When it comes to staffing, OR managers may feel they’re running faster to stay in the same place.

Managers say recruitment and retention are their greatest challenges. Efforts they are making to prepare their own OR staff may be a major reason vacancy rates and turnover rates have remained fairly steady over the past 4 years.

Just over half of managers—51%—are faced with a nursing shortage in their ORs. A little less than half—46%—have a shortage of anesthesia providers.

Managers cover for shortages primarily with overtime and extended hours for surgery. A few have had to close ORs. In all, 57% have vacancies for RNs, and 48% have vacancies for surgical technologists (STs), roughly the same as last year.

The average vacancy rate for those with openings is 8.6%, on a par with the 8.4% average for all RNs reported by the American Hospital Association.

The findings are from OR Manager’s 2004 Salary/Career Survey. Results on the staffing portion of the survey are reported in this issue. This is the fourth year staffing questions have been asked. The rest of the survey results will be in the October issue.

The survey was mailed in May to 1,229 OR Manager subscribers and had a return rate of 34%. A separate survey

Continued on page 19
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Salary/Career Survey

Learn what your colleagues are making and what they see as their biggest rewards and challenges.

A leadership gap

Why recruiting perioperative directors is difficult and what’s needed to help.

OR Manager

The monthly publication for OR decision makers

September 2004 Vol 20, No 9

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

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OR Manager (USPS 743-010). (ISSN 8756-8047) is published monthly by OR Manager, Inc, 1807 Second St, Suite 61, Santa Fe, NM 87505-3499. Periodicals postage paid at Santa Fe, NM and additional post offices. POSTMASTER: Send address changes to OR Manager, PO Box 5303, Santa Fe, NM 87502-5303. OR Manager is indexed in the Cumulative Index to Nursing and Allied Health Literature and MEDLINE/PubMed. Copyright © 2004 OR Manager, Inc. All rights reserved. No part of this publication may be reproduced without written permission.

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Editorial

OR managers seem to be dealing with a “new normal” in staffing. From the numbers, it looks like staffing is holding on. The vacancy rate, turnover rate, and use of temporary staff haven’t changed substantially for the past 4 years, according to the staffing portion of the annual OR Manager Salary/Career Survey reported in this issue.

But the numbers tell only part of the story. A lot is going on behind the scenes.

A few years ago, much of the news was about bonuses. You still see headlines about big sign-on bonuses, but in the OR, it appears leaders have moved on to more creative strategies.

Indeed, if survey respondents were going to give themselves a “Golden Scalpel” award this year, many said it would be for recruitment and retention.

One manager wrote that her organization has developed an elective course for credit with the local university. Another, as a result of education provided to inexperienced OR RNs over the past 3 years, is using only 1 agency nurse—a big change from 5 years ago when this facility was down 8 nursing positions out of 20.

One manager said she would give the award to her orientation team. “They worked very diligently to create a positive, progressive orientation program that keeps the orientees interested and happy to be here,” she said.

Still another wrote, “There actually is a waiting list to work in our OR. Morale is very high.” She credits a unit-based council and positive relations with physicians as some of the reasons.

A new level for ladders

Read about other creative programs in this issue.

Two organizations have taken their clinical ladder programs to a new level (p 1). Maine Medical Center has set up a ladder for surgical technologists in addition to RNs. Two community hospitals in rural California have a well-thought-out RN ladder with a user-friendly format.

The Mayo Clinic Hospital in Phoenix has a new Perioperative Education Pipeline that not only provides education to RNs who want to move into the OR but also offers a career track to entry-level employees (p 21).

One of the nation’s fast-growing cities, Phoenix is attracting a lot of new residents, many of them retirees who bring along their needs for health care. Meanwhile, as in the rest of the country, the nursing population is moving toward retirement.

But managers aren’t wringing their hands.

“Our secret is to train, train, train. Once you get short staffed, you never recover,” says Rita Borden, RN, BSN, executive director of surgical services for the Sun Health system based in Sun City, Ariz, and the 2003 OR Manager of the Year.

Sun Health facilities currently have 4 surgical technologists (STs) and 3 RNs in a periop education program. Borden is particularly proud of a program that provides training for central service techs to become STs. Two OR employees, an ST and a secretary, recently completed study toward becoming RNs.

Sun Health also pays for RN employees to continue on to get their BSNs.

For many of you, there’s probably nothing new in these stories. You may have equally creative programs. It’s likely to be a theme for years to come.

It’s heartening to know that managers are building seawalls to help keep the worst of the tidal wave at bay.

—Pat Patterson

Orientation without an educator

In the staffing survey, 43% of community hospitals do not have an OR educator, yet most are hiring nurses without OR experience.

How are you managing orientation without an educator? Share your experience. E-mail ppatterson@ormanager.com for a possible interview.

Orientation without an educator

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How are you managing orientation without an educator? Share your experience. E-mail ppatterson@ormanager.com for a possible interview.
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ADVANCED STERILIZATION PRODUCTS
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JCAHO issues 2005 Patient Safety Goals


For the first time, goals are specific to the type of setting, such as hospitals, critical access hospitals, ambulatory care organizations, and office-based surgery facilities, among others. There continue to be 7 goals in all.

Two new goals have been added for hospitals:
- Requirements for surgical site verification are now covered under the Universal Protocol for preventing wrong surgery, which took effect July 1. The protocol applies to hospitals as well as ambulatory surgery and office-based surgery facilities.
- The goal on clinical alarms has been expanded:
  - The goal on patient identifiers now applies not only to giving medications and blood and taking blood samples but also to other specimens and any other treatments or procedures.
  - The goal on improving communication has a new requirement for caregivers to measure, assess, and if needed, take action to improve timeliness of reporting of critical test results and values.
  - The goal on medications has a new requirement for organizations to review a list of look-alike/sound-alike drugs annually and take action to prevent errors for these drugs.

The goals for critical access hospitals are identical to those for hospitals.

Surgical fire goal for ambulatory care

The goals for ambulatory care organizations, including ambulatory surgery centers (ASCs), and office-based surgery facilities are the same as the hospital goals—with 2 important differences:
- Reducing the risk of surgical fires is a new goal for ASCs and offices but not for hospitals.
- The goal on patient falls applies to hospitals but not to ASCs and offices.

For 2005, ambulatory organizations and office-based surgery facilities are required to educate their staff about fires. This includes “operating licensed independent practitioners” (like doctors) and anesthesia providers.

Why isn’t this a goal for hospitals also?

This year, the goals were specifically developed and ranked for each type of organization, explains Michael Kulczycki, MBA, executive director of JCAHO’s Ambulatory Care Accreditation Program. For hospitals, the surgical-fire goal did not rank as high as others that were selected.

“This does not mean hospitals should ignore the issue of preventing surgical fires,” he said. “However, the Joint Commission will not be surveying for that in the hospital setting for 2005.”

There is no readily available data on how many surgical fires occur in ASCs.

Continued on page 8
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SURGICAL INFORMATION SYSTEMS
in the OR Manager print version.

Visit us at Managing Today’s OR Suite Booth #313 in Chicago.
### 2005 National Patient Safety Goals

<table>
<thead>
<tr>
<th>Goal: Improve the accuracy of patient identification.</th>
<th>Hospitals &amp; critical access hospitals</th>
<th>Ambulatory care and office-based surgical facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Use at least 2 patient identifiers (neither to be the patient's physical location) whenever administering medications or blood products, taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>• <strong>What's new?</strong> Goal is expanded to include other specimens or other treatment or procedures.</td>
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<table>
<thead>
<tr>
<th>Goal: Improve effectiveness of communication among caregivers.</th>
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<th>Ambulatory care and office-based surgical facilities</th>
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</thead>
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<tr>
<td>• For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result “read back” the complete order or test result.</td>
<td>X</td>
<td>X</td>
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<tr>
<td>• Standardize a list of abbreviations, acronyms, and symbols that are not to be used throughout the organization.</td>
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<tr>
<td>• Measure, assess, and if appropriate, take action to improve the timeliness of reporting, and timeliness of receipt by the responsible licensed caregiver, of critical test results and values.</td>
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<tr>
<td>• <strong>What’s new?</strong> First requirement has been reworded. Third requirement is new.</td>
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<tr>
<th>Goal: Improve safety of using medications.</th>
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<tr>
<td>• Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride &gt;0.9%) from patient care areas.</td>
<td>X</td>
<td>X</td>
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<tr>
<td>• Standardize and limit the number of drug concentrations available in the organization.</td>
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<tr>
<td>• Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization and take action to prevent errors involving the interchange of these drugs.</td>
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<tr>
<td>• <strong>What’s new?</strong> Requirement on look-alike/sound-alike drugs is new.</td>
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<tr>
<th>Goal: Improve safety of using infusion pumps.</th>
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</tr>
</thead>
<tbody>
<tr>
<td>• Ensure free-flow protection on all general-use and PCA (patient-controlled analgesia) intravenous infusion pumps used in the organization.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>• <strong>This goal is unchanged.</strong></td>
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<table>
<thead>
<tr>
<th>Goal: Reduce the risk of health care-associated infections.</th>
<th>Hospitals &amp; critical access hospitals</th>
<th>Ambulatory care and office-based surgical facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Comply with current U S Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>• Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with health care-associated infections.</td>
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<td></td>
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<tr>
<td>• <strong>This goal is unchanged.</strong></td>
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(Continued on page 8)
and offices, noted Mark Bruley, vice president of accident and forensic investigation for ECRI, an expert on surgical fires. ECRI is a nonprofit organization that specializes in health care technology. ECRI estimates 50 to 100 surgical fires occur each year in the U.S., with 1 to 2 patient deaths. “Most of the cases we have investigated have involved ambulatory surgery, regardless of the type of facility,” Bruley said.

