What it takes to get OR cases started on time in the morning

Starting first cases of the day on time makes a big difference in how the surgical schedule goes. Delays starting at 7:30 am can snowball throughout the day, making it harder to finish on time and increasing overtime. But late starts are a stubborn problem.

Many pieces must come together for cases to start on schedule. The patient must arrive on time with all diagnostic work completed, paperwork must be in the chart, anesthesia providers need to have interviewed the patient and be in the room ready to go, the surgeon must be scrubbed, and the OR staff must have all of the instruments and equipment set up.

If any part slows down, everyone else tends to slow down too. Late starts are tough to fix. Attempts to improve can break down into finger pointing, with everyone accusing everyone else of being to blame for delays.

Like many, OR leaders at 866-bed St John’s Regional Health Center in Springfield, Mo, battled late starts for years. But the project caught on in the past year and a half, and since June 2004, St John’s has achieved a 90% on-time record for first cases of the day. With 28 ORs at 2 sites, the hospital is a Level 1 trauma center that performs about 27,000 cases a year.

These are steps St John’s took to improve its on-time starts:

Gather the right team

“The key to making any project like this successful is to have the physicians actively involved,” says Christy Dempsey, BSN, MBA, vice president for perioperative services.

Patient safety

Minnesota takes extra steps on wrong surgery, retained items

Public reporting of hospital errors is helping Minnesota take patient safety to the next level.

Even before the reporting began in 2003, hospitals in the state were taking extra steps to prevent wrong surgery and to avoid leaving objects behind in patients after operations.

In January, Minnesota became the first state to issue a public report detailing serious accidents by hospital. A total of 99 errors were reported between July 2003 and October 2004, resulting in 20 deaths and 4 cases of serious disability.

A 2003 law requires Minnesota hospitals to report 27 types of “never events.” These are events the National Quality Forum has identified that “should never happen” to patients in health care facilities.

More than half of the events—52 of the 99—involved surgery (box, p 18). The most common, accounting for 31, was a foreign object, such as sponge or needle, left in a patient. Another 19 involved either the wrong procedure or surgery on the wrong person or body part.

The only deaths from surgical events involved 2 normal, healthy patients who...
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**OR Manager** The monthly publication for OR decision makers

**April 2005 Vol 21, No 4**

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**Editorial**

Ready to be an open book? After years of hearing they will be measured on quality, health care providers are finding it’s actually happening.

It’s becoming easier for the public to get data on their doctors, hospitals, and other providers—warts and all.

This month, we report on Minnesota, the first state to publish specific data on hospital errors such as wrong surgery and retained foreign objects.

Recently, I went to the HealthGrades web site (www.healthgrades.com) and for $9.95 downloaded a report about Rose Medical Center in Denver where my son was born. The report looks much like what you would get from Consumer Reports if you wanted to buy a new dishwasher. There are the familiar little circles to show how Rose is doing on the Leapfrog Group’s Safe Practices. You can see that Rose gets 5 stars for its in-hospital mortality for heart attack patients, but only 1 star for coronary artery bypass.

The ratings are based on Medicare and Leapfrog data. Though the site has information on the methodology, it seems like the average person would have a tough time figuring out what the ratings mean.

**Rating doctors**

Public reporting is catching on. HealthGrades is introducing CompareYourCare, described as “the nation’s first scientifically constructed tool” to let patients rate their doctor visits and compare them to the latest evidence-based recommendations. Did you get your mammogram when you should? Did the doctor ask about depression? So far, the tool looks pretty cursory.

In yet another leap, state legislatures are passing laws to require hospitals to report their infection rates—a move infection control experts are wary about. Their practices and infections, surgical antibiotic prophylaxis, flu vaccinations for patients and staff, and surgical site infections, carefully defined. Their paper is at www.cdc.gov/ncidod/hip/PublicReportingGuide.pdf.

OR managers need to be aware of what’s happening in their states and how it might affect their facilities. If surgical site infections will be reported, it will be more important than ever to make sure surgical wound classifications are documented correctly.

There are many questions about public reporting of infections: Will the data be accurate? Will hospitals be compared fairly? Will the information help patients make good decisions?

Still, the train is leaving the station. Hospitals, infection control professionals, and clinical managers need to be ready.

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Pat Patterson
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What does the JCAHO expect for H&P?

What does the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) require regarding an update to the patient’s history and physical (H&P) before surgery? It is an area that has caused confusion.

JCAHO revised its requirement in 2004. The current requirement in the Provision of Care chapter is that an H&P must have been completed within 30 days before the patient was admitted or readmitted to the hospital. In addition, “updates to the patient’s condition since the assessment(s) are recorded at the time of admission” (PC.2.120). For outpatient surgery, the update is needed at time of arrival.

Regarding surgery, a medical records standard in the Management of Information chapter (IM.6.30) says the H&P plus any diagnostic tests and a diagnosis “are recorded before the operative or other procedure.”

“Essentially, we’re now requiring an update 100% of the time,” John Herringer, associate director of standards interpretation for JCAHO, told OR Manager in an interview.

How extensive does the update need to be?

“The update could range from writing ‘no changes’ to having to document a significant amount of detailed information about the patient’s condition that has changed,” Herringer says. “It would all depend on what the re-evaluation of the patient reveals. It needs to accurately reflect the findings: either that there are no changes or a detailed description of all the changes.”

Previously, an update was needed only if there were significant changes in the patient’s status or if the H&P was done 8 to 30 days prior to admission or outpatient surgery. (The latter was to comply with a Medicare requirement from the Centers for Medicare and Medicaid Services, or CMS.)

JCAHO’s requirements for the update now exceed those of CMS, Herringer noted.

CMS says there must be a complete H&P in every patient’s chart prior to surgery, except in emergencies. The H&P must be performed within 30 days before admission. In addition, CMS says there must be an assessment to update the patient’s status within 7 days before surgery. There must be an update note, regardless of whether there has been a change in status. This language appears in section 482.51(b)(1) of the CMS State Operations Manual, which outlines guidelines for state surveyors.

Because JCAHO now mandates an update for all patients, “our requirements now go beyond those of CMS,” Herringer says.

“For years, people have been confusing the CMS requirements with Joint Commission requirements,” he adds. Some believed the 7-day update requirement came from JCAHO when it actually came from CMS.

Now that JCAHO requires an update for every patient, that provision also covers the CMS requirement.

JCAHO has an interpretation of the H&P requirements at www.jcaho.org. Look under Accredited organizations, then Hospital, then Standards, then FAQ-Hospitals. The FAQ is dated Dec 3, 2004.

Update on JCAHO H&P standard

Several readers let us know that the information in the January issue on the Joint Commission’s H&P requirements was out of date. In this article, the Joint Commission provides the latest information.

JCAHO sessions at conference

Sessions at the Managing Today’s OR Suite conference Oct 19 to 21 in San Diego will help managers prepare for surveys:

- Meeting the JCAHO Infection Control Standard, with Helen Crouch, RN, MPH. How one facility implemented the standard, including working with front-line staff.
- JCAHO’s New Survey Method: Will You be Ready? with Michelle Pelling, RN, MBA. Getting the organization and staff ready for JCAHO’s unannounced surveys, beginning in 2006.
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New rulings on sharing savings with MDs

ew government rulings are creating a buzz about the potential to share cost savings with physicians for high-cost items like cardiac devices and orthopedic implants.

The Health and Human Services Office of Inspector General (OIG) issued 6 favorable opinions in February on “gainsharing” projects in which hospitals would share cost savings directly with physician groups. All were developed by Goodroe Healthcare Solutions (www.goodroe.com), an Atlanta-based consulting firm.

Observers say the rulings may open doors for aligning incentives with physicians to help control costs for physician-preference products, one of OCR’s biggest cost challenges.

The news caused some Wall Street analysts to upgrade prospects for stocks of for-profit hospital companies and lower ratings for orthopedic vendors.

A ‘game changer’?

The OIG opinions represent “a real game changer,” wrote analysts for investment bankers Leerink Swan & Co. If the projects take hold, they said orthopedic companies might not be able to sustain the 4% to 5% annual price increases they have been seeing.

Following suit, HCA, the nation’s largest hospital chain, said in February it plans to buy hip and knee prostheses only from the 3 largest manufacturers, down from about 15 now, the Nashville Tennessean reported. HCA also said it would ask the OIG for a ruling on sharing cost savings with physicians.

“Is seems like there is some wind in the sails” for gainsharing, says George Martin, MD, senior director of clinical process improvement for VHA Inc, co-author of the first gainsharing proposal reviewed by the OIG in the late 1990s.

The rulings could be a “lever to bring hospitals and physicians together,” he notes, saying tens or even hundreds of facilities might be moving in that direction by the end of the year.

Carefully designed safeguards

The OIG made clear the arrangements passed muster only because they were designed to prevent abuse (sidebar, p 8). Officially, an OIG opinion applies only to one set of facts and should not be construed to apply to other situations. But observers thought the opinions might signal a shift in the OIG’s approach to anti-fraud statutes.

Joane Goodroe, president of Goodroe Healthcare Solutions, has refined her gainsharing model for several years. Two of the hospitals involved are PinnacleHealth, Harrisburg, Pa, and Sisters of Charity Providence Hospital, Columbia, SC. Goodroe did not disclose names of the others.

Typically, the OIG has not allowed hospitals to share cost savings with physicians because such projects could sway physicians’ judgment and potentially undermine care for Medicare and Medicaid patients. For example, physicians might deny patients more expensive devices or shift more costly patients to other hospitals. These types of arrangements generally are illegal and could lead to big fines.

In fact, the OIG found most aspects of the arrangements it ruled on were potential violations but said the government would not impose sanctions because of the way the projects were designed.

Good data key

A major key to designing gainsharing projects properly is good data systems.

“We have developed software to measure cost, quality, and utilization both before and after the target opportunities,” Goodroe told OR Manager. Her firm claims to have data on more than 1 million cath lab and open-heart procedures for comparison.

The OIG noted that for each cost-saving recommendation, there was a way of measuring historical practice patterns and comparing them to practice after the project began so savings could be clearly identified and quality monitored.

