Pain and patient experience: A business partnership

Managing patients’ pain is no longer just a clinical goal—it’s a business necessity. The Centers for Medicare and Medicaid Services (CMS) has started incorporating value-based purchasing (VBP) scores, which include customer satisfaction, into hospital reimbursement payments.

Of the total VBP score, 30% comes from results from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, which includes patient satisfaction questions related to pain management.

Surgical patients’ perceptions of pain control and the staff’s efforts to control pain do affect overall HCAHPS scores, a study in the American Journal of Quality confirms. According to the study, “The odds of a patient being satisfied were 4.86 times greater if pain was controlled and 9.92 times greater if the staff performance was appropriate.” In other words, how the staff reacted...
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For over 20 years, the OR Manager publication has asked OR directors and managers in hospitals and ambulatory surgery centers (ASCs) to share anonymously information about their salaries, benefits, and management responsibilities.

The table of contents includes:

• Turnover rates stable, use of temp staff is down, annual survey finds
• Staffing for surgery centers is in a holding pattern
• Beyond bucks: Best ideas for recognizing staff
• Assisting at surgery: 1 in 3 ORs using assistants don’t require special qualifications
• Half of OR directors plan to retire by the end of the current decade
• Survey: ASC economic conditions may be easing pages
• Teaching hospitals adding business managers

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Editors

Last month we shared a positive view of the impact of health care reform on nursing. Kathleen Sanford, DBA, RN, CENP, FACHE, who will speak at the OR Manager Conference in September, said more emphasis on keeping people well will offer “an opportunity for clinical staff to make a difference” (see “Health care reform and the ‘Golden Age’ of nursing,” May 2013, p 5).

In a recent Perspective article in the New England Journal of Medicine, Peter I. Buerhaus, PhD, RN, and his colleagues raised several interesting points about the future of nursing. They, too, see some positive aspects of the Affordable Care Act (ACA), such as expanded grant programs for training and education of RNs and advanced-practice nurses. They also think the ACA will increase demand for RNs.

Just a decade ago, it looked as though nursing would be facing a severe shortage by now, the authors note. With fewer people entering the field in the 1990s and more career opportunities in other professions, a shortfall of up to 1 million RNs by 2020 was projected. Instead, the number of new RN graduates more than doubled, from 74,000 in 2002 to 157,000 in 2010.

In addition, new programs now serve a broad range of educational levels and appeal to different age groups. This trend bodes well for the future; continued growth will be needed to meet the expected demand for nurses, the authors say. However, they also raise some concerns:

• the uneven geographic distribution of the workforce, with notably fewer nurses in the Western and Northeastern US
• the potential attraction of careers other than nursing
• the possibility that RNs will lack leadership and management skills.

If OR leaders could simply gaze into their crystal balls, they might learn how to avert the consequences of these outcomes. More realistically, they’ll need to closely monitor developments in health care reform so they can adapt quickly and efficiently to the new laws.

The latest proposed rule from the Centers for Medicare and Medicaid Services, for example, includes changes to the criteria for 30-day readmission penalties, the Value-Based Purchasing Incentive Program, and the hospital-acquired conditions penalty. (Comments on the rule will be accepted until June 25, and a final rule will be issued by August 1; to learn more, visit www.cms.gov/apps/medicare/factsheets.asp.)

OR Manager will continue trying to help readers stay abreast of such changes and keep their ORs running smoothly. This month, we provide strategies for increasing first-time case starts, setting up a daily huddle, and growing surgical volume. We also share tips for managing a multigenerational workforce. It’s critically important to engage the younger members of the staff because they are the future of nursing.

Editorial

Engage younger staff members.

Reference

OR Manager™ Conference offers you the opportunity to come together with your fellow managers to get the strategies and tips you need to solve the challenges you face every day. Focusing on the 5 fundamental topics critical for an OR Manager: administrative, financial, clinical, interpersonal and technology, we’ll give you the essential training to take your leadership skills to the next level.

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Managing today’s multi-generational perioperative workforce can seem daunting, but understanding the strengths of each group and knowing how best to communicate with them can turn challenges into opportunities.

The first step toward promoting generational interrelationships—and to better manage perioperative services for the future—is to “create a generational profile of your OR employees to determine the breakdown by generation,” says Rose Sherman, EdD, RN, NEA-BC, CNL, FAAN.

For example, Generation X dislikes long meetings, so keep them pertinent and short. Generation Y likes the technology in the OR and embraces the notion of teamwork. Focusing on this aspect of the OR can help in recruiting new nurses. (To learn more about the different generations, see related article on p 14.)

“A generational profile can also help identify potential hiring biases, Sherman says. “If you have only 10% of Generation X and Generation Y employees, what does that mean for your succession planning?” She cautions that OR managers sometimes wrongly assume their staff aren’t interested in management positions. “Reach out and ask them. They might say no at first, but they will think about what you say.”

Successful generation management means creating a healthy work environment. Sherman says her research shows that younger nurses won’t tolerate a toxic culture. “If a Generation Y nurse doesn’t like the culture, she is out of there,” she says.

The sense of belonging to a community is important, and it can be difficult for a young nurse in the OR, says Sherman. The nurse may be 25 years old in an environment where the average age is over 50 and co-workers are focused on retirement. “You need to build a sense of community, or they will feel isolated.” Sherman recommends managers ask themselves how inclusive they are with the different generations.

Succession planning and work environment will compel OR managers to ask questions such as: Is there another way to do scheduling so that it’s more appealing to those in different generations? Does the environment provide the mentoring that’s needed? How can on-call be managed so it’s less intrusive on work/life balance? The answers may be difficult but are essential for long-term success.

To learn more, sign up for Sherman’s session, “Leading a Multigenerational Perioperative Workforce.” She will provide evidence-based information about each generational cohort and insights on leadership strategies to build team synergy. Case scenarios using real-time problems also will be discussed.

Register online at www.ormanager.com.
The injured were quickly assessed, stabilized, and loaded onto ambulances, many of which were already onsite for the marathon.

Emergency medical personnel coordinated ambulance service to 8 hospitals, spreading patients across the city to avoid overloading any one trauma center with too many critical patients.

“This coordination was key and really well done by the emergency medical system; it saved lives,” notes Peter Dunn, MD, OR executive medical director at Massachusetts General Hospital.

Three people died at the scene before their injuries could be treated, but everyone who was hospitalized survived. At least 14 people lost all or part of a limb. One of those seriously injured was a Massachusetts General oncology nurse, Jessica Kensky, RN, who lost a leg.

**Staff volunteered**

April 15, Patriot’s Day, was a hospital holiday at BIDMC. Only 1 urgent case was running at 3 pm.

Because of the holiday, trauma surgeon Alok Gupta, MD, wasn’t operating and had planned to take his child to the finish line, which was near his home. His child was napping, however, so he decided to take a nap.

Ambulance sirens and helicopters awakened him, and he received a cell phone call with a garbled message about mass casualties.

Dr Gupta proceeded quickly to the hospital and began directing the command center. Ten minutes after that, the injured began to arrive.

“Before OR teams could be called in, more than 50 staff members just showed up,” says Canacari, including more than a half dozen orthopedic surgeons as well as vascular surgeons, nurses, technicians, and central processing personnel.

Some came from the marathon and some from the ball park. Driving was almost impossible and cell phones were down, so they walked to the hospital.

OR nurses began setting up rooms with equipment for orthopedic and vascular procedures they anticipated would be needed.

“We had an outpouring from industry; they offered to provide whatever we needed for these patients,” notes Canacari.

Debra Martinez, BSBA, CRCST, the manager of central processing and a Brigade Command Sergeants Major in the Army reserves, was alerted by the Army immediately after the bombings and began calling her staff.

“She made sure there was enough staff to provide the needed instrumentation,” says Canacari. “It was seamless from their end.”

The first patient was in the OR 45 minutes after the first blast. By 4 pm, 6 operating rooms were running.

**Staff lingered**

Patriot’s Day is not a hospital holiday at Massachusetts General, so a full complement of surgeons and staff were working when the bombs exploded—both day and evening shifts.

Shortly after commenting that she would be leaving at 3 pm, Maureen Hemingway, MHA, RN, CNOR, clinical nurse specialist for the OR, heard her name paged overhead.

“This was unusual because I’m usually called or paged on my cell phone,” Hemingway told OR Manager.

When she answered the page, she heard: “There’s been a bombing at the marathon, and we’re not letting anybody go.”

Walking from her office to the main desk of the OR, she repeated that message to several people,
Friday lockdown brought new challenges to patients and staff

“Taking care of trauma patients is something we train for and know how to do. We move into high gear and take care of them,” says Maureen Hemingway, MHA, RN, CNOR, clinical nurse specialist for the OR at Massachusetts General Hospital.

But what happened on Friday, April 19, was new and challenging.

“On Monday we knew there was a bombing and we were getting [the] injured; on Friday we didn’t know what was going to happen,” says Hemingway.

With 1 bombing suspect killed overnight and another on the loose, and not knowing if the suspects were part of a larger conspiracy, state and local officials issued a directive at 8:40 am for hospitals to “shelter in place” and for residents to “stay in their homes.”

Local police and the FBI were searching the city and surrounding areas.

Even the term “shelter in place” was new to staff; lockdown was a more common term, notes Dawn Tenney, MSN, RN, associate chief nurse, perioperative and GI endoscopy services at Massachusetts General.

“Being on lockdown and having no idea if there were bombs outside or if someone was going to blow up the hospital was frightening,” says Hemingway.

Many of the elective cases had been cancelled, and “staff were on edge,” says Tenney.

