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OR management

ORs are stretched in providing additional anesthesia coverage

The surgeons want more OR rooms running later in the day and even on weekends. With reimbursement pressures, they say they need to spend more time in their offices seeing patients. But who’s going to provide the anesthesia coverage for these extended hours? Anesthesia providers say it isn’t financially feasible. They’re already unhappy about downtime during the day. They are asking the administration for a stipend, or a higher stipend. What’s going on?

Demographic and economic issues are pulling surgeons and anesthesia providers in different directions. Though there has been slow but steady growth in the number of anesthesiology residents in recent years, experts say anesthesia providers are still in short supply relative to the number of anesthetizing locations.

Though numbers of anesthesia providers are up, other trends are also at work:

• They are being asked to cover more sites—cath labs, imaging suites, pain clinics, and labor and delivery areas, but reimbursement has lagged for those services.

• Growth of ambulatory surgery centers (ASCs) has exploded, and they also need anesthesia coverage.

• Lifestyle issues such as vacation and predictable work hours are more important now.

Too little supply and more demand mean anesthesia providers have lever-

Continued on page 7

Managing people

Substance abuse in the OR: Why managers should not ignore it

The first of two articles.

Cecil King, RN, MS, CNOR, is a perioperative advanced practice nurse at Sinai Hospital in Baltimore. King is an outgoing, knowledgeable nurse. He’s a mover and shaker in the perioperative world: active in AORN, speaking at national meetings, and writing articles for nursing journals. He’s well respected by coworkers and colleagues.

He’s also 6 years into his recovery from drug addiction.

King, who speaks openly about his experience, is an example of why managers should identify clinicians with substance abuse problems and help them enter treatment. We need people like King to meet society’s health care needs. The good news is that 75% to 85% of nurses and physicians who enter treatment for addiction return to work.

What does an addict look like? Forget the image of the addict as a homeless person in a back alley. William Halsted, considered by many to be the “father of modern surgery,” was addicted to morphine while he was making great contributions to medicine. “Dr Bob” Smith, the founder of Alcoholics Anonymous, was a surgeon.

“This disease does not know a class,” says Marcia Rachel, RN, PhD, assistant dean for health systems and quality improvement at the University of

Continued on page 11
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Editorial

“Moments before a recent operation began, a Minnesota nurse said something important to a high-ranking, highly respected surgeon. “She said, ‘Stop.’

“Later, she would credit her intuition gained by years of working in operating rooms. She simply thought that something was wrong. As it turns out, her intuition was right.”

That’s the beginning of an op-ed piece that recently appeared in the Star-Tribune, the newspaper serving Minneapolis and St Paul.

The writer is Dana Langness, RN, BSN, MA, senior director of surgical services at Regions Hospital in St Paul.

Langness went on to discuss Minnesota’s annual report on adverse events, which had just been issued by the state’s Department of Health. Minnesota was one of the first states in the country to require hospitals and ambulatory surgery centers to report 28 types of serious events. The events include falls resulting in serious disability or death, foreign objects left in after surgery, and surgery on the wrong person or body part. The latest report, published in January 2008, includes 125 events reported between 2006 and 2007.

Sharing to learn
But the report is only part of Minnesota’s efforts to improve patient safety. The state requires each facility that has one of these adverse events to do a root-cause analysis. And the state works with health care organizations and others to share what is learned and improve practice.

As part of this effort, OR experts from around Minnesota have developed a detailed safe-site protocol as well as protocols to prevent retained foreign objects in surgery and in vaginal delivery. OR Manager will report about the retained object protocol in an upcoming issue. The protocols can be downloaded for free from the website of the Institute for Clinical Systems Improvement (ICSI) at www.icsi.org.

This year, Minnesota facilities are continuing their work to prevent wrong surgery:

• Some 90 hospitals and 24 surgery centers have signed up to implement best practices. Langness was writing about one of these—the “hard stop,” where staff are expected to speak up when they see a risky situation.

• Human factors researchers from the University of Minnesota are observing surgery at hospitals around the state to identify gaps in preoperative processes that allow these events to happen.

• A group of facilities in central and northern Minnesota is looking not only at how to prevent wrong surgery but also at improving informed consent, antibiotic timing, deep-vein thrombosis prophylaxis, and other issues.

We would guess the public knows little about this work. They see the headlines when an accident happens. But do they know that errors in Minnesota dropped by nearly 20% in the latest reporting period? These improvement projects no doubt had something to do with that.

That’s why Langness’ opinion piece is so important. She’s giving a voice to the OR managers, directors, physicians, and staff who spend countless hours refining their processes, holding in-services, gathering data, and monitoring compliance.

“You might presume that we in medicine dread this annual report,” Langness continued in her opinion piece. “After all, it shines a bright public light on our worst moments.” But, she continued, “That awareness is precisely why we value the report so highly.” Though the numbers are important, she noted, “What’s more important is what we are learning from them. In fact, the sharing of knowledge and data about past adverse events is one of our best tools in working to prevent future ones.”

Have you considered writing a piece for your local newspaper about the safety efforts at your hospital or surgery center? We think it’s work the public deserves to know about. —Pat Patterson

Read more about Minnesota’s patient safety activities at www.health.state.mn.us/patientsafety/.

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Upcoming

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

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Patricia Patterson: Editor
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Kathy Shaneberger, RN, MSN, CNOR: Consulting editor
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Is health care headed for a meltdown?

The key change American health care must make is new ways of paying for services, says health policy expert Stuart H. Altman, PhD. That is the only way to create an integrated delivery system that will keep health care alive.

Altman will deliver a special lecture on “Promising Changes for Improving Our Health Care System” at 4:30 pm, Thursday, Oct 30 at the 2008 Managing Today’s OR Suite Conference in Washington, DC. His lecture is sponsored by Cardinal Health.

“We have to move away from fee-for-service payment toward more bundled payments and more integrated services,” Altman says. “If we don’t, we’re going to have a meltdown in the system.”

‘Dark clouds on horizon’

“I’m not a doom-and-gloom kind of guy normally, but I see some pretty dark clouds on the horizon,” the economist says. “We can wait for them to come to us and just get rained on—or we can develop some kind of umbrella.”

The spokes of the umbrella have to be built from the basic philosophy behind reimbursement for Medicare and Medicaid and be reflected by private insurers, he says.

Veteran health care policymaker Altman, who is dean and Sol C. Chaikin Professor, National Health Policy, in the Heller School for Social Policy and Management at Brandeis University, Waltham, Massachusetts, is an economist who focuses primarily on health policy.

Among his achievements are 12 years as chairman of the federal Prospective Payment Assessment Commission (Pro-PAC), which advised Congress and the administration on the DRG system and reforms. He is also chair of The Health Industry Forum, which brings together leaders from across health care to develop solutions for critical problems facing the health care system.

Impact on the OR

The needed changes in health policy are an issue for operating rooms, Altman argues, saying OR leaders need to be aware of the issues and work with policymakers to reverse the fee-for-service trend.

The OR often is the economically healthiest part of a hospital, but it’s still connected to the rest of the facility, he notes.

“The OR is a critical part of any hospital. It can’t survive if the rest of the system is sick,” he said. And Altman has diagnosed some serious symptoms in the system.

“Hospitals are going to face very serious financial pressure in the near future,” he says, adding that change must start with health care advocates pressuring the Centers for Medicare and Medicaid Services and insurance boards. The future of American health care is at stake—both primary and specialty care.

“If we don’t change the way medical practices are reimbursed, services just won’t be there,” he warns. In the 1990s, he notes, the system started moving toward integrated care, beginning with primary care physicians and moving through the hospital and/or surgical care to skilled nursing care.

But payment was never bundled to encourage this integration, he says.

“The payment system didn’t reward that integration, and it all stopped,” he says. “If we don’t do the bundling of payment, if we just squeeze down on fee-for-service payments, it’s going to kill integration and kill services themselves. It’s a dead end.”

Ambulatory surgery centers are beginning to feel that squeeze already and are rethinking what services they can and cannot afford to offer, Altman notes. “It is an issue for them right now. And if we don’t change course, it will be an issue for all of the health care system.”

Altman has a master’s and PhD in economics from UCLA and taught at Brown University and the Graduate School of Public Policy at the University of California at Berkeley. He has served on the board of The Robert Wood Johnson Clinical Scholars Program and on the governing council of the Institute of Medicine. He is the chair of The Robert Wood Johnson Foundation-sponsored Council on Health Care Economics and Policy. The council is a private nonpartisan group that analyzes important economic aspects of the US health care system and evaluates proposed changes in the system. 

—Kate McGraw

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An anesthesiologist entering practice today commands an average starting salary of $300,000 plus benefits and 8 to 9 weeks of annual leave. Certified registered nurse anesthetists (CRNAs) and anesthesia assistants (PA-As) start at $164,000 on average with 6 weeks of leave.

Anesthesiologist’s pay package is a big expense for an anesthesia practice to absorb, notes William Mazzei, MD. "Most anesthesia groups don’t want to take the risk of hiring a new person, even if they can get them, and dilute the income for everyone else,” he says. If the hospital wants more services, anesthesia groups think the hospital should put up the money to support the risk of hiring a new person.

**Inpatient practice less desirable**

Logistical issues make the hospital setting less attractive financially for anesthesia groups, adds Dr Mazzei, an anesthesiologist who is medical director of perioperative services at the University of California, San Diego, and consults on anesthesia issues.

“There’s been a large increase in demand for anesthesia outside the operating room, but those areas are scheduled inefficiently from an anesthesia standpoint. So anesthesia groups are hesitant to assign anesthesiologists to those,” he says.

Meanwhile, ASCs are attractive. “Not only is the payer mix better, but the cases are short,” he points out. That’s an advantage because the anesthesia billing rate is higher at beginning of cases than for subsequent time increments.

An anesthesiologist who does 6 short ENT cases in an ASC and is out by noon can make more money than a person who comes to a hospital an hour earlier and finishes at 4:30 pm doing a CABG,” he says.

As a result, the desirability of an inpatient practice has gone down at a time when demand for those services is up. Hospitals also tend to have a high number of Medicare and Medicaid patients, who have lower reimbursement rates than patients with commercial insurance.

"Even if an anesthesia group bills perfectly and gets their bills out quickly, you can't generate market-level salaries with a pure inpatient practice,” Dr Mazzei observes. “Most groups that are primarily hospital based need a stipend to be able to guarantee a salary that will get new anesthesiologists to come.”

