A few simple rules for managing block time in the operating room

Block time is a huge issue for surgeons because it affects how they manage their most precious resource—time. How satisfied surgeons are with an OR has a lot to do with how well they think the OR’s leaders manage this valuable resource, specifically, their block time.

More than ever, block time is a strategic issue. In today’s competitive environment, surgeons have more options if they’re unhappy with their block time. They can take their cases to an ambulatory surgery center. They can move to a competing hospital or even a specialty hospital.

“The market is changing, and block time becomes part of the strategy for responding to that,” says William J. Mazzei, MD, a veteran medical director of perioperative services.

Block time can be used as a way to entice new surgeons, ideally those who will bring cases that contribute to the organization’s bottom line.

Dr Mazzei and Tom Blasco, MD, MS, shared advice on how to manage block time at the OR Business Management Conference in May in Albuquerque, NM. Dr Mazzei, a founder of the Association of Anesthesia Clinical Directors, is at the University of California, San Diego, and Dr Blasco is director of perioperative services at Advocate Lutheran General Hospital, Park Ridge, Ill. Both are with Surgical

Continued on page 9

AARP shares winning policies for keeping mature employees

A big part of coping with staff shortages is hanging on to the employees you already have—and an increasing number of those are over 50.

In 2002, 14% of the workforce was 55 and older. By 2012, 19% of workers will be at least 55.

More employers are taking steps to make workplaces attractive to older workers, and health care is leading the way. Hospitals account for 12 of the 35 2004 Best Employers for Workers Over 50 named recently by AARP.

AARP says these employers seem better prepared to meet the staffing challenges of an aging workforce. They also have programs and policies that are good for all ages.

Increasingly, employers are designing the workplace according to the life cycle of employees, says Vic Buzachero, senior vice president for human resources for San Diego-based Scripps Health, one of the winners. Employees in their 20s might want a schedule compatible with finishing a degree, parents with young children want to work during school hours, and staff in their 50s want to keep working but not 40 hours a week.

At the same time, health care faces special challenges. Hospitals are striving to hire and retain highly skilled employees when many are struggling just to keep their doors open.

Rising costs, low reimbursement, and
Please see the ad for MEDLINE INDUSTRIES INC. in the OR Manager print version.
A better preop process

ORs share their successes on getting patients ready for surgery.

Value analysis

What it takes to make value analysis an effective tool for technology decisions.

Editorial

The hospital chargemaster is being thrust into the public spotlight. Mainly the purview of green-eye-shade types, hospital charges are now the subject of 50 high-profile lawsuits against nonprofit hospitals and systems across the country. No less a lawyer than Richard F. Scruggs of Mississippi, who took on big tobacco, is leading the charge on behalf of uninsured patients who say they’ve been subject to hospital price gouging.

The latest headlines, in September in the Wall Street Journal and Washington Post, are about Paul Shipman, a 43-year-old Virginia man who had chest pain, called an ambulance, and was taken first to a nearby community hospital, then to Inova Fairfax Hospital in Fairfax, Va. There he had a cardiac catheterization and a stent inserted. By the time he checked himself out 21 hours later, he had racked up a $29,492 bill, which did not include the ambulance trip or the cardiologist’s fee, which brought the total to about $37,000.

Anatomy of a hospital bill

Shipman, a furniture salesman, had no insurance. He and his wife, Alina, said they thought because they were healthy, they could go without insurance until she finished her bachelor’s degree. As it is, they say they are overwhelmed by medical bills.

Ironically, if he had been covered, the reimbursement would have been a lot less. Medicare would have paid about $15,000 and Medicaid about $6,000 for the same services.

But as it was, he was billed $7,560 for a $3,195 cardiac stent, $39.15 for 1,000 mL of saline, and $1,050 for a balloon catheter that costs $200 to $400.


Such cases have big-time lawyers challenging the tax-exempt status of nonprofit hospitals, saying such charging and billing practices go against their obligation to provide charity care.

Shipman’s lawyer, Bryan Vroon of Atlanta, called the hospital pricing system “a Persian rug market of negotiations,” where insurers, providers, and suppliers cut their own deals, but only the uninsured are expected to pay full price.

But hospitals say they are between a rock and a hard place. Insurance companies, Medicare, and Medicaid are ratcheting down payments at the same time health costs are ballooning.

Inova officials told the newspapers it is one of the largest providers of uncompensated care in Virginia and incurred more than $100 million last year in unreimbursed costs. Inova said it began providing a 35% discount to uninsured patients in January. The hospital also said its charges are below the national median.

Despite the markups, hospitals aren’t raking in the dough. The American Hospital Association reports hospitals’ average margins for 2002 were 4.4%, and many are running in the red.

Obviously, hospitals need to be fair in what they charge the uninsured—it’s unjust to make them pay full freight when big insurers and the government have the muscle to negotiate discounts.

But the Shipman’s case also throws into sharp relief the issue of health care costs.

It’s true most people aren’t aware of the extent to which hospitals mark up their prices. But it’s also true that few are aware of the millions of dollars in uncompensated care that systems like Inova are shouldering.

One of the serious issues here, it seems to us, is the public’s and policy-makers’ shocking lack of awareness of what health care really costs—and their lack of willingness to tackle reforms that are needed to bring the system into a better balance.

—Pat Patterson
Please see the ad for SKYTRON INC. in the *OR Manager* print version.
**California alert follows scope lapses**

Strong recommendations from California’s Department of Health Services are a good reminder about endoscope reprocessing.

The department issued an alert for the state’s health care facilities Sept 20 after lapses in scope reprocessing led to over 5,000 patients in 18 months being offered testing for hepatitis B and C and in some cases HIV.

The lapses, reported by 8 facilities, primarily involved GI endoscopes, but similar problems have been observed with bronchoscopes and cystoscopes.

No illnesses have been directly tied to the investigations, but some cases of hepatitis were identified. The department said it could not exclude the possibility that infections might have resulted from endoscopy.

The department is now recommend-
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A consensus on improving antibiotic use

OR teams working to improve use of prophylactic antibiotics have a new advisory statement to help them.

The statement represents consensus in areas where there have been gaps and differences among current guidelines. “We invited all of the authors of published North American guidelines on antibiotic prophylaxis to come together,” says the lead author, Dale Bratzler, DO, MPH, of the Oklahoma Foundation for Medical Quality.

After a conference and a year of conference calls, the consensus statement was published in June.

Rather than producing another guideline, he says, the aim was to review existing guidelines, arrive at a consensus, and have the statement endorsed by the surgical specialties and related disciplines.

The statement offers specific recommendations for:

• gynecologic and obstetrical surgery
• total hip and knee replacement
• general colorectal surgery
• cardiothoracic and vascular surgery.

The article has a chart with suggested doses and timing for commonly used antibiotics.

Three key points:

1. Start the antibiotic on time

The workgroup endorsed the recommendation that, in general, infusion of the first dose of the antibiotic should begin within 60 minutes before the surgical incision.

Dr Bratzler notes “there was complete consensus on this,” in view of “overwhelming evidence” dating from the 1950s that giving antibiotics a short time before the incision results in lower infection rates. Studies have also shown that a single preoperative dose of antibiotic is effective.

2. Select the appropriate antibiotic

Though many antibiotics are available, in general, the older agents are effective for prophylaxis, and there is good evidence to support their use, the consensus group agreed. Newer broad-spectrum drugs used in front-line therapy should be avoided for surgical prophylaxis to reduce the emergence of antibiotic resistance.

Consensus on this point lends more weight to facilities that wish to develop an antibiotic formulary for prophylaxis, Dr Bratzler notes.

3. Discontinue antibiotics within 24 hours

Based on the evidence, prophylactic antibiotics should be discontinued within 24 hours after the end of surgery, the workgroup agreed.

“There is little evidence that continuing antibiotics past 24 hours makes any difference in reducing infection rates,” Dr Bratzler says. There is evidence, however, that prolonging antibiotic use drives up antibiotic resistance so that when surgical site infections occur, they typically involve resistant organisms.

Not all surgeons are comfortable with that advice. Some surgeons, for example, want to continue antibiotics until patients’ drains are removed. Though the presence of drains does increase infection rates, “there’s simply no evidence that continuing antibiotics will reduce that,” Dr Bratzler says. Most drains become colonized with organisms, and if the patient is on antibiotics, these are likely to be resistant organisms.

“The orthopedic surgeons clearly are on board with this,” he notes. The American Academy of Orthopaedic Surgeons (AAOS) takes the position that drains, if used, should be removed as quickly as possible. The statement’s section on drains was written by the chair of the AAOS infection control committee, Jason H. Calhoun, MD. AAOS issued its own recommendations on prophylactic antibiotics in June (www.aaos.org/wordhtml/papers/advistmt/1027.htm).

Some vascular and cardiac surgeons are also concerned, Dr Bratzler acknowledges. A deep sternal wound infection or an infected vascular graft obviously is devastating.

But, he reiterates, “we haven’t seen any evidence that continuing antibiotics beyond 24 hours reduces the infection rate.”

The Society of Thoracic Surgeons (STS) endorsed the statement, with the caveat that it state antibiotics should be discontinued in 24 to 48 hours for cardiothoracic and vascular operations. STS plans to develop its own statement on discontinuing antibiotics.

The statement was endorsed by 19 organizations, among them AAOS, the American College of Surgeons, the American Society of Anesthesiologists, the Association of periOperative Registered Nurses, and the Association for Professionals in Infection Control and Epidemiology.

Next steps

The advisory statement is an outgrowth of the National Surgical Infection Project sponsored by the Centers for Medicare and Medicaid Services and Centers for Disease Control and Prevention. The project began in 2002 and continues at the state level.

The next step, called the Surgical Care Improvement Project (SCIP), branches out to other postoperative complications in addition to infections. SCIP will involve a coalition from various disciplines, including surgeons, anesthesiologists, nurses, pharmacists, infection control professionals, and others to help “bring about national change in surgical care.” The group plans to work on issues such as cardiac arrest, pulmonary embolism, and deep-vein thrombosis. A pilot is underway in Kentucky, Ohio, and Oklahoma.

How are ORs doing on prophylactic antibiotics?

• 56% to 57% of patients undergoing surgery receive their antibiotics within the recommended time frame of 60 minutes before the incision.
• 92% of surgical patients receive at least one antibiotic that is consistent with guidelines.
• 41% of surgical patients have antibiotics discontinued within 24 hours of the end of surgery.

Source: Dale Bratzler, MD.

