Survey finds OR nurse staffing holds up in face of shortages

Staffing in operating rooms seems to be holding its own despite widespread worries about the nursing shortage.

Only 4% of ORs have closed rooms for more than 1 week because of a shortage of OR nurses, according to a recent OR Manager survey.

Anesthesia coverage is more of a problem. More ORs—20%—had shut down rooms because they did not have enough anesthesia providers.

The anesthesia shortage is likely to be felt at least through 2005, experts say.

The turnover rate for OR nursing personnel has improved slightly, as has the vacancy rate and weeks positions have been open. Use of contract staff is on a par with last year.

Turnover and vacancy rates in the OR continue to be lower than the national averages for all RNs.

Though the staffing situation in surgery appears relatively stable, the vast majority of surgical services managers—87%—say recruiting experienced OR nurses has gotten more difficult in the past year.

To cope with staffing challenges, managers continue their strategy of hiring RNs without surgical experience and providing the preparation themselves.

The results are from OR Manager’s 2003 Salary/Career Survey. Findings on the staffing portion of the survey are Continued on page 11
Please see the ad for
MEDLINE INDUSTRIES
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Annual Salary/Career Survey
Is your salary keeping pace? What about your benefits? Read results of this year’s survey.

The coming shortage: physicians
Will your OR have enough anesthesia providers and surgeons? A view of the trends.

Meeting staffing challenges
Is your OR suffering from “gaposis”– surgeons want to operate late in the day but staff want to go home? What strategies can help?

S
o you think perioperative nursing staff are difficult to recruit? Try surgeons and anesthesiologists. Surgical suites are facing a demographic tidal wave of patients in the next 10 to 20 years that could leave them scrambling for professionals on all three categories.

We’ve known about the nursing shortage for a while.
At the moment, despite the general RN shortage, OR nurse staffing seems to be relatively stable, judging by results on staffing from the 2003 OR Manager annual Salary/Career Survey reported in this issue.

But the pinch caused by a lack of anesthesia providers is already being felt. Our survey found 20% of respondents have had to close ORs for more than 1 week because they did not have enough anesthesia providers. That is far more than the 4% who closed rooms because of a lack of OR nurses.

The anesthesiologist supply dipped in the mid-90s. Though more residency slots are being filled, the shortfall is projected to continue at least through 2005.

Nurse anesthetists are affected by the same trends as nursing generally. Though enrollments in nurse anesthesia programs have risen lately, it’s not clear it will be enough to offset the falloff as nurses retire in the coming years.

Surgeon shortage forecast
Then, as we neared our deadline, we learned of a new study from UCLA that forecasts a shortage of surgeons by 2020.
The demand for some specialties will rise by nearly 50% as the over-65 population surges, according to the researchers, led by David A. Etzioni, MD, a general surgeon.
The greatest growth in demand, not surprisingly, will be in cataract and cardiac surgery, which are primarily performed in older adults.

All of this will mean increased competition among facilities to attract not only the best nurses but also the best surgeons and anesthesia caregivers.

One big challenge will be bringing this picture into focus for Congress, the White House, and state lawmakers. How is it going to be possible to attract the best people when physicians already find Medicare payment rates too low?

And Congress and state houses so far have made little progress on taming the high malpractice premiums that are driving some physicians out of state or out of practice.

On the hospital front, will we see “magnet” programs for physicians like we’ve seen for nurses?
The magnet program from the American Nurses Credentialing Center recognizes that the most effective way to attract and retain nurses is to support them as professionals and develop an environment that promotes excellence in practice.

There will be a lot of discussion in the coming years about how to make surgeons and anesthesia personnel the most productive.

You already know from experience what is going to be important to them in the surgical suite:
• a well-oiled surgical scheduling system that gives the surgeons convenient access to OR time without causing big gaps and late-running cases that create dissatisfaction for both perioperative nurses and anesthesia personnel
• skilled, competent perioperative staff who can give expert patient care and keep the surgery schedule flowing safely and efficiently
• a well-managed central sterile department that provides complete, well-maintained instrument sets and accurately picked supplies
• up-to-date surgical technology
• a focus on customer service and team collaboration.

Nothing new here—more challenges to come.
An upside is that hospital administrators will have to place recruitment and retention for all types of health care professionals at the top of their priority list.

—Pat Patterson
Please see the ad for
ADVANCED STERILIZATION PRODUCTS
in the *OR Manager* print version.
JCAHO adds goal on reducing infection

One new National Patient Safety Goal has been added for next year—reducing the risk of health care-acquired infection.

The six Patient Safety Goals for 2003 continue next year, for a total of seven.

The Joint Commission on Accreditation of Healthcare Organizations announced the goals July 21. The goals are effective for accreditation surveys beginning Jan 1.

Eliminating wrong surgery continues as a goal. JCAHO has issued a new “universal protocol” for preventing wrong surgery that must be implemented by July 1, 2004 (page 8).

The new goal for reducing infection risk has two requirements:

- Comply with the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.
- Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-acquired infection.

The new goal echoes JCAHO’s sentinel event alert on reducing infection issued in January. The difference is that organizations are scored on compliance with Patient Safety Goals, while sentinel event alerts aren’t scored unless they are also a safety goal.

Hand hygiene guidelines

The CDC’s hand hygiene guidelines, issued in 2002, recommend more widespread use of alcohol-based handrubs as well as gloving and washing hands.

The guidelines include recommendations for OR personnel on the surgical scrub as well as fingernails and artificial nails.

The guidelines say the surgical scrub may be performed either with an antimicrobial soap or alcohol-based rub and spell out requirements for the scrub.

In addition, the CDC strongly recommends against artificial fingernails and nail extenders for OR personnel and others involved in direct patient care for high-risk patients. Many facilities have adopted policies in the past year banning artificial nails for direct caregivers.

Natural nails should be less than 1/4 inch long. No recommendation is made on nail polish. Nurses’ long and artificial nails have been linked to patient infections, including deaths of infants in a neonatal intensive care unit in 1997.

Infections as a patient safety issue

The second requirement for reducing risk of infection is likely to be more controversial. Infection control experts point out that health care-acquired infections are multifactorial, and it can be very difficult to determine a root cause.

There is no question, though, that infections are a patient safety issue.

Infections are the most common complication in hospital patients. An estimated 2 million patients acquire an infection in US hospitals each year. Nosocomial infections add $4.5 billion to health care costs.
Please see the ad for ENCISION, INC in the OR Manager print version.
costs a year, the CDC estimates.

Surgical site infection was the second largest category of adverse events
in the well-known Harvard study published in 1991. That study is one source
for the Institute of Medicine’s 1999 estimate that 44,000 to 98,000 patients die a
year in hospitals from medical errors.

**Looking for root causes**

The CDC’s director, Julie Gerberding, MD, MPH, writing in the *Annals
of Internal Medicine* (2002;137:665-670), advocates taking a quality-improvement
approach to infection, much like that for medication errors. She suggested
that infection control teams consider conducting a root cause analysis if they
suspect an infection was preventable, even if the patient’s condition was complex.
They might ask, for example:

- Was aseptic technique used in inserting the urinary catheter?
- What was the staffing level? Low staffing has been associated with higher urinary tract infection rates.
- Was the patient a candidate for an anti-infective-coated catheter? Research suggests that such catheters, while more costly, can be cost-effective in high-risk patients.

If a surgical-site infection was involved, the surgical team would likely
participate in the root cause analysis, and questions would be asked about OR practices. The team would look for evidence that a prophylactic antibiotic was ordered, if appropriate, and when the antibiotic was given. There might also be questions about use of catheters and drains, instrument reprocessing, sterilization parameters, aseptic practice, and OR attire.