A new analysis shows anesthesia groups are being asked to cover more sites without an equivalent increase in cases and billings. Median total units and total time units billed per anesthetizing location for anesthesia groups fell by 13% and 21% respectively from 2004 to 2006, note Amr Abouleish, MD, MBA, and Todd B. Evenson, MBA in the December 2007 ASA Newsletter. The median number of anesthetizing sites rose by 15%, and median encounters fell by 10%. Economically, they say, groups are forced to negotiate compensation from facilities.

**How common are stipends?**

The number and amount of hospital stipends rose dramatically from 2000 to 2005, according to a survey by the American Society of Anesthesiologists. In all, 57% of hospitals paid a stipend in 2005, up from 50% in 2000.

In a new article, Franklin Dexter, MD, PhD, showed that 2 types of agreements are rational, meaning that other types increase profit for the hospital or anesthesia group at the expense of the other. For a bibliography and FAQs, visit www.franklindexter.net/bibliography_GroupManagement.htm.

**Tense standoffs**

Hospital administrators don’t always understand the market conditions, and that can lead to tense standoffs with anesthesia groups. Administrators, particularly those over 50 who remember when anesthesia providers were plenti-
Anesthesia contracts

• 57% of facilities in survey provide a stipend to anesthesia groups, up from about 50% in 2000.

Nonexclusive arrangement 9%
Competitive setting 14%
Employed 3%
Exclusive contract 74%


How difficult are anesthesia providers to recruit?

Of the 20 toughest-to-recruit medical specialties:
• Anesthesiology ranks 17th
• Certified nurse anesthetists rank 14th.


Conditions for anesthesia coverage are creating an imbalance that makes it difficult for hospitals to provide surgeons with enough OR time, recruit more surgeons, maintain market share, and increase revenue.

The shortage also creates more pressure for OR throughput so that cases will be tightly scheduled with little downtime. He says this can only happen if there is collaboration among all the professions—surgeons, anesthesia providers, and nurses. Ippolito advocates a culture in which all parties treat one another as customers (sidebar, p 9). Too often, he adds, expectations for the hospital and anesthesia providers aren’t clearly defined, even when there is an exclusive contract, and communication can break down and become adversarial.

Defining expectations

“I frequently hear from hospitals that the OR would run better if anesthesia stepped up to the plate,” Ippolito says. But if expectations aren’t defined, and anesthesiologists aren’t collaborating with OR leaders on issues like schedule planning, “then anesthesia can only be reactive.”

He advises that anesthesia providers and perioperative leaders develop expectations that at least include defining:
• what number of ORs will be staffed by hour of day and day of week
• how call coverage will be managed (in-house versus out-of-house, anesthesiologist or CRNA, etc)
• what services are required by obstetrics, and what is considered timely delivery of those services
• what is needed to develop and deliver effective and efficient preadmission screening services
• what the expectations are for anesthe-
Customer service in the OR

Patients are the OR’s primary customer. OR personnel also often think of surgeons as their customers because the surgeons refer the patients. Anesthesia providers are also customers, and their customers include patients, surgeons, and the nursing staff. Each group has different expectations and needs for the others. Compromise is required, and expectations need to be reasonable and clear, says Jerry Ippolito, president of OR Efficiencies, LLC, a consulting firm. Here are some of his suggestions for customer expectations.

Anesthesia providers as customers
As customers, anesthesia providers should be able to rely on:
• clear and agreed-upon expectations about the sites they staff
• competitive compensation and lifestyle for services given to meet expectations (potentially requiring a hospital stipend)
• an OR committee (or governance body) that has developed effective scheduling policies and procedures—and consistently enforces them
• surgeons’ offices that effectively communicate with OR scheduling
• surgeons who communicate effectively with anesthesia providers about difficult cases or complex patients
• nurses who effectively implement preadmission screening protocols that have been developed jointly with anesthesia providers
• charts complete on the day of surgery
• patients appropriately prepared for surgery in either the day-surgery unit or the inpatient unit
• ability to transport the patient to the OR in a timely manner for on-time case starts
• surgeons reporting on time to the OR for case starts
• experienced OR staff and appropriate case setups to reduce case times
• experienced charge nurses who work with anesthesia providers to run the day’s schedule
• experienced postanesthesia care staff who can function with relative independence.

Customer service by anesthesia providers
In providing customer service, anesthesia providers should be expected to:
• be current in state-of-the-art anesthesia care with an emphasis on ambulatory anesthesia
• maintain reasonable flexibility with regard to agreed-upon expectations; maintain an attitude of meeting or exceeding expectations
• assure consistent and reliable staffing for all anesthesia sites agreed to (it should be rare—one or twice a year—that an OR is shut down due to a lack of staff)
• collaborate with nursing to develop state-of-the-art preadmission guidelines; agree as a group to established guidelines
• screen all ASA III and above patients and assess all inpatients prior to the day of surgery
• develop processes to administer anesthesia consults for the preadmission unit
• call patients on the evening prior to surgery
• be as familiar as possible with patients’ conditions prior to the day of surgery
• review patient charts at least the day prior to surgery
• proactively work with nursing to plan and manage the schedule
• begin reviewing the schedule with nursing several days prior to surgery
• facilitate getting patients into the OR for on-time case starts
• help to expedite turnaround time between cases
• maintain an effective medical direction model where CRNA or anesthesia assistant direction is based on case complexity, patient acuity, and anesthetist skill level
• be available promptly to support anesthetists during cases
• be available promptly to anesthetists’ cases to expedite induction and emergence
• develop a staffing model and service agreement in which anesthesia staffing requirements for sites peripheral to the OR do not disrupt OR staffing
• develop a QI and education model for all anesthesiologists, CRNAs, and hospital staff (RNs and respiratory therapists) where appropriate
• assign leaders to foster skills and business development in key services such as cardiovascular; obstetrics; ambulatory care; pain management; and potentially neuro, trauma, and pediatric care
• play a key role in developing and sustaining the anesthesia practice’s own business by focusing on what is required to develop a marketable and financially viable surgical program with increasing case volume
• focus on delivering the highest level of patient care with respect for the patient’s time.

The care team model must be managed carefully, cautions Ippolito, because there are strict billing and direction requirements.

“Frequently, the hospital administration does not fully understand how complex anesthesia billing and compliance are and how easy it is to be in violation...”

Continued on page 10
of fraud and abuse statutes,” he says.

Some anesthesia groups have suffered big financial penalties for inappropriate billing under the care team model. In many of these cases, anesthesia groups did not intend to do things inappropriately or didn’t have appropriate checks in place, he notes. As a result, most anesthesia groups are conservative in interpreting the regulations.

In general, rules require that an anesthesiologist perform the preoperative evaluation and prescribe the anesthesia plan. The anesthesiologist must ensure procedures are performed by a qualified provider. The anesthesiologist must be “readily available” during the case, a term that is vaguely defined, and must personally participate in the most demanding parts of the procedure, including induction and emergence.

Using the care team model is a trade-off, Ippolito points out. More ORs or anesthesia sites may be covered at less expense, which can help reduce the need for a stipend or the amount. But the use of the care team model might slow down the ORs because an anesthesiologist must be present during each case for induction and emergence. That can affect surgeon satisfaction, with the potential for lost cases and lost revenue that can more than outweigh cost savings in anesthesia staffing, he points out.

Logistics of the care team model are more complicated in organizations that have more than one OR suite, such as a main OR and an ambulatory surgery unit.

“In one big OR suite, if you had 2 cases running late, one anesthesiologist could cover those 2 CRNAs. But if you have one case running late in each of 2 OR suites, you need 2 anesthesiologists,” notes Amr Abouleish, MD, MBA, professor of anesthesiology at the University of Texas Medical Branch, Galveston.

Anesthesia leadership

To serve everyone’s interests, Ippolito and Dr Mazzei both advocate a collaborative approach to OR governance, with joint leadership by surgeons, anesthesia providers, and nurses.

“That’s the most effective model in my experience and one that allows most problems to be solved amicably and quickly,” Dr Mazzei says.

They also recommend that anesthesia providers have a formal role in managing the daily schedule.

Dr Mazzei advises having a medical director of the OR who is an anesthesiologist. The medical director works with the OR nurse manager daily to run the schedule and address physician issues.

For most community hospitals and medical centers, Ippolito recommends developing a charge anesthesiologist function. One anesthesiologist is designated as the lead and is responsible for developing the role, working with other OR leaders to set up protocols, and training the other charge anesthesiologists.

“In an ideal world, the position should be limited to one person for consistency,” he says. “But seldom is one person willing to perform this task every day.” As a compromise, he recommends having 3 to 5 charge anesthesiologists, each with good organizational, interpersonal, and communication skills.

“Consistency is paramount,” he says. “This requires development of a function description as well as agreement on how policies and procedures are enforced.” The administration, OR managers, surgeons, and anesthesia providers must reach a compromise on the role’s definition, direction, expectations, and responsibilities.

The charge anesthesiologist acts as the anesthesia “go-to person” for the day. He or she works proactively with nursing to manage the schedule, organize add-ons and changes to the schedule, help resolve disputes, and make anesthesia assignments for the next day. For the position to be effective, the charge anesthesiologist should have minimal direct care responsibilities. But unless the position is supported with a stipend, in most hospitals, the charge anesthesiologist needs to have billable cases, Ippolito notes. He acknowledges that the logistics are more challenging when the charge anesthesiologist provides direct care rather than directing anesthesiologists.

“In these situations, it is even more important to have effective communication and schedule planning prior to the day of surgery to minimize the need for the anesthesiologist’s direct participation in running the schedule.”

Ippolito tells anesthesia groups that if they are reluctant to participate in developing clear expectations and don’t participate in schedule planning and administration, “they are putting someone else in charge of their business—they will constantly be in a reactive mode. They will not be able to provide customer service, and they will be regarded as not stepping up to the plate, regardless of how hard they try to or want to.”

William Mazzei is a consultant with Surgical Directions LLC. www.surgicaldirections.com.

Jerry Ippolito is president of OR Efficiencies LLC. www.OREfficiencies.com.

