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Strategic succession planning essential to OR economic success

Perioperative nurse leaders anticipate a tsunami of retirements will soon sweep away the wisdom that makes the OR the profitable cost center it is. A 2013 survey found that more than a third (37.8%) of OR nurse leaders plan to retire by 2018 and nearly two-thirds (64.8%) plan to exit their roles by 2022.

“If you don’t have succession planning, you may lose business in the OR,” says Anne Fairchild, MS, BSN, RN, CNOR, an independent perioperative consultant and chief executive officer of Vanguard Enterprises, LLC, in Tulsa, Oklahoma. “The turmoil that comes in the wake of losing your strong leaders can cause surgeons a high level of frustration,” she says. “Surgeons may end up working with staff not familiar with their preferences, which can translate into increased turnover time and fewer cases completed during assigned block time. The frustration can cause surgeons to look for another organization, taking their business with them.”

Replacing a leader is also pricey. “The cost of interim lead-

The three R’s of staff engagement: Relationships, rounding, and recognition

Staff in the OR must be fully engaged each day to ensure they are providing excellent patient care. But finding time to develop that engagement is particularly challenging for OR leaders.

“The OR environment is intense and dynamic, changing minute by minute,” says Amy Bethel, MPA, RN, NE-BC, from UnityPoint Health in Des Moines, Iowa. OR leaders need strategies for staff engagement that fit into their busy schedules and yield results. Two such strategies are employee rounding and recognition, both powerful tools for building relationships and empowering staff.

Why round?

Bethel defines rounding as proactively engaging, listening to,
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Editorial

Education is always high on my list of goals at the start of a new year, and OR Manager’s two annual events are excellent resources for new insights into the care of surgical patients. Both will feature experienced leaders addressing the key issues that affect the management of ORs in hospitals and ambulatory surgery centers alike.

The OR Manager Business Management Conference is coming up February 16-18 in Orlando. To see the agenda and register, visit www.orbusinessmanagementconference.com.

Planning is still under way for the OR Manager Conference, slated for October 7-9 at the Gaylord Opryland in Nashville. With well over 200 proposals to consider and advice from a stellar committee of OR leaders, we’re positioned to offer a comprehensive, cutting-edge program. Here’s a sneak preview:

- Emerging models of patient care, such as protocols for diabetic patients and surgical homes, will be presented. These types of programs reflect the way patient care has expanded beyond the traditional expectations for OR leaders and staff.

- Healthcare reform legislation makes it imperative for providers to be able to analyze data on patient care and outcomes. Attendees will learn new ways to do this at their facilities.
- New leaders are emerging as surgical services directors head toward retirement. Several sessions will help equip new managers with the skills needed to reach the next level.
- Traditional hierarchies are being upended by newer co-management models and shared governance structures. Thought leaders will share their experience and explain how others can adopt these models to enhance collaboration and communication among their staffs.

As always, the program will aim to educate OR leaders about ways to meet their facilities’ regulatory and budgetary requirements, and exhibitor programs will keep attendees up to date on technology designed for maximum efficiency and patient safety.

Of course, no trip to Nashville would be complete without hearing some live music. OR Manager is planning a special evening at the Wild Horse Saloon with a band and line dancing. A conference brochure will be available in the near future, but it’s not too early to register—visit www.ormanagerconference.com for more information.

—Elizabeth Wood
Sessions at the 2015 OR Business Management Conference include:

- Mapping the Perioperative Services Transformation
- Technology and Teamwork to Maximize Efficiency and the Patient Experience in the OR
- Staffing to Demand to Improve On-Time Starts, Case Length, and Turnover Times
- Using Lean for Supply Chain Management
- The Income Statement: The New Leader’s Role in Revenues and Expenses
- There is No OR University
- Delivering High-Quality Health Care for Low Cost: Rethinking the Way We Look at Supplies in the OR

www.ormanager.com/managementconference
FDA, Joint Commission cite safety concerns with power morcellation

Reports about problems associated with power morcellation in gynecologic surgery led to safety warnings in November 2014 by the Food and Drug Administration (FDA) and the Joint Commission.

The FDA on November 24 updated its Safety Communication on the use of laparoscopic power morcellation in hysterectomies and myomectomies. The previous Safety Communication was issued April 17, 2014.

In the update, the FDA says when laparoscopic power morcellation is used for hysterectomy or myomectomy in women with uterine fibroids, it poses a risk of spreading unsuspected cancerous tissue, notably uterine sarcomas.

Based on an analysis of currently available data, the FDA estimates that approximately 1 in 350 women having a hysterectomy or myomectomy is found to have an unsuspected uterine sarcoma. Currently there is no reliable method to predict or test whether a woman with fibroids may have a uterine sarcoma.

The FDA also issued an Immediately in Effect (IIE) guidance that urges manufacturers of power morcellators to include a boxed warning and two contraindications in their product labeling.

The boxed warning states that “uterine tissue may contain unsuspected cancer” and that use of laparoscopic power morcellators may “spread cancer and decrease the long-term survival of patients.” The warning also recommends that healthcare providers share this information with patients when considering using these devices.

The two contraindications advise that:
- Laparoscopic power morcellators are contraindicated for removal of uterine tissue containing suspected fibroids in patients who are peri- or postmenopausal or who are candidates for en bloc tissue removal through the vagina or a mini-laparotomy.
- Laparoscopic power morcellators are contraindicated for gynecologic surgery in which the tissue to be morcellated is known or suspected to contain cancer.

In a November 17 Quick Safety alert, the Joint Commission said its office of quality and patient safety had received a number of patient safety concerns regarding gynecologic surgery and power morcellation.

The Joint Commission notes that healthcare organizations have been quick to recognize the risk of procedures using power morcellation and to provide guidelines to physicians considering the use of power morcellation in a patient’s plan of care.

Included in the alert are seven safety actions healthcare organizations can take to support communication between physicians and patients, ensure safe and effective surgical procedures are performed, and inform patients fully about the benefits and risks of power morcellation.

—Judith M. Mathias, MA, RN

References


Allow staff to serve as interim managers.

Leadership

Succession planning
Continued from page 1

ership while you’re recruiting the right person, onboarding that person, and the 6 months to a year it takes that person to get up to speed can have a significant financial impact on the organization,” Fairchild says.

In addition to cost, the time needed for succession planning may seem daunting. However, it’s time well spent. “It doesn’t have to take a lot of time,” says Fairchild, who suggests setting aside as little as 4 hours per month. “Think of it as time that will provide a huge return on investment.”

Fairchild and several OR leaders share succession planning advice that can be adopted in any facility. The key is to establish a program that meets the organization’s strategic needs.

Get the right talent
“Our program is designed to get the right talent, know our talent, grow our talent, and move our talent,” says Kevin Lutz, DPM, chief operating officer for OhioHealth Grant Medical Center in Columbus. Grant performs more than 20,000 procedures annually in its 30 ORs.

Part of getting the right talent is evaluating the current leadership environment. “Look at whether your leaders are aligned with your organization’s vision and values, and if they’re not, mitigate any damages,” Dr Lutz says.

That may involve what he calls “hitting a hard reset,” where leaders are told (off the record) that they aren’t in alignment and given a day off with pay to consider whether they can commit to the organization’s direction. “If they decide they want to com-

mit, they have to come back with a written action plan,” Dr Lutz says. If not, the leader is asked to leave the organization.

A team that includes both managers and staff should interview candidates for open leadership positions, says Lisa Counts, MBA, BSN, RN, CNOR, administrative nurse manager for OhioHealth.

“You want to gain some insights into their personality and their leadership style. There are different leaders for different times,” she notes.

Managers should consider the leadership potential of those interviewing for open staff positions, she adds. “No one’s game ready to be a director or manager,” she says. Those with leadership potential can be nurtured from the time they join the organization, adding to the talent pool.

Know your talent
Knowing your talent ensures that your organization will have a ready pool of leaders. “You have to think about who will replace me and who will replace that person,” Dr Lutz says.

A common way to analyze talent on an organizational level is the nine-box grid (sidebar). “It’s easy to use,” Fairchild says, adding, “some experts suggest that every employee should be ranked, and although there’s value in that—because it helps you avoid missing someone with potential—I’m not sure how it’s possible to manage the process.” She suggests using the grid twice yearly, with annual review the minimum.

Leaders can also use software programs such as Halogen eSuccession, Peoplefluent.com, PeopleStreme.com, SuccessFactors.com, and TalentQuest.com.

Not everyone will self-identify as having leadership potential. “You have to show them that they can be a great leader,” Dr Lutz says. Counts will say to staff, “You have a lot of great leadership qualities. Are you interested in this?”

Interest is part of the “triangle” that Jayne Byrd, MSN, RN, uses to evaluate staff: performance; potential; and values, interests, and commitments.

“You may have a brilliant potential manager, but they aren’t willing or able to make a greater commitment because of family demands,” says Byrd, vice president, surgical services, at Rex Hospital, Raleigh, North Carolina, part of the UNC Healthcare System. Although it might not be the right time for someone to pursue a leadership role, having the discussion raises awareness and may lead to future management roles as the person’s situation changes.