Approximately 75% of surgical fires involve oxygen-enriched atmospheres, Bruley noted. Oxygen-enriched atmospheres are most common under the surgical drapes when an oxygen source is used on the face during monitored anesthesia care (MAC). This is very common in ambulatory surgery.

“The fact that the Joint Commission hasn’t made this a National Patient Safety Goal for hospitals doesn’t remove the burden to be proactive about preventing fires,” he said. “It’s a huge risk management issue regardless of whether it’s a goal targeted at your type of facility.”

Reconciling medications

The purpose of the new goal on reconciling medications across the continuum of care is to prevent medication errors that can occur if clinicians aren’t aware of all of the medications patients are taking, Kulczycki noted.

How will this goal apply to surgical facilities?

“The expectation is that the surgery center will get as accurate a list as possible from patients both of their medications and herbal products they may be using,” Kulczycki said.

“If they discharge the patient to any other provider setting, they need to make sure they provide as complete a list as possible to the other setting.” That includes postoperative pain medications.

For 2005, surveyors will be looking for some evidence that organizations are planning for this goal. Full implementation is not required until 2006.

Goal: Accurately and completely reconcile medications across continuum of care.

• During 2005, for full implementation by January 2006, develop a process for obtaining and documenting a complete list of the patient’s current medications upon the patient’s entry to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.

• A complete list of the patient’s medications is communicated to the next provider of service when it refers or transfers a patient to another setting, service, practitioner, or level of care within or outside the organization.

• What’s new? This is a new goal. During 2005, surveyors will look for evidence that planning is underway for implementation in 2006.

Goal: Reduce the risk of patient harm resulting from falls.

• Assess and periodically reassess each resident’s risk of falling, including the potential risk associated with the resident’s medication regimen, and take action to address any identified risk.

• What’s new? This is a new goal for hospitals.

Goal: Reduce the risk of surgical fires.

• Educate staff, including operating licensed independent practitioners and anesthesia providers on how to control heat sources and manage fuels and establish guidelines to minimize oxygen concentration under drapes.

• What’s new? This is a new goal for ambulatory care organizations and office-based surgical facilities.

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the Managing Today’s OR Suite conference Oct 6 to 8 in Chicago. Mark Bruley of ECRI will present a session, Surgical Fires: Awareness of a Continuing Risk. A conference brochure is at www.ormanager.com

ECRI resources

Free poster: Only You Can Prevent Surgical Fires, plus other publications on fires are at www.ecri.org, Professional Information, Medical Device Safety Reports.


Joint Commission resources


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Please see the ad for
INTEGRATED MEDICAL SYSTEMS
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Building a cross-generational workforce

Career strategist Marilyn Moats Kennedy will lead an all-day preconference seminar on managing today’s diverse generations at the Managing Today’s OR Suite conference October 6-8 in Chicago. OR Manager asked her how to keep Boomers, Busters, and Netsters working harmoniously.

What are the age-related issues in OR nursing today?

Kennedy: The shortfall of nurses after the Baby Boomers retire. The average OR nurse is 52; the average nurse is 47. The five highest birthrate years were 1946 through 1950. Hospitals are going to have to keep this whole group in their 50s and 60s happy because there are no replacements. You can’t hire what wasn’t born. Nursing will never make up for the shortages, so you’ve got to keep the older ones working and keep stirring the pot for the young ones with incentives.

What incentives can you offer different age groups?

Kennedy: Younger people want time off. Older people want money. Reward them appropriately.

How do we recruit bodies that don’t exist?

Kennedy: Give up the assumption that there is only one time to get them. You need to hit them at different points on the age spectrum. Start in junior high, then high school, then at the end of college. These are choice points to present your arguments.

Another great time is when women divorce in their 60s. It’s the age with the highest rate of divorce right now because it’s when their husbands retire. These women may have said, “for better or worse” but not “for lunch.”

Describe the nurse of the future.

Kennedy: He—there will be a lot more men—will be in his late 20s or early 30s and becomes a nurse as a second career. First, he has to get rid of his college debt with a well-paying but less meaningful job. Then he will choose nursing because people under 30 are obsessed with purpose and making a difference.

Managing a cross-generational workforce is like conducting an orchestra. Each age group brings different skills and attitudes. In the end, you get the intended result.

I manage several nurses in their 20s and mostly 30s. When I tell them a task needs to be done, they look at me with a blank stare. Obviously, my priority isn’t their priority. How do I manage this generation?

Kennedy: Do not hint or suggest. This age group is Teflon coated. You say, “Jane, do X.” They resent it when people try to manipulate them. To a Boomer you could say, “This needs to be done,” and she will get up and do it. —Leslie Flowers

The conference brochure is at www.ormanager.com. Or call 800/442-9918.

Marilyn Moats Kennedy is founder and managing partner of Career Strategies, a management consulting firm in Wilmette, Ill. She publishes Kennedy’s Career Strategist, a newsletter on career planning, job hunting, and office politics. Her web address is www.moatskennedy.com

Medicare changes policy on obesity

A new policy on obesity by the federal government may pave the way for studies to determine whether Medicare should pay for obesity treatments, ranging from surgery to diets to psychotherapy.

The policy, announced July 15 by Health and Human Services Secretary Tommy G. Thompson, removes language in the Medicare coverage manual that said obesity is not an illness.

The new policy is not expected to have an immediate effect on Medicare coverage. But as a first step, officials plan to convene a Medicare coverage committee in the fall to evaluate the evidence on obesity surgery for reducing heart disease and other illnesses.

Information about the policy is at www.hhs.gov/news
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was conducted for ambulatory surgery centers.

Recruiting gets tougher each year. More than 80% of managers say recruiting perioperative RNs has become more difficult in the past year—and 87% said it got more difficult the year before.

OR managers accept the fact that hiring experienced perioperative nurses is largely a thing of the past. Over 80% often hire RNs without OR experience—double the percentage of 1991—and expect to provide them with additional preparation for the OR.

**OR vacancies, turnover**

For those with RN openings, overall, the vacancy rate was highest in teaching hospitals (10.1%) and in the West (10.5%).

Vacancy rates are lower than in 2001 and about the same as in 2003.

On average, RN positions were open for 12.3 weeks and ST positions for 10.1 weeks. There was little difference by region. The time is not as long as in 2001, when the average was 16.5 weeks for RNs and 15.2 weeks for STs.

Vacancy rates for the OR are lower than the 14% for RNs in general reported by JWT Specialized Communications Healthcare Group, which consults on recruitment and retention.

**Temps and travelers**

Reliance on contract workers has been relatively steady over the past 4 years. This year, 23% report they routinely use agency staff and travelers to fill budgeted OR positions, similar to previous years.

When temps are used, they fill on average 7.8% of budgeted FTE positions. Of those who rely on temps, 77% use them for less than 10% of their budgeted FTEs. Two facilities reported 50% or more of their staff are travelers. Both are community hospitals, one in the West and one in the East.

Use of temporary staff is highest in the West, where 36% use them routinely. In the South, only 14% regularly use agency staff or travelers.

Larger departments are more likely to rely on temporary staff.
### Average staff turnover rate

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>Region</th>
<th>Overall</th>
<th>Community</th>
<th>Teaching</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNs</td>
<td>East</td>
<td>7.3%</td>
<td>7.2%</td>
<td>7.8%</td>
</tr>
<tr>
<td></td>
<td>Central</td>
<td>5.6%</td>
<td>7.7%</td>
<td>8.0%</td>
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<tr>
<td></td>
<td>South</td>
<td>7.3%</td>
<td>6.0%</td>
<td>8.3%</td>
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<tr>
<td></td>
<td>West</td>
<td>7.5%</td>
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<td></td>
</tr>
<tr>
<td>STs</td>
<td>East</td>
<td>7.1%</td>
<td>7.6%</td>
<td>5.4%</td>
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<tr>
<td></td>
<td>Central</td>
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<td>West</td>
<td>6.4%</td>
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*Note: Turnover was defined as the percentage of staff who have left and been replaced in the past year.*

### Average number of open positions in ORs

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>Region</th>
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<th>Teaching</th>
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</thead>
<tbody>
<tr>
<td>RNs</td>
<td>East</td>
<td>1.8</td>
<td>1.4</td>
<td>2.8</td>
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<tr>
<td></td>
<td>Central</td>
<td>1.4</td>
<td>1.2</td>
<td>1.8</td>
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<tr>
<td></td>
<td>South</td>
<td>1.0</td>
<td>0.9</td>
<td>1.2</td>
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<tr>
<td></td>
<td>West</td>
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<td>0.9</td>
<td>1.2</td>
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<tr>
<td>STs</td>
<td>East</td>
<td>1.1</td>
<td>0.9</td>
<td>1.7</td>
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<tr>
<td></td>
<td>Central</td>
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<td>0.9</td>
<td>1.7</td>
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<tr>
<td></td>
<td>South</td>
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<td>0.9</td>
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<td>West</td>
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### What percentage of budgeted FTE positions are open?

