Don’t let depression derail your staff’s morale and motivation

Depression affects 9% of adults in the US and 18% of hospital-employed nurses, including those who work in perioperative settings.

Nurses with depression not only suffer themselves, but their illness can impact their productivity and quality of care as well as their coworkers’ work lives.

Nurse managers need to be proactive in recognizing and caring for depressed staff, says Susan Letvak, PhD, RN, FAAN, professor and department chair at the University of North Carolina School of Nursing, Greensboro.

“Untreated, depression will sap the energy and motivation out of your most productive employee or yourself. But with the right help, depression can be managed, overcome, and worked around,” says Letvak, who has been researching the health and safety of the nursing workforce for more than 10 years.

Letvak presented “Looking out for the staff’s mental well being” at the 2013 OR Manager Conference.

Continued on page 11
Backed by more than 26 years of experience, the OR Manager Conference has been the #1 executive-level Conference to provide OR leaders a platform to receive the thought leadership and clinical education needed to be successful across 3 days of training.

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Until I heard Keith Siddel, PhDc, JD, MBA, CHC, speak at our OR Business Management Conference in February, I didn’t fully realize how much ICD-10 coding could disrupt billing and payment for services. Siddel, an attorney and healthcare finance expert based in Creede, Colorado, explained why providers should have been preparing for ICD-10 long before now and how other new laws are affecting the bottom line.

He expanded on those concepts in a subsequent interview with OR Manager (see cover story).

The news on March 31 that ICD-10 implementation would be pushed back until at least October 1, 2015, has been met with either relief or resentment, depending on how much effort has already gone into preparing for the change.

For Hardeman County Memorial Hospital-Quanah (Texas), the delay will help the 18-bed critical-access hospital survive, said Dave Clark, interim administrator, in a recent Modern Healthcare article. The hospital needs the time to get back on its feet after filing for bankruptcy last May.

“We made decisions 18 months or 2 years ago that we are going to do certain things and postpone certain things based on having to implement ICD-10,” said Michael O’Rourke, senior vice president and chief information officer at Catholic Health Initiatives, headquartered in Denver. O’Rourke and his peers at other facilities now must decide whether to cut back on their staffing and IT investment in ICD-10, and when to ramp it back up, the authors say.

Geisinger Health System in Danville, Pennsylvania, had planned to have all of its physicians trained on ICD-10 by May, according to Alistair Erskine, MD, chief clinical informatics officer. Now they’re trying to decide whether to continue running in ICD-10 and dual-code for billing in ICD-9 until 2015.

Leaders at Beth Israel Deaconess Medical Center in Boston likewise are grappling with this decision. ‘I’m going to recommend we... go ahead with as much ICD-10 as possible,” said John Halamka, MD, CIO—including dual-coding, using ICD-10 data in house, and ICD-9 data for billing. “Doing nothing but waiting on ICD-10 is not an option,” he said.

Lynne Thomas Gordon, CEO of the American Health Information Management Association in Chicago, applauded that advice. Healthcare organizations should strengthen their clinical documentation programs, she said. “Make sure you have your coders and stakeholders trained in ICD-10. If you’re dual-coding, keep doing it,” she added.

Siddel explains why the switch to ICD-10 coding should matter to surgical services directors and managers and what they can do to help their organizations prepare.

Food for thought—and hopefully a chance to be proactive instead of reactive, now that implementation isn’t imminent.

—Elizabeth Wood

Reference
Carlson J, Conn J, Andis Robeznieks A. Bruised by ICD-10 delay, healthcare execs huddle over what to do next. Modern Healthcare. Published online April 5, 2014.
With a background that includes everything from a Level 1 trauma center to large academic centers to companies involved in joint ventures, acquiring physician practices, and contract negotiations, Marian McCann, MBA, BSN, RN, CNOR, has had a wealth of experience in working with physicians.

She will share some of that experience and offer tips for building good relations with physicians during a general session at the OR Manager Conference in Long Beach, California, September 17-19.

In April she joined Long Beach Memorial as OR director, with oversight for more than 30 ORs, and she is also CEO of Hokua Consulting in Los Angeles.

Manage your own behavior
“We as professional nurses have the responsibility to treat others with dignity and respect,” McCann told OR Manager. “To be successful and have long-term lasting results in your relationships, you must first manage your own behavior. That sets the stage for a foundational relationship that is built on trust that you, as a professional and leader, can be counted on to behave in a predictable and supportive manner.”

Becoming a physician’s ally rather than an adversary should be the goal. “Perioperative nurses need to embrace the idea that the physicians are their partners as well as their customers,” McCann says. “The beginning thought in the OR leader’s mind should always be ‘yes, we can do that,’ and then work toward getting to ‘yes,’” she advises.

“I’ve seen many perioperative leaders try to go toe to toe with physicians, and no one likes to be talked to that way. Sometimes physicians have ideas about how to do things that they’ve picked up from other places that are even better. You can be devalued in the relationship with a physician or you can be enriched by it.”

What if a physician has a worse idea or is reluctant to make a change? Providing data and making a reasonable case for a new approach are strategies that McCann has found useful, but her trump card is sometimes peer pressure. She may, for example, say something like, “We’re under an imperative, and all of...
the other surgeons in your section have made the switch. You stand out as being noncompliant, and I know you like to have all good outcomes.”

She tries to “work the customer service angle” by providing good data and comparisons with the surgeon’s peers. And she may even post names of surgeons who have and have not complied with a new protocol or use team meetings to exert pressure on them.

**Manage your surgeon’s time**

If a surgeon is consistently late to the OR, it’s not helpful to have a confrontation then and there. “I’ll say something like, ‘we’re really glad you’re here and we’re going to help you get this done. I want to get on your calendar and make sure we’re doing everything we can to make your day go smoothly.’ I make it about them.” Later, during a one-on-one conversation, it’s easier to discuss the situation and find ways to make reasonable accommodations that allow you to plan, she says.

It’s critically important to take the temperature of the day/room/atmosphere. “I have seen train wrecks when leaders try to bring up administrative things with surgeons just as they are going into a major case. That is not a good time. Asking the surgeon when is a good time can also lead to negative results, if not asked at the right time. Never make the mistake of thinking that you or any OR issues trump anything else that is going on in the physician’s life,” she advises.

To nail down a convenient meeting time, ask the physician, “who best knows your schedule?” That may be a physician’s assistant, an administrative assistant, or even a spouse, and by building a good relationship with that person, you can build a better schedule for your OR.

**Keep calm and carry on**

In addition to respecting the physician’s time, remaining calm and measured when a physician is upset is key to maintaining good relations. McCann recalls having inadvertently irked a physician by having a hallway painted without consulting him. This physician had no family, and he had only ever worked in that particular OR.

“This OR was his home in essence, and I painted it without considering him. It never occurred to me to check paint chips with a physician for a hallway inside an OR. He was livid and hated the shade,” she says. After that, she included him in decorating decisions, and she soon won his trust.

“Twenty-five years ago, I would have railed against this man and his behavior. Today I see that there is more benefit to communication and inclusion versus cleaning up and repairing damaged relationships,” she says.

“People fear what they can’t control,” McCann says. “You can’t control other people, but you can control yourself. And to control yourself, you have to know yourself. And to know yourself, you have to do some exploration and learning,” she says. “None of us are always right.”

—Elizabeth Wood

Register online at www.ormanager-conference.com.
Healthcare reform

Continued from page 1

surance companies by about 30% to 40% and use the extra money to cover insufficient Medicare payments and patients who didn’t pay. “Now,” he says, “the ability to cost shift has virtually gone away. If you can’t make money on Medicare payments, you won’t survive.”

All this adds up to the need for OR managers to keep their view broad-based. “It’s becoming more and more important that we aren’t functioning just as a department head, but instead we understand the whole picture,” Siddel says. He cites 4 key areas that may have a significant impact on the bottom line: ACA, the 2-midnight rule, changes in the outpatient prospective payment system (OPPS), and implementation of ICD-10.

Reality of ACA

Siddel says the thinking behind the ACA was that by insuring everyone, unreimbursed costs could be controlled. Some key concepts of ACA to keep in mind include:

- For insurance exchanges, a formula based on age and income level is used to determine how much federal credit individuals will receive to help them pay for their health insurance.
- Insurance companies are required to cover preexisting conditions without an increase in premiums, which in many cases has led to a rate increase for everyone.
- Insurance companies have been incentivized to set up narrow provider networks to help control costs.
- Originally it was thought that across-the-board health insurance would mean increased patient volume, full reimbursement, and a healthier patient population. The reality, Siddel says, is much different. “Not everyone has signed up, the cost of the system is much more expensive than anyone ever imagined, and the networks are much narrower than anyone anticipated.”