Reference

Please see the ad for
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**Surgery scheduling**

**Utilization definitions**

In measuring block utilization, adjusted utilization is preferred to raw utilization.

**Raw utilization**

Total hours of elective OR cases performed within block time divided by the hours of allocated block time.

**Adjusted utilization**

Total hours of elective cases performed within OR block time, including setup and cleanup time.


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**Continued from page 1**

Directions, LLC, a Chicago-based consulting firm.

Managing block time is as much a political art as a science, they say.

Surgeons like block time because it’s like a reservation at a restaurant, says Dr Mazzei: “A surgeon knows that if he shows up at the appointed time, there will be space for him—and that’s a major satisfier.”

Here’s their advice:

**Block vs open time**

How much OR time should be blocked and how much should be left open?

**Strive for 80% of OR time blocked.**

There is no perfect number. But 80% probably is about right for a 10-OR suite in a mature market, Dr Mazzei notes.

If more than 80% of time is blocked, new surgeons can’t get on the schedule. But if only 50% of time is blocked, patterns are not well enough established to allow surgeons to work with the same staff and anesthesiologists consistently.

**Strategy also enters in.**

“For younger hospitals in growing markets that are trying to attract business, we have sometimes recommended adding block time even with as low as 50% utilization so it’s easier for new surgeons to get on the schedule,” says Dr Blasco.

“It’s an art in progress—you’ve got to constantly keep your eye on maximizing your revenue, keeping your customers satisfied, and working on your volume.”

**Have at least 2 open rooms.**

A general-purpose OR needs at least 2 ORs open a day to have the flexibility to move cases and add cases to the schedule, Dr Mazzei advocates. That holds true whether the department has 20 ORs or 2 ORs. There may be exceptions for a facility such as an eye center where routines are well established.

The rule is not rigid, he says, but the point is to have enough flexibility to accommodate changes and add-ons.

**Full-day blocks are better than shorter blocks.**

The best use of ORs is achieved with long blocks, they say. Best of all is to have long blocks with one specialty or surgeon in one room all day. This isn’t always practical, especially for community hospitals that have only a few surgeons in each specialty and who may be competitors.

“Eight-hour blocks are ideal because if the block takes the entire day, you have the greatest use of your OR time,” Dr Mazzei advises. A 12-hour block is even better for specialties such as spinal surgery that typically have very long cases.

Try to avoid blocks shorter than 8 hours, he recommends. With 4-hour blocks, OR time is not used as efficiently. Either morning cases runs over, or there is a gap at mid-day.

“Even worse are 2-hour blocks,” he says. “People think they are doing a surgeon a favor by giving him a 2-hour block at 9 am every Monday, but that is not a particularly good thing for the system.”

The rules can’t be written in stone, Dr Blasco adds. Certain surgeons may flourish with a shorter block time, such as a cataract surgeon who does a lot of cases quickly.

“If you have a choice to have every OR blocked just in the morning and leave the afternoon open, or to leave 2 rooms open every day and have blocks for only surgeons who can fill up an 8-hour day, choose the latter,” Dr Mazzei says.

**Have variable release times for different specialties.**

Variable release times are a quick way to build flexibility into a schedule where most of the time is blocked. Release times define when block time expires before the day of surgery. Release times can be different for different specialties. Specialties whose cases are booked far in advance, like joint replacement or cosmetic procedures, may have release times far in advance of the day of surgery. On the other hand, the cardiac service may need to hold its block until the day before surgery. Having a portion of release times far in advance of the day of surgery allows schedulers to add cases to blocks that otherwise would be underutilized.

Like in a restaurant, “if you hold all the tables for people who have reservations until right before dinner, you are going to have a lot of people who don’t show up,” Dr Mazzei notes. “It also means that anyone who calls up that day won’t be able to get a table.”

Suggested release times are in the sidebar on p 10. These “are empiric and are what surgeons are typically happy with,” he notes.

**Adjusting block time**

How block time is monitored and adjusted is one of the most sensitive issues perioperative leaders deal with.

Typically, blocks are adjusted according to utilization. Actually, from a scientific point of view, there are better methods than utilization for adjusting block time, notes researcher Franklin Dexter, MD, PhD, of the

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Surgery scheduling

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University of Iowa. The method depends on whether the OR is adjusting block time for operational reasons (to better match staffing to the existing workload) or for tactical reasons (to provide some surgeons with more convenient access to OR time). (See sidebar, p 11.)

Traditionally, surgeons are accustomed to using utilization for block-time adjustments, and that is what they perceive to be fair, Dr Mazzei contends. Again using the restaurant analogy, he says, “Who should be given the benefit of a reserved table? The answer would be, ‘We should give it to the people who are most likely to fill up the tables’”—that is, most likely to use their block time.

These are some guidelines Drs Mazzei and Blasco offered for managing block utilization.

Set a utilization target.

There are not universal benchmarks on appropriate utilization. This varies with market conditions, Dr Blasco notes. A target of 80% might be appropriate for a facility in a market that is not particularly competitive and wants to boost its volume because it is losing money. In a clearly competitive and wants to boost its volume because it is losing money. In a clearly competitive market, a target of 50% to 60% might be more appropriate because it avoids the risk of alienating surgeons who might go elsewhere.

Measure utilization monthly.

Inform surgeons of their block utilization monthly and report utilization monthly to the Surgery Committee. But don’t make changes quickly.

“The ideal is to tell the surgeons each month what their utilization is,” Dr Mazzei says. “You can also tell them you are not going to make changes for 6 months.” This gives the surgeons and the committee time to monitor utilization patterns, answer questions, and make sure the measurements are accurate.

In measuring block time, use “adjusted utilization” (which includes setup and cleanup time) instead of “raw utilization” (sidebar, p 9). Adjusted utilization allows surgeons’ block time to be measured more fairly, he explains. Consider two surgeons. One is a head-and-neck surgeon who does tonsillectomies in 30 minutes with a 15-minute cleanup time, for a total case time of 1 hour. In an 8-hour block, this surgeon can do 8 cases. The second is a neurosurgeon who does complex tumor resections, typically completing 1 case in 8 hours.

Who has the better utilization? Using raw utilization, the head-and-neck surgeon would have a block utilization of 50% (because his procedure time takes 4 of the 8 hours), while the neurosurgeon would have a block utilization of 100% because his procedure time takes the entire 8 hours.

Using adjusted utilization, however, both surgeons would have 100% utilization.

“We think adjusted utilization is the way to go,” Dr Mazzei says, because it is more equitable and recognizes that an appropriate amount of setup and cleanup time is essential for cases to be completed safely.

Set criteria for reducing block time based on utilization

These are sample criteria for managing block utilization:

• A target for block utilization is set, for example, at 80%.
• Surgeons are expected to maintain block utilization at 80% for 3 consecutive months.
• If utilization falls below the target for those 3 months, it is reviewed for an additional 3 months to see if there are variations.
• If utilization remains below 80% at 6 months, block time might be reduced.

Taking away block time is never easy. The most palatable approach is not to shave the time off of each block but to take out a whole block on 1 or 2 days, Dr Blasco advises. For example, a surgeon has a 4-hour block every Monday, but his utilization has been 60% or below for 6 months. The best approach is to take away 1 of the Monday blocks, leaving him with 3 blocks instead of 4 during the month.

“If you just shave off a few hours each day, that just makes the system more dysfunctional,” he says. “You have to take out entire blocks.”

Should blocks be granted based on profitability?

Should you consider the profitability of a surgeon’s procedures when granting block time?

This raises the highly controversial issue of economic credentialing.

The issue is coming up more and more because of trends hospitals are facing. As more well-paid surgical procedures move into freestanding surgery centers or specialty hospitals, hospitals have fewer profitable procedures to cushion losses from cases that are not profitable or lose money.

“There’s a tremendous economic incentive right now for hospitals to allocate their time carefully. More than in the past, they’re looking at revenue and profitability,” Dr Mazzei notes.

At the same time, some hospitals are lowering their OR utilization rates to try to attract surgeons. That increases the pressure to focus on profitable procedures because there are fewer cases.

The payer mix affects whether hospitals can afford to lower OR utilization. In a market with affluent patients, hospitals can break even with 30% utilization, Dr Blasco notes. But if most of the patients are on Medicare, a hospital needs 70% to 80% utilization to break even.

Granting block time based on profitability is politically charged, he cautions.

For example, say an ophthalmologist who plans to do cataract surgery has

Suggested block release times

<table>
<thead>
<tr>
<th>Service</th>
<th>Days</th>
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<tbody>
<tr>
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<tr>
<td>Cardiac</td>
<td>1</td>
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<tr>
<td>General surgery</td>
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<td>Neurosurgery</td>
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<tr>
<td>Ophthalmology</td>
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<tr>
<td>Orthopedics (joint)</td>
<td>14</td>
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<td>Orthopedics (spine)</td>
<td>3</td>
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<tr>
<td>Pediatrics</td>
<td>7</td>
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<tr>
<td>Plastic (cosmetic)</td>
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<td>2</td>
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<tr>
<td>Thoracic</td>
<td>3</td>
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Source: William J. Mazzei, MD; Tom Blasco, MD

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**Surgery scheduling**

**What’s the best way to adjust block time?**

What criteria should you use to make decisions about adjusting block time? Traditionally, OR committees have used surgeons’ utilization of blocks. But utilization isn’t the best way to make this decision, the research shows. The method to use depends on why block time is being adjusted, notes Franklin Dexter, MD, PhD. Are blocks being adjusted for operational reasons (that is, to fine tune staffing to match the existing OR workload)? Or are they being adjusted for tactical reasons (such as to provide more convenient access to OR time for some surgeons)?

Consider these scenarios:

**Scenario 1**

Your OR has a group of neurosurgeons with 91% utilization of their block time. They’re recruiting a new spine surgeon and need more OR time.

Dr Jenkins, a vascular surgeon, has 60% utilization of his block. It seems that he could use less time.

Should the OR Committee take some of Dr Jenkins’s block time and give it to the neurosurgeons? This is a tactical decision.

**Scenario 2**

The neuro service currently has a block allocation on Mondays of 3 ORs from 7:15 am to 3:30 pm. They have little underutilized time and often have overutilized time (ie, run late). How should their block be adjusted? This is an operational decision.

**Tactical decisions**

For tactical decisions such as those in Scenario 1, decisions increasingly are being made at least partly to meet financial goals, Dr Dexter says. The OR committee might, for example, look at the contribution margin for spinal surgery to decide if giving the neurosurgeons more block time would help the hospital financially. (Contribution margin = revenue – variable costs.)