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<td></td>
<td>South</td>
<td>4.6%</td>
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<td>West</td>
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<td></td>
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### Average number of weeks positions have been open

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<th>Community</th>
<th>Teaching</th>
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<tr>
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<td>STs</td>
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<td>West</td>
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### Do you routinely use agency/travelers to fill budgeted OR positions?

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<th>Community</th>
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</tr>
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<td>26%</td>
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<td></td>
<td>Central</td>
<td>21%</td>
<td>22%</td>
<td>14%</td>
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<td></td>
<td>South</td>
<td>21%</td>
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<td>14%</td>
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<tr>
<td></td>
<td>West</td>
<td>36%</td>
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### What percentage of FTEs are agency/travelers?

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<td>East</td>
<td>7.8%</td>
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<td>2.3%</td>
</tr>
<tr>
<td></td>
<td>West</td>
<td>13.0%</td>
<td></td>
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</tr>
</tbody>
</table>
Salary/Career Survey

Use of temps by number of ORs
1-5 rooms 13%
6-9 rooms 20%
10+ rooms 32%

“It is still less expensive for hospitals in total to pay for travelers than to pay a rate that would attract a full staff,” says Paul Wafer, RN, MBA, a perioperative nursing consultant in southern California. He says hospitals have tried to keep salaries down even though demand for nurses is high. The West has an additional recruiting challenge because it has some of the nation’s fastest-growing cities, including Phoenix and Las Vegas.

Hiring without experience

The vast majority of respondents—88%—are hiring RNs without OR experience. That’s a dramatic change from 41% in the first OR Manager Salary/Career Survey in 1991. The number who never hire RNs without experience in surgery fell to 12% in this year’s survey.

Experienced OR RNs are a little easier to find in the Central states, where 18% say recruiting is not at all difficult. That compares with 14% in the West and 9% in the East and 10% in the South.

“Growing your own” perioperative nurses is the new reality. Experienced OR nurses are moving toward retirement, and nursing schools provide little if any preparation in perioperative nursing. ORs accept the fact that they must educate their own perioperative staff.

Bonuses lose allure

Money is losing its luster as a recruitment tool, at least in the OR Manager survey. This year, 37% of respondents offer sign-on bonuses, down from 45% in 2003 and 51% in 2002. The median bonus is between $2,000 and $3,000, with only 11% paying more than $5,000.

Sign-on bonuses are most popular in the West, where 49% offer them, and least common in the Central region, where 22% do.

It’s hard to know what effect bonuses have on recruitment and retention.

Many who offer sign-on bonuses report they do not have openings in their ORs, though it’s impossible to know if bonuses are the reason. One facility that pays a $4,000 sign-on bonus and a $2,000 bonus after 2 years of employment has no vacancies and identifies its low turnover rate as a major achievement. Another offers a $5,000 bonus but has no open-

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Do you pay a bonus... for recruitment?

Yes 37%
No 63%

How much is the recruitment bonus?

< $1,000 8%
$1,001-$3,000 30%
$3,001-$5,000 30%
$5,001-$10,000 23%
>$10,000 11%

Do you pay a bonus... for retention?

Yes 18%
No 83%

How much is the retention bonus?

< $1,000 14%
$1,000-$2,000 23%
$2,001-$3,000 21%
$3,001-$5,000 18%
>$5,000 25%

Continued from page 13

Continued on page 16
**Salary/Career Survey**

**Enough educators in OR?**

Educators are taking on an increasingly important role as ORs hire more inexperienced staff and try to keep employees up to speed with new technology.

For the first time this year, the survey asked how many educators ORs have and whether they think their educational resources are adequate.

The range in the number of educators varies widely—36% have none, while 1 teaching hospital has 10. Most with no educator are community hospitals. In all, 42% of community hospitals have no educator, but only 15% of teaching hospitals have none.

For those with an educator, 73% had 1 person in that role.

Managers are split on whether they have enough educational support. About half of community hospitals say their resources are adequate, compared to two thirds of teaching hospitals.

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**Impact of shortages**

Though about half of respondents say they have a shortage of RNs or anesthesia providers, few have closed ORs for that reason. Only 6% (24 facilities) closed ORs for more than 1 week because they did not have enough nurses, and 14% (56 facilities) closed ORs because of a lack of anesthesia coverage. One facility reported closing a room every Monday because of the anesthesia shortage. Another manager wrote the hospital does not have a shortage because of its high pay for nurse anesthetists at $109 an hour.

The main ways of coping with the shortages are to have the staff work longer hours and to add hours to the surgical schedule. The majority of respondents—53%—routinely use overtime to staff their ORs.

ORs also are extending hours in the postanesthesia care unit and discharging patients later. ♦

—Billie Fernsebner, RN, MSN, and Pat Patterson

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**What effect has the nursing and anesthesia shortage had on your OR?**

<table>
<thead>
<tr>
<th></th>
<th>Nurses</th>
<th>Anesthesia Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do not have a shortage</td>
<td>49%</td>
<td>54%</td>
</tr>
<tr>
<td>Day of surgery cancellations</td>
<td>NA</td>
<td>3%</td>
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<tr>
<td>One or more ORs closed for more than 1 week</td>
<td>6%</td>
<td>14%</td>
</tr>
<tr>
<td>Loss of surgical cases to other facilities</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Longer patient waits for elective surgery</td>
<td>11%</td>
<td>17%</td>
</tr>
<tr>
<td>Extended hours for scheduled cases</td>
<td>33%</td>
<td>31%</td>
</tr>
<tr>
<td>Increased use of overtime to complete schedule</td>
<td>47%</td>
<td>31%</td>
</tr>
<tr>
<td>Increased use of agency/traveler nurses</td>
<td>16%</td>
<td>NA</td>
</tr>
<tr>
<td>Extended hours for PACU</td>
<td>31%</td>
<td>24%</td>
</tr>
<tr>
<td>Patients discharged home or to surgical floor later in day</td>
<td>23%</td>
<td>17%</td>
</tr>
</tbody>
</table>
Ambulatory surgery centers (ASCs) are having an easier time with recruitment and retention than hospitals.

A lower percentage of ASCs have vacancies, and it takes them less time to fill a position. They rely less on overtime, perhaps because most ASCs perform short cases during the day shift only.

The results are from staffing questions in the OR Manager Salary/Career survey, which was sent in May to 583 ASC managers with a return rate of 23%.

Some highlights:
- More than half of ASCs—58%—report no RN openings, compared to 43% of hospitals. And 75% have no openings for surgical technologists (STs), whereas 52% of hospitals do.
- Twenty five percent still have no problems recruiting experienced OR nurses, which is true for only 13% of hospitals.
- About half (49%) do not hire RNs without OR experience, while 12% of hospitals do not.

Still some have done a lot of work to prepare new recruits. One manager was proud that her center has offered the Perioperative Nursing 101 course from the Association of periOperative Registered Nurses to 3 nurses.

“We provided preceptors within the ASC. This took exceptional time and involvement of all senior staff,” says this manager of a 2-OR eye clinic.

The pick of nurses
ASC managers are less likely than hospital managers to name recruitment and retention as their greatest achievements or challenges.

Attracting and keeping RNs is easier in a surgery center than a hospital OR for a number of reasons, according to OR Manager interviews with ASC managers.

“The procedures are easier, there aren’t as many procedures to train on, you rarely have an emergency, the physicians are in a better mood—and the hours are awesome,” says Mindy Hoffman, RN, CNOR, manager of the Surgery Center for Sharp Chula Vista Medical Center in San Diego.

Effingham Ambulatory Surgery Center in rural Effingham, Ill, has a waiting list of nurses who want to work there. The center does not hire nurses without OR experience.

Though the median age of nurses in the area is about 40 years, Bales says she also has her choice of 20-something nurses.

Medical Center in San Diego.

Effingham Ambulatory Surgery Center in rural Effingham, Ill, has a waiting list of nurses who want to work there. The center does not hire nurses without OR experience.

Though the local hospital gives larger raises and better benefits, nurses are willing to give up a little for a better quality of work life, says the center’s administrator, Leanne Bales, RN, CNOR.

Though the median age of nurses in the area is about 40 years, Bales says she also has her choice of 20-something nurses.
Salary/Career Survey

Do you routinely use overtime to staff your ASC ORs?

- Yes: 35%
- No: 65%

Yes, elsewhere: 8%

Does your ASC pay a bonus to recruit clinical staff?

- Yes: 19%
- No: 82%

Numbers do not equal 100% due to rounding

Is recruiting experienced OR nurses more difficult?

