Utilization soars after block schedule is up and running

Block scheduling can be one of the most contentious issues that OR leaders face, but its effectiveness as an efficiency—and therefore cost management—tool makes it worth pursuing. Implementing block scheduling requires time, finesse, and dedication.

James X. Stobinski, PhD, RN, CNOR, says it’s easy for OR managers to underestimate the task. “It’s resource-intensive and it’s ongoing. You have to devote time to doing it well.”

Stobinski, director of credentialing and education for the Competency and Credentialing Institute in Denver, previously was director of surgical services for the Boise, Idaho, campus of St Luke’s Health System. Stobinski and Michelle Jackson, St Luke’s scheduling coordinator, launched a program in November 2010 to improve block utilization, an initiative that Jackson continues to manage.

Over 2 years, block utilization increased from running in the low
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Projects made about a decade ago told us to expect that the RN workforce would peak at around 2.2 million in 2012 and would then begin to shrink as nurses reached retirement age. Instead, say the authors of a recent Health Affairs report, there were 2.7 million RNs working in 2012—500,000 more than anticipated.

Judging by the results of this year’s OR Manager Annual Salary/Career Survey (cover story), staffing in hospitals and ambulatory surgery centers (ASCs) is fairly stable. About two-thirds of our hospital survey respondents say staff turnover and the number of open RN and surgical technologist positions have stayed the same in the past year, and about 70% of our ASC respondents say likewise.

Why have earlier projections not come true, and what does this mean for the future? The Health Affairs authors say that between 2002 and 2012, US nursing education programs nearly doubled, from around 74,000 to 181,000. Furthermore, some RNs who might have been expected to retire instead continued to work because of the 2007-2009 recession and the subsequent sluggish economy. But even apart from the recession, later retirement has become the norm of many RNs working in 2012—500,000 more than anticipated.

As for other RNs over 65, many are working in nonhospital settings, the authors say, such as nursing homes, ambulatory care settings, or schools. They note that baby boomers will ultimately retire and there may be a resulting shortage of RNs, but that shortage should be offset by the growing number of new nurses.

But what about the OR? Our survey respondents say that few RNs working in hospitals are currently open, but filling them with experienced nurses is more difficult than in the past. And as noted in our Special Report: Education (OR Manager, August 2014), the unique environment of the OR demands specialized skills—not just clinical knowledge but also critical thinking. Few schools of nursing offer this specialized education, and facilities vary widely in their approaches to staffing their ORs.

Among perioperative services leaders, just 4% of our hospital survey respondents say they plan to retire in 2014, but 68% say they plan to retire between 2015 and 2024. So it would seem that we can expect an ever-widening gap of OR nurse leaders and staff alike.

The overall nursing workforce may not be shrinking, but chances are the staffing challenges expressed by our survey respondents aren’t going away any time soon.

Elizabeth Wood

Reference
Auerbach D1, Buerhaus P1, Staiger D0. Registered nurses are delaying retirement, a shift that has contributed to recent growth in the nurse workforce. Health Affairs. Published online July 17, 2014.
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I ncreasing case volume, physician satisfaction, and patient safety are goals every OR leader strives to achieve. The 2014 OR Manager of the Year, Nancy Daughety, RN, has bragging rights to all three.

Daughety is administrative director of perioperative services at St Francis Hospital, Inc, a 376-bed community hospital in Columbus, Georgia.

Under her leadership, the OR has grown from 10 to 15 suites, surgical volume has more than doubled to 11,000 cases per year, and physician satisfaction has risen to an all-time high, says Deborah Saylor, MSN, RN, senior vice president, clinical care, and chief nursing officer at St Francis.

In addition, the hospital has not had a surgical sentinel event since 2010.

Daughety will be honored at a luncheon on Thursday, September 18, during the OR Manager Conference in Long Beach, California.

“We’re doing 65 cases a day, and we’ve had to get very creative with our staffing and hours to try to cover and keep the workload off of call people.” Daughety told OR Manager. Making the evening shift runs as quickly and smoothly as the morning shift, and having the right staff to handle the large volume are the obstacles she faces every day.

“She is known for quick and effective problem resolution, seeks and expects full engagement from her area’s leaders and staff, and is recognized widely by all as one who gets the job done,” says Saylor.

Among Daughety’s accomplishments:
• St Francis Hospital in 2007 received the Georgia Hospital Association’s first ever Josh Nahum-First Place Award for Achievement in Infection Prevention and Control for having reduced the rate of deep sternal wound infections among surgery patients to zero.
• The OR was the first department to implement Crew Resource Management to increase teamwork effectiveness, communication, and patient safety.
• Turnover time between cases has dropped to under 20 minutes.
• Daughety created a career ladder for surgical technologists that is evidence-based and focused on reward and recognition.

“With all of the growth and expansion in our operating room at St Francis Hospital, she has retained tenured employees throughout the years,” says William E. Taylor, MD, FACS, a surgeon at St Francis.

Daughety recognizes each individual and their unique contributions, and she is able to ask more from them as time goes on, he adds.

“Relationships are what endear you to people,” Daughety says. “I love pushing people to be the best they can be. And if they’re all they can be, your patients will get super great care.”

Daughety is never complacent. “I always think there’s something more I can do. I want to do my very best. I care a million percent, more I can do. I want to do my very best. I care a million percent,” Daughety adds.

Under her leadership, the OR has become the flagship department of St Francis Hospital, which is the community’s surgical hospital of choice, say her colleagues.

—Elizabeth Wood
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any younger,” Donna Doyle, MS, RN, NE-BC, CNOR, told OR Manager. Doyle is administrative director for surgery and anesthesia at Grant Medical Center, a level 1 trauma center that’s part of the OhioHealth system in Columbus. She says few schools of nursing offer a perioperative rotation for students, making it more challenging to encourage nurses to choose the OR as a specialty.

Survey highlights
Other key findings of the survey include:
• More than a third (38%) of perioperative services allocate time to patient rounding, a number likely to increase in the future (sidebar, p 9).
• Changes in surgical volume were fairly evenly divided among increased (33%), decreased (30%), and stayed the same (36%).
• Strategies for responding to economic conditions have stayed nearly the same for 4 years: reducing overtime (54%), eliminating open positions (47%), and requiring staff to take time off without pay (36%); however, 37% of respondents say they have reduced use of agency personnel compared with 29% in 2013.

About the survey
Data for the OR Manager Salary/Career Survey were collected from April to May 2014. The survey list comprised 800 OR Manager subscribers who are directors (or equivalent) of hospital ORs. The survey was closed with 138 usable responses—a 17% response rate.

To ensure representation of the target audience, results were filtered to include only the 131 respondents who work full time as a manager or director. The margin of error is ±7.9 percentage points at the 95% confidence level. This article features the staffing findings from the survey. Other findings, including compensation and management responsibilities, will be reported in the October 2014 issue.

Staffing profile
Nearly half (42%) of respondents reported no open RN positions, and 37% had only one or two. The average number of open staff positions was 1.5 for RNs and 0.9 for STs. That number was higher in teaching hospitals than in com-

Continued from page 1

Continued on page 8
Salary/career survey

Approaches for preventing readmissions

Survey respondents who said their hospitals are actively involved in preventing readmission of patients were asked, “What measures are being taken to prevent readmissions?”

Multiple respondents cited core measures such as falls prevention and the Surgical Care Improvement Project.

Planning for discharge was another important focus, as indicated by comments such as:
- aggressive care management planning
- care logistics model, C3s daily rounding, review of patients
- case management reorganization
- clinical pathways
- discharge planning and education, increased discharge instructions
- ensuring readiness for discharge, preoperative teaching about homecare, more printed instructions, postoperative phone calls.

