Background

Staffing in a perianesthesia unit is a continuous challenge with an ever-changing surgery schedule. An off-site surgical hospital for a large academic medical center previously had separate pre-operative and post-operative units. With the opening of a new hospital in 2018, a zone staffing model was used to implement a blended perianesthesia unit.

Methods

The Unit Coordinator and Educator shadowed other blended perianesthesia units within the system to evaluate their processes. A new zone staffing model was designed to meet our unique patient population, as well as the physical layout of the new unit. This unit has 24 bays with the capacity to staff up to four zones. When making the daily staffing schedule, zones are clustered together by surgeon/OR. There are 8 operating rooms at the location. The assignments are made in such a manner to decrease overall staff footprint and utilize Lean processes.

Considerations when making assignments:

- Number of first starts
- When cases are scheduled to end
- Type of anesthesia (general vs. MAC, and/or regional, or local only)
- Will a block be done preoperatively
- Outpatient vs. inpatient cases

Latest scheduled staff members are assigned to the zone with the latest scheduled patients out of the OR. As needed at the end of the day, the zones condense to one zone, allowing for cost savings with everyone blended we no longer keep two nurses in prep for one patient and two nurses for one patient in recovery, staffing can be adjusted where two nurses can cover the two patients.

An in-depth analysis on unit staffing budget impact has not yet been completed. However, hours of operation have increased without the need to increase FTEs.

Conclusions

Competency in all aspects of perianesthesia care has increased nursing proficiencies and improved delivery of patient care. Clustering of physicians and nurses by zones has enhanced the ability to respond to changes in the surgical schedule and prevented surgical delays. The same pre/post staff and OR staff work together for continuity of care through the day. Despite the magnitude of these changes, all members of the interdisciplinary team have embraced the zone staffing model and Press Ganey outpatient scores have sustained above the 90th percentile.

Zone staffing increases nurse autonomy, providing an opportunity for bedside nurses to use critical thinking and problem-solving skills. Zone staffing also promotes accountability, teamwork, and inter- and intra-professional communication, as members of the zone are accountable to each other in real time. Increased nurse autonomy and improved accountability, teamwork, and communication yield better patient experiences.

Assigning zones by OR has been largely successful as most times the patient can return to the zone postoperatively that they were prepped in. This decreases potential hand off issues with the continuity of care.

OR holds have essentially been non-existent since implementing the blended unit as staff has been able to adjust assignments within their zone while adhering to ASPAN staffing standards.

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