Staffing for Efficiency and Satisfaction
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I have no financial disclosure on this topic

Staffing Models

• Evolution of Staffing for ASC
• Traditional staffing models based on patient severity, length of stay, medication administration, separate nursing units
• How do ASC models differ from traditional staffing pattern?
Traditional staffing models

- “Team Nursing” – included team leader, medication nurse, charge nurse, nursing assistant/technicians
- Primary Nursing – one nurse provides care for certain number of patients, including medications, charting, orders
- State by State staffing guidelines – outline expected number of patients per staff nurse & technician/nursing assistant, varies with individual state board of nursing

Where are we now?

- ASC staffing changed these traditional models
- Hospital based models based on needs of the patient care units, levels of acuity of patient care, type of nursing unit
- How are ASC needs different – staffing for preop, pacu, OR, laser suites, front desk reception & billing office all within the same facility
- Staffing not only includes nursing and technical staff but may include coders, billers, medical records, front office receptionist

ASC needs

- Rapid patient admission and discharge – how does that affect staffing in those areas
- Fast surgical case turnover – what is the case mix, what is the staff mix
- Block time vs open scheduling – newer facilities may not have well established block time which allows for easier staffing
- Very busy facilities may need to consider staggered shifts to cover high case loads
ASC staffing addresses the needs of patients, physicians and facility staff

- ASC models may include outside providers who are not your staff members (AHF/credentialed staff)
- Each individual center is an entire entity – staffing, payroll, human resources, governing board

**Now how do we meet the needs?**

- Staff mix – determine which tasks can be done by various personnel – RN, LPN, nursing assistant, ophthalmic assistant, scrub technicians
- Think “outside of the box” with traditional roles
- Outline all of your daily tasks and how best to accomplish them
- What is your case mix, when are you busy/slow?
  - What are your special considerations

**OR needs**

- State laws require an RN to circulate in the OR
- Each OR = RN
- Minor Room = RN
- Femtosecond Laser Suite = RN
- SLT / Yag Laser Suite = RN
- How busy is your laser suite – can 1 RN cover both laser suites?
- How busy is the minor room – can 1 RN cover laser suites and minor room?
OR staff

- If 1 nurse covering both laser suite and minor room are the rooms in close proximity
- If 1 nurse is covering each room is there downtime for that staff member to do other tasks – i.e. post operative phone calls, peer review, pre operative assessments
- Your number of rooms total will give you a starting point for required RNs in those areas

Technicians

- What tasks do your technicians do?
- If you have 2 adjacent ORs how many technicians would you need for quick case turnover?
- Cross training for technical staff for OR, femtosecond laser suite, preoperative and postoperative areas
- What is your mix of staff and credentialed practice staff?

Efficiencies

- Credentialed practice staff can scrub for cases with their surgeons
- Credentialed practice staff can provide postoperative instructions and assist with preparation for discharge
- How does this help with satisfaction and efficiency?
- Surgeons are happy, allows more flexibility with your center staff
- Practice is reimbursed for the cost of their staff – remember to include those costs in your total budget for staffing
Pre and Postoperative Considerations

- How many preoperative and postoperative beds?
- Consider your block time, needs may vary from day to day
- What is the case volume and type of procedure
- Cataract procedures – rapid turnover
- How does Femtosecond laser affect your flow
- How does case mix affect your staffing – i.e. retinal procedure, glaucoma or combined procedures?

Staffing

- Cross training is key
- Staffing mix allows for better utilization
- Preop – try a 2 man team approach, charge nurse for pre/post to handle flow issues etc.
- Technicians can assist with admission and discharge – assist with positioning, connect to monitors, review post op instructions, provide refreshments, assist patient to auto

Mix it Up

- Preop – for each 3 beds try 2 teams – can be RN/RN or RN/technician
- Pacu – may be required to have 2 staff members, varies by state, always a best practice for patient safety
- PACU – may use combination of credentialed AHP or facility staff, RN/technician team works well
- Staffing will depend on surgeon’s routine – any postoperative medications, how fast do they turn over, case volume and mix.
**Pearls for Satisfaction**

- Cross Training a must for all areas
- Effective staff mix for your own center
- Staff involvement in scheduling – have you tried “self scheduling”
- Attempt to meet staff requests, not always possible but goes a long way
- Use of per diem and part time staff – what works best for your center

**Best Practices**

- Staff are assigned in and estimated out times each day
- Check timecards daily and hold staff responsible for timely arrival and departure
- Managers should be involved in staffing, lunch relief as needed – closer connection with staff
- Cross train wherever possible – important for sick calls or emergencies

**What does your staffing impact?**

- The obvious answer is patient care, but what else is affected?
- Budget considerations – staffing comprises 20-22% of your budget expenses
- Patient safety – poor staffing has been shown to impact wrong site surgery, increased infection rates, increased patient falls
The Joint Commission has shown that the most frequently cited root cause for sentinel events is “human factors.”

Those factors include staffing levels, skill mix, competency assessment and fatigue.

Poor staffing leads to poor staff morale, physician dissatisfaction, increase error and lower patient satisfaction.

What has worked for us

- Per diem on set days, can call off if not needed
- Flexible scheduling depending on volume - full-time staff work 3 or 4 days/week – aware that might be adjusted for busy times
- Split shifts for heavy volume days, “Snow birds” or closing for inclement weather

Are we happy yet?

- Have you considered “self scheduling” – staff feel that they have more personal control
- Satisfaction for Patients, Staff and Physicians
- Every changing and Evolving – discuss, innovate, try and try again
- Don’t forget reception and business ops
Some final thoughts

- Staffing and personnel issues remain the most difficult area of management
- Scheduling is never stagnant, it is always changing, don't be afraid to try something
- Involve management and staff in making major staffing changes
- Take a break, reassess and try again!

Thank you