- Very: 26%
- Somewhat: 49%
- Not at all: 25%

Open positions in ASC ORs

No open positions

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<thead>
<tr>
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<th>RNs (n=77)</th>
<th>STs (n=89)</th>
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<tbody>
<tr>
<td>RNs</td>
<td>58%</td>
<td>75%</td>
</tr>
<tr>
<td>STs</td>
<td>75%</td>
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</table>

Average number of open positions

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<tr>
<th></th>
<th>RNs (n=56)</th>
<th>STs (n=30)</th>
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<tbody>
<tr>
<td>RNs</td>
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<td>0.3</td>
</tr>
<tr>
<td>STs</td>
<td>0.3</td>
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</tr>
</tbody>
</table>

Salary/Career Survey director

Billie Fernsebner, RN, MSN, education director for OR Manager, Inc, has coordinated the OR Manager Salary/Career Survey for the past 8 years.

Thank you

OR Manager thanks its subscribers who generously took time to complete this year’s survey. We appreciate your part in gathering this information, which will be useful to your colleagues around the country.

program tailored to each nurse’s strengths as well as insecurities.

“Bonuses, hourly pay, and staff lunches—none of that really matters unless your staff is happy,” she says.

In her experience, an OR background is not as important to a nurse’s success in an ASC as enthusiasm, autonomy, a strong focus on customer service, and a sense of humor.

Fewer candidates

In Southeastern Michigan a nursing shortage is affecting ASCs.

“We are seeing fewer candidates even for Monday-through-Friday positions,” says Cheryl Dendy, RN, administrative director for the Ambulatory Satellites at St John Hospital and Medical Center, St Clair Shores, Mich.

“There are fewer nurses available in our market, and the economy still has not been poor enough to lure a lot of folks out of the home.”

The situation is frustrating because local nursing schools have a waiting list of people wanting to enroll. There are not enough slots because of a faculty shortage.

St John’s ambulatory units still require a minimum of 3 years of OR experience.

“We have a high standard for maintaining our patient and surgeon satisfaction scores,” which are in the top 2% to 8% nationally, Dendy says. St John has an extensive interview process that includes observation time in the center, which shrinks the pool further.

She is looking to retired nurses to come in during crunches. Though some may not be physically capable of handling the pace, they can run the surgical board and help with other projects.

Also difficult to find are experienced postanesthesia nurses.

“I rarely find one and have to do a lot of training,” she says. This is demanding in a multispecialty center that serves pediatric patients and requires a high level of skill.

Though the center could lower its hiring requirements, “we feel we have too much at risk. All of us are willing to do what it takes to keep the center running until we can best fill a vacancy,” she says. ✤
Something to reach for
MMC, a teaching center with 21 ORs on the main campus, a 5-OR surgery center, and a surgical volume of about 18,000 cases a year, introduced its ST ladder about 2 years ago, in addition to its RN ladder. The staff is 50% RNs and 50% STs.

“We are equally in need of recruitment and retention for techs as for RNs,” says Dumond. “We wanted to give them something to reach for if they don’t want to go back to school.” All STs must be certified within 3 months of employment.

The ST ladder has 3 rungs:
• CST I: Entry level. Performs scrub role on core cases for assigned services.
• CST II: Automatic advancement after 2 years as a CST I with a 2% increase in pay. Performs core and specialty procedures in assigned services.
• CST III: 5 years of experience plus approval of application with a 4% increase in pay. CST IIIs are expected to work at least 32 hours a week and function independently and proficiently in the scrub role in complex cases in their assigned area and maintain competency in other specialties. CST III candidates must document 20 hours of continuing education a year, including some classes outside the hospital.

“We also look for them to give in-services themselves,” adds Dumond. “We ask them to teach the difficult learner, such as the person who is having a hard time with orientation.” CST III applicants also must document participation in a department quality or improvement committee or community involvement, such as visiting schools to talk about careers in the OR.

Submitting a portfolio
The clinical ladder pay increases are in effect as long as STs stay at their level.

“In their yearly evaluation, if at Level III, they have to continue to meet the criteria for a Level III, or they drop back a level—you have to live up to that level on a yearly basis,” Dumond notes.

To advance from CST II to CST III, STs submit a portfolio, similar to what the nurses compile for their ladder. In the portfolio are letters of recommendation, proof of educational credits, a letter from the candidate addressing how he or she has fulfilled the requirements, and an interview with the review committee.

The review committee is made up entirely of STs. Dumond has been impressed with their leadership and impartiality. “They make decisions about people they work with every day, and they really do hold people to the line,” she says.

It took some time for the committee to learn to make decisions based on the documentation presented to them, such as peer reviews and recommendations from managers, rather than adding their own impressions about applicants or their performance.

In organizing the committee, Dumond asked for volunteers. It was key that the STs who volunteered had the respect of the staff and could drive the process.

A role for lead techs
Lead techs are an additional advancement opportunity for STs but are not part of the ladder. Lead techs assist with technical management of a cluster and earn 2% more than a CST III.

“Lead techs are viewed as leaders, even by the nurses. They are a great resource and are willing to share their information,” Dumond says.

Among their functions are to know the competencies of other STs in their cluster and give assignment advice to RN leaders, give input on STs’ performance evaluations, order instruments and equipment, send equipment out for repair, communicate with surgeons about instrument and supply needs, and help to arrange in-services. In the cardiac service in particular, the lead tech “has provided a huge role in keeping the team together,” Dumond says.

Tips for success
She finds the clinical ladder process has elevated the STs’ involvement and initiative.

“They have been more willing to address issues with each other rather than going to management. They are looking for ways to improve the system, and they are more interested in taking advantage of educational opportunities.”

Dumond’s tips for being successful with ST ladders:
• Be clear if seniority is not a qualification for advancement. “Even though we were clear, we had excellent techs apply because they had 20 years or more of experience but didn’t necessarily meet all of the criteria,” she notes.
• If applicants are turned down, be clear about how soon the person can reapply and exactly which criteria must be addressed.

“We learned we needed to be really clear about the expectations, how they could succeed, and when they could reapply,” she says.

Fine tuning an RN ladder
Hanford and Central Valley have worked to refine their nursing clinical ladder for 4 or 5 years. The system, with 2 small hospitals and an ambulatory surgery center, is in a rural community south of Fresno.

Simple at first, the ladder has “evolved into something that is a lot more meaningful,” says Harris. One of the changes was to award bonuses for ladder advances instead of increases in hourly pay. That avoids the problem of having to take back pay if a nurse decides to drop back a level.

The ladder, with 4 steps for RNs and 3 steps for LVNs, is based on a point system that is clearly spelled out in a packet nurses receive. The packet has ladder policies and procedures as well as worksheets for recording achievements in each category of the ladder’s professional development process.
Recruitment & retention

Continued from page 19

- development of self
- development of others
- commitment to patient care needs
- improvement of patient care
- improvement of unit or organization
- advancement of nursing/performance improvement.

“The ones who are the most successful fill out the worksheets as they complete the activities. We thought it was important to make it user friendly because nurses are so busy,” Harris says.

New employees can apply for the ladder immediately if they work at least 40 hours per pay period and have at least 2 years’ experience as a nurse. Experienced nurses are hired as an RN II, while new graduates are hired as an RN I.

Nurses can apply for advancement by the first of every quarter, submitting 12 months of documentation. Applications are reviewed by the system’s clinical ladder committee, chaired by Harris.

Nurses often go above and beyond the requirements. An RN IV requires 150 points, but some applicants have 180 points.

The bonus for advancing is $1,000 per step. Thus, a nurse who moves from Level II to III receives $1,000. A nurse can earn an additional $1,000 for moving on to Level IV in the same year. Levels must be renewed each year, and nurses receive bonuses for renewing. For example, an RN IV who wants to stay at that level must accumulate enough points to renew at Level IV for the next year. If she renews both Level III and IV, she receives a $2,000 bonus. But if the nurse decides to renew only at Level III, she receives a $1,000 bonus. The amount of the bonus is tied to the hospital’s financial status.

“We have found that a lot of nurses are doing the work already. All they are doing is documenting it and presenting it to the ladder committee,” Harris says. “It’s a nice way for them to capture it and showcase it.”

“It’s so heartwarming to see the development,” she adds. “We have nurses signing up to give in-services for CEUs. They also are doing the staff schedule. If they have time, they ask me if there are charts that need auditing.” They are taking the initiative to “close the loop” on performance improvement activities.

Fully staffed ORs

MMC and Hanford/Central Valley have no vacancies in the ORs.

“We are fully staffed, and we have been for about 3 years—we have not had a traveler in 3 years,” says Dumond. It helps that Portland has an ST education program, and the hospital has an internship program for OR RNs. The OR’s turnover rate is about 3%, and the whole hospital’s turnover rate is under the national average.

MMC’s administration strongly supports clinical ladders and other education efforts. Says Dumond, “Education is a priority here. It’s not easy to get people free, but we will struggle for education.”

Hanford/Central Valley also have no OR vacancies and have not used a traveler since 1994.

