When things go wrong in healthcare, it’s often because a key piece of information isn’t passed on or isn’t passed on correctly.

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How do you get everyone in the same movie? Part of the solution is to follow the same script. As part of its 2006 National Patient Safety Goals, the Joint Commission on Accreditation of Healthcare Organizations is requiring organizations to standardize handoffs. In this issue, we share some of the creative ways organizations are using to standardize handoffs.

**Creative approaches to handoffs help meet JCAHO’s safety goal**

Crowded emergency rooms, ambulance diversions, and bed capacity issues in the nation’s hospitals have created a crisis that politicians, administrators, and patient advocacy groups are scrambling to address. Many are focusing on the emergency departments (EDs) or building new beds. In some cases, that is the right approach. But in many cases, they aren’t looking in the right place.

The operating room schedule is the first place to look. Although it seems counterintuitive, research shows that the elective surgery schedule is the source of the variability that leads to peaks and valleys in hospital census (sidebar, p 20). Emergency admissions to the hospital, although not scheduled, actually are more predictable than elective surgical admissions (Graph 1, p 17). The variability caused by the elective surgical schedule causes capacity constraints for inpatient beds and the ED because patients are not able to be assigned to beds. Variability also causes staffing shortages and equipment conflicts at peak times.

**Smooth the elective OR schedule? A large hospital makes it happen**

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**Handoff articles**
- Page 11: What does JCAHO expect for handoffs?
- Page 12: Tips for introducing SBAR in the OR
- Page 13: ‘Passing the baton’ for smooth handoffs
- Page 15: A SHARED tool strengthens handoffs

**Surgical scheduling**

Smooth the elective OR schedule? A large hospital makes it happen

Crowded emergency rooms, ambulance diversions, and bed capacity issues in the nation’s hospitals have created a crisis that politicians, administrators, and patient advocacy groups are scrambling to address. Many are focusing on the emergency departments (EDs) or building new beds. In some cases, that is the right approach. But in many cases, they aren’t looking in the right place.

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**Peaks and valleys**

Block schedules for elective surgery are usually the result of surgeon preference or requirement, history, convenience, and utilization. Rarely is a block schedule built on the patient’s ultimate destination or case type. Examination of...
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Jennifer McClanahan, recovering from a quadruple coronary artery bypass, is being wheeled back from radiology when an alert transporter notices she isn’t responding to questions. The transporter summons the hospital’s Rapid Response Team.

“All of a sudden these people came running,” recalls her daughter. McClanahan had had a buildup of blood in her chest. After the response team stabilized her, she was taken to surgery.

“I wouldn’t be here if they hadn’t responded so quickly,” says McClanahan, referring to the response team, which is one element in the Institute for Healthcare Improvement’s (IHI) 100,000 Lives Campaign. The dynamic nonprofit, based in Boston, is a leader in advancing the cause of quality and patient safety.

Another patient, Carl Swanson, arrives at the hospital after a heart attack and is soon whisked to the cath lab for a balloon angioplasty. His caregivers “were like a drill team—they knew exactly what they were doing,” he says. The hospital had tackled “door-to-balloon time”—the time from when a patient enters the emergency department until the artery is cleared by angioplasty—and found ways to reduce it.

Their faces shine from IHI’s 2006 Progress report, which tells vivid stories of successes in the 100,000 Lives Campaign and other projects. The campaign’s goal is to get U.S. hospitals to commit to making changes that have been proven to improve care and prevent avoidable deaths.

The campaign is ambitious—save 100,000 lives by June 14, 2006.

IHI is keeping score. So far, 3,000 hospitals are enrolled. As of Feb 13, IHI says 35,678 lives had been saved.

IHI has come up with creative ways to get people involved. It offers practical tools like conference calls, web-based seminars, success stories, sample protocols, and mentor hospitals. IHI leaders even did a bus tour last fall to pump up interest.

Tell your SCIP story

Equally important but not as visible is the Surgical Care Improvement Project (SCIP). SCIP’s goals are just as ambitious—reduce 4 types of surgical complications by 25% by 2010:

- surgical site infections
- adverse cardiac events
- venous thromboembolism
- perioperative ventilator-related pneumonia.