“Their families were at home, and they couldn’t be together. They didn’t know what was going to unfold.”

There were many questions:
• What was the news telling us?
• What was the command center telling us?
• We’re safe, but what about our homes and families?
• When can I leave?
• When will it be safe?
• When can I go home?

The OR leadership team worked to keep staff informed. One team member went to the command center on a regular basis and brought updates to the staff and managers.

Access to the hospital had been restricted to one entrance, and staff were told to wear their IDs to move to other buildings on the campus.

Because the subways, buses, commuter rails, taxis, and hospital shuttle services had been shut down, the Thursday night staff and patients ready for discharge on Friday remained at the hospital.

The materials management office coordinated sleeping arrangements for staff and provided them with personal care items such as toothbrushes and towels.

By early afternoon, patients and some staff were allowed to go home because the search had started to focus in one area.

The evening staff were told it was safe to come to work, says Tenney, but most of the day staff did not leave until late afternoon and early evening.

As the search finally ended with the capture of the second suspect, the lockdown was lifted and staff, patients, and families were allowed to go home.

Continued on page 8

Human resources

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wristbands on patients, identifying them as Disaster Victim 001, Disaster Victim 002, and so on. “We were a little worried about the blood coming up from the lab going to the right patient because of the lack of identification,” notes Ferguson. An OR nurse was assigned to make sure the correct blood got into the correct room.

Investigators asked surgeons and nurses to save and catalogue the bits of shrapnel and other debris removed from patients. The nurses were careful to isolate any foreign bodies removed from wounds, putting them in specimen containers and plastic bags to be turned over to the FBI. “We assigned 1 nurse to be the liaison between the OR and the FBI,” says Ferguson. “We are used to holding onto bullets from gunshot victims, but this was not just 1 or 2 victims, and there was a lot of shrapnel from these patients to catalogue,” she says.

**Lockdown implemented**

BIDMC went into lockdown shortly after the bombings. About 40 police officers, FBI agents, and special agents screened anyone trying to enter the hospital—even staff with IDs. “They were supportive,” says Guglielmi, “but they wanted to make sure that person was an employee or had a family member in the hospital.”

Law enforcement personnel also wanted to see if anyone might have a fragment of information they could use, such as pictures on their cell phones from the event. Massachusetts General decided not to go on lockdown after consultation with Bonnie Michelman, director of police and security. She deployed her officers to secure the hospital campus, support families navigating through the hospital, and work closely with local and national law enforcement officials.

**Families reunited**

Lack of patient identification and separation from family members proved challenging.

Some of the injured were from out of state. Others had family members and friends admitted to other hospitals. “Family members arrived at BIDMC seeking information about their loved ones, but OR staff had not yet confirmed identities,” says Guglielmi.

Finally, Susan Dorion, MSN, RN, nurse manager of the peri-anesthesia areas, worked to collect all of the contact information from the families and partnered with social workers to make sure family members were connected to the correct patient. “We wanted to make sure no family contact information was lost,” notes Guglielmi.

**Staff supported**

It’s not only the injured but also the caregivers who need to make sense of what happened on April 15. They will need to engage with one another, and some will need assistance from counselors.

On April 17, Canacari gathered some 200 OR staff for a caring meeting. They sat in the round and discussed what had happened and how they felt about it. “We told them that we expected them to care for themselves as well as each other,” she says.

A direct hotline has been set up for staff to call anytime, and an employee assistance program is available.

“It was a life-changing experience for me, and I’ve been around a long time,” says Guglielmi. “Many of our staff are young, and we want to help them work through this over the next weeks and months.”

The Massachusetts General employee assistance program responded to the event immediately, alerting staff to opportunities for group or individual discussion sessions to share their experience. In addition, some frontline providers were contacted directly to offer support.

Massachusetts General chaplaincy members made rounds on the units to minister to the staff as well as the patients.

On April 25 and 26, Massachusetts General put together a healing event with volunteers offering massages, meditation sessions, yoga, and other opportunities to help staff.

These informal gatherings were helpful for some, others liked the larger gatherings, and others preferred not to participate and dealt with the events privately.

“The reality is, we all rise to the occasion and take care of patients extremely well. It is important also to take care of the care givers,” says Canacari. “We are proud of our staff and all of Boston’s health care community.”

—Judith M. Mathias, MA, RN

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Performance improvement

Pain and patient experience

Continued from page 1

was even more important than if
the pain was actually controlled.

The increasing attention on
pain management highlights
the deficiencies in acute surgical
pain management and can lead to
innovative approaches.

Challenges of pain management

“We are still not doing a good
enough job of managing pain,”
says Tong (T. J.) Gan, MD, MHS,
FRCA, professor and vice chair
of clinical research in the depart-
ment of anesthesiology at Duke
University Medical Center, Dur-
ham, North Carolina. Dr Gan also
served on the American Society
of Anesthesiologists (ASA) Task
Force on Acute Pain Management
when it updated its guidelines,
“Practice Guidelines for Acute
Pain Management in the Periop-
erative Setting,” in 2012.

Studies indicate how far clini-
cians need to go. A 1989 study
found that half of patients said
their pain was moderate, and 30%
said it was severe or extreme—and
a 2012 study found similar results.

“We [anesthesiologists] know
what to do for pain management,
but the implementation could be
improved,” he says. Part of the
difficulty is the lack of options
for treating pain. “Opioids are still
the gold standard,” he notes.

In many respects, opioids are
“good drugs” because there is no
ceiling effect, he notes. The down-
side is the side-effects ranging from
mild (nausea, vomiting, constipa-
tion) to severe (respiratory depres-
sion and death). “You’re constantly
balancing between managing side-
effects and managing pain.”

Recommendations on multimodal
therapy from the ASA guidelines

The American Society of Anesthesiologists recommends that “when-
ever possible,” anesthesiologists should use multimodal pain manage-
ment therapy. Other recommendations include:

• Central regional blockade with local anesthetics should be considered.
• Unless contraindicated, patients should receive an around-the-clock
regimen of COX-2 selective nonsteroidal anti-inflammatory drugs
(NSAIDs), nonselective NSAIDs, or acetaminophen.
• Dosing regimens should be administered to optimize efficacy while
minimizing the risk of adverse events.

The guidelines also state anesthesiologists should use options such
as epidural or intrathecal opioids, systemic opioid patient-controlled
anesthesia, and regional techniques based on risks and benefits for the
patient, and that these modalities are preferred over intramuscular
opioids ordered “as needed.”

Source: American Society of Anesthesiologists. Practice guidelines for acute
pain management in the perioperative setting: An updated report by the
American Society of Anesthesiologists Task Force on Acute Pain Manage-

Challenge of chronic pain

Another challenge is the number
of patients with chronic pain, ac-
cording to Barbara Godden, MHS,
RN, CPAN, CAPA, clinical coor-
dinator in the postanesthesia care
unit (PACU) at Sky Ridge Medi-
cal Center, Lone Tree, Colorado.

“A growing number of patients
routinely take drugs like Percocet,
Oxycontin, and Vicodin at home;
medical marijuana is legal in Colo-
rado. It’s often hard to get the pain
under control [in these patients].”

A third challenge is that “ex-
pectations are not realistic,” says
Donna Curtis Kent, MS, RN,
CNOR, an educator at AnMed
Health, Anderson, South Caro-
lina, which has 19 ORs. “Patients
need to know they aren’t going
to be pain free,” she says. It’s im-
portant for the staff to work with
patients to manage expectations,
starting before surgery.

Setting expectations

These are strategies for managing
patients’ pain control expectations
that these experts recommend.

Patient assessment, teaching

In the preoperative setting, God-
den says, nurses can assess pa-
tients for pain. They should ask
about chronic pain and bring po-
tential problems to the attention
of the anesthesiologist.

“We do a tremendous amount
of teaching,” she says. Nurses tell
patients, “You aren’t going to be
pain free, but we are going to get
you to a level where you are com-
fortable.”

Kent agrees patient teaching is
crucial: “We are trying to set real-
istic expectations and pain goals
with patients so they understand
what controlled pain means—
pain controlled well enough that
they can function and participate
in recovery. They need to know
that nurses will try to control the
pain.”

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Establishing pain goals
Kent says the staff work with patients to establish pain goals. One of the most important is to ensure pain is sufficiently controlled so they can complete physical therapy and participate in recovery, for example, using incentive spirometry.

Explaining pain options
Dr Gan recommends explaining pain control options to patients, including nonopioid medications, peripheral nerve blocks, and epidurals.

“That will increase their awareness so patients have fewer side-effects, resume food and liquids orally sooner, and recover faster.”

Using bedside handoffs
Another strategy Kent suggests is using bedside handoff reporting on surgical units. Both nurses are at the patient’s bedside for change of shift so they can engage the patient in a 3-way conversation on how effectively pain is being managed.

Nurses are encouraged to use sentences that reflect aspects of HCAHPS’s pain-related questions and address pain control goals. Examples:
- “We want to do everything in our ability to control your pain.”
- “What has worked to control your pain in the past?”
- “Make sure you call me if you need pain medication.”
- “What is the pain score that you can tolerate to participate in [a particular activity, such as walking in the hall]?”

Nurses need to explain that peripheral nerve blocks will wear off suddenly, Godden adds, so it’s important for patients to take pain medication ahead of that time. Postop calls also provide the opportunity to check on patients and encourage them to contact their physicians if pain control is not sufficient.

Setting expectations for staff
OR staff “think they don’t have something to contribute to pain management, but they really do,” says Godden. She is working with nurses from the OR and PACU to improve hand-off communication, including how the patient was positioned, whether a local anesthetic was given, and whether the patient has chronic pain.