For example, assume surgeons at your hospital use aprotinin in 80% of coronary artery bypass cases to help reduce the need for blood transfusion. Some use it all the time, others not at all. The literature might support using aprotinin on 10% of cases with certain indications. If you found only about 10% of your cases met criteria for aprotinin, your hospital might decide it could reduce utilization from 80% to 15% without risk. If you had access to benchmarking data, you could compare your practice with others for further guidance.

Goodroe maintains having an “outside party,” such as her firm, do the data analysis and monitoring is another safeguard. The firm is paid a monthly set fee not tied to cost savings.

No guarantee

Hospitals need to be clear about what these projects entail, observes Karen Barrow, RN, vice president of the group-purchasing organization Amerinet. “It takes a lot of time, and there is no guarantee” the plan will get past the OIG, she says.

Even with the new rulings, hospitals that want to emulate the projects would need to seek an OIG opinion or at least close scrutiny by their attorneys.

Also, the project has to be fully disclosed to patients before admission. The arrangement also could negatively affect clinical research or consulting arrangements physicians have with vendors. When physicians learn this, Barrow finds they often hesitate, especially in orthopedics.

As an alternative, she finds they often are interested in projects with indirect rewards. For example, the hospital might agree that, if physicians help save money on implants, half of the savings will go to purchasing equipment such as power drills for orthopedics to help shorten turnover time.

—Pat Patterson

The opinions (05-01, 05-02, 05-03, 05-04, 05-06, and 05-07) are at http://oig.hhs.gov. Look under Fraud Prevention and Detection, then Advisory Opinions.

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Cost management

Highlights of gainsharing opinions

These are highlights of the advisory opinions from the Health and Human Services Office of Inspector General.

Proposed arrangement

A hospital would share with a physician group a percentage of the hospital’s cost savings that come directly from specific changes in the physicians’ practices. For example, the surgeons agree to use some less costly items during surgery and agree to standardize on some products.

The hospital would pay the surgeon group 50% of the cost savings for implementing a set of recommendations over a 1-year period. At the end of the year, the saving would be calculated for each of the recommendations by subtracting the actual cost from the baseline. The surgeon group would distribute profits to its members on a per capita basis.

Questions for the OIG

1. Would this arrangement be subject to civil money penalties because it could induce a physician to reduce or limit services to Medicare or Medicaid patients?
2. Would the arrangement be subject to civil money penalties under the anti-kickback statute, which prohibits inducing physician referrals?

What the OIG said

Though the proposed arrangement would be improper and could potentially generate payments to physicians prohibited by the anti-kickback statute, the OIG would not impose sanctions.

Features of arrangement

In OIG opinion 05-01, for example, a consultant studied historical practices in a hospital’s cardiac surgery department and identified 24 specific cost-saving opportunities in 4 categories:

1. Opening packaged items, such as surgical trays, only as needed during the procedure. One example is disposables for the cell saver. The items would be readily available if needed.
2. Performing blood cross-matching only as needed. All patients would be typed and screened before the procedure, with the cross-match performed only when the patient requires a transfusion. The hospital does not outsource its blood supply. The delay in blood readiness should be minimal when a cross-match is necessary and would not adversely affect patient care.
3. Substituting less costly items for the items currently being used by the surgeons.
4. Standardizing certain cardiac devices where medically appropriate. The surgeons would work with the hospital to clinically review the vendors and products.

Why OIG would not impose sanctions

These are reasons the OIG said it would not impose sanctions on these arrangements:

- Cost savings for each separate recommendation were clearly identified.
- There was medical input to ensure the savings did not adversely affect care.
- Payments to MDs would be based on all surgery regardless of the patient’s insurance coverage.
- The hospital and surgeon group would provide written disclosures to patients whose care might be affected by the arrangement.
- The financial incentives would be reasonably limited in duration and amount.
- Because the surgeon groups’ profits are distributed on a per capita basis, any incentive to an individual surgeon to generate a disproportionate share of cost savings is mitigated.
- There are safeguards to reduce the likelihood that the project would be used to attract physicians or attract referrals from existing physicians, which would violate the anti-kickback statute.

Safeguards

The arrangement had these safeguards to protect against inappropriately reducing service to patients:

- For the cell saver, blood cross-matching, and product substitution, objective historical and clinical measures would be used to establish a “floor.” If the measure fell below the floor, surgeons would not receive a share of the savings. For example, the cell saver is set up for 100% of the cases but is used on about 30% of cardiac procedures. The surgeon group would not receive a share of any savings that reduced cell saver use below the 30% floor.
- For product substitution, historical usage was analyzed and thresholds established. Surgeons would not receive cost savings for savings beyond that threshold. For example, data indicated that certain less-expensive catheters could be used in 90% of cases without adversely affecting care. Thus, any savings from using less expensive catheters in more than 90% of cases would not be credited to the surgeon group.
- The surgeons would make a patient-by-patient decision on the most appropriate cardiac device to use. Individual surgeons would still have the same selection of devices as they did before the project began.

Other safeguards

- The volume of services would be monitored, and physicians would not share in cost savings for additional procedures performed over the volume in the base year.
- Patient demographics and severity of illness would be monitored to make sure physicians were not shifting more costly patients to other hospitals.
- Patients would be informed about the cost-saving project in writing.
First-year turnover is one of health care’s biggest staff retention issues. “We know that 27% of people who leave a job are already thinking about it within the first 90 days,” says Quint Studer, an expert in service and operational excellence in health care.

What can you do to keep them?

Studer has a prescription. It’s the kind of practical strategy he’ll share as keynote of the Managing Today’s OR Suite conference Oct 19 to 21 in San Diego. A former hospital CEO, Studer founded the Studer Group, a company that offers tools for improving employee retention, customer satisfaction, financial performance, and overall quality. The keynote, Hardwiring Excellence, is sponsored by Kimberly-Clark Health Care.

One of his prescriptions for keeping staff is a 30-day interview with new hires. Studer advises bringing in a new employee and saying, “Sue, it’s nice having you with us. I like to sit down with all of our employees after they’ve been with us for 30 days and ask a few questions.”

These are 4 areas to address in a 30-day interview:

1. **How do we compare with what we said we were going to be like during the interview process?**
   This question tests the organization’s values. Are you following through on what you said you would do? Is your behavior consistent with what you say your values are?

2. **Tell me what is going well here. Tell me who’s been helpful to you.**
   This gives the employee a chance to talk about what is positive. “When people are new, they’re frustrate, they are scared, and they may be feeling a little incompetent. This gives them a chance to reflect on where they’ve come,” Studer says. Also, by asking who’s been helpful, you’re harvesting wins. “When the employee names Nancy, I’m going to ask how she was helpful,” he says. “That helps me create a template for helping new employees.”

   It’s also a chance to recognize Nancy. “And how does that cause Nancy to treat the new employee? Even better,” he says.

   When a new employee says, “The OR here is the best I’ve ever seen,” that gets passed on to the OR staff. They, in turn, treat the new person better, and she learns the value of rewarding and recognizing others.

   It’s also an opportunity to find out who’s not helping so that can be addressed.

   “Why do people leave? Many times, it is because people are not treating them well,” Studer says.

3. **Before you came here, you were at the hospital across town. What are some of the things they do there that we could be doing better here?**
   This is an opportunity to learn what’s working elsewhere. “In health care, we are known to shut down intellectual capital,” he says.

   “When a new employee offers a suggestion from their former workplace, we’re likely to say, ‘Well, you don’t work there anymore. This is how we do it here.’ If you went to work at GE from Siemens, the first thing they would say is, ‘Tell me about what’s going on at Siemens.’”

   This question also sends the message that you’re approachable and value employee input.

4. **Is there any reason you are thinking about leaving?**
   Typically, employees bring up issues about scheduling or perhaps the training they thought they would get but haven’t yet. Or they might be confused about whether they are making good progress. This is an opportunity to reassure them.

**Key retention strategies**

“When these 4 questions, you’ve probably hit on 50% of the retention strategies,” he says. “You’ve let the new employee know you care about their professional development and care about reward and recognition. You’ve also let them know you’re approachable.”

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**Percentage of hospitals losing money on Medicare and Medicaid, 2003**

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The majority of hospitals lose money treating Medicare and Medicaid patients. Source: American Hospital Association.
AAMI advice on reprocessing instructions

Two new documents from the Association for the Advancement of Medical Instrumentation (AAMI) should help device companies develop clear reprocessing instructions that can be applied in health care facilities. They can also assist OR and Central Service managers evaluate instructions they receive from companies.

The first document, TIR12: 2004, gives guidance to manufacturers on how to perform validation studies for their reprocessing instructions. It also provides advice on choosing protocols that are feasible for facilities to perform.

The second, ST81: 2004, is a voluntary standard to guide manufacturers in labeling their devices and providing reprocessing instructions.

Importantly, ST81 calls on manufacturers to validate each step in the cleaning, disinfection, and sterilization process, says Sandra Lee, RN, BS, a sterile reprocessing consultant and educator who co-chaired the working group that developed the documents.

For example, on cleaning, the standard says the manufacturer shall give a validated manual method for cleaning plus at least one validated automated process unless the device can’t withstand an automated method.

Both documents can help users when they are considering purchasing a device, Lee says. TIR12 can assist them in understanding the kind of information manufacturers should provide so they can ask the right questions. In addition, ST81 lets them know what standard manufacturers should be expected to meet for reprocessing instructions.

“In the past, it has been difficult to get meaningful, specific information,” says Nancy Chobin, RN, CSPDM, Lee’s co-chair and educator at St Barnabas Healthcare System, Livingston, NJ. “There are many manufacturers that have provided detailed instructions to end users. However, there are just as many that do not.”

Meeting real-world needs

One challenge manufacturers face is making sure their reprocessing requirements match the real world, Lee notes.

Device manufacturers know what processes are compatible with the materials in their devices. But they also need to make sure methods they recommend are achievable and can be carried out safely, she adds. For example, is the manufacturer recommending a sterilization cycle that is used in industry but is not commonly used in health care facilities?

