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Recruitment & retention

New research looks at ergonomic stresses on operating room staff

Transferring a large patient to a gurney. Pushing a video cart. Donning a lead apron during a case. Scrubbing in for a long procedure. Wearing a helmet in orthopedic surgery. They’re a normal part of an OR staff’s day. They also take a toll on necks, shoulders, and backs.

This heavy physical work is getting more attention as a staff retention issue. More than half—52%—of nurses complain of low-back pain, according to researcher Audrey Nelson RN, PhD, FAAN, of the Patient Safety Center of Inquiry at the Veterans Affairs Medical Center in Tampa, Fla. A study by Trinkoff and colleagues found 47% of nurses in a sample had a back injury and 46% had a neck injury within the past year. Hospital nurses had the third highest injury rates of all workers, following only nursing home workers and truck drivers, in a 2000 report from the Bureau of Labor Statistics.

At that rate, you have to wonder how many nurses leave the profession because their body simply can’t take it any more. It’s a toll the profession can ill afford.

What can OR leaders do to keep employees from suffering musculoskeletal injuries? OR Manager talked with ergonomics researchers in the US and Europe about the most recent findings and strategies to prevent injuries.

Static posture a problem

New research from The Netherlands is providing some specific data on the physical stresses on OR staff.

Standing in one position for long periods is the biggest problem, the research shows. Static load—due to pro-

Joint Commission

Will you be ready for JCAHO’s unannounced surveys in 2006?

Preparing for a survey by the Joint Commission on Accreditation of Healthcare Organizations is almost a thing of the past. Starting in January, the accrediting body will move to unannounced surveys.

The intent is to encourage continuous compliance with the standards. “This is not something you can prepare for—you prepare to care for patients every day,” said JCAHO’s president, Dennis O’Leary, MD, speaking at the Association of periOperative Registered Nurses Congress in April in New Orleans.

2006 Patient Safety Goals, page 10

One of the best ways to always be ready is to practice using JCAHO’s tracer methodology. Most of the on-site survey is driven by the tracer process. There may be 8 to 12 tracers in a survey, occupying 50% to 60% of the surveyors’ time, notes Dr O’Leary. In a tracer, surveyors select a patient and use the patient’s record as a roadmap to move through the organization, checking on standards compliance and the overall system for...
Please see the ad for
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in the OR Manager print version.
Taming the chargemaster

Experts share strategies for charging for OR time and supplies.

Conflict-of-interest policies

Learn what your colleagues require from physicians and administrators.

Editorial

Here’s one of the best ideas we’ve heard in a long time—a National Nurse.

Teri Mills, RN, MS, ANP, says she came up with the idea after she asked several people in the supermarket if they could name the Surgeon General or describe his role. No one could. (He’s Richard H. Carmona, MD, and his biography says he has worked as a registered nurse, though he does not use that credential.)

Meanwhile, another Nurses Week had come and gone without much effect. Nursing continues to suffer an image problem. And estimates are that there will be a shortage of 400,000 nurses by 2020.

Mills, an instructor at Portland Community College in Portland, Ore, thinks an office of the National Nurse could do a lot to advance the nation’s health and, in the process, heighten the profession’s visibility. With nursing’s high level of public trust, she thinks a National Nurse would be able to connect with the average citizen.

“Here’s why,” she advocated in a May 20 opinion piece in The New York Times. “Prevention is the best way to lower health care costs. If people take care of themselves and don’t get sick . . . well, you know the rest. And who better to educate Americans on how to take better care of themselves than nurses?

“It’s the nurse whom the patient trusts to explain the treatment ordered by a doctor. It is the nurse who teaches new parents how to care for their newborn. It is the nurse who explains to the family how to comfort a dying loved one,” Mills wrote.

A weekly health address

Here are some things she’d have a National Nurse do:

• Highlight health education through 15-minute weekly programs that would also be available on the Internet.
• Help teachers spread the word about good health through downloadable lesson plans.
• Promote a National Nurse Corps to enhance health in the nation’s communities.
• Promote legislation for a healthier nation.
• Give public recognition to the work nurses do every day.
• Help stem the nursing shortage by

A National Nurse could advance the nation’s health.

attracting people to the profession.

Mills says she takes her inspiration from Florence Nightingale.

“She was the first political activist in nursing. She got into those smoke-filled rooms and asked for bandages during the Crimean War. She’s always been my role model. I think we need to take a stand for the nation’s health,” she says.

The response to the opinion piece has been “overwhelmingly positive,” Mills told OR Manager in an interview, noting that it was selected from among about 1,200 The Times receives weekly.

“I knew that once nurses heard about it, they would love the idea,” she says.

You can read more and sign a petition calling for a National Nurse at Mills’s web site, www.nationalnurse.info.

—Pat Patterson

Nurses at War archive seeks stories

Nurses who served during armed conflict are urged to submit their stories to an archive being developed at Brigham Young University in Provo, Utah. Nurses also are invited to contact the archive if they did not personally serve but have accounts and memorabilia of others who did.

Contact Patricia_Rushton@byu.edu or phone 801/422-5375 for more information. Some nurses’ stories are on the project’s web site at http://nursing.byu.edu/nursesatwar.

An apology

To those who received our Career/Salary Survey without a postage-paid envelope, we apologize for the inconvenience. Results of the survey will be published in the September and October OR Managers.
Please see the ad for

MEDLINE INDUSTRIES, INC.

in the OR Manager print version.
Link seen between OR schedule, safety

Is there a connection between nurse staffing, patient safety, and the elective OR schedule? A new article argues there is. The authors, Eugene Litvak, PhD, of Boston University, et al, say variation in the elective schedule can lead to peaks in patient census. Because hospitals today staff to their average demand, when admissions surge, nursing units can be understaffed. For example, say more surgeons have block time on Wednesday than on other days of the week. These additional patients may generate demand above capacity, causing downstream problems. A nurse on a postop unit might have 5 or 6 patients to care for rather than the average of 4, for instance.

Research has shown inadequate staffing is linked to adverse outcomes. One study estimates that for each additional surgical patient assigned to an RN above the level of adequate staffing, mortality increases by 7%. The report by Linda Aiken, RN, PhD, was published in JAMA (Oct 23-30, 2002; 288:1987-1993).

Litvak notes there’s also a link between sentinel events and staffing. Inadequate staffing contributes to 24% of all sentinel events in hospitals, according to the Joint Commission on Accreditation of Healthcare Organizations. Morale also suffers.

In sum, “a fundamental cause of error and injury in health care is stress, which appears in turn to reflect variation in caseload,” says Litvak, writing in the June Joint Commission Journal on Quality and Patient Safety. Litvak has published several articles on patient flow.

His coauthors are other heavyweights: Peter Buerhaus, RN, PhD, of Vanderbilt University, the leading researcher on the nursing workforce; Donald Berwick, MD, leader of the Institute for Healthcare Improvement; and 3 other physicians.

“Operational dysfunction”

Conventional wisdom says patients who come in through the emergency department cause most of the variation in caseload. But Dr Litvak’s work has demonstrated that the elective surgical schedule is equally responsible. (See November 2003 and December 2004 OR Manager.)

“This variation in the OR schedule is one of many examples of artificial variability that routinely produce severe operational dysfunction—both waste and stress—in all health care delivery organizations,” the authors say.

Reducing peaks and valleys

“By smoothing—reducing peaks and valleys in patient demand—hospitals can reduce many of the stresses needlessly placed on its nursing and other staff,” the authors say. This would also improve patient safety and quality of care.

They add that proper assignment and use of block times are keys to smoothing the elective surgical volume and thus easing stress on the system. But that is a highly sensitive and political issue, they acknowledge. Surgeons often organize their lives around their block time. Therefore, any decisions about block time need “to be data driven rather than emotionally driven,” the authors say. One hospital that smoothed the flow of elective cases is Boston Medical Center. (A case study, adapted from the December 2004 OR Manager, is published with the article.)

What to do?

The authors advocate “aggressive research” on all forms of “artificial variation” and pilot programs to test operation changes that could reduce system stress and improve flow based on research findings.

“If we fail to adopt such a research and action strategy,” they say, “we are likely to experience not only an unsustainable increase in hospital-related health care spending but also an increase in preventable in-hospital errors.”

JCAHO will hold 3 conferences this fall on managing patient flow and patient safety. Information is at www.jcrinc.com. Look under Education.

Reference

longed standing, trunk flexion, and neck flexion—is the most significant cause of injury in the OR no matter the age of the nurse, Hanneke Knibbe, MSc, RPth, a researcher and consultant with LOCO-motion in The Netherlands, told OR Manager in an interview.

“We did find a lot of musculoskeletal disorders in scrub nurses caused by prolonged standing and awkward positions,” says Knibbe’s colleague, Paul Meijsen, MAH, practical coach and education coordinator of the operating department at Catharina Hospital Eindhoven, The Netherlands.

“It is difficult to change positions when you are scrubbed in. When you look straight ahead with a straight neck, you can’t see the field, and you can’t do your job. So it is a very big problem, and there are no easy answers,” says Meijsen.

