Behind Closed Doors

What the Nurse Executive Should Know About Surgical Services

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Many nurse executives have never worked in the operating room (OR) and are often told they "don't understand" by the surgical services director. Often, nurse executives do not have the surgical background required to make informed decisions about problems associated with surgical services. The authors provide insight into issues that exist in the OR environment and present strategies for improving nurse executives' relationships with the OR staff, management and surgeons.

Operating room nurses comprise a unique breed. To understand them, one must understand the environment in which they practice. In no other hospital unit is there such a variety of physicians constantly present. Seldom does any other unit command the attention of top administration like surgical services.

The OR staff members have more direct access to the administrator than other nursing personnel. The surgical services director frequently enjoys a closer relationship with the administrator than most nursing directors. This situation contributes to the micromanagement that is more commonly found in the OR than in any other nursing unit.

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Personality Traits and Androgynous Gender

When dealing with OR staff, the personality traits of nurses attracted to the OR setting should be considered. Many articles have been published in specialty nursing journals about the "operating room personality." [1–4] Understanding this particular personality is important, especially when communicating with, recruiting and retaining OR nurses. This is especially true when the expense of replacing staff members is determined. It can take up to a year to orient OR nursing staff, and because more OR directors come up through the ranks—it is likely that they will also exhibit these personality traits.

Androgynous gender identity is a male personality type that displays emotional stability, assertiveness, practicality, self-sufficiency and control. This personality type is prominent in the OR environment. Successful OR nurses enjoy their work, and their strong, assertive personalities and self-images allow them to cope with the anxiety-producing atmosphere of the OR. In a well-run OR—this personality predominates.[1] Efforts should be made to select candidates for the OR who exhibit this personality type. This can be done using pre-employment testing with personality tools, such as DISC, Myers-Briggs or similar tools.

However, when physicians behave in an aggressive or abusive manner and there is inefficient scheduling and staff use, staff members often revert to passive/aggressive behavior, and health coping mechanisms fail. The OR then becomes similar to a dysfunctional family, with staff members displaying codependent behavior [2,3] and behavior similar to that of battered women [4].

When these behaviors are identified, the nurse executive should be alerted that the OR is in trouble, even if overt symptoms have not yet appeared. Staff members should be provided with the methods to deal with the excess stress that results from working in a "broken" environment. At the same time, efforts should be made to correct the underlying problems of the systems.

Frequently, OR staff members feel separated from nursing in general. Nurse executives may not make rounds in the OR as regularly as they do in general nursing units, adding to the feeling of isolation. This could be the result of the nurse executive not feeling comfortable "behind the red line."

Nurse executives can overcome this feeling of discomfort by spending a few hours with a nurse in the OR. Displaying a genuine interest and desire to learn about perioperative practices can go a long way toward

developing the trust and appreciation that leads to employee loyalty and retention.

Specialties and Equipment

Not only does the OR nursing staff deal with physicians on every shift, but they also deal with many different specialties. For example, an OR nurse may spend the morning scrubbing for ophthalmology and the afternoon circulating for orthopedics. Even in larger facilities, where nurses specialize in one or two surgical subspecialties, they may work with several different physicians.

Many ORs have implemented a team concept, with a coordinator responsible for several specialties. This allows staff members (nurses and technicians) to be experts in more than one specialty. An extensive knowledge of physician preferences, instrumentation and equipment is required when this organizational structure is used.

In addition, the OR staff members, even in a team configuration, are expected to have a working knowledge of all specialties when on-call. This expectation is somewhat unrealistic in view of the highly technical and rapidly changing OR environment. It is difficult to apply the adage "a nurse is a nurse" to the OR.

Operating room nurses control considerable resources in the equipment they must understand and use appropriately. Failure to do so can result in large repair costs and lost revenue during downtime. For example, endoscopic procedures requiring new and different instrumentation are evolving daily; some facilities now add a staff nurse who is responsible for the maintenance of the new high-technology equipment bombarding the OR. Many services now require the circulating nurse to be a VCR/video expert.

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Call Time

Unlike most nursing units, the OR requires call time for nursing staff. While significantly increasing the earning potential of these nurses, it creates issues such as unpredictable schedules and childcare problems. In addition, many nurses find themselves working through the night and then working regularly scheduled hours the next day—and taking calls several times a week. This can lead to staff dissatisfaction and morale problems. Operating room managers should monitor the staff to determine the effects of this work requirement. Solutions, including creative scheduling, may need to be developed if call requirements lead to staff turnover.

Standards of Practice

Like all nursing practices, perioperative nursing is patient-focused and incorporates the nursing process. This is not always recognized by those outside the OR because of the technical nature of this nursing specialty. This specialty focus will become more apparent as health care reform continues and outpatient procedures increase.

The Association of Operating Room Nurses provides well-defined standards for OR nurses [5] to become familiar with the Recommended Practices and Standards of Nursing. OR Management can help the nurse executive understand the similarities and differences between the OR and other nursing specialties.

Recruiting New Graduates

Most nurses receive no OR experience in nursing school programs; this necessitates a lengthy orientation to this complex area. Orientation length also is affected by the need for ongoing education to keep staff members aware of new technologies. Because of these factors, education costs are higher in surgical services than other units with comparable staffing.

In the past, new graduates were not allowed, much less encouraged, to begin their practices in the OR. This has changed in many institutions. Setting up a postgraduate curriculum to educate and orient new graduates has proved successful.[6] Although initially expensive, such programs can produce dedicated and competent OR nurses.

