How can ORs best manage block time for scheduling surgical cases?

Part 1 of a three-part series.

How can OR leaders best manage block scheduling? How is block time allocated? How often should block time be reviewed?

These are a few of the questions leaders ask about the scheduling of surgical cases.

To find out how some ORs handle block scheduling, we posed some frequently asked questions to four surgical services directors and the leading researcher on OR scheduling.

Two of the four directors are from community hospitals, and two are from academic medical centers. Three of the four were nominated for OR Manager of the Year in 2002.

A research perspective is provided by Franklin Dexter, MD, PhD, of University of Iowa Health Care, Iowa City, who has published numerous studies on OR scheduling and related subjects.

The hospitals participating are Munson Medical Center, Traverse City, Mich; Northwestern Memorial Hospital, Chicago; Poudre Valley Hospital, Fort Collins, Colo; and the University of Wisconsin Hospital and Clinics, Madison.

The responses are being published in three parts. The first part focuses on the initial setup of blocks. Part 2 will focus on block release time, and Part 3 will discuss ongoing management of blocks.

Air Force’s 11 patient safety tools build better team communication

Communication breakdowns are a leading cause of health care errors. More than 60% of sentinel events—and 78% of wrong-site surgery cases—reported to the Joint Commission on Accreditation of Healthcare Organizations have communication as a root cause.

When clinicians don’t communicate well, key information is not conveyed. Instructions are misinterpreted. People don’t speak up or are not heard.

A few years ago, when the Air Force’s Surgeon General called for a patient safety course to be developed after a sentinel event in one of the service’s facilities, the Air Force turned to what it knows best—aviation.

Building on a type of training called “crew resource management,” which teaches team behaviors such as briefings, cross checking, and conflict resolution, the Air Force developed what it calls “medical team management.” Health care personnel learn to recognize obstacles to teamwork and learn 11 patient safety tools. The tools are practical techniques any organization could use to strengthen team participation and communication.

The Air Force uses a “train the trainer” approach to teach the tools throughout its health care system, says Lt Col Beth Kohsin, Air Force patient safety program manager. The effort started
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**Recruitment and retention**
Creative call plans can be a tool for attracting and keeping nursing staff.

**Block scheduling**
Frequently asked questions on release of block time are answered by your peers and a leading researcher.

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**Editorial**

What can we do about recruitment and retention?” That’s probably the most common question we hear from our readers.

One answer is to support and develop your front-line leaders. It’s the best investment you can make to attract and keep nursing staff.

Experts and studies agree—nothing drives staff away faster than a poor relationship with their manager.

Here is some of the evidence:

- The number one reason staff leave is problem managers, according to exit interviews with thousands of health care workers conducted by JWT Specialized Communications Health-care Group.
- If the turnover rate in your department is higher than the hospital’s as a whole, it’s likely a manager is the reason, says JWT’s Greta Sherman.
- By and large, employees form their opinions about their employer from their experiences with their immediate manager, according to a meta-analysis of more than 100,000 employees by the Gallup Organization.
- For the most part, “people leave managers, not companies,” says authors Marcus Buckingham and Curt Coffman in their book about the Gallup project, *First, Break All the Rules* (Simon & Schuster, 1999).

**Making the commitment**

With so many competing priorities, it’s hard to find resources for educating and supporting nurses to be managers. But some organizations are making the commitment.

Catholic Health Partners (CHP), a Cincinnati-based nonprofit health system with 37,000 employees and 31 hospitals and other facilities, tracks the staff’s satisfaction with managers and identifies those in need of help.

CHP put managers on the radar screen after exit interviews with 300 employees, mostly RNs, found 25% were quitting because of their manager. “It was the number one reason they were leaving,” more than the reasons you usually hear from nurses, such as scheduling and workload, notes Deb Emoe, CHP’s corporate director of associate relations.

CHP developed a program where employees fill out a survey to rate their managers. Results are used to identify managers whose skills need reinforcement. Though the scores were kept confidential after the first go-around in the fall, managers’ future scores will be shared with their bosses.

Managers whose scores fall below a certain point are expected to set up a development plan that may involve classes, coaching, and online instruction, which may include courses from Harvard.

CHP has decided to take on an issue that has been ignored for too long. In many cases, nurses have been promoted primarily because of their clinical skills. Too few organizations have devoted the resources that could help their managers become better leaders. Now they are learning it can make a real difference.

“Management is a whole other skill set, and we are making it a high priority,” says Emoe. ☐

—Pat Patterson

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Materials management, OR design and construction, process improvement, and managing technology are major topics for the Fourth Annual OR Business Management Conference June 4 to 6 at the Capitol Hilton in Washington, D.C.

The conference opens June 4 with a welcoming reception, with the two-day conference June 5 and 6.

The conference is intended for OR directors, medical directors of OR, business managers, and others concerned with the financial success of surgical services.

Keynoting is Gail Scott, author of the new book, The Indispensable Health Care Manager, who will talk about leadership skills managers need to excel and identify key role shifts for management survival.

Judy Pins, vice president, Cardinal

Washington hosts OR business conference

Health, will close the conference with a presentation on the challenges of leadership.

Among topics for workshops and breakouts:

**OR design**

A track on OR design and construction will cover:
- designing the new OR suite
- managing during a renovation project, including safety, infection control, noise, and scheduling issues

**Materials management**

Half-day workshops will be devoted to:
- orthopedic surgery
- group purchasing organizations (GPO).

The orthopedic surgery workshop will cover what drives costs and how costs can be captured, analyzed, and monitored. Speakers will describe one hospital’s implant registry and how data is used for analyzing costs and quality, an extensive database on use and cost of orthopedic implants, and benchmarking data.

In the GPO workshop, speakers will discuss the decision about whether to participate in group purchasing and how to get the most out of group purchasing contracts.

Breakout topics in this track include one facility’s experience with stockless inventory, which has achieved 52 turns per year. Speakers will discuss their decision to outsource surgical packs and some instrument reprocessing.

**Other topics**

Among other topics at the conference are:
- **Process Improvement.** Six Sigma, an improvement methodology used in business, is being introduced in health care. This half-day workshop will use two tools from Six Sigma to illustrate how a process can be improved.
- **Technology and Patient Safety.** The increasing complexity of surgical technology has increased risk for patient injuries. This breakout will provide examples of incidents related to OR technology, with recommendations and solutions for patient safety.
- **Evolving Role of the OR Business Manager.** The business manager role is evolving to meet the needs of specific organizations. An OR director and business manager will describe how the role has developed over the past 6 years in their organization to support the department of surgical services.

The conference brochure is on the OR Manager website at www.ormanager.com or phone 800/442-9918.
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Facilities weigh risks of smallpox vaccination

Are clinicians at your facility going to volunteer for smallpox vaccination? If so, which ones? What is the risk they might infect vulnerable patients? What will happen if caregivers develop complications?

These questions and others surrounding President Bush’s Dec 13 announcement of a smallpox vaccination plan.

The plan would first vaccinate volunteers for domestic “smallpox response teams” as well as the military and civilians in certain “high-threat” areas with the unlicensed vaccine. Other adults who insist on being vaccinated could also receive the vaccine if they don’t have contraindications. A licensed vaccine would be available in 2004.

To help inform the debate, the New England Journal of Medicine published six articles on smallpox Dec 19 in an early release on its web site.

A confused public

The public has serious misunderstandings about smallpox that could lead many to make the wrong decisions. Responses to a Harvard survey indicate the public mistakenly thinks smallpox is less dangerous than it really is and believes vaccine risks are higher than they actually are.

“It has been a long time since Americans have had experience with smallpox, and we have a shocking lack of basic understanding of it,” Robert J. Blendon, PhD, lead author of the survey report in the New England Journal, told the New York Times (Dec 20).

The survey found 78% of Americans think there is a treatment for smallpox (there isn’t), and 87% think they are likely to survive an outbreak even if they become infected. In fact, about 30% of those infected in past outbreaks have died. Most did not realize the vaccine could prevent illness if given within 2 to 3 days of exposure.

At the same time, people are nervous about the vaccine; 25% said it was likely they would die of a vaccination, and 41% said it was likely to make them seriously ill. In reality, though smallpox is the most dangerous vaccine because it uses a live virus, it has caused about 15 life-threatening illnesses and 1 or 2 deaths per 1 million vaccinations.

What is risk to hospital patients?

Would vaccinating health care workers spread the disease to vulnerable hospital patients?

After reviewing past reports, Kent A. Sepkowitz, MD, of Memorial Sloan Ketterowitz writes in the New England Journal that in the past, nosocomial transmission has been fatal in up to 11% of cases. But hospitals today care for more patients with HIV, transplants, cancer, and other conditions that suppress the immune system.

