

## Interim OR Managers

### A viable alternative for hospitals

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*Originally published in the AORN Journal, Vol. 52 # 6, December, 1990. © Association of Operating Room Nurses, Inc.*

**T**he consultants arrive at General Hospital after a pleasant flight from St. Louis. They enter through the main entrance of the brick structure and ask directions to the assistant administrator's office. The assistant administrator seems relieved when they arrive. After everyone has settled in the office, the assistant administrator begins to describe the events of the past few weeks.

The former OR director, after a confrontation with the chief of surgery and the assistant administrator, walked off the job a week ago. OR nurses are refusing overtime and as a result, cases are being cancelled. Surgeons are calling the administrator and complaining about poor nursing morale and case scheduling issues. Also, staff are frustrated because supplies for cases are not always available the morning of surgery.

The consultants listen carefully and reassure the assistant administrator that their company has dealt with these issues in the past. An operational review is begun immediately. A full-time consultant is placed on-site to assist with the review and to begin forming strategies for the interim management assignment.

This scenario is a typical situation that consulting firms encounter when placing interim managers. The high vacancy rates for managers at hospitals throughout the United States has made the use of an interim manager during the search for a permanent manager an option for hospitals.

During the past year, we have provided eight interim managers with assignments varying in length from three months to one year for hospitals across the country. Using a consultant is a cost-effective way to provide expert management and ensure success for the new full-time manager because new systems are implemented before the permanent manager arrives. Harvey McKay, in his book *Swim with the Sharks Without Being Eaten Alive*, says, "It's not the employee you fire that haunts you, it's the one you don't."<sup>1</sup> Hiring the wrong manager in a rush could create the same "haunting" results. The interim manager is an excellent solution to fill the need while searching for the right person.

### Role of Interim the Manager

An interim manager provides day-to-day management in the OR. This person is viewed as an expert and is able to facilitate change at a greater pace than most in-house employees. Being a temporary employee enables the interim manager to avoid institutional politics that frequently are present in healthcare facilities. This freedom creates an open environment in which many of the personnel begin to participate by solving long-standing problems.

The interim manager has gained expertise from many different systems and can draw on these experiences to provide unique solutions. He or she can suggest a creative approach that might otherwise be overlooked. Change management and conflict resolution skills assist the interim manager in implementing changes with minimal disruption to the department. An interim manager has:

- excellent interpersonal/communication skills,
- the ability to act as a change agent and implement changes,
- analytical skills,
- conflict resolution skills,
- the ability to delegate,

- the ability to teach and train, and
- self-confidence.

The interim manager possesses the confidence to walk into new situations and immediately assess needs and implement changes based on knowledge and experience. The interim manager must have excellent communication skills to establish credibility with administrators, physicians, other managers, staff and ancillary department personnel.

The interim manager must be able to identify appropriate staff members to whom he or she can delegate responsibilities. This ability allows the interim manager to assess middle managers. The interim manager also may serve as a mentor or facilitator to assist others with upward mobility within the organization. In addition, an important attribute is the ability to train one's replacement.

The interim manager functions as part of the nursing management team. This gives nursing managers outside of the OR an opportunity to benefit from affiliation with a manager who has experience in many settings. Additionally, the interim manager has experience in conflict resolution and change management that the entire group can draw from and apply.

The interim manager also is a working member of the hospital management group. In this role, the individual participates in committees that affect the OR, interacts with the medical staff, and

acts as a liaison between the medical staff and administration. Close ties must be maintained with the chiefs of anesthesia and surgery.

Personnel management is the key duty in the day-to-day management of the OR. The interim manager may develop or revise job descriptions or performance evaluation tools as necessary. Screening and hiring new employees, evaluating and disciplining existing employees, and matching the right person to the right job is handled by the manager as part of the overall assignment. Although an interim manager does not like to be thought of as a "hatchet person," he or she may be designated to cut "deadwood" from the organization. This is an effective way to prevent the new permanent manager from being associated with immediate employee termination.

