Same-Day Surgery®

30th Anniversary

Covering Hospitals, Surgery Centers, and Offices for More than 30 Years

AHC Media LLC

IN THIS ISSUE

Financial Disclosure:
Author Sheryl Jackson, Senior Managing Editor Joy Dickinson, Associate Publisher Coles McKagen, Board Member and Nurse Planner Kay Ball, and Board Member and Columnist Stephen W. Earnhart report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Mark Mayo reports that he is an employee of Magna Health Systems and a consultant for DayOne Health.

NOVEMBER 2007
VOL. 31, NO. 11 • (pages 125-136)

Even patients who seem healthy can die unexpectedly — How will you respond?

A 27-year-old former college football player came in for an elective procedure to relieve hip pain. According to media reports, he hoped the surgery would clear a path for him to audition for a professional football team.[1] However, he seized on the operating table and went into cardiac arrest, reports said. Doctors successfully revived him, but he never completely recovered, they said. He later died.

This incident, which happened last spring at a Texas hospital, was followed by press coverage that included interviews with the deceased man's twin brother and his college sweetheart wife, who said a painkilling injection "went wrong."[1] The hospital said in its response that he experienced "a rare, but known complication of anesthesia." The family attorney has said a wrongful death suit is likely.[1]

A death or other sentinel event can happen in any outpatient surgery program at any time. **(See common situations that can be life-threatening, p. 129.)** When it does, you need to have policies and procedures in place to handle such incidences.

In ambulatory surgery, providers normally aren't thinking about the fact that they're caring for critically ill patients, says **Anne Dean Schilling**, RN, BSN, consultant with The ADA Group, a DeLand, FL-based consulting firm specializing in ambulatory surgical development and regulatory compliance. "We're thinking this is an otherwise healthy patient, and

FASA, AAASC merger said imminent

The Federated Ambulatory Surgery Association (FASA) and the American Association of Ambulatory Surgery Centers (AAASC) are reportedly going to merge into one organization, according to sources interviewed by *Same-Day Surgery*.

"There are real advantages to having one organization that represents the entire industry, particularly in legislative and Medicare efforts," says **Jack Egnatinsky**, MD, immediate past president of FASA. "They're doing

*(See **Merger**, continued on page 129)*

we've done 5,000 cases without any problems," she says. "When it does, the shock is unreal."

Here are the steps to follow when a death occurs:

• Show compassion to the family.

Don't be afraid to say, "I'm sorry this happened," Schilling says. You're not accepting blame, she says. "You're showing empathy and compassion for the family and caregivers."

The physician should state the facts but should not elaborate or admit blame, she says. Some states have passed "I'm sorry" laws to assure physicians that they can express sympathy and regret without increasing their liability risk, says **Linda Stimmel**, JD, partner and cofounder of Stewart & Stimmel in Dallas and a medical malpractice litigator. **(See list of state laws that protect words of sympathy, *Same-Day Surgery,* March 2007, p. 31.)** Most of these new laws are really just a clarification of regular evidence rules to publicize to health care providers that they need not be afraid to show compassion for patients in fear they may become plaintiffs, Stimmel says.

Facilities that have access to a chaplain may want to have that person also talk to the family, says **Sheila Mitchell**, RN, MS, BSN, CNOR, perioperative nursing specialist at the Center for Nursing Practice for the Association of periOperative Registered Nurses (AORN). Provide a quiet location for the family where they can talk and make phone calls, she suggests.

• Handle notification and documentation.

When a patient dies, don't remove any tubing or drains, says **Joan Blanchard**, RN, MSS, CNOR, CIC, perioperative nursing specialist at the AORN Center for Nursing Practice. "The patient needs to remain just as they expired until the coroner gets there," Blanchard says. It is permissible to cover the body with a sheet if the family requests to view the deceased, she says. Prepare the family for the body's appearance and explain that the tubings and drains won't be removed until after the coroner arrives, Blanchard says.

Document the facts in the record with no elaboration, Schilling says. Fill out an incident/occurrence report. "There should be no stories or drama, just what they saw," she says. Most states typically require a death report, Schilling adds.

• Address grief of staff.

Pull together members of your staff and the physicians that day to verbalize what they're thinking and feeling, Schilling says. "You don't want to send people out traumatized to their community and home," she says.

Remind staff that federal privacy requirements mean that they can't talk about the incident with family members, Schilling says. Provide grief counseling through a professional counselor, such as a psychologist, sociologist, or social worker, she says. "The staff will be in shock," Schilling says.

Hold follow-up sessions at staff meetings where you encourage them to share feelings, Mitchell advises. You can discuss the grieving process and how staff felt having to handle issues with the family, she says. Blanchard says to keep in mind that staff members may cope very well immediately after the death, but they may have

Same-Day Surgery® (ISSN 0190-5066) is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Same-Day Surgery**®, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m. to 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $495. Add $12.95 for shipping & handling. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $83 each. (GST registration number R128870672.)

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 16.5 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 16.5 Contact Hours.

AHC Media LLC is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AHC Media LLC designates this educational activity for a maximum of 20 *AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This activity is intended for outpatient surgeons, surgery center managers, and other clinicians. It is in effect for 24 months after the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Senior Vice President/Group Publisher: **Brenda Mooney** (404) 262-5403 (brenda.mooney@ahcmedia.com).
Associate Publisher: **Coles McKagen** (404) 262-5420 (coles.mckagen@ahcmedia.com).
Senior Managing Editor: **Joy Daughtery Dickinson** (229) 551-9195 (joy.dickinson@ahcmedia.com).
Senior Production Editor: **Nancy McCreary**.

AHC Media LLC

Editorial Questions

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

EXECUTIVE SUMMARY

A death or other sentinel event can happen in any outpatient surgery program at any time.

- "I'm sorry this happened" doesn't mean you're accepting blame.
- Incident/occurrence reports should contain only the facts.
- Address the grief of the staff, and remind them of privacy requirements. Use a chaplain for staff and family support if available.

concerns as they work through that situation. In that case, offer further counseling, she suggests.

If you have access to a chaplain's program, review their resources on death before an incident occurs, Mitchell suggests. These resources can prepare staff for what they'll experience with the family, for example, she says. "If they're doing this on a regular basis, whether they experience death in OR or not, at least they'll be prepared for it."

Establish a rapport with a chaplain who could be available to the staff and the family for support if a death occurs, Blanchard advises.

• Critique what happened.

Perform a root-cause analysis to determine the cause of the death, Mitchell says. **(See more on accreditation requirements, p. 128.)** In fact, a review of the quality of care should start the next working day, Schilling advises.

Determine whether all of the equipment was in good order, whether all of the processes were

Half of hospitals don't bill for 'never events'

If you make a mistake — a really big mistake — is it fair to bill the patient or insurer for the service?

Many health care providers are formally adopting policies that state they will not bill patients or insurers for the worst type of mistakes known as "never events" because they should never happen. One example is intraoperative or immediately postoperative death in an ASA Class I patient.

The Leapfrog Group, a patient safety organization, reports that just more than half (52%) of hospitals responding to its Leapfrog Hospital Quality and Safety Survey indicate they have adopted the Leapfrog Never Events policy, a list of actions they pledge to take whenever a never event occurs. By agreeing to this policy, hospitals pledge to take these steps when a never event happens:

- waive all costs directly related to the serious reportable adverse event;
- apologize to the patient and/or family affected by the never event;
- report the event to at least one of the following agencies: The Joint Commission, a state-reporting program for medical errors, or a patient safety organization;
- perform a root-cause analysis, consistent with instructions from the chosen reporting agency.

