Surgery scheduling

What’s the best way to manage urgent and emergent OR cases?

A surgeon calls and says, “I have an emergency.” The nurse at the front desk says, “OK, bring the patient to the OR.” But then the surgeon replies, “Oh, no. It will be an emergency at 5 pm.” The case is added to the schedule, and the surgeon arrives at 4:45 pm. Then another emergency arrives, and the first surgeon refuses to be bumped.

Scenarios like this happen every day in ORs. Too often, nurses end up in the middle of a conflict.

What are effective strategies for managing urgent and emergent cases that help avoid dust-ups at the OR desk?

Two veteran medical directors of ORs offer their suggestions. A researcher outlines the scientific way to order urgent cases (p 12). And a regional trauma center describes how it revised its bumping policy to make it more equitable (p 18).

Offering advice on urgent cases are William J. Mazzei, MD, medical director of perioperative services the University of California, San Diego, and a founder of the Association of Anesthesia Clinical Directors, and Tom Blasco, MD, MS, director of perioperative services at Advocate Lutheran General Hospital, Park Ridge, Ill. Both are founding partners of Surgical Directions, LLC, a Chicago-based consulting firm.

Manage block time well

The prerequisite to any plan for coordinating urgent cases is to have a fair and equitable system for managing block time, Drs Mazzei and Blasco emphasize.

“If surgeons perceive that block time is not well managed, they’ll do anything they can to make it work in their favor,”

Continued on page 10

Managing people

Study links disruptive behavior to negative patient outcomes

Disruptive behavior is a major source of nurses’ job dissatisfaction, research has shown.

But the effects can be even more far reaching, a new study finds.

In a survey of 50 hospitals by VHA West Coast, half to three-quarters of physicians, nurses, and administrators who responded saw a strong link between disruptive behavior and negative clinical outcomes (except for patient mortality, where one-quarter saw a link).

And 17% were aware of specific adverse events that had happened because of disruptive behavior.

Results from surgical services were comparable to the overall findings. (See chart, page 20.) In all, 22% of respondents were from surgical services.

Interestingly, disruptive behavior is almost as common among nurses as physicians—74% of participants said they had witnessed disruptive behavior from a physician at their hospital, and 68% said they had witnessed disruptive behavior by a nurse. The study is one of the first to examine disruptive behavior by nurses.

OR Manager interviewed the authors,

Continued on page 20
Please see the ad for
MEGADYNE
in the OR Manager print version.
Advertising Manager: Elinor S. Schrader:
OR Manager, Inc, East Holly Ave/Box 56, Pitman, NJ 08071. Telephone: 856/256-2300; Fax: 856/589-7463. John R. Schmus, national advertising manager. E-mail: schmus@ajj.com

Clarifications

Regarding the SurgiChip device for verifying surgical sites described in the January OR Manager (p 7), the device’s inventor, Bruce Waxman, MD, says he recently added the warning to the device label, “remove prior to sterile prep,” at the recommendation of the Food and Drug Administration.

In the February issue, in the chart on p 10, the number of installations for surgical management software was provided by the companies, not by KLAS Enterprises.

On-time starts

Getting first cases started on time makes the whole day go smoother. Read how ORs have improved in this key area.

Beta-blockers

Improving the process to make sure the right patients get beta-blockers to help reduce cardiac complications of surgery.

March 2005

OR Manager is a monthly publication for personnel in decision-making positions in the operating room.

Elinor S. Schrader: Publisher
Patricia Patterson: Editor
Judith M. Mathias, RN, MA: Clinical editor
Billie Fenzelbner, RN, MSN: Consulting editor
Janet K. Schultz, RN, MSN: Consulting editor
Kathy Shaneberger, RN, MSN, CNOR: Consulting editor

OR Manager (USPS 743-010), (ISSN 8756-8047) is published monthly by OR Manager, Inc, 1807 Second St, Suite 61, Santa Fe, NM 87502-3409. Periodicals postage paid at Santa Fe, NM and additional post offices.

Copyright © 2005 OR Manager, Inc. All rights reserved. No part of this publication may be reproduced without written permission.

Subscription rates: $86 per year. Super subscriber rates: $10. Address subscription requests to PO Box 5303, Santa Fe, NM 87502-5303.

OR Manager is indexed in the Cumulative Index to Nursing and Allied Health Literature and MEDLINE/PubMed.

Adverse surgical events reported in Minnesota

All reported events: 99
Surgical events: 52
- Wrong body part: 13
- Wrong patient: 1
- Wrong procedure: 5
- Foreign object: 31
- Death during or immediately after surgery in healthy patients: 2
Serious disability: 0
Death: 2

How are hospitals doing on patient safety for surgery? A new report on adverse events from Minnesota gives us a glimpse behind the curtains of the state’s hospitals.

It’s a sobering, yet hopeful, view. This is reportedly the first public report in the nation that names specific hospitals and errors they reported.

The report stems from a 2003 law that mandates reporting of 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—52 of the 99—events reported from July 2003 to October 2004 involved surgery (box). The most common error was a foreign object, such as sponge or needle, left in a patient after surgery.

These certainly are not the kinds of events you want to see listed under your hospital’s name, as the report does, page after page. You can download the report at www.minnesotahalthinfo.org.

Already, a change

Yet this is not a “gotcha” law.

It’s intended to be “a quality improvement initiative,” according to the Minnesota Department of Health, though there are stiff penalties for noncompliance.

The legislation was backed by a coalition of hospitals, physicians, nurses, and patient advocates. State funds were not used during the initial phase, though a small state budget is being sought. Hospitals send their reports, not to the state government, but to the Minnesota Hospital Association. The state health department then analyzes the data to see if there are patterns, shares findings with facilities, and will publish an annual report on the events.

The intent is to inform the public so citizens can ask providers what they’re doing to prevent similar mistakes.

Already, there’s been change.

Because of reports on wrong surgery, a collaborative of 10 health systems in Minnesota, called Safest in America, has taken a close look at its surgical verification protocol, first released in 2003, and added several steps.

One step is especially dramatic—CEOs in the member health systems agreed on Feb 1 to institute a “hard stop” for final verification for surgery. This means that if a discrepancy is found, all activities will stop until the discrepancy is resolved.

Also, because a cluster of wrong-site errors involved the spine, the group added a step for those procedures. The step calls for intraoperative imaging, with bony landmarks marked with an opaque instrument, to be compared to the preoperative imaging.

The collaborative also recommends a second final verification when an implant is involved.

Mandatory reporting is gutsy. We applaud Minnesota for taking such a bold step.

A big unanswered question: Is the information helpful to patients? Will they use it to ask good questions? Or will it scare them and make them even more distrustful of health care?

We suspect a lot will depend on what health providers do with the information. Will they be able to demonstrate they have made changes that bring errors down?

—Pat Patterson

Death: 2

Surgical events: 52

- Wrong body part: 13
- Wrong patient: 1
- Wrong procedure: 5
- Foreign object: 31
- Death during or immediately after surgery in healthy patients: 2
- Serious disability: 0

Surgical events: 52

- Wrong body part: 13
- Wrong patient: 1
- Wrong procedure: 5
- Foreign object: 31
- Death during or immediately after surgery in healthy patients: 2

Serious disability: 0
Death: 2

on adverse events from Minnesota gives us a glimpse behind the curtains of the state’s hospitals.

It’s a sobering, yet hopeful, view. This is reportedly the first public report in the nation that names specific hospitals and errors they reported.

The report stems from a 2003 law that mandates reporting of 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—52 of the 99—events reported from July 2003 to October 2004 involved surgery (box). The most common error was a foreign object, such as sponge or needle, left in a patient after surgery.

These certainly are not the kinds of events you want to see listed under your hospital’s name, as the report does, page after page. You can download the report at www.minnesotahalthinfo.org.

Already, a change

Yet this is not a “gotcha” law.

It’s intended to be “a quality improvement initiative,” according to the Minnesota Department of Health, though there are stiff penalties for noncompliance.

The legislation was backed by a coalition of hospitals, physicians, nurses, and patient advocates. State funds were not used during the initial phase, though a small state budget is being sought. Hospitals send their reports, not to the state government, but to the Minnesota Hospital Association. The state health department then analyzes the data to see if there are patterns, shares findings with facilities, and will publish an annual report on the events.

The intent is to inform the public so citizens can ask providers what they’re doing to prevent similar mistakes.

Already, there’s been change.

Because of reports on wrong surgery, a collaborative of 10 health systems in Minnesota, called Safest in America, has taken a close look at its surgical verification protocol, first released in 2003, and added several steps.

One step is especially dramatic—CEOs in the member health systems agreed on Feb 1 to institute a “hard stop” for final verification for surgery. This means that if a discrepancy is found, all activities will stop until the discrepancy is resolved.

Also, because a cluster of wrong-site errors involved the spine, the group added a step for those procedures. The step calls for intraoperative imaging, with bony landmarks marked with an opaque instrument, to be compared to the preoperative imaging.

The collaborative also recommends a second final verification when an implant is involved.

Mandatory reporting is gutsy. We applaud Minnesota for taking such a bold step.

A big unanswered question: Is the information helpful to patients? Will they use it to ask good questions? Or will it scare them and make them even more distrustful of health care?

We suspect a lot will depend on what health providers do with the information. Will they be able to demonstrate they have made changes that bring errors down?

—Pat Patterson

Death: 2

Surgical events: 52

- Wrong body part: 13
- Wrong patient: 1
- Wrong procedure: 5
- Foreign object: 31
- Death during or immediately after surgery in healthy patients: 2

Serious disability: 0
Death: 2
Please see the ad for MEDLINE INDUSTRIES INC. in the OR Manager print version.
Get with the flow, keynoter to advise

Patient flow is like one of those domino tournaments you watch on TV—if one domino misses the one in front of it, the whole process stops.

How well organizations keep their dominos lined up has a lot to do with how well they perform in today’s environment, both clinically and financially, notes Toni Cesta, RN, PhD, FAAN. Cesta will keynote the OR Business Management Conference May 2 to 4 in Tampa, Fla, in a talk entitled, “The Changing Health Care Landscape: Where Do We Go from Here?”

For hospitals, the landscape is bumpy. “What we’ve seen in the past 10 years is the ratcheting down of reimbursement due to managed care penetration,” Cesta says. Medicare reimbursement is also dropping. At the same time, costs are rising.

Lengths of stay are shorter. “This is a double-edged sword—it allows you to move more patients through the system, but they’re sicker,” she says.

This in turn raises patient safety issues because staffing ratios often haven’t risen to match patients’ severity of illness.

And with ambulatory surgery, more well-reimbursed surgical cases are moving out of the hospital, leaving a higher proportion of medical patients whose care isn’t as well reimbursed.

What do hospitals do about the big squeeze?

One answer is optimizing patient flow—moving patients through the system as efficiently and safely as possible.

Cesta is one of the few nurse leaders in the country with the title of vice president for patient flow optimization, which she holds with the nation’s third largest health system, North Shore-Long Island Jewish Health System based in Great Neck, NY.

What does a patient flow optimizer do? Cesta chuckles and says, “We identify points in the patient flow process, do a gap analysis to find out where the bottle-necks are, and work on how the process can be improved.”

Cesta’s role is to help hospitals streamline so they can make the most of the capacity they have. She has worked with teams that apply Six Sigma to patient flow processes and has developed metrics to measure improvement.

Working across boundaries

In her keynote, Cesta will discuss why perioperative services managers have an important role in patient flow and capacity management. She’ll also cover key metrics managers can use for measuring flow.

Increasingly, managers need to work across boundaries to resolve flow issues, she notes.

“If you’re having a problem in the perioperative department, you may not just be able to fix periop,” she says. “You may also need to fix the emergency department, discharge planning, and other areas.”

Variability in the elective surgical schedule can affect the availability of inpatient beds. Gaps in OR utilization can reduce a hospital’s potential revenue. Patients may end up boarding in the postanesthesia care unit because there aren’t enough beds elsewhere.