This reality has created several challenges, beginning with basic costs. Siddel cites the example of someone who earns $25,000 per year and buys a silver plan that has a premium of $100 per month. The out-of-pocket expenses for that plan are $4,500, well beyond the person’s means. (The maximum out-of-pocket cost for any kind of insurance plan is $6,400.)

Instead of signing up for insurance, this person could choose to simply pay the $100 annual fine for being uninsured. However, if the person required hospital care and couldn’t pay for it, the hospital or ASC would have to try to collect the payment or write off the charges as a charity expense. Siddel believes many patients will be surprised by the high out-of-pocket expenses.

Bundling is king for OPPS

A significant change in OPPS is ambulatory payment classification bundling. “Most clinical laboratory diagnostic tests performed on the same day as the surgery, for example, and ordered by the same primary physician will no longer be paid separately,” says Siddel. The only exceptions are molecular pathology lab tests.
Drugs, biologicals, and radiopharmaceuticals such as contrast agents are now bundled when they are used in a surgical procedure. The only exceptions are the very few items that qualify for “pass through” status such as TheraSkin and obinutuzumab injections. Although CMS claims that these charges are now bundled into payment for procedures, Siddel says in many instances the reimbursement actually has been “wiped out.” ORs must continue to analyze their bundled charges and time for procedures to ensure that everything is included and the associated costs have been taken into account. This is particularly important for device-dependent procedures, defined as procedures that require an expensive device. Because hospitals previously weren’t billing properly, Medicare initially had to implement device-dependent audits, and now CMS has decided to bundle everything required for a device-dependent procedure into 1 payment. Other newly bundled items include device removal, repair, or replacement procedures, and procedures described by add-on codes. In essence, CMS is paying providers for the primary procedure only, and all related items and procedures are no longer paid separately.

Although some of the most dramatic bundling changes won’t go into effect until 2015, Siddel advises hospitals to prepare now. “This year, you should be modeling all of the bundling of these device-dependent procedures so that you know what the impact is and what you need to do,” he says. OR managers should think about questions such as:

- Are your charges structured right?
- Do you have all your billable items in the charge master?
- What’s your cost for supplies, space, or staff, and how is that captured?

“These have always been important, but the more CMS bundles payments, the less room there is for errors,” Siddel notes.

CMS is also starting to standardize payments across delivery systems, so the reimbursement will be the same regardless of whether the procedure is performed in a hospital or an ASC. “Hospitals that are providing more complex services are losing money, and those providing less complex services on an outpatient clinic basis are making money,” Siddel explains. Hospitals are now competing for the same reimbursement dollars as ASCs and even physician offices, yet hospitals’ cost structures are much higher.

### 2-midnight rule still on hold

CMS has determined that if patients spend 2 midnights in the hospital, they’re considered inpatients in terms of level of care; if less than 2 midnights, they’re considered outpatients, in most instances, regardless of severity of illness or level of care provided. The 2-midnight time period is called a “medical utilization day” or “MUD.”

CMS has several times delayed enforcement of the 2-midnight rule, and on March 31, Congress voted to delay enforcement until March 31, 2015. Nonetheless, Siddel suggests surgical services directors work with surgeons and schedulers to ensure that “there is a better understanding of level of care and the elements required in the order because it will absolutely affect reimbursement.”

Historically, the challenge for OR managers has been surgical patients who undergo additional inpatient-only procedures and are then discharged as outpatients. Because they’re not considered inpatients, providers aren’t paid for the additional procedures.

Siddel says the new 2-midnight rule exempts inpatient-only procedures, and those patients are now automatically considered inpatients.

Surgical services directors have tried to be sure surgeons and staff understand that if an unplanned procedure is done, it’s important to verify the patient will be an inpatient, but as Siddel says, it’s a “burdensome problem.”

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Healthcare reform

Under the 2-midnight rule, physicians must write specific admission orders including key care elements. To facilitate correct documentation, some hospitals have created a template for surgeons to complete and sign. The template includes the reason for inpatient care, the anticipated length of hospital time that will be required, plan for care after discharge, and a statement that the physician has completed a note detailing why the patient needs to be an inpatient (sidebar.)

Adding to the challenge is the fact that the assignment of all Medicare appeals is on hold for 2 years. “If you don’t like what Medicare paid, you’re out of luck for at least 2 years,” he says.

More information about the 2-midnight rule is available from the American College of Surgeons website: http://www.facs.org/ahp/two-midnights.html.

**Why care about coding?**

“Coding now plays a key role in many areas—reimbursement, quality, and outcomes,” says Siddel. “At a minimum, OR managers need to understand what’s changing.” Although surgical services directors and business managers are not directly responsible for coding, the coding drives an organization’s ability to achieve revenue goals, and this will ultimately affect its service line. “We’re all in this together,” Siddel says.

The major coding change coming sometime in the future is the implementation of ICD-10.

On March 31, the Senate passed bill HR 4302, Protecting Access to Medicare Act of 2014, which prohibits the US Department of Health and Human Services from adopting ICD-10 as the standard until at least October 1, 2015, a reprieve from the October 1, 2014, planned implementation.

Siddel says the unexpected delay has divided the provider community. “Those who were behind in their preparations or are currently installing their electronic health records are happy with the extra 12 months. Those who were prepared and had invested significant resources into...
In any case, the transition to ICD-10 is likely inevitable so OR leaders still need to understand the new standard and its challenges.

ICD-10 brings a vastly increased level of complexity to coding. “What used to take 5 ICD-9 codes may now take 10 ICD-10 codes,” Siddel says. For example, the suture of an artery in ICD-9 has 1 code, but the same procedure has 276 codes in ICD-10.

As many as 30% of coders, whose average age is over 50 years, will retire instead of learning the new system, meaning a crop of inexperienced coders will encounter a complex new system—an electronic perfect storm.

“There is a game-changing event going on,” Siddel says. It’s expected that productivity in coding could drop as much as 50%.

ICD-10-CM (clinical modification) codes will be used for all inpatient and outpatient diagnoses, ICD-10-PCS (procedure coding system) codes will be used by hospitals for inpatient procedures, and CPT (current procedural terminology) codes will be used by healthcare providers for outpatient procedures. Although ICD-10 diagnosis codes have been used previously in other countries, the PCS coding is an untested, completely new coding methodology.

Effective documentation will be vital to avoid delays in reimbursement. In the past, missing documentation may have not affected the revenue cycle, but now claims must be sent back to the physician to answer queries before those claims can be submitted. By helping to ensure a completed document is obtained initially, perioperative services leaders can reduce reimbursement delays.

Siddel suggests OR managers talk with the health information management department to determine which surgeons’ claims tend to be held and why. Then revise documentation as needed to ensure all information is obtained during the initial event. Other strategies include:

- taking a basic course on ICD-10 to learn the terminology
- providing education to perioperative nurses (most facilities are offering between 1 and 3 hours of education)
- ensuring surgeons receive education
- having an electronic medical record
- having a clinical documentation improvement program.

Siddel also recommends OR managers get involved with test coding so they know what OR documentation needs to be revised. “Even if you do all of these things, there will still likely be a 13% to 15% loss in productivity [for coders],” he says.

No easy solution
Siddel uses an example to illustrate how the healthcare system will continue to be challenged because Medicare is not “prepaid” by those contributing to it. A patient born in 1944 who started working at age 21 in 1965 and worked until age 65 (2009) paid $64,000 into the Medicare system.

The average benefit for a Medicare beneficiary in 2008 was $11,000. Of that, the patient had to pay some out-of-pocket costs, so the actual benefit was $9,000. Assuming a personretires at age 65 and lives until age 83, the value of the benefit is about $173,000—far more than the person paid into it.

Siddel asks, “If people are paying around $64,000 into the system for an actual benefit of $100,000 more than what they paid into it, how long can that system sustain itself? We’ve committed to a level of care we can no longer afford.”

Cynthia Saver, MS, RN, is president of CLS Development, Inc, Columbia, Maryland, which provides editorial services to healthcare publications.

Reference
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Human resources

**Depression**  
*Continued from page 1*

**Perceptions create barriers**

“Anyone who has had depression or who works with someone with depression knows that it is a condition that is very difficult to live with. It is painful,” says Letvak.

Clinical depression has been described by sufferers as a black dog, a suffocating blanket, or an endless dark hole.

The 2 main signs of depression are:
- a persistent feeling of sadness or anxiety
- loss of interest or pleasure in usual activities that lasts for more than 2 weeks.

As part of her research, Letvak interviewed groups of nurses who admitted they had depression. She says she listened to their stories about what it took for them to get through a day, and “their stories were horrific.”

Letvak also talked with the depressed nurses’ healthy coworkers. Their responses were often less than sympathetic, she says. Some examples include:
- “We know they are down, but we are sick of it.”
- “We are tired of picking up the burden.”
- “We are tired of their affect.”
- “Why isn’t our manager doing something about them?”

