In a new alert, the Joint Commission adds its voice to calls to curb fatigue from extended work days and work hours. The alert highlights evidence linking fatigue to adverse events and outlines actions organizations can take to mitigate fatigue, especially among nurses and physicians.

The commission says the alert is purely educational, and there will be no change in the survey process.

Despite the evidence of risks posed by fatigue, health care has been slow to adopt changes, particularly for nursing, the commission says.

Numerous studies have linked nurse fatigue to patient safety, the alert notes. The first, a groundbreaking 2004 study, showed nurses working shifts of 12.5 hours or longer are 3 times more...
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C hecking e-mail, looking up airfares on your mobile phone, texting—it’s part of life today. But in the OR during surgery? The distraction of mobile devices isn’t limited to the sidewalk or car, it seems.

There’s growing concern that the obsessive attraction to little screens at best disrespects patients and at worst endangers their care.

Anesthesiologist Peter Papadakos, MD, says that when he was in training in the late 1970s and 1980s, it was routine to bar residents from studying or reading in the OR or on patient units. But today’s hospital is a “radical departure,” where everyone from the unit clerk to physicians seems to have their eyes glued to a mobile device, he writes in a commentary in Anesthesiology News (November 2011).

A surgeon’s personal calls His piece was picked up by The New York Times in an article on “distracted doctoring” (December 15, 2011). Among incidents the Times cites:

- A patient was left partly paralyzed after surgery; the neurosurgeon was distracted using a wireless headset to talk on his cell phone. “He was making personal calls,” the patient’s lawyer, Scott J. Eldredge, told the Times; at least 10, according to phone records.
- Anesthesia residents checked e-mail or entered logs on another case during surgery.
- A nurse was reprimanded for checking airfares on an OR computer during surgery.
- In a survey of perfusionists, 56% reported using a cell phone during cardiopulmonary bypass, though 78% believed cell phone use potentially poses a significant safety risk to patients (Smith T, Carling E, Searles B, Perfusion. 2011;26[5]:375-380).

Minimizing distraction Policies prohibiting use of mobile devices in the OR don’t seem realistic, judging from OR directors we’ve spoken to. Some ORs call for a “quiet time” or “zone of silence” during critical periods like the time-out and surgical counts (August 2011 OR Manager, p 14).

Appealing to professional responsibility is another approach.

Dr Papadakos conducts education for physicians on electronic distraction at his institution, the University of Rochester Medical Center in Rochester, New York.

“I point out that it’s a semi-addiction,” he says out, comparing it to cell phone use while driving.

The facts on that front are sobering—in 2009, 5,474 people were killed in crashes involving driver distraction. Drivers who use hand-held devices are 4 times more likely than other drivers to get in crashes serious enough to injure themselves, according to the US Department of Transportation (www.distraction.gov).

In the OR, adding electronic distractions to music, paging, and the whine of powered instruments isn’t a healthy combination—for patients or clinicians.

Maybe what we all need is a more mindful connection with the people actually in our presence.

—Pat Patterson
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Presented by:
Joint Commission targets fatigue

Continued from page 1

likely to make an error. Other studies have linked long shifts to the risk of errors, close calls, and decreased vigilance, as well as higher rates of nurse injuries.

“An overwhelming number of studies keeps saying the same thing—once you pass a certain point, the risk of mistakes increases significantly,” according to Ann Rogers, PhD, RN, FAAN, a sleep medicine expert at Emory University, quoted in the alert.

Residents’ duty hours have also been a focus of studies, and standards have been set by the Accreditation Council for Graduate Medical Education.

Steps to address fatigue

The commission suggests 8 steps to help address effects of fatigue from extended work hours. Here is a summary:

• Assess your organization’s fatigue-related risks, including assessment of off-shift hours, consecutive shifts, and other staffing practices.
• Assess handoff processes because they are a high-risk time, especially for fatigued staff.
• Invite staff input into scheduling to minimize potential for fatigue.
• Create and adopt a fatigue management plan that includes scientific strategies to fight fatigue, such as actively conversing with others, engaging in physical activity, using caffeine judiciously, and taking short naps.
• Educate the staff about sleep hygiene and fatigue’s effects on patient safety. Sleep hygiene includes getting enough sleep and practicing good sleep habits.
• Provide opportunities for staff to express concerns about fatigue, supporting their concerns and taking action.
• Encourage teamwork to support staff who work extended hours to protect patients from harm, such as second checks for critical tasks or complex patients.
• Consider fatigue as a potential contributing factor when reviewing all adverse events.
• For organizations with a policy for sleep breaks, assess the environment provided for sleep breaks.

12-hour shifts in the OR

Perioperative managers and directors gave extended shifts mixed reviews in a survey by OR Manager (September 2010 issue).

In all, two-thirds of participants used 12-hour shifts for nursing staff. Of those, the largest group said 25% or less of their staff worked these longer hours.

The top 3 reasons for 12-hour shifts in the OR were:
• matching operating schedules of some surgeons or specialties
• covering off-shifts
• aiding recruitment and retention.

Many said the extended shifts are popular with nurses, and doing away with them would be unpopular in a specialty where recruitment and retention are an issue.

AORN has a guidance statement on safe call practices plus a position statement suggesting that periop RNs not be required to work in direct patient care for more than 12 consecutive hours in a 24-hour period and not more than 60 hours in a 7-day period, consistent with an Institute of Medicine report. Exceptions, such as disasters, should be outlined in organizational policy.


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Hospitals have aggressive cost reduction goals coupled with more quality incentives.

“In the past, we would hear of goals in the millions of dollars,” says Lani Berman, MPH, MBA, senior vice president, performance services for VHA Inc. Today, she says goals are often in the hundreds of millions, especially for large health systems.

“To reach these aggressive numbers, you have to reach beyond pricing and standardization,” Berman says. Hospitals know they need support from physicians. An average-sized community hospital could lose more than $1.4 million annually starting in 2013 due to poor quality scores, notes a PricewaterhouseCoopers (PwC) report on hospital-physician partnerships.

At the same time, more than half (56%) of physicians PwC surveyed said they want to align more closely with hospitals to increase their income.

A megatrend
Physician employment “is a megatrend—in most cases, it’s going to be the model,” says Ken Mack, an independent consultant with long experience forging hospital-physician partnerships.

“We’ve seen a relatively quick evolution in reimbursement, and that dictates where physicians practice.”

A driving force is bundled payment, expected to become a common model in the next few years. Under this arrangement, hospitals, physicians, and other providers receive a single “bundled” payment for an episode of care, such as a total joint replacement. Medicare is conducting bundled payment demonstration projects. The aim is to encourage more collaboration among providers to deliver more efficient, coordinated care while maintaining or improving quality.

In the meantime, says Mack, depending on the local market, you can expect to see joint ventures, comanagement, and other types of physician partnerships.

Coming full circle
Where surgeons do surgery is coming full circle. Consider a urology practice, for example. Ten or 15 years ago, the urologists’ reimbursement came primarily from hospital-based procedures. Then they joined an ambulatory surgery center (ASC) where they could operate more efficiently and share in the profits.

As technology evolved and reimbursement policy changed, they began taking more procedures into their offices. Now, Mack says, many want to bring their procedures into a hospital-based ASC, where reimbursement is significantly higher.

Sharing in gains
Once surgeons are employed, Mack says, “There are lots of ways to participate in gainsharing.”

A model he favors both for the short term and long term is comanagement where a physician or group takes a role with the hospital to jointly manage a service line such as orthopedic surgery.

These arrangements can be designed so physicians can earn a bonus for meeting targets, giving them an incentive to participate in projects to manage costs and improve care.

“Clinical comanagement works better than having medical directors,” Mack says. Unlike most directorships, comanagement contracts are formal and typically go

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<th>Type of physician alignment with hospitals</th>
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<tr>
<td>Employment</td>
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<td>Directorships, stipends, management contracts</td>
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Setting goals
This is how a comanagement bonus might work. The third party sets year to year with specific, measurable goals. Generally, a third party sets the fair market value for the position to avoid any appearance of an illegal inducement for physician referrals.

Employment
Physicians are employed for medical services. In return, either a full-time or part-time salary is paid by a hospital, medical foundation, provider-based clinic, faculty practice plan, or group practice.

Joint venture
In a joint venture between physicians and a service line, such as an ambulatory surgery center, the venture owns the service line and bills third-party payers for patient services.

Comanagement
The hospital contracts with physicians to manage a service line either by direct contract or through a new-entity joint venture.

Directorships, stipends, and management contracts
Under a contractual relationship, a clinician leader provides leadership and administrative oversight.

Gainsharing
A structured arrangement between a hospital and physicians to share savings for a service without jeopardizing quality. The arrangement meets specific criteria set by the Health and Human Services Office of Inspector General.

Program reinvestment
A hospital and physicians collaborate to reach targets for cost and quality for a procedure or service line.
- The project extends beyond supply savings to include, for example, efficiencies, quality metrics, and length of stay.
- If targets are met, no cash payments are made to the physicians. Instead, the hospital shares savings by reinvesting into the service line. The reinvestment may be used for items such as capital equipment, additional personnel, and staff education to enhance the specialty.