Cesta notes that a new standard from the Joint Commission on Accreditation of Healthcare Organizations requires hospitals to do a better job of managing their capacity crunches. The standard calls on leaders to make sure patients receive the same level of safe and timely care throughout the organization—in other words, if patients have to stay in the PACU overnight, can you demonstrate they are receiving the same level of care they would receive on a medical-surgical unit or the ICU?

How well the health system uses its capacity and other resources has an influence on the quality and safety of its services, Cesta notes.

Confederation information

The OR Business Management Conference, May 2 to 4, at the Tampa Marriott Waterside Hotel and Marina, includes 4 all-day preconference seminars on Monday, followed by the 2-day conference, Tuesday and Wednesday.

The conference brochure and registration information are available at www.ormanager.com or phone 800/442-9918.
Please see the ad for SKYTRON INC.
in the OR Manager print version.
New Medicare requirements for informed consent have caught hospitals by surprise.

Under the requirements, which appear in interpretive guidelines for state surveyors, informed consent forms must include names and specific tasks for all persons, in addition to the primary surgeon, who will assist with the procedure. The same is true for operative reports.

The changes flew in under the radar last year when the Centers for Medicare and Medicaid Services (CMS) issued its State Operations Manual, which was published on the Internet for the first time. Many hospitals said they were not aware of the new requirements until recently.

The new guidelines say a “properly executed informed consent form” must contain, among other things, names of any practitioners other than the primary surgeon who will perform “important aspects” of the procedure and the “significant surgical tasks” they will perform. These tasks include “opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues.”

In addition, the operative report must include a description of “specific significant surgical tasks” performed by persons other than the primary surgeon.

Patient complaints

CMS officials told OR Manager the requirement is not really new but “a clarification.” CMS says the language was added because some patients have complained they were not informed that persons other than their surgeon would be performing parts of their procedure, such as harvesting the vein, without the surgeon in the room. The CMS officials said, that though they “could not comment on a theoretical situation,” Medicare requires every patient to be under the care of a physician, and “there is the clear expectation that a physician would be present.”

CMS says it is not aware of any hospitals that have been cited under the requirement.

Teaching hospitals react

The American College of Surgeons, the American Association of Medical Colleges (AAMC), and other groups are in discussion with CMS. CMS said it also is talking to the Joint Commission on Accreditation of Healthcare Organizations and the American Osteopathic Association, which also survey hospitals.

AAMC’s regulatory counsel, Ivy Baer, JD, MPH, says, “This has caused our members to be very worried. Suddenly, their informed consent forms are not in compliance.”

Compliance is particularly difficult in teaching hospitals, she notes, because the surgeon often does not know at the time of the informed consent discussion with the patient which resident or assistants will be present.

Typically, informed consent forms in teaching hospitals have a general statement that residents and students will be involved in the patient’s care but don’t list individuals’ names and tasks.

CMS to add exception

CMS says, at a minimum, it plans to address the situation by adding an exception to the informed consent section. The exception would state that at the time of surgery, “unforeseen circumstances” may require changing which individual practitioners actually are involved in conducting the surgery. This language already appears in the guidelines under the medical records section referring to informed consent forms.

The State Operations Manual is used by state surveyors to assess compliance with the Medicare conditions of participation.

If a hospital is found to be out of compliance, the state typically issues a statement of deficiencies, and the hospital is required to submit a corrective action plan. The state then resurveys to see if the deficiencies have been corrected.

Because the interpretive guidelines are not formal regulations, they are not subject to a formal rule-making process, and public comment is not required for revisions. Updates are issued periodically, sometimes through policy letters.

CMS does not have a projected time for revising the informed consent requirement but said it is comparing notes with other organizations.

Though CMS says hospitals should have been aware of the requirements, they are not easy to find on the CMS website. They are located in Appendix A of the State Operations Manual at www.cms.hhs.gov/manuals/107_som/som107ap_a_hospitals.pdf.

To find the State Operations Manual step by step, go to www.cms.hhs.gov/manuals. Click on Internet-Only Manuals. Scroll down to Pub 100-7 and click on Medicare State Operations. Scroll down to Appendices, then click on Table of Contents. Go to A: Hospitals and choose PDF file.

The informed consent requirements are in section 482.51(b)(2) on pp 270-271. The operative report requirements are in section 482.51(b)(6) on p 274. The medical records language on informed consent is in section 482.24(c)(2)(v) on p 161.
Automated dispensing devices are supposed to help prevent medication errors. But the percentage of errors that harmed patients is not much different with the machines (1.3%) than with med errors overall (1.5%), according to a new report on 2003 data from the US Pharmacopeia (USP).

Dispensing machines were implicated in almost 9,000 errors. There were 5 sentinel events, including 1 death, associated with automated dispensing devices. This is out of a total of 235,000 reports.

In all, 4.1% of error reports noted a dispensing device was involved. That doesn’t mean technology is bad. But it does mean the machines aren’t a panacea.

Automated dispensing devices are used in more than half of hospitals in the US. Similar to vending machines, they store and dispense medications in patient care areas. They are intended to help improve accuracy and efficiency in drug dispensing and aid in inventory management and billing.

**Trusting too much**

“It is the implementation of the technology and how it is managed that managers need to be aware of,” says USP’s Rodney Hicks, RN, MSN, ARNP, BC, MPA. “We’ve found in several of our cases that the staff abdicated some of their responsibilities—they trusted the machine too much.” For example, if the machine’s screen says to go to Drawer B, compartment B7, the staff person pulls out the medication without reading the label, assuming it is correct.

“Technology is not a substitute for professional judgment,” he says.

The majority of errors with the cabinets involved wrong amounts: The wrong amount was placed in the cabinet, or the wrong amount was taken out. “We need to figure out why it is difficult to get the right amount into the right pocket or the right bin,” Hicks says.

New generations of dispensing machines are safer, but many older models without as many safeguards are still in use. For example, in older machines, the whole drawer may open, giving access to many different drugs. Newer machines have compartments that open separately. The newest models use barcodes during replenishment—the employee scans the barcode on the product, and the right bin opens where the product is to be stocked. “These are the Cadillacs of these machines, but not every place has them,” Hicks says.

**Analyze failure modes**

USP recommends facilities perform a failure mode and effects analysis (FMEA) on processes surrounding use of automated dispensing devices and adopt corrective action if needed. Among issues to consider:

- Analyze which products are kept in the machines. Assemble a multidisciplinary team to examine which medications are kept in the cabinets, what the turnover rate is, and how they are replenished.
- “You don’t want to keep everything from A to Z in there,” Hicks says. “You’re looking for high-volume products or products you need ready access to.”
- Consult the machine’s manufacturer for tips and tools to avoid errors and integrate those into the FMEA.
- “You’re looking for high-volume products or products you need ready access to.”
- Examine usage and access requirements, responsibilities for oversight, and when and how safety checks are conducted.
- Review the machine’s manufacturer for tips and tools to avoid errors and integrate those into the FMEA.
- Examine use of human overrides that circumvent the machine’s safety features.
- Provide for ongoing monitoring and training on safety features. Study where there are gaps between humans and machines that compromise safety.

One case USP examined involved an antibiotic ordered by a surgeon for a patient in the recovery room. The pharmacy flagged the order because the...
New campaign aims to save 100,000 lives in 18 months

S
aving 100,000 lives of hospital patients over the next 18 months—and every year thereafter—is the goal of a project launched in December by the Institute for Healthcare Improvement (IHI), Boston.

The campaign aims to sign up 1,500 to 2,000 hospitals. About 500 had signed up as of Jan 18. Participants will commit to implement specific steps in at least 1 of 6 areas:

- Deploy rapid response teams at the first sign of patient decline.
- Deliver reliable, evidence-based care for acute myocardial infarction.
- Prevent adverse drug events by implementing medication reconciliation.
- Prevent central line infections by implementing a series of interdependent, evidence-based measures.
- Prevent surgical site infection (SSI) by delivering prophylactic antibiotics correctly as well as taking certain other steps.
- Prevent ventilator-associated pneumonia by employing evidence-based strategies.

“These are all changes that we have learned work. This is a collection of scientifically grounded measures that can avoid needless deaths,” IHI leader Don Berwick, MD, said in an informational phone call Jan 18.

IHI says it launched the campaign because, though organizations are working to make care safer, the pace of change “remains slow and fragmented.”

The campaign plans to focus on what IHI says are tested “life-saving methods” that should be widely practiced.

Dr Berwick said IHI is working with the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the Centers for Medicare and Medicaid Services (CMS), and others to develop consistent indicators for each recommendation. JCAHO and CMS are partners in the campaign.

“We want to make things easier, not harder, by aligning with others’ evidence-based measures,” he said.

No cost to join

Hospitals can sign up on IHI’s website. There is no cost to join.

Those who join will be able to participate in informational calls and have access to web-based tools such as e-mail lists and discussion boards. There will be conferences, such as IHI’s 1st Annual International Summit on Redesigning Hospital Care June 8 to 10 in San Diego.

By signing up, IHI says hospitals will agree to implement 1 or more of the 6 key steps and submit mortality data, which will be made public only in the aggregate.

Surgical infection prevention

On preventing surgical infection, IHI is encouraging hospitals to implement a set of interventions for all surgical patients. The 3 components are:

- guideline-based use of prophylactic antibiotics
- appropriate hair removal
- perioperative glucose control.

For antibiotics and hair removal, IHI refers to the Centers for Disease Control and Prevention Guideline for Prevention of Surgical Site Infection, 1999 (www.cdc.gov/ncidod/hip/SSI/SSI_guideline.htm).


Links to other tools are on the IHI web, including success stories on improving the antibiotic process and resources from the CMS Surgical Infection Prevention Collaborative, conducted in 2003.

CMS, JCAHO, and the Leapfrog Group are pushing hospitals to do better on giving prophylactic antibiotics.

The IHI campaign is supported in part by Blue Cross and Kaiser Permanente.

Partnering with IHI in addition to CMS and JCAHO are the Agency for Healthcare Research and Quality, the American Medical Association, the National Patient Safety Foundation, Premier Inc, and VHA Inc, among others.

IHI is a nonprofit organization founded by Dr Berwick to promote health care improvement.

For more on the campaign, go to the IHI web site at: www.ihi.org/IHI/Programs/Campaign/Campaign.htm. Or call 866/787-0831.
Dr Blasco comments. “Ultimately, the key to success is not so much how you triage the urgent cases but making sure the block scheduling system is functional so surgeons trust it and don’t abuse it.” (An article on managing block time is in the November 2004 OR Manager.)

**Have an urgent room.**

One major strategy for handling urgent cases is to build flexibility into the schedule by having an urgent room that is not scheduled until the day before surgery.

“If you routinely—at least once a day—have cases added that don’t easily fit into your schedule, you should consider having an urgent room,” says Dr Blasco. “If you have gaps in the schedule, this should not be an issue. But if your schedule is packed, and cases are being added on every day, an urgent room will help you handle extra cases without interrupting your elective schedule.”

Though facilities with as few as 5 ORs should consider having an urgent room, it becomes critical when a facility has about 10 operating rooms, Dr Mazzei adds. With 20 ORs, there should be 2 urgent rooms. If a specialty, such as orthopedic trauma, has enough urgent cases, then an urgent room can be designated for that specialty.

Though utilization of an urgent room will rarely be more than 50%, “the political goodwill you will buy is probably worth it,” he says. OR leaders might decide to keep utilization of the urgent room even lower to allow for greater OR access, particularly if the hospital is trying to attract new surgeons and build market share. They note, however, that greater access for elective cases should not be a driving force for having an urgent room.

**Consider how long to keep the room open.**

The norm is to keep the urgent room unscheduled until 24 hours before surgery, Dr Mazzei says.