References


Managing people

**Indicators of possible substance abuse**

Changes can be gradual over months or years and can be grouped into categories:

**Work patterns**
- Making rounds at unusual hours
- Signing out more narcotics than coworkers
- Choice of drug for patient is inappropriate
- Consistently late
- Inaccessible to staff
- Frequent absence from work or pattern of absenteeism on Mondays and Fridays
- Decline in job performance, such as more mistakes and poor charting without explanation (late sign)
- Frequently volunteering to work extra shifts
- Calling in sick frequently
- Frequent job changes.

**Behavioral symptoms**
- Change in behavior after health care worker “disappears” for lunch or other reasons
- Change in behavior (eg, mood swings, outbursts of anger, increased isolationism)
- Defensiveness, anxious behavior
- Changes in long-standing relationships with friends and coworkers
- Others’ perceptions
- Patient complaints of inadequate pain relief or sedation (nurse may be administering saline)
- Coworkers or colleagues complaints or concerns about behavior
- Physical signs and symptoms (often appear later)
- Weight loss or gain
- Poor physical condition or hygiene
- Fatigue
- Consistently dilated pupils
- Changes in speech patterns: slower or faster
- Frequent colds, chronically inflamed nostrils with runny nose.

**The stigma remains a barrier.**

Continued from page 1

Mississippi in Jackson, Mississippi. Rachel worked at the Mississippi Board of Nursing (BON) for 17 years.

Addiction doesn’t discriminate by race, age, education, or profession. Health care professionals with addiction are often like King: highly motivated achievers.

Many wrongly believe health care workers have a higher incidence of substance abuse. It’s estimated that 10% to 15% of health care professionals misuse drugs or alcohol during their career, similar to the percentage of the general population.

However, those who work in the OR and PACU have easier access to substances that can be abused than clinicians in other areas of the hospital. The specialty of anesthesia has a higher rate of drug abuse, again, probably due to easier access to drugs.

**Barriers to treatment**

The stigma remains a barrier to getting help even though addiction is a major problem in the US, says Jackie Westhoven, RN, CEAP, of Peer Assistance Services, Inc, in Denver. The company administers all dental and pharmacy peer assistance programs in the state, as well as employee assistance programs (EAP) for many health care organizations. It also provides services for individual nurses.

Westhoven says the stigma is easing a bit because “almost every family is affected by the substance issue: it may be a husband, brother, grandchild, or grandmother. We’re getting more open about it, but we have to do a better job.” In surveys returned as part of the company’s education programs, 75% of participants report knowing a family member with a substance abuse problem, and about that many report being aware of an employee with the problem.

Given the stigma, it’s not surprising the number one reason people don’t seek help is fear of exposure. Clinicians face the additional fear of losing their license—and their livelihood. It’s been reported that health care professionals are harsher towards colleagues who abuse drugs than towards those in the general population who do so, which doesn’t encourage clinicians to seek help.

**Health care professionals at risk**

Several factors put health care professionals at risk for substance abuse. Many believe their knowledge of drugs protects them from dependency. “We think we know how to use meds so we can manage it,” says King.

Stress in the workplace and nurses’ habit of caring more for others than themselves make nurses vulnerable. It’s not unusual for clinicians with addiction to have a history of family problems, family members with chemical dependence, previous emotional or mental problems, or sexual trauma.

Addiction can take the form of alcohol, controlled substances, or street drugs such as cocaine. Categories of anesthesia drugs abused include narcotic agonist-antagonists, barbiturates, benzodiazepines, dissociative drugs, inhalation agents, opioids, and propofol. Other drugs include nitrous oxide and ketamine. Fentanyl and sufentanil may be chosen because they can be used intranasally.

Often, the pattern of abuse starts years earlier, in high school or nursing school. “Many times, addiction starts with a valid prescription; when, for example, the individual becomes addicted to the medication and begins a pattern of obtaining the substance through other means,” says Nancy Brent, RN, MS, JD, an attorney in Wilmette, Illinois, who represents impaired nurses.

**Why you can’t ignore it**

Nurses have a legal and an ethical duty to report an impaired health professional.

Legal considerations include the nurse practice act and state BONs that administer and enforce the act, state laws about drug diversion and prescription fraud, and Drug Enforcement Agency (DEA) regulations. Most states require...
An ethical duty

Nurses have an ethical duty to their patients, their colleagues, the profession, and the community. These duties are outlined in documents such as the American Nurses Association Code of Ethics for Nurses, which emphasizes patient safety. The code also says the nurse has a responsibility to maintain safety and competence.

Legal and ethical mandates forbid “passing the buck” by simply terminating the nurse. “There has to be a mentality that this illness has to be treated,” says Brent. “If the individual doesn’t receive treatment, they can end up going to another facility and continuing their addictive behavior. Or, even worse, they may end up dying due to their addiction.”

In addition to legal and ethical responsibilities, managers must consider financial liabilities from factors such as increased absenteeism, higher use of health care benefits, increased workplace accidents, and deceased productivity. Ignoring the situation also contributes to poor overall morale when the staff already suspects a problem.

Early identification

The sooner you identify the problem, the faster the abuser can enter treatment and the better the odds of recovery. Rachel says, “It’s an illness. It’s predictable, progressive, and can be fatal. The worst thing a coworker or manager can do is to be blind to what’s going on.”

Yet managers may struggle with confronting an employee. Rachel says, “They ask themselves, ‘What if I’m wrong,’ but that’s not the point. You want to look at how the facts relate to the standard of care.”

Both Rachel and King recommend that managers focus on the work performance, not diagnosing the substance abuse problem. King adds, “Listen to your gut. If you think there is a problem, there likely is.”

Signs and symptoms of addiction often don’t appear in the workplace until late in the disease.

“Nurses need the job to support their substance abuse,” says Rachel. “Other pieces of their lives may be crumbling, but somehow they can keep functioning at work.”

Keep in mind that addiction can be subtle. “For many people, addiction sneaks up on them, and denial of any problem is strong,” says Brent. “Your observational skills have to be keen.” A common early finding is subtle changes in behavior, such as mood swings.

Another way to detect problems is to work closely with your pharmacy to obtain regular reports that compare medication use by person. Rachel adds that managers should spot-check documentation. “Those who falsify records are going to make a mistake as the addiction gets worse.”

Policy in place

A policy provides the manager with a blueprint to follow if substance abuse is suspected. Such policies should begin with a commitment to a drug- and alcohol-free workplace. It’s important to outline the procedure to follow if someone is suspected of substance abuse. This usually means referral to the EAP, or, if there is an immediate problem, walking the employee to employee health services for mandatory testing. An employee who refuses EAP assistance or testing is typically subject to termination.

Many times, those who enter treatment voluntarily are granted a medical leave of absence. Another section should address procedures for returning to work, which normally include a signed contract, restrictions on handling of narcotics, and random urine testing for drugs.

Medical staff bylaws should address what to do in the case of an impaired physician. Dr Bujak suggests having physicians sign that they have reviewed the policy in this area.

All policies need to be consistent with state laws, and thorough documentation is key.

Treatment and beyond

The human resources (HR) department is an excellent resource for managers. A conversation with an employee who is suspected to have an abuse problem is, to put it mildly, difficult. HR can role play the conversation with the manager, and in some cases, be present at the meeting. The good news is that clinicians are often highly motivated to succeed in treatment.

The second part of this series will discuss more about treatment, integration back into the workforce, and prevention. In the meantime, remember Westhoff’s words, “It’s a very treatable illness.”

Cynthia Saver is a freelance writer in Columbia, Maryland.

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Ground rules for vendors in the OR

Vendors bring many contributions to the OR, such as staff education and support to surgeons for new products. Like any external visitor to the OR, however, vendors must be managed appropriately to meet regulatory requirements. It takes collaboration to create a policy that works and to establish ongoing monitoring to ensure adherence.

Despite some challenges, vendors play a useful role in the OR.

“Vendors provide an excellent education service to us and our staff for products,” says Amy Bethel, RN, MPA, CNA, executive director of surgical services for Iowa Health in Des Moines. “Orthopedic vendors, particularly, have a tremendous knowledge for troubleshooting products.”

John Clarke, MD, FACS, clinical director of the Pennsylvania Patient Safety Authority, says it comes down to the perception of the vendor’s purpose. “Today, there is a lot of complex technical equipment, so if vendors can supply technical support that contributes to the success of the procedure, they will be perceived as helpful. If they are perceived as just there to sell products, they will not.” One example of a useful role is vendors who bring in equipment that they use to help surgeons set pacemakers and implantable defibrillators. It’s important to remember, however, that vendors should never touch patients directly.

Here’s how you can get the most from your vendor relationships while minimizing the risk of potential harm.

**Ground rules**

Leaders of the OR and materials management departments must craft a policy that addresses several areas, including vendor health status and education requirements. Surgeon involvement is key, and input from the quality improvement department is helpful in addressing patient safety and privacy issues. In essence, vendors are being “credentialed” to enter the OR. Fortunately, many resources, including sample policies online, are available to keep you from reinventing the wheel.

Vendors should complete an educational course before they step into the OR. Some product companies and many hospitals offer their own courses. Another option is to refer the vendor to the AORN OR Protocol, an online, self-study education program developed by AORN and HealthStream (www.healthstream.com/Products/STS/RepDirect/orProtocol.htm#). Neither AORN nor the American College of Surgeons (ACS), which both have guidance statements on vendor relationships, makes any recommendation for ongoing education for vendors.

Most hospitals provide packets of information and ask vendors to sign a form indicating that they agree to abide by the rules.

Once the rules are set, Bethel says it’s important to empower staff to hold vendors accountable. In her facility, vendors spend the most time with team leaders. “We tell them [team leaders] not to accept cold calls, to have an agenda for a meeting, and to escort them as needed.”

One challenge is the close working relationship that naturally arises between vendors and those who meet with them on a regular basis.

“Nurses get to know them well, so they might say, ‘I know him so he doesn’t wear a name badge,’” says Bethel. “It’s important for staff to understand that everyone must be held to the same standards.”

**Consent issues**

Based on recommendations from professional organizations, patients should be told that a vendor will be present during surgery. The AORN guidance statement says, “Patients have the right to be informed about the presence of a health care industry representative/invasive procedure setting during a surgical procedure according to local, state, and federal regulations.” The ACS statement on vendors says the patient should give “written, informed consent.”

Dr Clarke says this is no different from any other outside observer. “Patients need to know what the vendor will provide in terms of technical support so they can understand the benefit,” he says. “If you can’t explain the benefit to the patient, then maybe they shouldn’t be there.”

