Recent highly publicized outbreaks of infections linked to improper reprocessing of flexible endoscopes have raised concerns about infection prevention in gastrointestinal endoscopy procedures.

Because of the headlines, legislatures are hearing from their constituents that they are fearful of being exposed to infections, and legislatures are getting involved.

The Society of Gastroenterology Nurses and Associates (SGNA) is hearing the concerns as well and focusing on root causes to build prevention, Leslie Stewart, BA, RN, CGRN, told OR Manager.

Legislatures want to know what kind of infection prevention programs are being followed in endoscopy units and if qualified people are doing the appropriate jobs. Their constituents want validation that it is safe to have a screening diagnostic or therapeutic procedure performed in an endoscopy unit, says Stewart, past president of SGNA and former (retired) manager of endoscopy at Jersey Shore University Medical Center, Neptune, New Jersey.

The endoscopy community is looking for answers, says Stewart—not just the reprocessing steps defined in SGNA’s “Standards of infection control in reprocessing of flexible gastrointestinal...
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Editorial

At tending several professional meetings each year is a rewarding part of my job and a critical component of my ongoing education. As a non-clinician, I learn a lot from listening to healthcare professionals, and capturing some of what’s presented at these meetings is an attempt to keep readers abreast of developments in the field.

One theme gaining traction in recent months has been advances in education for perioperative nurses. Hence our Special Report: Education (pp 7-16), which presents some new initiatives that hold promise for succession planning and indeed the whole future of perioperative nursing. The articles in this report suggest that several organizations are responding to the Institute of Medicine’s recommendation for 80% of RNs to get their BSN by 2020.

You’ll learn about the collaboration between hospitals and academia that’s helping BSN student nurses get OR clinical experience. Adding AORN’s PeriOp 101 curriculum to the mix provides a theoretical component that rounds out their understanding of OR processes. Also in this section, we report on educational programs designed to help both new and experienced perioperative nurses maintain and develop skills.

One common theme in all of these articles is the specific demands placed on OR nurses vs nurses doing other types of patient care.

“You can have the clinical skills, but not have what it takes to be an OR nurse,” says the Cleveland Clinic’s Carol Pehotsky, MSN, RN, ACNS-BC, CPAN. “Even nurses who have experience in the ICU or medical-surgical unit need guidance as to how to apply critical thinking in the OR because the environment is so unique.”

This unique environment means that new graduate nurses aren’t always considered good candidates for the OR. But the early success of BSN programs that are using PeriOp 101 along with clinical education suggests just the opposite is true. Orientation time after completing such a program is dramatically reduced, according to Sharon Chappy, PhD, RN, CNOR, of the University of Wisconsin Oshkosh.

Another common theme is what I think of as the “value-added” aspects of education. Perioperative nurses find students in the OR less a burden than a boon because having to answer questions sometimes makes them rethink their processes. And even experienced OR staff who initially grumbled about mandatory refresher courses have come to see the value of making sure they keep up their skills.

Going to conferences is also a great way to keep up skills. There’s no substitute for hearing firsthand what experts think is important and conferring with colleagues in a live meeting environment.

The next meeting on my calendar is the OR Manager Conference (Long Beach, California, September 17-19). I’ve spoken with several of our presenters, and I can attest to the wisdom they’ll impart. I hope the OR Manager Conference is also on your calendar.

—Elizabeth Wood
Backed by more than 26 years of experience, the OR Manager Conference has been the #1 executive-level Conference to provide OR leaders a platform to receive the thought leadership and clinical education needed to be successful across 3-days of training.

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Take a breath with Conference speaker Juliet Funt

Keeping the OR trains running on time, keeping a lid on costs, and keeping team members’ behavior in check are a few of the hurdles in the path of every perioperative nurse leader each day.

Another stressor that is probably not even on the radar but should be is lack of time for strategic thinking. It’s a concept that will be explored during the closing general session at this year’s OR Manager Annual Conference in Long Beach, California, September 17-19.

Juliet Funt, owner and founder of WhiteSpace® at Work, a custom training and consulting firm based in Los Angeles, will share techniques in her talk, “Calling all OR Leaders! It’s Time to Reclaim your WhiteSpace®.”

What is WhiteSpace? It is open, unscheduled time for fluid, free-form thinking that can lead to creative solutions to problems, Funt told OR Manager.

“Without time to think and pause and reflect and recuperate, all sorts of problematic things are happening in healthcare,” she says. A pilot program tentatively slated for 2016 would attempt to correlate increasing WhiteSpace for nurses and physicians to a reduction in errors and an increase in patient satisfaction.

Time for strategic thinking is a trend that Funt anticipates will grow. “Everyone is being treated like a computer, as if they have unlimited storage capacity. We’re humans, and there’s a breaking point of effectiveness and focus,” she says. “I think people are becoming mindful of the price their businesses are paying for mindless business,” she says.

Moving rapidly throughout the day from one task to the next robs people of creativity, productivity, and engagement. “One of the things that’s lost is the ability to emotionally stabilize and recuperate,” she notes. “Medical professionals are working in an environment where literally life and death are on the line, so there’s an enormous amount of emotion.”

Learning to take tiny micro-pauses in the day can help you recalibrate how you feel. For example, she says, nurse leaders often interact with difficult people, and typically they just push ahead without acknowledging how those interactions make them feel. An “emotional rehearsal” is a technique that can be used to prepare for those conversations, she says.

“When you’re about to walk in the door and work with Dr X, and you know that you will be treated like an errant child, you pause and rehearse what will happen; you imagine what Dr X will say and rehearse what will happen; you know that you will be treated like a computer, as if they have unlimited storage capacity. We’re humans,” she explains. “I think people are becoming mindful of the price their businesses are paying for mindless business,” she says.

Funt will share other WhiteSpace tips and techniques during the conference. Plan to attend and get a fresh perspective on how to get through the day. For more information, visit www.ormanagerconference.com.

—Elizabeth Wood
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Academic-clinical partnership adds perioperative component to BSN curriculum

Including AORN’s PeriOp 101 curriculum in a bachelor of science (BSN) curriculum has allowed the University of St Thomas in Houston to break new ground in nurse education. Launched in May 2012, the program—a partnership between AORN, the University of St Thomas School of Nursing (UST), and Harris Health System—exposes student nurses to the OR clinical setting and allows them to work with OR staff nurse preceptors.

“Only one other nursing school in the country that we know of requires every nursing student to rotate through the perioperative area,” says Ann C. From, MSN, RN, CNOR, clinical nurse educator, Ben Taub General Hospital, Houston. “A few have a perioperative elective, but this program is truly an innovation.”

Harris Health System consists of Ben Taub General Hospital, a Level I trauma center with 586 licensed acute care beds, and Lyndon B. Johnson General Hospital, an acute care hospital with 328 licensed beds and a Level III trauma center. Both are teaching hospitals for medical schools and nursing schools.

The preceptor component of the program equips nurses with the skills needed to instruct, coach, and evaluate their students. Preceptors are advised by clinical faculty—expert nurses with advanced education and faculty qualifications.

Birth of an idea
UST reopened in 2012 after being closed for several years. Poldi Tschirch, PhD, RN, BC, was hired as dean, and discussions between Tschirch and Harris Health System’s Sharon Land, MBA, RN, NE-BC, CNOR, administrative director for perioperative services, were the catalyst for deciding to make perioperative nursing a required element of the new BSN program.

“The directors of nursing for the operating room and pre- and postanesthesia units for our two hospitals, as well as the perioperative nurse educators, were involved from the beginning,” From told OR Manager. Tschirch and Land introduced staff nurses to the concept at an OR staff in-service, and volunteers stepped forward to be taught to be preceptors for the students.

Tschirch drew up the budget and applied for a grant, which covered the cost of the faculty person to develop and administer the preceptor education program. This was developed simultaneously as the BSN program was being developed and approved, From explains.

BN students at the University of St Thomas in Houston practice OR skills in a mock operating room with a mannequin as a patient.
Used with permission, Ann C. From, MSN, RN, CNOR.

Program structure
The nurse preceptor program includes the following criteria: assessing the needs of the learner, creating an environment for learning, teaching and evaluating psychomotor skills, and giving feedback and evaluation. These four online modules take about an hour each to complete.

In addition, preceptors and clinical faculty engage in some role playing during two 8-hour workshops to help preceptors learn how to guide students and provide performance feedback, From says.

The clinical instructor assigns students to preceptors, and students work side by side with the preceptors, caring for all of the preceptor’s assigned patients for a given shift. Clinical instructors are responsible for ensuring

Continued on page 8
a positive learning environment, support of students, and safety of patient care.

“We chose 8 of the 25 PeriOp 101 modules for the UST students to complete before coming to clinicals,” From says. Those modules are:

• Introduction to Perioperative Nursing
• The Surgical Environment
• Aseptic Technique
• Perioperative Assessment
• Safety in the Surgical Suite
• Scrubbing, Gowning, and Gloving
• Positioning the Patient
• PeriAnesthesia Nursing.

The integrated BSN program includes 2 years of prerequisites and 2 years of the nursing program (including two summer semesters). Halfway through the program, students choose where to go for their summer externship, and in their final semester, they choose their clinical specialty area.

“Nursing students are exposed to most of the procedures that we do—orthopedic, general, ENT, oral, gynecologic, genitourinary, plastic, and eye surgery,” From says. Because Ben Taub is a Level I trauma center, she notes, students are exposed to trauma cases whenever possible. Students spend 3 full days in the OR and 1 day each in the preoperative holding area, postanesthesia care unit (PACU), and gastrointestinal endoscopy unit.

“We have 20 to 25 preceptors, three to four clinical instructors, and 30 to 40 students per class. A new class starts every June,” says From.

