The lingering effects of the recession continue to affect OR staffing, according to results of the 20th annual OR Manager Salary/Career Survey. Like last year, most OR directors and managers (78% vs 80% in 2009) said the economic downturn has had an impact on staffing. But this year’s results indicate stability and a few glimpses of optimism. OR directors reported less use of almost all strategies for adjusting staffing in response to economic pressure and, for some, declining case volume.

- More than half (52%) reduced use of overtime, down slightly from 59% in 2009.
- About one-third (36%) eliminated open positions compared to 42% last year.
- Only a few (8%) routinely use agency/travel staff to fill budgeted positions compared to 15% last year—and a big change from 22% in 2008.

The exception was a slight increase in the percentage of those who require staff to take time off without pay (39% vs 35% in 2009). Although the changes are not significant... Continued on page 7
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Selecting RNs who will stay
Second in our series on bringing new perioperative RNs on board.

The monthly publication
for OR decision makers

September 2010  Vol 26, No 9
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Editorial

“G
o into nursing—you can always get a job.” Many have heard that advice over the years. Sadly, that’s no longer true. In 2009, 44% of new RN grads couldn’t find jobs, up from 23% in 2008, according to the National Student Nurses Association (NSNA).

With the sluggish economy, nurses who have jobs are hanging on to them, leaving fewer openings for new recruits. Yet we know these new nurses will be needed in a few years. A nursing shortage of 260,000 is still projected by 2025, warns Peter Buerhaus, RN, PhD, FAAN, of Vanderbilt University.

New grads feel they’ve been betrayed.

“Without any experience, I cannot seem to do anything but spend my days filling out applications, knowing they will be rejected. It is a very depressing process,” one newly licensed BSN grad wrote to Sigma Theta Tau.

Another new grad sent out 100 applications and got only 1 phone call. “She took the job—she didn’t even ask about the pay,” NSNA’s executive director, Diane Mancino, RN, EdD, told OR Manager.

Not being able to find a job is of course distressing. Equally distressing, Mancino says, new grads don’t feel they’re getting much support.

Nursing schools, which haven’t had to worry about placing grads in the past, aren’t geared up to offer career counseling. Recruiters, bombarded with applications, often don’t acknowledge those they receive. And some nurse execs think new grads just aren’t trying hard enough.

“Many are disappointed in the profession,” says Mancino.

The danger is these new recruits will drift away, just as the recession starts to ease, and RNs are in demand again.

What strategies could help? Mancino offers some ideas for supporting new grads:
• Fund completion programs to help them move on to their BSN or master’s. Current federal funding focuses more on increasing diversity in nursing and on advanced practice, not helping entry-level RNs.
• Create more residency programs, including in perioperative nursing. “Nursing residencies would be a great opportunity to transition new gradurs,” Mancino says.

In the future, residencies may be an expectation. The National Council of State Boards of Nursing is proposing that new grads complete a standardized transition-to-practice program to maintain their license after their first year of practice.

Preliminary results from a new NSNA survey show 15% of students expressed interest in the OR.

• Get involved in mentoring. New grads who can’t get jobs have a tough time finding an experienced nurse to coach them. NSNA encourages them to join professional associations as a way to learn and stay in the loop. Informal mentoring is something any nurse can do to help ensure the future of the profession.

Despite the lack of openings now, the profession needs to keep these new grads engaged. The time is not far off when it will wish it had.

—Pat Patterson
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Longer talks aid informed consent

Surgical patients who take part in a longer discussion of informed consent—15 to 30 minutes—understand their proposed operation better than those who have shorter discussions, according to a report in the June 2010 Journal of the American College of Surgeons.

Asking patients to repeat back their understanding of the procedure also aided their comprehension of informed consent issues. The study is the largest ever conducted on the surgical informed consent process, the authors say. The informed consent process is intended to help patients to make sound decisions about their surgery. But many studies have found patients don’t have a good understanding of the issues related to their operations. In a survey of over 700 patients, the average patient understood less than half of the information related to the surgery.

"In our study, we found that patients with potential cultural or language difficulties from factors such as race, education, or age may limit informed consent comprehension,” said Aaron S. Fink, MD, FACS, attending surgeon at the Atlanta Veterans Affairs (VA) Medical Center and professor of surgery at Emory University School of Medicine, Atlanta.

But all patients benefitted from what the authors found was the strongest influence on patient comprehension—extending time spent on informed consent discussions plus having patients repeat back their understanding of the procedure.

How the study was performed

The study involved 575 patients scheduled for 1 of 4 elective procedures: total hip arthroplasty, carotid endarterectomy, laparoscopic cholecystectomy, or radical prostatectomy.

All informed consent discussions used iMedConsent, the VA’s computer-aided informed consent process, which provides a structured interview to create an informed consent document.

A random sample of patients participated in a “repeat back” discussion. They were asked to reiterate procedure-specific facts and provide additional information as needed. Patients’ comprehension was then tested.

Though the time spent explaining the consent process had the strongest impact on patient comprehension, other factors associated with improved comprehension were race, ethnicity, age, and type of procedure. Some of these factors suggest language and education barriers, highlighting the need for modified approaches to consent.

The repeat-back method was associated with improved comprehension, but the impact was weaker in the analysis that included consent time.

Reference

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significant statistically, one respondent cited “decreasing overtime cost” as the OR’s “greatest improvement” in the past year. The OR Manager Salary/Career Survey was mailed in March to 800 OR Manager subscribers who are directors or managers of hospital ORs; 294 usable surveys were returned for a response rate of 37%. The margin of error is ± 4.6 at the 95% confidence level. A separate survey was sent to nurse managers of ambulatory surgery centers (see page 12). This is the tenth year the staffing questions have been asked and the second year for the economic questions. Results from the remainder of the survey, including salaries and benefits, will appear in the October issue.

Looking at key staffing indicators, although vacancy rates increased slightly, over half of hospital ORs have no vacancies for RNs, and two-thirds have none for surgical technologists (STs). Staff turnover for both is about the same as last year, and it takes a little less time to fill positions. Most directors find the ability to recruit experienced staff about the same.

Several commented that less reliance on agency staff is their OR’s biggest improvement in the past year.

Open positions
This past year, the average number of open staff positions increased slightly to 2.1 for RNs compared to 1.8 in 2009 and to 1.9 for STs (surgical technologists) from 1.2. In contrast, nearly two-thirds of respondents reported staff turnover stayed the same as last year (5% for RNs and 6% for STs compared to 5% for both in 2009). Open positions were down from 2 years ago, when the average was 3.3 for RNs and 2.1 for STs.

Recruitment
Most managers (55%) find recruiting experienced RN staff no more difficult than last year, 19% find it is easier, and 26% (up from 19% in 2009) said it is more difficult. Vacancy rates were 6% for RNs and 8% for STs, compared to 6% for both in 2009.

Case volume
Staffing, of course, is directly related to case volume. Although overall the average case volume has fallen slightly (-0.3%), about one-third (32%) have experienced an increase, another third (36%) have seen a decrease, while one-third (32%) have seen no change in case volume.

Several respondents commented that their case volumes were up. “Doing a higher volume of cases with the same amount of staff,” one noted. Other comments included “17% volume growth,” and “Our volume increased 6% over the previous year.”

