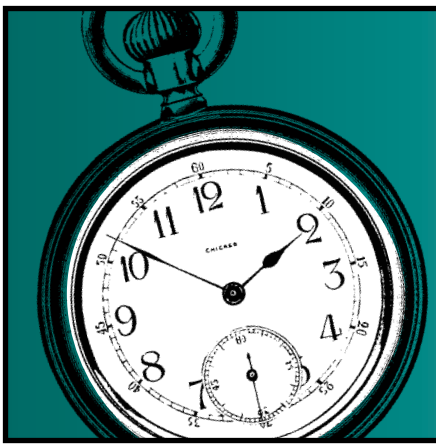

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IN THIS ISSUE

NOVEMBER 2004
VOL. 28, NO. 11 • (pages 121-132)

Awareness may be more common than you think — Can monitoring help?

Joint Commission issues sentinel event alert on awareness

Someone in the OR makes a comment about a patient's tattoo. In another case, a catheter doesn't get connected, and urine ends up on the OR floor. Someone gets mad about the mess and starts yelling. Do these situations sound like a bad day in the OR? Now imagine the patient wakes up in recovery and tells you she heard what your staff said, but she was paralyzed and unable to speak.

Awareness during anesthesia may not be as isolated as once thought. These are just two cases of awareness uncovered in a recently published study that determined about 100 patients per workday in the United States experience awareness, or 26,000 cases per year.[1] The Joint Commission on the Accreditation of Healthcare Organizations, which just released a sentinel event alert on awareness, points to other awareness studies[2,3] and that as many as 40,000 patients may experience awareness each year. **(See Joint Commission tips, p. 123.)**

In addition to patients who heard conversations in the OR, other patients reported feeling as if they couldn't breathe. Some felt their bodies being cut. One thought he was going to die and decided he'd just give up.

"I would most like people to know the incident of awareness during

EXECUTIVE SUMMARY

Recently published studies indicate there probably are 20,000-40,000 cases of awareness each year.

- The Joint Commission on Accreditation of Healthcare Organizations has issued a sentinel event alert on awareness and offered tips to reduce incidences.
- Monitors are useful for tritation of anesthesia, but they are not foolproof when it comes to preventing awareness.
- Monitors are not yet considered the standard of care; but if you are using them for some patients, sources recommend you use them for all patients.

anesthesia in the United States is generally underestimated," says **Peter S. Sebel**, MB BS, PhD, MBA, a professor of anesthesiology at Emory University School of Medicine in Atlanta. "It is a recognized complication, and we should look at ways of reducing it."

Sebel's study of 19,575 patients is the largest study of awareness ever conducted. Sebel is a paid consultant for Aspect Medical Systems in Newton, MA. While some studies have found no difference in awareness between outpatients and inpatients, one study found a high incidence of awareness among 56 elective surgical patients who were instructed to squeeze the observer's hand.

Of the 37 patients (66%) with an unequivocal response to command, which was defined by the authors as awareness, nine (25%) reported conscious recall after recovery. The Bispectral Index (BIS) was a highly significant predictor of awareness, the authors reported.[4]

The issue of awareness has gotten much national attention. The Joint Commission has issued a sentinel event alert on that topic. (For information on sentinel event alerts, go to www.jcaho.org. The most recent sentinel event alert issue is listed under "Latest Newsletters.")

Some awareness cases have received widespread press coverage, and patients report that awareness is a significant concern to them.[5]

"Of major concern are the subset of these patients who develop a post-traumatic stress disorder [PTSD]," says **Donald M. Mathews**, MD, associate chairman for academic affairs in the department of anesthesiology at St. Vincent's Hospital Manhattan and assistant professor of anesthesiology at New York Medical College in Valhalla, NY. The only data that speak to the issue of PTSD after awareness are from Scandinavia,[6] which suggest that about 20% to perhaps 40% of patients go on to develop PTSD, Mathews says. "I personally think that we are looking at a significant issue here," he says.

Some anesthetists aren't concerned about awareness because it's never happened to them before, Sebel acknowledges. "My answer to that is, 'It's never happened to you because you haven't looked for it,'" he says.

Also, patients often don't tell their anesthetist when they've been aware, says Sebel, pointing to a study that indicated 35% of patients who said they had experienced awareness never told their anesthesiologists.[7] "They're frightened," he says. "They think anesthesiologists will tell them they're crazy."

Anesthetists don't consider awareness as their biggest risk for complications, says **Sandra Ouellette**, CRNA, MED, FAAN, director of the Nurse Anesthesia Program at Wake Forest University Baptist Medical Center/The University of North Carolina — Greensboro in Winston-Salem and past president of the American Association of Nurse Anesthetists in Park Ridge, IL.

Also change comes hard to many medical professionals says Ouellette, who points to initial

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This publication does not receive commercial support.

Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Valerie Loner**, (404) 262-5475, (valerie.loner@thomson.com).
Senior Managing Editor: **Joy Daughtery Dickinson**, (229) 551-9195, (joy.dickinson@thomson.com).
Senior Production Editor: **Ann Duncan**.

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Editorial Questions

Questions or comments?
Call **Joy Daughtery Dickinson** at (229) 551-9195.

Joint Commission: Tips to Avoid Awareness

The Joint Commission recommends that health care organizations, which perform procedures under general anesthesia, do the following to help prevent and manage anesthesia awareness:

1. Develop and implement an anesthesia awareness policy that addresses the following:
   - Education of clinical staff about anesthesia awareness and how to manage patients who have experienced awareness.
   - Identification of patients at proportionately higher risk for an awareness experience, and discussion with such patients, before surgery, of the potential for anesthesia awareness.
   - The effective application of available anesthesia monitoring techniques, including the timely maintenance of anesthesia equipment.
   - Appropriate postoperative follow-up of all patients who have undergone general anesthesia, including children.
   - The identification, management and, if appropriate, referral of patients who have experienced awareness.
2. Ensure access to necessary counseling or other support for patients experiencing post-traumatic stress syndrome or other mental distress.

Source: Joint Commission on Accreditation of Healthcare Organizations. Preventing, and managing the impact of, anesthesia awareness. *Sentinel Event Alert* Oct. 6, 2004; 32:2-3.

resistance to pulse oximeters in the 1980s.

The controversial question is should "depth of consciousness" monitors, also known as "depth of hypnosis monitors" or "brain activity" monitors, be used, Mathews says. "In my opinion, yes," he says emphatically, pointing to studies published in the past year that show monitoring with the BIS monitor decreases the incidence of awareness in high-risk surgery[8] and during routine care.[9]

According to the Joint Commission, monitors — including the BIS — "may have a role in preventing and detecting anesthesia awareness in patients with the highest risk, thereby ameliorating the impact of anesthesia awareness."[10]

Others are supportive of the monitors, but for other reasons. "Sufficient studies have shown that these monitors are very useful in titrating the depth of anesthesia, to improve rate of quality of recovery, reduce the need for postoperative mechanical ventilation, and even allow the use of fast-track anesthesia," says **Rebecca S. Twersky**, MD, professor of anesthesiology at the State University of New York Downstate Medical Center and medical director at the Ambulatory Surgery Unit — Long Island College Hospital, both in Brooklyn.