To address consent issues, Bethel’s hospital includes a note on the patient’s consent form saying vendors may be allowed per the physician’s request. At one hospital, the vendor’s name is included on the consent form, and the OR at another facility even introduces the vendor to the patient before surgery.

**Practical ideas**

One of the biggest challenges with vendor management is proper identification. Some hospitals use name tags with photos to facilitate identification. Mary Johnston, RN, MSN, division director, surgical services, Highline Medical Center in Burien, Washington, says when vendors sign in, they receive a special badge. They leave a driver’s license or credit card until the badge is returned.

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**Vendor packet**

A typical vendor packet includes:
- need for current TB test results
- identification requirements
- validation of education on HIPAA (patient privacy)
- release of liability
- confidentiality agreement
- company evaluation of the vendor
- infection control practices
- occupational safety requirements, such as fire, radiation, and electrical safety
- dress code
- restricted areas in the OR
- appointment requirement
- loss of privileges policy

Adapted from information provided by Susan Nielsen, RN, MSA, CNOR, director of central processing at Beaumont Royal Oak in Royal Oak, Michigan; Mary Johnston, RN, MSN, division director, surgical services, Highline Medical Center in Burien, Washington; and AORN and American College of Surgeons position statements.
New products in the OR

A common issue is the vendor who arrives with a new product right before surgery. The OR manager has no assurance that the device is approved for use or that other key questions have been answered, such as whether reimbursement is available.

“We’ve had to really crack down on this because there have been times we haven’t been paid,” says Amy Bethel, RN, MPA, CNA, executive director of surgical services for Iowa Health in Des Moines.

In her organization, vendors must provide at least a week’s notice that a device or product is arriving so she can answer questions about reimbursement and sterilization.

“If we don’t know it’s coming, they [vendors] will not be paid,” she says. Surgeons have been educated on the process and the need for vendors to follow appropriate protocols.

Mary Johnston, RN, MSN, division director, surgical services, Highline Medical Center in Burien, Washington, requires vendors to complete a product worksheet that includes:

- product information (description, manufacturer, purpose/function, utilization assessment, and whether it is a replacement product)
- documentation of Food and Drug Administration clearance
- product cost
- coding (CPT, DRG, IDC-9 codes)
- the product’s intended patient population (0 to 18 years of age, 18 to 65 years, or older than 65 years).

Equipment must be checked by the biomedical engineering department and wiped with a disinfectant before being brought into the OR.

When rules are broken

What happens when vendors don’t follow the rules? Bethel says common violations include lack of appropriate credentials, roaming around the OR, and talking with surgeons with whom vendors don’t have appointments.

The correction process is one that managers know well. “First, we give them a verbal warning,” she says. If the problem continues, a written warning is given, and the vendor’s manager is notified. Next, the manager counsels the vendor in the presence of the vendor’s supervisor. “If they still don’t comply, they’re banned from the OR,” she says.

The presence of vendors in the OR is not likely to change any time soon.

“As technology advances, we’re going to see more of vendors,” says Bethel. “We’ll need them from the education side.” With a little work, the relationship between vendors and OR staff can be a positive one. ▶

—Cynthia Saver, RN, MS

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Susan Nielsen, RN, MSA, CNOR, director of central processing at Beaumont Royal Oak Hospital in Royal Oak, Michigan, has an inexpensive solution for identification—a color-coded sticker with Beaumont’s logo on it.

“We change the color daily so we know they’re current,” she says. She also requires vendors to purchase and wear yellow scrub tops with black pants. “It helps us identify them as vendors from a distance.”

Bethel says it’s most important to monitor traffic into the OR. At Iowa Health, the OR is designed so that vendors must don their jumpsuits in a room near the OR control desk, so it would be difficult for them to enter the OR without being seen.

Automated credentialing

Some hospitals have turned to external companies for help with managing vendors. These companies, which include RepTrax, Vendormate, Vendor Check, Status Blue, PreCheck, and Vendor Credentialing Service (VCS), use software to provide hospitals with real-time credentialing information about vendors in the companies’ databases. Usually the vendor companies pay a set fee per employee to be listed in the database, which hospitals access through a web-based system at little or no cost.

Some companies, such as VCS, offer badge scanners. The vendor scans the badge so the hospital receives a report verifying the vendor is credentialed. VCS provides 3 badge scanners at no cost. Hospitals can also purchase a label printer from VCS for about $200 to print out color paper badges for each vendor to wear in the OR.

VCS CEO Troy Kyle says hospitals list what they want to know about each vendor, and then VCS creates a profile for hospitals to access. He adds that OR managers should ask about how the database is updated.

“We don’t allow the company to upload its own information,” he says. “It goes through our customer service department so we can verify the primary source.”

VCS also provides its vendor clients with access to education programs their employees can take to meet credentialing requirements and enables managers of the vendors to access detailed tracking reports of their employees’ activities.

An option that will become more common in the future is a tracking system for all staff and external visitors to the OR, such as vendors. Personnel will wear or scan a badge each time they enter or leave an individual OR. If you do not have an automated tracking system, be sure to keep documentation such as vendor sign-in and sign-out sheets and entries in the intraoperative record.

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What comes after value analysis?

You’ve had a value analysis program for a number of years. You think it might have run its course. What’s next?

Value analysis, which has been in the forefront of supply chain management for years, is a systematic process for making purchasing decisions and identifying savings opportunities that consider not only price but also clinical efficacy, safety, and the impact on the organization. Value analysis teams can be housewide or focused on a specific department, such as surgical services.

Most ORs are using value analysis. The majority of respondents (53%) to the 2007 OR Manager Salary/Career Survey reported they have a value analysis program for surgery. (See October 2007 OR Manager.)

But after value analysis has been in effect awhile, it may be time for a fresh perspective.

At the University of Washington (UW) Medical Center in Seattle, after 6 years and $107 million in housewide cost savings, revenue enhancement, and cost avoidance, value analysis is morphing into other activities.

“One of the great successes of value analysis is that cost savings and waste reduction became embedded in what we do,” says Bill Anton, RRT, finance manager for surgical services. “What’s beyond value analysis?”

“We continue to embrace the philosophy,” Anton stresses, noting that value analysis has become so engrained, it happens almost automatically. “We aren’t advocating moving away from a successful value analysis program. Rather, UW has adopted a new structure and incorporated savings targets into departmental budgets. For the fiscal year ending June 30, surgical services has a savings target of $2 million and was within $180,000 of the goal in February.

Three major areas are targeted:

• supply chain
• purchased services
• patient safety.

Supply chain committee

A multidisciplinary committee is leading an effort to strip $10 million from hospitalwide supply spending. The primary supply cost metric is hospitalwide supply expense as a percentage of total net revenue, the same metric used by the University HealthSystem Consortium (UHC), an alliance of academic medical centers.

The medical center’s supply cost metric is supply expense as a percentage of total net revenue. Supplies include consumables, pharmaceuticals, blood, and implants. The operating plan goal is 19.2%. Through February 2008, UW was at 19%, a little better than the goal for the year.

In addition, the OR monitors the total expense per case, which includes labor, supplies, and purchased services.

A major OR initiative is to analyze surgical supply utilization by surgeon when multiple surgeons are performing the same procedure.

“We are going service by service,” says Anton, focusing currently on general surgery and orthopedics. “We are looking at what each surgeon is using and whether there is any difference in outcome from using less costly products. At the same time, we are trying to take waste out of our preference lists.”

UW has begun using Surgical Compass, a new product from the Advisory Board, which can hone in on expense and profit margin by surgeon and procedure.

Purchased services committee

Purchased services is a big budget bucket that takes in most nonlabor expenses except supplies and salaries. Examples are consulting fees, shipping, and contracts for outside services, such as lab tests.

Freight and handling fees

The OR is turning a spotlight on freight and handling fees.

“You need to figure out exactly what you’re paying for and if you should be paying for it,” says Anton. “We are catching costs we don’t think we should be paying and negotiating with the companies.” His staff discovered one vendor was charging a $100 handling fee just for switching implants and instruments in orthopedic sets. He instructed the implant room to no longer pay those charges.

Rental agreements

One of the OR’s largest rental costs is for the accessory kits patients take home after implantation of a ventricular assist device (VAD). VADs, battery-operated devices that help one or both ventricles of the heart to pump blood, are used temporarily as a bridge to transplant or on a permanent basis.

After a cost-benefit analysis of purchase versus rental, UW elected to purchase some kits after determining they could be used for the next 2 to 3 years. “In the next month, we will almost eliminate rental, which was running $80,000 to $90,000 a year,” says Anton. In the next month, we will almost eliminate rental, which was running $80,000 to $90,000 a year, says Anton. Savings are expected to be a minimum of about $55,000 in the first year.

Patient safety committee

The third arm of the cost management effort is to eliminate costs associated with patient complications and other hospital-acquired conditions. This is a national priority following Medicare’s announcement that as of Oct 1, 2008, it will no longer pay for certain hospital-acquired complications, such as catheter-associated infections, pressure ulcers, and certain injuries. States and private insurers are following suit.

UW’s targets this fiscal year are medication safety, infection control, and decreasing injuries, such as patient falls.

In the OR, the effort is part of an ongoing initiative to improve processes targeted by the Surgical Care Improvement Project (SCIP) and other quality improvement programs. Examples are improving glucose control for surgical patients, on-time administration of antibiotics, and appropriate administration of beta blockers.

“You can say this isn’t about the money; it’s about quality and safety. That’s true, and we would not launch patient safety measures just to reduce cost. But I think if these measures were

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Keeping ORs’ freight costs in bounds

With no margin for error in the operating room supply chain, the cost of obtaining the right products in the right quantities can easily get out of hand. While product prices can be somewhat regulated by contract, in an emergency, there is little point in quibbling over freight charges for delivery of critical care supplies.

If you need it, you need it. Yet there are ways to keep emergency orders—or “hot shots,” as one hospital calls them—to a minimum.

As in many other management practices, planning is the key. According to Irving, Texas-based group purchasing organization Novation, supply costs represent about 30% of health care expenses nationwide, and of that, 38% is for distribution and delivery. That means 11% of the nation’s health care costs are for supply chain logistics.