Despite flashes of optimism, the lack of overall significant improvement is congruent with the results from an American Hospital Association March/April survey—70% of hospitals reported reduced patient volumes, and 72% reported reduced volumes of elective procedures. In the same survey, 9 in 10 hospitals noted an increase in cases where no payment was received. These effects translated into 74% of hospitals reporting a reduced operating margin, and nearly half (44%) having less access to capital.

Persistent economic impact
Larger OR departments were more apt to reduce use of overtime and of agency/travel nurses than smaller ORs. Directors of 10 or more ORs (62%) were more likely to reduce overtime use compared to managers of fewer ORs (46% for 5-9 ORs and 42% for 1-4 ORs). Larger ORs were also more likely to have reduced use of agency/travel staff. For small departments with 1-4 ORs (55%), the most common strategy for adjusting staffing was requiring staff to take time off without pay.

Continued on page 8
Efforts to respond to the stagnant economy varied by region, with facilities in the West (37%) significantly less likely to reduce overtime, compared to 57% for the Northeast and Midwest and 54% for the South.

The West was also less likely to require staff to take time off without pay:
- West 28%
- Midwest 49%
- South 38%
- Northeast 34%.

But the West was significantly more likely (43%) than the South (19%) to reduce use of agency/travel staff. In all, 28% of ORs in the Midwest and Northeast cited this strategy.

Few ORs have had to resort to layoffs. Only 3% reported laying off management personnel, and 4% reported direct care staff layoffs, compared to 4% and 3% respectively in 2009. No teaching hospitals reported layoffs of direct care staff.

Vacancy rates and open positions
Just over half of hospital ORs (53%) report no open positions for RNs, and almost two-thirds (65%) report none for STs. Vacancy rates were 6% for RNs and 8% for STs, little different from the 6% for both groups in 2009—but lower than the 10% for RNs in 2008.

The average number of open RN positions, 2.1, and ST FTE positions, 1.9, increased slightly over 2009.

Though most directors (61% for RNs and 69% for STs) reported no change in the percentage of budgeted FTEs open, 28% reported fewer RN openings and 21% fewer ST openings. Only 11% saw increases in RN and ST positions.

Vacancies by type of facility
Teaching hospitals were significantly less likely than community hospitals (45% vs 61%) to report no change in the percentage of RN openings in the past 12 months. For STs, teaching hospitals were significantly more likely than their community counterparts to report a decrease in the percentage of open ST FTEs (27% vs 15%).

Vacancies by size of OR
Changes in vacancy rates also varied by number of ORs. Managers of large departments (10+ ORs) were more likely to say the percentage of RN openings had decreased (35% vs 14%). Significantly more large ORs said the percentage of open ST FTEs had decreased.
over the past 12 months, compared to medium-sized (5-9 ORs) and small departments (1-4 ORs).

Open RN positions take about 12.4 weeks to fill, down from last year’s 14.9, and it takes directors an average of 9.5 weeks to fill ST positions, essentially unchanged from 2009’s 9.8.

Variations in vacancies and open positions

Although RN vacancy rates changed little from 2009, ST vacancy rates were slightly higher.

Hospitals in the West (8%) had the highest RN vacancy rate, while for STs, the Northeast had the highest rate (12%, up from 4% last year), with the West close behind at 11% (also up from 4% in 2009). The Midwest and the South reported ST vacancy rates of 7% and 4%.

Most directors saw a fall in the average number of weeks RN positions were open. The Northeast was the longest at 16.9 weeks compared to 25.2 weeks last year. ST positions were open the longest in the Northeast at 14.3 weeks compared to 10.8 weeks last year. Two regions, the West and Midwest, reported taking less time to fill positions this year.

Teaching hospitals reported a higher average number of open RN and ST positions compared to...
community hospitals. Community hospitals have slightly higher vacancy rates than teaching hospitals but fill open positions more quickly than last year. In 2009, the average number of weeks an RN position was open was 15.8 weeks for community hospitals and 13.0 weeks for teaching hospitals. The average number of open weeks for ST positions was 10.1 weeks for community and 8.9 weeks for teaching hospitals.

**Staff turnover**

With the slow economy, OR staff are apparently staying in their current positions. The average turnover rate was 5% for RNs, unchanged from last year, and 6% for STs, up slightly from 5% in 2009. About two-thirds of the directors reported staff turnover for RNs and STs was about the same as last year. Compared to the previous 12 months, about a third of OR directors reported lower RN turnover, and fewer (23%) reported lower ST turnover (compared to 31% last year). Only a few ORs saw turnover increase, 7% for RNs, and 10% for STs.

Directors of 10 or more (35%) and 5 to 9 ORs (33%) were significantly more likely than those of 1 to 4 ORs (14%) to report a decrease in the RN turnover rate.

**Use of contract staff declines**

Fewer OR directors are routinely using agency and travel nurses to supplement their staffing, with only 8% reporting routine use of contract staff.

“We have completely eliminated all agency staff in 2.5 years,” said one respondent.

Those who use contract staffing say it comprises only an average of 9% of their total nursing staff.

Teaching hospitals are more than twice as likely as community hospitals to routinely use contract staff (14% vs 6%). For the fourth year, hospital ORs in the West (30%) were significantly more likely than other regions (10% for the Northeast, 3% for the South, and 1% for the Midwest) to use contract staff.

Of those who use overtime to stretch their staff, 17% use it always or almost always, while 55% use it occasionally, and 25% use it rarely. Teaching and community hospitals had comparable use of overtime, with 58% vs 55% using overtime occasionally.

**Positive changes**

Several respondents cited positive staffing changes. “No travelers. All permanent staff,” said one. Another had graduated 6 nurses from the AORN Periop 101 course.

Retention remains an important focus. “OR staff retention rate 96%,” one respondent said. Several
OR skill mix is stable

There is no significant change in the ratio of RNs to surgical technologists (STs) in OR staffing. The ratio of RNs to STs in hospital ORs was 63:37 compared to 62:38 for the past 2 years, according to the 2010 OR Manager Salary/Career Survey. Over the past 10 years, the ratio has shifted only slightly from 61:34 in 2000.

Federal Medicare regulations say surgical technologists and licensed practical/vocational nurses may assist in circulating duties with an RN immediately available.

The percentage of hospital OR respondents who have STs circulating with an RN in the same room was 6%, unchanged from 2009. No facility allows STs to circulate on their own, and only one allows STs to circulate with an RN “immediately available.”

Of the 17 hospitals that permit STs to circulate either with a supervising RN in the same room (16) or immediately available (1):
- 13 are community hospitals
- 7 have 10 or more ORs, 5 have 5 to 9 ORs, and 5 have 1 to 4 ORs.
In all, 6 hospitals reported having an all-RN staff.

Salary/Career Survey

Do surgical techs circulate?

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>ASCs</th>
</tr>
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<tbody>
<tr>
<td>Yes, RN in room</td>
<td>Yes, RN available</td>
</tr>
<tr>
<td>6%</td>
<td>1%</td>
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<tr>
<td>No</td>
<td>No</td>
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<tr>
<td>94%</td>
<td>93%</td>
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Note: No hospitals or ASCs allow STs to circulate on their own. One respondent allows STs to circulate with an RN immediately available.