On the other hand, infection control practices, such as occlusive dressings at the vaccination site, handwashing, and isolation, could limit potential spread.

He cautions that a vaccine program needs to develop slowly, with time to make adjustments.

Facilities raise questions

Smallpox vaccination raises tough management issues.

At least four hospitals have already declined to participate, and others were scaling back on plans. Most hospitals seemed to support the program but raised questions. Questions posed by the American Hospital Association included:

• What is the liability of facilities and workers from risks of smallpox vaccination? Hospitals have some protection under the new Homeland Security Act, but there are gray areas.

• What testing will be necessary to screen out at-risk employees, such as those who are HIV positive or pregnant?

• Should employees be placed on leave after being vaccinated to avoid transmitting infection to patients? How will staffing be covered?

• Will workers’ comp cover employees who have vaccine reactions?

The Centers for Disease Control and Prevention estimates 30% of those vaccinated will be unable to work for a period of time because of reactions.

Nursing staff concerns

The American Nurses Association (ANA) also outlined issues for nursing staff, such as who would bear the cost for lost work. ANA advocates that employers be responsible.

Who should not be vaccinated?

The government recommends that anyone who has the following conditions, or lives with someone who does, should not be vaccinated unless they have been exposed to smallpox:

• skin condition, especially eczema or atopic dermatitis

• weakened immune system, such as those who have had a transplant, are HIV positive, or are in cancer treatment

• pregnant women, or those planning to become pregnant within 1 month

• breastfeeding mothers

• allergic to the vaccine or its components

• under age 18.

Source: U S Department of Health and Human Services.

Another concern—what to do about the 8% to 12% of workers who have dermatitis due to latex sensitivity. Dermatitis is a contraindication for smallpox vaccination.

Resources


Department of Health and Human Services. www.hhs.gov/smallpox


OR Manager’s Toolbox

Check our web site for practical help on personnel evaluation, codes of conduct, and patient assessment. Go to www.ormanager.com. Look under The OR Manager’s Toolbox.
Paying back a gift of encouragement

Janet Mela, RN, MEd, CNOR, has never forgotten how it felt to struggle while going to school and trying to make ends meet. She remembers being recently divorced with two small children and working as an OR tech. There were nights of doing laundry while holding a child on one hip and a book in her free hand as she studied to become a nurse.

Today, as clinical director of perioperative and endoscopy services at John C. Lincoln-Deer Valley Hospital in Phoenix, Ariz, Mela says mentoring her staff and encouraging them to grow their own careers remain her greatest passions.

“I have encouraged everybody I’ve worked with to go to school,” she says. “At any given time, since becoming a manager 20 years ago, I have had two to eight staff members in school.

“I really encourage the technicians to go into nursing so they can continue to do what they love in surgery while expanding their opportunities.

“I ask the staff, especially the younger ones, ‘Where do you want to be 5 years from now?’ I keep telling them I did it, and they can do it, too. I’m not one tiny bit smarter, but I am focused, and I never give up. My biggest thing is paying back the gift of encouragement that was given to me.”

Original gift
The original gift Mela received came from a neurosurgeon in her hometown of Fort Wayne, Ind, who hired her as a private scrub tech. He let her schedule cases around her classes as she earned her associate degree in nursing from Purdue University.

Asthma forced a move to the Phoenix area, where she joined Scottsdale Memorial Health System as a neurosurgical nurse. Eight years later she moved from charge nurse to manager, which required a bachelor’s degree. She headed the surgery department with just two ORs and 15 employees.

She returned to school to earn her BSN on nights and weekends and a few years later was promoted to director of patient care services. As her responsibility grew, Mela returned to school to earn her master’s, with a focus on communication and career counseling.

By the time she left the Scottsdale position after 20 years, her responsibility had expanded to 15 ORs as well as other units and 150 employees.

“Most nurses pursuing a master’s either go for an MBA or for a master’s in nursing if they’re thinking about teaching,” Mela says. “I found that my master’s program with a focus on psychology and career counseling has really helped me to understand relationships. Teaching people how to stay calm in the stressful environment of the OR and coaching people through conflict resolution are two of the most valuable lessons I learned.

“Our biggest problem with retention and recruitment is people feel they aren’t understood and they can’t take a risk.

“Surgery can be a threatening environment, especially if you feel you don’t have the tools, education, or communication skills to be on an equal playing field.”

Family a priority
After 20 years at Scottsdale, Mela, recently remarried and with shifting priorities, was ready for a less demanding job. She worked as an RN first assistant but was lured to the John C. Lincoln Health Network, which had recently acquired a small hospital on the northwest edge of the city. She stressed in the job interview that she considered family the number one priority for herself and her staff.

“If things aren’t good at home, you can’t take good care of your patients,” she says. “If my staff has a problem that can’t be resolved, I may suggest that they go part-time so they can be dependable for their job and take care of their family. That’s how I run my OR and my life.”

She has few attendance problems and no open positions.

Facing hurdles
Upon joining Lincoln, Mela faced hurdles.

“The challenges included low staff morale and high turnover, inadequate procedures, poor confidence on the part of the surgeons, run-away expenses, and inadequate collaboration with other departments and disciplines,” Lincoln’s president and CEO, Dan C. Coleman, wrote in a letter nominating Mela for OR Manager of the Year.

“The transformation that Janet has led has been remarkable.”

Says Mela, “My number one goal was that everyone who worked here could work a full week and not have to go home on low census,” says Mela. Most of the staff was working part time at other facilities to compensate for leaving early because of the low census.

One solution: She abolished the vendor-pulled case-cart system so the staff could do the work instead. At the end of the year, she had stabilized the staff and saved more than $200,000. Everyone was working just for Lincoln.

Expecting respect
Physician-nurse conflicts also demanded immediate attention. With strong support from the administration, Mela quickly made it clear that problems would be worked on, but hostile behavior would not be tolerated.
“We just won’t overlook behavior that is disrespectful toward anyone,” she says. “That can be employees, our medical staff, volunteers, or our patients. “We must behave like adults. We can problem solve and even correct behaviors without having an environment of punishment. I wish there was a formula for solving these issues, but it’s really more on a case-by-case basis.”

To increase case volume, which was just several surgeries a day when Mela joined Lincoln, she drove to every surgeon’s office and talked to them about the staff, equipment, available times, and other services. She dropped off brochures about the OR and held luncheons for office managers and schedulers.

“They really started feeling like they knew who we were and were comfortable calling,” she says.

The area’s population growth has led to plans for a $40-million expansion that will double the hospital’s size.

Lincoln’s ORs now perform about 20 to 25 cases daily and have a full open-heart program, with just five ORs and a cysto room. Mela has extended hours with 8-, 10- and 12-hour shifts to meet the needs of the staff. The expansion will add two ORs, a 13-bed recovery room, and a 10-bed preoperative second-stage recovery area. Mela’s experience with similar growth at Scottsdale Memorial has helped her in sequencing the expansion and reassuring others through the process.

Saying thanks

In managing costs, Mela has found the staff can do much to complement the more formal value-analysis programs.

“If I were teaching nursing, the first thing I would teach would be ethics, the second would be business, and patient care would be third,” she says.

“If a nurse doesn’t know how to balance the OR checkbook, she can’t be held accountable. The staff want to help. We need to show them how.”

Twice a year Mela pulls out the financial reports during a staff meeting.

“Every time I do that, a lot of the staff will say, ‘You know, I think we could save money here or there.’ Your direct care gives have the best ideas.”

Mela also stresses to physicians that purchases are volume driven.

Her long-term goals are to teach others to lead, develop the business, and manage resources. Her dedication is to the people with whom she works.

“I believe strongly in the ethics and the energy. I think that the surgical work environment can be great if people can blend hard work, respect, and good times,” she says.

On payday, in what has become a valued routine, Mela personally delivers every check to each employee, saying, “Thank you for all your hard work.”

“I like to say thanks, and they like to hear it. I understand how it is. I started as a tech and did every job, and it was seldom anyone said thank you.

“It’s so simple but so important.”

Susan Klann is a freelance writer in Denver.

Distance learning course for periop nurses

A distance learning program in perioperative nursing has been launched by St Luke’s Hospital and Health Network and Northampton Community College, both of Bethlehem, Pa.

The 16-week program is expected to attract experienced RNs from around the country, including the armed services. The program, comparable to 45 hours of classroom instruction, is followed by 240 hours of clinical instruction.

Entering nurses must be sponsored by a health care facility with OR capabilities. The facility must sign an agreement saying the student meets enrollment requirements and must assign a clinical preceptor to the student. The student must have access to the OR to complete the weekly clinical requirements.