“You have to watch it very carefully,” notes Dr Blasco. The key is to have a strong, fair surgical services executive committee that monitors and enforces how the urgent room is used and prevents abuse by surgeons.

“The room has to be used for what it was intended for—urgent and emergent cases. If you have a surgeon who is doing elective cases in there because he can’t get on the block schedule, you have to do something different,” such as addressing issues with blocks.

**Have a triage team.**

Daily management of urgent and emergent cases is a team effort that involves the surgical scheduler, the OR manager, the medical director of the OR (typically an anesthesiologist), and the nurse at the front desk. The medical director must be perceived as unbiased and not catering to any one specialty. If there is no medical director of the OR, a physician should be assigned daily to manage urgent cases.

“The team needs to develop a relationship and determine how they will work together on a daily basis,” Blasco says.

Dr Mazzei adds, “The key is having a good working relationship between the person who is running the schedule, such as the medical director, and the person at the front desk. These leaders will be in frequent contact, so they both need good communication skills.” The medical director must also have access to a phone to be able to communicate with surgeons and others throughout the day.

**Have physicians talk to physicians.**

In making decisions about urgent cases, physicians must talk with physicians whenever possible and keep nurses from being caught in the middle, they advise.

“The medical director or physician running the schedule has to take charge, working physician-to-physician in most cases,” Dr Blasco says. As medical director, he tells nurse coordinators: “Never get yourself in the middle of one of these situations. Call me.”

**Management of urgent cases is a team effort.**

**Five principles for managing urgent cases**

1. Manage block time in a way that surgeons perceive to be fair.
2. Have a strong surgical executive committee that sets and enforces scheduling policies.
3. Have an open room to provide flexibility.
4. Have a medical director who works with the front desk to coordinate the schedule and mediate any conflicts with the surgeons. If there is no medical director, have a physician assigned each day to work with the front desk.
5. Have the medical staff designate who will make the final decision in case the medical director of the OR can’t resolve the issue.

Source: William Mazzei, MD; Tom Blasco, MD, MS.

**Should you have definitions?**

Some ORs go to great effort to define urgent cases and list types of cases that will be considered urgent. “I’ve never seen that work,” Dr Mazzei says.

The other option is not to have definitions. Life- and limb-threatening cases generally are obvious and will be done, bumping an elective case if necessary. Urgent cases generally will be done as they can be fitted into the schedule. If there is disagreement about whether to bump a case, the disagreement should be negotiated between the medical director and the surgeons involved.

**What about bumping cases?**

In smaller community hospitals that can’t afford a medical director, a common policy for bumping cases is to have the surgeon with the emergency call the surgeon whose case he would bump.

“That begins to put the surgeons in a situation where they have to make a decision among themselves about the triage,” Dr Blasco says. Admittedly, that system doesn’t always work. Ideally, the surgical executive committee should decide what to do about cases that are
Please see the ad for GETINGE/CASTLE INC. in the *OR Manager* print version.
How do we sequence urgent cases?

A review applying the science of OR management by researcher Franklin Dexter, MD, PhD.

How can OR leaders determine what order to use for performing urgent cases added to the surgical schedule?

Research has shown there is a set of ordered priorities that can be used for virtually all operational OR management decisions. The advantage of these criteria is that they apply equally to staffing, scheduling, sequencing, assigning, and moving elective cases (see www.franklin-dexter.net/OR_Staffing.htm).

This article outlines the priorities and gives examples showing how they can be applied.

Obtain a medical deadline

Medical criteria are the top priority in scheduling urgent cases (Dexter et al., 1999a). In sequencing urgent cases based on medical criteria, the time window for the best possible care is not defined by when the case is scheduled but by when the condition resulting in the need for surgery occurred. Therefore, when a case is scheduled, information is needed about the medical deadline for when the case needs to start to avoid the risk of increased morbidity or mortality.

A medical deadline is based on a patient’s clinical condition and on use of evidence-based medical literature. The surgeon knows the date and time of the event occurrence that requires urgent surgery (eg, hip fractured), or equivalent.

First-come, first-served cannot be applied systematically.

Medical criteria are the top priority in scheduling urgent cases (Dexter et al., 1999a). In sequencing urgent cases based on medical criteria, the time window for the best possible care is not defined by when the case is scheduled but by when the condition resulting in the need for surgery occurred. Therefore, when a case is scheduled, information is needed about the medical deadline for when the case needs to start to avoid the risk of increased morbidity or mortality.

A medical deadline is based on a patient’s clinical condition and on use of evidence-based medical literature. The surgeon knows the date and time of the event occurrence that requires urgent surgery (eg, hip fractured), or equivalent.

A best possible sequence of the submitted urgent cases can be determined using medical deadlines and estimated case durations from historical cases of the same scheduled procedure. For purposes of this article, I will use the criterion that the cases are performed based on the ordered priorities of:

1. Safety first.
2. Surgeon and patient access to OR time. For this application, this means the cases are performed unless they cannot be performed safely at the hospital.
3. Maximizing OR efficiency. For this application of decision making on the day of surgery, this means minimizing overutilized hours, ie, the time OR teams have to work past scheduled hours (Dexter & Traub, 2002).
4. Minimizing the average patient waiting time. Waiting time is measured from scheduled start times for elective cases and from when the patient and surgeon are available for urgent cases. Often the average patient waiting time is the same as the surgeon’s waiting time.

Some readers may be used to Priority 4 being first-come first-served; in other words, the first urgent case to be declared goes first. Example 1 shows that this will increase waiting times. Later examples show that first-come, first-served also cannot be applied systematically.

When there is more than one option after applying the four ordered priorities, then the decision can be made based on personal preferences of physicians, nurses, and/or patients.

Here are some examples of how the priorities apply:

Example 1

On Monday at 9 am, a surgeon posts an open reduction and internal fixation of multiple, comminuted, distal lower extremity fractures. The calculated medical deadline is 24 hours. The historical case duration from the OR information system is 5 hours. At 12 noon, another patient is scheduled for a laparotomy to drain an abdominal abscess. The patient has had fevers and leukocytosis for 2 days. The medical deadline is within 12

Continued on page 10

Continued on page 14
Please see the ad for GETINGE/CASTLE INC. in the *OR Manager* print version.
Surgery scheduling

Continued from page 12

hours. The historical case duration is 2 hours. At 1 pm, one OR is about to finish its elective cases. Both surgeons and patients are available. Which case goes first? No OR is likely to finish before 5 pm. Turnover times are 0.5 hours long.

Answer
Whenever a new case is scheduled, a case is completed, case durations are updated, etc, decisions should be reevaluated.

This is how the priorities would be applied: Safety is not affected by the sequence of the 2 urgent cases. OR efficiency (ie, expected overutilized OR time on the day of surgery) is the same regardless of the sequence. If the orthopedic case goes first, the average patient waiting time would be 2.75 hours, where 2.75 hours = (5 hours + 0.5 hour)/2 patients. If the general surgery case goes first, the average waiting time would be 1.25 hours, where 1.25 hours = (2 hours + 0.5 hours)/2 patients. Thus, the patient needing a laparotomy would have surgery first, because that sequence minimizes the average length of time the patients wait.

If instead, Priority 4 were first-come, first-served, waiting time would be increased.

Example 2
The scenario is the same as above, except that a second OR also will open at 3 pm. The remaining ORs will all likely be filled until 5 pm, the end of the scheduled workday.

Answer
Safety is again not affected by the sequence of the 2 urgent cases. Because more than one OR is available during scheduled hours for the cases, OR efficiency is evaluated by considering the urgent cases in descending order of case duration (Dexter et al, 1999b; Dexter & Traub, 2002). Assigning the longer case to the OR that will be available at 1 pm and the shorter case to the OR that will be available at 3 pm results in less overutilized OR time than performing the shorter case first in the OR that will be available at 1 pm. Therefore, unlike in the preceding scenario, the longer case goes first even though that results in a longer average wait for the patients. This is because maximizing OR efficiency is a higher priority than minimizing patient delays on the day of surgery.

In my experience, in practice, on weekdays afternoons, most decisions are made based on the goal of minimizing overutilized hours. How long patients wait in the afternoons is affected by the choice of OR allocations.

Example 3
At 4:45 am, a 14-year-old boy is brought to the emergency department. He has had abdominal pain for 36 hours. He has been vomiting, is febrile, and has rebound tenderness predominantly in the right lower quadrant. At 6:45 am, Dr. Jones calls the ORs to schedule the case.

The medical deadline provided is within 2 hours. The estimated case duration is 1 hour. Every OR is full with scheduled elective cases. Should an OR have its first elective case of the day postponed?

Answer
Because patient safety is preeminent, one or more elective case(s) will have to be delayed by 1 hour. This is because, among children requiring appendectomy, the risk of gangrenous and perforated appendicitis is greater among patients having surgery more than 37 hours after the onset of symptoms (Lau et al, 1987).

Example 3 continued
The expected times that the last cases of the day will end in each OR are 1 pm for OR 1, 1:30 pm for OR 2, and 3:30 pm or later for the other ORs. The appendectomy could be performed in either of those 2 ORs. OR 1 has 4 short cases scheduled in it. OR 2 has 1 long case scheduled. Which OR should be delayed in its start?

Answer
OR efficiency is maximized on the day of surgery by minimizing overutilized hours (Dexter & Traub, 2002). Scheduling the case either into OR 1 or into OR 2 would result in no overutilized OR time. Thus, the decision is unlikely to affect OR efficiency.

The next highest priority is to reduce patient delays on the day of surgery. The patient who will undergo the appendectomy is going to have surgery right away so does not need to be included. Scheduling the appendectomy in OR 1 would result in an average patient waiting time of 0.8 hours longer than expected, where 0.67 hours = (4 patients each delayed by 1 hour/6 patients). Scheduling the appendectomy in OR 2 would result in an average patient waiting time of 0.2 hours longer than expected, where 0.17 hours = (1 patient delayed by 1 hour/6 patients). Therefore, the appendectomy is performed in OR 2.

Example 3 shows that Priority 4 cannot be first-come, first-served because it is insufficient when urgent cases are mixed with elective cases (Dexter et al., 2004).

Example 4
A hospital has an OR team on-call from home on weekends. Upon arriving and setting up on Sunday morning at 8 am, the call team finds there are 2 cases to be done. One case was submitted the night before: insertion of an inferior vena cava filter, which is expected to take 1 hour. The second case was just called in: an open reduction and internal fixation of an ankle fracture, expected to take 3 hours. The patient needing ankle surgery is ready now. The patient needing filter placement will be ready in 45 minutes. Which sequence of cases should be used?

Answer
Medical deadlines are satisfied regardless of the sequence of the 2 cases. Since the OR team is on-call from home, all OR time is overutilized time. Maximizing OR efficiency means minimizing the total hours OR nurses and anesthesia providers are in-house. The 3-hour case is started first, because that sequence results in a more efficient use of OR time.

Example 5
A hospital allocates all but one OR from 7 am to 5 pm for elective cases. One OR is kept free for urgent cases and is allocated (ie, staffed) from 7 am to 11 pm.

Continued on page 16
Please see the ad for GETINGE/CASTLE INC. in the OR Manager print version.
Surgery scheduling

Continued from page 14

In addition, 2 OR teams are planned every workday to be on call working overtime until all but one OR is finished. Today, at 5:30 pm, many ORs finish nearly simultaneously. At 5:45 pm, the remaining 3 cases are reviewed, in the sequences submitted. All have medical deadlines to start within 2 hours. One patient has multiple orthopedic fractures, with an estimated case duration of 4 hours. A woman will undergo exploratory laparotomy and partial salpingectomy, with an estimated case duration of 1.5 hours. The third case is incision and drainage of a penetrating leg wound, with an estimated duration of 1.5 hours.

How should the cases be sequenced?

Answer

On the day of surgery, OR efficiency is maximized by minimizing overutilized hours (Dexter & Traub, 2002). The cases are considered in descending sequence of case duration (Dexter et al, 1999b). The 4-hour case is scheduled into the OR time allocated for urgent cases. Based on medical deadlines, the other 2 cases cannot wait until after that case is completed.