“We have been blessed. Our folks are tenured, and we have hired new grads, who have worked out beautifully,” Harris says. As a rural community, Hanford tends to have a staff that stays in the area. And with 3 facilities, she has the flexibility to move staff around if necessary to cover peak times.

Most hospitals to get full update, CMS says

Urban hospitals will see a 5.7% average increase in inpatient payments for fiscal 2005, and rural hospitals will receive a 6.2% average increase, in a final rule the Centers for Medicare and Medicaid Services (CMS) issued Aug 3.

For the first time in 2005, Medicare will link payments to participation in quality measurement.

Hospitals that report quality data to CMS will receive a full inflation update, while those that do not will receive 0.4 percentage points less than the full update.

CMS said the “overwhelming majority” of hospitals will be eligible for the full update but did not have a number as of Aug 6. Congress passed a law last year requiring hospitals to report on 10 quality measures or receive a lower payment update.

In May, 70% of hospitals had signed up to report data, and 40% had submitted data on at least one measure.

CMS also pledged to be more open in its decisions on paying for new medical technology, with more opportunities for public input.

Changes in technology payments

Among changes for 2005 are add-on payments for 2 technologies:

- an implantable neurostimulator for deep-brain stimulation for patients with essential tremor and Parkinson’s disease
- A device that provides cardiac re-synchronization therapy with defibrillation.

Add-on payments will continue for bone morphogenetic protein (BMP).

In addition, heart-assist devices, including left-ventricular assist devices (LVADs), will be assigned to the DRG for heart transplants, which will provide higher payment. LVADs originally were approved as a “bridge” therapy to transplant but are now approved as a “destination” therapy for patients requiring permanent mechanical cardiac support.

Also, a spinal fusion procedure requiring only a single incision is being removed from the DRG for spinal fusions requiring 2 incisions, resulting in a higher payment for the latter procedures.

The final rule also addresses the impact of changes in geographic classification of hospitals, with phase-ins for hospitals that would see a decrease in their wage index.

There also are provisions to aid critical access hospitals that serve Medicare patients in rural areas.

Information on the rule is at www.cms.gov
Perioperative Education Pipeline gives Mayo staff a career path

Perioperative managers have been reaching out to other nursing units to recruit RNs for the OR. One hospital is reaching even further into its ranks.

As part of the Perioperative Education Pipeline at the Mayo Clinic Hospital in Scottsdale, Ariz, a person with a high school education or GED who hires on in an entry-level position can follow a 9-year program to become a perioperative RN with a BSN. With 2 more years of education, the person can become a certified registered nurse anesthetist (CRNA) or a perfusionist.

The pipeline is a career pathway that supports the education of employees from the entry level on up. “We are a high acuity, tertiary care facility, and we need to have folks in the pipeline,” says Karen Bied, RN, BSN, director of perioperative services. The 200-bed hospital has 15 ORs in the main hospital and 4 ORs in an ambulatory surgery center.

The pipeline is one way of meeting the Phoenix area’s fast-growing need for health care. This year, 750 hospital beds are opening. Mayo’s beds are full, and it is adding new ORs. At this point, the ORs are fully staffed.

“This concept evolved because we want to give opportunities to people within our institution who want to further their education,” says Carolyn Leslie, RN, MS, CPAN, CNOR, one of the OR’s 2 perioperative education coordinators with Brad Haase, RN, MS, CNOR. For Mayo, a teaching institution, education is a primary mission and value.

Mayo provides tuition reimbursement for all employees from the day they are hired and arranges their schedules so they can take classes.

Entering the pipeline

A person can enter the pipeline at any point. An entry-level person accepted into the program begins taking community college courses in subjects such as medical terminology and basic life support.

From there, the person can move on to become a central service (CS) technician, taking more courses at the community college and gaining clinical experience at the hospital. A CS position provides a basic knowledge of surgical instrumentation, tray assembly, and sterilization practices.

With additional education, a CS tech can progress to become a surgical technologist (ST). Mayo partners with 2 ST educational programs.

“They go to school for the didactic portion and come here for their clinical experience,” notes Haase.

An ST can continue on to pursue a BSN and become an RN.

Currently, several people have completed the CS track, and several others are in the ST program. Some STs have gone on to become RNs, and a PACU nurse is enrolled in a CRNA program.

Courses for nurses

For nurses who want to come to work in the OR, the hospital has offered a perioperative nursing course annually for the past 5 years. The course is based on Perioperative Nursing 101 from the Association of periOperative Registered Nurses (AORN). The 12-week course typically has 3 to 5 students. Instruction is provided by the educators, with team leaders and guest lecturers providing some of the content.

Most of the staff serve as preceptors. They are required to take a 6-hour preceptor training program, which is a module in the AORN course.

“That’s critical for the success of the program,” Haase says.

The staff really enjoy precepting, he adds. “They will ask, ‘When are we going to get our next students?’”

OR orientation is conducted in phases. The basic orientation is 90 days for all new RN employees, including those with experience. After that, they are expected to take call in their specialty. Nurses orient to a primary specialty initially because Mayo’s ORs are organized by specialty.

A nurse who orients to orthopedics, for example, might work solely in that specialty for the first year because the service takes its own call. For general surgery, initial orientation might take 2 weeks to 2 months, depending on the nurse’s experience. After that, nurses rotate to other specialties they might encounter on call, such as gynecology, urology, and neurosurgery.

Share your successes at 2005 meetings

Share your successes with your colleagues at the conferences of OR Manager, Inc. Send proposals of about 500 words describing the session you wish to present. Sessions are approximately 1 1/2 hours long.

Managing Today’s OR Suite

Oct 19 to 21, 2005, San Diego

Managing Today’s OR Suite focuses on practical topics related to management of surgical services, such as achieving greater efficiency, management of information, leading and developing staff, and keeping costs under control.

The keynote address and general sessions feature nationally known speakers who have important messages for surgical services directors. If you wish to suggest a general session speaker, please obtain as much information about the person as you can, such as the speaker’s title, organization, address, and phone number.

OR Business Management Conference

May 2 to 4, 2005, Tampa, Fla

The OR Business Management Conference emphasizes financial management, materials management, OR technology/equipment management, and OR design and construction.

The deadline for proposals and suggestions for both conferences is Nov 1.

Fax or e-mail proposals to Billie Fernsebner, RN, MSN, education director, OR Manager, Inc, at 303/442-5960 or bferansebner@ormanager.com. If you have questions, please call 303/442-1661.

Have an idea?

Do you have a topic you’d like to see covered in OR Manager? Have you completed a project you think would be of help to others? We’d be glad to consider your suggestions.

Please e-mail Editor Pat Patterson at ppatterson@ormanager.com.

September 2004 OR Manager Vol 20, No 9
Hardiness in health care

The concept of hardiness in health care workers emerged in the mid-1980s after a landmark study at Illinois Bell Telephone (IBT) during the breakup of the telephone giants.

Salvatore R. Maddi, PhD, and his team of researchers at the University of Chicago studied 400 IBT employees over 12 years. In the most stressful years of the divestiture, during layoffs and reorganizations, they found almost two-thirds of the participants showed significant wellness breakdowns, including heart attacks, cancer, suicide, depression, anxiety, or divorce. But the remaining one-third maintained their health and performance and actually thrived.

“These hardy individuals had the attitude of ‘When the going gets rough, get more involved,’” says Maddi. “They either rose within IBT, left and started their own businesses, or rose up the ranks of a competitor.”

Since then, more than 600 studies related to hardiness have been conducted around the world, and Maddi’s trademark hardiness survey has been translated into 15 languages, he says. Maddi is the founder and director of The Hardiness Institute, Inc, Newport Beach, Calif.

“Hardiness is a combination of attitudes and skills that help you be resilient and turn stressful situations from potential disasters into growth opportunities,” Maddi says.

In nursing, studies over the last 2 decades have demonstrated that high-hardy nurses are more resistant to stress, strain, and burnout.

Sharon Judkins, RN, PhD, director of nursing administration at the University of Texas and Furlow’s research partner, showed in her study that for nurse managers, high hardiness is linked to lower levels of stress and higher problem-solving skills.

“Hardiness has emerged as a buffer strategy not only to diminish the negative effects of stress, but also to help develop coping skills that will benefit both individuals and organizations,” says Furlow.

3 Cs of Hardiness

According to Maddi’s original research and later work by nurse researchers, hardy nurses share these 3 personality attributes:

Commitment

Hardy nurses are deeply involved in life’s activities and have a knack of finding something interesting or important about whatever it is they are doing, say Judkins and Furlow. They do not give up easily under pressure and possess a strong sense of purpose and direction. They stay useful and don’t pull back into isolation and alienation.

Control

Hardy nurses believe they have great control over their lives and act to create better life situations. Consequently, they see workplace stressors as nonthreatening, natural, and meaningful, note authors Fox, Fox, and Wells. Nurse managers who are high-hardy often create fun, positive work environments. They don’t waste time on feelings of powerlessness or passivity. They keep trying to have an influence on their environment.

“Staff is empowered to make a difference because the manager believes both the manager and staff do make a difference,” says Judkins.