To define never events, Leapfrog uses the National Quality Forum's (NQF) definition of "serious reportable events." (For more information, go to www.qualityforum.org/projects/completed/sre.) The NQF's list includes errors such as performing surgery on the wrong body part or on the wrong patient, and leaving a foreign object inside a patient after surgery.

Not billing for the mistake is a key part of taking responsibility and making amends, says **Suzanne Delbanco**, CEO of The Leapfrog Group. "The hospitals who agree to our never events policy are also helping us to pioneer ways to tie payments for care to quality," she says. In the past, health care providers have seen the issues as separate, with the bills going out automatically regardless of the quality of care, she says. An analysis of survey results seems to show that smaller hospitals have a slight edge over larger ones in the rate of adoption of the Leapfrog Never Events policy. In the survey, 59% of small hospitals (one to 100 beds) had adopted the policy, compared to 53% of medium hospitals (101-250 beds) and 48% of large hospitals (251+ beds).

Hospitals that agree to the never events policy are twice as likely to have scored full points on the Leapfrog Safe Practices Score (SPS) than those hospitals that have not adopted the policy. The SPS, which Leapfrog says is an indicator of how committed a hospital is to maintaining high levels of quality and safety, asks hospitals how well they implement 27 of the NQF's Safe Practices. Thirty-three percent of hospitals who commit to the Leapfrog never events policy have scored full points on the SPS; only 17% of those who did not commit to the policy scored full points on the SPS. **(For more on the results of the Leapfrog survey, go to the Leapfrog Group's web site at www.leapfroggroup.org and select "2007 Leapfrog Top Hospitals and Survey Results" on the home page. For more on handling adverse events, see these *Same-Day Surgery* stories in the March 2007 issue: "When you have a serious adverse event, should you apologize, waive charges?" p. 29, and "Weigh waiving charges after an adverse event," p. 32.)** ■

SOURCES

For more information on handling patient deaths, contact:

- **Joan Blanchard**, RN, MSS, CNOR, CIC, and **Sheila Mitchell**, RN, MS, BSN, CNOR, Center for Nursing Practice, Association of periOperative Registered Nurses (AORN). Phone: (800) 755-2676, ext. 334.
- **Anne Dean Schilling**, RN, BSN, Consultant, The ADA Group, 911 E. Minnesota Ave., DeLand, FL 32724. Phone: (386) 956-1817 and (386) 736-6202. .E-mail: ADean9@cfl.rr.com or Anne@TheADAGroup.com. Web: www.theadagroup.com.

followed, and whether there was an interruption in processes that could have prevented or changed the outcome, she suggests. "Analyze every step of the process, and figure out where the breakdown was," Schilling says.

Make changes to policies as needed, and get every staff person inserviced, she says.

- **Address family issues.**

Consider sending the family a card and/or flowers to the funeral, Mitchell says. "Those are communication steps that often, in addition to open communication, have been proven to ease the family over the death of a loved one by showing they care," she says.

Should you bill the family? Yes, Schilling answers. "We would let the lawyers decide later about adjusting in a settlement," she says. Some experts say that if you don't bill the family, you're admitting blame, whether that's true or not, Schilling says. "It's the same as discounting services, which we can't legally do anyway," she adds. **(For other views on this issue, see story, p. 127.)**

Reference

1. Abrahams T. Aspiring athlete dies after undergoing elective surgery — Family members want answers. Accessed at http://abclocal.go.com/ktrk/story?section=local&id=5246068. ■

Do you have to tell The Joint Commission?

Requirements spelled out for patient deaths

When a patient death occurs in outpatient surgery, you do have a choice about whether you report the occurrence to The Joint Commission.

"In light of improving quality and patient safety, it's a nonpunitive action," says **Virginia McCollum**, RN, MSN, associate director of standards interpretation at The Joint Commission. When administrators decide to report a death or other sentinel event, they are not jeopardizing their accreditation "or getting in trouble," she says.

Sentinel events are handled confidentially, and the information is not shared with surveyors, says **Anita Giuntoli**, RN, MJ, BSN, associate director of the Office of Quality Monitoring at The Joint Commission. However, surveyors do determine whether all facilities have conducted root-cause analyses of any adverse events, McCollum says.

If a surveyor determines during the survey process that a sentinel event occurred with 12 months of the survey, the surveyor will inform the CEO and communicate that event to The Joint Commission central office. "If, in any way, shape, or form, we find out about a sentinel event, it's incumbent on us to explore with the organization and make sure they have taken appropriate follow-up steps," Giuntoli says.

When a facility reports a sentinel event to The Joint Commission, there are master's-prepared nurses who are experts in root-cause analyses who offer their help, she says. "We make sure the root-cause analysis is thorough and credible."

Once the analysis is complete, the organization is required to create a plan of action to address all the root causes, Giuntoli says. The organization must develop a measure to see if the plan is working, she says. For example, if the facility had a wrong-site surgery and failed to implement a timeout prior to surgery, one of the plans of action might be to perform a timeout in the future, designate who would lead the timeout, and who would document it. The organization would conduct 100% measurement of the frequency of timeout to determine the measure of success (MOS). "If it's not successful, we'll work with them until it is," Giuntoli says.

The expectation is that there will be a quality

RESOURCE

For information on how accredited facilities should address a sentinel event such as a death, go to www.jointcommission.org. Under "Sentinel Events," click on "Policy and Procedures."

improvement process, McCollum says. "We expect that they will take any adverse event — death or wrong site surgery or whatever the event is — collect, aggregate, and analyze data; and make changes based on the data," she says. "It's probably the most important thing you can do." ■

Life-threatening situations can occur in your program

Case studies show what can go wrong

There are some situations that come up repeatedly in ambulatory surgery settings that can be life threatening, warns **Anne Dean Schilling**, RN, BSN, consultant with The ADA Group, a DeLand, FL-based consulting firm specializing in ambulatory surgical development and regulatory compliance.

One of those situations is hesitating to tell physicians, particularly if they are owners, that they can't schedule a specific procedure at your facility, Schilling says.

She points to a case involving a 48-year-old patient who came in for a face lift, vein stripping, and liposuction. Other than having asthma, the patient was healthy. The center didn't allow any procedures that were scheduled to go longer than five hours. When the nurse scheduled the case, "she asked for five hours, but knew he couldn't get it done in five hours," Schilling says. The case took 11½ hours, she says. The patient was sent home at the end of the day, had a pulmonary emboli, and died, Schilling says.

You can establish criteria such as how long a procedure must be, but you must ensure that it is implemented and enforced, she says. Many staff members hesitate to enforce a policy when the physician owns part of the center, Schilling says. "The board needs to say, 'Our first job is to have a place that's safe for the patient,'" she says. When Schilling helps set up a new surgery center, she tells nurses that their first job is to protect the doctor. "Don't let him do things that put him at risk or patients at risk," she says.

It's often said that a nurse is the patient's last bastion of safety in the OR, Schilling says. "I thought, 'That's true,' when I heard it," she says. "It's also true when the physician is the owner."

Another problem that crops up repeatedly in ambulatory surgery programs is the failure to communicate critical patient information at handoff, Schilling says.