“It is often difficult for OR managers to thoroughly assess every employee due to time, resources, and other constraints,” says Yvonne Gardner, vice presi-
Leadership

The nine-box talent management tool

The nine-box talent management grid (see below) helps leaders assess the talent and potential of employees related to leadership. Yvonne Gardner, vice president of talent management and organizational effectiveness at Sutter Health in Northern California, says it’s easy for leaders to confuse high performance with high potential. “Some people are truly amazing at their current jobs, but managers should think through whether the individual aspires to be a leader, is engaged with the organization, and has the ability to succeed in a different role,” Gardner notes.

“There may be an employee who is very good at taking care of patients and surgeons, but doesn’t have good interpersonal skills with team members,” says Anne Fairchild, MS, BSN, RN, CNOR, an independent perioperative consultant and chief executive officer of Vanguard Enterprises, LLC, in Tulsa, Oklahoma. “Completing the nine-box grid requires a group effort. Ask your frontline managers to have each direct report complete an assessment form, then set aside a day where the entire perioperative leadership team ranks employees,” she suggests. “Identify missing skills that can be taught—and ones that can’t be taught—to help determine high performers.”

The assessment tool Fairchild recommends is from the website http://www.leadership-tools.com/access-free-tools.html, where you can download PDF versions of tools for free or pay a small fee to obtain copies in Word or Excel.

This talent management tool includes education and special training, key accomplishments in the past 2 years, personal strengths, personal development plan, desired next step leadership roles, number of years within the organization, number of direct reports, community involvement, and relevant work experience.

Gardner says that a common pitfall of the nine-box grid is that “Managers are sometimes hesitant to use the lower boxes. It can be hard to separate performance and potential, which is what the nine-box grid hopes to distinguish.” She recommends managers consider the risk of losing the person, the impact of that loss, and whether there is a successor to the individual.

For another example of a nine-box grid, see page 8.

<table>
<thead>
<tr>
<th>Potential</th>
<th>High</th>
<th>Moderate potential</th>
<th>Low potential</th>
<th>Low</th>
<th>Med</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>High potential Under performer Needs intervention</td>
<td>High potential Valued performer Needs development</td>
<td>Highest potential Outstanding performer Reward/ develop/ promote</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Med</td>
<td>Moderate potential Under performer Needs coaching</td>
<td>Moderate potential Consistent performer Needs opportunities</td>
<td>Moderate potential Strong performer Needs challenges</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>Low potential Under performer Needs counsel/exit</td>
<td>Low potential Moderate performer Needs engagement</td>
<td>Low potential High performer Reward and retain</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Low | Med | High

Performance

Courtesy of Anne Fairchild, MS, BSN, RN, CNOR.
The Nine Box Grid

<table>
<thead>
<tr>
<th>Need Attention</th>
<th>Core Team</th>
<th>High Potential Talent Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EXPERT CONTRIBUTOR</strong></td>
<td><strong>CURRENT STAR</strong></td>
<td><strong>READY NOW</strong></td>
</tr>
<tr>
<td>Deep technical expertise; well placed in current role</td>
<td>Ready to promote in current area ONLY and lateral move in current and other area.</td>
<td>Ready now for promotion in AND outside current area</td>
</tr>
<tr>
<td><strong>SOLID PROFESSIONAL</strong></td>
<td><strong>VERSATILE PROFESSIONAL</strong></td>
<td><strong>FUTURE STAR</strong></td>
</tr>
<tr>
<td>Performing as expected in current role</td>
<td>Broad knowledge, can easily flex and back up others as necessary</td>
<td>Ready to expand role AND lateral move in current and/or other area.</td>
</tr>
<tr>
<td><strong>TALENT RISK</strong></td>
<td><strong>INCONSISTENT PERFORMER</strong></td>
<td><strong>TOO NEW or WRONG ROLE</strong></td>
</tr>
<tr>
<td>Under-performing; likely on a performance improvement plan</td>
<td>Needs direction and follow up</td>
<td>Too new to evaluate or in the wrong role.</td>
</tr>
</tbody>
</table>

**LEADERSHIP POTENTIAL**

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**Grow your talent**
OhioHealth uses an individual development plan (IDP) for personal and professional success to help grow talent.

Employees are asked to consider career objectives and the needs in their personal lives, and to gather materials such as performance evaluations to help identify strengths and weaknesses. After they complete the IDP form, which includes sections for development opportunity, development actions, and three follow-up times, they discuss the form and the next steps with their managers.

Corporate leadership classes at OhioHealth provide opportunities to interact with different levels of management. In addition, the monthly surgery leadership team meeting now includes charge nurses and clinical leaders. Counts says, “It exposes them to discussions about strategy that they weren’t previously exposed to.”

Networking, participating in special projects, and attending conferences provide informal opportunities for growth. More formal leadership programs can be effective, too. A study in the Journal of Nursing Administration reported that 1 year after completing a leadership program in an acute care
hospital, all the participants remained with the organization and 73% had transitioned to a leadership role.

Fairchild recommends mentoring staff and assigning mentors from different levels of the organization.

“If I know that as a perioperative leader I’m going to be retiring within the next 5 years, then I should be looking at employees who might be able to step into my role. If they don’t have what they need, for example, a master’s degree, then I should mentor them in that area.”

She also has found job shadowing to be an effective technique. “It’s a way to mentor someone without a large time investment.”

At Sutter Health, Gardner says those high performers with high leadership potential participate in leadership development programs that are guided by the four E’s:

- Experience (What experience does the individual already have?)
- Exposure (Would it be beneficial to have exposure to other processes or people?)
- Education (What education would support advancement?)
- Exploration (What are the person’s goals?)

“Most people can look at the four E’s and understand what’s needed,” Gardner says. “For example, if a nurse in one of our programs recognized that she has limited formal leadership experience, we would look for opportunities to assign her to lead a unit project.”

Employees with leadership potential at Rex Hospital can move through three education courses: emerging leaders, strategic leaders, and advanced leaders.

“They work collectively on projects with others and have homework as part of the program,” Byrd says.

Those in the advanced leadership course have a mentor, usually a vice president or director, who meets with the employee monthly. Employees progress through the courses on their own time frame. Those who have leadership potential also receive career coaching and assessment.

“We often have multiple candidates for each role, so when someone leaves, we don’t have to advertise outside of the organization,” Byrd says. In 2013, 79% of open leadership positions at Rex Hospital were filled with internal candidates.

Move your talent

“Challenging your talent gives you a stronger bench,” Dr Lutz says. He recommends moving people to positions where they feel uncomfortable.

Several months ago, for example, Counts moved from perioperative operations to strategy and business development, where she is thriving.

It’s important to identify who needs immediate promotion so that the person doesn’t go elsewhere, she says. Of course, that’s not always possible. “Don’t be afraid to lose someone you’ve already lost,” Dr Lutz advises.

Moving staff to a managerial role can be challenging. One strategy is to “try out” a leadership role by serving in an interim position, with the understanding that if it doesn’t work out, the person can return to the staff position.

To attract nurses of the millennial generation to engage in leadership, Counts has rotated the charge nurse position in the OR.

“It allows for that generation to have flexibility with their time and to fill leadership needs,” she says.

An integral part of leadership

Managers and directors must be held accountable for succession planning if it’s going to be successful, Counts says. “They need to have direct accountability; otherwise, your organization won’t be prepared. Leaders have to approach succession planning strategically, the same way you would do the business, the marketing, and the specialty line growth.”

Gardner agrees: “People often make the mistake of seeing succession planning as one more thing to do and as separate from their other responsibilities. But if you put it in the context of what your role as a leader is—to develop and coach people to be successful—it becomes part of what you do as a leader.”

This approach also has the potential to ease the leadership burden. “If you can move people around more easily to fill gaps, I truly believe your leadership of the unit will become easier,” Gardner says.

Cynthia Saver, MS, RN, is president of CLS Development, Inc, Columbia, Maryland, which provides editorial services to healthcare publications.

References


Introducing the New 2015 Loyalty Program

For the first time, a special loyalty rate is available to attendees that register for OR Manager Conference, now through March 17, 2015.

The Loyalty Program recognizes your continued commitment by offering a special price point of a $300 savings for Value Package registrations. This discount is our way of thanking you for remaining loyal to OR Manager Conference for the past 27 years. In its 28th year, the OR Manager Conference brings together seasoned OR managers to lead the conference program and will continue to deliver the executive level programming you turn to us for. The Value Package is our all inclusive pass, granting access to all three days of conference events and exhibit hall access.

Join us October 7-9, 2015 in Nashville, TN by registering with the VIP Code: JANAD.
Staff engagement  
Continued from page 1

communicating with, building relationships with, and supporting your employees. “The number one purpose of rounding is to establish that personal connection with the employee, which creates trust,” she says.