Challenge

Hardy nurses see change, pressures, and disruptions, however painful, as opportunities for learning and growth. They tend to see the opportunity and excitement in change, while low-hardy nurses feel threatened and frequently respond with negativity, criticism, and even sabotage.

“If you’re hardy, you’re someone who deals with issues,” Furlow says. “And if you want to succeed in nursing, you need to be able to deal with conflict and challenge because change is the only constant in health care.”

Hardiness can be learned

Hardiness can be learned, says Furlow, who provides hardiness training over a period of 18 months.

“Research has shown that hardiness training that takes place in a few days is not retained,” she says.

HardinessMentors first provides a 3-day intensive for groups of no more than 10 people. They come back weekly for 6 weeks, then return at 3, 6, 12, and 18 months for 2- to 3-hour sessions. Participants are assessed on a hardiness scale at the beginning and end of each session.

The training builds skills in communication, conflict management, problem solving, anger management, and stress management, Furlow says.

Participants usually are nursing directors or middle-level managers—“the level that was devastated by reengineering in the ’90s and is lacking in managerial skills,” she says.

Maddi’s group, The Hardiness Institute, also provides training and developed the original HardiSurvey assessment, which is available through The Hardiness Institute’s website (www.hardinessinstitute.com).
Recruitment & Retention

**Strategies to encourage hardiness**

**Commitment**
- Encourage personal involvement in daily organizational life.
- Mentor protégés by sharing personal successes and failures.
- Establish interdepartmental mentors by pairing new managers with seasoned managers in other departments.
- Provide conflict management and assertiveness training to promote healthy group interaction and cohesiveness.
- Role-play and offer scenarios to discuss how staff as a group can commit to solving problems and issues together.

**Control**
- Provide an environment in which nurses feel a sense of influence over their practice.
- Create physician and nurse practice committees to establish standards of care collaboratively and determine how and when nursing interventions will be taken.
- Develop policies to allow nurses to practice to the extent of their skills and abilities.
- Provide open communication channels between administration and staff for sharing information and requesting input.

- Advocate manager participation in hospital budget preparation.
- Encourage and reward creativity among staff to generate ideas and implement new practices, such as solving scheduling issues.
- Discuss opportunities to increase a sense of autonomy, such as shared governance and self-scheduling.
- Discuss case studies to reinforce problem-solving strategies rather than fire fighting.
- Create a fun work environment.

**Challenge**
- Develop policies that promote participation in change, such as encouraging and rewarding active participation in committees and groups.
- Promote change as constructive—an evolution rather than a negative intrusion.
- Promote new learning experiences among staff.
- Engage staff in the change process and reward positive changes in behavior and practices.


**Hardiness retains nurses**

The best way to teach hardiness is through emulation, says Furlow. “Hardy managers transfer these skills to their staff.”

Results from hardiness training for 12 nurse managers who cover 20 departments at Osteopathic Medical Center in Fort Worth, Tex, showed that 6 months after the initial training by HardinessMentors, nursing staff turnover was reduced 63%. Moreover, this was at a time the hospital was for sale.

“The data reinforce our belief that if we made nurse managers more hardy, their staff would not turn over as quickly because managers would be able to deal with issues and emulate hardy behaviors,” Furlow says.

As organizations strive to become harder, they attract and retain a higher proportion of hardy individuals, reports Maddi.

A 1987 study by Rich and Rich found that some of the least hardy nurses are the youngest. They have higher burnout rates because they lack experience in handling stress, and the job may not meet their initial expectations.

A hardiness scale can help determine a nurse’s hardiness level and need for training. Less hardy nurses can then be developed and/or assigned to less stressful environments.

Furlow does not advise administering the hardiness assessment during the interview process for new employees unless it is used with every applicant because there could be equal opportunity issues.

Furlow concludes that fostering a culture of hardiness is the greatest deterrent to the negative effects of stress—staff burnout, poor work performance, acute and chronic health problems and high turnover.

“Many organizations pay consultants enormous fees to change the culture. By developing a high-hardy environment, administrators can reap the same benefits at a fraction of the cost.”

—Leslie Flowers

Leslie Flowers is a freelance writer in Indianapolis, Ind.

Salvatore Maddi can be reached at The Hardiness Institute at 949/252-0580 or hardiness1@aol.com.

Leslie Furlow can be reached at HardinessMentors at 877/331-4321 or Leslie@achievementors.com

**References**


“Smart” wristbands tested for patient ID

O

R managers are just starting to talk about a new technology—radiofrequency identification, or RFID—that is expected to replace many types of bar codes in 5 years and make patient identification and other functions more effective.

Two pilot studies are underway in ORs to evaluate the use of radiofrequency identification wristband technology in blood transfusions and surgical site verification.

Georgetown University Hospital in Washington, D C, a 609-bed teaching center, began its 100-patient study in March to compare bar-code technology with RFID to verify transfusions from donor to patient, says Gerald Sandler, MD, director of medicine at Georgetown, who is conducting the study.

In the second study, surgical nurses at 300-bed Valley Presbyterian Hospital in Van Nuys, Calif, will use readers to scan patients with RFID wristbands before surgery to ensure the correct body part is operated on, says Irwin Thall, manager for RFID in health care with Precision Dynamics Corp, a San Fernando, Calif-based wristband identification company.

Both studies are testing Precision’s RFID “Smart Band” wristbands.

“We are looking to prove several things,” Thall says. “We want to show the clinical efficacy of RFID technology and how it can make things in the OR work more smoothly, with improved record keeping and reduction of errors.”

Georgetown study

Like a growing number of hospitals, Georgetown’s OR has been using bar codes to track blood transfusions. Hospital studies have shown bar codes reduce medication error rates by as much as 85%, according to the U S Food and Drug Administration.

In Georgetown’s study, patients have been given wristbands embedded with both bar codes and RFID chips. Dual-use scanners have been specially developed for the study, Dr Sandler says.

Before a blood transfusion, nurses scan the bar code on the wristband to determine the patient’s identity. If the bar-code scanning fails, the nurse flips a switch on the reader and collects the patient identification using RFID.

“My intent is to try to find the optimal circumstances when bar codes should be used for patient, lab, and specimen identification and the optimal conditions to use RFID,” says Dr Sandler.

The FDA will require pharmaceutical companies to place bar codes on all hospital drugs by 2007. The agency says less than 1% of all US hospitals have bedside barcoding systems. If all hospitals use the technology, the FDA estimates bar codes could prevent more than 25,000 medical errors each year and save about $4.5 billion over the same time period.

In February, the FDA also backed use of RFID as an alternative to bar codes throughout the medication distribution system and as a tool to help reduce drug counterfeiting.

While bar codes can help reduce errors, Dr Sandler says the accuracy of reading bar-coded wristbands depends on the age of the patient and how long the patient has been wearing them.

“Scanning a patient’s wristband isn’t as easy as scanning a flat Wheaties box in a grocery store,” he says. “We have identified problems using bar codes. When we use bar codes in the outpatient department, it is 100% successful. But if a patient has been in the hospital 3 days, slept on (the wristband), and taken showers, it is not as effective. There are nonread errors. This has led us to test RFID.”

Another purpose of the study is to test a dual-use—bar code and RFID—reader system. “Once the FDA requires bar codes on medications, there is no reason to have another system for blood bags. We want one platform that can be used for both blood and medications,” he says.

RFID versus bar codes

Unlike bar codes, RFID’s signal can transmit through human bodies, clothing, and nonmetallic materials without the reader having a direct line of sight with the tag, Precision’s Thall says.

RFID also can have larger memory capacities, wider reading ranges, and faster processing than bar codes, he says. Combining a microchip and antenna, RFID provides wireless communication for accurate identification, tracking, and processing, he says.

Precision’s Smart Band’s RFID chip also can contain patient information such as name, blood type, allergies, and medications, Thall says.

Depending on signal strength, RFID chips have 5 feet to 25 feet of read range. RFID wristbands cost about $1.10 to $1.25 each, he says.

At Georgetown, nurses use a scanner attached to a portable digital assistant (PDA) to read the wristband chip, which displays the data on the screen and allows nurses to check the transfusion order and the actual blood product to be administered. “Sometime in the future we also may place an RFID reader along...”
Please see the ad for KARL STORZ ENDOSCOPY –AMERICA in the OR Manager print version.
What is RFID?

Radiofrequency identification (RFID) is an emerging technology that uses small, dime-sized chips to track a variety of supplies, equipment, patients, and staff.

Wal-Mart became the first major retailer to announce plans to require suppliers to put RFID tags on shipping crates and pallets by 2005. Gillette plans to purchase 500 million RFID tags for its consumer products. The U.S. Department of Defense announced similar requirements for its suppliers.

When the RFID chips are placed on products, electronic readers send out signals that activate the chip, which responds by transmitting identifying information back to the reader. The microchips within the tags contain more than 10 times the information of bar codes.

Unlike bar codes, RFID-tagged items do not have to be individually scanned. The chips can also be read within containers and from a distance in a passive, non-line-of-sight manner. "We expect to see active RFID tags for larger equipment and passive tags for smaller pieces like catheters and sutures," says Erin Sparnon, project engineer with ECRI, Plymouth Meeting, Pa. Some companies also are installing RFID chips in medical equipment like endoscopic instruments, she says.