Lee urges manufacturers to partner with health care facilities to learn more about their processes so the information they provide is achievable.

“I would love to see manufacturers provide this information on their web pages so health care personnel could have access to instructions 24/7. This would be a great customer service feature,” she says.

AAMI notes that the FDA used the first edition of TIR12 published in 1994 in preparing its guidance on designing, testing, and labeling reusable medical devices. ST81 is consistent with European and ISO standards, with some differences for application in the US.

For more information or to order the documents, go to www.aami.org or phone 800/332-2264 ext 217.

AAMI documents


ANSI/AAMI ST81: 2004. Sterilization of medical devices—information to be provided by the manufacturer for the processing of resterilizable medical devices. List price $80; member discount price $40.

Ten ‘Demandments’ of leadership

People panic in herds but recover one by one.” This quote from 1840 has lessons for managers today. Change can rattle a whole organization, but each employee recovers differently, notes William Moskal, EdD, of IRI Consultants to Management, Detroit.

Managers need to tune into individuals and help address their fears.

That’s one of “Ten Demandments” for High-Performance Leadership that Moskal, an organization development consultant, will discuss at the OR Business Management Conference, May 2 to 4, in Tampa, Fla. He also will give a general session on leadership. Moskal also will speak at the Managing Today’s OR Suite conference Oct 19 to 21 in San Diego.

Managers and staff are dealing with constant change, and “it’s the transitions that are hurting people,” Moskal says.

Leaders need to develop not only their management skills—the familiar nuts and bolts of planning, scheduling, and budgeting—but also their leadership side, which he defines as getting teams to move in the same direction.

Some “demandments” he will speak about:

- Moving from obstacles to opportuni-
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in the OR Manager print version.
After St John’s leaders had spent many years trying to solve this issue, the on-time project really kicked off when a perioperative services team participated in a patient-flow collaborative led by the Institute for Healthcare Improvement (IHI), a Boston-based nonprofit organization (www.ihi.org).

The IHI team presented its ideas to St John’s Perioperative Services Guidance Team, which meets twice a month and deals with operational issues such as block scheduling and performance improvement. Co-chaired by the chairman of the department of surgery and the director of perioperative services, the Guidance Team includes 5 surgeons; an anesthesiologist; managers of the OR, preoperative area, and postanesthesia care unit; and Dempsey as the administrative representative.

“This is a nimble group that works well together and has the respect of their peers,” notes Ken Larson, MD, FACS, a trauma surgeon and member of the patient-flow team. “That allows them to roll out something to the Surgical Executive Committee and say, ‘Hey, guys, we want to try this.’”

The Guidance Team reports to the Surgical Executive Committee, a much larger group—“the full Senate,” as Dr Larson terms it. Many issues are hashed out by the Guidance Team, and the Executive Committee generally accepts its recommendations.

**Agree on a definition of start time**

Consensus on a definition of start time is essential when tackling late starts, Dempsey emphasizes.

The team decided to define the official start time as the incision time.

“When we began looking at start time, we asked, ‘What has to happen before you can actually start a case?’ You have to have a patient, a surgeon, anesthesiologist, and the OR staff. All of them are present when the incision is made,” Dempsey says. “That is why we decided incision time was the best marker for start time.”

Other facilities might use different definitions, she notes. “However you define it, it has to be something you can track and that everyone understands and buys into.”

**On-time OR starts for first cases**

St John’s ORs have atomic clocks so times throughout the department are accurate.

**Establish a policy**

The goal is to have 90% of first cases of the day start on time. Surgeons and anesthesiologists must be on time for at least 90% of their cases in a month or incur a penalty.

For surgeons, on time means being in the room 10 minutes before the posted start time for a case, eg, 7:35 am for a 7:45 am case. Surgeons are not counted late, however, if the incision is made on time even if they are not in the room 10 minutes beforehand.

On time for anesthesia means having the patient in the room no later than 7:20 am for a 7:45 am case.

OR staff must be in the room in time to prepare the OR so the patient can be brought in the room by the appointed time.

Having patients’ histories and physicals completed is part of being on time. If a case is late because paperwork is not finished, whoever is responsible has the late case counted against him or her.

“In our hospital, the patient does not go to the OR until the H&P is on the chart,” Dr Larson says.

**Penalties**

Surgeons falling below 90% on time are at risk for losing their 7:30 am start time for 1 month, meaning their block does not start until 9 am. They also are not permitted to schedule outside of their block later in the day.

Anesthesiologists pay a financial penalty. Determining a penalty for them “was harder to define and took a little more time,” Dr Larson acknowledges. There wasn’t a big problem, because, as a group, anesthesiologists were on time 96% of the time.

Individual anesthesiologists who don’t meet the 90% goal pay a financial penalty into a pot shared by on-time anesthesiologists at the end of the quarter. Dr Larson declined to state the penalty amount.

The OR staff also is monitored for punctuality, though the physicians agreed the staff was not the problem. If a staff member is responsible for a delay trend, the person would be counseled, Dempsey notes.

**Waivers**

Surgeons and anesthesiologists who have a legitimate excuse for being late can fill out a waiver form. A legitimate excuse is giving emergency patient care elsewhere in the hospital. Meetings are not considered a legitimate excuse. Several regular department meetings
Giving anesthesiologists individual monthly reports on their on-time performance and paying a small financial prize helped Vanderbilt University Medical Center in Nashville, Tenn, make significant improvements in its on-time starts for first cases of the day and anesthesia prep time, a study has shown.

“Our hypothesis was that with the proper incentives—the reporting and a small financial prize—we could encourage our attending staff to really drive the process of getting the patients into the room on time,” says Paul St Jacques, MD, director of anesthesiology informatics at Vanderbilt, who led the study.

He and his colleagues tracked anesthesiologists’ performance on 5 indicators, both at 1 month to establish a baseline and at 6 months after the program began (sidebar).

Some dramatic results

Results were dramatic for 2 indicators. On-time starts for first cases of the day jumped by 42%, from 19% to 61% during the study period from Sept 1, 2002, to Feb 28, 2003.

The percentage of cases with an anesthesia prep time less than the target of 15 minutes rose from 57% to 73%.

Also improved was the mean number of anesthesia-controlled time delays during induction or emergence, from 15% to 3%.

The 2 other indicators didn’t improve significantly. These were delays due to waiting for an anesthesia patient evaluation and delays due to waiting for an anesthesiology attending.

The results showed attending physicians really can make a difference “as cheerleaders for getting patients in the room on time,” Dr St Jacques notes.

Behavior shifted more toward anesthesiologists asking, “What do I need to do to get the patient in the room? Do we need to start an IV? Do we need to get the antibiotics going?”

“We have found the incentives work,” he says.

Monthly reports

Each month, each of the participating anesthesiologists receives a report with graphs showing how he or she did on each of the indicators. The 20% top performers on each indicator receive $100, which goes into the anesthesiology department’s continuing education fund.

The program has continued since the study ended. Though there has been some drop-off in performance, “we still have a significant portion of the gains,” Dr St Jacques says.

The indicators were developed by a focus group of clinicians and managers who discussed which on-time factors were most important to surgeons.

The data is collected using Vanderbilt’s perioperative information system, which was developed in house. On each case, the circulating nurse and anesthesiologist collect specific time elements using a touch-screen button. Time elements entered by the circulating nurse populate the anesthesiologist’s screen and vice versa. There also are fields for entering reasons for delays. Circulating nurses use judgment in entering whether there are anesthesiologist-related delays in patient evaluation, excessive induction or emergence time, or an attending being unavailable. For example, during induction, did it take too long to put in an arterial line, or was the time necessary for clinical reasons?

The information system generates monthly reports, which are distributed through the divisions in the anesthesia department.

How has the on-time project helped the ORs improve?

Though time savings haven’t been

Continued on page 16

### Indicators tracked during study period

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of first cases of the day in the room on time</td>
<td>&gt; 90%</td>
<td>First case of the day for each OR, patient in the OR at or before scheduled start time</td>
</tr>
<tr>
<td>Anesthesia prep time less than 15 minutes</td>
<td>&gt; 90%</td>
<td>Time from patient in room to anesthesia team turnover to surgical team for positioning and preparation for surgery</td>
</tr>
<tr>
<td>Percentage of cases delayed due to waiting for an anesthesiology patient evaluation</td>
<td>&lt; 10%</td>
<td>Circulator nurse judgment that case progress was delayed by the need to wait for completion of an anesthesiology patient evaluation that could have been completed in a manner not to delay the OR</td>
</tr>
<tr>
<td>Percentage of cases delayed during anesthesia controlled time</td>
<td>&lt; 5%</td>
<td>Circulator nurse judgment that case progress was delayed by inappropriately excessive anesthesia procedure, induction, or emergence time</td>
</tr>
<tr>
<td>Percentage of cases delayed due to waiting for the anesthesiology attending</td>
<td>&lt; 5%</td>
<td>Circulator nurse judgment that case progress was delayed by inappropriate waiting for the presence of the anesthesiology attending</td>
</tr>
</tbody>
</table>

Visible manager keeps cases on time

Being visible is one manager’s best tactic for getting first cases started on time.

In the morning, she makes it a point to be in the preoperative holding area and at the OR front desk.

“If there’s any delay with patients, I can help manage that. Also, when the doctors come in, they have to walk right past me. They get used to seeing me,” says Carol DiCarlo, RN, MS, CNOR, clinical manager of the OR at Bradley Memorial Hospital in Stonington, Conn. Bradley Memorial runs 2 to 3 ORs and performs 2,600 cases a year.

“If the doctors are 15 or 20 minutes late, it sets the tone for the rest of the day,” she notes.

Goal 100%

The goal is 100% on-time starts for first cases of the day. A case is considered on time if the patient is in the room within 5 minutes of the scheduled start time. Over 8 months from May 2004 to January 2005, on-time starts for first cases improved from 78% to 91%.

Other strategies have also helped improve the process.

Data on on-time starts are reported monthly to the surgical section. Data is collected using a paper form (illustration). The ORs do not have an automated information system. Data for individual surgeons is not reported by name, but DiCarlo speaks to surgeons who have had late cases.

