Preparing patients for surgery is like conducting an orchestra—many players must come together to have a finely tuned process.

The aim is to have all of the information needed for the safe care of patients before they arrive at the ambulatory surgery center (ASC) on the day of surgery. Because physicians’ offices supply much of this information, careful coordination is needed. Here is how some ASCs manage the process.

**Develop a musical score**

The key to a harmonious process is to have criteria for preoperative evaluation developed by the ASC’s medical director and director of anesthesia. These criteria become the musical score all of the other players will follow. The criteria should identify:

- which patients need a preanesthesia evaluation before the day of surgery
- when preoperative tests are needed
- when further medical consultation is needed.

Well-thought-out criteria provide for safe care without requiring unnecessary testing. For example, which patients must have an electrocardiogram before surgery? When is blood work needed?

The criteria guide both the staff in the physician’s office and the ASC in making sure the recommended exams and tests have been carried out and are documented in the patient’s chart prior to surgery.

“You have to start with your medical director and chief of anesthesia. They need to reach an agreement on the minimal preoperative testing required based on disease processes, medications, and the patient’s history,” advises Nancy Jo Vinson, RN, BA, CASC, director of clinical operations for Acumen Healthcare, a Dallas-based ASC development and management company.

Routine preop testing is no longer recommended, according to the American Society of Anesthesiologists (ASA). Instead, preoperative testing should be performed selectively based on the patient’s condition and a reasonable expectation that test results will provide information that might affect care of the patient during surgery and anesthesia.

It’s generally thought that most patients having surgery in an ASC don’t need a preanesthesia evaluation in person before the day of surgery because they are generally healthy and not having highly invasive procedures. But that issue has become complex as more types of procedures are performed in the ASC and as more patients with underlying illnesses have outpatient surgery.

Though there is plenty of literature on preoperative evaluation, there are not many well-designed studies, ASA notes, leaving much room for debate and disagreement. An important resource is ASA’s Practice Advisory for Preanesthesia Evaluation (www.asahq.org/publicationsAndServices/preeval.pdf). ASA points out that this is called an “advisory” because there was not sufficient literature to call it a guideline or standard. The statement provides expert opinion, but it is up to physician leaders in each facility to reach their own consensus on what is required.
An appreciative audience

ASCs strive for a patient-friendly process that emphasizes safe care yet is convenient for patients.

“The intent is for the physician or surgeon to order all of the necessary diagnostic studies at the time the procedure is scheduled, based on the center’s criteria, and eliminate the need for the patient to come to the center for a preop visit,” Vinson says. Any tests that are needed can be scheduled by the physician’s office with the results faxed to the surgery center.

Assign a good conductor

The staff in physicians’ offices are the musicians who must all play from the same score. They need a good conductor at the ASC to keep everyone playing in tune.

Lisa Cooper, RN, clinical director at El Camino Surgery Center, Mountain View, Calif, a multispecialty center with an annual volume of 10,000 cases, recommends having a preoperative coordinator who is dedicated to communicating with surgeons’ offices and making sure charts are complete. She also advises having a fax machine in the preoperative area dedicated to receiving histories and physicals (H&Ps).

El Camino’s preoperative coordinator begins assembling charts 2 weeks before surgery. A checklist is attached to the outside of the chart to keep track of what is needed. A preoperative nurse calls patients 3 days before surgery, referring to the checklist to see if anything is missing. If an electrocardiogram is ordered but not done, for instance, she can ask when the patient plans to have it done. If the patient doesn’t know about it, the nurse calls the surgeon’s office.

Asheville Surgery Center in Asheville, NC, created the position of scheduler to schedule surgery and preoperative phone calls and coordinate with the office schedulers. The 9-OR facility, which performs about 1,300 cases a month, is affiliated with Mission Hospitals.

The majority of preoperative assessments are performed by phone, and surgeons’ offices have much of the responsibility for ensuring charts are complete. When the office staff calls to schedule surgery, a time is set for a preoperative assessment phone call from the ASC.