Though infection control professionals, with their training in epidemiology,
are skilled in analysis, taking a safety approach to infection will require a
change in attitude on everyone’s part, notes Patrice Spath, BA, RHIT, who commented on the subject for an article in the April OR Manager.

If a patient dies from a nosocomial infection, the organization will have to
be willing to ask, “Might the patient have recovered if it hadn’t been for the
infection?”

“If the answer is ‘yes,’ that means admitting the patient-care process was flawed in some way,” Spath observed.

As with other patient safety issues, that means overcoming fear and shame. It means being open to looking at infection as the result of larger system problems.

“That will take leadership and courage,” Spath noted. 

### JCAHO National Patient Safety Goals

1. **Improve accuracy of patient identification.**
   
   a. Use at least two patient identifiers (neither to be the patient’s room number) whenever taking blood samples or administering medications or blood products.
   
   b. Prior to the start of any surgical or invasive procedure, conduct a final verification process, such as a “time out,” to confirm the correct patient, procedure, and site, using active—not passive—communication techniques.

2. **Improve the effectiveness of communication among caregivers.**

   a. Implement a process for taking verbal or telephone orders or critical test results that require a verification or “read-back” of the complete order or test result by the person receiving the order or test result.
   
   b. Standardize the abbreviations, acronyms, and symbols used throughout the organization, including a list of abbreviations, acronyms, and symbols not to use.

3. **Improve safety of using high-alert medications.**

   a. Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride >0.9%) from patient care units.
   
   b. Standardize and limit the number of drug concentrations available in the organization.

4. **Eliminate wrong-site, wrong-patient, wrong-procedure surgery.**

   a. Create and use a preoperative verification process, such as a checklist, to confirm that appropriate documents (eg, medical records, imaging studies) are available.
   
   b. Implement a process to mark the surgical site and involve the patient in the marking process.

5. **Improve the safety of using infusion pumps.**

   a. Ensure free-flow protection on all general-use and PCA (patient-controlled analgesia) intravenous infusion pumps used in the organization.

6. **Improve the effectiveness of clinical alarm systems.**

   a. Implement regular preventive maintenance and testing of alarm systems.
   
   b. Ensure that alarms are activated with appropriate settings and are sufficiently audible with respect to distances and competing noise within the unit.

7. **Reduce the risk of health care-acquired infections.**

   a. Comply with current CDC hand hygiene guidelines.
   
   b. Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-acquired infection.

Source: Joint Commission on Accreditation of Healthcare Organizations.

The CDC guidelines are at [www.cdc.gov/handhygiene](http://www.cdc.gov/handhygiene). The CDC also has a fact sheet, slides, posters, and buttons available.

Check our web site for the latest news, meeting announcements, and other practical help. [www.ormanager.com](http://www.ormanager.com)
Deadline is July 1, 2004, to comply with wrong-site surgery protocol

Beginning July 1, 2004, organizations will have to comply with a new “universal protocol” for preventing wrong surgery. The protocol, approved in July by the Joint Commission on Accreditation of Healthcare Organizations, is based on consensus reached at a national summit in May.

The protocol is expanded from the 2003 National Patient Safety Goal on wrong surgery, which generated questions and controversy over surgical site marking. Preventing wrong surgery continues to be a Patient Safety Goal for 2004.

The final protocol has only minor changes from the draft released for comment in June. More than 3,000 comments were submitted, which JCAHO said were “overwhelmingly in support” of the protocol.

The protocol includes eight principles and three steps. The three steps are:

1. Preoperative verification process.
   - Purpose: “To ensure that all of the relevant documents and studies are available prior to the start of the procedure and that they have been reviewed and are consistent with each other and with the patient’s expectations and with the team’s understanding of the intended patient, procedure, and site, and as applicable, any implants. Missing information or discrepancies must be addressed before starting the procedure.” [This last sentence was added after the draft was issued.]
   - Process: “An ongoing process of information gathering and verification, beginning with the determination to do the procedure, continuing through all settings and interventions involved in the preoperative preparation of the patient, up to and including the ‘time out’ just before the start of the procedure.”

2. Marking the operative site.
   - Purpose: “To identify unambiguously the intended site of incision or insertion.”
   - Process: “For procedures involving right/left distinction, multiple structures (such as fingers and toes), or multiple levels (as in spinal procedures), the intended site should be marked such that the mark will be visible after the patient has been prepped and draped.”

   - Purpose: “To conduct a final verification of the correct patient, procedure, site, and as applicable, implants.”
   - Process: “Active communication among all members of the surgical/procedure team, consistently initiated by a designated member of the team, conducted in a ‘fail-safe’ mode, ie, the procedure is not started until any questions or concerns are resolved.”

Guidelines spell out details

The protocol is accompanied by guidelines with details for implementing the steps. JCAHO says it expects compliance with the guidelines as well as the protocol.

The guidelines, in addition to outlining specifically what is expected for site marking, list exemptions that respond to a flurry of questions from physicians and nurses around the country. Exemptions from site marking include:

- single-organ cases (eg, cesarean section, cardiac surgery)
- interventional cases for which the catheter/instrument insertion site is not predetermined (eg, cardiac catheterization)
- teeth—but indicate operative tooth name(s) on documentation or mark the operative tooth (teeth) on the dental radiograph or dental diagram.
- premature infants, for whom the mark may cause a permanent tattoo.

Clarifying another issue that has raised questions, the guidelines say: “The person performing the procedure should do the site marking.” The National Patient Safety Goal was silent on who should mark the site.

Despite all the attention focused on preventing this type of error, JCAHO says it continues to receive five to eight new reports of wrong-site surgery a month.

Information on the protocol is at www.jcaho.org

Call for abstracts: Share your successes

Have you developed new programs to retain perioperative staff or led a successful cost-management effort?

Perhaps you have found creative ways to foster leadership in your staff or develop a culture of patient safety.

Or perhaps you’ve heard a dynamic speaker you think your colleagues would benefit from hearing.

Share your ideas and successes with the planning committee for the 2004 Managing Today’s OR Suite conference. The committee is inviting proposals for the conference, which will be held Oct 6 to 8, 2004, at the Hyatt Regency Chicago.

Send a proposal of about 500 words describing the session you wish to present.

Provide enough information to give the committee a good understanding of the content.

Sessions are 1 1/2 hours long and focus on practical topics related to management of surgical services, such as achieving greater efficiency, management of information, leading and developing staff, and keeping costs under control.

The keynote address and general sessions feature nationally known speakers who have important messages for surgical services directors. If you wish to suggest a general session speaker, please obtain as much information about the person as you can, such as the speaker’s title, organization, address, and phone number.

The deadline for proposals and suggestions is Nov 1.

OR Business Management Conference

Proposals are also invited for the fifth annual OR Business Management Conference to be held May 12 to 14, 2004, at the Hyatt Regency Downtown in Albuquerque, NM.

Covered are topics such as financial management, materials and technology management, automation, and OR design and construction.

Please fax or e-mail proposals by Nov 1 to Billie Fernsebner, RN, MSN, education specialist, OR Manager, Inc, at 303/442-5960 or bfernsebner@ormanager.com

If you have questions, call her at 303/442-1661.
Please see the ad for KARL STORZ ENDOSCOPY-AMERICA in the *OR Manager* print version.
Please see the ad for
INTEGRATED MEDICAL SYSTEMS
in the OR Manager print version.
In the past year, has your OR canceled elective surgery because of a staffing shortage of nurses?