Knibbe and Meijsen are completing 3 studies in ORs in 16 hospitals on implementing ergonomic solutions to reduce static load. Among their findings:

• 2 out of 3 nurses stand longer each day than The Netherlands’ guidelines recommend.
• 75% of nurses who are scrubbed were in awkward positions and had flexed necks.
• 62% of nurses had non-neutral positions of the shoulders, and 53% had non-neutral positions of the back in excess of guidelines.

The researchers did not find a relation between injuries and staffing levels or between lifting and injuries. They also found no relation between footwear or standing pads and injuries.

Knibbe reported on the findings at the 5th Annual Safe Patient Handling and Movement Conference in March in St Pete Beach, Fla. The results also will be presented at the AORN World Conference in Barcelona in September and have been submitted for publication.

**Are older nurses at greater risk?**

Knibbe and Meijsen have not found a statistically significant relationship between increased age and injury. In general nursing populations, older nurses with back or neck problems tend to exit the profession, leaving a healthier, younger group.

It stands to reason that age would take a toll. Over time, continuous flexing, bending, and tension on the muscles cause changes. The accumulation of wear and tear over 5 to 7 years causes muscles to tire faster and hurt more often, Knibbe says.

“The younger you are when you enter the profession, the earlier you will have problems,” Meijsen adds.

The question about age and injury is complex, Jamie Tessler, MPH, ergonomics researcher and consultant at the University of Massachusetts, Lowell, told OR Manager. She spoke at the Association of periOperative Registered Nurses (AORN) Congress in April in New Orleans.

“There are studies that show more of a burden on older nurses, but other studies show new workers get hurt the most often. That may be because of isolation, inadequate training, or because senior employees might leave tougher tasks to the new employees,” Tessler says. Few studies have been published on job-related musculoskeletal injuries in the OR.

One thing that does seem clear—juries reported by OR staff are the tip of the iceberg. A show of hands at the AORN meeting indicated the majority thought 50% to 75% of injuries in their department were unreported.

**What can be done?**

What can be done to prevent injuries based on evidence so far?

The solution is in behavioral changes and sound ergonomic thinking by OR managers and staff, Knibbe and Meijsen say.

Hospitals in The Netherlands have adopted guidelines that scrub nurses are not to stand longer than 4 hours a day. “That is a maximum for nurses who want to stay healthy,” says Meijsen. Nurses both scrub and circulate and trade off on cases. He also recommends that scrub nurses take “micro-breaks” during the 4 hours.

“The scrub nurse should sit on a draped stool and look straight ahead for a short while in long cases,” he says. “There are moments in nearly every elective operation during which a nurse can sit, even if it’s only for a minute.”

Sitting even for a short time gives the
Fast facts on ergonomics

- 52% of nurses complain of chronic back pain.
- 38% of nurses have had occupational low back pain severe enough to require a leave from work.
- 12% of nurses have left nursing for good because of back pain as the main factor.
- 6%, 8%, and 11% of RNs reported changing jobs because of neck, shoulder, and back problems, respectively.


Overcoming myths

Managers and staff both need to get past myths about patient handling.

A common misconception is that nurses can lift a lot of weight as long as they lift it the right way. Tessler, in a review of 10 studies that examined the compressive force on the spine of patient handling, found all included tasks that exceeded safe limits set by the National Institute for Occupational Safety and Health—and 6 of the 10 reported tasks that exceeded the maximum acceptable weight limit for 75% of women.

“Plain and simple, patient lifting and repositioning are hazardous work, and many tasks exceed human physiological limits,” she says.

An international review of 63 studies by Hignett found strong evidence that training staff on proper lifting technique had no impact on work practices or injury rates. A multifactorial approach based on a risk assessment program was most likely to be successful.

Injuries on the night shift

Shift work also has an effect on musculoskeletal injuries. When nurses work nights, it takes more effort to do a task, which may result in a higher risk of being injured. Moreover, they may need more time to recover from an injury, says Acacia Aguirre, MD, PhD, medical director of Circadian, Lexington, Mass, a consulting and research firm that helps employers reduce the risks of shift work.

In one study led by Lipscomb, working long hours (>12 hours a day and >40 hours a week) and working other than the day shift were associated with a 50% to 170% age-adjusted rate of musculoskeletal disorders of the neck, shoulders, and back.

Dr Aguirre offered these suggestions, which may help reduce the risk of injuries during off shifts:

- Limit the number of days nurses work in a row to 7 days for 8-hour shifts and 3 to 4 days for 12-hour shifts.
- Nurses should not work more than 12 hours in a row, especially at night.
- If nurses rotate shifts, their schedule should rotate forward from mornings to evenings to nights rather than the reverse because the body adapts better to forward rotation.
- Avoid starting the morning shift before 6 am so the musculoskeletal system gets enough rest before beginning work.

It is a misconception that people eventually adapt to shift work. “The reality is that our bodies never really adapt 100%,” notes Ann Curley, RN, PhD, interim assistant dean at the University of Medicine and Dentistry of New Jersey School of Nursing, who participated in Circadian’s research.

She has completed a study on nurse injury rates that she has used to educate New Jersey legislators. She believes hos-
Ergonomics: Myths and facts

Myths and facts presented by Jamie Tessler, MPH, of the University of Massachusetts, Lowell, at the Association of periOperative Registered Nurses Congress in April.

Myth: Nurses get hurt because they lift improperly.
Fact: “Patient lifting and repositioning are hazardous, and many tasks exceed human physiologic limits,” says Tessler.

She reviewed 10 studies published from 1986 to 2001 that looked at the compressive force on L5-S1 of everyday patient-handling tasks:
• All 10 studies found common tasks that exceeded safe limits set by the National Institute for Occupational Safety and Health (NIOSH).
• 6 of the studies reported everyday tasks that exceeded NIOSH’s maximum acceptable weight limit.

Myth: Manual lifting is more dignified for the patient.
Fact: “What’s dignified about having your shoulder dislocated by the hook method of lifting, as some patients do?” asks Tessler. Studies on patient satisfaction with lifting devices show good results.

Myth: Equipment isn’t needed when a second pair of hands is available.
Fact: “Biomechanical studies of patient handling show that with 2-person lifts, you not only injure one employee but 2—both employees have exposures exceeding safe limits,” she says.

Myth: Workers get hurt because of hobbies at home and/or their own bad habits.
Fact: In studies that have controlled for these variables in a multivariate analysis, these factors do not emerge as contributors to musculoskeletal disorders, Tessler notes.

Myth: The benefits of using lifting devices are unproven and too expensive to consider.
Fact: On the contrary, “there is great equipment on the market,” Tessler says. Studies have shown that facilities that purchased lifting devices, did the proper training, and performed a before-and-after analysis have saved injuries and money.

A study by the Department of Veterans Affairs involving 6 hospitals evaluated results after the purchase of $750,000 in equipment. They recouped their investment in 1 year from savings in workers compensation costs. The researchers projected savings of $5 million over 9 years.

Myth: There isn’t enough scientific evidence to do things differently.
Fact: “We do have evidence that lifting devices significantly reduce the stress on the back to well below safe limits,” says Tessler.

Veterans Affairs
Patient Safety Center
www.patientsafetycenter.com

Web site has a section devoted to safe patient handling with resource guides, an algorithm for safe patient handling, sample policies, and other resources

Ergonomics in Health Care
www.ergonomicsinhealthcare.org

A comprehensive web site supported by a grant from the Occupational Safety and Health Administration has statistics and tools, including many prevention guides developed by universities and other organizations.

New York State Public Employees Federation (PEF)
www.pef.org/healthandsafety/files/patientsafetycenter.html

Publishes an equipment directory, Patient Handling Solutions, which describes lifting and transfer equipment and other helpful tools.

Check our web site for the latest news, meeting announcements, and other helpful tools.
www.ormanager.com
Are there national benchmarks for key OR efficiencies such as delays and cancellations? How does our OR’s efficiency compare with that of other facilities? These are common questions managers ask.

To provide national benchmarking information on OR key performance indicators, OR Manager, Inc., and McKesson Corporation are partnering to offer the OR Benchmarks Collaborative. The collaborative is a web-enabled dashboard that provides facilities with a methodology to measure and benchmark their key performance indicators.

The key performance indicators are:
- prime-time utilization
- start-time accuracy for the first case of the day
- start-time accuracy for subsequent cases
- estimated case-duration accuracy
- cancellation rate on day of surgery
- Supply cost per case for selected procedures

Standard definitions for the key performance indicators have been developed (sidebar).

**Key performance trends**

Participation in the OR Benchmarks Collaborative will be by annual subscription. Subscribers will submit data monthly from their information system to a secure web site, then have online access to data that will show trends for their key performance indicators and benchmark their performance with other facilities.

“As data for these key performance indicators are collected, we will be able to establish national standards or benchmarks for these key indicators,” said OR Manager President Elinor S. Schrader. “This will help health care facilities monitor, assess, and improve OR performance.”

“We will initiate a pilot program this summer and be ready to launch the OR Benchmarks Collaborative in October at the Managing Today’s OR Suite conference in San Diego,” said Tina Foster, RN, CNOR, MBA, vice president, Surgical Services Consulting, McKesson Provider Technologies.

“We are excited about being able to provide OR departments with the ability to improve their efficiencies. The dashboard will alert facilities to actionable areas for improvement and serve as an early warning system to flag potential problems. By improving OR performance, facilities should be able to positively affect the cost and quality of care.”