Skill mix in ASCs

Ambulatory surgery centers (ASCs) reported an average skill mix of 67:33 of RNs to STs, the same as last year.

In all, 6% of ASCs allow STs to circulate with an RN in the room, and 1% with an RN immediately available. ASCs that permit STs to circulate are more likely to be owned by physicians, to have fewer than 5 ORs, and are significantly more likely to be single specialty. No ASC allows STs to circulate on their own.

OR managers stated retention was the “greatest improvement” in their OR during the past year.

OR directors are using multiple techniques to improve staffing, such as providing team training, holding joint biannual meetings with physicians and nurses, involving staff more in decision making, starting shared governance, and encouraging certification.

Despite continued economic challenges, several reported increased satisfaction with one respondent listing this as the greatest improvement: “Maintaining patient satisfaction in the top 10% of Press Ganey Survey, while keeping morale high in a downturned economy.”

Perhaps the best summation of the state of staffing came from the respondent who said, “Like everyone else, same case volume, less staff, same great patient care.”

—Cynthia Saver, RN, MS

Cynthia Saver is a freelance writer and president of CLS Development, Inc, in Columbia, Maryland.

Mark your calendar!
Managing Today’s OR Suite Conference
September 28 to 30, 2011
Hyatt Regency Chicago
As health care facilities continue to face tight economies, the staffing picture of ambulatory surgery centers (ASCs) is much the same as last year. Compared to a year ago, most ASC managers say the number of open positions, staff turnover, and recruitment are about the same.

There are few open positions, and if you are a new graduate or an RN without OR experience, finding a job at an ASC may not be easy.

But ASCs are not affected as much as hospitals, according to the 20th annual OR Manager Salary/Career Survey. Two-thirds (66%) of ASC managers said the economic downturn had affected their staffing in the past 6 months, basically unchanged from 69% in 2009. This compares to 78% of hospital directors and managers.

Responses to downturn

Reducing overtime, requiring staff to take time off without pay, and eliminating open positions were once again the top three responses to the downturn.

Some commented these strategies have worked. “We have managed to keep the work hours down without jeopardizing quality of care,” said one manager.

For many ASCs, the economic situation is serious—43% of respondents report “financial difficulties,” up from 31% in 2009. These managers point to declines in elective surgery (81%) and changes in Medicare reimbursement (68%) as the primary sources of financial problems.

The OR Manager Salary/Career Survey was mailed in March to 1,000 OR Manager subscribers and an external list of nurse managers of ASCs, with 182 usable responses for an 18% response rate. The margin of error is ±6.7% at the 95% confidence level. Results from the remainder of the survey, including salaries and benefits, will appear in the October issue.

The largest group of survey respondents (45%) work in physician-owned ASCs, followed by joint-venture (25%), corporate/LLC (20%), and hospital-owned (8%) facilities.

Cutting back

With surgical procedure volumes and annual operating budgets down slightly from 2009, more managers reduced overtime (51% vs 44%), with fewer eliminating open positions (14% vs 20%), but the differences aren’t statistically significant. More than a third (37%) required staff to take time off without pay (essentially unchanged from 36% last year), and 13% (the same as in 2009) reduced use of agency/travel staff.

Some ASC managers cited staff participation as a key factor in making adjustments. “Ability to cross-train RNs to all areas and the willingness to flex when the schedule is tight,” said one respondent in answer to the question to name...
the OR’s “greatest improvement” in the past year. “Ability of staff to be very flexible in adjusting their schedule to fit the needs of the department,” one commented, while another leader noted, “working together to take time off without pay—so no one loses their job.”

**Staffing numbers**

There are few open positions for either RNs or STs. Most ASCs (83%) had no openings for RNs, and 89% had no openings for STs. ASC leaders reported only 0.3 RN and 0.2 ST open FTE positions. Both RN and ST positions are open an average of 9 weeks.

As in 2009, 79% of respondents reported no change in open RN positions compared to the previous year, with 85% (compared to 89% last year) reporting the same for STs. Only a small number of ASC leaders reported a higher number of open RN (4%) and ST (2%) positions. In all, 16% of managers said open positions had decreased for RNs, similar to the 12% reporting a decrease in ST open positions.

Most leaders (80%) said staff turnover, a key indicator of retention, stayed about the same for RNs compared to a year ago; 9% reported a decrease, and only a small number (11%) noted an increase. The pattern was similar for STs: 86% said turnover stayed the same, 8% reported it decreased, and only 6% noted an increase.

**Recruiting stays consistent**

Most ASC managers found recruiting experienced staff unchanged from a year ago. But in spite of stable turnover numbers, about one-fourth of ASC leaders reported greater difficulty in recruiting RNs (27%) and STs (21%). Nearly two-thirds of respondents (63% for RNs, 62% for STs) found recruiting to be about the same. Only a few (10% for RNs, 17% for STs) said it was easier.

“We were able to fill open positions and maintain our surgical case load,” said one respondent.

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**Salary/Career Survey**

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<th>How many FTE positions are open?</th>
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<td>RNs</td>
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<td>STs</td>
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<th>How difficult is it to recruit experienced staff compared with 12 months ago?</th>
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<td>RNs</td>
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<tr>
<td>More difficult 27%</td>
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<tr>
<td>Easier 10%</td>
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<td>Unchanged 63%</td>
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| STs |
| More difficult 21% |
| Easier 17% |
| Unchanged 62% |

<table>
<thead>
<tr>
<th>How do open positions compare to 12 months ago?</th>
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<tbody>
<tr>
<td>Open RN FTE positions</td>
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<td>Decreased 16%</td>
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<td>Increased 4%</td>
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<td>Stayed the same 79%</td>
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<th>Open ST FTE positions</th>
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<td>Decreased 12%</td>
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<td>Increased 2%</td>
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<td>Stayed the same 85%</td>
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‘Not welcome’ sign for new grads

ASCs have not rolled out the welcome mat for new graduates or RNs without OR experience. More than half (54%) hire neither. While 45% hire RNs without OR experience, only 19% hire new graduates.

Lack of experience isn’t always a drawback. One leader commented, “Hired a new graduate from surgical tech school. She has made my job a lot easier. She still has a lot to learn.”

Continued on page 14
Success in difficult times

In spite of challenging times, ASC managers report successes. When asked for the greatest improvement in the past year, several cited staffing examples, such as “no turnover,” “decrease in staff turnover,” and “employee retention.”

ASC managers are taking creative steps to staffing and economic challenges, including “cross-training preop and PACU RNs to OR” and “switching anesthesia providers from anesthesiologists to CRNAs.”

Some respondents even reported they have been able to expand the number of cases and their list of surgeons. “We continue to increase our cases with present surgeons and are recruiting new surgeons,” said one manager.

Profitability is key to staying in business, as one respondent acknowledged: “Reduced overtime, had no layoffs, made a profit despite decreased census.” Still, quality is the desired outcome. “We continue to strive to be the best for our patients,” said one manager.

—Cynthia Saver, RN, MS

Medicare to collect infection data

For the first time, all hospitals will have to report data on infections to receive their full payment update from Medicare in future years. Data will be collected on 2 types of infection:

- central line-associated bloodstream infections (CLABSI) starting January 1, 2011, for a full payment update in 2013
- surgical site infections (SSI) starting January 1, 2012, for a full 2014 payment update.