She points to a case in which a cataract patient was oxygen-dependent. The pre-op nurse noted the patient was oxygen-dependent. However, in the hectic turnover of cases, the patient went into the OR without an anesthesia preoperative assessment. The nurse noticed this omission; she called the certified registered nurse anesthetist (CRNA) in the OR and asked, "Would you like to do it?" The CRNA responded that it would be no problem. The CRNA missed that the patient was oxygen-dependent, and he was not given oxygen other than medical air. He arrested and was resuscitated, but he died after being transported to the hospital.

At this facility, a system had developed in which the CRNA didn't come out to get the report, Schilling says. "We're seeing more and more of that in surgery centers," she says. Due to short staff schedules and quick turnover, staff members are becoming totally reliant on paper documentation. Often anesthesia providers will transport the patients themselves without getting the pre-op

Merger

(Continued from cover)

the same things, making a parallel effort, and cooperating, so this would make it a much more effective agency. Also they'd have much more effective educational activities."

The Association of periOperative Registered Nurses (AORN) has worked closely with both organizations, says **Bonnie G. Denholm**, RN, MS, CNOR, perioperative nursing specialist at AORN's Center for Nursing Practice. "It would seem that anything we can all do to provide consistent messages to legislators and unity in health care among perioperative leaders would be a positive thing for our communities," she says. AORN looks forward to continuing the collaborative relationship with the newly merged organization, Denholm adds.

Official details of the merger are expected to be announced in the next few days.

However, at this point, it appears that the FASA conference still will be held in May in San Antonio, sources say. The AAASC meeting scheduled for April in Tampa, FL, is likely to be canceled, those sources say. Also, sources say Kathy Bryant, president of FASA, is likely to lead the new organization. They report that Craig Jeffries, executive director of AAASC, will not have a long-time leadership role in the newly formed association. ■

nurse involved. "That's very risky," Schilling says. "We're seeing all over the country that nurses are not passing off reports to other nurses."

Probably the biggest vulnerability in outpatient surgery is that staff members handle the same procedures over and over again, she says. It's like driving home from work, Schilling says. "You get in your driveway and you ask, 'How did I get here? I don't remember driving,'" she says. "You get into rote and fail to see intricate little pieces."

Conversely, staff may have some procedures that they do only once or twice a year, she says. In those cases, all of the staff members need a dress rehearsal in which they go over the entire process, Schilling says. "Prevention is the thing, having policies, processes, and protocols; educating the staff; and enforcing them," Schilling says. ■

Same-Day Surgery Manager

Cell phones and other things that annoy me

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

I had the pleasure of touring several facilities since last month. Three surgery centers and two hospital surgical departments stand out.

Let's start with personnel. I was to meet the administrator of a freestanding center somewhere in the Northeast. I approached the receptionist's desk and waited quietly behind an elderly couple checking in. The receptionist (I had to assume; she did not have on a name tag) was animatedly talking on a cell phone, oblivious to the three of us in line. I just assumed it must have been a surgeon or senior senator or someone equally as important. The elderly gentleman in front of me turned and looked and me and shrugged his shoulder and rolled his eyes in a "what-a-world" expression.

After looking at my watch three times and clearing my throat twice, I decided to take her on. I had nothing to lose. I wasn't having surgery like the couple in front of me, so I was not fearful of retaliation. "Is there someone else that can help us until your finish your call?" I asked politely. I was immediately flash frozen.

"Listen," she said to the other party, "I'll pick up something from the store after work or you can just go out to eat on your own." Click. So much for the senator theory.

I don't like cell phones. I never have, and I never will. They have snatched much of my personal freedom and significantly reduced productivity in the workplace. Most facilities have cell phone policies, but they rarely are enforced. By the way, there was a sign in the waiting room that said, "For the comfort of those around you, please turn off your cell phone." Cute.

Other things that annoy me:

• **Cigarette butts.**

I proceeded up the walkway of another surgery center. Beautiful flowers lined the sidewalk to the main entrance of the center. The intended illusion was shattered by several hundred cigarette butts scattered among the plants.

• **Clutter.**

How nervous would you be if you walked onto an airplane and had to twist and turn around old engine parts or discarded chairs and filing cabinets before you could reach your seat? Look down your corridors. What do you see that your patients see?

• **Loose lips.**

When you or your staff talk loud or in an inappropriate location, people who shouldn't hear you can hear what you say.

• **Hospital volunteers.**

I am all for helping senior citizens doing volunteer work in hospitals. There should be criteria for hire, however, that includes the ability to hear clearly and speak loudly.

• **Parking.**

If your patients have to park their cars further than a half-mile of your doors, you shouldn't be in business.

• **Pay-to-park lots.**

Come on. How cheap can you get when you charge patients $7,000 to repair their hernia and then slap another $18 on them to park their car?

• **Double doors that don't open.**

One of my fantasies is to break down the door of every set of double doors when one of them doesn't open. Put up a sign.

• **Drinking fountains.**

If your lips have to touch the base of the fountain because the vertical rise of water is only one-half inch, repair it.

• **Bathroom towel dispensers.**

If the automated paper towel dispenser in your bathroom gives you only a single-ply, 6-inch strip of paper per swipe, you have no business being in business.

Look around your workplace and use your common sense. You can change the way things are.

(Send Steve your list of what annoys you most in your workplace. We'll share your comments anonymously in a future column. *Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Contact him at 1000 Westbank Drive, Suite 5B, Austin, TX 78746. E-mail: searnhart @earnhart.com. Web: www.earnhart.com.)* ■

Surgeons reluctant to trade suture sharps

Will calls for change, new designs get point across?

Surgeons have long been reluctant to use blunt suture needles, but new messages from the American College of Surgeons (ACS), the Occupational Safety and Health Administration (OSHA), and the National Institute for Occupational Safety and Health (NIOSH) may get their attention. Those organizations are actively promoting the use of blunt suture needles.

They have a difficult mission. Suture needles are responsible for about one-fifth (21%) of all blood and body fluid exposures, according to 2004 data from EpiNet, a multihospital database of the International Health Care Worker Safety Center at the University of Virginia in Charlottesville. The operating room has been the slowest part of hospitals to adopt the use of the safer devices, which are required by OSHA's bloodborne pathogen standard.

"Blunt needles are underused in the United States. We are trying to let all of the 60,000 fellows of the college know about this issue," says **William Schecter**, MD, FACS, chairman of the ACS Committee on Perioperative Care and chief of surgery at San Francisco General Hospital. "This technology is out there. It can be used."

It has been two years since the American College of Surgeons first issued a position statement endorsing the use of blunt suture needles for fascia closure, but surgeons still are reluctant to adopt the technology. About 59% of all suture injuries occur while suturing fascia.[1]

Surgeons remain ignorant of sharps injury rates, says **Ramon Berguer**, MD, FACS, clinical professor of surgery at the University of California, Davis and chief of surgery at Contra Costa Regional Medical Center in Martinez, CA. "They remain a little wary on the use of blunt suture needles. Some of the early blunt suture needles were really blunt and difficult to use."

Berguer, a general surgeon and member of the ACS Committee on Perioperative Care, uses blunt suture needles and tries to eliminate sharp devices by using electric cautery and skin staples. "I get stuck at least once a year, and I think every surgeon just accepts that," he says. "I don't think we have to accept that. That's the mentality we have to change." In fact, a recent study found that 99% of surgical residents have at least one sharps injury during their training, but only about half of them are reported. **(See story, p. 132.)**

Hospitals must evaluate needles

Hospitals are required to evaluate blunt suture needles, just as they do blood collection devices. In a joint bulletin on blunt suture needles, OSHA and NIOSH note that "employers must use safer devices to replace corresponding conventional sharp-tip suture needles in their workplaces when clinically appropriate."