The monitors have enjoyed some popularity. Aspect says its BIS monitors are available in about 30% of hospital operating rooms in the United States.

The monitors would be particularly helpful in office-based surgery, Twersky says, because there often is not a formal recovery area, and patients often are expected to walk away from the OR table. "However, these uses are for titration of anesthesia, NOT because they are preventing recall or intraoperative anesthesia," she says. Patients who are well anesthetized do not remember, Twersky maintains. "You don't need a BIS, PSA, or other monitor to help you anesthetize a patient well," she adds.

The question really is about the frequency of intraoperative recall and whether these monitors can indeed prevent the occurrence, Twersky says.

"Thus far, the literature is not convincing enough that the monitors are foolproof," she says. "E.g., under intravenous general anesthesia with opioids, these monitors are not as sensitive to depth of anesthesia as they are with inhalational anesthesia."

There have been reports of anesthetists having digital readouts that would indicate patients are unconscious, when in fact, they end up being reported cases of awareness, Ouellette explains. "They're not 100% assuring that you will prevent it by using a monitor," she says.

For this reason, one disadvantage of the monitors is that they may give anesthesia providers a false sense of security, Ouellette says. Cost is another factor, she notes.

According to Aspect, the list price for the BIS machine is about $9,500, and the list price for the

SOURCES

For more on monitoring for anesthesia, contact:

- **Donald M. Mathews**, MD, Associate Chairman for Academic Affairs, Department of Anesthesiology, St. Vincent's Hospital Manhattan, Assistant Professor of Anesthesiology, New York Medical College, Valhalla. E-mail: dmathews@svcmcny.org.
- **Sandra Ouellette**, CRNA, MED, FAAN, Winston-Salem, NC. Phone: (336) 768-5107. E-mail: souellette@triad.rr.com.

For more on the BIS monitoring system, contact:

- **Aspect Medical Systems**, 141 Needham St., Newton, MA 02464 . Phone: (617) 559-7000. Fax: (617) 559-7400. Web: www.aspectmedical.com.

single-use sensor is $17.50 each.

Whether monitors should be used for all cases or just risk cases is very controversial, Ouellette says. "My personal opinion is, if the technology is available, why not use it in all cases?" she notes. Consider how you would react if you had the technology available, opted not to use it, and a patient experienced awareness.

Monitors should be used in "all cases with general anesthesia, especially with muscle relaxant use," Mathews maintains. All patients are at risk for awareness, he explains.

The American Society of Anesthesiologists in Park Ridge, IL, is developing a white paper and guidelines related to the issue of awareness that should be available in October 2005, sources say. At this point, "the ASA has not endorsed this monitor as a basic anesthesia monitor or a standard of care, and further investigation is needed," adds Twersky.

"In using this [monitor], it's another piece of data that you have that may guide your anesthetic management of the case," Ouellette sums up. **(For more information on patient awareness, see "Your patients' worst nightmare, and yours: Awareness despite anesthesia," *Same-Day Surgery*, December 1998, p. 149.)**

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How you can identify and prevent awareness

Awareness is caused when general anesthesia isn't sufficient to maintain unconsciousness and to prevent recall during surgery. Common causes include large anesthetic requirements, equipment misuse or failure, and smaller doses of anesthetic drugs, according to a recently published study.[1]

According to the Joint Commission on Accreditation of Healthcare Organizations, which has issued a sentinel event alert on awareness, contributing factors include the increasing popularity of intravenous (IV) anesthesia delivery, as opposed to inhalation, and the premature lightening of anesthesia at the end of a case to facilitate OR turnover.[2]

However, not everyone agrees.

"There are no data that I know of that support this statement," says **Donald M. Mathews**, MD, associate chairman for academic affairs in the department of anesthesiology at St. Vincent's Hospital Manhattan and assistant professor of anesthesiology at New York Medical College in Valhalla.

The practice of decreasing anesthetics at the end of the case to allow rapid emergence is long-standing and, to Mathews' knowledge, not controversial in any way, he says. "Most cases of the awareness occur during the induction and intubation or during the body of the procedure, not at the end," Mathews says.

The authors of the recently published study found increased awareness with sicker patients (American Society of Anesthesiologists physical status III-V) undergoing major surgery. The authors say this correlation may reflect the use of smaller anesthetic doses and light anesthetic techniques in sicker patients. Age and sex did not influence the incidence of awareness.[1]

Other studies are just beginning to be published that show gender differences in responding to a given amount of anesthetic, says **Sandra Ouellette**, CRNA, MED, FAAN, director of the Nurse Anesthesia Program at Wake Forest University Baptist Medical Center/The University of North Carolina — Greensboro in Winston-Salem and past president American Association of Nurse Anesthetists. In addition, obesity has been defined as a group at risk for awareness, she says.

To prevent awareness, anesthetists can take several steps, Mathews suggests.

Amnestics such as midazolam should be used in cases at high risk for awareness and those where continuous muscle relaxation is planned, he says.

"They should regularly check their vaporizers to ensure that they are full," Mathews says. "They should use anesthetic gas concentration monitoring and have alarms enabled so that if a gas concentration is falling unexpectedly, an alarm sounds."

During a difficult intubation, they need to remember to give repeated doses of hypnotic agents, he says. "They should never treat movement on the OR table with only muscle relaxants," Mathews says.

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Is your facility prepared for a disaster to hit?

Here are lessons learned from recent hurricanes

Is your center prepared for a disaster that could cause you to close your doors, contact patients and staff, and later reopen safely? Information from centers that weathered the recent hurricanes in Florida can apply to any disaster.

• Perform disaster drills.

At Kissimmee (FL) Surgery Center, disaster drills cover weather scenarios, terrorism, and building damage from car accidents, says **Lou Warmijak**, administrator.

Some drills include full evacuations, Warmijak says. "You can never be too prepared," he adds.

EXECUTIVE SUMMARY

You can never be too prepared for a disaster, say sources who faced recent hurricanes in Florida and share these lessons for all disasters:

- Perform disaster drills, including complete evacuations of your building.
- Obtain business interruption insurance, have a debris cleanup contract, and have systems in place to communicate with staff and with patients. Add remote access terminals and download the telephone program. Install phase monitors on all air conditioning units and vacuum pumps.
- Pre-disaster preparations may include turning off power, securing refrigerated medications, covering and moving equipment, and backing up computerized data.

Some drills are held using an actual patient and his or her family, Warmijak says. Patients are selected from those least likely to be upset by a drill, such as repeat endoscopy or pain management patients and families of firefighters and police officers. The drill is held after the patient is ready for discharge. After the drill, patients and families are asked what made them anxious and how they thought the staff handled the situation. Ancillary staff members fill in as pseudo patients in the drills.

• Obtain business interruption insurance.

Kissimmee Surgery Center lost six days of business in the recent hurricanes, Warmijak says. About 50% of those cases have been rescheduled, he says.

The corporation that owns his center does have business interruption insurance, and at press time, his center still was evaluating how much of its losses, including payroll, additional supply costs, and lost surgery, would be covered. "But it covers pretty much everything you lose during down time," Warmijak says.

