Safer Surgery: The preoperative testing process

Ten elements of safer surgery. The third in a series, this article focuses on presurgical evaluation.

Making sure patients have the appropriate preoperative preparation, including testing, is necessary not only for patients’ safe care but also for a smooth process on the day of surgery.

Advocate Health Care, a Chicago area system, has standardized preop testing requirements and the patient history form for 9 of its hospitals to help streamline the process. The preadmission testing (PAT) is one of 10 components of Advocate's Safer Surgery program (sidebar).

The project was led by David Young, MD, director of preanesthesia testing, and Cindy Mahal-van Brenk, MS, RN, CNOR, executive service line director for surgery at Advocate Lutheran General (ALG) Hospital in Park Ridge, Illinois. Dr Young is also a consultant with Surgical Directions.

ALG performs about 12,000 procedures a year in its main OR and 6,000 in its ambulatory surgery unit.

In developing its preoperative program, ALG strived to achieve what Dr Young terms “the ideal PAT state”:

- Patients are preregistered by phone within 24 hours of surgery scheduling. As soon as patients are preregistered, they are triaged for PAT.
- Patient charts are completed 3 days prior to surgery as a goal.
- The patient history tool is standardized in the patient record.
- Lab and ECG testing is conducted on site in a location convenient for patients.
- Testing is determined according to standardized guidelines based on the patient’s condition and complexity of surgery.
- Guidelines are established for lab and ECG results that will be considered abnormal.

Here’s a look at each step in the process.

Registration and triage

As soon as the hospital receives a surgical scheduling request, the patient is preregistered by phone, and the procedure is given an encounter number, allowing the nurses to document in the record.

When scheduling, surgeons’ offices must fax a standard form with certain required information, such as the patient’s diagnosis, the procedure, and any comorbidities. (See February 2013 OR Manager. The form is available in the OR Manager Toolbox at www.ormanager.com.)

The registration department contacts the patient to set up a phone screening or in-person appointment. The decision for phone screening or an appointment is primarily the surgeon’s choice. Patients who are admitted and do not have a primary care physician on staff are assigned a hospitalist, who will see them in PAT.
**PAT guidelines**

ALG prefers that surgeons and primary care physicians delegate preop testing and evaluation to its PAT department. Many physicians do so because it streamlines their process and helps ensure that a case won’t be canceled because the patient wasn’t evaluated according to the appropriate guidelines.

“A primary care physician doesn’t want to lose surgeon referrals by not having patients properly prepared for surgery,” Mahal-van Brenk notes.

**Preop appointments**

About 20% of ALG’s patients are seen in person before the day of surgery. The PAT unit is located on the first floor with valet parking available, and testing is performed at that location.

The PAT department has 2 sections. The preop evaluation unit where patients are seen is staffed by experienced RNs and hospitalists. Charts are assembled and preop phone calls are made in a separate office. The unit is staffed by 7 RNs.

**Meeting the 3-day goal**

Meeting the goal of having patients’ charts prepared 3 days ahead of surgery requires coordination. Documents are managed electronically using fax-filing software to avoid having to manage paper forms.

“When a patient’s information comes in, it goes into the patient’s chart—an electronic file folder—by day of the week they are having surgery,” Mahal-van Brenk explains.

Nurses review lab results and other information as it comes in, referring to guidelines for abnormal test results.

If a finding is abnormal, it is immediately sent to the primary care physician or to one of the hospitalists as the first line of triage.

If information is missing 3 days before surgery, nurses contact the office. Mahal-van Brenk instructs them to communicate directly with the physician or the physician assistant rather than leave a phone message. Text messaging can be helpful.

**Daily huddle**

Missing information is also addressed in the daily huddle held to review the next day’s cases. The huddle, attended by representatives from anesthesia, nursing, PAT, and sterile processing, reviews the schedule, chart completeness, and other preparations needed to make sure surgery proceeds safely and smoothly.

“If a chart is incomplete, we usually make a call [to the surgeon] to say it can’t be the first case,” she notes.

If an office has a pattern of incomplete charts, Mahal-van Brenk follows up herself, contacting the office and meeting with the staff if necessary. She also takes time to meet with new office staff.

“We meet one on one to get them on board and explain the process,” she says. “That builds relationships, and they have a resource to ask questions. That one-on-one time is key.”

**Achieving consensus**

Because the Advocate hospitals have worked together on multiple projects, a process was established for developing consensus on preop testing and evaluation guidelines. The guidelines were developed by a team of nurses and anesthesia providers who examined current standards and best practices, Mahal-van Brenk says.

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**Ten components for safer surgery**

The components of Advocate Health Care’s Safer Surgery initiative:

1. Perioperative governing body
2. Single path for surgical scheduling
3. Preanesthesia testing (PAT) with standardized protocols/hospitalists
4. Document management system for scheduling and PAT
5. Excellence in sterile processing
6. Crew resource management
7. Implementation of a critical safeguards checklist
8. Daily huddle
9. Error reporting
10. Just culture
Having a project manager is essential when conducting a project across multiple facilities, Dr Young stresses, adding that this role can’t be performed by a person who already has another clinical or management position. “Someone has to own the process who doesn’t also have a full-time position in their own facility.”

**Communicating with MD offices**

To make sure all of the physician offices were familiar with Advocate’s preop guidelines and the expectations, Mahal-van Brenk and Dr Young met with them directly.

In the meetings, “We let them know what we were doing, why we were doing it, and explained the hospitalist model.

“The hospitalists help them postoperatively,” she points out, “because they follow their patients in the hospital, managing their diabetes, resuming blood pressure medication, and so forth.”

—Pat Patterson

Previous articles in the series focused on OR governance (January 2013) and safer surgical scheduling (February 2013).

Mahal-van Brenk and Dr Young will present an all-day seminar on the 10 components of Safer Surgery at the OR Manager Conference September 23-25 at the Gaylord National Resort in National Harbor, Maryland. www.ormanagerconference.com