Measures of success

Responses to a preceptor survey were largely positive: Two-thirds of respondents (67%) said they felt they had benefited professionally from being a preceptor and were interested in precepting in the future. All respondents agreed that UST faculty had provided adequate support to their preceptors.

An OR skills lab at a nearby community college was added to the BSN program in 2013, From says. New nursing students are walked through this mock OR, which contains a mannequin “patient” that is transported from the mock preoperative area, to the mock OR, and to the mock PACU.

“We talk them through each area, important safety features, and the role of the nurse,” From explains. “This simulation of what they will see and do in the real hospital perioperative suite seems to greatly reduce their anxiety and give them a head start on what will go on in their clinical rotations.”

A great opportunity

In the final semester of nursing school, it would be beneficial to revisit the students and assess their interest in OR and PACU nursing specialties as a career choice, From suggests. Those who are interested could be counseled on the best way to present themselves as candidates.

“We are accustomed to having students of many disciplines taught here. The leadership is well aware of the nursing shortage, especially the further shortage of OR nurses, so implementing this program was a ‘no-brainer’ for us,” From says.

“Nursing students are typically not exposed to the OR and the PACU,” she notes. “Perioperative nursing staff are eager to turn around the misconception that OR and PACU nursing is not open to new graduate nurses. In fact, we have found that hiring new graduates yields excellent nurses who are loyal to the institution for many years.”

She says three nurses from the first graduating class were hired at Harris Health System in the perioperative areas.

The time and resources required for this program are well worth the investment in educating the next generation of nurses, From says. “Our facilities are situated within a highly competitive job market, The Texas Medical Center, so we welcomed the opportunity. The partnership between our facilities and the UST School of Nursing has been overwhelmingly positive for all involved.”

For others who may want to develop a program like this, From advises getting buy-in from the whole OR staff and management: “It takes a lot of resources, and it won’t be a good experience for anyone if people aren’t on board.”

—Elizabeth Wood

Reference
New perioperative immersion clinical steadily spreading its wings

A perioperative immersion clinical for nurses pursuing a bachelor of science degree has gotten off to a good start in Wisconsin. Launched in 2012, the program matches students with preceptors during the final semester of their senior year. Students complete 252 clinical hours and the entire AORN PeriOp 101 curriculum, which positions them to graduate with more comprehensive OR education and experience than students coming from more traditional programs, says Sharon Chappy, PhD, RN, CNOR, post-licensure programs director at the University of Wisconsin (UW) Oshkosh.

The catalyst for the program was an idea for succession planning at Theda Clark Medical Center, Neenah, Wisconsin. Several nurses were retiring, and some of newer nurses hired tended to leave the OR after spending 3 or 4 months in orientation.

Theda Clark leaders approached Chappy about having nursing students complete a clinical rotation in the OR as part of their senior-level clinical education. The program was structured by Chappy and Theda Clark’s director of clinical operations, Deborah Doyle, MSN, RN; OR nurse educator, Patricia Madigan, BSN, RN, CNOR; and OR manager, Laurie Conradt, BSN, RN, CNOR.

“We thought it would be great to have interested students complete a clinical rotation in the OR as part of their senior-level clinical education. The program was structured by Chappy and Theda Clark’s director of clinical operations, Deborah Doyle, MSN, RN; OR nurse educator, Patricia Madigan, BSN, RN, CNOR; and OR manager, Laurie Conradt, BSN, RN, CNOR. “We thought it would be great to have interested students complete a clinical rotation in the OR as part of their senior-level clinical education. The program was structured by Chappy and Theda Clark’s director of clinical operations, Deborah Doyle, MSN, RN; OR nurse educator, Patricia Madigan, BSN, RN, CNOR; and OR manager, Laurie Conradt, BSN, RN, CNOR. “Students feel they are a part of the team.”

Chappy sought grant funding from a UW Oshkosh Provost’s Initiative Grant to pay for the PeriOp 101 course, and then the undergraduate program committee approved having students in specialty clinicals for 14 weeks, she explains.

“We made it a competitive process; students had to apply and participate in an interview with the OR leaders and the potential preceptors at Theda Clark, as well as faculty from UW Oshkosh. That match with the preceptor and the student was a key factor to the students’ success,” she notes.

The structure
The nursing program at UW Oshkosh includes two clinical courses that a student completes in medical-surgical settings during the senior year. The first clinical course lasts 10 weeks, followed by a 4-week clinical immersion program.

Madigan, Doyle, and Conradt typically identify experienced perioperative nurses at Theda Clark who are good preceptor candidates—usually they have precepted new orientees in the past or have precepted students during a 4-week immersion, Chappy explains. However, the semester-long time frame is lengthier than that of most preceptor-student responsibilities, so this program requires a lot of dedication.

“The preceptors had to volunteer; they weren’t appointed,” Chappy says. “Preceptors must have a bachelor’s degree, but equally important, they must want to do it. One of our preceptors was finishing her PhD in nursing, and another was active in an MSN adult nurse practitioner program.”

Just one to two students per year are selected to complete clinical rotations in the OR. Each student has a primary preceptor and a secondary preceptor, Chappy notes, because some preceptors work 12-hour shifts, so at times a secondary preceptor is needed to ensure students can complete clinicals on days that fit with their academic schedules.

Madigan took the lead on developing the clinical schedule, modeling it on how a new nurse would be oriented to the OR. “Students are required to work two 6-hour shifts per week during the first 10 weeks because we wanted them to be in the OR more than 1 day per week,” Chappy says. “In the last 4 weeks, they complete 32 hours per week, working the preceptor’s schedule and even taking call and coming in for emergencies.”

Madigan also developed the schedule of which modules of PeriOp 101 the students would complete and when. “The students understood that the work on PeriOp 101 would be over and above their clinical hours, but they were excited about learning the theory behind what they were doing. They weren’t just learning from a preceptor,” Chappy notes.

Continued on page 10
During the first 10 weeks of the semester, students are also taking other senior-level courses, she adds.

**The outcomes**

Theda Clark is a regional trauma center, so students were exposed to a variety of neurologic, orthopedic, and other surgical procedures as well as organ harvesting. Many OR experiences for student nurses are observational, but in this clinical immersion, students learned beginning circulating nurse responsibilities that included patient skin prepping, preparing and opening cases, conducting time-outs, doing preoperative interviews and assessments, and participating in handoff communication.

“By the end of the semester, the preceptors were observing the students working as circulating nurses. It was very rewarding,” Chappy says.

“The students learned so many things that aren’t necessarily related to perioperative nursing. For example, their concept of sterile technique is phenomenal compared to what they would have learned elsewhere,” she says. Similarly, they learned advocacy and interprofessional collaboration. “They felt like they were part of the team rather than student nurses. These students seemed to have a leg up in communication skills with nurses and physicians compared to those in more traditional clinical training, with eight students per instructor.” Students are required to attend one AORN meeting or event during the semester, thereby also learning the value of membership in the professional organization.

Because students had to apply for this program, the OR staff knew they really wanted to be there. “Most of the time, the students worked well over the required 12 hours per week in the first 10 weeks because they wanted to follow through to the end of the case,” Chappy notes.

“So many times as a seasoned perioperative nurse, you don’t think about what you’re doing and why you’re doing it, because you’re so good at it,” she says. Having to answer students’ questions, however, sometimes made the staff look for information and consider the evidence on which policies and procedures are based. The OR staff said they felt invigorated by having the students there, according to Chappy.

Every graduating student completed PeriOp 101 and passed the final exam. Some were hired at Theda Clark, and some went to other facilities because typically openings at Theda Clark were filled by students who had completed the immersion clinical. Still others, Chappy says, realized that the OR was not for them, and that was a great learning experience. Even these students still benefited from the relationship with the preceptor and the depth of learning that occurs during such a rotation.

**The future**

The program is working so well that changes haven’t been needed, Chappy says—but she does have a wish list.

“One thing I would change would be access to PeriOp 101. I would like to have it on a UW Oshkosh server, but we can’t afford it,” she says. Students at Theda Clark were able to access the course through Theda Clark’s server so they could work on the modules at home, she notes. But in other facilities, students had to complete the modules at the healthcare facility. That was more difficult for them.

“The program has grown in popularity, and I wish we had more spots,” she adds. “I wish every hospital in our area could take a student in their OR every semester.”

The emergency room, rehabilitation/intermediate neuro unit, and ICU at Theda Clark have adopted this program, Chappy notes. Aurora Bay Care in Green Bay, Mercy Medical Center in Oshkosh, and Appleton Medical Center in Appleton, Wisconsin, have also participated in the OR clinicals, and other facilities in the state are expressing interest.

“For hospitals that anticipate having OR openings in the future, I would encourage them to contact a local school of nursing and try to do a program like this. Schools of nursing are always looking for excellent clinical opportunities for their students. Students can be a burden, but when they are on a unit for 14 weeks, they become helpful and productive,” Chappy says.

“New orientees to the OR typically aren’t new graduates because often times OR staff are afraid to hire new graduates,” she adds. However, the students who were hired after completing this program typically came off of orientation 3 to 4 months early compared with a new orientee, saving facilities anywhere from $16,000 to $25,000 in orientation costs.

—Elizabeth Wood

**Reference**

What do you do when your orientation program isn’t effective in educating and retaining OR staff? Carol Pehotsky, MSN, RN, ACNS-BC, CPAN, director of perioperative education at the Cleveland Clinic in Cleveland, Ohio, found herself in that position 3 years ago. “We blew it all up and started over,” she says. Pehotsky embarked on both a new role and a new education department.

Pehotsky and her colleagues in the education department—Anna Egan, BSN, RN, CNOR; Mary Tighe, MSN, RN, GCNS-BC, CNOR; and Julie A. Cahn, MSN, RN, ACNS-BC, CNOR—implemented the new orientation program in February 2012.