![Yes 2% No 98%](image1.png)

In the past year, have any of your ORs been closed for more than 1 week because of a staffing shortage of OR nurses?

![Yes 4% No 96%](image2.png)

**Average number of ORs closed:** 1.2

**Average number of days closed:** 34

Use of travelers was highest in the West and lowest in the Central region.

Six facilities had 30% or more of their staff made up of travelers—five community hospitals and one teaching facility. At two of these, 50% or more of the staff was temporary. One was a small facility in the East, and the second was a large teaching facility that did not give its location.

Though travelers are a help in filling staffing gaps, they can be hard on morale. That’s especially true if a nurse quits her job, joins a staffing agency, and comes back to the same employer as a traveler, at a higher rate of pay. “It does a number on our permanent staff,” one OR manager observed.

Some hospitals have adopted a policy saying they won’t accept travelers who live in the local area. They also have placed limits on the number of times a traveler can work at their facility before joining the hospital as a permanent employee.

Continued on page 15
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MOLNLÖCKE HEALTH CARE INC
in the OR Manager print version.
Please see the ad for MOLNLYCKE HEALTH CARE INC in the OR Manager print version.
**Recruitment & retention**

### Average staff turnover rate

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>Region</th>
<th>Overall</th>
<th>Community</th>
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<td></td>
<td>East</td>
<td>Central</td>
<td>South</td>
<td>West</td>
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<tr>
<td>RNs</td>
<td>6.8%</td>
<td>6.7%</td>
<td>7.3%</td>
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<td>5.5%</td>
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<tr>
<td>STs</td>
<td>7.0%</td>
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<td></td>
<td>6.7%</td>
<td>5.0%</td>
<td>8.7%</td>
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Note: Turnover was defined as the percentage of staff who have left and been replaced in the past year.

### Average number of open positions in ORs

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<thead>
<tr>
<th>Type of facility</th>
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<th>Community</th>
<th>Teaching</th>
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<td>East</td>
<td>Central</td>
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<tr>
<td>RNs</td>
<td>1.7</td>
<td>1.5</td>
<td>2.1</td>
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<td>1.5</td>
<td>1.6</td>
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<td>1.7</td>
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<tr>
<td>STs</td>
<td>1.1</td>
<td>0.9</td>
<td>1.6</td>
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<td>1.0</td>
<td>1.0</td>
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### What percentage of budgeted FTE positions are open?

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<th>Type of facility</th>
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<td>East</td>
<td>Central</td>
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<tr>
<td>RNs</td>
<td>5.4%</td>
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<td>5.7%</td>
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<tr>
<td>STs</td>
<td>6.6%</td>
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<td>5.9%</td>
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<td>8.3%</td>
<td>6.1%</td>
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### Average number of weeks positions have been open

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<tr>
<td>RNs</td>
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<td>14</td>
<td>10</td>
<td>13</td>
<td>14</td>
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<tr>
<td>STs</td>
<td>11</td>
<td>10</td>
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<td>10</td>
<td>9</td>
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### Do you routinely use agency/travelers to fill budgeted OR positions?

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<th>Type of facility</th>
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<td></td>
<td>East</td>
<td>Central</td>
<td>South</td>
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<td></td>
<td>25%</td>
<td>23%</td>
<td>28%</td>
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<td></td>
<td>24%</td>
<td>17%</td>
<td>23%</td>
<td>39%</td>
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### What percentage of FTEs are agency/travelers?

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<td></td>
<td>7.6%</td>
<td>7.7%</td>
<td>7.8%</td>
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<td></td>
<td>9.4%</td>
<td>6.0%</td>
<td>4.4%</td>
<td>8.9%</td>
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</table>
Similar to last year, 88% provide OR preparation. Hiring without experience continues to require experience in surgery:

<table>
<thead>
<tr>
<th>Vacancy rates</th>
<th>RNs</th>
<th>11.2%</th>
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<tbody>
<tr>
<td>Turnover rates</td>
<td></td>
<td>15.7%</td>
</tr>
<tr>
<td>Days to fill positions</td>
<td>45 days</td>
<td>22 days</td>
</tr>
</tbody>
</table>

Source: JWT Specialized Communications Healthcare Group.

Recruiting still tough

Though vacancy and turnover rates may have stabilized, recruiting experienced OR nurses isn’t getting any easier. The 87% who say recruiting RNs has become more difficult in the past year is up from 71% in 2002. For STs, 61% say recruiting is more difficult, about the same as last year.

Small ORs (1-5 rooms) and those in rural areas are more likely to say recruiting is very difficult. Attracting staff seems to be more difficult for community hospitals than teaching institutions.

Hiring without experience

Most surgical services managers accept the fact that experienced OR nurses are scarce. Most nursing schools haven’t prepared RNs for the operating room in a generation.

The overwhelming majority of respondents—89%—say they hire RNs without experience in the OR, a number little changed since 2000. Still, a minority continues to require experience in surgery:

Never hire RNs without OR experience

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<th>East</th>
<th>Central</th>
<th>South</th>
<th>West</th>
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<tbody>
<tr>
<td>10+ ORs:</td>
<td>7%</td>
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<tr>
<td>6-9 ORs:</td>
<td>12%</td>
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<tr>
<td>1-5 ORs:</td>
<td>16%</td>
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To compensate for the lack of OR-experienced RNs, managers typically hire nurses from other clinical areas and provide their own OR preparation. Similar to last year, 88% provide OR time for surgery. Two thirds had to limit OR access because of a lack of anesthesia providers.

The current shortfall is expected to continue at least through 2005, according to Armin Schubert, MD, and colleagues in a recent update in Anesthesia & Analgesia (2003;96:207-214).

The shortage is leading to tough negotiations between hospital administrators and anesthesia groups across the country, notes William Mazzei, MD, medical director of perioperative services and clinical professor of anesthesia at the University of California, San Diego, who has consulted with about a dozen anesthesia groups nationally.

Groups that have lost anesthesia providers are having difficulty recruiting new members either because of the salary level or work level.

Even in facilities that don’t have an acute shortage, anesthesiologists are demanding more efficient utilization of OR time. They are no longer satisfied with big gaps in the middle of the day and late cases running beyond normal working hours or, as he puts it, “being available 16 hours for 8 hours of surgery.”

“Groups are either negotiating for more money to recruit more providers, or they are seeking to reduce the workload by having ORs scheduled more efficiently,” Dr Mazzei says.

Some facilities that haven’t taken a proactive approach on these issues but instead accuse anesthesiologists of “not wanting to work” or even of being “lazy” have seen “implosions” where 20% to 40% of the anesthesia staff leave, he noted.

It could take 5 years to reach an equilibrium in the anesthesia labor supply. But even then it’s not clear the supply will be sufficient.

Recruitment into anesthesia residencies has risen steadily since 1996, surpassing its previous peak in 1992. But the demand for surgery continues to grow with the aging population.