One respondent noted that preventing readmissions begins early in the process, saying, “better evaluation and education of patient preoperatively.”

Respondents also reported greater follow-up after discharge:
- 30-day calls postoperatively
- written instructions given and postdischarge calls made at 1 day and 9 days
- discharge education, appointments, and phone calls
- postoperative phone calls and postdischarge phone calls made within 72 hours
- multidisciplinary committee working on transition record, aftercare, and follow-up calls
- transition clinic visit, health/disease management program with short phone call to check in daily.

Ongoing monitoring is a key component of preventing readmissions:
- all inpatient discharges reviewed by case management; all discharges with readmits within 72 hours tracked via peer review
- evaluate length of stay
- readmissions reviewed by specialty.

Not surprisingly, hospitals are targeting patients with diagnoses such as diabetes, heart failure, and chronic obstructive pulmonary disease. A few respondents reported that their hospital had created a new staff position focused on preventing readmissions.

Number of open FTE positions in ORs

<table>
<thead>
<tr>
<th>mean (median)*</th>
<th>Overall</th>
<th>Community</th>
<th>Teaching</th>
<th>Northeast</th>
<th>Midwest</th>
<th>South</th>
<th>West</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNs</td>
<td>1.5 (1.0)</td>
<td>1.3 (1.0)</td>
<td>2.2 (1.0)</td>
<td>1.5 (0)</td>
<td>1.6 (1.0)</td>
<td>1.3 (1.0)</td>
<td>1.7 (1.0)</td>
</tr>
<tr>
<td>STs</td>
<td>0.9 (0)</td>
<td>0.7 (0)</td>
<td>1.3 (0.34)</td>
<td>0.8 (0)</td>
<td>0.8 (0)</td>
<td>0.9 (1)</td>
<td>1.0 (0)</td>
</tr>
</tbody>
</table>

Staff turnover rate

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>Overall</th>
<th>Community</th>
<th>Teaching</th>
<th>Northeast</th>
<th>Midwest</th>
<th>South</th>
<th>West</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNs</td>
<td>6%</td>
<td>6%</td>
<td>7%</td>
<td>5%</td>
<td>7%</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>STs</td>
<td>6%</td>
<td>6%</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>8%</td>
<td>5%</td>
</tr>
</tbody>
</table>

*The mean is the average. The median is the midpoint in the distribution. The mean is influenced by extremely large and small values, while the median is not.

Continued from page 7

Community facilities (2.2 vs 1.3 for RNs and 1.3 vs 0.7 for STs). The number of open positions was comparable geographically.

Most respondents (92%) in hospitals say that STs do not circulate, compared to 81% in ambulatory surgery centers, where 11% permit STs to circulate with an RN in the room. The RN to ST ratio is 60:40, similar to previous years. STs comprise a higher percentage in the South (47%) and West (42%), compared to the Northeast (37%) and the Midwest (36%).
Turnover and recruiting

The average staff turnover rate (defined as the percentage of staff who have left and been replaced in the past 12 months) stayed stable at 6% for RNs (the same as 2013) and 6% for STs (7% in 2013). Compared to a year ago, most respondents said turnover had stayed the same for RNs and STs (65% and 63%, respectively).

Turnover for RNs and STs was comparable for both teaching and community hospitals. The lowest turnover for RNs was in the Northeast, and the lowest turnover for STs was in the Northeast, West, and Midwest.

About the respondents and their facilities

Most respondents work in a community hospital (72%) rather than a teaching hospital (18%), and the geographic distribution of respondents was fairly equal, although highest in the Midwest.

Only 22% of respondents said their facilities have achieved Magnet certification. When asked how Magnet certification affected their ability to recruit and retain staff,
most respondents said it was a benefit.

“My gut tells me that Magnet makes a difference,” Doyle says. “A nurse who is new to a Magnet environment can very easily distinguish the difference.” Only three of the 26 respondents who commented said Magnet status had no effect. Among the comments reflecting the benefits of being a Magnet facility were these:

• It has helped with recruitment and retention. Some nurses come here because it is a Magnet facility.
• It positively decreases turnover.
• Staff nurses want to know Magnet status before filling out applications.
• It is great for recruiting purposes; we are now getting our third designation.

Stable staffing, but changing market

Staffing may be fairly stable, but continued changes from ACA implementation, an aging workforce, and other regulatory and legislative initiatives mean OR leaders will continue to work hard to stay on top of developments and respond effectively. ✤

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

### Thank you!

OR Manager thanks those who generously took time to complete this year’s survey. We appreciate your part in gathering this information, which will be useful to your colleagues around the country.
Patient safety, satisfaction rise to top of priority list

OR leaders have always been committed to patient safety, but an increased focus on quality has them redoubling their efforts. With the recent initiatives linking patient satisfaction to reimbursement, it’s not surprising that OR leaders are emphasizing patient safety and satisfaction, as reflected in comments from the 24th annual OR Manager Salary/Career Survey (sidebar, p 13) and interviews.

Keeping patients safe
“The Affordable Care Act speaks a lot to quality, which we have been addressing in multiple forums,” says Kevin Behrns, MD, chair of surgery at the University of Florida (UF) Health in Gainesville. Managers at UF encourage all OR staff to think about how they can make the OR environment as safe as possible.

They do this by setting clear expectations and auditing performance, explains Diane Skorupski, MS, RN, NE-BC, CNOR, assistant vice president for perioperative services at UF. Every 6 months, the OR closes for 2 hours so that everyone who works in the OR, including surgeons, nurses, anesthesiologists, surgical technologists, residents, and support staff—500 to 600 people—can hear the results of the audit, which is conducted by nurses.

Examples of audit results include opportunities identified regarding elements of the briefing/time out/debriefing process and compliance with the prevention of retained surgical item policy.

The UF team also makes adjustments as needed. For example, instead of simply using a presurgery checklist, they have found it is more valuable to follow a list of discussion points as the team huddles with the patient.

Enhancing satisfaction early on
Marian McCann, MBA, BSN, RN, CNOR, a healthcare consultant and director of the OR at Long Beach Memorial Medical Center in Long Beach, California, says customer satisfaction “starts way back on the food chain at the physician offices.” This strategy includes providing educational materials—videos, classes, workbooks, or a combination of resources—for patients so they know what to expect before arriving for their preadmission testing. “Patients are most satisfied when they have the information they need for their recovery,” she says.

Working more effectively with physician offices requires outreach. McCann leverages surgeons’ desire for fewer postoperative phone calls. “The more calls they get, the less productive they are, so I tell them, ‘I have some ideas on how I can make your life easier,’” she says. “Nine times out of 10, they want to talk.” Once she has buy-in from the surgeons, McCann works primarily with the office staff to establish processes that improve patient satisfaction.

Timely service is key to satisfaction.

Embedding a customer service approach
A sharper focus on customer service has led many organizations to rethink every aspect of their practice, says Judy Pins, MBA, BSN, RN, vice president of Pins Productions, LLC, in Chicago. “In the past, hospitals used volunteers in surgical waiting areas. Sometimes the communication was good, and sometimes it was not,” she says. “Now hospitals are hiring people from the hospitality industry and offering concierge-type service.”

At UF, Skorupski says, “We provide hospitality and service education for all staff.”

Some organizations have turned to scripting to ensure consistency, but McCann cautions, “Scripting can come across as too paint-by-number and plastic. You have to say that this is an idea of what you can say.”

She prefers using role-play, whereby she is the nurse and the staff member is the patient. McCann begins with a scenario to illustrate how staff can inadvertently offend patients, such as by failing to make eye contact or calling older patients by their first names, and then she repeats the role-play from a positive approach.

“The experience makes such a difference,” McCann says. “They see that it took the same amount of time or less to treat the patient more humanely.”