More than 90% of the 49 “graduates” were still working in the OR 1 year after completing the program. The program accepts both new graduate nurses and nurses without OR experience.

Pehotsky credits their success to a new way of thinking about the perioperative role along with better integration of didactic and practice experiences.

Getting back to basics
One of the first questions Pehotsky asked was, “What does it mean to be a perioperative nurse?” Too often, orientation programs focus simply on skills such as electrocautery and surgical site preparation, but Pehotsky and her team realized that emotional intelligence and critical thinking are also vital for success in the OR. “You can have the clinical skills, but not have what it takes to be an OR nurse,” she says.

Although Pehotsky first thought that only new graduates would need socializing into the OR, the team found that wasn’t true.

“Even nurses who have experience in the ICU or medical-surgical unit need guidance as to how to apply critical thinking in the OR because the environment is so unique,” she says. For instance, a perioperative nurse needs to know how to tailor a conversation to advocate for a patient without distracting the other providers during critical moments in a surgical case.

The team also knew they needed to address floating, even though the Cleveland Clinic has 12 service lines for its 70-plus ORs, which handle more than 45,000 surgical procedures a year. “Philosophically, we don’t want to build a vascular nurse, we want to build an OR nurse,” Pehotsky says.

That meant incorporating brief rotations (2 to 3 days) in each service line into the orientation program. The rotations focus on circulating rather than scrubbing skills and are designed to expose new personnel to the service line staff, environment, equipment, and general processes.

Finally, analysis revealed that orientation had moved away from teaching nurses how to scrub, something that Pehotsky and her colleagues felt needed to change.

“Even if they don’t have to scrub within the service line for which they were hired, scrubbing gives them understanding and insights into working in the OR,” Pehotsky says.

“Having an opportunity to work with instruments and equipment at a psychomotor level provides the circulating nurse a deeper understanding of each item,” she adds. For example, circulating nurses can better prioritize obtaining an item in an emergency if they understand that item’s use.

Using a three-pronged approach
The analysis by Pehotsky and her team led them to develop a three-pronged approach to the content needed in the 12-week orientation program:

- Nursing knowledge covers topics such as scrubbing, hemostasis, anesthesia, and critical thinking.
- Surgical case knowledge focuses on terminology and the different surgical specialties.
- Social aptitude skills include concepts such as bullying, chain of command, and advocacy.

“Competence in all three areas is necessary to excel as a perioperative nurse,” Pehotsky says.

Each week of the program builds on the previous one as concepts become more advanced. For instance, week 2 under social aptitude skills contains effective communication; by week 5, participants are ready to discuss crucial confrontations, and in week 10, they are learning about generational differences. Similarly, week
2 of nursing knowledge contains gowning and gloving, week 6, code management, and week 11, anesthesia (sidebar).

The week’s schedule is also designed to foster skill building. During weeks 1 through 6, participants typically spend 1 to 2 days in class, then work with their preceptors for the rest of the week, ending with a postconference on Friday. Content is focused on the scrubbing role. “The first week they just scrub in and observe,” Pehotsky says.

Weeks 7 and 8 give participants the opportunity to scrub cases full time to apply what they have learned up to that date. Pehotsky says these 2 weeks were added based on feedback from orientees: “They wanted to have more time practicing scrubbing before learning about circulating.”

After their intensive scrubbing experience, participants return to the classroom during weeks 9 through 12, ready to concentrate

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### Information covered in the perioperative nursing orientation program

<table>
<thead>
<tr>
<th>Week</th>
<th>Nursing knowledge</th>
<th>Surgical case knowledge</th>
<th>Social aptitude skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction to perioperative nursing, environment, and safety</td>
<td>Deferred; focus on surgical terms, prefixes, suffixes</td>
<td>Welcome Expected social norms How to get the most from your preceptor Surgical conscience</td>
</tr>
<tr>
<td>2</td>
<td>Aseptic technique Scrubbing, gowning, gloving Sterilization and high-level disinfection</td>
<td>General and colorectal</td>
<td>Autonomy Socialization Effective communication</td>
</tr>
<tr>
<td>3</td>
<td>Surgical instruments Minimally invasive surgery Draping</td>
<td>Gynecological and genitourinary</td>
<td>Effective listening Effective speaking Emotional intelligence</td>
</tr>
<tr>
<td>4</td>
<td>Electrosurgical unit Medications Specimens</td>
<td>Ears, nose, throat, and plastics</td>
<td>Effective teamwork Kindness Negativity and gossip Bullying</td>
</tr>
<tr>
<td>5</td>
<td>Hemostasis Sponges and drains Counts Wound healing</td>
<td>Neuro and spinal</td>
<td>Crucial conversation Crucial confrontations Influencing</td>
</tr>
<tr>
<td>6</td>
<td>Environmental sanitation and terminal cleaning Code management</td>
<td>Orthopedic</td>
<td>Assertiveness Advocacy De-escalation Chain of command</td>
</tr>
</tbody>
</table>

**Weeks 7 and 8: Scrubbing in the OR to cement scrubbing knowledge**

<table>
<thead>
<tr>
<th>Week</th>
<th>Nursing knowledge</th>
<th>Surgical case knowledge</th>
<th>Social aptitude skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Assessment</td>
<td>Vascular</td>
<td>Stress management First case on-time starts Turnaround time</td>
</tr>
<tr>
<td></td>
<td>Documentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Latex allergies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Positioning and prepping</td>
<td>Cardiovascular</td>
<td>Cultural competence Generational differences</td>
</tr>
<tr>
<td>11</td>
<td>Anesthesia, perianesthesia</td>
<td>Pediatric</td>
<td>Patient satisfaction (HCAHPS) Employee satisfaction (Gallup)</td>
</tr>
<tr>
<td></td>
<td>Patient/family education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Professionalism</td>
<td>Recap, questions</td>
<td>Professional development</td>
</tr>
<tr>
<td></td>
<td>Critical thinking</td>
<td></td>
<td></td>
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<td>Complications</td>
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*Note: Various topics may be omitted, expanded, or switched depending on the needs of the current orientee group.*
on circulating skills and critical thinking. They again spend 1 to 2 days in class, work with preceptors the rest of the week, and attend the postconference.

“You want to avoid the trap of too much classroom time,” Pehotsky says. “PowerPoint is only one way of delivering information and not always the most effective way. The hands-on learning is what they really remember.”

Not surprisingly, she says that selecting the right preceptor is key. “Preceptors can be doing education in a live setting and making it a fun, interactive experience.”

Helping adults learn
Pehotsky emphasizes the need to base orientation on adult learning principles. For example, adults like hands-on experience, so participants practice working in a mock OR setting before venturing into the clinical setting. “It gives them a safe place to practice, and we can help them build their confidence,” she says.

Information is presented in “digestible chunks,” Pehotsky says. “Adults learn in a stepwise manner, but it’s not necessarily smooth. As adults, we benefit from receiving information in a variety of modalities, and it often takes multiple exposures before we ‘get it’ and can apply it in practice without prompting.”

The Friday postconferences are an ideal time for open discussion, but Pehotsky and her colleagues also have an open-door policy for participants.

“We tell them that if there is anything they need, seek out one of us,” she says, adding that although orientees may be assigned to a particular instructor, they should feel free to approach any of the educators. During their clinical experiences, participants also have the opportunity to interact with educators who are making rounds when they aren’t teaching.

Participants also complete an evaluation of the orientation program after week 8 and at the end of the course, but Pehotsky emphasizes that they need to take ownership of their learning experience. “Waiting until week 12 to tell us we didn’t meet your learning needs is too late,” she tells orientees. “Come and talk to us.”

The program also includes a weekly evaluation of the orientee’s progress, which is completed by the educator with input from the preceptor and the orientee.

Leaving the nest
Pehotsky estimates that it takes about 6 months for orientees to “leave the nest.” After the initial 12-week program, she says, the educator puts the responsibility on the orientee to complete the competency checklist.

The educator works collaboratively with nurse managers on the orientee’s 45-day and 90-day evaluations. The 90-day evaluation includes a discussion with the nurse manager, educator, and orientee on skills and experiences needed for the balance of the orientation period.

Of course, new employees can still contact one of the educators for assistance, and they can tap into ongoing staff education programs. Educators conduct rounds to deliver quick, bulleted type information, hold in-services twice a month, and work with staff on competencies. Pehotsky’s colleagues spend up to 20% of their time in the staff nurse role to maintain their clinical competence, and they also help with quality initiatives.

Looking to the future
Now that Pehotsky and her team have revamped orientation at the Cleveland Clinic, they plan to reach out to the other eight hospitals and 16 health centers in the system. “Not every facility has a perioperative educator and certainly not a department, so our vision is to determine how to reach out and be helpful,” she says.

Centralizing the classroom part of orientation at the main campus of the Cleveland Clinic is one idea the team is testing. Participants would then return to their facilities for the clinical portion.

Pehotsky and her colleagues are also modifying the orientation for several surgical technologists who are preparing to take the exam to become a registered nurse.

“We’re excited about this,” she says. “It pushes us to think about orientation a little differently; we can deliver education at a faster pace.”

Cynthia Saver, MS, RN, is president of CLS Development, Inc, Columbia, Maryland, which provides editorial services to healthcare publications.

Reference
For the past 3 years, Tanner Health System has conducted “Education Day,” a mandatory perioperative skills course that supplements online courses, in-services, and other types of education. Staff attend the half-day course on a Saturday in early January to learn about complicated high-risk, low-volume, problem-prone procedures as well as new policies and procedures.

Using this relatively slow period for refresher education has proved to be an affordable way to boost skills and build a more cohesive team.