The first group of students began the course on Jan 27. A second session will begin May 19. For information, phone 610/861-4160 or visit www.northampton.edu and click on Distance Learning.

More faculty key to nursing shortage

The nursing shortage won’t improve until there are more nursing schools and faculty, according to the Dec 15 New York Times. Nursing colleges are turning away thousands of qualified people each year because they lack space, faculty, and funding. Last year, nursing schools turned away nearly 6,000 qualified applicants, according to a survey by the American Association of Colleges of Nursing (AACN).

The message has gotten out that nursing is an exciting career, AACN president Kathleen Ann Long told the Times, but there’s not enough faculty to teach them. With nurses in high demand, they must take a pay cut to teach. Universities are not able to compete with hospital salaries for nurses with master’s degrees.

Hospitals are stepping in to help.

North Carolina Baptist Hospital is giving Winston-Salem State University $750,000 to hire more nursing faculty. And five hospitals and health agencies in Alaska have promised the University of Alaska $1.8 million to double the number of nursing graduates.

—www.nytimes.com
—www.aacn.nche.edu

Have an idea?

Do you have a topic you’d like to see covered in OR Manager?

Have you completed a project you think would be of help to others?

We’d be glad to consider your suggestions.

Please e-mail Editor Pat Patterson at ppatterson@ormanager.com
**Heads up on HIPAA**

**Small hospitals prepare to meet privacy rule**

Protecting patients is challenging in large hospitals but even more difficult in small-town hospitals where everyone seems to know everyone else. How do you maintain privacy when one neighbor is separated from another by only a curtain? How does a nurse respond when a relative sees her in the grocery store and asks about a neighbor’s surgery?

As the April 14 deadline approaches for complying with the patient privacy regulation of the Health Insurance Portability and Accountability Act (HIPAA), OR managers in small hospitals are educating their staffs.

Staff are shredding OR schedules at the end of the day. ORs are using only initials and numbers to identify patients and guarding privacy in preop and postop areas.

**Be reasonable**

“We try to be reasonable, and I think that is what HIPAA wants us to do,” says Sue Westfall, RN, MHA, CNOR, director of surgical services at Hanover Hospital, Hanover, Penn. In Hanover, everyone knows everyone else, and many people have lived there their entire lives.

Because of privacy issues, the hospital replaced the curtains in the preoperative holding area with walls when the new surgical department was built a decade ago. Seven of the preop spaces are individual booths, and three are in a communal area with curtains to accommodate patients on fracture beds who need more room than the booth allows.

Outpatients are admitted in these booths and returned to them before discharge, so they also are used as a Phase 2 recovery area.

Beds in the Phase 1 recovery area are separated only by curtains, but families are not allowed in the recovery area. Allowances are made for small children or special needs children, and these patients are isolated by curtains pulled around them.

Only patients’ initials are used on the OR schedule, and the schedule is given only to areas with a need to know, such as the radiology and pharmacy departments.

**Tightening up**

“There are so many points of entry to information. We all are going to have to tighten up,” says Marilyn Harris, RN, MSN, CNOR, director of surgical services for Adventist Health Hanford in Hanford, Calif, a system with two small hospitals (40 beds and 60 beds) and an ambulatory surgery center.

Adventist Health created a corporate compliance software program that all employees review. The program gives an overview of the privacy rule along with scenarios with questions for employees to answer. The scenarios involve billing issues, taking admissions information, and how to respect the privacy and confidentiality of a next-door neighbor who happens to be a patient.

“It focuses on true-to-life things that can happen to employees in a small-town hospital and how they should handle it,” says Harris.

In the preop holding area, the staff always pulls the curtains all the way around the patient and makes sure they keep their voices low. Harris is helping to design a new hospital that will have solid partitions instead of curtains.

Only initials are written on the OR board. The first initial and last name are written on the OR schedule, along with a number from the OR software program as an identifier. That number is also on the preference card that is used to pick up information inappropriately.

Only initials are written on the OR board. The first initial and last name are written on the OR schedule, along with a number from the OR software program as an identifier. That number is also on the preference card that is used to pick up information inappropriately.

**Limiting information**

“So far we are clear on the HIPAA rules for our own department. The key is controlling the information that is out there,” says Sandra Gothard, RN, BS, director of perioperative services for the 4-room OR at Adirondack Medical Center, Saranac Lake, NY.

OR schedules are not posted in the rooms, and no one carries an operative schedule in pockets. The only schedule in the OR is the board. Though the patient’s name is used on the board, the board is in a place where patients cannot see it as they come into the OR. OR schedules are no longer posted for surgeons and no longer are sent to surgeons’ offices.

Limited OR scheduling information is given to other departments involved with surgery. For example, sterile processing receives the name of the procedure, time, and equipment usage. Admitting gets the patient’s name, arrival time, and surgeon.

**Keeping an eye on visitors**

“Limiting visitors is important to maintaining privacy,” says Nancy Richards, RN, CNOR, surgery manager at Cobre Valley Community Hospital, Globe, Ariz.

“If I walk into the preop area and see a family member looking at everything going on and not focusing on the patient, I say to the nurses, ‘I think this person needs to go back to the waiting room.’”

Family is not allowed in Phase 1 recovery unless for a small child.

All hospital and office staff attend a HIPAA class and take a test after the class. They are told penalties for violations are severe; they could be fined, lose their job, or even go to prison for giving out information inappropriately.

They learn about patients’ rights, who is allowed to have access to a chart, and whether a patient has a say about who has access to their information.

“The hospital has been proactive in helping the staff to understand the HIPAA privacy rule because we are so small,” says Richards.

—Judith M. Mathias, RN, MA

Questions on the privacy rule? See the government’s answers to frequently asked questions at www.hhs.gov/ocr/hipaa/privacy.html

A summary is at www.ormanager.com
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with high-risk departments including the OR, emergency room, labor and delivery, and intensive care units.

These are highlights of the Air Force’s 11 tools for patient safety:

1. I’M SAFE
   This acronym forms a checklist team members use to check themselves out to see if they are fit and ready for duty.
   “This makes the individual accountable. Are they able to maintain a critical edge?” notes Kohsin.
   “When we work ill or tired, we are lauded as heroes, yet we are putting our patients at risk when we are not thinking clearly.”

Before reporting for duty, each person should ask:

I: Illness. Am I feeling well enough to carry out my duties effectively?

M: Medication. Am I taking any medications that might cloud my thinking, such as a tranquilizer or even an antihistamine?

S: Stress. What is going on in my personal or work environment that might interfere with my performing well?

A: Alcohol or drugs. Am I impaired in a way that might jeopardize patient care?

F: Fatigue. Am I too tired to function well?

E: Emotions and eating. Am I doing what I need to do to take care of myself emotionally and physically?

“In health care, we know eating well is essential to good health,” says Kohsin. “Yet how often are we working when our blood sugar is lower than our patients’? And are we getting enough exercise?”

2. Brief-debrief
   Briefing and debriefing are part of a team’s social contract for maintaining situational awareness and communication.

   Briefing sets the stage for a process, such as a shift or a surgical procedure.

   The team gathers at the beginning of the process to be sure everyone is at the same point. They compare notes about what they want to accomplish, resources available, and any obstacles.

   “A lot of people say it’s unreasonable to expect an entire team to come together and brief before going into the OR, but there are major organizations that are doing this,” notes Kohsin.

   The surgeon, anesthesiologist, and circulating nurse might meet for just 30 seconds so everyone is aware of critical aspects about the case.

   Debriefing takes place after the process is over: How did it go? What were the outcomes? Are there opportunities for improvement, such as complications or equipment that didn’t work?

   “If you come up with the lessons learned and share those with other teams, there may be applications to other cases,” she says.

   “That addresses one of the issues in patient safety—we’re not learning from other events.”

3. Sterile team environment
   During take offs and landings, flight crews have a rule that they talk only about business. The Air Force adapted this concept to health care.

   “There are critical periods when you need to have a ‘business-only attitude,’” Kohsin explains.

   The phrase is a signal to everyone that a procedure is entering a critical phase, and they should talk only about the task at hand. The purpose is to avoid distractions that might lead to errors.

4. Call out
   When team members come together to focus on a process, they call out each phase they are entering so the team knows it is OK to progress.

In the OR, it’s common for the team to call out at two points—the start time and the closing. They may also call out at other times, such as to say the sponge count is correct or to say the patient is coming off bypass.

“The point is to do this consistently and completely enough that the whole team is aware of where you are in the process,” Kohsin notes. “When you use call out, you need to make sure you are speaking loudly and clearly.”

5. Readback
   Readback, a technique for confirming oral orders, was adopted by the Joint Commission as one of its national Patient Safety Goals. The goals took effect in January and will be part of the accreditation survey.