The data will be publicly reported through the National Healthcare Safety Network (NHSN), the web-based infection surveillance system managed by the Centers for Disease Control and Prevention (CDC).

Reporting nursing data postponed

CMS says it decided to hold off on requiring hospitals to report on nursing-sensitive data. Though CMS had proposed that nursing data be reported to a registry, the agency decided that step is premature.

Reporting to registries was also postponed for implantable cardioverter defibrillator (ICD) complications, cardiac surgery, and stroke. CMS cited concerns about potentially inconsistent reporting, inaccurate comparisons of hospitals, and hospitals cherry-picking to report measures they do best on.

Hospital payments cut

Hospitals protested the government’s decision to leave in place a proposed 2.9% payment reduction to compensate for what it considers overpayments in 2008 and 2009 because of coding it says did not reflect patients’ severity of illness.

The net result will be a decline of 0.4% in inpatient payments in fiscal 2011 compared to 2010.

The final rule is posted at www.ofr.gov/OFRUpload/OFRData/2010-19092_PI.pdf
Evidence indicates extended work hours are a hazard to patients as well as to nurses. Now two nursing professors who have studied nurses’ working conditions call for alternatives to 12-hour shifts and urge the profession to rethink their extensive use.

“Nurses often prefer working a bunch of 12-hour shifts and then having lots of time off. But there is a big downside, as studies have shown,” Jeanne Geiger-Brown, RN, PhD, told OR Manager. “Nursing fatigue with 12-hour shifts is quite profound. And we know fatigue produces a lot of adverse consequences for patients and nurses.” She issued the challenge with Alison Trinkoff, RN, ScD, FAAN, in the Journal of Nursing Administration. Both are on the faculty of the University of Maryland.

Among findings are that 12-hour shifts increase the risks of needlestick injuries, musculoskeletal disorders, errors, and drowsy driving (sidebar, p 16).

Twelve-hour shifts started in the 1970s when there was a severe nursing shortage. Nurses themselves came up with the idea of 12-hour shifts as a way to solve the problem. They have since become a way of life in hospitals.

**Nurses, hospitals see advantages**

Advantages of 12-hour shifts are that nurses have more time off and fewer commutes. They also help nurses who have difficulty leaving on time at the end of their shift because of the need to finish charting and other work.

“If you can’t extricate yourself, it’s better to do that 3 days a week than 5 days a week,” Geiger-Brown notes.

Hospitals also see advantages.

On nursing units, they have to schedule only 2 shifts instead of 3. That also means fewer handoffs, which have been linked to missed communication, though the effect of fewer handoffs on patient safety hasn’t been studied.

**Consequences of fatigue**

Among the effects of fatigue, nurses who work 12-hour stints consecutively can become sleep deprived. In a new study, Geiger-Brown found nurses who work a string of 12-hour shifts averaged just 5.5 hours of sleep. Those who work nights slept an average of only about 5.2 hours, and some slept only 2 hours.

Night-shift nurses have to fight their “circadian pacemaker,” biologic rhythms that cause people to be awake during the day and sleep at night.

Some nurses realize they suffer ill effects from long shifts and leave the hospital for other work settings. But many are not aware of the toll fatigue takes on their ability to function. Sleep deprivation also has health effects including hypertension, diabetes and impaired glucose tolerance, obesity, heart attack and stroke, unhealthy behaviors, and depression, the nurse researchers say.

**What can managers do?**

Doing away with 12-hour shifts would put nurse managers and administrators in a bind, Geiger-Brown acknowledges. The shifts are popular, and managers and administrators are often evaluated on staff satisfaction and recruitment and retention.

She suggests strategies nurse leaders can use to mitigate the risks.

- **Consider that some nurses should not work 12-hour shifts.**

Among these are nurses with chronic illnesses such as diabetes, hypertension, epilepsy, and cancer or who are pregnant, making them especially vulnerable to fatigue.

- **Ensure nurses end their shifts on time.** “In my study, 12-hour shifts actually were 12 1⁄2 hours, but 50% of shifts were much longer—a lot were 13 or 13 ¹⁄₂ hours,” Geiger-Brown says.

- **Avoid having night-shift nurses stay for meetings at 7:30 am.** “Night nurses have a limited reservoir of wakefulness to drive safely,” she says.

- **Keep a fund for cab rides.** A nurse who feels too tired to drive can use the funds to take a taxi home and back to work. “Nurses don’t use it a lot, but it certainly could save their life or someone else’s life on the highway.”

- **Make sure nurses take their breaks.** “We found in our study that nurses would work a 12-hour shift without taking a lunch break,” she says. Not only are breaks mandated by law, “they show basic human respect and are necessary for employee well-being.”

- **Examine your unit’s culture.**

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Human resources

Literature on 12-hour shifts

Long hours worked
An analysis of logs kept by 393 nurses about their work found:
• 31% worked shifts of 12.5 hours or more.
• 14% reported working 16 or more consecutive hours at least once during the 4-week period.
• Nurses left on time at the end of their shift less than 20% of the time.
• The likelihood of an error was 3 times higher when nurses worked shifts of 12.5 hours or more. Risks of errors began to increase when shifts exceeded 8.5 hours.

A study of 2,273 RNs documented:
• More than half of hospital nurses typically worked 12 hours or more a day and more than 50 hours a week.
• Nurses were likely to work many days in a row without enough rest between shifts and during time off.

Long shifts and fatigue
The Institute of Medicine noted strong evidence linking long work hours (more than 12 hours in a 24-hour period, more than 60 hours in 7 days, rotating shifts, and insufficient breaks) to:
• slowed reaction time
• lapses in attention to detail
• errors of omission
• compromised problem solving
• reduced motivation
• decreased energy for completing required tasks successfully.
The institute recommended that nurses work no more than 12 hours in a 24-hour period and no more than 60 hours in a 7-day period.

Needlestick injuries
• Odds of a needlestick injury increased significantly when nurses worked 12 or more hours.
• 37% of these injuries were from contaminated or possibly contaminated needles.

Musculoskeletal injuries
• Odds of injuries increased in nurses working 12+ hours a day, even after adjusting for physical and psychological demands of the job.

Drowsy driving
• Nurses working 12.5 hours or more had twice the odds of drowsy driving and of a collision or near miss compared with those working 8.5 -hour shifts.

On some units, nurses always take their breaks and get out on time. On others, they gut it out and stay over. “Nurse managers are in a prime position to look at the culture of their unit and make nurses’ health a high priority,” Geiger-Brown advises.

Professional guidelines
The American Nurses Association (ANA) and AORN have statements on nurse work schedules and fatigue.

ANA’s statements generally say that employers and RNs have a responsibility to be sure work schedules provide for adequate rest and recuperation.

AORN’s guidance statement on safe call practices offers a framework for developing and implementing a call schedule that considers staff and patient safety.

AORN also has a position statement advising that perioperative RNs not be required to work for more than 12 consecutive hours in a 24-hour period and not more than 60 hours in a 7-day period, consistent with a recommendation from the Institute of Medicine. Exceptions, such as disasters, should be outlined in organizational policy.


