leadership

Lateral violence: Why it’s serious and what OR managers can do

A nurse hides a surgeon’s favorite instrument when a substitute fills in as the scrub. A circulator does not tell a new nurse who is scrubbed that she knows the shunt the surgeon selected has fallen on the floor. A newly hired RN who was previously a scrub tech is shunned by both camps. Is this just life in the OR? Is it part of a nurse’s rite of passage? Or is it something more insidious—bullying?

Research suggests these behaviors are prevalent and drive nurses away. The behaviors go by several names: lateral or horizontal violence, nurse-to-nurse bullying, sabotage, or the popular phrase, “nurses eating their young.”

The nursing literature over the past 20 years has documented lateral violence and its effects. Some researchers see a connection between nurse-to-nurse bullying and the behavior of oppressed groups. The thinking is that health care organizations tend to be hierarchies headed by physicians and administrators. A hierarchy places power in the hands of a few people at the top and disempowers nurses, who take out their aggressions on one another.

Bullying is especially serious for newly licensed nurses, says researcher Martha Griffin, RN, PhD, because it keeps them from asking questions, validating their knowledge, and feeling like they fit in—all necessary for them to build their knowledge and become part of the organization.

She has cataloged 10 behaviors that characterize lateral violence (sidebar, p 7).

Managing people

Mastering a steep learning curve: Trends in perioperative orientation

A solid orientation is a cornerstone for successful perioperative nursing. Choosing the right candidates and giving them the knowledge and skills to adapt to the surgical environment are essential to safe practice and to retaining staff. The learning curve for perioperative nursing is steeper than ever—83% of hospitals are hiring RNs without OR experience, and 55% are hiring new graduates, according to this year’s OR Manager Salary/Career Survey. We interviewed perioperative directors and educators from 5 organizations about orientation and how they prepare new recruits. And because they often don’t have OR experience to go by, we also asked how they select candidates they believe have the right qualities to become successful perioperative nurses (page 14).

Among the challenges:

• balancing the need for classroom education with an introduction to clinical practice
• getting orientees up to speed as quickly as possible while still giving them a grounding in the specialties
• building a bridge to practice by combining practical skills with adult learning and nursing theories
• collaborating across a hospital system for perioperative orientation
• seeking solutions for orienting nurses to constantly changing technology.

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**Periop process for anticoagulant therapy**

What’s needed to meet the Joint Commission’s new patient safety goal requirement?

**MRSA protocols for surgery**

Should preoperative patients be screened for MRSA? What other steps should be taken?

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**Upcoming**

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Should preoperative patients be screened for MRSA? What other steps should be taken?

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**Publisher’s Note**

**Periop process for anticoagulant therapy**

The ringing was persistent. Santa put down his sudoku puzzle and picked up his new iPhone.

“Don’t forget that you were going to cut the grass today,” reminded Mrs. Claus.

“No, it is worse than a Hummer with all the fuel it uses. Besides, it wakes up everyone in the neighborhood when I land on the roof.”

“Well, let me see if I can find some snow on eBay for Christmas Eve so that you and the reindeer can go on your appointed rounds,” responded Mrs. Claus. “Do you have your list ready?” she asked.

“Yes,” responded Santa. “And I have some terrific new presents.”

“For parents, I am bringing lead-testing kits for the toys under the tree that may have been made in China. All parents want to test the toys their children receive to make sure they are lead-free and safe.”

“As a stocking stuffer, I am giving all the children gift-wrapped alcohol-based sanitizers (no triclosan) to tuck in their backpacks to help avoid MRSA. Even though the concern about MRSA in schools is probably overblown, the scare can help to reinforce the many benefits of good handwashing.”

“For those who must share public space with loud incessant cell-phone talkers, I have special cell-phone jammers that silence those calls.”

“They are illegal, you know,” commented Mrs Claus, who reads *The New York Times* every day.

Santa reviewed his list. “With health care reform coming up as the hottest election issue, there is going to be a great deal of false information bandied about by politicians, interest groups, and people who are not well informed or who have their agendas.”

“As you know, since we both had bariatric surgery a number of years ago, we have been admirers and friends of the nurses and doctors that work in the OR. That procedure made a great deal of difference in our lives.”

“I hope that my friends in health care, especially those in the OR, will be informed and help their friends and colleagues understand the health care reform issues and the solutions that will be discussed. So I am giving them this high-tech false-information detection device. When it detects false information, misleading statements, and other nonsense, a red light starts flashing, and it emits a loud noise consisting of blah, blah, blah that overrides the speaker or other source.”

“That’s probably illegal, too,” sighed Mrs Claus. “But what is that large box that you are wrapping?”

“This is a special present for our leadership in Washington. It contains wisdom and compassion that I hope they will use as they move forward on health care reform as well as other issues that we are concerned about.”

“Like precious jewels, the holidays are many-faceted. For some it is a very religious time, for others it means gathering with families, giving (and receiving) gifts, or joining with friends for social gatherings.”

“For me, I enjoy bringing fun and laughter to children and adults alike.”

From Santa . . . and those of us at OR Manager, enjoy the holidays and welcome the New Year.

—Ellie Schrader
Please see the ad for
SKYTRON INC.
in the *OR Manager* print version.
Medical device companies would have to file reports with the government on prices for all implants sold, under a bill (S 2221) introduced Oct 23. The sponsors, Senators Arlen Specter of Pennsylvania and Charles Grassley of Iowa, both Republicans, say their aim is to make transparent the prices manufacturers charge hospitals participating in public programs like Medicare and Medicaid.

“The device makers actually prohibit hospitals from disclosing the price of a medical device to others. So hospitals have no idea what is a fair price,” Senator Grassley said. “This is a major reason why many hospitals pay absurdly more than others for the same medical device.”

Grassley said he is concerned because device costs, which are rising 8% to 15% a year, are taking up more of the Medicare payment, which means hospitals have less to spend on other aspects of care such as staffing. It’s also causing Medicare spending to rise “faster than it should” if hospitals pay more than the fair market price for implants.

Whether hospitals may compare implant prices has led to lawsuits. Last year, the nonprofit ECRI Institute sued Guidant Corporation, whose cardiac rhythm business has since merged with Boston Scientific, over the right to publish price comparisons of Guidant devices, such as pacemakers and internal defibrillators, as part of a service to subscribers.

Guidant countersued, saying ECRI Institute had “tortiously interfered” with its contracts with customers and had misappropriated “trade secrets” in obtaining Guidant prices, which it considers confidential, from hospitals. Court-mandated settlement discussions were underway in early November. If the discussions fail through, the case will proceed to trial.

Earlier in 2006, Aspen Healthcare Metrics, a consulting unit of the group purchasing organization MedAssets, settled a lawsuit by Guidant alleging that Aspen illegally induced hospitals to violate the company’s confidential pricing agreements for use in its consulting engagements.

Senator Specter said he’d received letters from hospitals, consumer groups, employers, and journalists about the secrecy of pricing for products like hip and knee implants and pacemakers.

A challenge to implement

A New York hospital wrote him that it spends about $300 million a year on supplies. Though pacemakers and joint implants account for only 3% of the items the hospital buys, these devices account for about 40% of the total spending.

An analyst for Wachovia told investors in October that a Washington, DC, consultant gave the bill about 50% odds of passing, noting that Senator Grassley is powerful and works across party lines. (There is no Democratic cosponsor.)

Though he could not comment on the pending litigation, Jeffrey Lerner, PhD, president and CEO of ECRI Institute, says he thinks the legislation is promising.

“For almost any other major purchase, like a house, customers are able to compare prices to help them make a decision. It would be very beneficial to bring that same shopping power into health care purchasing.”

If passed, the bill would be challenging to implement. Implants have many components, with different parts used for individual patients, making it difficult to compare prices for constructs. The government would need to determine how to classify the parts.

Under the bill, pricing would be posted on the Internet. Manufacturers who failed to report or misrepresented price data would be assessed penalties of $10,000 to $100,000.

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Please see the ad for
ADVANCED STERILIZATION PRODUCTS
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Leadership

Continued from page 1

“No other area in the hospital has a higher probability of lateral violence than the operating room,” says Griffin, who is director of nursing professional development at Brigham & Women’s Hospital in Boston and was a certified perioperative nurse early in her career. “People from the operating room call me the most, and I understand it because I’ve lived it.”

There’s consensus that lateral violence needs to be stopped. It’s not just inhumane—it has a corrosive effect on nurse recruitment and retention. It also affects patient safety. Experts agree communication breakdowns and lack of teamwork are a root cause of errors. If nurses are afraid to speak up because they fear being bullied by fellow nurses and physicians, patients can be harmed.