Jane McLeod, MSN, RN, co-founder of Capstone Leadership Solutions, Inc, in Sault Ste Marie, Michigan, agrees: “Any article on how to engage employees will tell you that you need to develop a personal relationship with your staff members so you know what makes them tick and what motivates them at work.”

Rounding can be particularly helpful for communicating with staff who are not very verbal. “You can capture feedback from those individuals who typically fly under that radar,” Bethel says. “Sometimes your most valuable feedback comes from those people who choose, for whatever reason, not to speak up.” For instance, a nurse might feel intimidated by other staff or is by nature reluctant to speak in a group.

And rounding provides an opportunity to reinforce positive behavior through recognition.

Rounding can be categorized into three tiers: executive leaders rounding on employees, leaders at the manager level rounding on employees, and leaders at all levels rounding on patients. This article focuses on establishing a program for leaders to round on employees.

Set expectations
A successful rounding program depends on engaging the entire leadership team. “Otherwise, it will be very difficult to meet your goal,” Bethel says. At UnityPoint, leaders are expected to round on 90% of their employees each quarter. The organization has established a process for rounding so it is done consistently (sidebar). Bethel emphasized that rounding has to be scheduled and purposeful. “Rounding is not management by walking about. People need to know the questions you are going to ask and when you plan to ask them,” she says.

UnityPoint uses the following questions:
• What’s working well?
• Is there an individual, group, or department that I can recognize for doing exceptional work?
• Are there any systems that need improvement?
• Do you have the tools and equipment you need to do your job?

Leaders also add a fifth question, which varies depending on the current environment, for example, asking about a newly implemented electronic health record system.

“Round with heart and purpose, so they know it’s not just a task for you,” McLeod says. “Draw them out.”

Before McLeod rounds, she asks herself, “What am I going to learn about this person that I don’t already know?” Encouraging her staff to share something about themselves has deepened her relationship with them and identified common interests like a love of cooking.

UnityPoint leaders use iRound, an app developed by The Advisory Board Company, a global research, technology, and consulting firm headquartered in Washington, DC, to remind themselves what they spoke about last time with the employee and to capture key points of the conversation. Bethel notes that it’s important to be comfortable with saying, “I don’t know,” and then following up.

Rounding process
Below is a summary of a purposeful rounding process.

1. Let employees know when you will be rounding, and share rounding questions ahead of time. The purpose is to ensure they have what they need to do their jobs well.
2. Start the conversation by making a personal connection with the employee. For example, ask about his or her family.
3. Ask the rounding questions (UnityPoint asks five questions). Drill down to obtain specific information.
4. Record issues on a rounding log.
5. Recognize and reward those who are identified by peers.
6. Establish a standing agenda item to report on rounding outcomes at staff meetings.
7. Post reports in the department.
8. Share the rounding log and report with your manager.
9. Repeat quarterly.

Source: UnityPoint. Used with permission.

Bethel says leaders need to know that not all staff may embrace rounding; some will view it with skepticism. In this case, she says, “The most important thing is to be prepared and make sure your follow-up is meticulous.” Leaders must also be prepared to answer tough questions directly, honestly, and compassionately.

Recognize staff
One of the most powerful benefits of rounding is identifying employees who deserve recognition. “You can get so caught up in the whirlwind of operations that you don’t think to recognize someone unless...”
it’s a ‘wow’ moment,” McLeod says. “It’s easy to overlook the little stuff, but that’s important as well.”

Tools for recognizing staff include thank you notes, annual awards, department celebrations, and direct recognition from colleagues and patients. The key is to be specific.

“If I just say, ‘you were awesome with that patient,’ you feel pretty good but you don’t know what you did well, so you’re not going to go out of your way to repeat that behavior,” McLeod says. However, if the leader gives specifics, such as, “you saw that the patient was anxious about his wife who was sick at home, and you took the time to call her so you could update the patient before he went to surgery,” the feedback reinforces the behavior. “What gets recognized and celebrated gets repeated,” McLeod notes.

The handwritten thank you note is a particularly simple, yet effective, tool (sidebar). “A written thank you note shows the person took time, and it reinforces the desired behavior,” Bethel says. She and McLeod recommend sending notes to the employees’ homes so they can share them with family members. “I’ve had some notes for years that were sent to my home,” Bethel says.

McLeod says leaders sometimes hesitate to send thank you notes because they worry staff won’t believe they are sincere. “You have to do it with heart,” she says. “You have to put your own personality into it.”

She buys thank you notes with funny pictures and in her signature color of orange. “Go crazy with the card itself,” she says. “Inside write the key behavior that you want to recognize and therefore have repeated.”

As with any feedback, Bethel says to be specific in what you write. “Outline the who, what, when, and where.”

McLeod says that some organizations she works with use a recognition toolkit created by its employee experience team. It might include thank you notes, coupons for a discount in the cafeteria, a free movie pass, or a ticket to be entered into a drawing for a small prize.

The toolkits help give leaders ideas for how to recognize employees.

Create a recognition program

Organizations may choose to create a more formal systemwide recognition program, but McLeod cautions that the decision to recognize should not be taken on by a committee. Instead, leaders—and employees—should be empowered to recognize without approval from a higher authority.

These overall programs should be accompanied by a rollout that explains the purpose and parameters. “Be clear that the intention of the program is to give recognition for behaving, performing, and contributing at a higher level and not just for working hard,” McLeod says. Otherwise, staff may simply reward each other for a challenging shift.

It’s also helpful to tie the program to standards and to have a catch phrase. McLeod says Southwest Health Center in Platteville, Wisconsin, uses the phrase “The Drive” to reflect the hospital’s drive on their journey to excellence. Employees who greatly exceed expectations receive a small toy car (called “Driven”) and a coupon to use in the cafeteria. In some organizations, the person is recognized in the hospital newsletter or entered into a monthly drawing.

Costs for such programs are relatively low—as little as $5,000 a year.

Follow-up

Lack of follow-up after rounding will quickly lead to staff disengagement and even resentment, but follow-up of process improvements increases employee satisfaction.

Sample thank you note

Dear Kyle,

I was talking with Cindy today, and she mentioned to me that you led the recent quality changes in the diabetes protocol the OR team has made. She specifically mentioned that you volunteered to rewrite the diabetes policy so that it meets the new guidelines from the American Diabetes Association. Thank you for your leadership in the OR and for the quality care everyone can now give because you cared enough to step up to the plate for your patients and our community.

You are deeply appreciated!

Jane

Courtesy of Jane McLeod, MSN, RN. Used with permission.
“You need to make sure staff understand that you have heard them and that you have taken them seriously,” Bethel says.

Leaders should document the conversations on rounding logs and address common issues. To facilitate this process, UnityPoint uses “stoplight reports.” The report below is communicated back to those in the department and may be shared with the leader’s immediate supervisor. Rounding logs are reviewed monthly with the leader’s supervisor.

At the end of the year, quarterly reports are summarized so leaders can talk about the successes over the year. “Staff sometimes forget that there has been follow-up,” Bethel says. The annual report serves as a reminder.

**Overcome barriers**

The tendency to focus on negative events is one barrier leaders must surmount when building relationships. “We in healthcare tend to look at things negatively because we’re constantly trying to figure out what’s wrong with the patient,” McLeod says.

She suggests leaders take time every day to reflect and write down three good things that happened during the day, so they start looking for positivity, and to set a goal of writing one thank you note a week. “You have to train your brain to think positively.” Once leaders focus on the positive, it’s easier for them to recognize it in others.

McLeod recommends creating an environment where positive feedback significantly outweighs negative, so that it becomes more prevalent in the workplace.

Perhaps the biggest barrier is time. “The most important thing is to have a plan; that’s what will make it successful,” Bethel says. For example, a leader might plan to round from 1 to 3 PM on Fridays. She acknowledges that sometimes plans can go awry in the OR but adds, “People have been successful in doing it.”

Fortunately, the time spent building a strong relationship with staff can, in turn, save leaders time. “When you recognize staff behaving, performing, and contributing at a higher level, you’re empowering them to repeat what they did,” McLeod says. “Leaders will find they have less on their plate because their staff will be coming to them wanting to take on other projects.”

Cynthia Saver, MS, RN, is president of CLS Development, Inc, Columbia, Maryland, which provides editorial services to healthcare publications.

**Stoplight report**

The stoplight report is a way to communicate how the ideas and concerns harvested during employee rounding are addressed. Green-light items have been addressed and are complete. Yellow-light items are in progress. Red-light items are issues or ideas that cannot be done with the reason why. The report should be posted and shared with staff.

*Courtesy of UnityPoint Health. Used with permission.*
The Centers for Medicare & Medicaid Services (CMS) has replaced the term “flash sterilization” with “immediate use steam sterilization” (IUSS) in surgical settings.

The change in terminology, which applies to Medicare-participating hospitals, critical access hospitals, and ambulatory surgical centers that are subject to Conditions of Participation or Conditions of Coverage, also comes with updates for CMS to use when surveying facilities.