• Have systems in place to communicate with patients and staff.

When you know a potential disaster is coming, such as a hurricane, verify your phone numbers for your key contacts, advises **William Phillips**, PhD, president of Riteway Services, a Winter Park, FL-based business that handles facilities management for ambulatory surgery centers.

"Make sure the numbers you have are actually good numbers," Phillips says.

Administrators and key contacts need to make sure they have a traditional telephone at their addresses that does not work from electrical power, he says. After the recent hurricanes, cell phone coverage was poor, and cordless phones weren't working because the electricity was off, he says.

Keep in mind that patients who live outside of your immediate area might not be affected by a disaster such as hurricane and may not realize afterward that you are closed, Warmijak points out. Also, roads may be unsafe due to downed power lines or debris. "That is another responsibility: to communicate with these individuals," he says.

At Kissimmee Surgery Center, when a potential disaster such as a hurricane is predicted, patients are contacted to determine if they want to continue with the procedure if the center is up and running, Warmijak says.

"A lot of them want to go through with the surgery," he says. However, keep in mind that some patients may not have power after a disaster, which might make their homes less than ideal

SOURCES

For more on surviving a disaster, contact:
- **William Phillips**, PhD, President, Riteway Services, 140 N. Orlando Ave., Suite 100, Winter Park, FL 32789. E-mail: wphillips@worldramp.net. Phone: (321) 303-7703.
- **Lou Warmijak**, Administrator, Kissimmee Surgery Center, 2275 N. Central Ave., Kissimmee, FL 34741. Phone: (407) 870-0573. Fax: (407) 870-1859. E-mail: lou.warmijak@hcahealthcare.com.

for recovery, sources say.

Staff members verify the patients' phone numbers, including cell phone numbers, and give them an anticipated time to hear from the center staff. "We tell them how to call the building, and we tell them if the answering machine doesn't come on, you know the building doesn't have phones and electricity," Warmijak says.

Also, for patients who live near the center, they are told that information about opening the facility will be posted on the front of the building or somewhere on the building.

The center has assigned its staff to teams who handle different levels of communication. For example, the business office team copies and carries home three to five days of schedules, including patients' and physicians' contact numbers. The materials manager communicates with vendors to let them know if the center is closed, when they expect to open, and to determine if there are any expected delays in shipments. Due to storm damage, some shipping services may not be available.

• Evaluate damage after disaster.

If you turned off the power before a potential disaster, have the building cleared of any structural or electrical problems before you turn it back on, Warmijak says.

Have an architect or a general contractor walk through within hours of the disaster, Phillips advises. Also, have an electrician check the power status, he suggests.

"Make sure the voltage is correct and all phases are correct," Phillips says. **(For more on preparing your building for a disaster, see story, right.)**

[Editor's note: Do you have suggestions that you'd like to share from your disaster preparedness experience? Go to www.same-daysurgery.com. Click on "forum." Your user number is your subscriber number from your mailing label. You password is sds (lowercase) plus your subscriber number (no spaces.) See question: "What lessons have you learned from going through a disaster or preparing for one?"] ■

Take these steps to protect your building

There are several steps you can take before a storm to ensure your building and its contents are protected, says **William Phillips**, PhD, president of Riteway Services, a Winter Park, FL-based business that handles facilities management for ambulatory surgery centers.

Riteway Services has a pre-checklist for facilities**. (See checklist, pp. 127-128.)** If a hurricane approaches that is expected to be a category 2 or above, facilities shut off their generators to secure power for later, Phillips says.

In preparation for recent Hurricane Francis, Kissimmee (FL) Surgery Center prepared for a Category 3 hurricane, which meant turning off all power. Once the power is turned off, heat and humidity build up in the facility, and all sterile packages must be resterilized, says **Lou Warmijak**, administrator.

Also, medications that need to be refrigerated will need to be stored when power is turned off, Phillips points out. Store them in dry ice or regular ice in a 90-hour cooler, he suggests. "Once you pack them, suck the air off them with a portable vacuum," Phillips advises.

At press time, Warmjak's center was gearing up for Hurricane Jeanne, which was predicted to be Category 1 or 2 and hit before the next workday. After the facility finished with the last patient of the day, all equipment was to be covered, and everything essential was to be moved off the floor, he said. Trash bags were going to be used to cover all electronic equipment and OR equipment, and the equipment was going to be moved into rooms with no windows.

All computerized data was to be backed up and moved off-site into waterproof areas, adds Warmijak. In addition, items could be stored in waterproof safes and also could be moved to secured locations owned by the hospital company that owns the center, he notes.

The managers were devising a plan that included a time to check out the building, post-disaster, Warmijak said. **[For checklist, go to www.same-daysurgery.com. Click on "Toolbox." Your user number is your subscriber number from your mailing label. Your password is sds (lowercase) plus your subscriber number. Under "Disaster Planning," click on "Restoration**

(Continued on page 129)

SEVERE WEATHER PREPARATION

rev: 9-03

FACILITY_____DATE_____

Admin Verify	Assigned Task	Action Check	Description	Staff Initial
			FACILITY PREPARATION	
			FACILITY STATUS. Event is after hours or the facility operation has already been determined to be closed.	
			TELEPHONE MESSAGE Program message at the facility advising callers of facility status.	
			INSPECT EXTERIOR. Move all loose material such as table's chairs and construction material from the site or to a secure location.	
			CONSTRUCTION ONGOING Advise all contractors to secure the construction site and materials and construction entrances or storage areas.	
			LAB SAMPLE BOXES Take in all lab specimen boxes from outside to the interior of the facility.	
			PATIENTS AND MEDICAL STAFF Determine closing items and notify patients and medical staff as necessary. As added precaution cover with plastic as added precaution from water damage or intrusion.	
			SUPPLIES / TRASH Put up all supplies and remove all trash format eh facility into proper containers. Close gates and covers on all receptacle areas as equipped.	
			ROOFTOP EQUIPMENT Ensure that the equipment is properly secured and all panels are securely fastened.	
			INSPECT ROOF Clear off all material on the roof that could be made airborne. Inspect all mechanical equipment and ensure all covers are in place and screwed tightly.	
			HIGH WIND PROTECTION	
			EXTERIOR WINDOWS AND DOORS Commercial grade. Inspect all windows and doors for cracking or damage prior to storm. Secure as necessary.	
			STOREFRONTS and AUTOMATIC DOORS Lock and secure doors and operators. Tape all openings and cracks to avoid wind driven water intrusion.	
			INTERIOR PREPARATION Move all furnishings from window areas to interior walls	
			INTERIOR PREPARATION Move all medical equipment away form building exterior window walls to interior protected walls.	
			PATIENT RECORDS Secure all patient records and charts in a secure location with in the records department as needed.	
			INTERIOR PREPARATION Place collection containers beneath all equipment penetrations roof drains and know leak areas.	
			ELECTRICAL PROTECTION	
			CONNECTION MODERATE TO LOW PREVALENCE OF UTILITY DAMAGE Hurricane 2 and below	
			Unplug all non-essential medical equipment and bring to interior walls. Includes anesthesia machines patient monitor X-ray and all connected equipment.	
			SEVERE HIGH WINDS Cover all computers and electrical equipment / medical equipment with plastic as added protection form overhead water intrusion in the event of a building envelope failure.	
			TELEPHONE EQUIPMENT If not protected by a surge suppressor or UPS disconnect and use emergency mailbox to leave message provided by Utility Carrier.	