SCIP, rolled out in August, 2005, has 10 heavy-hitters behind it, including the Centers for Medicare and Medicaid Services, the Joint Commission on Accreditation of Healthcare Organizations, the American College of Surgeons, the American Society of Anesthesiologists, and the Association of periOperative Registered Nurses.

Momentum has been slow to build. In early March, SCIP had 670 participants. More tools are being added to the SCIP web site, and much work is going on in those facilities.

In this issue, we start a series on SCIP projects (p 22). If your organization would like to tell its story, we’d like to hear about it!

QI can be challenging. It can be hard to see progress when you’re working to shrink numbers that are already small, like surgical site infections.

IHI’s report helps put a human face on the need for these projects. If you’re suffering from “QI fatigue,” take a minute and download the 2006 Progress Report from IHI’s home page at www.ihi.org.

It highlights the lives that have been saved and the suffering avoided because of QI. It will give you new energy for the hard work that QI brings.

—Pat Patterson

Share your stories about SCIP successes. E-mail ppatterson@ormanager.com

Have you had success with rapid response teams in perioperative areas? If so, we’d like to report on what you’ve accomplished.
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Medicare to cover more obesity surgery

Medicare announced Feb 21 it will expand national coverage for bariatric surgery to all Medicare recipients, including those over 65 as well as the disabled, who:
- are morbidly obese (body mass index of 35 or greater)
- have an obesity-related condition or disease
- have not been successful with medical treatment for obesity.

Coverage will be provided only if the surgery is performed by organizations certified by the:
- American Society for Bariatric Surgery (ASBS) Surgical Review Corporation (SRC)
- American College of Surgeons as a Level 1 Bariatric Surgery Program.

Three types of procedures will be covered:
- laparoscopic and open gastric bypass
- laparoscopic gastric adjustable banding
- open and laparoscopic biliopancreatic diversion and the duodenal switch.

In the new decision, the Centers for Medicare and Medicaid Services (CMS) reconsidered a proposal made last fall that would have excluded payment for the surgery for patients over 65, reserving it for the disabled. CMS says new data show that experienced surgeons have similar outcomes for patients of all ages.

Previously, Medicare covered some bariatric surgery but did not have a national policy. Coverage was decided region by region and applied only to surgery to correct an illness that “caused the obesity or was aggravated by the obesity.”

“The new coverage policy is binding on all Medicare contractors, and no local coverage policy may be inconsistent,” says ASBS, which requested the decision from CMS.

Poised to grow?

Will the decision spur growth of bariatric surgery?

Obesity procedures spiraled by 450% between 1998 and 2002, and about 170,000 procedures were performed in 2005.

But some private insurers backed off after some widely reported complications. Will the CMS decision encourage more insurers to provide coverage?

“Historically, the payers have followed CMS—it’s kind of like a Supreme Court ruling,” says Neil Hutcher, MD, president of ASBS. So far, health plans haven’t said much.

“I think they will be under tremendous pressure,” he told OR Manager, because current data show bariatric surgery can prevent, improve, or cure a number of obesity-related conditions like type 2 diabetes, heart disease, sleep apnea, and cirrhosis of the liver.

According to 2002 figures, Medicare covers about 6% of bariatric surgery, with private insurance paying for 83%; 3% were self-pay, and the rest were covered by other government programs and charity.

Medicare is a big potential source of patients.

By 2010, 475,000 people age 65 to 69 could be clinically eligible for bariatric surgery, according to the Agency for Healthcare Research and Quality (Eccinosa W et al. H Affairs. July-August 2005;24:1009-1046).

For self-pay patients, ASBS plans to introduce an insurance program this spring that would enable hospitals and physicians to buy coverage for complications from the surgery, which could boost the number of self-pay patients, Dr Hutcher says.

Experience means better outcomes

But only a limited number of facilities will be able to operate on Medicare patients. Because experience makes a difference in outcomes, Medicare coverage will be restricted to surgeons and hospitals that meet certain standards, including a volume requirement. That is why CMS is requiring facilities to be certified.

A study published last year by David Flum, MD, of the University of Washington, showed bariatric patients over 65 face a nearly 3-fold increase in the risk of early mortality (4.8% within 30 days)—more than double the risk associated with coronary artery bypass or hip replacement.

