What’s the most important ingredient for implementing specialty teams? “Staff input,” stresses Amy Tinsley, RN, BSN, CNOR, director of surgical services at the University of Missouri Hospital, Columbia, Mo, which implemented specialty teams in July 2005.

The project was spearheaded by a staff action team, which was responsible for developing the team structure and communicating with staff, faculty, and hospital leaders. Team members also interviewed and mentored applicants for team leader positions.

Specialty teams had been tried in the past but were not successful. The OR leadership group thought a new methodology had the potential to improve surgeon and staff satisfaction, aid staff retention, and help meet demands of complex technology (related article).

The hospital is a Level 1 trauma center with a medium-sized perioperative department with 14 main ORs and 4 outpatient surgery ORs that performs about 12,000 cases a year. The outpatient ORs are not participating in the team concept at this time but had a member on the action team.

“It’s difficult for an operating room with a relatively small staff to make teams successful, especially with the specialization and complexity of procedures today,” Tinsley says.

Tinsley thought the time was ripe for teams, believing it could help the ORs respond to a case volume that increased by 14% in the past 6 months.

Recent training in crew resource management (CRM) helped lay the groundwork for teams. CRM, successfully used in aviation and recommended by the Institute of Medicine, is a form of interdisciplinary teamwork that considers human error, human performance limits, and ways to counter error. The hospital provided CRM training in 2003 for teams in high-risk areas.

“CRM has helped us realize that everyone’s voice is as important as the next person’s when it comes to communication and patient safety,” says Tinsley.

The university had also hired a new chief of surgery who had been exposed to the team concept, which encouraged administrative and physician support. His role has been instrumental in promoting and sustaining the effort, Tinsley says.

**Action team leads project**

The action team included 5 staff RNs and 1 surgical technologist (ST) representing various shifts and specialties, with Tinsley and the OR educator, Nancy Lowry, RN, CNOR, serving as advisors. The members volunteered and made a personal commitment to the project goals. They met after work and were financially supported for their time.

The team concluded that the OR was on the generalist end of the generalist-specialist continuum (illustration, page 13). That meant that the staff would be assigned to teams but would maintain general competencies for core procedures to enable them to cover call responsibilities. Competencies will be determined with input from the staff members plus annual mandatory education.

The teams were selected by determining the number of cases from each service for the previous year and grouping similar specialties, explains Pam Kite, RN, one of the team members. After much discussion, the team decided on 5 specialty teams:

- general surgery
- orthopedics
The teams may be rearranged in the future as they grow.
The staff selected the teams they wanted to join, and the team structure was rolled out in July 2005. The staff work in their teams 85% to 90% of the time.

To support the teams, “We are doing a lot of continuing education, including team building,” Tinsley says. In retrospect, Lowry adds, more resources should have been used to reinforce leadership skills.

**Team leaders crucial**

Tinsley knew that how the team leaders were selected and oriented would make a big difference in the project’s success. Appointment is for 1 year. The position is 75% clinical and 25% management (see job description).

RNs and STs applied for the positions and were interviewed by the action team, notes team member Jennifer Tenholder, CST. An interview tool was developed to ensure consistency in rating the applicants.

The team leaders were selected before the teams were implemented and began giving the staff regular updates on the project.

“We kept everyone informed weekly and built the teams in stages so the transition was as smooth as possible,” Kite notes.

Team leaders are available around the clock as resources for their teams as well as for others who may be assigned to cases in their specialties during the day or on call, adds Pam Holliday, RN, another team member.

Team leaders meet with managers weekly. They are forming a council under the department’s shared governance model, which will give them a forum to discuss issues and make decisions.

The department is tracking how much time team leaders spend on management duties “to make it fair and have a baseline for reviewing the 25% management goal,” Tinsley says. “Following a year’s trial, we’ll evaluate whether 25% is enough time for them to meet their new responsibilities successfully.”

**An “in-house call” plan**

At present, call is not taken by specialty teams, except in cardiothoracic surgery. “Everyone else takes general call,” Tinsley says, adding that most of the staff has 20-plus years of experience.

The approach to call is changing. The hospital is adopting “in-house call” for weekdays to boost retention and help reduce the OR’s vacancy rate of 15% to 12%.

“We perform exit interviews with staff, and they have told us that they are getting older and don’t want all of the call and in-house holidays expected in a trauma center like ours,” Tinsley says. Some have left for smaller hospitals and outpatient surgery centers with weekday hours.

For call, 1 extra team is provided during the 3 pm-to-11 pm shift. When not staffing cases, the extra team provides relief, does special projects, or frees team leaders for management responsibilities.

Tinsley sold the concept to the administration as an aid to retention, noting that even though the plan is more costly, it would help reduce use of expensive travelers and save on training of new staff. So far, the plan has reduced ST vacancies by about 75% and RN vacancies by about 50%.

Weekends are covered by permanent staff on 12-hour shifts. Elective cases are not performed on weekends. The night shift is staffed with 2 full teams during the week.

**Upsides and downsides**

A major upside of specialty teams is that the surgeons like having consistent staff. They are already asking if the OR can provide specialists later into the evenings, which is difficult, Tinsley notes.

Staff satisfaction is hard to evaluate because of the amount of change in the organization. But she thinks the teams have helped the staff gel despite the changes.

The teams are a challenge when making assignments, notes Kite. If staff must be
assigned outside their specialties, team leaders are consulted to make sure at least one specialist is in the room with them.

As the director, Tinsley finds the team leaders “a godsend.”

“The team leaders have taken on more responsibility for staff development and department growth. Crew resource management has given them a good background to do that. Now, instead of 1 manager, the department more or less has 11,” she says.

Team leaders are empowered to express their ideas and implement them. Team leaders have taken initiatives on new projects such as shift-to-shift reports, relief reports, handoffs to other units, and quality improvement “that have promoted patient care and patient safety in our OR,” Tinsley says.

Members of the action team included Pam Holliday, RN; Pam Kite, RN; Jennifer Tenholder, CST; Jerry Stevens, RN; Jackie Beshears, RN; and April Martin, RN.

Tinsley and members of her team will present a breakout session entitled “Developing Specialty Teams: They’re Not Just for Large Hospitals” at the Managing Today’s OR Suite conference Nov 8 to 10 in Orlando, Fla.

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**Team leader job description**

**RN**
- Plan and coordinate patient care through perioperative course.
- Set documentation standards.
- Communicate with team members through e-mails and newsletters.

**Surgical technologists**
- Manage instrument trays and peel pack inventory for specialty.
- Plan and coordinate case needs with sterile processing.
- Define the standard for sterile table setup.

**Both**
- Manage preference cards.
- Manage staff scheduling and assignment plan.
- Direct staff growth and development through competencies and evaluations.
- Train staff to use new equipment.
- Meet targets for supply and implant cost management.
- Coordinate equipment management.
- Set standards of practice for department.
- Meet regularly with department chairpersons to increase communication between physicians and staff.

*Source: University of Missouri, Columbia.*

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