OR MANAGER CONFERENCE
How to make ‘funny’ a part of your leadership role...........5

SALARY/CAREER SURVEY
Staffing for surgery centers is in a holding pattern...........11

SALARY/CAREER SURVEY
Beyond bucks: Best ideas for recognizing staff..............13

ASSISTING IN SURGERY
Survey: 1 in 3 ORs using assistants doesn’t require special qualifications ............14

ASSISTING IN SURGERY
How strong is your oversight for first assistants?...............16

ASSISTING AT SURGERY
Opportunities grow for advanced practice RNs.............18

MANAGING PEOPLE
Staff satisfaction: Happy employees have a payoff......20

MANAGING PEOPLE
Older nurses: A resource too valuable to lose..............23

STANDARDS AND REGULATIONS
2013 IPPS rule advances Medicare quality programs........24

AMBULATORY SURGERY CENTERS
Caring for children? Consider their unique needs...............26

AT A GLANCE..........................32

Salary/Career Survey

Turnover rates stable, use of temp staff is down, annual survey finds

O R directors continue to struggle with an economy resisting improvement. More than two-thirds (68%) say the economy affected their OR staffing in the past 6 months, according to the 22nd annual OR Manager Salary/Career Survey—virtually unchanged from 69% in 2011. The economy may be causing employees to stay put. More than 70% of directors say their turnover rates for RNs and surgical technologists (STs) remained the same as last year. A possible harbinger of long-term staffing challenges is that 43% of respondents say recruiting experienced OR nurses has been more difficult in the past year.

Key findings
Other key findings include:
• The top three responses to the economic conditions of the past 6 months are the same as last year: reducing overtime (48%), requiring staff to take time off without pay (35%), and eliminating open positions (29%).
• Recruiting of RNs has become

Assisting at surgery

Survey: Wide variety of nonphysician personnel serve as assistants at surgery

M ore than 80% of ORs use nonphysicians to assist the surgeon, the OR Manager Salary/Career Survey finds. These include RN first assistants, physician assistants, certified surgical assistants, and RNs and surgical technologists without specialized qualifications. Though assistants work under the supervision of surgeons, ORs need a strong process for credentialing, privileging, and monitoring personnel who assist.

Special focus: Assisting at surgery

- Page 14: Survey: 1 in 3 ORs using assistants doesn’t require special qualifications
- Page 16: How strong is your oversight for first assistants?
- Page 18: Opportunities grow for advanced practice RNs
My OR needs to be healthy.

Help me enhance care, and improve efficiency and cost.

Challenged by a manual supply inventory system that included different processes in each of its 11 hospitals, Memorial Hermann Healthcare System engaged CareFusion to implement Pyxis® automated supply management systems in the operating room. Shifting their process thinking, leadership and clinician staff collaborated on driving toward enterprise standardization to improve operational efficiency and bottom-line revenue.

Join us at the OR Manager Conference, booth 415 to learn more, or visit carefusion.com/MemorialHermannStudy for additional details.
Editorial

The number of nurse practitioners is expected to double by 2025, according to a new report in the July 2012 Medical Care. How many will be perioperative nurses?

Advanced practice is a great opportunity for perioperative nursing.

Advanced practice RNs (APRNs) are critically needed to serve the nation’s health needs. They are a key to meeting the growing needs for primary care, care coordination, and service to an aging population.

Hospitals and surgical practices are realizing the value of advanced practitioners. APRNs and physician assistants (PAs) help prepare patients for surgery and follow them postoperatively, enabling surgeons to spend more time in the OR. With the right qualifications, they also assist at surgery.

A properly qualified APRN can bill Medicare and Medicaid.

That’s a powerful set of credentials.

Seize the opportunity

Who’s going to occupy the APRN role in surgery? Will it be perioperative nurses or APRNs without a perioperative background and PAs?

Perioperative nurses need to seize the opportunity, says Bob Salsameda, MSN, RN, NP-C, CRNFA, who’s taught an RNFA course in Los Angeles for 22 years.

Once an APRN master’s program is approved, says Bob Salsameda, “We see patients from the holding area through the PACU. Now we need to come out of our box and see patients postoperatively.”

APRNs without periop backgrounds are flocking to his RNFA course.

“The best clinician is a perioperative nurse,” he asserts. “We see patients from the holding area through the PACU. Now we need to come out of our box and see patients postoperatively.”

APRNs without periop backgrounds are flocking to his RNFA course.

To seize the opportunity, periop nurses need to understand the APRN credentials and the best path to follow to prepare for the role.

As a manager or director, you can help your staff learn more about the role. (See article, page 18.)

The National Council of State Boards of Nursing (NCSBN) has a consensus model it is calling on the states to adopt.

Though not without controversy, the model has been endorsed by 40 nursing organizations, including AORN.

Make no mistake—APRN qualifications are demanding:

• A second license or certificate would be required with an APRN-specific master’s degree.
• The license or certificate would be coupled with a population focus in one of 6 areas.
• Candidates would have to pass a national certification exam specific to their APRN credential.

Be aware that APRN credentials are siloed—a controversial element. Once an APRN master’s program and population focus are selected, a nurse would be locked into that APRN role. For instance, a nurse practitioner who chooses a pediatric focus would not be licensed as an APRN to practice with adults.

Keep an eye on developments. By embracing advanced practice, perioperative nurses can be at the forefront of health care, bringing their knowledge and skills to bear, not only in the OR, but throughout the patient’s surgical experience.

—Pat Patterson

Reference

What do surgical smoke and cigarette smoke have in common?¹,²

Carbon Monoxide - Formaldehyde - Hydrogen Cyanide - Methane - Toluene - Benzene

If you can smell it, you are breathing it.

- Removes 99.99% of toxins including HIV, bacteria, viruses, dead and live cellular material
- Removes chemical byproducts including benzene, formaldehyde, carbon monoxide and more
- Absorbs noxious odors
- Optimal flow rate maintains pneumoperitoneum
- Easy setup requires minimal staff involvement
- No attachment to wall suction, unobtrusive functionality

Simply attach SeeClear to the side port of the trocar to filter out harmful toxins. Freestanding, no attachment to wall suction needed.

SeeClear®
Laparoscopic Smoke Evacuation Systems

If you can smell it, you are breathing it.

Find out how SeeClear can benefit your OR staff. Call 800.243.2974 or visit www.coopersurgical.com

¹ Ulmer, B. C. 2008 The Hazards of Surgical Smoke AORN Journal 87(4) 721-738
How to make ‘funny’ a part of your leadership role

With all that managers have to balance—schedules, meetings, staff, reports, and shrinking resources, not to mention home, family, and school—who has time to think about being funny? Humor may be more valuable than you imagine, not only in dealing with stress but also in being a better manager.

Humor is a way “to put your own oxygen mask on first,” says Karyn Buxman, MSN, RN, CSP, CPAE. “Nurse managers do such a great job taking care of everyone else, but they also need to take care of themselves.”

A nationally known speaker, Buxman has focused in her research on humor, health, and communication. She’ll give the closing address, “What’s so Funny about Leadership?” at the OR Manager Conference October 24 to 26 at Caesars Palace in Las Vegas.

Maybe you didn’t think “funny” was part of your job description. “The cool thing is, you don’t have to be funny,” says Buxman. “The best leaders aren’t necessarily humor initiators. They are humor appreciators. They bring out the humor in others.”

And humor can become a habit.

“A lot of humor is just being in the moment,” she says. “It’s hard for us to stop, take a breath, and hear what’s being said.”

There are 3 areas in which Buxman says leaders can use humor: stress management, communication, and motivation.

Buxman says she will offer tools.

One is reframing—tuning yourself in to the funny side of things. Once you start looking for it, she says, you start seeing humor everywhere.

“It’s not always that laugh-out-loud funny. It’s that amusing, internal chuckle. You start hearing things that other people miss.”

Buxman has contributed to several Chicken Soup books; has authored titles, including Amazed & Amused: How to Survive and Thrive as a Healthcare Professional; and is publisher of the Journal of Nursing Jocularity.

