Finding a balance for specialty teams

How do you strike the right balance between specialists and generalists on the perioperative nursing staff? What is the extent of specialization your department can sustain? It’s an important question for OR managers. Technology is advancing so rapidly that it’s difficult to expect all of the staff to be able to perform any type of case.

Specialty teams first became common in open-heart and neurosurgery. These cases have complex case setups and require specialized staff knowledge and skills. Similar demands have arisen in orthopedics, endoscopy, vascular surgery, and other specialties. Surgeons are demanding a highly competent and dedicated staff for all their cases. Nursing staffs are divided in their opinions but seek a solution that meets their needs and improves overall patient care. Finding this balance can be difficult, especially in small to medium-sized operating rooms where case volumes and staff numbers would not support specialty teams.

Though it’s difficult if not impossible for the staff to maintain competencies to scrub or circulate on all cases in all specialties, many departments still expect all staff to be generalists because they must provide staffing for call. Some departments resolve this by having specialty-specific call teams. But that creates additional expense and is a dissatisfier for staff, who must take call more frequently.

Perioperative managers need a consistent and comprehensive approach that meets the staff’s needs and provides the same standard of care for all specialties. This article describes a method for identifying and managing a nurse practice model that strikes the right balance.

Specialization as a continuum

Specialization can be thought of as a continuum of OR nursing practice (illustration).

On one end of the continuum is the generalist practice model, in which all RNs and surgical technologists (STs) are completely trained and maintain a competency in all specialties. They are expected to do any case at any time.

On the other end is the specialist practice model, in which RNs and STs are assigned to specialties and may even subspecialize in certain types of cases, equipment, or patient interventions. Often, these teams provide on-call staffing for their specialties 24 hours a day, 7 days a week.

Most departments will find themselves somewhere in between. Two common points in the middle of the continuum are:

• the “generalist with specialty preferences,” in which the staff are still expected to work on all cases, but some staff work more consistently within 1, 2, or 3 specialties. This is often referred to as informal specialization.
• the “specialist with general competencies” in which each staff member works in 1, 2, or 3 specialties but is expected to maintain general competency for other specific cases, equipment, or patient interventions typically encountered on call.

It is important to note that a staff member with a “general competency” has a solid perioperative nursing knowledge base, which requires a complete orientation and a basic rotation through the specialties. The rotation focuses on achieving competency for specific cases, equipment, and patient interventions that all staff need
when serving on call. This approach supports the ability to make daily assignments when there is not enough case volume in a specialty for it to be staffed exclusively by specialists.

The model can be different for each shift. For example, the “specialist with general competencies” model might work well for the day shift, but the generalist model might be better for evening or nights. A key is that the staff select where they want to practice to provide the best care to patients.

How do you determine where your department should fall on the continuum? Among considerations are:
- the volume in the specialties
- whether cases for specialties are consistently scheduled in certain rooms
- types of cases performed outside of prime-time hours
- whether ORs are located at multiple sites
- growth and development level of the staff.

The key factors are case volume and complexity. But equally important are the staff’s satisfaction and commitment to the degree of specialization in their practice.

The steps in developing a nursing practice model are outlined below.

**Step 1**
Form a representative staff action team with the task of identifying the practice model and the extent of specialization.

Forming an action team of RNs and STs is a major success factor in developing a model. The team provides clinical input and helps ensure the opinions of the entire staff are represented. The team is given a specific charter with the goals, deliverables, and boundaries for the task. All shifts should be represented. The team needs to debate the advantages and disadvantages of the extent of specialization, as well as address any staff satisfaction issues with their current practice. (A sample charter is at www.ormanager.com.)

**Step 2**
Explore the extent of specialization on the continuum and select the best fit for the department.

Issues to consider include:
- What is the current extent of specialization?
- What is the level of staff and surgeon satisfaction with the current practice?
- What are the current and projected case volumes and complexities of each specialty?
- Is there control of the patient scheduling process (i.e., are cases from different specialties mixed in a given OR suite per day)? If the staff commits to specialization, it will be almost impossible to assign staff to their specialty cases consistently if
the scheduling plan allows a mix of specialties in a single room during a day. If the surgeons can’t change this arrangement, it would be better to coach the staff to select a practice model toward the generalist end of the continuum.

- Does the department have ORs in different geographic locations? If there are multiple surgical sites, the team will need to explore how the model applies to each site. Each site might select a different extent of specialization depending on patient needs.

When exploring these considerations, the action team should communicate with the staff and obtain feedback. Often, multiple short surveys are distributed at the end of these staff meetings to obtain immediate reactions.

Sample questions are:

- List 2 things that are of the most concern to you regarding specialty teams.
- List 2 dissatisfiers about our current nurse practice.
- What do you think specialty team members’ responsibilities should be for planning patient care?
- List your first, second, and third choices for a team.

In addition to communicating with the staff, the department manager or director should explain the process and obtain feedback from the surgeons and surgery department. Expectations should be set for the extent of specialization that may be achieved and the timeline for implementation. Most surgeons are eager to support this effort and can be more supportive if they understand the process.