Block utilization is not the best choice for making tactical decisions regarding block time, says Dr Dexter. He cites 5 reasons from the literature:

1. **Utilization does not help to reduce patient waiting times**, which is usually a goal of patients as well as clinicians and administrators.

2. **Utilization is poorly related to contribution margin.** A surgeon or service with high utilization can still lose money for the hospital if reimbursement for these cases doesn’t cover costs.

3. **Efforts to increase utilization can actually reduce margins;** for example, the hospital signs an insurance contract hoping to increase surgical volume, but not many of the patients have surgery, and the contracted rates are too low to cover the costs.

4. **Utilization is poorly related to variable costs.** Surgeons with equal utilizations can have different variable costs. For example, 2 surgeons have 70% block utilization. The first surgeon does outpatient breast surgery, which has one of the lowest hospital variable costs per OR hour, while the second does joint replacement, which has one of the highest variable costs per OR hour.

5. *It is questionable whether utilization can be estimated precisely for this purpose if the surgeons in question have a low utilization.* A 2003 study by Dr Dexter and his colleagues found, for example, that if during 1 quarter, 1 surgeon had a block utilization of 65%, and another surgeon had a block utilization of 80%, statistically there is at least a 16% chance that the 2 surgeons have the same utilization rate. “This measured difference may be random chance,” he says. For surgeons with low utilization, it would take more than 10 years worth of data to measure block utilization accurately enough to be of practical value in making block-time decisions.

**Operational decisions**

Decisions such as those in Scenario 2 are operational decisions that should be made to improve OR efficiency, Dr Dexter says. For this purpose, OR efficiency is defined as a balance between underutilized and overutilized OR time. An OR doesn’t want underutilized time because revenue isn’t coming in while the OR is incurring labor costs, and it doesn’t want overutilized time because clinicians have to work late, which is a dissatisfier and can be costly if the staff must be paid overtime.

Achieving OR efficiency involves matching the staffing allocation as closely as possible to the existing workload, he notes.

In Scenario 2, depending on the details of the neuro service’s workload, the decision based on OR efficiency might be to increase the neuro service’s OR allocation (or block) from 7:15 am to 6 pm in 2 of the 3 ORs. The anesthesia providers and nurses gain by having more predictable work hours (ie, fewer overutilized hours). The purpose of this block adjustment is not to encourage more neurosurgery, because the neurosurgeons are already getting their cases on the schedule, but to achieve a better balance between underutilized and overutilized time.

“Generally, what surgeons care about are tactical decisions: ‘How can I grow my practice?’” he says. “What anesthesiologists and nurses generally care about are decisions on the day of surgery: ‘Will I finish on time?’”

More information on Dr Dexter’s research and consulting is at www.FranklinDexter.net.

**References**


Leadership is key

The rules for managing blocks are only guidelines. The real key is leadership, stresses Dr Blasco. Leadership should come from a surgical executive committee. The committee needs to abide by these important principles:

• “The system must be scrupulously fair,” he says. “If there is any favoritism, the surgeons will sniff it out, and it will never work.”
• The system has to be changed gradually.

“The last thing you want to do is to make significant changes quickly,” he says. “You have to gradually work with people who are interested in change, let the momentum build, and other people will come on board.”

—Pat Patterson

Unfunded mandates make it difficult to balance employee needs with other demands like burgeoning technology.

Still, some are doing it. Here is a look at some of their best practices.

A master’s to go

Nurses who want to earn a master’s degree have classes come to them at Loudoun Healthcare, Leesburg, Va, under a partnership with George Mason University, Fairfax, Va. Students can take 1 or 2 classes a semester after work at the hospital without having to drive through rush-hour traffic.

This “best practice” has assisted dozens of nurses to pursue their studies, AARP reports.

In exchange for tuition forgiveness, nurses sign a contract to work for a certain number of months for each course taken. Tuition is paid by the Loudoun Healthcare Foundation. RNs who don’t have their BSN can go straight to a master’s degree.

“It’s been a retention tool,” says Carol Mahood, RN, the clinical recruiter.

The first class of 10 to 12 will graduate in the spring. Several perioperative nurses are in the program.

George Mason has similar programs at about 12 sites in the DC area, says Beverly T. Boyd, the university’s director of professional development. She says off-campus courses now account for 50% of the enrollment in graduate nursing programs.

Communicating across generations

The most serious challenge to retention is in an employee’s first 1 to 3 years on the job, notes Buzachero. An organization can lose 60% of new hires in that period.

“We find our senior people are a huge help in getting these new employees acclimated,” says Buzachero. On the other hand, senior employees may be frustrated themselves, and their attitudes can hard on new recruits.

To try to bridge the gap, Scripps’s leaders came up with a fun in-service program called Crossing the Generation Chasm. The voluntary program gives managers ideas for leading 4 generations—the “modern matures” (60+), the baby boomers (40s and 50s), Gen X (20s and 30s), and Gen Y (early 20s). The program’s leader takes on the role of a manager, acting out situations with the 4 generations, deliberately stereotyping them to make a point.

“You might have the baby boomer who’s big on reaching consensus, the Gen Xer who’s asking, ‘Where’s the next level of training for my advancement,’ and the ‘modern mature’ who says, ‘Just tell me what needs to be done,’” Buzachero explains. The leader takes the group through a series of exercises on how to coach each group.

Scripps has added other programs to fit generational needs—alternative work schedules, such as 3 12-hour shifts; phased retirement with full-time benefits for 20 hours of work per pay period; and a beefed-up retirement program.

As a result, Buzachero says, 75% to 80% of employees rate Scripps as a “great place to work,” up from about 50% 30 months ago. Now the focus is on the 20% who aren’t as satisfied because “they touch our patients, too,” he says.

Phased retirement

St Mary’s Medical Center in Huntington, W Va, set up a phased retirement program. Their voluntary program gives managers ideas for leading 4 generations—the “modern matures” (60+), the baby boomers (40s and 50s), Gen X (20s and 30s), and Gen Y (early 20s). The program’s leader takes on the role of a manager, acting out situations with the 4 generations, deliberately stereotyping them to make a point.

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OR's policies friendly to a senior staff

Should veteran staff be excused from call? Who should have to work nights and weekends? Who decides who will leave early on a light day?

Staff make these decisions, not managers, at 440-bed St Mary’s Medical Center.

A self-scheduling committee “gives the staff a say in their own destiny,” notes Tammy Nimmo, RN, MS, CNOR, director of surgical services at St Mary’s, recently named one of AARP’s 2004 Best Employers for Workers Over 50.

The OR has virtually no turnover, and much of the staff has been there for years. The last time there was an opening for a surgical technologist (ST), there were 30 applicants.

The not-for-profit hospital in Huntington, W Va, a community of 52,000 on the Ohio River, is a Level II trauma center with 16 ORs and a surgical volume of about 11,000 cases a year. The unit is staffed 24 hours a day and has a Saturday OR schedule.

The staff is not unionized.

The scheduling committee worked hard to develop staffing policies that work for older and younger staff alike, Nimmo says. The committee is made up of 2 RNs and 2 STs, representing staff with both more and less seniority.

At first, the staff thought self-scheduling would mean everyone “got the perfect schedule,” she says. “We talked about this in our staff meetings, with a lot of humor. We’d say, ‘Now, we all know that Mr Smith didn’t want to have his ruptured aneurysm on Sunday either,’ and they would see the need.”

“They always come through,” she adds. “If there is a trauma, they will call in and volunteer. Or someone will say, ‘I need to work tomorrow. Dr X is having a big case.’”

Some of St Mary’s staff-friendly policies:

Tiers for staff scheduling

A tiered system for staff scheduling is based on seniority:

• Tier 1: The most-senior staff work Monday through Friday with no weekends and no call.

• Tier 2: Staff work no evenings or nights, take call, and work every 3rd Saturday.

• Tier 3: Staff work every other Saturday and participate in call.

Call policies

• Staff employed at the hospital for 20 years or more do not have to take call.

• Call pay has 2 levels:
  —Employees on the payroll prior to Aug 1, 2001, receive the traditional call rate of 2 hours of overtime pay for every 8 hours of call plus overtime for all hours called in. For example, an RN earning $25 an hour would receive $75 for 8 hours of call, or $9.38 per hour. Senior employees are grandfathered into this rate.
  —New hires receive 20% of their base pay per hour of call. Thus, an RN earning $25 an hour would be paid $5 an hour for call. All called-in time is overtime whether the staff have worked 40 hours that week or not.

• Signup for call. People who take call sign up for how much they want. “Those who want the most, get the most,” Nimmo says. “You always have the 22-year-olds who are buying a house and want the call.”

Leave-early list

The staff voted to use a voluntary daily signup list for leaving early. The charge nurse uses the list to adjust staffing to the OR schedule.

“We go through those who sign up first,” says Nimmo. “We’ve never had to mandate staff to leave.”

Staff who do go home early still accrue sick time and vacation time even if they work less than 40 hours a week.

 Plenty of shift options

Staff can choose from 8-, 10-, and 12-hour shifts. Those who work straight 3 pm-to-11 pm or 11 pm-to-7 am shifts do not have to work weekends. Staff can elect to work 3 12-hour shifts with full benefits, which is popular with mothers of young children. The OR also uses per-diem and part-time staff. Some staff elect to work only weekends.

Generous benefits

The hospital provides full family coverage for health insurance at no expense to the employee. For example, if a staff member marries a spouse with 5 children, and the couple has custody, the hospital will cover them all. There also are dental insurance, short-term and long-term disability, and 12 days of sick time per year, which can be accumulated.

Extra pay for certification

RNs who are certified receive a $1,000 annual bonus. About 50% of RNs have their CNOR. STs receive a pay increase when certified.

Collaboration with education programs

The hospital has its own RN associate degree program in partnership with Marshall University, and there are 2 ST schools in the area. RN students can work in the OR during school. They begin working full time in the summer as an ST. In the fall, they continue to work 20 hours a week as an ST to accommodate their class schedule. When they graduate, they learn to circulate. The hospital provides tuition reimbursement.

“Unfortunately, we’ve had times when there were no positions open,” Nimmo says.

Strong focus on standards

“We believe strongly in the AORN standards,” says Nimmo, referring to the Association of periOperative Registered Nurses. She says students want to do their clinical rotations at a hospital with a high level of professionalism.