But the study clearly demonstrated that mortality was low for Medicare patients whose surgeons had the highest volume of...
Bridging the gap between physician and nurse cultures

Health care is like trying to make music—the members need to play in harmony.

Physicians, by and large, are used to playing solo. “In our world, you’re rewarded by how often and how loudly you play,” says Joe Bujak, MD, FACP.

It’s a different world from nursing, where the members try to play together.

How do you bring these 2 worlds together?

It’s an increasingly important question, says Dr Bujak, who will talk about nurse-physician relations as keynoter at the Managing Today’s OR Suite conference Nov 8 to 10 in Orlando, Fla. The keynote is sponsored by Kimberly-Clark Health Care.

“The whole sense of teamwork has to catch on—it’s so foundational,” Dr Bujak says.

Yet both physicians and nurses bring attitudes and habits that tend to stand in the way.

“We’re hierarchical and status conscious, and think everyone is there to do our bidding,” he says, speaking of physicians.

Some nurses tend to abet that behavior, “though I hope nursing is moving beyond that,” he says. A nurse who’s singled out as a favorite, for instance, may defend a physician who behaves badly.

What to do to bridge the gap?

“Here are some things I would propose,” he says.

• What if we relabeled the timeout before surgery? What if we saw it more as a time to build a team?

“We could see it as a grand attempt to acknowledge how we all have come together at this moment to make a difference for this patient. I think that would go a long way toward creating a sense of teamwork,” he says.

• What if we looked at how we assign people in the OR?

“I think a lot of tension could be reduced if people operated with the same team most of the time,” he suggests. As people work together regularly, they gain respect and appreciation for each other.

Another strategy he’ll discuss—“appreciative inquiry.”

“The physicians who behave badly really are in the minority,” he says. “The majority are respectful and true teachers in the OR.” In appreciative inquiry, you identify the critical elements that allow the majority to be successful.

“That gives you insight for what you can build on,” he says. Encourage one of them to take a leadership position and set the expectations.

“It could make a huge difference, because most people want to do the right thing,” he says.

Dr Bujak is vice president, medical affairs, at Kootenai Medical Center, Coeur d’Alene, Idaho, where he has responsibility for quality improvement and outcomes measurement. He also mediates conflicts for organizations, often involving physician behavior.

He is coauthor of Leading Transformational Change: The Physician-Executive Partnership (Health Administration Press, 2001).

Download the conference brochure and register online at www.ormanager.com

New conference schedule

The schedule for the Managing Today’s OR Suite conference will be different this year.

The changes:
• The keynote address will start at 4:30 pm on Wednesday, Nov 8, following the all-day preconference seminars. A welcoming reception will follow in the exhibit hall, with Disney characters in attendance.
• The conference will close at 2:30 pm on Friday, Nov 10, after the luncheon and special program, sponsored by Advanced Sterilization Products.

This schedule will allow attendees to get a head start to enjoy Walt Disney World Resort or get home for the weekend.
Crucial conversations: A key for safety

What’s the best way to approach a surgeon who is repeatedly rude to a nurse who raises a concern about a patient’s informed consent?

What do you say to a nurse whose peers have been working around her poor assessment skills for years?

These conversations are about patient-safety issues, but they’re difficult because they involve confronting people, says David Maxfield, director of research at VitalSmarts, a company that studies and incorporates best practices into management.

“Confronting people is hard,” Maxfield says. “If it were easy, we’d all do it. My father says it’s one of those skills you need to learn at your mother’s knee or some other low joint.”

Working with the American Association of Critical-Care Nurses in 2004, Maxfield studied 1,700 nurses, physicians, clinical staff, and administrators in 13 hospitals across the US.

The study identified conversations that are difficult but essential for health care professionals to master, resulting in the reports Silence Kills: The Seven Crucial Conversations for Healthcare and Dialogue Heals (www.silencekills.com/sidebar).

His research also led to 2 management bestsellers: Crucial Conversations and Crucial Confrontations, published by McGraw-Hill.

Maxfield spoke with OR Manager about the findings and how to conduct crucial conversations.

What are the most crucial concerns health care professionals need to talk about?