“Better efficiency will also benefit surgeons by reducing wasted time and increasing their productivity,” Schrader added.

**Web-based seminars**

More information on the OR Benchmarks Collaborative will be available through a series of web-based seminars this summer. Web seminars are scheduled for the following times:
- Wednesday, July 13, 4:00–5:00 pm EDT (3:00–4:00 pm CDT; 2:00–3:00 pm MDT; 1:00–2:00 pm PDT).
- Friday, July 29, 1:00–2:00 pm EDT (noon–1:00 pm CDT; 11:00 am–noon MDT; 10:00–11:00 am PDT).
- Wednesday, August 10, 4:00–5:00 pm EDT (3:00–4:00 pm CDT; 2:00–3:00 pm MDT; 1:00–2:00 pm PDT).
- Friday, August 26, 1:00–2:00 pm EDT (noon–1:00 pm CDT; 11:00 am–noon MDT; 10:00–11:00 am PDT).

To participate in a web-based seminar, please fill out the form on the OR Manager web site at www.ormanager.com. More information about the OR Benchmarks Collaborative is at www.orbenchmarks.com or 303/442-1661, or Tina Foster at tina.foster@mckesson.com or 828/231-8438.

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**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

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**Key performance indicator definitions**

These are working definitions of the key performance indicators used by the OR Benchmarks Collaborative. Using a consistent set of definitions among health care facilities makes data comparisons more accurate and meaningful so benchmarking is more effective.

**Prime-time utilization**
- Prime-time is when all rooms are available for scheduling (eg, 7 am–3:30 pm; 7:30 am–5 pm, etc).
- Utilization equals the number of minutes actually used for patient care plus turnover time divided by the number of minutes available.

**Start-time accuracy for first case of the day**
- Applies to first case in every room with start time before 9 am.
- Start time is when patient is in the room.
- On-time case is +/- 15 minutes of time indicated on the OR schedule.

**Start-time accuracy for subsequent cases**
- Subsequent cases are all cases following the first case of the day in every room.
- Start time is when patient is in the room.
- On-time case is +/- 15 minutes of time indicated on the OR schedule.

**Estimated case-duration accuracy**
- Estimated case duration is the time from patient in the room to patient out of the room plus setup/cleanup time (turnover time).
- Calculated as estimated case time +/- actual case time.
- Accurate means +/- 15 minutes from estimated case time.
- Measurements = 0-15 minutes less/more (accurate); 16-30 minutes less/more; 31-60 minutes less/more; 61+ minutes less/more.

**Cancellation rate day of surgery**
- Percent of cases cancelled after 3 pm on the day prior to the day of surgery.

**Supply cost per case for selected procedures (optional)**

- On-time case is +/- 15 minutes of time indicated on the OR schedule.
Labeling meds is 2006 JCAHO goal

Perioperative departments will be required to have a process for labeling all medications on the sterile field. That is 1 of 2 new National Patient Safety Goal requirements for 2006 issued May 31 by the Joint Commission on Accreditation of Healthcare Organizations.

The 2 new requirements that apply to hospitals, critical access hospitals, ambulatory surgery centers, and office-based surgery facilities are:

- Implement a standardized approach to “hand off” communications, including an opportunity to ask and respond to questions. This is a new requirement under the goal: “Improve the effectiveness of communication among caregivers.”
- Label all medications, medication containers (eg, syringes, medicine cups, basins), or other solutions on and off the sterile field in perioperative and other procedural settings. This is a new requirement under the goal: “Improve the safety of using medications.”

“Do not use” abbreviations

In addition, JCAHO is modifying the requirement for “do not use” abbreviations, which also falls under the communication goal. JCAHO will continue to require use of its 6 official “do not use” abbreviations but will no longer require each organization to identify its own additional 3 “do not use” abbreviations. Failure to substantially eliminate “do not use” abbreviations has one of the highest noncompliance findings during surveys, at 27%. The official list of prohibited abbreviations is at www.jcaho.org. Look under National Patient Safety Goals.

Two requirements are being retired:

- The requirement to remove concentrated electrolytes from patient care units. This requirement will continue to exist in accreditation manuals.
- The requirement to ensure free-flow protection on all general-use patient-controlled analgesia IV pumps. JCAHO says compliance has been over 99%, and manufacturing and availability issues have been resolved.

The total number of goal requirements stays the same. Compliance with the goals and requirements (or acceptable alternatives) is a condition of accreditation.

New hand-off goal

JCAHO explains that there are many types of hand-offs in health care. Examples are nursing shift changes, physicians transferring responsibility for a patient, staff leaving the unit for a short time, and anesthesiologists reporting to postanesthesia care nurses.

The primary objective of a hand-off, JCAHO says, is to provide accurate information about a patient’s “treatment and services, current condition, and any recent or anticipated changes.”

JCAHO lists the attributes of effective hand-offs on its web site. Effective hand-offs:

- are interactive communications that allow for questioning between the giver and receiver of information
- include up-to-date information on the patient
- limit interruptions
- require a process for verifying the receiving of information, including repeat-back or read-back, as appropriate
- give the receiver an opportunity to review relevant historical data about the patient.

The attributes are listed at jcaho.org. Look under National Patient Safety Goals, then Rationale and Interpretive Guidelines.

Labeling of medications

Fatal accidents have happened when medications on the sterile field were not labeled.

Late last year, a 69-year-old Seattle woman died during surgery when a technician accidentally injected her with the skin prep agent chlorhexidine rather than contrast media as indicated, the Institute for Safe Medication Practices (ISMP) reported in a Dec 2 error alert (www.ismp.org). The hospital had decided to switch from brown povidone-iodine to the clear chlorhexidine solution, resulting in 2 look-alike solutions on the sterile field. The mix-up severely injured blood vessels in the patient’s leg at the injection site. In the next 2 weeks, her condition deteriorated, her leg amputated, she had a stroke, and multiple organ failure led to her death, ISMP said.

Less than half of hospitals always label containers on the sterile field, according to ISMP’s 2004 data (chart). That was an improvement over 2000, when 25% reported full labeling, and 24% reported no labeling.

“This still points to an area that needs significant improvement,” ISMP says.

The Association of periOperative Registered Nurses (AORN) planned to have a tool kit on safe medication administration ready in time for its National Time Out Day on June 22. The kit will include a CD, a self-directed learning module, and other resources. Information is at www.aorn.org.

AORN issued a guidance statement on safe medication practices in 2004, which has steps for improving safety. The statement is in the AORN Standards, Recommended Practices, and Guidelines book (phone 800/755-2676) and online at www.aorn.org/about/positions/pdf/7f-safemeds-2004.pdf.

The 2006 JCAHO goals and related information are at www.jcaho.org/accredited-organizations/patient+safety/npsg.htm.
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delivering care and services.

“If you really walk staff through the tracer methodology, it’s an incredible educational experience,” says Michelle Pelling, RN, MBA, of the ProPell Group, Newberg, Ore, who consults on survey readiness.

“It really gives you a better understanding of how well your care processes are working.” She suggests preparing for unannounced surveys by using tracers to drill down into care processes.

“By performing individual tracers on your more complex patients, you are able to ‘stress test’ your processes and determine where you need to improve.”

Two questions to ask in preparing for an unannounced survey, she says:

- Do your policies and procedures support compliance with the standards?
- Where do you need to improve?

The tracer process allows surveyors “to connect the dots” to see how care is actually delivered. “If there’s any kind of a breakdown in the process, it’s pretty apparent,” Pelling comments.

If you stress-test your processes, improve where necessary, and hold the staff accountable for following procedures, most of the time you will meet the standards or other regulatory requirements as a by-product, she says.

“What I like about doing tracers routinely is that it helps you continually evaluate and improve what you should be doing for your patients. Then when the surveyors come, you can say, ‘This is the way we do it here,’” she says.

**Types of tracers**

The 2 kinds of tracers are:

- individual patient tracers
- system tracers.

Individual tracers follow the care of a specific patient. System tracers focus on areas JCAHO knows to be problematic, such as medication management, infection control, performance improvement, and staffing.

**Surveying the continuum**

The tracer process will bring the surveyors to surgical services—perhaps several times—as part of the continuum of care. In contrast to previous surveys, surveyors may come to the surgery department more than once as they follow the care of surgical patients.

“Mock tracers allow you to ‘stress-test’ your processes.”

“They will look for patients who may have gone directly from the emergency department or a critical care unit to the OR as well as those who come for planned or elective surgery,” Pelling says.

**How are tracer patients selected?**

Knowing how JCAHO selects patients for tracers is important because it can help you decide which patients to choose for mock tracers, Pelling notes.

Surveyors will select patients from your organization’s clinical service groups (CSGs), which are patient populations your organization serves. They may also select:

- patients who cross programs, such as medical patients who suddenly require surgery
- patients who have complex surgical procedures and require critical care
- patients who have special communication needs, such as those who don’t speak English or who are aphasic because of a stroke.