The Association of Operating Room Nurses' Project Alpha is a program designed to reintroduce OR experience into the nursing curriculum.[7] Nurse executives should investigate the opportunities of instituting this type program, because it will help graduate nurses understand the OR environment and give them an opportunity to make an informed decision regarding OR nursing after graduation.

The OR Management Difference

The OR is different from the general nursing unit or critical care unit because it is seldom a true 24-hour unit. It also has a rigorous call schedule and more direct contact with physicians. The budgets for capital, supplies and personnel usually are larger and more

difficult to control than budgets for other units.

Most ORs do not have 24-hour responsibility for patient care, and they are not always staffed for 24 hours with in-house personnel. When there is a night shift, employees are frequently expected to handle the cases that come in, and they are responsible basically for preparing the OR for the next day. This system can break down if the OR is busy at night and there is no backup staff to prepare for the next day's cases. Delays ensue, which can result in disgruntled physicians. Contingency plans should allow for additional staff when the in-house staff is busy with cases. Second-call teams are a big investment; the OR manager must be able to justify this if it is the backup plan.

Monitoring the performance of both evening- and night-shift employees is sometimes challenging. Other nursing unit managers rely to some degree on the house supervisor to provide input for personnel evaluation. Nursing supervisors often are willing to bypass this area when making rounds, especially if they are required to change clothing.

Another major difference is that most nurses can float to provide assistance to another unit. Because of the unique care provided in the OR, the staff usually has to provide its own coverage, sometimes at great personal cost.

The OR manager must deal with the frustration of nursing personnel called in to perform loosely defined emergency cases at physicians' convenience. Staff members feel that on-call is for emergency procedures only and frequently become angry when called in to perform an obvious elective case. This view is not always shared or supported by the hospital administration. The OR manager must have an understanding of the facility's philosophy and be able to articulate this understanding to the staff to diffuse anger.

Furthermore, although the OR budget contains a larger than average amount of overtime dollars, the indiscriminate use of the call crew for elective procedures can result in the OR manager having to justify excessive overtime. This is further complicated if the same personnel that worked with elective cases all night must work the regular shift the next day. They may feel that they have been abused as a convenience to the surgeon.

When nursing units experience census variation, staff members are usually called off for an entire shift. In the OR, what appears to be a light schedule can increase quickly with add-on cases. Even if staff members finish cases early, often they cannot leave because physicians have scheduled cases after office hours.

OR budgets are more complex than the average nurse manager's budget. Most nurse managers can control capital expenditures without much difficulty. Maintaining control over a budget is a difficult task for the OR manager. The nurse executive or administrator usually has a contingency budget for equipment that was not on the approved capital budget list; however, the OR manager may be responsible for staff education, which can be both extensive and expensive.

The supply budget can be affected by the same phenomenon. For example, when laparoscopic surgery revolutionized general and gynecologic procedures, the supply line item for sutures increased three- to five-fold because of the shift to autosutures. Unless the OR manager was in control of things, the result could have been a considerable variance. Equipment may have been added to the capital budget, but the effect on the supply account may not have been considered.

The OR budget differs from that of other nursing unit budgets in the amount and variation of inventory. It is not unusual to find between 3,000 and 6,000 line items. Also, even with consignment and "just in time" inventory, the OR can have more then $500,000 in stock at any given time. With this amount and variation, many factors can affect the budget after it is set, leading to unforeseeable variables. These were outlined well by Mailhot and coworkers[8] and include such things as the following:

The OR budget differs from that of other nursing unit budgets in the amount and variation of inventory.

- Supplies purchased for one type of technology and not used entirely before the technology becomes obsolete;
- New surgical procedures requiring more expensive replacements;
- Regulatory changes (from the Centers for Disease Control, the Occupational Safety and Health Administration, etc.) that increase the cost of supplies and affect the time required to process instruments or clean rooms, adding cost to the personnel budget;
- Inflation and government trade agreements—the OR generally uses more foreign-made items than general nursing units;
- Excessive repair costs due to improper education of staff on equipment use, or surgeon/employee mishandling;

- Addition of surgeon staff members, requiring increased supplies and equipment not anticipated in the budget process; and
- Unexpected loss of surgeon staff members after the purchase of exclusive supplies and equipment.

Reporting Mechanisms

Surgical services may report through many different channels in an organization. It is not unusual for surgical services to report to the chief operations officer or directly to the administrator. When surgical services reports to the nurse executive, there can be a problem with micromanagement. For example, an angry surgeon seldom stops to talk to the nurse executive, but instead goes right to the top administrator. This reporting error is further compounded when the administrator goes to the OR supervisor. Nurse executives may be left totally out of the loop even though it is their area.

Operating room managers should maintain close relationships with nurse executives and keep then informed as any incidents occur, so that the nurse executive can notify the administrator of the problem before the surgeon. Operating room managers should also be empowered by nurse executives to intercede with the surgeon before the problem is discussed with the administrator. When physicians see their

difficulties resolved by the OR manager and nurse executive, they will be less likely to go directly to the administrator. This changing of communication requires closer relationships between the nurse executive and surgeons.

The establishment of an OR executive committee comprised of the chiefs (or chairs) of surgery and anesthesia, the OR director and the nurse executive can provide a forum that will help the nurse executive understand the language and operations of the OR and foster closer relationships with the physicians.

Conclusions

The OR is a high revenue-generating area that presents many challenges and an equal number of rewards. By becoming more involved with the OR arena, nurse executives can broaden their horizons and gain respect for the unit behind the closed doors.

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