There’s also a proliferation of locations needing anesthesia services—ambulatory surgery centers, surgical hospitals, office facilities, pain clinics, and imaging centers, among others.
Recruitment & retention

Bonuses not as lavish

Sign-on bonuses seem to be losing some of their glitter.
Less than half of respondents in this year’s survey say their organization offers a sign-on bonus, down from 2002. Some wrote in that their organizations were discontinuing bonus programs.
Bonuses aren’t as lavish. The average is $2,900, compared with $3,300 in 2002. Only 5% (9) pay more than $5,000. The largest bonus was $7,000.
Recruiters say big sign-on bonuses now often are spread over 2 to 3 years to give the new employee an incentive to stay.
Some ORs report their facility offers a bonus even though they have no vacancies in surgery.
Hospitals in the South (52%) and West (50%) are more likely than those in the East (39%) and Central (37%) regions to offer bonuses.
Reflecting the difficulty of recruiting in cities, bonuses are more common in urban areas (56%) than in suburban (45%) or rural (36%) locales.
Larger facilities with 10+ ORs are much more likely (55%) to offer a sign-on bonus than smaller ones with 1-5 ORs (29%).
Despite the emphasis on retention, the percentage offering bonuses that entice staff to stay is about the same as last year.
As with sign-on bonuses, retention bonuses are more common in larger facilities (29%) than smaller ones (15%).
Examples of retention bonuses include:
• $1,000 for RNs who work more than 900 hours in 6 months
• clinical ladder bonuses of up to $5,000
• $1,000 bonuses for achieving certification.

Has recruiting become more difficult in the past year?

Perioperative RNs

Surgical technologists

Is recruiting experienced OR nurses more difficult?

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<th>Overall</th>
<th>East</th>
<th>Central</th>
<th>South</th>
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<td>Very</td>
<td>43%</td>
<td>41%</td>
<td>42%</td>
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<td>44%</td>
<td>45%</td>
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<td>13%</td>
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The OR Manager Salary/Career Survey is coordinated by Billie Fernsebner, RN, MSN.
Please see the ad for BOVIE MEDICAL in the OR Manager print version.
New GI scope guidelines have wide endorsement

New guidelines from the American Society for Gastrointestinal Endoscopy (ASGE), endorsed by ASGE and ten other groups, provide recommendations on preventing infection from flexible GI endoscopes.

The guidelines repeat the well-known message—that all published episodes of pathogen transmission related to GI endoscopy have been associated with failure to follow established cleaning and disinfection guidelines or with use of defective equipment.

Among those endorsing the guidelines are the Joint Commission on Accreditation of Healthcare Organizations, Association of periOperative Registered Nurses, Association for Professionals in Infection Control and Epidemiology, and Society for Gastroenterology Nurses and Associates.


They can be downloaded for free at www.asge.org. Registration is required.❖

New stents could hurt hospitals’ finances

Though a breakthrough for patients, drug-eluting stents could financially challenge hospitals in the short term, according to Moody’s Investors Service.

The new stents were approved by the Food and Drug Administration in April.

Though Medicare pays more for drug-eluting stents than conventional ones, the payment is likely to fall short of the full cost, the credit rating agency said.

In the long run, the stents could reduce the need for cardiology procedures, including repeat angioplasties and cardiac surgery, which typically are one of a hospital’s most profitable programs, Modern Healthcare reported.

Drug-eluting stents, which are coated with a drug that inhibits growth of scar tissue, have a list price of $3,195, about three times the cost of a conventional stent.

Please see the ad for KIMBERLY-CLARK CORPORATION in the OR Manager print version.
ASCs less likely to hire RNs without OR experience

Though most ambulatory surgery centers (ASC) say recruiting OR nurses has become more difficult in the past year, only 54% say they need to hire RNs without OR experience. Nearly half—46%—never do.

That’s far different than hospitals, 89% of which hire without experience.

Turnover rates and vacancy rates for ASCs are low, similar to what hospital ORs are experiencing.

When there is an opening, ASCs take about half as long to fill it as a hospital OR does.

And ASCs are less likely to rely on use of temporary personnel; 12% use temps routinely, compared with 25% of hospital surgery departments.

Very few ASCs—only 3% (4)—have had to close ORs for more than a week because of a lack of OR nurses. And only a few have had to cancel surgery for that reason.

The results are from the staffing portion of OR Manager’s 2003 Salary/Career Survey.

The survey was mailed in May to 607 managers of ASCs doing general surgery. The list includes OR Manager subscribers. The return rate was 26%.

Findings on ASCs from the Salary/Career Survey will be in the October issue.
Please see the ad for OLYMPUS ENDOSCOPY in the OR Manager print version.
Please see the ad for
DUPONT
in the *OR Manager* print version.
Please see the ad for DUPONT in the *OR Manager* print version.
Listen to your most important customers.
Your surgeons.

The Surgeon Satisfaction Survey is to be conducted in September/October 2003

For a sample of the survey questionnaire, registration materials, or additional information, call 800/442-9918 or fax 505/982-7766.

Visit our website at www.orbenchmarks.com

An excellent way to listen to your surgeons is through OR Benchmarks's Surgeon Satisfaction Survey.

Physicians feel more comfortable with an independent, external source that asks about their satisfaction through a confidential survey.

In a user-friendly questionnaire, OR Benchmarks asks about how easy and efficient your surgeons find your scheduling. We ask how satisfied they are with your preoperative testing protocols. They tell us whether they find the nursing and management staff clinically skilled and responsive to their needs.

Open-ended questions allow for additional comments.

Thank you

OR Manager thanks its subscribers who generously took time to complete this year's survey.

We appreciate your part in gathering this information, which will be useful to your colleagues around the country.

Recruitment & retention

Is recruiting experienced OR nurses more difficult?

Very 30%
Somewhat 48%
Not at all 22%

Do you routinely use overtime to staff your ASC ORs?

Yes 36%
No 64%

Do you offer training for OR nurses?

Yes, at the ASC 63%
Yes, elsewhere 13%
No 24%

Does your ASC pay a bonus to clinical staff?

Yes 24%
No 76%

Average ASC staff turnover rate

RNs 6.8%
STs 4.7%
Please see the ad for CBPN in the *OR Manager* print version.
have made significant progress.

But the Senate’s chief GPO critic, Sen Herb Kohl (D-Wis), said he thinks “not enough is happening” quickly enough.

Right after the hearing, he asked the Secretary of Health and Human Services to appoint a watchdog to oversee group purchasing in health care.

In a new report issued July 16, the General Accounting Office (GAO) found that although GPOs had adopted codes of conduct, the codes weren’t uniform, and some had clauses that could limit their effectiveness.

GPOs tout progress

Executives for Premier Inc and Novation told the senators about steps they have taken.

On physician preference items, Premier Inc’s chairman and CEO, Richard Norling, said the alliance now has multisource contracts with no commitment levels or bundling. Neurosurgery products, which were previously grouped, have been separated into 11 categories, for instance.

Norling said Premier has brought in outside organizations, including the respected nonprofit ECRI to help assess new technology.

A Premier spokesman told OR Manager that the GPO will be looking at unbundling a number of contracts, including those in the surgical area.

Mark Mckenna, head of Novation, said that among changes his organization has made is not to have sole-source contracts unless there is no alternative and the contract is approved by a clinical council. For example, for safety needles and syringes, Novation has expanded from one vendor to four.

But a small-company executive, Salid Hilal of Applied Medical Resources Corp, which makes trocars and other minimally invasive surgery products, charged GPOs essentially act like “commissioned sales representatives” for dominant companies, and “freeze out” small companies like his.

Hilal noted, however, that Novation had recently agreed to entertain a bid from his company after previously refusing.

Periop council aids in review

Novation’s perioperative council has taken several steps since the GPO adopted new operating principles last year, said Zee Robertson, Novation’s senior director for the surgical service line, in an interview with OR Manager. The 19-member council is made up primarily of perioperative nurses representing member hospitals.

The council has reviewed the entire surgical services contract portfolio to identify “clinical preference” items, Robertson says. Clinical preference items are those that meet a specific definition, including being used in direct patient care.

“For clinical preference items, most often, we want a dual or multi-source agreement to give clinicians more selection,” she says.

As part of opening up the process to new technology, the periop council has added ten products from seven companies, including four from Applied Medical Resources.

