to Mistakes composite. And this composite measures the extent to which staff are told about patient safety problems, learning rather than blame is emphasized, and staff are treated fairly when they make mistakes.

Another interesting finding was that smaller ASCs with one or two operating or procedure rooms were more positive than ASCs with six or more rooms on both the Response to Mistakes and Staffing, Work Pressure and Pace composites. And this finding is actually common across other patient safety culture surveys. We find that smaller organizations tend to report more positive perceptions of patient safety culture.

***Smith, Slide 31***
So we also looked at the results by staff position, and this was really eye opening. We looked at doctors, physicians and surgeons, excluding anesthesiologists, and found that they were much more positive, particularly about Staffing, Work Pressure and Pace and Staff Training, compared to nurses.

And you can see that for Staffing, Work Pressure and Pace it was a 94 percent positive compared to a 64 percent positive. So that's a clear difference in the way patient safety culture is perceived across the ASCs in the pilot study. And then there was a 20 percent gap for Staff Training. And it should also be noted that this is also a common theme when we look across some of the other Surveys on Patient

Safety Culture. We find that doctors or surgeons tend to be much more positive than other staff, particularly nurses.

***Smith, Slide 32***
So some of the last bit of analysis that we did is we looked at the composites to see how they were correlated with the overall rating on patient safety. We found that they were all significantly related to the single item and found that the strongest correlation between the overall rating on patient safety was with Organizational Learning-Continuous Improvement composite.

***Smith, Slide 33***
So now that we've gone through some of the results I wanted to bring your attention to the toolkit materials that are available on the AHRQ Web site. The final survey is out there, both in English and in Spanish. You can also request the Data Entry and Analysis Tool, which is an Excel file that has various tabs and macros. Now, this tool is very helpful for ASCs that want to administer the survey on paper, because it allows the center to take the respondent-level data and put it into the Excel tool and it will automatically generate charts and statistics of the results, so you don't have to mess with any sort of statistical analysis or any sort of fancy reporting. It gives you actionable, colorful charts that are easily read.

Also out on the AHRQ Web site the Pilot Study Preliminary Comparative Results document, and, again, that provides some more detailed explanations about how calculations for the survey items and composites are done.

And at this time we should note that there is no comparative database for the ASC Survey.

***Brown, Slide 34***
And so now I'm going to hand it over to Erin Brown. Erin?

**Erin Brown**

Thank you, Scott. Welcome, everyone. My name is Erin Brown, and I am the Director of Nursing at Digestive Health Clinic.

***Brown, Slide 35***
And we are a state-of-the-art physician-owned outpatient healthcare facility. We provide comprehensive care for diseases of the digestive system and liver for adult patients, and we perform endoscopic procedures such as EGDs or upper endoscopies and colonoscopies in our Idaho Endoscopy Center, which is a AAAHC-accredited free-standing ambulatory surgery center.

***Brown, Slide 36***
We currently have seven physicians and two nurse practitioners who evaluate and treat patients in our outpatient clinic area, and our physicians practice in our ASC as well as other outpatient and inpatient hospital facilities in the valley.

***Brown, Slide 37***
Our ambulatory surgery center structure consists of four pre-op rooms, four procedure rooms, five recovery rooms and five stepdown stations. For full-time staff we have 11 RNs, one LPN, seven certified medical assistants. We also have three part-time or PRN nurses and one endoscopy manager. And only our physicians practice in our ASC.

***Brown, Slide 38***
Regarding the patient culture survey response rate, we actually had a great response rate of 98 percent. And the process we used to attain such a high rate was that our awesome data quality and systems manager distributed the surveys to providers and staff with an envelope with each of their names on it. When the survey was completed, each person placed their survey into the envelope and sealed the envelope when they turned it in. The manager then marked that name as returned and mailed the sealed

survey in a separate envelope to Westat. Every week the manager sent out an email to the providers and staff as a reminder.