Kent recommends that nurses tap into others’ expertise by calling for a pain consultation for general advice or advocating that the physician order a pain consultation for patients with special needs such as chronic pain.

Godden, who is also the editor of ASPAN Breathline and immediate past director for clinical practice at the American Society of PeriAnesthesia Nurses (ASPAN), says the association’s clinical practice guidelines for postoperative pain management are being revised. She is working on competencies related to multimodal pain management.

Expanding the options
A multimodal approach, recommended in the ASA guidelines, involves using multiple options to control pain (sidebar). These range from medications given by various routes, including epidural or peripheral nerve blocks, to holistic interventions such as preoperative massages or local application of ice to the postoperative site.

Dr Gan says the multimodal approach uses “a number of different pain medications working by different mechanisms to increase the efficacy of each drug while reducing the side effects of medication.” Using drugs from 2 or more classes leads to lower doses and fewer side-effects compared to using each drug separately.

The multimodal approach can reduce the use of opioids by as much as 40%, he notes.

Part of a multimodal approach is preemptive pain medicine. For example, says Kent, patients having total knee replacement “receive an opioid, NSAID, gabapentin, and acetaminophen plus a nerve block prior to surgery, so that pain is not so severe after surgery.”

Perioperative pain management
The ASA guidelines recommend options such as epidural or intrathecal opioids, systemic opioid patient-controlled analgesia, and regional techniques based on risks and benefits for patients.

Though peripheral nerve and epidural blocks have their place, Dr Gan says, “one has to consider the patient’s wishes; they often don’t want an additional needle.” Many procedures on the limbs and shoulders are amenable to a peripheral nerve block, he notes. Long-acting local anesthetics and paravertebral and transversus abdominis plane blocks are being...
Greenwich Hospital, a 206-bed hospital in Greenwich, Connecticut, put a multimodal pain management approach in place for patients undergoing hip or knee joint replacement.

“Joint replacement surgeries have become the most common surgeries, and they are the most painful,” says anesthesiologist Mark Chrostowski, MD, who spearheaded the program, which significantly reduced opioid use and improved patient satisfaction. The program received the 2012 Connecticut Hospital Association’s John D. Thompson Award for Excellence in the Delivery of Healthcare Through the Use of Data.

Pain management approach

Pain management begins preoperatively when patients attend an education session about what they can expect before, during, and after surgery. Tori Kroll, RN, who coordinates the program, notifies the surgeon or Dr Chrostowski if a patient has chronic pain so the surgeon, anesthesiologist, and patient’s pain management physician can collaborate in establishing an effective pain control plan.

Before surgery, patients take nonopioid medications to control pain and inflammation. The anesthesiologist gives a local anesthetic via a nerve block to numb the surgical area; total knee patients receive a single injection, and total hip patients receive the anesthetic through a peripheral nerve block injection or a catheter. After surgery, patients continue the nonopioid medication and, if a peripheral catheter was placed to give the local anesthetic, it is connected to a patient-controlled analgesia (PCA) pump.

Kroll visits patients twice daily in the hospital to assess their progress, including how well pain is controlled, and follows up several months after surgery.

Medication protocol

Dr Chrostowski developed this protocol, but he says specific medications may vary, and it’s important to use other tactics such as patient education. Physicians can simply choose an order set to order the protocol.

Preoperative medications
- Acetaminophen 975 mg by mouth (PO) once
- Celecoxib 200 mg PO once
- Gabapentin 900 mg PO once
- Local anesthetic through a peripheral nerve block injection or a catheter.

Intraoperative medication
- Decadron 4 mg IV (as requested by certain surgeons).

Postoperative medications
- Acetaminophen 975 mg PO 3 times daily
- Celecoxib 200 mg PO 2 times daily
- Opioid pain medications as needed.

The bottom line

Analysis of 1-year data for 424 patients showed that those who received the protocol:
- used an average of 40% less opioids during the hospital stay
- decreased use of PCA by 47%.

In fact, many surgeons have stopped ordering PCA pumps because patients haven’t needed them. Other advantages included fewer side-effects from opioids and better adherence to physical therapy.

With the program, Dr Chrostowski says, “We have noticed a marked improvement in patient satisfaction.” Compared to 854 other hospitals, Greenwich Hospital is in the 95th percentile of patient satisfaction, according to Press Ganey data.

Creating a successful program

Dr Chrostowski says that to increase the likelihood of success, it’s important to take time to plan and launch the program. Kroll and Dr Chrostowski spent 6 months reviewing the evidence, developing the protocol, and talking to every anesthesiologist and surgeon who performs total joint procedures. Implementing the protocol took 2 to 3 months. They also educated nurses and physical therapists. Thereafter, the protocol was fine-tuned every month based on observations and feedback from nurses and physicians.

Dr Chrostowski cites data collection as another reason for the program’s success. “We started to see how well patients were doing and shared that with the surgeons. The data really helped us get everyone onboard.”

A change in mindset has also given the program a boost. “Instead of just reacting to pain, we’re being proactive, treating pain before it starts,” he says.
Implementing a daily huddle protects patients, avoids delays

Could you and your team find 30 minutes a day to prepare for the next day’s surgical schedule? The effort can be worthwhile.

A Chicago-area hospital has found that a half-hour daily huddle not only heads off delays and cancellations but also spots clinical and patient safety issues so they don’t become obstacles the next day. The huddle team has caught near misses, including surgical side and site discrepancies. They also have identified patients with unresolved clinical problems; made sure loaner sets and implants are on hand; and saved time and aggravation.

The huddle also serves as the first step in the patient identification process.

“We are actually saying the patient’s name and double checking the procedure ordered,” notes Cindy Mahal-van Brenk, MS, RN, CNOR, executive service line director for surgery.

Better pain control needed
More education, better pain control options, and “the need to focus on doing a better job” are the factors contributing to more effective pain management, Dr Gan says.

• Anesthesiologists should become more involved in postop pain management.
• Better pain control options include more use of nonopioid medications and taking an opioid-sparing and, whenever possible, opioid-free approach.

“We are still not there. There are a lot of things we can do to improve,” he says.

—Cynthia Saver, MS, RN

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

References


Safer Surgery series

This series of articles covers Ten Elements for Safer Surgery developed by Advocate Health Care, a 10-hospital system in the Chicago area.

Previous articles in the series focused on:
- OR governance: January 2013
- Safer surgical scheduling: February 2013
- Presurgical assessment: March 2013
- Excellence in sterile processing: April 2013
- Checklists: May 2013.

All-day seminar

An all-day seminar on the Ten Elements for Safer Surgery will be presented at the OR Manager Conference, September 23-25, 2013, at the Gaylord National Resort in National Harbor, Maryland. For more information, go to www.ormanagerconference.com.

30 minutes but can take 45 minutes if the patient list is complex.

Attendance is expected and documented. The employed staff nearly always attend; attendance by the nonemployed personnel is at 50% to 75%, Mahal-van Brenk estimates.

Follow a set agenda

Having a standard agenda moves the meeting along. ALG’s agenda starts by recapping the current day’s problems. Then the bulk of the time is spent reviewing the schedule for the next day.

“We review the entire schedule case by case. It was slow at first, but it has gotten much faster,” Dr Young says.

“We are looking for any problems that might occur the next day. Is there enough time allotted to the cases? Is a surgeon scheduled at more than one site? Are there pending lab results?” Decisions are made about adjusting the schedule.

Among other issues discussed: Were loaner sets delivered? Are new implants being brought in? Will the company rep be on hand? Are there patients with complex allergies or antibiotic needs?

They also review issues that surfaced during the preanesthesia process.

“Prior to this, nurses didn’t have a forum to express concern about a patient they thought was high risk,” Dr Young observes. “Now they are able to bring this up and share it with the entire team.”

In one example, the huddle resolved an issue with a patient who was scheduled for a total hip revision. Normally, 2 units of blood would be ordered. But no blood had been ordered, and the case was scheduled for 1 1/2 hours.

Dr Young, who led the huddle that day, thought that didn’t make sense.

“We got the surgeon on the phone. It really was a cup change, not a total revision,” he says. “So the time was appropriate and so was not having additional blood. We saved ourselves aggravation.”

At times, the issue is as simple as a language barrier. The presurgical department then arranges for a translator to be present when the patient arrives, providing a source of comfort for both the patient and family.

Keep leaders involved

Having a physician champion is essential, as it is for other patient safety initiatives. Mahal-van Brenk stays involved as well.

“For the first 3 months, you need a consistent leadership presence, so people know this is serious,” she says. She still attends periodically to reinforce that message.

Teach presentation skills

Nurses have learned to hone their style for their huddle presentations, which for some is a new skill, like presenting on rounds.

“It takes a while to learn the key elements,” says Dr Young.

Nurses know they will be expected to know something about each patient, which he thinks has helped them to organize their time better.

The huddle program at ALG has helped to resolve not only scheduling issues but also a broader range of concerns that affect safety and efficiency.

“The problem was how to coalesce all of the information that is floating around in everyone’s head and put it together to minimize the risk of delays and cancellations,” Dr Young says. “The huddle has helped us achieve that.”

—Pat Patterson

Dr Young is also a consultant with Surgical Directions. www.surgicaldirections.com.

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Because people are living and working longer, 4 generations of employees are now toiling side by side—and not always in harmony. Creating a workplace where all generations can thrive is both challenging and crucial to a manager’s success.