   Readback is a method for ensuring that the message sent by one person is received as expected by the intended person.

   “This does not mean simply repeating back the information but making sure the receiver understood the information as you intended it to be understood,” says Kohsin.

   In giving your phone number, for example, you would ask the other person to repeat the number back to you, then confirm to them that the number is correct. Too often, this last step is omitted.

6. Checklists
   Checklists are simple step-by-step instructions on how a critical process should be performed.

   “This decreases reliance on memory and the chance of making a wrong step in a process,” Kohsin explains. Experts have learned from aviation that even an expert’s ability to perform a critical routine can be impaired by stress or fatigue.

   “We advocate that when you have a standard or guideline that must be followed to the letter, you need a checklist.

   “We also tell people to post their checklists in a prominent location, like on the crash cart—not in a three-ring binder on a shelf.”

   In developing a checklist, make sure it is complete, concise, and follows the latest standards and guidelines.

7. Dynamic skepticism
   Teach team members to maintain an...
Patient safety

attitude of constant questioning and evaluation of the patient care environment.

"Avoid trusting what seems obvious and check the facts," says Kohsin. Don’t just rely on a monitor, for instance, but be alert for all of a patient’s clinical signs.

“This doesn’t mean a mistrust of others but maintaining vigilance.”

8. Assertive statements

The Air Force teaches all team members to use assertive statements as a nonthreatening method to give input to the team or to communicate concerns.

“In a stovepipe culture like the military, lower ranking personnel may not feel they can speak up,” Kohsin notes. “We teach them a diplomatic way to express their concerns.” In addition, higher ranking personnel are taught that they have a responsibility to listen and respond.

There are five elements to making an assertive statement:

• Get the individual’s attention.
• State the concern.
• State the problem.
• Offer a solution.
• Obtain agreement.

On a patient unit, for example, a nurse tells an aide she wants a postoperative patient up and walking. The aide is concerned the patient’s blood pressure is low. The aide goes to the nurse and says, “Excuse me, Linda. I have a concern. I took the patient’s blood pressure, and it is a little low. Before getting her up, I would like to check the blood pressure a couple more times. Is that all right?”

The nurse should avoid saying something like, “Give me a break. Just do what I asked you to do.” Instead, she might say, “I agree. That is a great plan.” If she disagrees, she might say, “I appreciate your input. This patient’s blood pressure has run low for a couple of weeks, but she has done fine walking.”

Even if the subordinate’s concern is unimportant, it’s important for the senior person not to squelch the person’s input but use it as a teaching opportunity.

9. Two-attempt rule

If one person has a concern and gives an assertive statement, but the team doesn’t respond, that person or another team member can assert the concern a second time. The assertive statement is repeated in the same manner.

If the person still does not get a response and has a concern about patient safety, the person has a responsibility to take the concern up the chain of command to a supervisor.

10. Conservative response

Sometimes a disagreement gets out of hand and an argument or fight ensues. Perhaps two physicians are arguing about whether to proceed with a case.

In the conservative response, one would say, “Look, we are not getting anywhere. Let’s step back, seek more information, then come back and make a decision.”

Notes Kohsin, “Of course, you can’t always do this in an emergency. But the important point is to be diplomatic and not to let the matter escalate.”

11. Step back

This is a dramatic gesture to get the team’s immediate attention.

The classic example is during a code when the team is ready to do a cardioversion, and someone is leaning on the table.

Someone will say, “Step back!” Everyone takes a step back for a moment to get reoriented.

The same principle can apply in other emergencies where there is confusion. Someone can say, “Step back,” as a signal to the team to stop, assess the situation, and decide how to proceed.

What are the outcomes?

Improving teamwork may seem like a good idea, but is there evidence that it improves patient outcomes?

“Crew resource management originally was introduced in aviation with-
Ensuring correct surgery in the Veterans Health Administration

Days to hours before surgery

Step 1: Consent form
The consent form must include:

- patient’s full name
- procedure site
- name of procedure
- reason for procedure

Step 2: Mark site
The operative site must be marked by a physician or other privileged provider who is a member of the operating team.

Do NOT mark nonoperative sites.

Just before entering OR

Step 3: Patient identification
OR staff shall ask the patient to state (NOT confirm):

- their full name
- full SS# or date of birth
- site for the procedure

Check responses against the marked site, ID band, consent form and other documents.

Patient safety

Immediately prior to surgery

Step 4: “Time out”

Within the OR when the patient is present and prior to beginning procedure, OR staff must verbally confirm through a “time out”:

- presence of the correct patient
- marking of the correct site
- procedure to be performed
- availability of the correct implant

Step 5: Imaging data

If imaging data is used to confirm the surgical site, two or more members of the OR team must confirm the images are correct and properly labeled.

This poster illustrates the steps in a new directive on correct surgery issued in November by the Department of Veterans Affairs (VA) National Center for Patient Safety.

All VA facilities were required to comply with the steps by Jan 1.

The directive is intended to help VA facilities standardize their approach to ensuring surgery is performed on the right patient and the correct site. Because the center has been a leader in patient safety, the directive may also be of interest to other facilities that are developing policies.

To help everyone get the picture, the VA has developed a laminated poster, a 20-minute video on correct surgery, a PowerPoint presentation, and supporting articles, explains Erik Stalhandske, MPP, MHSA, a program manager for the center. VA facilities also are receiving a brochure that explains the new procedure to patients.

Responsibility for implementing the policy is assigned to each facility’s medical director or designee.

The directive was pilot tested at ten VA medical centers in the summer, and the VA says the majority of OR personnel found the steps worthwhile, sensible, and likely to help prevent incorrect surgery.

The VA is telling its facilities to make sure the steps are documented in the patient’s record and to monitor compliance.

The VA’s correct surgery directive, which includes a sample policy, as well as the poster, a patient brochure, and frequently asked questions are on the Internet at www.patientsafety.gov
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**Patient safety**

**Frequent questions on marking the surgical site**

These frequently asked questions about surgical site marking are answered by the Department of Veterans Affairs (VA) National Center for Patient Safety.

The FAQs help explain the VA’s new directive on correct surgery, which all VA facilities were expected to implement by Jan 1. (See pp 14-15.) Other organizations may also find the answers of interest.

**Why do we have to mark all sites, even ones on the midline, like for a coronary artery bypass?**

Over 50% of incorrect surgeries are not laterality mistakes but something else, such as the wrong patient or wrong procedure. In a review of the VA database, 36% of incorrect surgeries were done on the wrong patient, usually a patient scheduled to get a different procedure. A patient is likely to speak up if he understands he is supposed to have an operation on his chest at the midline, and the surgeon wants to mark a site on his abdomen or leg.

**What kind of pen or marker should we use?**

Any nontoxic marker that will not wash off when the site is prepared can be used to mark the site. Surgical pens are available from surgical supply companies. “Sharpie” indelible ink pens also can be used. Some non-VA hospitals have even used special-order self-inking rubber stamps.

**Is it OK to reuse markers? Does the marker have to be sterile?**

We searched the literature on this topic. There is no evidence that markers have transmitted disease from one patient to another. The site will be prepped with an antiseptic after the mark has been applied. But just in case, common sense would dictate that if a mark is being applied to a patient’s broken skin or to a patient known to have a communicable skin disease, the marker should be discarded after that use.

**How about marking the skin of patients with very dark skin?**

It is true that the mark may not be as readily apparent as the mark on a light-skinned patient, but a dark blue or black marker will provide a discernible mark on any patient.

**Why not mark the incorrect site?**

The Department of Veterans Affairs’s new directive on correct surgery recommends marking only the correct site—not the incorrect one or both.

The VA addressed this issue during a pilot test of the directive in ten VA facilities.

“One obvious reason is that there isn’t always another site to mark,” says Noel Eldridge of the VA’s National Center for Patient Safety.

“There are wrong procedures done that have nothing to do with left versus right on the correct patient.” An example is a procedure on the wrong patient or at the wrong place near the correct site.

It’s also more difficult to explain and teach a policy that requires sometimes marking two places and sometimes marking one place.

“When only the place where the surgery is to occur is marked, it is clear that is the site,” he says.

“In our scenario, an unmarked site will only cause a good kind of confusion because those involved will say, ‘Where’s the mark?’ They will know that except in emergencies, an unmarked site should not be the site for a surgical procedure.”

To make sure the site gets marked, the VA’s directive includes a step just before the patient is brought into the OR where the staff should confirm that the site has been marked.

**Why not mark the incorrect site?**

The mark should be unambiguous and whenever possible placed so it will be visible in the operative field after the site is prepared and draped. The ink should withstand the skin prep.

Marking the correct site does mean sometimes marking small sites or sites where the patient might not want a large mark, like the face.

