Getting MD, staff buy-in for QI projects

What does it take for an ambulatory surgery center (ASC) to have a quality improvement program that both physicians and staff buy into?

El Camino Surgery Center (ECSC) in Mountain View, Calif, rates high in physician satisfaction on a number of measures, including QI, in the OR Benchmarks Surgeon Satisfaction Survey. Satisfaction has steadily improved in the 5 years ECSC has done the study. With 6 ORs and 1 procedure room, the center performs 9,000 procedures a year and is accredited by the Accreditation Association for Ambulatory Health Care.

In the survey, 89% of ECSC’s surgeons agreed with the statement, “The quality improvement process is effective for problem solving.” That was up from 72% in 2003.

More than 75% agreed with the statements, “Results of quality improvement studies are shared with the medical staff,” and “I have adequate input into cost and quality issues.”

The survey, offered by OR Manager, Inc, measures physicians’ satisfaction with a number of indicators, including OR management, clinical staff, scheduling, preoperative testing, anesthesia, and equipment and supplies as well as QI.

“ECSC has consistently been the best performer for quality improvement in our surgeon satisfaction surveys,” says Ellie Schrader, president of OR Manager.

“Although this is an important area, it generally does not receive high scores on these surveys.

“Overall, 91% of the physicians are satisfied with the QI efforts at ECSC. For the other facilities participating in the study, the median score was only 27% of physicians indicating satisfaction.”

These are some strategies that ECSC thinks make a difference:

Prompt feedback to physicians

“We provide a lot of feedback to our physicians,” says Lisa Cooper RN, BSN, the clinical director. She or the medical director, Ray Brizgys, MD, respond to any issue or complaint, usually within a day.

Unusual incidents are recorded on the center’s quality review reports (formerly called incident reports).

“I will call the physician right away so he knows there is a review process for this,” Cooper says. There also is feedback to the physician on how the issue will be resolved.

“I think we go to solution pretty quickly. It’s not just the responsiveness, but how can we solve it,” adds the executive director, Julie Butner, BSN, MSA.

To track postoperative infections and complications, the center sends a letter every month to all surgeons who performed cases there in the past month, enclosing a list of the procedures they did that month. The list has columns where the surgeon can mark Yes or No for:

• postoperative infections
• postoperative complications
• hospitalizations.

There is a column to indicate whether the complication or infection has been resolved as well as a section for comments. The list is printed out from the center’s
information system. Butner estimates that 80% to 100% of the surgeons return the forms. About 180 surgeons are on staff. The return rate is audited quarterly.

Recently, another form was added for surgeons to return if there is an infection to get more specific information. The form lists signs and symptoms to check off as well as treatment that was provided and whether the patient was hospitalized.

"Before, we would get forms with the Yes circled, indicating there was an infection, and it looked like our infection rate was high. But when we investigated, we found these were superficial infections. We found we weren’t getting the right information,” Cooper says.

If there is a complication, Cooper fills out a quality review report and sends it to the Medical QI Committee.

A medical director committed to QI

“Our medical director does an excellent job of overseeing our Medical QI Committee,” Butner says. “He also does an excellent job of communicating with the physicians one-on-one and having things directed to specialty department meetings where they address quality issues.”

Give the staff an active role

Staff are included in the QI process.

“We are committed to having the staff’s input and giving them ownership,” Butner says. “Luckily, our governing body supports this culture.”

Formerly, QI was handled by the center’s leadership committee, made up of managers and team leaders. Once a quarter, they turned their regular leadership meeting into a QI meeting, which everyone found to be efficient. Recently, this became a staff-level QI committee, which also meets quarterly, with volunteers from each department. Members include, in addition to the administrator, clinical manager, and medical director, staff from human resources, the preop area, postanesthesia care unit (PACU), QI nurse, OR, the center core, and materials management. The QI nurse is a staff nurse who works on QI projects in addition to her clinical duties.

Perform relevant QI studies

Ideas for QI studies may come from the quality review reports, forms the surgeons return, the staff committee, the medical QI committee, and patient satisfaction surveys. About 2 to 4 QI studies are done each year.