• assisting the OR to meet its budget.
  “Under the law, you cannot pay physicians for savings, except under formal gainsharing,” such as the Goodroe model, he says. But a bonus can be paid for meeting the budget, which, of course, includes both cost and revenue.

Comanagement is flexible, in that it can be structured to contract with an individual physician or a group, Mack says.

Looking to the long term
He sees forward-thinking physicians starting to say, “I need to partner with a hospital for a long-term relationship.”

They see that if they partner with one health system, they are more likely to be able to influence the OR to become more efficient as well as to improve on their clinical measures than if they operate at multiple facilities.

The PwC report found orthopedics to be the specialty least interested in employment, at 25%.

But Mack says he’s hearing orthopedic surgeons—whom he says tend to be 2 to 3 years ahead of their peers on business matters—approaching hospitals about partnering in other ways.

Benefits of partnering
As physicians begin partnering with hospitals and working with OR leaders, they’re realizing they could see benefits. By collaborating on standardized protocols, they may find they can do an additional case because of improved throughput. The hospital might agree to hire an additional physician assistant to help manage orthopedic case flow. They might find ways to streamline the preop process so patients are cleared for surgery in a timelier manner.

Continued on page 8
OR economics

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Similarly, as surgeon partners begin to see the data on the hospital’s costs, they are more likely to be involved in managing those costs. They are also more apt, Mack says, to go back to their peers and say, “I’ve seen the data. We aren’t going to stock that implant anymore.”

“There is no question orthopedics is going to be bundled,” he says. With arrangements like cost management, physicians and hospitals will have a way to transition from the current system of discounted fee for service to bundled payment.

“I really believe that with bundled pricing, if you start working now, by the time you need it, you will be true partners,” he says.  

—Pat Patterson

References

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Shared savings change dynamics between a hospital and surgeons

A n agreement with orthopedic and spine surgeons to share savings has enabled a large medical center to make major strides on its implant costs. It’s also provided eye-opening opportunities to improve patient care.

Under the agreement, termed gainsharing, a hospital and physicians enter into a formal contract to share savings through a mutual effort to reduce costs for certain services without jeopardizing quality.

The project, now in its third year at St Luke’s Regional Medical Center in Boise, Idaho, has contributed to savings averaging more than 50% for premium total joint implants.

St Luke’s now pays an average of about $4,800 for a total joint prosthesis, down from about $10,000 when the project began, notes Angela Christensen, MBA, BSN, RN, administrator of surgical services.

Sharing savings

The biggest savings were in Year 2, totaling $6.5 million out of $30 million to $35 million spent for joint and spinal implants. Christensen acknowledges St Luke’s probably was paying more for implants than others and thus had a bigger opportunity for savings.

About half of the surgery at St Luke’s is spinal and joint procedures. St Luke’s and its sister Meridian Medical Center have an annual volume of about 900 total joints and 500 spinal procedures.

The gainsharing arrangement is administered by Goodroe Healthcare Solutions, a unit of VHA Inc, which negotiated the legal agreement with the surgeons, maintains the database for patients treated under the agreement, and provides data analysis.

Savings from the project are shared 45% by the hospital and 45% by the physicians, with 10% set aside in an educational fund for the staff.

A new day for implants

Gainsharing has changed the dynamics with surgeons. At the beginning, Christensen says, vendors would often bring in an implant a surgeon had requested, and the hospital didn’t know about it until it received the invoice.

As in most hospitals, the orthopedic surgeons and neurosurgeons have close relationships with vendors. Surgeons often have worked with the same brand of implants since residency and rely on the service vendor reps provide.

Rather than limiting surgeons’ choice, St Luke’s savings have come through a capitated approach to implant pricing and engaging the surgeons to work with the hospital.

“We wanted to make sure the clinical end user had the decision of which vendor to use,” she says.

To help change the dynamics, Christensen formed a 3-person team, consisting of herself, be-
cause she has a relationship with the surgeons; the contracting di-
rector of supply chain; and the OR
business manager.

The capitated pricing approach pays vendors a specified amount for each implant construct, regard-
less of vendor, an approach many organizations have adopted. The
hospital has 6 total hip constructs and 6 or 7 for total knees.

“It took a lot of trust,” Chris-
tensen says. “You have to be hand
in hand with the surgeons. Com-
munication is number one.”

The team asked for the sur-
geons’ support. For example, if a
vendor took issue with the con-
struct pricing, they asked if the
surgeons would be willing to wait
30 days to use that vendor while the hospital negotiated.

She’s seen a closer relationship
develop with the surgeons.

“They’re now comfortable call-
ing me or the business manager
and saying, ‘The vendor is telling
us this new thing is coming out. Can you find out how much it will
cost? I told them I couldn’t use it
without the permission of the hos-
pital.’ That has never happened
before.”

Transparency builds trust
Transparency with the surgeons is essential to develop trust, she adds.

“We let them know all the ven-
dors we have contracted with and
what we are paying for each con-
struct.” Surgeons signed a con-
dentiality agreement pledging not
to give the pricing information to
vendors.

The hospital also shares the
surgeons’ data with them in regu-
lar reports. Trust has reached the
point where the surgeons’ average
cost per case is reported by name.

“We have had open, candid dis-
cussions,” says Christensen.

One surgeon, for example, al-
ways used 2 packages of antibi-
otic-impregnated cement for a
primary total hip. His colleagues
questioned that, saying the litera-
ture didn’t show the antibiotic ce-
ment makes a difference in infec-
tion rates. The surgeon decided he
wouldn’t change his practice, but
at least the conversation occurred.

Data highlights outcomes
Tracking quality data is a key to
help ensure patient care doesn’t
suffer from cost reduction efforts. The Goodroe database provides
detailed information on patients’
demographics, comorbidities, and
outcomes.

St Luke’s was pleased to learn,
for example, that 80% to 90% of its
total joint patients are discharged
to home rather than a rehab facil-
ity, which exceeded the Goodroe
benchmarks.

It also found opportunities to
improve. The data showed that el-
derly hip fracture patients with co-
morbidities had a higher length of
stay, at 9.5 days, and a higher mor-
tality rate than the benchmarks.
They also had more complications
like pneumonia and deep vein
thrombosis.

That prompted a review by the
clinical staff and surgeons to see
what they could do differently.

“It was good to have the sur-
geons around the table talking
about what each felt was impor-
tant for these patients,” Chris-
tensen says.

“We were actually able to map
the critical pathway with an entire
order set. Before, each surgeon did
his own thing.”

Among the issues: Should pa-
tients be rushed to surgery so they
could get out of bed sooner to
prevent pneumonia? What about
patients who are on Coumadin or
have comorbidities like poorly con-
trolled diabetes or malnutrition?

Anesthesia providers got in-
volved to discuss what type of an-
esthesia was best. Elderly patients
who have general anesthesia can
have problems with confusion. Re-
gional anesthesia has advantages
for pain control without motor
loss, less use of opioids for postop
pain, and physical therapy.

Collecting the data
Though the project entails a lot of
data collection, Christensen says it’s manageable.

Most data fields are similar to
those documented by nurses in
the OR information system. These
were mapped to the Goodroe da-
base. For the 10 to 15 fields that
could not be mapped, a clerical
person enters the data.

The OR business manager ad-
ministers the project, ensuring data
integrity and preparing quarterly
presentations for the surgeons.

Gainsharing lessons
Christensen offers these lessons from the project:

• Do your homework up front to
develop constructs with clear
definitions. Link the vendors’
brands names to the appropriate
constructs so there is no confu-
sion.

• Make sure definitions are all in-
clusive to cover, for example, cutting blocks, screws, and pins.

The need for inclusive defini-
tions became clear when one ven-
dor introduced a new total-knee
technology that allowed a custom
cutting block for each patient. That
meant the patient needed a CT
scan (an additional patient charge),
plus the cost of the cutting block,
which could only be used for that
brand of implant.

Gainsharing started the hospital
on the path toward greater collab-
oration, enabling breakthroughs
not only on costs but also for safer,
more coordinated care. ❖

—Pat Patterson
For implants, balancing choice and cost control

**Negotiating with orthopedic vendors can be frustrating as OR leaders strive to balance competing agendas among companies, surgeons, and the hospital. Kimberley Murray, MS, RN, CNOR, administrator for the orthopedic and spine service line at St. Joseph’s Hospital (SJH) in Syracuse, New York, reduced frustration by adopting a program that increased surgeon satisfaction and improved the OR’s bottom line. SJH is a 431-bed, nonteaching, not-for-profit hospital with 12 inpatient OR rooms and 2 surgery centers.**

“We have been successful by being able to control the process,” says Murray. That process has enabled SJH to maintain or decrease costs despite rising implant costs.

**The case for planning**

Gaining control over orthopedic expenditures, particularly implants, is an important financial move according to Murray. The American Academy of Orthopedic Surgeons forecasts knee replacement volume will jump by 670% and primary hip replacements by 174% between 2006 and 2030. SJH performed approximately 1,600 joint replacements in 2011—a 20% increase over 2010.