**What happens during tracers?**

When tracing a surgical patient, surveyors move through the continuum, typically including the preop unit, the holding area, surgery, postanesthesia care, and the postoperative unit. One typical approach is to start with a patient on a medical-surgical unit and review the medical record, mapping the patient’s course of care through the process. Examples of questions they might ask a surgical patient:

- How was informed consent obtained?
- Is there an advance directive?
- What kind of teaching did the patient receive prior to surgery?
- How is the patient’s pain assessed and documented?

- Did the patient have a history and physical (H&P) on the chart prior to surgery?
- Was the H&P updated as required under PC.2.120?
- When did the anesthesia provider do an assessment, and does the documentation comply with the organization’s policies?
- Were preoperative antibiotics ordered? If so, were they given within the timeframe identified by your organization?
- For equipment used in the OR, how do you maintain this equipment?
- How were you trained to use it?

“If the documentation is flawless, they may have limited questions. But if they question compliance with a standard, say in the preop holding area, they will ask more questions. They may ask to review more records to evaluate compliance with the standard in question,” Pelling comments.

Once in the OR department, surveyors will check for compliance with other standards, as they always have. Examples are security of medications and narcotics, security of gases, sterilization processes, and equipment management and storage. They may ask the staff what they would do in the case of a disaster.

Managing OR fires is likely to come up because it was the subject of a Joint Commission Sentinel Event Alert. “They may ask about the fire triangle and what special training the staff has had to manage a fire in the OR,” Pelling says. “They may ask if you have guidelines for minimizing oxygen concentration under the drapes,” a major hazard for surgical fires. Other fire-related questions may concern education for the staff, surgeons, and anesthesiologists on controlling heat sources and managing fuels.

**Patient safety goals**

Count on the National Patient Safety Goals being surveyed during the tracer process. In preparing your staff, think about how the safety goals apply in surgical services. For example, under the goal for reducing the risk of health care-associated infections, surveyors are likely to observe how your hand hygiene practices comply with the Centers for Disease Control and Prevention guidelines (www.cdc.gov/handhygiene). The 2006

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Please see the ad for GETINGE in the OR Manager print version.
**Tips on getting ready for tracers**

These tips from Roberta Froth, RN, PhD, CNAA, were provided in a Joint Commission Resources audioconference earlier this year:

**Prepare the team**

Explain the new survey process and purpose of tracers. Focus on the standards and your processes and practices. “The aim is not to find out who is ‘not doing it right,’” Froth says. “Rather, it is to look at your processes and set up a system so it is easy to do the right thing and hard to do the wrong thing. Ask yourself, ‘What do we have to do to make it a stronger system?’”

**Practice with a closed medical record**

Practicing with a closed record can help ease anxiety for staff who may be apprehensive about tracers. Though this doesn’t provide the depth you get with a current patient, it gives the staff a chance to practice on questions about issues such as informed consent, advanced directives, and medication management.

**Do demonstrations and role playing**

Have someone pose as a surveyor and practice with a closed record. For example, the mock surveyor might say to a staff nurse: “I see this patient received pain medication. Can you show me where in the record this was assessed and documented?” After giving the nurse a chance to find the information and respond, the mock surveyor could say: “Now was this pain reassessed? What pain scale do you use?” The nurse would then identify those in the record.

**Provide sample questions**

Sample open-ended questions can help the staff practice responses, especially in the early phases of preparing for tracers.

**Make standards, policies available**

Make sure the staff has access to the Joint Commission standards, policies, and procedures. Many organizations provide these electronically so they are easy to access.

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**Is the care given consistent with the policy?**

Continued from page 12

goals were announced May 31 (related article).

Surveyors are sure to query how you’re complying with JCAHO’s Universal Protocol for preventing wrong surgery and may ask to observe the process during a procedure. The Universal Protocol includes 3 steps for surgical site verification:

- preoperative verification
- marking the operative site
- a “time-out” immediately before starting the procedure.

The time-out means that prior to starting the procedure, the surgical team pauses to review these 6 elements:

- correct patient identity
- correct side and site
- correct procedure to be done
- correct patient position
- special equipment
- correct implants, if applicable.


**What’s the best way to be ready for a survey?**

Probably the best method to ensure continuous readiness is to do plenty of mock tracers with the staff, Pelling says. Mock tracers should include persons across all disciplines—nurses, physicians, and ancillary staff from physical and occupational therapy, nutrition, social work, and respiratory therapy. Don’t overlook temporary and per diem staff.

Be sure to provide training to those who will lead tracers, she adds. “People doing the tracers need a general understanding of what the standards are,” she advises. They also need a good understanding of professional practice so they can assess processes as they go along to see if changes are needed. For example, if a tracer reveals that the pain standard isn’t being complied with, the tracer leader needs to know what steps are needed to correct practice.

Pelling’s clients often ask her for a list of mock tracer questions. But she advises thinking beyond a list of questions.

“People may think they’re doing tracers when they go to different departments and ask a series of questions. That is not what a tracer is,” she notes. “Others may use the questions to quiz the staff but not in relation to a particular patient. That may help establish a baseline of knowledge about the standards, but it doesn’t really prepare people to talk about the process of care for an individual patient.”

Instead, it’s more meaningful to select a patient, map the patient’s course of care, and ask questions that elicit information about how care is given for that individual.

“If you have a general knowledge of what the Joint Commission expects and know the general process of care for certain types of patients, such as those having coronary artery bypass, questions can flow naturally from the care process itself,” comments Elizabeth Lemons, RN, BSN, CPHQ, vice president of quality for 683-bed Baptist Hospital in Nashville, Tenn. She has found this method works better than trying to think of tracer questions to match each of the standards.

The standards tend to flow in the same order that patient care happens, she notes.

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**Conference session on JCAHO surveys**

Michelle Pelling, RN, MBA, will lead a breakout session entitled, The JCAHO’s Unannounced Surveys: Will You Be Ready? at the Managing Today’s OR Suite conference Oct 19 to 21 in San Diego.

You can download a brochure and register online at www.ormanager.com.
Please see the ad for GETINGE in the OR Manager print version.
Pelling suggests starting with questions about when the patient first enters the organization, such as “When the patient came in, how did she receive information about her care? How is the patient involved in her care? Is the informed consent present? The advanced directive?” Then move into the assessment: “Is the history & physical present? Was it done within 24 hours of admission? Is the nursing assessment present and complete? What problems need to be addressed? And so on.”

It’s important to focus not just on what your policies say but whether the care given is consistent with the policy, she adds.

For example, the question might be, “How often do we reassess a patient for pain after surgery?” Your policy might say every 4 hours for the first 48 hours, unless the patient complains of pain. Though this is the policy, is the staff actually doing that? If not, that should be addressed.

To develop an understanding of tracers, Joint Commission Resources (www.jcrinc.com) has videos, books, conferences, and other resources. These have scenarios and examples for tracers, including some for surgery. (See Resources.)

**How much practice?**

How many mock tracers should you do?

There is no set number.

“Every organization is different,” Pelling says. The value is in thinking of tracers as a tool that can help you evaluate your processes of care and systems of communication regardless of whether you are preparing for a survey or not.

“Going through tracers is a wonderful learning experience for the staff. You should do as many tracers as you think necessary to determine how well you are doing and to give the staff an opportunity to participate,” she says. “You want to see whether the different departments are working together.”

It’s important not to overdo it. Tracers can get a bad name if they take the staff away from their duties for too long. She’s heard of 6-hour tracers that turn everyone off.

Tracers, she says, are really 2 tools in one:

- An assessment tool for asking, “How are our processes working? Do they need to be modified? Can the staff describe what they do? Are we compliant with the standards and with our own policies and procedures?”
- A tool for educating staff about the critical nature of hand-offs, potential breakdowns in the course of care, and the importance of communication, not only orally but through documentation in the medical record.


**Musical spoof, Damaged Care, featured at Managing Today’s OR Suite**


They’re daily worries in health care. But managers will have a chance to laugh about them in Damaged Care, a musical review, during a special luncheon at the Managing Today’s OR Suite Conference, Oct 19 to 21 in San Diego. The event is sponsored by Advanced Sterilization Products. The 45-minute spoof is written and performed by 2 physicians, Greg LaGana, MD, and Barry Levy, MD, who were classmates at Cornell Medical College in New York City in the late 1960s.

They originally dreamed up the show for a class reunion, Dr Levy says, finding a way to make light of the time pressures and insecurity they and other health professionals feel. It went over so well that they took it on the road. They’ve since done more than 80 shows, more than half for students, nurses, physicians, and other health care groups.

They’ll entertain with lyrics to songs such as “No Time,” “Another Outbreak,” “Health Care Business,” and “The Spare Part Blues.” They say there will be lyrics specially written for the OR director audience.

“The main thought behind this is that we’re all responsible for the health care system we have—and that’s good news and bad news,” Dr Levy says.

Both performers hold day jobs. Dr LaGana is an internist at Merck Pharmaceuticals in New Jersey, and Dr Levy is a specialist in occupational and environmental medicine and an adjunct professor at Tufts University Medical School, Boston. The music director and accompanist, Brad Ross, is a composer, songwriter, and pianist who has had 2 productions at the Kennedy Center in Washington, DC.

