Strong leadership, meticulous auditing, and close followup are some factors that have kept Baptist Hospital of Miami, Florida, in the top 10% of performers in the Hospital Quality Incentive Demonstration. The demonstration, conducted by the Centers for Medicare and Medicaid Services and Premier, pays hospitals a little more for meeting quality indicators (related article).

The hospital, part of nonprofit Baptist Health South Florida, has 18 ORs and performs about 15,500 to 16,000 surgical procedures a year.

In Year 2 of the demonstration, Baptist Hospital scored from 94% to 100% on all 5 measures for total hip and knee replacement. Preliminary data from Year 3 showed it was at 98% or 99% on discontinuing the antibiotic within 24 hours after total joint surgery, a measure many hospitals have found difficult to meet.

It’s taken persistent effort.

“These measures are difficult to hardwire. There are a lot of details to these processes. It didn’t happen overnight,” notes Michele Ryder, RN, MSHSA, vice president, who was previously director of surgical services.

Here are some strategies Baptist Health’s leaders have found to be effective.

Stay ahead of the curve
Read constantly. Keep an eye out for new evidence on surgical quality, they suggest.

“We started early—that’s the key,” says Ryder. She and the director of perioperative services, Patti Waisbrot, RN, MSHSA, stay abreast of the literature and try to anticipate new quality measures. They have already begun auditing compliance with the perioperative beta-blocker protocol. Baptist began adhering with appropriate hair removal well before it was accepted as a quality measure and has achieved 100% normothermia for surgical patients.

“The evidence-based measures give you a target to shoot for,” Ryder adds.

Thinh Tran, MD, corporate vice president and chief quality and patient safety officer for Baptist Health, adds: “There are more indicators out there all the time. You need to stay ahead in understanding the indicators and prioritizing them. You need to help the staff build on them so they are not overwhelmed.”

Make PI a way of life
“Performance improvement has to be alive and well in your department,” Ryder says. Baptist Health won the Sterling Award, Florida’s version of the Malcolm Baldrige Award, several years ago.

“That put us firmly on the road to performance improvement,” she says.

Once managers and staff get used to the PI approach it becomes the way they tackle any project, even one as simple as moving a bed space. PDCA, or Plan-Do-Check-Act, is their PI model.

Get staff and physicians involved
“Your employees have to be as well trained in performance improvement as you are on the management team,” Ryder notes. “We have a philosophy of advocacy and evidence-based practice. We all have pride in what we do.”

A lot has to do with how a change is presented to the staff, she adds.

“If you present something as different or new, it can be perceived as negative.” She finds it helps to say to the staff, “This is how you would want your mom or dad to be treated. That is how we want care to be delivered for everybody.”
Plenty of education and coaching are provided. Once the learning curve is completed, the staff are held accountable for following protocols.

The physicians, she says, “are collaborative, from our chief of surgery on down.” If audits show stragglers who aren’t following protocols, Ryder and Waisbrot meet with them to reeducate them. If necessary, the issue is reported through the medical chain of command.

**Make it easy to do the right thing**

“Do as much templating and standardization as you can,” Ryder suggests.

For total joint replacement, for example, the hospital uses preprinted preop and postop antibiotic order sheets so it is easy to order the right one. The orders provide for 3 doses, not to extend beyond 24 hours. The policy on discontinuing antibiotics at 24 hours is now included in orientation for new staff nurses on the nursing units.

The time of the preop dose and surgery end time are documented on the postop order sheet. “That way, the pharmacy knows when they receive the order how to time the doses to avoid going over the 24 hours,” Waisbrot says.

For total joint cases, the antibiotic is given in the OR by the anesthesiologist. This allows for any delays that might prevent the drug from being given within the recommended 1-hour window before the incision. For most other cases, the antibiotic is given in the preop area by the RN.

The antibiotic is included in the timeout before the surgical incision. For example, the circulating nurse says, “The antibiotic was administered at 7:35.” The time is also written on the whiteboard in each OR.

**Audit incessantly**

“Once you make a process change, you have to audit it incessantly,” Ryder says. Baptist Hospital has an internal surgical services audit and a hospital audit.

Surgical services auditing and reporting are manual. For each procedure, the preop documentation is matched with the OR record to see when the antibiotic was given and when the incision occurred. The auditing is reviewed every day.

“We can immediately identify a breakdown and follow up quickly,” notes Dr Tran. “The data has power with the physicians,” he adds. Though the auditing is painstaking, the data is important when having discussions with physicians about accountability. It also tends to bring out their competitive instincts.

“You can look at the data and say, ‘You know, everyone is doing their part, but you’re not. Here’s the evidence that could potentially impact your patient,’” Dr Tran says. That helps to drive the process forward.

**Keep an eye on the dashboard**

With so many measures to monitor, it can be easy for compliance to drop off.

“You can’t allow it,” Dr Tran stresses. “You have to make it part of your staff meetings.”

Baptist Health includes the quality measures on its management dashboards, which are reviewed monthly. The data also goes to Premier where it is audited independently.

“When we find an error occurred, we are talking to the staff immediately,” he says. “It’s always in the front of everyone’s mind.”

**Improving the process for total joints**

Other steps have been taken to improve the process and outcomes for total joint replacement:

**Peripheral nerve blocks.** Nerve blocks are now being used for total joint patients rather than epidurals or spinal blocks.

“That was at least a 6-month learning curve because we had to get our whole anesthesia team involved,” Ryder notes. But the blocks have improved patients’ pain control, ability to start physical therapy earlier, and length of stay.

“It’s decreased our DVT rate as well,” she says, referring to deep vein thrombosis.

**Patient flow.** To improve patient flow, the surgeon sees 2 patients at a time in the preop area. The surgeon talks with each patient, reviews the informed consent, and
marks the surgical site. The first patient then goes to the OR while the second patient is having the nerve block administered.

**Preop showers or baths.** Patients are instructed to take 2 preoperative showers with the antiseptic Triseptin, one the night before and one the morning of surgery. Inpatients are bathed by the nursing staff. Surgical site infections are down by 37% since the baths and showers were started, Ryder notes.

**Normothermia.** Patient temperatures are monitored by tracking temperatures closely, keeping patients covered, using warming blankets and warmed IV fluids, and not using alcohol-based prep solutions.

“We make sure 100% of our patients are normothermic,” says Ryder, not only those having total joint surgery or colorectal surgery, which is what the original measure called for.