Penalties for tardiness are backed by the chief of surgery. Surgeons who are late three times in 6 months risk losing their first-case start time for 3 to 6 months. Also, a late surgeon can have his case bumped if another patient is ready.

Expectations for anesthesia

No one has yet lost first-case start time. But a surgeon who was 45 minutes late had his case bumped. He complained to the administration, but DiCarlo says the chief of surgery backed her decision.

Recently, when the hospital contracted with a new anesthesia group, administrators told the chief of anesthesia during the negotiations that starting on time would be an expectation.

“The doctors like starting on time,” DiCarlo says. “If they know you’re serious, and the patient will be in the room, they will be there. It is a mindset to prove that things will get going, and I help to expedite that.” She has coached surgeons to call if they know they are going to be late, which they are accustomed to doing.

Infection risk lower for older patients

Surprisingly, older patients had a lower risk of surgical site infection (SSI) than younger patients in a large new study.

Risk of infection declined by 1.2% a year for patients age 65 and older, while the risk rose by 1.1% a year from age 17 to 65, according to a prospective study involving 144,485 patients at 11 hospitals led by researchers from Duke University Medical Center, Durham, N C.

The researchers could not tell why the risk declined. One possible reason is that older patients at greater risk for complications are less likely to have surgery than younger patients.


QI indicators for on-time starts

Function: Care of the patient
Source: Operating Unit

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Dimension of performance</th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
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<tbody>
<tr>
<td>Adherence to start time</td>
<td>Efficiency</td>
<td>100%</td>
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<td>Number of first cases</td>
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<td>Number starting on time</td>
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<tr>
<td>Percent starting on time</td>
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<tr>
<td>Average lateness of cases that didn’t start on time (minutes)</td>
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</table>

Tolerance is up to 5 min from scheduled start time.

Source: Bradley Memorial Hospital, Stonington, Conn
OR Business Management Conference

May 2-4, 2005
Tampa, Fla

A two-day conference plus all-day preconference seminars for OR professionals concerned with the business management of the OR.

General sessions and breakouts will focus on:

- OR Efficiencies
- Materials Management
- OR Design and Construction
- Cost Management

The conference brochure is available at www.ormanager.com or phone 800/442-9918.
Process improvement

Continued from page 12

were rescheduled to avoid late starts.
Waiver forms are kept in each OR. The
late physician, not the nurse, must fill out
the form, which must be submitted with
in 24 hours. Late forms are not accepted,
even if the excuse was legitimate.
Waivers are reviewed by the chair-
man of surgery and forwarded to the
Guidance Team if there is any question
about whether a waiver should be
accepted.

“At first, we didn't get many waivers
until we got ready to take block time
away.” Dr Larson says. “After the first
penalty phase when we did take some
block time away, we were inundated
with waivers.”

Plan for data collection and
reporting

St John's developed a plan for collect-
ing and reporting data monthly for all
first cases of the day.

Time elements for each procedure are
recorded by circulating nurses in the
perioperative information system. The
time elements include: patient in the
room, induction, surgeon in the room,
incision, dressing on, and patient out of
the room.

The team decided to have nurses
record the times in the information sys-
tem rather than manually. Using the
information system enables data to be
collected and reported easily. Plus, the
team found that when nurses document-
ed online, they were less likely to fudge
times to cover for physicians than when
they used a manual form.

A report is produced every other week
for the Guidance Team. Each month the
Surgical Executive Committee receives a
report showing results for individual sur-
geons and anesthesiologists.

Pilot test the policy

“It is important to trial your policy
first to make sure it will work,” Dr
Larson says. The trial should have a spe-
cific start and end date.

St John's tested its policy for 1 month
with the general surgeons and found the
data collection worked as planned. The
team then announced the penalty phase
would begin 1 month later. That gave the
surgeons time to make any needed schedul-
ing changes.

“We saw a good jump in our on-time
starts when we announced the penalty
for the surgeons,” Dempsey says.

Enforce the policy

For the policy to be effective, it has to
be enforced. During the initial penalty
phase, 1 surgeon lost block time, and 6
more were placed on probation.

“They have never missed the target
again,” Dr Larson said. “They know
we’re tracking it, and we are going to
institute a penalty if they fall short, so
they are not late any more.”

“Now that everyone’s on board, we’re
almost always over 90%,” Dempsey
says.

Both stressed the need for backing
from a strong leadership committee with
representation from the surgeons.

Surgeon involvement is why the
Perioperative Services Guidance Team
has been effective, Dr Larson notes.

“When a surgeon is told, ‘We do not
accept your waiver,’ it is the surgeons on
the team who are saying that, not the OR
manager. That has worked very well.” A
surgeon always has the option to present
his or her case to the team.

Sitting down together

“We have found as we have talked to
others around the country that it is often
hard to get administrative support for
decisions made by these committees,”
Dempsey comments. “That really ties the
hands of anyone trying to make process
improvement in the operating room.”

“The policies you make have to
stick,” Dr Larson says. “You cannot
allow an end run. In our organization, if
the chair of the department of surgery—
who chairs the Perioperative Services
Guidance Team and the Surgical
Executive Committee—had less than
90% for on-time starts, he would lose his
block time. That’s the way it is. The rules
apply to everybody.

“It’s not an administration-driven
thing; it wasn’t an anesthesia-driven or
surgeon-driven. It was all of us sitting
down together to try to make it better.”

The effort has been worth it.

“A couple of weeks ago, I was able to
show a chart to our physicians that we
were over 90%,” notes Dr Larson. “I was
also able to say, ‘This has made life better
for all of us. Thank you.’

Reference

St Jacques P J, Patel N, Higgins M S.
Improving anesthesiologist perform-
ance through profiling and incen-
16:523-528.
Please see the ad for BFW INC. in the OR Manager print version.
died during or immediately after surgery, considered a “never event.” The causes were not identified.

In all, 30 of the state’s 136 hospitals reported at least 1 “never event.” Fairview-University Medical Center, the teaching hospital of the University of Minnesota and one of the largest hospitals in the state, had the most at 13, with 1 death. Abbott Northwestern was second with 9 errors and 2 deaths.

**Aim to learn**

The aim of public reporting, says the Minnesota Department of Health, is to learn and prevent harm.

“This is a ground-breaking day for health care in Minnesota,” the state’s health commissioner, Dianne Mandernach, told the Minneapolis Star Tribune in announcing the report. “The first step is learning why these events occur and then fixing the system so it won’t happen again.”

State officials also noted that, though people may be surprised by the events, the errors are rare. The state’s hospitals treat nearly 600,000 inpatients each year, in addition to 1.5 million emergency visits and 300,000 outpatient procedures.

The reporting system has stimulated efforts to look deeply into the causes of the surgical mistakes to identify what more can be done to prevent them. Two major projects are underway.

**Fine-tuning surgical site verification**

Safest in America, a collaborative of 10 hospital systems in the Twin Cities and Rochester, Minn, area, introduced a safe-site protocol for surgery in 2003. In December 2004, the collaborative added further steps following a review of recent events. Work on the protocol began even before the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) introduced its Universal Protocol for surgical site verification, Alison Page, RN, MSN, MHA, vice president for patient safety for Fairview Health Services, told OR Manager.

The goal was to standardize the process for all of the collaborative’s hospitals. Each hospital was doing site marking a little differently, which was confusing for physicians who operated at more than one location.

One step in the original protocol goes beyond JCAHO requirements. JCAHO’s protocol says the person performing the procedure “should” mark the surgical site. Safest in America says the person performing the procedure “will” mark the site. (One member of the collaborative opted out of this requirement.)

**New steps added**

As reports of wrong-surgery errors kept coming in, the collaborative decided more was needed. A work group interviewed the surgical teams involved in the incidents to learn what happened and why.

They discovered 10 of the 14 errors would have been prevented if all 3 parts of the site-verification protocol had been followed: discussing the procedure and site with the patient and reviewing the informed consent, marking the surgical site, and conducting a time out before the procedure begins.

They also noticed a pattern—5 of the 14 events involved the spine.

“We learned that in all of these cases, an intraoperative radiograph had not been done,” Page says. The task force went back to the drawing board with neurosurgeons, orthopedic surgeons, and others.

From that came an additional step introduced in December: For spinal surgery and other procedures involving a level, such as the ribs, a high-quality intraoperative image will be taken, with the bony landmarks marked with an opaque instrument, and compared with the preoperative imaging. The final verification of the images will be conducted by the practitioner performing the procedure.

Also, on Feb 1, CEOs of all Safest in America hospitals agreed to implement a “hard stop” rule. That means if any discrepancies are discovered during the verification process, or if all the steps are not followed, the process is stopped until the discrepancy is reconciled.

“This means the train stops and does not go forward until the situation has been resolved,” Page says.

One Safest in America hospital recently used the “hard stop” when a neurosurgeon refused to mark the skin for a spinal surgery, as required by hospital policy, the Safest in America protocol, and JCAHO. The patient, who was in the holding area, was notified and was understandably upset.

“Everyone pulled together. We notified the patient’s internist, and he told us to find another neurosurgeon,” says the director of surgical services. The surgery took place a couple of days later.

The Safest in America protocol, developed in collaboration with the Institute for Clinical Systems Improvement, is at www.icsi.org. Enter search term “safe site protocol.”

**When to x-ray for retained object**

HealthEast St Joseph’s Hospital in St Paul, Minn, has empowered the staff to help prevent objects from being left in patients. The hospital had an instrument retained after a complex 10-hour case that involved multiple surgeons, multiple surgical fields, and several staff and physician change-overs.
After a root-cause analysis, a task force came up with an action plan and new policy recently approved by the Surgical Committee.

The policy states: “The surgeon or operating room staff may initiate a call for an x-ray if there is a concern that an instrument or a sponge may still be in the patient. This may be done regardless if the surgical counts are correct.”

Situations where this may occur could be but are not limited to:
- abdominal/thoracic cases that involve multiple surgeons or multiple surgical fields
- lengthy procedures that include numerous staff and/or surgeon turnover
- emergency cases such as ruptured aortic aneurysms and emergency cesarean sections.