“For example, we recommend that if a finger is to be operated on, the finger should be marked,” he says.

It is easier to put an X or two-letter initial on a finger than to write “correct” on one finger and “wrong” on the other five fingers—the four on the same hand and the same finger on the opposite hand that might be a potential wrong site.

On the face, the VA found marking a small X or initial near the eye was acceptable to both staff and patients.

“Mandating that the surgeon write ‘correct’ next to one eye and ‘wrong’ next to the other would have been unreasonable,” he notes.

The VA recommends not using adhesive stickers to mark a site.

“I have no illusion the steps in our directive are magical or perfect,” says Eldridge. “But I am confident that because we pilot tested the system, it is reasonable in what it requires of staff and is likely to be effective.”

**Other than a physician, what kind of privileged providers can mark a site?**

Under the VA’s directive, it must be a privileged provider who is scrubbed in as part of the OR team and scheduled to be in the OR for the procedure. Privileged providers may include, for example, podiatrists, nurse practitioners, and physicians’ assistants.

**What if the person who marked the site is not available to do the surgery?**

The absence of the person who marked the site is not a reason to cancel the operation. If the person who marked the site cannot participate in the surgery as planned, then the surgery should take place with another provider filling in if this would normally occur. The change in staff should be documented and discussed in the “time out” in the OR. It is expected that this would be unusual.

**What kind of mark is acceptable?**

We recommend that the physician or
other privileged provider use his or her two- or three-letter initials. Other options are to use an X or the word “yes.” It is strongly recommended that only one of these options be adopted for each facility and used consistently. The most important thing is that the mark be unambiguous.

Where should we mark?
The marks should be as close as possible to the site of the incision. A significant fraction of incorrect site surgeries are on the sites close to the intended site, for example, the wrong intervertebral space, the wrong finger on the correct hand, or the wrong side of the knee. Marking very close to the site (on the correct finger) rather than just in the general area (like the back of the hand for a procedure involving the finger) can help prevent some wrong-site surgeries.

What are you recommending for VA facilities that have been marking only the site opposite the surgical site with an X? What should they start doing?
We recommend that they do not use X to indicate the correct site. The facility should select a single standard that requires surgeons and other providers to mark the surgical site with the word “yes” or their initials.

How about marking embarrassing spots?
We recommend to VA facilities that they must mark the site or very near to it. A surprising number of incorrect surgeries in the VA over the past 3 years have been to sites in the groin, genitals, or somewhere on the buttocks. Patients with illnesses or other medical problems in these areas are used to being examined in these otherwise private areas.

If an awkward conversation is necessary to do this, contrast this with how unpleasant it would be to explain to the patient why the wrong side of his scrotum was operated on or why his hemorrhoid was removed when he was scheduled for surgery on his lower back.

The VA’s FAQs are at www.patientsafety.gov
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Q1. Do you assign individual blocks, office blocks, service blocks, or a combination?

Munson: We do it almost entirely by individual, though there are many circumstances where individuals in the same office share a block. We track utilization by individual.

Northwestern: Initially, we assigned blocks to services. Five of the 12 services did not assign individual time to surgeons. Those that did assign individual time did so with the approval of the department chair or division chief. We provided the chair or chief with individual surgeons’ utilization by day of the week. We also surveyed the surgeons to request preferred days for OR time. Both of these data sets were used in determining the surgeons’ individual blocks. We have allowed one service to split its block between two office groups.

Poudre Valley: We assign individual and office blocks.

University of Wisconsin: We assign all service blocks. If a service wishes to assign blocks internally to individual surgeons, that’s a selection they make within the department.

What the research says

Dr Dexter: I am not aware of data in the scientific literature to indicate that any one works better or worse than another when OR time is allocated based on OR efficiency. However, OR time cannot be allocated accurately based on utilization data. For example, suppose a random samples. They are repeat

individual surgeons are not independent random samples. They are repeated measures data, also known as longitudinal data, time series data, or quality control data. For example, suppose a surgeon has 8 hours of OR time at an ambulatory surgery center every Tuesday. Then having 3 months (ie, 13

weeks) of that surgeon’s block time utilization data would not be analogous to a situation in which the data were not correlated, such as measuring an oral drug’s effect on the blood pressure of 13 patients. A better analogy would be taking hourly blood pressure measurements on the same patient for 13 hours.

In any event, these findings show one of the primary reasons why allocating OR time based on OR efficiency works so well, whereas utilization is such a poor criterion in practice for most surgical suites to use in allocating OR time for individual surgeons.

Q2. Do the blocks stay in a specific room or move to different rooms depending on the needs of the day?

Munson: Blocks move when they need to, but they stay in the same room quite a bit. We do not have ORs designated for specific types of cases, though there are two rooms where we do primarily heart procedures. But we try to keep cases in certain rooms because of supplies. Our ORs are split onto two floors. We do all of the ophthalmology cases in one area, though we will do any surgery in those rooms if those surgeons are not working.

Northwestern: The block will be moved to any room depending on the needs of the case, the room requirements, and the location of implants needed for specific cases.

Poudre Valley: If a surgeon is running over in his block and someone is to follow, we would move that case to another room so that surgeon can start his block as soon as possible.

University of Wisconsin: We do not assign rooms to a block; the block is allocated time only. Room assignments are made on the basis of case need.

The Any Workday system of OR scheduling

Three types of elective case OR scheduling systems have been described (Dexter, Macario, 2002). The system most widely used in the US, referred to as the Any Workday method, is based on the strategy that the surgeon and patient choose the day of surgery and cases are not turned away for lack of OR time, provided the case can be done safely, even if the case likely will be performed in overutilized time. Because there are a limited number of ORs, the facility may not be able to provide a convenient start time to the surgeon and patient. Provided, however, that the case can be performed safely on the day chosen by the surgeon, the facility will perform the case. Often the facility will force the surgeon to call these cases “add-on” or “urgent” cases, but in the end, the cases get done. In such surgical suites, the objective in allocating OR time should be to maximize OR efficiency. This method and others have been studied in the references listed at the end of the main article.

—Franklin Dexter, MD, PhD
University of Iowa

What the research says

Dr Dexter: Suppose that OR staffing and case scheduling decisions are made based on four guiding principles, listed in order of importance:

• safety
• access to OR time on Any Workday (see sidebar)
• maximizing OR efficiency
• minimizing patient delays on the day of surgery.

Then the case should be moved if that would be expected to increase OR efficiency (Dexter, 2000).

To understand the consequences, it is necessary first to define OR efficiency. In their now classic study published in 1999, Strum, Vargas, and May...
Maximizing OR efficiency is identical to minimizing overutilized hours.

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showed that OR efficiency can be measured functionally.

Underutilized OR time is the difference between allocated OR time and the total hours of elective cases including turnover times performed during the allocated OR time. For example, staff are scheduled to work from 7 am to 3 pm. An OR’s last case of the day ends at 1 pm. Thus, there are 2 underutilized hours.

Overutilized hours are the hours that ORs run longer than the regularly scheduled OR hours. For example, an OR is staffed from 7 am to 3 pm. The last case of the day ends at 5:30 pm. Thus, there are 2.5 overutilized hours.

The inefficiency of use of OR time equals the sum of two products: hours of underutilized OR time multiplied by the cost per hour of underutilized OR time and hours of overutilized OR time multiplied by the cost per hour of overutilized OR time.

The cost per hour of overutilized OR time is invariably more expensive than the cost per hour of underutilized OR time because of overtime and the desire of staff to get home on time.

OR efficiency is the value that is maximized when the inefficiency of use of OR time has been minimized.

Answering the question, most surgical suites cannot make adjustments to staffing on the day of surgery that reduce regular labor costs. This is because, in most surgical suites, staff are not sent home early without pay when they have been scheduled to work. Consequently, on the day of surgery, the cost of underutilized time can be considered a “sunk” cost (Dexter, Traub, 2002). The cost per hour of underutilized OR time effectively equals zero. As a result, maximizing OR efficiency on the day of surgery is identical to minimizing overutilized hours (ie, preventing rooms from running late).

This result makes intuitive sense. Suppose that, on the day of surgery, people work fast, have brief turnover times, and finish an OR on time instead of 1 hour late. Then overutilized hours have been reduced, and OR efficiency has been enhanced. To maximize OR efficiency, when a case can be moved on the day of surgery from overutilized hours to hours that would otherwise be underutilized, OR efficiency has been increased (Dexter, 2000; Dexter, Traub, 2002). With that said, safe patient care is always more important than maximizing OR efficiency.

For example, suppose it is 12 noon. OR 1 is finishing. OR 2 has 1 hour remaining in its second case, followed by a 1-hour case. The person working at the OR desk needs to decide whether to move the last case from OR 2 to OR 1.