When Letvak asked the managers about the depressed nurses and their coworkers, they told her:
- “The nurses take care of each other.”
- “They pick up the burden when someone is down.”
- “I am not needed here.”
- “I really don’t know what to do.”

These responses show a knowledge gap, says Letvak, because managers are aware of a staff health problem but they don’t know what to do about it.

**Fear leads to avoidance**

Letvak learned from focus groups of managers the reasons they ignore mental health issues among their staff members.

**Ignorance.** “We all know it is happening, but we really don’t know what to do. We are afraid to tackle anything more than we already have on our plates,” the managers told Letvak.

**Fear of reprisal, physical harm.** Some managers said they were afraid they could get hurt by some of their employees who were about to snap. Though these comments were made while discussing nurses with anger and high stress issues rather than

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**Free online tools offer alternative to professional help**

Studies have shown that depression is the most prevalent mental health problem in adults, with 9% meeting the criteria for depression, including 3.4% with major depression that is debilitating and doesn’t allow them to work, says Susan Letvak, PhD, RN, FAAN, professor and department chair at the University of North Carolina School of Nursing, Greensboro.

Approximately 80% of people with depression have some level of functional impairment, and 27% report serious difficulties in work and home life.

Yet, only 29% of all depressed individuals report having contacted a health professional in the past year, and among the subset with severe depression, only 39% reported having done so.

“One of the biggest reasons they don’t seek help is the stigma and fear it will be on their records,” she says.

Letvak recommends the following free online tools for those who are reluctant to seek diagnoses and treatment from professionals:

- **MoodGYM** ([https://moodgym.anu.edu.au/welcome](https://moodgym.anu.edu.au/welcome)) is a cognitive-based therapy program that starts with a depression scale and works through a series of exercises and journaling. It has been clinically proven to reduce depression with or without medication.

- **PHQ-9** [Patient Health Questionnaire-9] ([http://www.phqscreeners.com/overview.aspx](http://www.phqscreeners.com/overview.aspx)) asks people whether any of 9 items have happened to them in the past 14 days on a scale of 0 (never happens) to 3 (happens every day).

  Among the items are little interest or pleasure in doing things, feeling tired or having little energy, and having trouble concentrating, reading the newspaper, or watching television.

- **CUDO** [Clinically Useful Depression Outcome Scale] ([http://www.scribd.com/doc/6449363/CUDOS-form](http://www.scribd.com/doc/6449363/CUDOS-form)) contains 18 items that assess major depressive disorder criteria as well as psychosocial impairment and quality of life. These include having problems with concentrating or making decisions and having insomnia or hypersomnia. Symptoms are rated on a 5-point Likert scale indicating how well the item describes the person in the past week.

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Continued on page 12
nurses with depression, Letvak says she found the comments concerning. “These managers are afraid to go to the parking lot because of certain employees, yet they let them come to work and take care of patients.”

Fear of being tough. Managers fear they will earn a reputation as being tough and unforgiving to employees experiencing difficult periods in their lives. “Managers are being evaluated at a level they have never been evaluated at before,” says Letvak. It used to be that managers weren’t questioned, but now more evaluations are being performed on managers than on their staffs. “It’s coming from all sides. They are managed by their staff. They are managed by their senior administrators. And the manager is blamed for all patient and doctor issues.”

Because it is an incredibly difficult time to be in management, notes Letvak, managers don’t want to seem cold; they want to be supportive of their employees.

Fear of litigation. Managers are afraid that if they talk about personal issues or mental health concerns with an employee, they could be sued for interfering in that person’s life.

Address the issues
Managers have to be able to recognize when staff members have mental health problems that impact performance and interpersonal relationships. This doesn’t mean managers should go on a “seek and destroy” mission to look for nurses with depression, notes Letvak, but they should be aware of performance issues such as:
• medication or charting errors
• poor quality of care

Topping the list of how to manage a depressed employee is to not ignore the problem, says Letvak. Managers should seek support and guidance from human resources. They should never try to counsel depressed employees by themselves.

“As the manager, your role is to set up a private meeting with the employee, state what you are observing, and then listen when

Federal laws make accommodations for depressed employees
Managers must be aware of 2 federal worker laws to properly manage a staff member with depression.

Americans with Disabilities Act (ADA)
(http://www.dol.gov/dol/topic/disability/ada.htm) A disability is a physical or mental impairment that substantially limits 1 or more major life activities (seeing, hearing, or performing manual tasks).

“What managers don’t realize about the ADA is that it does not legally require specific accommodations for an employee if that employee’s restriction causes ‘undue hardship’ on the operation of the unit in terms of cost and available resources,” says Susan Letvak, PhD, RN, FAAN, professor and department chair at the University of North Carolina School of Nursing, Greensboro.

The law still requires that the employee satisfy the requisite skill, experience, education, and other job-related requirements to perform job functions with or without reasonable accommodations.

In addition, under this law, nurse managers have to consult with human resources before honoring or refusing restricted duty requests.

“Don’t take it upon yourself to refuse, or you will be in trouble with the ADA,” she says.

Letvak recommends the federal government’s Equal Employment Opportunity Commission website (http://www.eeoc.gov/) for more information.

Family and Medical Leave Act (FMLA)
(http://www.dol.gov/whd/fmla/) The Act, which is administered through the Department of Labor, says employees can take up to 12 weeks a year of unpaid time with job-protected leave, and health benefits will still be provided to care for themselves or a family member. The time can be taken at 1 time or in increments, and the absences cannot be held against the employee.

There is also an amendment to FMLA called the National Defense Authorization Act that allows for 6 months of unpaid leave (with job protection) for an employee to take care of a family member who has been injured while on active duty (and some of these are soldiers with mental problems) or 12 weeks of leave when an employee’s family member has been called up for active duty.
the employee starts talking to you,” says Letvak. She suggests using SET—a program mental health groups are recommending for managers with depressed employees.

- S stands for support. Identify the problem. Let the employee talk about the problem. Use a personal statement of concern, such as: “I am sincerely worried about how you are feeling.” The emphasis should not be on the manager’s feelings; avoid statements such as: “Your behaviors are causing me extra work and stress.”
- E is for empathy. Attempt to acknowledge the depressed employee’s shut-down feelings with a phrase such as: “How awful you must be feeling.” It is important not to confuse empathy with sympathy. If a manager says, “I feel sorry for you,” it could elicit anger or withdrawal from the employee.
- T stands for truth or reality. “This is the hard part,” says Letvak. Managers have to emphasize that the depressed employees are ultimately responsible for their work commitments and that others’ attempts to help them cannot preempt this primary responsibility. The manager makes a “truth statement” that a problem exists, it can’t be hidden any more, and something has to be done about it.

Communication with the depressed person needs to include all 3 messages, says Letvak. However, even when all 3 parts are enacted, sometimes the employee will become defensive and disregard anything the manager has said. Then a corrective action plan is essential.

Finally, managers must document that they met with the employees and that they agreed on corrective action plans.

Know the signs, and don’t ignore the problem.

Document and discuss

Using a standardized corrective action form helps the manager document in a consistent manner and protects the manager, says Letvak.

In the documentation, the manager should:

• Identify the issues and policies discussed in the conversation.
• Summarize the events and facts that led up to the meeting.
• Use clear statements in factual, nonpunitive language.
• State the action plan in clear, measurable steps to improve performance by a specific date. “If you leave the date open ended, the employees won’t feel any pressure to change and will just go on doing what they are doing,” says Letvak.
• Document what will happen if the employee does not follow through. “This is hard to do,” says Letvak, “but if you don’t, they will think they are not being held accountable.”
• Sign and date the document. The manager and employee both have to sign and date the document. Employees can document a response if they choose. “Some employees will refuse to sign, but managers can tell them that signing doesn’t mean they acknowledge it, it only means they heard it,” says Letvak. “They have to sign,” she adds. “If they don’t sign, they can go home right now.”

• Set a follow-up meeting (date and time) while the employee is in the room.

Be proactive

The manager sets the tone on a unit and must have a commitment to a healthy workforce, placing a high value on employees’ physical and mental health, notes Letvak.

To ensure a healthy work environment, managers need to do regular risk assessments for increased stress on their units—either doing the assessments themselves or bringing in an outsider.

Letvak recommends the latter approach. “Ask these people to look around and tell you what they are seeing and feeling. You won’t believe what they will tell you,” she says.

If managers do risk assessments themselves, says Letvak, more than likely the employees will say: “Everything is great. I am doing great. Please rate me as great because I want a raise.” They are not going to tell you how they really feel, she says.

Finally, once stressors are identified, something has to be done about them, says Letvak.

“I still remember all those nurses saying, ‘my manager knows and isn’t doing anything about it.’”