The OR Manager conference, celebrating its 25th anniversary, starts on Wednesday, October 24, with 9 preconference seminars. Following are the 2-day conference and exhibits.

Participating in the conference is the AORN Leadership Specialty Assembly.

The conference offers tracks for new perioperative managers, OR business managers, and ambulatory surgery center managers.

Management Boot Camp

New for 2012 is an all-day Management Boot Camp on October 24 sponsored by the Competency and Credentialing Institute (CCI). The session is a kickoff for the CCI Certificate Program for Surgical Services Management. Boot Camp participants will complete 2 of the program’s more challenging subjects: Financial Management and Surgical Services Management.

For more information and to register, go to www.ORManagerConference.com

Learn more about Karyn Buxman at www.karynbuxman.com
Picture this. More cases in less time. Collaboration, not competition. Accountability, not finger pointing. Surgeons coming to you, not going over your head. O.R. peace. That’s the power of Syús. Using our patented analytics, Syús transforms your O.R. data into actionable visualizations, so surgeons, anesthesiologists, administration and your staff—the whole surgical team—can see what’s really happening in your O.R.—and what could be.

To see the power of Syús, visit www.syus.com/ORpeace and download the free Surgical Excellence Report we’ve prepared for your hospital. Play with the interactive Surgical Excellence Explorer. The first 25 O.R. managers to sign up and qualify will win a more thorough analysis and review using the Syús system—a $5,000 value that will start you on the path to increased revenue, significant savings, and higher surgeon and staff satisfaction. The path to O.R. peace.
slightly more difficult, up to 43%, compared to 40% in 2011 and 26% in 2010.

• More OR directors (72%) say their RN turnover rate stayed the same in the past year compared to 64% in 2011.

• About two-thirds (61% for RNs and 69% for STs) of respondents say there hasn’t been a change in open positions in the past year, similar to 2011 responses.

**About the survey**
The OR Manager Salary/Career Survey was mailed in March 2012 to 800 OR Manager subscribers who are directors/managers of hospital ORs. The survey was closed with 194 usable responses, a 24% response rate. To ensure representation of the target audience, results were filtered to include only the 185 respondents who work full time in a hospital. The margin of error is ±6.3 percentage points at the 95% confidence level. This article features the staffing findings from the survey. Other findings, including compensation and management responsibilities will be reported in the October 2012 issue.

Most respondents work in a community hospital (75%) rather than a teaching hospital (23%), with the location split almost equally among suburban (34%), rural (36%), and urban (29%). Nearly all respondents (90%) work in not-for-profit facilities.

**Staffing profile**
The average number of open staff positions was higher this year at 3.6 for RNs (compared to 2.4 in 2011) and 2.0 for STs (1.1 in 2011). The number of RN open positions was higher in teaching hospitals (5.8) than in community facilities (2.3).

Positions were open an average of 11 weeks for RNs and 8 weeks for STs. Community facilities tended to fill RN positions more quickly than their teaching counterparts.

Almost half of OR directors reported no open positions for RNs (42%) and no open positions for STs (46%).

Although half (51%) use overtime occasionally, only 24% (23% in 2011) of OR directors reported they “always/or almost always” use it, while 21% use it rarely, and 4% never use it. As in the past,
directors in teaching hospitals tend to use more overtime than community hospitals (38% in the always/almost-always category compared to 21%).

**Recruiting a challenge**
The average staff turnover rate is low at 5% for RNs and 6% for STs. Turnover rates are higher in teaching hospitals, but similar across geographic regions.
Turnover is defined as the percentage of staff who have left and been replaced in the past 12 months.

It may be fortunate that turnover is low considering that 43% say it’s more difficult to recruit experienced RNs than a year ago, compared to 26% in 2010.

More than half of directors from teaching hospitals say recruiting is more difficult. Difficulty in recruiting is similar by region, but the West reported the least difficulty.

Only 6% of respondents say it’s easier to recruit RNs. Despite the difficulties, use of temporary staffing continues to fall, with only 12% of respondents reporting its use compared to 25% in 2008. Teaching hospitals are more
likely than community hospitals to use agency or traveler nurses (33% vs 6%), with distribution fairly equal across regions. That may reflect the more stable staffing that has followed the financial crisis, as many nurses have stayed in their positions and requested more hours to shore up family incomes. Hospitals have also realized that a permanent staff is safer for patients because they are familiar with the organization’s policies and protocols. And many hospitals have found that retaining nurses makes more economic sense than relying on travelers while they go through the costly, time-consuming process of recruiting and orienting replacements. ❖

—Cynthia Saver, MS, RN

Cynthia Saver, president of CLS Development, Inc, is a freelance writer based in Columbia, Maryland.
A weak economy continues to affect staffing in ambulatory surgery centers (ASCs), according to the 22nd annual OR Manager Salary/Career Survey, with about 80% of nurse managers saying staff turnover stayed the same compared to 12 months ago, similar to 2011 results.

Other staffing parameters are also similar to last year. 

ASC managers have responded to economic conditions by reducing overtime (38%), requiring staff to take time off without pay (32%), and eliminating open positions (16%). Only 3 respondents reported direct-care staff layoffs, and 2 reported management layoffs.

More than one-fourth (29%) say economic conditions have caused financial difficulties for their ASCs, most commonly because of changes in third-party reimbursement (71%) and declines in elective surgery (67%).

About the survey
The OR Manager Salary/Career Survey was mailed in March 2012 to 1,000 nurse managers of ASCs who were either OR Manager subscribers or part of an external list. The survey was closed with 198 usable responses—a 20% response rate. To ensure representation of the target audience, results were filtered to include only the 180 respondents who work full time in an ASC. The margin of error is ±6.8 percentage points at the 95% confidence level. This article features the staffing findings from the survey. The rest of the findings will be reported in the October 2012 issue.

As in 2010 and 2011, most respondents (45%) work in physician-owned ASCs, followed by joint venture (26%), corporate or LLC (14%), and hospital-owned (9%) facilities. Nearly two-thirds (64%) of ASCs are multispecialty. The most common types of single-specialty ASCs are ophthalmology (40%) and gastroenterology (21%).

Nearly half (49%) of ASCs are in suburban settings, with 33% in urban and 14% rural locations.

How has the economic downturn affected your ASC’s staffing in the past 6 months?

| How has the economic downturn affected your ASC’s staffing in the past 6 months? | Overall |
|---|---|---|
| Reduced use of overtime | 38% | 51% | 44% |
| Required staff to take time off without pay | 32% | 37% | 36% |
| Eliminated open positions | 16% | 14% | 20% |
| Reduced use of agency personnel | 8% | 13% | 13% |
| Had layoffs of management | 1% | 0% | 0% |
| Had layoffs of direct care staff (RNs and STs) | 1% | 5% | 5% |

Note: The questions were first asked in 2009.
Staffing overview

Few ASC managers are rolling out the welcome mat to new staff, with 74% reporting no open FTE RN positions and 85% having no open FTE surgical technologist (ST) positions, results similar to last year.

ASCs are more open than in the past to hiring staff without a peri-operative background. More than half—58%—say they will hire RNs without OR experience, and 26% hire new graduates. That's a jump from 5 years ago, when 47% would employ nurses without OR experience, and 19% would take new grads.

Only 5% of respondents say they have 4 or more open RN positions. ASC managers reported an average of 0.8 RN (slightly up from 0.4 in 2011) and 0.2 ST (comparable to 0.3 from 2011) open positions. Positions stayed open an average of 9 weeks for RNs and 8 weeks for STs.

Compared to 12 months earlier, most respondents—78% for RNs and 86% for STs—said the number of open positions stayed the same. The turnover rate was also stable, with most saying it was about the same as last year for RNs (80%) and STs (85%).

Most respondents (55% for RNs and 58% for STs) say recruiting experienced staff is unchanged from 12 months ago. About a third (37%) have found RN recruitment more difficult, and 29% report more difficulty recruiting STs. Those results are similar to those in 2011 (43% for RNs and 33% for STs), but higher than 2010 (27% for RNs and 21% for STs). ❖

—Cynthia Saver, MS, RN

Cynthia Saver, president of CLS Development, Inc, is a freelance writer based in Columbia, Maryland.