Nurse directors and managers play a pivotal role in defusing lateral violence. “Directors carry the culture code of the organization. They are responsible for what they ignore or what they pay attention to—they set the standard.” says Kathleen Bartholomew, RN, MN, author of Ending Nurse-to-Nurse Hostility: Why Nurses Eat Their Young and Each Other (HCPro, 2006).

Is lateral violence increasing?

There are no studies documenting whether bullying is increasing, but “if you ask nurses about it compared with 10 or 15 years ago, they will say it is more common,” says Bartholomew. She became interested in lateral violence after she entered nursing at age 38 and experienced it herself and later observed it as nurse manager of a 57-bed orthopedic unit in a large hospital.

She thinks the cost cutting that began in hospitals in the late 1990s is a factor. Shrinking resources, inefficient systems, and managers’ broader span of control have fueled stress, she believes.

“Nurses are the last line of defense between patients and the system, and they take more on themselves because we’re never going to say no,” she says.

Plus, with more nurses working 12-hour shifts, they no longer have time to go out after work. They have less chance to socialize and bond.

Coupled with social changes like more single parents, more people working longer hours each a week, and longer commutes, people are carrying a heavier load of stress.

A role for nurse leaders

Though nurse managers and directors are stretched themselves, Bartholomew urges them to realize “this is not small stuff—the camaraderie and ability to communicate on your unit are mandatory for teamwork.”

To address lateral violence, managers need training to make sure they have the needed skills, according to Karen M. Stanley, MS, APRN, BC, and Mary M. Martin, DNS, ARNP, of the Medical University of South Carolina (MUSC) in Charleston, who are also studying lateral violence.

“Participants reported over and over that they believed their nurse manager was aware of the behavior but did not take action to stop it,” they say. They have developed a survey to measure lateral violence, which is slated for publication in Issues in Mental Health Nursing.

What we know works

Griffin published a well-known study on lateral violence in 2004 in which 26 newly licensed nurses were taught about lateral violence. They learned about ways to respond to common forms of lateral violence, with laminated cue cards as reminders.

A year later, in focus groups, they were asked about their experience with lateral violence, use of the cue cards, and their socialization. Almost all (96%) had seen lateral violence during the year, and 46% said it was directed at them. All had responded to the incidents, though they said it was difficult. But the outcome was that the lateral violence stopped. Retention for the whole group of 62 newly licensed nurses in that year was 91%, compared to a national rate of 40% to 60% in other studies.

For the past 3 or 4 years, education on lateral violence has been included in the orientation of all nurses new to Brigham & Women’s. Nursing staff also receive 1 hour of education during annual “competency days” given by nursing units. The education includes a short video illustrating incidents that have actually happened at the hospital followed by a 10- to 15-minute discussion.

Griffin is conducting a 2-year study designed to measure the perception of nurses’ workplace behavior and the perceived impact of education on lateral violence.

What can managers do?

This is advice from experts on lateral violence.
Please see the ad for SPECTRUM SURGICAL INSTRUMENTS in the OR Manager print version.
Lateral violence in the OR

Examples from OR Manager readers:

I worked with a nurse who actually once risked the patient to make herself look good and me look bad. We were doing a carotid, and I was scrubbed. I had a set of Javid shunts on my field, and before the incision, the surgeon looked at all of them and tied a suture around the one he wanted. He told us he didn’t think he would need it, but if he did, he would need it fast and didn’t want to have to wait for me to find it.

The case started, then, yes, he needed the shunt. I reached on my back table, but it wasn’t there. As I was frantically searching, with the surgeon pretty angry with me, my circulator buddy reached into her pocket, pulled out the shunt with the string around it, dangled it in front of all of us and said, “Oh, doctor, look what I found on the floor after you drooped!”

All that time she knew the shunt had fallen off my table; she was present and listening when the surgeon explained why he would need it fast. Yet she didn’t bother to let us know she found it on the floor.

My manager was in the room. While this nurse was dangling the shunt in front of all of us, my manager went to the vascular cart, grabbed another shunt and got it on the field pronto, so thankfully, the patient was okay.

The surgeon didn’t stop fussing at me for the rest of the case because I had dropped the shunt and didn’t realize it. As the circulator knew would happen, the surgeon did not hold her responsible at all.

—Director of surgical services

I was working for a supplemental staffing agency. My first assignment allowed me to experience lateral violence first-hand while in the scrubbing role. The surgeon had 2 favorite instruments that were essential for him to complete his planned surgery—diamond jaw Metzenbaum scissors and a diamond jaw needle holder. His favorite circulating nurse was gone for the day. I made a request for the instruments, but they were nowhere to be found. The case was completed with an unhappy surgeon who voiced my incompetence to the rest of the team and the supervisors.

Two weeks later, I was in the same scenario, except this time his favorite circulator was there. I again requested the diamond jaw instruments. The circulator retrieved both, the surgeon was happy, and the procedure was completed. Then the surgeon explained to the circulator that during his last case, the instruments were nowhere to be found. The circulator stated she didn’t understand the problem because the instruments were right where they belonged. Where they had really been was in her locker.

—Former perioperative director

Shortly after graduating in 1999, I took a job as a circulating nurse in the OR. This seemed to be a natural extension of my previous 9 years of experience as a scrub tech. What I didn’t understand going into the job is that the hospital had an unwritten hierarchy.

The OR had a locker/lounge area that was used by all female personnel at the beginning of the shift, but only scrub techs used it during the day as a lounge area. The main lounge/break room was used by the OR nurses. No one explained the idiosyncrasies of the OR setup to me during my orientation.

My preceptor introduced me to everyone as a scrub tech turned circulator. After those introductions, I was even more displaced. I was never made to feel welcome in the “nurses’” lounge. When I would enter, all conversation would quickly become a low simmer rather than the previous boisterous engagements. I was constantly whispered about in that lounge, pointed to, and my name was often brought up loudly during those whispering conversations.

I tried to use the “scrub” lounge a few times and found that when I entered the room, most of the scrubs either ignored me or fled to other areas of the OR.

My preceptor never took the opportunity to show me how things should be done or how to prep correctly. Instead, she took every opportunity to throw me into a situation where I was not totally comfortable, and then scolded me when I didn’t do things the “right way.” She would often tell me that since our room or case was delayed, I should take a break. As soon as I would take a 5- to 10-minute break, she would stand in the hall upon my return and scold me by saying loudly, “Where have you been?”

When I approached my director, she said that she preferred for the staff to handle their own difficulties.

—Nurse manager, outpatient endoscopy center

Continued from page 7

violence and on ways managers can intervene to help their staffs.

Educate yourself

“Educate yourself about lateral violence and why it exists,” Bartholomew advises.

“As a manager or director, you are charged to see that your key people, your managers or your charge nurses, are educated, can handle conflict, and can set a standard of professional behavior.”

One thing every nurse can do: Never be a silent witness.

“If you can do only one thing to lower the hostility, you should stop listening to nurses bad-mouth other nurses,” she says. “Gossiping can’t exist without an audience.”

Examine your own leadership style

Adopt a style of leadership that moves away from top-down authority toward consensus building, Griffin advises. Give nurses more autonomy over their practice through structures such as shared governance. “The more you empower them, the less victimization there will be,” she says.

Set behavior standards

Griffin outlines expected professional behaviors in her 2004 article.

The Medical University of South Carolina has standards of behavior for all employees based on core values. These include accountability, respect, excellence, and adaptability. Each value has expected behaviors, and all are reviewed with each employee. Employees are asked to sign a commitment to uphold the standards, which is included in their personnel record, says Stanley. They are evaluated on adherence to the standards and rewarded by merit pay. Employees can choose not to sign, but the manager explains they will still be held to the standards.

Educate managers

Stanley recommends including education about lateral violence in regular educational offerings for charge nurses and preceptors.

Continued on page 10
Opening managers’ eyes to lateral violence

A workshop using real clinical narratives helps nurse managers learn about lateral violence at a community hospital in the Northeast. The hospital has also adopted a policy on lateral violence, which is in the early stages of implementation.

Donna DeRobbio, RN, MSN, collected the narratives as part of a research study she conducted on lateral violence at Westerly Hospital, Westerly, Rhode Island, under a grant from the University of Rhode Island.

“Because these are real incidents, it’s an effective way to introduce the subject of lateral violence,” she says.

The goal of the workshop is to raise consciousness, assist managers in identifying lateral violence, and encourage them to think about the problem.

“You want managers to learn to see patterns of behavior. This is not judging someone on a personal level for having a bad day,” she says. “It’s about the impact on patient care.”

Managers discuss narratives

The workshop is typically conducted for a group of 8 nurse managers, who are divided into small groups, preferably with others they don’t know. Each group is assigned one of the narratives (sidebar). The group reads the narrative, and members discuss them. They then respond to the following questions:

• What questions must the nurse have had at this moment? How did the other person(s) present influence the nurse’s understanding of what happened?
• Who was there to help the nurse?
• What would you hope the nurse would be doing in the future?
• What questions must the nurse have had at this moment? How did the other person(s) present influence the nurse’s understanding of what happened?