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## Operational Review

At the beginning of or before an interim management assignment begins, we conduct an operational review. The operational review is a consulting approach to analyzing departmental operations. In addition to the OR, this review encompasses all surgical services including the postanesthesia care unit (PACU) and ambulatory surgery departments.

During the operational review, we conduct interviews with nurses, surgical technicians, surgeons, anesthesiologists, nurse anesthetists, ancillary department heads and support personnel including transporters, technicians and unit secretaries. The interviews include a structured interviewing tool that helps quantify the information obtained. Digression is encouraged, however, to ensure that all issues are discovered. Staff is interviewed in small groups; physicians and department managers are interviewed individually. We use staff surveys to ensure that the same general information is obtained from each group.

We secure pertinent information and establish rapport with the staff to ease our transition from review to interim manager status. These interviews provide an opportunity to explain the situation to everyone involved.

We gather and analyze departmental statistics, including documents containing policies, procedures and chart forms. Usually the forms or formats do not meet the needs of the department and must be updated. Frequently, we streamline chart forms to allow personnel to record information with a minimum of labor.

Interim managers review quality assurance procedures to ensure that Joint Commission on Accreditation of Healthcare Organizations standards are being met, using AORN recommended practices as the foundation. The operational review provides the interim manager with objective data to enhance productivity and address problems.

The key components of the review include:

- Organization

- Job responsibilities
- Staffing and productivity
- Case scheduling
- Staff scheduling
- Materials management
- Instrumentation and equipment review
- Orientation and staff development
- Physical plant review
- Ancillary departmental issues

## Organization

The key element in an optional review is organization. An appropriate organizational chart designed for case volumes is essential to manage an OR successfully.

We have used various organizational designs based on hospital requirements and existing systems. Factors that need to be considered include corporate and local culture, geographic location, economic concerns, staff availability and physician mix.

## Job responsibility

We carefully review job descriptions for all positions and recommend appropriate revisions. Job responsibilities of OR personnel must be consistent with the needs of the department.

## Case Scheduling

Another major aspect of the operational review is case scheduling. Block, modified block, first-come-first-served scheduling, or a combination are choices in case scheduling. Policies and procedures governing the implementation of the chosen system are just as important as the methods used.

Case scheduling is a highly personal issue for surgeons and affects their private practices. Surgeons find it difficult to change the scheduling system. Case scheduling also is an economic issue. The financial officer has a great interest in room utilization and employee overtime. Both of these are affected by the scheduling practices used in the OR. The interim manager can facilitate revision or completely overhaul the case scheduling system. Because an interim manager has experience with many scheduling

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Figure 1  
**Action Plan**  
**Operating Room/Recovery Room**

*Objective: Provide consistent guidelines for nursing employee scheduling.*

Action Steps	Person Responsible	Target Date	Completion Date
1. Develop possible schedules to provide adequate coverage and to coincide with scheduling decisions and analysis of cases by time of day and day of week.	Consultant	12/90	12/90
2. Investigate need for saturday schedule for nurses.	Consultant	01/91	01/91
3. Conduct staff meetings for input.	Consultant	11/90	11/90
4. Have nurses request alternative schedules (i.e., 10 or 12 hour shifts)	Consultant	11/90	11/90
5. Finalize schedule.	Consultant	12/90	12/90
6. Implement			
7. Evaluate, make revisions as necessary.	Consultant	01/91	01/91
8. Provide report to administrator for trauma designation consideration.	Consultant	01/91	01/91
9. Investigate staffing needs for trauma coverage.	Consultant	01/91	01/91
10. Revise schedules for trauma schedule.	Patient Care Manager	02/91	

designs, he or she serves as a consultant as well as a member of the group.