As OR leaders know, orthopedic replacement surgery is expensive. In 2007, medical device expenses totaled $80 billion, with implants accounting for a substantial portion, and costs for implants are expected to rise 9.8% annually to $23 billion by 2012, according to Health Care Management Review.

Unfortunately, “Medicare reimbursement has not kept pace with rises in costs of implants,” says Murray.

Murray says one of the challenges in managing costs is that joint implants “are driven almost exclusively by physician choice.” She had to balance the desire to control costs with the desire to encourage other orthopedic surgeon groups in the area to move to SJH.

“We had to engage physicians in a nontraditional manner,” she says. That included managing the triad of who participates in purchasing orthopedic implants: the hospital, the surgeon, and the vendors.

**It takes three**

“Vendors are very skilled at what they do,” says Murray. Vendor representatives had developed close alliances with the surgeons over the years and had to understand the new ground rules.

“We have no discussions [about implants] with any vendors unless all 3 entities [vendor, surgeon, hospital representative] are there. That’s a dramatic change,” says Murray, who often serves as the hospital’s representative, particularly when new technology is discussed.

“The hospital and physician have to stand firm,” she says, adding, “We made it clear to the vendor that the hospital and physician are aligned.”

Murray traces surgeon support for the change back to the creation of the orthopedic service line in 2008, which put the service line in the hands of her and a medical administrator, Seth Greenky, MD. (See May 2010 OR Manager.) “We do everything together,” she says. They are members of a governing council that reports directly to the CEO. In practice, they interact with the CEO on a regular basis.

The service line includes a co-management agreement with the orthopedic groups. Murray advises collaborating with a consultant knowledgeable about governmental regulations to develop the agreement so it meets legal requirements.

“If you work in partnership with physicians to improve quality, to improve patient satisfaction, to improve implant costs, and to lower the cost of care, it’s completely legal to share some of those financial gains with the physicians you work with,” she says.

SJH sets aside money as “at-risk payment” that is linked to quality improvement and indicators such as those from the Surgical Care Improvement Project, reduction in complications, and patient satisfaction goals. “Physicians are incentivized to help improve quality.”

The bar is set high; in fact, in the 2 1/2 years the agreement has been in place, the total amount has never been issued. But money isn’t the primary motivator for surgeons, says Murray. “It’s more that the feel they are involved and improving quality of patient care, and the hospital appreciates what they are doing.”

**Strategies at the heart of SJH’s success in orthopedic vendor negotiations are competitive bidding, primary and secondary vendors, and product fairs.**

**Competitive bidding**

Murray says SJH conducts a competitive bidding process for all implants at least every 2 years, rotat-
**Orthopedic purchasing agent**

At St. Joseph’s Hospital, the central purchasing department was responsible for the OR, which meant those conducting vendor negotiations typically did not have a clinical background and deferred to the surgeons for decisions.

With hard work and effective “selling,” Murray was able to create a new position, orthopedic purchasing agent, which reports to her.

“This was one of our [she and Dr Greenky] toughest battles,” she says.

As part of the proposal, Murray wrote a job description and conducted a return on investment analysis for the position. Ultimately, she had to make her case to the CEO, and it took 6 months to receive approval. Since the position started 16 months ago, Murray says a running tally of savings has demonstrated its value.

The purchasing agent “manages all facets of product acquisitions,” she says, a task that promotes integration. For example, for a robot purchase, the agent would manage the capital purchase, consumables, and service contract to obtain the best price and service.

For this type of position, Murray recommends a person familiar with the OR.

“We had someone who rose through the ranks with materials management, so she knew the supply chain process specific to the OR.”

The purchasing agent doesn’t have to be a nurse because the OR specialty coordinators are the clinical experts. The orthopedic purchasing agent must also adhere to the policies of the purchasing department.

“Meeting attendance is high because the surgeons know they have a tremendous influence over decision making,” says Murray. Surgeons who don’t participate forfeit the right to take part in the decision.

Costs are benchmarked against those obtained from The Advisory Board’s Surgery Compass program, which allows the user to enter a price and compare it with national averages. The program takes geography into account. Murray says other options include Orthopedic Network News and ECRI Institute.

Based on the analysis, the committee decides who will be asked to participate in the vendor fair.

**At the fair**

All the vendors set up in one room, which allows the surgeons, physician assistants, residents, and staff to go from one table to another. “Everyone participates,” says Murray.

After the fair, the OSC reconvenes to choose which vendors will move forward to the product trial.

“All physicians are required to participate in the trial process,” says Murray. “No other products can be introduced. During the month of the trial, we don’t exclusively use the current company’s products.” Implant costs are what the vendor presented in the bid.

After the trial, the OSC chooses the primary and secondary vendors. The hip and knee vendors are usually different. If 2 companies had comparable implants and similar prices, Murray says value-added services such as clinical education and patient education would be used to help make the decision.

Continued on page 14
A 4-year study shows patient outcomes didn’t change significantly when hospitals and physicians joined in a pay-for-performance (P4P) program for 8 types of surgery. The researchers say this is one of the first studies of P4P to look at patient outcomes.

The project used a gainsharing model in which 3 New York City hospitals and about 300 physicians shared savings while tracking outcomes to make sure financial incentives didn’t jeopardize quality.

“Our premise was that if P4P was done correctly, there should be no effect on quality, and we put this to the test,” Faiz J. Bhora, MD, MBBS, FACS, one of the researchers, told OR Manager. Participating hospitals were Beth Israel Medical Center, St Luke’s Hospital, and Roosevelt Hospital.

Examining the results for 1,768 patients having major surgery from 2007 through 2010, the study found morbidity and mortality rates weren’t statistically different before and after the project was implemented.

For example, in 269 colorectal operations, the complication rate went from 30% before the project to 22% afterward. For lung operations, complications increased slightly, while death rates declined slightly.

“We also wanted to make sure we were not cherry-picking our cases by selecting perhaps the less severely ill patients,” Dr Bhora says. “From our data, we thought we were not because the case mix index and severity score for the hospitals were no different before and after.”

Procedures studied in addition to colorectal surgery were gastric bypass, appendectomy, cholecystectomy, arterial bypass, carotid endarterectomy, and complete and partial lung removal.

Tracker outcomes
Dr Bhora stresses that the study tracked patient outcomes rather than use of process measures such as giving and stopping antibiotics on time or removing the Foley catheter on time.

Outcomes were monitored through the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP), which collects data on 138 variables, and the Society of Thoracic Surgeons database.

Among complications monitored were pneumonia, pulmonary embolism, unplanned tracheal intubation, acute renal failure, bleeding requiring transfusion, cardiac arrest, coma, stroke, superficial surgical site infection, and wound disruption within 30 days.

Cost savings
The researchers estimate that P4P saved about $20 million over the 2 years studied through aspects of care such as shorter length of stay, decreased OR time, more selective use of nonessential technology, and decreased ICU costs.

Every 6 months, participants receive a dashboard showing them their cost breakdown for the OR, ICU, medications, and so forth for specific DRGs compared with their peers.

Dr Bhora says of the study: “It appears from our limited data that one can achieve cost savings that are fairly significant without sacrificing quality.

“This should come as no surprise because the health care system is redundant in many aspects. It is wasteful, it is expensive, and there clearly are areas where things can be done much better and more efficiently with no detriment to patient care.”

The project was conducted by Continuum Health Partners, a 5-hospital system that accounts for about 22% of patient discharges in Manhattan.

The study was presented at the American College of Surgeons Clinical Congress in October 2011 in San Francisco.

OR economics

FDA calls for postmarket studies on surgical mesh
The Food and Drug Administration (FDA) on January 3, 2012, called on manufacturers of surgical mesh used for pelvic organ prolapse (POP) and of single-incision mini-slings used for stress urinary incontinence (SUI) to perform postmarket studies.

The companies will need to submit study plans to the FDA that address specific safety and effectiveness concerns.

The FDA earlier reported on serious complications associated with the use of mesh for POP.

—www.fda.gov
Balancing staff productivity with open OR time

With hospitals under ever greater economic pressure, perioperative managers are expected to hew closely to staffing productivity targets, meaning they must match staffing as closely as possible to the hours of surgery actually performed. They’re also expected to grow surgical volume. Hospitals’ revenue depends on it.

“Every OR has to be growing volume, or their hospital is going to be out of business. As costs are escalating, and reimbursement is declining, if you’re not growing volume, you’re losing money compared to last year,” says Randy Heiser, MA, president and CEO of Sullivan Healthcare Consulting, Ann Arbor, Michigan. “You cannot run an operating room that is 100% full and hope to grow your volume.”

A tough spot
That’s a tough spot for perioperative managers—grow your volume but meet your staffing target, goals that are mutually exclusive. Failure to meet staffing targets can lead to a negative performance review.

This relentless focus on productivity standards, in Heiser’s view, is diverting managers from focusing on the OR’s primary customers—patients and surgeons.