“I can hardly think of a person who has left” the OR, she says. “It’s not because of me—it’s because of the hospital and their peers.” The staff has a strong bond, she adds. Recently, when a beloved colleague died, the staff held several events to raise donations for his spouse.
OR costs growing faster than drug costs

Operating room costs grew at a faster rate—32%—than drug costs, which rose by 22% between 2000 and 2002. Costs also climbed for diagnostic imaging (36%), intensive care (27%), and medical supplies (26%).

The primary data source for the analysis was Solucient’s Projected Inpatient Database, an all-payer database that includes about 20 million discharges per year from about 2,500 acute care hospitals. OR costs are a category in cost reports from hospitals to the Centers for Medicare and Medicaid Services.

Source: Solucient. Reprinted with permission.

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program after more older staff members wanted to work part time.

Previously, employees’ pensions were based on their highest salary during their last 5 years of employment. But that would penalize employees who went part time before they retired. Instead, the pension is now based on the employee’s highest 5 years of earnings.

“That’s huge,” says the hospital’s nurse recruiter, Jennifer Gore, RN, BA, ONC. Nurses feel they can work part time without jeopardizing their retirement pay, which is an incentive to stay.

St Mary’s also set up a program to bring back nurses who’ve been out of the workforce, in one case for 23 years.

The returning nurses are paid the entry-level RN hourly wage with no benefits and receive training during an orientation period. They typically work fewer than 8 hours a day and fewer than 20 hours a week, convenient for mothers who have kids in school. A staff development nurse plans their learning needs.

“It’s been very successful,” says Gore. “These nurses were scared to come back, but this gives them a way in.”

Balancing lifestyles

Having a say in decisions and being able to balance their personal and professional lives are keys to attracting and keeping nursing staff for the St Louis-based SSM Health Care (SSMHC) system.

A third of the staff is 50 and older. SSMHC has 20 hospitals and other facilities in Missouri, Illinois, Wisconsin, and Oklahoma. SSMHC also was the first health care organization to win the prestigious Malcolm Baldrige Award in 2002, partly because of its employee-friendly policies.

Shared governance and flexible schedules are major staff satisfiers, surgical services directors say.

The 12-room OR at SSM St Mary’s Hospital Medical Center, Madison, Wis, has a turnover rate of 1%, as does the hospital as a whole, notes Beverly Beine, RN, MS, director of surgical services. The national turnover rate for perioperative RNs is 7% according to the 2004 OR Manager Salary/Career Survey (September issue).

Nurses can choose to work part time or full time and have a choice of 6-, 8-, 10-, and 12-hour shifts. The staff do their own scheduling for night-shift call and weekends, working from a request book.

Six-hour shifts are common with people going back to school, Beine notes.

“We strongly support furthering education through tuition reimbursement and loan forgiveness,” she says. Through these programs, nursing assistants are going to surgical technology school, surgical technologists are going to physician assistant school, and nurses are pursuing bachelor’s and master’s degrees.

New staff who come to SSM DePaul Health Center in St Louis from other facilities say it “feels different” because they are allowed to make decisions about issues, notes the administrative director of surgical services, Mindy Manley, RN, BS, CNOR.

For example, the staff developed a policy for who takes call when the on-call person calls in sick.

“Though I could develop a policy, it made more sense to me for the staff to decide how they were going to cover it,” she says. Sometimes they cover it in 2- or 4-hour increments per person.

“I have tried other strategies in other places, and I have found nothing works as well as giving the staff responsibility and letting them work it out for themselves,” says Manley.

Supply cabinets: An open or closed case?

With a large part of their supply budgets being spent in the OR, hospitals are looking for better ways to manage how supplies are used, charged for, and restocked.

Automation can help. One way to harness automation is to place supplies in locked cabinets, like vending machines. To gain access, staff must log in and record what they are taking. The cabinets have software that can be linked to other information systems for patient charging, supply tracking and replenishment, and cost accounting.

Some ORs that have been using closed cabinets are looking to combine the cabinets with open bins or supply carts, some of which have automated features. They have found closed cabinets have advantages but also limitations in the OR. They are costly, and staff may not always record everything they take. Also, it’s not easy for staff to grab items they need quickly like an extra pair of gloves.

One answer is a hybrid system that combines closed cabinets with open bins or supply carts.

Managers need to look carefully at the flow of supplies and which type of system will give them the best compliance and data capture, says Donna Maddox, RN, manager of upstream materials management process. To gain access, staff must log in and record what they are taking. The cabinets have software that can be linked to other information systems for patient charging, supply tracking and replenishment, and cost accounting.

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“You have to look at trends and patterns of how you are staffed and then look at the goals for your supply delivery system,” says Maddox, a former OR manager who helped install a closed-cabinet system while at Barnes-Jewish Hospital in St Louis.

After using the closed system for nearly 3 years, Barnes-Jewish will add an open-supply-cart system for less expensive and more commonly used supplies—gloves, gowns, syringes, and sponges.

Good planning needed

“If you can manage an open system that has exposure to fewer people, it can be successful,” she says. “An open system that is exposed to large numbers of people increases your variability.”

Closed systems give better accountability, she says, because nurses or technicians, in most instances, must log in before taking out supplies. Closed cabinets also have the advantage of identifying accurately which patients the supplies are used for.

Open-bin automated systems are increasingly popular for hospitals of all sizes, says Carol Reilly, senior vice president of clinical practice for Implementation Specialists in Healthcare (ISH), West Orange, NJ, which consults on materials management.

For any kind of automated inventory system to work properly, managers need to plan carefully and think through their current processes.

“You have to have accurate doctor preference cards,” Reilly says. “ORs also need clear protocols that identify people who are able to pull supplies.”

Vendors offering automated supply systems that are used in the OR include Pyxis of Cardinal Health, San Diego; Omnicell, Palo Alto, Calif; and PAR Excellence, Cincinnati.

Managers and other experts talked about issues ORs need to consider to make automation part of their inventory management process.

Looking for flexibility

Most hospitals that choose Pyxis select secure cabinets, but a few want to start with a closed system to manage only consignment and implantable items, says Rob Sobie, Pyxis’s marketing director for Automation and Information Services at Cardinal Health.

The Hospital of St Raphael, a Pyxis client in New Haven, Conn, is taking a hybrid approach. It has open and secure systems in the OR core, open systems in some rooms, and closed systems in some rooms.

Sobie recommends closed systems for “total management control,” including inventory tracking, charge capture, supply replenishment.

“There are rare instances where a hospital experimented with secure automation and wanted to go with an open system,” he says. One client had one of its sites move from a secure to open system and saw compliance go from 90% to between 57% and 62%. He says the client is considering returning to a secure system because of an increase in supply costs.

Brook Langley, operations manager for materials management at 500-bed St Mary’s Medical Center in Knoxville, Tenn, says materials managers she talks with have mixed opinions about closed versus open systems.

“There is some confusion about which direction to take,” she says. “Some materials managers feel they need supplies in a closed environment. Some don’t. The vendors market the closed systems as ideal, but the biggest thing to know is that every hospital is different.”

Langley suggests selecting a vendor that has a flexible system.

“Look at the product: how it flows and how it charges the patient. Listen to vendors (describe) how their system works, but make sure they will listen to what you want before you go to automation,” she says.

Though there are no independent cost-benefit studies, vendors say closed systems achieve return-on-investment within 18 months and reduce inventory by 10% to 30%, depending on the hospital.

A question of compliance

Paul Carlson, perioperative services business manager at the Nebraska Medical Center in Omaha, is evaluating open systems and closed systems for the OR. Currently, most units in the hospital have a combination of open and closed supply stations.

“In the OR, we want to use the system for supply billing, reporting, and inventory replenishment,” he says.

Carlson advises ORs to be careful in what system they choose: “What works in a med-surg unit might not work in the ...

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Materials management

Open and closed supply stations

Entering data with a Pyxis system, which uses open bins and closed cabinets.

Secure supply station

Staff log into a locked cabinet. The door opens. Items are displayed in trays. A selection is made. The staff member scans the barcode on the item and enters the patient identification with a keyboard. Some systems have computer screens with patient names listed. In those systems, nurses enter the supply name, touch the patient name on the computer screen, take the item, scan the code, and press 'save' on the monitor. Systems also can be designed not to require the nurse identification step.

A nurse uses a probe to record inventory data using the Par Excellence open-bin system.

Open-bin system

A nurse locates an item by color-coded plastic bins. For example, airway products are in blue bins, medical surgical products in yellow, and blood products are in red bins. For supply inventory and replenishment, the nurse enters or scans the identification of the product and patient.

Sobie notes several Pyxis clients have documented compliance rates of more than 90% using closed stations. Three include the Hospital of St Raphael; the Medical Center at the University of South Carolina, Charleston; and Munroe Regional Medical Center, Ocala, Fla.

“Huge change for the staff”

An internal study of a closed cabinet system on one medical-surgical floor found the staff increased charge capture by 19%, Carlson says. “Closed systems force greater compliance, but it is a huge change for staff,” he notes.

Before making a choice, he advises making sure staff is comfortable with the systems being considered. Also, while cost is important, having a good relationship with the vendor is equally important.

He also advises asking the vendor several questions, which should be answered in the affirmative:

- Can the system support multiple asset locations?
- Can multiple users be logged on at one time to the system?
- Can the system use scan technology to credit items returned?
- How will the system handle cases picked 36 hours in advance?

Closed cells and case carts

Barnes-Jewish, with 887 beds, has been using different inventory management systems for the OR departments on its 2 campuses.

The north campus, which was Jewish Hospital before a merger 8 years ago, has enough space for case cart delivery. Instead, supplies are located in 2 nearby storerooms and other locations, Maddox says.

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OR. They are different environments.”

Complicating Carlson’s decision is that the 735-bed medical center has 3 separate campuses with 3 separate OR configurations and processes.

“The intent is to eventually design one system and process that will work for all 3 locations,” he says.

“For the case-cart picking area, we are leaning toward open technology,” he says. “But in the cores, should it be open or closed? If open, are you going to get 50% compliance by hitting a button, and is that good?”

He thinks the goal of supply automation systems should be to operate near 100% compliance. “This is a major challenge for this type of automation,” he adds.

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**Options for smaller ORs**

Automated supply systems with open bins are an option for smaller hospitals and surgery centers that might not be able to afford closed supply stations. “Smaller hospitals (70 to 200 beds) are less likely to purchase closed cabinet systems because these systems normally cost 4 times more than open-bin systems,” says Dick Felger, vice president of sales and marketing for PAR Excellence Systems, Cincinnati. The company offers both open bins and locked cabinets for outpatient surgery centers, cath labs, and hospital ORs.