First, the person at the desk should assess whether moving the case would be safe. If the team in OR 1 has the expertise to perform the case, the equipment is available, and the surgeon can start earlier, then she should assess the impact on OR efficiency. In this example, overutilized OR time would be expected to be zero whether or not the case is moved; then OR efficiency would not be increased by finishing earlier. The decision would be made based on the fourth criterion, whether moving the case would reduce how long the patient waits on the day of surgery.

Q3. Do you assign blocks in whole days, half days, or some other variation? How often do blocks repeat—daily, weekly, biweekly, or monthly?

Munson: We try to assign a full day for efficiency. Some are half-day. We prefer to give a whole day every other week rather than a half-day once a week. It is more efficient not to have one surgeon finishing a block and another surgeon starting.

Northwestern: We primarily assign whole and half-day blocks. The blocks repeat daily, weekly, or in alternating weeks.

Poudre Valley: All of the above.

University of Wisconsin: Blocks are whole or half-days. That selection is based on patient population and case needs.
**OR efficiency**

What the research says

Dr Dexter: Suppose OR staffing and case scheduling decisions are made based on the four guiding principles listed in Question 2. Then only one service/group/surgeon can be allocated a specific OR on a given day (Dexter, Macario, 2002). It is irreconcilable to (1) provide a service/group/surgeon with access to OR time on Any Workday and (2) limit the service/group/surgeon to scheduling its cases only until the end of a morning block. You can’t say, “Dr Jones, we want all of your cases every day, but you also have to be done by 12 noon.”

Regarding how often blocks repeat, the master surgical schedule is a cyclic timetable that defines the number and type of ORs available at a facility, the hours that ORs will be open, the surgical services given priority for the OR time, and the scheduling system to be used for the OR time. For example, if all services have the same allocations every week, a 1-week cycle is being used. If some services receive allocations every other week, a 2-week cycle is in place.

For a surgical suite using Any Workday, the statistical method to determine OR allocations calculates staffing independently for each service and day of the week. Day of the week is the best predictor of a service’s workload (Dexter, Epstein, and Marsh, 2001; Strum, Vargas, and May, 1999). Consequently, the master surgical schedule in the statistical method usually has a 1-week cycle (Dexter, Macario, 2002). A commercial software product used for allocating OR time to minimize staffing costs, CalculatOR™ (Medical Data Applications, Ltd, Jenkintown, Pa. www.mda-ltd.com), uses a 1-week cycle. Still, a cycle of other than 1 week could be used. The 2002 article by Dexter and Macario has an extensive discussion of this issue.

Q4. How do you determine how much time to give to each surgeon, office, or service?

Munson: We use their historical need. That is defined as elective surgery in-room time, the average weekly need. That is tracked through our information system. We track utilization quarterly. Since we use patient in-room time as the numerator, we assume 75% to 80% utilization is fairly full with the balance needed for room turnover and unusable time at the end of the day.

Northwestern: Initially, we performed a retrospective study and allocated block time by service, aiming for utilization in the range of 80% to 85%.

Poudre Valley: It depends on volume and physician request. It’s pretty informal. If the surgeon is new, and we don’t know his volume, we will shoehorn him into an existing block. Then we will review his utilization for 4 months to 1 year to see if he needs an individual block. That is tracked using our software. If a new surgeon is coming on like gangbusters, we might assign a block faster.

University of Wisconsin: Block time allocation is based on past utilization and the hospital’s strategic initiatives.

What the research says

Dr Dexter: The method to allocate OR time to maximize OR efficiency is described in the references. The software CalculatOR is available for this purpose. Following is a brief conceptual description of the process.

The best staffing solution is found for each service/group/surgeon on each day of the week by considering all possible staffing solutions, starting with 0 hours and progressively increasing staffed hours until additional increases in the staffed hours cause the inefficiency of use of OR time to decrease for that service/group/surgeon (Dexter, Epstein, and Marsh, 2001).

For example, on three Mondays, a service/group/surgeon performed 12, 7, and 15 hours of cases including turnover times. The staff works 8-hour shifts, with overtime scheduled by rotation. The relative cost of underutilized to underutilized hours is considered to equal 1.75. This includes the direct cost of overtime at time and a half (1.50) plus an increment (0.25) for indirect costs of employee dissatisfaction, resignation, and recruitment and training costs (Dexter, Traub, 2000). Since publishing this study, I’ve found many facilities use a value of 2.00. First, this value is easy to interpret in that an overutilized hour costs double time. Second, if OR allocations are planned correctly, then with a ratio of 2.00, the service should finish early approximately twice as often as it finishes late.

The equation in Question 2 is applied. If the service were allocated 0 hr of OR time each Monday, then the cost of the inefficiency of use of OR time would be 59.5 hours, (1.75 x (12 overutilized + 7 overutilized + 15 overutilized)). If the service/group/surgeon were allocated 8 hours of OR time each Monday, then the cost would be 20.25 hr (0 underutilized + 1 underutilized + 0 underutilized + 1.75 x (4 overutilized + 0 overutilized + 7 overutilized)). If the allocation were two 8-hour ORs each Monday, the cost would be 14 hours (4 underutilized + 9 underutilized + 1 underutilized). If the allocation were three 8-hour ORs each Monday, then the cost would be 38 hours (12 underutilized + 17 underutilized + 9 underutilized).

Therefore, the service/group/surgeon should be allocated two 8-hour ORs to maximize OR efficiency. Importantly, this does not mean that the service/group/surgeon is restricted to scheduling 16 hours of cases. Rather, the hospital, anesthesia group, OR nurses, etc, plan two 8-hour ORs because that is the best staffing for them to maximize OR efficiency while caring for the patients.

Q5. What percentage of the entire available time is blocked?

What percentage is left as open time?

Munson: We would like to have it at 80:20, but we are 100% blocked now. We are at capacity and don’t have enough ORs.

Northwestern: We were targeting to have 30% open but achieved only 23% initially.

Poudre Valley: We are 85% blocked and 15% unblocked.

University of Wisconsin: We presently struggle with having too much time blocked. It has been recommended by a

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OR efficiency

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consultant that we aim for 60% blocked, 30% open, and 10% urgent. We recently added two blocks per day, allocating one to orthopedic trauma and the other to urgent transplant cases. Recently, we allocated two blocks a week to oncology cases and are going to add a third block shortly. Those rooms, in addition to our daily trauma room, have been very helpful in coordinating our daily/weekly add-on list.

What the research says

Dr Dexter: For some services/groups/surgeons on some days of the week, greater OR efficiency results when that service/group/surgeon is not allocated any OR time for that day of the week. This happens when the cost resulting from the assignment of one 8-hour OR exceeds the cost of doing the cases in overutilized OR time.

For example, suppose that Dr Jenkins does 2 hours of cases every Wednesday. The relative cost of overutilized to underutilized OR time is approximately 1.75. If he were allocated one 8-hour OR each Wednesday, the cost would be 6 hours. If he were allocated no OR, the cost would be 3.5 hours; 3.5 = 2 x 1.75. Therefore, he would not be allocated OR time on Wednesday. He would, however, have access to OR time on Wednesdays (as well as all other workdays) for his cases, provided the cases could be performed safely.

Each service/group/surgeon not receiving an OR allocation on a given day should then be combined into other unblocked time (Dexter, Epstein, and Marsh, 2001; Dexter, Macario, 2002). The calculations to maximize OR efficiency are repeated for this other unblocked time on each workday. At least one OR is provided daily for unblocked time because in Any Workday all surgeons have access to OR time on whatever weekday they choose, provided the case can be done safely.

Q6. How do you handle vacations and holidays, such as the week between Christmas and New Year’s and the day after Thanksgiving? Do you maintain the block schedule or open the entire schedule on a first-come, first-served basis?

Munson: Based on the historical schedule, we operate at three-fourths time and first come, first served. We may suspend the block schedule for Christmas. We also may suspend the block schedule for spring break. The whole town is on the same spring break schedule, and the town closes down.

Northwestern: We maintain the block schedule but close rooms after we determine the needs.

Poudre Valley: We maintain the block schedule regardless of holidays. Physicians can release block time, and we will reassign it.

University of Wisconsin: On holidays, we do not run an elective schedule. On days with a half schedule (ie, the day after Thanksgiving and during the anesthesiologists’ convention), the rooms are open first come, first served for services with block time, with a limit of one half block each to allow greater access equitability.

What the research says

Dr Dexter: Suppose that staffing and case scheduling decisions are made on the four guiding principles discussed in Question 2. Then forecasts of each service/group/surgeon’s total hours of cases including turnover times would be used to determine what allocations would maximize OR efficiency for a holiday week. The forecasts are based both on historical case duration data (eg, from the previous year during the holiday week) and other a priori knowledge (eg, asking surgeons if they will be out of town).