“The biggest challenge and opportunity for growth is to recognize that you have different generations working together for a common purpose,” says Lori Coates, BSN, RN, CNOR, manager of perioperative surgical services at Weiser Memorial Hospital, a critical access hospital in Weiser, Idaho, that averages 60 cases a month. “It affects everything: change, motivation, team building, recruiting, and increasing productivity. A manager needs to pull everybody together.” Here are some ways to do that.

Distinguishing generations
OR managers must understand generational profiles and needs (sidebar). “The generations want different things out of work, and they approach work differently,” says Jerry Henderson, MBA, BSN, RN, CNOR, CASC, assistant vice president for perioperative services at LifeBridge Health/Sinai in Baltimore. “It’s important to get staff to accept that it’s different, not wrong.” LifeBridge Health/Sinai has 26 ORs with an annual volume of more than 20,000 patients. Here’s a closer look at each generation.

Traditionalists and Baby Boomers. These generations like to communicate in person and are sometimes puzzled by younger generations. They also tend to prefer schedules that don’t require them to work more than 8 or 9 hours a day, says Mike Supple, senior vice president for B. E. Smith, a health care executive search and leadership solutions firm in Lenexa, Kansas.

Generation X. This generation wants action and gives OR managers innovative ideas “because they have enough experience to identify the problem, and they are more individualistic—so they are driven to solve the problem without worrying about what the group thinks,” says Rose Sherman, EdD, RN, NEA-BC, CNL, FAAN, associate professor in the Christine E. Lynn College of Nursing at Florida Atlantic University in Boca Raton and director of the college’s Nursing Leadership Institute.

Generation X nurses want to “constantly move up,” says Coates. She encourages education and certification, and she provides opportunities for taking on more responsibilities. Advance- ment doesn’t have to mean a title change, says Christine Ricci, MBA, RN, chief communications officer at B. E. Smith. “Keep expanding their role,” she says. “Give them exposure to things they haven’t done before.”

Generation Y. Generation Y’s time is valuable to them, says Coates. “They want to spend time with their family.” This generation appreciates a handwritten thank-you note and personal recognition. For example, when employees obtain their CNOR certification, their names are added to a plaque that is prominently displayed in the OR.

A common complaint from managers is that members of Generation Y crave constant feedback. “That’s understandable,” says K. Lynn Wieck, PhD, RN, FAAN, the Mary Coulter Dowdy Distinguished Nursing Professor, College of Nursing and Health Sciences at the University of Texas at Tyler. “They’re needy because as parents we’ve insinuated ourselves into everything they’ve done. We’ve raised them that way.”

Generations X and Y prefer to balance their work and personal lives by working longer hours for a shorter number of days, Supple says.

Giving recognition
Wieck, who has conducted research studies on generational differences, says all generations want personal attention from their managers. “They just want to be appreciated,” she says. “This costs the least and is the easiest to provide.”

Some hospitals have also developed programs to individualize recognition. Henderson says that LifeBridge Health has a points program whereby managers can “print out certificates, assign points, and then give them to employees who can buy things with the points.” Employees can also enter contests to win drawings, or certificates can be used in the cafeteria.

In her research, Wieck also found that the most important incentive for all 4 generations was a cohesive work environment.
“That’s something that’s not going to cost you money.”

**Managing each generation**
Managers must be able to manage each generation. For example, Generation Y nurses like the OR’s team approach and want to be included in decisions, which makes them ideal candidates for task forces and committees, Henderson says, and younger generations tend to be more adaptable to change.

Sherman shares the story of a Baby Boomer manager who noticed that the Generation Y nurses never came into her office to sit down and have coffee, but they were the first to respond to an e-mail or text message. The manager realized she would need to establish a relationship with that generation in a different way, and she set up groups for those who text message.

To leverage generation differences, Ricci suggests managers encourage mentorship among the generations. “Mentorship helps Generations X and Y appreciate the experience, knowledge, and wisdom that the Baby Boomer or Traditionalist brings,” she says. Another strategy, advocated in the Harvard Business Review article “Mentoring Millennials,” is reverse mentoring, where a member of the younger generation mentors a manager. For instance, a manager who needs to learn more about social media might select a Generation Y nurse as a mentor. Reverse mentoring not only provides positive feedback for younger nurses but also gives them insight into the manager’s role.

Supple says another technique for leveraging differences is to “take a process and have representation from each generation discuss how to improve it.” This allows a creative approach that often results in many good ideas.

Managing each generation includes offering a menu of benefits. The top priorities for older generations are retirement plans and cutting back on hours, while younger nurses are looking for what Wieck calls “high-dollar” opportunities, such as overtime, extra shifts, and call premium pay. “They’re paying back loans and have kids, so they need the money,” she says.

**Fostering communication**
A simple strategy for dealing with generational differences is to talk about them. For example, if a Generation Y nurse is asking for constant feedback, Wieck says it is a good idea to say something like, “I know you’re used to having a lot of input, but I’m used to my generation, where we expect to be independent. Let’s talk about how we can meet in the middle.”

OR managers also need to
adapt to generational styles of communication. Generations X and Y are accustomed to sharing their opinions. Empowering staff nurse councils can help provide an opportunity for them to give their input. Wieck recommends rotating at least part of the council each year to ensure all generations are represented.

Although Baby Boomers and Traditionalists are used to communicating in meetings, Wieck says younger generations want to post on Facebook or send a text message. OR managers need to strike a balance. In addition to meetings, for example, a manager could create an internal web-based communication page.

Wieck also recommends using e-mail or text messages as coaching tools, sending a message such as, “You have made so much progress. I think you need to work on your knowledge of medications specific to the OR, so I’ve signed you up for the next medication education day.” Of course, serious performance problems should be discussed in person.

With younger generations, John Olmstead, MBA, RN, CNOR, FACHE, director of the surgical services and emergency department at Community Hospital in Munster, Indiana, says managers have to be “much more direct and much more clear in their communication; it needs to be a closed-loop communication.” For example, the manager may need to specify that a nurse who has completed a case should complete 3 case carts and let the manager know when that task is done.

Managers and staff must understand that mobile devices are useful, but they need to be used within established parameters. For example, Olmstead says, nurses are not permitted to use computer tablets in front of patients.

Providing education
Educational programs on generational differences can help staff understand that their generation’s perspective isn’t necessarily the same as those of other generations. “Staff really enjoy learning about the generations,” Sherman says. “They can apply that at work, but also at home with their family.”

Henderson says that during orientation, all staff attend a 4-hour class on lateral violence, which includes generational differences. “You can refer back to the class and what they learned when talking about generational issues,” she says. “It gives you a common language for discussion.

“We challenge people not to make assumptions about motivations,” adds Henderson. “Don’t judge someone by your own standards.” Managers can also provide education by helping staff role-play how to approach someone of a different generation if a conflict exists: “Walk them through it. Ask them, ‘have you thought about where else they might be coming from?’”

One common source of friction is the perception of job commitment. “The older generation says the younger generation isn’t as committed,” says Henderson, “but if you talk to the younger nurses, you find that it’s not that they don’t want to work, it’s just that they want to voice a different way of doing things and don’t feel they are heard.”

Olmstead says part of the perception can be traced to the fact that younger generations “don’t link their identity to a job.” That includes not just nurses, but also physicians, lab technicians, and other hospital workers. Olmstead, who is a Generation X manager, notes that commitment is often a function of life situation rather than generation. For example, young nurses who are new to their career are often more flexible, but nurses with young children or older parents are not.

Another issue is work ethic; older generations believe younger generations don’t work as hard as they do. But Ricci says, “All generations are equally productive, but they just do it differently.” If given a project, for instance, older generations tend to plan in more detail how they will approach it and rely less on technology. Younger generations will likely be more informal and spontaneous in their approach and may tap into technology; for example, they may send tweets to communicate progress.

Addressing call
In a study of OR managers, Sherman found that Generation Y nurses are particularly resistant to taking call. “The OR is really going to have to look at on-call and how they have done it historically,” she says. “It’s competing with other specialty areas that have tremendous flexibility and don’t require call.”

To address the challenge of coverage for late procedures, Lorna Eberle, BSN, RN, CNOR, director of perioperative services at Providence St. Peter Hospital in Olympia, Washington, is using more internal per diem staff. Perioperative services include 11 ORs with an annual volume of 8,500 patients a year.

The OR staff voted that the per diem staff, who must work a minimum of 6 shifts a month, do not have to take call—a strategy designed to attract more per diem
CHANGES in staff responsibilities and greater collaboration have contributed to dramatically improved first-case on-time starts at the University of Louisville Hospital, Louisville, Kentucky—from about 35% to 86% in a little over a year. Turnover time has been reduced, too, with slow but steady progress suggesting that revamping existing structures can pay off.

The academic medical center, which has 14 ORs and an annual case volume of close to 9,000, serves as a Level 1 trauma center for a relatively large uninsured patient population. When Lisa Jackson, MHA, BSN, RN, CNOR, began her tenure there in 2009 as director of the main OR, she found a culture that lacked a focus on efficiency. Over the past 4 years, Jackson has worked with her management team to turn the OR culture 180 degrees so that it now focuses on a collaborative approach to achieving efficiency while still maintaining patient safety and excellent outcomes.

Jackson spent the first few years laying the groundwork for change. “In the first year, I didn’t force major changes but instead helped the management team understand that change would come,” she says. “I had to take it slow.”

In March 2012, the management team accelerated change by launching “March Madness,” an appropriate theme given that the University of Louisville is known for its excellent basketball team. A key part of March Madness was assigning a certified registered nurse anesthetist (CRNA) to partner with OR nurse leaders to improve throughput.