The policy states: “Any positive x-ray reading is called to the surgeon stat. If the radiologist is not immediately available, the surgeon will read the x-ray.”

**Why do objects get left behind?**

Human factors experts have helped Fairview-University Medical Center (FUMC) in Minneapolis analyze why objects get left in patients. FUMC reported 6 instances of retained foreign objects to the state.

Though a root-cause analysis was conducted after each incident and corrections made, the problem kept cropping up, notes Susan Noaker, PhD, director of quality and patient safety.

In one case, throat packing was left in after an ear, nose, and throat procedure. The root-cause analysis showed the count was off because the resident had cut the packing in half.

That practice was halted, but a similar incident occurred, which was traced to supervision. In other incidents, sponges were retained.

“When we did our root-cause analyses, people swore they did their counts and followed the policy,” Noaker says. “We began to think there might be something going on related to human factors and the culture in the OR.” Two human factors experts from the University of Minnesota, Kathleen Harder, PhD, and John Bloomfield, PhD, were invited to conduct an analysis of the count process as well as specimen handling in the OR.

Harder, a cognitive psychologist, explains that as a human factors expert, she focuses on how to design systems and technology used in those systems to make work processes easier and more user-friendly.

Harder and Bloomfield spent 5 days observing surgery at FUMC and its sister Riverside campus. They were advised by an OR nurse, Judy Sevada, RN, CNOR. They also conducted 2 focus groups with physicians, circulating nurses, and scrub techs.

**Observations on counting**

Among their observations about the counting process were:
- Though a count policy was in place, it wasn’t always followed.
  “For example, the policy states that both individuals involved in a count should do the count together and count out loud. But we didn’t observe that to be the case,” Harder says. “When both people count together, it is a double check that reinforces that both people are actively involved in the counting process.”
- When the scrub tech was counting, the circulator did not always view the items being counted, as the policy directed.
- The sequence of the count was not always followed as specified in the policy. “If you don’t follow a scripted order, it becomes easier to miss an item,” Harder says.
- Counts were frequently interrupted by pages for physicians and others in the room.
- The circulator sometimes had to leave the room to get instruments, interrupting the count.
- Counts were not recorded in a consistent format. Though the white board was used to record initial counts, in some ORs, the counts were not updated in a timely manner on the white board. Instead, they were recorded on a count worksheet or other piece of paper.

**The count policy wasn’t always followed.**

- There was variation between the campuses in what should be counted. Specifically, should cautery tip covers be counted?
- Policies changed frequently, making it more difficult to be in compliance. After a sentinel event occurred, the policy was changed to prevent a future error. But that remedy can set up other problems in the work process, Harder observes.

Underlying these was a cultural issue: Staff members did not always feel comfortable speaking up when they saw a safety issue.

“One of the learnings from aviation is the importance of the crew feeling they can speak up to the pilot,” Noaker says. That culture has only recently begun to gain momentum in health care.

**Improving counts**

The human factors analysis led to several recommendations, which FUMC is implementing:
- There is a need to reinforce existing policy and explain why it is important to perform certain steps, such as counting together. This information needs to be conveyed both to the nurses and physicians.
- The white board should be used as the primary record so the count is visible to everyone.
- Team members should be empowered to call a halt when they feel safety has been compromised. FUMC is planning assertiveness training for the OR staff.
- The count should have priority. The hospital is re-examining which paging, if any, should be answered in the OR.
- When extra supplies or trays are needed, the circulator should call out for them rather than leaving the room during a count.
- Consensus is needed on which specific items will be counted.
- Closing and final counts should start with the surgical field and move out. That avoids “confirmation bias.” Harder explains: “By looking at the white board, you know how many..."
Patient safety

Continued from page 19

needles are supposed to be in circulation. If you quickly count the needles you have on the table, then move into the surgical field, you are likely to find what you expect to find—that is confirmation bias. You might inadvertently think a needle that isn’t there is there.

- The hospital is re-examining how often policies should be revised.
- “People can’t adapt to frequent changes and continue to be successful,” Harder says. “We are recommending—and this assumes the policy has been carefully crafted and thought out—that a policy be implemented and kept in place for a significant period, such as 12 months, before it is revised.”

FUMC is considering whether to involve human factors experts in ongoing monitoring. Harder argues that it’s necessary to have someone from outside monitor the process.

“As a case in point, after some sentinel events, when they queried the people involved, they all maintained they followed the policy. Perhaps they believe that. But their behaviors were not in sync with the most recent version of the policy,” she says. “So the question is: Did they realize they weren’t following the policy? Or did they not understand what the policy is? There are a lot of different issues. That is a reason why you can’t evaluate yourself.”

The report, Adverse Events in Minnesota Hospitals, is available at www.minnesotahealthinfo.org

Workplace

New federal nurse overtime bills introduced

The US House and Senate introduced bills Feb 10 that would prohibit requiring nurses to work more than 12 hours in a 24-hour period or 80 hours in a 14-day period except in a declared emergency.

The Senate bill introduced by Sen Edward Kennedy (D-MA) would provide for up to $10,000 in civil penalties against hospitals that force nurses to work extra hours after completing a shift.

The bill also would give the Department of Health and Human Services authority to investigate overtime complaints and fine violators. At least 10 states have passed similar bills, and measures have been introduced in 15 other states.

“The Safe Nursing and Patient Care Act would prevent health care facilities from forcing exhausted nurses to work extra shifts, an unsafe practice that puts both patients and nurses at risk,” said Barbara Blakeney, MS, RN, president of the American Nurses Association.

—www.nursingworld.org

Big physician shortage could be coming

Americans may soon face a shortage of physicians that will make it hard to find convenient, quality health care, according to several new studies described in the March 3 USA Today. The country needs to train 3,000 to 10,000 more physicians a year—up from the current 25,000—to meet the growing needs of an aging, wealthy nation, the studies say. The nation will have a shortage of 85,000 to 200,000 physicians in 2020 unless action is taken soon.

This prediction is an about-face for the medical profession, which 10 years ago predicted a glut of doctors.

Medicare, which provides funding for medical education and faces enormous financial pressure in coming decades, already spends 3% of its budget training physicians and may not have the resources to train more.

—www.usatoday.com

Advocates ask sponsors to drop “ER” ads until nursing image improves

The Center for Nursing Advocacy launched a campaign asking 23 major corporate sponsors of the NBC/Warner TV drama “ER” not to place more advertising on the show until it dramatically improves its portrayal of nurses.

The center says “ER” is the most influential purveyor of the “handmaiden” image of nursing. For years, the center says, the show has refused to address nurses’ concerns, despite repeated requests. The center argues that lack of public understanding is a key factor in the global nursing shortage.

—www.nursingadvocacy.org/action/letters/er sponsors_1.html

Judge rules against Schwarzenegger on nursing ratios regs

A California judge overturned Gov Arnold Schwarzenegger’s emergency changes to nursing ratios regulations March 3.

The ruling concerns one of the Schwarzenegger administration’s most controversial decisions, the Los Angeles Times reported. Last year, the governor issued an emergency order suspending a law requiring 1 nurse to every 5 patients in California hospitals. The ratio was mandated in a law that took effect in 2004. He cited a severe nursing shortage and hospital closures as the reason. The California Nurses Association (CNA), a union, sued the governor to overturn the order and enforce the 1:5 ratio. The judge ruled in favor of CNA in most respects. The California Hospital Association said it would appeal the judge’s decision.

ANA seeks state legislation to prevent nurse injuries

The American Nurses Association is promoting state legislation to protect nurses from potentially disabling musculoskeletal injuries. Many of the injuries are from lifting and moving patients. A bill (HB 1672) in the State of Washington would require hospitals to set up a program to prevent such injuries, including a no-lift policy. An Ohio bill (HB 67) would require a loan program for nursing homes to implement no-lift programs. California introduced legislation (SB 363) to require hospitals to set up a back injury prevention program.

—www.capitolupdate.org
Materials management

Spine costs: A bigger problem than joints

A column on cost and quality issues in orthopedics.

2005 will likely be the first year that hospital purchases of spinal implants and related accessories will exceed those for hip and knee implants. Many products sold today for treating spinal disorders did not exist as few as 6 years ago, and their proliferation has made containing their costs a major headache for hospitals.

According to the Millennium Research Group of Toronto, Ontario, sales of spine-related devices and products to US hospitals exceeded $3.4 billion in 2004, up 19% from 2003. The spine segment of the orthopedic market is growing at a faster rate than the market for hip and knee implants, estimated to be at $3.3 billion in 2003.

Since 1994, sales of spinal devices have increased 15-fold, while sales of joints have approximately doubled. If you assume an annual growth of 11% in the hip and knee implant market and a 21% growth in the spine market, the 2 markets intersect in 2005 (graph). This means that in 2005, hospitals will spend more for spinal devices than for joints.

With the Food and Drug Administration’s approval of the artificial spinal disc in October and wider application of spinal monitoring, it is likely that this disparity will grow even further.

Spinal devices proliferate

Spinal supplies include the hooks, rods, plates, screws, bone, and bone substitutes used for spinal surgeries, such as fusions and disc excisions (pie chart, p 22). Other categories of spinal devices that didn’t exist a couple of years ago include vertebral compression fracture surgical supplies (mainly products manufactured by Kyphon), thermal therapy (including the IDET procedures), bone morphogenic protein (BMP) (Medtronic Sofamor Danek’s InFUSE and Stryker Orthobiologics OP-1, which recently received a humanitarian device exemption for spinal fusions). Interbody fusion devices, which barely existed in 1997, in 2004 represented a market of over $675 million, roughly split in half between machined bone and nonbone cages and other devices.

Overlapping technologies

Although spinal fusions account for just over one-third of spinal surgeries in the US, almost 90% of implants sold to hospitals are used to enhance spinal fusions. These devices have been developed to improve the fusion rate, the assumption being that well-fused vertebral fusions will result in a more successful outcome. This has resulted in a proliferation of overlapping and potentially redundant technologies, including bone grafts and bone substitutes, spinal growth stimulators, anterior and posterior fixation of the spine, and bone morphogenic proteins.