***Brown, Slide 39***
So, regarding our survey results, this slide shows our percent positive scores on four of our patient safety culture composites, ranked from highest to lowest compared to the pilot study site. We looked at the percentages as well as the areas that we could immediately address and improve upon. We then discussed the survey results with our endoscopy staff.

***Brown, Slide 40***
The lower percent positive composite scores that we focused on for improvement in our ASC are presented on this slide, and they are Staff Training; Response to Mistakes; Communication Openness; Staffing, Work Pressure and Pace.

***Brown, Slide 41***
And regarding sharing the results with our staff, we did this in a staff meeting. And in the past there was time for open discussion at the end of our staff meetings, but staff seldom spoke up and expressed concerns. But this survey provided us with anonymous feedback, and we were surprised about some of the results, as they proved to show more open and honest remarks.

Since realizing this, we continually -- we now continually ask staff at meetings for input to improve communication, teamwork and patient care issues to help facilitate staff engagement. And at the end of our staff meetings we also implemented what we call a retrospective review of what went well and what did not during the past month. This open and honest discussion has been very beneficial, and staff have vocalized more with this sort of venue.

Also worth mentioning is that during the survey period our endoscopy center was going through a staff transition. So we attributed some of the lower scores due to being short staffed. We also added a fourth procedure room in the ASC and were in the process of hiring and conducting training for new staff.

So with all this information, we decided to focus on these four areas, because they were our lowest percentages, and they are all pretty interrelated.

***Brown, Slide 42***
The first area we addressed was Communication Openness, and our result was 73 percent positive versus 85 percent for the pilot ASCs. And we looked at the breakdown of the composite to further see what needed improvement. And we found that lack of effective communication was the reoccurring concern expressed by staff.

***Brown, Slide 43***
So based on this information, a change we implemented is that we assigned recovery nurses to specific rooms each day to help improve face-to-face communication with physicians, facilitate continuity of care and validate staff concerns. Previously nurses rotated as needed and were not assigned to specific recovery rooms, but our new flow has a nurse actually assigned to a recovery room. The nurse can then discuss intraop concerns, plan of care and have an open discussion regarding patient issues with the provider. And an example of an intraop concern would be if the recovery nurse has a question regarding the patient's response to sedation, it can be addressed with the physician at this time, thus validating the nurse's concerns.

***Brown, Slide 44***
Our second area of focus was Staffing, Work Pressure and Pace, and our result was 55 percent positive versus 76 percent for pilot ASCs. And again we broke down the composite further and addressed the results with staff individually and in meetings, asking more specifically about their concerns. And staff concerns that came out of the meetings and also in the survey were our staff felt that we do not have enough nursing staff to handle the workload, which definitely made sense due to our staffing transition

during this time. Staff also felt rushed when taking care of patients. And nurses felt there were areas where certified medical assistants could help more but were not yet trained.

***Brown, Slide 45***
Based on this feedback a change we implemented is that we trained our certified medical assistants to remove patient IVs prior to discharge, especially when there is a shortage of nursing staff. And this task is within the CMA's scope of practice. Furthermore, the team dynamic with this change contributes to the overall balance of patient flow and solidifies the importance of patient safety. We also hired additional RNs with the addition of our fourth procedure room.

***Brown, Slide 46***
Our third area of focus was Staff Training, and our result was 79 percent positive versus 78 percent for pilot ASCs.

***Brown, Slide 47***
And our last area of focus was Response to Mistakes, and our result was 78 percent positive versus 82 percent for the pilot ASCs. And the breakdown of the results showed areas for improvement related to Staff Training/Response to Mistakes as a learning opportunity instead of blame, and enhancing communication between staff when patient safety problems occur.

***Brown, Slide 48***
Based on this, the changes we implemented were ongoing staff training to provide additional drills to develop more confidence in performing tasks. Additional drills included more disaster drills, event of patient transfer, and more incapacitated provider drills. In regard to staff training, we covered areas of IV insertion, conscious sedation, scope reprocessing and overall infection control. Training is also reinforced in our monthly company newsletter that is distributed to all staff.