Sheryl Michelson, MS, RN, BC, manager of perioperative education at Stanford University Medical Center, Stanford, California, says the organization uses the
C-I-CARE framework (http://stanfordhospital.org/clinicsmed-Services/medicalServices/nursing/patients/cicare.html) to ensure a consistent approach with customers:

• Connect with people by addressing them by the name they prefer.

• Introduce yourself and your role.

• Communicate what you are going to do, how long it will take, and how it will impact the patient.

• Ask permission before entering a room, examining a patient, or undertaking an activity.

• Respond promptly to patient questions or requests, and anticipate patient needs.

• Exit courteously with an explanation of what will come next.

“It’s not rocket science, but it’s a whole-hospital effort to improve patient and family satisfaction,” Michelson says. She adds that “way finding” is another initiative. “We train everyone to be alert for people who look lost and offer to take them where they need to go, even if it means being a little late.”

Tending to the basics

Achieving patient satisfaction doesn’t have to be complicated. Colleen Becker, MSN, RN, CCRN, director of perioperative services at Barnes-Jewish Hospital in St Louis, Missouri, says her facility has a patient experience committee made up of staff from the OR and postanesthesia care unit (PACU).

One initiative has been to avoid bringing patients to the OR too early. Another has been to give families a business card with the name of the circulator in the room where their loved one is having surgery and the number of the surgery front desk, so they can call with questions.

The volume of calls has not been a problem, and this system “puts a little bit of power back in the patient’s family’s hands,” Becker says.

For outpatients, the circulator and scrub personnel sign a thank you card and mail it to the patient and family after surgery. One group even has its photo on the front of the card.

Anticipatory satisfaction

Patient concerns are addressed on an ongoing basis at Stanford. For example, patients order room service instead of having to eat at the same time as everyone else.

Salary/career survey

Continued from page 11

The OR Manager webinar series, now under the direction of Ellen Lord, MS, RN, CNOR, is an important resource for continuing education as well as best practices to optimize efficiency and performance.

Webinars are presented twice a month. Attendees who complete a brief online posttest and evaluation satisfactorily may earn 1 contact hour per webinar.

Topics to be addressed in fall 2014 include hemostatic agents, perioperative leadership, succession planning, and the value of certification.

About Ellen Lord

A retired Army Colonel, Lord built her perioperative career within the military, both at home and abroad. Her background includes service at Walter Reed Army Medical Center (now part of the Walter Reed National Military Medical Center in Bethesda, Maryland), and Fitzsimons Army Medical Center in Aurora, Colorado, where she served as chief nursing officer of perioperative services. She managed the perioperative services at medical centers around the globe for more than 30 years and served as the perioperative nursing consultant to the Army Surgeon General. In addition, she has spent more than 20 years teaching perioperative courses and mentoring both military and civilian nurses.

Since retiring from active duty, Lord has specialized in perioperative operations, education, mentoring, and sterile processing consulting.

Lord holds a bachelor’s degree in nursing from George Mason University in Fairfax, Virginia, and a master’s degree in nursing from the University of Colorado, Denver. She is certified in perioperative nursing by the Competency and Credentialing Institute in Denver.

Questions or suggestions regarding webinars may be sent to her at zlord@ix.netcom.com.
Small steps can make big strides

The Affordable Care Act and value-based reimbursement have sharpened the focus on patient safety and satisfaction. Survey participants were asked to comment on, “What steps has your hospital taken or will it take in 2014 to increase patient safety and satisfaction while still meeting its revenue goals?”

Patient safety

- Hired a performance excellence engineer for perioperative services, leading to process mapping and Lean techniques.
- Use technology to prevent patient falls, and offer staff and physician training on use of surgical safety checklist to prevent errors.
- Hold a daily safety meeting with all administration and managers.
- Audit and use tools similar to those used in high reliability organizations.
- Use bed alarms, no-slip strips on floor, yellow slippers to prevent falls.
- Continue to work with our safety ambassadors and on Joint Commission standards.
- Require ACLS (Advanced Cardiac Life Support) for all OR nurses, and end tidal CO₂ monitoring.
- Implemented a fall prevention program.
- Use infection prevention measures.
- Follow national protocols.
- Use safety calls, safety huddles; report on safety concerns; continue to cross-check each other.
- Offer a high reliability and safety program for all staff.
- Use a staffing skills matrix, and increase educational opportunities.
- Increase patient teaching, improve antibiotic stewardship.
- Increase education for patients and staff.
- Redesign time-out and retention of foreign objects campaigns.
- Initiate electronic tissue tracker.
- Use smart IV pumps.
- Hold staff accountable.
- Conduct patient safety rounds and respond to identified issues; these rounds are held with staff by nursing and physician members of executive management.
- Use several patient safety fellows along with checklists for surgical site infections and hand-offs.

Customer satisfaction

- Require 100% staff training for patient experience. Patient safety and patient satisfaction committees meet monthly, go over data, and improve processes.
- Provide patient experience, service recovery training for staff.
- Conduct administrative rounding on patients.
- Focus on HCAHPS.
- Use director incentives to meet patient satisfaction and safety goals.
- Reduce noise.
- Improve communication.
- Initiated a website for patients to access their medical records for test results, make office appointments.
- Implemented a “catch the call” campaign, focusing on information conveyed to all patients on day of surgery.
- Scripted key words at key times regarding medications, privacy, procedures, and patient and family involvement in care.

“Patients can go on TV and pick what they want from a menu, and it’s delivered within 45 minutes,” Michelson says.

Managers like Michelson also make monthly rounds and quarterly evening rounds on units they are not familiar with, taking time to speak with employees, patients, and families to discover what is and isn’t working.

Customer-focused initiatives were started 3 years ago, and patient satisfaction scores since then have soared, with some areas hitting 100%. Benefits also spill over to employees; they are happy with the focus on satisfaction, according to Michelson.

Donna Doyle, MS, RN, NE-BC, CNOR, administrative director for surgery and anesthesia at Grant Medical Center, a level 1 trauma center that’s part of the OhioHealth system in Columbus, agrees that a proactive approach to customer satisfaction is essential, including ensuring that the right types of beds are available. “We’re increasing the number of intermediate beds to help drive down PACU holds, which increases patient and family satisfaction,” she says.
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**Patient safety, satisfaction**  
*Continued from page 13*

Time is another important component of customer satisfaction. “You can’t have a good relationship with patients and families if you don’t offer timely service,” says Dr Behrns. In addition, ongoing measurement of satisfaction is key. Dr Behrns says that when patients return to the clinic after surgery, they take an electronic survey on an iPad, answering questions such as, “How well did the surgeon prepare you for the OR?” Data are shared with the individual surgeons and factored into their annual performance reviews.

**Service recovery**

Despite everyone’s best efforts, sometimes problems arise, such as when surgery is delayed because of an emergency. “When there are misses, we try to do rapid service recovery so the patient and family know that if our service doesn’t meet the mark, we want to correct the problem,” Dr Behrns says.

In these situations, service recovery helps mitigate patient and family frustrations. “The basic rule is that you always apologize, but sometimes you can do a little something extra, whether it’s offering a free parking pass or lunch, or giving patients who are delayed in the PACU a warm blanket,” Michelson says. “It’s amazing how people appreciate the simple things.”

**Value of relationships**

Whether it’s patient safety or satisfaction, what’s clear is that interprofessional relationships and consistency are vital. “The key to our success is the alignment of anesthesiology, surgeons, and nurses,” Skorupski says. “All three get the same message and are held to the same standards.”

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

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Scheduling

Block schedule
Continued from page 1

70% range to exceeding the average target for all surgeons. Here is how St Luke’s used best practices to make that transition.