It also hurts morale, he says, because when OR time is unfilled, staff are often sent home early, depriving them of a full paycheck.

Some ORs opt to use part-timers, but that entails more handoffs, which is a patient safety hazard, and requires more resources for orientation and education.

The problem, he says, is that finance departments apply the same types of productivity standards to ORs that they do to nursing units, which doesn’t work.

A competitive market
In one example, a tertiary hospital in a competitive market had 4 rivals within a short distance of each other. About 80% of the surgeons worked at more than one hospital, and about 30% worked at all 4, so it was easy for a hospital to lose market share quickly.

The hospital had made a deliberate decision to run the OR at about 65% prime-time utilization in an effort to capture more volume from surgeons.

But the finance department saw that the OR’s productivity was at 6.05 worked hours per hour of surgery for direct-care staff, including RNs, surgical technologists, and RN first assistants. That compared to the target of 3.79 worked hours per hour of surgery.

The finance department told the surgical services administrator the department was overstaffed. But the administrator responded that to meet the target, she would have to cut the number of rooms running almost in half, which was inconsistent with the objective of attracting surgeons.

The final staffing standard, at 6.53 worked hours per hour of surgery for all intraoperative staff, incorporated the strategic goals of the perioperative program and provided staffing for a targeted utilization of 60%.

Strategic approach
Addressing this dilemma takes a strategic approach by perioperative leaders and senior executives that is based on an OR coverage plan, Heiser suggests. The coverage plan includes open time and guides the staffing. The plan is developed by the surgical services governing body, which should include leaders from nursing, surgery, and anesthesia as well as a member from the senior administration such as the CEO or COO. The governing body sets the OR’s strategic direction and develops and enforces policies. (For more on OR governance, see the June 2010 OR Manager.)

Coverage plan example
Here’s an example of what a coverage plan might include:

• 10 ORs will be staffed for 8 hours from 7:30 am to 3:30 pm Monday through Friday.
• The target utilization will be 85%, with 75% of the capacity for surgeon elective blocks, allowing for open, nonblocked OR time.
• The productivity standard for direct-care staff will be based on the target utilization. That might mean, for example, increasing the productivity target by 25% to 30% or even 100%, depending on much competition there is for surgeons in the local market.
• On the day of surgery, the person running the schedule will...
make the decision to fill any remaining open time by slotting in add-on cases and/or allowing some surgeons to “flip” rooms. In flipping, a second room is set up before a surgeon finishes the previous case, allowing the surgeon to move directly to the next case.

Many ORs use flipping as a way of improving customer service to surgeons. Though flipping requires more staff and thus can cause the OR to fall short of the productivity target, it can pay off if it attracts enough additional well-paying cases. Flipping should be a business decision guided by clear, consistent policies and viewed as a tactic that is in line with the hospital’s business objectives and strategic plan. (For more, see December 2010 OR Manager.)

If some time is unfilled, the staff isn’t automatically sent home unless nothing can be done to fill the time.

C-suite involvement

Having an executive from the C-suite on the OR’s governing body is a major asset, Heiser says. The executive serves as a liaison with the senior administration and the finance department. That can help to reconcile the objectives of meeting staffing benchmarks and having open time to recruit surgeons.

The executive, for example, could go to finance, explain the OR’s coverage plan, and say: “We need to suspend the productivity standards for the OR. Or we need to modify them so they are consistent with our growth goals.”

Raising the standard doesn’t mean loosening up on management of the daily schedule or hiring new staff, he points out. He says it can even reduce some case times because the staff is not as inclined to slow their pace so they can stay and be paid for a full 8 hours.

“This actually improves morale because people who are full time are actually working full time.”

References

Patterson P. Flipping ORs: Does this common practice make business sense? OR Manager. 2010; 26(12):1, 6-8.
Patterson P. Is your OR leadership team up to health care reform challenges? OR Manager. 2010; 26(6):1, 6-7.

Managing ortho implants

Continued from page 11

decision. Murray communicates the outcome to the surgeons and then turns over the process to the orthopedic purchasing agent.

“It may be 4 to 6 weeks until the contract is negotiated,” says Murray, who adds, “We always put language in the contract about new technology. If there is a new generation of an item, the pricing has to be consistent with the current product. If the item is radically different, we do a separate negotiation.”

Murray also notifies the vendors of the decision. “We have relationships with all of them [vendors]. They are people we know, so we typically share with them high level detail as to what made us go with the vendor.”

Be focused and follow up

Murray recommends attacking one area at a time.

“It’s only when we drilled it down and broke out orthopedics as a separate section of vendor negotiations that we were able to make significant differences,” she says. Another key to success is ongoing measurement of financial impact, monthly surgeon volume, and quality indicators. ❖

—Cynthia Saver, MS, RN

Cynthia Saver, a freelance writer, is president, CLS Development, Inc, Columbia, Maryland.

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Guideline: Test all patients for blood glucose levels

A ll patients should have their blood glucose levels tested on hospital admission under a new guideline from the Endocrine Society.

Observational studies report 32% to 38% of patients in community hospitals are hyperglycemic.

Hyperglycemia is linked to an increased risk of complications and mortality and is found even in non-diabetic patients, the society notes.

The guideline has recommendations for practical and safe glycemic targets plus protocols and system improvements to achieve glycemic goals.

The guideline, “Management of hyperglycemia in hospitalized patients in non-critical care settings,” will be in the February 2012 Journal of Clinical Endocrinology & Metabolism. ❖
Editor’s note from ECRI Institute

This report provides a detailed overview of the training and learning curve for surgeons who wish to perform robotic-assisted surgery (RAS) using the da Vinci Surgical System (Intuitive Surgical, Inc., Sunnyvale, CA, USA) for various clinical indications. We address issues pertaining to implementation of an RAS program and training new teams and surgeons to do RAS. Because it does not focus on a particular clinical indication, this report does not include some information typically found in standard sections of Emerging Technology Evidence Reports (i.e., Incidence/Prevalence, Safety, Competing/Complementary Technologies, Future Trends, Reimbursement, Cost-effectiveness, Evidence Base, Results).

Technology description

The da Vinci Surgical System has three or four robotic arms, each with attached instruments. The arms have seven degrees of freedom and are remotely controlled by a surgeon from a console.

While seated at the console, the surgeon views the surgical field through a magnified high-definition, three-dimensional vision system. Throughout the procedure, the patient lies on an operating table positioned next to the patient-side cart, and a bedside assistant performs necessary functions on the patient and robot (e.g., instrument exchange).
Surgeons are using da Vinci Surgical Systems to perform robotic-assisted surgery for many indications in children and adults. Some conditions commonly treated with RAS include cancer, heart conditions, gynecologic disorders, kidney disorders, and obesity. The procedures performed with greatest frequency using the da Vinci system are prostatectomy and hysterectomy, which together accounted for approximately three-quarters of the da Vinci surgical procedures performed in 2010.

The purported advantages of RAS compared to open surgery include a shorter hospital stay and recovery time, less pain and perioperative blood loss, and smaller surgical incisions. Compared to other minimally invasive approaches such as traditional laparoscopy, the purported benefits of RAS include less blood loss; shorter hospital stay; three-dimensional surgical field view; an intuitive design with the ability to perform more precise instrument movement; motion downscaling, anti-tremor filter, and increased degrees of freedom in surgical instruments which enable the surgeon to manipulate instruments in directions not possible by the human hand; and reduced surgeon fatigue.

Purported disadvantages of RAS include the lack of haptic feedback, greater consumption of operating room resources, higher costs for some procedures, limited options for trocar placement, and potential to lose sight of surgical tools while looking at the surgical field through the magnified display.

Learning Curve

RAS has introduced a need for surgeons to learn new types of surgical skills. The clinical learning curve begins when surgeons start to perform real procedures on real patients. Currently, no consensus exists regarding how to define the end of the learning curve, which can serve as a measure of skill acquisition and proficiency. Some commonly reported surgical aspects used to gauge a surgeon’s place on the learning curve include intraoperative parameters (e.g., instrument use proficiency, estimated patient blood loss during surgery, operative time, the patient’s warm ischemic time, lymph node recovery rate); procedure complication rates; procedure conversion rates to open surgery; pathologic outcomes (e.g., positive surgical margin rate, biochemical recurrence); and patient-oriented outcomes (e.g., continence, potency). Other nonclinical quantitative criteria include camera motion, dexterity, grip force, hand movements, and relative phase.

The articles we retrieved and reviewed reported a range of learning curves for the following procedures:

- Hysterectomy, benign or unspecified: 20 to 50 procedures
- Hysterectomy, oncologic: 4 to 24 procedures
- Sacralcolpopexy: 10 procedures
- Nephrectomy: 19 to 30 procedures
- Cystectomy: 11 to 30 procedures
- Prostatectomy, intraoperative and functional outcomes: 10 to 500 procedures
- Prostatectomy, pathologic outcomes: 30 to 300 procedures

Training

Manufacturer-sponsored training on the da Vinci Surgical System involves product training, clinical training, and continuing clinical education for teams of surgeons and operating room staff. This training pathway focuses on developing da Vinci-related knowledge and skill and learning and applying da Vinci-specific techniques and clinical applications with peer-to-peer education. Training is provided through distance learning, on-site and off-site.
training, procedure practice, clinical support, and additional tools and support. Although the manufacturer does not directly offer clinical training and continuing clinical education, Intuitive Surgical may help coordinate these portions of a surgeon’s training with providers (i.e., independent surgeons, societies, academic institutions).