Read more about the show at www.damaged-care.com

You can download the conference brochure and register online at www.ormanager.com.
The ground is shifting in cardiovascular services. Historically, cardiac surgery has been the economic engine of many hospitals. Six or seven years ago, cardiac services made up 25% to 40% of hospitals’ margins. Then along came drug-eluting stents, and coronary artery bypass graft (CABG) volumes started shrinking. A hospital that counted on heart surgery for 25% of its margin might have seen that fall to 15% to 20%.

The response isn’t just to ask, “How can we get more CABGs?” Instead, hospitals need to retool their business, advises Todd Burchill of the Tiber Group, Chicago-based consultants. Tiber was acquired by Navigant Consulting this spring.

“We want to get people thinking not only about new ways of attracting business but also transitioning from a surgical, CABG-based program to a cardiology-based program,” he says. That will likely mean doing a larger number of smaller-revenue procedures.

Also, as outpatient volumes grow, hospitals are being left with sicker patients. Some could have difficulty generating enough business to care for their cardiovascular inpatients effectively and efficiently. That’s likely to lead to a consolidation of cardiac surgery programs.

Burchill outlined some planning assumptions for hospitals to consider.

**Cardiac volumes are shifting**

Cardiac volumes as a whole will continue to increase, but growth is expected to be in areas such as left-ventricular assist devices (LVADs), automatic implantable cardioverter-defibrillators (AICDs), and congestive heart failure where hospitals haven’t had much of a margin.

“A lot of the volume now is focused around new devices, which are expensive,” Burchill observes. “Reimbursement hasn’t caught up with the cost of the device, let alone the cost of the care that’s needed. A lot of our clients want to be early adopters and are investing in these new technologies and services but without the strong economic base they had in the past.”

**CABG no longer cash cow**

CABG surgery, hospitals’ historic cash cow, is diminishing. In a study with OhioHealth, Tiber found the system’s cardiac surgery volumes fell 24% from 2000 to 2004.

At the same time, indications are increasing for expensive new devices like LVADs, meaning more patients qualify.

“We need to get a better handle on how to integrate these technologies in our programs in an economically viable way,” he says.

A major challenge is the lack of alignment between hospital and physician incentives. A cardiologist may want to put in a $20,000 AICD without understanding the economic consequences to the hospital.

“These decisions have to be addressed at the senior level to set policies and rules of engagement so you can get on the same page with your physicians,” Burchill says.

**CT/MRI may replace some invasive caths**

As CT and magnetic resonance imaging progress, they will begin replacing some invasive diagnostic cardiac catheterizations. Diagnostic caths are fairly profitable, but noninvasive scans will not be as well reimbursed. How rapidly this shift occurs will be market-specific. Some physicians will be enthusiastic and others more conservative.

“Organizations really have to think about how they are going to integrate this into their overall cardiovascular programs,” Burchill says.

Eventually, the advanced scans will enable more patients to have their cardiac disease detected early so it can be treated without surgery. A patient who might once have had a $25,000 CABG would instead have a $500 CT or MRI scan with a $5,000 balloon.

**Drug-eluting stents will see growth**

Drug-eluting stents, which already have had a dramatic impact on surgery, will continue to spur evolutionary change.

“This technology is pretty much where it is going to be, though you probably will see different sizes of stents implanted in smaller arteries and for… Continued on page 18
bifurcated lesions,” expanding the indications, Burchill comments.

Hospitals need to work with their cardiologists on protocols and standards to manage stent utilization. Medicare reimbursement currently is based on 1.5 stents per patient. “If you look at your data and see you are using an average of 2.1 per patient, you will be losing money,” he points out.

**Quality measures will steer patients**

Talked about for years, quality measurement is starting to see some action. Medicare has pilot projects to reward hospitals for better performance on quality indicators, and where Medicare goes, private payers tend to follow.

“Going forward, you might see special designations for facilities to treat certain types of patients and do certain types of procedures,” says Burchill. “Why not be proactive and lead some of that effort in reporting your outcomes?”

Patients will be more involved in facility selection. As more decisions and financial consequences are pushed down to consumers, patients will be “getting online to compare hospitals the same way they buy a car or new piece of furniture,” Burchill says. “The days when the patient said, ‘I’ll go wherever the doctor tells me to go,’ are starting to erode.”

**Stand-alone angioplasty centers will proliferate**

Some states now allow primary and even elective angioplasty without on-site surgical backup.

Currently, a lot of hospitals may have cardiac surgery programs so they can do interventional cardiology procedures. With stand-alone angioplasty programs, that will no longer be necessary in some areas.

“We’re going to see a huge proliferation of stand-alone angioplasty, and as a result, we might start to see consolidation of open-heart surgery programs.”

Say you’re in a market with 1 or 2 other hospitals, you’re in a certificate-of-need (CON) state, and you have the only angioplasty program with surgery backup. Consider the impact if your competitors move into stand-alone angioplasty.

“I think this will have a big impact on well-established programs that have a franchise in those services,” Burchill says.

**Cardiac surgery programs will consolidate**

As drug-eluting stents allow more patients to be treated in the cath lab, smaller cardiac surgery programs may have trouble sustaining themselves. As a result, a community-based program that performed 150 to 200 CABGs a year might see its volume dwindle to 100 or so.

“We might see some of these programs consolidate because they can’t economically support stepping up to become a more complex surgical program,” he says.

**Will statins reduce acute myocardial infarctions?**

Treatment of acute MIs has been a predictor of cardiac business for a hospital. With many patients taking statins, there may be a long-term impact on cardiovascular disease.

This is yet another factor that could mean less surgery and interventional treatments, with less revenue from those services.

**Shift will affect facility planning**

The shift in cardiac services has huge implications for facility design, Burchill notes. Will your facility need fewer ORs and more interventional rooms? Who will occupy those rooms? Will it be interventional radiologists, who don’t bring patients? Or will it be the cardiologists who are big revenue producers?

“You need to work through these turf battles,” Burchill advises. Can you have one type of universal procedure room rather than doing these procedures in the OR, the cath lab, and the radiology department?

Multiple locations can create a “free-for-all with no standardized credentialing, protocols, or billing,” Burchill notes.

“The economics of cardiac services are changing quickly, and organizations need to be planning for how to make the transition,” he notes.

More information on the Tiber Group is at www.tiber.com.

**Specialty hospital moratorium expires**

The moratorium on specialty hospitals expired June 8. Congress did not take action to extend it.

Republican congressional leaders came out against extending the moratorium in May, citing a lack of evidence that specialty hospitals are harming community hospitals.

Instead, action is likely to be regulatory. The Centers for Medicare and Medicaid Services (CMS) outlined steps it plans to take to address incentives that may favor specialty hospitals:

- Adjust DRGs so payments more accurately reflect severity of illness. CMS said it would look at cardiac, orthopedic, surgical, and perhaps other DRGs that are allegedly overpaid and may create incentives for physicians to create specialty hospitals.

- Reform payment rates for ambulatory surgery centers (ASCs). Payment rates for orthopedics and certain other procedures are more favorable for hospitals than ASCs, which may cause physician owners to build specialty hospitals instead of ASCs. CMS already plans to reform the ASC payment system to reduce the differences.

- Give closer scrutiny to whether facilities meet the definition of a hospital. A CMS study suggests some specialty hospitals may have outpatient volumes that are too high to meet Medicare’s definition of a hospital.

- Review procedures for approving hospitals for Medicare participation. CMS will review whether specialty hospitals with a limited scope meet all the core requirements of a hospital.
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Uniform preop review for high-risk patients

A n internist clears an elderly woman for hip fracture surgery, but the anesthesiologist says she’s not stable. What’s the surgeon to do?

Staten Island (New York) University Hospital put the decision in the hands of specially trained hospital-based physicians who were granted privileges to perform preoperative assessments and clear patients for surgery.

A number of concerns led the 785-bed teaching hospital to create a uniform clearance protocol, including inconsistent pulmonary and cardiac preoperative assessments, variances in medication management, and disrupted surgery schedules caused by last-minute cancellations.

But the case that kicked off the system’s change was the death of a 78-year-old woman, who died in the OR during repair of a femur fracture that occurred at her nursing home. The woman’s medical history included chronic obstructive pulmonary disease, hypothyroidism, and laryngeal cancer. Her internist evaluated the patient prior to surgery and classified the patient as ASA 1 (American Society of Anesthesiologists physical status), with no contraindications for the OR. But the anesthesiologist evaluated the patient as ASA 3. Surgery proceeded, and the patient died after anesthesia induction.

Following a mortality review, the medical staff performance improvement subcommittee conducted a root cause analysis.

“Practitioner accountability cannot be minimized, but blaming an individual does little to make the system safer and prevent recurrence,” says Joseph Conte, vice president of quality and risk management.

The medical staff decided that a uniform, criteria-driven assessment protocol was essential and needed to be performed by physicians who received special training and were privileged, Conte says.

“The assessment of high-risk patients undergoing surgery has become a domain unto itself,” Conte says. The chairman of medicine, Tom McGinn, MD, embraced the concept and championed the protocol’s development and implementation.

The process improvement team, which included physician leaders of the departments of medicine, surgery, anesthesiology, and critical care, as well as administrators from quality and risk management, developed the protocol.

Criteria were derived from sources such as the American College of Cardiology and the Goldman criteria of cardiac risk for noncardiac surgery.

