Clinical management

Specialty staff versus generalists: How do ORs strike the balance?

In the middle of the night, a patient arrives with a leaking abdominal aortic aneurysm, and the surgeon wants to insert an endograft. Or a patient arrives with a major pelvic fracture. Another patient needs an image-guided craniotomy. Who will answer the call? In an ideal world, specialized teams for these cases would be available 24/7. But in the real world, for most ORs, the on-call staff must be generalists, able to handle any type of case that comes through the doors. But with today's technology, general skills may not be enough.

Striking the balance between specialists and generalists is one of their biggest staffing challenges, OR Manager readers say.

Mary Murphy, RN, BSN, CNOR, director of surgical services for the 13 ORs at Munson Medical Center in Traverse City, Michigan, remembers when perioperative RNs and surgical technologists (STs) were prepared with basic skills that could apply to any specialty.

"Now with all of the technology, the skills aren't transferable—the technology is mind blowing," she says.

Munson has tried using clusters of specialties, attempting to cross-train staff within clusters.

"This has only been marginally successful," she says. "We are challenged with having additional staff on a daily basis to accomplish this."

All staff are expected to maintain competency for on-call cases except where there is a designated closed team. There is a closed team for open-heart surgery, and a closed team was recently formed for endovascular grafts.

"But it's still a challenge," she says. "The surgeons would like specialty teams 24/7, but we can't provide that."

Bonuses for closed teams

Members of closed teams receive a quarterly bonus as an incentive for taking their own call. The bonus is based on how much additional call these teams take in comparison to the staff taking general call, who do not receive a call bonus. Murphy says this model has been successful in retaining staff on the closed teams, which have frequent call responsibilities.

Munson has developed another model for the retinal surgery service. Staff are not on call, but a list is maintained of staff with retinal surgery expertise. If there is an after-hours retinal case, the staff with retinal expertise are called in. If they agree to come in, they are paid time and a half plus a $300 bonus.

"This model has been effective in this service, and we are considering expanding it to certain cases in other specialties, such as image-guided craniotomies or a fractured acetabulum," Murphy says. "The surgeons realize there are no guarantees, but so far it has worked well in the retinal service."

Moving to pods

Geisinger Medical Center in Danville, Pennsylvania, a Level I trauma center with 24 ORs, moved from specialty teams to a pod system more than a year ago. The change was made because the specialty teams weren't large enough to keep the staff on the teams consistently, notes Debra Strausser, RN, OR operations manager. It was also difficult to align the staffs’ schedules with the surgeons’ block time.
There are 5 pods, which were developed with input from the staff:

- cardiac and pediatrics (an unusual combination, Stausser acknowledges)
- orthopedics and neurosurgery
- urology and gynecology
- general surgery (including minimally invasive surgery and liver and kidney transplants)
- plastic, eye, ENT, and vascular surgery.

The pods work better for staffing because the nurse manager of each pod uses the surgeons’ blocks as templates for assigning staff, Strausser notes.

As a Level I trauma center, Geisinger has permanent staff 24/7, supplemented by call on weekends and holidays. There are specialty call teams for the cardiac and transplant services, and a specialty eye team is being implemented for call as well.

The general OR call group consists of 4 staff, a combination of STs and RNs. These 4 staff are not assigned a call order; rather the OR charge nurse can call in the team member who best meets the needs for the type of case to be done.

A vision for the future

Rex Healthcare in Raleigh, North Carolina, has a large group of generalists on all shifts but specialty teams for cardiothoracic surgery and ophthalmology. The cardiothoracic team takes its own call, but ophthalmology does not, notes Jayne Byrd, RN, MSN, associate vice president for surgical services.

The goal is to move to all specialty teams for 7 am to 7 pm, with generalists for nights, weekends, and holidays.

“It may take years to get there,” Byrd says. Maintaining competencies for generalists will be a major feat.

“Right now, (the generalists) are our most seasoned staff. But with retirement issues looming, it will be a challenge,” she says. “What they bring are critical thinking and intuition more than a basic skill set, and those are things that can’t be taught.”

Specialty teams have a “huge role” in physician satisfaction, Byrd notes. But they mean more call teams are needed. That is in conflict with staff satisfaction and retention because call is a dissatisfier for staff.

A generalist-specialist model

Saint James Health System, which serves Chicago’s southern suburbs, introduced a specialist-generalist practice model about 2½ years ago. Saint James has 2 campuses: Chicago Heights, with 10 ORs, and Olympia Fields, with 6 ORs; the combined surgical volume is about 10,000 a year.

The model, developed by consultant Gerald Biala, RN, MS, considers staff specialization to be on a continuum from generalist to specialist. At the generalist end of the continuum, all RNs and STs maintain competency in all cases—they can do any case at any time. At the specialist end, all RNs and STs are assigned to specialty teams and often take their own call. (See June 2006 OR Manager.)

Most ORs find themselves in between, Biala notes. Two common points on the continuum are:
• the “generalist with specialty preferences”—the staff are expected to work on all types of cases, but some work consistently within 1, 2, or 3 specialties.
• The “specialist with general competencies”—each staff member works in 1, 2, or 3 specialties but is expected to maintain general competency for cases commonly performed on call.

All staff members with generalist competencies must have a solid perioperative nursing knowledge base, Biala stresses, which requires a complete orientation plus a basic rotation through the specialties. The rotation focuses on achieving competency for cases all staff need to perform when on call.