In an August 29, 2014, Survey and Certification (S&C) Memorandum (14-44), CMS said the change was recommended by organizations with expertise in infection prevention and instrument sterilization because the term “flash sterilization” is outmoded. CMS noted that practices associated with IUSS have been implicated in surgical site infections and pose an increased risk of complications because of incomplete reprocessing steps. IUSS also entails an increased risk of inadvertent contamination during transfer to the sterile field and damage to the instruments as well as risks related to wet instruments and the potential for burns.

Therefore, CMS says, use of IUSS, even when all steps are performed properly, should be limited to situations in which there is an urgent need and insufficient time to process an instrument by using terminal sterilization. In addition, CMS says, IUSS is not considered an appropriate substitute for maintaining a sufficient inventory of instruments.

The memorandum also reiterates and updates information on nationally recognized infection prevention guidelines and professionally acceptable standards of practice with respect to IUSS, and it supersedes S&C Memorandum 09-55, which was issued September 4, 2009.

More detailed questions
The 2009 memorandum (09-55) was built around ambulatory surgery centers and had only seven questions for surveyors to use to assess the appropriateness of the flash sterilization cycle:

- Is the sterilizer labeled for this cycle by the manufacturer?
- What is the sterilizer manufacturer recommended load for that cycle?
- Is the containment device labeled by its manufacturer for use in that cycle?
- For what load is the containment device recommended by its manufacturer?
- Is the chemical indicator labeled for use in this cycle by its manufacturer?
- If a biological indicator is used, is it labeled for this cycle by its manufacturer?
- If the cycle is used frequently, is it checked regularly with a biological indicator?

The new 2014 memorandum, which includes 17 surveyor questions and subquestions, lays out precisely what surveyors must assess (sidebar). If the answer to any of the questions or subquestions is “no,” or if IUSS is used in a manner that places patients at risk for infection, CMS says a citation is warranted.

Also included in the 2014 memorandum (14-44) are 14 recommendations from a 2011 position paper adopted by the Association for the Advancement of Medical Instrumentation (AAMI), the Association for Professionals in Infection Control and Epidemiology (APIC), AORN, and four other professional organizations. That paper recommends replacing the term “flash” sterilization with IUSS.

“In the memorandum, the recommendations are formed into the surveyor questions, and that becomes the open book test, if you will, for the healthcare facility,” John R. Rosing, MHA, FACHE, vice president and principal, Patton Healthcare Consulting, told OR Manager.

Rosing cautioned that each of the 14 recommendations and 17 questions represents a deal breaker or a limiting factor. “If an organization wants to continue to use the process of IUSS, it will have to satisfactorily meet all of the recommendations and address and answer all of the questions,” he says.

Too many hurdles?
“The level of detail, such as the type of indicator to use and the parameters around exposure time, temperature, and drying time, creates a number of large hurdles for hospitals to jump over,” says Rosing.

In a session on survey preparation at the 2014 OR Manager Conference in Long Beach, California, Jennifer Cowel, MHSA, RN, vice president and principal, Pat-
Sterilization & infection prevention

Survey questions for IUSS

• Is immediate use steam sterilization (IUSS) reserved for immediate use needs when an instrument has been contaminated and there is no sterile replacement available, or for an item that cannot be packaged, sterilized, and stored before use?
• Is there a process in place to ensure IUSS is not used for implants, instruments used on patients with known or suspected Creutzfeldt-Jakob Disease or similar disorders, devices or loads not validated with the specific cycle, and single-use devices?
• Are instruments to undergo IUSS first cleaned and disinfected following the manufacturer’s instructions for use (IFU)?
• Is there evidence that all personnel who perform IUSS:
  — have the necessary time, equipment, supplies, and facilities readily available
  — have been trained and are able to correctly follow the manufacturer’s IFU with respect to each instrument, sterilizer, container, and cleaning supplies
  — have had their competency verified before they undertake IUSS and periodically thereafter?
• Can personnel provide evidence that the sterilizer cycle being used for IUSS is indicated in the device manufacturer’s IFU?
• Are physical monitors documented that cycle parameters are met for each load?
• Is there evidence that the sterilizer is being maintained as required by the IFU?
• Is the rigid sterilization container, packaging, or tray used consistent with how it is labeled by the manufacturer?
• Is the rigid sterilization container consistent with the manufacturer’s recommendations (eg, load weight, configuration of instruments)?
• Are chemical indicators (CIs) used labeled for IUSS by the manufacturer?
• Is a Class 1 CI placed outside each sterilization container/package unless the internal Class 4, 5, or 6 CI used inside each package is visible?
• Is a Class 4, 5, or 6 CI placed in each container?
• If a biological indicator (BI) is used, is it labeled for IUSS by its manufacturer?
• If IUSS must be used on an implantable device, is the load checked with a BI and a Class 5 CI?
• Are all monitoring (physical, chemical, and biological) results evaluated by trained personnel at the conclusion of the IUSS process before the instrument or device is used?
• Are instruments sterilized using IUSS aseptically transported and cooled prior to use?
• Is there evidence that the healthcare provider or supplier is monitoring personnel for adherence to policy and procedures for IUSS?

— Adapted from Centers for Medicare & Medicaid Services’ Change in Terminology and Update of Survey and Certification (S&C) Memorandum 09-55 Regarding Immediate Use Steam Sterilization (IUSS) in Surgical Settings.

Cowell Healthcare Consulting, noted that because of the requirements in the new memorandum, some OR managers are questioning whether they can do IUSS correctly in the OR.

One question that Cowel sees as an easy target for the surveyors to find noncompliance with is: “Are instruments that are sterilized using IUSS aseptically transported and cooled prior to use?” This question comes from the recommendation: “The items are assumed to be wet and hot and need to be transported in a manner to minimize both exogenous contamination and injury to personnel. Sterile heat protective gloves (eg, potholders or towels) may be used to carry the containment device directly to the point of use.”

Cowel asked the attendees, “How many of you sterilize the mitts you use to transport hot instrument containers?” No one raised their hands.

This is the kind of detail surveyors may be looking at, says Cowel. “If they see an unsterile mitt hanging next to the sterilizer, they can score you on it.” This question and recommendation represents a new threshold, and staff will have to use sterile towels if the mitts aren’t sterile, she says.

Moving IUSS to SPD

Because of the prohibitive thresholds ORs must meet, some are suggesting IUSS should be done in the sterile processing department (SPD), notes Rosing. This might be especially beneficial in

Continued on page 17
Protective eyewear is supposed to prevent infectious materials from reaching the eyes of OR staff, but recent research has revealed a link between reusable protective eyewear and an increased risk of cross contamination and infection.

“We found that the protective eyewear itself can be a causal factor in ongoing contamination,” Victor Lange, MS, MSPH, ICP, CRC, CRA, told OR Manager. “If staff are reusing eyewear between cases and not properly disinfecting them, the remaining bioburden can pose an infection risk to workers and patients.”

Lange, director of infection prevention and control/quality and risk management, Promise Hospital of San Diego, has a background in research on improving outcomes related to occupational and patient infections.

Not able to find existing clinical literature on eyewear contamination, Lange investigated eyewear use by OR staff and whether reusing eyewear poses a unique risk.

“We know infectious pathogens can be introduced into the eyes either directly via splashes or droplets, or from touching the eyes with contaminated fingers or other objects,” says Lange. “What we found in the study is that many sprays and splashes can happen without OR staff members knowing it.”

They may not feel liquid splashing them in the face, but there still can be an aerosolized mist or even a particulate matter that can be introduced into their eyes or onto eyewear, he says.

Contamination
Lange collected 315 pieces of protective eyewear (276 disposable and 39 reusable) worn by OR staff during 71 surgical cases. The cases occurred in four ORs over a 30-day period.

Using sterile technique, he cultured all surfaces of both disposable and reusable eyewear at the end of each case, and he cultured all reusable eyewear again after disinfection. Germicidal wipes were used to disinfect the eyewear.

Nearly half of all eyewear tested cultured positive for contamination post use.

A total of 37.7% of the disposable eyewear and 94.9% of the reusable eyewear cultured positive for contamination post use. In many cases, contaminants were found on eyewear even though staff members were unaware of being splashed or sprayed.

After disinfection, 74.4% of the reusable eyewear remained contaminated with pathogens known to cause hospital-acquired infections (sidebar).

These included:
• coagulase-negative Staphylococcus (43.9%)
• Gram-positive cocci (36.1%)
• Bacillus (10.6%)
• diphtheroids (5.6%)
• Micrococcus (3.5%).

Were staff to reuse the eyewear, as they often do, unaware of contamination, they risk increased exposure. For curiosity’s sake, Lange says he also disinfected and recultured some of the disposable eyewear because some facilities may reuse disposable eyewear between cases for cost savings. Of the 25 pieces he recultured, 96.4% remained contaminated. Disposable eyewear

Staff should use disposable eyewear.