“We only recommend a closed or secure system if the supplies are within access to a lot of people—out in an alcove or corridor,” Felger says. “The other reason might be if certain items are very expensive (pacemakers, for example). If you have a $1,000 piece of equipment, you might want that locked up.”

In contrast to closed cabinets, which are like vending machines, an open supply system generally is a series of color-coded bins stacked on shelves or hanging on louver. Both systems require users to enter the patient’s name and scan the supply item for data collection.

**A small hospital’s experience**

Marymount Medical Center, an 89-bed hospital in London, Ky, installed an open-bin system in 2003. During the first 6 months, the OR reduced inventory by 37%, increased revenue, and improved staff efficiencies, says Maureen Phelps, director of materials management.

“We went to an open system for ease of the user (nurses and materials managers), and it made the whole replenishment system work better.” Phelps says. Cost also was a big factor. The open system was less expensive than closed stations.

With the system from PAR Excellence, a computer that stores supply data is located in the surgery department. Supply usage data helps ORs manage supply chain activities, including product utilization analysis and cost accounting by doctor, patient, or procedure. (More information is at www.PARExcellencesystems.com.)

“We recommend consolidating supplies so each item has its own bin,” Felger says. “When items are picked for the tote or case cart, a probe or scanner can be used to collect the data.”

The hospital can choose either iButtons or barcodes. With iButtons, a probe collects item data from stainless steel buttons on the shelf or bin. The data is downloaded into the department supply information system.

“If the facility uses barcodes, a handheld scanner is used to record each item dispensed or credited to a patient. (But only about 50% of packages have barcodes at the unit of issue.)

Marymount uses probes to record supplies in all departments except in the cath lab, where it uses scanners because those supplies have barcodes.

“We have found the iButton technology works 100% of the time,” Felger says. “Barcodes have more long-term maintenance. But a lot is personal preference and the strategic plan of the hospital.”

Tina Johnson, Marymount’s supply resource coordinator, says previously OR nurses pulled supplies for their own cases from stocks in each of the 5 ORs and 2 endoscopy rooms.

“Nurses are happy because they are now free to do other things,” Johnson says.

Phelps says the OR department did not have a central core. She worked with Anthony Eversole, RN, director of perioperative services, to set up a central core area and organize supplies.

They also implemented a case cart system with the help of Shawna Gilbert, a materials management clerk.

Like most supply information systems, the PAR Excellence systems can be linked to a facility’s materials management, patient billing, and cost accounting systems, Felger says.

“The primary function of the system is to manage inventory,” he says.

“Many hospitals have OR scheduling and charging systems, but fewer have systems to decrement inventory.”

Open or closed systems are an improvement because they manage inventory “in real time” by deducting supply items as they are used, he says.

“When integrated with materials management, the information is sent to that system or to the vendor for replenishment,” he notes.

Both types of systems free nurses to spend more time with patients, Felger says. “It is an easier process for nurses to get at open bins than a closed system. We are finding the majority of clients prefer open systems and can easily justify open systems.”

—Jay Greene
Volunteers pitch in to help educate perioperative staff

Many ORs are getting along without an educator. In fact, 42% of community hospitals in the 2004 OR Manager Salary/Career Survey said they do not have a perioperative educator (September issue).

Mercy General Health Partners in Muskegon, Mich, is one of those.

These are some ways the surgical services department is educating its staff:

Preceptor program

“Our nurses attend a preceptor class given by the hospital-wide educator geared toward the adult learner,” says Terri E. Grego, RN, BSN, CNOR, clinical leader for surgery at the 180-bed hospital, which has 8 ORs and 2 cystoscopy rooms.

Newly hired RNs are assigned to a preceptor who has attended the class and who coordinates their orientation.

For each RN who completes orientation, the preceptor receives $300, which is part of RNs’ union contract. The preceptor does not receive a bonus if the new RN does not complete orientation, which is an incentive for them to provide support.

Orientation packet

Orientation for perioperative nurses is guided by a packet developed by the department’s shared governance committee. The packet includes, among other things, skills check-off lists and specialty check-off lists, which the preceptor initials, and a scavenger hunt to help orientees learn to locate OR supplies and equipment.

Grego meets with orientees midway through their orientation and again at the end when she signs off on their completion of the program.

Competency monitoring

An RN first assistant has volunteered to monitor staff competencies and notifies Grego of personnel who have not completed their requirements in a timely manner.

“She is very good about distributing, grading, and tracking the competencies, along with providing additional support and education to those who need it. I don’t know what I would do without her,” Grego says.

Jay Greene is a freelance writer in St Paul, Minn.

Staff survey of education needs

Twice a year, Grego takes an informal survey that asks the staff what areas they need more information about, such as specific equipment, instrumentation, procedures, nursing skills, or computer skills.

Equipment fair

After the survey of learning needs is completed, a volunteer staff RN works with the materials coordinator to plan a twice-a-year 2-day equipment fair, held from 9 am to 5 pm. All staff are required to attend the fair and complete competencies.

Upon entering the fair, each person receives a folder with instructions on how to proceed.

“We try to make it fun,” Grego says. “The staff have really grown fond of these events.”

Stations are set up with activities such as tourniquet application, Chick or fracture table positioning, CO2 or oxygen tank exchange, or glucose monitoring. Company representatives help provide instruction when appropriate. Food and drink are offered.

“Having an educator within the department would be my preference,” Grego says. “An educator provides coordination and consistency. Without an educator, you need to focus on utilizing each other’s strengths, along with physician and sales representative support, to provide educational sessions and other needs.”

She is currently working on having staff members develop monthly in-service programs on topics they need to learn or find interesting.

The department continues to work on justifying the need for an educator. The hospital participates in a Gallup workplace survey, which may give them evidence to argue for more education. Scores have not been improving for 2 of the questions, which are: “My fellow employees are committed to doing quality work,” and “This year, I have had opportunities at work to learn and grow.”

Would you like to share how your OR is managing without an educator? Contact ppattersor@ormanager.com for a possible interview.
Joint Commission

Will staff be ready for no-knock surveys?

Getting ready for a survey by the Joint Commission on Accreditation of Healthcare Organizations can mean a big scramble: Will the staff be ready? Are policies and procedures up to date—and is everyone tuned into what they are?

It’s time to stop scrambling.

In 2006, the Joint Commission moves to all unannounced surveys. Organizations will need to be in a state of constant readiness. And they’ll have to make sure the staff is prepared to talk to the surveyors.

The staff has moved to center stage in the survey process. Under the tracer method introduced this year, surveyors spend most of their time interviewing the staff who deliver care. They do this by selecting patients’ charts and tracing their care through the process.

Perioperative leaders whose hospitals did well on surveys earlier this year shared tips about how they prepared—and how they plan to stay prepared for the future.

A readiness strategy

Franklin Square Hospital Center in Baltimore adopted 2 strategies to keep accreditation readiness in the foreground.

A patient-safety-first philosophy

“We’ve moved away from the attitude of, ‘We have to do this because the Joint Commission says so,’” says Chet Wyman, MD, of the Department of Anesthesiology and Perioperative Medicine. The 200-bed hospital performs 15,000 to 17,000 procedures a year. “Instead, we are saying, ‘We are going to improve the way we do things because it is better for patients.’ Now everything we do, we bounce off the paradigm of patient safety.”

A readiness committee

Franklin Square formed a readiness committee as part of its quality council about a year before the survey.

The committee assigned “chapter experts” for the accreditation manual who review their chapters and prioritize areas where they think there are deficiencies. Then they develop a plan, present it to the committee, implement the plan, and report back regularly on progress.

The committee also makes sure policies are consistent throughout the organization. OR leaders, for example, helped develop a housewide policy on JCAHO’s Universal Protocol for preventing wrong surgery, which applies wherever invasive procedures are done.

Prepare the staff

The hospitals helped the staff get in shape for tracers and are making sure they stay in shape for unannounced surveys.

Harness the Internet

Dr Wyman set up a news group in Lotus Notes on patient safety, moderate sedation, and pain management.

“It’s like a chat room where people can pose questions to chapter experts, and we answer them,” he says. If they don’t know the answer, they find other experts who do. For a question about postoperative management for sleep apnea, he wrote to an expert who sent a copy of a lecture, which he posted on the bulletin board.

“We used to have brown bag lunches, but people might not be able to get there, and they might not think of their question at the time of the luncheon.” With the discussion groups, questions can be posted at any time.

Conduct mock tracers

Franklin Square started preparing the staff with mock tracers a few months before the survey.

“To me, this was the smoothest and most prepared the staff have ever been. I think it’s because we started far in advance,” says Debbie Kisner, RN, PhD, CNOR, director of surgical services. The hospital has already started doing practice tracers to stay prepared for unannounced surveys.

In the mock tracers, says Kisner, “We would pull a chart and say, ‘Show me where I’d find the consent for this? How can I tell that this was an informed consent? What does that mean?’”

Dr Wyman notes, “We treated the mock tracers like the real thing. We started by saying, ‘We are not trying to find fault. This is a learning process.’” Word spread quickly the hospital meant business. At first, a number of problems were identified, but with more practice, there were fewer.

Leaders worked with the staff on things that needed to be fixed, such as pain documentation. The policy says pain will be documented using an analog scale of 1 to 10. But instead, nurses might write a note, such as, “Patient has a little pain.” Managers reviewed the policy and explained how to improve documentation.

Have staff educate staff

Involving the staff in educating each other was a successful approach at Mary Washington Hospital in Fredericksburg, Va. Heather Carelock, RN, MHA, CNOR, administrative manager of the OR, found the staff was even more assertive in drilling their peers than managers might be. They would say, “They’re going to be asking you these questions. You need to be ready.” They would persist until the peer answered the question correctly.

To help this effort, the hospital’s readiness team created sample tracer questions or used sample questions from other hospitals, then scripted responses.

Practice, practice

Other ideas for helping the staff prepare included:

- Role play during in-services. At inservice sessions, Carelock would call on people and say, “Joe, tell me what you’ve done to improve your care this year?” Or, “What does Focus PDCA mean?” (referring to the quality improvement method). Though people think they know the answers, they need to practice saying it out loud to gain confidence.

Continued on page 21
How did the new tracer process go?

The staff may be nervous about talking to a Joint Commission surveyor. But they can also find it rewarding because it gives them a chance to talk about how they care for patients, say managers who have had surveys recently.