Donna DeRobbio, RN, MSN, collected the narratives as part of a research study she conducted on lateral violence at Westerly Hospital, Westerly, Rhode Island, under a grant from the University of Rhode Island.

“I’ve found that sessions that allow coworkers to learn about lateral violence and practice dealing with it together to be the most effective,” she says.

A community hospital in Rhode Island holds workshops for nurse managers where they discuss clinical narratives about lateral violence incidents that have actually happened to nurses at the hospital (sidebar).

Provide nurses with skills

Nurses need skills to be able to address conflict with peers, such as conflict management and assertiveness. Bartholomew said it took about 2½ years of coaching before she saw a true cultural change on her unit. But the changes are long lasting once the staff can recognize lateral violence, see the damage it is causing, and have the skills to handle it.

“Nurses need to learn how to go to a peer and say, ‘I heard you said something about me,’ or, ‘I was worried when you rolled your eyes after something I did,’” she says. “The reality is that we are not having these crucial conversations and lack the assertiveness skills to deal with these conflicts effectively. Learning these skills is critical to professional relations, quality of care, and patient safety.”

Give new nurses a shield

Teach newly hired nurses how to shield themselves from lateral violence. As Griffin illustrated in her study, coaching nurses on methods for deflecting lateral violence, along with cues, can be effective.

Give new nurses a chance to bond

Provide support for orientees to help keep them from feeling isolated.

“Never hire just one nurse—always
Counts off in 1 in 8 general surgery cases

Surgical count discrepancies occur surprisingly often, in about 1 in 8 general surgery cases in a new study. The counts took an average of 13 minutes to resolve. In 60% of cases, the discrepancy was a misplaced item, such as a sponge on the floor or in the trash.

The study of 148 general surgery cases is believed to be the first to document surgical count discrepancies based on direct observation.

In none of the cases was an item left in a patient’s body.

Counting took an average of 8.6 minutes per case, or about 6% of the operative time. Discrepancies were most often related to sponges, followed by instruments and needles. Counts after personnel changes were more likely to involve a discrepancy than if the original personnel were present.

“I think people have an idea that these discrepancies are happening. But I don’t think anyone would have expected it to be 1 per 8 cases, or 1 per 14 hours of operative time,” Caprice Greenberg, MD, MPH, a surgeon and lead author of the study from Brigham & Women’s Hospital, Boston, told OR Manager in an interview.

Discrepancies increase the risk of retained foreign bodies, she says, “because every time the count is off, we don’t have an accurate count of what is going on.”

Is technology, such as bar-coded sponges, the answer?

She and her colleagues have completed a randomized controlled trial of bar coding technology, being reviewed for publication, which will provide some data. The new study will also help by providing a baseline on how counts are performed currently. The results can be used as a control to see how new technologies perform, Dr Greenberg says.

“One thing people need to remember when we think about these new technologies is, while they’re designed to improve on the current situation, they may or may not achieve that goal,” she says. “They might also introduce new system complexities or unintended consequences that we need to think about.”

The study is a followup to a 2006 report of observations of 10 complex general surgery cases that found counting to “significantly compromise” case progress and patient safety. In that study, 14.5% of the incision time was spent on counting. In contrast, the new study, which involved routine cases, found counting took significantly less time.

The report was presented at the American College of Surgeons meeting in October in New Orleans. An abstract is in the September 2007 Surgical Forum supplement to the Journal of the American College of Surgeons.

References


Most technical errors involve experienced surgeons, complex patients

Most technical errors in surgery happen in routine operations with experienced surgeons and involve complex patients and technology or systems failures, a new study shows.

Examining 258 malpractice claims involving injuries due to errors, the researchers found 52% involved technical errors. The majority of these cases—73%—involved experienced surgeons, and 84% happened during routine operations. Two-thirds (65%) were linked to manual error, 9% to judgment, and 26% to both manual and judgment errors. In all, 61% of the errors were attributed to patient complexities, such as emergencies, difficult or unexpected anatomy, or previous surgery. Technology or systems failures contributed to 21%.

The authors recommend that surgical research should focus on improving decision making and performance for routine operations on complex patients and circumstances. Common interventions such as having experienced surgeons for complex procedures and increasing supervision for trainees will address only a minority of errors, the authors say.


Offer two-way feedback

Preceptors give feedback to new nurses every day. Do you also encourage new nurses to give feedback to preceptors?

Bartholomew says one preceptor was shocked when she heard her orientee say, “I need to know I’m not in your way, that I am not a bother.” The preceptor didn’t understand why the nurse felt that way.

“The preceptor’s body language conveyed what she was thinking, but she had no idea she was communicating that,” she notes.

Practice self-evaluation

“To truly embrace change involves self-evaluation,” Griffin says. “You need to think about, ‘How does this organization function?’ We all need to be looking at that.

You really can’t change the people on the front lines if the leadership does not support them.”

—Pat Patterson
Managing people

Continued from page 1

Building enthusiasm
Columbia Hospital
West Palm Beach, Florida
250 beds, 7 ORs
Gary G. Reardon, RN, MSN, MS, CNOR, director of surgical services

Just 1 year after graduating from nursing school, I became an OR manager. I took on the responsibility of opening a new hospital in Canada where I had to hire and train all the staff. That was where I developed my orientation program. Based on that history, it did not bother me when I came to Columbia Hospital 10 years ago that nurses weren’t coming through the door prepared for the OR.

I have been meeting with schools in the area to help them see the importance of having a perioperative course for nursing students. I have told them I am willing to develop an OR program for their students, such as a 6-week internship.

Here at Columbia, I had to work to remove the fear that staff and administration had about hiring nurses without OR experience. I pointed out that I was confident I could train them to become great OR nurses.

New nurses begin with a general orientation to the hospital and then start the orientation to surgical services. They go over policies and procedures. They then spend time in all the departments that report to surgical service and have relationships with surgical services, such as admitting, the lab, and sterile processing.

We do it in bite-size pieces. One week they concentrate only on the admission of the patient to the preop holding area. Another week they just focus on preop preparation and documentation. I want to make sure they understand the process their patients go through before they see them in the OR.

By the end of the first month, they are rotating through the services with their preceptors—scrubbing and circulating.

Once they rotate through all of the services, they are placed on call with a backup team member. When called in, they have the choice to call their backup in or not. If they feel comfortable doing a case without a backup person, that’s fine because I believe it gives them self-confidence and autonomy. The staff also self-schedule.

The rotation builds confidence.

If nurses excel in certain cases, we try to assign them to those cases, but if not, they understand. Everybody has to be able to perform any case on call.

We have no vacancies at the present. We have a high retention rate, with some staff here for 20 years.

I love what I do, and I like to help get people enthusiastic about what they’re learning.

Periop internship pays off
Christiana Care Health System
Wilmington, Delaware
4 surgical sites, 52 ORs
Beth Fitzgerald, RN, MSN, CNOR, perioperative nurse internship manager

In response to a growing shortage of perioperative nurses, Christiana Care Health System developed a “grow our own” perioperative internship program in 2000. It was costly but has paid off. Our internship program has staffed 56% of the OR positions in 4 facilities in the Christiana system, and we have an 83% retention rate for the orientees.

Our 6-month program starts in September and March, and we offer 6 college credits through Delaware County Community College. We have taken 2 to 16 interns through the program at one time.

The first 2 weeks begin with classes on aseptic technique, policies and procedures, and AORN recommended practices. I teach scrubbing, gowning, and gloving in a simulation lab in the shell of two 2 ORs that were never finished.

After the first 2 weeks, we begin to practice what has been taught in the lab. On Mondays and Fridays, we have classroom time to review subjects such as electrotherapy, positioning, or malignant hyperthermia. On Tuesday, Wednesday, and Thursday, we move into the clinical setting and begin scrub rotations. Interns scrub with a dedicated preceptor in one service for 4 weeks, then circulate with a dedicated RN preceptor in the same service for 4 weeks. Every week features a different competency, such as counting or specimens. It sounds elementary, but it works because interns can focus on one subject at a time.

Following this classroom and clinical segment, we have a graduation party. Then the interns enter a 3-week scrub rotation with surgical technologist preceptors who have been carefully chosen. They scrub for 3 weeks in one service such as general surgery or gynecology, and follow their preceptors’ schedules. Because we are a trauma center, this schedule allows the interns to work all shifts and weekends. Then they move into the circulating role and are with RN preceptors for 3 weeks, again following their preceptors’ schedules.

The rotation builds confidence and solid knowledge of the services. After this rotation is completed, they begin another 6-week rotation in another service.