RITEWAY Services, Inc.

P.O. Box 2923 Winter Park, Florida USA 32790 407 478 RITE (7483)
wphillips@ritewayservices.net Facsimile 407 628 4720

SEVERE WEATHER PREPARATION

rev: 9-03

FACILITY_____DATE_____

Admin Verify	Assigned Task	Action Check	Description	Staff Initial
			COMPUTERS Shut down all computers in all areas. Secure the server routers and microwave equipment.	
			HVAC EQUIPMENT Secure and shut down all refrigeration section of unprotected rooftop equipment. Unprotected equipment is any equipment without separate phase monitors installed for Three phase electrical operated equipment.	
			LIGHTING Secure all lighting except life safety lighting circuits.	
			EQUIPMENT Secure all equipment prior to leaving the facility. Shut down air compressors, vacuum system equipment, sterilizers and boilers.	
			MEDICAL GAS Secure all medical gas system services. Disconnect anesthesia machines and turn all equipment OFF.	
CONDITION HIGH WIND AND SEVER DAMAGE LIKELY Hurricane 3 and above				
			Comply with all actions above and turn the generator control to OFF. (Emergency Power will not come on when left in this condition)	
			Secure all mechanical equipment and roof top ventilation equipment.	
			For duration of the storm log off fire alarm and security systems.	
			Outage planned for 24 hours or less before restoration. Remove all frozen and refrigerated medications and cold pack in coolers within the facility. Place in isolated interior location and clearly label for restocking.	
MISCELLANEOUS ALL CONDITIONS				
	RWS		Notify security company to only report alarms with perimeter and motion sensor combined signals.	
	RWS		Refuel and top off generators.	
	RWS		Inspect areas for compliance exterior and interior.	
	RWS		Ensure all trash is removed from facility.	

TIPS

Remember whenever you call someone to leave a message or obtain a status advisory leave your numbers you desire them to return call you on.

As a KEY CONTACT make certain you have a telephone at home that will work without being plugged into an electrical circuit.

CHARGE ALL CELLULAR PHONES ANDS EXTRA BATTERIES.

If medications and tissues are cold packed have at least three to four knowledgeable people to respond on call back to replace these items in the refrigerators and freezers. In the event of a severe storm some people may not be able to communicate or get out of their homes for several days.

RITEWAY Services, Inc.

P.O. Box 2923 Winter Park, Florida USA 32790 407 478 RITE (7483)
wphillips@ritewayservices.net Facsimile 407 628 4720

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Inspection Checklist." Also see "Indoor Air Quality Procedures."]

"That's when the response is put out to staff that the building is open and we're ready to work, or we're closed and they should wait to hear from us," he says.

After Hurricane Charley, the center had no electricity or phones, so the leaders posted a notice on the building about the situation and the anticipated return of electricity, Warmijak says.

Keep in mind that if your telephone system goes without power for 72 hours, it may lose its programming, Phillips points out. Add remote access terminals and download the telephone program before a disaster, so you can access the telephone programming from your facility's computer later, if needed, he suggests.

This process can be handled by your telecommunications provider and takes about 15 minutes, Phillips says. "The cost is minor compared to someone sitting there and reprogramming your system for two days," he adds.

Also, install phase monitors on all air-conditioning units and vacuum pumps, Phillips advises. The monitor will prevent your power from restoring if the voltage or phase is not correct, he says. Air-conditioning or electrical contractors can provide those monitors for about $75 per installation, Phillips says. "That's not too bad, considering that otherwise you may lose a motor that, in a disaster situation, may take you a week to get."

There are automatic and manual phase monitors, Phillips says. "We always use the automatic," he says. "If we have a lockout situation [with the power], we don't know when that will occur, and we're not sure when it will be restored." Those systems also work well for thunderstorms, he points out.

Also have a prearranged contract for debris cleanup before a hurricane actually hits, Phillips advises. "After the storm hits, you can get to work, and they're cleaned up right after the storm," he says. ■

Same-Day Surgery Manager

Favorite questions about major issues you face

By **Stephen W. Earnhart**, MS
President & CEO
Earnhart & Associates
Austin, TX

One area of this column I really enjoy is the questions I receive from readers. Some months, I receive 80-120 e-mails. This month, I went back over the past six months and pulled up some of my favorites.

• **Issue: Suture cost climbing.**

Question: Our suture cost over the past year has skyrocketed! We tried everything to find out what we were doing to cause the costs to go up so dramatically. It mostly was high-end sutures that were climbing. After umpteen hours and meetings trying to track it down, our janitor solved the problem. It seems the vendor was lifting the ceiling tiles in the suture room and shoving hundreds of packs there and then replacing them with new ones.

Answer: Check the ceiling as a cost-control measure! Also, in similar situations, obtain a rebate from your supplier for deceitful actions.

• **Issue: Poor customer service complaints.**

Question: We try; we really do try to please the whole surgical staff, the nurses, patients, and the administrative staff of the hospital. But no matter what we do, nothing seems to help. Last month the patient satisfaction surveys said patients did not feel they had a chance to "bond" (give me a break!) with staff. You know our situation. What the heck can we do to bond with our patients better?

Answer: Have pictures taken of all your surgical staff and post them in the waiting rooms with the first name and title. See what happens.

Follow-up: The last two patient satisfaction surveys conducted showed significant improvement in bonding with staff. It's hard to be critical of someone when you know who he or she is.

• **Issue: Investor relations.**

Question: Our surgery center is owned by 12 surgeons who have nothing else going for them. They constantly are coming into my office and asking to see "stats" or wanting to know how much money they are making or how many cases they did and was it over the cases that were budgeted. They bug everyone on staff with questions all the time. What can we do to get them off our backs?

Answer: Hold monthly investor meetings after hours. Using presentation graphics software,

present all the stats and numbers as compared to budget for every possible line item. (Do not use handouts; people will read while you are talking.) Put a bar graph outside your office of all other indicators you are now monitoring.

Follow-up: This advice worked! After a few months of investor meetings, most had had their fill of numbers and left staff alone. However, find ways to keep investors engaged at your center as a way of recognizing the role they play in your center's success.

• **Issue: Storage space.**

Question: We have no room in our surgery center to use the bathroom. Yesterday, we had to move boxes into stalls in the women's locker room. (We couldn't use the men's!) We have to move boxes aside to use the toilet. This center is far too small with no room left for files or patient records. We cannot expand; we're in a stand-alone building that's maxed out. What can we do?

Answer: Consider renting a unit in one of the climate-controlled storage buildings. You could rent a 10' x 30' space for $200 per month.

Follow-up: The center moved nonsensitive material to storage unit to make room for patient records. Make sure anything you store off-site is in a climate-controlled space. Heat and humidity can rot paper and eat thru metal quickly.