Hard-to-manage costs

Several problems face hospitals that are trying to manage spinal implant costs:

- the anatomy of the spine itself
- the payer mix of patients having surgery
- the proliferation of new technologies treating spinal conditions.

Osteoarthritis accounts for a large percentage of patients receiving hip and knee replacements. But there are a number of unrelated reasons that patients receive back surgery, including trauma, congenital deformities, arthritis, degenerative disc disease, spondylolisthesis, tumors, compression or pathological fractures, generalized back pain, and other pathologies. Patients suffering back pain may be completely debilitated and desperate for solutions, including surgery. In contrast, joint pain is more chronic, and surgery is often less urgent.

Many patients with spinal implants are younger (40-somethings) with relatively good insurance. Because hospitals often can pass on additional costs to insurers, there generally is less incentive to decrease prices of spinal devices than there is for joint replacements, which are primarily performed in the Medicare-aged population with a fixed DRG payment. The fixed DRG payment for a joint replacement becomes a lever and a target in negotiations to reduce the cost of the implants. Because insurers for spinal procedures don’t generally have these restrictions, there is less consensus and focus on that problem.

The proliferation of technologies used for spinal fusions can be seen in a sample patient from 1997 and 2003 (sidebar, p 22).

Track record lacking

The proliferation of these new technologies means that there is not much of a track record for comparing surgical outcomes with the different devices. While outcomes of hip and knee surgery have been reported for periods

Sources: Millennium Research Group, Toronto, Ontario.

Sales of hip & knee implants and spinal devices to US hospitals, 1994-2004

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The proliferation of technologies used for spinal fusions can be seen in a sample patient from 1997 and 2003 (sidebar, p 22).

Track record lacking

The proliferation of these new technologies means that there is not much of a track record for comparing surgical outcomes with the different devices. While outcomes of hip and knee surgery have been reported for periods

Continued on page 22
of up to 30 years, a typical trial reporting outcomes of spine surgery is around 2 years. There are a number of reasons for this disparity in outcomes reporting including that the technology changes quickly, many events may affect patients’ subsequent back pain, and it has been difficult to develop consensus on what a successful outcome is. Nevertheless, patients with pedicle screws and other hardware will likely be living with these devices for the rest of their lives, which, compared to the age of a typical joint patient, will be several decades longer.

**Ideas for managing costs**

Hospitals trying to manage their spinal implant costs should attempt the following:

- Review with your surgeons potentially redundant technologies. Many of the devices used to promote fusion are additive. Specific guidelines should be developed for BMP, demineralized bone matrix, bone growth stimulators, and anterior/posterior fusions, among others.

- Contracting may have limited benefit. Many hospitals ask vendors to bid on single-level constructs, 2-level constructs, anterior constructs, etc.

This makes sense only if you have a handle on how many procedures fall into these categories. And recognize that the source of demineralized bone, spacers, and BMP often are excluded from negotiated contracts. These add-ons may exceed the costs of fusion plates and screws.

- Encourage creativity on the part of surgeons. I have seen situations in which BMP was replaced with demineralized bone matrix products, which then were replaced with autologous bone marrow aspirate mixed with autologous bone from the patients’ fusion site. Is one any better than the other? Unfortunately, nobody really knows.

- Review ICD-9-CM coding. The ICD-9-CM procedures are constantly changing, and it requires a significant effort to ensure procedures are coded appropriately. Among the most frequently missed codes are the ICD-9 codes for interbody fusion devices.

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**Materials management**

<table>
<thead>
<tr>
<th>Sales of spinal surgery devices to US hospitals, 2004 (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>VCF $175.5</td>
</tr>
<tr>
<td>Thermal therapy $61.5</td>
</tr>
<tr>
<td>Stimulation $205.4</td>
</tr>
<tr>
<td>Growth factors (BMP) $259.0</td>
</tr>
<tr>
<td>Bone grafts $153.5</td>
</tr>
<tr>
<td>Interbody fusion $675.4</td>
</tr>
<tr>
<td>Platelet concentrators $30.0</td>
</tr>
<tr>
<td>Thoroaco-lumbar fusion $1.3 billion</td>
</tr>
</tbody>
</table>

**How costs compare**

Here’s how costs might compare for a patient having a single-level L5-S1 fusion in 1997 and in 2003. Many products used today were not available in 1997.

**1997**
- L5-S1 posterior lumbar fusion
  - 39-year-old male, smoker
  - Sofamor Danek TSRH rod/screw system
  - Total $3,207

**2003**
- L5-S1 posterior lumbar fusion
  - 51-year-old male, smoker
  - Sofamor Danek TSRH 3D rod/screw: $4,682
  - RTI Precision bone dowel: $2,800
  - Synthes DBX bone paste: $630
  - Sofamor Danek bone-void filler: $458
  - Sofamor Danek BMP (large) $4,900
  - Total: $13,470

**Source:** Orthopedic Network News

**College of Surgeons publishes safety manual**


Among topics covered in the 200-page book are the scientific basis of surgical patient safety, specifically human factors and systems analyses; processes affecting surgical patient safety such as decision support, electronic prescribing, and error reporting; and legal challenges for surgeon participation in patient safety activities. The book includes strategies for preventing wrong-site surgery, safe use of blood and blood components, and patient safety in trauma care. Individual copies are $20 for ACS members and $25 for nonmembers. The publication order number is 05PS-0001. Orders can be placed online at www.facs.org/commerce/2004catsplash.html.

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Stan Mendenhall is editor of Orthopedic Network News,
www.OrthopedicNetworkNews.com

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Continued from page 21
Counseling to help problem employees

Managing people

Part 2 of a 3-part article.

Every manager has to deal with performance, attitude, behavior, or other employee problems. Too many managers and supervisors seem to want to ignore or minimize the problems, however. For the sake of other employees, managers should deal with problems as they arise. Ignoring the problem can lead to disgruntled co-workers and a message to employees that they can underperform or act inappropriately.

One of a manager’s key roles is to help employees learn how to become better employees. When a problem arises that requires you have a discussion with the involved employee, you must become a coach and a counselor. The manager’s role is to assist the employee in understanding the issue at hand, listen to the individual’s feedback, and provide input that will help the employee deal with the issue.

Employee problems fall into 2 categories:

- behavior issues
- substandard performance.

Sorting out the underlying cause is an important first step in the employee counseling process. To determine whether you have a staff member with a performance problem or a behavior problem, ask yourself:

- Is this something the person can do but won’t?
- Is it a condition, circumstance, or behavior over which this person has complete control? If you answer “yes” to either question, you are probably dealing with an individual who has a behavior problem.

Confronting behavior issues

Although it may be uncomfortable to address an employee’s behavior, it is possible to do so effectively. Begin by considering exactly what behaviors you want changed. Write them down and assign a degree of importance to each. A bad attitude can mean many things, so clearly define what behaviors constitute a bad attitude. Just as important, define their impact on the department. Do they cause morale problems? Inefficiencies?

Mistakes? Hold a counseling session with the staff member to discuss the changes you want and provide the rationale for the changes. Ask the employee what he or she needs in the way of training or support to make these changes. Explain how you’ll be monitoring the employee’s future performance and what will happen if behavior does not change. Be sure you don’t ignore any future behavior problems or you’ll just reinforce the problematic behavior. Also, make sure to praise the staff member for progress you see.

Plan a course of action

While there may appear to be barriers to changing a problem behavior, these may simply be excuses. Listen carefully to what the employee has to say and probe to determine the difference between an excuse and a truly extenuating circumstance. Before meeting with the staff member, plan your entire course of action. This includes the types of disciplinary actions that you can and are willing to carry out if the behavior does not improve.

To illustrate the importance of pre-planning, consider the following situation. I once had an employee who began to arrive late almost every morning. When I asked her for the reason she was late, she said her husband just started working the night shift and often did not get home on time with the car. I reiterated why it was critical for her to be on time and asked what ideas she had for solving the problem. She said she couldn’t control when her husband got home, so there was nothing she could do. We discussed several possible solutions, including riding the bus or carpooling with neighbors or other hospital employees. No matter what solution I suggested, she had a reason why it wouldn’t work. I had no choice but to tell her that her job required her to be at work at 7 am. If that could not be worked out, I told her I had a part-time afternoon shift position she could have. Of course, it would pay less than she was currently making because of the shorter hours. By the next Monday, she had figured out a way to get to work on time, and we never had another lateness problem.

A behavior problem will be most easily resolved if it is dealt with as soon as it appears. Observe the problem and document it specifically and accurately. Third-hand information is hard to prove and only leads to finger-pointing, excuses, and blaming. This means you must spend time around your employees and check out complaints personally.

Dealing with substandard performance

Performance relates to an employee’s ability to apply knowledge and skills in actual practice. Performance may relate to specific standards of practice or procedures or to more general aspects of the job such as managing time and communicating with others. If a staff member routinely fails in performing his or her job responsibilities, you are probably dealing with a performance problem.

Start your investigation of the problem by confirming that the staff member knows what is expected and knows the 5 Ws and 2 Hs (who, what, when, where, why, how, and how much) of your expectations. If the individual can’t understand that he or she is doing something wrong, the performance problem may be an easily correctable miscommunication or orientation oversight.

If a performance problem is confirmed, discuss the concern with the individual. Ask questions to draw out the employee’s views of his or her performance and plans for improvement. You can always add points later in the discussion if the employee doesn’t raise them first.

Formal counseling

If performance does not improve within the agreed-upon time frame, it is...
time for a more formal counseling session. Ensure that the employee is prepared to talk about his or her performance by scheduling the counseling discussion ahead of time. Ask the individual to prepare for the meeting by considering his or her own actions in the areas of concern. The staff member should already be aware of what he or she needs to improve and, if given the opportunity, the person may be able to constructively criticize his or her own performance.

Begin your counseling meeting with a general question about the employee’s performance in the areas of concern: “How would you rate your performance during the last three months?” If you get a general response like, “Pretty good,” follow up with a more focused question: “What in particular seems to be getting in the way of the plans for improvement we discussed previously?” or “Why do you think we are having this meeting?”