Utilization challenges
Jackson manages scheduling for 41 ORs in six facilities with an annual volume of more than 27,000 cases, as well as scheduling for ancillary departments such as endoscopy and cardiac catheterization, which have an annual volume of more than 10,000 procedures. She leads physician block scheduling committees at two of the system’s ORs and is responsible for monitoring block usage and block time reporting, establishing positive relationships with surgeons and their office staff, and supervising scheduling staff.

Jackson and Stobinski started the block utilization initiative in response to what she calls “an unmanaged system of block scheduling.” Surgeons could have any available time on the schedule, and all blocks had the same automatic release time.

“There was no monitoring and no systematic approach,” she says. Although St Luke’s had a policy, adherence to the policy wasn’t consistent and many surgeons didn’t know its parameters.

Both Jackson and Stobinski point to several key lessons learned from their ongoing journey to effective block scheduling.

Obtain high-level support
“You must have the support of the highest level of the hospital to do block scheduling and sustain it,” Stobinski says. “Without that, the task is impossible. Surgeons will just go around you to the chief of surgery or a member of the C-suite.” The highest level includes the chief of surgery, chief operating officer, chief financial officer, and chief executive officer.

To obtain support, Stobinski says OR leaders must be able to talk the language of finance: “Lay out the facts, and explain the business case. It’s not about who is in charge; it’s for the greatest good of the hospital.” The millions of dollars of difference between 70% utilization and 90% utilization will grab senior executives’ attention.

Stobinski suggests explaining how block scheduling can help in recruiting and retaining surgeons. Filling a large block at a single hospital makes the surgeon’s life easier and provides a steady source of income. Of course, there are risks. “It’s possible that some surgeons won’t like the discipline and order you need to run a block schedule well, so they may leave and go to a competitor,” he says. OR leaders can help manage that risk through good surgeon relations.

Build surgeon partnerships
“You have to develop a genuine rapport with the surgeons,” Stobinski says. One way to do that is to involve surgeons in the change. Refining block schedule policies was “something we did with the surgeons, not to them,” Jackson says. “We honed in on surgeons who were frustrated with the process when we opened up the scheduling committee.”

All surgeons were invited to serve on the committee, but she and Stobinski personally invited those they thought would be particularly effective. They told them policy decisions affecting resources and utilization would be made at the meetings. Surgeons from multiple specialties attended.

“We made good use of the time and kept the meetings focused,” Stobinski says. Gathering and sharing literature related to best practices for block scheduling worked well, according to Jackson. “We had doctors participate in weeding through the information,” she says. “We asked questions like, ‘how would that work here?’”

The committee decided to base release of block schedule time on specialty. The release time is 3 business days for general, thoracic, neurology, and spine surgery; 5 business days for general orthopedic, urologic, gynecologic, ENT, and ophthalmologic surgery; and 10 business days for total joint orthopedic, plastic, and dental surgery. Flexibility is achieved by assigning block time to specialty groups, individual surgeons, or offices based on utilization.

The committee developed a policy that includes a definition of block time, how to schedule and allocate it, the required utilization target, measurement and reporting frequency, how block time utilization is calculated, when blocks are released, and how to request block time.

Although Jackson and Stobinski were unable to convince the chief operating officer to attend meetings, Stobinski regularly met with him to explain what was happening. Jackson continues to send monthly block utilization reports to top administrators.
Ensure data accuracy

Stobinski says a common mistake that OR leaders make is assuming that their current data are sufficient for making decisions related to block scheduling. “Don’t make the assumption that your data are up to the task,” he says. “Know your data and know everything that went into gathering the data.”

Jackson agrees: “Have a person responsible for making sure the data are accurate, and spot check the data against the schedule.” Otherwise, you risk losing credibility and alienating the surgeon. An additional staff person may be needed for data monitoring, but Stobinski says the position will easily pay for itself in money saved.

As part of her other duties, Jackson initially monitored data at St Luke’s, and her responsibilities:

<table>
<thead>
<tr>
<th>Block Name (Alphabetic)</th>
<th>Day of week</th>
<th>Minutes released prior to deadline</th>
<th>Total block minutes available (less encumbered &amp; released)</th>
<th>Total block minutes used (including setup &amp; cleanup)</th>
<th>% block used (F divided by E)</th>
<th>Actual Usage of block (releases not factored)</th>
<th>% available time released</th>
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</tbody>
</table>


Continued on page 18
Scheduling

Continued from page 17

ility gradually evolved into her current role.

Stobinski recommends an electronic record system that will help capture data. “Make sure the nomenclature works, and you get the data you want,” he says. “Plenty of systems provide numbers, but you have to be able to break it down to the language of the surgeon.”

He suggests working with the vendor to refine the system as needed. Jackson says St Luke’s currently uses McKesson Resource 1 for tracking. “We go through the data to be sure surgeons get credit and download the data monthly into an Excel sheet” (sidebar, p 17). Data are monitored at least weekly and often daily.

“Anticipate that people will question your data,” Stobinski suggests. Identifying what those questions might be will help OR leaders better prepare for meetings with surgeons and hospital executives.

Educate widely
To inform surgeons about the new policy, open houses were held at a meeting center close to the hospitals where they practiced. The surgeons’ office staff were also invited to attend. “We had to orient surgeons to when their block time was and when it was released; many of them didn’t know. Then we explained the changes that were coming,” Jackson says.

After the orientation, attendees received a follow-up letter recapping the information, and nonattendees received a different letter that also provided key information.

At the first hospital campus, orientations were held during the beginning of the month, and implementation followed that same month. Subsequently, implementation occurred after a full month had passed from orientation, which Jackson says worked better.

“We let people know that we were in transition and that we were going to implement step by step,” Jackson says. No punitive action was taken after the first quarter of implementation; instead, the time was used to answer questions and build familiarity with the system.

“We created some fairly aggressive expectations, but took time building to them,” she says, noting that it’s important to consider negative consequences to a too-soon enforcement policy. For example, although the utilization target was 75% with no more than 25% release, they didn’t initially look at release time because they wanted the surgeons to release the time if they weren’t using it, Jackson says.

Jackson and Stobinski also visited surgeons’ offices to meet with scheduling staff and discuss reports. Surgeons who were successful with the new block scheduling initiative shared their stories, which helped reduce resistance. “I can’t say we won everyone over, but most people have seen the benefit,” Jackson says.

She adds that OR leaders trying to implement new block scheduling processes should “go slowly and methodically and have one-on-one conversations.”

Surgeons new to St Luke’s receive a reference book that includes scheduling information. Jackson also meets with them to help them get off to a good start. Unless they are in an existing group, new surgeons typically don’t receive a block until their volume patterns are established. And, of course, less popular days and times become available sooner.

Enforce through peers
Enforcement is one of the thorniest problems of block scheduling. “It’s best to stay away from a Draconian approach,” Stobinski says. “We try to make everything come from their peers,” Jackson adds.

Surgeons receive quarterly utilization reports. The scheduling committee reviews blocks not meeting utilization goals and recommends ones that should be placed on a 3-month observation (probationary) period. Surgeons receive a letter notifying them of this action, followed by monthly updates. At the end of 3 months, the committee again reviews the data. If there is no improvement, the chief of the service line or the chief of surgery talks to the surgeon.

Expectations and consequences are clearly outlined in St Luke’s scheduling policy. For example, the policy states that 75% utilization with less than 25% release is needed to maintain the allocated block time. If this fails to occur:

• 60% to 74% utilization will result in a reduction of 1/4 of current block time
• 50% to 59% utilization will result in a reduction 1/2 of current block time
• <50% utilization will result in loss of block time.
Scheduling

Utilization is calculated from when the surgeon’s first patient’s wheels arrive in the OR to the last patient’s wheels out, including turnover times of up to 1 hour. Cases scheduled outside of block time aren’t included in utilization.