(Editor's note: Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Do you have any questions? Contact Earnhart at 8303 MoPac, Suite C–146. Austin, TX 78759. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.) ■

NEWS BRIEFS

2005 survey fees will be increased

The Joint Commission on Accreditation of Healthcare Organizations' survey fees will increase for 2005. The fee increase, only the second in the last decade, will vary by program and, within programs, will vary by the types and volumes of services provided.

The Joint Commission also announced plans to institute a subscription billing model in 2006 that will allow accredited organizations to begin to spread their survey fees over the three-year accreditation cycle. The Joint Commission has significantly changed the survey process in the past two years and added a variety of new services that have increased the costs of conducting surveys, says **Dennis S. O'Leary**, MD, president, Joint Commission.

The final fee schedule had not been set as of *Same-Day Surgery* publication date but the estimated average increase for ambulatory care surveys is $810 and for hospitals is $2,700.

For specific pricing for your same-day surgery program, contact the Joint Commission Pricing Unit at (630) 792-5115 or pricingunit@jcaho.org. ▼

Cost, revenue information available on PA centers

Detailed cost and revenue information for all ambulatory surgery centers (ASCs) in Pennsylvania is available in a recent report from the Pennsylvania Cost Containment Council.

The report also highlighted higher ASC margins compared to hospitals and other providers is largely driven by the way ASC report their net income on a pretax basis, according to the American Association of Ambulatory Surgery Centers (AAASC). In Pennsylvania, ASC uncompensated care is at 1.11%, compared to 2.07% for hospitals, according to the AAASC. The rapid growth of ASCs has not had a major effect on the overall volume of outpatient care provided by hospitals, AAASC said in its report.

A copy of the report is available at www.aaasc.org/advocacy/ASCFactSheet.htm. At the bottom of the page, click on "Pennsylvania Health Care Cost Containment Council Report." ▼

GAO: Hospitals not getting enough reimbursement

Report targets drugs, devices for outpatients

Hospitals may not be receiving adequate reimbursement for drugs, devices, and other services provided in the outpatient setting because of a flawed rate-setting methodology used by the Centers for Medicare & Medicaid Services (CMS),

according to a recently released report from the Government Accountability Office (GAO).

Based on information from 113 hospitals, the GAO found that charge-setting methodologies for drugs, devices, and other outpatient services vary greatly across hospitals and across departments within a hospital. CMS's methodology does not recognize hospitals' variability in setting charges, and therefore, the costs of services used to set payment rates may be under- or overestimated, the GAO pointed out.

GAO recommended that the administrator of CMS collect data on excluded claims and analyze variation in hospital charges to determine if the outpatient payment rates uniformly reflect hospitals' costs of providing outpatient services, and, if they do not, to make appropriate changes to the methodology. CMS stated that it will consider GAO's recommendations.

(Editor's note: For a copy of the report, go to www.gao.gov. Search for "GAO-04-772.") ■

CALENDAR

- **Ambulatory Surgery Nursing Conference**, May 13-14, 2005, Greenville, SC. Sponsored by Clemson University, Continuing Education in Nursing. For information, contact Olivia Shanahan. Phone: (864) 656-3078. Fax: (864) 656-1877. E-mail: olivia@clemson.edu. ■

CE/CME instructions

Physicians and nurses participate in this CE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answers listed in the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing this semester's activity, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. ■

CE/CME *questions*

17. According to a recently published study in *Anesthesia & Analgesia* (2004; 99:833-839), how many patients experience awareness?
    A. About 10 per workday in the United States
    B. About 100 per workday in the United States
    C. About 500 per workday in the United States
    D. About 1,000 per workday in the United States

18. When you shut off power in preparation for a disaster, how should you store medications that require refrigeration, according to William Phillips, PhD, president with Riteway Services?
    A. Store them in dry ice or regular ice in a 90-hour cooler.
    B. Move them to another health care facility.
    C. Have staff take them home and store them in their personal refrigerators.
    D. They cannot be stored; they must be disposed of.

19. Administrators and key contacts need to make sure they have what kind of communication device at their addresses, according to Phillips?
    A. Cell phone
    B. Cordless telephone that works from electrical power
    C. Traditional telephone that does not work from electrical power
    D. Two-way radios

20. What perk does El Camino Surgery Center offer to employees that does not cost the surgery center any money, according to Lisa Cooper, RN, BSN, clinical director of the center?
    A. Team approach to work
    B. Newsletters
    C. Clinical education
    D. Discounted massages at the center

CE/CME answers

17. B **18. A** **19. C** **20. D**

COMING IN FUTURE MONTHS

- It's discharge time, and the patient has no caregiver
- New treatment more comfortable for patients?
- Reaping benefits of community involvement
- Top reasons for claim denials in outpatient surgery
- Tips for avoiding lawsuits in your program

CE/CME objectives

After reading this issue you will be able to:

- Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care and management. (See *Awareness may be more common than you think — Can monitoring help?* in this issue.)
- Describe how those issues affect clinical service delivery or management of a facility. (See *Is your facility prepared for a disaster to hit?)*
- Cite practical solutions to problems or integrate information into your daily practices, according to advice from nationally recognized ambulatory surgery experts. (See *Take these steps to protect your building* and *Fight rising costs of hiring by keeping current staff.*) ■

United States Postal Service
Statement of Ownership, Management, and Circulation

1. Publication Title	2. Publication No.	3. Filing Date
Same-Day Surgery	0 1 9 0 - 5 0 6 6	10/01/04
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$495.00

7. Complete Mailing Address of Known Office of Publication *(Not Printer) (Street, city, county, state, and ZIP+4)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta,
Fulton County, GA 30305
Contact Person: Robin Salet
Telephone: 404/262-5489

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not Printer)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do Not Leave Blank)*
Publisher *(Name and Complete Mailing Address)*
Brenda Mooney, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

Editor *(Name and Complete Mailing Address)*
Joy Daughtery Dickinson, same as above

Managing Editor *(Name and Complete Mailing Address)*
Valerie Loner, same as above

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
Thomson American Health Consultants	3525 Piedmont Road, Bldg. 6, Ste 400
	Atlanta, GA 30305

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☐ None

Full Name	Complete Mailing Address
Thomson Healthcare, Inc.	Five Paragon Drive
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12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates.) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☐ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

PS Form **3526**, September 1998 *See instructions on Reverse)*

13. Publication Name: Same-Day Surgery
14. Issue Date for Circulation Data Below: September 2004

15. Extent and Nature of Circulation			Average No. of Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total No. Copies *(Net Press Run)*			1221	1222
b. Paid and/or Requested Circulation	(1)	Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. *(Include advertiser's proof and exchange copies)*	837	830
	(2)	Paid In-County Subscriptions *(Include advertiser's proof and exchange copies)*	7	5
	(3)	Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	4	5
	(4)	Other Classes Mailed Through the USPS	28	7
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2)*			876	847
d. Free Distribution by Mail *(Samples, Complimentary and Other Free)*	(1)	Outside-County as Stated on Form 3541	25	21
	(2)	In-County as Stated on Form 3541	2	2
	(3)	Other Classes Mailed Through the USPS	0	0
e. Free Distribution Outside the Mail *(Carriers or Other Means)*			29	25
f. Total Free Distribution *(Sum of 15d and 15e)*			56	48
g. Total Distribution *(Sum of 15c and 15f)*			932	895
h. Copies Not Distributed			289	327
i. Total *(Sum of 15g, and h.*			1221	1222
Percent Paid and/or Requested Circulation *(15c divided by 15g times 100)*			94	95

16. Publication of Statement of Ownership
Publication required. Will be printed in the November 2004 issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: Publisher
Brenda L. Mooney
Date: 9/20/04

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including multiple damages and civil penalties).