And actually can you go back one slide? Thank you. In regard to Response to Mistakes, we do our best to continue to treat mistakes as learning opportunities, and when mistakes are identified immediate training is done with staff to resolve the mistake. We discuss and implement corrections to prevent the mistake from recurring, and we discuss the changes at staff meetings during our retrospective discussions.

***Brown, Slide 49***
Okay, next slide. Thanks. Our plan going forward is to continue to collaborate with our other departments on workflow improvement, because some changes involve interdepartmental coordination; initiate staff competency evaluations more frequently, as it promotes continual staff training; perform periodic company-wide re-surveys to identify areas where staff have concerns; continue to share survey results, as this promotes effective staff communication; and also to strengthen our Patient Safety Sustainability Plan. And this is an ongoing plan that focuses on patient safety outcomes, integrating multiple patient safety components with quality improvement.

So, in closing, in order to build a culture of safety it is important to remember that progress takes time and the journey never really ends. Thank you.

**Scott Smith**

***Tinsley, Slide 50***
Thank you, Erin. That was a wonderful presentation, and you are correct that, wow, culture and improving healthcare quality really never does end. And you provided some really great examples of how to use the survey to continue on that journey.

Now let's turn it over to Terry Tinsley. Terry?

**Terry Tinsley**

Hello. Thank you very much. I am Terry Tinsley and am Nurse Manager at Underwood Surgery Center, which is in Orlando, Florida.

***Tinsley, Slide 51***
And our center is a physician-owned multispecialty surgery center. The CRC there, that's the doctors' offices downstairs there. There are six physicians that own the facility. And we have the outpatient surgical center on the second floor there.

We perform endoscopy procedures and surgeries associated with their practice involving colon and rectal and orthopedic and plastic procedures, as well. We are also a AAAHC-accredited free-standing ambulatory surgical center.

***Tinsley, Slide 52***
This is our medical staff, our six physician surgeons that treat patients in our center, as well as the orthopedic and plastic surgeons that also practice at our facility. There are a total of 12 doctors that practice here.

And the survey was given to our entire staff of employees.

***Tinsley, Slide 53***
We have nine pre-op and recovery room bays. We have three endo suites and three OR suites. And all of our staff, like I was saying, did take -- including business office -- did take the survey.

***Tinsley, Slide 54***
We have one administrator, and I'm the Nurse Manager, one RN coordinator that does the scheduling. Six of our surgeons are practicing here, and plastic and orthopedic, and full-time RNs, six RNs, one MA, three OR techs. And we have part-time nurses, six RNs and three OR techs.

***Tinsley, Slide 55***
So here we go. Seventy-three percent was our response rate. Twenty-two out of 30 surveys were completed.

***Tinsley, Slides 56-57***
I think at first that I was pretty -- a little bit disappointed because only four out of our 12 doctors did respond to the survey, especially since there was a lot of advertising for the survey, flyers, reminders in staff meetings. And a second survey was given for those who had perhaps maybe lost the survey or misplaced or trashed the survey, hopefully not. So there were lots of opportunities to know about the survey, so I was a little disappointed in that. But we did gain a lot of information still, in spite of that, and very useful information.

So these were our top-performing results. They weren't too bad. But we really wanted to focus on the communication aspect of the results, considering that's very -- so vital in running an outpatient surgical center and the culture of safety that is so important in our center.

***Tinsley, Slide 58***
Okay, so the survey results were shared in the staff meetings, and as well as the board meetings. And it surprised me that the doctors were surprised that the communication and the openness was not as good as they thought it should have been. They didn't feel that as doctors they were the least bit intimidating, as you can imagine. But, so we have encouraged staff to share what improvements that might be made.