For an individual hospital, one way to control those costs is to avoid running out of a product, an event that often triggers an emergency order. Based on Novation estimates, the average freight charge by a third-party distributor such as FedEx is $40 per purchase order. In an emergency, the charge for same-day delivery can jump to $250, or more than the price of many products.

In addition, ordering direct from the manufacturer, a common occurrence for complex clinical items, costs more even not accounting for freight. The average cost of sending a PO through a distributor is about $12, including clerical labor and administrative functions. To place the same PO directly with the manufacturer costs an average of $60, again not including freight.

How to avoid running out

According to Ken Boggs, vice president of supply chain at Moses Cone Health System, a 5-hospital integrated delivery network in Greensboro, North Carolina, the trick is to monitor utilization to identify potential shortages.

“We try and limit how much we order overnight,” Boggs says. “The OR manager looks at a list monthly to make sure nothing has snuck through on us.” Boggs recognizes that nurses are invested in having a reliable supply chain and want to stay involved.

“In general, OR nurses want to keep some of the responsibility to order supplies, because they know the products. In the Moses Cone ORs, the staff requests supplies from purchasing, so technically they are not ordering them.”

He says his department has good relations with OR departments. “My advice is to plan ahead,” he tells them, “so you don’t get so far down on stock.”

Diane Strack, vice president and nurse executive at West Allis (Wisconsin) Memorial Hospital, worked with her system’s centralized materials management department to overhaul par carts, eliminating the need for last-minute orders. For OR nurses, she explains, “the biggest concern is having the supplies available when they need them. The biggest fear is, in a case, being asked for specialized equipment, and it’s not available.”

Before the par cart overhaul last year, she recalls, overnight FedEx orders happened frequently “because someone thought someone else had ordered it.” Now, she adds, “there’s no overnight at all.”

Every 6 months the staff review par levels, noticing any changes in supplies physicians have been ordering, or if they have had to order additional items. They then reset par levels.

Travis Johnson, senior director of medical-surgical distribution at Novation, has seen similar situations. At one hospital, he recalls, “they had 3 years’ supply of one type of suture on hand. Maybe they just naturally kept ordering a supply and didn’t look at utilization, at how many turns.”

His advice to OR managers is to open up a good communication channel with the materials management department. “I’ve seen where that relationship can be strained at times,” he notes. “The materials staff is really there to help you. That’s where the procurement expertise lies. You need to take a look at the appropriate reports and stocking levels.”

A strategic approach to logistics

The health care supply chain is complex. The typical hospital buys from about 440 different manufacturers, each with its own payment system and account numbers. Contracts, both group and local, have helped push prices down, so further savings must come from finding economies in logistics.

But distributor markups are also reaching the point of inflexibility. Fuel costs have risen more than 100% in the past several years, while contracts naming preferred distributors have bargained fees down to an average 5%.

The 3 major US med-surg distributors are Cardinal Health in Dublin, Ohio; Owens & Minor in Richmond, Virginia; and McKesson Corporation in San Francisco. Together, they represent about 75% of the $80 billion med-surg distribution market. A fourth company, Medline Industries in Mundelein, Illinois, is rapidly increasing its share of that market.

Unlike third-party shippers, health care distributors take ownership of the products they sell, and resell them to hospitals at cost plus their fee. However, as the prices of products such as gloves, gowns, and other commodity-type products are bargained down, the dollar value of the fee decreases also.

Distributors often try to avoid this revenue squeeze by promoting their own private label products, on which their profit margins are higher. Manufacturers respond by offering better deals to hospitals, sometimes even offering to sell to them directly.

Hospitals may choose to avoid the distributor fee by buying directly, but then they must bear the added costs of maintaining the inventory.

According to Johnson at Novation, hospitals need to look beyond distribution costs and improve the overall logistics pattern.

“One of the things we’re seeing is that hospitals spend so much through distributors they tend to look at just lowering the distribution price. We’re seeing a need to take a more strategic look at the supply chain all the way to the patient.”

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Freight costs

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That, he says, is where OR managers and other nursing staff can partner with materials management to keep the focus on getting the right supplies to patients. Johnson stresses “managing the most appropriate staff” for supply functions, which means giving more responsibility to materials managers and letting nurses get back to the bedside.

He has seen one Novation hospital that expects to save $40,000 annually in each of its critical care units “by getting the right people to get products to the patient.” While OR managers rarely make hospitalwide logistic decisions, they should encourage, and participate in, long-range planning to improve the efficiency of the supply chain. Novation offers members a 4-part checklist for materials management departments considering distribution strategy:

- Analyze the existing warehouse and central storage space, noting current problems or inefficiencies and projecting future needs.
- Survey receiving dock space and consider how needs may change in the future.
- Assess the availability of staff and resources in each facility and determine how needs would change in a different logistics system.
- Map the physical arrangement of each hospital in the organization.

Bargain for savings

Ideally, distributors should deliver most commodity supplies. Physician preference items may follow a different route, because vendors often agree to deliver them directly to physicians. Under many contracts, vendors agree to absorb the costs of delivery of preference items. Clinicians can help streamline the process by working with materials management.

Value

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shored up, the cost savings would follow.”

Practice lean thinking

The director of UW’s lean thinking program sits on the supply chain committee as an advocate for eliminating waste. Lean thinking, pioneered by Toyota and described in the book Lean Thinking by James P. Womack and Daniel T. Jones (www.lean.org), advocates tightening processes and making small, sustained changes that result in significant improvements.

One lean project was to go through all patient units systematically, updating par levels and supply delivery dates.

“This not only reduces cost but is a nurse satisfier because the nurses have the supplies they need,” Anton points out. “It also eliminates hoarding because nurses know they will have supplies available.” (For more on lean thinking in the OR, see the March 2007 OR Manager.)

Don’t neglect the fundamentals

Being diligent about cost management means a continual focus on fundamentals. “A lot of this is basic. You just have to have a program to address it and keep at it,” Anton says.

- Contract review. Systematic contract review can make a big difference in what your hospital is paying.
  “Go through all of your contracts by dollar amount and volume, making sure you are benchmarking pricing, getting the best pricing—and then locking in the price for as long as possible, at least 3 years.”
- Benchmark pricing data. Anton says he’s “somewhat heartened” that Congress is considering a bill to require price transparency of implants. The bill (S 2221), introduced in October 2007 by Senators Charles Grassley and Arlen Specter, would require companies to submit to the government their prices for certain implantable devices. Prospects for passage are unknown, but it’s a sign lawmakers realize the impact of rising devices costs. In the meantime, benchmarking services are the only means hospitals have to find out if they are receiving the best pricing, Anton says.
- Vendor access controls. Like many organizations, UW is fine-tuning policies and procedures for sales representatives’ access to the surgical department.
  “We want to automate this more,” says Anton, referring to systems with scannable badges reps must use to enter the department. “We want them identified, and we want to know why and when they’re here.”
- Business planning. Faced with constant requests to add new products and services, like all ORs, Anton and his team are redoubling efforts to develop business plans and cost-benefit analysis before a new technology or procedure is introduced.
  “You need to find out specifically which devices, instruments, and equipment the surgeons will be using,” he says. Then work with the OR business manager or finance department to find out what reimbursement the hospital will receive and whether there will be a margin for the service.

Recently, Anton worked with the orthopedic surgeons to perform an analysis for hip resurfacing. They determined the procedure would have a positive margin. They also learned it would help to capture patients who might need a total hip replacement if not eligible for resurfacing.

With health care costs slated to rise to about 20% of the nation’s economy in the next 17 years, OR leaders will be challenged to keep up the relentless pressure on costs.

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The importance of cleaning in earnest

A regular column on sterilization and infection control issues.

When you sterilize an instrument set, you know what the standards are. Sterilizers must provide a sterility assurance level (SAL) of 10 to the minus 6 (10^-6). Biological indicators are used to test the efficacy of the sterilizer. Chemical indicators or chemical integrators are placed in instrument sets to allow an OR nurse to determine whether an instrument set has been exposed to the sterilization process.

But there is no standard for measuring cleanliness. There is no cleaning monitor you can place in an instrument set. You can only determine whether something is cleaned by visual inspection, which may vary depending on your eyesight, available light, and whether a lighted magnifying glass was used. Products are available to test the efficacy of automated washing systems. But many instruments cannot be cleaned in automated systems, and some facilities, particularly small ambulatory surgery centers, do not have automated washing systems.

Yet effective cleaning is a prerequisite to effective sterilization or disinfection. Ineffective cleaning can compromise sterilization or disinfection and has been associated with adverse patient outcomes. Because there is no objective measurement to define when a device is clean, the best guarantee is consistent and strict adherence to:

- the manufacturer’s instructions for cleaning
- the AORN Recommended Practices for Cleaning and Caring for Surgical Instruments and Powered Equipment
- the cleaning guidelines in AAMI ST79: Comprehensive Guide to Steam Sterilization and Sterility Assurance in Health Care Facilities from the Association for the Advancement of Medical Instrumentation.

Cleaning is defined by AAMI as the removal of contamination from an item to the extent necessary for further processing or for the intended use. AAMI notes that:

“...cleaning consists of the removal, usually with detergent and water, of adherent soil (eg, blood, protein, and other debris) from the surfaces, crevices, serrations, joints and lumens of instruments, devices and equipment by a manual or mechanical process that prepares the items for safe handling and or further decontamination.”

Cleaning removes microbial contamination and organic and inorganic material, which if not removed, can interfere with sterilization or disinfection.

Here is advice to help ensure your organization is taking the steps needed for effective cleaning.

In the operating room

Cleaning should begin as soon as possible after a device is contaminated. Cleaning begins in the operating room, and steps to promote removal of contamination may begin during a procedure.

Some key points:

- Instruments that have been used should be kept moist to prevent adherence of debris. Blood, tissue, or mucus that is allowed to dry on surgical instruments is difficult to remove and will lengthen the time necessary to clean the instrument effectively. Cool water easily removes most blood. If blood dries and is not completely removed during the washing process, it can be baked onto a device when exposed to the high heat of sterilization, in a process called denaturing.
- Cleaning in the operating room starts by placing contaminated instruments in a basin of cool water or wiping them with a moist sponge during surgery. Unfortunately, many instruments, particularly those with long lumens used in endoscopic surgery, do not fit horizontally in a standard basin. While the handle may be fully immersed, the inside of the lumen may not make contact with water.
- Instruments should be kept free of gross soil. A moistened lap pad may be used for this purpose. Saline should not be used for removing debris because it can cause deterioration of instrument surfaces.
- Lumens should be irrigated with water using an appropriate-sized syringe. The intent is only to prevent adherence of debris, not to complete the cleaning process. Care must be taken not to create aerosols during this process. Irrigation should be gentle and the distal end of the lumen positioned below the surface of the water.
- Before transport to a decontamination area, arrange instruments with heavy instruments on the bottom of the tray and lighter or more delicate instruments placed on top or in a separate container. Open box locks and instrument jaws.
- Transport instruments immediately in a containment device labeled with a biohazard label to a designated decontamination area.

