AAAHC clarifies standards for 2005

Clearer, more defined wording in some standards should help ambulatory surgery centers (ASCs) prepare for surveys with the Accreditation Association for Ambulatory Health Care (AAAHC). The 2005 standards, released in February, took effect March 1.

Highlights were reviewed by Beth Derby, RN, MBA, an AAAHC surveyor and executive vice president of Health Resources International, West Hartford, Conn.

Quality improvement

Chapter 5, which focuses on peer review, quality improvement (QI), and risk management, has been expanded to give more information on what AAAHC expects, Derby notes.

“There are significant changes compared to the older version,” she says. “It is designed to be used as an educational tool by the organization being surveyed. It will serve as a guide and should identify components surveyors are likely to be evaluating.”

The aim is to help facilities see a connection between components of a QI program—having a written description of the QI program; outlining QI goals and objectives; developing a process to identify problems and concerns that need to be addressed; and addressing those through QI activities, such as studies and benchmarking. Also, linkages need to be defined between QI activities, peer review, and risk management.

The chapter suggests the kind of QI activities a facility should engage in and offers ways to identify problems that could be studied, such as complications or hospital transfers, medical-legal issues, results of patient satisfaction surveys, or staff concerns.

For instance, as you develop your facility’s QI plan, you identify a goal to reduce postoperative nausea and vomiting. You decide to monitor this through postoperative phone calls to patients. In the calls, nurses find that 75% of patients having gynecologic laparoscopy say they have nausea after they go home. This also is a source of dissatisfaction on patient satisfaction surveys.

“That would trigger the thought, ‘Maybe we should study this. Our outcome isn’t desirable; let’s look at this in more depth,’” Derby suggests.

You have already taken the first steps in a study—you have identified the problem and outlined the extent of the problem. You then devise actions to help resolve the problem and reevaluate to see if those solutions worked. This might entail working with anesthesia providers to refine the prophylactic antiemetic regimen. You would test those solutions by keeping track of the postdischarge nausea rate for these patients after the new regimen is introduced. If the solution doesn’t work, a new study would begin.

How should benchmarking be used?

AAAHC has also clarified language on benchmarking and its role in QI. The standard says facilities must participate in benchmarking to compare key performance measures with other organizations or with best practices.

“Benchmarking means identifying the bar set by others and asking, ‘How do we compare to them? What is the benchmark we are going to use? What can we do to improve care in our center so we can achieve this threshold?’” Derby notes.
For example, in your study of nausea and vomiting, you find the medical literature reports that the postdischarge rate for nausea in GYN laparoscopy patients is 16% to 60%. You could use this as a source for benchmarking.

**How many QI studies?**

As in the past, the AAAHC standards do not specify the number of QI studies facilities must conduct in a year. There is no magic number, Derby says. Instead surveyors will evaluate the QI program based on the size and scope of the facility.

“If you are a facility doing 6,000 procedures a year with 4 to 6 ORs and 100 physicians on staff, and you have done only 1 QI study, the surveyor might say, ‘I think an organization of this size and diversity must have had more than 1 item they could study,’” she says.

On the other hand, if a facility with 2,000 cases a year, 2 ORs, and a group of 5 physicians did 12 QI studies, the surveyor might wonder about the depth of those studies.

In other words, surveyors will look to see if the scope of the QI program and studies conducted are in proportion to the size and scope of the ASC’s services.

Another way surveyors will evaluate the depth of the QI program, Derby says, is to review committee minutes, clinical records, and other documents. They may spot problems the ASC’s leaders have identified. The surveyors might then ask if these problems have been the subject of a QI study.

**Ensuring safe care**

The revised standards spell out more clearly what surveyors will look for to help ensure patients are receiving safe care.

“There is now more detail in the standards to help organizations know what the surveyors will be looking for,” Derby says.

In Chapter 6, which addresses clinical records and health information, standard 6-G has been broadened to say any abbreviations and dose designations used in the clinical record must be standardized according to a list approved by the organization.

Surveyors have always looked at abbreviations in their review of clinical records, Derby notes, but now this is explicitly stated in the standards.

**Surgical site verification**

Though surgical site verification is not a new requirement, the 2005 standards are more specific about what is expected.

In Chapter 10, for surgical services, standard 10-R says the organization uses a process to identify the procedure being performed and the surgical site, and involves the patient in the process. For the first time, the standard requires the person performing the procedure to mark the site.

There is more detail about how site verification will be conducted. Standard 10-S requires the operating team to verify:

- the patient’s identity
- intended procedure
- correct surgical site
- all equipment used for the procedure, including any implants, is immediately available in the OR.

In addition, the operating surgeon “is personally responsible for ensuring all aspects of this verification have been satisfactorily completed immediately prior to beginning the procedure.”

**Who must be present for discharge?**

AAAHC has revised Chapter 9 for anesthesia services as well as Chapter 10 to clarify what is expected for patient discharge.

“This has been an ongoing discussion across the country,” Derby notes.

In Chapter 9, revised language in 9-L says a physician or dentist must be pres-
ent—not merely immediately available—until a patient’s medical discharge after surgery and anesthesia. In addition, Chapter 9 and 10 both state that personnel qualified in advanced resuscitative techniques must be present until all patients are physically discharged.

In other words, Derby says:

• The physician must be on the premises until the patient has been assessed and determined to be medically ready for discharge.

• In addition, a person who is trained in advanced resuscitation (advanced cardiac life support, or ACLS, for adults and pediatric advanced life support, or PALS, for children) and can initiate resuscitation is present until the last patient leaves the facility. This person does not need be a physician unless required by state law or regulations. In some cases, states have stricter standards than AAAHC. If so, “you always have to meet the higher standard,” Derby says.

**CLIA-waived testing**

Chapter 16, Pathology and Medical Laboratory Services, has been reorganized so facilities can more easily tell which standards they must meet. The chapter has been divided into 2 sections. Section I applies to facilities that meet requirements for waived tests under the Clinical Laboratory Improvement Amendments of 1988, or CLIA. Section II applies to facilities that must be certified under CLIA.

**Alternate power backup**

New language in Chapter 8, Facilities and Environment, clarifies that alternate power must be available in all patient care areas. That includes the OR and recovery areas as well as treatment areas and areas where emergency services are provided. In the past, some might have interpreted the standard to mean they could have battery backup for the OR but didn’t necessarily need backup power for the postanesthesia care unit.

“Alternate power has to be available for all patient care areas,” Derby notes.

In addition, regarding emergency drills, a footnote has been expanded to reinforce that the 4 emergency drills required per year should be appropriate to the organization’s activities and environment. Examples include medical emergencies, surgical fires, hurricanes, tornados, earthquakes, bomb threats, or other emergencies.

The AAAHC 2005 Accreditation Handbook for Ambulatory Health Care is available for $130 at www.aaahc.org or by phoning 847-853-6080.

**Reference**