Expected overutilized OR time is the same whether one OR team on-call stays late and does both cases, or both teams stay and each does one case. Thus, OR efficiency is not affected by the decision.

The average length of time patients wait will be less if both teams stay to each finish one case. Consequently, both cases are started right away.

As in Example 3, first-come, first-served is not sufficient as Priority 4 for decision making. If Priority 4 is to minimize waiting time, all decisions are made. The point is that first come, first served cannot be applied systematically.

Comments

Some surgeons may alter medical deadlines to obtain a higher priority for their cases. This can be monitored and reviewed by the surgical services committee (Dexter et al, 1999). Nonetheless, in my opinion, nothing is more important in sequencing urgent cases than having the appropriate OR allocations for urgent cases. For example, regardless of how urgent cases are sequenced, if urgent cases frequently postpone elective cases, physicians, nurses, and patients will be dissatisfied. Improved case sequencing will not solve a problem caused by lack of an OR allocated for urgent cases.

Summary

Because the medical deadline is determined in hours, there is a precise mathematical definition for OR efficiency, and the impact on patient delays can be estimated. The priorities described above will give a single answer to a sequence of urgent cases.

—Franklin Dexter, MD, PhD
Associate Professor, Departments of Anesthesiology and Health Management & Policy University of Iowa, Iowa City

Franklin Dexter, MD, PhD, has published more than 100 articles on the science of OR management and related issues. Visit www.frankindexexter.net.

References


Dexter F, Traub R D. How to schedule elective surgical cases into specific operating rooms to maximize the efficiency of using operating room time. Anesth Analg. 2002;94:933-942.


Many call-ins not due to illness, survey finds

Most employees who call in sick aren’t actually physically ill. Only 38% of unscheduled absences are due to illness, according to a survey by CCH Inc, a human resources consulting organization.

The remaining 62% are because of family issues (23%), personal needs (18%), stress (11%), and an “entitlement mentality” (10%), meaning the employee felt entitled to the time off.

Absenteeism in 2004 climbed to a 5-year average of 2.4%, the survey found. The average annual per-employee cost of no-shows was $610, slightly lower than the $645 cost in 2003.

One factor influencing higher absenteeism may be that fewer employers are allowing employees to carry sick time over from one year to the next. The percentage of employers that allow carryover of sick time dropped to 37% in 2004 from 51% in 2000, CCH said.

Morale affects absenteeism. Organizations reporting good or very good morale reported a 1.9% rate of unscheduled absences, compared with 2.9% for those who said morale was poor or fair.

“We know with certainty that morale has an impact on unscheduled absence rates and the associated costs,” said Theresa Houck of CCH.

With 4 generations of employees in the workplace, employers need to begin facing the different needs and work-life balance issues of these age groups, Houck said.

Short-sightedness on generational issues could have “long-term ramifications, not just on costs and rates of absenteeism, but on many other issues around recruitment, retention, and morale,” she said.

More information on the survey is at www.cch.com

Health care workers and others who work nights or 12-hour shifts were more likely to be absent from work last year than other employees.

Their absenteeism rose to 12.4% last year compared with 5.8% in 2003, according to a study by Circadian Technologies, a consulting firm.

Shift workers are more likely to suffer from fatigue, stress, and sleep problems and react by asking for more time off or calling in sick, the report said.

Please see the ad for BFW INC. in the *OR Manager* print version.
A fair policy for bumping OR cases

When an elective case must be bumped by an emergency, how do you make it fair?

A regional trauma center in northern Michigan designates a primary bump room each day to manage this situation. The room is designated about 6 months in advance, and a calendar is sent to surgeons and kept at the front desk.

Designating a bump room “has made a huge difference” over the previous policy, in which a few specialties bore the brunt of bumps, says Robert Cline, MD, medical director of the OR at Munson Medical Center in Traverse City, Mich.

Steps in bumping

In both new and old policies, the first 3 steps are the same:
1. Life-threatening emergencies go into the first available room.
2. If the bumping surgeon has block time at the time of the bump, he will bump himself.
3. If there is an empty, unscheduled OR for which staff is available, the bumping case will go into that room to avoid interrupting other surgery.

In the new policy, Step 4 was revised. Under the old policy, if Steps 2 and 3 did not apply, the case would bump either into a room blocked for the bumping surgeon’s group practice, or if that was not available, into a room blocked for the bumping surgeon’s specialty. Under the new policy, the emergency goes into the designated primary bump room.

The goal of the revised policy is to ease the burden on the orthopedic and general surgeons, who have the most emergencies and were being bumped most often. The revised policy evens out the impact across the specialties.

The heart rooms, ophthalmology, and plastic surgery are exempt from bumping. The cardiac surgeons bump themselves. The ophthalmology room is poorly located for emergency cases. And plastic surgery was excluded because it has many self-pay cosmetic cases.

A community obligation

Munson’s 13 ORs are packed because of a growing volume and a strict state certificate-of-need law that limits the ability to build new ORs. Recently, the hospital and physician investors opened an ambulatory surgery center (ASC), which relieves the crunch somewhat. This has created enough open time in the main OR to have an add-on room available 2 1/2 days a week. But bumping still happens a few times a week.

As the hospital became recognized as a regional trauma center, “we began recognizing this as a community obligation,” Dr Cline says.

Naturally, the change wasn’t popular with specialties such as otorhinolaryngology, gynecology, and urology that don’t have many emergencies.

Introducing the change

To introduce the change, Dr Cline and Mary Murphy, RN, BSN, CNOR, the director of surgical services, presented the idea at one of the hospital’s twice-yearly retreats for surgeons.

“We don’t always have great attendance at our retreats, but at this one, we did,” Murphy says.

They suggested a 6-month trial of the new policy. To help monitor the policy, a bump log is maintained at the front desk. Surgeons who are bumped are encouraged to check with the OR desk to confirm that the bumped case was recorded. The log is available for review. Surgeons with block time have their room designated as the bump room about once every 8 weeks.

“We have reported back on how many bumps there have been and how many times a bump interrupted a surgeon rather than being accommodated in an empty room,” Dr Cline says. There were very few complaints during the trial, and the new policy was made permanent in February 2004.

A surgeon who feels his case was bumped inappropriately is asked to write a letter to the chief of surgery documenting the situation.

How does the bump policy work for nursing?

“The nurses in charge of the desk like this because it isn’t their decision on who gets bumped,” says Murphy. “It gives them a structure and framework to work with. They still get caught if someone is irate, but I think the policy has helped the management of bumps.”

Munson Medical Center’s bump policy is posted in the OR Manager Toolbox at www.ormanager.com.

One OR cost-sharing project OK with OIG

The Health and Human Services Office of Inspector General (OIG) said it would not sanction an unnamed hospital and group of cardiac surgeons who share savings from a project to curb waste and standardize supplies and practices during surgery.

A proposal to share savings from opening surgical trays only as needed would not run afoul of the law, the opinion said.

Sharing other cost savings from curbing blood cross matching, substituting less costly items, and standardizing products did fall under gainsharing prohibitions, but the OIG still deemed them acceptable because:

- The hospital clearly identified each of the cost-saving proposals.
- There would be disclosure to patients.
- The measures did not appear to adversely affect patient care.
- The payments were subject to certain caps and thresholds.
- The payments were of a reasonable amount and duration.

The OIG said the proposed arrangement posed a low risk of fraud or abuse. But the OIG said the opinion applied only to this specific arrangement, and it still has concerns about many arrangements between hospitals and physicians to share cost savings.

The opinion is at http://oig.hhs.gov/fraud/docs/advisoryopinions/2005/ao0501.pdf.
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.
Alan H. Rosenstein, MD, MBA, and Michelle O’Daniel, MHA, MSG, of VHA West Coast about the survey findings. The new study, reported in the January American Journal of Nursing, is a follow-up to a study reported in 2002 that found disruptive behavior has a serious impact on nurses’ satisfaction and morale.

HR Manager  Vol  21, No 3  March 2005

Managing people

How often do you think there is a link between disruptive behavior and the following:

<table>
<thead>
<tr>
<th></th>
<th>Overall</th>
<th>Surgical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse events</td>
<td>66% (961)</td>
<td>69% (209)</td>
</tr>
<tr>
<td>n = 1,465</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n = 302</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Errors</td>
<td>71% (1,034)</td>
<td>73% (222)</td>
</tr>
<tr>
<td>n = 1,467</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n = 306</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient safety</td>
<td>53% (773)</td>
<td></td>
</tr>
<tr>
<td>n = 1,462</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n = 302</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of care</td>
<td>72% (1,053)</td>
<td></td>
</tr>
<tr>
<td>n = 1,461</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n = 303</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient mortality</td>
<td>25% (366)</td>
<td></td>
</tr>
<tr>
<td>n = 1,444</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n = 303</td>
<td>27% (82)</td>
<td></td>
</tr>
</tbody>
</table>

Source: Rosenstein A H, O’Daniel M. VHA West Coast. Used with permission.

How does your new study add to the research on disruptive behavior?

AR. This has shown that certainly disruptive behavior is not a one-way street—it’s a two-way street. There’s a significant amount of nurse disruptive behavior. Nurses are very aware of disruptive behavior in their peers—72% of nurses reported having observed other nurses’ disruptive behavior, while only 47% of physicians said they had witnessed disruptive behavior by a nurse.

But the most striking thing is the impact on the patient. Everybody talks about system-related issues and human factor issues related to patient safety. Unfortunately, until recently, the human factor issues were getting secondary attention. I think a groundbreaking bene-

Q How does your new study add to the research on disruptive behavior?

AR. This has shown that certainly disruptive behavior is not a one-way street—it’s a two-way street. There’s a significant amount of nurse disruptive behavior. Nurses are very aware of disruptive behavior in their peers—72% of nurses reported having observed other nurses’ disruptive behavior, while only 47% of physicians said they had witnessed disruptive behavior by a nurse.

But the most striking thing is the impact on the patient. Everybody talks about system-related issues and human factor issues related to patient safety. Unfortunately, until recently, the human factor issues were getting secondary attention. I think a groundbreaking bene-

Q It is interesting that you found that disruptive behavior by nurses was almost as common as disruptive behavior by physicians.

MO. We were actually shocked when we found that, too. When we presented our data last year to a roundtable attended by nurse leaders from around the country, we did not know what the reaction would be. But everyone was nodding that, yes, they see this from nurses in their facility. We have had the same reactions from nurses and physicians as we have presented the data.

Q What were some examples of disruptive behavior by nurses that you found?

AR. One example was when nurses place phone calls to physicians at night and have no knowledge of the patient or are hostile. If you wake a physician up in the middle of the night, and you’re semi-hostile and not prepared, it really does provoke disruptive communication. There also were many statements about nurses’ disruptive dealings with people in respiratory therapy, pharmacy, physical therapy, and even unit clerks.

Q How did the patterns for surgical services compare with what you found in the rest of the study?

Continued from page 1

Alan H. Rosenstein, MD, MBA, and Michelle O’Daniel, MHA, MSG, of VHA West Coast about the survey findings.

The new study, reported in the January American Journal of Nursing, is a follow-up to a study reported in 2002 that found disruptive behavior has a serious impact on nurses’ satisfaction and morale.

Q How does your new study add to the research on disruptive behavior?

AR. This has shown that certainly disruptive behavior is not a one-way street—it’s a two-way street. There’s a significant amount of nurse disruptive behavior.

Q How often do you think there is a link between disruptive behavior and the following:

Definition of disruptive behavior

Disruptive behavior was defined in the survey as “any inappropriate behavior, confrontation, or conflict, ranging from verbal abuse to physical and sexual harassment.”

fit of this research is that it highlights what human factor issues can do as far as resulting in either a positive or a negative patient outcome.