Source: Victor Lange, MS, MSPH, ICP, CRC, CRA, director of infection prevention and control/quality and risk management, Promise Hospital of San Diego. Used with permission.
is not intended for reuse, and the reculture proved contamination also remained behind.

**Disinfection**

Because of the design features of protective eyewear, it is difficult to eliminate all contaminants, says Lange. This increases the likelihood of OR staff not only transferring those contaminants to subsequent patients, but also contaminating their own eyes as a result of touching their eyewear and then rubbing their eyes.

For proper disinfection, protective eyewear would have to be immersed in a disinfectant bath for a certain amount of time and allowed to dry. However, the time it would take to do this would be prohibitive, he says.

**Protection**

Lange recommends that OR staff wear disposable protective eyewear for all cases, not just cases where splashes and sprays are anticipated, and dispose of the eyewear at the end of each case.

Any reusable eyewear would have to be designed in such a way that it cannot harbor contaminants, he says, such as a single molded piece of plastic or other material. Anything else increases infection risk for staff and patients.

—Judith M. Mathias, MA, RN

**References**


**IUSS**

Continued from page 15

newer ORs that are built without substerile rooms and have mini SPDs next to the OR.

For example, he says, the second recommendation in the memorandum states: “The same multistep process used to prepare the instrument for terminal sterilization must be completed for IUSS. Cleaning must be performed in an area that has all of the equipment (eg, sinks and mechanical and/or ultrasonic washers), cleaning agents, tools (eg, brushes), water quality, and availability of information needed to follow the medical device manufacturer’s IFU [instructions for use] regarding both cleaning and IUSS.”

The corresponding surveyor question asks: “Are instrument(s) to undergo IUSS first cleaned and disinfected following the manufacturer’s IFU?”

“This recommendation and question present multiple hurdles for performing the steps for IUSS in the OR, he says.

“Newly constructed OR suites don’t have substerile rooms, so there is no sink suitable for doing the decontamination and cleaning. Old ORs have a substerile room, but AORN has said for years that decontamination and cleaning of instruments should not be done in substerile room sinks because there is too great a risk of something flying through the air and contaminating surfaces.”

To do this step properly, it should be done in the decontamination area of the SPD, he says.

“When it comes right down to it,” says Rosing, “the only thing you should really use IUSS for is an instrument you’ve dropped on the floor, and you absolutely need it immediately. For every-thing else, regulations are making it too prohibitive to do IUSS in the OR.”

—Judith M. Mathias, MA, RN

**References**


Patient Safety in the OR will address:

- procedures for managing the alarms identified following steps are required as of January 1, 2016:
  - ‘Operation Zero’ targets surgical site infections
  - The Joint Commission, ECRI Institute, and American Society for PeriAnesthesia Nurses' extended hours
  - The Joint Commission targets fatigue from clinician fatigue
  - Joint project targets prevention for colorectal surgery
  - Curbing OR traffic: Finding ways to minimize the flow of personnel
  - Have you taken steps to avoid the abuse of IUS?
  - Top 10 Actions You Can Take Now: 10 things you can do now to improve alarm conditions in your health care organization
  - How can you assess who needs to hear them and why? How can you have clinically actionable alarm signals and why?
  - Fast action, team coordination critical when surgical fires occur

Joint project targets prevention for colorectal surgery and unnecessary alarm signals.

Too many leads-off alarm signals could be a result of inadequate skin preps and lack of preoperative and postoperative best practices, and more.

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Children’s Hospital of Los Angeles (CHLA) is renowned for patient care, but by early 2013 the increased complexity of new technology and other factors had eroded efficiency. Orthopedics had fallen to the bottom quartile compared to national benchmarks for turnover times, and executive leadership called for change.

Within orthopedic surgery, spinal fusion procedures were identified as the culprits dragging down turnover times. “These are large and complex surgical procedures, with a lot involved in terms of equipment and instrumentation. So we started with that,” explains Dawna Willsey, MSN, RN, CNOR, OR manager.

One aim was to enable one of the orthopedic surgeons to perform two spinal fusion procedures on most days, rather than just one. “We recognized that if we could improve the flow, we could improve turnover rates as well as our ability to more efficiently utilize his block of time,” Willsey told OR Manager.

The hospital assembled a multidisciplinary team to address problems using Lean principles and techniques. In the process, they gained an appreciation of the complexity that goes into turnover times, according to senior project manager Wendy Lin, MPH.

“So much went into turnover. The process is kind of like peeling back an onion. We started from the beginning and really looked from end to end at all the factors that could contribute,” Lin says.

**Identifying waste**

With the full support of executive leadership, a team led by Lin was organized in July 2013 comprising Willsey, the orthopedic surgeon, anesthesiologist, individuals from surgical admitting, the preoperative area, sterile processing, the postanesthesia care unit (PACU), ICU, the admitting floor, circulating nurses, surgical technicians, and patient care service aides. “We had a great interdisciplinary team that worked on this,” Willsey says.

The team followed four patients from the time they arrived for surgery until the room was turned over, taking notes and recording their observations about potential time-wasting factors.

Based on the information they gathered, Lin drew up current-state maps for surgical admitting, the preoperative area, room setup, anesthesia, positioning/prep, surgery, PACU, and turnover.

For each of those phases, the maps denoted each event in which the patient was engaged (such as “patient receives lab draw” during admitting, and “patient receives Emla for IV” during preop), the duration of each event (“value-added time”) and, for admitting and preop, the duration in between each of the events (“non-value-added time”).

Team members’ observations were added to the maps above the time charts in yellow star shapes known as “Kaizen bursts.”

The surgical admitting map showed that the time spent for the four cases ranged from 20 minutes to 121 minutes, with an average time of 68 minutes. Nearly half of that time was “non value added,” during which the patient waited until the OR team was ready for the next step.

“People tend to know their own areas, but when you follow the patient through [the operative process], you get the patient’s perspective, which is what Lean is all about: your customer’s time and value,” Lin says. “There were so many waits in between. You have to think, ‘Would the patient want to pay for this?’”

Taken together, the current-state maps highlighted the following problem areas:

- Redundant preoperative processes resulted in increased patient wait times.
- Inconsistent patient preparation and room and case readiness resulted in decreased on-time starts.
- Cleaning processes for room turnover were disorganized.
- There was a large volume of unused instruments.

“The issue we were trying to solve was the turnover time. But when we mapped out the process, we identified some other issues that we needed to look into,” Willsey notes.

**Standardizing work**

The current-state maps were placed on a large wall poster so that the entire team could discuss them during a 3-day Kaizen event. “That’s how we do it at Children’s. We’re very collaborative. We looked at the map and asked, what can we do to fix this?” Willsey says.

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“We got everyone in a room together and looked at everything from a systems perspective, rather than finger-pointing. We talked about how to build standard workflow and how to get rid of some of the waste,” Lin explains. The team came up with a list of what to tackle right away and what to accomplish within the next 30 days.

Some changes were easy, such as updating surgical preference cards, adding hooks to hang lead x-ray gowns near anesthesia staff to shorten the distance to reach the gown tree, and writing a standard operating procedure (SOP) to ensure that an oxygen tank always comes with the bed to transport the patient upstairs to the patient care unit after surgery.

For the systemic process changes, they drafted future-state maps—visuals of how the flow should go—for evening or staff case prep, surgical admitting, preoperative, intraoperative, and room turnover. Within those areas, they created a total of 14 SOPs defining each staff person’s tasks. Systemic changes included:

- Moving the lab draws, assessments, and IV starts from surgical admitting to preoperative in an effort to decrease patient wait time, needle sticks, and redundancies in documentation.
- Coordination of clinician “interviews” with the patient to avoid repetition and save time.
- Creation of visual checklists for room readiness and case setup, which helped decrease the rush to get missing items into the room and avoid delays.
- Establishment of a standard workflow for the entire process from room setup to turnover to instrument cleaning, in an effort to reduce delays, inconsistency, and repetition of steps.

Time goals were set for each step, and the processes made more sequential.

In one major time-saving change, the point at which the patient is asked to undress was moved from admitting to the preoperative area. Most spinal fusion patients are adolescents who aren’t eager to disrobe, Willsey points out. “We were asking them to change downstairs in another department and travel upstairs to preop. It’s not reasonable to ask them to do that.”

Indeed, the teens would often don two robes or keep their underwear on, which sometimes wasn’t noticed until they were in the OR. Now patients keep their clothes on until they’re upstairs, and they are put on a gurney with a gown, a patient belongings bag, and a blanket.

Another major undertaking involved opening up and thinning out all the surgical trays. The surgical technician led this effort in an effort to decrease patient wait time, needle sticks, and redundancies in documentation.

Behavior change is the hardest part of Lean.

Saving time and money
Audits were conducted at baseline and at 30, 60, and 90 days postintervention. At 60 days, total surgical admitting and preoperative time had dropped from 150 minutes to 112 minutes, with admitting time reduced from 68 minutes to less than 2 minutes. Average turnover time was reduced from 63 minutes at baseline to 54.5 minutes at 90 days, and first case on-time starts improved from 71% at baseline to 86% at 90 days.