**Step 3**

**Identify the team structure.**

Single- or multiple-specialty teams can be formed. Case volumes per specialty and consistency of scheduling of cases are the prime considerations. At a minimum, a specialty needs to conduct surgery 5 days per week to warrant a specific group of nurses and STs. Often, it’s better to combine similar specialties (eg, general and plastic surgery) into a larger team to plan for adequate staff coverage. Remember that the team structure can evolve as case volume and complexity changes.

Issues to consider:

- Should we combine specialties into a smaller number of teams?
- What are the current numbers of staff?
- Are agency staff used, and can they be incorporated into the specialty teams?
- Who should be identified as the leader or leaders on the team (include RNs and STs)?

Team leaders should be appointed based on their leadership qualities first, not necessarily on whether they are the best nurse or technician for that specialty. The team leaders function as coordinators for the team and need to have good facilitation, conflict resolution, and communication skills. The team leader must not be allowed to dictate the practice decisions but should lead the team to identify its best practice plan. It is a good idea to have these team leaders attend a team leadership seminar and have specific objectives that measure their effectiveness as leaders.

**Step 4**

**Identify the on-call teams needed.**

The need for on-call teams varies with each hospital. The main drivers are typically the amount of emergency surgery (ie, the trauma-level designation) and whether staff are provided on call or around the clock.

The need for staff to be prepared for call is the single greatest obstacle in implementing increased nursing practice specialization. But this obstacle may not be as great as it seems. Often, the perception of the variety and complexity of cases performed by call staff is greater than what actually exists. Therefore, it’s wise to produce a report from the OR’s database to display actual cases performed on call and their frequency. Typically, no more than 10 to 15 types of procedures are performed during on-call hours.

Once the on-call data are reviewed, the action team recommends the cases to be included in the expected general competencies for all staff, which enables the team...
to determine the number and types of on-call teams. At times, the decision to change the call-team structure can be delayed until after general competency self-assessment and refresher training are completed. These activities often raise the staff’s confidence and comfort with taking call.

**Step 5**

**Plan for staff scheduling and daily assignments.**

Control and coordination of scheduling and assignments are important for a specialty team model to be successful. Staff scheduling must take into account planned coverage of rooms by specialty team members, not just overall coverage of rooms.

Daily assignments are determined first by assigning specialty team members within their specialty. The person responsible for making assignments must have a resource guide that lists every staff member with each person’s assigned specialty. In addition, each staff member should submit needs for refresher training for cases to be assigned outside of the specialty to maintain competency.

**Step 6**

**Form teams and plan for implementation.**

Forming the teams and planning their initial activities is an important step in making the teams successful. Consider offering a basic team-building seminar to ensure members have an understanding of team functions and skills to get them started successfully. The team’s first task should be to define competencies. They can then move on to other initiatives, such as preference card maintenance and instrument/equipment management. After the team achieves some early success and begins to function well, it should reach out to surgeons. Team planning with individual surgeons as well as attendance at surgeons’ department meetings is the next step to maximize growth and outcomes from the team structure.

**Step 7**

**Implement a staff competency program based on the nurse practice model.**

As the department begins to implement the new model, the team needs to develop competency assessment tools that are approved by the department manager or director. A staff development coordinator or educator can help the team in adapting a basic competency tool already in use.

The first set of competencies developed should target the general competencies for on-call cases identified earlier in this process. The competencies are then distributed to all staff so they can perform a self-assessment. The self-assessment is reviewed with the manager and becomes part of the staff member’s training and development plan, and annual evaluation process. Training needs identified through this process are communicated to the person making assignments to ensure the staff members are assigned to these types of cases.

Next, competencies are developed to address the in-depth knowledge and skills for advanced practice for each specialty. At this point, specialization shifts into high gear, and staff, surgeons, and patients will begin to gain the most from specialization.

**Step 8**

**Expand and conduct staff training.**

Staff training and development programs may need to be revised and expanded to address the nurse practice model and the extent of specialization selected. The basic orientation course usually remains the same, but the initial rotation to the services may be modified to focus on the general competencies.

Tools may be needed to assist the staff with quick refreshers for the general competency cases. Commonly, preference cards have been used for this purpose, but they may not be as helpful as other types of tools. Examples are having instruction cards attached to equipment and resource manuals available for a quick review of procedures.

One creative learning tool is to record short videos of common case setups that the staff can view on their computer monitors before a case. Videos can illustrate
assembly of instrumentation such as power equipment or draping and setting up of the sterile field.

**Step 9**

**Maintain ongoing monitoring.**

It’s important to identify and track the effects of implementing a change in practice. Specific monitors should be identified to measure the outcomes. Some examples are the frequency of assigning staff within their specialty team, measures of staff and surgeon satisfaction, specific patient quality outcomes, or even measures of efficiencies like case delays.

**Future of specialization**

Intraoperative patient care is evolving, and approaches to specialization may need to be modified. For example, the focus of some teams may change from the traditional surgical specialties to specific technologies, such as endoscopy. The basic knowledge and skills for endoscopy are transferable across specialties. Other developing technologies are robotics and endovascular and intraluminal approaches to surgery. Perioperative nurse leaders will need to be prepared to adapt their nurse practice models as technology develops. ✫

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