When we reviewed the literature, we found some research, particularly in the ICU and the emergency department, on the benefits of good team collaboration and positive patient outcomes. But we couldn’t find much on the negative impact of bad team communication and collaboration. That’s what we tried to show in this study. This has a profound effect, and it is an issue that needs to be addressed.

Q It is interesting that you found that disruptive behavior by nurses was almost as common as disruptive behavior by physicians.

MO. We were actually shocked when we found that, too. When we presented our data last year to a roundtable attended by nurse leaders from around the country, we did not know what the reaction would be. But everyone was nodding that, yes, they see this from nurses in their facility. We have had the same reactions from nurses and physicians as we have presented the data.

Q What were some examples of disruptive behavior by nurses that you found?

AR. One example was when nurses place phone calls to physicians at night and have no knowledge of the patient or are hostile. If you wake a physician up in the middle of the night, and you’re semi-hostile and not prepared, it really does provoke disruptive communication. There also were many statements about nurses’ disruptive dealings with people in respiratory therapy, pharmacy, physical therapy, and even unit clerks.

Q How did the patterns for surgical services compare with what you found in the rest of the study?

Continued on page 22
Please see the ad for KARL STORZ ENDOSCOPY-AMERICA in the *OR Manager* print version.
Managing people

Continued from page 20

MO. The results were consistent with the whole group. Some actually were a bit higher in surgical services, such as the perceived link between disruptive behavior and adverse events or errors. It’s usually more intense in the surgical units and the intensive care units.

Q Were there examples of disruptive behavior from surgical services?

MO. One respondent stated: “Nurse-physician public argument about the care of patient, with escalating voices, including demeaning behavior toward the nurse. Nurse did not back down, and the physician continued the argument in public. This affected the entire unit.”

Another said: “Poor communication postop because of disruptive situation resulted in delayed treatment, aspiration, and eventual demise.” Another respondent wrote: “Physician was told twice that sponge count was off. She said, ‘They will find it later.’ Patient had to be reopened.”

Q How do you hope the results will be used?

AR. We have been going around the country talking about the data. We have noted that for organizations that have been dealing with this but haven’t been able to confront it, having data is an entree for them to start an initiative to create positive change. The findings on job satisfaction and nurse satisfaction are really important, and that started creating change. But in this study, we’re actually looking at patient mortality, patient safety, and clinical outcomes. That really has a significant impact on what the administrations of hospitals have to do. It’s their responsibility now that the data is out there.

Q Based on your findings, what do you recommend organizations do to address disruptive behavior?

AR. We have been working with hospitals, nurses, and physicians. We are not just giving them the data but actually working on a whole plan. But they have to be committed to it right up front.

The first thing we need to do is an internal assessment to find out where they are. We will do a survey and give them a hospital-specific report that compares their findings to the aggregate group.

Then we meet to share the data with them. This is done differently in each organization. In some, we’ll meet separately with the nurses and physicians, and in some we’ll meet with a multidisciplinary group. The idea is to stimulate discussion so people understand their responsibility and lead them to develop a solution.

The solution, basically, is having a code of conduct policy that people adhere to and that is consistently applied across all disciplines. For more significant incidents, there needs to be a disruptive behavior policy.

MO. One important point: When we are making a presentation and give our definition of disruptive behavior (sidebar, p 20), we find that physicians often don’t recognize that verbal abuse is part of disruptive behavior. Some of them don’t appreciate the impact of their behavior.

Q Your previous study found that less than 50% of respondents thought their hospital’s policy for handling disruptive behavior was effective. What is needed to give a policy clout?

AR. First, the administration needs to be extremely supportive of it. This has to be the way of doing business. Second, it really helps to have a champion. It certainly helps to have a physician champion if you are dealing with a disruptive physician policy.

Part of backing up the policy is to make sure people are treated the same. It can’t be that the physician who brings in a lot of money is treated differently. The administration needs to bite the bullet. We have had examples where nurses stood up to a cardiovascular surgeon who admitted the bulk of cardiovascular patients, and eventually the surgeon’s privileges were suspended because he couldn’t get along with the staff.

The administration needs to be able to say that the policy is consistently applied, and people will be treated equitably.

MO. We also get feedback that people don’t want to report disruptive behavior for a multitude of reasons. One reason is that they think the reports go into a black hole. So we suggest there be some kind of feedback to the person who reported the behavior. This has to be done without breaking confidentiality.

Another reason people don’t report is that they fear ramifications, such as losing their job. So it is extremely important to have a nonpunitive culture.

AR. This needs to be a major, far-reaching effort that goes deeply into the organization to have the right culture that enables this situation to be improved.♦

For information on the study, e-mail the authors arosenst@vha.com or modaniel@vha.com.

References


Authors to present session
Alan H. Rosenstein, MD, MBA, and Michelle O’Daniel, MHA, MSG, of VHA West Coast will present a session on their disruptive behavior study at the Managing Today’s OR Suite conference Oct 19 to 21 in San Diego.

A conference brochure will be in the April OR Manager and will be posted at www.ormanager.com.
Eighteenth Annual
Managing Today's OR Suite
San Diego
Manchester Grand Hyatt
October 19-21, 2005
Look for the conference brochure with the April issue of OR Manager.
Making disruptive behavior policy real

Physicians respect me.” How many staff nurses would agree with that statement? Three years ago, only 60% of nurses surveyed at Shands Hospital at the University of Florida, Gainesville, agreed.

But the numbers were lower in the OR and postanesthesia care unit (PACU), 50% and 35% respectively.

That was the signal something needed to change, says the nurse manager for perioperative services, Gail Avigne, RN, BA, CNOR. She and other managers set about developing a policy for addressing disruptive behavior.

“Unfortunately, abusive and disruptive behavior has been tolerated for a long time. It has been something that we in hospitals don’t want to talk about,” she says. “But with the nursing shortage, it becomes imperative that we try to change things.”

Nurses who don’t feel respected can vote with their feet and have their choice of employers.

Since Shands implemented its new policy, survey results have improved—58% of OR nurses in the last survey agreed that “physicians respect me.” The PACU improved more slowly to 40%.

Avigne offered this advice for implementing a disruptive behavior policy:

Draft the policy.

Avigne and her colleagues drafted the policy with a flow chart to show the steps.

“Basically, the policy is simple,” she says. “The goal is to have an environment that is open and where employees’ concerns are listened to.” The definition of disruptive behavior generally covers any behavior that creates a “hostile work environment.”

The policy starts with the employee documenting the incident. The manager then meets with the employee to discuss what happened. Next, the manager and medical director of the OR meet with the employee and physician involved. Perhaps 98% of incidents are resolved at that level. The policy outlines further steps for the 1% to 2% of incidents that are more serious or reflect a pattern of behavior.

Support from the top is number one.

Use data to focus attention.

Data from the employee survey was a way to jump-start conversations about the proposed policy with hospital executives, senior physicians, and the legal department.

Avigne not only shared the survey data but also statistics about the impact of disruptive behavior on nurse retention (sidebar).

Get backing from the top.

Garnering support for the policy at the highest level is “absolutely the number one thing,” Avigne says.

She first went to the chief of the medical staff and legal department to get support.

“I showed them the data so they could see why it was so important to work on this. We had to have an action plan.”

She also went to her own superior, the vice president of operations, as well as the vice president for human resources and the CEO and asked them to sign on.

“The good thing about having a shortage of nurses is you can use that as an opportunity to fix things you might not have fixed before because it is so hard to do,” she says. “It causes people to listen when they might not have listened before.”

This process took months, she acknowledges, but getting support was essential for the policy to have clout.

Disruptive behavior also was added to the credentialing policy for physicians’ reappointment to the medical staff.

Communicate the policy.

After the policy was approved, Avigne and other managers met with physicians to inform them about the policy. They started with the chairmen and then went to the medical staff committees, the rest of the medical staff, and the faculty. As with the executives, they began by sharing the data about the employee survey and nurse retention.

“Physicians often don’t realize the repercussions a negative interaction can have on themselves and the nurses. Many of them don’t think it’s a big deal,” she says.

“Yet, nurses won’t stay in a place that is abusive. With the shortage, they can go anywhere they want.”

Instill a culture of trust.

The steps in the policy are straightforward on the surface, but executing them is challenging, she notes.

Though the vast majority of incidents can be resolved in the first 2 steps, it takes mentoring and active involvement by the manager.

“You need to instill a culture of trust and safety,” Avigne says. “Employees fear that surgeons are powerful, and if
Please see the ad for CTC CARDINAL HEALTH in the *OR Manager* print version.
Managing people

Disruptive behavior: What’s the law?

An interview with Deborah Krohn, RN, JD, of the firm of Siegel & Krohn, Towson, Md.

Q When does disruptive behavior cross the line into being a potential legal liability for a health care facility?

DK. Of course, disruptive behavior can run the gamut from disrespect to more serious behavior. First of all, an organization may face legal liability if the disruptive behavior is linked in any way to discrimination on the basis of age, sex, race, disability, or religion. For example, if a person is demeaning or critical of a staff member by saying, “You’re too old to learn this new technique,” you could have an employment claim on your hands.

Second, if there is disruptive behavior that can be viewed as either sexual harassment or contributing to what is called a “hostile work environment,” that could be the basis for a very strong employment liability problem for the facility.

A hostile work environment may arise when an employer maintains an environment where: a) offensive conduct of a sexual nature (eg, uninvited touching or groping, lewd comments, dirty jokes, etc) is either tolerated or encouraged; and b) that conduct makes others feel uncomfortable and unreasonably interferes with an employee’s performance in the workplace. A hostile work environment can also exist on the basis of racial discrimination, sexual orientation discrimination, religious discrimination, disability discrimination, or age discrimination.

For example, an employee could make a claim against an employer for a hostile work environment if the employee is within hearing distance of sexually harassing conduct, even though that employee is not the target of the harassment.

Another way in which disruptive behavior could lead to legal problems is if it occurs in front of patients and families. Consider the example of a physician who criticizes or demeans a nurse in the presence of a patient or family. If there happened to be an adverse outcome from that care, the disruptive behavior could plant a thought in the patient’s or family’s mind: “Maybe something is wrong here. Maybe there was standard care.” In that situation, the disruptive behavior could contribute to the patient filing a malpractice suit.

Q Because disruptive behavior can be hard to define, how do you make it clear what is unacceptable?

DK. It is generally recommended that you have very clear language about disruptive behavior in your personnel policies and in the medical staff bylaws. The policy should describe precisely what behavior is unacceptable and detail the consequences of conduct that would violate the policy or bylaw. That language should be presented to new personnel when they join the institution. It also should be discussed during the annual review. That way, you establish and maintain a clear and reasonable expectation of acceptable professional conduct with new personnel.

Q When an incident occurs, when is it time for a manager to get higher-ups involved?

DK. I think managers are best served by going through appropriate channels to contact their legal department or lawyer relatively early in a situation and without hesitation. That way, managers can get any guidance they may need and know where the facility stands. It also gives the legal department a heads-up that there might be a problem that needs to be addressed. As an attorney, I would rather hear about a situation in its infancy, while there is some opportunity for intervention and remedy, than later at a fulminate stage. I think most legal departments would feel that way.

Q What is important about documenting disruptive behavior?

DK. I think the manager is the one who should document the behavior. As a manager in this situation, you need to guard against rushing to judgment. You need to be objective: Is this a legitimate complaint? Are we unfairly targeting the person considered disruptive?

You need to document these incidents because you need to discern whether there is a pattern of disruptive behavior. For the most part, a single incident does not a disruptive person make—we all have had our bad days. It is the pattern that is most concerning, and that’s what documentation can help make clear. You need it because people do not have good memories (“Uh, what was it that happened last June to one of the other nurses?”) and because people who’ve been victims may no longer be employed at your facility. If they’re not there anymore, you don’t have their story.