References

Mixed reviews for 12-hour OR shifts

Perioperative managers and directors give 12-hour shifts mixed reviews. Two-thirds responding to an online survey by OR Manager say they use these extended shifts. On the plus side, they say the shifts help in covering off shifts and weekends and aid recruitment and retention. Negatives include juggling a mix of shifts and filling the gap if a 12-hour person is off. A number expressed misgivings about fatigue and patient safety.

A few—7 of the 272 respondents—said fatigue from 12-hour shifts was linked to an error at their facility. Examples were a wrong-site surgery, a retained object, and medication errors. In the wrong-site surgery case, the “RN blamed a long shift for her being too tired to complete the patient safety checklist/timeout,” one person wrote.

In interviews, managers said doing away with 12-hour shifts, as 2 nurse researchers advocate in the related article, would be unpopular with the staff at a time when recruitment and retention are a priority. They say they strive to balance the department’s needs with those of the staff, keeping in mind risks of fatigue to patients and nurses.

The upside of 12-hour shifts

“If I took away 12-hour shifts, nurses here would be unhappy,” says Mary Diamond, RN, MBA, CNOR. “Out of 14 days, you work 6 and get 8 days off. It’s nice if you want your time off to really be time off.” She is director of surgical services at TriCity Medical Center, Oceanside, California, which has 12 ORs.

Diamond says she has shared with the staff the research on the risks of 12-hour shifts and is cautious in scheduling.

“With overtime, we don’t like the staff to work more than 4 hours beyond their 8 hours,” she says. She is also careful that nurses who work 12-hour shifts aren’t scheduled for much call.

She asks nurses to be honest about their fatigue and ability to withstand 12-hour duty.

Under California law, nurses who work 12-hour shifts are entitled to 3 rest breaks and 2 meal breaks, though they can waive the second meal break. Any work past 12 hours must be paid double time.

The disadvantage is that 12-
Human resources

Pluses, minuses of 12-hour shifts

In OR Manager’s online survey, some 150 participants took time to comment on the positives and negatives of 12-hour shifts.

Here are examples.

The positives

Among comments on the positive aspects:

- “It helps prevent mandatory overtime as well as covering off-shifts and weekends. It also contributes to staff retention and ultimately staff satisfaction.”
- “It enables later shift coverage to get add-ons done as well as some like the work balance.”
- “We cut overtime by almost 1,000 hours the first year we started 12-hour shifts.”
- “Yes, if they are scheduled appropriately, and you ensure that the staff get adequate breaks during the shift.”
- “We use an 11a to 11p shift to cover evenings. The staff like the 3-day work week, and it gives us lunch break help for the day shift. We also use a weekend plan that is 7a to 7p. This helps the staff to not have as many weekend rotations and on-call commitments.”

Tough to make it work

Others cited negative effects:

- “It is difficult to have the right number of staff doing 12-hour shifts. The right mix of 12, 10, and 8-hour shifts is difficult, and we recently went back to all 8-hour shifts due to short staffing.”
- “Managing productivity is problematic if the case volume slows after 3 pm. Staff resent having to go home early if it happens often.”
- “Many that said they wanted it were exhausted—3 consecutive shifts is too much! Then there is call to consider. Negative impact has caused me to change the schedule.”
- “It is not always easy to make these schedules work; some staff prefer 3 days in a row; some like them with a day in between. When a staff member calls off, it is a significant amount of time to try to accommodate and backfill—if you can backfill at all.”
- “When the shifts are all scheduled consecutively without a day off in between, staff are tired and more prone to be cranky or make errors. We have started a policy that they can’t work more than 2 12-hour shifts in a row. (The exception is weekend staff who are long-term employees and would lose their weekend pay plan differential.)”
- “Patient safety concerns. Many staff work in 2 places, and 12-hours shifts allow more hours in their second job.”

The survey was posted in July 2010. The majority of respondents (69%) were from community hospitals, and 65% manage 10 or more ORs.

In Idaho, which has 17 ORs and is staffed around the clock, 12-hour shifts are one option offered.

“It’s definitely a staff satisfaction factor. It also makes the week simpler to cover,” says Jody Hughes, RN, who schedules the staff.

The 12-hour shifts help leaders accommodate needs of RNs as their lives and family needs change, a consideration in an area where there is not a large pool of RNs to draw from.

Hughes weighs needs of the department with those of individual nurses. Some prefer to work 12 hours on 3 consecutive days, such as Monday, Tuesday, and Wednesday of one week and Wednesday, Thursday, and Friday of the next, with 6 days off in between. Others find consecutive shifts too demanding and might work 12 hours on Tuesday, Thursday, and Friday.

Hughes also helps nurses ease off of 12-hour shifts if that no longer works for them. For older nurses, especially, going back to 8 or 10 hours can “put the spring back in their step,” she says.

Another challenge is finding a good match between the shifts nurses want to work and the surgical specialty. Those who want to work 12-hour days may be a good match for specialties with long cases. Nurses who work 8- or 10-hour days are more likely to be assigned to specialties with shorter cases. A nurse who changes shifts may face the tough decision of changing specialties.

Keeping teams intact

At the University of Alabama at Birmingham (UAB), with more than 40 ORs, 12-hour shifts keep teams intact for surgeons and specialties whose cases run past 3 pm.

Plus, the longer shifts benefit the staff because “it allows them to...”

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hour nurses are only available 3 days a week. Diamond notes, “You have to balance it so you don’t have a lot who work Monday, Tuesday, and Wednesday and are off Thursday and Friday.”

Accommodating nurses’ needs

At St Luke’s Boise Medical Cen-

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Bringing new perioperative RNs on board

First in a series on selecting and hiring perioperative nurses and integrating them into the staff.

O
R managers have often sought the magic bullet for recruiting and retaining qualified RN circulators. In 10 years of developing a successful model for onboarding perioperative RNs, we’ve learned that success requires a kaleidoscope of ingredients rather than a single approach. Our long-term success is measured by a high completion rate for the perioperative training program and by the fact that over 50% of the present clinical RN staff is a product of this process.

Perioperative leaders face challenges in attracting and keeping RNs. The OR setting is increasingly complex, and as the average age of the OR RN circulator approaches 50, the pool of experienced recruits is shrinking. In some metropolitan areas, ORs may be able to recruit by offering incentives to lure RNs who don’t have to relocate to take a new position. But the majority of hospitals don’t have this luxury.

It has become increasingly evident that ORs need to train their own circulators. In this past year, the perioperative training program at St Luke’s Boise Medical Center in Idaho garnered over 100 applicants from all over America. Young nurses appear willing to relocate almost anywhere with the promise of specialty training. This presents a hospital with the challenge of identifying the appropriate candidates, integrating them into its culture, and building loyalty for long-term employment.

This series outlines how St Luke’s has found success with its onboarding process for RN circulators. The 14 steps fit into 3 categories:

- identification
- integration
- perpetuation.

This article covers Steps 1 through 4 of the identification process, the initial steps of employee selection.

As Idaho’s largest employer, St Luke’s is also the state’s only health system with 4 full-service hospitals as well as smaller clinics and rural connection hospitals. The 403-bed hospital in Boise has 17 ORs and a perioperative staff of over 160 who support the daily schedule of 55 to 80 cases. The ORs are staffed around the clock. Because St Luke’s is Idaho’s only children’s hospital, about a third of our surgical caseload involves pediatrics.