If the hospital uses conventional needles, justification must be documented in the exposure control plan. The surgeons' preferences are secondary to the regulatory requirements, says **Sheila Arbury**, RN, MPH, COHN-S, health scientist in OSHA's Directorate of Science, Technology and Medicine. "If they're able to do the procedure using blunt sutures without any harm to the procedure, the patient, or [other clinical concerns], they really need to try this," Arbury says.

OSHA inspectors rarely venture into the OR arena. Most of OSHA's inspections are triggered by complaints, and complaints are rare from members of the tight-knit OR teams. So OSHA and NIOSH are trying to promote blunt suture use through their alliances and partnerships — by encouraging The Joint Commission to call for their use, by working with vendors to improve the availability of various needles and suture materials, and by spreading the word among health care workers.

Still, despite surgeons' recalcitrance, hospitals are subject to citation if they don't use blunt suture needles where clinically appropriate, says **Dionne Williams**, MPH, team leader in OSHA's Directorate of Enforcement Programs. "It can't be infeasible in

Use data to push sharps safety in the OR

Surgeons respond with safer practices

Although blunt suture needles are rare in the operating room, other safer practices have begun to take hold.

At Gwinnett Medical Center in Lawrenceville, GA, **Vangie Dennis**, RN, CNOR, CMLSO, advanced technology manager, places an emphasis on data and scientific literature as she tries to convey her sharps safety message to surgeons. For example, she shared information on the protective benefits of double-gloving. One study showed that of 88 glove perforations during surgery, only 6.8% perforated the inner glove.

She also shared information about sharps injuries in the hospital's OR. Dennis put a poster above the scrub sinks showing hands with red dots that indicated the sticks occurring in different surgical departments. "I blitz them with information," Dennis says. "I let them know how many sticks we've had. They want data."

When Dennis implemented a neutral zone for passing instruments, she used an incentive program to get the OR teams' attention. Surgeons and other OR personnel may place one item in a "passing zone" or multiple items in the designated neutral zone.

She organized a "Neutral Zone Round-Up" with "Neutral Zone Sheriffs." Nurses wearing badges would "ticket" people who used the neutral zone, but in this case, the tickets results in a reward: a candy bar. The names of surgical personnel also were placed in a bucket for a weekly drawing for $10 certificates to Starbucks, the local movie theater, and other prizes.

Now that work practices have improved, Dennis plans to move forward with promotion of blunt suture needles. She has developed a presentation on sharps exposures in the OR and gained the support of some surgeons who are willing to try the needles. She plans to meet with the safety committee and surgical department committees.

Dennis also will place information about suture needle injuries and the American College of Surgeons statement on blunt suture needles above scrub sinks and in the doctors' lounge.

A recent incident may make surgeons more receptive to change. A general surgeon retired after contracting hepatitis C from a needlestick and suffering from an acute infection. "That shook some people up," says Dennis. ■

every single surgical procedure [to use blunt suture needles]," she says. "If we're looking at [a hospital's] exposure control plan and they're writing that they're infeasible altogether, that would raise a question in our minds. It's not going to be appropriate in every single situation, but if it is appropriate for some procedures, we'd like to see that incorporated in the plan."

Blunt needles reduce injuries

Even surgeons who support the use of blunt suture needles have found impediments, however. **Janet Stein**, MD, participated in a study of blunt suture needles in gynecologic surgery sponsored by the Centers for Disease Control and Prevention (CDC). The study, published in 1997, showed that blunt suture needles could significantly reduce needlestick injuries in the OR.[2] Each increase in the use of blunt suture needles was associated with a decrease in injuries. Based on the findings, the CDC estimated that if half of the curved suture needles were replaced with blunt needles, injuries would drop by 87%. Surgeons reported technical difficulties with the blunt suture needles in only 6% of the cases, and patient care was not affected.

"It's a no-brainer to me. If it's available, why would you use anything else?" says Stein, who is now vice chair and director of the residency program in the Department of Obstetrics/Gynecology at Beth Israel Medical Center in New York City and the Manhattan campus of Albert Einstein College of Medicine.

However, in the years after the study, surgeons no longer used the blunt suture needles at the hospital. Often, the preferred suture material wasn't available with the needles or had to be special ordered, Stein says. Other advances in the OR such as laparoscopy and the use of cautery led to reduced injuries. In addition, other safer practices, such as hands-free passing of instruments, became routine. But surgeons never became fully comfortable with the blunt suture needles, she says.

"Calling something a 'blunt needle' really turns surgeons off," Stein says. "We really wanted to call them safety needles, and we thought people would be a lot more interested in using them if we called them safety needles."

Stein hopes a resurgence of interest in blunt suture needles will lead to increased acceptance among surgeons.

Surgeons need to request the products that will work best for them, stressed Schecter. "I think the profession as a whole is going to have to deal with

this issue and work with industry," he says. "Industry will provide whatever we need if we ask for it."

The Association of periOperative Registered Nurses (AORN) also supports the use of blunt suture needles, as well as other techniques to reduce injuries, such as double-gloving.

Present detailed data about the types of sharps injuries occurring in the OR, advises **Carol Petersen**, RN, BSN, MAOM, CNOR, perioperative nursing data set manager with AORN. Work through the OR steering committee or other multidisciplinary teams to implement changes, Petersen says. Surgeons will want scientific evidence that new devices will improve safety while safeguarding patient care. "Always go into those meetings prepared," Petersen says.

(Editor's note: The American College of Surgeons position statement is available at www.facs.org/fellows_info/statements/st-52.html. For more information, see these* Same-Day Surgery *stories: "Hospital cuts sharps injuries in the OR," April 2005, p. 40, and "Advice on turning your OR into a sharps safety zone," April 2004, p. 44.)

References

1. Jagger J, Bentley M, and Tereskerz PM. Patterns and prevention of blood exposures in operating room personnel: A multi-center study. *AORN J* 1998; 67:979-996.
2. Centers for Disease Control and Prevention. Evaluation of blunt suture needles in preventing percutaneous injuries among healthcare workers during gynecologic surgical procedures — New York City, March 1993 — June 1994. *MMWR* 1997; 46:25-29. ■

Expect the unexpected with media coverage

At events, ensure patient privacy, positive results

(Editor's note: This is the second part of a two-part series on sponsoring community events and open houses. In last month's issue, we covered open houses. In this month's issue, we give you suggestions for handling the media.)

One of the benefits of sponsoring community events or open houses is increasing awareness of your facility's name in a positive light. While most outpatient surgery program managers are pleased with direct contact with business leaders, referring physicians, potential patients, and community members, media coverage increases the audience that learns about the program.

Members of the media were notified about the opening of the Corvallis (OR) Clinic Surgery Center, the first freestanding multispecialty center in the area. Staff members prepared for the local print media, but she and her staff were not prepared for some media activities, admits **Judy Corwin**, director of marketing and public relations for the Corvallis Clinic.

"We have a very good relationship with our local media, which is primarily print, and we worked with a reporter prior to the opening on an article that was timed to appear the week of our grand opening," Corwin says. Press releases were sent to all of the local radio stations as well as all print media and to television stations that cover the area but are located almost 50 miles away. "We really didn't expect television coverage and should have been better prepared," Corwin says.