Lin says at 4 months the new habits appeared to have stuck. “After 120 days, if you’re still doing it, the behavior is pretty much changed. Behavior change is the hardest part of Lean. The tools are pretty straightforward.”

Because most spinal fusion cases are scheduled during the summer when kids are out of school, the team is now auditing to see how often the surgeon who participated in the project is able to perform two procedures a day. The team is also working on expanding this project to the rest of the orthopedic ORs and to other ORs in the hospital.

Miriam E. Tucker is a medical writer based in Bethesda, Maryland.

Reference
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Performance improvement

Getting all OR staff to buy into debriefing process boosts efficacy

The main distinction between good and bad debriefings comes down to the level of staff engagement. That’s what the surgical team at the University of Colorado Hospital, Aurora, learned during a project designed to improve the quality of the 30- to 60-second conversations held after surgery.

“In a good debriefing, everyone is engaged. They don’t necessarily stop what they’re doing, but they can speak while the surgeon is closing. The surgeon, anesthesia provider, scrub person, and circulating nurse are all engaged. Everybody has a piece of it,” says Suzanne Sortman, MA, BSN, RN, CNOR, manager of the inpatient operating room at the hospital.

The team had hit a stumbling block because people were having difficulty speaking up about what they thought went well or what didn’t, according to Katherine Halverson-Carpenter, MBA, RN, CNOR, patient care services director for obstetrics and perioperative services. “We were very good at validating counts and specimens, but we weren’t doing as well with the qualitative concerns.”

They set out to improve the debriefing process in 2012. But the team’s journey toward optimal perioperative communication actually began a few years earlier.

Briefing and debriefing

The debriefing, which is held after every surgical procedure, is designed to facilitate appropriate handoff of care, verify pathology reports, ensure that specimens are labeled correctly, and—ideally—give everyone a chance to identify opportunities to improve patient care.

Give people permission to speak up.

“It’s good for process improvement to get instant feedback. Otherwise, you won’t remember,” says Paul Maroni, MD, associate professor of surgery at the hospital and one of four physician champions of the project to improve the debriefing process.

In early 2008, the hospital conducted a pilot program implementing both briefings and debriefings in the cardiothoracic surgery department. Denver-based Safer Healthcare (www.saferhealthcare.com) was hired to conduct a 4-hour training for all staff members. That training included a Situation Background Assessment Recommendation, a standardized way of communicating aimed at improving patient safety, as well as briefing and debriefing checklists. Over the following 9 months, the hospital expanded the communication training to all surgical departments.

In October 2010, the World Health Organization (WHO) launched its Surgical Safety Checklist (http://whqlibdoc.who.int/publications/2009/9789241598590_eng_Checklist.pdf?ua=1), which included questions to be asked and standard steps to be taken before the induction of anesthesia, before skin incision, and before the patient leaves the operating room. In line with the WHO’s recommendations, the University of Colorado Hospital staff revised the checklist to fit the facility’s specific needs.

Briefings last about 60 seconds before each procedure and include elements such as confirmation of the patient’s identity, surgical side, and site; information about the operating plan and any backup plans; introductions of staff members and discussions of any particular concerns about the patient; and verification that all necessary equipment is available.

Debriefings include standard questions to be addressed following all surgical procedures (except obstetrics, which has a different list):

• Are the sponge, sharp, and instrument counts complete?
• Has the name of the operative procedure been verified?
• Are the specimens labeled and verified?
• Did you identify what went well/what did not, and reformulate a response plan?
• Did you identify key concerns for recovery and management of this patient?

The form also includes a checklist for patient handoff and follow-up.

In April 2011, the hospital used grant money from the Cardinal Health Foundation (www.cardinal.com) to bring back Safer Healthcare, this time as outside consultants to observe and evaluate the quality of their briefings and debriefings.

The verdict: The briefings were going well, but there were problems with the debriefings. “We adopted the briefing aspect more quickly than we did the debriefing. We needed to make the debriefings more robust,” Sortman says.
Using proprietary tools, Safer Healthcare evaluated engagement of the anesthesiologist, nursing staff, and surgeon, and the quality of their communication. Deficiencies were seen in terms of discussing what had gone well or not well and following up with any problems.

“ The surgeon would say he didn’t have a particular instrument or that an antibiotic wasn’t given on time, but no one ever followed up with what didn’t go well. That was part of our [subsequent] training,” Halverson-Carpenter notes.

One problem, she says, is that the briefings and debriefings had been entirely nurse-driven. “Part of the gap, we realized, is we didn’t have surgeon champions to initiate [the briefings and debriefings.] We needed the physician to flatten the playing field and give the staff permission to speak up if they saw something wrong.”

In 2012, the department applied for and received a second Cardinal Health Foundation grant, which was used to bring back the Safer Healthcare consultant team to help improve the debriefing process.

**Beefing up the debrief**

Although some organizations have mandated that the surgeons lead the debriefing process, the Colorado hospital team decided not to do that. “ We didn’t make it mandatory because people tend to push back when you say they have to do something. This has been a very grassroots approach. The surgeons agreed to modify the debriefing to better meet the needs of their patient population and to increase the quality of the communication,” Halverson-Carpenter says.

Some of the surgeons were initially reluctant, but a few instances of mislabeled specimens and wrong implants convinced them the extra effort was worthwhile.

“We tried to communicate early on what’s in it for the surgeons. We have made them believers. Some of the surgeons who pooh-poohed it through the whole 4-hour training session have become our strongest advocates. I think it’s really important to capture the ‘good catches’ and communicate the good catches, then staff will buy into it,” Halverson-Carpenter says.

“ Ultimately,” she says, “they became very invested in this as a patient safety technique. No one wants to do the wrong thing.”

One of the most effective improvement tools was a series of videos demonstrating “good” and “bad” debriefings, with Dr Maroni “starring” as the surgeon and other staff members playing their own roles. In a bad debriefing, people kept talking and didn’t focus on the task at hand, or they covered only one or two of the components in the surgical procedure. In a good debriefing, everyone was focused.

“That was one way to have some fun with the educational piece and help the team reach the next level,” Sortman says.

“It’s a time management and judgment call. If it’s a routine closure and you’re getting close to the end and applying dressings, there’s time to discuss how the case went,” Sortman explains.

One helpful tool for the debriefing is a preference card for each type of procedure that lists all of the necessary equipment and can be modified as needed. Using preference cards can help avoid situations where a needed instrument is discovered missing after the procedure has already started, Dr Maroni says.

It can take 5 to 10 minutes to retrieve a missing tool, which is a substantial amount of time lost in a 20- to 30-minute procedure, Dr Maroni notes.

When things like that happen, they are addressed in the debriefing. “We check our recipe card and make sure the tool is there. Those are things we talk about,” Dr Maroni explains.

Monthly chart audits are another key to achieving and maintaining success, Sortman says. “Our documentation keeps us on the straight and narrow.”

**Measuring success**

At Safer Healthcare’s follow-up 4 to 6 months later, 98% of the focus group surgical teams had participated in the trainings and included all of the required elements in their briefings, compared with just 60% of other teams from the hospital that did not participate in the trainings. Debriefing scores for the participating teams were 63% favorable, compared with just 30% favorable for the control group (nonparticipating) teams.

The reviewers determined that physician engagement and leadership were subjectively improved in the participating teams and played a key role in the superior results.

It took persistence, Sortman says. “It certainly didn’t happen
Union membership has declined steeply in recent decades. Increasingly, organized labor is targeting the healthcare industry as a growth opportunity. This is creating a leadership challenge for OR directors and managers.

In 2012, approximately 21% of hospitals in the US had a union nursing staff. That percentage could soon increase as an unintended consequence of healthcare reform.

Labor relations expert Jim Trivisonno was recently quoted in Modern Healthcare: “The Affordable Care Act means people will have to look at costs, and that sometimes leads to change and less job security. And that leads to more organizing activity.”

Unions can play a positive role in healthcare, but they often create obstacles to effective OR management. Surgical services leaders need to understand the labor dynamics that could soon have a larger effect on OR staffing decisions.

Complex challenge
Healthcare unions are concentrating their efforts on several issues. Top priorities include clinical quality and safety.

Shortly after the nation’s first Ebola patient died last fall in Dallas, nurses across the country staged protest actions. Union leaders argued that hospitals were not providing nurses with adequate training and protective equipment to care for infected patients. The protests succeeded in focusing public awareness on Ebola readiness and safety.

Nurse unions have also prioritized staffing issues. In 2013, union supporters in Congress introduced the Registered Nurse Safe Staffing Act. This bill would require hospitals that participate in Medicare to appoint a committee to create a unit-by-unit staffing plan. These committees would be composed of “at least 55% direct care nurses or their representatives.”

Nurse staffing is a complex issue, and supporters of the bill argue that higher RN ratios will cut costs by reducing complications. Including more RNs in the staffing mix can also reduce overtime and agency costs. However, this legislation could also work against efforts to introduce appropriate efficiencies in OR staff structures.