At the end of this 6-month orientation, the interns leave the internship cost center and move to the OR site to continue specialty orientations.

After completing the program (from 9 to 11 months, depending on the site), we ask the new graduates to select a first and second choice of service to specialize in.

The interns sign a 2½ year contract and are obligated to pay back $7,500 if they don’t complete it. With our high retention rate and having staffed the majority of OR positions in the system, we think we have been successful.

Bridge to practice
Northwestern Memorial Hospital
Chicago
744 beds, 52 ORs in 3 pavilions
Christine Bloomfield, RN, MS, CNOR, program manager for perioperative education

Northwestern Memorial Hospital and Northwestern Academy, the teaching arm of the hospital’s human resources department, have integrated surgical services with professional education, forming what we call a “bridge to practice.”

The program, created a year ago, combines the expertise and practical knowledge of the OR educator with the adult learning theories used by the academy to
Managing people

build a new approach for OR orientation. The program is based on the premise that an orientation program needs to integrate practical expertise with adult learning theory and nursing theory.

We start with 6 weeks of AORN’s Periop 101 curriculum, with a half a day in the classroom and half a day in the OR. Two OR educators teach the classes with me, as well as preceptors.

After this phase, new nurses choose a service to specialize in and spend 2 weeks scrubbing and 2 weeks circulating in that specialty. We have specialized call teams for each service, so there is no need for them to learn all services.

The bridge-to-practice concept combines Periop 101 with kinesthetic learning, an adult teaching and learning style in which the student learns by actually carrying out a physical activity. That enables nurses to apply the principles they learn in Periop 101.

With this approach, we believe orientees will retain information at a much higher rate.

Our major focus is on evidence-based practice. We want nurses to know why they are practicing a certain way and not just do things because that is the way it’s always been done.

Because we just started this program, we don’t know the effect on retention. One of my goals is to make our retention rate our indicator of success.

**System effort**

Memorial Hermann

Houston, Texas

11-hospital system

Deborah Alpers, RN, administrative director of perioperative services, Memorial Hermann Southwest

About 5 years ago, the majority of hospitals in the Houston area had stopped their training programs for OR nurses. As it became more difficult to fill vacancies, at Memorial Hermann Southwest we knew we needed a breakthrough. I convinced the administration that my part-time educator should be made full time, and we launched an OR internship program.

The program is now part of the Memorial Hermann system’s educational and recruitment plan.

Based on AORN’s Periop 101 curriculum, the program consists of 4 weeks of classroom instruction followed by 18 weeks of clinical experience in which the interns rotate through the specialties. Every other Monday for the 18 weeks, orientees return to the classroom to discuss a specific specialty and share progress. This gives them the opportunity to work in a specialty before hearing the lecture specific to that specialty. We found this to be more helpful than including all of the specialty lectures in the initial 4-week classroom component.

After the 18 weeks of clinical experience, the interns are working in the ORs with their preceptors. Usually, within 6 months from the beginning of the program, interns are taking call with a buddy.

The classroom is set up with a mock OR in a central location. The classes have had 12 to 16 interns each. The interns sign a 2-year contract to continue working with the Memorial Hermann system. So far, only one nurse has broken the contract because her husband was transferred. She did pay the $2,500 fee.

The program is a collaborative effort, with education staff from multiple facilities working together to plan and teach the course. As a result, OR education is now standardized throughout the system. Hospitals have participated whether they have a participant in the program or not. The system effort has been especially valuable to the smaller hospitals.

Many of us look for nurses within our own facilities who want the opportunity to become OR nurses.

**Orienting by technology**

Massachusetts General Hospital

Boston

900 beds, 42 ORs

Marion Freehan, RN, MPA/HFA, CNOR, nurse director, main ORs

With so much new technology, we had to look at what would be a realistic orienta-

—Judith M. Mathias, RN, MA
Managing people

Which candidates are the keepers?

How do you know a nurse is a good fit for the OR—even if the person doesn’t have OR experience? There’s a body of research that shows that the better the fit between an organization and an employee, the longer the person is likely to stay.

Managers often say they have a “gut feeling,” about who will make it in the OR. That’s one piece of the puzzle, but you need to make sure you have a selection process that is job related, objective, and consistent, advises Charles Handler, PhD, an organizational/industrial psychologist specializing in employee selection.

You want to ensure every applicant is evaluated based on the same criteria. That’s also the best way to ensure the process can stand up to legal scrutiny, says Handler, founder of www.rocket-hire.com, a website that focuses on employee screening and assessment.

Of course, you will review a candidate’s nursing experience and clinical skills. You will check references to verify previous employment. But you also want to know how applicants would handle situations in the OR. Known as “behavioral interviewing,” this is based on the premise that the best predictor of future behavior is how a person responded to similar situations in the past.

Keys to behavioral interviewing:

• Relate the situation directly to the job. Don’t ask something like, “If you were an animal, what would you be?” (OR examples in the sidebar.)

• To help ensure objectivity, rate responses using a scale planned out in advance. The scale might outline behaviors that represent excellent, average, or poor responses, Handler suggests.

You might have a committee of managers and staff develop the scenarios and model responses, with input from the HR department.

One example of a scenario: “This job may require you to work overtime on short notice. How would you handle that?”

Examples of responses:

• Excellent: “There have been times I have done this. I have changed my schedule to meet my work commitment, even though it meant missing a personal event.”

• Average: “I’d do what I can, but my own life is important, too.”

• Poor: “This is basically just a job. I would have trouble making last-minute changes.”

Be sure to train managers and staff who will be interviewing so they fully understand the process, Handler adds.

Tips from OR managers

Deborah Alpers, RN, administrative director of perioperative services at Memorial Hermann Southwest in Houston, says she asks a lot of questions about difficult scenarios.

“If they tend to blame others and don’t suggest steps they can take to make the situation better, that turns me off,” she says. She also finds those who make lists and take notes during the interview tend to have good organizational skills, a quality she is looking for.

Beth Fitzgerald, RN, MSN, CNOR, perioperative nurse internship manager for Christiana Care Health System, Wilmington, Delaware, has applicants write an essay about why they want to be an OR nurse.

“For one person, it was because a family member had a good experience with surgery, and the candidate kept talking about how wonderful the OR was. For another, it was the excitement they felt about wanting to work in surgery. I find the new graduates especially refreshing.

Interviewing scenarios

Two scenarios used by Christiana Health Care System, Wilmington, Delaware:

Scenario 1

You are assigned to a trauma case involving a 15-year-old with multiple life-threatening injuries from a motor vehicle accident. The patient is not expected to survive but is brought to the OR to do everything that can possibly be done. The trauma surgeon is visibly upset and has brought 4 other surgeons with him. This is going to be a busy case with 5 procedures taking place at one time (neurosurgery, orthopedics, general surgery, plastics, and cardiovascular).

• How will you handle this case emotionally?

• How will teamwork play a role in this procedure?

Scenario 2

You have been asked to form a team and revise a policy on retained foreign objects. Describe how you would facilitate this teamwork and encourage participation among the unengaged OR staff.

Interviewing questions

Some questions asked at Memorial Hermann Southwest in Houston:

1. Tell us about a time when you were proud of your decision-making skills. Pick a problem you have had to solve, give the details involved in it, and tell us what you did in creating the solution to that particular problem.

2. Give a detailed example of what you do in your current position to organize yourself to begin your day and throughout your day.

3. Tell us about a time when you have had to deal with a person in a position of authority, and you had a difference of opinion. How did you handle this situation?

4. Tell us about a time when you were able to achieve something by doing more than was expected.

5. Describe a situation in which you were expected to work with an individual you personally disliked. What happened?

6. Talk about a time when you made a personal sacrifice to reach a work objective.

7. Pick an example from your current job that would reflect on your ability to deal with pressure and/or stress.

8. What types of things make you angry in the work setting?

9. When has a customer or co-worker been able to make you act less mature and professional than you normally do?
Managing people

because they are energetic and excited about wanting to learn perioperative nursing,” she says.

At Columbia Hospital in West Palm Beach, Florida, Gary G. Reardon, RN, MSN, MS, CNOR, says he looks past the lack of OR experience for something else—potential and energy.

“My first question is: ‘Why do you want to be an OR nurse?’” Reardon says. “If they talk about wanting to get away from so much shift work, or they have a babysitter problem, or they really like to work days, I don’t waste my time.

“But if someone says, ‘I really want to work in the operating room, if someone would just give me a chance,’ I keep talking. If I see that desire, I hire them. These were the characteristics someone saw in me years ago and gave me a chance.”

Avoiding inappropriate questions

Another benefit of a structured, job-related interview is that it helps avoid improper questions. “Asking inappropriate questions in a job interview is probably the easiest way to get sued,” Handler says.