***Tinsley, Slide 59***
Excuse me just a second. So what we have decided to do with our communication is, especially during the operation time and the timeout, is to -- we realize that 40 percent of the people didn't feel comfortable in speaking up. So we wanted to find out why and to maybe make it a little bit easier for people to speak

up. And if you don't feel like the doctor is encouraging you to speak up, then that is definitely a problem. And, again, the doctors were surprised that the employees felt kind of intimidated. And it does start with the doctor in the room with a culture of feeling safe to speak up.

***Tinsley, Slide 60***
So what we have done for the next slide is to implement a new surgical procedure checklist. And there's two main things on this that we really wanted to focus on. One was at the beginning of the case to everyone say their name. And even though you've worked with people many, many times, sometimes just opening your mouth and saying something, verbalizing your name and making sure you know everybody in the room, sometimes there's reps in the room or X-ray technicians that we don't know, so even if you know the people for a long time, it just helps to open your mouth and get a good feeling of being able to speak up.

***Tinsley, Slide 61***
And then the next part would be that we were going to focus on is to have the doctor say, "Is there anyone that has any safety issues?" So in order to do that we are working on implementing this new surgical checklist, and we have signs in the rooms that just remind each other to say, "Yes, this is what we really want to focus on," other than the regular pause, which we do very well, and the patient's name, the operation and all those, antibiotics. But the two things we are focusing on is really just learning to speak up, and especially if you have any problems in voicing some concern.

***Tinsley, Slide 62***
It's important that all staff feels a freedom and encouragement to speak up during the procedure. So this was something, again, we really, really want to work on. And I know I sound like a broken record, but when you don't talk and you feel like someone has more authority, then it's really a concern for the patient. So even though most of the time it says our percentage was 74 percent on that. So there's always room for improvement.

***Tinsley, Slide 63***
And another thing we have done which has been wonderful, our medical director has also encouraged us to speak up. And he is like a champion for us, and he has spoken with the other partners in talking with them about being able to have them also say they may feel a little bit intimidated, so what we want to do is have you say this out loud. And the doctors have been doing that, and it really does make for an open and better communication. So he meets with the doctors quarterly to emphasize this point, and so that's something that -- it's a work in progress, but we are doing much better than we have before.

***Tinsley, Slide 64***
So it looks like here our near-miss, 100 percent, I mean, it looks pretty good. And it is good. But there's always room to do better. And we just want to encourage reporting of possible problems as often and as much as possible.

***Tinsley, Slide 65***
Also, you can't ever lose by helping people out, by just giving them a little treat or two. And we've encouraged this. When people have something that they have an idea or they find something that's expired, they have a safety issue that comes across, or they're worried about something, we just -- we thank them for contributing and to make them -- give them a little treat, so candy, movie tickets, candles, chocolate, pick something, and we just want to encourage them to bring it to us and to share their ideas, because it's very important that everyone feels a part of making this a very safe environment for our patients.

***Tinsley, Slide 66***
So what we are going to do is we're going to take the re-survey, re-survey our staff with the survey. And I think that this time just because we've been going through this, I think more people will be willing to take the survey, and maybe even the doctors will, too -- I'm looking forward to that -- and just continue sharing with the staff any problems that we have and just reporting, keeping the doctors informed about how

we're doing and just continue what we're doing and just enjoy the process of taking the survey again. It was a great thing to do, and I would encourage anyone to do it. So thank you so much.

**Scott Smith**

***Smith, Slide 67***
Thank you very much, Terry. That was terrific. It's great to hear about all the ways that you're using the survey to improve the culture in your ASC.

And actually now we're going to move on to the Q&A portion. And, as a reminder, to submit questions just simply click on the Q&A icon at the bottom of your screen and type your question into the Q&A box and select Submit.

And it looks like our first question here is actually for Terry. And the question is around the gift basket that you just mentioned. So how often? Is that working? How is it going?

**Terry Tinsley**
Yes, it's working. Everyone, they enjoy it, to just come pick out something, I mean, if they have an issue, an expired drug and supplies, things like that. It seems to be working. They enjoy it.