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2. In cases where the stockholder or security holder is a trustee, include in items 10 and 11 the name of the person or corporation for whom the trustee is acting. Also include the names and addresses of individuals who are stockholders who own or hold 1 percent or more of the total amount of bonds, mortgages, or other securities of the publishing corporation. In item 11, if none, check the box. Use blank sheets if more space is required.
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PS Form **3526**, September 1999 *(Reverse)*

Same-Day Surgery®
Covering Hospitals, Surgery Centers, and Offices for More than 25 Years

Fight rising costs of hiring by keeping current staff

Good communication and support for staff efforts improve retention

The good news for respondents to the 2004 *Same-Day Surgery* Salary Survey is that more than 68% of survey respondents saw their salary increase between 1% and 6% in 2004.

Even better news for almost 11% of survey respondents was the 7% to 10% they reported. In 2003, only 5.44% of respondents received a 7% to 10% increase. **(See chart on how much salaries have changed, below.)** The *SDS* salary survey was mailed in July to 944 subscribers and had 115 responses, for a response rate of 12.2%.

The bad news is that same-day surgery managers are having to face increasing salaries at the same time they try to attract new employees and deal with shrinking reimbursement.

Experts interviewed by *Same-Day Surgery* point out that there are ways to recruit and retain employees without resorting to salary wars.

"Our challenge is that we are competing with larger, urban institutions for nurses," says **Mary Jane Sutton**, RN, MSN, director of The Surgical Center at Lake Norman in Mooresville, NC.

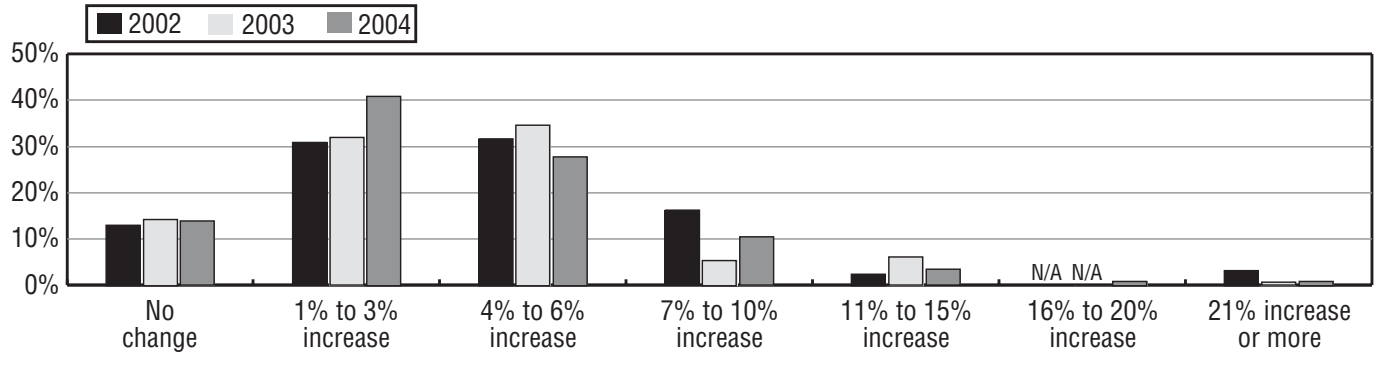
Sutton's facility is a freestanding center affiliated with a hospital, as were almost 16% of survey respondents, but she says that geographically and size-wise, her hospital and location present a challenge in recruitment. **(See chart on work setting, p. 2.)**

"Not only do the larger hospitals pay more, but nurses who live closer to Charlotte [NC] do not want to commute 30 miles one way to work," she adds.

"We do have an advantage over hospital-based programs because we don't have weekend, holiday, or evening coverage."

In addition to the attractive hours, there also is

How Has Your Salary Changed?



a family atmosphere, Sutton adds. "Because we are a small staff, we have a chance to get to know everyone, and we all get along well," she says.

Because a good relationship between administration and staff reduces turnover rates and increases word-of-mouth promotion of the center as a good place to work, the managers of El Camino Surgery Center in Mountain View, CA, have developed a range of methods to communicate among the 70 staff members, says **Julie Butner**, RN, BSN, MS, executive director of the center.

"We delay the start of procedures one Friday each month to enable all staff members to attend a staff meeting," she says. The delay in the start of the workday is worth the effort and potential lost revenue because it gives Butner and other managers a chance to communicate directly with all staff members at one time, she adds.

In addition to the monthly staff meeting, teams meet weekly to address issues the employees face, clinical programs are provided for clinical staff once each month, newsletters are inserted in paychecks twice each month, and the leadership team of managers and supervisors meets twice each month, Butner points out.

"We also have a bulletin board in the employee lounge that has an area titled 'Must Read' so that all employees can quickly check for timely announcements," she adds.

One of the perks offered by El Camino that does not cost the surgery center anything, other than a little unused space, is discounted massages offered to staff members by a local masseuse, says **Lisa Cooper**, RN, BSN, clinical director of the center. "We keep a sign-up sheet for massages on our bulletin board, and employees can schedule a massage at the end of the day on the one or two days each month that the masseuse visits," she explains.

Employees can relieve stress with a massage at a deeply discounted rate of about $40 for an hour, and the masseuse charges the surgery program nothing, she adds.

"Staff members love this extra benefit because it is easy to use and shows that we do realize that they have stressful jobs," she adds.

Offer advancement opportunities

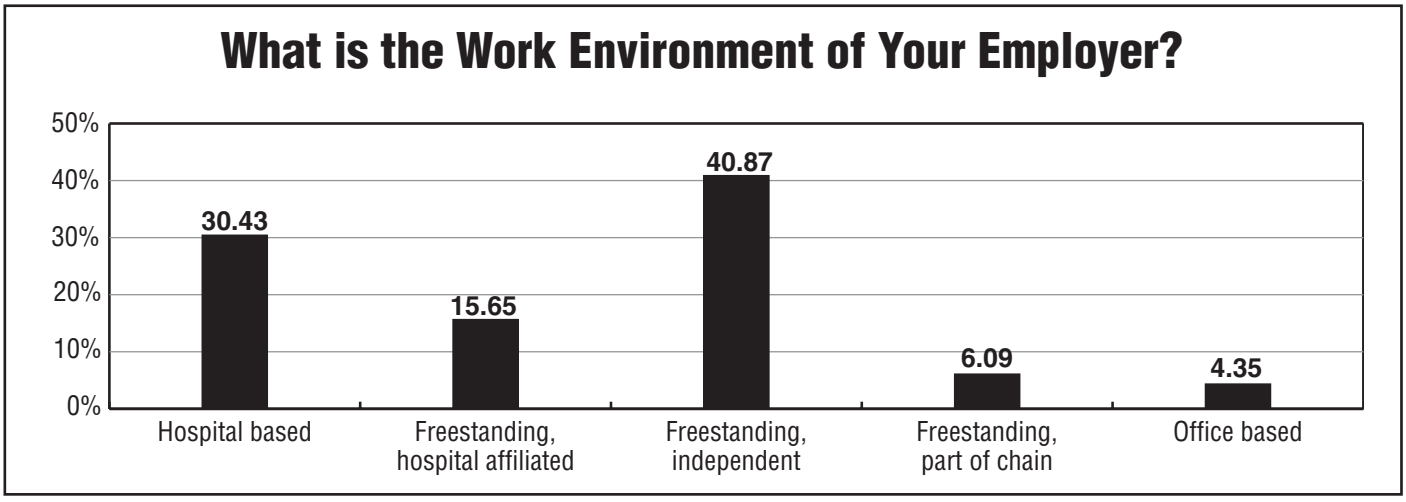
One of the reasons that The Surgical Center at Lake Norman lost employees in the last year was the need to move elsewhere to receive a promotion, says Sutton. "With a small staff, we don't have a lot of room for movement," she says.