Worked with patients

Two television stations sent reporters and cameras to show the facility and to interview patients. "We scheduled their visits ahead of time to enable us to get patient permission to be interviewed and to get waiver forms signed," she says. "We also prepared the patient for the type of questions the reporter might ask, and we made sure they were comfortable answering the questions."

Patients were told that reporters would ask about their procedure and how they felt, but patients should not go into too many personal details that might make them uncomfortable, she explains.

One television station's visit and resulting coverage went very well, says Corwin. Unfortunately, the other station was more than one hour late arriving at the surgery center, which meant the patients who had been prepared for the interview had left, she says. "When the reporter and cameraman arrived, they wanted to go through the facility and talk with patients, but I was hesitant because none of the patients in the facility had been prepared and none had signed privacy waivers," she says. Because she wanted to be flexible, she allowed the reporter and camera operator to go into the patient areas to shoot "B" roll, which is video only. Corwin had explained that patients could not be interviewed because no one had been approached about releases. However, as she accompanied the reporter and camera operator into the recovery area, a patient told the reporter

that she wanted to be interviewed. "I could not jump in and stop the interview at this point without offending the patient," she explains.

Although the patient's comments were not negative, she had not been given any of the information about the center that the "prepped" patients had been given. The patient went into more detail about the procedure and her condition than Corwin thought necessary for television. "I learned my lesson," she says. "I was hesitant to proceed with the television visit, but I went ahead anyway," she says. Corwin will now let reporters know that if a television crew is that late for a visit, another day or time will be scheduled, she says. "It was too much of an imposition on our patients and our staff, and the results were not what we wanted." ■

Outbreak leads to 70% absentee rate

Norovirus event brings pandemic lessons

Imagine a communitywide outbreak so pervasive that employees fell ill at work, 40% called in sick, and even the chief nursing executive pitched in to work as a staff nurse.

"Within 24 hours, we had a 70% absentee rate in med-surg," says **Shannon Akers**, LPN, employee health nurse and infection control assistant at Missouri Baptist Hospital — Sullivan. "From there, the absentees just kept coming."

This scenario sounds like one from a pandemic influenza drill — but it was a real-life episode of norovirus at Missouri Baptist Sullivan, a rural hospital about 70 miles from St. Louis. Missouri Baptist — Sullivan, part of BJC Healthcare, is a small hospital with just 75 beds and a daily census of about 16 in its medical/surgical unit. It serves about 20,000 patients a day in its emergency department and has about 500 employees. The 2006 norovirus outbreak at the facility illustrated how vulnerable all facilities are to the spread of infection and how an easily transmissible infectious disease can affect the hospital's operations, Akers says. She presented information about the outbreak at the annual conference of the Association of Occupational Health Professionals in Healthcare in late September.

Before this outbreak, the threat of a pandemic "seemed very distant and far away," she says. "I just never felt we were going to be impacted by anything big. I have definitely changed my mind about that. I don't think we're sheltered from anything."

The hospital ultimately controlled the outbreak through rigorous adherence to hand hygiene and infection control precautions. But the lessons learned from the outbreak still are shaping the hospital's employee health policies and pandemic planning, Akers says.

Akers vividly remembers when the outbreak began. The hospital's infection control specialist was checking into reports of influenza in the community and found out about cases of gastroenteritis at the local high school. That was the first warning sign.

Noroviruses, also known as Norwalk-like viruses, are highly contagious; exposure to as few as 10 virus particles can lead to infection, according to the Centers for Disease Control and Prevention. It is spread through fecal contamination of food or water or through environmental or fomite contamination.

In Missouri, norovirus had affected about half the passengers on a cruise ship on the Mississippi River. But it also had traveled along the interstates and moved through the state from other sources. **Monica Clonts**, RN, communicable disease nurse at the Crawford County Health Department in Steelville, MO, who had worked with Missouri Baptist, says "It's highly contagious. We just watched it creep its way across the state."

With norovirus, symptoms can appear within 12 hours of exposure. Although the hospital employees were greatly affected by the virus, only six patients, in the geropsychiatric unit, contracted norovirus from a hospital-based transmission. "We attribute that to the enormous commitment our employees showed to patient safety," says Akers. "It was the employees who contained this. We're very proud of them."

To contain the outbreak, environmental service workers scrubbed the hospital clean with bleach — twice. Health care workers were meticulous about hand hygiene. Anyone with symptoms was instructed to stay home, and ill employees were told to stay home for 72 hours after the symptoms subsided.

Weaknesses in planning

The outbreak pointed out weaknesses in the hospital's emergency planning, says Akers. "What this showed us was that we were deficient

in offering our employees options," she says. "We don't have a day care [center]. We didn't have staff properly cross-trained. If there was an emergency in a department, there wouldn't be anyone to replace them. Those are areas that we're looking at to improve."

During the outbreak, employees received spot training to enable them to work in different departments. However, the hospital is gearing up for more cross-training. Akers and her colleagues are also taking a closer look at how to provide day care and meet other employee needs during an emergency. The hospital also monitors spikes and trends in employee absences.

Communication is key

Communication with the health department also was a key to controlling an infectious disease that had spread throughout the community. The health department tracks trends in gastrointestinal and respiratory illnesses. "It was a group effort to get this investigated and contained," says Clonts, who noted that the relationship between the hospital and the health department grew stronger as a result of the outbreak.

It took about 30 days to control the hospital outbreak, and the norovirus eventually died out in the community. "It's my understanding that it just kept moving down the highway," says Akers. ■

CNE/CME instructions

Physicians and nurses participate in this CNE/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 with the **December** issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CNE/CME *questions*

- **Identify** clinical, managerial, regulatory, or social issues relating to ambulatory surgery care.
- **Describe** how current issues in ambulatory surgery affect clinical and management practices.
- **Incorporate** practical solutions to ambulatory surgery issues and concerns into daily practices.

17. In terms of patient deaths, what role can a chaplain play?
A. Talk to the family when the death occurs.
B. Provide resources on death before an incident occurs.
C. Provide support to the family and staff after a death.
D. All of the above

18. Which of the following is true in terms of a patient death and The Joint Commission?
A. Accredited facilities must report a death, and it is punitive.
B. Accredited facilities must report a death, but it is nonpunitive.
C. Accredited facilities are not required to report a death to The Joint Commission unless they are going to be surveyed in the next 12 months, and it is nonpunitive.
D. Accredited facilities are not required to report a death, and it is nonpunitive.

19. According to the EpiNet database of the International Health Care Worker Safety Center at the University of Virginia in Charlottesville, what proportion of all sharps injuries occur from blunt suture needles?
A. 12%
B. 21%
C. 33%
D. 51%

20. How does Lee Memorial Health System's seasonal employment option appeal to senior nurses, according to Kristy Rigot, system director of human resources?
A. Nurses get benefits six months of the year.
B. Nurses can take up to six months off and still receive benefits for a full year.
C. Nurses can work whenever they want to work.
D. Nurses don't have to maintain their license for a full year.

Answers: 17. D; 18. D; 19. B; 20. B.

COMING IN FUTURE MONTHS

- Procedure grows in popularity, but what are risks, limits?
- How to cut surgical site infections in half
- Effective method for reducing surgical site infections
- Should you use a substitute for glutaraldehyde?

