Three-part strategy suggested to improve patient throughput

Efficient throughput—difficult to achieve, yet essential to long-term financial success—is a Holy Grail for OR nurse leaders, who spend much time and energy seeking it. Given all the demands of their role, how can leaders best use their time to gain the most benefit from throughput initiatives? One method is to focus on communication—the underlying component of any successful throughput effort.

But leaders need to narrow the broad topic of communication to be most effective. “You have to pick something specific to work on,” says Randy Heiser, MA, president and CEO of Sullivan Healthcare Consulting, Inc, in Ann Arbor, Michigan. “Too many people try to do everything at once.”

Three strategies to improve communication are building trust, implementing technology, and using checklists effectively.

Trust
In the frenetic perioperative environment, it’s easy to forget the basic principle that good communication depends on trust. “The only way I’ve found to build trust is to hold everyone accountable for doing their job,” says Heiser. Otherwise, staff will waste time checking the work of others. For instance, if an OR circulating nurse discovers the preoperative area nurse hasn’t ensured the patient’s most recent lab work is in the medical record, the circulator will feel the need to check for this with every patient. “You create an environment where the circulator does everything the preop nurse was supposed to do, adding as much as 15 minutes to the case,” Heiser says.

Another way to create trust is to bring departments closer together by rotating staff. “Have a circulator in the OR spend 1 day every 3 or 4 weeks in the preoperative area, or have surgical techs spend a day in instrument processing,” Heiser suggests. This low-cost initiative encourages team members to identify ways to ease the work of others. For example, a surgical technologist may realize he can easily organize used instruments in a way that speeds cleaning.

Using the team specialty model can also build trust. You might choose to have a core group of preoperative nurses focus on orthopedic patients. These nurses can then work with orthopedic OR staff, creating a longitudinal team. “Use the team concept in the PACU [postanesthesia care unit], preop, and instrument processing,” says Heiser, adding that instead of having all sterile processing technicians work on all instruments, subspecialties such as orthopedics should be created to further build connections across departments.

The challenge of these types of initiatives is that it can take more time to manage staff. “Now I have to be sure to schedule people to fit the service they work on,” says Heiser. “It can create a scheduling nightmare.” Yet the additional time invested in these efforts can pay off in improved throughput—and better patient outcomes.

One way to minimize scheduling challenges is to be sure everyone is competent in procedures that are done on an “on-call” basis, so specialization doesn’t extend to this area. Heiser points out that the number of on-call procedures is limited.

A final, yet vital, advantage of holding people accountable is that, Heiser says, “You can more easily see where the system is broken.”
Technology
Technology can be a useful tool for improving throughput. Matthew Boles, MD, MSc, interim clinical leader for surgical services at Salem Hospital in Salem, Oregon, says the hospital uses large computer monitors in the OR, preoperative area, special processing department (SPD), and PACU to provide staff, managers, and physicians with “real-time data on how we are doing with various metrics.” For example, by 8:30 am, everyone knows which ORs started on time. Those in ORs with low turnover times can claim “bragging rights” at the end of the day for a job well done.

“It’s fun for everyone to see the data in real time,” says Dr Boles. “We can express appreciation and offer rewards, too.” For instance, those who do well might receive a gift card for a cup of coffee.

Nurse managers, with some input from anesthesiologists, decide what is posted on the monitors, which can be customized for departments. The SPD monitor, for example, includes the number of days since a report of a dirty instrument. Information on the monitors has included start time, turnover time, adherence to surgical care improvement project (SCIP) metrics, and unit productivity.

Dr Boles knew that staff and others appreciated the monitors, which have been used since 2009, when they were temporarily out of action because of a computer project. “It’s a testament to the monitors that people missed them,” he says.

OR staff at Salem Hospital also use technology to save time by cueing other departments. When a surgery is nearly complete, the circulating nurse “hits a button on the telecom system to alert PACU and the preop area,” says Dr Boles. This saves a phone call, while giving PACU time to prepare to receive the patient and the preoperative area time to transport the next patient to the OR. The PACU nurse receives a report from the anesthesiologist.

Nurses also use portable phones to send a group text message to those who need to know when the room is ready for turnover, which saves more time. For instance, environmental services staff don’t have to wait outside the room for the procedure to finish so it can be cleaned.

Checklists
“Checklists can get stale, repetitive, and boring,” says Dr Boles. “We try to make it interesting by focusing on safety and the real reason for using the checklist.” Salem Hospital has taken checklists to new heights, using them at key points in time—during scheduling, the day before surgery, and the day of surgery.