“In the past, especially in the OR, nurses would go into their rooms, pull the curtains, and stay out of the way,” notes Debbie Kisner, RN, PhD, CNOR, director of surgical services at Franklin Square Hospital Center in Baltimore, Md. With the new survey process, they can’t do that.

With the new tracer process, “the surveyors came to the OR the first day and said, ‘OK, let me see the chart of an inpatient and an outpatient,’” she says. “Then they would talk to individual nurses and say things like, ‘Tell me about your care plans and how you individualize them. Tell me how you use the Universal Protocol’” (for surgical site verification).

“There weren’t ready-made textbook answers, but the staff was telling how they take care of patients.”

They did well, and Kisner found she liked the patient focus.

One big difference from previous surveys—rather than visiting the surgery department once, a surveyor might come back at any time during the survey as part of a tracer that starts elsewhere, such as on a nursing unit or in the emergency department.

That kept the department on its toes for the entire week, says Heather Carelock, RN, MHA, CNOR, administrative manager of the OR, at Mary Washington Hospital in Fredericksburg, Va, surveyed in May.

The physician surveyor visited the surgical areas and traced a fictitious patient having a laparoscopic cholecystectomy. He asked to see a preference card as well as a written plan of care. He wanted to see that the plan followed the patient into the postanesthesia care unit.

Carelock found the tracer process in the OR wasn’t as obvious as it was on nursing units, where a surveyor would pick up a chart and talk to a nurse for 20 minutes about care given.

Among other areas surveyors asked the staff about:

- Surgical site verification
- Preoperative consent process
- Histories and physicals

Surveyors asked about surgical fire prevention, which was the subject of a JCAHO Sentinel Event Alert in June 2003.

At Franklin Square, the staff could point to fire-safety posters posted in each OR. St John has fire-response steps printed on each employee’s name badge. Plus, the staff could discuss the OR’s policy, which outlines duties of OR personnel in a fire.

At Mary Washington, the OR staff
Which MDs make the most for hospitals?

Three of the five top earners for hospitals are surgical specialists. On average, a physician generates $1.9 million a year in net revenue for a hospital. But the top surgical specialties generate more than $2 million per FTE physician:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Net annual revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopedic surgery</td>
<td>$2.9 million</td>
</tr>
<tr>
<td>Cardiology (noninvasive)</td>
<td>$2.6 million</td>
</tr>
<tr>
<td>Cardiology (invasive)</td>
<td>$2.5 million</td>
</tr>
<tr>
<td>General surgery</td>
<td>$2.4 million</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>$2.4 million</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>$1.7 million</td>
</tr>
<tr>
<td>Urology</td>
<td>$1.3 million</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>$860,000</td>
</tr>
</tbody>
</table>

Orthopedic surgery also had the highest rate of revenue growth over the past 2 years, at 61%.

“From botox to bariatric surgery, more procedures are being done today than ever before, and that increases the value of specialists to hospitals,” says James Merritt, of Merritt, Hawkins & Associates, which conducted the survey. The revenue includes both net inpatient and outpatient revenue derived from patient referrals and from procedures performed at the hospital. The survey of 4,000 hospital CFOs had 146 responses. More information is at www.mhagroup.com.

Clinical nurse leader: A new role takes shape

The American Association of Colleges of Nursing (AACN) and nursing leaders are calling for creation of a new nursing role, the clinical nurse leader (CNL).

The idea is to provide a master’s prepared clinician at the bedside who would have the same educational preparation as a pharmacist, physical therapist, or social worker.

The CNL would be accountable for client outcomes by applying research-based information to design and carry out plans of care, according to an AACN white paper. The CNL also would coordinate, delegate, and supervise care of other members of the health care team. The role is not seen as management and would not be limited to the acute care setting.

Task forces have been at work on outlining the role and potential requirements. There are 81 pilot programs underway in the US. Seminars and regional meetings are being held around the country.

—www.aacn.nche.edu/NewNurse

Joint Commission

had prepared by holding interdisciplinary fire drills involving anesthesiologists, nurse anesthetists, surgeons, and nurses.

Sterilization

Questions surveyors asked staff in the sterile core concerned:

• whether flash sterilization is done, and whether implants are flash sterilized
• examining the flash sterilization log
• the process for recalling instruments in case an indicator signals a sterilization load is faulty.

Are doctors involved?

At Mary Washington, the surveyor “really was looking for interdisciplinary discussions” among the surgeons, nurses, and anesthesiology providers, Carelock notes.

“He wanted to see doctors were involved in improving care.” He wanted to see proof in the OR Committee’s minutes that they had identified a problem and followed it through the performance improvement (PI) process.

“I was very impressed that they wanted to know related to surgery how we’re using data to improve what we are doing,” adds Dr Wyman, of Franklin Square. The hospital has PI data on issues such as first-case starts.

“They wanted to see our data. They said, “Show us where you started, where you’ve come. Show us what you did related to the data and what you have done since you put those new processes in place.”

JCAHO resource

The Joint Commission has posted the “Rationale and Interpretive Guidelines” for the 2005 National Patient Safety Goals on its website at www.jcaho.org/accredited+organizations/index.htm

Continued from page 19

• Include new employees, off-shift employees, and employees at all levels. When Mary Washington hired 2 new orderlies right before the survey, the OR educator sat down with them, asked sample questions, and helped them compose responses.

It’s important to practice with employees on all shifts because surveyors can visit during off shifts.

• Make it fun.

As survey time got closer, Franklin Square and Mary Washington instilled some fun into the preparations. “We had fairs, candy, Jeopardy games, treasure hunts, and lots of laughs and teamwork,” Carelock says. Franklin Square played a Jeopardy game and gave candy bars to staff who gave correct answers during mock tracers and in-services.
“New vision” needed to bring minorities into health professions

The Sullivan Commission on Diversity in the Healthcare Workforce issued what it called “a new vision” for health care aimed at increasing the number of minorities in the health professions. The lack of an adequately diverse and trained workforce “may be as great a problem for minorities as is the lack of health insurance for the more than 44 million Americans,” said the commission chair, Louis W. Sullivan, MD.

The commission’s vision called for a change in the culture of health professional schools, new and nontraditional paths into the health professions, and commitment “at the highest levels.” Among specific steps, the report called for shifting from loans to scholarships, reducing dependence on standardized testing for admission, and enhancing the role of 2-year colleges in preparing professionals.

The American Association of Colleges of Nursing endorsed the findings, noting that only 12% of nurses are from minority backgrounds, though 30% of the U.S. population is made up of minorities.

Florida Hospital to pay employees for rest time during storms

Florida Hospital based in Orlando, Fla, said it will pay employees for every hour they are required to be at work during a storm, even sleep time, a vice president for the system told the Sept 28 Orlando Sentinel. During Hurricanes Charley and Francis, the hospital paid hourly workers for just a portion of their rest time. For example, employees were paid for 8 of their 12 hours of rest time. That caused an “uproar among employees” and set off an investigation by the US Department of Labor, the paper reported. The city’s other major system, Orlando Regional Healthcare, reportedly started paying hourly workers double time for every hour at their facilities during a storm. The hospital uses a voluntary system for storm emergencies, which works especially well for employees with young children who don’t want to leave them, a spokesman said.

Do nurses understand perils of shift work?

After 12 hours of work, the risk of making a mistake can be twice that after 8 hours on duty, according to studies cited by the Institute of Medicine in its report, “Keeping Patients Safe: Transforming the Work Environment of Nurses,” released earlier this year. The report concluded there is no evidence that any amount of training, motivation, or professionalism can overcome the performance deficits associated with fatigue, sleep loss, and circadian variations in alertness.

An article in the September AJN provides education for RNs on the perils of shift work and suggest specific actions nurses can take to alleviate the impact of shift work. The article offers continuing education credits.

——Hughes R, Stone P. AJN. September 2004; 104 (9): 60-64.
New clues on how to inactivate prions

New research is offering clues for methods to get rid of prions without damaging delicate instruments.

Inactivating prions on surgical instruments has been seen as difficult. Current methods rely on harsh chemicals or extended sterilization cycles that can damage or destroy instruments.

Three reports published this year provide evidence on gentler methods that could be effective. None is cleared in the U.S., but some are starting to be available in Europe.

Prions are misshapen proteins that cause disease without the help of DNA or RNA. The misfolded particles cause spongy holes and inflammation in the brain that are hallmarks of transmissible spongiform encephalopathies such as Creutzfeldt-Jakob disease (CJD) and mad cow disease.

Prions attach tightly to surfaces and have been considered hard to remove with usual sterilization and disinfection techniques. But researchers are making progress.

One significant advance—scientists for the first time have an animal model they can use to measure the effectiveness of prion inactivation methods. The model assumes a worst-case scenario with no cleaning.

Using the model, researchers now have solid data on treatments recommended by the World Health Organization (WHO). Two of three methods tested—soaking in sodium hydroxide or sodium hypochlorite—were effective in a study by French researchers funded in part by the Steris Corporation. The third method, an extended prevacuum sterilization cycle of 134°C for 18 min, on its own, was not. But in an important finding, simply immersing the item in water made this extended cycle much more effective.

“A simple cleaning step followed by sterilization in water in a gravity-displacement-type sterilizer [at 21°C for 20 min] is probably more effective than anything else that has been recommended,” says Gerald McDonnell, PhD, senior director of technical affairs for Steris and a co-author of a study led by Fichet of France. This method would not be appropriate for heat-sensitive items, however.

Highlights of other findings:

**Alkaline cleaners**

Alkaline detergents showed great promise in activating prions in all 3 studies, though they are not cleared for this claim in the U.S.

“The message we are hearing loud and clear is that alkaline cleaners are very effective against prions, and they have much better materials compatibility than sodium hydroxide,” notes Martin Favero, PhD, director of scientific and clinical affairs for Advanced Sterilization Products (ASP), a Johnson & Johnson company.

A Steris alkaline cleaner used in the pharmaceutical industry actually degrades prions and does not harm instruments, Fichet and colleagues found. Steris is making the product available in Europe for medical devices under the brand name, HAMO 100.

A German study led by Yan and funded by ASP also found an alkaline detergent showed a “significant reduction” in infectivity, whether the terminal method was disinfection or sterilization. The detergent was tested at 70°C. It has since been tested at 50°C with similar results, Favero says.

**Vaporized hydrogen peroxide**

Also promising is vaporized hydrogen peroxide (VHP) sterilization.