Maxfield: In our study, 1,700 health care professionals reported that an average of 10% of their co-workers engaged in the following behaviors and did so for long periods of time without being held accountable:

- broke rules
- made mistakes
- did not provide support
- were incompetent
- were poor team workers
- acted disrespectfully
- micromanaged or bullied.

Is the health care environment more open to these conversations now?

Maxfield: Yes, definitely. With the emphasis on patient safety, human errors can no longer be swept under the rug.

How do we have these crucial conversations?

Maxfield: For more detailed guidance, I recommend reading Crucial Conversations and/or Crucial Confrontations or viewing actual conversations on the web site (www.crucialconfrontations.com).

Here are the basics:

Work on yourself first

You need to prepare yourself before you speak. First decide what the right problem is to discuss. Problems don’t usually come in tiny boxes; they come in giant bundles. Take the time to unbundle the problem and sift out the real or most presenting issue.

We use a skill we call CPR—Content, Pattern, Relationship. If your concern is with a single incident, “You arrived late for the briefing before this morning’s first case,” then you’re dealing with Content. If the problem repeats over time, “You often skip our briefings. You missed three today,” then you need to talk about that Pattern. If your real concern is about your working relationship, talk about that: “It’s common for you to skip briefings and leave before the case is over. I’m concerned about what you see your role to be here.” The mistake people make is to talk about a single incident when their real concern is far larger—involving a Pattern or Relationship.

Another task is to tell yourself the whole story—not just the one you first see or react to. Ask yourself a humanizing question, “Why would a reasonable, rational, and decent person do that?” rather than, “What’s the matter with that person?” This will help you understand what will motivate the other person to change behavior.

Confront with safety

The first 30 seconds set the tone for your entire conversation. Your overall

Silence Kills: Major findings

The study found a direct link between peoples’ ability to discuss emotionally and politically risky topics and key performance indicators, such as patient safety, quality of care, and nursing turnover. Highlights:

- Only 1 in 10 health care professionals speaks up when faced with safety concerns. Far fewer speak up if the concern is with a physician.
- 62% of nurses and 84% of physicians and other providers saw co-workers take shortcuts that could be dangerous to patients.
- 48% of nurses and 88% of physicians and other providers said they work with people who show poor clinical judgment.
- Fewer than 10% of nurses, physicians, and other clinical staff directly confronted colleagues about their concerns, and 1 in 5 physicians said they saw harm come to patients as a result.
- The 10% of health care workers who raised these crucial concerns observed better patient outcomes, worked harder, and were more satisfied and committed to staying in their jobs.

Source: www.silencekills.com

Continued on page 9
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goal is to confront with safety to avoid defensiveness. You must help the other person know you care about his or her best interests. To do that, we simply describe the gap—the difference between what you expected and what actually happened—rather than lead with unhealthy conclusions or accusations. Let the other person know your goal is to solve problems and make things better for both of you. Whenever the other person gets defensive, back up and recreate safety.

The second step in the confrontation is to motivate with consequences that matter to the other person, such as, “When you arrive late for the briefing, we often end up a bit confused. We don’t know how to help you the most. That can cause unnecessary delays.”

If the issue is about a person’s ability, explore root causes and workable solutions together. For example, “Some ORs use checklists to make briefings more complete and go faster. What could we do to make the briefings work for you?”

Move to action

Agree to a plan and followup method. Make a plan complete with the acronym WWWF: Who, does What, by When, and Follow up. Stay focused and flexible. As other issues come up, don’t meander. Consciously choose whether to change the discussion to the new issue.

What would an effective crucial conversation look like to address this scenario: A surgeon who is clinically respected and brings a lot of business to the hospital is verbally abusive to the nursing staff.

Maxfield: Disrespect and abuse require 2 kinds of solutions. First, there needs to be a clear prevention policy that is endorsed by the hospital. I work with a hospital that is implementing what they call their “Principles of Mutual Respect.” They’ve collected examples of sarcasm, insulting language, emotional blowups, and physical intimidation or attacks that must stop.

But they haven’t stopped there. They didn’t want to create one more line in the sand that physicians couldn’t cross. Instead, they’re making sure they solve problems for the physicians who are getting angry.