Documentation can also help your direct dealings with the disruptive individual who seemingly doesn’t get it—the person who doesn’t understand that his or her behavior is disruptive and the destructive impact that it has. In this case, you can get out the documentation and say to the person, “Well, on March 13, this happened, on April 20 this happened,” and so on. This kind of data is far more persuasive than poorly substantiated anecdotes of allegedly disruptive conduct.

Finally, if there is a bad patient outcome, documentation may be able to help establish whether there was a link between the outcome and disruptive behavior.

Q It’s one thing to have a disruptive behavior policy and another thing for employees to trust it. What makes a policy effective?

DK. Three things make a policy effective:

• content
• dissemination
• enforcement.

First, for content, your best bet is to...
Managing people

Continued from page 24

they report them, they could be fired.”

A manager has to deal with incidents as they come up, though that may seem overwhelming at first. “You need a couple of success stories. Then the word spreads, and people will know it will be taken seriously,” she says. “You can’t shy away from it. I’ve had many soul-searching conversations with nurses and physicians. It’s almost like being a psychologist, I guess.”

Two books she suggests for building communication skills are Daniel Goleman’s Working with Emotional Intelligence and Crucial Conversations by Kerry Patterson and colleagues. (See Resources.)

The first step, having the employee document the incident, is necessary, she notes.

“Employees are reluctant, but documenting is important. Just as you use documentation with employees, you can use it with physicians,” she says. Documenting the incident does 2 things: It creates a paper trail, and it allows the employee to think through what happened.

Avigne then meets with the employee to work through the incident. “We have a clear code of conduct stating what is acceptable and unacceptable behavior.

Second, the code of conduct must be widely disseminated to the staff and physicians. This means you present it, you talk about it at staff meetings, and you discuss it at annual reviews and exit interviews. Your staff should know you have a policy, and they should be able to articulate it. They should be able to say how they can report their concerns. This promotes conversation and awareness. Many organizations offer training about behavior expectations.

Third, there must be clear consequences for violations that are spelled out in your policies and procedures and in your medical staff bylaws. If the disruptive behavior provision of your policies or bylaws has been violated, you must act. You’ve talked the talk—now you must walk the walk. When you enforce what’s on the books, it sends a clear and unambiguous message to the staff that the facility is serious about addressing disruptive behavior.

You need a couple of success stories.

try to review what they might ‘own,’” she says. “Typically, we do own a piece of it—there’s often a reason a physician gets upset.”

In the next step, she and the medical director of the OR, David Paulus, MD, meet with the employee and the physician involved. Avigne often has the physician read what the employee wrote as a way to “start the conversation,” she says.

Though the matter most often will be resolved at this step, she keeps the documentation. If the matter is not resolved, it is taken to higher levels, which involve the employee relations and legal departments as well as physician leaders.

Educate employees.

A recent addition is a class for employees entitled Maximizing Your Relations with Physicians that is offered by the Human Resources Department. Course content includes:

• helping employees be aware of their own feelings, needs, and concerns and how to manage them
• developing awareness of physicians’ feelings, needs, and concerns
• developing good working relationships with physicians by learning skills such as listening and giving constructive feedback
• discussing the disruptive behavior policy and how to use it.

“This is a culture that has been around forever, and it is hard to change,” she adds. “It won’t change in a year or even 2 years. It might take 5 or 6 years.

“Management has to create an environment where people feel safe by communicating that there is a process, and employees will be supported.”

Disruptive behavior and nurse retention

• The RN shortage is expected to grow to 25% by 2020 if current trends continue, with at least 400,000 fewer nurses than needed.


• 24% of sentinel events could be attributed to a problem with nurse staffing, communication gaps, a lack of teamwork, or other “human factors.”


• A study of nurses in the U.S., Canada, England, Scotland, and Germany showed:

  • 41% of nurses were dissatisfied with their jobs.
  • 22% planned to leave their job in less than 1 year
  • 33% of nurses younger than 30 planned to leave their job in less than 1 year

Strongest reasons for discontent were overwork, staffing cutbacks, increased caseloads, increased non-patient care duties, concerns about care quality, verbal abuse, and lack of administrative support.


Resources


Traditional separations between the perioperative and interventional imaging departments are disappearing as advances in medical technology alter the locations of surgical and interventional imaging procedures.

While most of the change is occurring in large teaching hospitals and academic medical centers, some community hospitals are also starting to address the trend through integrated architectural designs, says Bill Rostenberg, FAIA, FACHA, Anshen + Allen Architects, San Francisco.

"Integration of imaging and surgery is not limited to academic centers," he says. "It follows an evolution in healthcare that is most dramatic in academic medical centers, as they tend to be the early adopters."

The goals for an integrated interventional surgery and diagnostic suite are to avoid unnecessary duplication of space, staff, and equipment and build in flexibility for new procedures, he says.

These types of designs are underway at several Kaiser Permanente hospitals in California and UCLA Medical Center’s Westwood and Santa Monica replacement hospital projects.

"(Westwood) is probably one of the most visible examples of a new replacement facility that is responding to the integrated interventional suite," Rostenberg says. Santa Monica UCLA Medical Center is still in the early phase of development.

Less-invasive procedures drive change

There are early signs that this blurring between departments is happening in general and community hospitals, he notes.

For example, surgery, cardiac catheterization labs, and interventional imaging departments have historically been physically and functionally separate units. "This is true now even though the same procedures take place in different departments," he says.

But some hospitals also are interested in new "integrated" designs that share support space in such areas as supply and the post-anesthesia care unit (PACU).

"Any hospital, regardless of size, is interested in providing services that are less invasive and do not require unnecessary duplication of staff and equipment," Rostenberg says. "We are seeing complex procedures done in interventional rooms that 5 years before were only done in the OR. There are overlapping surgeries in the OR, cath lab, and interventional imaging."

For example, interventional radiologists are doing procedures that include angiographies, balloon angioplasty, biliary drainage and stenting, central venous access, fallopian tube catheterization, gastrostomy tube placement, needle biopsy, thrombolysis, transjugular intrahepatic portosystemic shunts (TIPS), and vena cava filter placement, according to the Society of Interventional Radiology (SIR), Fairfax, Va.

Interventional radiology is a branch of radiology that was born in the 1970s and earned recognition as a medical specialty by the American Board of Medical Specialties in 1992. There are approximately 5,000 practitioners in the US.

Blurred lines causes turf battles

The growth of interventional radiology has led to turf battles, in some instances, between surgeons, cardiologists, and interventional radiologists, Rostenberg says.

"The turf battles tend to be stronger in academic medical centers, but it also happens wherever minimally invasive surgery is in demand."

Competing specialty physicians "are looking at the same pool of patients to expand their markets," he says. "This affects nursing and staff at hospitals that don't have a solid game plan."

Minimizing turf battles by integrating departments takes leadership from the top, he says, noting, "Every department is competing for patients. At a certain point, the CEO has to help create a vision for departments to work more collaboratively."

In situations where ORs and interventional radiology departments are evolving along separate lines, problems include finding trained staff, purchasing equipment, and finding space for preoperative and postanesthesia care.

"Suddenly, you need 3 times the space, support staff, and infrastructure," Rostenberg says. "I am seeing hospitals recognize this problem and begin planning for integrated platforms with surgery, cath lab, and interventional radiology. With an integrated model, these 3 areas can be modular-
The OR Business Management conference May 2 to 4 in Tampa, Fla, features an all-day seminar and 5 breakout sessions on OR design and construction.

The all-day seminar, titled “Getting What You Want and Need in OR Design and Construction,” will be presented by a team from Toronto General Hospital, Toronto, Ontario, which has built a 22-room OR department. The department has a state-of-the-art communication system that includes digital, wireless, computer, and intercom—the only such system in North America today. The team will discuss how they negotiated with the architect to get a suite that met their needs.

Breakout sessions
The 5 breakout sessions include:
- “Using Guiding Principles in OR Design and Construction,” with Aileen Killen, RN, PhD, CNOR, and David P. Jaques, MD, FACS
- “Blurring Boundaries Between Surgery and Interventional Imaging,” with Bill Rostenberg, FAIA, FACHA
- “Design Trends for Surgical Facilities,” with Anthony Roesch, AIA
- “Emerging Technologies Affecting Design and Construction of OR Suites,” with Jay Ticer of ECRI
- “Developing a Freestanding Ambulatory Surgery Center,” with Matt Chance, MHA, CHE, and Terry Hayes, RN, MSN, ARNP, CNOR.

Download the conference brochure and register online at www.ormanager.com. Or phone 800/442-9918.
Help! I have a problem employee

First of a 3-part series on handling problem employees.

People in surgical services must work together to get the job done. Staff members rely on one another for information, supplies, and support. A problem employee creates a weak link that can threaten the quality of services and the safety of coworkers and patients. The longer management tolerates substandard work and negative behaviors in employees, the worse they tend to become. Worse yet, other employees notice that some people are getting away with things and, in time, everyone begins adjusting their performance downward to the lowest level tolerated. Before long, the majority of employees are simply doing just enough to stay out of serious trouble and collect their paychecks. Even potentially excellent staff members function at less than half of their capacity in such an environment.

The way to stop this downward spiraling trend is for managers to recognize, confront, and resolve staff performance problems as quickly as possible. Even overlooking marginal performance can lead to further declines in performance.

Common types of problems

Dealing with employee performance problems is perhaps the most difficult and unpleasant task that managers must perform. Confronting these situations takes time and energy. It may seem easier to just ignore a problem employee. This is not as uncommon as one might think in organizations where firing an employee is a multi-step process. Yet lack of action sets up everyone for lower performance and creates morale problems.

Regardless of how well you manage the people in your department, performance problems will occur from time to time. Some of the more common types of problems are:
- habitual tardiness
- missed deadlines
- doing just enough work to get by
- frequent errors
- being unable to perform a task, even after repeated training

Looking for patterns

Obvious performance problems, such as an employee showing up for work in an impaired physical state, must be addressed immediately. Passive performance problems, although sometimes more difficult to recognize, must also be addressed. If an employee seems to be having trouble getting the job done or you are receiving complaints about the employee from other staff, look for a pattern:
- Does the employee frequently "forget" policies or procedures?
- Are there regular misunderstandings that get in the way of the job being completed correctly?
- Does the employee continually ignore supervisory directives?
- Is the employee frequently giving reasons why a task cannot be done properly?

Taken case by case, these behaviors may seem inconsequential, but a pattern of such behaviors may be a symptom of employee insubordination. It is important that you identify and deal with passive performance problems in the same manner as you would for more obvious problems.

Causes of problems

Why an employee does not meet performance standards can be generally categorized into 1 or more of 4 causes:
1. Performance standards have not been clearly communicated to the employee.
2. The employee hasn’t received feedback on his or her performance.
3. The employee’s performance is hampered by lack of knowledge, skills, or resources.
4. The employee isn’t motivated or has a negative attitude.

In this first of 3 articles, you’ll learn some techniques for avoiding the common causes of poor staff performance. In the remaining 2 articles, you’ll learn how to handle problem situations that require coaching, counseling, or disciplinary action.

Cause 1: Standards are not clearly communicated.

It is the manager’s job to establish performance standards and communicate these standards to employees on an ongoing basis. Remember to be specific when setting standards. Below is an example of performance standards for a circulating nurse with clear and specific performance expectations:
- Functions effectively as a circulating RN. Plans, directs, provides, and supervises perioperative care of surgical patients of all ages.
- Assists in setting up and performance of cases by assembling equipment and supplies according to physician preference lists.
- Assists in setting up and performance of cases by opening sterile packs, instruments, and supplies according to sterile technique.
- Performs sponge, needle, and instrument counts with scrubbed person.

Performance standards should not be simply posted or given to employees. During the interview, the new hire’s probationary period, and at regular performance evaluations, the standards and performance expectations should be reviewed with employees. Make sure employees understand the performance standards for their job. To check if an employee understands the standards, one technique is to ask him or her to summarize the expectations.