Continued from page 11
Beyond bucks: Best ideas for recognizing staff

Motivation means more than money. That’s a message perioperative nursing directors have taken to heart.

The 2012 OR Manager Salary/Career Survey asked OR managers and directors for their most successful ways of recognizing staff beyond salary raises and bonuses.

Most often mentioned by hospital OR directors are:
- thank you notes
- acknowledging staff in front of peers
- thanking them directly
- small gifts like movie tickets and gift cards
- food.

Written and verbal thank yous plus public recognition are the most popular choices for ambulatory surgery centers (ASCs). ASCs are more likely than hospitals to reward staff with paid time off.

Thank you notes
By far the leading choice by hospital OR directors, thank you notes are meaningful and cost little.

“I often write thank you notes and send them to their homes,” writes one OR director. “I have received many comments on how much they appreciate them.”

Some enlist senior administrators and surgeons.

A director in a 25-bed hospital with 1 OR mentions sending “personal thank you notes to their home by myself and the CEO.”

In a 26-OR department, the director asks surgeons to write letters of commendation to the staff.

Public recognition
Directors say they make a point to acknowledge staff members in front of colleagues.

A director of 6 ORs invites senior administrators, the CEO, associate vice president, or chief nursing officer, to come to the department to thank the staff.

Sharing stories of outstanding patient care is another manager’s approach. Another recognizes staff daily during rounds.

A small 76-bed hospital holds an annual surgical staff banquet where employees are recognized.

Some managers encourage peers to recognize each other. A director of a 3-room OR takes time at staff meetings for all staff to write an appreciation to their coworkers.

“Coworkers recognize each other on a ‘Be a Star’ board,” writes one respondent.

An ASC gives a Quite Clearly Exceptional certificate for outstanding service. Other facilities name an employee of the month or quarter with a monetary award.

For one facility, the employee of the month is voted on by peers—not management. A few give longevity awards for 5, 10, and 15 years of employment.

Direct thank you
Simply taking time to say thank you each day is the most effective recognition, say some.

“Letting them know consistently that they are doing a good job and saying, ‘Thank you,’” is the best gesture for a director in a 25-bed hospital.

An administrator of surgical services makes a point to thank the staff “for their service on a daily basis.”

“Always meaning ‘thanks’ when it is said,” another emphasizes.

Small gifts
Simple gifts like movie tickets and gift cards for coffee, gas, restaurants, even lottery tickets are another way to show appreciation.

In one 3-OR facility, 2 names are drawn monthly, and winners receive a voucher to the hospital’s cafeteria or gift shop.

One respondent with 4 ORs says: “I buy gifts for Perioperative Nurse Week and Surgical Technologist Week with my own money—recognition goes a long way.”

Says one director, “We give WOW cards that say, ‘You wowed me today by . . . ,’” with a note about what the person did. The cards can be redeemed at the hospital gift shop or coffee cart.

An ASC has a “kudos” program: Staff give kudos to fellow employees. The person with the most kudos at the end of the month gets a $25 gift card.

Food
There are few better ways to express gratitude than food.

Breakfasts, lunches, ice cream, and pizza are all popular thank you gestures. One director gives gifts of homemade salsa.

“They love a free lunch, even Subway,” says one respondent with 17 ORs.

Adds another: “Chocolate in my office—endless supply. Employees and surgeons love it!”

“Starbucks for everyone on a busy day,” says an ASC manager.

Continued on page 14
Professional recognition

“Don’t micromanage—autonomy, trust!” is the best way to acknowledge and encourage staff, offers a nurse manager of 5 ORs.

Self-governance and empowering staff to make critical decisions are the best type of recognition for a 78-bed hospital.

An ASC manager finds it’s effective to give staff additional staff responsibilities or promotions for things they want to do. Another facility gives paid time for committee work and a dedicated shift to complete it.

A few give the gift of time. An ASC on a slow day lets staff go home with pay when cases are done. An OR reduces call assignments as a reward. Some give additional paid time off.

Building relationships

Sometimes, the best reward is intangible. Some say they recognize the staff simply by showing respect and courtesy. Others help out when the schedule is busy so shifts end on time. They listen, provide feedback, and follow up promptly on concerns.

Several conduct rounds to communicate and give feedback.

“After specific questions, doing all I can to get what they want,” says one director of 5 ORs, who rounds on a schedule.

In perhaps the ultimate form of recognition that serves both patients and staff, one respondent says, “I have their backs when it comes to patient safety and quality!”

Assisting at surgery

Survey: 1 in 3 ORs using assistants doesn’t require special qualifications

Who assists at surgery in your OR? If not physicians, most commonly they are RN first assistants (RNFAs) and physician assistants, OR Manager subscribers report in a new survey.

Only 15% of respondents say they do not use nonphysicians as assistants.

Not surprisingly, more community hospitals (89%) use nonphysicians in this role than do teaching hospitals (79%), which have residents to assist.

The vast majority—nearly 9 in 10—say their assistants are credentialed or privileged to practice in the OR. But for about one-third, not all of the assistants have specialized qualifications in surgical assisting, though that is recommended by major associations (charts).

The first assistant responses are part of the 2012 OR Manager Salary/Career Survey mailed in March 2012 to a sample of OR Manager subscribers who are directors of hospital operating rooms. The response rate was 24%. The margin of error is ±6.3 percentage points at the 95% confidence level.

Surgical assisting by nonphysicians has become common in the past 15 to 20 years as insurance reimbursement has declined for physicians who assist.

The high percentage of respondents (87%) who say their nonphysician assistants are credentialed or privileged is a gain over 15 years ago when an OR Manager survey found that 78% credentialed RNFAs, and 76% credentialed other nonphysician assistants.

In the 2012 survey, the smallest facilities (1-4 ORs) were the least likely to say that they credential assistants (75%) and to say that their assistants have specialized education and training (52%).

Employment of assistants

Employment arrangements are mixed. For 34% of respondents, assistants are hospital employees, for 21% they are not, and for 30%, it is a combination. Teaching hospitals (43%) are more likely to employ assistants than community hospitals (33%).

Employment arrangements for

Which categories of nonphysician assistants at surgery does your OR use?

<table>
<thead>
<tr>
<th>Assistant Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician assistants (PAs)</td>
<td>69%</td>
</tr>
<tr>
<td>RNFAs/CRNFAs</td>
<td>54%</td>
</tr>
<tr>
<td>Certified surgical first assistants</td>
<td>29%</td>
</tr>
<tr>
<td>Surgical technologists (not specifically trained as first assistants)</td>
<td>28%</td>
</tr>
<tr>
<td>RNs (not trained as first assistants)</td>
<td>24%</td>
</tr>
<tr>
<td>Certified surgical assistants (CSA, SA-C)</td>
<td>21%</td>
</tr>
<tr>
<td>Other</td>
<td>9%</td>
</tr>
</tbody>
</table>

OR Manager Toolbox

Check out the OR Manager Toolbox on our website for helpful forms and policies.

www.ormanager.com
assistants are driven by the individual market and region, note directors of surgical services.

In some markets, surgeons expect the hospitals to provide first assistants, and hospitals provide them for competitive reasons. But in other markets, surgeons do not have that expectation.

Market forces also play a role in the types of practitioners used to assist.

Having assistants is nice for turnover between surgical cases, some directors say, because there are 3 individuals to help with the process instead of only the scrub person and circulating nurse.

**Variety of qualifications**

Though PAs and RNFAs are the most common assistants reported in the survey, respondents use a variety of other personnel in the assisting role: RNs and STs without specialized training, certified surgical first assistants (CSFA), certified surgical assistants (CSA and SA-C), and others. —Pat Patterson

**Reference**

ORs turn to non-MDs, but reimbursement lags. OR Manager. 1997;13(9): 1, 16, 18.
Assisting at surgery

How strong is your oversight for first assistants?

Experts offer this advice on oversight of assistants at surgery. Experts on the first assisting role offer this advice on oversight of assistants at surgery.

Know the scope of practice
Assisting at surgery in most states is a function delegated by the surgeon, and persons who assist perform their intraoperative functions under a surgeon’s supervision.