VHP combined with cleaning completely removed prion infectivity in the Fichet study—a significant finding because it doesn’t damage surfaces, including electronic equipment. Steris does not currently have a VHP technology with governmental approvals for health care sterilization. Steris has used its VHP technology to decontaminate buildings with anthrax.

A modified cycle of ASP’s Sterrad system, which uses hydrogen peroxide gas plasma, also was effective in reducing prion contamination. When accompanied by precleaning with an alkaline detergent, the modified cycle with 4 injections (basically a double cycle) resulted in complete inactivation of prions. These experiments used the industrial model Sterrad 100 GMP because it could be programmed. The next step will be to test a hospital-type Sterrad unit using the same protocol, Favero says.

Other cleaners

Other cleaners had mixed results. Two Steris products, Environ LpH, a general surface phenolic disinfectant, and Klenzyme, an enzymatic cleaner, were effective against prions. Cleaning with Klenzyme followed by gravity-displacement steam sterilization at 121°C for 20 min eradicated prions, according to the Fichet report.

ASP’s enzymatic cleaners, on the other hand, seemed to have no effect. Favero said scientists do not yet know why the enzyme formulations had different results.

**Peracetic acid**

The Steris System 1 and its proprietary formulation, Steris 20, which uses peracetic acid, partially reduced the risk of prion transmission, Fichet et al found.

The Yan study found another peracetic acid formulation (0.35% at 5 min) had no effect on prions.

Though work is still to be done, results suggest there is a broader range of choices beyond the methods recommended by WHO, says Favero, and there now is a scientific basis for evaluating how well those methods work.

References


Joann Gillaspie, RN, didn’t get it. Benchmarking data showed that for prostate biopsy patients, her surgery center was below average for the indicator that measures pain control after discharge. Nurses collecting data during postoperative phone calls were surprised to learn patients didn’t understand the discharge instructions.

“We told them to take anything they would take over the counter for a headache, like Tylenol or ibuprofen, and we gave them a patient instruction sheet to take home,” explains Gillaspie, who is quality coordinator at Spring Park Surgery Center in Davenport, Iowa.

A quality improvement team dedicated to fixing the issue discovered 2 breaks in the system. First, nurses verbally gave this information to patients before and after they gave them midazolam (Versed), which has an amnesiac effect. The patients simply didn’t remember. Second, the type of pain medication wasn’t specified on the patient information sheet.

Amending these processes has brought Spring Park’s benchmark score to above average, and the center continues to review postoperative instructions annually, Gillaspie says.

Spring Park is among ASCs that use benchmark data from Surgical Outcomes Information Exchange (SOIX) to assist in determining performance improvement goals. SOIX, one of several ASC benchmarking programs, compares 10 quality indicators for 35 procedural categories (www.soix.com). (See September OR Manager for an overview of benchmarking in ASCs.)

Improving recovery time for cataracts

At Blake Woods Medical Park Surgery Center in Jackson, Mich, SOIX data showed the average time for recovery from cataract surgery was 30 minutes. In 2001, Blake Woods was at an hour.

Changes obviously had to be made, says CEO Margaret Acker, RN, MSN, especially when ophthalmologists were waiting around for their cases to be ready. In addition, when orthopedics and podiatry were added to the center, which has 3 ORs and performs about 5,000 cases per year, Acker says ophthalmology turnaround time had to be reduced to make space for the new cases.

Acker coordinated a QI team, and the members used Edward Deming’s total quality improvement cycle of “plan, do, study, act.”

As a result, the center converted 3 stations that had been used for general anesthesia recovery to intake stations. A nurse who staffs the reception area now brings back a patient, fills out documentation, inserts eye drops, then takes the patient to a preoperative nurse and returns to the reception area for the next patient.

“We used to prep 1 patient at a time. Now we can do 6,” Acker says.

Another issue was the actual surgery time. Before, cataract procedures took Blake Woods’s ophthalmologists 14 minutes; now they take 10.

Two changes made the difference. First, Blake Woods created a position for an RN who helps prepare and transport patients for cataract surgery. This is how it works:

The RN brings patients from the preoperative area to the OR and reports to the circulating nurse to verify the patient’s identity, type of surgery, site, and allergies.

While the circulator completes the documentation, the RN tapes the patient’s head and prepares the surgical site. Then the RN leaves to deliver the next patient to the next OR, reporting to the circulator as before. After the surgery is finished in the first OR, the RN returns to deliver the patient to the recovery area and returns to get the next patient. This process continues through the day.

“The surgeons are never waiting, because they go back and forth from room to room,” Acker says, adding that the nurses take turns circulating or prepping, so they are not performing the same duties all day.
The nurses were concerned about adverse reactions.

“The nurses figured this out and did it themselves,” Acker says. “It told me that we are in a QI environment, and I’m not the only one playing the game.”

A shorter recovery for prostate biopsies

Back in Iowa, Gillaspie also is passionate about quality improvement. “My whole heart is with QI,” she says. “I can’t think of a better way to ensure we’re giving the best care to our patients so they leave satisfied, pain free, and remember their time with us as pleasant.”

Spring Park has 3 ORs, a lithotripsy room, and a laser room, performing 6,100 urology and ophthalmology procedures a year. Gillaspie says SOIX benchmarking data changed how surgeons handled sedation for prostate biopsies. Previously, anesthesiologists gave prostate biopsy patients moderate sedation, which prolonged discharge time because they had to go to second-stage recovery. Benchmarking data showed the average recovery time for prostate biopsies is 25 minutes; Spring Park was at 40 minutes. This evidence convinced the surgeons to perform local blocks, bringing recovery time down to 20 minutes, as well as lowering the cost per case.

Her advice to other centers is to keep QI simple. “Your project doesn’t have to be something outlandish to improve upon,” she says. “Do what is pertinent to your clientele. Just because the center down the street is doing QI in one area doesn’t mean it’s pertinent to you.”

Also, “No center is perfect. But you can strive for it when it comes to patient satisfaction.”

Allaying discharge concerns

Based on SOIX benchmarking data, Findlay Surgery Center in Findlay, Ohio, reduced recovery times up to 60% for certain procedures.

“Our recovery times were twice the average because we had 2 more traditional ENT surgeons who kept the tonsillectomy patients 4 to 5 hours postoperatively to make sure they wouldn’t have a bleeding episode at home,” relates administrator Cheryl Cunningham, RN. Findlay is a multispecialty ASC with 4 ORs and performs about 6,000 procedures a year.

“We collected enough articles from the literature and spoke with other facilities who did a lot of the same procedure to convince the physicians to drop their times by 60%,” Findlay says. “Our follow-up study showed that complication rates did not increase.”

Nurses in the GI recovery area also contributed to delayed discharge times, Findlay says. SOIX data showed Findlay’s time was between 37 to 40 minutes for discharge, compared to the average of 26 minutes.

“The patients met discharge criteria, but the nurses were concerned about adverse reactions between the IV sedative and other pain medications the patients might take at home,” Cunningham says.

The QI team developed a medication in-service program that reviewed the half-life of particular sedatives and when to be concerned. As a result, discharge time for GI patients dropped by about 35%, Cunningham says.

Quality improvement at Findlay primarily is physician driven, says Cunningham. A quality improvement committee that includes physicians, nurses, the business office manager, and an endoscopy representative meets annually to determine QI goals for the year. They review benchmarking data as well as incident reports and patient satisfaction surveys to determine subjects for study. Every other month the committee reports progress to the center’s board of directors and produces a year-end report.

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Reducing the risk of surgical fires is a new 2005 National Patient Safety Goal for ambulatory care organizations, including ambulatory surgery centers (ASCs), accredited by the Joint Commission on Accreditation of Healthcare Organizations. (The goal does not apply to hospitals.)

The goal has 2 elements:

- educating the staff, including licensed independent practitioners (such as physicians and anesthesia providers), about controlling heat sources and fuels
- establishing guidelines to minimize oxygen concentration under the drapes.

What is the hazard?

The greatest hazard leading to surgical fires is oxygen-enriched atmospheres under the drapes. Three out of 4 surgical fires are oxygen enriched from open oxygen sources, according to data from ECRI, a nonprofit health care research organization in Plymouth Meeting, Pa.

Oxygen-enriched atmospheres are common in ambulatory surgery because an increasing number of procedures are performed under monitored anesthesia care (MAC) with the frequently perceived need to provide supplemental oxygen.

“Whenever you deliver 100% oxygen through a tube to the face, you run the risk of creating a hazardous oxygen-enriched atmosphere under the drapes,” says Mark Bruley, ECRI’s vice president for forensic investigation, who has investigated surgical fires for 25 years.

The high oxygen levels under the drapes can seep to the area of the fenestration, reaching the surgical site where energy sources like electrosurgery or lasers are being used.

High oxygen concentrations are especially hazardous in head and neck or upper chest surgery because the heat sources are near where oxygen is flooding the patient’s face.

“When concentrations reach 40% to 50% or higher, they can create conditions for an oxygen-enriched flash fire—with the fire being easily ignited on the surgical towels, the patient’s hair, and the surgical drapes, in most cases.”

Bruley outlined practical ways to meet the safety goal based on ECRI’s research.

Establish guidelines

To meet the goal’s requirement to minimize oxygen concentration under the drapes, he suggests that ASCs develop a policy and procedure. (He added that even though JCAHO did not make preventing surgical fires a 2005 National Patient Safety Goal for hospitals, hospitals still need to be proactive in reducing the risks of surgical fires.)

A good reference is ECRI’s free 8 1/2 x 11 in poster, Only You Can Prevent Surgical Fires. A new edition was issued in July.

The poster addresses specific steps for reducing fire risk:

- at the start of surgery
- with open delivery of supplemental oxygen
- during oropharyngeal surgery
- when using electrosurgery, electrocautery, or lasers.

The poster notes that the recommendations need to be considered individually for each patient.

“Everything that needs to be written into a policy and procedure is in the bullet points in this poster,” Bruley says. “It summarizes more than 25 years of investigation and teaching on surgical fire prevention.”

In fact, he says, the policy and procedure could simply refer to the poster, stating: “We have incorporated the following guidelines to be employed by the surgical, anesthesia, and nursing staff.” The poster could then be attached to the policy.

The poster is on the OR Manager website at www.ormanager.com under the OR Manager Toolbox. Large, colorful versions of the poster are available for purchase from ECRI at www.ecri.org.

Provide education

Meeting the goal’s requirement for education needs to be an interdisciplinary effort, Bruley points out.

