Use of agency staff and travelers is a fact of life with today’s staffing shortages. Temps help fill in during vacancies and surges in volume. Ideally, they support the rest of the staff and help keep them from burning out.

About 25% of ORs use temporary staff, according to the OR Manager Salary/Career survey published in the September 2003 issue. On average, when temps are used, they make up 8% of the staff.

Usually, temporary personnel are clinical experts and can step in after a brief orientation. But for them to be used effectively, the facility needs a well-organized process for introducing temps into the system, documenting their expertise, and monitoring their performance.

The Joint Commission on Accreditation of Healthcare Organizations requires organizations to determine qualifications and competencies for all staff, including temporary personnel.

Complying with standards is not the only reason to have a good process. Agency personnel are costly, and the facility needs to use them effectively to get the most from its investment. And temps who don’t blend well with the staff can take a toll on morale.

Massachusetts General Hospital (MGH) in Boston reorganized its orientation for temporary personnel about a year ago. The new process includes a grid to track their orientation, a 1-month assessment tool, and a revised orientation packet.

MGH has been using 18 to 20 travelers, mostly surgical technologists (STs), which are hard to recruit in that area. Travelers make up about 9% to 10% of the OR’s clinical staff of 190 direct-care FTEs. A major teaching hospital with 40 ORs, MGH performs about 24,000 procedures a year.

MGH decided to revise its orientation after managers heard from the staff that the travelers’ expertise often didn’t match what they needed. A staff survey found 35% thought travelers didn’t always have the skills needed for complex cases, and 25% said there was a lack of accountability.

Travelers received a 1-week orientation but were overwhelmed with paper that made it hard for them to find key information they needed.

In addition, there was confusion about what travelers could or could not do. There were questions about their real skill set. For example, what does it mean when they say they have had a “little ortho”? Sometimes, a traveler would actually have different experience than what their paperwork portrayed. There also were questions about whether they could serve as preceptors or work off-shifts.

“Accountability and lines of reporting weren’t clear.

“They might be on a different team every day. There was no tie-in to keep track of their performance competence, or attendance,” notes Marion Freehan, RN, MPH/HA, CNOR, nurse manager for the main operating room.

She decided it was time to streamline the process and organized a task force to do so. The goals were to:

• increase travelers’ support for OR operations
• improve the efficiency of the orientation process
• develop tools to assess, verify, and document competency
• improve communication
• develop reassessment tools.

New process, new tools

The revised traveler orientation process still takes 1 week but gives the traveler, the staff, and managers a better idea of what is expected.

“Most traveling nurses are experts and have a good knowledge base. The hard
thing here is the size of our institution,” comments Sue Hanneffant, RN, BSN, a clinical coordinator. “We try to keep them in one cluster. They need orientation primarily to find out where things are and who the key resource staff are. We keep them with a buddy for about 4 days. We tend to get feedback very early on how they are doing.”

In addition to a perioperative skills checklist, new tools have been added, including:

• an orientation grid that tracks and verifies activities that have been performed and when
• a checklist to document orientation to specific equipment
• a 1-month agency assessment form of the traveler’s clinical and social performance facilitated by the orientation coordinator with team leaders after consulting with the traveler’s preceptors and team members.

For the equipment checkoff, travelers can state whether they have used the equipment without a formal demonstration.

“We take it as an honest assessment,” Freehan says. Though she would prefer a hands-on demonstration on every item, that isn’t realistic. She has learned from other hospitals that they accept an oral verification. In an equipment-intensive specialty like orthopedics, travelers may be asked to demonstrate competence on critical equipment.

“We have stressed that if a traveler isn’t comfortable with a piece of equipment, they are accountable for speaking up,” she says. Agency personnel are included in orientations for new technology and equipment for their clusters.

The traveler’s orientation packet and personnel file documents have been pared down and reorganized (sidebar).

“Before, we had reams of information and policies and procedures,” Freehan notes. The new packet includes key items like the confidentiality agreement. Travelers are shown where to find resource books that have the complete set of MGH policies.

Travelers are assigned to a home team or cluster with oversight by the clinical service coordinator. When reviewing resumes, the nurse manager makes a preliminary assignment based on the traveler’s experience and depending on projected staffing needs at the time. MGH requires at least 2 years of experience. The decision to renew a contract is a consensus among the nurse manager, clinical service coordinator, and staffing/scheduling coordinator. Agency personnel are not used as preceptors unless absolutely necessary, Freehan says.

To help address morale issues, the OR leaders decided to limit contracts for individual travelers to 1 year.

“After a year, travelers start to feel like part of the staff and want to join negotiations for time requests, assignments, team placement, and so forth,” says Freehan. Limiting the contracts helps to reinforce that the relationship is contractual.

“We also won’t take them if they have worked at MGH, live in the area, and go to work for a traveling agency, even if they have been gone from the hospital for a couple of years,” Freehan says.

She is upfront about MGH’s expectations during the interview. She tells traveler candidates that MGH expects them to work two weekends and two off-shifts a month. There is no call, and overtime needs management’s approval.

“The staff’s perception is that the travelers get the ideal times. The message we send is, ‘You are here to supplement our staff.’ The travelers are expected to do everything our permanent staff is expected to do.”

The changes have made a difference. A staff survey done 9 months into the new process found 100% satisfaction. ❖
Traveler orientation

The process used at Massachusetts General Hospital, Boston:

Orientation materials
Traveler orientation packet:
• Welcome letter
• Time sheet
• ID badge card with telephone numbers
• Locker assignment
• Main OR organization chart with list of team leaders and other key personnel
• Team expectations
• Streamlined policies
• Map of ORs

Traveler personnel file:
• Assessment forms
• Respirator clearance form
• Confidentiality statement
• Network log-on request form
• Skills checklist
• Traveler orientation grid

Orientation process
Day 1
Meet with nurse manager:
• Review contract and orientation plan.
• Review administrative policy.
• Initiate verification and documentation of orientation criteria.
• RNs attend a 2-day Department of Nursing orientation.

Meet with perioperative orientation coordinator, who facilitates orientation plan including:
• Skills assessment
• Equipment checklist
• Emergency equipment review

Days 2 to 5
Orientation to clinical areas:
Assignments are made in collaboration with team leadership.

Assessment
Performed by clinical teams after 1 month. (Contracts are limited to 1 year.)