Physician assistants (PAs) work as members of physician-directed teams. RN first assistants (RNFAs) function under the surgeon’s supervision intraoperatively but also have a nursing scope of practice. Surgical technologists (STs), who are not licensed, when assisting work under the direct supervision of a surgeon.

For RNFAs, know your state’s nurse practice act and how it applies to the role in your facility, advises Judy Dahle, MS, MSG, RN, education coordinator for OR Manager.

“Make sure the RNFAs in your facility are working within their scope,” says Dahle, who set up an RNFA role for a Southern California hospital when she was director of surgical services.

Some resources:
• AORN’s Position Statement for RN First Assistants outlines a scope of practice. An update is expected in Fall 2012.
• AORN has a state-by-state chart with state RNFA scopes of practice and qualifications at www.aorn.org/Clinical_Practice/RNFA_Resources/First_Assisting_%28RNFA%29.aspx#axzz1zDD5dXqa.
• The American Academy of Physician Assistants provides a statement on scope of practice at www.aapa.org.
• For certified surgical assistants, a scope of practice is offered by the National Surgical Assistant Association at www.nsaa.net.

Expect specialized education and training
On-the-job training for assistants is no longer appropriate. The role requires specialized education and training.

“This is a patient safety issue,” says Denise Jackson, MSN, RN, CNS, CRNFA, who practices at the Shannon Medical Center/Shannon Clinic in San Angelo, Texas. Jackson is also a member of the AORN board of directors.

AORN, the Association of Surgical Technologists, and the American College of Surgeons all have statements specifying that first assistants need education and training that prepare them in the assisting role.

It’s not uncommon for facilities to allow RNs and STs to assist who have learned on the job, says Kathleen Brooks, PA. She finds facilities use the term “first assisting,” for a wide variety of activities from holding a laparoscopic camera to truly performing a part of the surgery.

“A lot grow into the role without obtaining a credential or validation of their skills through any external source,” notes Brooks, who is vice president of clinical operations for Jackson Surgical Assistants, Atlanta, a firm that contracts with hospitals for assisting services.

Have a strong credentialing process
The Centers for Medicare and Medicaid Services (CMS) stipulates that hospitals using nonphysician first assistants must have a “credentialing process to grant specific privileges to individual practitioners.” The statement is in the Medicare hospital interpretive guidelines for state survey agencies at section 482.51(a)(4). State surveyors use these guidelines in validation surveys to see that hospitals are meeting the Medicare Conditions of Participation.

Consider who credentials assistants
Should assistants be credentialed through the medical staff office or human resources department?

AORN does not have an official position on this issue, Jackson notes.

She adds that the AORN Position Statement on the RNFA “clearly states that a process for granting clinical privileges should be established and should include a mechanism to verify qualifications, such as education, and define the lines of accountability.”

At Longmont United Hospital, Longmont, Colorado, which has 6 ORs, both PAs and RNFAs first assist. RNFAs function under a job description and report through nursing. The PAs are credentialed through the medical staff process, says Janet Lieber, BSN, RN, CNOR, CRNFA, director of perioperative services, who is an experienced RNFA.

She sees an advantage in RNFAs reporting to nursing. When assistants report through the medical staff, she comments, “you don’t have a lot of control.”
A new PA, for example, might be credentialed after a brief observation and review of qualifications but would not be up for review under the medical staff process again for 2 years.

In some hospitals, credentialing seems to be defined loosely. “Hospitals will say, ‘Yes, we credential,’” notes Brooks. But that may mean they simply collect assistants’ certification information and place it in their personnel file. They may not check to be sure assistants have renewed their certification and kept up with their CEUs.

Typically, she says, nurse practitioners and PAs who assist are credentialed through the medical staff office, but RNs, STs, and certified surgical assistants (CSAs) are often managed through the HR process. The question is how closely their activities and competencies are monitored and evaluated.

Brooks feels strongly that assistants need to be credentialed: “They are doing complex things in the OR. It’s ultimately the hospital’s risk, because first assistants are functioning in the hospital, whether they are employees or not.”

**Individualize privileges**

Clinical privileges and the job description need to be individualized for each practitioner, Jackson advises.

“They should delineate the surgical tasks and procedures practitioners are allowed to perform and the level of surgeon supervision when performing these duties,” she says. “The generic, across-the-board list [of tasks] is not good. Privileges need to be specific to the education and training of these individuals, in my opinion.”

In her facility, RNFAs and PAs as well as some surgical technologists (STs) who are employees of the Department of Surgery assist. All are credentialed through the medical staff process with privileges and level of supervision delineated for each individual, depending on education and license.

When a new function is added, privileges are requested.

For example, a surgeon wanted Jackson to pull chest tubes, which was not part of her initial privileges. Under the medical staff process, the surgeon had to validate her competency for that task and submit a request to the credentialing office to add that privilege.

The AORN position statement outlines elements of a clinical privileging process. Jackson notes that the process must include a mechanism to ensure that persons who function in the role maintain their credentialing and competencies.

Kathleen Brooks will present a breakout session titled “Surgical First Assisting: Programs Standards and Challenges” at the OR Manager Conference October 24-26 at Caesars Palace in Las Vegas. Learn more and register at www.ormanagerconference.com

**RN obesity risk factors vary with schedules**

For nurses who work long hours or other “adverse work schedules,” including required call, the risk of obesity is linked to less sleep and exercise.

In contrast, in nurses with more favorable work schedules, obesity was linked to more unhealthy behaviors, such as smoking and alcohol use. Job stress also affected obesity risk.

“Adverse work schedules may be an overriding work-related factor of nurse obesity,” says Alison Trinkoff, ScD, RN, of the University of Maryland, Baltimore.

Nurses with adverse work schedules may also have difficulty with access to healthy foods.

These nurses may need extra support to prevent obesity and its health effects, note Trinkoff and her colleagues.

Their study analyzed data on more than 1,700 female nurses, comparing 700 nurses with “adverse” schedules with 1,000 nurses who had more favorable schedules. Adverse schedules included long hours, high work burden, required call/overtime, and/or lack of rest.

About 55% in both groups were overweight or obese.


**Resources**

**American College of Surgeons**

Statement on Surgical Assistants

—www.facs.org/fellows_info/statements/stonprin.html#anchor129977

**AORN**

First assisting resources

—www.aorn.org/Clinical_Practice/RNFA_Resources/First_Assisting_%28RNFA%29.aspx#axzz1yM3nfl1q

**Association of Surgical Technologists**

Position Statement on First Assisting

Does your hospital have advanced practice RNs (APRNs) who want to assist in surgery? Are your perioperative nurses, including RN first assistants, interested in advanced practice?

Here are things to know about this developing role.

What is an APRN?
The APRN is a direct patient care role that requires advanced clinical knowledge and skills.

A consensus model from the National Council of State Boards of Nursing (NCSBN), which seeks to standardize the role, is likely to govern APRN practice in the future. The model, known as LACE, addresses licensure, accreditation, certification, and education (sidebar).

NCSBN seeks to have state boards of nursing adopt a separate additional APRN license based on the LACE model by 2015.

What is the APRN’s scope of practice?
Currently, the scope of practice varies by state, which the LACE model seeks to change. Under the model, state boards of nursing would license APRNs as independent practitioners without requirements for collaboration, direction, or supervision.

What are the qualifications?
The LACE model specifies a master’s degree specific to 1 of 4 APRN roles with a population focus plus national certification, also specific to the role.

Important to note: Master’s-prepared RNs would be eligible for an APRN license only if their master’s is in one of the 4 roles: nurse practitioner, clinical nurse specialist (CNS), certified nurse-midwife, or certified registered nurse anesthetist. Thus, nurses with a master’s in nursing, education, or administration would not be eligible unless they earn an additional APRN master’s and certification.

A caveat: Some states don’t recognize the CNS as an APRN.

“Check that before selecting a master’s program. You might not want to spend time and money on a curriculum if you won’t be able to use that to the fullest extent after you graduate,” advises Julie Mower, MSN, RN, CNS, CNOR, credentialing and education program manager for the Competency and Credentialing Institute (CCI), the governing body for the CNOR and CRNFA credentials. CCI conducted a job analysis of the APRN role in perioperative nursing in 2011, which would be the basis for any future exam for that role.

