Clinical management

Ideas for improving the preop process

Here's what some facilities have done to make the day of surgery go smoother.

On-time paperwork

Everything but the update note to the history and physical (H&P) must be done upfront for patients to be scheduled as first case of the day at Rush University Medical Center in Chicago.

The H&P, consent, and required lab results must be received by 11 am on the day before surgery for surgeons with priority to receive their priority time slots and for surgeons without priority to be scheduled into the best remaining slots.

If the H&P, consent, and lab work are received after 11 am but before 4 pm, cases are scheduled into the remaining time slots.

If the chart requirements cannot be completed by 4 pm, the surgeon’s office must complete an “exception form,” says Kim Humbarger, RN, BSN, director for the Ambulatory Surgery and Postanesthesia Care Units.

The form explains why requirements could not be met, and when requirements will be completed on the day of surgery and by whom. Cases with exception forms are not scheduled as first cases.

The update note refers to the Medicare rule and Joint Commission standard requiring the H&P to be completed no more than 7 days before surgery. An H&P older than 7 days must have a note updating the H&P. Surgeons can document the update on the day of surgery. An H&P completed 30 days or more before surgery is considered too old to meet the requirement and cannot be updated with a note.

The preoperative clinic, staffed by 5 RNs and 3 clerical staff, screens 80 to 100 charts for outpatients and same-day admissions per day. In all, 600 to 700 nursing assessments are done by phone each month for patients scheduled to be admitted to the hospital after their procedure. Surgeons may schedule a preanesthesia evaluation at the clinic for patients considered at high risk, which averages 2 patients per day. Surgeons can also send same-day admission patients to the clinic for preop lab testing, the H&P, and consents if house staff are available. Preop open-heart patients, for example, usually are seen in the clinic. The visit ensures that a specimen is in the blood bank prior to the day of surgery.

Chief medical officer steps in

The chief medical officer (CMO) speaks with surgeons who do not have patients’ H&Ps and consent forms completed in a timely manner at Garden City Hospital in Garden City, Mich.

“We have a policy that all H&Ps and permits have to be on the chart by 11 am the day before surgery,” says Annette Krupa, RN, BSN, CNOR, director of surgical services for the 6-OR department. But the policy was not enforced until the new CMO came.

He asked Krupa to track cases that did not have an H&P completed on time. She had the unit secretary create a simple form to record the surgeon’s name, columns to check for incomplete paperwork (eg, H&P, consents), the medical record number, and the date.

Krupa gave the logs to the CMO who visited the surgeons in their offices, showed them the log, and stressed the importance of having the paperwork completed. Many of the logs were from the same high-volume surgeons.

“It’s made a huge impact. We went from about 75 a month in the spring to probably 10 last month,” she said in October.
Phone screening by nurses

Phone screening by nurses sets the stage for a well-oiled preop process at Great River Medical Center in West Burlington, Iowa.

About 90% of patients are reached by phone before the day of surgery, notes Angela Myers, RN, director of surgical services. Patients do not come in before the day of surgery unless the physician orders an anesthesia evaluation. Standard orders developed by the anesthesiologists about a year ago have helped make this process more consistent.

If nurses aren’t able to reach patients in the afternoon, they call them at home in the evening. If they get a recording, they leave a message simply asking the patient to call about “your plans for tomorrow,” without mentioning the surgery.

“We’re persistent in our calls. It makes our schedule go so much better. Our no-show rate is very low,” Myers says.

The calls also give nurses a chance to begin educating patients about their postoperative care and to set expectations for a timely discharge.

Justifying a preop clinic

A teaching hospital justified the cost of its preop clinic by figuring the financial impact of lost revenue from delays. The clinic is staffed primarily by advanced registered nurse practitioners (ARNPs).

“We went to the administration and said, ‘If we funded these ARNPs, it would be at least a win-win or a wash, or in the best scenario, we would make money,’” says Gail Avigne, RN, BA, CNOR, manager of the ORs and other departments at Shands Hospital of the University of Florida, Gainesville.

The cost-benefit analysis was described by Gordon L. Gibby, MD, an anesthesiologist at Shands in an article (Int Anesthesiology Clin. 2002;40:17-30). He argued that a preop clinic could improve the process by:

• reducing unnecessary lab tests and improving reimbursement for testing that was done through proper coding
• educating patients about preop instructions such as NPO status
• reducing variability in anesthesiologists’ decisions about day-of-surgery workups
• reducing the number of no-shows
• improving coding for comorbidities, which could lead to higher reimbursement
• making sure insurance verification is completed.

It’s easier to improve the process in a preop clinic rather than getting every clinic and doctor’s office to adhere to the same process, Dr Gibby observed.