Who is most likely to be successful?

An essential step in onboarding new RN circulators is identifying the individuals who are most likely to be successful. The stereotype of individuals best suited to working in an OR isn’t always positive. We need to work on improving the culture of the OR while seeking positive individuals to become a part of this evolving culture.

The underlying theme that guides my process is ownership of the decision. For example, if I took the first 6 people to sign up for a perioperative program, most would likely quit between the second and fifth months. The same 6 might also be successful if nurtured to make an informed decision about this career choice.

Strong support upfront

Our long-term success is enhanced by strong support upfront. Nurses entering our Periop 101 program can expect support during precepting/mentoring for the first 7 to 8 months before they assume full patient responsibility. The process is incremental as they develop confidence in one area before moving on to another. Our philosophy is that if we treat them like traveling staff and just drop them into the workflow, they will treat us like travelers and keep their bags packed.

When I first became an educator, I inherited a nurse, Bonnie, whom the director had brought to the OR simply because she wanted a change from the ICU. She didn’t have a good understanding of what she was getting into. She was an expert in her specialty, but now she was a novice in a specialty where she knew little. She actually had nightmares in which she couldn’t figure out whether to put the kick bucket at the surgeon’s right or left leg. She hadn’t been properly introduced to the OR so she knew the obstacles along with the opportunities.

Reflecting on Benner’s Novice to Expert model, James Stobinski, RN, MSN, CNOR, director of surgical services at St Luke’s, states that RNs who are experts in their specialty step back to the novice...
stage when they move to the OR setting. Identifying the individual who is ready for this change is critical.

**Realistic milestones**

A participant needs to have realistic milestones identified, including the obstacles to success. As educators and managers, we are still nurses and have an obligation to make sure prospective employees make informed decisions. We need to develop a process that ensures that when the tough times arise as they become a circulator, they don’t blame us for convincing them to join the program. Participants should be able to think back and realize they were aware of the personal costs and agreed in advance.

I have found the steps in this series of articles largely to guarantee success in onboarding RNs new to the OR.

**Step 1. Developing selection criteria**

To establish a baseline for gauging potential candidates, it is necessary to develop formal selection criteria. There are a number of factors to consider. Would you include new graduate RNs? If not, are there exceptions? I typically don’t accept new grads unless they have other life experiences that may give them an advantage, such as a number of years as an LPN or certified surgical technologist (CST).

Even then, I am likely to provide a medical-surgical nursing component to their orientation. There is little substitute for nursing experience for learning time management and basic nursing and assessment skills.

Other components in the selection criteria may include recent acute care experience, teachability, willingness to enter a 2-year commitment, and anything else you or your organization may deem appropriate. Through all of these criteria, the quality I seek is passion for this specialty. I need to know perioperative nursing is something the candidate really wants to do and is not just a checked box in an online job site.

**Step 2. Advertising**

Never underestimate the importance of advertising your program. Depending on factors such as the economy, nursing shortages, and the reputation of your program, you may need to either use additional measures or in some cases, tone down your advertising.

In the past, we have typically advertised in-house, locally, online, and sometimes regionally. National exposure is also gained from being included in the national data base from using AORN’s Periop 101 program.

In the past 2 years, we have kept a perpetual online position posted. This draws in people when they are searching rather than our simply hoping the ad is posted in September. As a result, I have been able to draw people into our health system 6 to 10 months in advance of the program with the hope that they will be selected when the program is next offered.

This year, I trimmed our advertising as our pool of applicants grew. In the end, we were able to consider over 100 applicants from at least a dozen states. It then becomes a challenge to do a preliminary screening, balancing fairness to each applicant with fiscal responsibility to the organization.

**Step 3. Initial screening**

Reviewing over 100 applicants can be a daunting task. Without selection criteria, it would be even more difficult. I screen the applications for key elements of which the selection criteria are just one aspect. Can you see passion for the specialty in an application? I believe you can. One applicant has applied for 116 RN positions this year. That doesn’t give me a strong sense of a passion for OR nursing! Other applicants seem to have passion until I read the cover letter and note they forgot to tailor the letter for an OR position.

One applicant this year applied from Florida and selected only the one position. This gave me the sense that if she was going to move to Idaho, it would be for one purpose only. This passion carried through in her tailored cover letter, follow-up email, and phone call. Matching these qualities with the following onboarding steps, this candidate set herself apart. It is possible to be fooled, but this one step usually leads to selection of successful candidates.

**Step 4. Phone interview**

The next step is to engage the individual in a telephone conversation. I let them know up front that this is not the interview but a preliminary step. I gauge their interpersonal communication skills. How did they answer the phone? Are they enthusiastic about this opportunity? Have they done research into what this decision may involve?

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12-hour shifts

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have 2 days off during the week without affecting their benefit time,” says the OR’s clinical coordinator, Sandra Daily, RN, BSN. They can schedule doctor and dentist appointments without using leave time.

She adds that most nurses tell her they feel no more tired after 3 12-hour days than after a regular week of 5 8-hour shifts. Plus, at 3 pm, a nurse can find it hard to leave on time.

UAB can often match the shift to a nurse’s preferences.

Weekends are staffed using the Baylor Plan, in which nurses work 2 12-hour shifts and are paid for 36 hours, a schedule that “is very appealing for nurses with young children,” Daily says.

Particularly for young nurses, offering a variety of shifts gives a hospital an edge in recruitment and retention, notes Barbara Doster, RN, MBA, administrative director of perioperative services.

Twelve-hour shifts can work well for weekends in large hospitals, notes Kathleen Miller, RN, MSHA, CNOR, of PeriopRx Consultants, Gilbert, Arizona. The shifts start at 7 pm Friday and end at 7 am Monday.

Using 12-hour shifts on the weekends keeps the primary staff working Monday through Friday on their designated specialty teams rather than having to rotate to weekends.

“That makes the physicians happy because they pretty much have the same staff Monday through Friday, and that makes their days much more efficient,” she says. Weekend teams also become more efficient at the types of cases they typically do.

“It’s a win-win-win situation for managers, surgeons, and staff,” says Miller, noting the arrangement worked well for a large health system where she previously worked.

A win-win-win

With stronger candidates, I have 2 options. If they are from out of state, I set up a telephone interview to include 2 other members of our OR leadership team, knowing that if we invite this candidate to the next level, it will cost money and time. For those closer to home, I ask whether they are interested in proceeding to the next step by coming to our operating room for an observation.

—Reuben J. DeKastle, RN, MHSA, CNOR
Clinical Educator
St Luke’s Regional Medical Center
Boise, Idaho

The downside for staffing

Enthusiasm for 12-hour shifts is not unanimous.

“The downside from a staffing viewpoint is there is less flexibility because (12-hour nurses) only work 3 days, and you have to cover the other days as well,” says Renae Battie, RN, MN, CNOR. She also points out that 12-hour nurses figure as 1 FTE even though they work only 72 hours rather than 80 in a 2-week pay period.

In the Franciscan Health System, where Battie is regional director of perioperative services, 12-hour shifts are used but not a great deal. The system has 5 hospitals in western Washington State.

