

Assessment of ACGME Core Competencies Using an Ambulatory Surgery Patient Questionnaire

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Learner audience: Anesthesiology trainees

Needs Assessment: The ACGME Outcome Project, now in phase 3, requires “full integration of the competencies and their assessment with learning and clinical care.” The ACGME asks for use of external measures, such as patient surveys, to “verify resident and program performance levels.” In anesthesia, such feedback can be difficult to obtain, particularly from the ambulatory surgery patients that constitute almost 70% of the surgical population at Beth Israel Deaconess Medical Center. We describe the addition of core competency questions to an existing quality assurance survey.

Curriculum: Residents solicit surveys during their ambulatory and regional anesthesia rotations, with the goal of obtaining a return of at least 15-20 completed surveys. The written survey is given to the patient prior to surgery, includes a stamped, addressed return envelope. The bulk of the survey inquires about the patient’s experience with pain, nausea, and vomiting at 24 and 48 hours after surgery. Although originally designed as a quality assurance instrument, the data obtained from this portion of the survey is valuable as a means of Practice-Based Learning and Improvement, one of the six core competencies. Residents can see how their choice of intra- and post-operative systemic and/or regional analgesia and anti-emetic selection impacts patient symptoms and satisfaction after they leave the hospital. They can then use this information to refine their practice in the future. Additional survey items address the Interpersonal and Communication Skills and Professionalism competencies. For example, the patient is asked “Did your anesthesiologist show interest in your anesthetic concerns and answer your questions well?” and “Did your anesthesiologist explain anesthetic choices, risks and benefits of each in an understandable way?” We also address global professionalism on a 10 point visual analog scale.

Impact: Completed surveys are reviewed with residents during each semi-yearly evaluation. Patterns within the survey answers are sought, and individualized competency goals created. The discussion also assists in educating the resident about the core competencies and related expectations.

MRN _____ Date _____ Attending _____ Resident _____
 PNB _____ LA _____

AMBULATORY SURGERY PATIENT QUESTIONNAIRE
 (Please Circle Your Answers and Mail Using the Stamped Envelope Provided)

Did your anesthesiologist:
 A.) Show interest in your anesthetic concerns and answer your questions well? Yes No
 B.) Treat you with respect? Yes No
 C.) Explain anesthetic choices, risks and benefits of each in an understandable way? Yes No
 D.) Allow you to choose the type of anesthesia, if an option was available? Yes No
 E.) Place your intravenous with minimum discomfort? Yes No

24 Hour Questionnaire
Nausea
 1.) Did you have any nausea during the first 24 hours after surgery? Yes No
 If yes, how many times did you feel sick to your stomach? _____
 On a scale of 0-10, where 0 is no nausea and 10 is the worst imaginable, you had (circle one):
 None 0 1 2 3 4 5 6 7 8 9 10 Worst

2.) Did you take any medicine(s) for the nausea? Yes No
 If yes, what did you take? _____

Vomiting
 3.) Did you vomit/retch during the first 24 hours after surgery? Yes No
 If yes, how many times did you vomit/retch? _____
 On a scale of 0-10, where 0 is no vomiting and 10 is the worst imaginable, you had (circle one):
 None 0 1 2 3 4 5 6 7 8 9 10 Worst

4.) Did you take any medicine for the vomiting/retching? Yes No
 If yes, what did you take? _____

Nausea and Vomiting Management Satisfaction
 5.) How well did you feel your nausea and vomiting was controlled by all the medicines you took during the first 24 hours after surgery. On a scale of 0-10, you were (circle one):
 Not Satisfied 0 1 2 3 4 5 6 7 8 9 10 Satisfied

Pain
 6.) Did you have any pain during the first 24 hours after surgery? Yes No
 If yes, what medicines did you take? _____
 How many pills/tablets? _____
 What strength (dose)? _____

7.) On a scale of 0-10, rate your worst pain during the first 24 hours (circle one):
 None 0 1 2 3 4 5 6 7 8 9 10 Worst

8a.) If you received a peripheral nerve block, at what time and date did it wear off? _____
 8b.) If you had a block, when did you take your first oral pain medication? _____

Pain Management Satisfaction
 9.) On a scale of 0-10, rate your satisfaction with pain management during the first 24 hours after surgery:
 Not Satisfied 0 1 2 3 4 5 6 7 8 9 10 Satisfied

Anesthesia Care Team Professionalism
 10.) On a scale of 0-10, rate the professionalism of your anesthesia care team (circle one):
 Unprofessional 0 1 2 3 4 5 6 7 8 9 10 Professional

Did You Experience Any Of The Following Symptoms After Your Surgery?

Drowsiness	Yes	No
Weakness	Yes	No
Dizziness	Yes	No
Fatigue	Yes	No
Muscle aches	Yes	No
Sore throat	Yes	No
Shivering	Yes	No

OVER

48 Hour Questionnaire
Nausea

1.) Did you have any nausea between 24-48 hours after surgery? Yes No
 If yes, how many times did you feel sick to your stomach? _____
 On a scale of 0-10, where 0 is no nausea and 10 is the worst imaginable, you had (circle one):
 None 0 1 2 3 4 5 6 7 8 9 10 Worst

2.) Did you take any medicine(s) for the nausea? Yes No
 If yes, what did you take? _____

Vomiting
 3.) Did you vomit/retch between 24-48 hours after surgery? Yes No
 If yes, how many times did you vomit/retch? _____
 On a scale of 0-10, where 0 is no vomiting and 10 is the worst imaginable, you had (circle one):
 None 0 1 2 3 4 5 6 7 8 9 10 Worst

4.) Did you take any medicine for the vomiting/retching? Yes No
 If yes, what did you take? _____

Nausea and Vomiting Management Satisfaction
 5.) How well did you feel your nausea and vomiting was controlled by all the medicines you took during the period 24-48 hours after surgery. On a scale of 0-10, you were (circle one):
 Not Satisfied 0 1 2 3 4 5 6 7 8 9 10 Satisfied

Pain
 6.) Did you have any pain between 24-48 hours after surgery? Yes No
 If yes, what medicines did you take? _____
 How many pills/tablets? _____
 What strength (dose)? _____

7.) On a scale of 0-10, rate your worst pain between 24-48 hours (circle one):
 None 0 1 2 3 4 5 6 7 8 9 10 Worst

Pain Management Satisfaction
 8.) On a scale of 0-10, rate your satisfaction with pain management between 24-48 hours after surgery:
 Not Satisfied 0 1 2 3 4 5 6 7 8 9 10 Satisfied

Overall Anesthesia Care Satisfaction
 9.) On a scale of 0-10, rate your overall satisfaction with your anesthesia experience (circle one):
 Not Satisfied 0 1 2 3 4 5 6 7 8 9 10 Satisfied

10.) I would like to have the same anesthesiologist again for a future operation (circle one):
 No 0 1 2 3 4 5 6 7 8 9 10 Yes

11.) I would like to have the same type of anesthesia again for a future operation (circle one):
 No 0 1 2 3 4 5 6 7 8 9 10 Yes

Comments or Suggestions

THANK YOU FOR YOUR COOPERATION