Novation has also set up an online technology forum where vendors can post information about new products.

In October, the periop council plans to take a look at Novation’s only major bundled contract for surgical products, which is for sutures and endomechanical devices, to see if it should be taken apart.

Bundling is rapped

Some question whether unbundling contracts for sutures and endomechanical devices makes sense. There are only two major vendors, and dual sourcing would be unlikely to provide as good a price.

But bundled contracts have raised eyebrows among GPO critics. Such contracts combine an array of products in a single package.

Customers who agree to buy the bundle get a discount on all of the products in the package. Bundled contracts are the most controversial when they involve a variety of unrelated items from a single manufacturer.

Critics say bundling stifles competition because it can give one manufacturer a major share of the market and close out others, particularly smaller vendors.

The government is extending its scrutiny of bundling to some companies that do business with GPOs.

Connecticut’s attorney general, Richard Blumenthal, told the July 17 New York Times his office had subpoenaed Johnson & Johnson for information on the way it markets sutures and endomechanical devices. He also said several other companies are being examined but declined to name them. The intent is to see if bundling violates antitrust statutes and fraud and abuse regulations.

Johnson & Johnson has said it does not consider the contracts anticompetitive.

The GAO’s new report says bundling may be declining. The report examined practices of seven national GPOs, including Premier Inc and Novation. For one of the two (not identified), single-manufacturer bundled contracts made up about 40% of its med-surg purchasing under contracts...
in effect Jan 1. But the GAO found interest in bundling was on the wane.

**Why is bundling an issue?**

“The problem is, it’s a good deal for a big company, but it’s bad for small manufacturers,” Lynn Everard, a health care supply chain consultant, told *OR Manager*. Everard testified at the hearing as a critic of GPOs.

“When these deals get made, the dominant manufacturer wants to lock up business by bundling its products in a contract. The smaller manufacturer that doesn’t have a broad product line but has a better price won’t get used in those hospitals.

“If the GPO believes everything is equal,” he added, “it will award the contract on the basis of the bundle that produces the most fee revenue for the GPO. A small company doesn’t have the wherewithal to pay that much in fees.”

If smaller companies have trouble competing, that could stifle innovation.

“More competition is what we need to get prices down,” he argues.

Everard would like to see Congress take one of two actions:

- Eliminate the safe harbor for health care GPOs. The safe harbor was set up by Congress under the federal antikickback statute to protect GPOs receiving fees from contracted vendors. GPOs also operate in an antitrust “safety zone” granted by the government in 1996.
- Set up oversight of GPOs with rules for their business practices and penalties for violations.

Everard also would like to see more hospitals declare their independence from GPOs. He contends hospitals actually can save more by contracting independently than they can with GPOs. Everard and his associate, Patti King, have set up the nonprofit Foundation for Healthcare Integrity (www.healthcareintegrity.org) to work for group-purchasing reform.

*The GAO report is at www.gao.gov*

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*OR Manager* is offering a new option—the “super subscription.” You can continue to receive the print version of *OR Manager* every month, plus an early electronic version, which will be available on the *OR Manager* web site, www.ormanager.com 2 to 3 weeks before your print copy.

You will also have access to *OR Reports*, our monthly review of the latest studies on the OR environment, and regular e-mail bulletins with news you need. The price: $129 a year.

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Please see the ad for SKYTRON, INC. in the OR Manager print version.
Hospitals to get bonuses in new Medicare demo

Hospitals belonging to Premier Inc will be able to get higher Medicare payments if they meet quality measures for five conditions—acute myocardial infarction, heart failure, hip and knee replacement, pneumonia, and coronary artery bypass graft (CABG).

The voluntary 3-year pilot project announced in July is a partnership between Premier, a group purchasing alliance, and the Centers for Medicare and Medicaid Services (CMS).

Premier expects about 300 hospitals will participate.

Hospitals will be scored on quality measures for each condition. Premier will track performance through its online database called Perspective.

Hospitals in the top 10% for a given condition will receive a 2% bonus from Medicare. Hospitals in the second 10% will receive a 1% bonus.

There would also be penalties in the third year for poor performers. A baseline will be set at the bottom two percentiles after the first year. Hospitals that fall below that in the third year would have Medicare payments cut. CMS does not expect that to happen because it expects hospitals at the bottom to improve at least above the baseline level.

Data from the participating hospitals will be published on the CMS web site.

If the pilot is successful, CMS could propose expanding it to all hospitals, but that would require action by Congress.

The quality indicators for surgical conditions in the demo are:

**Coronary artery bypass graft**
- Aspirin prescribed at discharge
- CABG using internal mammary artery
- Prophylactic antibiotic received within 1 hour prior to surgical incision
- Prophylactic antibiotic selection for surgical patients
- Prophylactic antibiotics discontinued within 24 hours after surgery end time
- Inpatient mortality rate
- Postoperative hemorrhage or hematoma
- Postoperative physiologic and metabolic derangement

**Hip and knee replacement**
- Prophylactic antibiotic received within 1 hour prior to surgical incision
- Prophylactic antibiotic selection for surgical patients
- Prophylactic antibiotics discontinued within 24 hours after surgery end time
- Postoperative hemorrhage or hematoma
- Postoperative physiologic and metabolic derangement
- Readmissions 30 days postdischarge
- Discharge to home/home health ✦

Please see the ad for ECRI in the OR Manager print version.
**Technology in Surgery**

**Is it time to add a robot to your team?**

*R* obotic surgery has moved from fiction to fact, and surgeons’ interest is growing.

Is it time to invest?

Though the technology shows significant potential, surgical robotics is in its infancy, and widespread use of true robotic surgery is probably years away. Even hospitals with sufficient capital can’t yet justify the $1 million or so required to purchase a telemanipulation surgical robot, such as the daVinci or Zeus.

For most facilities that are interested in getting into robotics now, the first step is likely to be the less sophisticated “surgical-assist” robots. Surgical-assist robots are sufficiently developed and affordable for a typical hospital to consider. The most common type of surgical-assist robot is the robotic endoscope holder, which holds and positions an endoscope during minimally invasive surgery (MIS). An example is the Aesop 3000 from Computer Motion, which ECRI evaluated recently. Robotic endoscope holders typically cost less than $125,000 compared with more than $1 million for telemanipulation surgical robots.

Because telemanipulation systems are expensive, have limited application, and so far have shown little if any benefit over manual surgery, these systems probably are more suited to large teaching hospitals that want to train surgeons who will eventually have access to improved technology.

For most hospitals at present, in ECRI’s view, the success of surgical-assist robots is mainly in helping to build a safety record for robotics in general and in allaying concerns about robotics. For now, it is unrealistic in most cases to expect more tangible outcomes, such as eliminating a staff position or significantly boosting revenue. More likely, a robotic endoscope holder will allow occasional reassignment of a surgical assistant to other duties. Whether a robotic endoscope holder could help increase revenue depends on whether the facility could expand its patient base. This might be possible if the facility could increase its volume of endoscopic procedures, especially cardiac procedures. This offers some potential for offsetting the cost. But whether the robot can actually pay for itself depends on how successful a facility is in marketing its use. ECRI has heard of situations where robotic endoscope holders were purchased but quickly relegated to the supply closet, either because the surgeons were not interested in the technology or did not feel it offered sufficient clinical advantages.

These are some questions to ask if your facility is considering a surgical-assist robot, such as the robotic endoscope holder.

**Are the facility’s surgeons interested in exploring the surgical application of robots?**

Many surgeons believe robots will shape the future of surgery, and interest has increased tremendously. Because most hospitals can’t afford to invest in an advanced robotic system, a robotic endoscope holder may be a good first step. Using a robotic endoscope holder allows surgeons to overcome the novelty and challenge of operating with robotics.