“Each instructor has an achievable amount of specific objectives to cover in 5 or 10 minutes,” explains DeNene Cofield, BSN, RN, CNOR, director of surgical services. “It’s a very focused patient safety refresher. The staff hate coming in on a Saturday, but at the end of the day, we hear, ‘I didn’t want to come, but I’m so glad I did because I learned a lot.’”

Tanner, a nonprofit regional health system serving west Georgia and east Alabama, includes a 211-bed acute care facility (Tanner Medical Center/Carrollton in Carrollton, Georgia) as well as two smaller acute care and critical access facilities (Villa Rica in Villa Rica, Georgia, and Higgins General Hospital in Bremen, Georgia).

Under the leadership of Cofield and Anne Medlin, BSN, RN, CNOR, perioperative nurse educator, Education Day was developed to provide a comprehensive basic skills overview for perioperative services staff from all three facilities.

Getting started
Previously, hospital skills day education had focused on patient care unit nursing rather than perioperative services. “Members of the surgical services and gastrointestinal clinical practice councils, consisting of managers and clinical staff nurses, were tasked with developing a curriculum to address areas needing improvement or to correct problems at some of the facilities,” Cofield says.

As part of the annual review process at Tanner, each team has three goals and each individual has three personal goals, Cofield explains. “Many staff have goals about becoming knowledge experts on a specific policy or piece of equipment or process,” she says. These individuals become departmental education specialists and ultimately teach a session on Education Day.

“Sterile processing technicians are very effective teachers, and all are certified in sterile processing; they understand their processes well, so they can teach IUSS [immediate-use steam sterilization] as well as other aspects of the department,” Cofield notes.

Vendors also participate. “Most vendors will provide this education free of charge as a value-added service and for the additional exposure it gives them to the staff,” Cofield says. “One year we had our laser contractor here; this year, we had our Cell Saver contractor here. Often times, if the leadership team is reviewing a problematic issue, they will add an item to the Education Day agenda, but most of the ideas come from the practice council.”

Setting up and implementing
Surgical Services at Tanner Medical Center consists of a 23-room short stay area, a large postanes-
thesia care unit (PACU), a state-of-the-art sterile processing area, 11 ORs, and three multispecialty rooms for endoscopy and other minor procedures. For Education Day, the PACU was used for code cart demonstrations and two of the ORs were used for orthopedic demonstrations. In addition, three rooms were used for endoscopy education including scope reprocessing.

This year, 105 staff members participated. Each short-stay room was converted into individual classrooms. “We took all the staff to the clinical space, so the thermal ablation demonstration was in one room, and the next room had a Cell Saver overview, and so on,” Cofield says.

Two staff members were assigned to each station so that they could take turns teaching and going through the stations, Medlin explains. “Not everyone had to go to every station. This was designed for education, not a competency, so presentations were limited to 5 to 15 minutes. Most were done in under 10 minutes, and they were constantly being repeated.”

Team members were assigned to certain stations based on their roles; for example, clinical technicians, surgical technologists, and nurses in the OR worked with the positioning table—how to set it up, clean it, and position patients properly. Similarly, endoscope reprocessing was required for all employees who work in endoscopy.

Each station typically has a 5 to 1 ratio of “students” to “teacher,” or sometimes even a 1 to 1 ratio, Cofield explains. At some stations, especially the high-acuity stations like the Cell Saver, by 10 or 11 am, the teacher begins to get a breather because not all staff are assigned to such stations.

At this year’s stations, teaching included:
• demonstrations of complex orthopedic positioning, including spine and fracture tables
• code cart reviews (both adult and pediatric)
• a review of new policies and procedures, including the online surgical checklist and an updated policy on prevention of retained surgical items.

Additional topics included chest tube management, assessing ports, electrosurgical units, IUSS reduction, the Universal Protocol, blood administration, and pacemakers, Medlin says.

Covering all the bases
Education Day takes place in early January because it’s typically a lower-volume time of year. Staff are often flexed off the schedule in January, Cofield explains, and by participating in Education Day, they get their hours back.

“We incurred virtually no overtime,” she notes.

A “Save the Date” flyer is posted 6 months before the event, and attendance is mandatory; there are almost no exceptions. Activities for children age 8 or older, a continental breakfast, snacks, and beverages are provided.

“We have two call teams available on the weekend,” Cofield explains. “Because of the way our OR is designed, we ‘unrestrict’ the two rooms closest to the double doors, so when people come in they don’t have to dress in scrubs. We pull everything out of the rooms before the weekend, and at the end of Education Day, everything is terminally cleaned and put back in order.”

If a case needs to be done, patients are rerouted and managers help clear the hall to give the patient privacy. “We have a whole regimen for how to get a case into the OR and reroute the traffic to the OR and back to the recovery room during the 4 hours,” Cofield says.

Looking backward and forward
“The first year, we were under construction,” Cofield recalls. “We tried to use the education rooms that are one floor up from the operating room. We assumed people would know how to get from the rooms back to the OR, but staff from the other facilities had a hard time finding their way around. Now the entire event is held on one floor.”

In part because of the physical conditions that first year, everything was given a fleece warm-up jacket with their names monogrammed, she adds.

To help orient staff from the smaller facilities, Medlin now goes to those hospitals to review instructions with them prior to the event and includes a map in their packets. Facilitators also are on hand to direct attendees.

Staff say they miss the door prizes that were previously offered, so those will be brought back. Because the event is held early in the year when people tend to diet, it’s important to offer...
food like fresh fruit and vegetables. It’s a little more expensive, Cofield says, but she figures she spent less than $1 per person on food. She also wants to offer more structured activities for the children next year.

“We look at the evaluations every year, and if the nurses request a new station, we try to accommodate that in the next event,” Medlin says. She compiles the evaluations and sends them electronically to the managers so they can review them with the staff. Practice council members and Cofield also get a copy.

“The staff are learning to think about what areas might be good for Education Day,” Cofield notes, so there’s higher awareness throughout the year about what specific refreshers may be needed.

“Some of the seasoned nurses asked us to do more complicated stations next year, such as the difficult airway cart demonstration and blood gas interpretation,” Medlin says, so there will be a general track and a complex track in the future.

“Our anesthesiologists have been involved in teaching every year,” Cofield notes. “They talk us through how we can help them during a complicated intubation or putting in lines.”

Next year there will be a backup call team as well. The more experienced staff are on call, so they are assigned to fewer stations. There are certain minimums everyone must achieve, Cofield says, and there are always “overachievers” who go to all of the stations and thus get higher marks on the Validation Sheets that are part of their employee records.

“You can’t educate on everything annually, but you can go through your policies and procedures and identify the problem areas,” Cofield says. An added benefit of an event like this is the team-building. “People meet each other outside of the work environment and realize that they need to value each other for their specific areas of expertise,” she explains. “Whatever it costs us is worthwhile because we reap the rewards in collegiality and being a more cohesive team in ways we can’t measure.”

Education is also offered through online courses, in-services, and “Mindbuilders,” an organization-wide effort by all the nurse educators to help staff earn four contact hours, twice a year. Monthly CNOR education will be offered in the future.

“I think we have to attack staff education like we do everything that seems overwhelming,” Cofield says. “It’s like eating an elephant—you do it one spoonful at a time. Keep it simple. Let the staff leaders prioritize and get it done. Next time staff face a clinical situation and they can go back to that clinical learning experience, they appreciate it.”

Finally, she says, “I guarantee that next year, we’ll have door prizes!”

—Elizabeth Wood

Reference
Medlin A, Cofield D. Education day for surgical services. Poster session, 2014 AORN Surgical Conference & Expo.
Infection prevention

Endoscopy staff

Continued from page 1

endoscopes” and the “Multisociety guideline on reprocessing flexible gastrointestinal endoscopes,” but how to build a true quality program focused on infection prevention.

“A good part of that is knowing who your personnel are and the proper training of your personnel to fulfill their roles,” says Stewart. In endoscopy, that can get complicated, she says, because staff members have many different levels of education, including RNs, licensed practical nurses (LPNs), and licensed and unlicensed endoscopy technicians. Validating the preparedness and continued competency of unlicensed endoscopy technicians has proved to be a bigger challenge than knowing what the steps are for reprocessing an endoscope, Stewart notes.

SGNA member surveys also have shown personnel competency to be an important issue in addressing infection prevention (sidebar).

Standards, guidelines not enforced

Unlike operating room staff, unlicensed and uncertified personnel can work in an endoscopy procedure room or in the decontamination area without any validation of competency requirements.

SGNA provides a guideline addressing entry-level recommendations for unlicensed personnel (sidebar, p 18). SGNA also recommends that facilities validate that their staff members are competent to work in endoscopy, and offer standards and guidelines to assist in that process. However, no national or state legal requirements mandate that facilities comply with the recommendations as they apply to unlicensed personnel.

As a result, “unlicensed endoscopy technicians are only as good as the person who teaches them their skills,” says Stewart, “and therein lies the pitfall. If endoscopy technicians aren’t correctly instructed in an orientation program, their skills and knowledge maintained with education, and their competencies validated with testing, errors can and do occur.”

Certification programs growing

In the 1990s, SGNA had a program that prepared endoscopy technicians for the certification exam offered by the Certifying Board of Gastroenterology Nurses and Associates—which was the certifying board for gastroenterology nurses at the time. Participation was encouraged but was not legally required.

This program was eliminated in 1998 because of low utilization, and the low number of test takers did not provide test validation.

SGNA continues to offer multilevel education programs online and onsite to prepare endoscopy technicians, but they remain voluntary. The Certification Board for Sterile Processing and Distribution (CBSPD) and the International Association of Healthcare Central Service Materiel Management (IAHCSMM) offer certifying processes for sterile processing technicians, but the decision of whether to require certification is left to each individual institution. These certifications only validate that technicians can reprocess endoscopes and equipment. They do not certify their competence to assist during a procedure.