—Judith M. Mathias, MA, RN

References


Google is the best company in America to work for, according to Fortune Magazine. Thousands of smart, creative individuals want to work there, not only for perks like nap rooms and free food, but also because of Google’s reputation for supportive management, effective communication, and rewards for a job well done.

Not all of Google’s methods can transfer to the OR. But perioperative leaders seeking to create a culture that molds motivated, top-performing, happy employees can take a cue from Google and implement simple changes that won’t break their OR budgets.

OR leaders, some of whom work at facilities that were also on Fortune’s top 100 list, told OR Manager they have developed programs to keep their employees satisfied and eager to come to work—which, in turn, leads to better patient care. Here are some of their approaches:

• listening to employees
• identifying and acting on their concerns
• rewarding and recognizing staff
• leading by example
• empowering individuals by providing opportunities for professional growth
• setting and measuring specific goals.

First, listen up
The OR at Torrance Memorial Hospital in Torrance, California, had the lowest employee satisfaction rate in the hospital when Patricia Jill Andrews, MHA, BSN, RN, CNOR, became the new assistant director for perioperative services in April 2013. “When I got there, the staff were working so hard and doing so well in less than ideal circumstances, but they didn’t like coming to work,” she says. “My goal was to make the OR enjoyable because we spend so much time together.”

Less than a year later, the environment has changed from punitive and uncertain to positive and upbeat, says Mary Williams, BSN, RN, clinical nurse III in the OR at Torrance Memorial, a 400-bed facility with 19 ORs. “I’ve seen a vast improvement in morale. It’s an environment that makes you want to work. From my standpoint, it has turned around 360%.”

Williams, who has worked at the hospital for 40 years, says she previously felt unsupported and was always walking on eggshells. “Now I feel I have the support of the director and the assistant director.”

Andrews says her recent patient satisfaction scores may indicate her staff is indeed happier. Every 6 months, employees take a survey and rank the hospital on a scale of 0 to 4 in the following areas: pride, job satisfaction, standards of behavior, dignity, and being kept informed by management.

“We went up from a 2.71 average to a 3.18 average of the 5 areas,” Andrews says.

Listening to employees and finding out what concerns them about their work is the most important step when trying to improve employee morale, says Andrews. In one-on-one sessions, she asks each employee, “If I gave you a magic wand, what is the one thing you would change?”

A “Moving Forward” committee consisting of RNs and surgical technologists helps interpret the comments. “Initially they met without management present so they could speak openly, and then the feedback was shared with management. Management joined the committee after a month of weekly meetings,” Andrews explains.

The committee identified 2 recurring themes: a lack of teamwork and bad morale. “That’s what we set out to tackle,” she says.

Michael Garcia, JD, RN, vice president of operations at Houston Methodist Hospital in Houston, holds routine staff meetings. Houston Methodist has 71 ORs and is licensed for 1,119 beds. Garcia invites every member of the OR team, as well as staff from the preoperative area, the postanesthesia care unit, and the sterile processing department, to attend, along with perfusionists and anesthesiology technologists.

After providing a quick update on the organization and the OR, he answers as honestly and thoroughly as he can several of the top 10 questions submitted by employees prior to the meeting. The top 10 questions are listed on a PowerPoint, and employees simply call out a question number.

To take the pulse of the staff at Morristown Medical Center in Morristown, New Jersey, Pam Mestel, MSN, RN, CNOR, manager of perioperative services, asks them to fill out engagement surveys every year. Morristown
Medical has 27 inpatient ORs and 6 ORs in its ambulatory surgery center. The surveys, which are administered electronically to each employee via email, ask employees how involved their managers are with staff, if they feel they are heard by management, if they have opportunities for professional development, and if communication between departments is sufficient.

Managers review the survey and develop action plans to respond to areas employees cited as needing improvement, Mestel says. The plans are reviewed year to year to see if any progress has been made in those areas.

Silly things count
In addition to asking Torrance Memorial’s OR employees why they weren’t happy, Andrews started doing some “silly but effective” things, such as posting photos of employees as babies on bulletin boards, along with photos of their Valentines and pets. She also recognizes employees every 3 days for something positive they have done by giving them a lottery scratch ticket.

One of her more successful ideas was buying small Teddy bears for the OR from the dollar store. Employees can take a bear with them on vacation and then photograph themselves with the bear so the photo can be posted at the hospital. These simple techniques, she says, help the staff to have fun together.

The book Eat THAT Cookie!: Make Workplace Positivity Pay Off... For Individuals, Teams, and Organizations by Liz Jazwiec, RN, provided Andrews with inspiration for transforming her staff, she says.

Jazwiec, a speaker and consultant based in Oak Lawn, Illinois, says if OR leaders want to motivate their employees, they first have to acknowledge how tough a job healthcare really is and the negative things they and their staff members may be doing that make it even tougher.

Maintaining a victim mentality and negative outlook is something hospital leaders and employees too frequently embrace, according to Jazwiec. “Why are people in healthcare in general so negative?” she asks. “Because we allow it. What you permit, you promote. It is the leader’s responsibility to put together an initiative that will drive negativity out of the department.”

OR leaders can boost morale by promoting 1 or 2 things that have gone right during a shift, such as having all the supplies that were needed, having no absenteeism, or properly maintaining OR temperature, she says.

Recognize and reward
Morristown’s Mestel says she chose to work at the hospital in part because leaders lived up to their promise of acknowledging and rewarding employees as part of the culture. This includes management recognizing staff and staff members acknowledging their peers for a job well done. Morristown is part of the Atlantic Health System, which was selected as Fortune’s 25th best company to work for.

Houston Methodist Hospital was ranked 46 of the 100 best companies to work for by Fortune. Garcia believes the hospital deserves this ranking because of the focus on delivering and improving quality care. Achieving goals such as reducing central line and catheter-associated infections are recognized, and employees are rewarded.

Examples of monetary rewards range from lottery scratch cards to gift cards to cash bonuses of $5 to $125 or more.

Scripps Memorial Hospital in La Jolla, California, rewards employees with cash bonuses equal to a discriminate number of pay days based on whether the facility meets certain metrics, such as patient satisfaction and financial performance, says Bernadette Roberson, MSN, RN, CNOR, director of surgical services.

Don’t overlook employees who shy away from the spotlight, Andrews advises. She makes a point of recognizing nurse attendants, and she keeps track of staff she recognizes.

“I believe in the carrot, not the stick,” says Mestel. For example, when employees were frequently calling in sick, she started an honor roll for perfect attendance. If an employee doesn’t call in for a year, that person receives a monetary bonus. “The staff love it,” she says.

When staff member Marilyn Albanese, RN, came to Mestel because employees were not working together to accommodate one another’s scheduling needs, she gave Albanese a chance to fix it herself. Albanese researched a group app that allows her to send a text to everyone when the schedule is posted so they can’t say they didn’t know their schedules well in advance. She also came up with a shared drive so staff members could see they were not the only person who had to work Fridays, Saturdays, or Sundays.

“Pam listened to the staff’s dissatisfaction and frustration about the schedule and then empowered us to take our schedule back and encouraged and supported the entire process, which, in turn, increased staff morale,” Albanese says.

Food is used to encourage em-
The most important room in the hospital: that’s what a landmark 1969 case in Canada—Laidlaw v. Lions Gate Hospital—called the phase I postanesthesia care unit (PACU) because of the dangers to patients receiving that level of care (ASPAN). Especially during the first phase of postanesthesia care, patients are typically in a physiologically vulnerable state and require close monitoring of their basic life-sustaining body systems. They may be unconscious or semiconscious and thus unable to fully participate in their care, answer questions, or advocate for themselves.

Further challenges to optimal postanesthesia care include high patient volume and fast turnover, which may mean a high potential for wrong-patient errors, constant handoffs to and from the setting, challenges to communication and care coordination, and pressure to “keep patients moving.”

This article offers an action plan to help risk managers and their organizations address issues such as safety culture, personnel and care coordination issues, handoffs, patient assessment and monitoring, specific clinical and safety challenges, and discharge.

Claims and lawsuits
Most anesthesia malpractice claims result from intraoperative events. However, postanesthesia care deserves special risk management attention because of the potential for serious adverse outcomes.

According to data from the American Society of Anesthesiologists’ (ASA) Closed Claims Project Database, 7% of the 1,332 claims that have occurred since 2000 were PACU events and 11% were postoperative events (occurring after PACU discharge but before discharge from the facility). Severity of patient injury was greater in postoperative and PACU claims than in intraoperative claims, even though the median payment amount of $312,500 was similar across the 3 phases. Other ways in which intraoperative, PACU, and postoperative claims differed are shown in the sidebar on p 15.

A separate analysis of 33 closed PACU claims over a 15-year period found that the most common allegations were improper management of the surgical patient (18%), anesthesia-related allegations unrelated to anesthesia administration (15%), improper administration of anesthesia (12%), and failure to monitor the patient’s physiologic status (9%). Most commonly, the primary responsible party was an anesthesiology professional (48%) or nurse (39%).