Consider the entire hospital
Balancing block time and open scheduling is a challenge. St Luke’s is currently working toward 80% block time and 20% open time. “Allocating too much block time decreases your flexibility,” Jackson says.

She advises OR leaders to avoid half-day blocks, which create inefficiencies. The scheduling committee also tries to level service lines. “You have to look at how much equipment you have,” Jackson says. “You can’t put all your neuro surgeons on Monday. Instead of buying multiple sets of equipment, spread them out over more than 1 day.”

Leveling benefits patient care units, too. “You don’t want to overwhelm the neuro units by scheduling too many neuro cases on 1 day,” says Jackson, who adds that unit managers rely on the OR’s block schedule to establish staffing patterns. “It helps them to allocate their resources.” When making adjustments to reflect fluctuations in volume—for example, during spring break—Jackson says the scheduling committee tries to consider the impact on non-OR sections of the hospital.

Jackson sees the future bringing a greater emphasis on overall hospital benefits. For instance, currently block time is granted based on when the request is received. “I think we are going to have to add ROI [return on investment] into that decision so that we’re evaluating profitability,” she says.

Maintain commitment
“Good block utilization requires an ongoing commitment and a continual process of monitoring and maintenance,” Stobinski sums up. “It’s resource-intensive, but it benefits patients, surgeons, and the hospital.”

Cynthia Saver, MS, RN, is president of CLS Development, Inc, Columbia, Maryland, which provides editorial services to healthcare publications.
Thorough environmental cleaning limits the number of microorganisms that can be transferred to the patient and the healthcare provider, thus helping to prevent healthcare-associated infections. A team consisting of perioperative nursing, sterile processing, environmental services, and infection prevention staff needs to be established to develop cleaning procedures for all areas of the facility, including the sterile processing area.

Routine cleaning as well as special cleaning procedures for multidrug-resistant organisms, construction, and environmental contamination—such as flooding or spills of chemicals or blood, body fluids, or other potentially infectious materials—should be addressed. These policies and procedures should be reviewed and revised periodically and readily available to personnel performing these tasks.

Some of the aspects to consider are described in this column, but readers should also consult the section on environmental cleaning in the 2014 AORN Perioperative Standards and Recommended Practices.

Cleaning materials
This team should select the cleaning materials to be used. Cleaning chemicals (eg, detergent, disinfectant, or a combination) should be registered and rated as hospital grade by the US Environmental Protection Agency (EPA), according to Recommendation 1 of the AORN Recommended Practices on environmental cleaning. A low-level disinfectant should be used. High-level disinfectants or liquid chemical sterilants should not be used because they are not labeled for this use, and alcohol is not an EPA-registered disinfectant.

The cleaning chemicals should target the microorganisms that need to be removed, and these chemicals should be compatible with surfaces, cleaning materials, and equipment. Follow the cleaning chemical manufacturer’s written instructions for use (IFU) for dilution; contact times needed to kill targeted microorganisms; ventilation; types of cleaning materials, tools, and equipment to use; and disposal (also follow local, state, and federal regulations). Consider the cost, personnel ergonomics and safety, and effect on the environment when choosing these products.

Always check the expiration date of the chemicals before using. Clean environmental services with a detergent prior to disinfection. This can be a combined detergent and disinfectant product or two separate products. Always follow the manufacturer’s written IFU.

Reusable or disposable cleaning materials (eg, mop heads, cloths) may be used. Microfiber or low-linting cotton cleaning materials are popular. Reusable mops or cloths should be changed after each use and not returned to the cleaning solution container, which would then become contaminated. Disposable mops and cloths should also be discarded after each use to prevent cross-contamination. Disassemble cleaning equipment according to the manufacturer’s written IFU, and clean, disinfect, and dry before storage to prevent the growth of microorganisms.

Wet and moist mopping are effective in reducing organic soil on floors. Items that contact the floor for any amount of time, eg, instruments that are dropped when preparing trays for sterilization, should be considered contaminated and re-cleaned.

Follow the SDS (Safety Data Sheet) and standard precautions to prevent contact with blood, body fluids, or other potentially infectious materials when choosing the appropriate personnel protective equipment (eg, gloves, mask or N95 respirator, and protective eyewear).

Terminal cleaning in sterile processing
AORN defines terminal cleaning as “thorough environmental cleaning that is performed at the end of each day when the area is being used.” Both AORN and AAMI (Association for the Advancement of Medical Instrumentation) ST79 recommend that sterile processing be terminally cleaned the same as the operating, delivery, and invasive procedure rooms. AAMI ST79 (Section 3.4) states that the best practice is to provide separate housekeeping facilities for the decontamination and clean areas to avoid transferring contaminants from “dirty to clean” areas.

AORN recommends that terminal cleaning and disinfection of the sterile processing areas “be performed daily when the areas are being used.” Terminal cleaning should not be performed when personnel are actively decontaminating instruments. Cleaning should progress from cleanest to dirtiest areas. Specific AORN recommendations for ter-
Sterilization & infection control

Terminal cleaning (Recommendation IV) are as follows:

• Clean floors with a wet vacuum or single-use mop and a disinfectant using the disinfectant manufacturer’s written IFU contact time to prevent disease transmission. Disinfect floor surfaces in the center of the room (highest level of contamination) before the perimeter (lowest level of contamination). Clean the distribution, preparation and packaging, sterile processing, and sterile storage areas (cleanest work surfaces) before cleaning the decontamination area (dirty work surfaces) to reduce the possibility of contamination of clean areas.

• Damp-dust with an EPA-registered disinfectant and a clean, low-linting cloth from top to bottom all horizontal and other work surfaces and high-touch objects: work tables, countertops, furniture (eg, chairs and stools); sterilizers and sterilizer carts; shelving; sinks; pass-through window; door handles and push plates; telephone and mobile communication devices; computer accessories; and trash and linen receptacles.

• Remove trash from receptacles when full and at least daily.

Scheduled cleaning
Scheduled cleaning is a cleaning schedule that defines areas and equipment that should be cleaned on a regular (eg, weekly, monthly) basis.

AAMI ST79 states:
• Walls, storage shelves, and air intake and return ducts should be cleaned on a regularly scheduled basis and more often if needed.
• Stained ceiling tiles should be replaced, and any leaks causing the stains should be repaired.
• Lighting fixtures or covers should be cleaned at least once every 6 months.

AORN recommends (Recommendation V) a schedule for cleaning the following:
• Clean and soiled storage areas
• Storage cabinets, sterile storage area (except floors)
• Ventilation ducts (including air vents and grills) should be cleaned and filters changed on a routine basis according to the manufacturer’s written IFU
• Eye wash stations and aerators on faucets should be cleaned and disinfected on a routine basis
• Sterilizer service access room
• Elevators
• Pneumatic tubes and carriers
• Lounges, waiting rooms, offices
• Environmental services closets

Joint Commission Surveys
The Joint Commission will have on their white gloves while surveying the cleanliness of the department and will be looking for dust bunnies. The Commission will observe and ask about the frequency of departmental cleaning, including:
• Daily versus deep cleaning
• Behind closed doors and under racks
• Hidden corners and high level flat spaces
• Behind and around automatic cleaning equipment

• Sterilizer service access room, including the tops of sterilizers
  The Commission will also ask if the dirty room is clean.

Role of personnel
Designated cleaning responsibilities are important to reduce the number of items that personnel forget to clean. Environmental cleaning service and sterile processing personnel need to decide who is responsible for cleaning what.

In the surgical processing area at Overlake Hospital Medical Center in Bellevue, Washington, Don Williams, CRCST CIS, CHL, manager, has environmental cleaning service staff do the wet mopping, empty the trash, and clean walls, vents, and lights. Sterile processing staff clean all work surfaces on a daily basis: sterilizer carts, sterilizer chambers, and storage shelves and cabinets. This list should be expanded to cover all the areas discussed above.