**Will the robot help the facility perform new types of MIS procedures, or will it significantly improve procedures the facility already performs?**

Though robotic endoscopic holders offer performance that is in many ways superior to that of a human scope holder—they hold the scope steady, respond precisely to the surgeon’s commands, and don’t get tired or bored—most endoscopic procedures can be performed without these devices.

A robotic endoscopic holder may, however, allow facilities to perform procedures that are extremely difficult if not impossible to perform with a human scope holder. Examples are:

- endoscopic coronary artery bypass graft (e-CABG)
- laparoscopic radical prostatectomy.

The e-CABG requires the scope to be very close to the surgical site and the image to be greatly magnified. This requires an image stability a human assistant cannot achieve. The e-CABG currently is the “holy grail” for surgical robotics because of the high reimbursement margins for cardiac surgery. But endoscopic surgery still is limited to single vessels. And despite the good reimbursement, there is no additional payment for a robot. So a facility would need to be sure the extra cost of the robot would not consume the margin.

There also is a learning curve for e-CABG, though the learning curve is not as great for using a robotic endoscope holder as it is for learning to operate a telemanipulation system, particularly if the surgeon is already accustomed to endoscopic surgery. During the learning phase, it is not unusual for any type of robotic surgery to take twice as long as the same operation performed using standard open or endoscopic techniques.

Further complicating the picture is the Food and Drug Administration’s recent approval of drug-eluting cardiac stents, which may reduce the overall volume of CABG surgery. Though robotics could really shine in cardiac surgery as well as in other types of surgery, it’s too early to know whether the potential will pan out.

For laparoscopic radical prostatectomy, the advantage of the Aesop robotic endoscope holder that ECRI evaluated is to provide extra room for the surgical team. The robot’s small footprint gives the surgical team more space to maneuver. Though that many be true for the telemanipulation systems as well, ECRI has not examined those systems.

Facilities performing e-CABG or laparoscopic radical prostatectomy

Continued on page 32
Please see the ad for CENSIS TECHNOLOGIES INC. in the OR Manager print version.
could benefit from purchase of a robotic endoscope holder, though ECRI still encourages facilities to do their homework before making a purchase. Facilities may also benefit if they frequently perform long endoscopic procedures where fatigue is a factor. But unless a facility can answer “yes” to both of these questions, the purchase of a robotic endoscope holder probably will not be justified at this time.

—Dan Alt
Health Devices Group
ECRI, Plymouth Meeting, Pa

Dan Alt can be reached at dalt@ecri.org

ECRI, a nonprofit organization sometimes called the Consumer Reports of health care, is known for its objective approach to medical device evaluation. Visit www.ecri.org or phone 610/825-6000.

Workplace

Awards given for quality care

Three hospitals and a health system have been honored for leadership and innovation in quality, safety, and commitment to care.

Abington Memorial Hospital in Abington, Pa, won the top prize of $75,000 in the American Hospital Association’s American Hospital Quest for Quality.

Two other finalists, Beaumont Hospitals in Royal Oak, Mich, and the University of Wisconsin Hospital and Clinics in Madison, each received $12,500.

The common focus of the winning facilities was a culture of safety and a blame-free environment where reporting of errors is encouraged and facilitated among staff, patients, and families.

The awards are supported by grants from the McKesson Corporation and Foundation.

—www.aha.org/questforquality

Shorter work hours for residents costing millions

New rules by the Accreditation Council for Graduate Medical Education that limit work hours for residents will cost teaching hospitals millions of dollars a year. The increased costs come from hiring additional personnel to cover hours residents are no longer allowed to work, according to the July 10 Chicago Tribune.

Effective July 1, residents work hours fell from 130 or more hours to about 80 hours a week. The rules also require residents to have 10 hours of rest between daily work hours and being on call.

Chicago’s Northwestern Memorial Hospital is expected to spend more than $5 million a year in additional staff and hospitalists, who care for patients while in the hospital.

The University of Chicago Hospitals expect an additional $3 million in costs each year to make up for lost resident time. The biggest single cost comes from personnel such as nurse practitioners and operating room nurses who serve as surgical assistants, according to the hospital’s vice president for planning.

—www.chicagotribune.com

Please see the ad for OLYMPUS ENDOSCOPY in the OR Manager print version.
Please see the ad for PERIOPTIMUM in the *OR Manager* print version.
Almost every month, a surgical specialty meeting is held somewhere in the US. Surgeons come back, and soon you find a request for new equipment on your desk. Or you may find the equipment has already been ordered, and the surgeon has plans to use it as soon as it arrives. And, by the way, the surgeon needs a company representative in the OR to provide advice as he begins using the equipment.

Ambulatory surgery centers (ASCs) have close relationships with industry representatives, and they depend on each other. Surgeons and nurses rely on reps for their expertise in the equipment they sell. Reps obviously depend on physicians and ORs for their sales.

For the most part, these relationships are positive and supportive. But there also need to be clear boundaries. With the technology explosion and concerns about patient privacy and safety, surgery facilities are taking a more proactive approach to their relations with vendor reps. They are developing policies and procedures to clearly define sales reps’ roles in the facility and specify how their presence will be authorized and their activities governed.

“It’s important to point out to physicians that they need good policies to protect themselves and the facility. Policies are important to minimize the center’s liability and protect the investors,” points out Nancy Jo Vinson, RN, BA, CASC, director of clinical operations for Acumen Healthcare, Dallas. Vinson spoke on the topic at the 5th International Congress on Ambulatory Surgery in May in Boston.

High-profile cases

Some notorious incidents have pointed out the need for good policies. In one high-profile case in 1997, a young woman died at Beth Israel Medical Center in New York City after what should have been a routine hysterectomy. The procedure was performed with a new device investigators said hadn’t been properly introduced into the facility. There were initial reports that a sales rep might have operated the device’s controls, but a state panel later found no evidence that he operated the equipment and said his presence did not affect the care the patient received.

More recently, the Guidant Corporation pled guilty in June to 10 felonies and agreed to a $92 million fine to settle charges over thousands of incidents in which its abdominal aortic aneurysm graft’s delivery system malfunctioned. In some cases, when the delivery device became stuck, to avoid an open procedure, sales reps instructed the surgeons how to free the device by breaking the handle and removing it in pieces, even though this technique had not been tested, and neither the doctors nor the reps had been trained on its use. In some cases, patients died. Patients have filed lawsuits.

Strike a balance

The ASC’s administrator and medical director should be involved in drafting the policies, getting buy-in from the physicians, and educating the physicians and nurses about the expectations. Policies should strike a balance between the legitimate role a sales rep can play in technical support and education and the ASC’s concerns for patient safety, privacy, and risk management.

Two good resources for developing policies are statements from the American College of Surgeons (ACS) and Association of periOperative Registered Nurses (AORN) approved in 2000. A self-learning module for sales reps is available from ECRI, a nonprofit organization that assesses health care technology (sidebar).

Accrediting bodies consider observers in the OR to be primarily an issue of patient privacy and confidentiality.

The Joint Commission on Accreditation of Healthcare Organizations says
Please see the ad for SURGICAL INFORMATION SYSTEMS in the *OR Manager* print version.
It’s not good enough to have a casual statement on your consent form.

patients have a right to privacy and should be asked to give their consent if observers will be present during their procedures.

The Accreditation Association for Ambulatory Health Care (AAAHC) does not address vendor relations directly, but its standards say patients’ privacy and confidentiality will be protected. AAAHC’s surgical services standards say that only authorized persons are allowed in the surgical area.