From studies dating back to the early 1990s, he figured that with a preop clinic, Shands might be able to save $15 per patient in lab costs, $30 in reduced delays, and $44 in reduced cancellations while gaining $27 in reimbursement. He estimated the clinic’s cost, which is primarily salaries, would be $41.45 per patient based on the 1999-2000 budget.

To fund the clinic, the administration agreed to a small increase in the OR charge.

“Many of our patients are ASA III and above,” says Avigne, referring to American Society of Anesthesiologists physical status. “The complexity of outpatients now is incredible, which justifies the need for a presurgical workup. It isn’t as difficult for the ASA Is and IIs, which you can screen over the phone.”

She estimates the 80% of patients having surgery in the main OR come to the presurgical clinic.

The clinic is open from 7:30 am to 6 pm and is staffed by 3.5 ARNP FTEs, 1 RN FTE, 3 clerical staff, and 2 medical assistants. The clinic screens 25 to 45 patients a day. The annual surgical volume is 14,000 procedures.

The clinic has gone from being a walk-in clinic to scheduled appointments, “which has been much more effective,” Avigne says.
Who should come to the clinic?

To decide who should come in for a preoperative appointment, Shands is introducing a “bubble sheet” filled out by the patient in the surgeon’s office. The sheet, which is a basic review of systems, has “bubbles” for patients to fill in, like a standardized test.

The nurse practitioners in the presurgical clinic will review the bubble sheets when calling the patients. They then see if patients fit protocols for preanesthesia evaluation developed by the nurse practitioners and anesthesia department. The protocols cover areas such as congestive heart failure, hypertension, diabetes, and angina. The protocols are posted on the hospital’s Intranet so they are readily available.

“If patients fall outside the protocols, the ARNPs call the anesthesiologist on call or the medical director,” Avigne says. “What they look for primarily is to make sure patients don’t need a cardiac or pulmonary workup.”

It’s important for patients at least to touch base with the clinic by phone, she adds. For example, a patient might check “no” to the question about high blood pressure on the bubble sheet. But in the phone call, the nurse might find out the patient actually is on blood-pressure medication, which is why the patient thought he didn’t have high blood pressure.

Shands has started developing a web-based bubble sheet that patients may eventually be able to fill out online.

A smoother process

Christiana Care Health System in Newark and Wilmington, Del, has taken steps to smooth the preop process for its 4 surgical sites. Christiana Care has 2 hospitals and 2 attached surgery centers with a total of 55 ORs and 46,000 annual procedures. The steps include:

• a system for ranking surgical procedures according to risk, which helps determine which patients will be seen by an anesthesia provider before the day of surgery
• a computerized nursing assessment form
• a policy not to send patients to the OR if the H&P and consents are not on the chart
• a medical communications form for specialists to use in documenting their evaluation.

The ranking system classifies procedures 1-4, depending on their invasiveness. For example, a hemorrhoidectomy is a 1, and a craniotomy is a 4. The ranking plus the patient’s ASA status help to determine what type of assessment patients need.

“We prioritize patients using the numbering system. Anyone who is scheduled for a level 4 procedure, we call to make sure they come in to see an anesthesiologist before the day of surgery,” says Kathy Cook, RN, nurse manager of the Perioperative Evaluation and Preparation (PEP) department at Christiana Hospital in Newark. Patients having level 1 to 4 procedures are screened by phone, starting a week in advance. Charts are filed by date in alphabetical order.

In the phone screening, nurses use the computerized assessment form, which is part of Cerner’s PowerChart. The system has “pull-forward” logic—if the patient was assessed 2 weeks ago, when the nurse opens the assessment form, the system pulls forward the patient’s history. “That way, if the patient forgets to mention medications they are on, you can remind them,” says Constance Przybylek, project manager for perioperative services.

Automatic alert

The system also automatically sends a note to the OR team alerting them to key factors about each patient, such as a body mass index (BMI) over 40, latex allergy, or a history of malignant hyperthermia.

The goal is to have all of the patient’s paperwork complete 24 hours before surgery. “The nurses have a calendar in the computer system that reminds them to look
for what they have requested,” she adds.

If the H&P and consents are not on the chart, patients are not taken to the OR.

One of the facilities goes a step further—"If they are in our same-day surgery area or on the floor, they are not allowed to be transferred to the OR preop or holding area until we have all of those pieces in place, unless it is a trauma case," notes Sarah Holton, RN, nurse manager for the main OR.

The medical communication form is sent to specialists when a consultation is requested. The form provides specific information about the patient’s medical problems and risks for perioperative complications.

How are you improving your preop process? If you’d like to share your successes, e-mail Pat Patterson at ppatterson@ormanager.com