Quality assurance and performance improvement
These programs provide data to evaluate worker safety and determine whether the performance of environmental cleaning meets benchmark goals of the organization. Process monitoring ensures compliance with regulatory standards (eg, Occupational Safety and Health Administration), recommended practices (eg, AORN, AAMI, Centers for Disease Control and Prevention), manufacturer’s written IFU, and the facility’s policies and procedures with regard to monitoring of the environmental cleaning and disinfection process as well as reporting and investigation of adverse events (eg, outbreaks, product failures, inadequate cleaning).

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Keep up skills with ongoing education.

“”
Total joint arthroplasty volumes have ballooned in the last two decades, and reimbursement has not kept pace with costs. Rising implant prices are a major driver of hospital spending on these procedures. As the aging US population creates growing demand for joint replacement, controlling implant costs is becoming a top priority for OR leaders.

Some hospitals have sought to control implant costs through a demand matching strategy—carefully delineating which patients can receive which implants. While demand matching is a useful clinical tool, it has little ability to affect prices. The strategy may help ensure patients do not receive unnecessarily expensive implants, but the OR must still pay the prices set by vendors. In practice, gains achieved by limiting product usage can be eroded by vendor pricing adjustments.

Recently, an orthopedic specialty hospital in New York experimented with an alternative approach to controlling implant costs. Leaders used market data, price point ceilings, and a focused negotiation strategy to reduce average implant prices and total procedure costs.

Launching the project
The Hospital for Joint Diseases (HJD) is a Manhattan orthopedic specialty hospital that is part of the New York University (NYU) Langone Medical Center. As an academic medical center that performs up to 4,000 joint replacement procedures per year, HJD is ideal for testing implant cost control strategies.

HJD began focusing on implant costs 4 years ago. Working with NYU’s supply chain analyst, clinical leaders calculated the average cost of knee and hip implants by procedure and by physician. Although costs were not excessively high, the data revealed an opportunity to reduce expenses. The data also uncovered a wide variation in implant costs between individual surgeons: approximately $1,268 for knee implants and $1,208 for hip implants.

In 2011, HJD launched an initiative to control implant costs through price negotiation. The goals of the initiative were to decrease the average cost of orthopedic implants and to decrease physician variation in implant costs.

Setting price points
The first step of the initiative was to establish standard prices for implant hardware. Clinical leaders used the hospital’s historical cost data and industry-wide data from the University HealthSystem Consortium. They developed market-supported price points for four implant categories:

- routine total hip replacements
- routine total knee replacements
- high-demand total hip replacements
- high-demand total knee replacements.

The price points represented the reasonable charge the hospital was willing to pay for implants in each category. (Vendor contracts do not permit the disclosure of exact price information.) “Routine” denotes standard hardware that meets the physical demand and longevity needs of most patients.

The HJD price point strategy differs from strict demand matching in key respects. Demand matching is the practice of matching implant types to the expected level of physical demand. This requires a decision matrix based on patient age, weight, activity level, health status, and other indicators. The premise of demand matching is that different orthopedic implants demonstrate different benefits.

In contrast, the price point strategy is based on the premise that clinical research—in most cases—does not demonstrate any patient benefit from more expensive hardware. “The research does not support the use of more than two demand categories,” says Joseph Bosco, MD, vice chair for clinical affairs at HJD and a leader of the hospital’s implant cost initiative. The expectation is that routine implants are appropriate for most patients.

Aligning surgeons
Surgeon support is essential to the success of a price point strategy. At HJD, clinical leaders made physician communication a priority. One goal was to educate surgeons on the economics of joint replacement.

“Usually, surgeons have no idea what the hardware components cost, and individual surgeons have no idea how they compare to other doctors in terms of costs,” Dr Bosco says. “We thought it was important to be transparent with
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the data, so we developed cost dashboards.” The quarterly dashboard reports quantified each physician’s average joint replacement costs (including implant costs) and ranked physicians against their peers in terms of costs.

Clinical leaders also communicated implant utilization expectations. “We made it clear that there was no incremental cost benefit to using high-demand, expensive components in every patient,” Dr Bosco says. “Any use of high-demand implants needed to be approved in advance.”

Getting approval

HJD created a straightforward review process. Surgeons must provide clinical justification for any patients they think require a more expensive implant. A surgeon committee reviews requests on a case-by-case basis.

Criteria include patient age, activity level, and anatomy, but exceptions are limited and well defined. For example, patients must be under age 55 or heavier than 300 pounds to be considered for a high-demand implant.

During the first year of the initiative, the most common reason for granting an exception was an anatomic variation that called for nonstandard hardware. A patient with hip dysplasia or an abnormally shaped femur, for instance, will often require a more expensive implant.

Notifying vendors

Once price points were established and surgeons were on board, HJD presented the price point structure to implant vendors. Vendors were permitted to offer hardware products in each implant category at the category’s specified price point. The message was simple: If you want to do business at our hospital, you must meet these price points.

According to Dr Bosco, the reaction was varied. “Vendors that were doing very little business at our hospital were happy to meet the price point,” he says. “For them, it was an opportunity to expand their business with us.”

In contrast, high-volume vendors resisted the new system. Some initially refused to adjust their pricing. “In these cases, we asked surgeons to switch temporarily to a different brand.” After just a week or two of no sales, initially reluctant vendors agreed to sell hardware at HJD’s new price points.

Reducing costs

During the first year of the price negotiation initiative, HJD surgeons performed 1,090 total knee replacements and 1,022 total hip replacements. The initiative reduced implant costs significantly:

- Average implant costs for total knee replacement decreased $1,042, a reduction of 26%.
- Average hip replacement implant costs decreased $876, a reduction of 22%.

The initiative also succeeded in trimming the variation in surgeon-specific costs:

- The standard deviation for knee implants was reduced by 50%—from $1,268 to $637.
- The standard deviation for hip implants was cut 65%—from $1,208 to $418.

Overall savings were dramatic. According to Dr Bosco, HJD saved just over $2 million on joint implant hardware during the first 12 months of the initiative. Approximately half of this amount was returned to the orthopedic surgery department to fund research and education.
Environmental cleaning

Continued from page 21

AORN states that EVS and SP personnel should receive initial and ongoing education as well as ongoing competency verification of their understanding of the principles and performance of the processes for environmental cleaning.

To monitor the effectiveness of the environmental cleaning process, AORN states (Recommended Practice X.c) cleaning practices should be measured using qualitative (eg, visual, fluorescent marking) and quantitative measures (eg, adenosine triphosphate cultures) as part of process improvement. Quantitative measures provide more information about cleaning effectiveness faster than a visual method, and they allow you to determine whether problems are improving, stabilizing, or worsening.

Checklists help to prevent human errors or missed cleaning of items, and they facilitate communication between environmental cleaning service and sterile processing personnel. A sample checklist is available in the AORN Environmental Cleaning Tool Kit available on their website.

The three cleaning steps recommended by the AORN environmental cleaning recommended practice (Recommendation VI.b) establish a routine for cleaning so that items are not missed during this process. Following these steps will reduce the risk of cross-contamination of environmental surfaces by limiting the transmission of microorganisms:

- Move from the clean areas into the dirty areas.
- Start from the top and work down.
- Use a clockwise or counter-clockwise method.

Martha Young, MS, CSPDT, is president, Martha L. Young, LLC, providing SAVVY Sterilization Solutions for Healthcare in Woodbury, Minnesota. She is an independent consultant with long experience in medical device sterilization and disinfection.