If a service/group/surgeon is expected to use so few hours of OR time that allocating 8 hours of OR time would likely achieve a lower OR efficiency than 0 hours, then no time is allocated to that service/group/surgeon. The service/group/surgeon can still schedule cases on Any Workday, but into other unblocked open first-come, first-served OR time (see Question 5). If every service/group/surgeon is best allocated 0 hours of OR time during the holiday period, then the entire schedule would be planned for first-come, first-served unblocked time. The appropriate staffing for that unblocked time should be estimated based on the forecasted workload using the method in Question 4 above. (Dexter, Epstein, Marsh, 2001).

Next month: Handling block release time.

OR Manager acknowledges the assistance of Kathy Shaneberger, RN, MSN, CNOR in the development of this series.

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The public is becoming more comfortable using the Internet. More people are shopping and banking online. Internet Christmas shopping was up this year.

But what about giving a health history on line? Would patients be comfortable sharing their health information through a web site?

Could collecting patients’ information electronically help streamline the preoperative process?

In December, nine of the 20 hospitals in the Utah-based Intermountain Healthcare (IHC) system began giving surgical patients the choice of submitting their health histories through the facilities’ web sites at www.ihc.com/surgery.

Patients first call to preregister with the hospital’s phone bank. If they are interested in using the online service, they are given the web address. They go to the IHC web site, choose the link for their facility, look for the surgical instructions, and click on the link for the online health history form.

The form, protected by a secure connection with 128-bit encryption like that used in Internet banking, takes about 30 minutes to fill out. There are fillable boxes and buttons similar to those used by web retailers like Amazon. Certain fields are required, and the form cannot be submitted until it is completed.

The form has a place where the patient can request a nurse to call, provide a phone number, and give a convenient time to call.

At the hospital, “the form prints out just like our paper form and goes right into the chart,” says Rebecca Hales, RN, BSN, CNOR, manager of the Cottonwood Surgical Center, Murray, Utah, who spearheaded the web development process. The form is identical to the manual version and has links so the pages don’t get mixed up.

A nurse reviews the form. If she has questions, she calls the patient or flags the chart to review on the patient’s arrival. Even if the nurses are satisfied with the information, all patients are called to give them their surgery time, review preoperative instructions, and ask if they have any questions.

To protect confidentiality, only four to five persons at each facility have access to the account where the health histories are received. Once the form is printed out, the file is deleted.

“It saves us an enormous amount of time, and the nurses absolutely love it,” says Hales. A health history for a patient with a complex condition can take a half-hour to 45 minutes to complete.

Hales does not yet know how many patients will participate. In an earlier version that used e-mail, about 40 patients a month submitted their information electronically out of an average monthly surgical volume of about 500 patients. Even at that level, she estimated she will save 0.5 FTE once the program takes hold.

“Even if you get three quarters of the information you need, it saves time for the nurse,” she says.

The online form is convenient for patients because they can complete it at any time, day or night. The information is saved on the site for 36 hours to allow them time to come back to it if they wish.

Working with IS

The idea for an online form began about 3 years ago.

“We do almost 100% phone assessment for our surgical patients, and the load was getting heavy,” Hales says.

“I sat down with the nurses, and we brainstormed. We thought about faxes, then someone said, ‘What about the Internet?’”

The group first needed to find out how many of their patients had Internet access and would access the information if it were available. Nurses at Cottonwood began asking patients during their postoperative phone call. They
discovered the rate was fairly high because of Utah’s well educated population and the number of high-tech companies located there.

The initial idea was to provide registration and the patient’s health history online.

Hales talked to the head of IHC’s information systems (IS) department. Although he agreed this was a goal for the future, he said that for now, the system could handle confidentiality for the health history only.

Working with IS and Moore (www.moore.com), a company that specializes in business forms, Hales and her team converted the health history form to an electronic version. Once the form was developed, it was easy for other IHC facilities to adopt it because most use the same health history form.

The cost of developing the web-based form was about $1,000. If each facility in the system had decided to use a different form, the cost would have been $1,000 per facility.

Hales is spending some time troubleshooting. In the early weeks of the program, some patients were sending their form to the wrong facility. Also, some were getting stuck as they filled it out. The form takes several screens, and patients cannot advance to the next screen until they fill in all required spaces in the current screen, which some found confusing. They also cannot submit the form until all required boxes are completed.

“It would have been nice if we had a local number where patients could call for instructions,” she says.

What about confidentiality?

Cottonwood had a survey by the Joint Commission on Accreditation of Healthcare Organizations during the time it was permitting patients to submit health histories by e-mail. When the surgeon surveyor asked about privacy, Hales explained that the system used the same type of encryption that Internet banking uses. He was satisfied with that response.

“The system has the same level of security as Internet banking.”

“When we told him that only four or five people have access to the file where the histories are received, he was very comfortable with it,” she says.

Also important to the Joint Commission is the fact that the electronic form has the same information and format as the manual form because it is an indication that all patients are receiving the same level of care.

Physicians have not expressed any concerns about the online histories, Hales notes. Because the printed form is the same no matter how the information is submitted, they really don’t see any difference.

She and other managers plan to start informing physicians about the electronic health histories so they can tell their patients about it. One plan is to give the physicians note pads that include the web address.

While developing the electronic form took time, Hales thinks the effort will pay off in the long run by helping to relieve the nursing staff.

Now that the form is up and running, IHC will track its usage and monitor whether it improves patients’ satisfaction with the registration process.

She acknowledges that support from IHC’s strong IS department made the project easier, as did the fact that the IHC facilities for the most part all use the same forms.

“If you’re going to do this in your own facility, you will need IS support,” she says. “You will also need consultation from someone who develops web pages and from business people who know how to develop a fillable form.”

What did it take to get the project moving?

“Persistence and the belief that it was possible!” she says.

To view IHC’s surgical instructions, including the link to the health history form, visit www.ihc.com/surgery. Choose Cottonwood Surgical Center. (Patients have to register before they have access to the form.)
Should Congress freeze ASC payments?

A federal panel is discussing whether to recommend to Congress freezing 2004 Medicare payments to freestanding ambulatory surgery centers (ASCs).

A staff analysis for the Medicare Payment Advisory Commission (MedPAC) found ASC payments are “more than adequate” and may be creating an incentive to shift procedures from hospitals to ASCs.

But an ASC trade group says the analysis is flawed. The American Association of Ambulatory Surgery Centers (AAASC) says payments actually have gone up slowly, and the shift to ASCs is for other reasons.

Because the government doesn’t have good cost data to judge if payments are sufficient, the MedPAC staff based its recommendation on ASC market trends.

According to MedPAC’s analysis, the number of ASCs doubled between 1991 and 2001 and increased by 50% from 1996 to 2001. ASCs seem to have strong access to capital, and two of the largest surgery center companies have had favorable investment ratings.

“These market factors lead us to conclude Medicare payments to ASCs are more than adequate and that a reduction in the current rate might be warranted,” staff analyst Ariel Winter told MedPAC at its December meeting.

He proposed that MedPAC consider recommending to Congress:

• Not updating ASC payment rates for 2004. If Congress doesn’t act, ASCs would receive a projected inflationary update of 2.7%.

• Ensuring ASC payment rates do not exceed outpatient hospital rates for the same procedures. The result, based on 2001 volume, would likely reduce ASC payments by 7%.

The recommendations do not apply to hospital-based ambulatory surgery units.

Disputed findings

Disputing that conclusion, AAASC wrote MedPAC Dec 27 saying Medicare actually updated payments in only 5 of the past 12 years, and updates averaged only 1.88% a year between 1991 and 2002.

AAASC cites a number of other reasons for surgery center growth:

• Many states have loosened certificate-of-need laws, which previously restricted ASC growth.

• Surgical advancements, such as minimally invasive techniques and faster-acting anesthetics, have enabled more procedures to be done in ASCs.

• Medicare has expanded the list of ASC-approved procedures, which gives patients a broader choice in surgical settings.

• ASCs are attractive to surgeons because they have better control over their schedules, which enables them to perform more procedures in a day and generate more income.

Rates in question

Winter showed MedPAC a chart of four high-volume procedures for which ASC payment rates are higher than hospital outpatient rates:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>ASC rate</th>
<th>Outpatient hosp rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>After-cataract laser surgery</td>
<td>$446</td>
<td>$246</td>
</tr>
<tr>
<td>Diagnostic colonoscopy</td>
<td>$446</td>
<td>$413</td>
</tr>
<tr>
<td>Upper GI endoscopy, biopsy</td>
<td>$446</td>
<td>$387</td>
</tr>
<tr>
<td>Epidural injec</td>
<td>$333</td>
<td>$250</td>
</tr>
</tbody>
</table>

He estimated about 150 (12% to 13%) of the approximately 1,000 Medicare-approved ASC procedures have higher payment rates for ASCs than hospitals.