What can an APRN do in perioperative nursing?
The APRN role is appealing to surgeons because it allows them to maximize their time in the OR, Mower says.

Among duties an APRN can perform, depending on the state:
• Admit/discharge patients. The additional knowledge from advanced courses helps APRNs to do more complete history and physicals. They can also make postop rounds and discharge patients.
• Prescribe medications. Most states grant APRNs at least some prescribing authority.
• Bill for their services. Under Medicare and Medicaid, the 4 types of certified APRNs, if appropriately certified, can bill for their services. Some commercial insurers also accept APRN
claims. Some will reimburse RNFAs who are not APRNs, though Medicare and Medicaid will not.

Because the majority of patients are on Medicare or Medicaid, Mower notes, “It behooves you to become a certified APRN; then you don’t have to worry about whether you can bill.”

AORN is developing a position statement on the APRN in perioperative nursing, expected in Fall 2012.

Will APRN certification be available for perioperative nursing?

CCI hopes eventually to provide an exam, but it isn’t feasible right now, Mower says. One obstacle is the small number of nurses who might be candidates.

Are APRNs becoming RNFAs?

APRNs are showing increasing interest in RNFA courses.

In fact, 75% of the students in this year’s RNFA course at the University of California Los Angeles extension program are APRNs, says Bob Salsameda, MSN, RN, NP-C, CRNFA, who has taught the course for 22 years.

“Every year it’s increasing,” he says. “I see that as the future.”

Are there APRN programs for perioperative nurses?

Mower says she knows of 2 APRN master’s programs with a perioperative option at this time:

• Western University of the Health Sciences, Pomona, California, offers a family nurse practitioner program with a perioperative option for qualified RNFAs and other perioperative nurses to obtain their APRN certification. The new perioperative option was set up in collaboration with the OR Nursing Council of California (ORNCC).

• Uniformed Services University of the Health Sciences, Bethesda, Maryland offers a perioperative CNS program.

What is a good population focus for periop nurses pursuing an APRN?

The decision depends on a nurse’s career direction.

“It’s a personal choice. You need to look at where you want your career to go,” advises Suzanne Ward, MN, MA, RN, CNOR(e), of the ORNCC who worked with Western University of the Health Sciences on its new perioperative option.

For an RN who wants to care for a general surgical population, the best choice is the family nurse practitioner focusing on the family/individual across the lifespan, she notes. Care of adults is included in that focus.

For a nurse who plans to focus exclusively on adults, pediatrics, or women’s health throughout his or her career, one of those population focuses might be a good choice.

But be aware the APRN roles are siloed, Ward cautions. That means, in the future, under the LACE model, a nurse’s APRN license would be specific to the role and population focus. That is, an APRN licensed as an NP in pediatrics would not be licensed as an APRN to care for adults. On the other hand, an APRN licensed as an NP in family practice would be licensed for any age group. ✤

—Pat Patterson

CCI has an educational tool kit for the APRN role in perioperative nursing at www.cc-institute.org.

Resources

Advanced practice RN


National Council of State Boards of Nursing

APRN videos

What is an APRN?

APRNs and You

www.ncsbn.org/2732.htm

APRN Consensus Model Legislation map

www.ncsbn.org/aprn.htm#certification

Georgetown University

Nursing license map

Clickable state map shows nursing licensure requirements for each state. http://nursinglicensemap.com/

OR Manager Toolbox

Check out the OR Manager Toolbox on our website for helpful forms and policies.

www.ormanager.com
Managing people

Staff satisfaction: Happy employees have a payoff

Near two-thirds (60%) of employees who leave a position do so because of their relationship with their direct supervisor, according to the Studer Group, a health care consulting organization.

“Satisfaction is about relationship,” says Marcus Erb, senior research partner at the Great Place to Work Institute, which helps organizations become better places to work.

“What makes employees happy is the quality of interactions with their managers. As a leader, you need to establish that relationship.”

Staff satisfaction has a ripple effect.

“With more satisfied, more engaged staff, you see better service to patients,” Erb says. “If team members aren’t engaged, patients will pick up on that.”

Surgical services directors also have a financial incentive to focus on staff satisfaction. Medicare plans to factor patient experience scores into its new value-based purchasing program, which affects reimbursement beginning in October 2012.

Evidence of payoff

Evidence of the payoff for staff satisfaction is in the numbers. Fortune magazine’s 100 Best Companies to Work For performed 3 times better in the general stock market and had at least 50% less voluntary turnover compared to national averages, according to Great Place to Work. In fact, the 100 best companies in the health care and social assistance category averaged 7.2% turnover compared to the national average of 17.4%.

“There is a direct correlation between engagement and quality, safety, and productivity. Engaged employees take ownership of what they do,” says Kathy Becker, MBA, RN, of the Studer Group.

Here’s expert advice on developing a strategy for staff satisfaction.

Conduct an assessment

As with a preop surgical patient, staff satisfaction needs to be assessed. Experts say a formal assessment should be done at 12- to 18-month intervals.

It’s best to “have a variety of ways to measure satisfaction,” says Lil LeBlanc, MBA, SPHR, assistant vice president of HR strategy and culture at Baptist Health South Florida.

The organization has been widely recognized for its quality work environment, including being named to the 100 Best Companies for Working Mothers and Working Mother Hall of Fame by Working Mother magazine and landing on Fortune’s 100 Best Companies to Work For list many times.

Baptist Health annually administers the Gallup Employee Engagement Survey, which asks 12 core questions and 18 customized questions for Baptist Health employees.

Three years ago, Baptist Health added the Employee Opinion Poll, developed with the Corporate Leadership Council, Washington, DC. This poll asks about manager effectiveness, intent to stay, and how the organization delivers on the employee experience. It also measures discretionary effort—the degree to which someone is willing to go “over and above” job requirements without additional incentives such as extra pay.

Other hospitals collaborate with Great Place to Work and use the institute’s tools such as the Trust Index Employee Survey, the Workplace Culture Assessment, and the 360 Management Trust Appraisal. Erb says managers can also use free websites like SurveyMonkey to collect data. Informal assessment through casual conversation should be ongoing, he adds. For example, each quarter, a manager can ask employees, “How are we doing? What is the organizational climate like?”

Have the right mindset

“Managers have a responsibility for creating an environment that is healthy for people,” says Jo Manion, PhD, RN, NEA-BC, FAAN, author of The Engaged Workforce and 7 other books. But she understands that’s not easy.

“Manager’s jobs are extraordinarily difficult,” she says. “There are so many distracters that it is easy for us to take our eyes off the ball.

“Some managers think, ‘I pay them, isn’t that enough? Do I have to make them happy, too?’ The truth is, you can’t make someone else happy.”

Erb says communication and collaboration are essential for establishing a trust, the essence of the relationship between managers and employees, and that boosts satisfaction.

“Trust is built on how they see their manager: if the manager is credible, whether they feel a level of respect, and whether there is a fair playing field,” he says.

Have the right mindset for each employee interaction, Erb advises.

“Ask, how am I going to build
Managing people

Understanding motivation

Understanding an employee’s motivation and being able to provide that individual’s motivating factor goes a long way to improving staff satisfaction, according to Jo Manion, PhD, RN, NEA-BC, FAAN, author of The Engaged Workforce and other books.

She cites 5 key intrinsic motivators:

**Healthy working relationships**
People know they have healthy relationships when they like and trust the people they work with and give and receive respect, Manion advises.

She suggests that managers “pay attention to the positive/negative ratio of communication. Positive interactions need to outnumber negative by at least 5:1. This doesn’t mean you don’t give negative feedback. It means you up the amount of positive interactions.”

**Meaningful work**
Understand that “meaningful” varies among employees. To learn what is meaningful to each person, Manion suggests asking, “Tell me about the best day you’ve ever had in the OR, a day when everything went really well.” Other questions might include: “Describe a time when we pulled together as a team,” or “Describe a time in your career when you were at your best.”