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Staffing in ambulatory surgery centers (ASCs) is remarkably stable, although surgical volume is increasing in many centers and recruiting is becoming more difficult, according to the 24th annual OR Manager Salary/Career Survey.

More than 70% of respondents said both the percentage and number of open RN and surgical technologist (ST) positions remained the same as a year ago. However, half said it was more difficult to recruit experienced RNs, and a third said it was more difficult to recruit STs.

Nearly half (44%) of respondents said the volume of surgical procedures had increased in the past year, 34% said it remained the same, and only 20% reported a decrease. One respondent who has seen a decrease in surgical volume attributed the drop to higher deductibles on patients’ insurance plans.

Other survey findings include:
• Strategies for responding to economic conditions remained the same compared with last year. Nearly half of respondents reported reducing overtime, a third said they required staff to take time off without pay, and 19% said they eliminated open positions.
• The skill mix of RNs to STs is 60% to 40%.

About the survey
Data for the OR Manager Salary/Career Survey were collected from April to May 2014. The survey list comprised 1,000 nurse managers of ASCs who were either OR Manager subscribers or part of an external list. The survey was closed with 111 usable responses—an 11% response rate. To ensure representation of the target audience, results were filtered to include only the 104 respondents who work full time in an ASC as a manager or director. The margin of error is ±9.3 percentage points at the 95% confidence level.

Distribution among ASC ownership where respondents work was fairly evenly divided among physician (35%), joint venture (31%), and corporate/LLC (23%). Two-thirds of respondents work in multispecialty ASCs; of these, the top specialty was ophthalmology (40%), followed by orthopedics (26%) and gastroenterology (17%).

This article features the staffing findings from the survey. Other findings, including compensation and management responsibilities, will be reported in the October 2014 issue.

Turnover and recruitment
Turnover remained relatively unchanged from last year’s survey, with 75% of respondents reporting that turnover stayed the same for RNs (vs 71% in 2013) and 83% of respondents reporting turnover staying the same for STs (vs 79% in 2013).
reporting the same turnover for STs (80% in 2013).

The low turnover is reflected in the low number of open positions for both RNs and STs. In fact, two-thirds of respondents have no RN positions open, and 31% have only 1 to 3. Those numbers are even lower when it comes to STs; 88% have no open positions.

In 2013, 42% of managers found recruiting RNs more difficult; that number is now up to 50%. A third of respondents report that recruiting STs is more difficult than in the past.

**Patient safety action plans**

Respondents to the survey were asked, “What steps has your ASC taken or will it take in 2014 to increase patient safety and satisfaction while still meeting its revenue goals?”

Many respondents cited checklists as a means to enhance...
Medicare reimbursement, allowable procedures at forefront of ASC challenges

Leaders of ambulatory surgery centers (ASCs) can expect to continue facing challenges related to reimbursement even as they try to increase the kinds of procedures that can be performed in their facilities, say experts with the Ambulatory Surgery Center Association (ASCA). Other key factors that will determine their future success include quality measurements, facility design requirements, and use of electronic health records (EHRs).

“Our number one regulatory and legislative goal is to move ASCs off the CPI-U [Consumer Price Index for All Urban Consumers] factor,” Steve Miller, ASCA’s director of government and public affairs, told OR Manager. That’s one reason the association is working to pass the Ambulatory Surgical Center Quality & Access Act of 2013 (H.R. 2500/S. 1137). The bill has more than 60 cosponsors, but given the current legislative gridlock, Miller thinks passage this year is unlikely.

The bill focuses on how ASCs are reimbursed and how the Centers for Medicare & Medicaid Services (CMS) decides on which procedures an ASC can perform (http://www.ascassociation.org/ASCA/GovtAdvocacy/Legislation/ASCQualityAccessActof2013). The main goals of the bill are to:

• Change the ASC update factor from the CPI-U to the more appropriate Hospital Market Basket Index.

• Establish a value-based purchasing program that saves Medicare money and provides a bonus pool to ASCs that meet certain quality standards.

• Direct CMS to add a representative of the ASC community to be appointed to the Advisory Panel on Hospital Outpatient Payment, which helps determine ASC facility fees and which procedures Medicare will reimburse ASCs for providing.

• Create more transparency within the Medicare procedure approval process by requiring CMS to disclose which of six criteria triggers the exclusion of a procedure from the ASC-approved list.

Reimbursement and procedures

“There is an increasing discrepancy between what Medicare pays to a hospital outpatient department and an ASC,” says David Shapiro, MD, past president of ASCA and a member of the ASC Quality Collaboration Board of Directors. He adds that he tells legislators, “Patients will receive the same care, with the same equipment, with the same surgeon, at two different sites that might be across the street, but Medicare pays about twice the amount for the hospital-based procedure.” That’s why ASCA is working to have CMS base annual ASC reimbursement updates on the Hospital Market Basket Index instead of the CPI-U.

Increasing the number of procedures performed in an ASC can boost revenue, but expanding the list can prove difficult, particularly because those outside CMS don’t know how the agency decides which procedures to add to the annual list.

“We need transparency in the procedure approval process,” says Miller. “We don’t know why a procedure isn’t allowed to be done.”

Currently Medicare reimburses hospital outpatient departments (HOPDs) for performing about 360 procedures that it will not reimburse ASCs for providing to its beneficiaries. Because CMS doesn’t give a reason for denying a procedure in the ASC setting, ASCs can’t refute these decisions. Shapiro notes that sometimes private payers may, unfortunately, look to the CMS list when deciding what they will reimburse, creating additional reimbursement headaches for ASCs.

On the other hand, Shapiro says, “Some private payers have been more progressive as to what they’ve allowed ASCs to perform, so when it comes to Medicare beneficiaries, we’re faced with the ability to safely perform a procedure on someone who is 64 years old, but we can’t do the same procedure on someone who is 65 years old because of CMS constraints.” Yet, he notes, certain procedures could safely be performed at an ASC for a significantly lower cost compared to hospitals.
“Moving more procedures into the ASC is going to be a major push of ours over the next several years, not just on the Medicare side, but on the commercial side, too,” Miller says. For example, he notes that total hip, total knee, and spine procedures are being done every day as outpatient procedures, but CMS limits nearly all of them to inpatient procedures. (Some spine surgeries are permissible in an ASC.)

What’s more, private insurers are already paying for many of these procedures. Miller acknowledges that not every patient is suitable for undergoing surgery in an ASC, but allowing healthy patients access to ASCs could save CMS millions of dollars.

**Reaping the benefits of savings**

Currently ASCs receive reimbursement from CMS of about 55 cents on the dollar in comparison to HOPDs for the same procedure. Moreover, ASCs don’t receive any of the savings that they generate for the Medicare program. That’s why the ASC Quality & Access Act of 2013 includes a provision for value-based purchasing that would allow ASCs to share in cost savings.

“AsCs generate substantial cost savings of about $2.5 billion a year, and we think centers should share in that,” Miller says. In the proposed plan, CMS would set a spending goal for procedures eligible to be performed in an ASC. If spending on those procedures fell below the target, the difference would be in a savings pool. Half of any money saved would be returned to CMS, and the rest would be used for bonuses for high-performing facilities or for facilities that demonstrated the greatest increase in quality.

“You want to incentivize people to do the right thing,” Miller says. “If you reward only the highest performance, it may become a disincentive for facilities to try to improve their quality.”

Miller cites a recent success story in working with CMS. The agency was requiring radiologists to sign off on paperwork related to imaging, so ASCs had to pay a radiologist to simply sit and sign papers, even though surgeons and other ASC employees are qualified to perform this task. ASCA was able to convince CMS to drop the radiologist on staff signature requirement, which CMS estimates will save ASCs $41 million every year.

**Quality and satisfaction at the forefront**

Unlike hospitals, ASCs don’t use HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems), but that doesn’t mean quality isn’t a focus, particularly given the new quality reporting requirements from CMS.