Although basic robotic skills training can be applied within and across specialties, procedure-specific training is required to develop the proficiency required to perform a specific surgical procedure. Non-manufacturer-sponsored training programs have emerged that focus on acquiring clinical robotic skills. Clinical RAS skills are taught during surgical residency training, fellowship training, five-day mini-fellowship courses, two-day courses, and proctorships. Program content varies widely and can include didactic training, instructional videos, dexterity skills, inanimate models, simulators, animal or cadaver laboratories, case observation, and clinical experience.

### Credentialing

According to the Society of American Gastrointestinal and Endoscopic Surgeons and the Minimally Invasive Robotic Association, surgeons can receive RAS credentials only from the institution where they wish to perform RAS, based on surgical proficiency, not on number of procedures performed. Some medicolegal risks may be associated with improper training and credentialing in RAS.

### Adverse Events

Several studies have reported a higher complication rate for novice surgeons than for “experts,” although this rate typically decreases as the surgeon progresses through the learning curve. However, we have not assessed this evidence to determine its validity or draw any conclusions.

### Training Costs

Intuitive Surgical charges $3,000 to train each surgeon, and trainees are typically responsible for travel expenses incurred to attend training sessions.

### Learning Curve Costs

During the learning curve, additional costs are associated with the decreased efficiency of a new robotic surgeon. According to one report that examined the costs associated with the robotic-assisted prostatectomy learning curve, the average learning curve was 77 cases (range, 13 to 200), costing an average of $217,034 (range, $49,613 to $554,694).

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*Excerpted with permission from ECRI Institute’s database of Emerging Technology Evidence Reports. The complete report can be purchased from ECRI Institute’s Health Technology Assessment Information Service at htais@ecri.org.

ECRI Institute is an independent nonprofit health services research agency designated as an Evidence-based Practice Center by the U.S. Agency for Healthcare Research and Quality. The Institute maintains the strictest conflict-of-interest standards in the health care industry to protect against biases and ensure the integrity of its information.*
SELECTED RESOURCES

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Is your OR’s clinical documentation as specific as it needs to be? That’s the key question perioperative directors and managers need to ask as their organizations gear up for ICD-10.

The big date is October 1, 2013. Starting then, all claims have to be submitted using the ICD-10 coding sets. No extensions. No grandfathering.

Much of the effort falls to the health information management (HIM) department. But clinicians play a critical role because thorough documentation is the foundation for complete and accurate coding.

And coding under ICD-10 is certainly specific:
- ICD-10-CM, used for diagnosis coding, has 68,000 codes compared to about 13,000 in ICD-9-CM.
- ICD-10-PCS, for procedure coding, has about 70,000 codes compared to about 4,000 ICD-9 procedure codes.

ICD-10 codes are also longer and can capture more detail. ICD-10-CM, for example, has 50 codes for complications of a retained foreign body, compared to only 1 code in ICD-9-CM, the American Health Information Management Association (AHIMA) points out.

Examples:
- T81.535: Perforation due to foreign body accidently left in body following heart catheterization
- T81.530: Perforation due to foreign body accidently left in body following surgical operation
- T81.524: Obstruction due to foreign body accidentally left in body following endoscopic examination
- T81.516: Adhesions due to foreign body accidently left in body following aspiration, puncture, or other catheterization.

### Expanding codes

Codes for postoperative complications have been expanded, with a distinction between intraoperative complications and postoperative disorders. Examples:
- D78.01: Intraoperative hemorrhage and hematoma of spleen complicating a procedure on the spleen
- D78.21: Postprocedure hemorrhage and hematoma of spleen following a procedure on the spleen.

### A big upside

The transition is challenging, but the specificity has a big upside.

AHIMA notes that use of ICD-10 will yield more detailed information, enabling a deeper understanding of complications, design of more robust algorithms, and better tracking of patient outcomes. That will be a big boost for quality measurement and improvement efforts down the road.

### Managing the transition

You can expect to be hearing from the HIM department as your organization gears up.

According to AHIMA’s implementation plan and timelines, HIM specialists will be assessing clinical documentation during 2012 and 2013, carrying out strategies for improvement as needed. They will also be assessing how the transition will affect coder productivity. Some predict coder productivity could fall off by as much as 50% after October 1, 2013, in turn, holding up claims and reimbursement.

No one really knows what the impact will be, says AHIMA’s manager of professional practice resources, Melanie Endicott, MBA/HCM, RHIA, CCS, CCS-P.

There is a remedy: Get coders up to speed ahead of time, she advises.

AHIMA recommends that coders start practicing with ICD-10 6 to 9 months ahead of time. Some organizations will have coders practice in advance by dual coding with both ICD-9 and ICD-10.

### What to know about ICD-10

Here are things for periop managers and directors to keep in mind.

**Documentation is critical**

Correct coding—and thus, proper billing and payment—depends on good documentation.

“We need to have good, accurate documentation from all health care providers so we can assign the appropriate codes,” Endicott says.

Coders use physician documentation to assign codes, but sometimes nursing is reviewed for further clarification.

“It’s important for the HIM department to work with the nursing staff to provide education on any documentation gaps that are identified,” she says.

**Be specific**

Be as detailed as possible in coding both for diagnoses and procedures. Coders will need to know, for example, the laterality of surgery, types of implants, and site of implant placement.

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“When we construct an ICD-10-PCS code for a procedure with an implant, we need to know how the implant was placed,” Endicott says.

For spinal surgery, for example, coders need to know the approach used (eg, anterior or posterior), type of device used, and where it was placed.

“We don’t necessarily need to know down to the serial number of the device, but we need to know how [the surgical site] was approached, where it was affixed, and some detail about the device, such as whether it was an interbody fusion device or a cage.”

If surgery is to treat an injury, detail about the injury needs to be identified. If a knee injury is being treated, for instance, coders will have to assign a character in the code to indicate whether this is the initial injury; a follow-up visit; or a sequela, such as a late effect of a previous injury.

Check up on operative reports
You can aid readiness by reviewing sample operative reports with your coding specialists to see if documentation needs to be enhanced.

Based on what she’s seen in operative reports, Endicott says much of the information needed for ICD-10-PCS coding is already there, but it’s important to review individual operative reports to identify any gaps.

Physician documentation
To educate physicians about the transition, Endicott says many organizations have an ICD-10 team or committee reviewing documentation and working on issues to make sure all clinicians are aware of the implications and are on board.

Impact on ASCs
Ambulatory surgery centers will continue to use CPT codes for procedures. ICD-10-PCS codes are intended only for inpatient procedures.

But like all providers, ASCs will need to use ICD-10-CM for diagnosis coding, so their coders need to be up to speed with this code set. AHIMA estimates coders in settings outside acute care will need about 16 hours of ICD-10 education focusing on ICD-10-CM.

ASCs’ documentation may need to be enhanced for diagnosis coding, however. In one example, codes for diabetes, which many patients have, have changed.

Endicott explains, “We are no longer concerned with whether the diabetes is in control or out of control. But we still need to know whether it is Type 1 or Type 2 and if there are any specific complications from the diabetes, such as kidney failure or glaucoma.”

Staying in touch with your HIM professionals and ICD-10 readiness team should enable you to have your clinical staff ready to meet the challenges presented by ICD-10.

—Pat Patterson

Resources
American Health Information Management Association
ICD-10 Implementation
–www.ahima.org/icd10/
Center for Medicare and Medicaid Services
CMS ICD-10 website
Contexo Media
Coding resources
–www.contexomedia.com/

Metal-on-metal implants no better in study
A new study from Australia provides strong evidence that metal-on-metal implants for hip replacement have a higher failure rate than other implants. Drawing on data from Australia’s orthopedic registry, researchers found the effect held across all age groups and was most pronounced with a large head-size implant (>32 mm) and in women.

“The Australian study showed that not a single new artificial hip or knee implant introduced over a recent 5-year period was any more durable than older ones. In fact, 30% of them fared worse,” the December 23, 2011, New York Times reports.

The study is in a supplement to the Journal of Bone and Joint Surgery reporting on an international conference on joint replacement outcomes that included 29 orthopedic registries. The conference was part of an ongoing discussion on how best to track joint replacement outcomes.

An editorial notes that the American Joint Replacement Registry (AJRR) was set up in 2010 and piloted in 2011. Widespread data collection is slated to begin.

Stakes are high in the US because over 700,000 joint implants are performed each year, and volume is growing rapidly.


