Perioperative services overhaul proves effort is worth the time

Getting a zero deficiency rating on a recent Joint Commission survey and bringing sterile processing in house are 2 of many improvements made at MedStar Georgetown University Hospital over the past decade.

When Frances Baldwin, MBA, RN, assistant vice president of perioperative services, joined the hospital 11 years ago, Georgetown had recently become part of the MedStar Health System, and a redesign of perioperative services was desperately needed.

“There was no perioperative organizational structure in place. There was 1 perioperative director with limited resources and support staff. It was a difficult situation,” says Baldwin. “I saw that there needed to be an organizational structure within perioperative services—without that, it would be difficult to fully evaluate all of the operational, safety, performance, and financial issues and make the necessary improvements.”

MedStar Georgetown, a 609-bed acute care teaching and research hospital in Washington, DC, is 1 of 10 MedStar Health hospitals in the Maryland and Washington, DC, area.

Starting from scratch

The assistant vice president for perioperative services was a new position, and thus Baldwin was able to start from scratch. She perceived several critical needs:

• Sterile processing was outsourced, and there were a lot of operational inefficiencies and clinical issues as well as staff and surgeon dissatisfaction.
• Perioperative services had about 65% agency staff, with no clear recruitment and retention plan to improve staffing.
• The main postanesthesia care unit (PACU) was slated for renovation, but much planning was needed to move the project forward.
• An organizational structure along with policies and procedures for perioperative services had to be created.
• A financial plan was needed to manage revenue and expenses, particularly labor and supplies.

“The whole hospital was in a turnaround mode, and it was a challenging time,” she says. Baldwin’s goals were to figure out the best way to organize the various departments, build relationships with physicians and associates, and get buy-in from top leadership.

“I spent the first couple of months in all of the areas assessing the major issues. I began to develop an organizational structure that would work well and a proposal to get the critical leadership positions approved. During the time it took to recruit for roles such as an OR director, a pre- and postoperative services director, and an SPD [sterile processing department] director, I had interim people in place,” she explains. “At the same time, the SPD project was going on. That included developing a business plan to purchase instrumentation, develop a staffing plan, gain approval for the positions, recruit, and hire.”

The PACU design was also underway, and this project needed further review to ensure sound financial management and participation from all the key stakeholders.

“I had to do all of those things somewhat simultaneously,” Baldwin notes.
Establishing an SPD

“Outsourcing sterile processing functions can work, but it wasn’t effective for MedStar Georgetown at that time,” Baldwin says. Significant delays, inefficiencies, and other operational concerns occurred daily.

“We shared data showing number of trays processed and number of complaints from physicians, and we explained why a functioning SPD is essential to a smooth-running OR,” she says.

Hospital leaders were persuaded; they bought 55,000 instruments and hired a director as well as 45 FTEs. Bringing the SPD in house allowed for much greater control of a high-risk operation. Results include immediate-use steam sterilization rates in the 1% or less range monthly.

Increasing understanding

When Baldwin joined the hospital, there was a lot of momentum to improve the perioperative departments. “In some respects, the budgeting process was more straightforward at that time,” she says. In addition, the chair of surgery was a very helpful partner.

Elements to consider in preparing for a Joint Commission survey

Answering the questions below helped MedStar Georgetown staff prepare for Joint Commission surveys.

- Know the current National Patient Safety Goals and how we meet these goals.
- In this area how do you assure patient safety?
- What performance improvement measures are being reviewed in your area?
- What are some of the performance improvement projects being done in perioperative services?
- How do you communicate with non-English-speaking patients?
- What would you do if you suspected that a patient (adult or child) was the victim of abuse or neglect?
- How would you get information about chemicals or other agents used in your area?
- Do you have fire drills?
- What is the evacuation plan for your area?
- Where are pain history, nutritional screening, and functional screening documented?
- When is pain reassessed after an intervention in perioperative areas?
- Where is the nursing plan of care documented, and what do you do to meet these goals?
- Where can details about the Emergency Operations Plan and Emergency Preparedness Communication Center be found?
- Who in the hospital needs to know these codes besides staff?
- How are emergencies and clinical codes communicated throughout the hospital?
- How does the hospital evaluate effectiveness of disaster plans and clinical codes?
- What team members are required for oxygen valve shut-off in perioperative services?
- When is medication reconciliation initiated in perioperative services?
- Where are your policies kept?
- Please practice finding and reviewing policies.
- Date & time all medical record entries.
- How do you address cultural diversity and competency on this unit?
- How do you supervise students on this unit?
- What departmental orientation did you get when you started on this unit?
- What special training for these unique populations have you received?
- What competencies did you complete this year?
- Have you had any training in recognizing impairment?
- How do you notify someone of an adverse patient event?
- What department is responsible for making sure that all patient-related equipment is checked prior to use?
- How is clinical engineering notified that a piece of equipment is out of order and needs to be serviced?