For hospital surgery departments, costs are not the only issue. Unions can hamper efforts to improve OR performance by persistently blocking change. This can be especially problematic for an underperforming OR that requires significant improvements in processes and organization.

Although unions do present many leadership challenges, effective OR directors can learn to mitigate conflict and work constructively with union representation.

Alecia Torrance, MBA, BS, RN, CNOR, senior vice president of clinical operations at Surgical Directions, a consulting firm in Chicago, has experience with leading both union and non-union ORs. Torrance recently shared several strategies for working effectively with union staff.

Create a discussion forum. Difficult relations between OR management and union staff can be exacerbated by poor communication. The solution is to establish a forum for discussing union concerns.

Torrance recommends monthly meetings between OR leadership and labor representatives.

“A regular nursing council meeting provides the opportunity to go over any issues the union wants to bring forward, typically clinical practice issues, policies and procedures, and pay issues,” Torrance says. “The agenda should be established collaboratively by the union and management, and it’s critical that it be a defined agenda that is set ahead of time.”

Monthly meetings are not a cure-all, but they do provide an organized setting for hearing union concerns and explaining management decisions. Union nursing councils can be a natural fit in Magnet hospitals, which emphasize nurse participation in shared decision making.

A council system also provides an added benefit for OR managers. “As a director, when a staff member comes to me with a complaint, I can say, ‘Go to your representative on the council and have them put it on the next agenda,’” Torrance notes. Groundless complaints often go no further.

Be ready to make your case. It is always important to make sure staff understand the rationale for new policies or procedures. But
when staff are unionized, poorly explained changes can result in big headaches.

Torrance worked recently at a high-volume urban surgery department with a union staff. One of her goals was to improve efficiency by converting sequential work steps into parallel processes. The union pushed back. “They believed that parallel processing would increase infections because it sped up the traffic in and out of the OR,” she says.

OR leadership responded by doing research and bringing in experts to provide independent assurance.

“We provided the data, explained what was happening, and even got the hospital’s infection control director to come to a council meeting to talk about why parallel processes do not increase risk,” Torrance says. Keeping good minutes at council meetings proved to be important because challenges continued to arise even after an agreement had been reached on process reform.

Compromise effectively. When working with unions, clear victories can be rare. The key to success is to make effective compromises.

“Say you are trying to improve start time accuracy,” Torrance says. “Part of that is streamlining workflows during the 30 minutes before the first case of the day.” But nurses who are accustomed to inefficient processes will often feel rushed by streamlining efforts. If the nurses are represented by a union, resistance to change can be strong.

“One possible compromise is to move nurses’ arrival time from 7 am to 6:45 am, giving them an extra 15 minutes on prep,” Torrance says. Because nurses will also leave earlier at the end of their shift, the department will be “losing” 15 minutes per staff member per day. However, given the importance of first case on-time starts to overall department efficiency, the trade-off is worth it.

Work hours can become a major issue. At the urban hospital noted above, Torrance worked with OR leaders to develop nursing specialty teams. The goal was to provide surgeons with a higher level of clinical support. The problem was that specialty teams would require changes to the shift structure.

“A lot of the nurses worked 12-hour shifts,” Torrance says. “If some of the nurses switched to 8- or 10-hour shifts, we could implement specialty teams with the same headcount. Otherwise, we would need to hire additional staff.”

The union opposed this change and brought in a professional mediator. “It was a time-intensive process, but we did end up with a resolution,” Torrance says. Several volunteer staff members were assigned to more than one specialty team. This provided the flexibility to staff the teams without increasing full-time positions.

“No it wasn’t an ideal solution, but it was functional,” Torrance says. “It achieved agreement between the hospital, the union, and surgeons, and it allowed us to move forward with an important service enhancement.”

Compromise to keep moving forward.

Do not give up on corrective action. Union presence can make it harder to take corrective action with underperforming staff. Don’t throw in the towel, though. Verbal and written warnings are often critical to making staff take OR policies seriously.

“Any time you are delivering any kind of verbal warning, a union representative has to be in the room,” Torrance says. “In my experience, union reps can become very combative, to the point where they take over the conversation for the employee.” If an OR director is unprepared to manage these encounters, staff may conclude they cannot be held accountable for problems like chronic tardiness.

Two strategies are important. First, make sure you carefully document the employee behavior that is leading to the disciplinary action. Second, involve hospital human resources personnel in corrective action meetings.

“Good HR people are trained to handle these encounters, and they can be extremely helpful in making the discussion more balanced,” Torrance says. If a case does go to the grievance process, having clear documentation and HR backup is critical.

Know when to draw the line. Although compromise is essential, OR leaders should be aware of the point where union demands become unreasonable.

At the high-volume surgery department referred to earlier, the union demanded 1 hour of paid time off per pay period—so nurses could go to the bank and deposit their paychecks. This “employee benefit” is not known in any industry or profession. The request was rejected outright.

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OR business performance

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“The lesson is that you shouldn’t be afraid to say no to requests that don’t have a lot of merit,” Torrance says.

Proactive effort
Workers are less likely to unionize when they feel they are valued and their needs are addressed. OR directors should cultivate a staff-focused leadership style.

“One of the keys is being approachable,” Torrance says. “OR directors should make themselves available by rounding regularly and interacting with staff.” Transparency is also important. “Effective leaders are upfront about their goals for the OR, and they are committed to sharing data about department performance.”

Nurses should be involved in decision making. “OR directors and managers should also advocate for their staff and help their nurses develop professionally,” Torrance says.

Making sure compensation is in line with community standards is critical. But for many OR nurses, predictability is just as important as pay. Creating an efficient, high-utilization schedule that enables a predictable shift structure will help staff balance work with other responsibilities.

New Year’s resolution
Staff-focused leadership is important in any OR, unionized or not. “As the organized labor trend unfolds this year, surgical services leaders should place renewed emphasis on building an OR where all nurses can thrive,” Torrance says. “In ORs where leaders create a positive, productive, and rewarding work environment, nurses are able to meet their needs without turning to a union organization.”

This column is written by the perioperative services experts at Surgical Directions (www.surgicaldirections.com) to offer advice on how to grow revenue, control costs, and increase department profitability.

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Debriefing
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“Having a stable OR team that meshes well together makes for efficiency in the OR,” Dr Maroni notes. “Everyone wants to feel they’re doing something important for the patient. I think the debriefing is a good way to make sure we’re acknowledging the needs of everyone who’s in there.”

Miriam E. Tucker is a medical journalist in Bethesda, Maryland.

Reference

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Most ambulatory surgery centers (ASCs) have some form of computer-based recordkeeping, such as scheduling and billing systems. So far, however, few have made the leap to electronic medical records (EMRs).

With an EMR, clinicians enter data at the point of care, and that information is accessible to other clinical and administrative departments. The expanded capabilities of an electronic health record (EHR) allow other caregivers and the patient to see and update health information through secure Internet portals. For ASCs and other providers, immediate savings can result from staff efficiency and the end of maintenance costs for paper records.

However, as with conversion to the ICD-10 coding system, up-front purchase and training costs, initial loss of efficiency at start-up, and general reluctance to change a process that has worked in the past continue to make ASCs hesitate. To position themselves for the future, they will need to begin now. New health legislation, technological advances, and rising consumer involvement in their healthcare demand it.

What is an EMR?
The Healthcare Information and Management Systems Society (HIMSS) defines an EMR as a computer-based record of a patient’s conditions and treatment, created and maintained by a healthcare provider such as an ASC. HIMSS recognizes eight stages of adoption (0 to 7), based on the number of departments or outside service providers that participate. For example, pharmacy, laboratory, and radiology reports would appear in a Stage 1 record.

In its 2014 survey, HIMSS found the largest proportion of US hospitals, or 29.5%, had reached Stage 5 (sidebar, p 28).

The EMR system includes a clinical database, a list of acceptable medical terms, and real-time processing capability, allowing users to search for and update patient information. At the higher stages, the EMR has a function that allows physicians to enter care instructions on a personal computer or smartphone. This capability is called “computerized physician order entry (CPOE).”

According to HIMSS and other technology experts, there is a distinction, often overlooked, between EMRs and EHRs. The EHR is owned by the patient, and the patient can review and contribute to it. EMRs are records created by various caregivers that may be compiled, along with a patient access portal, into an EHR.

True EHRs are rare, except in comprehensive care organizations such as Kaiser Permanente and Department of Veterans Affairs hospitals.

The website www.HealthIT.gov offers the official definitions of EMRs and EHRs. The site is maintained by the Office of the

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National Coordinator for Health Information Technology (ONC), which is part of the Department of Health and Human Services (HHS).

According to the ONC, “One of the key features of an EHR is that it can be created, managed, and consulted by authorized providers and staff across more than one healthcare organization. A single EHR can bring together information from current and past doctors, emergency facilities, school and workplace clinics, pharmacies, laboratories, and medical imaging facilities.”