Areas to emphasize in education:

- The guidelines and the policy for minimizing oxygen concentration.
- Fuels, including alcohol-based prep
Anesthesia providers and surgeons need to talk to each other.

Most anesthesia machines have the capability of mixing oxygen with medical-grade air to give an oxygen concentration low enough to avoid a flash-fire hazard (at or below 30%), he says.

Probably the most effective safety practice is for surgeons and anesthesia providers to talk to one another during the procedure. For example, during head and neck surgery when open delivery of supplemental oxygen is being used, the surgeon might ask before using electro-surgery, “How much oxygen are we delivering to this patient?” If the level is high, he might wait at least 1 minute while the anesthesia provider stops the supplemental oxygen, if possible, for that patient.

Bruley says he thinks the new Patient Safety Goal “demands that anesthesia providers and surgeons talk to each other about minimizing oxygen concentrations under the drapes.”

Responding to fires

Though the focus should be on fire prevention, every facility should have a response plan as part of its safety program, Bruley says.

The Joint Commission in “compliance tips” for meeting the goal recommends that facilities for fire response:

- Implement and test procedures to ensure appropriate response by all members of the surgical team to OR fires.
- Make sure staff is trained in preventing and extinguishing fires. This includes being able to locate and use the fire extinguishers.
- Staff should be prepared for risks for each type of surgery they participate in.

The compliance tips are in a special report on the 2005 National Patient Safety Goals in the September Joint Commission Perspectives on Patient Safety.

The July AORN Journal has articles on fire education and preparedness.

Bruley emphasizes key points about fire response:

- ECRI does not recommend use of fire blankets for surgical fires.

“...We believe fire blankets provide a false sense of security in the operating room,” he says. “In a fire where the patient’s hair and OR table drapes are involved, you will likely have only a few seconds to react before the patient is seriously burned.” There is not enough time to get the fire blanket off the wall, unfold it, and apply it to the patient.

The best approach to extinguishing a drape fire, he says, is to immediately turn off the flow of gases to the patient, pull the drapes and other burning materials off the patient, and extinguish the fire on the floor, either by stamping it out or with a CO2 fire extinguisher if indicated.

Other problems with fire blankets are that the blanket may trap oxygen being delivered to the patient that also is feeding the fire, and the fire can continue to burn, Bruley says. Typical wool fire blankets may burn themselves if the oxygen is still flowing to the patient, adding fuel to the fire. The blanket also can cause further injury by displacing sharp instruments left in the sterile field. Another issue is fire blanket packaging, which is not consistent among manufacturers. It may take extra time to figure out how to get the package open.

For fire extinguishers, ECRI recommends a 5 lb CO2 fire extinguisher in each operating room.

“We do not recommend water, dry chemical, or water mist extinguishers,” Bruley says.

The CO2 extinguisher should be mounted inside the OR near the entrance. A CO2 extinguisher can extinguish small OR fires on cloth, plastic, or paper as well as any burning liquid or electric-

Continued on page 28
continuously energized fires. CO₂ extinguishers will work in an oxygen-enriched environment. Equally important, CO₂ extinguishers don’t leave a residue and won’t harm the patient, staff, or equipment.

Fire extinguishers are rarely needed in OR fires.

“Extinguishers have been used in only 3 or 4 of the hundreds of OR fires ECRI has investigated,” he says.

Resources
ECRI. Only You Can Prevent Surgical Fires. Free poster available at www.ecri.org. Click on green Patient Safety Center logo, then scroll down left side.

ECRI. A clinician’s guide to surgical fires: How they occur, how to prevent them, how to put them out. Health Devices. 2003;32(1):5-24. This article also rates 8 OR fire safety videos, finding 3 worth consideration. Check to see if your facility subscribes or to purchase a copy, call 610/825-6000 ext 5888. The article has been formally accepted by the National Guideline Clearinghouse administered by the federal Agency for Healthcare Research and Quality. The guideline is available at www.guideline.gov/summary/summary.aspx?doc_id=3688&nbr=2914.


QI teams form to work on each goal. Either Cunningham, the director of nursing, or the OR supervisor heads a QI team. They also follow a total quality management matrix, mapping out the current process and voting on and ranking solutions.

Although everyone involved in the process participates, nurses are rarely taken away from patient care to attend meetings.

“There just isn’t time,” Cunningham says. “To get nurse input, we’ll pull them together on the fly. Usually, one of us will leave the committee meeting and go ask the nurses their thoughts or comments on what we’ve come up with. Sometimes we catch them during the last 10 minutes of lunch or during a period in a procedure when only one nurse is needed.

Her advice to other centers is to get the team leaders involved. “We really rely on the team leaders to champion and outline the process to their staff. If they’re not driving quality improvement, it will get lost because patient care is the priority to nurses.”

She notes the key to QI is continuous review of processes. “If it’s broke, fix it, then keep following it.”

—Leslie Flowers

Leslie Flowers is a freelance writer in Indianapolis.
GPO oversight bill introduced

Two senators introduced a bill Oct 1 that would impose more oversight on group purchasing organizations. The bill, titled the Medical Device Competition Act, would:

- direct the Department of Health and Human Services to write rules on GPO practices
- prevent GPOs from accepting fees from suppliers unless HHS certifies the GPO does not violate the rules
- ban vendor fees exceeding 3% of goods and services sold.

The bill introduced by Mike DeWine (R-OH) and Herb Kohl (D-WI), leaders of the Senate antitrust subcommittee, follows almost 3 years of investigation by the subcommittee. Critics have charged that some GPO practices hamper competition and innovation by excluding smaller companies from gaining access to hospital purchasing. GPOs are funded by fees from suppliers under a special exception to Medicare’s antikickback law.

The group purchasing industry has expressed strong opposition to legislation, saying voluntary measures are the best approach.

—http://dewine.senate.gov
—www.higpa.org

CMS proposes expanding payment for implantable defibrillators

The Centers for Medicare and Medicaid Services (CMS) proposed Sept 28 to expand coverage of implantable cardioverter defibrillators (ICDs). The action, when final, would increase the number of Medicare beneficiaries eligible for ICDs by one third, to about 500,000. CMS expects to cover about 25,000 patients the first year, with a potential to save 2,500 lives.

The expanded coverage is based on new clinical studies showing for the first time that certain patients who have never had a heart attack are likely to benefit. The proposal recommends covering most of the population studied in the trial, including patients with heart failure and poor function of the left ventricle.

ICDs typically sell for $20,000 to $35,000. After a comment period, CMS has 60 days to review comments and issue a final policy.

—https://www.cms.hhs.gov/mcd/viewdraftdecisionmemo.asp?id=139

Action urged on patient safety bill

A coalition of more than 60 health care organizations and many state medical societies urged Congress in September to take action on the Patient Safety and Quality Improvement Act (HR 663). The bill had passed both Senate and House and was in conference committee. The legislation would create a confidential, voluntary system for reporting health care errors without legal ramifications. “It is critical not to miss this opportunity to improve patient safety,” wrote the coalition, which included among others, the American Hospital Association, the American Medical Association, the Joint Commission on Accreditation of Healthcare Organizations, and the American Nurses Association.

Now in its fourth edition, the classic reference, Core Curriculum for Perioperative Nursing, has guided the orientation of thousands of OR nurses since it was first published in 1991.

This respected guide has been updated to reflect changing practice.

The book includes basic competencies for expected performance, lesson plans for classroom activities, outlines for clinical focus days, and performance checklists. The extensive references have also been updated.

As hospitals and ambulatory facilities face an increasing shortage of nurses, many are hiring nurses without OR experience and providing on-site training. This book is the perfect guide for such training.

The book can be used for orientation of nurses who are experienced in perioperative nursing as well as those who are new to this specialty.

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Emory hospital notifies patients following CJD case

Emory University Hospital in Atlanta said Oct 1 it had notified 98 patients who had brain and spinal surgery after the Sept 10 brain biopsy of a patient who later had a preliminary diagnosis of CJD.

After the biopsy, the instruments were sterilized according to the hospital’s normal procedures. After the preliminary diagnosis, on Sept 15, the hospital resterilized all neurosurgical equipment according to World Health Organization (WHO) guidelines for CJD. On Sept 27, the hospital resterilized all surgical equipment that could be sterilized according to the WHO guidelines as a further precaution. The hospital also said it adopted a new policy that calls for treating every brain biopsy as a potential case of CJD and sterilizing instruments using the WHO guidelines.

Six cases of CJD have been associated with neurosurgical equipment. All occurred before 1976, and the instruments were not reprocessed using currently accepted methods.

—www.emoryhealthcare.org

JCAHO, CMS to use same quality measures for hospitals

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Centers for Medicare and Medicaid Services (CMS) have agreed to use identical hospital quality measures for clinical conditions. That includes measures for heart attack, heart failure, pneumonia, and surgical infection prevention. The basic measures for surgical infection prevention are:

- prophylactic antibiotic administered within 1 hour prior to surgical incision
- prophylactic antibiotic selected according to current guidelines
- prophylactic antibiotic discontinued within 24 hours.

The measures apply to the overall rate of correct antibiotic use and the rate for specific surgical procedures.

Aligning the measures will make it easier and less costly for hospitals to comply with requirements for data collection and reporting, the two organizations say. The specification manual for the measures is on the JCAHO web site.

—www.jcaho.org/pms/core+measures/aligned_manual.htm

Anesthesia risk of tattoos and pierced tongues

Body ornamentation may carry health risks for anesthesia, the American Association of Nurse Anesthetists says. Theoretically, a needle inserted through a tattoo could result in a tissue core containing pigment that could lead to possible neurological complications, AANA said. The association referred to a Canadian study involving a woman receiving epidural anesthesia during labor and delivery who had a tattoo covering her entire back, making it impossible for the anesthesia provider to find a lumbar interface not covered by the tattoo. The woman received the epidural without incident. No adverse effects from needles inserted through tattoos have been reported. But AANA says the long-term implications are unknown. AANA also warned about people with tongue ornaments who might need to be intubated in an emergency.

—www.aana.com

Report looks at surgical supply chain indicators

Custom packs, suture, and orthopedics are the leading areas for supply standardization in a new report on surgical supply chain indicators from the Association for Healthcare Resource & Materials Management (AHRMM). Who drives standardization is split—39% have a hospitalwide committee, and 39% have a dedicated OR committee; the rest said “other.” The report, with 112 responses, examines how supplies are managed and reports on performance indicators. The 2004 Performance Indicators Study on Healthcare Surgery Supply Chain is $100 for AHRMM members and $150 for non-members.

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