HIPAA and sales reps

Sales reps’ presence is a gray area under the privacy rule of the Health Insurance Portability and Accountability Act (HIPAA). The issue has yet to be addressed by the government in any of its HIPAA guidances.

Amy Fehn, an attorney with Wachler & Associates, Royal Oak, Mich, which consults on HIPAA, advises ASCs that the best approach is to:

• carefully define the reasons why sales personnel need to be present during patient care
• have patients sign an authorization if a sales rep will be present during their care.

A patient authorization is a specific document required under HIPAA when a person’s protected health information will be disclosed for purposes other than treatment, payment, or health care operations. At the very least, ASCs should require sales reps to sign a confidentiality agreement, Fehn says. In her opinion, a business associate agreement doesn’t fit the situation because sales reps who observe surgery aren’t providing a service to the center. Under HIPAA, business associates are parties who are exposed to patient information while providing a service on behalf of a covered entity; examples are lawyers, accountants, and billing firms.

Another HIPAA expert, Robert Tennant of the Medical Group Management Association, says the issue hinges on whether sales personnel will have access to patients’ protected health information. For example, the surgeon says to the rep before a procedure, “We are performing a hysterectomy on Mrs Jones today.”

“That clearly is disclosing protected information,” says Tennant. “Prudence would dictate that you should either have the rep sign a business associate agreement if they are performing a service with the patient’s information for the ASC or a confidentiality agreement.”

On the other hand, if the rep only provides in-service education and is not exposed to patient information, Tennant advises that a business associate agreement probably isn’t necessary but a confidentiality agreement would be wise. “That would put the rep on notice that any incidental exposure to patient information must be protected,” he says.

Review state law

Your state may have specific regulations pertaining to patient privacy and observers in the OR. You need to know what the state law is because a state law may take precedence over HIPAA or other federal regulations.

What areas should the policy address?

These are specific areas that should be addressed in a vendor relations policy.

Define vendors’ roles

The policy should spell out company representatives’ role in the ASC, such as to provide in-service education and technical assistance. AORN’s statement advises that reps should not scrub in on cases. Regarding equipment, AORN says reps “with specialized training may perform remote calibration to adjust devices to the surgeon’s specification,” such as pacemakers or a laser.

“But it should be not the other way around—they don’t tell the surgeon what he needs for specifications,” Vinson cautions. “The surgeon should have enough knowledge about the equipment to give the sales rep directions, not vice versa.”

Sales reps should attend only to equipment of the company they represent and should not operate or troubleshoot equipment made by other vendors.

Define the approval process

The policy should spell out the process for authorizing sales personnel to be in the facility and in the OR. Among issues to consider:

• How far in advance approval should be sought. AORN recommends both the reps’ presence and purpose for being there should be determined in advance.
• A requirement for an identification badge with the rep’s name and company
• The person in the ASC who is authorized to approve sales reps’ presence and ensure compliance with policies
• Sanctions if the policy is violated. For example, if there are repeated violations, the policy might say that the company will be contacted, and the rep will no longer be allowed at the facility. If a physician continually violates the policy by bringing reps
Please see the ad for TRUMPF MEDICAL INC. in the *OR Manager* print version.
Resources on vendors in OR

American College of Surgeons
312/202-5000
www.facs.org
Statement on issues to be considered before new surgical technology is applied to the care of patients. ST-23.
—www.facs.org/fellows_info/statements/st-23.html

Statement on health care industry representatives in the operating room. ST-33.
—www.facs.org/fellows_info/statements/st-33.html

Association of periOperative Registered Nurses
800/755-2676
www.aorn.org


ECRI
610/825-6000 ext 5888
www.ecri.org

Can be ordered as a separate article for $75. Can be photocopied within the same facility.

Continued from page 36
into his or her cases, the policy might state that the matter will be reported to the medical staff executive committee.

Determine qualifications
The policy should define the qualifications and competencies sales reps will be expected to demonstrate before being an observer. AORN recommends developing a system to document that sales personnel have completed instruction in:

• principles of asepsis
• fire and safety protocols
• infection control practices
• bloodborne pathogens
• patients’ rights.

Additional areas might include HIPAA and knowledge of the ASC’s pertinent policies.

There are a variety of ways of accomplishing this, ranging from documenting instruction provided by the sales rep’s company through providing training in your own facility or organization.

“All of these areas should be reviewed with the rep,” says Vinson. At a minimum, reps need to know where the exits are in case of a fire, what a sterile field is and how to avoid contaminating it, how to protect themselves from contact with blood and other body fluids, and how to conduct themselves in accord with patients’ rights.

At facilities Vinson’s company manages, the reps receive a review sheet covering each of these areas. They also are asked if they have completed hepatitis B immunization and had a recent TB test. She finds that for many, this is a company requirement.

Patient consent
The policy should include a requirement that surgeons notify patients and obtain their consent for observers. Or, if your center determines it is necessary to comply with HIPAA, patients could be asked to sign an authorization form acknowledging a sales rep will be present. The consent or authorization form should be included in the patient’s medical record.

Says Vinson, “It is not good enough to have a casual statement on your consent form that says any observer can be in the OR,” which might have been the practice in the past.

Donna Slosburg, RN, BSN, CASC, national surgery specialist for HealthSouth, says its ASCs typically have a consent form signed by the patient, physician, and vendor before a sales rep is present in the OR.

“This way, all parties involved are aware of the vendor’s presence and reason for being in the OR,” she says.

Physicians generally call in advance to let the center know a sales rep is coming because they are aware of the consent protocol.

Documentation
The policy should provide that the sales rep’s presence during a procedure will be documented in the OR record by the circulating nurse. The information also should be documented in the physician’s operative note.

Joint Commission adds core measure requirements

Hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations will be required to gather and use data on an additional set of core performance measures beginning in January.

The new requirement will increase the scope of data collection and reporting from two to three core measure sets.

Hospitals currently can choose from four core measure sets that address acute myocardial infarction, heart failure, community-acquired pneumonia, and pregnancy-related conditions.

New measure sets are expected to become available over the next 6 to 24 months. These will address surgical infection prevention, ICU care, pain management, and inpatient pediatric asthma.

Core measures are part of the Joint Commission’s ORYX initiative aimed at integrating outcomes and other performance measurement data into the accreditation process. The goal is a continuous, data-driven accreditation process focused on results of care.

—www.jcaho.org
Please see the ad for ADVANCED STERILIZATION PRODUCTS in the *OR Manager* print version.
Make clear rules on block scheduling

Q. Block time raises a lot of questions at our facility. We'd like your advice on these issues: What should we require for block time utilization by our surgeons? How often should block time be adjusted? What should our release time be for block time that is not scheduled? Also, what are your suggestions for adjusting block time of surgeon owners who may not be utilizing their block time at the expected level?

A. As a company, we deal with many surgeons on a day-to-day basis, and we ask them questions. The responses, more often than not, lead to opportunities. We currently have about 4,500 surgeons in our database whom we have formally interviewed. Each interview is held one on one and in private, so we are pretty confident we are getting accurate feedback. This data has proven to be very helpful in designing programs around what surgeons are looking for in surgery, both inpatient and outpatient.

For this column, we tapped into our databank for information on block booking. Of the 4,456 surgeons in our databank, 38% like it, want it, and say they cannot survive without it. Another 35% percent hate it, never want to deal with it, and would draw blood to avoid it. An additional 15% want some sort of combination of block booking and first-come, first-served; 10% could care less either way; and 2% admirably evaded answering the question.