The OR soon found significantly improved outcomes. The percentage of first cases starting on time (within 5 minutes) rose from about 35% in December 2010 and early 2011 to a range of 82% to 86% in the fourth quarter of 2012.

Here’s how the OR at University of Louisville Hospital did it.

Performance improvement

Efficiency soars in wake of strategic OR cultural changes

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Organizational changes

Jackson began by working with her management team, which included leaders from the sterile processing department, preadmission testing, and preoperative, intraoperative, and postanesthesia care units, to make changes so staff would have what they needed to do their jobs. Early on, it was made clear that the OR had the complete support of the administrative director of surgical services, Marty Brewer, MA, BSN, RN, CNOR, and the hospital executive team, which would approve the resources and financial support required for the changes that needed to be made.

“They were no preference cards, and people had to scramble for instruments,” Jackson says of one of her early challenges.

An OR system support specialist was hired to update the OR information system and guide the preference card update; the RN team leaders, who are staff...
nurses, created the cards based on their clinical knowledge. Within the first year, Jackson assumed responsibility for the sterile processing department, which helped in managing instrument availability.

Another early step was tackling the need for OR governance. Brewer and Jackson formed a perioperative governance committee, called the perioperative management team, which includes OR leaders (Brewer, Jackson, and clinical managers), anesthesia and surgeon leaders, a representative from the executive team, and a representative from quality and patient safety.

One of the first tasks of the committee was to create an OR scheduling policy and procedure. The perioperative management team now routinely reviews block time utilization along with other key performance indicators.

Daily dose of data
In March 2012, the chair of the anesthesia department appointed Ian Farah, CRNA, to be the dedicated anesthesia charge person who would assist the OR charge nurse in coordinating the daily schedule—a move that Brewer and Jackson advocated for and that Jackson credits with helping to create momentum for a deeper look at efficiency, beginning with first-case starts.

Every day, Brewer, Jackson, Farah, and the clinical managers for the preoperative area and the OR were in the preoperative/holding area to monitor first cases headed to the OR.

“We stood at the desk and watched,” Jackson says. “For the cases that didn’t start on time, we determined the cause of the delay.” Sources of delays ranged from the surgeon or resident not being present to problems with insurance authorization.

Each day, Jackson sent an email with the percentage of first-case on-time starts and a list of cases that didn’t start on time, including the reason why, stating the reason objectively. The email went to C-suite executives, hospital vice presidents, chairs of the OR governance committee, surgical department chairs, the anesthesia chair, Farah, the preadmission testing charge nurse, and OR nurse leaders, among others. This helped keep upper-level administrators informed so that they could speak with physicians behind the scenes and be supportive of needed changes. This strategy paid off when Jackson was able to obtain more resources for the preadmission testing department.

“All time we find something that is going to be a barrier to being efficient, we address it in real time,” says Jackson. In the case of first-time starts, that included developing a new policy requiring patients to receive a history and physical and to sign surgical consents before the day of surgery. If a resident is late to a case, Jackson or Farah talks with the resident first, and if the situation doesn’t improve, the next step is the surgeon who has authority over the resident.

Once improvement had been sustained over about 4 months, Jackson substituted a monthly emailed report for the daily emails. However, the leadership team (minus Jackson and Brewer) still meets in the OR every day to monitor first-time starts.

Farah plays a significant role in achieving on-time case starts. He talks with surgeons the night before they operate to ensure they are ready for their cases, letting them know if there is missing information such as a history and physical, and he follows up on the day of surgery, starting at 6 am.

The team is also working on reducing turnover time, which is slowly trending downward from 42 to 45 minutes during the fourth quarter of 2011 to 39 to 40 minutes during the fourth quarter of 2012. “We’re trying to reduce it by 3 minutes each year,” Jackson says, with a target of 37 minutes for 2013. Strategies to reduce turnover time have included a Lean Six Sigma project to study time between cases, improved communication, and ongoing efforts to make sure patients are present and ready for to-follow cases.

“The number one thing you have to have to achieve efficiency is data, and you have to share that data with all key players,” Jackson advises. She participates in the OR Benchmarks Collaborative (McKesson, San Francisco), so she can compare her hospital’s data against national averages. (The OR Benchmarks Collaborative provides 20 key performance indicators that subscribers can analyze and benchmark against other facilities nationwide.)

Preparing patients
In preadmission testing, adding 3 nurses to the original 2 and adding a certified nursing assistant/unit secretary, who assists with paperwork and tasks such as ECGs, helped improve efficiency.
CRNA as a scheduling partner: A tipping point for change

Lisa Jackson, MHA, BSN, RN, CNOR, director of the main OR at University of Louisville Hospital, says the anesthesia chair’s decision to assign Ian Farah, CRNA, to partner with the OR in running the schedule was a “tipping point” for boosting efficiency. “He has every surgeon’s, resident’s, and anesthesia provider’s numbers in his phone and texts them all day long,” Jackson says. “It’s the best communication I have seen in an OR. It’s much better than calling them.”

Make staff accountable
Farah holds surgeons (including residents) and anesthesia providers accountable for meeting time commitments. “I coordinate the schedule, and I’m responsible for communication between the OR, surgeons, and anesthesia providers. I promise to deliver to them, and they promise to deliver to me.”

Farah says a key element of his success is having the support of the chair of the anesthesia department. “I report directly to him,” Farah says. If Farah is having difficulty with anesthesia providers, he notifies the chair, who intervenes.

Every Monday, Farah receives a printout of all cases for the week, which he reviews to determine if the time frames are appropriate and if a surgical resident will be available to start the case. “I call surgeons to fill in empty time,” he says, adding that he coordinates with the scheduling department. If he knows a surgeon won’t be able to complete a case in the scheduled time, he notifies the next surgeon and, if possible, moves the next case to another room.

Farah also assigns anesthesia for the cases and keeps nurses in the preoperative/holding area apprised of the schedule so they can ensure that patients are ready for surgery on time. Jackson credits the entire OR team, along with Farah, for boosting physician satisfaction. “They are thrilled. It makes their day so much better,” Jackson says. The percentage of physicians who said the OR “met or exceeded expectations” in the area of throughput rose from 52% in 2010 to 86% in 2012.

Establishing the relationship between Farah, the OR charge nurse, and the preoperative charge nurse was challenging at first, Jackson says, adding that the key is to define role responsibilities. Farah communicates with the surgeons and anesthesia providers and collaborates with the OR charge nurse when a schedule change is needed. “He doesn’t know the types of OR tables, the expertise of the staff, or what it takes to change a room,” Jackson says, which is why the OR charge nurse makes the final decision on changes. Farah then communicates with the surgeons and anesthesia providers.

Communicate and collaborate
To promote a better working relationship between Farah and the charge nurses, Jackson holds an OR charge group meeting every 2 weeks to discuss topics such as expectations, what is working, and what isn’t working. “It gets everything on the table so we can talk about it,” she says. Conflicts are “often not intentional, they’re just a misunderstanding.” Jackson has also coached Farah and the OR charge nurses individually on how to better collaborate.

Farah and the charge nurses must address staff concerns as they make changes in processes. “It’s a change in culture—a change in attitude,” says Farah about the push to improve on-time case starts. “OR nurses push back from safety concerns, but they’re getting used to it.” In fact, he credits the entire OR team with achieving improvements.

Farah spends the majority of his time running the schedule, but occasionally he delivers anesthesia to maintain his clinical skills.

For example, Jackson says, patients scheduled to arrive the day of surgery are evaluated by phone or a visit before that day. The staff issue appointment reminders and call physician offices when a history and physical or surgical consent has not been completed before the day of surgery. Patients who miss their preadmission testing appointment are called and rescheduled.

The preadmission testing now has 4 rooms instead of 3. Electronic documentation allows easier access to data such as how many patients are seen or called before surgery.

Factors for success
Jackson says that improvements in preadmission testing, better on-time case starts, initiation of a designated CRNA for running the schedule, surgeon and anesthesia governance, and accountability are the top contributors to improved efficiency. But the team isn’t resting on its laurels. “We now see what we can do,” says Jackson, “and we’re proud of what we’ve accomplished.” The team plans more improvements as they continue their quest for better efficiency.

—Cynthia Saver, MS, RN

Cynthia Saver, a freelance writer, is president, CLS Development, Inc, Columbia, Maryland.
New AORN recommendations focus on infection prevention, patient safety

ORN leaders’ efforts over the past few years have led to evidence-rated recommendations for some of the 2013 Perioperative Standards and Recommended Practices (RPs), representing “landmark progress in the evolution of recommended practices,” according to Ramona Conner, MSN, RN, CNOR, manager of the standards and recommended practices. Conner introduced speakers who gave updates on the RPs for prevention of transmissible infections, sterile technique, and sharps safety at the AORN Congress in March 2013 in San Diego. Here are highlights of the session. For complete language, see the 2013 Perioperative Standards and Recommended Practices.

Sterile technique
AORN’s Recommended Practices for Sterile Technique have replaced the RP for Maintaining a Sterile Field and now include the RP for Selection and Use of Surgical Gowns and Drapes.

A change in the recommendation about sterile fields generated audible surprise during the presentation by lead author Sharon A. Van Wicklin, MSN, RN, CRNFA, CPSN, PLNC, CNOR, a perioperative nurse specialist with AORN.

AORN has had a long-standing recommendation that, once created, the sterile field should not be left unattended until the procedure has been completed, and this has not changed. The new recommendation is that if there is an unanticipated delay or during periods of increased activity, such as when the patient is being brought into the room, the sterile field that will not be immediately used may be covered with a sterile drape (illustration).