They found the most common reasons for blowups are that the patient arrived late or improperly prepped, a surgical technologist or nurse made a mistake that created a dangerous situation or a delay, or one of the staff was below par in a skill set. Adding the commitment to solve problems that led to the abusive responses makes it clear the hospital isn’t villainizing physicians. They are making the OR a more effective, efficient, and safe place to work.

For the actual conversation:

1. Work on yourself. Before holding the conversation with the surgeon, decide what the problem is. The problem isn’t the incident; it’s the pattern of abuse. Second, determine the mutual purpose—what is this surgeon trying to achieve, and why is the surgeon so frustrated? Third, ask yourself, what is it I really want long-term out of this conversation—for me, the surgeon, and for the OR? Finally, remind yourself why you respect this surgeon.

2. Create safety. Find a private place and ask the surgeon’s permission to bring up a problem. Make it clear you want to help, not attack, the surgeon. You say: “I’d like to talk about what happened this morning when the surgical tech wasn’t prepared. It was clearly a frustrating situation for you and for me, too. My goal is to make this place less frustrating—to make it more efficient, effective, and safe. Can we talk?”

Next, explain the gap and provide motivation: “You have very high standards, and I want to make sure all of my people meet them. I don’t want you to think I disagree with your standards. (A contrasting technique.) I want to talk about how you react when someone doesn’t meet your standards. You often say things like, ‘Are you trying to kill my patient?’ or ‘How did they let you graduate nursing school?’ Other times, you raise your voice and lash out at them or call them idiots. When you do that, the spotlight turns to you. I end up having to protect them when I’d rather be coaching them to fix the problem that has us all frustrated.”

3. Move to action. “I know nobody can change this sort of thing overnight. I’d like permission to give you some kind of signal when I see you starting to get upset. If I could give you a subtle reminder, you could catch yourself. Would that be okay?”

What are the qualities of the 10% of health care workers who are already effective at conducting crucial conversations?

Maxfield: They are able to speak up about difficult, touchy topics without attacking the person or watering down their message. They find a way to be completely frank and at the same time completely respectful. What we’ve learned from studying these people over the past 25 years is that their “gift” is actually a comprehensive set of skills that anyone can learn. ●

—Leslie Flowers

References


Seminar: Crucial Conversations

David Maxfield will present a preconference seminar, Silence Kills: Crucial Conversations in the OR, Wednesday, Nov 8, at the Managing Today’s OR Suite conference Nov 8 to 10 in Orlando, Fla.

Leslie Flowers is a freelance writer in Indianapolis.
Please see the ad for
SPECTRUM SURGICAL INSTRUMENTS
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What does JCAHO expect for handoffs?

Standardizing handoffs is a requirement of the 2006 National Patient Safety Goals of the Joint Commission on Accreditation of Healthcare Organizations, which took effect Jan 1.

What does JCAHO expect?
Tips were given in a Jan 25 audioconference by Joint Commission Resources (JCR) and the Association of peri-Operative Registered Nurses (AORN). Speakers were Chris McGreevey, RN, MS, of JCR and Doreen Wagner, RN, MSN, CNOR, representing AORN.

The handoff requirement (Goal 2e) states that organizations must “implement a standardized approach to handoff communications, including an opportunity to ask and respond to questions.”

Examples of perioperative handoffs include transfer of responsibility at shift changes, breaks, or lunch and handoffs between units, such as the emergency room and OR, holding area and OR, OR and postanesthesia care unit (PACU), and PACU and patient unit. Handoffs also occur when reporting critical lab and radiology results.

What should be communicated?
The minimum list, according to JCAHO’s implementation guidelines for the 2006 goals, includes the patient’s:
- diagnosis
- current condition
- changes in treatment
- recent or anticipated changes
- what to watch for.

Additional items might include the patient’s:
- current medical status
- resuscitation status
- current medications
- allergies
- recent or pending lab values
- problem list
- to-do list for incoming physician or nurse.

What will surveyors look for?“Surveyors will be looking for consistency in the staff’s responses to determine if the organization has developed a standardized approach and communicated it effectively in the organization,” McGreevey said. If surveyors hear inconsistent responses, they might want to know more about staff training and education materials.

This doesn’t mean the handoff has to be the same everywhere, she added. Different departments or physician groups might use different approaches.