Update coming for ASC list

Medicare is expected to issue an expanded list of Medicare-approved ASC procedures early this year.

Though the list was not published by the end of 2002, as the government had projected, observers expect the revised list shortly.

Representatives of the American Association of Ambulatory Surgery Centers (AAASC), who met with the Centers for Medicare and Medicaid Services (CMS) in December, said the delay was expected to be “weeks, not months.”

“We’re not suggesting that ASCs overall receive higher payments than outpatient departments,” Winter elaborated.

“We’re saying there are certain high-volume procedures where that’s the case, and perhaps [that] might be encouraging shifting of services to the ASC setting.”

The reason some ASC payments are higher, noted MedPAC’s chair, Glenn M. Hack Barth, JD, is that ASC payments are based on an old payment system that has been updated for inflation. But the panel decided revamping the payment system would be complicated and is not a priority, given that ASC facility payments make up less than 1% of total Medicare spending.

In a statement of principle most of the panelists seemed to agree with, David Durenberger, a former senator and a health policy expert, said he thought differences in payment driven by differences in the cost of providing a service should not provide financial incentives to shift the site of care. In other words, the payment system shouldn’t encourage procedures to move to a setting that receives higher payments because it has higher costs.

Continued on page 28
The problem is that the government lacks the information to make policy decisions because it doesn’t have a handle on outpatient costs either in the ASC or in the hospital. Nor does it have adequate information to know whether where a patient has surgery makes a difference in outcomes.

The chairman recommended the panel set aside the bigger questions about restructuring the payment system and focus on the immediate issue about whether to freeze payments and adjust payments for procedures for which ASCs receive more than hospitals. MedPAC probably will make a decision about its recommendation in March.

MedPAC is an independent 17-member panel that advises the government on Medicare payment policies.

New fire safety rules effective March 11


The Life Safety Code is a set of requirements from the National Fire Protection Association.

CMS has been going by the 1985 code, though the Joint Commission on Accreditation of Healthcare Organizations has adopted the 1997 code.

Ambulatory surgery centers (ASCs) were pleased, saying the final rule is less burdensome than a 2001 draft. “Most ASCs should not require expensive retrofitting to comply,” said Craig Jeffries of the American Association of Ambulatory Surgery Centers (AAASC).

Key points for ASCs:
- Existing ASCs will not have to have a Type I Essential Electrical System (EES) or upgrade medical gas capabilities, provided they still meet Life Safety Code requirements that applied when the center was constructed. ASCs will have to meet the 2000 code if these systems are altered or renovated, however. New facilities will need to have a Type I EES.
- The final rule does not change requirements for vertical openings, such as stairwells, and fire-rated wall standards for ASCs.
- ASCs will have to upgrade emergency lighting consistent with the code but will have 3 years to do so. ASCs may also request waivers for specific provisions, which will be evaluated on a case-by-case basis.

—Federal Register, Jan 10, 2003, pp 1374-1381.

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Health Policy & Politics

West Virginia surgeons protest insurance costs

Four hospitals in the northern panhandle of West Virginia cancelled surgery Jan 2 after more than two dozen surgeons took leaves of absence to protest malpractice insurance costs. Doctors in six other cities in the state said they were close to walking out.

The West Virginia Hospital Association said the walkout had left the panhandle with “almost no emergency surgeons.” At least one patient had to be transferred 90 miles to another hospital, the New York Times reported.

The American Medical Association said the state’s malpractice rates are among the highest in the country. One surgeon said he had to borrow money twice last year to pay $73,000 a year for insurance.

West Virginia’s governor unveiled a plan Jan 9 he said would provide doctors tax breaks and other credits for 3 years. The plan would be funded by $20 million from the state’s tobacco settlement fund. The governor also proposed capping damage awards and taking other steps to curb malpractice lawsuits.

Doctors said they were taking a wait-and-see attitude to see if the plan would adequately address their concern.
—www.nytimes.com There is a charge for articles from the archive.
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Hospital leaders call for Medicare and Medicaid relief

Hospital administrators traveled to Capitol Hill in early January to urge lawmakers to provide more funding for patient care.

Workforce shortages, spiraling costs for liability insurance and drugs, and disaster preparedness are all reasons more funding is needed, American Hospital Association President Dick Davidson said at a Jan 8 press conference.

Hospitals are finding it harder and harder to keep up because many of them receive less than the cost of care from Medicare and Medicaid, he said.
—www.hospitalconnect.com

Funding for shortage top priority for nursing groups

Funding for the Nurse Reinvestment Act is at the top of the legislative agenda for nurses in the new Congress, which convened in January.

Congress has yet to put up the money for the legislation passed last year. Nurse advocates want to keep the law from being overwhelmed by other priorities, such as smallpox vaccination and bioterrorism.

The law will establish loans and scholarships to those who agree to serve in shortage areas and provide grants to hospitals to apply for the magnet hospital program administered by the American Nurses Credentialing Center. Groups are asking for $250 million for fiscal 2003.

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Joint Commission says nosocomial infections should be reported

Deaths or permanent loss of function that appear to be related to nosocomial infection should be reported as sentinel events, Joint Commission on Accreditation of Healthcare Organizations President Dennis O’Leary, MD, said Dec 17.

The commission says it is receiving a “disproportionately low volume” of reports related to nosocomial infections.

The commission says that its sentinel event pool is the “only national database” that collects and categorizes all types of events and their causes and, thus, is a “unique resource” for facilities and patient safety experts. Sentinel event reporting is voluntary.

—www.jcaho.org

Health care costs shoot up in 2001

Greater use of hospitals and prescription drugs and the declining influence of managed care drove costs up at the fastest rate in a decade, the journal Health Affairs reports.

In 2001, health spending:
• rose 8.7% to $1.4 trillion
• accounted for 14% of the GDP
• averaged $5,035 for each person in the US.

The major reason for the increase is increasing use of goods and services needed to care for the aging population, according to economist Katharine R. Levit.

—www.healthaffairs.org

Bariatric surgery best for long-term control of morbid obesity

Bariatric surgery offers the best treatment to produce sustained weight loss in morbidly obese patients, concludes a review in the Journal of the American Medical Association.

The increase in popularity and demand for bariatric surgery is attributed to several factors: no new nonsurgical treatments for morbid obesity that are effective long term, the success of the Roux-en-Y bypass technique, and increased awareness because more medical centers are adding bariatric surgery programs.

Investigators have reported improvement or resolution of obesity-related diabetes and significant improvement of left ventricular ejection fraction and blood pressure, cardiac chamber size, and ventricular wall thickness. Also reported are significant decreases in total cholesterol and triglyceride levels.


Consumer Reports offers tips on choosing hospitals

A survey of 21,000 Consumer Reports readers found 78% were highly satisfied with care they received in a hospital.

Surgical patients were more satisfied with pain relief than medical patients, 49% of whom said relief was suboptimal. And patients generally were pleased with information received before surgery. In all, 97% said their surgeon explained the surgery in a way they or a relative could understand.

But for 22% of patients, care was marred by unanswered calls, inadequate pain relief, pressure to leave the hospital too soon, or complications.

Just 60% said their hospital was adequately staffed, and only 55% strongly agreed that nurses responded promptly to calls.

Consumer Reports encouraged patients to take a more active roll in choosing their hospital and offered tips—including bringing their own help.

—www.consumerreports.org

GHX, Medibuy merger a leap for e-commerce

The merger Jan 1 of two big electronic marketplaces, Global Health Exchange, Westminster, Colo, and Medibuy, Nashville, Tenn, creates the largest e-exchange in health care, the January Hospital Materials Management reports.

The other major player is Neoforma, San Jose, Calif, which hosts online purchasing for two major GPOs, Novation, Irving, Tex, and MedBuy, London, Ont.

The growth of hospital e-commerce so far has been glacial. The merger could help break through one of the major obstacles, the lack of a uniform language and standards for e-exchange.

Hospitals’ margins hold

Hospitals’ average overall margins held steady at 4.2% in 2001, the same level as in 2000, the American Hospital Association reports.

But one in three hospitals was operating in the red.

Hospitals continued to battle higher costs for labor, technology, liability insurance, and bioterrorism preparedness.

At the same time, volume is rising. Total admissions increased 2.3%, and total aggregate inpatient days grew by 1%. The average length of stay dropped slightly to 5.1 days from 5.2 days.

The figures are from AHA’s Hospital Statistics 2003.

—www.hospitalconnect.com