In the decontamination area

Instruments should be cleaned according to an established protocol by personnel who have demonstrated competency in instrument cleaning.

In an ideal world, soiled instruments would be immediately transported to the decontamination area, where they would be received by a certified instrument processing technician wearing personal protective equipment (PPE), who would immediately begin the decontamination process. The technician would determine which instruments must be manually cleaned and appropriately prepare and place all others in an automated system.

In reality, instruments may sit for a long time before they can be cleaned.
Selecting a detergent

Selecting a detergent is not a simple task and should always be done in conjunction with the detergent manufacturer, considering:

- the device materials
- anticipated bioburden
- water quality
- whether a manual or automated process will be used.

Because hard water may cause staining of instruments, a water-softening system may be necessary. The mineral content of the water must also be factored in.

Automated washers

For automated washers, detergents with a high pH are most effective. They can, however, be harsh on devices made from materials other than stainless steel. A milder detergent may be used on softer metals such as aluminum and on glass.

Manual cleaning

Manual cleaning formulations generally have a neutral pH of between 7 and 9. A detergent with a neutral pH will minimize damage to soft metals but will not dissolve water-insoluble proteins, making brushing and mechanical friction especially important.

Enzymatic detergents

Nonenzymatic detergents take longer to dissolve proteins. Because enzymes are effective for breaking down organic substances, most facilities use a detergent containing one or more enzymes. For facilities that specialize in orthopedics, a detergent with a lipase enzyme, which is effective on fats and organic materials, may be most appropriate. For facilities that specialize in vascular procedures, a detergent with a protease enzyme may be most appropriate. Protease enzymes are effective on blood, mucus, and proteins.

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Sterilization & Infection Control

Inspect instruments for cleanliness.

Because of work loads, instrument turnaround priorities, and possible unavailability of automated washing systems. For this reason, instruments should be kept moist, either by adding a moistened towel to the transport container or applying a foam, spray, or gel intended for this purpose.

If the delay is prolonged, such as over a weekend, use a precleaning disinfectant to prevent biofilm formation. A biofilm is a mass of bacteria tightly adhered to a surface and not easily removed. Although biofilms may form on many surfaces, they are more common in lumened devices. If a biofilm breaks loose within a patient, the infection consequences can be severe and can lead to death.

Automated cleaning systems

Automated cleaning is preferable to manual cleaning. Automated cleaning systems are consistently effective and reduce the risk of exposing personnel to microbial contamination. Automated systems include washer-disinfectors, washer-decontaminators, washer-sterilizers, sonic irrigators for lumened devices, and ultrasonic cleaners. Phases in automated systems may include rinsing, enzymatic soak, detergent wash, ultrasonic cleaning, chemical germicide rinse, lubrication, and drying.

When automated systems are used, the manufacturer’s instructions are paramount. The instructions help in determining the device’s compatibility with the intended cleaning process, the correct type and concentration of detergent, necessary water quality, temperature, time, and care and maintenance of the equipment.

Whenever possible, monitor the process with products designed for automated processes. There are products for monitoring the cleaning efficiency of washer-disinfectors and ultrasonic cleaners and for monitoring cleaning efficacy within lumens.

Manual cleaning

Though automated cleaning is preferred, manual cleaning is needed in some situations, such as when the instrument inventory is inadequate, and there is need for quick turnaround. Although manual cleaning poses the greatest risk for inadequate cleaning, if performed correctly, it can be as effective as automated cleaning. The keys are:

- knowing the requirements of the process
- demonstrated competence
- consistency in practice.

Here are some reminders on effective manual cleaning:

- Instruments should be cleaned in a dedicated area away from patient care.
- Instruments should never be cleaned in the scrub sink or with scrub brushes intended for surgical hand antisepsis.
- Personnel performing cleaning should wear PPE, including general-purpose utility gloves (not examination gloves); a liquid-resistant covering with sleeves; and when there is risk of splash or aerosols, eye protection, such as goggles or a full face shield. PPE should be worn regardless of the number of instruments that will be cleaned. Having PPE available at the point of use encourages compliance.
- Instruments should be disassembled and in the open position prior to cleaning.

Follow instructions precisely

Cleaning instruments with detergent is not like washing dishes at home. The instructions for use and concentration must be followed precisely. Detergent that is too concentrated or diluted can compromise the sterilization or disinfection process.

Here are a few tips:

- To encourage compliance with dilution instructions, mark the sink with a piece of tape or similar material to indicate the correct water level. Make sure to have available a measuring device or cup equivalent to the amount of detergent specified in the instructions. You may want to consult with the engineering department about tethering the measuring device to the sink so it will always be available.
- The sink should be deep enough to allow complete immersion of the devices, and cleaning should be done below the surface of the water.

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Sterilization & Infection Control

- Water temperature should not exceed 140°F and should be within the range indicated on the instructions for use. A thermometer to test the temperature should be readily available.
- Devices should be cleaned below the surface of the water.
- Items that cannot tolerate immersion should be cleaned in a manner that prevents aerosolization. A lint-free soft cloth moistened with detergent solution should be used to wipe these instruments.
- Soak lumened devices vertically to prevent formation of air bubbles that can occur when these are placed horizontally. Lumens should be brushed with an appropriate-sized brush. Brush diameter should be large enough for the bristles to make contact with the wall of the lumen but not so large as to cause the bristles to collapse. A variety of different-sized brushes should be available and in good condition. Brushes that show signs of wear should be discarded. At a minimum, brushes should be decontaminated at least daily.
- Pay particular attention to difficult-to-clean areas and devices. These include box locks, serrations, hinges, crevices, lumens, and devices such as flexible reamers and biopsy forceps where debris can easily be trapped and go unnoticed.
- Change cleaning solutions frequently to maintain properties of the agent and to prevent the buildup of bioburden.
- Following cleaning, rinse instruments thoroughly. Tap water is acceptable for all but the final rinse. Treated water is recommended for the final rinse. Sterile water or water filtered through a 0.2 micron filter is preferred but may be prohibitively expensive.
- After cleaning, inspect instruments for cleanliness visually, preferably using a lighted magnifying glass. One method for verifying the cleaning process is to expose the device to a 2% hydrogen peroxide solution. If bubbles appear, it is an indication that cleaning was ineffective. This process should be done periodically as part of a continuous quality improvement process.

Special cleaning challenges
Contaminated gastrointestinal flexible endoscopes have been linked to infections. These devices should be cleaned according to the guidelines of the Society of Gastroenterology Nurses and Associates (www.sgna.org).

Instruments that have been in contact with prions should be cleaned according to a specific prion deactivation protocol, as recommended by AORN. In developing a protocol, consult recommendations of the World Health Organization and the Centers for Disease Control and Prevention.

Conclusion
Fortunately, the days are long gone when it was thought that anyone who knew how to wash dishes was competent to wash surgical instruments. All staff responsible for instrument cleaning should have demonstrated competence. One method for developing competencies is to group instruments into processing needs, such as lumened devices, devices with difficult-to-clean areas, lensed instruments, and powered instruments, and determine the necessary competencies for each.

Cleaning is an essential step in instrument reprocessing and must be done in accordance with accepted protocols. It is no longer acceptable to discover “sterile dirt” after an instrument set is opened.

- Cynthia Spry, RN, MA, MSN, CNOR
Independent Clinical Consultant

Severe nursing shortage predicted

The US needs to brace for a severe shortage of nurses, according to research in a new book by Peter Buerhaus, PhD, and colleagues. Buerhaus, a professor of nursing at Vanderbilt University, is an expert on the nursing workforce.

Though the supply of RNs has improved, the shortage is in no way solved, the authors say. Demand for RNs is expected to continue to grow at 2% to 3% per year. But the supply is expected to grow little as large numbers of nurses retire. The deficit of full-time nurses is expected to grow starting in 2015, reaching 285,000 in 2020 and 500,000 (16%) by 2025.

The book also addresses policy options to help employers, educators, and others take action to strengthen the current and future RN workforce.

The book, titled the Future of the Nursing Workforce in the United States: Data, Trends and Implications, is available from Jones and Bartlett Publishers. The coauthors are Douglas Staiger, PhD, of Dartmouth University, and David Auerbach, PhD, of the Congressional Budget Office.

—www.fpbpub.com/catalog/9780763756840/

References


Do you have a question on sterilization and infection control? Send questions to Pat Patterson, editor, at ppatterson@ormanager.com. We’ll consider them for the column.
Surgical mortality, complications high in heart-failure patients

Elderly patients with congestive heart failure who have major surgery have much higher risks of mortality and hospital readmission than other patients admitted for the same procedures—including patients with coronary artery disease, according to a new study from Duke University.

“We observed a 63% greater risk of operative mortality and a 51% greater risk of 30-day readmission among patients with heart failure compared to patients without heart failure or coronary artery disease,” said Adrian F. Hernandez, MD, an author of the study, the largest of its kind, published in the April Anesthesiology. Heart failure was also the most important factor for predicting readmission.

In the study, which involved 159,000 patients, the researchers found heart failure in almost 20% of elderly patients having common surgical procedures, much higher than past estimates of 5% to 12%.

“Anesthesiologists and other physicians should ensure patients with heart failure are as stable as possible with minimal symptoms and are on optimal medications before surgery,” Dr Hernandez said.

Physicians should also pay close attention to patients’ early postoperative care and follow up with them soon after surgery to identify signs and symptoms of worsening heart failure, he added.


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 29 to 31 in Washington, DC.

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.

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

Nominations are judged by the OR Manager advisory board.

The conference brochure was included in the April OR Manager. You can also download the conference brochure and register online at www.ormanager.com.