What’s in the OR Manager Toolbox?
Look in the OR Manager Toolbox at for sample forms, policies and other helps.
You’ll find the Toolbox at www.ormanager.com.
When Providence Sacred Heart Medical Center and Children’s Hospital in Spokane, Washington, decided to tackle waste and inefficiencies in its 4,400 square-foot-case cart and sterile supply room, leaders set modest goals for improvement: increase case picking productivity by 4% and relocate enough items to create 6 carts of space for growth.

Using a Lean methodology called “5S,” a team of staff, managers, and Lean specialists spent 2 days reorganizing their department. The results went beyond initial expectations, increasing productivity by 16% and identifying 14 carts for future growth and expansion.

Sterile supply’s customers include 34 ORs. As a tertiary facility and the only Level 2 trauma center for 280 miles, Providence Sacred Heart completes more than 21,000 procedures annually.

Initial measurements showed the sterile processing department’s (SPD) productivity at 2.5 cases per hour, or 24 minutes per case. With a growing demand for supplies and pressure to do more with fewer resources, the department decided to focus on becoming “Lean” in its operations.

**Flow equals efficiency**

“The walls in the SPD are not made of rubber. They do not stretch, regardless of how much we try to stuff into them,” says Ron Weaks, director of materials management.

“The solution is to make the room more maneuverable by organizing supplies to match the flow. Flow equals efficiency.”

Lean, or “Lean thinking,” has been used in manufacturing for decades but is relatively new to health care. The core idea behind Lean is minimizing waste while maximizing customer value.

With pressure to reduce cost, Providence’s Operational Excellence Department began using Lean tools at the 644-bed hospital in 2009.

In 2010, a value stream map (VSM) was completed on supply chain processes. A VSM is a detailed map of a process that includes the time taken to complete each step, the wait time between steps, and a determination of whether that step is value added or waste. The VSM always looks for waste from the customer’s perspective by asking, “Would my customer be willing to pay for this step or this wait time?”

**Case cart opportunity**

From this work, the case cart space was identified as a key opportunity to remove waste.

The 5 “S’s” are Sort, Set in Order, Shine, Standardize, and Sustain. Providence has added a sixth “S” for Safety.

A typical 5S involves bringing together key staff members for one or more days to overhaul a specific space. The area is emptied, and as each object is removed, it is categorized by whether it should be kept, repurposed, or thrown out. Floors, walls, shelves, and equipment are cleaned, and the team begins planning the layout and organization that best supports their work.

Appropriate par levels, frequency of use, flow of traffic, and room for growth are all considered. The team discusses the plan and must reach consensus before the work continues.

The remainder of the event is focused on placing everything in its new place, labeling shelves and containers, and making sure there are visual cues to help staff maintain the change. These cues (also called kanbans) can be as simple as a photo of the completed space showing the appropriate layout or

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**Day 1: The Lean 5S team at Providence Sacred Heart Medical Center and Children’s Hospital comes together to clean and reorganize the sterile supply area.**

Continued on page 22
The 5S’s of Lean management

What is 5S?
A methodology for organizing, cleaning, developing, and sustaining a productive work environment. 5S creates a visual workspace where abnormal conditions are easily recognizable, supplies are identified, and process standards are visible.

Sort
Separate the necessary from the unnecessary—the most critical of the 5S steps. Sorting forces an objective look at all the supplies in the workspace, identifies additional supplies needed, and establishes proper par levels.

Set in order
Determine a place for necessary items. Places supplies based on frequency of use, ensures less frequently used items are still accessible, labels bins/cupboards/shelves for quick and easy refilling, and labels equipment and mobile items for easy identification.

Shine
Inspect and clean the work area daily. Identifies items and clutter that do not belong, determines supplies that need replacing, cleans surfaces, and communicates standards.

Standardize
Set standard rules for Sort, Set in order, and Shine. Establishes scheduled inspections, ensures everyone is trained in the standards and inspection routines, and makes the first 3S’s a habit and part of a daily routine.

Sustain
Creates conditions and structures that help sustain a commitment to the 5S system. Trains everyone in 5S, schedules 5S audits, outlines responsibilities, creates accountability, and encourages staff through rewards and recognition.

6th S: Safety
Ensures that the first 5S’s support a safe work environment. Obstacles are removed, reaching and lifting are reduced, pathways are kept clear, and broken equipment is quickly identified.

Source: Tonya Dean, Providence Sacred Heart Medical Center.

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tape on the floor showing where a cart should be placed.

5S benefits
5S has many benefits, including removing frustrations and obstacles, improving communication and employee satisfaction, increasing safety, and improving space utilization—but the most important is employee involvement. By design, a 5S event gives staff the opportunity to provide creative input on how their workspace should be organized.

Trust the process
“I have participated in many 5S events in our 1.7 million-square-foot complex, and the number one thing I tell each team is to ‘trust the process.’ It works,” notes Tony Hill, materials manager.

“There are significant costs associated with time. Streamlining our operations through 5S measurably reduces that time-cost factor as well as the inventory-cost factor and the potential for errors.”

After the team had identified baseline metrics and determined timing and staffing requirements, the event was scheduled for 2 days over a weekend. This reduced customer impact and allowed more staff to attend. By adjusting staff schedules and using supplemental shifts, the event was completed with no overtime.

A total of 19 people participated, the majority of whom were frontline staff. Management provided input, but staff decided how to best utilize the space.

After initial training on how to conduct a 5S, the team broke into 3 groups, and each focused on evaluating the needs of a specific area.

The groups then reported back to the team on their recommendations and agreed upon the plan for the next 2 days. Coming together periodically throughout the day to discuss progress and obstacles ensured good communication and shared decision making.

Cart by cart
Cart by cart, every bin was addressed. Items were regrouped by procedure type, expired stock was removed, bin sizes were adjusted, and quantities were modified to match par levels. Similar items prone to picking errors were separated.
Shelves were added or removed to better use the available space, and high-use items were placed in convenient reach. Large and heavy items were removed from upper shelves, and carts were reordered to ensure the best possible flow for staff picking cases.

Vendor items were moved to a dedicated space labeled “vendor row,” and instruments were organized by procedure and spread across more shelves to reduce stacking.

Throughout the process, floors were polished, liners added to shelves to protect supplies from damage, bins cleaned, and old stickers and tape removed.

Finally, all items were color coded by source; relabeled to match their new row, shelf, and bin locations; and their positions were entered into the inventory and billing information systems.

**New space is discovered**

In total, separate par locations were reduced from 9 to 6, 14 carts of space were made available for new stock, space was reserved on every cart for expansion, and the need for overflow carts was eliminated. The newly polished floors were retaped to establish cart boundaries and ensure proper cart placement.

**5S outcomes**

Case cart staff members now pick 3 cases per hour, supply damage is less frequent, and picking errors have been reduced. While the staff was initially hesitant to go through such a dramatic change, they report they are happier with the new space and appreciate the improved flow and access to supplies.

The director of perioperative services, Jo Quetsch, MA, RN, NE-BC, says she is happy with the project’s results.

“I was a little skeptical before I was able to visually inspect the project completion results, but I was immediately impressed with the orderliness of supplies and new naming system for supply location,” she says.

“I was even more excited about applying the 5S concept to the remainder of Sterile Reprocessing, because as we grow the business, we will have a growing demand for supplies and instruments. The core team has gained momentum with other perioperative 5S opportunities. Future plans include a “5S marathon” over holi-

Continued on page 24
Performance improvement

Bins before (top) and after 5S (below). Bin sizes were adjusted and quantities modified to match par levels.

Continued from page 23
day downtime to engage more staff and to maximize resources needed for upcoming projects.

Sustaining gains
Nine months after the 5S event, efficiency gains have been sustained. Nine of the 14 carts have been used for new supplies, and there is still room for growth. The areas are periodically audited to ensure the gains are sustained and to look for new opportunities to use Lean. Plans are already underway to complete dozens more 5S events throughout materials management and surgical services.

—Tonya Dean, Six Sigma Black Belt, Operational Excellence
—Tony Hill, Materials Manager
—Mary Hamilton, Sterile Processing and Decontamination Manager

FDA to monitor cataract devices for TASS

The Food and Drug Administration (FDA) announced in December 2011 a program to monitor devices used in cataract surgery to stem outbreaks of toxic anterior segment syndrome (TASS).

The FDA is collaborating with the Centers for Disease Control and Prevention and the American Academy of Ophthalmology (AAO) on the program, which includes:

- setting up a registry with AAO to collect information about cataract surgery devices and patient outcomes
- standardized methods to test for TASS-related contaminants
- an agreement with the CDC to collect and send samples from suspected TASS outbreaks to the FDA for analysis.

TASS outbreaks have affected patients from hundreds of surgery centers over the past 11 years, the FDA says. TASS usually occurs within 48 hours after cataract surgery. Symptoms include blurry vision and redness. Many cases resolve without treatment, but some people develop serious complications.