Inappropriate questions are those that place people in a protected class at a disadvantage. Examples of protected classes are race, ethnicity, religion, national origin, age, sex, and disability status.

For example, it’s not legal to ask applicants about their plans to bear children, their date of birth, their marital status, or whether they own a car unless these questions can be shown to be directly related to a person’s ability to do a job.

Incisionless surgery for acid reflux disease

Surgeons at Ohio State University performed the first incisionless procedures in the US for gastroesophageal reflux disease, the university reported in October.

The procedure allows reconstruction of the valve at the top of the stomach using a new device introduced through the mouth and advanced into the stomach. The EsophyX device by Endogastric Solutions has been cleared by the Food and Drug Administration.

Patients are usually in the hospital overnight and are symptom free, Ohio State surgeons report. They say the procedure leaves no external scarring, causes little postoperative pain, and reduces recovery time.

—www.endogastricsolutions.com

Patient safety

A time-out tool helps to improve compliance at the patient’s bedside

The highest priority of any health care provider is to ensure patient safety. The single most important tool for preventing errors is the ability to communicate. According to the Joint Commission, the number one cause of sentinel events is a breakdown in communication among the surgical team, patient, and family. For wrong surgery, in 2006, communication was second only to procedural compliance as a root cause of these events.

The Joint Commission requires accredited organizations to adopt the Universal Protocol for preventing wrong surgery. The Universal Protocol has 3 major requirements:

- a preoperative verification process
- marking the operative site
- a time-out immediately before the procedure.

The protocol applies not only for operative procedures but also for non-OR procedures performed at the bedside. (The only exception for bedside procedures is that the site does not have to be marked if the person performing the procedure is with the patient from the time of the decision to perform the procedure until the procedure is performed.)

After reviewing the Joint Commission’s guidelines for the Universal Protocol and our current policy, we developed a standardized process to be used for all surgical procedures that occur outside the operating room.

In collaboration with our Central Sterile Processing Department, we identified specific instrument trays that would be used for bedside procedures. We attach to the outside of each tray a time-out document, which serves 2 purposes. The first purpose is to identify the tray as one that will be used for bedside procedures requiring a time-out verification. The second purpose is for the document to be used as a written verification of the procedure, ensuring all necessary components of the time-out are included.

In addition to this document, a fluorescent green sticker labeled Time-Out is visible on the wire cart where the trays are kept. This green sticker is used by the nursing units and the Central Sterile Processing Department. Implementation of this standardized process has reduced the incidence of bedside procedure events related to the Universal Protocol.

—Stephanie Landmesser, RN, MSN, CNOR
Clinical Nurse Educator of Perioperative Services
Lankenau Hospital
Wynnewood, Pennsylvania

A copy of the bedside time-out verification tool is in the OR Manager Toolbox at www.ormanager.com.

Check our website for the latest news, meeting announcements, and other practical help.

www.ormanager.com
Are your operating rooms ‘efficient’?

The 8 metrics are based on the literature.

Excess staffing costs due to OR allocation not being based on maximizing OR efficiency

Nothing is more important than to first allocate the right amount of OR time to each service on each day of the week for its case scheduling. This is not the same as the block time! To illustrate, imagine that 2 cases each lasting 2 hours are scheduled into OR 1 with OR nurses and an anesthesiologist scheduled to work an 8-hour day. The matching of workload to staffing has been so poor that little can be done the day of surgery to increase the efficiency of use of the staff. Neither awakening patients more quickly nor reducing the turnover time, for example, will compensate for the poor initial choice of staffing for OR 1 and/or how the cases were scheduled into OR 1.

Optimal allocation of OR time should be based on historical use by a particular service (ie, unit of OR allocation such as surgeon, group, department, or specialty) and then using computer software to minimize the amount of underutilized time and the more expensive overutilized time (Strum et al, 1999).

Underutilized hours reflect how early the room finishes. In the example above, if staff were scheduled to work from 7 am to 3 pm, but instead the room finished at 11 am, there would be 4 hours of underutilized time. The excess staffing cost (Strum et al, 1999) would be 50% (4 hrs/8 hrs).

On the other hand, if 9 hours of cases are performed in an OR with staff scheduled to work 8 hours, then the excess staffing cost is 25%. Overutilized hours are the hours that ORs run longer than the regularly scheduled OR hours, or 1 hour in this example. The calculation is as follows: 1 hr/8 hrs = 12.5%, which is then multiplied by the additional cost of staying late, which often is assumed to be a factor of 2 (related to monetary overtime cost paid to staff, as well as recruitment and retention costs related to unhappy staff because they have to stay late unpredictably).

OR suites can reasonably aim to achieve a staffing cost that is within 10% of optimal (ie, workload is perfectly matched to staffing).

If the key is to allocate appropriate time to each service based on historical OR use, how do you deal with rooms consistently running late on the day of surgery? The answer: Make the allocated time into which cases are being scheduled longer. For example, if a surgeon does 12 hours worth of cases every day he is in the OR, don’t plan 8 hours of staffing (7 am to 3 pm) and have everyone frustrated by having to stay late (overtime). Rather, schedule his cases into 12 hours of allocated time (7 am to 7 pm). That way, anesthesia and nursing staff know they will be there for 12 hours when they arrive at work, and overtime costs (financial and morale) will be reduced. The common response to this approach is, “No one wants to be there until 7 pm.” The answer is, “You are there now until 7 pm, so why not make the scheduled OR time 12 hours long and have a more predictable work day duration?” Thus, optimizing staffing costs is finding a balance between overtime and finishing early.

Start-time tardiness

Start-time tardiness is defined as the mean tardiness of start times for elective cases per OR per day. Reducing the time patients have to wait for their surgery once they arrive at the hospital (especially if the preceding case runs late) is another important goal. If a case is supposed to start at 10 am (patient enters OR), but the case starts at 10:30 am, there are 30 minutes of tardiness. In computing this metric, no credit is given if the 10 am case starts early (for example at 9:45 am).

The tardiness in starting scheduled cases should total less than 45 minutes per 8-hour OR day in well-functioning OR suites. Facilities with long work days will have greater tardiness because the longer the day, the more uncertainty about case start times. Having patients’ medical records ready to go with all needed documents is essential for on-time starts.

Case cancellation rate on day of surgery

Cancellation rates vary among facilities, depending partly on the types of patients receiving care, ranging from 4.6% for outpatients (van Klei, et al,
OR throughput

A scoring system for OR efficiency with 8 performance indicators

<table>
<thead>
<tr>
<th>Metric</th>
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<th>1</th>
<th>2</th>
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</thead>
<tbody>
<tr>
<td>Excess staffing costs &gt;10%</td>
<td>5% -10%</td>
<td>&lt; 5%</td>
<td></td>
</tr>
<tr>
<td>Start-time tardiness (Mean tardiness of start times for elective cases per OR per day) &gt; 60 mins</td>
<td>45-60 mins</td>
<td>&lt; 45 mins</td>
<td></td>
</tr>
<tr>
<td>Case cancellation rate &gt; 10%</td>
<td>5% -10%</td>
<td>&lt; 5%</td>
<td></td>
</tr>
<tr>
<td>PACU admission delays &gt; 20%</td>
<td>10%-20%</td>
<td>&lt; 10%</td>
<td></td>
</tr>
<tr>
<td>Contribution margin (mean) per OR hr &lt; $1,000/hr</td>
<td>$1,000/hr-$2,000/hr</td>
<td>&gt; $2,000/hr</td>
<td></td>
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<tr>
<td>Turnover times (Mean setup and cleanup turnover times for all cases) &gt; 40 mins</td>
<td>25-40 mins</td>
<td>&lt; 25 mins</td>
<td></td>
</tr>
<tr>
<td>Prediction bias (Bias in case duration estimates per 8 hr of OR time) &gt; 15 mins</td>
<td>5-15 mins</td>
<td>&lt; 5 mins</td>
<td></td>
</tr>
<tr>
<td>Prolonged turnovers (% of turnovers that are more than 60 mins) &gt; 25%</td>
<td>10%-25%</td>
<td>&lt; 10%</td>
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</tbody>
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2002) to 13% (Pollard, et al, 1999) to 18% (Basson, et al) at VA medical centers. Many cancellations are due to nonmedical problems such as a full ICU, surgeon unavailability, or bad weather. OR cancellation rates can be monitored statistically (Dexter, Marcon, et al, 2005), and well-functioning OR suites should have cancellation rates less than 5%. Monitoring cancellations correctly is not taking the ratio of the number of cancellations to the number of scheduled cases (Dexter, Marcon, et al, 2005).

Postanesthesia care unit admission

PACU admission delays are defined as the percentage of work days with at least one delay of 10 minutes or greater in PACU admission because the PACU is full. It is important to adjust PACU nurse staffing around the times of OR admissions. Algorithms exist that use the number of available nursing hours to find the staffing solution with the fewest number of understaffed days (Dexter, Epstein, 2005; Marcon, Dexter, 2006).