Several years ago, ASCA assembled a group of stakeholders who identified possible quality measures for ASCs that could be discussed with federal regulators. These include patient burn, patient fall, hospital transfer and admission, and wrong site/side/patient/procedure/implant surgery.

Other possible measures followed, including prophylactic IV antibiotic timing, safe surgery checklist use, facility volume data on selected ASC surgical procedures, influenza vaccination coverage among healthcare workers, appropriate follow-up interval for endoscopy/polyp surveillance, and avoidance of inappropriate colonoscopy interval for patients with a history of polyps.

Since then, CMS has also proposed some other quality measures. “We’re not really happy with all of them, but we’re working on getting some modified and developing other measures of quality,” Miller says.

Part of the problem is that many of the regulations don’t fit with the ASC care model. For example, CMS added a requirement that patients undergoing cataract surgery in an ASC undergo a visual field analysis 90 days after the procedure, but, of course, by then patients are long gone from the ASC. In its proposed ASC payment rule for 2015, CMS is recommending that this reporting measure be made voluntary.

“Especially since physicians are already being asked to report this information (results of a visual field analysis 90 days after the procedure), we think this proposal is a step in the right direction,” adds Miller.

Shapiro notes that when it comes to customer satisfaction as a measure of quality, ASCs have a distinct advantage: “ASCs are very customer focused. It’s one of the areas where we have thrived.”

Unfortunately, measuring customer satisfaction has varied across states. Shapiro says that CMS is currently piloting a new customer satisfaction survey and estimates that it will be implemented within a year.

“It remains to be seen how CMS mandates the reporting of the instrument,” he adds. He anticipates that the first proposed ruling will require reporting in 2015, with a link between amount of reimbursement and customer satisfaction established in 2016.

Continued on page 30
Facility design requirements
ASCs are also affected by the 2014 Guidelines for Design and Construction of Hospitals and Outpatient Facilities released by the Facility Guidelines Institute (FGI). Here is a summary of new requirements related to ASCs:

• The minimum OR size in the outpatient setting is 250 sq ft, which replaces classification of OR size based on anesthesia use. What used to be called Class A rooms are now procedure rooms, and the minimum size is 150 sq ft. Endoscopy rooms have a minimum size of 200 sq ft.
• The minimum number of required Phase I postanesthesia care unit patient care stations is 1.5 per OR.
• At least one scrub station must be next to the entrance of each OR. (A scrub station with two scrub positions may serve two ORs as long as it’s located next to the entrances.)
• A 44.5-inch clear opening is now required for doors that may be used for wheeled-bed stretchers.

(For more information about the guidelines, see OR Manager, July 2014, pp 1, 7-11).

EHRs
ASCs weren’t included in the Health Information Technology for Economic and Clinical Health (HITECH) Act, so they weren’t eligible for bonuses or penalties related to EHRs. Unfortunately, those exclusions also meant that they weren’t given any incentives to implement EHRs. “That’s why products designed for ASCs haven’t been developed in the marketplace,” Miller says.

ASCA is working with federal regulators on a voluntary certification program for EHRs in ASCs. An ASCA task force has made recommendations that were approved by the ASCA board. The next step is to seek approval from the National Office of Coordinator for IT to make these criteria part of a voluntary certification program. “We think it’s important because information needs to be accessible in all settings so there is a complete health record,” Miller says.

Be aware
ASC leaders will have their hands full keeping abreast of upcoming initiatives, and it’s essential to stay informed. Shapiro advises ASC managers to get involved in the formation of accountable care organizations (ACOs) in their regions.

“ASCs have proven to be the flagship for providing the type of healthcare that ACOs aspire to: cost-effective, high-quality, patient-centered care,” he says. “To the extent that ASCs are part of ACOs, they will find themselves a place in that community; if they are not at the table, they could just as easily be left out of healthcare provided in the community.”

Shapiro suggests ASC leaders talk to surgeons, hospitals, and payers about developments and be visible. For example, suppose there are two ASCs in a community. A hospital looking to buy an ASC to help reduce costs as part of an ACO will choose the one that has already established a relationship with the hospital. “The other will be left to languish if there aren’t a significant number of independent practitioners to sustain it,” Shapiro says.

“There is still a great deal of uncertainty regarding how Obamacare will work in practice,” he adds. “That book is yet unwritten, and for ASCs there’s still a lot of uncertainty.” He emphasizes that ASC leaders must be most aware of what consolidation is occurring at the local level.

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

Continued from page 27

patient safety and noted that they are continuing their current safety initiatives while adding new ones:

- Create an action plan for fall prevention, given the age of our patient population.
- Continue to involve staff with safety initiatives to ensure that they remain enforced.
- Focus on single-dose meds, medication reconciliation.
- Implement Omni Cell medication carts.
- Hold quarterly quality and infection control meetings with our key clinical staff and medical director to address any concerns.

Respondents also highlighted their educational efforts:

- Increase staff education.
- Increase staff training regarding patient safety.
- Increase staff training with an emphasis on satisfaction survey responses.
- Educate all staff and providers about hand hygiene.
- Conduct several audits, training, and spot checks.

The importance of achieving optimal patient satisfaction was indicated by comments such as:

- Will continue to investigate patients’ complaints and rectify, for example, loudness of and dimness of waiting room.
- Continue to provide the most efficient waiting time for patients before procedures.
- Made new education videos for patients based on what patients said they needed to know.

One ASC leader commented, “Patient safety and satisfaction have always been our priorities. We never compromise them for revenue.”

Challenging times

In addition to the usual staffing challenges, ASC leaders are coping with changes spurred by the Affordable Care Act and—in many cases—a higher surgical volume. To learn more, see p 28, and look for a report on how ASCs are responding to the ACA in our October issue.

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

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How have economic conditions in the past year affected your OR staffing?

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ASA launches patient education initiative
The American Society of Anesthesiologists has launched a Perioperative Surgical Home Learning Collaborative—a national initiative designed to improve a patient’s experience before, during, and after surgery.

The collaborative of more than 40 healthcare organizations will work together on care redesign strategies to:
- improve outcomes and the quality and safety of care
- enhance the patient’s surgical experience
- reduce costs by eliminating cancellations and delays in surgery
- lower complication rates and readmissions
- reduce lengths of stay.


RSI data back need for team training, other improvements
The natural history of retained surgical items supports the need for team training, early recognition, and prompt retrieval, finds a study.

This post hoc analysis of data from a seven-center retrospective study of RSIs found that most RSI cases involved team/system errors and two or more safety omissions or variances. Isolated human error was found in less than 10% of cases.

Results also showed that most RSIs removed in the first 24 hours were asymptomatic. Longer RSI retention was associated with a progressively greater proportion of symptomatic patients and morbidities.


Electronic reminders help prevent SSIs
The use of electronic reminders, such as text messages, e-mails, or voice mails, significantly increased patient compliance with a preadmission antiseptic showering protocol with 4% chlorhexidine gluconate, a study finds.

CHG skin surface concentrations were significantly higher in patients who received alerts than in those who were not reminded.

A wide variation in the amount of unused CHG, however, suggests that rigorous standardization is required to maximize the benefits of this strategy, the authors say.


Some total knees classified as inappropriate
More than one-third of knee replacements in the US were classified as inappropriate in a study from Virginia Commonwealth University, Richmond.

Using a patient classification system developed and validated in Spain, researchers compared validated appropriateness criteria with 205 actual cases of knee replacements.

They found that 44% were classified as appropriate, 22% as inconclusive, and 34% as inappropriate.

The study highlights the need for consensus of patient selection criteria among US surgeons treating patients with the potential need for knee replacement surgery, the authors note.