The most common risk management issues were failure to note clinical information (eg, vital signs), provider communication about the patient’s condition, failure to follow policies and procedures, issues involving physiologic monitoring, inadequate training, inconsistent documentation, inadequate documentation of the date and time, lack of clinical assessment, and alteration of documentation (Ross and Ranum).

Action plan
This action plan outlines key steps organizations can take to ensure safety and minimize liability and regulatory risks in postanesthesia care. It is not exhaustive; other efforts not listed here include evaluating the effectiveness of and ad-
herence to patient safety practices, assessing and managing patients’ pain, screening for postoperative delirium, setting standards for staff competency and assessing whether staff meet those standards, and ensuring appropriate staffing and scheduling.

**Foster a culture of safety**

Tasked with developing “an organizational infrastructure to promote perianesthesia safety,” ASPAN’s Safety Committee created the ASPAN Safety Model that emphasizes advocacy, communication, teamwork, and efficiency as the focus for patient safety improvement. The authors encourage perianesthesia nurses to keep asking themselves, “Where is the harm? What can we do to prevent it? If something was to go wrong, what would it be and how would it happen? What will we do about it?” (Krenzischek et al.).

Nurses play a central role in establishing organizational culture. One article describes several ways perianesthesia nurses can advocate for patient safety, including speaking up for patients, advocating for a safe work environment, assessing for nurse fatigue, and advocating for the nursing profession (Windle et al.).

Safety culture surveys, teamwork and communication training, clinical standards, predictive and reactive system analysis, results of studies on patient safety issues, and SBAR (Situation, Background, Assessment, Recommendation) are some tools that can be used to systematically improve safety.

**Institute formal quality improvement**

Postanesthesia care can benefit from formal quality improvement activities that promote continuous surveillance and improvement. ASPAN’s standard on quality improvement states that perianesthesia nurses should continually monitor and evaluate care and that a multidisciplinary approach should be used to address opportunities for improvement. Both process and outcome measures should be used (ASPA). Organizations may also wish to participate in the Anesthesia Quality Institute’s National Anesthesia Clinical Outcomes Registry. Participants can submit data on demographics of the anesthesiology practice, case-specific process and demographic data, outcome data, and data for risk adjustment. The outcome data includes a list of 26 critical adverse patient care events compiled by ASA. Participants receive summary reports with their data and aggregate data.

**Ensure adequate space, equipment, and supplies**

Necessary space, equipment, and supplies must be available in every location where postanesthesia care is provided. The Centers for Medicare & Medicaid Services’ (CMS) Conditions of Participation generally require hospitals to have “adequate provisions for immediate postoperative care.” According to CMS’s interpretive guidelines, this means that postoperative care conforms to acceptable standards of practice, the postoperative care area is a separate area of the hospital with limited access, policies and procedures outline requirements for transfer to and from the postoperative care area, and the hospital has provisions for close observation of patients not transferred to the postoperative care area (CMS).

DNV (Det Norske Veritas) standards require hospitals to have “equipment, clinical staff, and plan of care provisions” for postoperative care (DNV). ASA’s standards for postanesthesia care specify that a physician who can manage complications and provide cardiopulmonary resuscitation to postanesthesia patients should be available in the facility (ASA “Standards”).

ASPA also has a practice recommendation that lists equipment necessary for each phase of perianesthesia care, including phase I, phase II, and extended postanesthesia care. The practice recommendation notes that equipment should be of appropriate sizes to meet the needs of the populations served (ASPA).

**Define anesthesiologists’ responsibilities**

CMS requires policies to delineate postanesthesia responsibili-

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**Characteristics of intra- and postoperative claims**

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<th>Intraoperative claims</th>
<th>PACU claims</th>
<th>Postoperative claims</th>
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<tr>
<td>Equipment problems</td>
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<td>12%</td>
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*Source: Posner, Karen L., PhD (Project Manager, ASA Closed Claims Project).*
ties (CMS). Nurses perform most direct patient monitoring and care during the postanesthesia period, but anesthesiologists are responsible for medical supervision and coordination of care in the PACU (ASA “Standards”). The anesthesiologist should remain responsible for evaluating and treating postanesthetic complications (ASA “Statement on the Anesthesia Care Team”) and should stay with the patient “as long as medically necessary” and until the receiving provider has all necessary information (ASA “Guidelines”).

Anesthesiologists are also responsible for documentation of anesthesia care in the record. Elements include the patient evaluation on PACU admission and discharge; records of vital signs, level of consciousness, and medication administration; unusual events, including complications; types and amounts of intravenous fluids and blood products administered; and postanesthesia visits (ASA “Statement on Documentation”).

ASA’s standards for postanesthesia care generally state that “an accurate written report of the PACU period” should be maintained. They encourage scoring patients’ physical status at admission, appropriate intervals thereafter, and discharge (ASA “Standards”).

Implement structured handoffs

Handoffs are especially risky for postanesthesia patients, and the quick progression of patients through the PACU means that handoffs occur all the time. An initial step is defining when patients are ready for transfer. CMS’s general interpretive guidelines on immediate postoperative care state that policies and procedures should outline requirements for transfer to and from the recovery room (CMS).

Handoffs start when the patient leaves the OR. ASA’s standards state that a team member who is knowledgeable about the patient’s condition should accompany the patient to the PACU. During transport, the patient should be “continually evaluated and treated . . . with monitoring and support appropriate to the patient’s condition.” On arrival, the accompanying provider should reevaluate the patient and give the PACU nurse an oral report, including information on the patient’s preoperative condition and surgical and anesthetic course. The patient’s status should be documented. The accompanying provider may leave the PACU only once the PACU nurse accepts responsibility for the patient’s care (ASA “Standards”).

Barriers to effective handoffs include incomplete transfer of information, other communication issues, distractions, incomplete or inconsistent teams, omission or inefficient performance of clinical tasks, and poor standardization (Segall et al.).

Recommendations include teamwork and handoff training, standardized handoff processes and protocols, ready availability of equipment and fluids before patient arrival, completion of urgent clinical tasks before information exchange, and allowing discussion of questions or concerns (Segall et al.).

An ASPAN practice recommendation likewise emphasizes the importance of using a structured handoff process and lists elements to include in handoff reports as well as when preparing the patient for transport (ASPA

Patient assessment and monitoring

While the patient is in the PACU, his or her condition must be evaluated continually. Observation and monitoring methods should be chosen based on the patient’s medical condition, but the ASA standards state that oxygenation, ventilation, circulation, level of consciousness, and temperature require “particular attention” (ASA “Standards”).

Similarly, the Joint Commission requires that hospitals assess the patient’s physiologic status “immediately after the operative or other high risk procedure and/or as the patient recovers from moderate or deep sedation or anesthesia” and monitor physiologic status, mental status, and pain as indicated by the nature of the procedure and anesthesia administered. The medical record must contain information on the patient’s postoperative vital signs and level of consciousness; medications, fluids, and blood products administered; and unanticipated events and their management (Joint Commission).

Medication safety

In an analysis of 645 PACU medication errors from MEDMARX, 6.8% resulted in harm. Of the 44 errors that resulted in harm, 1 led to a near-death event and another required further hospitalization.

Of all errors, 60% occurred during administration, 22% occurred during prescribing, and 11% occurred during transcription or documentation of the order. The most common types of errors...
were improper dose or quantity (25%), omission (20%), prescribing error (15%), and unauthorized drug (14%). The most common reported causes were performance deficit (46%), failure to follow procedure or protocol (24%), communication (17%), documentation (13%), and knowledge deficit (11%). Contributing factors were identified in 161 records; the most common were distractions (47%), workload increase (16%), and inexperienced staff (15%).

Review of the reports revealed recurring issues, such as hanging the incorrect epidural solution, wrong-dose and wrong-drug errors involving patient-controlled analgesia, administration of medications despite previous identification of allergies or contraindications, extra or omitted doses of medications (ketorolac, antibiotics, and pain medications, most frequently), lack of proper patient identification, and errors involving high-alert medications (Hicks et al.).

Practices to improve medication safety include the following (Windle et al.; ASPAN):
- proper labeling
- easy identification of high-alert medications
- no unit storage of concentrated high-alert medications
- opioid medications in a secured place at the bedside
- bedside medication labeled with patient name and drug and dose
- use of standardized abbreviations
- use of safe practices for verbal and telephone orders
- communication of patient allergies and drug reactions
- maintenance of nurse competencies in medication use.

Monitor adherence to discharge policies
Patients may be discharged from postanesthesia care only when they are physiologically ready. To that end, healthcare organizations should have postanesthesia discharge policies and procedures to promote safety and ensure that physicians maintain responsibility for discharge.