CBSPD’s Certified Flexible

Continued on page 18

SGNA infection prevention survey findings

Infection prevention remains the key patient safety issue in the practice of gastrointestinal endoscopy. A survey of members of the Society of Gastroenterology Nurses and Associates found the following infection prevention concerns:

• staying current on latest infection prevention information
• adequate orientation, training, and consistent manufacturer instructions
• time and cost required for infection prevention education
• diversity in sense of urgency and importance—from “very concerned” to “why all this concern”
• diversity in preparedness—from “very prepared” to “overwhelmed”
• financial pressure on resources
• inconsistent infection prevention quality measures
• lack of standardization—mixed signals between regulatory agencies, organizational documents, and manufacturer instructions
• site/setting not always ready to embrace infection prevention principles
• inadequate training and lack of knowledge by everyone on the team as well as inconsistent monitoring
• diversity of roles among team members involved in infection prevention
• lack of evidence-based knowledge to defend principles.

Continued on page 18

August 2014 OR Manager Vol. 30, No 8
Infection prevention

Continued from page 17

Endoscope Reprocessor exam focuses exclusively on flexible endoscopes, whereas the sterile processing technician examinations do not, says Nancy Chobin, RN, CSPDM, CRER, assistant vice president of sterile processing, Barnabas Health System, West Orange, New Jersey. CBSPD also has separate exams for technicians who work in surgery centers, says Chobin, a member of the CBSPD committee that develops questions for certification exams.

Chobin says she believes so strongly about the need for a national standard for flexible endoscopes that she submitted a request to the Association for the Advancement of Medical Instrumentation (AAMI) to develop a document specifically for flexible endoscope reprocessing. AAMI approved the request, and Chobin co-chairs a committee that has been working on the document since 2012.

Chobin anticipates that the document, which covers all aspects of reprocessing including quality assurance, will be available in early 2015.

“This is an important document because it is a consensus document developed by all of the regulatory and standard-setting organizations,” says Chobin.

Legislation pending

Quality-focused legislation, such as Senate Bill 313 in the US Senate, would establish requirements for Board of Medicine licensure of surgical assistants and certification of surgical technologists. As the bill was rolled out through several states for review, sterile processing technicians were added, and endoscopy assistants and technicians may be added in the future, says Stewart.

State hospital associations are fighting this bill because of the costs involved. “They are saying, ‘we are overeducated and oversurveyed now, and we really don’t want to put in more money to educate endoscopy technicians,’” Stewart explains.

Some states are using Senate Bill 313 as a template for their own programs and regulations. They are adding requirements, or they are shifting over existing requirements for surgical and sterile processing technician licensing to endoscopy technicians.

Along with this, the Department of Veterans Affairs and New York State have been pushing since January 2013 to have endoscopes reprocessed in the sterile processing department (SPD) instead of in the endoscopy unit by unlicensed technicians. What’s happening, says Stewart, is that hospitals are either bringing SPD personnel into endoscopy to do the reprocessing or they are sending endoscopy personnel to SPD to reprocess the equipment and then bring it back to the endoscopy unit.

“In order to send their scopes to SPD and then have them returned, the endoscopy unit would have to have a huge inventory of endoscopes,” she says, “or the turnaround would drastically slow down the schedule or bring it to a halt.”

It is very unrealistic, says Stewart, but that is exactly what some Veterans Affairs hospitals around the country are doing because they could not control the barrier breaches that were occurring.

Chobin adds that she does not

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SGNA recommendations for unlicensed personnel in GI endoscopy

The Society of Gastroenterology Nurses and Associates recommends the following requirements, knowledge, and skills for unlicensed assistive personnel in gastrointestinal (GI) endoscopy.

Entry-level recommendations:
- high school graduate or equivalency
- previous patient care experience with healthcare training
- basic life support
- strong intrapersonal skills
- communication skills.

Clinical knowledge and competency recommendations:
- knowledge of anatomy, physiology, and pathology of the organs of the GI tract
- basic knowledge of the respiratory, cardiac, and neurological systems and their impact on the endoscopy patient
- knowledge of medical terminology
- knowledge of medications frequently used in GI procedures and patient responses to those medications
- knowledge of GI endoscopy procedures and related equipment
- knowledge of infection prevention principles
- knowledge and understanding of reprocessing standards of endoscope and accessory equipment
- knowledge of patient safety in all areas of endoscopy.
allow flexible endoscopes to be reprocessed in SPD because most SPDs don’t have sufficient equipment, space, or dedicated personnel. Also, transporting the endoscopes back and forth between units can damage them.

“Flexible endoscopes are highly technical equipment, and reprocessing should be done by technicians who do it over and over again and have developed an expertise,” she says. “It is not something anyone should do once a week or once every 2 weeks or when someone is on vacation—that’s how we get into trouble.”

Education programs a priority

OR directors who have endoscopy personnel under their supervisory umbrellas are setting up their own educational programs for technicians because surveyors are asking them how they validate their endoscopy staffs’ competency. Others are replacing endoscopy technicians with SPD personnel or with OR technicians who carry a license or certification.

Stewart and Phyllis Russo, BSN, RN, CGRN, have authored and present the Endoscopy Assistant/Technician Orientation and Competency Program, which is presented in 15 sessions for new and experienced endoscopy technicians learning their roles and preparing for certification. They also present a 1-day update session that assists skilled technicians in validating competency and preparing for the certification exam.

They teach these programs at community colleges in New Jersey and in ambulatory surgery centers throughout the country. OR directors and endoscopy managers can send their technicians to these programs instead of building one of their own, says Stewart.

(For more information on these programs, contact Stewart at les-tew710@aol.com.)

SGNA has an associates and an advanced associates program that is similar in content, but it is web based. “Though it lacks the hands-on ability offered in our program,” says Stewart, “it can be very useful to the technicians with RN support and observation.” (http://www.sgna.org/Education/AssociatesandTechnicians.aspx)

“Education is a priority. Managers know that their unit is only as good as their weakest tech,” says Nancy Schlossberg, BSN, RN, CGRN, nurse manager, Bon Secours Health Center at Harbor View Endoscopy Center, Suffolk, Virginia. “A facility can have the best nurses and techs in the world, but one incorrectly reprocessed endoscope can generate far-reaching, uninvited negative front page news. Anyone who touches an endoscope must understand and competently demonstrate the required reprocessing steps,” says Schlossberg.

This also includes managers and charge personnel, notes Stewart, because surveyors are beginning to take a different look at endoscopy reprocessing.

In the past, surveyors would talk only with managers about their process. Then during a certain period, surveyors wanted to talk only with the technicians doing the reprocessing and to see a demonstration of their process. Now surveyors are asking technicians the hows and whys of what they are doing, and they are asking the managers to demonstrate the skill. Their theory, says Stewart, is that if managers can’t demonstrate the skill, they can’t teach the technician to do it properly.

“In addition to making sure your personnel can competently demonstrate all the reprocessing steps, you need to have an individual who can ‘ride herd’ on everyone who handles the scopes and related equipment to ensure compliance with current infection prevention guidelines and endoscope instructions for use,” says Schlossberg. In her unit, that person is a technician. “If she sees a staff member not handling a scope properly or failing to wear appropriate personal protective equipment,” for example, “she immediately brings it to their attention,” she says.

“This technician also serves as our infection prevention champion,” says Schlossberg, referring to the SGNA Infection Prevention Champions Program. The goal of the program is for each endoscopy facility in the country to have a team member enroll as a champion. This person acts as the link to the most current infection prevention news and ensures the most current and safest practices are followed (http://www.sgna.org/InfectionPrevention.aspx). The champion can be an RN, LPN, or endoscopy technician.

Use of unlicensed personnel growing

In response to a 2010 change in Medicare regulations placing deep sedation under hospital anesthesia services, endoscopy suites began having anesthesiologists and certified registered nurse anesthetists (CRNAs) administer sedation rather than RNs.

“As a result, we are seeing the declining use of RNs and the greater use of unlicensed personnel in the procedure room, especially in surgicenters,” says Stewart.

Continued on page 20
Infection prevention

Continued from page 19

SGNA guidelines state that an RN should be in each endoscopy procedure room, but SGNA holds no regulatory ability to enforce these guidelines, she says. In surgicenters, it is not uncommon to have an RN in charge of several endoscopy rooms staffed with endoscopy technicians who assist the physicians with the procedures.

The Joint Commission requires that an RN supervise the patient’s care, and Medicare guidelines stipulate that an RN must be available onsite. In limited compliance, endoscopy units define these regulations by having an RN in the admitting area, an RN floating between several procedure rooms, and an RN in the postanesthesia care unit. “By the letter of the law, they are complying with these requirements, but in the middle of this is the RN’s responsibility to delegate procedure responsibilities to the endoscopy technician and the opportunity for much confusion,” says Stewart.

The 2014 American Society for Gastrointestinal Endoscopy’s “Guidelines for safety in the gastrointestinal endoscopy unit” recommend having an RN in a room where moderate sedation is given and an RN, LPN, or unlicensed assistant in a room where either no sedation or deep sedation is given. “As much as I believe the technician plays a significant role in the procedure, I believe an RN needs to be in the room to support the technician and assist the physician to ensure patient safety,” says Stewart. “I do not believe we can replace the value of the RN in the endoscopy procedure setting, but if this is becoming an increasing trend, we must take a serious look at endoscopy technician education to meet these challenges,” she says.

State guidelines define what licensed and unlicensed personnel are permitted to do during a procedure, such as inject a polyp with saline or snare a polyp, but people are ignoring state regulations, says Stewart.