### Staffing

Combining the appropriate number of staff members with a desirable skill mix makes staffing challenging. To determine the appropriate number of staff, the consultant uses proprietary information developed by Higman Healthcare, St. Petersburg, Fla., and comparative statistics based on paid hours per procedure and hours of OR time billed. Formulas are used to determine staffing ratios. Skill mix, use of RN first assistants and types of

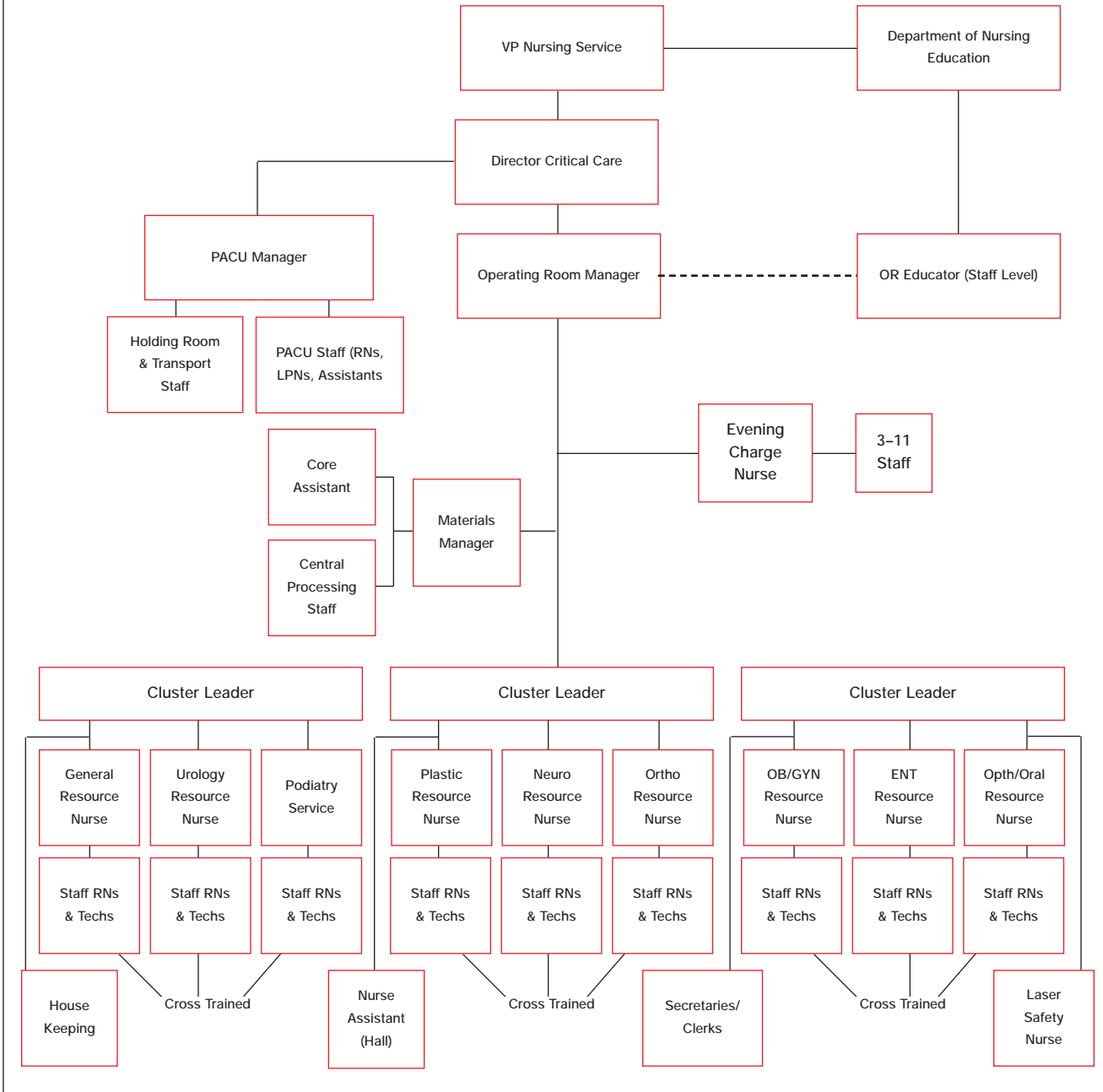
**We apply data concerning the number and length of cases, including start and stop times, and the types of procedures to time graphs to display actual versus required staffing.**

procedures performed are considered before developing recommendations. Benefit time also is taken into account when the interim manager recommends full-time equivalent staff. Frequently, the problem is not too little staff but failure to match case times with staffing schedules. We apply data concerning the number and length of cases, including start and stop times, and the types of procedures to time graphs to display actual versus required staffing.