Please see the ad for CAROLINAS HEALTHCARE SYSTEM in the OR Manager print version.
Safe injections stressed after Nevada outbreak

Health officials are underlining the need to follow safe injection practices after a recent hepatitis outbreak in Nevada. Reuse of syringes and medication vials is believed to be the source of 6 cases of hepatitis C in patients who had procedures at the Endoscopy Center of Southern Nevada in Las Vegas.

Some 40,000 patients treated at the center over 4 years were sent letters telling them they may have been exposed to hepatitis B and C and HIV, state officials announced Feb 27. A seventh case was linked in March to a sister facility, the Desert Shadows Endoscopy Center in Las Vegas.

The Centers for Disease Control and Prevention (CDC) said it is the largest notification of its kind.

Five of the infected patients had procedures and received injected anesthetics on the same day. Genetic testing on 4 cases identified that the cases likely came from a common source. Officials said they did not think the exposures resulted from the endoscopy procedures themselves.

The investigation led to closure of the center and limited operations for other locations owned by the Gastroenterology Center of Nevada.

Search warrants served

A criminal probe was also reportedly underway. Search warrants were served on the practice’s 6 locations on March 10 by the FBI, state attorney general, and US Health and Human Services Inspector General. Officials were said to be investigating possible Medicare and Medicaid fraud and possible criminal wrongdoing.

Five certified registered nurse anesthetists (CRNAs) reportedly voluntarily surrendered their licenses because of the incident. The center’s majority owner, Dipak K. Desai, MD, agreed to stop practicing medicine until the state medical board completes its investigation. The Endoscopy Center of Southern Nevada is not accredited.

Meanwhile, state inspectors fanned out to survey all of the state’s 50 ambulatory surgery centers (ASCs). The state has been criticized for falling behind in inspections, news reports said.

As of March 20, 26 ASCs had been inspected, with infection control deficiencies found at some, including problems with injection safety and endoscope reprocessing. In all, 32 of the ASCs are accredited by an organization such as the Accreditation Association for Ambulatory Health Care or the Joint Commission, but 18 are not accredited.

Adhere to basic principle

The state urged clinicians to review proper use of needles, syringes, and medication vials. The Southern Nevada Health District posted a diagram of how it believes the contamination occurred (illustration, p 26).

The state’s epidemiologist, Ihsan Azzam, MD, said, “We believe this outbreak could have been prevented by adherence to basic principles of aseptic technique for preparation and administration of parenteral medications.”

He referred to recommendations from the CDC (sidebar, p 27). The American Society of Anesthesiologists and the American Association of Nurse Anesthetists (AANA) also have guidelines for injections (resources).

The president of the Nevada State Society of Anesthesiologists, Jonathan Zucker, MD, told OR Manager the incident has nationwide lessons: “Anything that carries a ‘single-use’ or ‘do-not-reuse’ label simply should not be reused. Quite simply, syringes are ‘do-not-reuse’ items under all circumstances.”

Continued on page 26
Unsafe injection practices and disease transmission

Reuse of syringes combined with the use of single-dose vials for multiple patients undergoing anesthesia can transmit infectious diseases. The syringe does not have to be used on multiple patients for this to occur.

1. A clean syringe and needle are used to draw the sedative from a new vial.
2. It is then administered to a patient who has been previously infected with hepatitis C virus (HCV). Backflow into the syringe contaminates the syringe with HCV.
3. The needle is replaced, but the syringe is reused to draw additional sedative from the same vial for the same patient, contaminating the vial with HCV.
4. A clean needle and syringe are used for a second patient, but the contaminated vial is reused. Subsequent patients are now at risk for infection.


What the state found

In a Jan 17 inspection at the Endoscopy Center of Southern Nevada, state surveyors noted that the charge nurse said propofol was used from a multidose vial and discarded at the end of the day. Two CRNAs said propofol bottles were used on more than one patient.

The state found the center in violation of accepted standards of practice, referring to instructions from propofol’s manufacturer, AstraZeneca, which state that the drug is single use. The state also referred to the CDC’s recommendations, which say single-dose vials are never to be used for more than one patient.

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Similar problems were found at the Desert Shadow Endoscopy Center, also owned by the Gastroenterology Center of Nevada. A CRNA there told the surveyor that the unused portion of propofol vials was given to the next patient with a new syringe. The nurse manager said the CRNAs had been instructed to use single-use propofol vials. But there was no evidence of a written policy or documentation that the CRNAs had carried it out.

At another Las Vegas facility with different ownership, Gastrointestinal Diagnostic Clinic, surveyors found infection control deficiencies. In observing patient care, they saw an anesthesiologist draw up propofol from the same vial for 2 patients, according to the state’s report. The report said they never observed the anesthesiologist opening new syringes.

The anesthesiologist told the surveyors he thought it was OK to use a single-use propofol vial for more than one patient because he believed the purpose of the single-use vial was to prevent bacterial growth in cases that take a long time. Asked what he would do when he used the same vial for more than one patient, he said he would change the needle and reuse the same syringe. He said he thought it was safe to reuse the syringe because the drug was injected through a high port on the IV line. But a surveyor observed that when patients were transferred to the procedure room, their IV bags were laid on the gurney. In one case, blood flowed back into the IV tubing, which would have contaminated the IV line.

Reusing syringes is contrary to the CDC guidelines. The ASA guidelines state that after entering or connecting with a patient’s IV line, the syringe and needle should be considered contaminated and used for only one patient.

Several state reports cited centers for not having appropriate policies and/or for failing to ensure policies and procedures were followed. In some cases, the centers lacked documentation that they were verifying employee orientation and training, reviewing privileges, and assessing the quality of care according to their own policies.

A well-known hazard

The Nevada case is the most recent of a number of incidents in which patients have been infected because of reused syringes and vials. There have been 600 reports of HCV transmission in health care settings in the past 15 years, many from unsafe injection practices (sidebar).

In November 2007, it was reported that an anesthesiologist in New York State was being investigated for reusing syringes to draw up medication from multiuse vials. The state contacted more than 9,000 patients he had treated, recommending that they be tested for hepatitis and HIV.

In 2003, the CDC reported on more than 200 patients who likely were infect-
Guidelines for injection safety

Review the CDC’s safe injection practices with your nursing and medical staff:

- Use a sterile, single-use, disposable needle and syringe for each injection and discard intact in an appropriate sharps container after use.
- Use single-dose medication vials, prefilled syringes, and ampules when possible. Do not administer medications from single-dose vials to multiple patients or combine leftover contents for later use.
- If multiple-dose vials are used, restrict them to a centralized medication area or for single patient use. Never re-enter a vial with a needle or syringe used on one patient if that vial will be used to withdraw medication for another patient. Store vials in accordance with manufacturer’s recommendations and discard if sterility is compromised.
- Do not use bags or bottles of intravenous solution as a common source of supply for multiple patients.
- Use aseptic technique to avoid contamination of sterile injection equipment and medications.

The Nevada incident is not isolated. In the past 15 years, there have been more than 600 reports of HCV transmission in health care settings. Almost all have a common culprit—unsafe injections. And most are from developed countries: the US, Europe, Australia, and Japan, writes infection control expert Miriam Alter in the January Journal of Hepatology (2008;48:2-4). Some examples:

- multidose vials and saline bags contaminated by reuse of needles/syringes
- use of a single needle or syringe to give IV medications to multiple patients
- use of a single spring-loaded finger-stick device without changing the platform to monitor blood glucose.

All types of settings were involved—inpatient units, oncology and hematology units, inpatient and outpatient surgery, GI labs, emergency departments, and so on.

Alter recommends that all clinical staff have regular in-service education on injection safety.

Resources

American Association of Nurse Anesthetists


American Society of Anesthesiologists


Centers for Disease Control and Prevention


Syringes are a do-not-reuse item.

The CDC issued its safe injection recommendations in response. In 2002, a phone survey by the American Association of Nurse Anesthetists (AANA) found 3% of anesthesiologists responding said they reused needles and/or syringes on multiple patients. Reuse was reported by 1% of CRNAs, other physicians, nurses, and oral surgeons.

From these results, AANA estimated about 1,000 providers might have exposed millions of patients to contaminated needles and syringes.

Not an isolated incident

The Nevada incident is not isolated. In the past 15 years, there have been more than 600 reports of HCV transmission in health care settings. Almost all have a common culprit—unsafe injections. And most are from developed countries: the US, Europe, Australia, and Japan, writes infection control expert Miriam Alter in the January Journal of Hepatology (2008;48:2-4). Some examples:

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Alter recommends that all clinical staff have regular in-service education on injection safety.
What works to reward the ASC’s staff?

With reimbursement for ambulatory surgery centers (ASCs) becoming tighter, the need to run an efficient and productive facility has never been greater. ASCs can hope that staff will recognize the highly competitive times and step up efforts to help improve the performance of the center and keep it profitable without sacrificing quality.

But sometimes a simple pep talk is not enough—which is why some ASCs have turned to staff bonus plans to help reinforce the staff’s motivation.

“It is a morale booster—it makes employees feel like they’re a part of the whole and not just a cog in the wheel,” says Dawn Q. McLane, RN, MSA, CASC, CNOR, chief development officer for Nikitits Resource Group, an ASC development and management company based in Broomfield, Colorado. “I think employees see it as something the physicians are doing personally as a way of thanking them for their work.”

A bonus plan can yield potential short- and long-term benefits, but to realize these requires careful planning. Even then, a bonus plan can have an opposite effect of what is intended.

Plan encourages initiative

The Outpatient Surgical Center of Ponca City, Oklahoma, has seen productivity and financial benefits as a result of the staff bonus plan initiated in 2005.

“We introduced it when we needed to emphasize everybody being involved and participating,” says Steffi Cowan, RN, operations manager for the center, who developed the plan based on another ASC’s plan she read about.

The plan bases most of the bonus money on points individual staff member earn throughout the year. Employees can earn points by reaching goals such as perfect attendance or completing tasks such as achieving certification, attending a seminar related to a staff member’s job description, or participating in a group community service or public relations project representing the center.

Employees can earn points.

Employees propose projects

Employees are also encouraged to propose their own projects for points. One employee redid the material safety data sheets (MSDS) notebook. A nurse became certified to teach cardiopulmonary resuscitation (CPR) and is working to receive her advanced cardiac life support (ACLS) training certificate, so now she serves as a staff educator. Another employee is typing all of the physician preference cards and ensuring they are current and readable.