Physicians will say the unlicensed personnel are working under their licenses, and, therefore, they can complete these tasks under their supervision. But that is not correct, says Stewart.

State guidelines define what licensed and unlicensed personnel are permitted to do during a procedure, such as inject a polyp with saline or snare a polyp, but people are ignoring state regulations, says Stewart.
Legally, technicians can do only what the state practice act permits. Many endoscopy technicians bring a high level of education and experience to their role, but many have limited educational and medical backgrounds and don’t understand the legal limitations, she says.

The problems crop up when complications or a breach in technique occurs, and unlicensed personnel don’t understand what is actually happening. In a survey of endoscopy technicians in New Jersey in 2001, Stewart says, many responded that they didn’t fully understand what was going on in the procedures for at least 2 to 2 1/2 years. They had to learn the language and just the basics of anatomy, physiology, and pathology that most nursing students learn in the first semester.

“The technicians are not the guilty parties,” Stewart adds. “They want education, they want certification, and they want licensure. They want a system that recognizes their value. They want our trust and respect. But the system is not building in the opportunity for them to get that education, and if it’s not required and enforced by the State, it’s not going to happen.”

In the meantime
What OR and endoscopy managers need to do when hiring technicians is validate their level of education and their ability to maintain competency. They also need to observe the technicians first hand and do biannual or annual tests of competency to make sure they are following recommended guidelines for infection prevention practices.

“It is a lot of responsibility for managers,” says Stewart, “but until the state requires either licensure or certification, it falls to the managers to ensure their competency, which also ensures quality of care and patient safety.”

—Judith M. Mathias, MA, RN

References


Senate Bill 313: Surgical assistants and surgical technologists; licensure and certification by Board of Medicine. http://leg1.state.va.us/cgi-bin/legp504.exe?121+sum+SB313


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Having more reliable performance data will boost your credibility

Most OR leaders use performance reports to inform and guide critical decisions. The problem is that in most hospitals, the data used to create these reports are not reliable.

Why? Even the smallest surgery department is too complex for the most sophisticated OR data solution. To yield reliable reports, information technology (IT) systems require extensive customization and ongoing attention. Unfortunately, most OR leaders have not invested the time or resources to optimize their technology. As a result, physicians and staff do not trust the OR’s performance data, which ultimately undercuts the goals of data-driven decision-making.

Successful data analysis programs require careful planning and leadership commitment. Better-performing ORs follow seven steps to capture reliable performance data and use it effectively.

Customize measures
Many surgery departments try to build a data strategy on the base reports prepackaged in their information systems. In fact, most “canned” reports are not useful for managing an OR. To secure reliable information, you need to customize system reports to your OR’s unique needs.

First, construct measures based on your OR’s operating policies. How do you define a late start? In some hospitals, a delayed case is any procedure that begins more than 5 minutes late. Other ORs extend the window to 10 or 15 minutes. And how do you define start time—as “patient in room” or “incision start”? Make sure the measures used to generate performance data reflect your operating standards.

Second, customize measures to your organization’s performance goals. If improving preadmission testing (PAT) performance is a priority, you will need a PAT performance report to identify problem areas and evaluate process changes. It is unlikely your information system’s base model reports address your unique PAT issues. You will need to create a custom report with measures such as “percentage of charts complete on the day before surgery” and other relevant metrics.

Validate the data
Idiosyncrasies in the way an IT system processes information can alter the meaning of simple measures. For example, say a case is canceled 30 minutes before its scheduled start. A nurse marks the cancellation and reschedules the case for the following week. In some systems, this action will rewrite the create date, thereby erasing the cancellation. To accurately measure same-day cancellations, you must understand the inner mechanics of your system and create the time stamps needed to yield a valid report.

Data auditing is essential. Cross-check system reports with manually tracked performance data. When an audit reveals a discrepancy, examine the underlying information fields and revise the data field map to generate accurate performance metrics.

Build credibility
Performance reports are tools for driving organizational improvement. But if stakeholders—especially surgeons—doubt your data, efforts to change processes will make little headway.

First, educate circulating nurses and other OR staff on the importance of collecting accurate data. Most electronic record systems include many more time fields than older paper-based systems, so data capture is more challenging than ever.

Second, teach staff to make effective judgment calls. Many surgical information systems require the user to assign a reason for any delayed start. Some nurses automatically select “surgeon was late,” even when other factors are at play. Other nurses sidestep confrontation by selecting “other.” Both practices undermine the credibility of the data.

The solution is communication. Encourage OR nurses to initiate a dialogue: “This is a late start—what should I enter as the reason?” Alternatively, the nurse can suggest a reason and ask for feedback. OR leaders can help by modeling this dialogue and making sure all physicians and staff understand that the process is focused on finding root causes, not on assigning blame.

Process “manually”
Many types of raw performance data are not usable until they have been evaluated by a person.
OR business performance

**FY 14 Surgical Services Dashboard** for the period ended May 31, 2014

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<td>▲</td>
<td>17.3%</td>
<td>Blue</td>
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<td>60.5%</td>
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<td>-1.0%</td>
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<td>▲</td>
<td>10.5%</td>
<td>Blue</td>
<td>5.0%</td>
<td>110.0%</td>
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<td>64.5%</td>
<td>5.8%</td>
<td>Green</td>
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<td>8.7</td>
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<td>12 Mos May '14</td>
<td>Progress</td>
<td>Target</td>
<td>% Variance</td>
<td>Trend</td>
<td>12 Mos Mar</td>
<td>12 Mos Apr</td>
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<td>Red</td>
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**Key**
- **Progress Indicator**
  - Achieving target: Green
  - Unfavorable to target by <5% Variance: Yellow
  - Unfavorable to target by >=5%: Red

High-level OR leadership reports like this one for a surgical services executive committee should emphasize performance goals and progress indicators.

*Source: Surgical Directions.*

Manual intervention is particularly important for tracking block time utilization.

For example, say a urologist has an individual block on Wednesday morning, but the schedule also includes a robotic urology block (shared by the entire service) during the same period. How do you allocate this surgeon’s robotic cases? Even where block time rules are clear, an individual will still need to evaluate the situation and make a decision.

Utilization decisions are even more complex when you fold in block time release rules. The bottom line is that human judgment is required to generate useful reports.

**Tailor reports**

OR information systems capture a huge amount of data. For these data to become useful information, they must be filtered to meet the needs of the individual user. An effective reporting strategy tailors information to specific OR stakeholders.

For example, all OR stakeholder reports should include the monthly delayed-start rate. It is an important indicator of progress against efficiency goals. But frontline OR leaders should also receive a daily report of delayed cases so that they can address specific efficiency problems immediately.

The standard turnover time metric is “wheels out to wheels in.” Surgeon reports, however, should also include personal “gloves off to next incision” data. Most ORs do not track this metric, but it can provide surgeons with a useful gauge of patient care and OR efficiency.

Anesthesia providers should also receive tailored data. For instance, an anesthesiologist who runs the board needs information to help manage the afternoon draw-down. Provide a report of rooms in progress by hour.

High-level leadership reports should emphasize performance goals and progress indicators. For example, a dashboard report for a surgical services executive committee (sidebar) could include volume, efficiency, and market share performance targets; actual performance data for several time frames; variance and trend indicators; and a simple system for characterizing current progress.

Sharing targeted reports with surgeons, as well as anesthesia and nursing staff, helps everyone get a clearer picture of what is occurring in the OR and what they can do to improve processes. As performance numbers improve, weekly

*Continued on page 24*
or even daily positive results energize the entire department.

**Slice the numbers**
Effective leaders excel at finding creative ways to drill down on performance data. For example, say an OR’s on-time start rate is less than 80%. Weak performance in a handful of spots could be dragging down the entire department. To find out, query the delayed-start report by:

- **Service line.** Is there a problem with a particular specialty group?
- **Physician.** Do a few surgeons account for the bulk of delays?
- **Specialty team.** Do certain nurse/surgical technologist/certified registered nurse anesthetist teams need to adopt better processes?
- **Length of delay.** If “on time” is defined as within 10 minutes, what percentage of delays are 11-24 minutes, 25-39 minutes, and 40-55 minutes?

Finding the answers to these questions can help you understand the severity of the problem, locate broken processes, and identify opportunities for education.

**Focus on solutions**
Many surgeons and nurses see data collection as an effort to assign blame. OR leaders need to stress that the goal is to understand the causes of problems so that the department can find solutions.

For example, say “contaminated instrumentation” is a leading cause of case delays. Do certain staff members need additional education? Does sterile processing reflect current best practices? Does the department need an equipment upgrade? Thinking in terms of root causes will help uncover solutions.

What do you do when performance data indicate that surgeon tardiness is a problem? Often, surgeons do not arrive on time because they know their room will not be ready when scheduled. In that case, the burden of proof is on the OR staff. Staff in both the preoperative area and the OR need to prove to physicians that they will be ready and waiting at the scheduled start time for all cases. Only then can the OR turn to surgeons and enforce arrival-time expectations.

**Selecting a platform**
The foundation of a strong data analysis program is appropriate technology. The first step in selecting a platform is to understand the pros and cons of different IT options.

Electronic medical record (EMR) systems centralize patient information, making them a candidate for data analysis. The main drawback is that an EMR system is designed to function as a patient record, not for reporting. To generate useful operational reports from an EMR, staff must perform extensive work “under the hood.”

Business intelligence platforms are designed expressly for reporting. Powerful capabilities make them relatively complex, so you will need to hire someone who understands the architecture of your specific system.