Contribution margin per OR hr

An OR suite that puts up with excessive surgical times can schedule itself efficiently but still lose its financial shirt if many surgeons are slow, use too many instruments or expensive implants, etc. These are all measured by the contribution margin per OR hour. The contribution margin per hour of OR time is the hospital revenue generated by a surgical case, less all the hospitalization variable labor and supply costs. Variable costs, such as implants, vary directly with the volume of cases performed.

This is because fee-for-service hospitals have a positive contribution margin for almost all elective cases mostly due to a large percentage of OR costs being fixed. For US hospitals not on a fixed annual budget, contribution margin per OR hour averages $1,000 to $2,000 US per OR hour (Dexter, Ledolter et al, 2005; Dexter, Blake, et al, 2002; Macario, Dexter, et al, 2001).

Turnover times

Turnover time is the time from when one patient exits an OR until the next patient enters the same OR. Turnover times include cleanup times and setup times but not delays between cases. Based on data collected at 31 US hospitals, turnover times at the best performing OR suites average less than 25 minutes (Dexter, Epstein, et al, 2005). Cost reduction from reducing turnover times (because OR workload is less) can only be achieved if OR allocations and staffing are reduced (Dexter, Abouleish, et al, 2003). Despite this, turnover time receives lots of attention from OR managers because it is a key satisfier for surgeons.

Sometimes an OR suite reduces turnover times (by providing more staff to clean the room, for example), but new problems arise (such as not enough time for sterilizing instruments for the new case or not being able to take the patient to the PACU because there are no beds) that were “hidden” by long turnover times.

Times between cases that are longer than a defined interval (eg, 1 hour because the to-follow surgeon is unavailable) should be considered delays, not turnovers (Dexter, Macario, et al, 1999).

Prediction bias

Prediction bias is defined as bias in case duration estimates per 8 hours of OR time. Prediction error equals the

Continued on page 18
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actual duration of the new case minus the estimated duration of the new case. Bias indicates whether the estimate is consistently too high or consistently too low, and precision reflects the magnitudes of the errors of the estimates. Efficient OR suites should aim to have a prediction bias that is less than 15 minutes (Dexter, Macario, et al, 2005). A reason for bias can be surgeons consistently shortening their case duration estimates because they have too little OR time allocated and need to “fit” their list of cases into the OR time they do have. In contrast, surgeons may purposely overestimate case durations to keep control of or access to their allocated OR time so if a new case appears, their OR time is not given away.

Remember that lack of historical case duration data for scheduled procedures is an important cause of inaccuracy in predicting case durations. In general, half of the cases scheduled in your OR suite tomorrow will have less than 5 previous cases of the same procedure type and same surgeon during the preceding year (Zhou, et al, 1999).

It would be nice to have no uncertainty in case duration prediction. But it is present. The problem is looking for a single number that is correct most of the time. You won’t get accurate estimates by using historical case duration data. Rather, from the historical data, you’ll get an assessment of the uncertainty. With proper management weeks to months ahead of time, the groundwork for an efficient (well-functioning) OR suite should be in place. Statistical process control could be used to prospectively monitor a dashboard of items, such as the ones discussed above.

— Alex Macario, MD, MBA
Department of Anesthesia
Stanford University School of Medicine

Summarized with permission from Macario, A. Are your hospital operating rooms “efficient”? Anesthesiology. 2006;105:257-260.

References
Abouleish A E, Dexter F, Epstein R H, et al. Labor costs incurred by anesthesiology groups because of operating rooms not being allocated and cases not being scheduled to maximize operating room efficiency. Anesth Analg. 2003;96:1109-1113.


Elective ORs better for emergencies in study

Emergency patients were operated on more efficiently by reserving capacity in elective ORs rather than having dedicated emergency ORs, in a new study from The Netherlands.

The study used a simulation model to examine the 2 approaches to reserving capacity for emergencies. The outcome measures were waiting time, staff overtime, and OR utilization.

Results indicated that the policy of reserving emergency capacity in all elective ORs led to improved waiting times for emergency surgery from 74 minutes to 8 minutes. Overtime was reduced by 20%, and overall utilization increased by about 3%.

The results led to the closing of the emergency OR at the Erasmus University Medical Center in Rotterdam.

Please see the ad for
MATROX GRAPHICS INC.
in the *OR Manager* print version.
Managing Today’s OR Suite

Managing people a theme at conference

The power of teams and a culture of collaboration were themes at the Managing Today’s OR Suite conference Oct 3 to 5 in San Diego. The conference attracted 726 attendees for the 2-day conference and 390 for the preconference seminars. They visited an exhibit featuring 88 companies.

Attendees gave the conference high ratings, with 92% rating it as “excellent” or “very good” and 100% saying they thought the content would be valuable in their work settings.

Barbara Johnson, RN, BSN, MHA, was honored as OR Manager of the Year. Johnson, director of perioperative nursing at Piedmont Hospital in Atlanta, said she has “the best perioperative team in the universe.” She advised managers, “Don’t think you have to have all the answers—rely on your staff.”

Select for talent

How do you build great teams?

One answer is to select people who have the right talent, said Curt Coffman in his keynote, sponsored by Kimberly-Clark Health Care. Coffman told of a man who asked a circus performer how he trained his dogs to do amazing tricks. The reply: “I find the ones who can do it, and I pick them.”

“It’s more effective to find the role that fits the person than try to rewire someone to fit the role,” he said. “If you can find someone and reposition them, they can become a great performer.”

Coffman is coauthor with Marcus Buckingham of the best seller, First, Break All the Rules: What the World’s Greatest Managers Do Differently (Simon & Schuster, 1999).

Becoming a resonant leader

Great leaders like Nelson Mandela have high emotional intelligence—the ability to manage their emotions and inner potential for positive relationships, said Annie McKee, PhD, who spoke at a special lecture sponsored by Cardinal Health, Medical Products and Services. McKee is author with Richard Boyatis of Resonant Leadership, which builds on their work with Daniel Goleman on emotional intelligence.

Such leaders, she said, “know how to manage emotion in themselves and others to move them to do what needs to be done. “They are very clear about what is important to them. And they understand themselves well enough to talk, walk, and live what is important to them.”

After McKee’s lecture, the audience gathered poolside for a gala wine-tasting reception sponsored by Integrated Medical Systems International, Inc.

Failure is not final

The message from CDR Scott Waddle, USN (Ret), about his recovery from a devastating error in which the submarine he commanded caused the death of 9 people, struck a cord with the audience during a session sponsored by the J2 Group, Inc, Perioperative Health Systems Consulting. Waddle, who had had a stellar career...
with the Navy, commanded the nuclear submarine USS Greeneville. On Feb 9, 2001, during a visit to the submarine by a group of civilians, he ordered a maneuver that caused the submarine to rise to the surface in seconds, crashing into a Japanese fishing trawler, thought to be miles away. The trawler sank in less than 3 minutes, killing 9 people, including 4 17-year-old students.

Waddle emotionally described his devastation. “How did we miss this?” he kept asking himself right after the crash. After being relieved of command, he told his crew to tell the truth. Waddle spiraled into deep despair, even briefly thinking about taking the lives of his family and himself. But he turned to his long-held tenets: integrity, accountability, and responsibility.

At the court of inquiry, Waddle told the truth and took responsibility for the incident. He testified and sent letters of apology to the families, whom he was not allowed to meet. He was allowed to retire and retain his pension.

He finally wrote a book, *The Right Thing*, and in 2002, was able to travel to Japan to apologize in person.

He encouraged the audience, which responded with a standing ovation, to think about what they would do if tested by something like a sentinel event, advising, “Keep your character and integrity intact.”

Creating a just culture

How can you hold people accountable without finger pointing? One answer is the Just Culture Model.

David Marx, JD, president of Outcome Engineering, LLC, Plano, Texas, who developed the model, explained that just culture falls in the middle of the continuum from a blame-free culture to a punitive culture.

“We are fallible creatures,” Marx said. “Rules that say we can’t make mistakes will fail.” Instead, a just culture balances 3 duties—avoid causing unjustified risk or harm, produce an outcome, and follow a procedural rule—with organizational and individual values such as safety, cost-effectiveness, equity, and dignity.

Creating a just culture takes time, he said, because managers’ and staffs’ expectations must change. Managers must understand risk, design safe systems, and facilitate safe choices by staff. The staff should be expected to look for risks, report errors and hazards, help design safe systems, and make safe choices. The staff needs to learn to ask, “What is the risk not worth taking?” which Marx said is the most important question.