Booking a table

With that in mind, let's look at the block-booking dilemma. I like analogies to life situations.

Block booking is essentially a reservation. Let's say you are going to dinner on Saturday night, and you don't want to wait for a table. You call ahead and reserve—block book—a table. Your evening is pretty well planned now. You don't have to worry about rushing around or getting to the restaurant early—you are taken care of.

Conversely, so is the establishment. Their goal is to make money. They can only make money if their tables are full of happy, eating people.

Let's take it a step further. After dinner, you want to celebrate, and you know you just might celebrate a bit much. So you wisely call Holiday Inn Express and make a similar reservation for that night. It is right across the street from the restaurant so you can walk right over there. But unlike the restaurant that so graciously accepted your reservation, the wise people in the hotel business would like you to back up your reservation with a credit card.

"Not a problem," you tell them as you roll out the numbers of your card. "Just be sure you cancel this before 6 pm, or we will charge you for the room," the voice from the hotel says.

"As if that will happen!" you quip back.

The day unfolds, and you spend time working in the yard, dealing with kid issues, and about 6 pm you look at your spouse and you both come to the same conclusion: "I'm too tired to go out. Why don't we order a pizza and stay in?"

"Great idea!"
And so it goes.
"Should I call the restaurant and cancel our reservation, honey?"
"Naw, they deal with that all the time. They know people won't show up. Not a problem."
"Exactly. What can they do anyway?" you say, chuckling.
"What about the hotel room?"
"Oh, yes," you say, jumping off the couch. "Get them on the phone right now—tell them we had an emergency, and we have to cancel the room for tonight. Hurry, it's almost 6 o'clock, and they will charge my credit card if we don't cancel right now."

Run it like a business

So is your surgery center a restaurant or a hotel? If you book an airline flight and don't show up, you still paid for the ticket. Most car rental companies now charge for "no shows" as well.

Please tell me the difference between a surgery department and these examples. If you are going to use block booking for elective, nonemergency scheduled cases, you need to run it like a business—because that is what it is.

If you are a surgeon, and you tell me you are going to fill an operating room for 5 hours every other week, then you had better do it because your "reservation" prevents me from letting someone else use that time to pay my staff who are hanging around waiting for their paychecks.

"But," you say, "I filled 3 hours of my slot!"
"Great, you say. Then I only have to pay three fifths of my expenses? I don't think so!"

Set clear rules

If you are going to block book, you need rules. Make them exceedingly clear. Remember, your surgeon is your client. But also remember you need revenue to survive.

I personally like the first-come, first-served way of booking cases, but I can objectively see both sides of the issue.

Set a limit on the blocks. For example, during any one quarter (or month or week; you choose the time frame), the surgeons' block will be for only the number of hours the block was used during the previous period. Say the surgeon used only 75% of the time allocated; therefore, his or her time has been reduced by 25% for the next period.

Always keep at least one operating room "off book," so when surgeons actually do go over their time, they can book their other cases on a first-come, ...
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first-served basis in the nonblocked room.

As a facility that wants to be successful, you need to make sure your operating rooms stay full. Have a cut-off point for booking every block. You know your center or department better than anyone else, but a common practice is to say that if a block is not full 3 business days before the day of surgery, you have the option to reduce the block time or eliminate it completely. Yes, people will get mad at you over this—but they get mad at you anyway so why not do it over something that is good?

The surgeon owner

If the surgeon is a partner in the facility, he or she has a vested interest in the utilization of the facility. Thus, the surgeon should be willing to adjust the block so it is more in line with actual usage. If the individual isn’t amenable to self-adjust the time, I would add an item to the agenda for the next meeting of the partnership entitled “Block time utilization by physician.” If that doesn’t do it, or if the other partners don’t seem to care about it, then let it go and find other issues to focus on.

—Stephen W. Earnhart

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Earnhart & Associates has benchmarks from hundreds of facilities across the country. To find out how to receive free benchmarks, visit www.earnhart.com

If you’d like to submit a question for the column, please e-mail it to ppatterson@ormanager.com.

On-line continuing education in OR and anesthesia management

Franklin Dexter, MD, PhD, is offering educational modules on using OR and anesthesia information system data to enhance managerial decision making for:

• OR staffing and block time allocation
• OR financial assessment for strategic decision making
• anesthesia staffing to increase productivity and reduce costs
• economics of anesthetic drugs and supplies.

The course web site is at www.FranklinDexter.net. Slides and synchronized audio are also available on CD. Credit is available from the University of Iowa Carver College of Medicine. For information, e-mail Franklin-Dexter@uiowa.edu.

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What leads to surgeons’ errors?

Inexperience and lack of competence, communication breakdowns, and fatigue or excessive workload are the most common system factors leading to errors by surgeons, according to confidential interviews with 38 surgeons from three Massachusetts teaching hospitals who reported on 146 incidents.

More than 30% of the incidents resulted in permanent disability and 13% in patient death. A total of 77% of the errors involved injuries related to a surgical or other invasive procedure, 13% involved unnecessary or inappropriate procedures, and 10% involved unnecessary advancement of disease. Two-thirds of the errors occurred intraoperatively, 27% preoperatively, and 22% postoperatively.


Device harvests patient’s own stem cells for spinal fusion

A new minimally invasive surgical device allows surgeons to harvest and use a patient’s own stem cells for spinal fusion surgery.

The new technique (Cellect, DePuy AcroMed, a Johnson & Johnson Company) uses a needle to collect bone marrow cells from the hip area and then processes the cells so they can be grafted onto the spine.

Bone harvesting for spinal fusion is traditionally performed through a 3- to 5-inch incision. More than a fourth of patients continue to feel pain in the hip area up to 2 years after harvesting surgery.

The new technology, developed in collaboration with the Cleveland Clinic Foundation, allows surgeons to selectively control or increase the population of bone-forming cells in a region where new bone tissue is needed.

—www.jnj.com

Rings increase risk of hand contamination

Ring wearing was associated with a 10-fold higher median count in skin organisms in surgical intensive care unit nurses. Risk of contamination increased with the number of rings worn in a study from the Centers for Disease Control and Prevention in Atlanta and Cook County Hospital and Rush Medical College in Chicago.

Researchers also compared hand hygiene agents used by the nurses and found that hand contamination with any transient organism was significantly less likely after use of an alcohol-based hand rub compared with plain soap and water, but not after use of a medicated hand wipe.


Patients adding pounds to qualify for surgery

Patients who fall short of the pounds needed to qualify for weight-loss surgery are eating more to gain pounds.

Desperate patients turned down for the surgery are returning to their doctors weeks or months later after intentionally gaining 10, 15, or even 25 pounds to qualify.

This new phenomenon is one reason that the American Society for Bariatric Surgery (ASBS) decided to hold a major conference next spring to re-evaluate guidelines for who qualifies for the surgery, according to the July 8 Wall Street Journal.

Presently to qualify, a patient must be at least 100 pounds overweight or have a body mass index of at least 40. Surgeons say the guidelines for bariatric surgery need to be re-evaluated because severely overweight patients inevitably will develop serious problems even if they aren’t yet 100 pounds overweight.


Hospital web sites feature live surgery

Taking reality programming to a new level, hospitals are beaming surgeries—from tummy tucks to open-heart repairs—live to the public on their web sites.

Live web casts of surgeries are used to educate doctors promote the hospital’s name, and generate business, according to the July 16 Boston Globe.

For Brigham and Women’s first live web cast, the chief of surgery narrated the action from the next room so the surgeon could focus on the surgery. Questions e-mailed to the hospital by the viewers were answered out loud by the narrator.

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