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	10/01/07
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)*
Coles McKagen, 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
AHC Media LLC	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
Thompson Publishing Group Inc.	1725 K Street NW, Suite 700
	Washington, D.C. 20006

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 2007

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)*			991	881
b. Paid and/or Requested Circulation	(1)	Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. *(Include advertiser's proof and exchange copies)*	657	609
	(2)	Paid In-County Subscriptions *(Include advertiser's proof and exchange copies)*	6	3
	(3)	Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	3	6
	(4)	Other Classes Mailed Through the USPS	27	38
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2)*			693	656
d. Free Distribution by Mail *(Samples, Complimentary and Other Free)*	(1)	Outside-County as Stated on Form 3541	24	24
	(2)	In-County as Stated on Form 3541	1	1
	(3)	Other Classes Mailed Through the USPS	0	0
e. Free Distribution Outside the Mail *(Carriers or Other Means)*			20	20
f. Total Free Distribution *(Sum of 15d and 15e)*			45	45
g. Total Distribution *(Sum of 15c and 15f)*			738	701
h. Copies Not Distributed			253	180
i. Total *(Sum of 15g, and h.*			991	881
Percent Paid and/or Requested Circulation *(15c divided by 15g times 100)*			94%	94%

16. Publication of Statement of Ownership
Publication required. Will be printed in the November 2007 issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: Brenda L. Mooney, Publisher — Date: 9/27/07

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).

Instructions to Publishers

1. Complete and file one copy of this form with your postmaster annually on or before October 1. Keep a copy of the completed form for your records.
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.
3. Be sure to furnish all circulation information called for in item 15. Free circulation must be shown in items 15d, e, and f.
4. Item 15h., Copies not Distributed, must include (1) newsstand copies originally stated on Form 3541, and returned to the publisher, (2) estimated returns from news agents, and (3), copies for office use, leftovers, spoiled, and all other copies not distributed.
5. If the publication had Periodicals authorization as a general or requester publication, this Statement of Ownership, Management, and Circulation must be published; it must be printed in any issue in October or if the publication is not published during October, the first issue printed after October.
5. In item 16, indicate date of the issue in which this Statement of Ownership will be published.
6. Item 17 must be signed.

Failure to file or publish a statement of ownership may lead to suspension of second-class authorization.

PS Form **3526**, September 1999 *(Reverse)*

30th Anniversary
Same-Day Surgery®
Covering Hospitals, Surgery Centers, and Offices for More than 25 Years

Tackle nursing shortage by attracting, keeping senior nurses

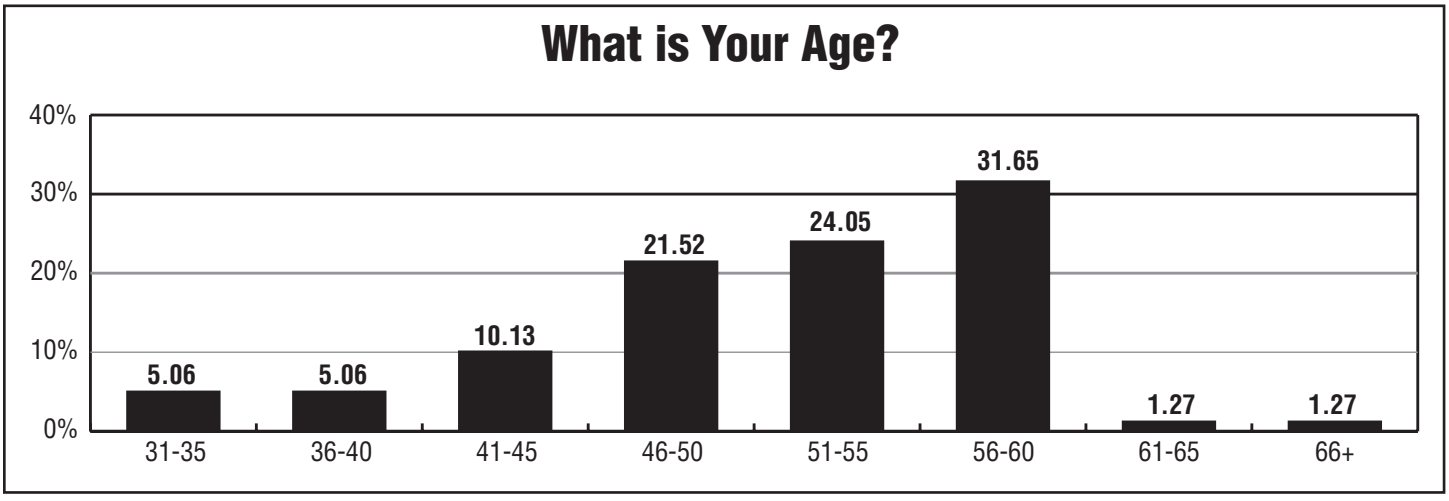
Attractive employment options encourage nurses to put off retirement

With almost 49% of the respondents to the 2007 *Same-Day Surgery* Salary Survey reporting that their staff sizes have increased during the past year, the challenge of recruiting new employees and retaining experienced employees grows and is exacerbated by the nursing shortage and the aging of the work force.

Salary survey respondents are representative of the aging work force, with more than 58% of respondents over the age of 50. **(See chart, below.)** One tactic to address the nursing shortage and the increasing work force age is to offer employment programs that provide senior employees a reason to continue working past the age they might retire, or to return to work after retiring, according to experts interviewed by *Same-Day Surgery*.

Lee Memorial Health System in Fort Myers, FL doesn't just claim to be a good place to work for employees older than the age of 50, the health system has been recognized three years in a row by the American Association of Retired Persons (AARP) as one of the best employers for workers older than of 50 due to innovative programs that address the needs of senior workers. Lee Memorial is one of five hospitals or health systems included in the AARP's top 10 best employers for mature workers for 2007. "We make a special effort to recruit senior nurses throughout the health system, including our outpatient surgery departments," admits **Kristy Rigot**, system director of human resources for Lee Memorial.

The recruitment begins with a specially designed brochure for distribution to the 3,000 volunteers throughout the health system, Rigot says. "We have found that our volunteers are an excellent source of referrals of new employees," she says. Not only have volunteers referred friends or family to Lee Memorial



but many times, volunteers with health care backgrounds will decide to re-enter the work force when they see the variety of flexible employment plans offered by the health system, Rigot says. Lee Memorial also uses senior placement agencies to recruit mature workers or retirees, she adds.

Flexibility is a key concern for working seniors, so Lee Memorial offers job-share positions, flex pools for nurses who want to select the number of hours they work, and 36-hour weeks that pay 40 hours of salary, points out Rigot. "If a nurse is physically unable to work three 12-hour days to make up the 36 hours, we adjust the schedule to include six- to eight-hour shifts that total 36 hours," she says.