Continued on next page
Elements to consider in preparing for a Joint Commission survey (Continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tr>
<td>How do you know that a piece of equipment is compliant and performance maintenance has occurred?</td>
<td>What two unique identifiers does your hospital use?</td>
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<td>What kinds of waste does the hospital have? What are the correct disposal containers for each?</td>
<td>When do you use the patient identifiers?</td>
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<td>What do we do with patients’ home medications?</td>
<td>What is meant by life safety?</td>
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<tr>
<td>How do we address look-alike/sound-alike medications?</td>
<td>What types of things might you report to security?</td>
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<td>What other medication safety practices does the hospital have in place?</td>
<td>What department maintains lights, HVAC, water, and generators?</td>
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<tr>
<td>Do unauthorized staff have access to medications?</td>
<td>How do you identify patients at risk for, or who have an infection?</td>
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<td>What do you do with the rest of a medication in an opened vial?</td>
<td>What do you do when a patient has an infection?</td>
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<td>When do you override medication?</td>
<td>What are you doing to prevent the transmission of infection among patients?</td>
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<td>What are your high alert medications?</td>
<td>What personal protective equipment is available to you?</td>
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<td>How do you ensure safety with high risk meds?</td>
<td>What have you taught the patient’s visitors about decreasing the transmission of infection?</td>
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<td>What is the time range to resolve and reconcile Pyxis discrepancies?</td>
<td>What disinfectants do you use?</td>
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<tr>
<td>Do unauthorized staff have access to medications?</td>
<td>What do you do to prevent the transmission of an airborne illness such as TB?</td>
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<tr>
<td>What two unique identifiers does your hospital use?</td>
<td>Do you perform any invasive or diagnostic procedures on this unit?</td>
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<tr>
<td>When do you use the patient identifiers?</td>
<td>How is the time-out performed?</td>
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<td>What is meant by life safety?</td>
<td>Do you do any waived testing here?</td>
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<tr>
<td>What types of things might you report to security?</td>
<td>How long is the vial of test strips good for?</td>
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<td>What department maintains lights, HVAC, water, and generators?</td>
<td>How long can the control solutions be used?</td>
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<tr>
<td>How do you identify patients at risk for, or who have an infection?</td>
<td>What is your role in assuring patient safety? (Pick several that apply to your area!)</td>
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<tr>
<td>What do you do when a patient has an infection?</td>
<td>How do you know that travelers/agency staff are competent to work here?</td>
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<tr>
<td>What are you doing to prevent the transmission of infection among patients?</td>
<td>What is a sentinel event?</td>
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<tr>
<td>What personal protective equipment is available to you?</td>
<td>How do you report a patient safety issue?</td>
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<tr>
<td>What have you taught the patient’s visitors about decreasing the transmis sion of infection?</td>
<td>How do you document critical values results?</td>
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<tr>
<td>What disinfectants do you use?</td>
<td>Describe some actions you can take to increase patient satisfaction scores.</td>
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<tr>
<td>What do you do to prevent the transmission of an airborne illness such as TB?</td>
<td>What would you do if your patient evidenced suicidal ideation?</td>
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<tr>
<td>What date do you use for multidose vials?</td>
<td>How do you know if a physician is competent to do a procedure?</td>
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<tr>
<td>What do you do with the rest of a medication in an opened vial?</td>
<td>Source: MedStar Georgetown University Hospital</td>
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But changes in leadership and reporting structures that came later brought new challenges as well as opportunities. “My reporting structure changed several times,” she says. “I had to build a relationship with a new person and determine the best way to work together toward a common goal of constant improvement.”

Baldwin has previously reported to the patient care services vice president, the chief nursing officer (CNO), and the vice president of surgical services. Currently she reports to the chief operating officer with a dotted line to the CNO.

Trying to increase the level of knowledge and understanding about safety issues, financial concerns, resource allocation, the SPD, and materials management at the senior executive level led to a redesign of the governance structure in the last year and a half. Baldwin’s efforts coincided with a period when the hospital president and other executives were seeking details about financial, materials, safety, and operational areas within perioperative services, so the timing was right for a change.
Achieving success

“Success came through focusing on the basics. For example, there was no preoperative holding area near the main operating rooms, and that didn’t meet the accepted standards of care. Patients received preoperative care on a different level of the hospital and then were brought to the main OR. This approach was inefficient, required multiple stops for our patients, and created the potential for complex inpatients to receive less than smooth preoperative care,” she says.

Baldwin’s strategy was to over-communicate—and even educate in some ways—keeping in mind that her audience didn’t necessarily understand the perioperative environment. As a result, they were able to create an OR holding department next to the main operating room.

Adding a PACU for procedural patients was another victory. Patients from interventional radiology or the cath lab, for example, were recovered in the main PACU. Baldwin built a case for getting additional PACU beds. Her data analysis showed a gap between the standard in terms of recovery spaces per procedural room vs the number of recovery spaces available in the hospital.