Data warehouse systems capture data feeds from information systems throughout an enterprise, and they offer robust reporting and tools (interactive dashboards, gauges, thermometers, etc). The main benefit is that a data warehouse enables apples-to-apples comparisons of consistent data across ORs and facilities. The downside can be inconvenience. OR leaders must submit report requests to a data management team, explain their needs, and wait for the results.

**Securing expertise**
What personnel do you need to enable effective data analysis? Your staff investment depends on your requirements and your resources.

In a small hospital, surgery department leaders might assign simple reporting duties to the OR business manager. Talented business managers can become adept at manipulating the EMR to generate useful reports. Many large hospitals and health systems, on the other hand, maintain a full data reporting team to manage the data warehouse.

There is an effective middle option for many hospitals—hiring a dedicated data analyst for the OR. Strong candidates understand not only the business intelligence platform, but also OR operations and finances. Combining these unique knowledge sets, an OR data analyst can produce sophisticated performance reports that leaders can use to guide clinical, financial, and strategic improvement. If the hospital has a data warehouse, the analyst can use his or her knowledge of OR processes to get full value out of the system.

This column is written by the perioperative services experts at Surgical Directions (www.surgicaldirections.com) to offer advice on how to grow revenue, control costs, and increase department profitability.
Personnel who contract vaccine-preventable illnesses not only expose vulnerable patients to diseases but also may miss work to care for themselves or sick relatives. Controlling outbreaks costs money and can drain hospitals of important resources.

In 1993, two pertussis outbreaks at Children’s Hospital Medical Center (Cincinnati, Ohio) cost $85,400 to control, and about half of that amount was used to fund a paid 5-day leave for the 79 employees with suspected pertussis. Other incurred costs included security staff to monitor the elevator to ensure compliance with the visitor restriction policy and temporary child care services for siblings of inpatients, who were among those restricted from visiting patients (Walker et al.; Christie et al.).

Vaccines have helped to eliminate or limit some very serious diseases in the United States and throughout the world. Various federal agencies and groups have recommended that healthcare personnel be immunized against specific illnesses because of the inherent risks for staff and patients.

**Recommended immunizations**

The Centers for Disease Control and Prevention’s (CDC) Advisory Committee on Immunization Practices (ACIP) recommends that healthcare personnel be immunized against specific illnesses because of the inherent risks for staff and patients. Health Administration (OSHA) requires employers to make the HBV vaccine available to such employees. For certain other diseases (eg, meningococcal disease, typhoid fever, polio), ACIP recommends vaccination only for specific groups at high risk (ACIP).

In recent years, ACIP and the CDC’s Healthcare Infection Control Practices Advisory Committee have emphasized that the recommendations apply to all healthcare personnel—not just those with responsibility for direct patient care (ACIP).

Healthcare organizations should review the vaccination and immunity status of healthcare personnel upon hire and at least annually. Immunization records should be maintained for healthcare personnel. In the event of an outbreak, up-to-date, well-organized records can help the hospital identify susceptible personnel and take appropriate action (ACIP).

**Seasonal flu**

Some populations, such as adults age 65 and older, pregnant women, and young children, are more sensitive to influenza infection than the general population and may develop severe complications from the flu (CDC Epidemiology; CDC “Influenza Vaccine, Inactivated”). Vaccination is the most effective method of preventing influenza and its complications (Fiore et al.). The seasonal influenza vaccine is available as both an inactivated form and a live, attenuated form. The inactivated vaccine is administered via intramuscular injection, and the live, attenuated vaccine is given by nasal spray (CDC “Influenza Vaccine, Inactivated”).

The inactivated vaccine is recommended for anyone who comes in close contact with patients whose immune systems are so weak that they require care in a protected environment (eg, a bone marrow transplant unit). Healthcare personnel who are in contact with people who have stronger immune systems can opt for the live, attenuated nasal spray. More precautions are associated with this form of the vaccine, however (CDC “Influenza Vaccine, Live”).

Severe reactions to the influenza vaccine are rare; however, people with egg allergies should not get it. Mild symptoms may occur within 1 to 2 days of receiving the inactivated vaccine (CDC “Influenza Vaccine, Inactivated”).

**Pertussis**

The beginning of a pertussis infection can mimic the common cold. However, after 1 or 2 weeks, a severe cough develops. Among infected children age 6 months or younger, nearly 12% get pneumonia; 83% of pertussis deaths occur in infants age 3 months or younger (CDC Epidemiology). Apnea, encephalopathy, and death may also occur (Sandora et al.).

A pertussis vaccine has been...
available since the 1940s, and at least 95% of US children between the ages of 19 and 35 months are vaccinated against this illness (Sandora et al.; CDC “National”). However, reported cases in the United States have increased steadily from a historic low of 1,010 in 1976 to a high of 27,550 cases in 2010 (CDC “Pertussis—United States”; CDC “Pertussis”).

Hepatitis B virus
Although most adults who become infected with HBV recover completely, people who become chronically infected may eventually develop serious health problems, including liver damage, liver cancer, or death. Most people with chronic HBV infection are asymptomatic and can remain so for 20 to 30 years (CDC “Hepatitis B Information”).

Potential modes of transmission include percutaneous injury and contact between infective material and nonintact skin or mucous membranes (CDC Epidemiology). Without immunity to HBV, the risk of contracting the disease if exposed to infected blood from a single needlestick or cut ranges from 6% to 30% and depends on the hepatitis B e-antigen status of the source individual (CDC “Exposure”).

HBV vaccination is recommended for healthcare personnel who are at risk for exposure to blood or body fluids. For personnel at high risk for occupational percutaneous or mucosal exposure, testing for immune response should be performed 1 to 2 months after the last dose, and revaccination and retesting should be performed as necessary (ACIP).

Measles, mumps, and rubella
Measles is another virus-caused respiratory disease. Early symptoms include fever, cough, runny nose, and conjunctivitis; a rash develops 7 to 18 days after exposure (CDC Epidemiology). Pregnant women who get measles may have a miscarriage, give birth prematurely, or have a baby with a low birth weight (CDC “Measles”).

Mumps is transmitted through
respiratory droplets. Most people who become infected with mumps recover; however, some complications have been known to occur, including inflammation of the testicles, the brain or tissue covering the brain and spinal cord, the ovaries, or the breasts. Temporary or permanent deafness may also occur (CDC “Mumps”).

Rubella is also transmitted through the respiratory system. Although symptoms are usually mild and complications are uncommon, infection during pregnancy is a major concern because it may lead to fetal death, spontaneous abortion, or premature delivery. Birth defects such as deafness, cataracts, heart defects, mental retardation, and liver or spleen damage may occur. Up to 85% of infants infected in the first trimester of pregnancy suffer at least some effect (CDC Epidemiology).

Varicella
Varicella, or chickenpox, is a highly contagious disease that causes an itchy rash of blister-like lesions. Healthy children may experience a mild form of the illness with malaise, itching, and a fever for 2 to 3 days. A recurrent infection, called herpes zoster or “shingles,” may have more severe symptoms. Potential complications of varicella include bacterial infection of the skin, pneumonia, and central nervous system manifestations (eg, aseptic meningitis, encephalitis) (CDC Epidemiology).

This vaccine has been recommended for healthcare personnel who are not already immune to the disease. Before the vaccine was licensed in 1995, varicella was endemic in the United States. Vaccination coverage has decreased the incidence of this illness by 83% to 93% in studied areas. The vaccine effectiveness ranges between 72% and 85%, and immunity is most likely permanent (CDC Epidemiology).

Review immunity status of workers annually.

Standards and guidelines
Federal regulations. In addition to ACIP and OSHA’s above recommendations, the US Food and Drug Administration has urged healthcare organizations to ensure that flu vaccination programs are available for all personnel (US Food and Drug Administration).

Joint Commission. Standard IC.02.04.01 specifically requires hospitals to offer flu vaccination to licensed independent practitioners and staff (Joint Commission).

Professional associations.
Many professional associations and other organizations have discussed the importance of healthcare personnel immunization, especially against seasonal influenza. The Society for Healthcare Epidemiology of America supports requiring annual flu vaccination as a condition of employment or privileges for all staff— even students, volunteers, contractors, and those who do not have direct contact with patients (Talbot et al.).

The American Hospital Association, the Association for Professionals in Infection Control and Epidemiology, and the National Patient Safety Foundation have also issued policies or statements supporting mandatory flu vaccination for healthcare personnel as a condition of employment (American Hospital Association). However, some other organizations, including the American Nurses Association and the SEIU Nurse Alliance, support flu vaccination of healthcare personnel but oppose requiring it as a condition of employment (Wood).

Flu vaccination rates among healthcare personnel
Despite the importance of healthcare personnel immunization, participation in flu vaccination programs varies. During the 2010 to 2011 flu season, 71% of healthcare personnel who worked in hospitals said they had been vaccinated. Vaccination rates were lower among those who worked in long-term care facilities (64%), ambulatory or outpatient settings (61%), and home health (54%). Across all healthcare settings, vaccination rates varied by occupation: 84% among physicians and dentists, 70% among nurses, and 57% among administrative personnel (CDC “Influenza Vaccination Coverage”). (See sidebar, p 28.)

In the 2011 to 2012 flu season, two web-based surveys conducted by CDC in mid-November 2011 identified reasons healthcare personnel do or do not get vaccinated against seasonal flu. Additional studies have identified other common reasons for declining the seasonal flu vaccine, including fear of reaction, lack of concern, doubts of the vaccine’s efficacy, and belief that they are not at risk (Hollmeyer et al.).

Vaccines are a valuable tool to

Continued on page 28
help staff members prevent the exposure of patients to harmful illnesses. Healthcare organizations should take steps to ensure not only that staff members’ vaccinations are up to date, but that their vaccination programs are designed to help staff understand the benefits of annual immunization.