Staffing patterns for nurses rarely match the case scheduling. As a result, there is too

Figure 2  
**Surgical Services Organizational Chart**

Examples of a revised organizational plan supplied by the consultant.

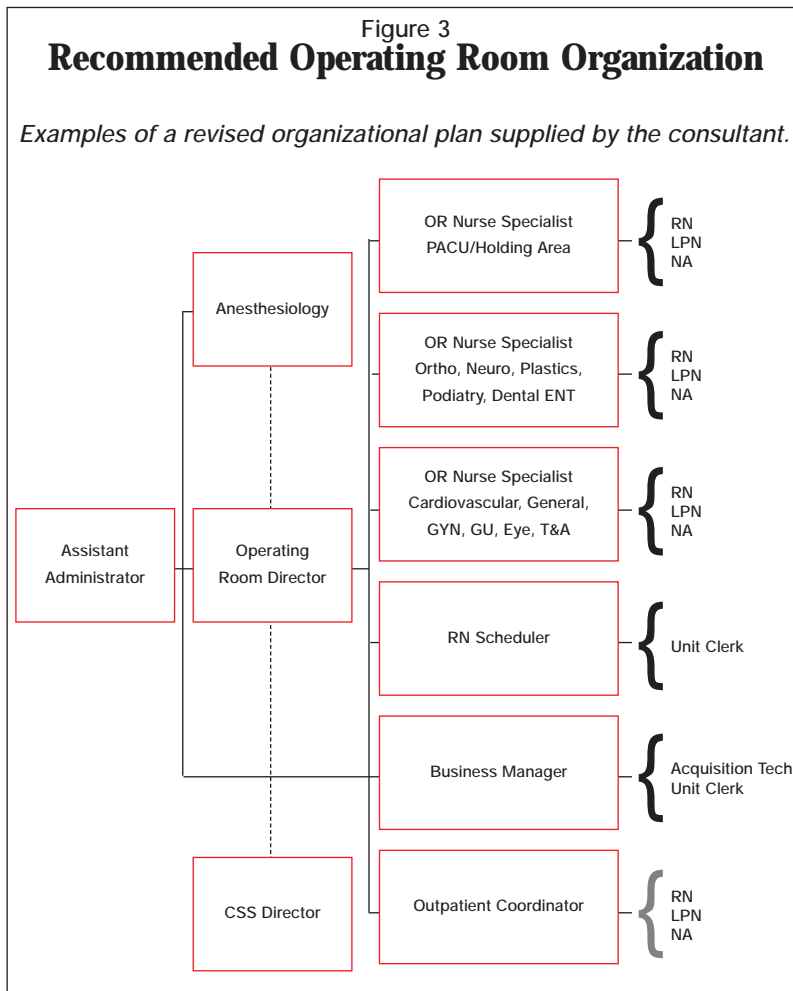


much overtime in the OR, which leads to tired, resentful staff members and decreased revenue. Interim managers consider the options of alternative shift lengths, variable start times and creative scheduling. We evaluate practice patterns for the surgeons, emphasizing later afternoon hours and Saturday scheduling. Any major changes in the scheduling policies and procedures may result in distress

for the staff. Interim managers recognize this and respond appropriately. After staffing requirements are outlined and guidelines written, self-scheduling may be implemented.

**Materials Management.**

Supply and equipment budgets in surgical services expand annually. Without a strong commitment to



inventory control and economical reordering, the hospital might lose revenue and frustrate surgeons and nurses. After materials management needs are evaluated, most facilities employ a fulltime employee position to coordinate this process. When responsibility for ordering is divided among many people, overstocking or understocking can occur.

A computerized system is a plus in establishing economical reordering. Manual systems, however, can be effective if properly designed and implemented. A centralized area to house supplies is helpful in maintaining inventory control. This can be in the central services department if a case cart system is used, or in the OR. A good materials manager can save the hospital much more than his or her annual salary.