Recently, ECSC began collecting data on opened but unused orthopedic supplies.

“Our circulating nurses have been gathering information for a year,” Cooper says. “If a supply such as a disposable anchor is opened but not used, we track the information.” ECSC has done a procedure cost analysis on orthopedic supplies and presented it to the surgeons at their specialty meeting.

Another recent study came out of the center’s patient satisfaction survey. The survey is given to each patient at discharge. Surveys are conducted twice a year of a sample of patients. The return rate was 43% in 2004.

“We were getting high numbers on postoperative nausea and vomiting,” Butner says. “The numbers were wildly off compared with those we were getting from the physicians in the letter we send to them. We wondered, ‘Do we have a problem?’”

Before introducing any interventions to address the issue, they decided to validate the results.

“We constructed a study that had the nurses making the postoperative phone calls do much more detailed questioning about nausea and vomiting,” Butner says.

The nurses found a very low percentage had nausea and vomiting, which didn’t match the results from the patient satisfaction surveys. They began to look at how the question on the survey was worded and concluded that was the source of the problem.

The question read: “Did you experience any unexpected problem relating to your surgery that would have required you to contact your physician? If so, circle the nature of the problem.” This was followed by a list.

They decided the question was ambiguous, and some patients thought they should check it even if they didn’t contact their surgeon.
The question was reworded to say: “Did you call your physician? If so, please indicate the reason (with a list).”
Since then, the results have been more consistent with the physician results.
“The lesson from this is that you really need to look at what you are asking and how you are asking it,” says Butner. “You may not be getting the data you think you are getting.”
Cooper adds, “It is interesting how this played out, because what we thought was the problem could have taken us off in the wrong direction. It really was not a problem with the patients but with the survey tool itself.”

Keep QI studies user friendly
Weaving the data collection into an activity the staff is already doing is a good way to get them involved and make QI studies efficient, Cooper notes.
In the nausea and vomiting study, “instead of the nurses having to do a whole new data collection, we attached it to the postop phone call, which they normally do anyway,” she says.

Share QI results
Information on QI study results is posted and reported in ECSC’s regular mailings to physicians.
For example, for a while the center conducted a campaign to reduce sharps injuries. Regular reports on injuries were posted in the bathroom stalls and on bulletin boards. Raising consciousness helped because in 2004, the center reported no staff injuries and a physician injury rate that was half what it had been the year before.

For information on OR Manager’s surgeon satisfaction surveys, call 800/442-9918.

Ideas for ASC QI projects
Looking for new ideas for quality improvement projects in your ASC? Here’s a list to get you started, provided by Donna Slosburg, BSN, CASC, senior vice president, surgery operations, HealthSouth, and Nancy Burden, RN, MS, CAPA, CPAN, director of health services, Morton Plant Mease Health Care, Clearwater, Fla.

Outcome projects
• Procedure analysis: cost and best practice, eg, for cataract surgery
• Emergency preparedness: Advanced cardiac life support
• Adequacy of postoperative instructions
• Efficacy of regional blocks for pain control
• Antiemetics efficacy
• Antibiotic utilization
• Postoperative pain
• Length of stay
• Specimen management
• Availability of responsible drivers for discharged patients

Service and customer satisfaction projects
• Patient postprocedure follow-up
• Patient confidentiality
• Patient wait times
• Turnover times
• OR block utilization

Regulatory projects
• Histories and physicals on the chart before surgery
• Nursing documentation
• Compliance with Joint Commission on Accreditation of Healthcare Organizations National Patient Safety Goals
• Compliance with biohazardous waste regulations
• Patient confidentiality breeches
• Compliance with Centers for Disease Control and Prevention hand hygiene guidelines (www.cdc.gov/handhygiene/)

**Cost management projects**
• Late-arriving physicians
• Inventory turnover
• Medical supplies standardization
• Registration and/or scheduling errors
• Staffing and overtime
• Implant reimbursement