Remember, employees are not mind readers; they may not know what’s important or critical. Be sure to prioritize tasks and responsibilities. It is also helpful to communicate the big picture and how the employee fits in it.

Cause 2: Employee hasn’t received feedback.

All of your staff members need to know how they are doing on a regular basis. Give as much time to praising the good performers as you do to counseling those needing improvement. When an employee excels, even in the smallest ways, point it out. If an employee exhibits poor or marginal performance, don’t wait until the next formal evaluation to point out the problem. As close as possible to the poor performance, talk
Managing people

with the employee about the problem and jointly explore ways to correct it.

**Cause 3: Employee lacks knowledge, skills, or resources.**

An employee’s work may be hampered by a lack of knowledge or skills to do the job. This can be especially problematic if the employee is given new job responsibilities or expected to work with new technologies or assist with new procedures. If an employee hasn’t been adequately trained on how to do his or her job, it’s unlikely he or she can meet performance expectations. Resolving this cause requires providing instruction in how to do the job. Another obstacle may be existing processes, methods, or systems that interfere with the employee’s ability to do the job. These underlying root causes must be addressed to lessen the impact on staff job performance.

**Cause 4: Motivation and attitude.**

If employees have clear and understandable performance standards, know how they are doing, and have been appropriately trained, there may be another reason why an employee isn’t meeting performance standards—his or her motivation or attitude. To determine if motivation or attitude is a problem, ask yourself, “Has the employee been able to do the job well in the past?” If performance has rarely been a problem, look for other factors. Some common reasons for poor staff motivation or attitude and actions you can take to resolve these factors are in the chart.

Whatever the reasons for poor or marginal performance, you need to address problems when they occur. Not addressing the issue sends the message to everyone in the department that the manager doesn’t see the performance as a problem. Often, silence is interpreted as condoning the behavior. Managers who want to be seen as nice tend to ignore employee problems. These managers often hope problem employees will improve without any intervention, and when they do not, they drop hints. Instead of coaching, counseling, and terminating employees who do not improve, some managers ignore the problems or encourage the employee to transfer to another department. What do these managers get for being nice?

**What to do about bad attitudes**

<table>
<thead>
<tr>
<th>Reasons for poor motivation or attitude</th>
<th>Suggested actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual is not committed to your department or organization.</td>
<td>• Describe to the employee how his or her job is critical to the success of the department and the organization.</td>
</tr>
<tr>
<td></td>
<td>• Secure the employee’s buy-in to the value of the organization’s mission and vision and the department’s contribution.</td>
</tr>
<tr>
<td>Individual is not challenged by the job.</td>
<td>• Ask the employee if he or she has ideas on how to improve the job.</td>
</tr>
<tr>
<td></td>
<td>• Counsel the employee on how to gain the skills necessary to advance in the department or organization.</td>
</tr>
<tr>
<td>Individual resists change.</td>
<td>• Introduce change in stages, not all at once.</td>
</tr>
<tr>
<td></td>
<td>• Make sure the employee sees the value and reasons for change and his or her role in making the change successful.</td>
</tr>
<tr>
<td>Individual has personal problems that are affecting work performance.</td>
<td>• Suggest the services of your employee assistance program.</td>
</tr>
<tr>
<td>Individual perceives that co-workers are not doing their jobs, and yet nothing is being done to fix those problems.</td>
<td>• Validate this concern before taking action.</td>
</tr>
<tr>
<td></td>
<td>• If co-workers are exhibiting poor performance, address the issue immediately! Ignoring poor performance will ultimately affect the whole department.</td>
</tr>
<tr>
<td></td>
<td>• If poor performance of co-workers is not validated, coach the unmotivated individual.</td>
</tr>
<tr>
<td>High-performing individual is “rewarded” with more work because you know the person will get the job done.</td>
<td>• Distribute workload fairly; otherwise, you’ll burn out your high-performing staff members.</td>
</tr>
</tbody>
</table>

Source: Patrice Spath, BA, RHIT.

They lose their employees’ respect. Staff members know that their manager is shirking responsibility by not dealing with performance problems.

Because causes of employee problems can be broad and varied, and each factor plays on the others, the exact cause may at first be hard to see. But, whatever the cause, the good news is that most times it is curable. Feedback, coaching, and counseling, as well as performance evaluations, are tools managers can use to correct poor performance. All employees should be receiving ongoing feedback and coaching throughout the year as a regular part of their performance cycle. If, after feedback and coaching, the employee is still performing below expectations, the manager should move to counseling.

In part 2 of this series, you’ll learn how to positively address employee performance problems by using good coaching and counseling techniques. ✤

—Patrice Spath, BA, RHIT


She will be speaking at the Managing Today’s OR Suite Conference, Oct 19-21, in San Diego on “Demystifying Comparative Performance Data” and “Reducing Human Factors That Contribute to Errors.”
What does it take for an ambulatory surgery center (ASC) to have a quality improvement program that both physicians and staff buy into?

El Camino Surgery Center (ECSC) in Mountain View, Calif, rates high in physician satisfaction on a number of measures, including QI, in the OR Benchmarks Surgeon Satisfaction Survey. Satisfaction has steadily improved in the 5 years ECSC has done the study. With 6 ORs and 1 procedure room, the center performs 9,000 procedures a year and is accredited by the Accreditation Association for Ambulatory Health Care.

In the survey, 89% of ECSC’s surgeons agreed with the statement, “The quality improvement process is effective for problem solving.” That was up from 72% in 2003.

More than 75% agreed with the statements, “Results of quality improvement studies are shared with the medical staff,” and “I have adequate input into cost and quality issues.”

“ECSC has consistently been the best performer for quality improvement in our surgeon satisfaction surveys,” says Ellie Schrader, president of OR Manager. “Although this is an important area, it generally does not receive high scores on these surveys.

“Overall, 91% of the physicians are satisfied with the QI efforts at ECSC. For the other facilities participating in the study, the median score was only 27% of physicians indicating satisfaction.”

These are some strategies that ECSC thinks make a difference:

**Prompt feedback to physicians**

“We provide a lot of feedback to our physicians,” says Lisa Cooper RN, BSN, the clinical director. She or the medical director, Ray Brizgys, MD, respond to any issue or complaint, usually within a day.

Unusual incidents are recorded on the center’s quality review reports (formerly called incident reports).

“I will call the physician right away so he knows there is a review process for this,” Cooper says. There also is feedback to the physician on how the issue will be resolved.

“We provide a lot of feedback to our physicians.”

“Although this is an important area, it generally does not receive high scores on these surveys.

“Overall, 91% of the physicians are satisfied with the QI efforts at ECSC. For the other facilities participating in the study, the median score was only 27% of physicians indicating satisfaction.”

These are some strategies that ECSC thinks make a difference:

**Prompt feedback to physicians**

“We provide a lot of feedback to our physicians,” says Lisa Cooper RN, BSN, the clinical director. She or the medical director, Ray Brizgys, MD, respond to any issue or complaint, usually within a day.

Unusual incidents are recorded on the center’s quality review reports (formerly called incident reports).

“I will call the physician right away so he knows there is a review process for this,” Cooper says. There also is feedback to the physician on how the issue will be resolved.

“I think we go to solution pretty quickly. It’s not just the responsiveness, but how can we solve it,” adds the executive director, Julie Butner, BSN, MSA.

To track postoperative infections and complications, the center sends a letter every month to all surgeons who performed cases there in the past month, enclosing a list of the procedures they did that month. The list has columns where the surgeon can mark Yes or No for:

- postoperative infections
- postoperative complications
- hospitalizations.

There is a column to indicate whether the complication or infection has been resolved as well as a section for comments. The list is printed out from the center’s information system. Butner estimates that 80% to 100% of the surgeons return the forms. About 180 surgeons are on staff. The return rate is audited quarterly.

Recently, another form was added for surgeons to return if there is an infection to get more specific information. The form lists signs and symptoms to check off as well as treatment that was provided and whether the patient was hospitalized.

“Before, we would get forms with the Yes circled, indicating there was an infection, and it looked like our infection rate was high. But when we investigated, we found these were superficial infections. We found we weren’t getting the right information,” Cooper says.

If there is a complication, Cooper fills out a quality review report and sends it to the Medical QI Committee.

A medical director committed to QI

“Our medical director does an excellent job of overseeing our Medical QI Committee,” Butner says. “He also does an excellent job of communicating with the physicians one-on-one and having things directed to specialty department meetings where they address quality issues.”

**Ambulatory Surgery Advisory Board**

Gwendolyn Grothouse, RN
Administrative director, Apple Hill Surgical Center, York, Pa

Barbara Harmer, RN, BSN, MHA
Senior consultant, HealthCare Consultants, Inc, Celebration, Fla

Jerry Henderson, RN, MBA, CNOR, CASC
Executive director, The SurgiCenter of Baltimore, Owings Mills, Md

Diana Procuniar, RN, BA, CNOR
Nurse administrator, Winter Haven Ambulatory Surgical Center, Winter Haven, Fla

Donna Gelardi-Slosburg, RN, BSN, CASC
Senior vice president, surgery operations, HealthSouth, St Petersburg, Fla

Rhonda Tubbe, RN, CASC, CNOR
Administrator, The Surgery Center of Nacogdoches, Nacogdoches, Tex
Ideas for ASC QI projects

Looking for new ideas for quality improvement projects in your ASC? Here’s a list to get you started, provided by Donna Slosburg, BSN, CASC, senior vice president, surgery operations, HealthSouth, and Nancy Burden, RN, MS, CAPA, CPAN, director of health services, Morton Plant Mease Health Care, Clearwater, Fla.

Outcome projects
- Procedure analysis: cost and best practice, eg, for cataract surgery
- Emergency preparedness: Advanced cardiac life support
- Adequacy of postoperative instructions
- Efficacy of regional blocks for pain control
- Antiemetics efficacy
- Antibiotic utilization
- Postoperative pain
- Length of stay
- Specimen management
- Availability of responsible drivers for discharged patients

Service and customer satisfaction projects
- Patient postprocedure follow-up

Cost management projects
- Late-arriving physicians
- Inventory turnover
- Medical supplies standardization
- Registration and/or scheduling errors
- Staffing and overtime
- Implant reimbursement

Give the staff an active role

Staff are included in the QI process. “We are committed to having the staff’s input and giving them ownership,” Butner says. “Luckily, our governing body supports this culture.”

Formerly, QI was handled by the center’s leadership committee, made up of managers and team leaders. Once a quarter, they turned their regular leadership meeting into a QI meeting, which everyone found to be efficient. Recently, this became a staff-level QI committee, which also meets quarterly, with volunteers from each department. Members include, in addition to the administrator, clinical manager, and medical director, staff from human resources, the preop area, postanesthesia care unit (PACU), QI nurse, OR, the center core, and materials management. The QI nurse is a staff nurse who works on QI projects in addition to her clinical duties.

Perform relevant QI studies

Ideas for QI studies may come from the quality review reports, forms the surgeons return, the staff committee, the medical QI committee, and patient satisfaction surveys. About 2 to 4 QI studies are done each year.

Recently, ECSC began collecting data on opened but unused orthopedic supplies. “Our circulating nurses have been gathering information for a year,” Cooper says. “If a supply such as a disposable anchor is opened but not used, we track the information.” ECSC has done a procedure cost analysis on orthopedic supplies and presented it to the surgeons at their specialty meeting.

Another recent study came out of the center’s patient satisfaction survey. The survey is given to each patient at discharge. Surveys are conducted twice a year of a sample of patients. The return rate was 43% in 2004.

“We were getting high numbers on postoperative nausea and vomiting,” Butner says. “The numbers were wildly off compared with those we were getting from the physicians in the letter we send to them. We wondered, ‘Do we have a problem?’”

Before introducing any interventions to address the issue, they decided to validate the results.

“We constructed a study that had the nurses making the postoperative phone calls do much more detailed questioning about nausea and vomiting,” Butner says.