Surveyors may directly observe some handoffs. “They will listen to see if the handoff is interactive—are the participants asking and responding to questions?” she said.

Strategies for improving handoffs
Wagner discussed strategies organizations can use to improve handoffs:
- Organize a multidisciplinary team to help develop policies and procedures.
- Discuss barriers to communication and develop solutions. For example, if reports are given in places that are noisy or distracting, how can that situation be improved?
- Include the entire team. Discuss barriers to handoff communication that may arise because of hierarchies, for example, between residents and attending physicians and physicians and nurses. Make sure there is leadership backing to address these barriers.
- Address language barriers for clinicians who do not have English as their first language. Promote use of accepted abbreviations, both when speaking and writing. Continue to use techniques like repeating key parts of verbal reports to confirm information.
- Some organizations are using technology to improve communication. Examples are integrated documentation software and patient tracking systems, such as electronic greaseboards, that convey information about patients’ locations and status.
- Ensure that the staff has time to complete handoffs and be sure information is accurate.
- Develop a standardized handoff tool. Some are using the easy-to-remember acronym SBAR:
  - Situation
  - Background
  - Assessment

What is a handoff?
JCAHO defines a handoff as a “real-time interactive process of passing information from one person (or team) to another for the purpose of ensuring continuity and safety of a patient’s care.” The primary objective is to provide accurate information about a patient’s:
- care, treatment, and services
- current condition
- recent or anticipated changes.

Attributes of effective handoffs
- Listening without interrupting or talking over the other person
- Allowing for questions and comments to provide context
- Covering pertinent safety issues, such as any near misses during the patient’s care
- Describing potential problems
- Verifying information by repeating or reading it back, especially if the handoff is not face to face
- Minimizing interruptions
- Providing opportunities to review the patient’s pertinent historical data.

Go beyond the checklist
Checklists are not the only answer to standardizing handoffs, Wagner cautioned. “They may save time, but they don’t provide context and significance of the data,” she said, which is why it’s important to provide an opportunity to ask questions and allow for responses.

More information on the National Patient Safety Goals is at www.jcaho.org.
Tips for introducing SBAR in the OR

S BAR, a handoff model originally developed for communication on submarines, has been adapted for health care by Kaiser Permanente. An acronym, SBAR gives teams a simple tool for structuring communication:

- **Situation**
- **Background**
- **Assessment**
- **Recommendation**

Many organizations are considering SBAR as a method for standardizing handoffs to comply with the Joint Commission on Accreditation of Healthcare Organizations National Patient Safety Goals.

Kaiser Permanente introduced SBAR after realizing that different members of the team have different communication styles, explains Suzanne Graham, RN, PhD, director of patient safety for California Kaiser Permanente.

Nurses tend to talk in broad brush strokes about the care plan. Physicians want the bottom line: “What’s the problem, and what do you need?”

**Putting SBAR into practice**

Graham offered tips for implementing SBAR for nurse and physician teams:

**Prepare the culture**

In a culture that improves communication and enhances safety, the hierarchy is flattened so clinicians at all levels feel safe to speak up and participate. The inevitable mistakes are seen as systems problems that need to be analyzed and corrected, not a personal failure. Staff are taught assertion skills for stating problems politely and persistently until they get an answer—old methods of communicating such as “hint and hope” are fraught with risk, Graham says.

**Make SBAR part of a project**

Learning how to use a new communication technique like SBAR is more meaningful if the team has an immediate opportunity to apply it, Graham notes. For example, it might be part of a project to improve surgical safety.

**Train the whole team together**

“Generally, nurses use SBAR with physicians, so the physicians need to know they will be the receiver of a standardized form of communication,” Graham says. “Physicians should learn to be good receivers and not put SBAR down.”

Physicians tend to like SBAR, she adds, because it reminds them of SOAP (Subjective, Objective, Assessment, Plan) notes, which are used for medical documentation.

Recently, when team training was provided for perioperative staff at a Kaiser Permanente facility, the surgical schedule was arranged so staff and physicians could attend the 2-hour education at the same time. Training was offered 3 times to cover all shifts.