This recommendation shows how evidence can change practice; recent research demonstrates that covering the sterile table “may actually help to preserve the sterility of the field and to prevent environmental and microbial contamination,” Van Wicklin said. For example, a study of 41 total joint replacements showed that covering the instruments during periods of increased activity shortened overall exposure time and led to a 28-fold reduction of instrument contamination.

Sterile fields should be covered in a manner that does not allow the portion of the cover that falls below the sterile field to come above the sterile field.

AORN also recommends that organizations work with their infection prevention personnel to develop a standardized procedure for covering the sterile field.

According to Van Wicklin, covered sterile fields should be monitored, and policies about monitoring, uncovering the field, and the length of time the sterile field is covered should be determined by each individual facility, ideally with the help of an infection preventionist.

Gloves
One new recommendation is to use a closed assisted gloving method; the open assisted gloving method should be used only when closed assisted gloving is not possible or practical, according to Van Wicklin. This is not a change but rather a clarification based on the evidence.

The double-gloving recommendation, also a part of the RP for prevention of transmissible infections and the RP for sharps safety, was added to the sterile technique RP because of its importance as a means to prevent surgical site infection (SSI), she noted. The recommendation is to double glove during procedures when there is potential for exposure to blood, body fluids, or other potentially infectious materials.

“There may be rare occasions when double-gloving is not absolutely necessary, but the amount and quality of the evidence that supports the recommendation for double-gloving is very clear,” she
said, citing support from the Centers for Disease Control and Prevention (CDC), the American College of Surgeons, and the American Academy of Orthopaedic Surgeons (AAOS). In addition, a meta-analysis of 5 trials found that significantly more perforations were detected when a perforation indicator system (ie, wearing a colored pair of surgical gloves underneath a standard pair of surgical gloves) was used than when it was not (77% vs 21%, respectively).

The RP includes specific times for changing gloves:
- after each patient procedure
- after touching the surgical helmet system, ie, hoods and visors (new)
- after adjusting the eyepieces on an operating microscope (new)
- after direct contact with methyl methacrylate
- when gloves begin to swell on the hands
- when a perforation is suspected or actually occurs
- every 90-150 minutes (new).

Several studies have shown a positive correlation between the rate of glove perforation and the length of time that they’re worn. AAOS recommends changing outer gloves at least every 2 hours. Recognizing that gloves cannot be changed at a precise time during a procedure, AORN recommends a span of time during which gloves should be changed (ie, every 90 to 150 minutes). But the published literature does not provide an answer on whether to change 1 or both gloves, Van Wicklin pointed out.

Other sterile practices
- Based on studies showing high levels of contamination of the C-arm drape, another new recommendation is to consider the upper portion of the C-arm drape contaminated.
- A recommendation is added to use the isolation technique during bowel resection and resection of metastatic tumors. This can be accomplished with a single or dual setup, and instructions are included in the RP.
- Minimizing the number of personnel in the OR is not a new recommendation but is emphasized in this RP, Van Wicklin said. Studies have documented the relationship between increased numbers of personnel and higher levels of particulates in the environment.

Sharps safety
The Recommended Practice for Sharps Safety, previously a guidance statement with suggested strategies for preventing injuries, is now a new RP expected to be released to e-subscribers in June 2013 and will be published in the 2014 Perioperative Standards and Recommended Practices book, according to lead author Mary Ogg, MSN, RN, CNOR, a perioperative specialist at AORN.

There have been 132 documented cases of patient to health care worker transmission of HBV, HIV, and HCV, she noted. The RPs are based on regulations from the Occupational Safety and Health Administration.

This RP recommends the following:
- Safety-engineered devices (eg, safety scalpels, needleless IV connectors).
- Blunt suture needles unless contraindicated. A review by the Cochrane Collaboration (highest level of evidence) found that blunt suture needles reduced glove perforations by 50% and lowered disease transmission. These have been rated as acceptable in 5 of 6 studies.
- Alternative wound closure devices.
- A neutral zone or hands-free technique for passing sharps, blades, and needles.
- Double-gloving.
- A glove perforation indicator system.

Transmissible infections
Perioperative actions to prevent transmission of health care-associated infections (HAIs) are included as part of a new section of the Prevention of Transmissible Infections RP, according to Lisa Spruce, DNP, RN, ACNS, ACNP, ANP, CNOR, director of evidence-based perioperative practice for AORN and lead author of this RP.

There are 500,000 surgical site infections per year; SSIs make up 1.7 million of all HAIs, based on statistics compiled by the CDC. SSIs are the second most common type of HAI after urinary tract infections. Actions to prevent SSIs include:
- maintain a clean environment and surgical attire
- use skin antiseptics
- use good hand hygiene
- minimize OR traffic
- verify adequate sterilization.

The research on the merits of decolonization of the patient is conflicting, especially on *Staphylococcus aureus* in the nasal pharynx, Spruce said. Physicians may or may not elect to do this, so it’s important to keep an eye on developments.

The CDC recently issued an alert on carbapenem-resistant Enterobacteriaceae. A tool kit available at www.cdc.gov/hai/organisms/cre/cre-toolkit/index.html provides guidelines for preventing this HAI.

A new recommendation involving prevention of central
Patient safety

Surgical Wound Classification Decision Tree

Is there a wound?

NO

No Wound Classification

YES

Is the wound
• clean (ie, not infected or inflamed) or
• the result of a non-penetrating, blunt trauma?

YES

Class I Clean

NO

Was the procedure free from entry into the respiratory, alimentary, or genitourinary tract?

YES

Class II Clean - Contaminated

NO

Was the wound primarily closed or drained with closed drainage (eg, bulb drain)?

NO

Was the respiratory, alimentary, or genitourinary tract entered under controlled conditions without
• evidence of infection or contamination or
• major break in technique (eg, spillage from the gastrointestinal tract)?

YES

Class III Contaminated

NO

Is the wound
• fresh, open, or accidental; or
• is there gross (ie, visible) spillage from the gastrointestinal tract or
• is there non-purulent inflammation present?

YES

Class IV Dirty, Infected

NO

Is this an old wound (ie, greater than 4 to 6 hours) with
• retained devitalized tissue (eg, gangrene, necrosis), or
• existing clinical infection (eg, purulence), or
• perforated viscera?

REFERENCES

NOTE: These are the original source documents for development of the CDC surgical wound classification system.

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line-associated bloodstream infections (CLABISIs) is included because clinicians put in lines in the OR, Spruce said. They should use the same technique used to insert these lines at the bedside. The CDC recommends use of a maximal sterile barrier (ie, hair cover, mask, sterile gown, gloves, full-body drape).

She encouraged clinicians to follow CDC guidelines for prevention of catheter-associated urinary tract infections (CAUTIs). Use catheters only as indicated, not just for convenience; document the date and time of insertion; and remove them as soon as possible after surgery, preferably within 24 hours. She emphasized that perioperative RNs should be educated and demonstrate competency on catheter insertion.

A new feature is a useful surgical wound classification decision tree that was reviewed by the CDC (chart). Also new is a quick reference table for care and transportation of patients who are on contact, airborne, or droplet precautions.

Accrediting (eg, Joint Commission) and regulatory agencies (eg, the Centers for Medicare and Medicaid Services) require all facilities to have an infection control plan, so “this should be a very easy RP for you to implement,” Spruce said.

—Elizabeth Wood

References


OR Business Performance

Surgical growth hinges on good service line information

OR Business Performance is a series intended to help OR managers and directors improve the success of their business.

Does your hospital’s CEO expect you to grow surgical volume in the upcoming fiscal year?

Hospitals have always depended on surgical services to drive revenue and profit. Today, in the face of increasing costs and declining payment, many executives see OR volume growth as the key to maintaining a positive operating margin. But there are 2 challenges that prevent ORs from achieving both growth and margin.

• Competition. Most private not-for-profit hospitals continue to experience declining surgical case volumes as procedures migrate to surgery centers and physician offices.

• Not all service lines are profitable. “Growth for the sake of growth” may end up increasing expenses without improving department profitability.

OR leaders can overcome both challenges by gathering accurate service line information and using it effectively. Analyze data to pinpoint service lines for profitable expansion, and leverage surgeon feedback to understand how best to pursue expansion opportunities.

Create a data-driven strategy

The first step is to quantify the profitability of each OR service line. This requires access to the invoice system, so you will need to work with your hospital’s finance department (some hospitals have created a dedicated “decision support” team within finance). Ask finance staff for a report showing revenue, contractual allowances, and expenses per procedure. Aggregating the per-procedure data by surgical specialty will allow you to see the average profitability.

The profitability analysis on p 24 shows aggregated charges and expenses for neurosurgery. The analysis includes average gross patient revenue, average contractual allowance (blending all payer discounts), and average direct and indirect variable expenses for all neurosurgery performed within a specified time period. The bottom line is the specialty’s average contribution margin per case.

The next step is to identify market share by service line. In most hospitals, the planning department is responsible for calculating this information, using publicly available hospital discharge data.

Compare your hospital’s discharges per OR service line to your competitors’, and develop market share percentages for all specialties. In some cases, it makes sense to calculate market share for specific procedures, such as robotic prostatectomy.

The third step is to combine profitability and market share information to outline your OR’s basic strategic opportunities. In the April issue of OR Manager, we included an example of a service line “bubble graph” that visualizes the OR strategic landscape. Breaking this idea down to its simplest components, we can group service lines into 3 categories (see p 25):

• higher-profit services that currently command a high percentage of market share
• higher-profit services with lower market share

Continued on page 24
• lower-profit services.

Services in the second category are an OR’s core growth opportunities. These are high-margin specialties with room to win more market share. Strategic efforts should focus on growing case volume in these profitable service lines.