“The assessment isn’t groundbreaking, but it’s good practice and sound medical management,” Conte says. “Physician buy-in was a lot easier because the protocol is evidence-based and criteria-driven.”

The hospital rolled out the uniform preoperative assessment in January 2001. Prior to implementation, Staten Island’s mortality rate for hip fracture repair surgery had been 4.9%, well within New York State’s benchmark average of 5.1%. Following implementation, the mortality rate decreased to 2.7% for both 2001 and 2002. In 2003, the mortality rate decreased to 1%—an 80% reduction from the baseline, Conte says.

Improved OR flow

The assessment protocol also had a dramatic impact on surgical flow.

“This type of situation was the worst for the OR,” Conte says. “The internist said OK to surgery, but the anesthesiologist said no. It created delay and confusion in the OR schedule and turmoil for the patient’s family.”

Christine Griffiths, RN, associate vice president for perioperative services, says cancellations for hip fracture surgeries have plummeted since physicians began using the preoperative assessment. Although Griffiths does not have exact figures, she says OR labor and supply costs for fractured hip patients have decreased significantly, because “we’re not setting up, staffing, and breaking down rooms that aren’t being used.” The radiology department also saves because it isn’t paying for an x-ray technician to set up a fluoroscopy unit during surgery.

Also, because patients are more stable prior to surgery, they are more stable after surgery.

“They achieve higher Aldrete postanesthesia scores, have fewer complications, and require less intensive monitoring,” she says.

Is rushing to the OR necessary?

Initially, the only complaints Griffiths heard about the protocol were from orthopedic surgeons waiting for their patients to be cleared. “But once they saw how well their patients were doing, that stopped,” she says.

Conte adds that most of the orthopedic surgeons embraced the protocol because the medical management of their patients is closely monitored postoperatively. “Many of them use the clearance process for all of their elderly patients who sustain all types of traumatic fractures,” he says.

The uniform preoperative assessment goes against the long-held belief that hip-fracture repairs should be performed within 24 hours of fracture. A study published by Gretchen M. Orosz, MD, and colleagues in the Journal of the American Medical Association demonstrated that earlier surgery is not associated with improved mortality, although it is associated with reduced pain and length of stay for patients medically stable at admission. But most of the elderly patients, primarily women, who undergo hip fracture repairs at Staten Island are not medically stable at admission, Conte says.

“This is a very fragile population,” he says. “Seventy percent of these patients are at least 80 years old, and most are on poly-pharmaceuticals, have diabetes, heart failure, or pulmonary issues. They can’t stand a lot of insult.”

Surgery usually takes place within 48 hours of admission, but frequently, the assessment reveals unrecognized cardiac and pulmonary issues that must be stabilized before surgery.
Privileged physicians

About 24 hospital-based physicians volunteered to begin performing the pre-operative assessment protocol. “These are medical and surgical intensivists, cardiologists, and hospitalists who already manage the complex patients, and they’re at the hospital 24/7," Conte says.

Some internists resisted having other physicians placed in charge of clearing “their” patients for surgery, Conte says, “but we felt that to medically manage an elderly patient for surgery, a physician needed to be privileged.”

Approximately 45 additional physicians have become privileged after taking an in-house continuing medical education class or a 2-day class offered by Richmond County, where Staten Island is located. Other physicians attended a 2-day class offered in Philadelphia by Geno Merli, MD, coauthor of Medical Management of the Surgical Patient.

The privileged physicians also must agree to assess patients within 12 hours of admission.

The emergency department serves as the entry point for most of the patients who participate in the protocol, Conte says. “Any hip fracture patient in the emergency department who is 65 or older immediately goes into the protocol.”

In fact, the ED is integral to the success of the process, Conte says. “Their early notification of a properly privileged provider to initiate medical clearance has been instrumental,” Conte says. “When variances occur, it generally is because of miscommunication at this level.”

Often, the orthopedic surgeon chooses which privileged physician will perform the assessment. “This is one way we can allow some flexibility in the system,” Conte says.

After clearance, the surgeon or designee adds the patient to the OR schedule. Out of 11 inpatient operating rooms, 1 is designated for add-on cases such as the hip fracture repairs.

References


Grants announced for nursing faculty

Federal officials announced the first in a series of grants to increase the number of nursing instructors. The $1.1 million is the first of more than $12 million earmarked for workforce training in health care and biotechnology, the US Labor Secretary, Elaine Chao, said at a news conference reported June 7 by The New York Times.

The nursing shortage has become a chicken-and-egg problem, said US Representative Nita M. Lowey. “Without enough educators in the field, we can’t train nurses,” Lowey said. “And without more nurses, we can’t expect more faculty to rise out of the ranks of nurses.”

The American Association of Colleges of Nursing said nursing schools had to turn away about 33,000 qualified applicants in the past year because of a lack of instructors.

Some of the grant money may be used to compensate hospitals that agree to share their nurses with teaching programs.
Working together as a team means more than making sure your OR runs at peak efficiency, said Toni G. Cesta, PhD, RN, FAAN, in her keynote at the OR Business Management Conference May 2 to 4 in Tampa. Teamwork also means coordinating patient flow with departments such as admissions, emergency, laboratory, imaging, and housekeeping, she said.

“JCAHO’s new standard for managing patient flow raises the bar for everyone,” Cesta said. “We need to be more sophisticated in setting up processes to move patient care in the most effective way we can.”

On Jan 1, the Joint Commission on the Accreditation of Healthcare Organizations implemented Standard LD.3.15. The so-called “managing patient flow standard” requires hospitals to identify all of the processes critical to patient flow through the system from admission to discharge. Hospitals also need to develop processes to accommodate surges during peak times.

“OR nurses are very good at finding ways to work around broken systems. They don’t have time to fix them,” Cesta said. “When we get more than 90% occupancy, patient flow grinds down. There are not enough resources, and patients line up for MRIs and lab tests.”

Need for ‘people programs’

Attracted by 4 all-day seminars and 12 breakout sessions, 307 OR directors, OR business managers, and others concerned with the financial management of surgery attended the conference. Topics ranged from materials management to OR design and construction.

Cesta, vice president of patient flow optimization for the The North Shore-Long Island Jewish Health System, Great Neck, NY, also spoke of the importance of improving patient care outcomes by adopting best practices.

William F. Moskal, EdD, the speaker for Wednesday’s general session, also talked about the crucial role of leadership in a hospital. At its best, leadership can strengthen relationships among workers. The effects can produce positive business results for the team and institution. But poor leadership can create resentments that sap enthusiasm and productivity.

“Don’t put in a quality program,” he advised. “Put in a people program—people get results.”

Moskal, senior partner with IRI Consultants to Management, Detroit, stressed the need to work collaboratively with other departments to improve processes.

“We as leaders need to issue fewer orders and more challenges,” he said. Leaders who foster trust within their teams get better results, he said.

Examples of leadership skills that increase trust include listening more than talking, asking questions, seeking commitments, assigning responsibility, encouraging top performers, and expecting results.

“One way to start is to fix a patient flow problem in the hospital. “Start a chain letter with the statement of the problem and the desired outcome,” he suggested. “Ask people within your department to come up with 5 solutions. Then take the list to other departments.
and ask each to add 3 more solutions.”

He said challenging departments to find solutions is an effective way to improve patient flow. "If they own (the problem), they will take care of it," he said.

**Design for patient safety**

Other conference highlights:

- When designing an OR department to prepare for new technologies while at the same time keeping rooms staff-friendly, Aileen R. Killen, RN, PhD, CNOR, and David P. Jaques, MD, of Memorial Sloan-Kettering Cancer Center, New York City, suggested making 95% of the ORs of similar dimensions and the remainder specific to procedures.

  “Staff and patient safety should be your guiding principles," Jaques said. "Most of our rooms are 600 square feet with 8-foot high ceilings. We built a mock-up room with booms and lights so staff could feel comfortable once we moved in.”

  After visiting 10 new ORs, Jaques said the team found they all shared a common problem: insufficient storage space. “We ended up the same way. We don’t have enough storage space.”

  For safety, Killen said the priority was to design rooms so all cords and wires are off the floors. “We use 2 booms to bring enough power so everything is off the floors, and nobody will be tripping over things,” she said.

- A networking session for business managers yielded similar problems and projects. Billie Fernsebner, RN, MSN, education specialist for OR Manager, Inc, led the discussion, which covered topics such as supply and implants standardization, financial disclosure and conflict of interest forms, credentialing for vendors, and capitated pricing arrangements.

- As more ambulatory surgery centers are built, hospitals are performing surgery on more severely ill patients while facing declining reimbursements, said Jeff Peters, president and CEO of Surgical Directions, a Chicago-based consulting firm. He also said hospital ORs need to improve efficiency and quality to maintain market share.

  “Improving surgeon satisfaction is an important goal for OR managers,” he said. Some satisfiers include on-time surgery starts, good anesthesia coverage, and efficient workflow.

- Deciding whether to renovate the OR or build a new department usually depends on increased volume projections and physician needs, said Anthony R. Roesch, an architect and principal with Boldt Consulting Services, Chicago.

  Roesch said if a facility projects a 10% increase in utilization, it is safe to justify $1 million per OR in capital expenditures. But he estimated the cost to replace an average-size surgical department of between 10 to 20 ORs at about $2.3 million per OR. Renovation costs average $1.7 million per OR.