ONC defines an EMR as “a digital version of the paper charts in the clinician’s office. An EMR contains the medical and treatment history of the patients in one practice.”

Where are we now?

HIMSS, which tracks technology use, reports that as of October 1, 2014, only 3.4% of US hospitals had fully implemented what HIMSS considers a “complete EMR.” That is a small increase from the 1% adoption rate HIMSS reported in 2010. A complete EMR includes data sharing among caregivers, including ASCs. However, nearly 30% of hospitals had multifunction EMRs and were on their way to completion. Meanwhile, 4.4% of hospitals had not even begun to adopt EMRs.

Information technology consultant and HIMSS fellow Marion Jenkins, PhD, estimates that fewer than 10% of ASCs have established true EMRs, and their adoption rate has remained stagnant. “Not much has changed with ASCs other than consolidation and acquisition by hospitals, which is driving them more toward hospital systems,” he says.

The Wallingford, Connecticut-based company SourceMedical markets its Vision EHR to ASCs, and a statement on its website notes: “Despite the many benefits EHRs offer, widespread adoption remains slow within the ASC community. Many ASCs are reluctant to move forward for fear of implementations that are non-conducive to an ASC workflow.”

ASCs do not usually see patients more than once, so EMRs may seem impractical, Jenkins adds. “Most patients won’t come back,” he says.

There may be an additional factor: When the Centers for Medicare & Medicaid Services (CMS) began implementing the Patient Protection and Affordable Care Act (ACA) provision offering financial incentives for EMR and EHR use, the agency did not include ASCs. It did, however, include physician practices, which may be owners or investors in ASCs, so adoption may expand via practices as well as hospitals.

The timeline is briefly as follows:

- October 1, 2014: Medicare-eligible hospitals began tracking EMR use for reporting in 2015.
- November 30, 2014: Hospitals were required to attest to meaningful use, as defined by CMS, of their EMRs.
- December 31, 2014: This marked the end of the reporting period for physicians and other healthcare professionals.
- February 28, 2015: This is the attestation deadline for healthcare professionals.

Healthcare providers who have not met the deadlines will forfeit incentive payments from CMS. ASCs, however, are not included in the incentive program, called Health Information Technology for Economic and Clinical Health Act (HITECH).

Choosing an EMR

With a growing number of vendors either adding ASC-specific EMRs to their product lines or specializing entirely in serving ASCs, it should be easier to find an appropriate EMR. Based on
comments from users and industry experts, a few ground rules emerge for selecting an EMR.

• Suitability. ASCs frequently are associated with hospitals or physician practices, and will be encouraged—or perhaps required—to adopt those systems. Yet, ASCs have different needs. An ASC might have many specialties, with varying workflows and types of procedures. The EMR must be flexible enough to include data from each type of case.

• Adaptability. Although the ASC structure and caseload may be unique, its EMR is part of a system that includes other caregivers, insurers, and contracted service providers, such as outsource billing companies. Interfacing with multiple systems is one of the main challenges of installing a new EMR.

• User friendliness. The EMR system should be easy to learn even for people without extensive computer experience, and it should be expandable to add new specialties. The transition from paper should be no more than a few weeks, though the benefits may not appear for several months. The vendor should provide in-person training at least to some of the staff, who can then train others.

• Meaningful use. ASCs are not (yet) subject to reimbursement penalties, but they should insist that EMRs have the capacity to become full EHRs and comply with CMS requirements for “meaningful use.” Briefly, to achieve meaningful use, healthcare providers must use the technology to improve care coordination and involve patients and their families in their own care, while maintaining privacy and information security. Ultimate goals include better clinical outcomes and more comprehensive research data. HHS defines 3 stages of meaningful use, to be completed by hospitals and physicians by 2016: data capture and sharing, advanced clinical processes, and improved outcomes.

HHS and its ONC division have certified certain vendors and products as compliant with meaningful use requirements.

**Early adopters**

Among ASCs that have implemented EMRs are Harmony Surgery Center in Fort Collins, Colorado, and Stratham Ambulatory Surgery Center in Stratham, New Hampshire. Stratham, with one OR and one procedure room, has a volume of about 200 cases per month. The Vision EHR from SourceMedical was installed when Stratham opened in 2009.

“We never had paper,” clinical director Deb Menke, BSN, RN, CNOR, recalls. “It was a learning curve at first.” Since then, SourceMedical has completed several upgrades, she notes.

Stratham is an example of a small, independent ASC using a basic EMR. The Vision product is not a true EHR because it is not accessible electronically by patients or other healthcare organizations. It is on an in-house server, maintained by the ASC’s information technology consultant. Users see and enter data on Windows-based tablets. When an outside physician or hospital needs to see a patient’s record, Stratham prints a hard copy. Records cannot be transmitted by email, Menke notes, making them highly secure.

Harmony is gradually building its own model, using different vendors for different components and retaining paper records for several specialties. One reason for the hybrid model, according to administrator Rebecca Craig, RN, CNOR, CASC, CPC-H, is that, like many ASCs, Harmony has its own business software, and it has been difficult to find commercial EMRs that can be integrated with these legacy systems.

“An EMR would have one vendor for the entire system,” Craig explains. “The other software systems we utilize would interface with the EMR.”

Harmony, with four ORs, is affiliated with the University of Colorado Hospital (UCH). About 50% of the case volume consists of gastroenterology procedures, and most of the others are pain management. The use of ProVation MD, a software template designed for clinical procedure documentation, allows physicians to input information, eliminating the need for dictation and transcription.

In 2012, Harmony implemented AmkaiCharts, the EMR product from Amkai Solutions. “Once the
Continued from page 29

ProVation procedure report has been completed, we have an interface engine, Corepoint Health, which we love, that automatically sends a PDF file to AmkaiCharts,” Craig explains. MedTek, a transcription company, delivers operative reports in PDF format directly to AmkaiCharts.

The next step will be to add CPOE after physicians have had training on the EpicCare inpatient clinical system, the product adopted by UCH. “We are hoping to implement our CPOE component next year, which will make us close to paperless,” Craig says.

Craig has used her experience to design a presentation to help other ASCs select and implement EMRs. “There’s a learning curve,” she warns. Clinicians must master the skill of typing data on a laptop or other device. “It adds another dimension for nurses,” she notes.

Worth the effort

No one denies that exchanging a traditional paper file system for a keyboard and monitor will be a challenge. Equally difficult for some employees will be sharing information with colleagues to eliminate silos. But the law, the marketplace, and impact of technology on the ASC workflow will make the move inevitable.

It may help to remember that the process will be worthwhile in the end. As SourceMedical’s website reminds customers: “The biggest benefit to implementing an EHR system is the ability to deliver higher quality care.”

—Paula DeJohn

References


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At a Glance

Lap banding vs lap gastric bypass
Laparoscopic Roux-en-Y gastric bypass resulted in much greater weight loss than laparoscopic adjustable gastric banding, but it had a higher risk of short-term complications and long-term subsequent hospitalizations, according to a study of 7,457 patients from 10 healthcare systems.

However, gastric bypass patients had a lower risk of long-term subsequent intervention procedures (0.73) than lap band patients (3.31). In an accompanying editorial, Justin B. Dimick, MD, MPH, and Jonathan F. Finks, MD, from the University of Michigan, Ann Arbor, note that this concerning trend in long-term safety and effectiveness of the lap band, coupled with the emergence of sleeve gastrectomy, “may be the beginning of the end of gastric banding.”


Readmission rate not linked to postop mortality
Hospital readmission rate alone is a limited measure of hospital quality because of the poor correlation between readmission and mortality rates, finds a study.

More than 1 million patients and nearly 300 hospitals were analyzed for seven surgical procedures. The overall 30-day mortality rate was 3.79%, and the 30-day readmission rate was 12.69%.

Of the total, 63.3% had expected ratios for both outcomes. However, 85% were discordant for readmission and mortality, and almost a quarter of discordant hospitals had expected or low readmission rates but high mortality rates.


CMS releases CY 2015 physician fee schedule
Under the CY 2015 Medicare physician fee schedule final rule released by the Centers for Medicare & Medicaid Services, payments to physicians will be reduced by 21.2%, starting April 1, 2015. CMS also plans to transition all 10- and 90-day global services to 0-day global services in CY 2017 and CY 2018, respectively.

The final rule modifies the Open Payments program for annually reporting financial relationships between physicians and drug/device manufacturers and eliminates an Open Payments exclusion that was allowed for speakers at accredited continuing education events.

The final rule was published in the Federal Register on November 13, 2014.

Joint Commission recognizes top performing hospitals
The Joint Commission on November 13 released its annual report summarizing 2013 performance data for more than 3,300 accredited hospitals.

The report also recognizes hospitals with exemplary performance in providing evidence-based interventions for certain conditions, including surgical care.

A total of 1,224 hospitals earned recognition by the Top Performer on Key Quality Measurers Program—an 11% increase from the previous year.
—http://www.jointcommission.org/annualreport.aspx