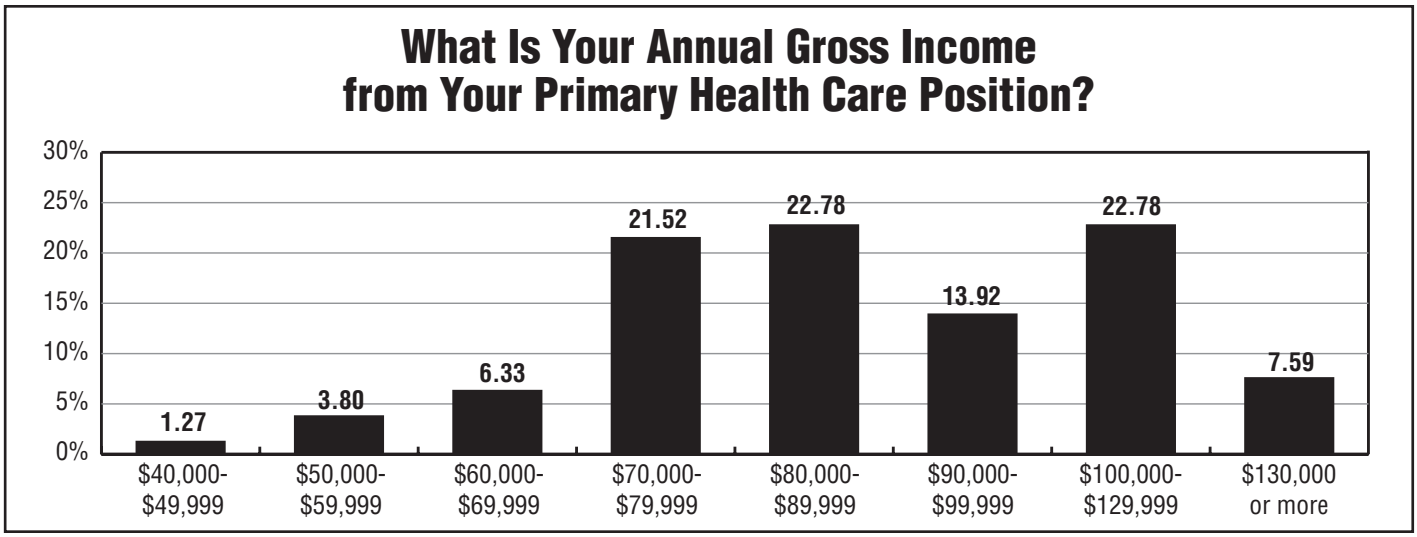
About 35% of Lee Memorial's work force is over the age of 50, "primarily because we are located in an area that attracts seniors because of our weather and our quality of life," Rigot says.

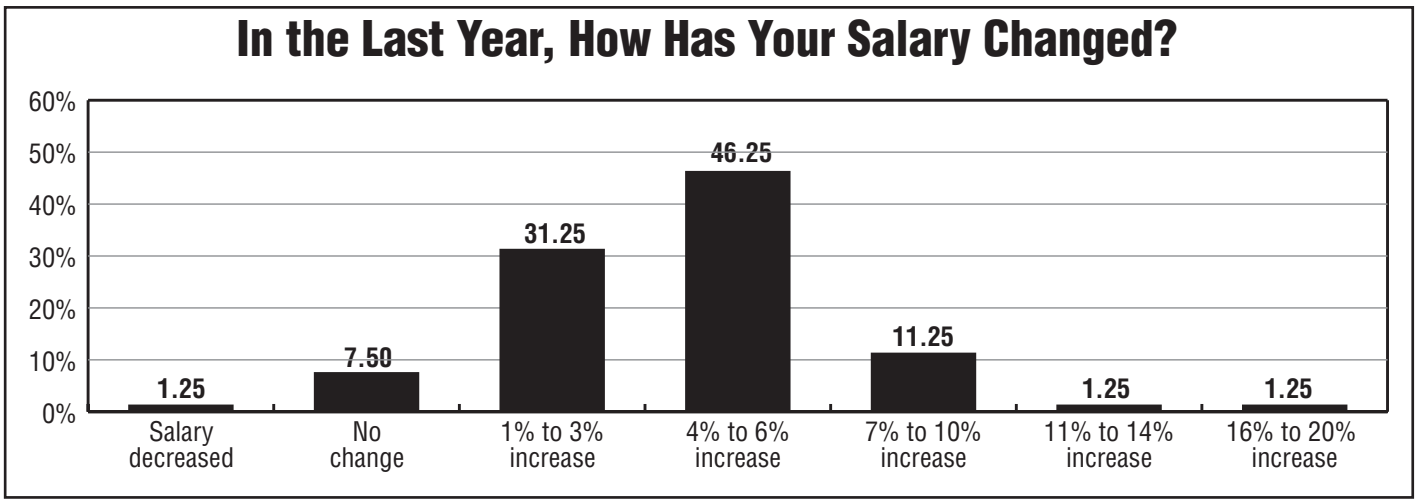
To appeal to snowbirds who live in the area only six months of the year or seniors who don't want to work full time the entire year, two seasonal employment options enable employees to work full time during the health system's busiest months for six months, then either take six months off to return to their homes in the north or just reduce hours for up to six months to enjoy vacations, gardening, or other hobbies, she says. Both options offer employees a chance to continue receiving full benefits at the same cost as employees working full time throughout the year, Rigot adds.

The ability to attract senior nurses or other employees might be related to your location, admits **Kathy Harris**, vice president of human resources at Mercy Health System in Janesville, WI. Salary survey respondents represent all regions of the country as well as different types of locations such as urban and rural.

"Our geographic area is somewhat rural, and many of our clinics are located in small communities in the southern Wisconsin and northern Illinois areas," she says. "We do compete with Madison and Milwaukee and some of the Chicago suburbs for work force talent."

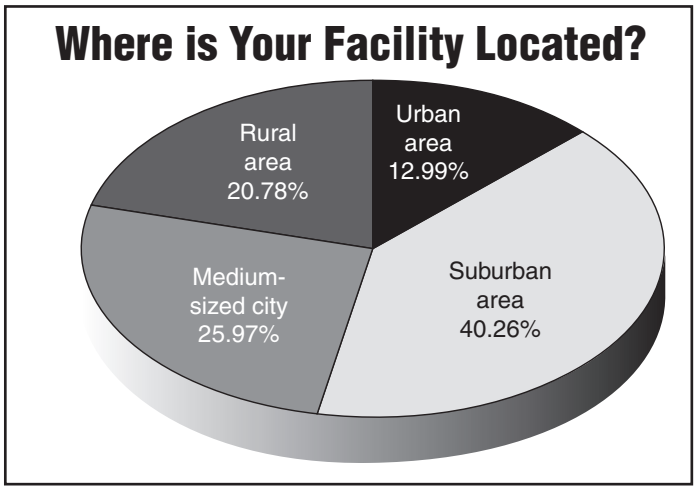
Because Mercy Health System is a large organization, there are several approaches to attract or keep mature nurses, she says. One key approach to





the needs of older nurses is the Low Lift Program, in which nurses' work areas and equipment are redesigned so that there is less physical lifting, Harris says. "We offer specific education opportunities for nurses to learn about the special lifting equipment and safe patient handling," she adds.

Another key program is the work-to-retire program, in which longer-term nurses can reduce hours and transition into retirement, while staying eligible for benefits, says Harris. The program allows employees age 50 and older with five years of service the opportunity to work reduced, pool, or work-at-home schedules, she says. It also allows employees ages 55 and older with 15 years of service to work seasonally, for 1,000 hours in a year at their discretion, while maintaining full part-time benefits such as health and dental insurance for the entire year, she explains.



Offer senior staff a chance to affect workplace

Freestanding surgery programs or smaller hospital systems may not have the resources or flexibility of a large number of employees to be able to offer formal reduced hour programs, but there are benefits to working in a surgery center that do attract senior nurses, says **Pam Neiderer**, RN, BSN, clinical service manager at Surgical Center of York (PA).