The nurses found a very low percentage had nausea and vomiting, which didn’t match the results from the patient satisfaction surveys. They began to look at how the question on the survey was worded and concluded that was the source of the problem.

The question read: “Did you experience any unexpected problem relating to your surgery that would have required you to contact your physician? If so, circle the nature of the problem.” This was followed by a list.

They decided the question was ambiguous, and some patients thought they should check it even if they didn’t contact their surgeon.

The question was reworded to say: “Did you call your physician? If so, please indicate the reason (with a list).” Since then, the results have been more consistent with the physician results.

“The lesson from this is that you really need to look at what you are asking and how you are asking it,” says Butner. “You may not be getting the data you think you are getting.”

Cooper adds, “It is interesting how this played out, because what we thought was the problem could have taken us off in the wrong direction. It really was not a problem with the patients but with the survey tool itself.”

Keep QI studies user friendly

Weaving the data collection into an
Frequently asked questions on ASC QI

Lorraine Jordan, CRNA, PhD, a surveyor for the Accreditation Association for Ambulatory Health Care (AAAHC) and director of research for the American Association of Nurse Anesthetists Foundation, responds to frequently asked questions on quality improvement in ambulatory surgery centers.

Q How many QI studies should we do in a year? Is there an AAAHC standard for the number of QI studies we must do?
LJ. The number of QI studies is dependent on the number of patients as well as physicians that the facility serves. In general, 2 to 3 studies are recommended every year with constant monitoring of the survey results. For instance, if you are monitoring patient satisfaction and have made changes based on the results of your patient satisfaction survey, you should continue to monitor those changes over time to see if you have improved the quality of care for patients.

There is no AAAHC standard for the number of QI studies to be conducted in a year; however, the guideline is 2 to 3 studies per year.

Q What are good ways to identify topics for QI studies?
LJ. In my mind, the cornerstones are patient satisfaction and quality outcomes. If you are monitoring patient satisfaction and you start to see negative trends in the data, those are the things you would want to change. For instance, if you see a trend where patients say, “I had no idea that the anesthesia bill was going to be separate from the facility bill,” you can take a proactive approach to try to decrease those concerns in the future. One possibility is to develop a brochure or fact sheet to be sent to patients before they are admitted.

You can also identify topics by asking, “In which areas do we want to be the best to differentiate ourselves from other institutions?” If you’re not the best now, find out why you aren’t and what you have to change to make a difference.

Also look at the services you perform. If the majority of your cases are cataracts, maybe you want to focus on that specialty, such as the cost of equipment or personnel.

One of the things I often hear about is patient waits. This a troubling issue for patients and families. You want to monitor the wait time for patients and explore why it is so long. Asking probing questions will help you better define the problem and begin to solve the issue.

You also want to monitor outcomes, particularly the infection rate. If you have an increase in the infection rate, how can that be addressed? What factors are contributing to the increase in infections? Does one surgeon or procedure have a higher infection rate than others?

Q What should our sample size be?
LJ. That varies depending on what you are studying and the severity of the issue. Ideally, you want a sample that is representative of the population you are studying. One way you can tell if your sample is adequate is to look at the quality of the information you are getting and whether the data reflects what is actually occurring.

Using a statistical power analysis is the ideal way to determine the sample size. But I don’t think you always have to be that sophisticated for many of the issues ASCs are dealing with. For example, if you have 5 infections from 1 surgeon, you can reasonably assume there is some sort of problem.

One guideline: If you are studying a physician’s group of patients, it is recommended that at least 25 cases be studied to detect negative outcomes or events.

Q How can we get physicians involved in QI?
LJ. It is critical to bring physicians in at the ground level of studies, not at the end. You want physicians to be part of the team, instead of having the nurses collect all of the data and hand it over.

Hints for successful QI projects

These hints are offered by Donna Slosburg, BSN, CASC, senior vice president, surgery operations, HealthSouth, and Nancy Burden, RN, MS, CAPA, CPAN, director of health services, Morton Plant Mease Health Care, Clearwater, Fla.

• To select an idea for a QI study, ask, “How can we do ____ better?”

• Standardize data collection so you are comparing “apples-to-apples.”

• Use benchmarks, such as guidelines from professional organizations (Association of periOperative Registered Nurses, American Society for PeriAnesthesia Nurses, and Society of Gastroenterology Nurses and Associates) and accrediting agencies (Joint Commission on Accreditation of Healthcare Organizations and Accreditation Association for Ambulatory Health Care).

• Create easy-to-use data collection tools and place them in the most appropriate spots such as:
  — on the medical record
  — on anesthesia machines
  — in the postanesthesia care unit
  — at bedsides
  — with the surgical schedule
  — wherever else data will be generated.

• Enthusiasm is contagious—leaders must show interest.

• Use performance improvement (PI) tools such as:
  — flow charts
  — action plans
  — “fishbone” diagrams.

• Link performance improvement involvement to individual team member job descriptions and performance appraisals.

• Remember: PI is everyone’s responsibility!
Please see the ad for MICROTEK MEDICAL INC. in the *OR Manager* print version.
activity the staff is already doing is a good way to get them involved and make QI studies efficient, Cooper notes.

In the nausea and vomiting study, “instead of the nurses having to do a whole new data collection, we attached it to the postop phone call, which they normally do anyway,” she says.

**Share QI results**

Information on QI study results is posted and reported in ECSC’s regular mailings to physicians.

For example, for a while the center conducted a campaign to reduce sharps injuries. Regular reports on injuries were posted in the bathroom stalls and on bulletin boards. Raising consciousness helped because in 2004, the center reported no staff injuries and a physician injury rate that was half what it had been the year before.

*For information on OR Manager’s surgeon satisfaction surveys, call 800/442-9918.*

---

**Which anesthesia practices fare best?**

Anesthesia practices in the best financial shape are involved in more surgical procedures, handle less chronic pain care, and do little Medicare business, a survey by the Medical Group Management Association found.

Surgical anesthesia makes up only 71% of total cases but generates 83% of a practice’s median revenue. Chronic pain, on the other hand, represents 10% of a practice’s cases but generates only 3% of its revenue.

**Most receive stipends**

The vast majority—almost 86%—of respondents report they receive a stipend.

“One look at how Medicare’s anesthesia reimbursement rates affect practice revenue, and it is clear why so many practices receive stipends from their hospitals,” said Shena J. Scott, MBA, president of MGMA’s Anesthesiology Administration Assembly.

Practices with more than 50% of their revenue from government payers had a median revenue of $31.11 per ASA unit compared with $39.78 for practices with less than 30% of their revenue from government payers. (ASA units are used in anesthesia billing.)

“Clearly, commercial payers and hospital stipends are subsidizing Medicare patients,” Scott said. “The market can only sustain that disparity for so long. At some point, the laws of economics will force the best quality providers out of heavy Medicare practices, and Medicare patients will suffer from compromised access to care.”

Larger practices are more likely to use nonphysician providers than smaller practices, according to the survey. Practices with 50% or more of their revenue from government programs had the highest ratio of nonphysician providers.

The MGMA Cost Survey of Anesthesia Practices is available by phoning 877/275-6462 ext 888 or visiting www.mgma.com/store.

---

**What advice would you give ASCs to help strengthen their QI studies?**

LJ. Probably the most important thing is to brainstorm on the issue and pare it down. The secret of a good QI study is developing a research question that is not too broad. The question has to be clear and focused.

Even though you may have a huge issue, and you want to address 10 problems all at once, you need to focus on 1 issue at a time. Analyze that issue, develop a strategy for resolving the problems related to it, and then move on to the next issue.

Facilities tend to want “save the world” instead of solving just one problem at a time.

**Do you see patient satisfaction as a good QI study?**

LJ. I personally believe it is the cornerstone of any kind of QI study. If you don’t have satisfied patients, over time you won’t have any patients. It is good to try to see things through your patients’ eyes because they see things we do not encounter every day. You need to know what your patient satisfaction surveys are saying.

**How would you bring benchmarking information into QI studies?**

LJ. The role of benchmarking is to try to define a gold standard for the industry that applies to you. The difficulty is finding facilities that are similar to yours. You always need to know how the study was done and the characteristics of facilities in the study before you can apply the findings to your facility.

Some good approaches are:

- Develop a network in your own area and compare yourself with your peers.
- Participate with the national groups in the ASC industry, such as the AAHCH Institute for Quality Improvement (www.aaahc.org) and the Federation of Ambulatory Surgery Association (www.fasa.org).
- Use guidelines from professional organizations such as the American Association of Nurse Anesthetists (www.aana.com), the American Society of Anesthesiologists (www.asahq.org), the Association of periOperative Registered Nurses (www.aorn.org), the American Society of PeriAnesthesia Nurses (www.asp.org), and the Association for Professionals in Infection Control and Epidemiology (www.apic.org). From a risk management standpoint, you want to be following these guidelines anyway.
- Use government resources such as the Centers for Disease Control and Prevention (www.cdc.gov) and the National Guideline Clearinghouse of the Agency for Healthcare Research and Quality (www.guideline.gov).
Please see the ad for SULLIVAN LAKIER GROUP 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.

A conference brochure will be included in the April issue. The brochure and registration information also will be available at www.ormanager.com.

Please see the ad for PERIOPTIMUM in the OR Manager print version.
Please see the ad for
ADVANCED STERILIZATION PRODUCTS
in the OR Manager print version.
More injuries from care of obese patients

More than a quarter (28%) of VHA hospitals participating in a survey said worker injuries increased in the past year from caring for obese patients. Back injuries were the most common.

In all, 84% offer training in care of obese patients, and 55% have purchased special equipment to turn and lift patients, according to the survey by Novation, the supply arm of VHA Inc.

Costs of caring for severely obese patients rose 24% in the past year.

“These are not patients coming in for bariatric surgery but are being seen for other medical conditions,” says Sandy Wise, RN, MBA, Novation’s senior director of medical and surgical services.

The survey queried 584 directors of materials management and directors of surgical services with a response rate of 14%.

—www.vha.com

Audio conference on electrosurgical safety

ECRI will hold an audio conference titled “Electrosurgery and Patient Safety: Critical Measures for Minimizing Risk,” on March 16 from 1 pm to 2:15 pm EST. The focus is on dangers of electrosurgery and safeguards health care facilities should implement. Registration is $129 for members of ECRI services and $229 for nonmembers.

To register, phone 610-825-6000, ext 5891, or e-mail circulation2@ecri.org.

Study: CPR often done wrong

Cardiopulmonary resuscitation (CPR) is often inadequately performed by physicians, paramedics, and nurses, according to 2 studies in the Jan 19 Journal of the American Medical Association.

Two common problems are rescuers not pushing hard enough or frequently enough on the chest to restart the heart and rescuers breathing air into the lungs too often, either mouth-to-mouth or through tubes.

In a study involving 67 adults at the University of Chicago, doctors and nurses failed to follow at least one CPR guideline 80% of the time. Failure to follow several guidelines was common. The other study involved 176 adults with out-of-hospital cardiac arrest treated by paramedics and nurse anesthetists in Akershus, Norway; London; and Stockholm. Chest compressions were done half the time, and most were too shallow.


Few speak up about problems

Health professionals frequently see problems that could harm patients, but they often fail to talk about them, a new study finds. In a survey of more than 1,700 clinicians and administrators:

• 84% of physicians and 62% of nurses and other clinicians have seen coworkers taking shortcuts that could endanger patients.

• 85% of physicians and 48% of nurses and other providers work with persons who show poor clinical judgment.

• Fewer than 10% of physicians, nurses, and other staff directly confront their colleagues, and 1 in 5 physicians say they have seen patients harmed as a result.

With the study, the American Association of Critical-Care Nurses and VitalSmarts, a training company, released recommendations to promote skilled communication and collaboration. The recommendations emphasize the urgent need for hospitals to implement communication training and education.

—www.rxforbettercare.org