“It makes people think about what they might be able to do to improve things and to look at problem solving in a more positive way,” Cowan says. “I have them come to me all the time with ideas. I can’t think of a single quality improvement, employee training, or patient education idea that hasn’t been successful.”

The ASC turned to the bonus plan when it wasn’t in a financial position to give raises on top of cost-of-living increases and promotions. By offering the opportunity to earn bonuses instead, the center didn’t have to plan for an increase in salary, with a prospect of another increase the following year.

“Everyone knew we weren’t in a place to be giving raises the year we initiated this, and the opportunity to earn a bonus was something they really liked,” Cowan says. “It also helps offset the fact that we don’t pay as high an hourly wage as the local hospitals. The bonus plan gives the staff a chance to be recognized for their efforts and to feel appreciated for the value they bring to the surgery center.”

Staff education crucial

Once you commit to offering a bonus plan, you need to consider the expectations your staff may associate with bonuses. This is especially important for plans that distribute the bonuses from an unpredictable pool of money rather than a percentage of salary. If the pool declines from one period to the next, or if staff members perceive a bonus pool as too small, employees may be disappointed rather than uplifted, says McLane, who has implemented and overseen several bonus plans.

The administrator must keep the staff informed about the ASC’s financial status.

“If you’re sharing financial data with them, and if they know you’re not having as good a year as last year, and they know why, they’re not going to expect as much in their bonus,” McLane says.

Sharing financial information with staff members helps keep their expectations realistic and can also serve as motivation.

“That’s when they buy into the goals of the center and say, ‘We can make this better,’” McLane says. “But they have to have the [financial] information for them to feel like it’s important to do the extra work.”

Quarterly bonus more immediate reward

The Boulder (Colorado) Surgery Center has seen a positive effect from quarterly bonuses. Money for its bonus plan comes from up to 2.5% of the quarterly distribution made to the ASC’s shareholders.

“This incentive program has created great awareness among personnel in understanding how complex the issues are and, if nothing else, it provides ownership in the center,” says Jean Day, director of clinical operations for Pinnacle III, an ASC development company based in Fort Collins, Colorado.
this role, Day serves as the director of Boulder Surgery Center and developed its bonus program in 2006.

Similar to the Outpatient Surgery Center of Ponca City, Day compiles a list of goals for the staff to achieve during each quarter based on tasks she believes the staff can, should, and must complete. But unlike the Ponca City Center, staff work together to earn the bonus. Each goal is assigned to individual staff members (such as overseeing a fire drill), a few staff members (such as reduction of the inventory of a particular device), or larger groups (such as completing the Joint Commission’s periodic performance review). These staff members are responsible for achieving the goal.

The percentage of success in completing these tasks is the percentage of the bonus pool that becomes available for the staff members.

Day chose to make the bonus program quarterly because she feels short-term goals offer the greatest opportunity for achievement. For example, staff members worked in the fourth quarter of 2007 to reduce Boulder’s suture inventory by 25 different sutures, yielding about $2,000 in cost savings. If they had to wait until December 2008 to receive the bonus associated with the work, Day fears recognition of their efforts would have been lost.

“I think they would lose that association of, ‘Gee whiz, I really worked hard on that, but now I have to wait,’” she says.

Day has worked to make sure the bonus program does not allow staff to feel the bonuses are an entitlement. One tactic is not to give bonuses around the December holidays.

“I’m against December distributions because it looks like a gift,” she says.

McLane agrees. Once staff members start to associate the bonus with a gift, they come to expect it every year and may even anticipate—and possibly personally budget for—a certain amount, she says.

**Bonus can help retention**

The staff bonus plan at Tucson (Arizona) Orthopaedic Surgery Center takes a different approach. In its plan, the entire staff is challenged to meet criteria throughout the year as a team. These criteria have included meeting targets for:

- clinical hours per case
- total hours per case
- how many days bills stay in accounts receivable
- patient satisfaction

Bonus money comes from a pool budgeted at the beginning of each year, and the percentage distributed to staff members corresponds to the percentage of satisfactory meeting of the criteria. The program was started in 2006 to reward and motivate staff members.

“We think the center has been successful, and the success is attributable a great deal to the staff’s performance, so it’s just a way of sharing with the employees the financial and operational successes of the surgery center,” says Stuart Katz, FACHE, CASC, the executive director. “Employees look forward to it—they do a very good job. It probably helps with retention more than anything else.”

Using these criteria has served the ASC well. By emphasizing the throughput of patients and turnover of rooms, which are both under staff control, he says improvement has made it easier for physicians to perform cases.

“The physicians can then do more procedures, which is important to the patient population because they can have their surgeries done in a timelier fashion,” he says.

It is also important to the physicians. Katz has seen a physician-owner of another ASC avoid going to that center because the staff was struggling with some of the criteria included in Tucson Orthopaedic’s bonus plan.

“The turnover times were terrible, the delays were extended, and the [local] hospital offered an alternative for a busy physician, so he opted to take his cases there,” he says.

**An approach to avoid**

Because staff bonus plans are a potentially effective method of improving an ASC’s efficiency and profitability, it may seem like a good idea to consider tying a percentage of staff salaries to the ASC’s overall financial success.

But this is exactly the type of plan you should avoid, says Susan Kizirian, RN, MBA, chief operating officer for Ambulatory Surgical Centers of America (ASCOA), an ASC management company based in Hanover, Massachusetts.

Kizirian implemented such a program at an ASC in the late 1990s prior to joining ASCOA. The program revolved around “saving money and making money,” attempting to show the staff how their contributions resulted in strengthening the success of the organization. Expenses such as supply and service costs were reviewed, as were the types of services and cases performed and the compensation compared to the cost to perform the case. The monthly bonus was tied directly to their contributions.

“But they really can’t control the bottom line,” Kizirian says. “They’re in control of segments of various tasks that operationally are interlaced to achieve a higher level of performance.”

She found the program frustrated the staff because only so many changes could be implemented, and they could not see the connection between their efforts and the organization’s financial ups and downs.

“In the marketplaces we hire them from, they have not experienced this style of compensation,” Kizirian says. “They are accustomed to a guaranteed salary with annual raises.”

She says a bonus program can work—if it’s reserved for the ASC’s primary leader—the administrator. Kizirian

Continued on page 30
sees strong leadership by the administrator as the “driving force” behind an ASC’s success.

“In the systems where I see a bonus paid monthly, you see high quality, excellent performance, and you see loyalty and longevity from the administrator to the center,” she says. “Administrators can tolerate the risk of tying financial and organizational performance to their compensation.”

While some ASCs give bonuses as a percentage of salary for administrators, Kizirian suggests basing the amount on a percentage of cash receipts plus other quality and performance indicators.

“If they’re tied to that, then that’s what they focus on,” she says. “If they’re tied to a percentage of salary, it’s meaningful as an annual goal but less motivating.”

Outline your ideas in advance

Don’t make promises you can’t keep

If you’re considering offering any type of staff bonus plan, McLane has one final piece of advice: Do not talk about it until you are ready to implement the plan.

“Never talk about it to staff before you talk to the physicians,” she says. “Never say to the staff, ‘I’m going to try to get you a bonus,’ or promise them something that you haven’t gotten approved yet.”

When you talk to the physicians about your interest in offering staff bonuses, McLane suggests outlining your ideas for the program in advance.

“Know what you’d like to give to the staff, what you think is fair, and what’s reasonable to ask the physicians to give back to the staff,” she says.

—Rob Kurtz

Rob Kurtz is a freelance writer in Odenton, Maryland.

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Postop morbidity higher later in the day

For nonemergency surgery, surgeons should keep in mind that cases starting later in the day may have a higher risk of complications.

A multicenter study found nonemergency procedures starting between 4 pm and 11 pm were associated with a higher risk of morbidity than those starting between 7 am and 4 pm. Later start time was not significantly associated with mortality, however.

The researchers conducted their analysis of nonemergency general and peripheral vascular surgery in the Veteran’s Affairs medical system using outcomes data from the National Surgical Quality Improvement Program (NSQIP).


Studies conflict on MRSA screening

Two studies report conflicting findings on admission screening of hospital patients for methicillin-resistant Staphylococcus aureus (MRSA).

Widespread screening of surgical patients on admission for MRSA did not reduce the number of hospital-acquired infections in a study reported in the March 13 JAMA. Swiss researchers screened 10,193 surgical patients; a control group of more than 10,000 surgery patients was admitted without screening. Rates of hospital-acquired MRSA infections did not differ significantly for the screened and unscreened patients.

Another study did support screening of all hospital patients, finding the tests can “sharply reduce” the incidence of hospital-acquired infections. That study appeared in the March 18 Annals of Internal Medicine. The researchers, from Chicago’s Evanston Northwestern Healthcare, said the Swiss researchers tested only 30% of patients instead of 100%. When the Chicago researchers tested only a percentage of patients, they came to the same conclusion that testing made no difference. But when testing was expanded to all patients, they said hospital-acquired MRSA infections plummeted by 70%.

A JAMA editorial points out that MRSA causes only 8% of hospital-acquired infections. Simple, cost-effective interventions, such as hand hygiene programs, would have the benefit of reducing all infections, the authors note.


Routine use of BIS to reduce anesthesia awareness not supported

Use of the bispectral index (BIS) did not reduce the frequency of anesthesia awareness. Nor was it associated with reduced administration of volatile anesthetics in a study comparing BIS and end-tidal gas (ETAG) protocols for decreasing anesthesia awareness. The study was published in the March 13 New England Journal of Medicine.

Anesthesia awareness occurred even when BIS values and ETAG concentrations were within the target ranges. The results apply only to patients receiving anesthetic gases, not total IV anesthesia. Care plans should be based on evaluation of data, not fear of litigation or public demand, an editorial says.


Healthy kidney removed by mistake at Minnesota hospital

A surgeon removed the wrong kidney from a patient with kidney cancer at Methodist Hospital in St Louis Park, Minnesota, in March, the Minneapolis Star-Tribune reported. The mistake was not identified until the next day when a pathologist noticed the kidney taken from the patient had no evidence of cancer. The error apparently originated in documentation in the clinic, according to news reports.

Standard protocols were followed in the Methodist OR to prevent wrong-site surgery, the reports said. As a new safety step, surgeons will be required to double check MRI or CT scans before starting surgery, KARE 11 TV reported.

— www.startribune.com