Technology for tracking

While RFID is seen as the next generation of bar codes, or at least more effective in some health care situations, RFID has a limited range, which restricts it in applications like patient tracking, says John Pantano, vice president of sales and marketing with Radiance, a Lawrence, Mass.-based indoor positioning solutions company.

For tracking patients, staff, and equipment, a growing number of hospitals and surgery centers use a combination of radiofrequency (RF) and infrared (IR) technology, says Todd Brown, vice president of products with PeriOptimum, a Pittsburgh-based OR software development company.

Providence St. Vincent Medical Center in Portland, Ore.; Spectrum Health Endoscopy Center, Grand Rapids, Mich., and Massachusetts General Hospital (MGH), Boston, are some organizations that use a combination RF/IR tracking system for patients and equipment.

MGH has been studying Radiance’s RF/IR badges for about 19 months to help them reengineer their perioperative process, says Pantano. In MGH’s prototype OR of the Future, the system is used to measure patient flow time, wait time, resource utilization, and their variances. (See June OR Manager.)

The passive tags continuously transmit RF and IR waves to receivers connected to MGH’s local area network. The system also tracks medical devices such as external pacers, infusion pumps, and telemetry transmitters.

The savings from RF/IR or RFID tracking technology come not simply from deploying the systems but from using the information to improve the entire OR process, says H. T. Snowday, vice president of product development with Versus Technology, a Traverse City, Mich.-based company that makes wireless locating systems.

"ORs are experimenting with the idea that they can use the tracking system to be notified when a patient moves from one area to the next," Snowday says. For example, when a patient moves out of the preoperative area, the next staff person to see that patient would be notified through the computer system, he says.

"This automates the process and increases throughput," Snowday says. "In the future, when you integrate scheduling with tracking, you can also use the information to change schedules on the fly. If a procedure is late, you can move around ORs to make sure you don’t have to cancel a surgery at the end of the day."

Versus also is evaluating use of RFID chips on medications, injectables, and small equipment.

Next steps

One of the challenges over the next 2 years is to integrate wireless tracking systems—both RFID and RF/IR—with surgical scheduling and billing systems, says Pantano.

"We will see more software applications to help track patients in real time, maintain schedules, or help determine if schedules are falling behind or if there are problems or bottlenecks that can be adjusted," he says.

Tracking systems also can be connected with billing systems to speed reimbursement. "You put a (RF/IR) tag on an infusion pump, and you can track how long that pump is infusing a drug into a patient. Once the pump is removed, the patient is no longer using the therapy, and you can bill for that time," Pantano says.

Versus also is evaluating use of RFID chips on medications, injectables, and small equipment.

~Jay Greene

Jay Greene is a freelance writer in St Paul, Minn.
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Workplace

Hospitals invest to save nurses’ backs

Duke University Hospital in Durham, N C, spent $670,000 in the first phase of a program to install patient lifts and teach nursing staff to use them, reports the Aug 8 News & Observer, a North Carolina newspaper. WakeMed, based in Raleigh, N C, has spent more than $650,000 on inflatable mats and lifts. A recent study found that every day the hospital has at least one patient who weighs more than 350 pounds. Rex Healthcare, also in Raleigh, has invested what it said was “significant money” on ergonomic devices.

They’re all part of an effort to improve care for heavier patients and save wear and tear on the nursing staff.

Nurses have one of the highest occupational injury rates of any profession—12.5 per 100 workers, according to the Bureau of Labor Statistics. The American Nurses Association estimates more than one third of nurses suffer from back-related injuries and that 12% of nurses leave the profession annually for that reason.

—www.newsobserver.com

A “mommy and daddy” track to attract nurses

Though it will be no surprise to many managers, Vanderbilt Children’s Hospital in Nashville, Tenn, is offering flexible shifts as short as 4 hours. The family-friendly schedule is intended to lure parents of young children back into nursing, reports the Aug 9 Tennessean. Nurses can be eligible for benefits at 30 hours a week.

Several other Nashville-area hospitals offer flexible scheduling. At Centennial Medical Center and Southern Hills, part of HCA Inc’s TriStar Health System, nurses who work 20 hours a week can qualify for benefits by working 20 hours a week. Nurses there also qualify for benefits by working 20 hours a week.

As in many areas, though more students want to enroll, nursing schools have turned away applicants because they did not have enough faculty or clinical training programs.

—www.tennessean.com

Residency programs complying with work-hour limits

Physician training programs are doing a pretty good job at staying within new resident work limits imposed last year. In all, 95% of 2,000 programs were in compliance.

Many programs used schedule changes, night float, and other modifications to bring duty hours below the limits, the Accreditation Council for Graduate Medical Education reported Aug 4. Some replaced residents’ services with care by nurse practitioners, physician assistants, or hospitalists.

The council turned down a request to increase surgical chief residents’ limit to 88 hours, citing a lack of data to show the limit was having a negative effect.

The limits restrict residents to 80 hours of work averaged over 4 weeks, and 10 hours of rest between duty hours, among other rules.

❖

—www.acgme.org
There are a number of reasons why an ambulatory surgery center (ASC) might want to benchmark—

physician owners want to know if revenue is on target, you think you need more staffing, or your accreditation survey is coming up. You want to know where you stand, and someone suggests signing up for a benchmarking program.

Before jumping in, you need a good understanding of what benchmarking can do and can’t do for your ASC. You need to know the benefits and limitations so you know you are being compared appropriately.

Independent ambulatory surgery centers (ASCs) are small businesses that need a basis for comparison, and benchmarking is a good way to achieve that, says Susan Kizirian, RN, MBA, director of the Southeastern Surgery Center in Tallahassee, Fla.

Benchmarking can provide guideposts for budgeting and forecasting. For example, the Ambulatory Surgery Performance Survey by the Medical Group Management Association (MGMA), conducted in collaboration with the American Association of Ambulatory Surgery Centers (AAASC), has data on measures such as revenue per case and total operating cost per case.

The Federated Ambulatory Surgery Association (FASA) provides benchmarking to its members on financial as well as clinical indicators.

Learning from others

Probably the most important benefit—and best reason to benchmark—is to learn from others so you can improve.

“If you’re benchmarking just because of accreditation standards, you’re not getting out of it all that you could. The reason to benchmark is to find out who’s doing things differently and getting better results,” comments Jennifer Green of Surgical Outcomes Information Exchange (SOIX), a not-for-profit organization that provides benchmarking for ASCs.

Benchmarking can also help with insurance contracting, particularly if your ASC does especially well on measures such as complication rates or efficient patient flow.

Another benefit is to build stronger working relationships within the ASC.

“Like QI, benchmarking can be a teambuilding activity,” says Naomi Kuznets, PhD, director of the Accreditation Association for Ambulatory Healthcare’s Institute for Quality Improvement (AAAHC IQI), a nonprofit organization that provides clinical benchmarking for ASC procedures. Comparing your center’s performance with others injects a spirit of competition that motivates people to work together.

Benchmarking can also be a manager’s ally. Perhaps you have started reporting to a new boss who is not from the ASC industry, and you need to provide information on the median days in accounts receivable and other business measures. Or a new investor has signed on, and you want to educate that person about ambulatory surgery.

There may be the need to counter what Kizirian calls “fish stories,” tales about how much money someone has made investing in another ASC or how low someone else’s supply costs are. Benchmarking can give you a factual basis for responding to anecdotes.

Of course, benchmarking and quality improvement are also accreditation requirements of AAAHC and the Joint Commission on Accreditation of Healthcare Organizations.

What to look for

Independent ASCs have several benchmarking programs to choose from (sidebar). Corporate-owned centers usually participate in their company’s own program. Some consultants and management companies also have their own benchmarks.

Criteria to consider in assessing a benchmarking program:

1. Will the program protect your facility’s confidentiality?

Continued on page 30
Benchmarking success stories

How 3 ASCs used benchmarking results:

Support for more nursing staff

The nurse manager of an independent multispecialty ASC with 4 ORs performing 6,000 cases a year was having difficulty staffing the ORs during vacations and providing lunch relief. Turnover time was slowing on busy days. Surgeon satisfaction was dropping, and morale was sinking. Younger Gen X and Y employees wanted a more balanced life, with more time off and less overtime.

Using data from a benchmarking report, she showed the center’s board that the center’s staffing was below the median by 2.5 FTEs for the size and type of facility. The board agreed to increase staffing.

How many staff for the business office?

An ASC administrator hired a new business manager from another setting who wanted to hire more employees for the business office because that is what she was used to. He showed her the benchmarking report, which showed the center actually was staffed at the 75th percentile for centers of its same surgical volume. The business manager agreed to make adjustments.

Getting real on revenue

The administrator of a large multispecialty ASC was being held to unrealistic goals for gross revenue and net profit by the center’s governing board. He was restricted in the new surgeons he could recruit to bring in more revenue. The administrator showed the board a benchmarking report showing that the center’s gross revenue was at the 75th percentile, net income was at the 90th percentile, and operating costs were below the median. The board accepted the findings and reset the goals to more realistic levels.