Probe further by asking what the person has already done to improve performance, and provide feedback to substantiate the continued performance problems. Assist the employee in re-evaluating improvement actions by asking, “Knowing what you know now, what would you have done differently?” or “What changes would you make if you worked on this problem again?” By using the probing technique, you can reduce some of the employee’s defensiveness.

Counseling like a pro

Addressing behavior or performance problems with an employee is a difficult discussion because it is very personal. “Constructive criticism” is a phrase commonly associated with employee counseling. Many managers struggle to find a way to tell employees that they are performing a job responsibility poorly and need a different approach, a training course, or something else. Unfortunately, many staff members feel personally criticized and become defensive.

Managers must clearly communicate to an employee that a problem exists, provide constructive feedback, and do it in a caring manner. How a manager handles problems as they arise can have a significant impact on employee morale.

If an employee is not made aware of behavior or performance problems, it is more difficult to terminate the individual should that become necessary.

To coach and counsel an employee effectively, keep these things in mind:

- Talk about what you perceive, what you feel, and what you need. Be extremely clear.
- Restate the employee’s remarks by paraphrasing to be sure you fully understand what has been said as the employee discusses the issue.
- Talk about what the employee does. Stay away from personality traits. Address behavior and don’t become a psychologist.
- Zero in on observed or known behavior or performance. Be careful about how you approach an employee about hearsay. Try to avoid dealing with hearsay unless you have a strong reason to suspect it is true.
- Be specific and discuss only one issue at a time.
- Provide some positive feedback in addition to the negative feedback. Try to start the conversation in a positive manner.
- Allow the employee to give feedback freely. But be careful to not get caught in a repetitive conversation that goes nowhere or dwells on excuses.
- Finally and, perhaps most important, listen, listen, listen!

Remember to follow up

Following the counseling session, make sure that what you’ve discussed doesn’t fall through the cracks. This is especially critical if you’re coaching someone for the first time. Make a note in your calendar or computerized tickler file to remind you of the re-evaluation date. Then step back and give the employee a chance to improve—don’t interfere unless asked for assistance.

It is safe to assume that the majority of the people working in surgical services want to do their best, work hard, make good impressions, and get along well with coworkers, managers, and physicians. Although poor performers are not the norm, they are bound to emerge on occasion. The majority of employee problems can be resolved if the manager confronts them—and confronts them as soon as possible. The worst thing you can do is to ignore the problem, hoping it will go away on its own. Effective employee coaching and counseling can help to ensure that small, easily reconciled problems don’t grow into larger, unmanageable ones.

In part 3 of this series, you’ll learn how to address these rare, yet highly stressful, large unmanageable employee performance problems.

—Patrice L. Spath, BA, RHIT
Health Care Quality Specialist
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Identity theft plagues patients

Identity thieves are targeting hospital patients by getting information right off their medical records. Recently, the University of Chicago Hospitals reported that a former employee had stolen identity information from as many as 85 patients, according to the Feb 22 Wall Street Journal.

The biggest vulnerability of hospital patients is their Social Security numbers, which often double as a medical identifier. New technologies such as bar-coded wristbands and electronic medical records accessible only by password will help thwart identity theft.
Gathering data and assembling it into easy-to-read graphs helped one ambulatory surgery center (ASC) improve its record for on-time starts.

Staff nurses suggested the project to help identify why their hours were regularly being extended at the end of the day. They suspected the reason cases were not starting on time was that some of the surgeons were late.

If behavior was going to improve, the ASC’s quality improvement manager knew they needed solid evidence on the reasons for the delays. She organized a team and developed a QI study.

“We wanted to know if it was because the physicians were late, anesthesia providers were late, or the process was delayed—patients were late, equipment wasn’t in the room, and so on,” says Jayne VanValkenburgh, RN, PhD, CPAN, QI manager for the Everett Clinic ASCs. The Clinic, based in Everett, Wash, is a multispecialty group practice with more than 200 physicians and 2 ASCs. The study was conducted in 1 ASC during 1999 and 2000. The ASC did not have a computerized information system at that time.

Defining a late start

The first thing the QI team did was to define “late start” and get buy-in on the definition, including from the physicians.

The team decided a case would be considered late if the patient arrived in the room 5 minutes or more past the scheduled start time. Physicians would be considered late if they were not in the facility and ready for surgery within 5 minutes of the scheduled case time.

To prepare for data gathering, the team discussed which questions they most wanted to answer to provide evidence that would help change behavior. The questions they identified were:

- Why were cases starting late?
- Were the surgeons the main reason for late starts?
- Was it a few surgeons who were late, or was it across the board?

“If the problem was not the physicians, we wanted to let the nurses know so their perceptions would change,” VanValkenburgh says.

To find the answers, they decided to gather data on the time surgeons arrived in the facility and were ready for surgery (recorded by the OR charge nurse) and the time the patient was in the room (recorded in the OR record). If the surgeon was late, the charge nurse recorded the number of minutes late and tried to determine the reason. If the patient was in the room late due to other factors, the charge nurse recorded that information.

Causes documented

For each late case, the cause was documented:

- physician late
- previous case ran over
- anesthesia provider late
- process issue (eg, patient late, waiting for an electrocardiogram, equipment not available).

They decided to collect data for the first case of each physician’s block.

“We didn’t think it was fair to study only first cases of the day. We also wanted to capture data on the later blocks,” VanValkenburgh says.

Baseline data was gathered during the third quarter of 1999 and the first 3 quarters of 2000.

Reports to surgeons

At the end of each quarter, VanValkenburgh aggregated the data, entered it in an Excel spreadsheet, and used it to create 2 graphs (illustrations, p 26):

- a pie chart showing the percentage of late starts attributed to each of the 4 causes
- a bar chart showing the number of late minutes per physician for that quarter and the previous quarter.

Each surgeon received a report with the bar chart; his bar was identified by name, but the others were identified only by department (Ortho 1, Ortho 2, etc).

“We decided to use the number of minutes surgeons were late rather than the percentage of cases that were late so we could better show the impact of the lateness,” she says. For instance, if one surgeon was late by 6 minutes for 3 times in 10 starts, he or she would be on time 70% of the time, with little impact on the schedule. But if a surgeon was late by 60
minutes 3 times in 10 starts, he or she would be on time 70% of the time, but the impact of the lateness would be much greater.

**Competitive instincts**

In all, 60% of the delayed minutes were because of a late surgeon. Two orthopedic surgeons were late the most often.

Seeing the graphs helped bring out the surgeons’ competitive instincts, VanValkenburgh notes.

“Once we gave them the charts, they really did improve on their late minutes,” she says. The total number of late minutes, which was over 2,000 in the first quarter of the study, fell by 35% to 1,300 minutes in the third quarter of the study.

The tardiest surgeons also improved—one by more than 60% and the other by more than 40%.

“The most important thing is to have valid data in a form that is easy to see and understand,” VanValkenburgh says. “Physicians are data driven, but they need to have the data in a format they can relate to. You also need a way of measuring your progress.”

The data gathering and reporting were time consuming, she acknowledges. It is easier with a computerized information system because fields can be devised to capture the desired data, and it can be more easily retrieved. But it still takes a person to create and distribute the reports and drive the change effort.

Despite the time it took, the project “was well worth it,” she says. “We are not hearing as many complaints from the staff because they know we looked into the problem, and something changed as a result.”

Once a QI project like this is successful, it’s easier to get the staff’s buy-in on future projects because they see that change will happen, VanValkenburgh comments.

**Public programs to pay half of health bill**

By 2014, the nation’s health spending will be almost 19% of the gross domestic product, up from 15% in 2003.

Public programs like Medicare and Medicaid will be paying about half the bill, according to a Feb 25 web-exclusive article in *Health Affairs*.

The new Medicare prescription drug benefit will lead to a “substantial shift” in spending to the public programs from private payers, say the authors, from the Centers for Medicare and Medicaid Services.

Hospital spending is expected to grow at an average rate of 6.2% over 10 years starting in 2005. Much of the growth will be from Medicare and Medicaid—not good news if trends continue. About 60% of hospitals lose money treating Medicare and Medicaid patients, the American Hospital Association says.

—[www.healthaffairs.org](http://www.healthaffairs.org)
AAAHC clarifies standards for 2005

Clearer, more defined wording in some standards should help ambulatory surgery centers (ASCs) prepare for surveys with the Accreditation Association for Ambulatory Health Care (AAAHC). The 2005 standards, released in February, took effect March 1.

Highlights were reviewed by Beth Derby, RN, MBA, an AAAHC surveyor and executive vice president of Health Resources International, West Hartford, Conn.

Quality improvement

Chapter 5, which focuses on peer review, quality improvement (QI), and risk management, has been expanded to give more information on what AAAHC expects, Derby notes.

“There are significant changes compared to the older version,” she says. “It is designed to be used as an educational tool by the organization being surveyed. It will serve as a guide and should identify components surveyors are likely to be evaluating.”

The aim is to help facilities see a connection between components of a QI program—having a written description of the QI program; outlining QI goals and objectives; developing a process to identify problems and concerns that need to be addressed; and addressing those through QI activities, such as studies and benchmarking. Also, linkages need to be defined between QI activities, peer review, and risk management.

The chapter suggests the kind of QI activities a facility should engage in and offers ways to identify problems that could be studied, such as complications or hospital transfers, medical-legal issues, results of patient satisfaction surveys, or staff concerns.

For instance, as you develop your facility’s QI plan, you identify a goal to reduce postoperative nausea and vomiting. You decide to monitor this through postoperative phone calls to patients. In the calls, nurses find that 75% of patients having gynecologic laparoscopy say they have nausea after they go home. This also is a source of dissatisfaction on patient satisfaction surveys.

“That would trigger the thought, ‘Maybe we should study this. Our outcome isn’t desirable; let’s look at this in more depth,’” Derby suggests.

You have already taken the first steps in a study—you have identified the problem and outlined the extent of the problem. You then devise actions to help resolve the problem and reevaluate to see if those solutions worked. This might entail working with anesthesia providers to refine the prophylactic antiemetic regimen. You would test those solutions by keeping track of the postdischarge nausea rate for these patients after the new regimen is introduced. If the solution doesn’t work, a new study would begin.