—www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm284239.htm

Providence Sacred Heart Medical Center & Children’s Hospital
Spokane, Washington

Team members making this possible include: Jon Gilliland, Teresa Snyder, Anita Cumpton, Corinne Sims, Terry Bichler, Joyce Greear, Scott Labes, Marilyn Carman, Mary Hamilton, Sue Wren, Dale Fitch, Tony Hill, Brent Hoke, Jason Baker, Lee Benson, John Gamalielson, Mike German, Jennifer Offereins, and Tonya Dean.
A study finds fewer complications with team training in surgical suites

An OR team training program adopted by the Veterans Health Administration (VA) has been linked to a decrease in surgical complications in a new study.

An earlier study found the same program was associated with lower patient mortality rates.

The Medical Team Training (MTT) program, introduced nationwide by the VA in 2006, is based on crew resource management techniques used in aviation. The program requires preoperative briefings and postoperative debriefings guided by a checklist and using cognitive aids. The aim is to improve communication in the OR and help the staff work together as a team.

Decrease greater with training

In the retrospective cohort study, the researchers analyzed data from 119,383 procedures at 74 VA facilities, comparing 42 facilities that implemented MTT with a control group of 32 facilities that had not yet been trained.

Though surgical complications declined in both groups, the decline in the MTT group was 20% greater.

“After adjusting for surgical risk, we found a decrease of 15% in the morbidity rate for facilities in the MTT program and a decrease of 10% for those not yet in the program,” they write.

In the earlier study, published in 2010, the team training was associated with an 18% significant decrease in surgical mortality for trained facilities compared with a 7% decrease in facilities that had not been trained (see December 2010 OR Manager).

Teams receive support

The training consists of 2 months of preparation followed by a 1-day learning session. The facilities receive sample checklists and briefing/debriefing tools that they adapt to their needs. The training session, the VA provides 4 quarterly follow-up phone interviews to provide support to assess the implementation.

Beyond a checklist

The authors note that the VA’s MTT program goes beyond a checklist to focus more broadly on teamwork, including use of briefings. It also provides support for facilities before and after the training.

The outcomes were measured using the VA’s Surgical Quality Improvement Program (VASQIP), which has been adopted by the American College of Surgeons for its National Surgical Quality Improvement Program (NSQIP). More on the VA’s MTT program is at www.patientsafety.gov/MTT/index.html

Reference


More bacteria on home-washed OR scrub suits

Home-laundered OR scrub suits had significantly higher bacterial counts than hospital-laundered scrubs in a new study.

The researchers quantified bacteria on swatches cut from unwashed, hospital-laundered, home-laundered, new cloth, and disposable scrubs.

Hospital-laundered scrubs were all processed in an industrial laundry facility with water temperatures of at least 71.1°C, as recommended by the Centers for Disease Control and Prevention. No details were known about home laundering conditions.

Results showed home-laundered scrubs had a significantly higher level of bacteria than the hospital-laundered variety. There was no statistical difference in the total number of bacteria on hospital-laundered scrubs and on unused new and disposable scrubs.

Types of pathogens

Of the unwashed scrub swatches, 79% were positive for some type of cocc, with 3% classified as Staphylococcus aureus but none confirmed as MRSA.

No Staph aureus was found on any of the home-laundered, hospital laundered, or new scrubs, though many other types of potentially pathogenic organisms were found. In all, 44% of the home-laundered scrubs were positive for coliform bacteria, and 93% were positive for fungi.

C difficile was not isolated from any of the scrubs tested, washed or unwashed.

The study did not test whether microbes were transferred to patients.

For a variety of reasons, survey inspectors this year are looking more closely at ambulatory surgery centers (ASC) and other outpatient facilities for evidence of compliance with sharps-safety guidelines. Bloodborne pathogens, of course, have been a concern since awareness of HIV and hepatitis C emerged.

Physicians and nurses have long been wary of the injury potential of needles and scalpel blades as well as that from scissors and other sharp instruments. Because operating rooms are likely sites for blade- and needle-related injuries, surgery centers are a logical focus of attention. Nevertheless, ASC sources say inspections have been spotty over the past decade.

Focus on South
Recently, however, the Centers for Medicare and Medicaid Services (CMS) and the Occupational Safety and Health Administration (OSHA) have announced they will move to enforce more consistently the sharps safety guidelines that have been on the books. The initial focus is on southern states, as part of OSHA’s regional approach to inspections.

A recent review marking the 10th anniversary of the 2000 Needlestick Safety and Prevention Act indicated needlesticks have actually increased in that period. The Exposure Prevention Information Network (EPINet) at the University of Virginia, Charlottesville, tracked injuries before and after the act took effect and found that while nonsurgical sharps injuries decreased by 31.6%, surgical injuries increased by 6.5%.

The act had directed OSHA to revise its standard for bloodborne pathogens (29 CFR 1910.1030).

The EPINet study showed that the dangers, recommended precautions, and incidence rates are the same for various types of facilities with a few exceptions. Teaching hospitals have higher injury rates because they have medical students, for example. Hospitals are generally able to put more pressure on physicians to adopt safety precautions, such as use of scalpels, blunt suture needles, and double gloves.

Sharps-Safety Toolkit
In response to the findings, AORN issued a new Sharps-Safety Toolkit in April 2011.

“Currently, there is not a lot of education about the act,” according to Barbara Kalavik, a spokeswoman for BD (Becton Dickinson) in Franklin Lakes, New Jersey, a manufacturer of safety syringes and other devices.

OSHA inspectors are not always current on the law, either. Lee Anne Blackwell, BSN, EMBA, RN, CNOR, one of the group directors of clinical services at Surgical Care Affiliates (SCA), Birmingham, Alabama, recalls a visit where the inspectors admitted they were more familiar with in-
industrial facilities than with health care.

“We didn’t know whether that would be a good or bad thing at first,” she says. “They stated that these surveys resulted from OSHA deciding that they needed to look at areas that they have ‘ignored’ over the years, so they picked bloodborne pathogens.”

**ASC scrutiny continues**

Some ASC industry observers suspect OSHA and CMS may still be reacting to an incident of 3 years ago in stepping up ASC safety inspections.

Even though the issue was different, patient exposure rather than staff injury, ASCs are still feeling the pressure of public opinion following a 2008 incident. Nevada health officials determined that up to 50,000 people were at risk for the disease because of poor safety practices at the Las Vegas Endoscopy Center.

Writing in *JAMA*, Melissa K. Schaefer, MD, and a panel of researchers noted, “The chain of events resulting from the hepatitis C virus outbreak investigation and patient notification in Nevada highlighted the lack of focused attention to infection control in ASCs.”

Referring to the current wave of inspections, an AORN memorandum to members states, “The [OSHA] releases to do not cite the initial causation for the inspections other than the OSHA regional administrator in Atlanta stating, ‘Employers must take seriously their responsibility to protect workers from these health risks.’” OSHA’s intent is to avoid overlooking non-hospital medical facilities, according to spokeswoman Kimberly Tucker.

“OSHA believed that needle-stick and sharps-related incidents in these establishments may be underrepresented because ambulatory surgical centers and other outpatient centers fall under a standard industrial classification code that does not require them to record or report nonfatal injuries involving needlesticks and sharps,” Tucker told OR Manager.

**A regional emphasis**

The recent inspections are part of OSHA’s Regional Emphasis Program, which targets specific regions and local offices. The program applies only in states where OSHA has jurisdiction. OSHA’s Region IV has 8 states, but 4 operate under state plans (Tennessee, Kentucky, North Carolina, and South Carolina).

The remaining 4 states are Georgia, Alabama, Mississippi and Florida, and OSHA surveyors have been visiting ASCs and other outpatient facilities in those states. Next up will be outpatient centers in the Philadelphia and Pittsburgh areas, according to Tucker.

**Compliance counts**

As Blackwell notes, OSHA imposes the same sharps safety guidelines on inpatient and outpatient facilities. Even physician owners of ASCs are required to comply with the bylaws, including safety guidelines.

“Physicians have a responsibility to comply with OSHA in ASCs as well as in hospitals,” she says.

As a result, the sharps safety program an ASC develops is likely to look much like those at hospitals. The program should promote use of safety devices, including retractable needles and spill-proof sharps containers, and establish procedures to avoid injury from passing instruments during surgery. One method is to have surgeons place instruments on the Mayo stand where scrub persons can see them before picking them up.

Even so, the best rules and products cannot replace common sense, adherence to best practices, and alertness. Blackwell recalls an incident she witnessed as an OR nurse when a surgeon leaned his elbow on the Mayo stand during a procedure. On it was a new 15 blade ready for use, and it penetrated the surgeon’s gown and flesh. “He finished the case, and then we had to treat him,” Blackwell recalls.

The incident occurred before safety scalpels entered the market, so Blackwell began leaving blades on a different table, out of reach. “I have never kept the scalpel on the Mayo since that time.”

**Products that protect**

Under pressure from nursing organizations and manufacturers, hospitals and group purchasing organizations began contracting for products engineered for safety, despite higher prices and some re-

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**Ambulatory Surgery Centers**

**OSHA’s regional emphasis program**

Under OSHA’s Region IV program, federal surveyors are visiting ASCs and outpatient facilities in 4 states:

- Georgia
- Alabama
- Mississippi
- Florida

**Continued on page 28**
sistance from clinicians. Sources say both obstacles have diminished over the past decade.

OSHA does not approve specific products but requires employers to analyze hazards and select appropriate products. If a hazard exists, but no safer product is available, the traditional product can be used. OSHA does require employers to survey the market annually to identify any improvements in safety technology.