The stories will deliver clues as to what employees value. For one, it might be functioning as a team on a complicated case; for another, it might be learning a new procedure. Generational status can affect what an employee finds meaningful, she notes. For example, veteran employees highly value their ability to support themselves and their families, while younger generations are “more interested in learning opportunities and having skills that are portable so they can move around.”

**Competence**
Competence translates into, “I feel good when I’m good at what I do,” Manion says. “Pin down the strengths of the person and make sure they can use those strengths in their job.” Offer opportunities for staff to develop competencies.

**Autonomy**
Know that staff members feel autonomous when they “are able to make decisions about their work.” Manion says it’s important for managers to give staff as much independence as possible. “If someone is told what to do every step of the way, they aren’t going to be happy.”

**Progress**
Keep in mind that staff want to be able to feel, “Something changes as a result of my having been part of this,” says Manion. “Something is different. Something is better.”

Of course, managers can’t always make immediate changes to meet staff needs.

She says that even if change happens down the road, employees need to know they are on the path to where they want to go. For example, a nurse may need to attend an educational program to obtain a slot on the open-heart team.

“You also have to be honest with people about their competencies and coach them,” she adds. Manion encourages managers to ask people what is important to them. “One reason managers don’t do that is that they are afraid of being told something they can’t do,” she notes. “Say, ‘If I can’t do that, then what else would be important to you?’ By the third or fourth response, people will come up with something you can do.”

Focus communication
Becker recommends “purposeful rounding,” where the direct supervisor has a planned, one-on-one interaction with every employee at least monthly.

This is more focused than “management by wandering around,” she notes.

For example, instead of simply asking, “How are you?” ask questions such as, “What is going well? Who do you like to work with? Do you have the tools you need to do your job? What processes aren’t working?”

Such questions help build the manager-employee relationship and help address other factors important to employees, such as efficient work systems, tools and equipment to do the job, and appreciation.

Proactive, purposeful rounding can extend to the director’s other customers, including physicians, patients, families, and contacts in other departments.

Track your rounding to ensure you complete all of your contacts and to document results, Becker suggests.

Seek employee input
Another source of focused communication is to seek employee input for decision making.

Be aware that your perception...
Managing people

Staff satisfaction: What works?

How can you assess the value of a program designed to increase staff satisfaction before investing in it?

Great Place to Work offers 5 hallmarks of a successful program:
• variety
• originality
• all-inclusiveness
• degree of human touch
• integration with the culture.
“These differentiate a great workplace,” says Marcus Erb of the Great Place to Work Institute.

Variety
Erb cites the example of orientation for new hires. For instance, rather than one or two meetings with the hiring manager, the orientation might have multiple events to orient the new hire to the team’s operations and culture as well as several opportunities to meet their new coworkers, both within and outside the department.

Originality
A clever example is when the human resource person asks the new employee filling out forms the name of his or her favorite candy and has it on the desk when the new employee returns from a tour.

All-inclusiveness
Everyone receives a strong orientation and welcome, no matter their role or other differentiating factors.

Human touch
For example, “a new employee isn’t just given a manual, she’s given a buddy to help her,” says Erb. The buddy assists with tasks such as finding the cafeteria.

Integration
The program must be integrated with the organization’s culture and other programs.

Staff should know results of quality metrics they are responsible for, such as the time-out before surgery. “It reinforces why what they do is so important on a daily basis.”

Baptist Health relies on employee advisory groups as a pipeline for feedback and ideas.

Managers nominate staff, who serve for 1 year or more.

“For example, if we want to roll out a new benefit, we show them the communication plan to be sure it’s clear,” LeBlanc says. These committees fall under the human resources department.

Close the loop
Inform staff of how employee survey results are used and report on progress in addressing identified problems.

Be specific when asking for input and explain how it will be used, Erb advises.

Senior hospital leaders also need to interact with OR staff, asking them similar types of questions, says Becker. “Visibility and approachability let employees know their leaders are listening to them.”

Hold employee forums
Quarterly forums are useful to keep staff informed and help them understand organizational goals. “It’s the job of leadership to translate goals to what they mean to the staff,” says Becker.

Closing the loop includes providing feedback for the staff. That’s challenging when the feedback is negative.

“You aren’t trying to get people to like you; you’re trying to get people to trust you,” Erb notes.

Employees need the “whole picture,” both positive and negative. And employees consistently say they want to know how they are doing.

Set aside time to give feedback. “Build time into your schedule, whether it’s weekly, monthly, quarterly, by project, or some other schedule that works for you,” Erb says.

Great place to work on a budget

“Any place can be a great place to work,” Erb says. “You don’t have to have a budget, just take a sincere interest in your employees.”

Start having individual and group meetings with employees or even “take employees to lunch or dinner. That’s a powerful way to get information and build trust,” he advises.

Staff satisfaction benefits managers on a personal level, too. “If your staff is happier, you are happier,” says Erb.

—Cynthia Saver, MS, RN

Cynthia Saver, a freelance writer, is president, CLS Development, Inc, Columbia, Maryland.

Reference

Continued from page 21
Older nurses: A resource too valuable to lose

The average age of a perioperative nurse is higher than the average of 47 for nurses overall. That makes retaining older nurses a critical need for OR managers.

The immediate problem has subsided in recent years because of the poor economy. Still, “We’re concerned that as soon as the economy changes and 401ks and 403bs recover, we’re going to see an outflow of nurses,” says Lil LeBlanc, MBA, SPHR, assistant vice president of HR strategy and culture at Baptist Health South Florida.

Hospitals are taking steps to meet the needs of older nurses, enhancing satisfaction and improving retention. (Like AARP, this article defines “older” as over 50.)

Retaining quality staff
Scripps Health, a Southern California health care system consistently named as one of AARP’s Best Employers for Workers over 50, provides examples of how to increase older nurses’ satisfaction, including giving nurses who are 60 years old or have worked at the hospital for 30 years the option of reducing the amount of OR call.

“If we hadn’t made the change, we would have run the risk of losing those experienced and tenured nurses,” says Donna LoCurto, BSN, MHA, RN, director of surgical services for Scripps Memorial Hospital La Jolla, which has 18 ORs and an annual case volume of 9,500 inpatients and 3,300 in the ambulatory surgery center.

“We wanted to retain our investment in these very good employees and give them the opportunity to work more years.” Staff of all ages accepted the change, likely because the OR Unit-based Council suggested it as a way to retain nurses.

Providing options
The staged retirement program at Scripps allows employees who want to retire gradually by reducing their work schedule to maintain medical and dental benefits with the same premiums as regular active employees. Employees age 55 and older with at least 10 years of service are eligible to continue coverage at the same premium contribution level as part-time employees. Those with at least 20 years of service may be eligible to continue coverage at the same contribution level as full-time employees.

LoCurto also taps into Scripps’ resource pool, which includes employees who can scrub, circulate, or serve as an interim educator or supervisor. Employees in the pool stay a minimum of 3 months in any of the system’s 5 campuses. Currently, LoCurto has 2 resource employees and says, “These nurses are top notch. Instead of having an agency or traveling nurse, you have someone who contributes to the esprit de corps of the OR.”

The resource pool usually allows employees on a leave of absence to return to the same position.

Scripps offers a variable work schedule to meet the needs of OR nurses. For example, schedules can be modified to meet employee needs as well as needs of the department.

Promoting a healthy lifestyle
Scripps supports a healthy lifestyle through its Wellness Program. Participants earn credits for participating in wellness challenges, online seminars, preventive exams, health living programs, and more. By completing a Wellness Assessment, one Wellness Challenge, and at least 15 credits per year, participants receive free employee-only health insurance.

Other benefits older employees value are annual contributions to retirement plans, financial planning information, family medical coverage, and long-term disability.

Maintaining a quality workforce
Innovative programs can help perioperative leaders keep older employees happy. Happy employees contribute to a workforce well positioned to achieve optimal patient and business outcomes. ❖

—Cynthia Saver, MS, RN

Cynthia Saver, a freelance writer, is president, CLS Development, Inc, Columbia, Maryland.