How should benchmarking be used?

AAAHC has also clarified language on benchmarking and its role in QI. The standard says facilities must participate in benchmarking to compare key performance measures with other organizations or with best practices.

“Benchmarking means identifying the bar set by others and asking, ‘How do we compare to them? What is the benchmark we are going to use? What can we do to improve care in our center so we can achieve this threshold?’” Derby notes.

For example, in your study of nausea and vomiting, you find the medical literature reports that the postdischarge rate for nausea in GYN laparoscopy patients is 16% to 60%. You could use this as a source for benchmarking.

How many QI studies?

As in the past, the AAAHC standards do not specify the number of QI studies facilities must conduct in a year. There is no magic number, Derby says. Instead surveyors will evaluate the QI program based on the size and scope of the facility.

“If you are a facility doing 6,000 procedures a year with 4 to 6 ORs and 100 physicians on staff, and you have done only 1 QI study, the surveyor might say, ‘I think an organization of this size and diversity must have had more than 1 item they could study,’” she says.

On the other hand, if a facility with 2,000 cases a year, 2 ORs, and a group of 5 physicians did 12 QI studies, the surveyor might wonder about the depth of those studies.

In other words, surveyors will look to see if the scope of the QI program and studies conducted are in proportion to the size and scope of the ASC’s services.

Another way surveyors will evaluate the depth of the QI program, Derby says, is to review committee minutes, clinical records, and other documents. They may spot problems the ASC’s leaders have identified. The surveyors might then ask if these problems have been the subject of a QI study.

Ensuring safe care

The revised standards spell out more clearly what surveyors will look for to help ensure patients are receiving safe care.

“There is now more detail in the standards to help organizations know what the surveyors will be looking for,” Derby says.

In Chapter 6, which addresses clinical records and health information, standard 6-G has been broadened to say any abbreviations and dose designations used in the clinical record must be standardized according to a list approved by...
Surgical site verification

Though surgical site verification is not a new requirement, the 2005 standards are more specific about what is expected.

In Chapter 10, for surgical services, standard 10-5 requires the operating team to verify:

- the patient’s identity
- intended procedure
- correct surgical site
- all equipment used for the procedure, including any implants, is immediately available in the OR.

In addition, the operating surgeon “is personally responsible for ensuring all aspects of this verification have been satisfactorily completed immediately prior to beginning the procedure.”

Who must be present for discharge?

AAAHC has revised Chapter 9 for anesthesia services as well as Chapter 10 to clarify what is expected for patient discharge.

“This has been an ongoing discussion across the country,” Derby notes.

In Chapter 9, revised language in 9-1 says a physician or dentist must be present—not merely immediately available—until a patient’s medical discharge after surgery and anesthesia. In addition, Chapter 9 and 10 both state that personnel qualified in advanced resuscitative techniques must be present until all patients are physically discharged.

In other words, Derby says:

- The physician must be on the premises until the patient has been assessed and determined to be medically ready for discharge.
- In addition, a person who is trained in advanced resuscitation (advanced cardiac life support, or ACLS, for adults and pediatric advanced life support, or PALS, for children) and can initiate resuscitation is present until the last patient leaves the facility. This person does not need to be a physician unless required by state law or regulations. In some cases, states have stricter standards than AAAHC. If so, “you always have to meet the higher standard,” Derby says.

CLIA-waived testing

Chapter 16, Pathology and Medical Laboratory Services, has been reorganized so facilities can more easily tell which standards they must meet. The chapter has been divided into 2 sections. Section I applies to facilities that meet requirements for waived tests under the Clinical Laboratory Improvement Amendments of 1988, or CLIA. Section II applies to facilities that must be certified under CLIA.

Alternate power backup

New language in Chapter 8, Facilities and Environment, clarifies that alternate power must be available in all patient care areas. That includes the OR and recovery areas as well as treatment areas and areas where emergency services are provided. In the past, some might have interpreted the standard to mean they could have battery backup for the OR but didn’t necessarily need backup power for the postanesthesia care unit.

“Alternate power has to be available for all patient care areas,” Derby notes.

In addition, regarding emergency drills, a footnote has been expanded to reinforce that the 4 emergency drills required per year should be appropriate to the organization’s activities and environment. Examples include medical emergencies, surgical fires, hurricanes, tornados, earthquakes, bomb threats, or other emergencies.

The AAAHC 2005 Accreditation Handbook for Ambulatory Health Care is available for $130 at www.aaahc.org or by phoning 847-853-6080.

Creative ways to encourage flu shots

Only about 40% of health care workers get their flu shots.

Free vaccine along with mobile carts and other ideas have helped organizations boost their vaccination rates. Some even give out gifts, the Centers for Disease Control and Prevention (CDC) reports.

At the Veterans Affairs Medical Center in Minneapolis, nurses operated a mobile vaccination cart during 2 weeks in October. Vaccination rates rose to 65% in 2003-2004.

The Mayo Clinic, Rochester, Minn., used a peer vaccination program that enabled nurses to vaccinate coworkers and offered incentives, such as movie tickets and health books.

Flu shots were given during grand rounds. “Champions” talked up the vaccine and handed out educational material. The program helped boost vaccination rates to 77% in 2003-2004. The report was in the March 4 Morbidity and Mortality Weekly Report at www.cdc.gov/mmwr.
Please see the ad for SPECTRUM SURGICAL INSTRUMENTS in the OR Manager print version.
Nominate OR Manager of Year

Each year at the Managing Today’s OR Suite conference, a manager or director is named OR Manager of the Year.

This year’s conference will be Oct 19 to 21 in San Diego. The OR Manager of the Year will receive an expense-paid trip to the meeting, including airfare, hotel, meals, and registration.

In recognizing an individual manager, the award honors all OR managers for their important roles. It is a way of celebrating nursing management in surgical services.

Readers of OR Manager are invited to nominate a manager for the award. Simply write a letter of about 300 words describing what makes the manager deserving of the award.

Send the letter to OR Manager, Inc, OR Manager of the Year Award, PO Box 5303, Santa Fe, NM 87502-5303. The deadline for entries is July 1.

Nominations are judged by the OR Manager advisory board.

The conference brochure and registration information are available at www.ormanager.com.

Could you reduce your supply costs on total knee replacement procedures?

As a benchmark, in a recent OR Benchmarks study, median supply costs for this procedure were $3,700. How do your costs compare?

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• Total knee replacement
• Lumbar laminectomy with spinal implants
• Laparoscopic cholecystectomy

OR Benchmarks compares supply, labor, and anesthesia costs from participating facilities. OR Benchmarks also tracks procedure and turnover times, as well as patient prep and induction times. When you participate, you receive an extensive report benchmarking your costs and times and identifying opportunities for cost savings.

For more information on how your facility can participate in the 2005 OR Benchmarks program, go to www.orbenchmarks.com or call Judy Dahle, toll-free at 1-877/877-4031.

Please see the ad for TVL HEALTHCARE INC in the OR Manager print version.
Please see the ad for 3M HEALTHCARE in the OR Manager print version.
At a Glance

**American College of Surgeons plans to review surgeons**

The American College of Surgeons announced Feb 17 that it will set up a program to verify training and competence of surgeons who perform innovative surgery and to accredit hospitals and centers where this surgery is performed. Bariatric surgery programs will be the first area to be addressed.

ACS said it will address other new procedures and technologies as they emerge. ACS cited its programs to review trauma centers and cancer programs as precedents for the new endeavor. A timeline for the new program was not announced.

—www.facs.org

**AHA study finds unfair advantage at specialty hospitals**

Physician-owned limited-service hospitals have led to increased costs and use of services, forced service cutbacks at full-service hospitals, and placed emergency and trauma services at risk, according to an American Hospital Association report released Feb 16.

AHA says it found “physician-owned limited-service hospitals treat healthier patients, serve fewer low-income patients, and limit services to those that tend to be financially rewarding.”

According to AHA, margins for physician-owned limited-service hospitals can be as high as 44% or $700,000 per investor in a single year. The average operating margin for a community hospital is 3.3%. AHA wants Congress to permanently ban physician self-referrals to specialty hospitals. A temporary ban will expire in June.

—www.aha.org

**CDC gives advice on public reporting of hospital infections**

The Centers for Disease Control and Prevention’s infection control advisers issued recommendations Feb 28 for states considering public reporting of hospital infection rates.

So far, 4 states (Illinois, Pennsylvania, Missouri, and Florida) have passed laws requiring reporting, and 30 more states are said to be considering bills.

The CDC’s advisers recommended that states be sure to:

- Use established public health surveillance methods.
- Involve infection control experts in the process.
- Track practices for preventing infections, in addition to measuring infection rates.
- Provide regular, confidential feedback to health care providers.

The CDC also recommended measures states could use in infection reporting.

Three recommended process measures are:

- central line insertion practices
- surgical antimicrobial prophylaxis according to guidelines
- influenza vaccination for patients and personnel.

In addition, 2 outcome measures are recommended:

- central line bloodstream infections (laboratory confirmed)
- surgical site infections by type of operation, stratified by risk.

— www.cdc.gov/ncidod/hip/ 
PublicReportingGuide.pdf

**Hospitals need to do more to prevent surgical infections**

Hospitals fail to follow basic procedures to reduce the chances of infection by giving antibiotics within 60 minutes of surgeries, according to a study in the February *Archives of Surgery*.

Nearly 44% of the 34,133 patients tracked did not receive the antibiotic within the 60-minute target zone. Almost 10% didn’t get a dose until 4 hours after the procedure began. The correct antibiotic was administered to 93% of patients. But only 41% of patients had their antibiotic discontinued within 24 hours of surgery, as recommended.

Surgical site infections occur in about 2% of the 30 million operations in the US each year. Mortality is 2 to 3 times higher than in uninfected patients.

Surgical infections increase hospital charges by an average of $3,000. Costs may tally more than $30,000 for infections after orthopedic or cardiac operations.