According to BD’s Kalavik, popular devices include:
- syringes with detachable needles
- safety needles with shields that are activated with one hand
- needles with beveled tips to facilitate low-angle injections
- blood-collection sets that feature push-button retraction before removal from the patient
- an ergonomic lancet that is activated by skin contact and then automatically retracts into the device.

One ASC’s approach
For several years, Newport Bay Surgery Center in Newport Beach, California, has been using safety devices in its 3 ophthalmology ORs, including detachable needles and shielded blades, as well as using the Mayo-stand passing procedure. Staff nurse Crissy Benze, BSN, RN, says the changeover went smoothly with “not a lot of backlash.”

Newport Bay uses safety needles from Beaver-Visitec and McKesson and safety blades from Beaver-Visitec and Oasis.

As for sharps injuries, Benze says, “Between using the safety devices and regular staff training and education, the incidence of sharps injuries has been minimized to a rare occurrence.”

The sharps safety plan
For the SCA centers Blackwell serves, she has distributed a list of guidelines and areas to review before inspectors arrive and a report on the experiences of several centers that have already been inspected. (See sidebar for areas to review.)

The CDC offers a web-based Sharps Safety Workbook at www.cdc.gov/sharpsafety/resources, and SCA has developed its own self-study program and test.

At a recent OSHA site visit, Blackwell says the surveyor walked through the ASC, looking for bedside sharps containers, glove box locations, and protective apparel availability and noted how the staff made use of these resources. She took photographs and took the exposure control plan for later review. The surveyor reviewed OSHA300 injury logs and asked for documentation of training. She interviewed 2 employees about the safety equipment and training available to them. She also asked the employees about specific safety procedures and how the rules were enforced.

All of the safety plans and products in the world cannot protect OR personnel unless they are used. Blackwell says, “Commitment from top management and dedication and accountability from health care workers to follow the current and best practice guidelines can ensure long-term compliance.

“It takes center leaders, including medical executive committees and governing boards, to review, accept, and implement the policy and support the program,” she says.

“Then all others in the organization must help to drive the best practice to reduce the risks of exposure and injury by using safety

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**Are you ready for an OSHA visit?**

Areas to check for bloodborne pathogens (BBP) compliance:
- Review the Bloodborne Pathogens Plan for currency and completeness.
- Record employee exposures and injuries. Be sure logs are current.
- Using OSHA’s BBP policy, consider ways to make the plan facility specific in the areas of:
  - exposure control
  - risk assessment
  - postexposure follow-up
  - safety device review and evaluation
  - training certification.

Continued on page 30
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Cataract surgery by residents takes more time, costs more

Ophthalmology residents take significantly more time to perform cataract surgery than experienced attending surgeons, to the tune of $8,000 a year per resident, a study reports.

Researchers measured the procedure time from initial incision to removal of surgical drapes when attending surgeons operated alone, residents assisted, or residents were the primary surgeons.

Mean times were 28 minutes 12 seconds for the attendings, 27 minutes 43 seconds with residents assisting, and 49 minutes 54 seconds when residents operated alone.

Residents’ times improved and within 6 months were not significantly different than the attendings’ times, note the researchers from Penn State College of Medicine, Hershey, Pennsylvania.


References
AORN. Memorandum to members: OSHA to conduct inspections of outpatient care centers. April 26, 2011.
AORN. Sharps Safety Toolkit. Available to members at www.aorn.org/PracticeResources/Toolkits/SharpsSafetyToolKit/DownloadOrViewTheSharpsSafetyToolKit

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On December 22, 2011 the U.S. Food and Drug Administration (FDA) announced that STERIS can continue to provide support on the STERIS System 1® (SS1) through August 2, 2012.

**However, this only applies to customers who have completed the following:**

- Placed an order for a legally-marketed alternative technology to replace all SS1s
- Completed a “Certificate of Transition”
- Returned the completed certificate to STERIS corporation

This is important for healthcare facilities that rely on the SS1 to process critical devices and must purchase a replacement option. At Advanced Sterilization Products (ASP), we have received many questions from customers regarding the December 22 FDA announcement on the SS1 transition deadline.

**Q. Do I have another six months to purchase an alternative to my SS1?**

A. No. The deadline to purchase a legally-marketed alternative remains February 2, 2012. However, healthcare facilities that have open orders to replace their SS1(s) and have completed the STERIS “Certificate of Transition” by February 2, 2012, may continue receiving support for their SS1(s) through August 2, 2012.

**Q. What do I need to do by the February 2, 2012 deadline?**

A. If you have not already, place your order for an alternative technology and fill out the “Certificate of Transition.” If you have ordered a replacement system that will not be installed prior to February 2, 2012, you should also complete the “Certificate of Transition” so that there is no disruption to device processing at your facility.

**Q. What alternatives to the SS1 does ASP offer?**

A. The ASP STERRAD® NX® System uses a hydrogen peroxide gas plasma sterilization process that provides the sterility assurance level (SAL) of $10^{-6}$ that you require for processing heat-sensitive critical devices. The STERRAD® CYCLESURE® 24 Biological Indicator (BI) provides evidence of proper sterilization conditions in accordance with AAMI, AORN, and CDC guidelines.†

For high-level disinfection, we offer the EVOTECH® Endoscope Cleaner and Reprocessor (ECR), the first commercially available system that both cleans* and high-level disinfects endoscopes. The system makes labor-intensive and time-consuming manual endoscope processing a thing of the past.

**Q. If I have placed an order for an ASP system, when will I receive it?**

A. We have ample supply to help you transition in advance of the August 2, 2012 deadline. The date you receive your system will depend on the readiness of your facility and when you ordered your system. Your ASP representative will contact you with an installation date for your system. For more information, please contact your local ASP representative, visit www.aspjj.com/alternatives or call 888.783.7723.

To date, we have successfully helped thousands of facilities upgrade to ASP terminal sterilization and high-level disinfection systems. Using a team approach, our sales associates, service engineers and clinical educators are here to provide world-class service and clinical education support to help your facility make a smooth transition.

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For more answers to your pressing questions, please visit www.aspjj.com for the ongoing ASP Video Webisode series that will address issues that your facility faces every day. You may also Like Us on Facebook.com/aspjj or Follow Us on Twitter.com/aspjj.com

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* Does not eliminate bedside precleaning. Manual cleaning of medical devices (endoscopes) is not required prior to placement in the EVOTECH® ECR when selecting those cycles that contain a wash stage.
Most adverse events not reported
Hospital staff didn’t report 86% of adverse events to incident-reporting systems, partly because they didn’t perceive the events to be reportable, according to a report by the Health and Human Services Inspector General released January 6, 2012.

Examples of events not reported were deaths caused by health care-acquired infections such as septic shock and by excessive bleeding because of blood-thinning medications.

Among recommendations are that government agencies should develop a list of potentially reportable events, assist hospitals in using the list, and provide guidance to accreditation surveyors on assessing hospital efforts to track and analyze events.

Hospitals are required to track and analyze instances of patient harm as a Medicare condition of participation.

—http://oig.hhs.gov/oei/reports/oei-06-09-00091.asp

Preop consults vary widely by hospital
The rate of patients who have preoperative consults varied widely among hospitals in a study of 200,000 patients from Ontario, Canada.

Depending on where the surgery took place, the chance of a patient having a consultation could be as low as 5% to as high as 90%, the researchers found. The differences were not explained by how sick patients were.

Nor was the rate of referrals consistent with the risk of surgery. Procedures with lower risks often had higher rates of consults than procedures with much higher risks.

The authors call for more research to determine which patients benefit from preoperative consultation.


Aiding nurses’ compassion fatigue to protect patients
An innovative program at Barnes-Jewish Hospital in St Louis is one of a growing number of efforts to aid nurses with stress and compassion fatigue, the January 3, 2012, Wall Street Journal reports.

Meditation, stress-reduction workshops, staff retreats, and discussions after difficult patient situations are some of the methods. Compassion fatigue is a combination of secondary traumatic stress from witnessing suffering and of burnout. Hospitals are tackling the problem amid a growing shortage of nurses and concern that patient care may suffer, the article says.

—www.wsj.com

New York introduces bill to require BSN for new RNs
New RNs would have to earn bachelor’s degrees within 10 years to keep working in New York State if a new bill passes, the Associated Press reports.

No state law currently requires a 4-year degree, though New Jersey and Rhode Island have considered similar proposals, AP says.

The New York legislation died in committee in the last session but has bipartisan support and could be debated early this year, the report said.

The 2010 Future of Nursing report from the Institute of Medicine recommended increasing baccalaureate-prepared RNs to 80% by 2020. Currently, about half of the RN workforce has a bachelor’s degree or higher.