While most *SDS* salary survey respondents represented administration — with more than 45% holding the title of chief executive officer, director, or administrator and almost 60% making more than $70,000 per year — all of the experts interviewed by *Same-Day Surgery* admit that the ability to be promoted or be eligible for a higher salary bracket is key to retention. **(See chart with respondents titles, p. 3, and see gross incomes, p. 3.)**

"We have an advantage when it comes to recruiting nurses because we have a large pool of hospital-based nurses who want to move to the freestanding center," says **Meaghan Reshoft**, RN, MBA, CASC, director of the Day Surgery Center at Northwest Community Healthcare in Arlington Heights, IL.

Unfortunately, most of the nurses are not operating room nurses, Reshoft adds. "We do pay hospital-level salaries, but we don't require weekend and evening hours, so we can attract operating room nurses from outside the hospital system," she explains.

Once Reshoft has hired nurses, they do have a number of ways to increase their responsibilities



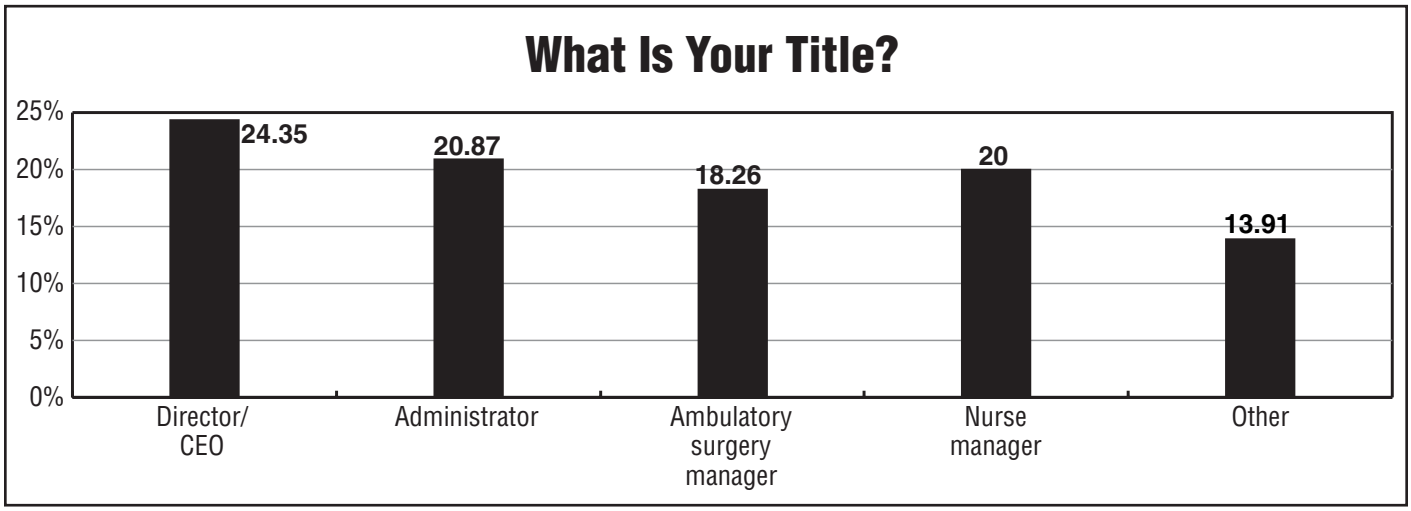
and pay level without leaving the surgery center.

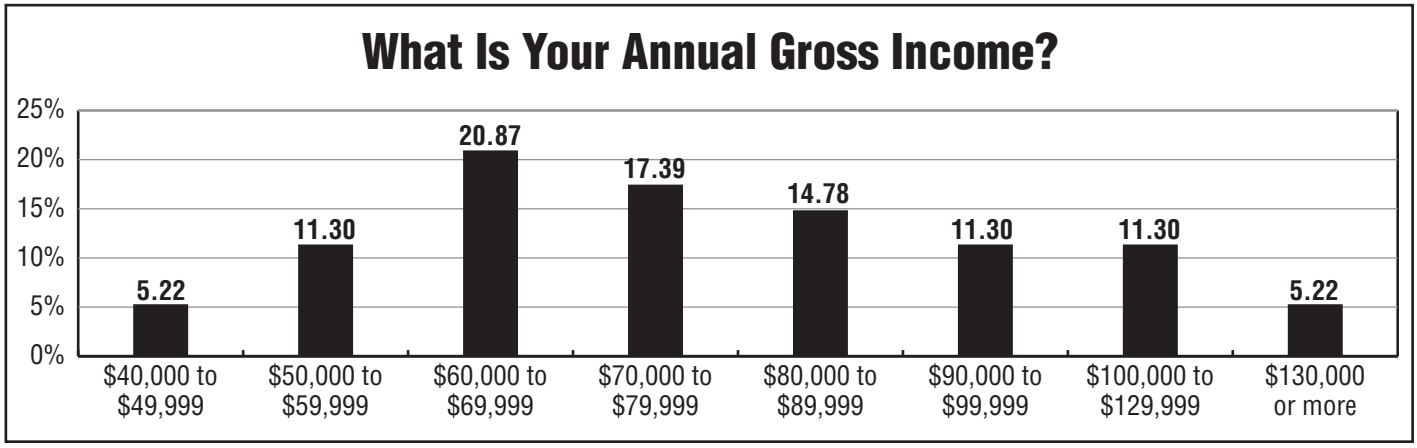
"Nurses who want to take on additional responsibility can apply to become a clinical resource nurse and add $1 per hour to their salary," she says.