Source: Susan Kizirian, RN, MBA, interviewed on use of the Medical Group Management Association’s Ambulatory Surgery Center Performance Survey.

5. Will the organization provide a sample report you can look at?

Is the information reported in a way that will be useful to you? Ask for a sample report to see whether the information would assist your center in making changes.

6. Do the reports include information about best performers?

Learning from best performers about how they achieved their results is one of the chief benefits of benchmarking. AHAHC IQI focuses on quality improvement. AHAHC IQI studies have focused on top 3 ASC procedures—cataract removal, arthroscopy, and colonoscopy—because most facilities have enough data on those to be able to participate in benchmarking. AHAHC IQI provides benchmarking in 35 procedural categories and is launching facility-level benchmarking.

Fear factors

Managers may feel their anxiety levels rising when the subject of benchmarking is raised. What if the center’s performance isn’t in line with others? Will they be held accountable?

Kuznets cautions against using benchmarking results for accountability because most studies aren’t large enough to provide statistical power. Instead, the focus should be on quality improvement.

Kuznets recommends that managers...
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Benchmarking programs

The following programs provide benchmarking for ambulatory surgery centers.

Accreditation Association for Ambulatory Health Care. Institute for Quality Improvement

Clinical benchmarking studies for surgery centers include cataract extraction and lens insertion, colonoscopy, knee arthroscopy, and liposuction. Studies are open to all ambulatory care organizations, whether AAAHC accredited or not.

847/853-6079. www.aaahciqi.org

Federated Ambulatory Surgery Association

The Outcome Monitoring Project is a free quarterly benchmarking study for FASA members. Studies include staffing, financial, and procedural indicators as well as patient satisfaction. Breakdowns for multispecialty and single-specialty facilities.

703/836-8808. www.fasa.org

Medical Group Management Association

Ambulatory Surgery Center

Survey conducted in collaboration with the American Association of Ambulatory Surgery Centers. Information on staffing, accounts receivable, clinical facility, charges, revenue, and expenses. Participants include MGMA and AAASC members.
877/275-6462. www.mgma.com

OR Benchmarks

A service of OR Manager, Inc. Surgical procedure studies look at direct costs for supplies, anesthesia, and labor and procedure and turnover times. Also conducts surgeon satisfaction surveys.

800/442-9918.

www.orbenchmarks.com

Surgical Outcomes Information Exchange

Benchmarking studies for ASCs compare information on 10 quality indicators for 35 procedural categories. Indicators range from complication rates to overall patient satisfaction. Membership includes networking with best performers.

877/602-0156. www.soix.com

People have to be willing to put the time into it.

A dilemma in benchmarking is balancing the need for detailed data with the limited time and resources ASCs have for filling out questionnaires.

“Regardless of how you do it, performance measurement takes time,” says Green. “Some centers have made performance measurement part of their day-to-day activities with regular feedback to the staff” to see if the center’s performance stacks up with others. For example, your revenues may be up and complication rates down. But you might find your recovery time is longer than others, and you may still find room for improvement.

Participating in benchmarking creates a conundrum, Kizirian notes: The more detailed the data a report requires, the more useful a report can be. To achieve that level of detail, participants must be willing to collect the information. But the more data they must look up, the less likely they are to want to participate—and the less valid the results.

One barrier is the variation in ASCs’ accounting systems.

“The most common obstacle is that people don’t collect their financial data in such a way that they can report it easily on our survey,” Kizirian says.

She is helping to address this in presentations at AAASC and MGMA meetings.

If your center plans to participate in benchmarking, the best advice is to look at the program in depth so you understand how you will be compared and how you can be prepared to understand and explain the results.

It’s also helpful if you accept a QI philosophy, seeing benchmarking as one piece in the continuing effort to improve your center’s performance.

AAAHC IQI has a new publication to guide ASCs in quality improvement and benchmarking at the basic, intermediate, or expert level. Quality Improvement and Benchmarking: A Workbook of Strategies and Tools for Success can be ordered by phoning 847/853-6079 or visiting www.aaahciqi.org. Price is $85.
Please see the ad for SPECTRUM SURGICAL in the OR Manager print version.
Senate passes bill for voluntary error reporting

The U.S. Senate on July 23 passed legislation to set up a confidential voluntary system for physicians and hospitals to report medical errors without facing legal ramifications. Errors would be reported to groups called Patient Safety Organizations, which would analyze the information to offer feedback on how to improve the health system. The U.S. House approved a similar measure in March. The two bills must now be reconciled. The legislation has bipartisan support.

U.S. links immigrant patients’ status to hospital aid

The federal government is offering $1 billion to hospitals that provide emergency care to undocumented immigrants. But to get the money, hospitals would have to ask patients about their immigration status, “a prospect that alarms hospitals and advocates for immigrants,” The New York Times (Aug 10) reports.

The largest allocations would go to California, Texas, Arizona, New York, Illinois, and Florida.

When Congress decided to provide the money last year, state officials and hospitals saw it as a breakthrough. But hospital execs and immigrant rights groups say questioning patients about their status would keep immigrants from seeking care and might cost hospitals more than they gain.

Hospital outpatient payment update proposed

Hospitals would get a 3.3% inflation update for outpatient services in fiscal 2005 under a proposed rule issued Aug 9 by the Center for Medicare and Medicaid Services (CMS).

The rule would reduce a patient’s maximum copayment to 45%, down from 50% this year. Medicare is gradually reducing coinsurance to 20% of the total payment.

For the first time, new Medicare beneficiaries would be entitled to a welcome physical, a service approved by Congress last year. Medicare would pay a physician fee plus $75 to hospitals for the exam. Hospitals also would get a pay boost for routine screening already covered by Medicare. For example, flexible sigmoidoscopy payments would increase by 7.42% and screening colonoscopies by 9.9%.

Under new technology, the rule would continue to set rates for brachytherapy on charges adjusted to cost and create new definitions for new codes for high-activity brachytherapy.

CMS would extend a program to protect payments for small rural hospitals with fewer than 100 beds and for sole community hospitals in rural areas.

Comments will be accepted until Oct 8 with a final rule expected by Nov 1.

—www.cms.hhs.gov
Please see the ad for LAWSON SOFTWARE in the OR Manager print version.
National consensus on antibiotic prophylaxis for surgery

In general, the first dose of antibiotics should begin 60 minutes before the surgical incision, and antibiotics should be discontinued within 24 hours after the surgery, according to a national workgroup on antimicrobial prophylaxis to prevent surgical site infection. Their consensus statement has specific recommendations for gynecological and obstetrical surgery, total hip and knee replacement, cardiothoracic and vascular surgery, and colorectal surgery.

Endorsing the statement were the American Academy of Orthopaedic Surgeons, the American College of Surgeons, the American Society of Anesthesiologists, the Association of periOperative Registered Nurses, and the Association for Professionals in Infection Control and Epidemiology, among many others.


JCAHO needs more oversight, GAO says

The Joint Commission’s pre-2004 hospital accreditation process did not identify most of the hospitals that state surveys found had deficiencies in Medicare requirements, the General Accounting Office (GAO), a government watchdog, reported July 20. The review conducted from 2000 to 2002 identified 31% (157) of hospitals with deficiencies. Of these, JCAHO did not identify 78% as having deficiencies.

The GAO recommends that Congress consider giving the Centers for Medicare and Medicaid Services (CMS) the same kind of oversight over JCAHO’s hospital accreditation program that it has over other accreditation programs. GAO said it did not evaluate the new process JCAHO implemented this year. JCAHO took issue with GAO’s methodology. A bill has already been introduced in Congress.


Massachusetts panel issues advice on obesity surgery

An expert panel formed by the Massachusetts Department of Health issued recommendations for weight-loss surgery for the state’s hospitals Aug 4. The panel was formed after several patients died last year.

Among highlights:
- Institutions performing weight-loss surgery should perform more than 100 cases a year and have high-volume surgeons who perform 50 to 100 cases a year.
- Surgeons seeking provisional privileges for open obesity surgery should be proctored for 10 cases by a surgeon with full privileges for open weight-loss surgery. For laparoscopic surgery, surgeons should be proctored for 25 cases by a fully privileged surgeon in laparoscopic weight-loss surgery.
- Surgeons seeking full privileges for both open and laparoscopic surgery should have their first 15 cases reviewed by a committee, which should include the chief of surgery and an experienced weight-loss surgeon.
- Nurses who care for patients with severe obesity should complete a competency-based orientation that enables them to identify potential complications and prevent adverse outcomes.

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JCAHO alert on infant deaths and injury during delivery

Team training should be held in perinatal areas to teach staff to work together more effectively, the Joint Commission on Accreditation of Healthcare Organizations recommends in a July 21 Sentinel Event Alert. Teams also should hold clinical drills for high-risk events such as shoulder dystocia, emergency c-section, maternal hemorrhage, and neonatal resuscitation, JCAHO advises. In 47 cases of perinatal death or permanent disability reported to JCAHO since 1996, 72% identified communication as the root cause, with 55% saying organizational culture was a barrier to teamwork.