Moskal closed the conference with a lively talk about how managers can take home lessons. “Choose 1 or 2 things you learned, write them down, determine if they are within your control, and develop a plan of how you bring them home to your team,” he said. ◆

— Jay Greene

Jay Greene is a freelance writer in St Paul, Minn.

**ORB introduces ‘low carb’ studies**

To help facilities benchmark surgical supply costs, OR Benchmarks is introducing a “low carb” version of its surgical procedure studies. This low carb version will benchmark just surgical supply costs.

Facilities participating in the studies will submit cost data on surgical supply costs for specific procedures. By benchmarking their costs with other facilities, they will be able to see if their costs fall within best practice guidelines or whether they may be able to save costs.

Regular OR Benchmarks procedure studies include labor and anesthesia costs as well as prep, induction, procedure, and turnover times. “Although all these factors affect costs, supply costs are the most important, and these are the costs the OR director manages,” says OR Benchmarks Director Judy Dahle, RN, MS. “These abbreviated studies will allow manager to zero in quickly on their supply costs.”

**Cost drivers identified**

“From the thousands of cases that OR Benchmarks has studied over the past nine years, we have identified the surgical supply cost drivers,” she adds.

The low carb studies are a cost-efficient way to look at supply costs for high-cost procedures. Subscribers will receive worksheets electronically to fill out during actual procedures. “We don’t rely on physicians’ preference cards or dated surgical records,” Dahle explained.

“We ask participants to record the actual supply usage for 3 to 5 cases because this gives a more accurate picture of costs.”

Three procedure studies will be offered—total hip replacement, total knee replacement, and laparoscopic cholecystectomy.

Participants will receive a concise report showing how their supply costs, including implants, compare with other facilities. Opportunities to save costs will be identified.

OR Benchmarks is a service of OR Manager, Inc. Returning OR Benchmarks participants and OR Benchmarks Collaborative participants receive a 20% discount.

For more information and a registration form, go to www.ormanager.com or www.orbenchmarks.com. OR Benchmarks Director Judy Dahle can be reached at jdahle@earthlink.net. ◆
If OSHA knocks, will you be prepared?

A compliance officer from the Occupational Safety and Health Administration (OSHA) arrives at your ambulatory surgery center (ASC), will you be ready?

OSHA’s mission is to ensure every working man and woman has a safe place to work. To carry out this mission, the agency develops standards that employers must comply with. Failure to comply may result in a financial penalty. To ensure employers are abiding by the agency develops standards that

employers must comply with. One ASC received a $500 citation for improper recordkeeping related to maintenance of the OSHA Form 300 Log of Work-Related Injuries and Illness. The 300 Log is a record of occupational injuries and illnesses kept by calendar year. There is a partial exemption for ASCs for maintaining this form, Dr Estes notes, but the exemption applies only if the ASC is 100% owned by medical doctors.

What happens during an inspection?

What can you expect if an OSHA compliance officer arrives at your facility?

First, the compliance officer must identify himself or herself, show credentials, and explain why he or she is at the facility, Estes notes. Next, the officer will ask for an opening conference. This is the time when the ASC demonstrates it is in compliance by showing its safety programs, documentation of employee training, and the OSHA log (if applicable) for the past 5 years.

After reviewing the paperwork, the compliance officer conducts a walk-through inspection to verify information presented during the opening conference. The office asks questions of the employees and observes their actions as well as conditions in the facility. The officer may take pictures so be reminded about patient rights and privacy. With the walk-through inspection completed, the compliance officer will conduct a closing conference.

“A lot of times they will try to do this by telephone, though you have the right to have a face-to-face closing conference,” Estes says. During the closing conference, the officer discusses the alleged violation. The violation is only alleged unless or until the ASC actually receives a Notice of Proposed Penalty by certified mail.

If an OSHA citation is issued, it will arrive at the facility within 180 days by certified mail. The facility has 15 working

Assign responsibility for safety.

office to come to an ASC is an employee or patient complaint, he says. For example, a staff member might be concerned about the number of sharps injuries and call OSHA, which is an employee’s right. Or a patient might witness a working condition he or she thinks is unsafe and contact the agency. Regardless of how a complaint reaches OSHA, it must be followed up, which could mean a visit to the facility.

Over the past year and a half, 20 ASCs have had an OSHA compliance inspection, Estes says. Of these, 13 were the result of a complaint, and 4 were from referrals by other government agencies, such as the fire marshal, state surveyor, or even state elevator inspector.

From these inspections, ASCs were cited with 20 serious violations with over $20,000 in financial penalties. The 3 most common OSHA standards cited were:
- 1910.1047 Ethylene Oxide
- 1910.1030 Bloodborne Pathogens

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Most common OSHA citations

These are the most-cited OSHA standards in ambulatory surgery centers. Use this checklist to see if your ASC is in compliance with the major requirements.

Ethylene Oxide 1910.1047
Ethylene oxide (EO) is a sterilant used for items that cannot be steam sterilized. EO has a variety of physical and health hazards. The OSHA permissible exposure limit (PEL) is 1 part per million (ppm) over an 8-hour time-weighted average with a 5 ppm excursion level.

Compliance checklist:
Last reviewed: ____________

- Is there a workplace assessment for the PEL?
- Is there periodic monitoring by breathing zone air samples representative of 8-hour time-weighted average and 15-minute short-term limit?

Bloodborne Pathogens 1910.1030
The standard covers exposure to blood and other potential infectious materials and life-threatening bloodborne pathogens such as hepatitis B virus, hepatitis C virus, and HIV.

Compliance checklist:

- Is there an Exposure Control Plan designed to eliminate or minimize employee exposure? The plan must be reviewed and updated at least annually.

Hazard Communication 1910.1200(e)
The standard covers exposure to hazardous chemicals used in the surgical area, such as peracetic acid and methylmethacrylate (MMA) bone cement. The standard requires employers to inform employees of chemical hazards and have Material Safety Data Sheets for all hazardous chemicals used in their facilities.

Compliance checklist:

- Is there a list of hazardous chemicals known to be present in the facility?
- Is there a procedure for reviewing labels and other forms of warning on hazardous chemicals?
- Is there a procedure for making available instructions on Material Safety Data Sheets?
- Is there a procedure for employee information and training?
- Is there a policy on methods to be used to inform employees of hazards of nonroutine tasks?

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Avoiding an OSHA citation means being in compliance with the standards applicable to your ASC.

He points out, however, that a checklist alone is not sufficient. He suggests implementing these 5 keys to safety:

1. Assign the responsibility for safety to all levels of management and to an individual who will handle day-to-day safety activities.
2. Develop and implement a comprehensive, written health and safety program. The plan should include an accident prevention plan and safety programs to protect employees from specific hazards such as bloodborne pathogens and chemical hazards.
3. Make a management commitment to safety and employee training. OSHA mandates a considerable amount of training regarding its standards. The employer is responsible to determine which standards apply and which employees are affected by the standards. Many of the standards require employee training to be conducted:

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OSHA resources

Coastal Training Technologies
Publisher of employee training materials has videos, handbooks, CD-ROMs, and web-based courses. Phone 900/725-3418 or visit www.coastal.com.

Eagle Associates, Inc
Publishes American Practice Advisor, a monthly journal, for $160 a year. Also offers an on-line training program for $20 per person annually for firms with 20 or fewer employees. Phone 800/777-2337 or visit www.eagleassociates.net.

HCPro

HealthStream
Company provides online education on OSHA and other regulatory agencies. Phone 800/933-9293 or visit www.healthstream.com.

International Board of Environmental Health & Safety (IBOEHS)
Plans to have a Safety Kit for ASCs available in August. Contact Adrian Estes at Dr.Estes@comcast.net.

Occupational Safety and Health Administration
The eTools section of OSHA website has summaries of standards and educational materials. Go to www.osha.gov and look under the Compliance heading for eTools.

The Training Network
Company offers videos, DVDs, CDs, and manuals on workplace safety and human resource training issues. Phone 800/397-5125 or visit www.trainingnetwork.com.

The employer is responsible to determine which standards apply.

• upon initial assignment
• annually
• whenever an employee changes jobs or there is a change in procedure.

OSHA rarely mandates a time limit for training; the only requirement is that the employer is responsible to ensure that employees understand the training.

To demonstrate compliance, the ASC must show the compliance officer documentation of training.

4. Conduct safety inspections frequently enough to be able to identify a workplace hazard in a timely manner.

5. Enforce a safety disciplinary action policy. Establish a policy such as 3 strikes and you’re out for safety infractions: The first violation can be a written warning, the second can be a written warning plus appearance in front of the safety committee, and the third violation is grounds for termination.

Employee education
Employee education videos and manuals on the OSHA standards are also available. OSHA does allow training videos, Estes notes. “But someone must be readily available to answer questions,” he says. Unfortunately, no one video covers all of the topics mandated by OSHA. To provide the needed training, an ASC would need to use a number of videos, which can be time consuming. (Sources of OSHA training materials for health care are in the sidebar.)