“We could still use additional beds, but adding the procedural phase I PACU helped significantly,” she notes. “We now provide consistent recovery care to patients having procedures from multiple departments within the hospital in one location. Our physicians, staff, and patients have responded enthusiastically.”

Prepping for JC surveys

Every 3 years the Joint Commission performs a full accreditation survey, arriving at a hospital unannounced. For a facility the size of MedStar Georgetown, which includes 23 ORs, 400 FTEs, and 10 departments within perioperative services, this is usually a 4-day survey.

A survey team including a physician surveyor, a nurse surveyor, an administrator, and a life safety surveyor will speak with many associates, trace patients and processes, review files, and fully evaluate the physical environment throughout the organization.

“In the perioperative environment we were fortunate to receive zero deficiencies on our last survey,” Baldwin says. The most recent survey was successful because her team revamped their tissue process, redesigned their specimen process and policies, redesigned the universal protocol and checklist with regard to surgical site verification, and rounded every day.

“We created our own survey checklists for rounding, and we partnered with our facilities management department to develop an organized approach to addressing facilities’ needs in the perioperative environment. The main OR dates back to the 1960s, so it is a daily effort to keep the physical plant in good repair,” she explains. “We created a Joint Commission ‘super user’ team of staff nurses and surgical technologists, and we provided extra education about Joint Commission standards, the National Patient Safety Goals, and our performance improvement initiatives [sidebar]. While our efforts resulted in a positive Joint Commission survey, the most important result is that our physical environment is better for our patients, our staff are more aware of important safety and operational considerations, and the quality of care we provide continues to improve.”

Fostering communication

In addition to daily huddles, perioperative services staff have a number of other meetings to share information.

“The OR Safety Committee worked to improve our process for following the universal protocol at MedStar Georgetown, which includes proper patient identification,
site marking in the preoperative area, performing an anesthesia and surgical time-out in the OR, and using a surgical safety checklist to document the process,” she says. Their checklist is a paper 3-tiered checklist modeled on the World Health Organization’s checklist.

Anesthesia does a before-induction time-out, and the surgeon leads the surgical time-out and debriefing to discuss the postoperative plan of care.

Getting input from staff is also important. “I’ve tried to think about how policy and process changes will impact the people doing the work and the patients we care for each day. We always put the patient first in these discussions. Whatever the change might be, the first question should be, ‘how will this affect our patients?’”

She adds that it’s important to listen to people’s ideas. “A lot of times you’ll discover things needing improvement by listening to your team, to your surgeons, and to your patients. Once people understand that their ideas matter, it is much easier to increase engagement and create more innovative approaches to make care more seamless.”

Working with MedStar Health is very positive, Baldwin says; there’s significant focus on collaborating as a system to provide safe, coordinated care and a positive patient experience.

“We share information and ideas for improvement throughout the system, which gives us a great opportunity to improve processes rapidly. A perioperative director leadership group meets monthly to work through issues and develop solutions that help all the hospitals.”

Understanding the goals of the executive team and the CEO is critical to the success of a perioperative leader. “Building a positive working relationship at the executive level means that when resources are necessary to achieve targets, credibility has already been established,” Baldwin explains.

Over time, she says, she has become more proactive in requesting resources and support. Her role evolved from sending suggestions for agenda items for the OR executive committee to creating the agenda for meetings with her hospital leaders. Recognizing that she used to feel somewhat intimidated when interacting with senior executives, she has learned to rely on her own expertise. “I tell myself to remember when I enter a potentially difficult executive-level discussion that in the perioperative environment at this organization I am the subject matter expert, and through sharing my knowledge I can help us achieve our goals organizationally and in perioperative services,” she says. “When I finally decided I have to be the one driving this, I found that it’s worked very well. It has been an effective way to govern in the perioperative environment.”

Another very effective strategy has been to present complex data clearly through concise PowerPoint presentations using bullet points. “Doing so has kept me focused and helped to frame the discussion and increase understanding,” she says. In addition, anticipating questions from the audience and including the answers as part of the presentation can help move the agenda forward.

**Continuing to advance**

In September 2013, Baldwin says, the hospital moved from PICIS to Cerner Surginet as its electronic health record system in the perioperative environment, and recently implemented PeopleSoft for materials and human resources management across the organization. “I want to see those systems become more fully functional,” Baldwin says.

Other goals are to expand space, further improve the patient’s experience, and
continue to keep patient safety at the forefront of their endeavors. “Our perioperative governance structure continues to evolve through adding more surgeons from multiple specialties to our committee. This is helping to increase surgeon engagement and involvement in a variety of improvement initiatives,” Baldwin says.

Frances Baldwin will be a presenter at the OR Manager Conference, September 17-19, in Long Beach, California. ✴

—Elizabeth Wood