Discharge criteria, when used, must be approved by the anesthesiology department and may vary depending on the patient’s destination. If the physician responsible for discharge is not available, the PACU nurse may determine that the patient meets discharge criteria and document the name of the physician who accepts responsibility for discharge in the record (ASA “Standards”; Joint Commission; DNV).

CMS’s general interpretive guidelines on immediate postoperative care state that policies and procedures should outline requirements for transfer to and from the recovery room. These guidelines state that the postoperative check performed before transfer out of the PACU should assess some of the following, depending on the type of anesthesia and length of surgery (CMS):
- level of activity
- respirations
- blood pressure
- level of consciousness
- patient color.

References
American Society of Anesthesiologists (ASA):


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EHR Institute Perspectives

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Morale boosters

Continued from page 15

employees to have fun together and to reward teams. “We do a lot of celebrations,” says Roberson. “I have a staff member who likes to plan parties. She plans a huge summer picnic that includes all the departments in surgical services.” The OR staff also favor potlucks and include them during OR recognition week.

Lead by example

Andrews tackled a lack of teamwork at Torrance Memorial by rolling up her sleeves and helping the staff herself. “I get in there and work,” she says. “Employees won’t stand outside the door if I am pitching in.”

She also goes on rounds every 2 hours, she excuses herself from a meeting if a staff member calls and says she is needed, and she answers most of her emails from 3:00 pm to 5:00 pm, when all is usually quiet.

“It’s easy to sit at your desk and answer emails or see every salesperson who walks in during the day, but what are your priorities?” she asks. “Mine is the staff.”

At Houston Methodist, leaders strive for an atmosphere of collegiality where all members are held to the same standard regardless of title or education. “There are no raised voices,” Garcia says. “We work as a team to focus on the patient.”

Tackle the naysayers

All organizations have employees who are skeptical of efforts to improve morale. They may manipulate other employees to join forces and undermine a change in culture.

The book Eat THAT Cookie was named for just those types of employees. When Jazwiec was consulting with an obstetrical department, she designated a “no negativity” day and brought in trays of smiley face cookies for every shift. One employee said the cookies were professionally insulting. Jazwiec suggested that her colleagues tell her to hush up and eat that cookie. “That story always gets proactive with resolutions.

Don’t get discouraged

It’s easy to become discouraged when you’re trying to improve morale, Andrews says. “I had a potluck and only 2 people brought anything,” she says. “Don’t get discouraged. Keep pushing. The more you prove you are committed and dedicated to your cause, the more people will join you.”

If her staff are happy and satisfied, Andrews believes, good patient care will follow. “But,” she says, “I have to start by having a good foundation, and my employees are my foundation.”

Patricia Jill Andrews will be a presenter at the OR Manager Conference, September 17-19, in Long Beach, California. ♦

Janet M. Boivin, BSN, BA, RN, is a freelance writer in Cary, Illinois.

Reference

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The expanded volume of interventional cardiology in recent years has played a major role in the growing prevalence of hybrid ORs. As a result, many perioperative services leaders have had to develop systems for managing hybrid ORs along with traditional ORs.

“Management of hybrid ORs is really a collision of traditional hospital management and service line management,” says David Wyatt, MA, MPH, BSN, RN, CNOR.

“We are starting to talk seriously about the business case for hybrid ORs, along with interprofessional standards and how we are staffing these rooms,” says Wyatt, administrative director of perioperative services at Vanderbilt University Medical Center (VUMC), Nashville, Tennessee.

Cardiovascular services has been at the forefront of service line development, with the focus primarily on getting cardiac surgeons and cardiologists to work together to refer patients to the hospital. “For many years, that did the trick,” says Wyatt.

But now more procedures are being performed in the cath lab than in the OR, and cardiac surgeons and interventional cardiologists are credentialed to do some of the same procedures. These changes have created tension between surgeons and cardiologists, and turf wars have cropped up not only in the cardiovascular world but also in neuro intervention, which is performed by neurologists, neurosurgeons, and neuroradiologists.

“The neuro intervention specialties are even more complicated to deal with than cardiac,” notes Wyatt, “because they don’t have the background in collaboration that cardiac has had over the years.”

**Collaboration between service lines**

Successful management of hybrid ORs and their utilization begins with collaboration between the service line and operations administrators, notes Wyatt.

A cardiology (service line) nurse administrator and Wyatt, the perioperative (operations) administrator share the top spot on the management structure for cardiac hybrid ORs at VUMC (sidebar, p 23).

The director of the cath lab, electrophysiology (EP) lab, and cardiac surgery reports to both Wyatt and the cardiology administrator, and a matrix report goes to both service line and operational management.

This management structure also holds true for the neuro and vascular hybrid ORs, with Wyatt as the operations administrator over all 3.

The service line approach is very provider- and patient-centric, notes Wyatt. Though service line administrators may not fully understand operations, they do understand how to promote the flow of referrals between physicians and the hospital, how to bolster collaboration among physicians, and how to ensure optimal patient flow through the system, he says. On the other hand, the service line approach can become too costly for the system.

“We have had to balance moving forward with new technology and services for our patients without draining our resources,” says Wyatt.

Each new request for hybrid technology has brought forth change in how business is done in the OR and the need for a more systematic approach to collaborating with services performing image-based procedures.

“For example,” he says, “biplane imaging technology is tremendously expensive, and you really have to think systematically about who will be using it or there may not be a return on investment.” VUMC has a stroke program that is highly dependent on hybrid ORs because of the need for biplane imaging by the neuro specialists. Cardiac and vascular specialists may also use biplane or single plane imaging.

Before building new hybrid rooms, Wyatt says, they look at which specialists would potentially use the rooms, the like procedures they perform, the like equipment they use, and the best placement for each room (sidebar, p 23).

**Placement of hybrid rooms, equipment is key**

Several years ago, VUMC built its first hybrid room adjacent to the cath lab on the first floor. The main OR suite (with 35 rooms) is on the third floor.

“When the cardiac nurses and anesthesiologists had to venture off the third floor, they were out of their comfort zone,” says Wyatt. “It took them a while to get comfortable doing coronary bypass surgery on the first floor because they knew if they ran into an emergency situation, the cath lab staff weren’t much help, and they couldn’t go next door to get help.”

In early 2014, VUMC opened 4 new hybrid rooms on the fifth floor of the hospital—2 are used...
primarily for EP cases and 2 primarily for interventional cardiology cases, and the surgeons are able to use any of them for open cases if necessary.

The third floor main OR suite has a neuro interventional hybrid room and a vascular hybrid room. Another neuro interventional and potentially a cardiac surgery hybrid room will be built on the third floor this year, and the urologists also want a room, says Wyatt.

The rationale for building the cardiac hybrid room on the third floor is that it will allow cases that are primarily surgical with some imaging rather than cases that are primarily imaging with the potential for open to be performed close to the rest of the cardiac surgery and anesthesia teams.

“When we built our first hybrid OR on the first floor, we learned a lot about space and placement of equipment,” notes Wyatt. Cardiologists were more involved in the initial design than was the surgical team, and the perfusionists had limited space for the pump and their equipment. “The perfusionists had a lot more input in our design of the fifth-floor hybrid rooms,” he says.

Input from the anesthesiologists is also important, he adds. “Placement of anesthesia equipment can make or break you.”

Wyatt recommends having a construction crew build a mock room. Then move as much equipment as possible into the mock-up to see how everything fits.

“Your construction manager may not understand that a column that juts out of the wall only 12 small inches can [radically affect] placement of your sterile field and the anesthesiologists’ equipment,” he says.

VUMC hybrid rooms are typically larger than non-hybrid rooms. Wyatt recommends target-
ing a space that is 1,000 sq ft in order to accommodate the equipment and staff required to do these complex cases.

“The room will look as big as a football field when it is empty, but when all of the equipment is in, it looks so crowded it is amazing,” he says (sidebar at right).

**Cross-training teams is challenging**

Historically, when an interventional team and an OR team are both working in the same room for a hybrid case, 1 team is doing nothing while the other team is working.

“This made us start thinking about how to have more versatile teams and cross-training staff,” says Wyatt. A new interventional hybrid team model was designed that included staff competencies and standards of practice.

The difference in standards of practice between specialties caused problems early on. For example, in cases that are primarily image-based, radiation exposure is a concern. Radiation detection devices need to be placed at the point where the team members are at the highest risk—their hands—so they wear radiation detection rings under their gloves.

Because AORN recommends against wearing rings under sterile gloves, this practice made OR staff uncomfortable. “We had to educate the OR staff on the balance between putting staff and physicians at a higher risk by not allowing them to wear the detection rings or going against the standards,” says Wyatt.

On the other hand, staff from the interventional settings sometimes found themselves involved in procedures that changed from percutaneous to open, and they did not have the skill sets to assist in these procedures. “They had to learn the supplies and equipment and sterile technique needed to transition from a percutaneous to an open procedure.”