Initial model
Saint James started with the “specialist with generalist competencies” approach, notes Paula Harms, RN, MBA, director of perioperative services. During prime time, the staff spent most of their time on specialty teams in clusters but maintained general competencies so they could take call. The off-shift staff were generalists. In late 2007, the staff asked to shift to a generalist-with-specialist-competencies approach.

“The staff felt they were so focused on their specialties that it was hard for them to go to other types of cases,” Harms says. “Staying in the assigned specialties sometimes made it difficult for the staff to rotate into other cases. Also, people can become territorial, both staff and physicians.”

She credits the staff for realizing this was happening and asking to become more generalist. “The shift has been fairly invisible to the surgeons, which speaks volumes about the ability of our staff,” Harms says.

This is the current team structure:
• Chicago Heights has 4 teams: orthopedics; neuro-spine; general surgery-gynecology-urology; and ophthalmology-ENT-vascular.
• Olympia Fields, a Level I trauma center, also has 4 teams: orthopedics (with some orthopedic trauma) and podiatry; neuro-spine (with a subdivision of pelvic trauma); and general surgery (with bariatrics) plus gynecology, vascular, ENT, maxillo-facial, plastic, urology, and ophthalmology; and open-heart surgery.

Steps toward implementation
These are the steps Harms and her team used to implement the model:

Gathered data. Data were gathered and analyzed, with Biala’s help, to identify:
• surgical volume by specialty
• cases performed during off-shifts to aid in developing a list of procedures all staff would need to be competent to perform
• potential procedures that would be added as new surgeons were recruited.

Involved the staff. Each campus organized a team of staff to recommend which version of the generalist-specialist model to adopt and present it to the rest of the staff. The staff then developed the list of procedures that would require generalist competencies. The generalist competencies basically include understanding the preference list for a case, knowing how to set up the room, and being familiar with the equipment.

Involving the staff was a key step, Harms says, because it created ownership for the model.

Developed competencies. St James developed its own competency educational materials and checklists. One assistant nurse manager was assigned to the project for 3 months, consulting with the staff. The educational materials are available in notebooks and on CD-ROM for those who need to learn a new procedure or review.

Hardwired the model. Staff members are responsible for monitoring their own competency lists and making sure they get the experience they need.

“If they don’t feel they are rotating enough, they speak up.” Harms says. To hardwire the process, staff members’ competency lists will be included during their annual performance review to check on their progress.

Managing the model
Harms says the model is working well for her as a director.
“It makes capital planning easier,” she says, because the staff are more involved in identifying equipment and disposable needs for certain procedures. They also assist in the management of other supply and equipment needs.

Specialty team leaders have taken the lead on identifying educational needs.

“Team leaders choose a topic every month that they would like the whole staff to be educated on,” she says. They also plan in-service programs. Each specialty gives a report at the monthly staff meeting.

The team model has “had a huge impact on communication,” Harms adds. Each campus has a white board where the staff inform each other what equipment is out for repair, what loaners are in, what new devices are coming in, and other important information about the specialty.

Advantages and disadvantages

These are pros and cons Harms sees with the generalist-with-specialist competencies model:

Advantages include:

- The model empowers teams to take leadership in their specialties.
- Staff and team leaders identify education needs for the department.
- The model provides a foundation for maintaining competency, which Harms believes improves patient care and professional development.
- Service to the physicians has improved.
- The staff have taken an active role in planning for new procedures, such as bariatrics and pelvic fractures.
- Daily operations have improved, including communication and supply and equipment management. The model “has been more outcome driven and proactive,” she says.

Among the disadvantages:

- “You have to manage the territorialism of the staff and the surgeons,” she says.
- As with any staffing model, “you can’t put it in place and leave it—you continuously have to re-evaluate,” Harms says.
- Having some specialization has worked well as business has changed. For example, when a bariatric surgeon was recruited, staff met with him to develop the service. The same was true for pelvic fractures. That established good communication between the surgeons and staff from the beginning.

Advice for implementing the model

Harms offered this advice for implementing a staffing model:

- Seek surgeon and administrative support.
  
  The Saint James administration supported the project, and surgeons were willing to get involved. “I believe the staff saw that commitment, and that helped make the project successful,” she says. She also suggests getting assistance from someone who has a clinical understanding and expertise in the model.
- Use data to drive decisions. Have good information about the nature of your business. For example, what is your volume in each specialty? What cases are you doing on the off-shifts? That will determine the generalist competencies needed.
- Get the staff involved. “The staff has to choose the model,” she says. “The OR director has to trust the staff and surgeons to do a good job. They are the best resources you have.”
- Rely on managers and team leaders. Daily leadership is needed to keep the change process on course. Managers need to advocate for the change when enthusiasm flags. They need to offer support and remain focused on the goal.
- Remember this is a journey. “This is not a project that you put in place and walk away from. It takes time to plan, implement, and readjust as it develops,” Harms advises. “You need to set goals and timelines and hold people accountable. It’s easy to say you don’t have time. You as the director need to commit to the project. Provide a lot of education to all stakeholders. You need to keep bringing peo-
ple back to the vision—communicate where the department was and where we want the department to go.”

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Reference

Staff input key to specialty team success. OR Manager. 2006;22(6):15-16.