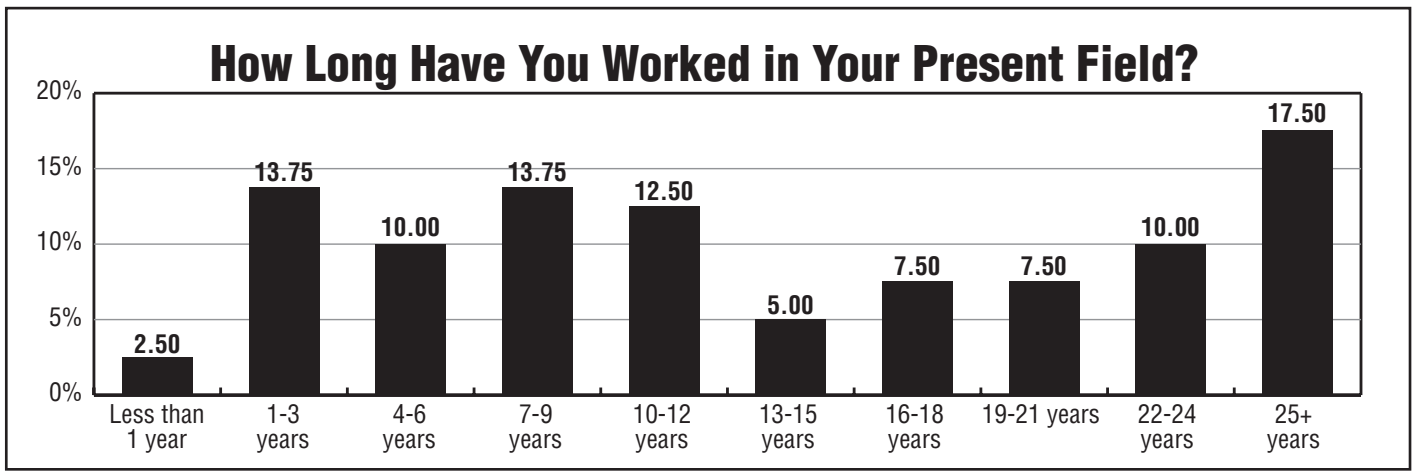
"Surgery centers don't have weekend or evening hours, and the schedule is fairly predictable," she says.

The small staff also give every nurse an opportunity to participate in committees that present recommendations that can affect everyone's job, says Neiderer. "We don't have many standing committees other than quality improvement or infection control, but we do put together committees to study issues as they arise," she says.

Nurses can volunteer for issues that interest them and participate in decision making that affects their jobs, Neiderer says. The addition of new equipment or services, studies of different performance improvement areas, or evaluation of educational opportunities are a few examples of special committees that can be convened. "We also promote a family-oriented philosophy at our center, so if an employee needs a few hours to go to a child's activity at school or a doctor's appointment, we work with the staff person to cover their job for a few hours," she says.

With 14 years experience in outpatient surgery, Neiderer is typical of most survey respondents, of whom more than 57% have worked in outpatient surgery for 15 or less years **(See chart, below.)** "I did, however, have 14 years of experience in a hospital setting before I moved to outpatient," she says. Neiderer's staff nurses also have many years of experience before they move to outpatient because she does not hire new graduates. "We are a busy, small center with no time to train people for surgery," she says. "For that reason, I only hire experienced surgical nurses."

Because administrators want to find out what is important to employees before developing retention strategies, Lee Memorial conducts both



a health systemwide annual employee survey and monthly surveys with employees chosen at random.

"Results of both types of employee surveys show that, regardless of age or experience, salary levels are not an indicator as to whether an employee will stay at Lee or not," says Rigot.

"Salary levels do attract new employees, but our employees say that input into decisions affecting their jobs, resources that enable them to do their job effectively, and the opportunity to grow and develop are the reasons they choose to stay," says Rigot. To address the interest in furthering their education or developing new skills, Lee Memorial offers three types of educational assistance that appeal to senior workers, she points out. "We reimburse tuition for nurses who are going back to school to earn another degree, we also pay for a nurse refresher course for nurses who want to re-enter the work force after time off, and we offer educational grants for one-time courses," she explains.

Senior nurses also like to fill the role of teacher for less experienced staff, Neiderer says. "We have a mentor program that matches an experienced nurse with a nurse who is new to our center or new to a surgical specialty," she says. The mentor works with the new employee to make sure that the new employee is comfortable asking questions and learning a new job, she explains. A mentor program is a great way to tap into the knowledge of senior employees as well as demonstrate respect for their experience, she adds.

As you evaluate your employment options for senior employees, be sure to keep their specific needs in mind, suggests Rigot. "Our senior nurses want meaningful work, the ability to set their own schedules, a position that matches their lifestyle, and the opportunity to maintain benefits," she says. In fact, managers work with senior nurses to ensure that they don't lose Social Security benefits while they work, Rigot says. "We have nurses who are job sharing and must keep track of their hours so that they don't work over the limit allowed for retention of Social Security benefits," she says. "When one of the employees gets close to the limit, managers rearrange schedules to help the employee avoid going over the limit."

It isn't difficult to develop employment options that are attractive to experienced employees, Harris says. "One very important tip is to ask the staff what kind of programs would help them stay in the work force longer," she says. "The answers to this will give you a great foundation to design programs that meet the needs of your staff."

While it is important to look at best practices and identify many different options that are being used by other employers, pick the ones that fit your organization, Harris suggests. **(For ideas from other employees, see AARP link in resource box, below.)** "Not all best practices work in all settings," she says. "Always ask employees what is important to them." ■

RESOURCES

To learn more about recruiting older employees, contact senior placement agencies such as:

- **Experience Works**, an Arlington, VA-based national agency that pairs low-income seniors with employers. Phone (866) 387-9757. E-mail: info@experienceworks.org. Web: www.experienceworks.org.
- **Operation ABLE:** Coaching and referral service; provides counseling to employers interested in retaining and attracting older workers, Boston. Phone: (617) 542-4180. E-mail: able@operationable.net. Web: www.operationable.net.
- **Senior Community Service Employment Program (SCSEP)**, part of the AARP Foundation, helps financially eligible individuals 55 and older remain in or re-enter the work force. Provides training for workers and referrals for employers. National office phone: (202) 434-2020; state SCSEP offices located nationwide. To find a local office, visit the AARP SCSEP web site at www.aarp.org/scsep.

For a free complete listing of AARP Best Employees for Workers Over 50 as well as descriptions of innovative programs, go to:

- **www.aarp.org/money/careers/employerresourcecenter.** Under "Best Employers for Workers Over 50," click on "Honored in 2007."

For more information on low-lift products, contact the following manufacturers:

- **Hovermatt patient repositioning products.** Manufactured by HoverTech International, D.T. Davis Enterprises, Bethlehem, PA. Phone: (800) 471-2776. E-mail: hovermatt@earthlink.com. Web: www.hovermatt.com.
- **Ergo Slide no-lift patient transfer systems.** Manufactured by ErgoSafe Products, St. Louis. Phone: (866) 891-6502. Web: www.ergosafe-products.com.
- **EZ Lift battery/electric patient lifting systems.** Manufactured by Kinetic Concepts, San Antonio. Phone: (800) 275-4524. Web: www.kc1.com**.** For information on EZ Lift, select "bariatric support" in the left navigational bar.