Cross-training began with staff from the cath lab; however, they found working in the OR challenging and they had low competency scores. “What we failed to take into consideration was that people work in the cath lab because they like to do cath lab procedures, and people work in the OR because they like to work in open procedures,” says Wyatt.

Forcing OR staff to work in an environment where they are limited to handling wires and balloons all day is not satisfying for them. Taking nurses out of the cath lab or interventional suite where they were used to doing a variety of things, such as providing sedation and monitoring patients, was too big of a shift for them.

Instead of cross-training all staff, Wyatt says, they had to change their strategy and be more selective of the people they cross-trained.

“I have had to realize, the hybrid arena is a different world,” says Wyatt. “People are working in new practice settings and with standards of practice that are new to them. We have to think very clearly about that and be sensitive to those differences to foster the collaboration needed to manage hybrid rooms successfully.”

—Judith M. Mathias, MA, RN

Source: Vanderbilt University Medical Center, Nashville, Tennessee.
Most perioperative leaders are concerned about turnover time. And rightly so—lengthy turnovers squander expensive OR minutes. The typical surgery department, however, gives less attention to case time. Many OR directors view case time as a lower priority that is largely out of their control.

This is a mistake. Prolonged case times could be wasting up to 10% of available OR minutes, and long cases create schedule inefficiencies that prevent optimal utilization.

Case time problems are not unsolvable. Leading ORs have developed several perioperative process changes that address the root causes of extended case duration without interfering with surgeons’ operative technique. These organizations have established effective ways to work with physicians on case time reduction.

Data drives change

To tackle the problem of lengthy case times, OR leaders must first establish that there is both a problem and an opportunity to improve. The only way to do this is to obtain reliable data.

Step 1 is to establish appropriate definitions. Case time is defined as “wheels in to wheels out,” not “cut to close.” The distinction is important because many of the factors that contribute to long case times originate in perioperative processes outside of the actual surgery.

Step 2 is to develop mechanisms for accurately tracking perioperative events. Make sure circulators are well trained in documentation processes and understand the importance of accurate time-stamping. In addition, create an effective clinical measurement strategy. The secret to identifying specific throughput problems is to break down case times into 6 key intervals:

- patient in to anesthesia ready
- anesthesia ready to prep end
- prep end to incision start
- incision start to incision close
- incision close to OR discharge ready
- OR discharge ready to patient out

Step 3 includes monitoring and analyzing case time data. Begin by conducting a baseline study to determine current average case times per interval. Once you have baseline numbers in hand, slice the data by surgeon and by procedure.

Within each procedure type, identify surgeons with consistently shorter case times. What do the most time-efficient surgeons do that is different from their peers? In addition, examine better-performing anesthesiologists and nursing teams. What practice patterns lead to faster setup and patient preparation?

Asking these questions—and developing solid answers—requires a multidisciplinary approach. A task force consisting of surgeons, anesthesiologists, nurses, and other clinical specialists should work together to identify specific process problems and solutions to improve patient throughput.

Improving efficiency

The case time reduction task force should begin by identifying opportunities to simplify pre-incision and postclosure processes. Many ORs are able to reduce average case times significantly by implementing a handful of process changes:

- Move anesthesia prep outside the operating room. In many departments, anesthesiologists start all IVs, arterial lines, and pain blocks in the OR. This practice extends case time unnecessarily. Instead, work with the anesthesia department to perform these procedures in the preoperative holding area or a dedicated procedure room.

Some hospitals have created a dedicated block room and secured additional anesthesia coverage to help speed perioperative flow. In addition, consider empowering nurses to start IVs before transporting the patient to the OR.

- Convert sequential steps into parallel processes. In many surgery departments, the OR must be completely set up before the patient arrives. However, some setup tasks can be performed during patient prep and induction. For example, scrub personnel do not have to finish setting up the back table before the patient enters the room as long as necessary supplies and equipment are in place.

Similarly, breakdown does not need to wait until the patient is out of the room. Nursing staff can begin cleaning up and tak-

Continued on page 26
ing carts out of the room during closure, keeping 1 table and 1 instrument tray sterile just in case a need arises.

**Simplify supply setup.** ORs can reduce supply expenses by analyzing and rationalizing surgeon preference cards. This effort can also simplify and speed preoperative setup. Weeding out rarely used items reduces the number of supplies that need to be prepped. Greater supply standardization helps nurses become more familiar with items in use. It also helps staff create standard approaches to specific procedures.

**Use PAs for complex cases.** Certain specialties—notably, neurosurgery, orthopedic surgery, and cardiovascular surgery—require more complicated setup and call for a higher level of support. For these specialties, hiring specialized physician assistants (PAs) can cut case times significantly. PAs are particularly important for procedures with significant technology setup.

**Require surgeon presence.** In many ORs, the attending surgeon is usually not in the OR during setup and patient positioning. In our experience, the pace of work is typically slower whenever a surgeon is absent. Once the surgeon does arrive, he or she often requests changes to positioning, draping, and/or equipment setup, adding further time to the case.

In addition, many surgeons leave the room before closure. Work slows down once more and, depending on the skill of the resident or other staff, the case can be extended significantly.

**Pave the way for discharge.** Patients are sometimes held in an OR because bay space is not available in the postanesthesia care unit (PACU). Often, the PACU is backed up because a room is not available in the inpatient surgical unit.

OR directors need to work with other nursing managers to resolve these problems. Fixing postoperative bottlenecks is the key to reducing OR discharge intervals.

Don’t forget about on-time starts. When the first case of the day starts late, it creates inefficiencies that reverberate through the remainder of the schedule. Creating preoperative processes that ensure on-time starts (at least 95%) will help optimize perioperative flow and allow care teams to perform cases as efficiently as possible.

**Working with surgeons**

Once you have started fixing perioperative problems and unit bottlenecks, you can begin to address
surgeon-controlled processes that drive long case times.

Surgeon factors can lead to significant variance in average case times for the same procedure. For example, we recently worked with a hospital where umbilical hernia repair ranged from 30 minutes to 3 hours, depending on who held the scalpel.

The starting point for any surgeon initiative should be data transparency. Develop case time dashboards and share them with the surgical staff. Dashboards should include the surgeon’s personal case time averages along with department comparisons for like procedures.

Surgeons respond to data-driven decision-making, so this tack will engage them intellectually in case time reduction. Dashboards will also promote healthy competition among surgeons to improve case time performance.

Involve department chairs in your case time reduction initiative. Data will undoubtedly identify some surgeons with very long case duration averages. Department chairs should work with these outlier surgeons individually to address the specialty-specific issues and practice patterns that are leading to extended cases.

Highlighting best practices can help encourage surgical staff to become more efficient. Recruit surgeon champions to address case time issues during department meetings. Some hospitals have created transition to practice rooms (TPRs) for senior residents with top-quartile case time performance. TPRs reward efficient physicians while showcasing best practices for the entire staff.

The most successful case time reduction initiatives are driven by peer accountability. This approach underscores the importance of a physician governance body for an OR—a Surgical Services Executive Committee (SSEC). A surgeon-led SSEC is in a strong position to commission a case time reduction plan, endorse recommended changes, and hold peers accountable for performance improvement.

**Strong benefits**

From the hospital viewpoint, reductions in nonproductive OR utilization support stronger financial outcomes. In terms of performance metrics, lower average case times automatically translate into higher primetime utilization rates. When OR utilization is managed properly, the result can be higher case volumes leading to higher revenue and profitability, with quality and safety maintained or even enhanced.

For example, say a 12-room OR averages 800 cases per room per year, for a total annual volume of 9,600 cases. Department leaders successfully reduce average case time by 10%, which allows them to accommodate additional volume. A realistic 6% volume increase translates into 576 extra cases per year. Given an average contribution margin of $6,500 per procedure, the volume growth enabled by case time reduction produces a $3.7 million increase in net profit.

While many surgeons will view a case time reduction initiative as a challenge, a successful effort can increase their satisfaction. Efficiency improvements will enable many surgeons to complete more cases within their allotted block, thus producing higher practice revenue.

**Coming up**

A successful case time reduction effort can improve patient throughput. Another way to boost OR efficiency is to improve upfront processes for scheduling cases. In the next OR Business Performance column, we will highlight several techniques for ensuring an accurate schedule that supports OR efficiency, safety, and cost control.

This column is written by the perioperative services experts at Surgical Directions (www.surgicaldirections.com) to offer advice on how to grow revenue, control costs, and increase department profitability.

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Nobody wants to come to work some morning and find a team of inspectors waiting. There is nothing like a surprise exam to make one nervous. Yet inspections are necessary—and not necessarily evil.

Ambulatory surgery center (ASC) inspections are required for Medicare certification by the Centers for Medicare & Medicaid Services (CMS), by many states for state certification or licensing, and in response to complaints and serious incidents.