“We have robust presurgical screening,” Dr Boles says. Physician office staff must complete a checklist and fax it to the scheduling department before they can schedule a case (see checklist on p 11). He says getting office staff to use the checklist “was a hard sell. We let them know that getting the information in a standardized fashion lets them use their block time more efficiently.” It also helps reduce the likelihood of cancellation because of failing to obtain insurance preauthorization. “We gave office staff input into the development process so they would feel ownership,” adds Dr Boles.

Each day, key stakeholders, including representatives from “every area where the patient will be touched,” meet in a “huddle” and use a checklist to focus on the next day’s cases. “It’s one last time to make sure all our i’s are dotted and all our t’s are crossed,” Dr Boles says. The 15-point checklist covers critical areas such as whether a patient is a Jehovah’s Witness and whether blood is ordered.

On the day of surgery, nurses in the preoperative areas complete a checklist on the computer and use a handoff tool for communicating with the anesthesiologist
and OR staff. Staff in the OR use 3 main time-out checklists:

- **Preinduction.** The circulator and the anesthesiologist complete this checklist, which includes the patient’s American Society of Anesthesiologists score and critical information such as whether suction is available.
- **Immediately before the incision,** which includes site identification.
- **At the end of the case,** but before the patient leaves the room, which includes blood loss and any anticipated problems.

To encourage participation, Dr. Boles says OR leaders involved surgeons in the decision process and added a surgeon champion. Noting the value of humor, he adds, “We also did a funny video to launch the last revision of the checklist.”

Heiser recommends that staff sign checklists so they can be held accountable. If during the time-out, for example, it’s discovered that a laboratory report is missing, the circulator must speak up and then contact the staff member who signed the checklist. “You only have to do that once or twice before it takes hold,” he says. Keeping track of problems can also help identify larger issues. For example, if the OR is always waiting for someone to check an ECG, perhaps a change in process is needed.

Checklists are also embedded in perioperative services at Jefferson University Hospital in Philadelphia. The hospital system, which consists of 58 ORs in 3 hospitals and a surgicenter and performs about 35,000 cases each year, collaborated with the Joint Commission Center for Transforming Health Care to audit their procedures related to preventing wrong-site surgery.

An audit in which consultants observed the use of a surgical checklist in the OR found that although staff were compliant in using the checklist, “there was a wide range of how people were doing the process despite receiving training,” says Monica Young, DNP, MBA, RN, CNOR, vice president of perioperative services. She adds that it’s important to “watch people live to see if they are doing what you want them to do. Often that is where you fall short.” A 2013 study of 107 OR staff supports Young’s point: It found a “lack of rigor” when it came to applying the surgical checklist.

In response to the findings, Young identified a core group of about 8 people...
who used the checklist correctly and had them serve as trainers during cases. For 1 month, the trainers, who included charge nurses, managers, and a physician, watched the time-out and modeled the appropriate behavior when the process wasn’t conducted according to set standards. “They were third parties who could correct behavior without having to then be in the room all day with those whom they had corrected,” says Young.

Young adds that the audit also found that “nursing was carrying too much of the responsibility for the checklist.” Surgeons, anesthesiologists, and nurses had to learn their specific responsibilities based on their roles.

Other best practices
At Jefferson, the staff in the holding area and the anesthesiologist implemented a handoff communication tool to ensure needed information was in the patient’s medical record. The tool decreased the number of times information was missing and “both staff and anesthesia felt it promoted a meaningful dialogue and made communication more structured,” says Young.

The team also holds a “mapping” meeting each day at 1 pm to discuss the next day’s schedule. Attendees include Young; managers for the OR, SPD, preadmission testing, and holding area; and the nurse specialty team supervisors. Before the mapping meeting, staff in preadmission testing enter missing information into a database and run a report that the team reviews. The team addresses problems such as missing consents or laboratory test results and discusses other factors such as needed equipment and staff experience with complicated procedures.

Leadership commitment
As with most change in the OR, nothing can happen without strong leadership.

“When communication works well, jobs get easier, but you need an effective governance structure to make good communication happen,” says Heiser. He adds that such a structure “starts at the top. You need strong surgeon, executive, and nursing leadership and commitment.” The structure should focus on the right outcomes, including quality care, improved customer service, and increased case volume. Heiser suggests that with every decision leaders ask themselves, “How will this decision contribute to these 3 goals?”

He adds that leaders should establish the metrics to be measured and evaluated so that “people aren’t working on their own metrics.”

Of course, involving the right people is key. “If we get all the stakeholders together, that’s when we succeed,” Dr Boles says.

—Cynthia Saver, MS, RN

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