Battie is also concerned about the research related to how productive and safe a person is after 8 hours of work, while acknowledging the plus side—continuity across shifts and more free time for the staff.

—Pat Patterson

Onboarding

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Some know nothing about the OR. Others already know about our program: the fact that St Luke’s has Magnet status for excellence in nursing and the potential for CNOR certification after 2 years in the OR.

I ask them to outline their nursing career while I measure this against their application/resume. I then describe our usual program and note what types of questions this may arouse. Do they prompt me for the next step, or does the conversation fizzle?

Many times, I end the conversation by stating that I am reviewing multiple applications and have enjoyed conversing with them, leaving future steps open, closed, or nebulous.

References


Safety checklists are not the only concept the operating room has gleaned from aviation.

Ten years ago, the 26-room OR suite at the Ohio State University (OSU) Medical Center in Columbus purchased the type of luggage scanner used in airports to scan used linen and waste bags and recover accidentally discarded instruments, reaping large savings.

The scanner provides an immediate visual image of metal items in trash or linen bags, notes Lynda Petty, RN, director of perioperative education, policy, and process improvement at OSU.

Compared to metal detectors, she says the scanner gives few false readings, limiting the staff’s exposure to blood and body fluids from having to search bags for lost items.

An answer to instrument loss

It all started with a newspaper article about a small town courthouse purchasing a metal-detecting unit to prevent guns from being taken into the courtroom, Petty says. A group from the OR traveled to the courthouse to see the unit and realized it could be a simple solution to the big problem of lost instruments.

The OR had lost an expensive camera plus many instruments, and the staff were blaming each other. Central sterile supply staff were saying, “You’re not returning our instruments.” OR staff were saying, “We aren’t throwing instruments away; central supply is losing them.” The departments were not unified as a team, says Petty.

The scanner cost about $35,000, which the group thought was a reasonable price considering the expense of the equipment and instruments they believed were being thrown away. The cost of new instruments was running at about $1 million per year because of the high volume of surgery, the addition of new surgeons, and the need to replace lost instruments.

The OR had conducted trials of metal-detecting devices marketed for the OR but found the devices gave too many false alerts. Plus, the staff risked exposure to blood and body fluids from digging through contaminated trash and linen only to find what appeared to be a lost instrument was really a suture pack or electrosurgical unit cord, says Petty.

After the courthouse tour, the group proposed purchasing the scanner to the medical director of perioperative services, who approved. It didn’t take long to convince the hospital administration the scanner was a good idea, says Petty.

Cost recovered quickly

The scanner from Heimann Systems (now part of Smiths Detection, www.smithsdetection.com), paid for itself the first year. “Within the first few months, savings from finding lost instruments were in the 5 figures,” Petty says. “We found ronguers that cost from $1,200 to $1,600 each and many towel clips and hemostats.”

The scanner also allows staff to save a picture of the lost instru-
ment. “In the beginning, we took pictures of the lost instruments and posted them weekly with the cost to show how much we were saving,” she says.

The scanner not only proved OR staff were throwing instruments away but also raised everyone’s awareness about the problem. As time went on, fewer instruments were lost.

“The proof was in the picture,” says Petty. “It made it a nondebatable issue to track the instrument back to the person who was responsible. We knew which room the bag came from, and who had thrown the instrument away.”

Petty says the scanner has needed no repairs since it was purchased. The clinical engineering department performs routine preventive maintenance.

**Simple to implement**

Petty says the scanner was simple to set up, use, and implement. It requires a 6 ft by 8 ft area and a standard electrical outlet. “You just plug it in, place a bag on the conveyor belt, push a button, and look at the screen. The process takes only seconds.”

The scanner is located in the dirty materials handling room where case carts, trash, and linen are taken at the end of cases. Perioperative techs who take the case cart and trash and linen bags to the materials handling room are responsible for running the bags through the scanner and watching the scanner screen. Every bag from the OR is expected to be run through the scanner. The screen immediately shows the contents of the bag and any instrument it may contain.

If the scanner shows an instrument, the tech reports it to the charge nurse along with which room the bag came from. The person who threw the instrument away is asked to retrieve it from the bag. If that person is busy on another case, the charge nurse retrieves the instrument.

The perioperative techs wipe the scanner after each use, and the scanner is terminally cleaned at the end of each day.

The radiation exposure to the staff is limited and requires no precautions, just like in an airport, says Petty. Before purchasing the scanner, the hospital’s radiation safety officers ensured the equipment met all safety regulations.

“It is so simple. There is nothing difficult about it. It has been a successful solution for us,” says Petty.

—Judith M. Mathias, RN, MA

Continued from page 23

Above: This trash bag contained two pairs of expensive scissors.

Right: The scissors show up on the scanner screen.
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Certification: What is the value?

Contributed by Competency & Credentialing Institute.

The operating room is an increasingly specialized and complex practice area. Technology advances rapidly, and consumers of perioperative care demand safe, quality treatment.

“Surgical intervention requires a well-honed team of experts that trust each other, from the physicians to nurses and surgical techs,” Larry Asplin, RN, MS, CNOR, RT(R), president of the Competency & Credentialing Institute (CCI), the organization that administers the CNOR certification program for perioperative nurses, said.

“In my experience, certified nurses are knowledgeable on a broader range of topics, which leads to more credibility with their team members.”

Environment requires more

State licensure has historically been used to demonstrate that nurses have the necessary knowledge to perform their jobs. Today, the environment requires more. The value of voluntary certification, in this case the CNOR credential, has grown to meet this demand. While licensure and registration for nurses demonstrates minimal competence, specialty certification denotes a more advanced level of knowledge and practice in a specialty area.

Since the CNOR program was launched in 1979, nearly 33,000 nurses have voluntarily earned the credential. In the past 3 years, the total number of certificants has increased nearly 10%.

Perioperative nursing is not the only certification program that has experienced growth, according to the American Board of Nursing Specialties (ABNS), the membership association for the industry. The ABNS membership represents more than 500,000 certified nurses.

Research has not conclusively linked CNOR certification or other specialty certifications to better patient outcomes. Many believe, however, that the recruitment and retention of perioperative nurses, who exemplify the qualities associated with certification, including expert knowledge, clinical judgment, and professionalism, positively influence patient safety and satisfaction.

Certification and empowerment

Nursing retention is a key strategy for addressing the workforce shortage. Organizations that certify nurses are beginning to investigate how certification may affect feelings of empowerment in the workplace and nurses’ intent to leave their positions or the profession.

A 2010 article in the American Journal of Critical Care summarizes the efforts of the American Association of Critical-Care Nurses (AACN) and the AACN Certification Corporation to determine if and how certification affects empowerment.

AACN’s research study was built on a larger organizational theory that argues that employees who have access to empowerment structures (more autonomy, opportunities for growth and learning, etc) are more effective at work.

The results showed significant differences in total empowerment scores between AACN-certified nurses and noncertified nurses. Further, nurses who held AACN certification and another national certification, such as the CNOR, had the highest empowerment scores.

Though limited in scope, the study adds to the literature on the concept of certification and empowerment and poses a question to managers and employers: If certification may enhance feelings of empowerment, and if a nurse values certification, how can the institution do more to support it?