**Scott Smith**
That's great to hear. And hopefully other ASCs might be able to try to implement something like that, as well.

It looks like that we got another question here wondering about when I was discussing the structure and identifying ASCs as separate structures from hospitals did I mean the legal structure from a hospital. And the answer is I meant physical structure. So we're thinking about an ASC as its own separate building, completely independent of the hospital. It may be hospital affiliated or partially or wholly owned by the hospital. It may be on a campus. But it is its own separate building, away. And that's what we think of as being an independent, at least culture, of an ASC.

So let's see here. We actually have another question, and this one is for Erin. It looks like, Erin, how did the medical assistants feel about the added responsibility of removing patient IVs?

**Erin Brown**
They actually were excited and eager to learn the skill and take on a new task. They actually really appreciated that. And they still do it by coordinating with the nurse. If the nurse delegates that to them after their assessment, the medical assistants help out with removing the IV. So they actually really enjoy that.

**Scott Smith**
And as a follow-up question, do they do that frequently or just when you're short staffed?

**Erin Brown**
It depends. Sometimes it's when we are short staffed, and sometimes just when that nurse gets behind in a different room, a recovery nurse gets behind in another room she'll go in and talk to the patient, make sure the patient is okay to have the IV removed, and then delegate that to the medical assistant.

**Scott Smith**
Okay. Thank you very much. Our next question is I want to compare my results to similar ASCs. How can I do that? The short answer is go to the pilot study results for the Ambulatory Surgery Center Survey on Patient Safety Culture, and we provide breakouts by multispecialty versus single specialty, not hospital affiliated versus hospital affiliated, breakouts of number of surgery/procedure rooms, and then we also show staff positions. We do that by the composites and the individual items. So I know that some ASCs want to compare particularly to a category that they fit in, and that would be where you'd want to go on the AHRQ Web site.

Let's see. Next question is can you put more than one ASC in the Data Entry and Analysis Tool? What you want to do is do it independently for each ASC. And you can calculate the scores for each of your ASCs. And then if you wanted to, say, as a system know what your overall system score is you could put in all the ASCs at once, and that would give you sort of an aggregate level, and then it would also be able to get the individual ones, as well.

Another question we've gotten, let's see, is I've been noticing the response rates for physicians has been historically low. Has there been any work to understand why this is? Perhaps I'll ask Erin and then Terry if they can discuss how they try to get their physicians to answer the survey and if they'll do anything differently next time they survey their ASCs. Erin?

**Erin Brown**
So, we -- our administrator actually holds weekly meetings with the board, which is all of our physicians. And so he also helped by encouraging them to complete the survey. And then our manager, our data quality and systems manager, is very diligent and persistent and helped with that, as well.

**Scott Smith**
Thank you. And, Terry, you had mentioned that you had a lower response rate.

**Terry Tinsley**
Right. I did, and I'm wondering how I can make it better. And I think I will have the medical director just talk to them a little bit. But I would put them out and they would be laying there when I would leave. So I would hand them to the physicians.

But I hope that they will do better next time as far as being interested. So I think lots of times they're just busy. They're just busy, and that's just something that they -- one thing else they have to do. And if they find out really how important it is they might do that. So we'll be talking to the medical director just to encourage them to fill it out.

**Scott Smith**
I'll also note that as we were going through the pilot study we talked with several sites where they held a physician meeting and just wouldn't let them leave until they filled out the survey and turned it back in. And that was the --

**Terry Tinsley**
That's a good idea.

**Scott Smith**
That was the best way. They just weren't going to leave until they filled it out. So that's a good one.

Here's a question around do you consider the pilot study results to reflect ASCs nationwide. No, we do not. Certainly only 59 ASCs, with more than 5,300 across the U.S., is a very, very small sample of the total Medicare-certified ASCs out there. This was merely just a pilot to refine the Ambulatory Surgery Center Survey on Patient Safety Culture and then make it available for use for all the ASCs. So no, this is not representative, and we hope that more ASCs will start using this survey in their practices.