A carrot a day keeps your staff

Closing the conference was Max Brown, of the Carrot Culture Group, a division of OC Tanner Company, which produced the best seller *The Carrot Principle*, a book based on the simple concept that recognizing employees generates commitment and leads to high-level performance. The luncheon was sponsored by Advanced Sterilization Products.

Conveying his message with humor, Brown had volunteers toss stuffed carrots into the audience to make his point that recognition is what keeps top employees—“98% cite lack of recognition as the number 1 reason they leave,” he said.

For recognition to be authentic and successful, Brown said it must be frequent, timely, and specific.
CMS sets final 2008 ASC payment rates

For 2008, ambulatory surgery centers (ASCs) generally will be paid at 65% of hospital outpatient department (HOPD) payments, under a final rule issued Nov 1 by the Centers for Medicare and Medicaid Services (CMS). The rule, effective Jan 1, 2008, sets rates for the first year of the new ASC payment system, the most significant change in Medicare ASC reimbursement in 20 years.

The same rule updates the hospital outpatient payment system, resulting in an average overall outpatient payment increase of 3.8%. From now on, ASC payments will be updated jointly with the hospital outpatient payments.

The new rule does not make changes in the ASC payment system itself; those rules were final in August.

The new payment system patterns ASC payments after the hospital outpatient system. As such, ASCs will be paid according to rates set for APCs (ambulatory payment classifications) rather than the groupers ASCs are used to. But CMS will report payment rates by CPT code so ASCs will not need to determine which APC a CPT code belongs to, FASA notes in an overview of the rule on its website (www.fasa.org).

The Nov 1 rule also finalizes at 3,390 the list of procedures payable in the ASC setting in 2008, which is 819 more than the current list.

As part of the new payment system, CMS adopted a new policy that will allow ASC payments for any procedure not specifically excluded from the list. Excluded procedures, in general, are those that are on the CMS inpatient list, typically require active medical monitoring and care after midnight on the day of the procedure, or are deemed to pose a safety risk for Medicare patients in ASCs. Under the new policy, Medicare will now pay for laparoscopic cholecystectomy in ASCs. FASA argues that lap chole should have been included on the list even under the old system.

In response to public comments questioning the safety of some procedures in ASCs, such as balloon angioplasty of the peripheral vessels, CMS says its medical experts did a comprehensive review. As a result, CMS decided to leave on the ASC list iliac and venous angioplasty (CPT 35473 and 35476) but to exclude femoral-popliteal angioplasty (CPT 35474) for safety reasons.

A list of the excluded procedures is at www.cms.hhs.gov/ASCPayment. On the left, look for CMS-1392-FC. Scroll down to Appendix EE.

Four-year phase-in

Payment rates under the new ASC system will be phased in over 4 years for procedures currently on the ASC list, giving ASCs time to adjust. Procedures added to the list will transition immediately to full payments under the new system.

FASA said it would post on its website the national 2008 ASC payments plus what rates would be if the rates were fully adopted in 2008. FASA will also post a rate calculator ASCs can use to determine what their local payments will be.

Why will ASCs be paid 65%?

CMS says the 65% amount was set to keep the ASC payment system budget neutral. FASA explains how this was determined: CMS sets payments for each APC based on the APC’s relative weight, a measure CMS uses to rank the costs of performing procedures in one APC compared with the costs of other APCs, plus a uniform conversion factor that applies.

Continued on page 24
Bill seeks higher pay rate for ambulatory surgery centers

A new bill (S 2250) introduced by Sen Mike Crapo (R-ID) on Oct 26 seeks to improve the reimbursement system for ambulatory surgery centers. The bill, a companion to House Bill 1823, would continue to link ASC payments to the hospital outpatient rate, as in the current CMS rule. But the bill seeks to set ASC payments at 75% of what hospital outpatient departments receive rather than the 65% provided for ASCs in 2008.

Sen Crapo said the bill would allow ASCs to provide more services, encourage competition, and generate savings for Medicare and its beneficiaries.

For more, visit the FASA website at www.fasa.org.

Key facts on ASC 2008 payment rule

- For 2008, ASCs will generally be paid 65% of hospital outpatient department (HOPD) payments.
- A total of 3,390 procedures will be payable in the ASC setting in 2008, up by 819 from the current list.
- There is a 4-year phase-in to the new payment system for procedures currently on the ASC list.
- New procedures added to the list will be paid under the new payment system immediately.
- Some procedures are not affected by the 65% ASC discount: from HOPD payments:
  - Procedures requiring a device that costs more than 50% of total APC reimbursement.
  - Procedures frequently performed in physician offices, for which the ASC payment will be the lesser of the payment rate determined using the 65% methodology or the cost of the physician’s office expense for the procedure when performed in the office.

Sources: Centers for Medicare and Medicaid Services, FASA.

The final payment update rule is at www.cms.hhs.gov/ASCPayment. The rule was scheduled to appear in the Nov 27 Federal Register, which will be posted at www.gpoaccess.gov/fr.

New bill seeks to set ASC pay at 75%.

There are some procedures that will not be paid at 65% of the HOPD rate, FASA notes. These include the following:

Device-intensive procedures

ASCs will be paid more for procedures that require use of a device that costs more than 50% of the total APC reimbursement. For these, ASCs will be paid the same as HOPDs for the device, with the 65% discount for ASCs applied to the rest of the APC reimbursement. In all, 45 procedures are designated as device intensive for 2008.

Procedures frequently performed in physician offices

ASC payments for 365 procedures performed more than 50% of the time in physician offices will be less than 65% of HOPD payments. For those, CMS limits payment to the lesser of the payment rate determined using the 65% methodology or to the cost of the physician’s practice expense when performed in the office.

Continued from page 23 to all APCs. The relative weights for each APC are determined using hospital cost reports. The relative weight is then multiplied by a uniform dollar conversion factor to get the national HOPD rate.

In 2008, the relative weights for calculating ASC payments for each APC will be the same as the relative weights used for HOPDs. The process for calculating the payment rates will also be the same, except different conversion factors will be used for ASCs and HOPDs. In 2008, the ASC conversion factor will be 65% of the hospital conversion factor. Local adjustments are also applied.

This is the percentage CMS believes is budget neutral, meaning that even if the new ASC payment system was not implemented for 2008, CMS figures the overall ASC payment rates would still total 65% of the HOPD rates.

Because of differences in the annual updates, ASCs believe payments between surgery centers and HOPDs will continue to diverge over time. The ASC community is seeking legislation to remedy that. A Senate bill was introduced in October that would set ASC payments at 75% of HOPD payments. ASCs maintain this would allow them to provide more services at a lower cost to Medicare patients than what hospitals provide.

Procedures not paid at 65%

There are some procedures that will not be paid at 65% of the HOPD rate, FASA notes. These include the following:

Some commenters asked CMS to include other procedures with expensive implants in this category. One is injecting implant material into urethral or bladder tissues for incontinence (CPT 51715). But CMS declined, saying its payment policy is final for 2008.
Tips for a successful hire in your ASC

The temporary staffing agency you use for your ASC assures you it conducts thorough background checks. You decide to hire the accounts receivable clerk sent from the agency. Your prehire background check reveals the clerk spent time in prison for embezzlement. You escort the clerk out the door.

Most managers have some kind of horror story about a seemingly good hire gone bad. Hiring in an ASC is often challenging. The ASC administrator may double as the human resource (HR) manager, or the HR resource may be off-site and not readily available.

“You don’t necessarily have a lot of backup,” says Lisa Cooper, RN, BSN, CNOR, chief executive officer of El Camino Surgery Center in Mountain View, California. How can you enhance your chances of making a smart hire? Heed this advice from the experts.

Common mistakes

The most common mistake managers make is talking first and too much, says Susie Hardin, vice president of human resources for Symbion in Nashville, Tennessee. “People explain the company and job up front, then ask the candidate about themselves, but you’ve already given them the answers. It’s better to let the candidate speak first.”

Another common mistake is basing a decision to hire on a person’s credentials or past jobs, assuming he or she will know the clinical procedures performed in the ASC. Hardin suggests asking candidates to explain the steps of a procedure rather than asking for a yes or no as to whether they know how to do it.

Ann Bures, RN, MA, CHCR, past president of the National Association of Health Care Recruiters (NAHCR), reminds managers they need to understand their work environment and work group dynamics. “What kind of person will fit with the group? If you have an assertive group, can a candidate stand up to that?” Bures suggests asking the candidate, “How do you introduce yourself to a new work group?” and “Describe a time when you encounters a difficult situation with a coworker.”

Honesty is a 2-way street between the manager and the candidate. “Be clear about the negatives, too, because every place has good and bad,” says Cooper. “If there will be a lot of overtime, don’t hide it; be upfront about it.” Otherwise, the staff member may leave, putting you back where you started.