To assist ASCs with OSHA compliance, Estes is assembling a Safety Kit for ASCs, similar to one he prepared for the nursing home industry a few years ago. The kit, which is scheduled to be available in early August, will include:
• A manual explaining the 5 keys to safety and providing a sample health and safety program specific to ASCs
• A resource book on the fundamentals of occupational safety
• A 20-minute, no-frills video covering OSHA-mandated training applicable to an ASC, with a reproducible 10-question quiz suitable for documenting employee training.

For more information on the Safety Kit for ASCs, contact Adrian Estes at Dr.Estes@comcast.net.

New technology causes stress and burnout
Introducing new technology into the operating room can create significant job stress and burnout, according to a study from Boston’s Massachusetts General Hospital (MGH).

Researchers used the MGH’s Operating Room of the Future (ORF) project to evaluate the effect of introducing new technology on staff satisfaction and burnout.

They found that different groups respond very differently to the same new technology. More exposure to the ORF technology resulted in a greater sense of personal accomplishment among surgeons but less among nurses. It caused more emotional exhaustion among surgeons but less among nurses.

Staff who had worked in the OR for 6 to 10 years had a greater risk for burnout across all categories. General surgeons experienced more emotional exhaustion among surgeons but less among nurses.

Staff who had worked in the OR for 6 to 10 years had a greater risk for burnout across all categories. General surgeons experienced more emotional exhaustion than other physicians.

The researchers recommend that ORs identify groups at high risk for burnout before initiating any new technology project. These personnel should receive additional support to manage technology transitions.

Preadmit nurse avoids rushed assessments

A fter relying on phone calls to assess patients preoperatively, one ambulatory surgery center (ASC) has decided to have 80% of its patients come to the facility before the day of surgery. Many surgical facilities have gotten away from face-to-face preadmission assessments because patients who have outpatient surgery are typically healthy, and less preoperative testing is being done than in the past.

But as the general population develops more health care needs, Big Sky Surgery Center in Missoula, Mont, has found phone interviews don’t always pick up problems that could cause delays and cancellations on the day of surgery. The center is in a rural area, and some patients drive up to 200 miles for their medical care.

Problems not always identified

The center was seeing more obese patients, who often have airway problems that weren’t always identified in a phone interview. When these patients came in for an assessment, appointments were taking longer. Nurses performing preadmission assessments felt rushed because they also needed to be taking care of the center’s other patients. Staff also were staying an hour or more in the afternoon to conduct phone assessments, which resulted in overtime.

After a 6-week time study, the center’s leaders were amazed when they discovered how much time the assessments were taking, says Barbara Samsoe, RN, CAPA, preoperative and postoperative charge nurse. The time study helped them to justify a full-time preadmission nurse who is available to assess patients from 10 am to 6:30 pm.

Patients aren’t required to make appointments because many drive a long distance and need to be seen the same day as their physician’s office visit.

The freestanding center, owned 65% by physicians and 35% by the hospital, has 3 ORs and 2 procedure rooms and performed 3,100 surgeries and 1,300 pain management procedures last year. Pain management patients do not come in for a preadmission appointment.

Justifying a preadmission nurse

Before the preadmission nurse was hired, a nurse in the preop or recovery area would be assigned to carry a beeper to alert her when a preadmission patient arrived. The nurse then would transfer care of the current patient to a coworker to conduct the preadmission assessments.

“We weren’t able to do the preadmission visits at the level we felt we should be. We were rushed because we had other more pressing things to do, like recovering a patient just coming out of the OR,” says Samsoe.

The clinical director, JoAnn Timmerhoff, RN, CPAN, CAPA, recommended a time study to see if another staff member was justified for the preadmission area. For 6 weeks, staff nurses kept track of the time they spent on preadmission appointments and how many patients they saw per day. They monitored time spent calling for patients’ records from other facilities and making calls to anesthesia providers. They also documented how many patients came in for each surgeon.

Surgeons are encouraged to have their patients come in for a preadmission appointment. One surgeon goes so far as to tell his patients that if they don’t come in for a preadmission assessment, their surgery will be cancelled, Samsoe says, adding, “We wish all of them would do that.”

If patients do not come in before the day of surgery, a nurse calls them the night before.

The study showed that the amount of time spent on the preadmission visits and calls warranted another staff person.

Unrushed visit gleams better information

The dedicated preadmission nurse has improved care because patients can have a thorough assessment, Samsoe says. It is also more efficient because problems are identified that could affect the surgical schedule.

“Not having the needed information impacts the surgery schedule, surgeons, anesthesiologists, and staff, not to mention the patient, if surgery has to be cancelled,” he says. Since the preadmission nurse position was added, these problems are rare. Generally, the only problems encountered on the day of surgery now are with patients who haven’t come in for their preadmission visit.

When the preadmission nurse finds an anesthetic concern, she immediately notifies the anesthesiologist. If the anesthesiologist can’t be reached, she calls the medical director, who is also an anesthesiologist, to evaluate the patient. Specific tests may be ordered based on anesthesia guidelines. Patient information on cardiac, pulmonary, or renal problems is shared with the surgeon and anesthesiologist if the patient has not already communicated this information to the surgeon. Preoperative and postoperative instructions are also given.

The new preadmission nurse, Andi Dreiling, RN, says the dedicated position and ability to conduct interviews and assessments has a number of benefits:

• allows time to explore a patient’s health history and follow up on issues such as past problems with systemic disease, anesthesia, or the airway
• allows for gathering of information from other facilities and physicians before the day of surgery
• allows for individual attention to

Continued on page 28
patients and families with anxiety or emotional concerns

- prevents RNs from being called away from care of other patients to conduct the preadmission interview
- allows focused attention, which increases the atmosphere of caring and adds to patient satisfaction
- allows pediatric patients and their families to tour the facility and develop trust.

Another benefit is that when the preadmission nurse doesn’t have patients waiting, she helps with breaks and lunches, says Samsoe. She also makes postoperative phone calls. The preadmission nurse has helped reduce overtime.

For other ASC managers who would like to establish a preadmission nurse position, Samsoe advises: “Get the data. Do a time study. Keep track of your time to see if it justifies another nurse.”

She notes that the surgeons and anesthesiologists are pleased with the preadmission program and consider it a benefit of the facility.

“Because our preadmission nurse is so thorough, we find the postoperative course is quite seamless,” she says. “It has been a great source of pride for us that some anesthesiologists tell us how nice it is to come to Big Sky because they know they will have all the information on their patients beforehand,” says Samsoe.

—Judith M. Mathias, RN, MA
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Malpractice coverage tightens for bariatric surgery

The number of candidates for obesity surgery is growing, and the number of procedures is expected to grow, but more slowly, the May 27 New York Times reports.

“Some malpractice insurers have dropped bariatric coverage, and some surgeons have stopped performing the operation rather than pay sharply higher insurance premiums,” the report said. New York State’s largest malpractice insurer said it would end all coverage for bariatric surgeons July 1 unless the state approves a 50% increase in premiums. The increase would bring the premium for bariatric surgeons in Manhattan up to $93,000 from $62,000.

Big insurers like United Health Group, Aetna, and Cigna typically offer bariatric coverage only as a rider employers can purchase for an extra charge.

—www.nytimes.com (registration required)

College of Surgeons launches bariatric surgery accreditation

To address quality concerns for obesity surgery, health plans are setting up networks of physicians and hospitals with good results.

The American College of Surgeons has opened enrollment in its new accreditation program for bariatric surgery centers. Centers must implement the ACS bariatric surgery standards. Enrollment is $10,000, and centers will be inspected within 6 months. To maintain accreditation, centers must complete an annual report and have a site visit every 3 years.


Little difference in on-pump vs beating-heart bypass surgery

Results from coronary artery bypass operations are similar whether performed while the heart is stopped or beating, says a report in Circulation. The journal reviewed hundreds of studies that compared coronary artery bypass grafting without cardiopulmonary bypass and cardioplegia or off-pump CABG.

A review found advantages and disadvantages for each type but no overall difference in rates of survival. The skill of the surgical team and quality of the hospital play a much greater role in determining results than the type of procedure. The death rate ranged from less than 1% to more than 6% in most studies.


Defensive medicine nearly universal in high-risk fields

Defensive medicine is widely practiced in surgery and other high-risk fields and may lead to increased costs, lower quality of care, and less access to services, finds a study published in the Journal of the American Medical Association.

Researchers surveyed 824 Pennsylvania physicians in the specialties most frequently involved in litigation: emergency medicine, general surgery, neurosurgery, obstetrics and gynecology, orthopedic surgery, and radiology.

Some 93% of the doctors reported sometimes or often engaging in defensive medicine. More than 59% said they often ordered more tests than medically indicated.


Intensive rehab as effective as surgery for low-back pain

Surgery to relieve chronic lower back pain is no better than intensive rehabilitation and nearly twice as expensive, according to the British Medical Journal. Researchers in Oxford, England, found little difference when they compared the effects of surgery with rehabilitation on 349 back pain sufferers who had either spinal fusion surgery or intensive rehabilitation involving exercises and cognitive behavioral therapy. Thirty patients in the therapy group later had surgery.

—Fairbank J, Frost H, Wilson-MacDonald J. British Medical Journal. May 23, 2005. Published online at http://bmj.bmjournals.com/cgi/content/abstract/bmj.38441.620417.8Fo1?ef