Reference
Medicare’s inpatient prospective payment rule for fiscal year 2013 updates payment rates and adds to quality initiatives like value-based purchasing (VBP) and quality reporting. The rule issued August 1, 2012, takes effect October 1, 2012. Here are the highlights.

Payment rates
Inpatient payment rates will increase by 2.8% for 2013. This is a net update after adjustments for inflation, documentation and coding, and productivity.

Penalties for readmissions
Hospital payments for excess readmissions for heart attack, heart failure, and pneumonia will be reduced for discharges on or after October 1. The rule finalizes the method of adjusting payments.

Value-based purchasing
Medicare’s new VBP program, which goes into effect October 1, starts to reward hospitals for how well they perform or improve rather than just paying them for their volume of services. The rule makes final operational details for the program and adds 3 VBP measures that would affect payment for FY 2015:
• central line-associated bloodstream infection (CLABSI)
• The Patient Safety Indicator (PSI-90) composite measure covering 8 PSIs, such as pressure ulcers and postoperative indicators for hip fracture, sepsis, and pulmonary embolism/deep vein thrombosis (PE/DVT)
• Medicare spending per beneficiary for episodes spanning 3 days before admission to 30 days after discharge.

Two measures are finalized for FY 2016: a PSI composite measure and 30-day mortality rates for acute myocardial infarction, heart failure, and pneumonia. CMS says it plans to propose additional measures for FY 2016.

Seven measures from the Surgical Care Improvement Project continue to be part of VBP.

Inpatient quality reporting
For FY 2015, Medicare is reducing the number of inpatient quality measures to be reported from 72 to 59. One measure to be removed in the future is SCIP-VTE-1: Surgery patients with recommended venous thromboembolism prophylaxis ordered. Others slated to go away are postop measures for respiratory failure, PE/DVT, and wound dehiscence as well as foreign object retained after surgery.

For future years, Medicare will add inpatient measures of interest to surgical services:
• readmissions related to hip and knee replacement
• use of surgical safety checklists.

Safe surgery checklists
To meet the checklist measure for FY 2016, hospitals would have to report whether they use a safe surgery checklist that includes the 3 perioperative periods. The Centers for Medicare and Medicaid Services says it will not require any specific checklist or process.

The checklist measure is already final for hospital outpatient reporting to affect payments starting in CY 2014 and for ambulatory surgery centers (ASCs), affecting payments starting in CY 2015.

Total hip/total knee measures
Two measures would affect payments for FY 2015:
• Total hip/total knee complications, specifically, the hospital-level risk standardized complication rate (RSCR) following elective procedures
• Total hip/total knee 30-day readmission rate.

What’s new for HACs?
Under the HAC program, hospitals are not paid at a higher MS-DRG rate for patients who develop certain of these conditions.
New HACs added for FY 2013 are:
• surgical site infection following cardiac implantable electronic device (CIED)
• iatrogenic pneumothorax with venous catheterization.

ASC quality reporting
The rule makes final several administrative and reporting requirements for the ambulatory surgery center (ASC) quality reporting program. These include administrative, data completeness, and waiver or extension request requirements.

Data collection for measures that affect ASCs’ CY 2014 payments begins October 1, 2012. ASCs that fail to report and meet the requirements will see their Medicare payment update reduced by 2 percentage points. (See January, June, and July 2012 OR Manager.)
Let SpecialtyCare clinicians raise the performance of your OR

SpecialtyCare can help you improve clinical outcomes, patient safety and operating efficiency, all while reducing costs. As the most experienced provider of outsourced clinical services for the OR, we work side by side with surgeons, anesthesiologists and nurses in more than 750 hospitals across the country. And if our contract retention rate of 98% is any indication, they value our partnership. Look into SpecialtyCare — the OR performance people.

To learn more about SpecialtyCare, call (800) 633-3445 or email info@specialtycare.net

www.specialtycare.net
Like their older, larger, and sicker fellow patients, children can be candidates for outpatient surgery, and some ambulatory surgery centers (ASCs) opt to specialize in treating the younger set.

There is more to expanding an ASC’s patient base to pediatrics than putting a few toys in the waiting room (although that is a necessary step). Neither is it sufficient to purchase or lease smaller furniture, needles, apparel, and medical devices, although these, too, are necessary.

Clinical staff needs to realize that treating younger patients requires an understanding of their unique clinical characteristics.

“Children have different vital signs parameters, and assessing that population is much more difficult,” explains Gina Radewan, BSN, RN, surgical coordinator of Southeast Wisconsin Ambulatory Surgical Center in Kenosha, Wisconsin. In a previous position, Radewan served as circulating nurse for many pediatric procedures. Vital signs that would be alarming in an adult are normal for small children, she notes.

Keith Metz, MD, is an anesthesiologist and medical director of Great Lakes Surgical Center in Southfield, Michigan, where he specializes in pediatric procedures, primarily ear, nose, and throat (ENT). While it is possible to set aside a day or two each week, or a particular section of an ASC, for pediatrics, it is important to generate enough volume to maintain competence, he notes.

According to the Accreditation Association for Ambulatory Health Care (AAAHC) 2012 Handbook, ASCs that treat pediatric patients need to have appropriate equipment, medication, and resuscitative capabilities, as well as “a safe environment,” defined as space and supplies dedicated to pediatrics and personnel trained in the specialty.

There is no outpatient pediatric surgical specialty or accreditation and no professional group representing this subgroup of outpatient surgery, however. For example, the Tampa (Florida) Pediatric Surgery Center (PSC) could treat adults, according to administrator Teri Ulm. However, along with its affiliated ASC in Odessa, it chooses to specialize in patients age 21 and younger. The average age is between 2 and 3, and 80% of those are ENT, primarily tonsils and ear tubes. Together, the Tampa and Odessa centers average 10,000 cases per year.

What you need to succeed
According to Dr Metz, the number 1 requirement for any ASC contemplating pediatrics is “staff that really wants to take care of kids.”

Training and experience are critical. Nursing and anesthesia staff should be experienced in pediatrics and certified in Pediatric Advanced Life Support.
The center will have to invest in child-appropriate equipment and supplies. These include gowns, masks, socks, intravenous sets, endotracheal tubes, blood-pressure cuffs, and warming devices.

A pediatric emergency cart must be available with a defibrillator and pediatric doses of medications.

Finally, a separate waiting room or area with plenty of toys is helpful.

**Patient selection**

As Dr Metz notes, children presenting for outpatient surgery tend to be otherwise healthy, compared with older adults, who may have age-related conditions or comorbidities.

“The main concern is unanticipated respiratory problems,” Dr Metz says.

The smaller size and lower weight of children can affect their response to medications.

“Children are not simply little adults,” he says, “and they respond differently to anesthetics and other medications.” In addition, younger ones often cannot, or will not, comply with instructions.

Unlike adults, he adds, they must be considered as part of a family unit. Concerns, attitudes and behavior of parents and other caregivers may be the deciding factor in the appropriateness of outpatient surgery for a particular child.

**Age only one factor**

While PSC considers anyone under 21 a pediatric candidate, most of its patients are far younger. But age is only one factor in deciding, “Who are kids?”

Dr Metz’s patients range from about 50 weeks postconception to 12 years. Any significant comorbidities must be managed, and the list of typical procedures is short: ENT, hernia repair, ophthalmology, and urology.

Along with age, weight is a significant factor in eligibility for outpatient surgery.

“Lower-weight children may be especially susceptible to dehydration after some types of procedures,” Dr Metz says.

According to his ASC’s guidelines, full-term infants must be at least 46 weeks postconception, while premature infants must be at least 50 weeks postconception. If determined to be high risk, they must be admitted for 24 hours of cardiorespiratory monitoring. In such cases, according to Dr Metz, “a wiser choice would be to have those children treated in a more specialized setting.”

As with adults, malignant hyperthermia is a possible risk, and those with a family history of the condition should be evaluated by an anesthesiologist. For a child who has had a previous incident or a diagnosis of malignant hyperthermia through biopsy, Dr Metz recommends moving the procedure to a hospital.