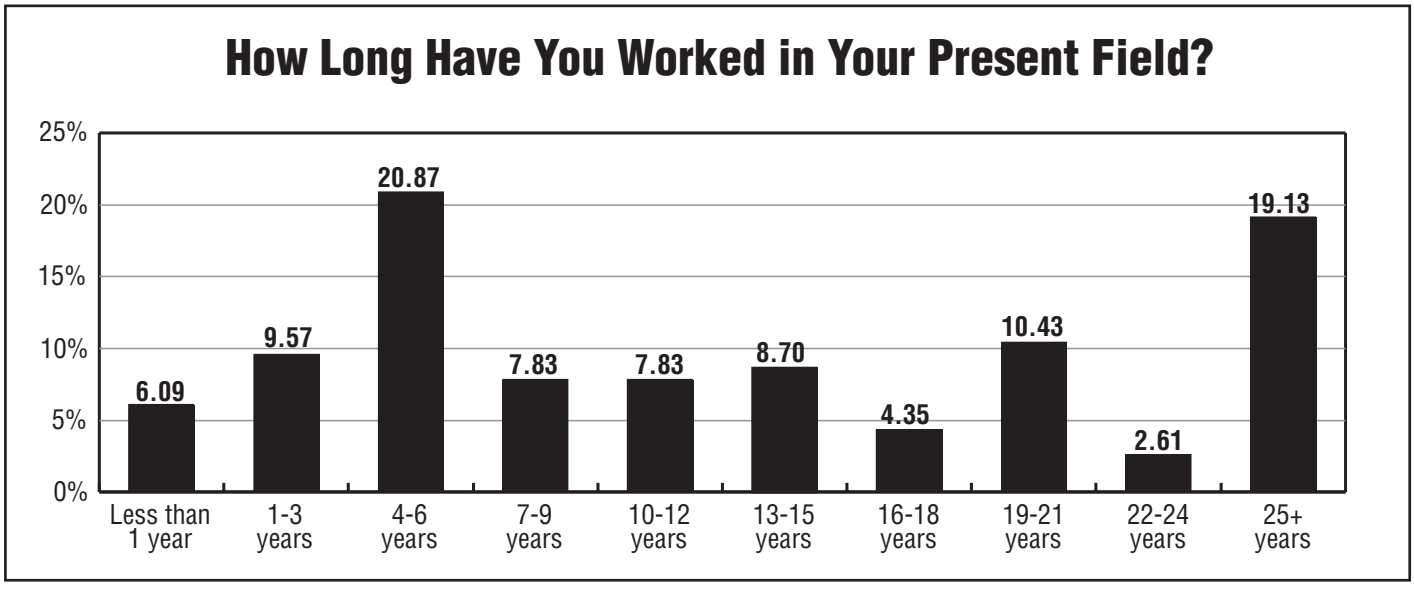
"Clinical resource nurses take part in quality improvement activities and staff education and become experts to whom other staff members can go to for help," she adds.

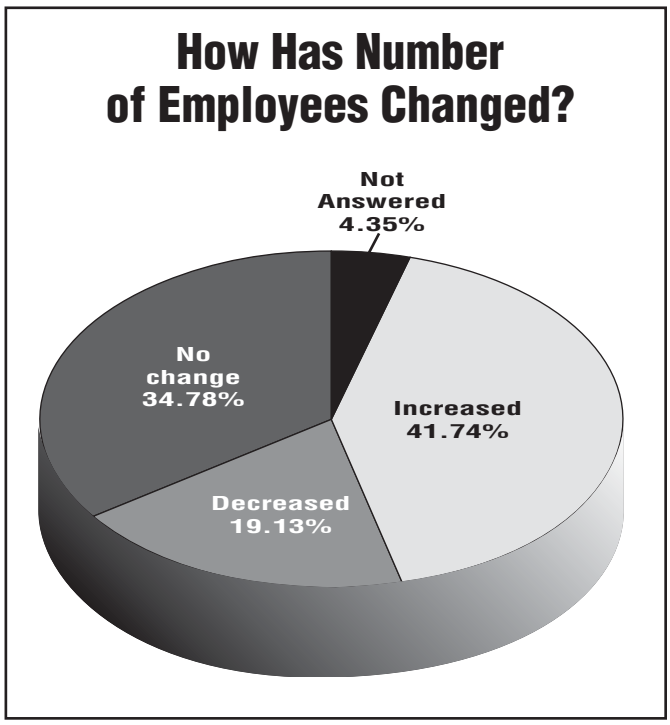
Another education program that will boost nurses' salaries when they complete their degree and position them for more responsibility is a BSN completion program, Reshoft notes.

"We've contracted with a local university to









provide courses for nurses who want to complete their BSN on the hospital's campus," she explains. This program is scheduled to begin in January 2005, she adds.

It is important to offer competitive salaries to attract employees, Cooper points out.

"We don't offer the highest salary in the area, but it is competitive; and we make sure that job applicants understand that benefits such as no weekend work, corporate 401K match, and an outstanding work environment make up for any differences in our salary levels and the salary levels of other surgery centers," she says.

Most importantly for retention of current nurses, Cooper doesn't pay top dollar to hire specific people, she says. "The salaries we offer new applicants are the same salaries current employees earn. We don't want to make current employees appear to be valued less than new employees," she adds.

Almost 42% of survey respondents saw the number of employees in their same-day surgery program increase in the past year. In the 2003 salary survey results, 56% reported increases.

Cooper reminds other managers to work on retention activities so that they don't have to constantly be hiring new employees. **(See graph on how number of employees has changed, above.)**

One way to keep good employees is to make sure they know you are there to support them as they do their job, she says.

El Camino's management is very responsive to requests for instruments or other items that staff members say will help them do their job better, Cooper explains.

"I received a request from our orthopedic nurses for a third ACL [anterior cruciate ligament] instrument set so that they would not spend as much time sterilizing and setting up for cases," she says.

"Although two ACL sets is probably enough, purchasing a $7,000 instrument set to show my support of the nurses' efforts is far less than the $55,000 that I have read is the cost to replace an operating nurse who leaves," Cooper admits.

El Camino's efforts to retain nurses have been successful, with a 30% turnover rate in 2002 cut in half by 2004, she points out.

Retention of employees means retaining the experience and skills that have helped your same-day surgery program grow, Sutton adds.

More than 53% of salary survey respondents report 10 or more years of experience, with more than 19% of those respondents reporting more than 25 years of experience. **(See chart p. 3.)**

"The average age of our operating room nurse is 53 years old, so my challenge is finding younger nurses willing to join us and stay with us long enough to give us the same level of experience when my other nurses retire," she says.

Sutton is optimistic. "I have filled three of my four vacancies, and I only need one more to have a full staff," she says. ■

SOURCES

For more information on retention and recruitment activities, contact:

- **Julie Butner**, RN, BSN, MS, Executive Director, El Camino Surgery Center, 2480 Grant Road, Mountain View, CA 94040. Phone: (650) 961-1200. Fax: (650) 961-7041. Web: www.ecsc.com.
- **Mary Jane Sutton**, RN, MSN, Director, The Surgical Center at Lake Norman, 131 Medical Park Road, Mooresville, NC 28117. Phone: (704) 660-4572. Fax: (704) 660-4501. E-mail: mary.sutton@inrmc.hma-corp.com.
- **Meaghan Reshoft**, RN, MBA, Director, Day Surgery Center at Northwest Community Healthcare, 675 W. Kirchoff Road, Arlington Heights, IL 60005. Phone: (847) 618-7075. Fax: (847) 618-7069. E-mail: mreshoft@nch.org.