What perioperative nurses value

Understanding what perioperative nurses value is one way for surgical departments and hospitals to ensure they are hiring and retaining nurses with these skills and fulfilling their responsibility to their patients.

“I have found with my staff that the rigorous undertaking of studying for the CNOR exam enhances their critical thinking skills,” said Asplin, who works at St Cloud Hospital in St Cloud, Minnesota.

In 2003, CCI conducted a large-scale research project to answer the question of what a perioperative nurse values. Responses by participants revealed that certified perioperative nurses perceived the value of their certification to be in 3 areas: personal values, recognition...
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by others, and professional practice.

Nurses who earned the CNOR credential felt a strong sense of personal accomplishment and satisfaction and expressed confidence in their clinical abilities. The respondents also agreed strongly with statements that indicated certification:

- validates specialized knowledge
- indicates professional growth
- indicates attainment of a practice standard
- provides evidence of professional commitment
- provides professional challenge
- enhances professional credibility.

The research CCI conducted using the proprietary Perceived Value of Certification Tool has been replicated across different nursing specialties and by ABNs with similar results.

“Nursing is a profession; it’s not just a job,” Jay Bowers, RN, BSN, CNOR, a clinical educator and CNOR-certified nurse responsible for 18 operating rooms at West Virginia University Hospital, said. “As a certified nurse, I am required to continue my education, and that better not only me but also my patients and peers.”

CNOR credential

The CNOR credential is awarded for a 5-year period, during which candidates must participate in activities to enhance their knowledge and ensure they stay current with their practice.

Recertification is an essential element of the credentialing process. If certification provides some assurance to employers and the public of the certified nurse’s achievements, it is reasonable to provide that assurance at more than one time in an individual’s career.

The research that CCI and other certifying bodies conducted allowed the industry to start to quantify what value certification carries for fellow nurses, patients, and employers. The study showed that intrinsic factors (accomplishment, accountability, professional challenge) are strong motivators for earning the CNOR, but extrinsic forces also play into the equation.

“The leadership at my hospital very much understands how important certification is and supports it as part of our overall professional development,” Jim Stobinski, RN, MSN, CNOR, director of surgical services at St Luke’s Regional Medical Center in Boise, Idaho, said. “We address certification in all of our job descriptions and, all other factors being equal, prefer to hire certified nurses.”

Hospitals and certification

CCI conducted a survey of certificants attending the 2010 AORN Congress to gather information on how hospitals supported certification (sidebar).

Stobinski’s own job performance evaluation includes metrics related to his staff’s performance on the CNOR exam. Certification, he reports, also played an important role in St Luke’s achievement of Magnet Status from the American Nurses Credentialing Center (ANCC).

ANCC’s Magnet Recognition Program recognizes health care organizations where nursing excellence is prevalent. Professional certification contributes to the ability of a hospital to earn Magnet Status. Organizations must supply evidence that they support professional development and certification.

Encouraging candidates

Brenda Edwin, RN, BSN, a 35-year veteran of the OR and surgical services educator at Houston Northwest Medical Center in Houston, Texas, is spearheading her department’s efforts to ensure that the 40 eligible perioperative nurses successfully pass the CNOR exam. The hospital’s desire for Magnet Status was a catalyst for the effort, but Edwin says certification also contributes to the high quality of care her team provides.

“The bottom line is that CNOR certification will make me the best practitioner in the OR that I can be, and I will be a better advocate for my patients’ safety because of it,” she said. “Earning this certification is a personal accomplishment that shows nurses that they know and understand the latest in caring for their patients.”

One factor limiting access to certification is cost. The exam fee is $295 for AORN members and $375 for nonmembers. Employers can help eliminate this barrier by providing reimbursement for exam fees.

“Our managers went to bat for the nurses who wanted the CNOR by covering the initial exam fee,” Edwin said.

More importantly, managers and employers can create a culture in their surgical departments that promotes certification as an element to improving patient safety.

“Certification is a pathway to

Continued on page 30

How hospitals support CNOR certification

- 40% provide increased compensation
- 58% reimburse for exam fees
- 40% reimburse for recertification fees
- 49% reimburse for continuing education activities.

Source: CCI survey at 2010 AORN Congress with 700 respondents.

Human resources

Continued from page 26
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help nurses fulfill their desire for professional achievement and growth and embrace their position not just as a job, but as a career,” Asplin said. “We demand a board-certified surgeon. Why wouldn’t we demand our nurses be board certified also?”

—Cynthia Allen, MA
Communications Consultant
Competency & Credentialing Institute

References


Proposals invited for 2011 conference
Share your success at the 2011 Managing Today’s OR Suite conference, September 28 to 30 in Chicago.
Submit your proposal for a 75-minute breakout or a full-day preconference seminar at
www.ormanager.com/mtors/abstract/submittal-form.htm
The conference focuses on practical topics related to surgical services management, such as OR throughput, staffing, and cost management.
The conference will include a track related to business management of the OR. A separate OR Business Management Conference will not be held in 2011.

Deadline is October 15, 2010. Questions? E-mail Judy Dahle, RN, MS, education coordinator, at jdahle@ormanager.com or call 1-877/877-4031.

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At a Glance

Health care-associated MRSA infections drop

Hospital-onset MRSA infections dropped by 28%, and community-acquired MRSA infections fell by 17% from 2005 to 2008 in a new CDC report in JAMA.

MRSA bloodstream infections showed an even sharper drop, with a 34% decrease in hospital-onset and a 20% decrease in community-onset infections.

Though the reason for the decrease is not known, the authors say a number of factors may have contributed, including infection prevention practices in hospitals.

The study covered a population of some 15 million people in 9 metropolitan areas from 2005 to 2008.


CRNAs provide safe care without MD supervision

Certified registered nurse anesthetists (CRNAs) can safely provide anesthesia services without physicians supervising them, finds a study in Health Affairs. Though Medicare prohibits reimbursement when CRNAs provide care without physician supervision, starting in 2001, states were allowed to opt out of the physician supervision requirement.

This study of nearly 500,000 Medicare patients found no evidence that opting out of the oversight requirement resulted in increased patient deaths or complications.

The authors recommend that Medicare repeal the physician supervision requirement for CRNAs.

The study was funded by the American Association of Nurse Anesthetists. The American Society of Anesthesiologists says the study is flawed because it used billing data, which doesn’t adequately reflect complications, among other objections.


New AORN RP on preventing retained items

AORN has released its new “Recommended practices for the prevention of retained surgical items,” formerly titled “Recommended practices for sponge, sharp, and instrument counts.” The new RP advocates a multidisciplinary approach to accounting for soft goods, sharps, and instruments and standardized measures for addressing count discrepancies. The RP says adjunct technologies may be considered to supplement manual counts. The RP is available for purchase from AORN.

—www.aorn.org

Joint Commission asks input on Universal Protocol

The Joint Commission is conducting an online survey on the 2010 revisions to the Universal Protocol, which were effective in January.

The survey seeks feedback on whether organizations were able to implement the changes and whether there has been an effect on patient care and processes. The survey is open through Sept 10 for hospitals, critical access hospitals, ambulatory care, and office-based surgery accreditation programs.

The Joint Commission says it plans no additional changes to the Universal Protocol for the immediate future.

—www.jointcommission.org/PatientSafety/UniversalProtocol/