Then there is the risk of attention-deficit/hyperactivity disorder (ADHD). A study published in February 2012 by the Mayo Clinic in Rochester, Minnesota, found that children who received general anesthesia 2 or more times before the age of 2 were more likely to develop ADHD by age 19. Parents often ask questions about the issue, and clinical staff should be prepared to respond.

**Screening for sniffles**

When a young patient arrives for surgery sneezing and coughing, different standards apply than for adults.

“Do I have to cancel every kid with a cold?” Dr Metz asks. The answer is no, but careful evaluation is necessary. “Many kids have runny noses. It’s not always serious, like bronchitis.”

For one thing, he notes, the average child gets 6 to 7 upper respiratory infections (URI) per year. Counting recovery periods, he says, “There are only 9 weeks a year during which the average child is not suffering from or recovering from a URI.”

Meanwhile, there are aspects to ENT procedures that may relieve URIs, such as removing tonsils and adenoids or placing ear tubes.

**When not to go ahead**

What should prevent the decision to go ahead with surgery despite a cold is the appearance of serious symptoms. One is a temperature above 101°F. Others are severe laryngitis, malaise, sore throat, sneezing, cough, congestion, and runny nose.

*Continued on page 28*
Continued from page 27

Risks include oxygen desaturation, bronchospasm laryngospasm, and respiratory failure. Endotracheal intubation increases the chance of complications.

“The evidence indicates that kids with colds do worse,” Dr Metz concludes, “and the younger the patient the higher the risk.”

**Preop fasting**

Another risk of anesthesia is aspiration pneumonia, and it is the reason food and liquids are withheld before surgery. For children, again the rules are different, and, according to Dr Metz, they are changing.

American Society of Anesthesiologists (ASA) guidelines for preoperative fasting in pediatric patients call for stopping solid food 6 hours before surgery; formula, 6 hours; breast milk, 4 hours; and clear liquids, 2 hours.

A newer protocol is emerging, he says, which would allow formula up to 4 hours before the procedure; breast and animal milk, 3 hours; and clear liquids, 1 hour.

Screening protocol makes a difference in a facility’s ability to operate efficiently and in the patient’s experience. A 1997 study at the University of Michigan Medical Center (related to the hospital outpatient department, not an ASC) showed that of 127 children whose elective outpatient surgery had been cancelled, 34.6% were cancelled due to URIs, 30.7% for other medical reasons, and the rest for failure to fast for the required period, scheduling errors, or lack of transportation. Of all the cancellations, 22.8% occurred on arrival at the surgery center.

**The family factor**

Should parents or other family members accompany pediatric patients into the OR? That is a matter of debate. Based on her experience, Radewan is all for it. Dr Metz offers pros and cons.

“Studies show that family members benefit from being present when the doctors and nurses are working on the patient during a cardiac arrest so it would make sense that the same principles would apply for a patient going under anesthesia,” Radewan notes.

When permitted in the OR for a pediatric procedure, parents stay only until the IV is inserted, not during intubation.

According to Dr Metz, “99% of the time, they appreciate the opportunity to be there.”

Benefits, he says, include reduced anxiety and increased compliance for the child, as well as higher satisfaction for both parents and child.

“Family dynamics” play a role, and having certain relatives present could be more disruptive than helpful, he notes. A parent may have an adverse reaction to the situation. There may be family disputes, especially if parents are divorced. In some cases, there may not be enough space in the OR to proceed safely with additional people.

Scheduling and logistics are also important. The University of Michigan study found that canceling pediatric procedures often caused one or both parents to miss work or to make an unnecessary trip.

Once they are admitted, young patients need a separate place to wait with their families, with furnishings appropriate for children, and no long waiting periods. “It’s good to get kids in and out early, so they don’t have to wait,” advises Dr Metz.

With adequate planning, training and commitment, pediatric surgery can be a rewarding specialty for an ASC: The patients are adorable, innocent, and generally healthy. As Dr Metz notes, “Older patients are often responsible for their ill health. It’s never the kid’s fault.”

—Paula DeJohn

**References**


For 25 years, the OR Manager Conference has provided you with strategies and tools you can use to help your OR run more efficiently, effectively and safely. This year will be no different, with a more robust and educational program than ever before!

Register today with VIP Code: ORMADVANCE to save with the Advance discount!

www.ORManagerConference.com
The Only Safety Scalpel That Fits Your Favorite Handle

With CABO you’ll get:
• to use your favorite scalpel handle
• a sheath that fully retracts for a clear view of the blade
• simplicity … load CABO the same way you load a blade

Check out our other Safety Scalpel Systems with the added benefit of our Polymer Coated Blade

SPSS Metal Handle

The perfect Disposable

We are very pleased to announce a new and improved website to better meet your needs and enhance the delivery of the important content you receive in OR Manager every month.

You will immediately notice that the new website has enhanced navigation features allowing you to search by topic, issue, date and much more, while the home page showcases the articles and features from the current issue.

Check out the new website today!

www.ormanager.com
ALL MANAGEMENT POSITIONS ARE NOT CREATED EQUAL AND THIS IS WHY...

It’s different at Kadlec Regional Medical Center. You can make decisions here. Your peers want to see you succeed. Leadership genuinely appreciates you. You are always growing professionally. You enjoy coming to work!

KADLEC REGIONAL MEDICAL CENTER HAS THE FOLLOWING OPPORTUNITIES AVAILABLE:

Administrative Director • OR Manager

COME EXPERIENCE THE DIFFERENCE:

• 10 (shelled for 12) state of the art (new construction) surgery suites

• Providing a full range of services including Cardiothoracic, Open Heart, and Neuro with all the newest technology

• Great Pacific Northwest Location right in the middle of Washington State Wine Country!

• Tenth in the U.S. Best Performing Small Cities (Milken Institute, 2011)

• Lowest cost of living in Washington State (ACCRA, 2010)

• Second best city for employment in the U.S. (Manpower, October 2009)

• Fourth largest metropolitan statistical area (MSA) in Washington State

• Major communities are Richland, Kennewick and Pasco

• Population of 275,000 and growing

• Average price of homes: $214,000

• No State Income Tax!

Visit us at Booth 630 at the 25th Annual OR Manager Conference October 24-26, 2012
Nurse burnout is linked to infection rates

Nurse burnout leads to higher health care-associated infection rates and costs hospitals millions of dollars annually, new research finds.

The study of more than 7,000 RNs in 161 Pennsylvania hospitals found more than one-third were suffering from burnout. Multivariate analysis showed a significant association between burnout and urinary tract and surgical site infections.

Hospitals in which burnout was reduced by 30% had a total of 6,239 fewer infections for an annual saving of up to $68 million, the authors note.


Earlier antibiotics lower C-section surgical infection rates

Giving antibiotics within 1 hour before a cesarean section instead of when the umbilical cord is clamped cut surgical site infections in half in a study that followed more than 8,000 women over 8 years.

The practice of waiting to give antibiotics until the time of cord clamp evolved out of concern that the drugs might hide signs of sepsis in the newborn, the lead author says.


Endo vein harvest not linked to higher mortality

Endoscopic vein-graft harvesting compared with the open procedure is not associated with a higher rate of death for Medicare patients having coronary artery bypass surgery, according to a study.

No significant differences were found in risk of long-term mortality or the composite of death, myocardial infarction, or revascularization. Patients having the endoscopic procedure had significantly fewer wound complications.

The Food and Drug Administration requested the study because of safety concerns about endoscopic vein-graft harvesting. The study involved more than 235,000 Medicare patients.


GAO: More needed on injection safety in ambulatory setting

The Government Accountability Office in a new report recommends that the Department of Health and Human Services take more steps to address injection safety in ambulatory settings, including:
- resuming collecting data on unsafe injection practices to permit continued monitoring of those practices
- using the data for continued monitoring of ambulatory surgery centers
- strengthening efforts of the One and Only Campaign for safe injection practices not overseen by the Centers for Medicare and Medicaid Services.

The report was compiled for a US House of Representatives subcommittee to examine bloodborne pathogen outbreaks from unsafe injection practices in settings such as physician offices and ambulatory surgery centers. The agency also looked at federal oversight and efforts to improve injection safety.