There also is the newly created position of preoperative unit clerk, who has been invaluable in making sure all of the lab work and the H & Ps are on the patient’s chart before surgery, notes Patti Campbell, RN, BSN, preoperative and postoperative nurse manager.

More than 95% of all charts are complete the day before surgery. “It is rare for an incomplete chart to delay surgery,” she says. Vinson cautions ASC managers to make sure they have more than one staff member who is experienced with the preoperative process. She does not advise assigning the same person to this duty every day because the system can fall apart if that person is gone. Rotating the responsibility ensures that several staff members know what is required to complete a chart for surgery.

Education for schedulers

Asheville has been proactive in educating office schedulers and creating a good working relationship, says Joanne Taylor, RN, OR manager. Schedulers are updated frequently on any new protocols, and regular education sessions are held for them.

The center has developed packets with forms for office schedulers to complete when a patient is scheduled. The completed documents are faxed to the ASC’s unit clerk along with any preoperative orders. The unit clerk has a filing cabinet dedicated to surgeons’ preoperative paperwork.

Good coordination with offices is also important for cost-effective materials management, Taylor adds. The center uses custom packs, which must be ordered as needed from an off-site distribution center. Having the patient’s chart completed in a timely manner is necessary so the correct supplies can be ordered.
Presently, Asheville is educating office schedulers about a new intraocular lens protocol. Because the center has reduced its lens inventory, office schedulers must request the lens that will be needed on the day of the patient’s office exam. Taylor says the facility has saved several hundred thousand dollars this past year by streamlining supplies.

“Adaptive part of this has been our ability to get the doctors’ offices to let us know way ahead of time what procedure will be done and what supplies will be need- ed,” she says.

**Thinking outside the box**

Vinson has developed a 2-page ambulatory surgery preadmission questionnaire for Acumen’s centers to provide to physicians’ offices. In addition, she translates each center’s preoperative evaluation criteria into easy-to-follow instructions for the office staffs. The office staff completes the questionnaire when the patient is scheduled for surgery and faxes it to the ASC. The questionnaire includes a section where any needed lab tests can be listed. Patients then can have this lab work completed when convenient before surgery, and the office staff can fax the results to the ASC.

The preadmission form allows the ASC’s nurses to identify information ahead of time that could affect a patient’s care on the day of surgery, such as knowing that the patient is in a wheelchair, is obese, or is on dialysis. For example, when the staff learns 2 weeks before surgery that a patient is on dialysis, they can more easily arrange for the patient to have dialysis just before surgery. Not knowing about the need for dialysis until the day before surgery can cause the case to be delayed.

Communication between offices and the ASC can break down if the ASC staff worries more about having a specific form than the information that is needed, Vinson comments. For example, the ASC staff might insist that the surgeon use a specific form for the history and physical, even though the surgeon’s progress notes copied from the patient’s office chart has the needed information.

In the Acumen centers that use this process, Vinson says 85% of patients have the preoperative assessment completed without coming to the center before the day of surgery. Success is based on how willing the office staff and ASC staff are to be flexible and think outside the box, she says.

“If the ASC staff gets hung up on forms versus the information, the office staff are going to be reluctant to implement the new process, and the ASC staff will be reluctant to facilitate it.”

Relationships with physicians’ offices take constant nurturing, Vinson notes. She adds that coordination of the preoperative process with physicians’ offices can be a good subject for quality improvement studies. For example, if there seems to be a rise in incomplete paperwork or delays and cancellations because patients aren’t prepared, the ASC manager could set up a simple form to track these deficiencies by surgeon’s office. If a pattern develops, the manager could organize an informal QI team to look into the situation and identify the cause. Perhaps the office has a new scheduler who is not completely oriented or has run out of preoperative packets. Once the gap in the process is identified, the situation can be addressed, and the orchestra can be playing back in tune.

—Judith M. Mathias, RN, MA
—Pat Patterson