According to ASC managers, routine CMS inspections or surveys are becoming more frequent and more detailed. Where they used to occur at 5- to 10-year intervals, now the trend is 3 to 5 years.

“If you haven’t had a survey in the past 4 years, you can expect one soon,” cautions Jan Allison, RN, director of accreditation and survey readiness for Surgical Care Affiliates (SCA) in Deerfield, Illinois.

Surveyors will not only return sooner than usual; they also may be more experienced than previously and have an eye out for details they might have ignored before.

The why and the how
For those who are new to ASC management or who have not experienced a survey in quite a while, the CMS instructions to surveyors provide reminders of what to expect.

To receive Medicare payment, ASCs must meet Conditions for Coverage (CfC) established by CMS, which generally are followed by insurance companies. Surveys are the means to determine if an ASC meets the CfC.

Survey authority and compliance regulations are covered in 42 CFR 416 Subpart B and 42 CFR Part 488 Subpart A. Because CMS delegates certification authority to states, the survey instructions are part of the CMS State Operations Manual. Among organizations authorized to conduct Medicare surveys are the Joint Commission and the Accreditation Association for Ambulatory Health Care (AAAHC).

One quick way to fail a survey is to deny access to the surveyors. “Should an individual or entity refuse to allow immediate access upon reasonable request to either a state agency or CMS surveyor, the Department of Health and Human Services Office of Inspector General may exclude the ASC from participation in all federal healthcare programs in accordance with 42 CFR 1001.1301,” the manual states. It also stipulates that “all surveys are announced.”

The year 2008 was something of a turning point in ASC survey history. That year, CMS proposed...
revised CfCs, which took effect in January 2009 (the first revision since 1982), and ordered an increase in the frequency of surveys, with a goal of maximum 3-year intervals. Also in 2008, the public was alarmed by news of an outbreak of hepatitis C at a Nevada endoscopy clinic in late 2007. The infection was traced to misuse of needles and reuse of single-use medication vials. The outbreak prompted an investigation by the Centers for Disease Control and Prevention (CDC) as well as a recommendation for clinician education and stricter surveillance.

Meanwhile, CMS and state health departments were able to act on the decision to step up surveys by using federal stimulus funds that became available in 2009. They hired new, less experienced surveyors to expand the staff.

That was 5 years ago. By now, those surveyors are more familiar with the new CfCs and better at sizing up an ASC’s operation and deciding which of the 100s of regulations to focus on.

“Surveyors are learning what to look for,” Allison says. “They have a more critical eye than ever before.”

For example, to assess infection control and hand hygiene, they may look beyond hand washing between patients to notice whether a nurse has performed hand hygiene after touching a privacy curtain.

In the OR, they notice when items are left on the anesthesia cart after being removed from their packaging but not used during the procedure. They check to see that those items are not used on future patients.

Surveyors now often look under equipment and furniture for rust, tape residue, or other possible sources of contamination.

Nurses have remarked on the level of detail. They ask Allison why “what was okay in the past is suddenly not okay.” She responds, “Either a code or regulation has changed, or it was never in compliance and was overlooked in the past.”

**Surveyors have eased up on radiology.**

Surveyors spend as much time observing clinical activities as they do inspecting documentation, and both are critical, he says. “You have to provide proof of every step in response to an incident. If you didn’t document it, it didn’t happen.”

Based on various reports, the following are some of the most common potential discrepancies surveyors will be looking for in upcoming reviews:

- **Governing board oversight.** The board should meet at least quarterly and record its proceedings.
- **Peer review.** Physicians must review each other’s work, both routine cases and adverse events. The ASC must maintain review summaries for each physician. Larger ASCs may have peer review committees to oversee reviews, whereas smaller ASCs will give that responsibility to the quality improvement committee.
- **Infection control program.** An ASC should have its own infection control manual. The manual may be based on model documents from AORN, the CDC, or other sources, but it should be tailored to the individual facility. The ASC must show that it follows the manual. An infection control coordinator must be appointed and trained. Sterilization of instruments and
Ambulatory Surgery Centers

devices must be done in accordance with the manufacturers’ instructions, which should be available to the surveyor. Patient care equipment should be cleaned after each use. Surveyors also will look at hand hygiene, air quality, and humidity.

- Quality improvement program. ASCs must have quality assurance and performance improvement (QAPI) programs supervised by their governing boards, as documented in the minutes. To demonstrate an active QAPI program, the quality council should meet at least quarterly to review and analyze quality data. Surveyors will be looking for trends such as a series of incidents.

- Pharmaceutical services. Staff must use proper technique for safe injections. They must label syringes and multidose vials with expiration dates, and control narcotics with double-locked cabinets and restricted key access. The consulting pharmacist can help with preparation by reviewing with staff the laws regarding controlled drugs and good management practices.

- Quality reporting. As ASC quality reporting rules are implemented, surveyors will be paying more attention to use of the new quality codes on Medicare claim forms, as well as Internet reporting for the newer codes.

Dealing with discrepancies
The survey ends with an exit conference to review findings, but the survey results are not official until the survey organization sends a letter to the ASC.

Expect the surveyor to find a few discrepancies. “There will always be something,” Goehle says. “Nobody is going to come out of a survey totally clean. You will always get comments.” He recalls that a surveyor told an ASC manager, “You’re lying if you say nothing has gone wrong in 3 years.”

Most citations are at the level of noncompliance with 1 or more standards. If surveyors find a serious threat to patient safety or a repeated failure to meet a particular standard, they issue a condition-level citation, which triggers a repeat inspection and possibly more serious sanctions, including closure. One type of serious discrepancy is improper response to an incident such as a patient fall or hospital transfer.

For every deficiency, the surveyor requires a plan of correction, which must contain the following components:

- what you will do to correct it
- who will be responsible
- when the problem will be corrected (for Medicare surveys, the deadline is 30 days)
- what process you will use to ensure it will not happen again.

Goehle calls this “closing the loop.” The next time a survey is done, the surveyor will check to verify that the problem that was cited has been corrected.

Despite the discomfort it may cause, any citation can provide a learning experience and path to improvement in patient outcomes. But surveyors can make mistakes. It is possible to successfully challenge a citation. Goehle recalls a case in which the surveyor was in a hurry and refused to examine an ASC’s disaster response manual. Later, he cited the ASC for not having a manual. ✥

—Paula Defohn

Reference

Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients, and ASC-10, Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps—Avoidance of Inappropriate Use. Data collection for those measures began April 1. ✥

Fewer blood transfusions linked to lower HAI risk

In a meta-analysis, elderly patients having hip or knee surgery had a 30% lower risk of healthcare-associated infections when fewer red blood cell transfusions were used.

Researchers from the University of Michigan Health System and VA Ann Arbor Healthcare System evaluated all HAIs reported in some 8,000 transfused patients, including pneumonia, sepsis, and surgical site infections.

Overall, for every 38 patients considered for transfusion, 1 patient would be spared a serious infection if fewer transfusions were used, the researchers say. They recommend more restrictive transfusion strategies.


Conventional wisdom about checklists challenged

Six months after surgical safety checklists were implemented in Ontario, Canada, no significant reductions in operative mortality or complications occurred, a study finds.

The adjusted mortality risk within 30 days of surgery was 0.71% before checklist implementation and 0.65% afterward. The adjusted risk of surgical complications was 3.86% before and 3.82% after.

The findings suggest that earlier claims about better outcomes associated with the use of surgical safety checklists were overstated, the authors say.


Outpatient, inpatient total joints yield similar results

Patient outcomes for same-day total joint replacements were comparable to those of patients admitted to the hospital and staying at least 1 night after surgery, researchers reported March 13 at the annual meeting of the American Academy of Orthopaedic Surgeons in New Orleans.

However, readmission rates were higher, though statistically nonsignificant, for outpatient total joints—14 of 137 (10.2%) outpatients and 7 of 106 (6.6%) inpatients were readmitted within 30 days.

Outpatient total joint procedures could cut costs and improve satisfaction, but concerns about patient recovery and Medicare financial penalties for 30-day readmissions have deterred surgeons and hospitals from routinely performing these procedures, the authors note.


Some outcome measures unreliable as hospital performance indicators

Risk-adjusted morbidity and mortality outcomes have low reliability for profiling hospital performance, finds a study of 55,466 patients.

For overall morbidity, reliability depended on sample size and event rate. Reliability was low for abdominal aortic aneurysm repair (sample size, 25 cases per year; event rate, 18.3%) and higher for colon resection (sample size, 114 cases per year; event rate 26.8%), for example. For mortality outcomes, the less frequent the procedure and event rate, the lower the reliability.

Clinical registries should eliminate sampling, adjust for reliability, and use advanced modeling strategies, the authors concluded.