Overlooked but vital

“I’ve seen it over and over again,” says Hardin. “Hiring managers don’t check references. So many problems could have been prevented if only a thorough reference check was done.”

Hardin recommends using only supervisors, not coworkers, for references and remembering that if the candidate gives you the name, chances are the reference will be positive. She calls the candidate’s immediate supervisor first because he or she will frequently provide more information than the human resources department, which often gives only dates of employment.

Even limited information can be helpful, particularly when evaluating the length of employment listed on the resume, especially for those candidates who list only years. For example, a nurse lists her tenure at a previous job as 2005-2007, implying she was employed for 2 years. However, further research reveals she started in December 2005 and left in January 2007, closer to 1 year and half the experience, a significant difference.

Cooper is particularly interested in the tenure of candidates for jobs in lower salary brackets. “Those positions are a little easier to fill, so if they are moving around, it likely means they are job hopping.”

With these candidates, Cooper also focuses more on the details of getting to work on time because people with lower incomes often have fewer resources to fall back on.

Screening for secrets

Criminal background checks and drug screens have become routine in job hiring. An offer of employment is made contingent on the results of screening, background checks, and reference checks.

It’s not unusual for these checks to come back positive. Hardin estimates that about 25% reveal misdemeanors such as possession of marijuana, writing bad checks, reckless driving, driving without a license, and driving under the influence (DUI) without injury to another person. Felonies such as rape or burglary are “few and far between.”

Cooper counsels manager to be careful when hiring a company to conduct background checks. She recommends contacting local hospitals and major businesses to obtain recommendations. “I would not just look on the Internet,” she says. Cooper adds that managers should also evaluate the company a staffing agency uses for checks to ensure it’s doing a good job.

How does a history of drug use or a criminal record factor into the hiring decision? Hardin recommends considering if it was a misdemeanor, how long ago it occurred, how old the person was at the time of the infraction, and whether it was an isolated incident or part of a pattern. “Consistency is very important, in case you are ever challenged in court.”

Another factor is how forthcoming the candidate is. During the interview Cooper likes to ask, “We run an extensive background check. Is there anything you’d like to tell me before we do that?”

“If they don’t say anything, and something comes up on the check, that’s probably reason enough not to hire them,” she says.

Take time now, not later

Making the right hire takes time. It’s not easy being patient when you’re faced with open positions.

“People get desperate,” says Cooper, “they make a quick decision and don’t wait until the fit is right.” But not taking time during the hiring process can cause problems down the road and more time on the manager’s part.

To avoid the hasty hire, “managers

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More questions to hire by

Most of these interview questions fall into “behavioral interviewing,” a technique predicated on the idea that a person’s past performance indicates future performance. It emphasizes questions that elicit descriptions of specific behaviors in response to various situations.

1. What do you want from a job and a company?
2. Why did you leave your previous position?
3. Tell me about a time you had a physician throw an instrument or engage in another act of conflict.
4. Describe your personality to me. “Usually they’ll say they are a ‘people person,’” says Hardin. “But I’ve had people tell me they were selfish, opinionated, or self-centered.” She recommends doing this before you share what kind of employee you are seeking.
5. What would your current manager say about you? How would he or she describe you as far as your work ethic and reliability?
6. Describe some of the typical aspects of your day.

“You need to ask about how they handle nurse-surgeon friction,” says Ann Bures, RN, MA, CHCR, past president of the National Association of Health Care Recruiters.

Surgeon faulted in wrong-site case

A neurosurgeon, J. Frederick Harrington, MD, bears most of the blame for operating on the wrong side of the patient’s head in July at Rhode Island Hospital, the state’s health department concluded in October, the Providence Journal reported.

The case involved an 86-year-old man with a subdural hematoma who was admitted through the emergency department and had the wrong side of his head treated. When the error was discovered, treatment was performed successfully on the correct side. The patient later died. Results of the investigation into the cause of death had not been reported at press time.

The state found Dr Harrington failed to check the CT scan images of the brain but relied on his memory and failed to pause before the procedure began when someone in the OR questioned him.

The state said systems issues at the hospital contributed to the error. The hospital has been studying the issues and making changes to prevent similar events in the future, an administrator from the hospital’s parent company told the Journal. Among these are new procedures for emergency cases.

Access the article on the Journal website at www.projo.com. Enter search term “Frederick Harrington.”

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must be prepared,” says Bures. She recommends a structured approach, including reviewing the application, having a set of probing questions, and using a questionnaire related to ambulatory surgery.

Bures uses the Healthcare Selection Inventory (HSI) from TestSource, a company in Grand Rapids, Michigan, that specializes in assessment and retention in health care (http://testsource.com). The HSI Feedback Report provides an overview of the candidate’s potential for success on the job and includes three scales: Overall Performance Index, Retention Index, and Service Excellence Index. The tool takes a candidate about 20 to 30 minutes to complete and can be done before the interview. Similar tools are available from other companies.

Bures credits the inventory, face-to-face interview, and time in the OR shadowing another employee as a combination that’s worked well for her. She prepares the staff with questions they can ask the candidate during the shadowing experience. Shadowing helps ensure a good fit and gives peers a chance to ask questions.

Partnership and processes

Bures recommends working closely with your HR contact to ensure an efficient, effective interview process. That will help save time and lessen the chances of making a poor decision.

After employees have been on the job for about a month, Hardin likes to ask them if the job turned out to be what they expected and if it matched with what they heard in the interview. That step will help fine-tune your hiring process.

“You have to be an investigator, a critical thinker, and a good listener to match the right person to the right job. It can be a challenge, but the reward is a satisfied, long-term employee.”

—Cynthia Saver, RN, MS

Cynthia Saver is a freelance writer in Columbia, Maryland.
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Eye surgery errors rare but serious

Errors in eye surgery are rare, happening in an estimated 69 cases out of 1 million. But consequences can be serious, a new study finds. The most common error was implant of the wrong lens, accounting for 63% of mistakes. These errors most often happened because lens specifications weren’t checked before the case.

The Universal Protocol, if followed, would have prevented 85% of the errors, say the authors, from Albany Medical College, Albany, New York. The protocol, mandated by the Joint Commission, requires steps to verify the surgical site.

In the analysis of 106 cases occurring between 1982 and 2005, the wrong eye was injected with anesthesia in 14 cases (13%), and the wrong eye was operated on in 15 cases (14%). In 8 cases, confusion involved the wrong patient or procedure. In 2 cases, the wrong tissue was implanted.

The most severe injuries involved the wrong implant or tissue.

The study led by John W. Simon, MD, was reported in the November Archives of Ophthalmology.

Orthopedic implant makers post MD consulting fees

Orthopedic implant makers have posted on their websites lists of the physicians to whom they are paying consulting fees and the amounts. The postings are part of an agreement by the companies with federal prosecutors in September related to alleged kickbacks to surgeons. Also posted are the agreements with prosecutors, which spell out how the companies have agreed to handle consulting.

The lists of consultants and payments are on websites of Zimmer, Smith & Nephew, Biomet, DePuy Orthopaedics, and Stryker.

Excess disinfectants harm electronic equipment

Four federal agencies issued a public health notice Nov 2 cautioning about hazards associated with inappropriate use of liquid disinfectants and cleaners on electronic medical equipment.

In the past 2 years, the agencies have learned of equipment fires and malfunctions and health care worker burns due to corrosion of circuits caused by disinfectants or cleaners that penetrated equipment housings. Examples of affected equipment are infusion pumps, ventilators, and sequential compression device pumps. The notice includes recommendations.

The notice was issued by the Food and Drug Administration, Centers for Disease Control and Prevention, Environmental Protection Agency, and Occupational Safety and Health Administration.

Most invasive MRSA infections related to health care, CDC reports

Invasive infections caused by Methicillin-resistant Staphylococcus aureus (MRSA) may be twice as common as thought, and most—85%—are associated with health care, according to a report by the CDC.

In the study:

- 58% of invasive MRSA infections occurred outside the hospital but among persons with risk factors for MRSA, such as hospitalization within the past year
- 27% were hospital-onset
- 14% were community associated (had no documented health care risk factor). The remaining 1% could not be classified.

The researchers estimate 94,360 MRSA infections occurred in the US in 2005, and 18,650 were associated with death—exceeding deaths from AIDS, Parkinson’s disease, emphysema, or homicide.

MRSA infections and deaths were higher for the elderly, African-Americans, and men.


First certification for bariatric nurses

The first certification program for bariatric nurses has been established by the American Society for Metabolic & Bariatric Surgery (ASMBS). To be eligible for the certified bariatric nurse (CBN) examination, an RN must have at least 2 years of experience in caring for morbidly obese and bariatric surgery patients. Exams are offered twice a year through a week-long computer-based testing program.

Information and registration for the exam are available on the ASMBS website.

—www.asbs.org