Just as important, however, are service lines in the first category. Highly profitable services with a strong market presence are critical to your OR’s financial performance, so you must also focus on retaining this existing profitable volume.

Low-profit service lines (category 3) should not be part of efforts to grow or expand in the near future. At the same time, a well-rounded strategy cannot ignore services in this category. Many of these services are driven by community need, hospital mission, and core competencies spelled out by hospital leadership.

Once you have identified strategic priorities, the next step is to cultivate growth. That means developing a sales process that draws surgeons to your OR.

The good news is that a strong “needs-based” selling process can achieve positive results across all 3 strategic categories.

**Focus on needs-based selling**

A growth strategy cannot be passive. OR managers must understand surgeons’ needs and be proactive to help them achieve their goals.

Hold regular meetings with surgeons to discuss their concerns, listen to their suggestions, and go over recent data. This process not only builds goodwill with the surgical staff, but will enable you to identify surgeon needs that will help you grow volume.

Say you have targeted cardiovascular surgery as a growth service. What can you do to persuade CV surgeons to bring more cases to your department?

Talks with surgeons could reveal that the heart group wants access to the latest series of interventional catheters. Of course, further discussion and financial analysis are necessary, but an investment in this equipment could pay off in increased market share.

Meetings are sure to uncover complaints, but that is a good thing. For example, a surgeon might insist that the OR needs to hire 5 more scrub techs. Try to uncover the root issue. Asking the right questions might reveal that the surgeon is frustrated by high turnover times. If that is the case, the solution is likely not adding staff, but improving processes. Either way, the discussion gives you the chance to clear away the obstacles that are keeping cases out of your department.

Use analysis to fine-tune the selling process. One technique is to segment the surgical staff into “loyalists” and “splitters”—surgeons who divide their caseloads between your hospital and other facilities. Ask splitters what you can do to earn more of their business. The answers will allow you to prioritize changes that can be made to attract more volume.

A refinement of this technique is to identify surgeons who appear to be transitioning caseloads away from your OR. Talk to these surgeons to understand how they perceive your department, and then try to make improvements that will help win back case volume.

Meetings with surgeons who are critical to OR strategy should include a representative from senior hospital administration. In all of these discussions, it is important to be responsive. If a surgeon voices a concern during a meeting, follow up on that concern promptly.

**Service Line Profitability Analysis**

To begin developing an effective growth strategy, work with the finance department to quantify the profitability of each surgical service line. Below is a sample profitability analysis for neurosurgery (based on real cost/revenue data from a Midwestern not-for-profit hospital with a payer mix of 48% Medicare, 37% commercial, 5% Medicaid, and 10% self-pay/charity care).

<table>
<thead>
<tr>
<th>Service Line Profitability Analysis</th>
<th>$50,800</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average gross patient revenue</td>
<td>$50,800</td>
</tr>
<tr>
<td>Average contractual allowances</td>
<td>34,050</td>
</tr>
<tr>
<td>Expenses:</td>
<td></td>
</tr>
<tr>
<td>&gt; Hardware</td>
<td>5,800</td>
</tr>
<tr>
<td>&gt; Variable supplies</td>
<td>1,000</td>
</tr>
<tr>
<td>&gt; Fixed supplies</td>
<td>100</td>
</tr>
<tr>
<td>&gt; Labor and benefits</td>
<td>3,000</td>
</tr>
<tr>
<td>&gt; Radiology</td>
<td>550</td>
</tr>
<tr>
<td>&gt; Pharmacy</td>
<td>700</td>
</tr>
<tr>
<td>&gt; Laboratory</td>
<td>200</td>
</tr>
<tr>
<td>&gt; Anesthesia</td>
<td>300</td>
</tr>
<tr>
<td>&gt; Recovery room</td>
<td>150</td>
</tr>
<tr>
<td>&gt; Neurosurgery floor</td>
<td>3,000</td>
</tr>
<tr>
<td>&gt; PT/OT</td>
<td>200</td>
</tr>
<tr>
<td>Total expenses</td>
<td>15,000</td>
</tr>
<tr>
<td>Average contribution margin per case</td>
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</tr>
</tbody>
</table>
Match your competition
For hospital OR directors, 1 issue that comes up consistently in discussions with surgeons is efficiency. In most markets, surgeons can perform cases more quickly and efficiently in an ambulatory surgery center (ASC) than in the hospital. This is a serious challenge to growth strategy, but it is not insurmountable.

First, hospital ORs must do their best to match the convenience offered by their competitors. For surgeons, the elements of convenience are:

• **Access.** Cases can be scheduled easily and within a reasonable time frame. Hospital ORs can improve schedule access by implementing an efficient block schedule (see OR Manager May 2013, p 21).

• **Preparation.** Patients are fully prepared for surgery, with no last-minute issues causing a delay or cancellation. Developing a strong preadmission testing (PAT) process helps ensure patients are ready.

• **Readiness.** Nurses understand the case, and the correct supplies and equipment are ready and available. Work with staff to optimize nursing team skills and materials management.

• **Efficiency.** Efficient turnover between cases makes the best use of surgeon and staff time. In certain situations, consider providing high-volume surgeons with a transition-to-practice room (or “flip room”) to maximize productivity.

In addition to increasing surgeon convenience, OR managers should leverage strengths in the area of quality. Surgeons want to perform procedures in a reputable institution that ultimately delivers superior clinical outcomes. As a competitive strategy, this represents several opportunities:

• **Specialty support.** The chance to work with a nursing team that specializes in orthopedics, vascular surgery, or spine surgery is very attractive to physicians. The additional cost of a specialty team can be offset through cross-training and will often be justified by additional surgical volume. Another option is to work with the anesthesia department to develop specialization in anesthesia services.

• **Safety.** In the current environment, a reputation for surgical safety is increasingly valuable. Strong PAT processes boost safety, and the use of checklists, good team communication, and error reporting help create an exceptional safety environment.

• **Disease management.** Hospital ORs can help surgeons improve patient outcomes by developing clinical pathways for common diagnoses—for example, perioperative protocols for preoperative anemia or diabetes. “Centers of excellence” that provide comprehensive disease management for procedures like joint replacement or bariatric surgery are another option.

Begin with pilot programs in 1 or more core specialties. Monitor outcomes and publicize the results. Strategically, you need to provide key surgeons with a compelling reason to choose your OR. Surgeons and patients alike will migrate toward institutions that provide superior results.

**Just ahead**
As you begin to grow volume in profitable service lines, protecting your profit margin will become increasingly important. A key element of guarding profitability is managing direct variable costs. The next “OR Business Performance” will show how to control spending on the low- and mid-price supply items that make up a large part of OR expenses. Learn how to identify waste, rationalize supply use, reduce inventories, and get the most out of supplier contracts.

This column is written by the perioperative services experts at Surgical Directions (www.surgicaldirections.com) to offer advice on how to grow OR revenue, control costs, and increase department profitability.
Anyone undergoing surgery is at heightened risk of falling, especially during recovery from sedation, and for the most vulnerable patients, a fall can be disabling or even deadly. Falls are among the adverse events monitored by the Centers for Medicare and Medicaid Services and state surveyors. The science of assessing fall risk has advanced in recent years, focusing mostly on inpatients and those in long-term care facilities, while outpatients have been assumed to be healthier and therefore at less risk.

Even so, ambulatory surgery centers (ASCs) are looking for ways to keep their patients safe from falls and, more importantly, safe from injury. ASC patients may be at risk from a number of factors: medications, age, and surroundings such as obstacles and uneven floors. They also face risks associated with surgery.

Strategies from the VA
According to the ASC Quality Collaboration Quality Report for the third quarter of 2012, ASCs nationally reported a patient fall rate of 0.134 per 1,000 admissions. The report covers 1,381 ASCs with a total of 1,477,319 admissions, or 198 falls.

Despite a healthier patient population, ASCs face 2 risks that differ from those in hospitals: Nearly all of their patients undergo surgery, and therefore anesthesia or sedation, and until now, ASCs rarely had procedures in place for assessing and managing fall risks.

The Department of Veterans Affairs (VA) categorizes fall risks as either extrinsic (external to the patient) or intrinsic (internal, belonging to the patient). Extrinsic risks might include low lighting, clutter, spills, medication, and loose electrical cords. Internal risks are contained within the patient, and could include muscle weakness, poor vision, chronic disease, low blood pressure, and balance problems.

The VA uses the Morse Fall Scale to assess its acute and long-term care patients. The scale grades 6 factors:
- previous falls
- secondary diagnosis
- ambulatory aid such as a cane
- IV or heparin lock
- impaired gait
- mental status.

Based on the severity of each factor, the clinician compiles a score ranging from 0 to 51, with 0 to 25 indicating low fall risk, 25 to 45 a moderate risk, and higher than 45 a high risk.

Now, the VA is transferring that knowledge to outpatients. Pat Quigley, PhD, is associate director of the Veterans Integrated Service Network (VISN 8) Patient Safety Center of Inquiry at the James A. Haley VA Medical Center in Tampa, Florida. She administers fall prevention clinics for at-risk VA patients. Following a consultation with the patient, the clinic staff creates a treatment plan. “We give them the knowledge and skills to be safer,” Quigley says.

The experience has given her insight into what is most likely to cause falls. “The number 1 indica..."
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tor of fall risk is a history of previous falls,” she says. “It’s a marker that other things are going on.”