Let's see. We have a question here for -- oh, so, let's see, Terry, you mentioned you were going to be surveying again in September 2015.

**Terry Tinsley**
Yes.

**Scott Smith**
Erin, when were you guys planning on starting to survey again?

**Erin Brown**
We were thinking probably August for our re-survey.

**Scott Smith**
Okay. And that seems to be a year-over a year survey. And I'll stick with you, Erin, does that seem like a good time for you guys to do this annually?

**Erin Brown**
Yes, August is a good time for that. It's kind of towards the end of the year, but not close enough to, for example, ICD-10 implementation in October. So we'll probably use August going forward.

**Scott Smith**
And Terry, is the annual time frame what your survey -- what your center is looking at adopting?

**Terry Tinsley**
Right. Well, yes. We're thinking about it.

**Scott Smith**
Okay. And here's a question about how long does it take to complete the survey. Erin, why don't you -- how long did it seem like it took for your staff?

**Erin Brown**
Maybe 10 minutes. Not very long, depending on if the staff had extra to say. But it was about 10 to 15 minutes, I would say.

**Scott Smith**
So for ASCs that are sort of on the fence about whether or not to administer the survey, the time to take it--

**Erin Brown**
No, it doesn't seem very long. It's definitely worth it.

**Scott Smith**
Okay. Thank you very much.

And, let's see here, Terry, would you -- what would you do different about your next survey administration coming up in September besides trying to get a higher response rate for doctors? Would you do anything different with the staff?

**Terry Tinsley**
Well, I thought that it was such a -- I thought it was such a fantastic way, because of all the flyers that -- you did a great job getting the word out. We had signs up and we had -- then the ones that didn't respond got another survey. So I thought that was pretty good. So, goodness, I'm kind of at a loss to know what else to do other than just -- but, like I said before, just because we've been talking about it now, maybe they will be more encouraged to do it, because let's see what else we can find out.

**Scott Smith**
And, let's see, following up with that, we seem to have quite a few questions around the survey itself and getting response rates, a question around the business staff, the administrative staff. Did you -- I believe you surveyed those, Terry?

**Terry Tinsley**
Yes.

**Scott Smith**
And you will continue to survey them in the future?

**Terry Tinsley**
Yes.

**Scott Smith**
Okay. And Erin?

**Erin Brown**
Yes, we surveyed business and administrative staff, management.

**Scott Smith**
Okay. And let's see, wow, it looks like we're running short on time here. I think we'll try to get one more question in. Let's see. Did either of you offer any kind of incentive to your staff for completing the survey? And, Terry, I'll start with you.

**Terry Tinsley**
No, not other than just we would get some great information.

**Scott Smith**
And you got a great response rate without having to use an incentive. And Erin?

**Erin Brown**
We basically did the same thing. We're going to get great information from this. And I think just word of mouth, by the staff saying, "Hey, this is a good survey, you should do it," I think that helped, as well.

**Scott Smith**
Okay.

***Smith, Slide 68***
Well, it looks like that we're running out of time here. So if you're interested in receiving email updates about the Patient Safety Culture Surveys, including announcements of future events, visit the AHRQ Web site and select Email Updates from the top navigation bar. You'll be able to sign up for Patient Safety Culture Survey updates by the various survey settings, including hospital, medical office, nursing home, community pharmacy and, the newest member, the Ambulatory Surgery Center Survey.

***Smith, Slide 69***
And once again I'd like to say thank you to our presenters and our audience for coming to this Webcast today and listening in. We really appreciate your support and your interest in improving healthcare quality in ambulatory surgery centers.

Please remember to complete the Webcast evaluation here at this link. It helps us to improve our offerings and plan future events that meet your needs.

We invite you to visit the AHRQ Web site and contact us at any time by email or phone. I know there are still some questions we weren't able to get to, but if you're able to contact us on email we'd be happy to answer those.

Thanks again for joining us, and have a good day.