References


Hollmeyer H G, Hayden F, Poland G, et al. Influenza vaccination of health care workers in hospitals—A review of studies on...
Surgeons perform about 600,000 hysterectomies per year in the US, but less than 1% of these take place in ambulatory surgery centers (ASCs). Richard Rosenfield, MD, is trying to change that.

Before he founded Pearl Surgery Center in Portland, Oregon, Dr. Rosenfield performed outpatient hysterectomies at several local hospitals as an advanced laparoscopic surgeon. He believes that with the right surgeons and the right patients, the time has arrived for ASCs to become the setting of choice for many hysterectomies.

So far, that’s been an uphill battle, mainly because relatively few surgeons have the requisite training and because of general uncertainty surrounding the Affordable Care Act (ACA).

“Innovation has not only improved the technology,” Dr. Rosenfield says, “but we can do [laparoscopic hysterectomies] more efficiently and at lower cost than hospitals.” For many procedures, the trend has been a shift from open to laparoscopic or robotic. For hysterectomies, laparoscopic is least expensive when performed in an ASC, he notes, and has been proven safe, even for women with large uteri or large fibroid tumors.

“CMS [Centers for Medicare & Medicaid Services] is pushing for this type of approach to healthcare,” he says. “For one thing, ASCs will see more Medicaid patients as the ACA takes effect. Reimbursement, however, has lagged policy changes.”

For example, Medicare pays for an ASC-based laparoscopic hysterectomy only if the specimen weighs 250 grams or less—and that payment does not cover the actual cost. Industry representatives such as the Ambulatory Surgery Center Association (ASCA) are lobbying to change that, citing research that demonstrates the procedure is safe for larger organs as well.

Cheaper, safer, yet still rare

Hysterectomy is the second most common surgical procedure performed on a woman, after cesarean section, according to the American Congress of Obstetricians and Gynecologists (ACOG). The most common indications are uterine fibroids, menstrual disorders, uterine prolapse, and endometriosis.

In 2008, according to ACOG, 112,000 hysterectomies, or 18% of the total, were performed in hospital outpatient departments, either laparoscopically or through vaginal access or a combination of the two.

“This is a multibillion-dollar issue,” Dr. Rosenfield told fellow ASC managers at the annual ASCA conference in May. He cited a study showing that a robotic hysterectomy performed in a hospital costs on average $8,868, vs $6,679 for laparoscopic and $6,651 for open surgery. However, a laparoscopic hysterectomy performed at an ASC costs an average of $4,000.

Part of the reason, Dr. Rosenfield says, is the rising cost of ro-

Continued on page 30
Advantages are lower infection rates and costs.

Laparoscopic supracervical hysterectomies (LSH), and 63 were total laparoscopic hysterectomies (TLH). An additional 57 candidates were excluded, not for clinical reasons, but for lack of adequate insurance.

The average time in surgery was 88.6 minutes for LSH and 125.5 minutes for TLH. The average time to discharge was 145.5 minutes for LSH and 168.2 minutes for TLH.

Of the 502 cases, there were 21 adverse events (18 requiring hospitalization), or 4.2% of the total. The rate of complications was far below the national average, Dr Rosenfield notes, with no mortalities and no long-term complications.

Since then, the number of cases has surpassed 750 at Pearl. “The protocol and technique are reproducible and scalable,” Dr Rosenfield says. Surgeons who add the procedure to their ASC practices will be able to take advantage of the expected increase in the insured population under the ACA, especially those who will become eligible for Medicaid.

Yet, he notes, only 1% of ASC cases nationally are gynecologic procedures.

Patient selection
Patricia Krajeck, MBA, BSN, RN, CNOR, is director of Pearl Surgi-Center. Successful ASC-based laparoscopic hysterectomy depends on surgical expertise and careful patient selection, she told OR Manager.

Specific to the specialty is consideration of whether the patient has had previous abdominal or laparoscopic surgery; various pathologies and comorbidities could exclude a patient from the ASC environment. When a patient’s body mass index (BMI) exceeds 34 kg/m², the anesthesiologist must be notified.

As with most other surgical procedures, patients are told to fast for 8 hours and to arrive 1 hour before the surgery.

In the 502 cases Dr Rosenfield tracked, average patient characteristics were as follows:
- age: 43.6 years (range, 19 to 64 years)
- BMI: 29.1 kg/m²
- uterine mass: 110.0 grams (range, < 90 grams to > 2,000 grams).

More than half of the patients, 298, had prior abdominal surgery. Of those, the average number of prior procedures per patient was 1.7.

Dr Rosenfield performs laparoscopic hysterectomies with trocars and high-resolution cameras. He uses five ports and two hands.

“The environment is one variable you can control (to avoid complications), and an ASC is less stressful if you are organized,” he says. However, expertise is important and there are greater risks than with most other ASC procedures. “You’re not likely to hit the vena cava in knee surgery,” Dr Rosenfield told ASCA attendees. “But with a hysterectomy, we’re into the peritoneal [cavity], so we have to face reality.”
Recovery following surgery

The Pearl recovery protocol consists of two phases. The first lasts for not less than 60 minutes, during which time the patient emerges from general anesthesia. Phase 2 begins when the patient meets discharge criteria. These criteria are based on guidelines of the American Society of Perianesthesia Nurses (ASPA). They include tolerating fluids by mouth; being able to void, stand, and walk; and having nausea under control. Patients are discharged by wheelchair, Kragelöf notes.

Patients go home with two prescriptions: Ondansetron for nausea and Norco (hydrocodone and acetaminophen) for pain.

They must have an escort and someone to stay with them for 24 hours. After that they can remove the Band-Aid covering the incision. They are encouraged to drink fluids with high sugar content, to relieve nausea, and to avoid spicy foods and alcohol. They are advised to use a stool softener. They are instructed not to have intercourse or place any object (such as a tampon) in the vagina and to lift nothing heavier than 20 pounds for 14 days.

The day after surgery, they are encouraged to move around to diminish the risk of blood clots, but to avoid strenuous activity, and they are told to take a week off from work. Finally, Kragelöf adds, they are warned not to sign any documents or make major decisions during the first 24 hours following surgery because of remaining effects of the anesthesia.

Seeking early adopters

“Is GYN the new spine?” was the title of Dr Rosenfield’s ASCA presentation. With clinical, financial, and legal conditions paving the way for adoption, he and other proponents of laparoscopic hysterectomies are seeing a few remaining obstacles to widespread acceptance among ASC managers.

“The problem is, the typical ObGyn doctor does not have as high a volume of surgery as other specialties,” Dr Rosenfield explains. “Some need to develop expertise.” He conducts training programs in the technique for fellow gynecologists.

A study published in 2009 in the Review of Obstetric Gynecology found similar obstacles to acceptance. “Vaginal and laparoscopic hysterectomies have been clearly associated with decreased blood loss, shorter hospital stays, speedier return to normal activities, and fewer abdominal wall infections,” the researchers state in their report.

“The relatively slow adaptation of laparoscopic hysterectomy may in part be attributed to inadequate exposure and training during residency,” they add. “Relatively low reimbursement rates may also curb provider enthusiasm for additional training and incorporation of the laparoscopic hysterectomy into their surgical armamentarium,” they conclude.

According to Dr Rosenfield, rewards await those who meet the changing environment with new skills and new offerings. His mantra, whether addressing colleagues, Medicare officials, or the public, remains: “Outpatient laparoscopic hysterectomy is safe, feasible, and cost-effective when performed in the setting of a free-standing ambulatory surgical center with same-day discharge home.”

—Paula DeJohn

References


Immunization

Continued from page 28


Patients’ perspectives of care not linked to postop morbidity, mortality
Patients’ perspectives of their care do not correlate with the incidence of postoperative morbidity or mortality, finds a study.

An analysis of Michigan Surgical Quality Collaborative data on nearly 42,000 patients found no significant differences in risk-adjusted morbidity rates between hospitals with the lowest and highest HCAHPS total scores (24.5% vs 20.2%).


Factors affecting readmission rates
Poverty level, educational attainment, and housing vacancy rate had a significant effect on calculated 30-day readmission rates in a study.

Researchers compared readmission rates for hospitals in Missouri using two types of models: one used by the Centers for Medicare & Medicaid Services for public reporting of condition-specific hospital readmission rates of Medicare patients and one that adds census tract-level socioeconomic data.

The model including socioeconomic data narrowed the range of variation in readmission rates from 6.5% to 1.8% for acute myocardial infarction, 14% to 7.4% for heart failure, and 7.4% to 3.7% for pneumonia.


JCR announces preliminary Hospital Engagement Network results
Joint Commission Resources has announced the preliminary results of its Hospital Engagement Network (HEN) that is working to reduce preventable injuries and complications from healthcare-associated conditions and infections. Data from 39 of the 50 hospitals participating in HEN are included.

Among the preliminary results:
• 15.77% decrease in catheter-associated urinary tract infections
• 20.89% decrease in central line-associated bloodstream infections
• 86.22% decrease in pressure ulcers
• 42.85% decrease in surgical site infection for abdominal hysterectomy
• 2.27% decrease in 30-day all-cause readmissions for Medicare patients.

—http://www.pwrnewmedia.com/2014/joint_commission/hen_results/

Anesthesiologists list tests, procedures to avoid
A survey of anesthesiologists has identified the top five perioperative practices that are supported by the least amount of clinical evidence.

Five practices the authors recommend avoiding are:
• baseline lab tests in healthy patients without significant systemic disease
• baseline cardiac diagnostic and stress testing in asymptomatic, stable patients with no cardiac disease
• routine use of pulmonary artery catheter in low-risk cardiac surgery patients
• administration of blood in young healthy patients without ongoing blood loss and with low, normal hemoglobin levels
• routine administration of IV colloids to replace blood or other fluids.