Specific risks that might apply to ASC patients include:
• old age, because of associated conditions like declining vision and diabetes
• irregular heartbeat, which may cause fainting or blackout; the screener should ask, “Have you fainted before?”
• low blood pressure; the screener should ask, “Do you get dizzy when you stand up?”
• certain diagnoses, such as stroke and diabetes, due to loss of feeling in the feet
• medications and interactions, especially anticoagulation drugs
• osteoporosis of the hips
• sedation after surgery.

For ASC patients, the admission interview is likely the first and best opportunity to identify fall risks. In that context, Quigley advises, address the immediate circumstance. Help patients avoid falls by warning them, and their families or escorts, that they will be unstable. Explain that staff will be with them at all times after the procedure.

ASCs can reduce environmental risks for all patients, she adds, by installing raised toilet seats and railings. She and others note that a large percentage of falls occur when a patient feels an urgent need to use the toilet, forgetting the effects of sedation on their balance and reflexes.

“Create a safe environment that is elder friendly,” Quigley says.

While inpatients at risk of falling often are given colored arm-bands or slippers, Quigley notes that ASCs need to consider all their patients as fall risks. They should make wheelchairs available and alert staff to the need for surveillance and patient education.

Although it may be impossible to prevent all falls, the main goal should be to prevent injuries. The Centers for Disease Control and Prevention reports that for people over age 85, the number 1 cause of death is falling. The reason is head injuries, which can lead to bleeding and complications such as infection.

If a patient starts to fall, the caregiver should first protect the head, Quigley advises. “You can’t always catch them, and a staff member could be hurt trying,” she says, “so focus on the head: You always want to protect the head on the way down.”

**Statewide survey**

In 2012, the Minnesota Hospital Association (MHA) surveyed members to learn how they screen outpatients for fall risk and what preventive measures they use.

That year’s annual adverse event report showed that 79 falls had occurred at hospitals and ASCs in Minnesota, an increase of 11% from 2011. Six patients died as a result of falling. The most common injuries from falls were hip fractures, upper or lower extremity fractures, and head trauma.

Although most of those falls occurred in inpatient settings, MHA wanted to learn more about outpatient fall management, according to Julie Apold, senior director of patient safety. She and her staff worked with Quigley to assess the survey results and develop strategies to avoid outpatient falls.

The best strategy in the outpatient setting, Apold concludes, is to identify patients at risk of falling as early as possible. “If we can identify them early, we can put interventions in place to prevent them from falling or from being injured if they do fall.”

The Minnesota survey showed hospitals were aware that all surgery patients, including outpatients, are susceptible to falls, and that age is a good predictor of falling. Other conditions to consider were confusion, dizziness, recent falls, inability to walk, and seizures.

The most frequent interventions against outpatient falls were helping the patient out of the car and assistance with all activities: walking, wheelchair use, dressing, and using the bathroom. Patients and their escorts were warned about the potential for falls and the need for assistance.

**The Hartford experiment**

An incident in 1 of Hartford (Connecticut) Hospital’s 2 owned ASCs triggered an effort to reduce the number of falls among outpatients. After a patient with multiple sclerosis fell, the ASC asked for guidance in preventing further falls. Because the hospital had protocols designed only for inpatients, a group was appointed to try to adapt those protocols for outpatient use. ASCs, in addition to other outpatient units such as radiology and oncology, participated.

“The goal was to develop a risk assessment form that would be applicable to all outpatients,” explains Cheryl Larsen, BSN, RN, nurse manager of pre- and postoperative care.

One of the first things they learned was that clinicians perceived outpatients as healthier
Minnesota's adverse event reporting system has led to patient safety improvements

The number of patient falls, wrong-site procedures, and suicides increased slightly in Minnesota during 2012, but pressure ulcers, medication errors, and objects left in patients decreased, according to a recent study of the state's hospitals and surgery centers.

The “Adverse Health Events in Minnesota 2012 Public Report,” released in January 2013, has inspired renewed efforts to avoid wrong implants and retained objects, while the state hospital association continues to examine ways to prevent falls. Last year, the reported events resulted in 14 deaths and 89 serious injuries.

Minnesota began putting patient safety under a microscope in 2003, and in 2008, ambulatory surgery centers (ASCs) joined hospitals in submitting required adverse event reports to the state health department. Those adverse events are compiled into an annual public report that offers recommendations for improvement.

State law places responsibility on facilities to track, report, and improve performance in 5 general categories: surgery, patient protection, case management, environmental, and criminal. Using a secure online database maintained by the health department, every facility must report each adverse event within 15 days of occurrence, and a designated quality reporting specialist must then develop and file an action plan. Within 30 to 90 days, the facility must measure the success of the plan and report the results to the state health department.

“It’s a lot of work for them,” says Rachel Jokela, the report’s author. As the state’s adverse health events program director, she has seen both improvement and regression, but she says the reports have led to development of best practices and better awareness of risks. In the report, she urges hospitals and ASCs “to dig deeper into the heart of the issues, to the culture of the organization as a whole.”

The ASC perspective

The most common events for ASCs are wrong site or wrong patient, retained objects, and falls, with the current focus on preventing wrong-site surgery.

Lakewalk Surgery Center in Duluth, Minnesota, reported only its second event in about 50,000 procedures—a retained sponge—with no resulting patient harm. A stand-alone center, Lakewalk has 6 ORs and 3 procedure rooms.

“It’s a really good program,” administrator Joe Majerus says of the state’s tracking program.

At Lakewalk, a standing committee called the Peer Review Quality and Risk Management Committee, or PQR, meets quarterly to review risk and quality issues. The committee includes 5 nurses, 2 physicians, and Majerus, the administrator.

After the retained sponge incident, the PQR ordered a root cause analysis, and 3 changes were made:

• A section was added to the surgical record for noting “sponges in” and “sponges out” times. A nurse initials the record after confirming sponge recovery with the surgeon.

• A brightly colored magnet was attached to the door of the OR with a reminder to verify placement and removal of sponges. This is important, Majerus says, because during longer procedures, the circulating nurse’s shift may end before the procedure is done, which means the replacement nurse must verify sponge counts.

• Management communicated the changes in a memorandum to all physicians and nurses, and those changes were discussed at staff meetings.

Regardless of the setting, surgical adverse events have similar causes and remedies, so hospitals and ASCs have been working together to reduce these events.

Verifying IOLs

The 2012 report generated a series of safety alerts from Minnesota’s health department. One covers verification of correct implants, both intraocular lens (IOL) and orthopedic.

The IOL portion advises that surgeons submit IOL requests in writing before any case preparation begins.

Every request should contain at least the following information:

Continued on page 30
and therefore at less risk of falling. In a 3-year period, however, there were 143 falls with 40 injuries in the hospital’s outpatient facilities.

In addition, outpatient units had less information than was available in the main hospital. “For instance,” Larsen notes, “if you first see a person on a stretcher, you don’t know if they use a cane.”

They developed a questionnaire to screen all outpatients for a history of falls, confusion, and impaired mobility, and they included some variation in the questions based on the type of outpatient treatment received.

In 2010, the group introduced the new screening form to Hartford Hospital’s outpatient staff, and it has continued to track fall and injury rates. At the same time, it mandated new fall-prevention practices for outpatients. These include:

- green wristbands for high-risk patients
- patient and family education
- assistance with all patient transfers
- assistance with dressing or undressing
- bathroom assistance and supervision.

While falls have not been entirely eliminated, Larsen says the group is encouraged by the increased awareness of fall risks and efforts to implement the recommendations. Reporting of falls has increased, she says, and staff are more active in prevention, even asking for additional coverage for patient assistance when necessary.

—Paula DeJohn

Reference

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Anesthesia not linked to dementia risk in older patients
A recent population-based study found no significant association between exposure to procedures requiring general anesthesia after age 45 and incident dementia.

Researchers identified residents of Olmsted County, Minnesota, who were diagnosed with dementia between January 1, 1985, and December 31, 1994. They analyzed 877 cases of dementia with sex- and age-matched controls. Of the dementia cases, 615 (70%) underwent 1,681 procedures requiring general anesthesia; of the controls, 636 (73%) underwent 1,638 procedures. Anesthetic exposure was not significantly associated with dementia, nor was any association found when exposure was quantified as number of procedures, they said.


Diagnostic errors more dangerous, costly than surgical mistakes
Diagnostic errors account for the highest proportion of malpractice claims, most severe patient harm, and highest total of penalty payouts, finds a study of more than 350,000 malpractice claims from the National Practitioner Data Bank.

The researchers say that among 350,706 paid claims, diagnostic errors (n=100,249) were the leading type (28.6%) and accounted for the highest proportion of total payments (35.2%).

Diagnostic errors resulted in death and disability almost twice as often as other error categories, and diagnosis-related payments between 1986 and 2010 totaled nearly $39 billion.


Cardiac arrest survival highest in OR, PACU
Perioperative cardiac arrest was associated with improved survival when it occurred in the OR or PACU in a study.

Researchers identified more than 2,500 instances of perioperative cardiac arrest from 234 hospitals in a national cardiopulmonary resuscitation registry.

Of these patients, 1 in 3 survived cardiac arrest, with survival 25% to 65% higher if the arrest occurred in the OR or PACU versus the ICU or general inpatient areas.


Mortality lower in Magnet hospitals
Lower patient mortality found in Magnet hospitals can be attributed largely to nursing characteristics, but there is a mortality advantage beyond better nurse staffing, education, and work environment, according to a study.

After controlling for nursing factors and hospital and patient differences, researchers found that patients treated in Magnet hospitals had 14% lower odds of mortality and 12% lower odds of failure to rescue.

The mortality advantage of Magnet hospitals seems related to their membership in a network where innovation is encouraged through the process of retaining Magnet recognition, the authors conclude.