### Instrumentation and Equipment

We evaluate the amount, quality and processing of instrumentation. The number of instruments used in a set might be an issue that needs to be addressed. We assess counting methods, methods of decontamination, packaging and sterilization of instruments and develop appropriate action plans if changes are necessary. The changes often include decreasing the number of instruments in sets and updating preference cards.

Equipment and technology are growing at an alarming rate. As a result, methods of product evaluation and standardization of equipment are part of the review. The recommendations should take economic factors into consideration.

If lasers are used in the facility, we recommend that a laser safety officer position be developed with an RN placed in this position. This individual can be an existing staff nurse who continues to function in a nursing role and has knowledge of or interest in lasers. Larger facilities with a variety of lasers might consider this a full-time responsibility.

### Orientation and Staff Development

We evaluate staff orientation and development programs. Who is responsible for orientation and in-service needs? Is there an OR educator position listed on the organizational chart? These answers are obtained by reading orientation manuals, reviewing the current organizational chart and interviewing staff members. The perception of the orientation program given by staff members is considered when we make recommendations. With the expanding high-tech environment, in-service programs are essential.

### Physical Plant

The physical layout is assessed in the operational review. We evaluate traffic patterns and provide recommendations based on the best possible

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application of the existing floor plan. The interim manager might be involved with planning the renovation or new construction of a facility. Because the interim manager comes to the facility with an objective viewpoint, increased options for space use are identified.

### Ancillary Department

Because the OR does not exist in a vacuum, we consider ancillary department interactions during the review. We identify issues and develop recommendations. The interim manager, in conjunction with the ancillary department manager, formulates an action plan to satisfy the needs of both departments.

After completing the review, we present a draft report with recommendations to the administration. After the report is reviewed and changes made, we distribute a final report to other individuals designated by administration. This may include the board of directors, medical staff, middle management groups, OR committees and OR staff.

Recommendations in the final report are formatted into action plans to provide the facility a road map for implementation (Fig 1). Many times these recommendations include solutions previously identified by staff and/or managers, but not given credence by administration.

We use a team approach during the operational review and action plan implementation. As many as four consultants may be on-site at various times. Each consultant represents a different field of expertise including personnel management, clinical expertise, facilities management and financial analysis. In addition, corporate office personnel are available to assist at any point during the consultation of interim manager phase of operations.

### Examples and Outcomes

Facilities hire consultants to resolve problems in the system. Inherent to fixing the problem is change. Samples of changes implemented at client sites follow.

#### Revised Organizational Charts

When appropriate, we have implemented revised organizational charts (Fig. 2 and Fig. 3). This involved developing new job descriptions and performance evaluations, interviewing and selecting personnel to fill additional positions and monitoring new managers.

#### Blueprints

We have reviewed blueprints for new or renovated facilities with the architects. We made suggestions that were implemented in clinical settings.

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#### Case Cart Systems

We designed and implemented new case cart systems. These projects involved coordinating workflow and responsibilities between central service and the OR.

#### Orientation Programs

We restructured orientation programs to include OR personnel in programs provided for other nursing departments (i.e., preceptor training, management concepts).

#### Policy and Procedure Manuals

Policy and procedure manuals were revised according to Joint Commission requirements and AORN recommended practices and standards.

#### Department of Surgery Committees

To ensure input from surgeons, anesthesiologists, anesthesiologists, nurse managers, RN staff, technicians and the material manager, we established surgical services committees.

### Conclusion

The use of an interim manager in the OR is a viable alternative for hospitals. This option allows hospitals time to select and promote a promising candidate from within or to organize a candidate search. An experienced interim manager is able to assess the department, formulate plans and implement needed changes. This sets the stage for the success of the permanent OR manager.

### Reference

1. H. McKay, *Swim with the Sharks Without Being Eaten Alive: Outsell, Outmanage, Outmotivate, and Outnegotiate Your Competition* (New York City: Wm Morrow & Co, Inc., 1990).