**Develop scenarios**

As an exercise, have small groups develop scenarios for how SBAR would be used in different situations. Graham did this recently at a kickoff for an organization that was introducing rapid-response teams.

“I asked each table to come up with a situation when they would call a rapid-response team,” she explains. “Then I said, ‘Put it in SBAR. How would you tell the response team what is going on using SBAR?’”

**Develop a template**

Coach nurses to have information in front of them when they call a physician. Physicians say that is key to making communication more successful. Graham recommends that nursing units develop a template with questions physicians could attend the 2-hour education at the same time. Training was offered 3 times to cover all shifts.

**Reference**


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**SBAR: Perioperative examples**

**Preoperative nurse to OR nurse**

**Situation:** “Mary, I’m going to be sending Mrs Porter over to you in a few minutes for repair of her fractured ankle. I want you to know what’s going on with her. I’m concerned about her emotional status. I’ve also alerted Dr Anesthesia and Dr Surgeon about my concern, but they have agreed to go ahead with the surgery because she needs this procedure to salvage her foot.”

**Background:** “She was in an auto accident last Friday, and her husband was killed. Her children are all at the funeral home making arrangements for his burial. She’s made some comments about not wanting to live. Her vital signs are stable; the foot is cool and slightly mottled. We’ve just given her some Versed.”

**Assessment:** “I think her emotional status is such that this will be a very difficult period of time for her, especially during induction and awakening from anesthesia.”

**Recommendation:** “I suggest that you meet her as soon as possible and stay with her during induction and emergence from anesthesia.”

**Anesthesia provider to nurse in postanesthesia care unit**

**Situation:** “Sue, this is Mr Smith. We’ve just completed a colon resection on him.”

**Background:** “He’s 72 years old, and the procedure was done for colon cancer. He also has emphysema and his O2 saturation has not been very good since extubation.”

**Assessment:** “His current O2 saturation is 85%, with respirations of 6 per minute. Other vital signs are stable, dressings are clean and dry, and he’s starting to respond to voices.”

**Recommendation:** “Please put him on 5 liters of O2 and keep me informed of his O2 saturation and other vital signs.”

**Credit:** Kathy Shaneberger, RN, MSN, CNOR.
‘Passing the baton’ for smooth handoffs

Just as runners in a relay race plan each step for passing the baton, the perioperative team needs to plan for the safe handoff of patient care from one caregiver to another.

The primary objective of a handoff, according to the Joint Commission on Accreditation of Healthcare Organizations, is to provide accurate information about a patient’s “treatment and services, current condition, and any recent or anticipated changes.”

At Sharp Mary Birch Hospital for Women in San Diego, the perioperative services team developed a process to improve handoffs. The protocols, modeled on passing the baton, standardize information to be conveyed when responsibility for a patient is transferred:

• the preoperative area to the OR
• OR team to OR team
• OR to the postanesthesia care unit (PACU).

“Relay runners don’t stop to pass the baton. The transfer is smooth as they continue running. We want the same thing for our patients,” says Denise Foster, RN, BSN, manager of perioperative services.

**Ask the staff**

Foster began by asking the staff what they need to know during handoffs and what would be helpful to them. “They know what they need more than anyone else does,” she says.

The staff, in particular the surgical technologists (STs), got the ball rolling on developing a handoff procedure for the OR team. Some STs said they needed better information when they relieved each other during cases, Foster says. That led one ST to develop a handoff procedure for the STs and RNs.

Unlike circulating nurses who have documentation to consult in handoffs, scrubbed persons rely on oral information, such as the status of the case, what instruments are being used, how many sponges have been used, which medications are on the field and back table, and what the needle count is. The STs thought they needed a structured format for this information.

Now detailed information is communicated when one scrubbed person relieves another. Each OR has a tip sheet posted that describes the handoff. Similar tip sheets are posted for the preop-to-OR handoff and OR team-to-PACU handoff (illustration, p 14).

**Involving the patient**

The preop-to-OR handoff includes the patient in the process, which not only makes the handoff more personal but reassures patients about the caregivers and care they will receive, Foster says.

The exchange is guided by a communication tool known as A-I-D-E-T (Acknowledge, Introduce, Duration, Explain, Thank you) that outlines fundamentals of customer service. The tool was developed by the Studer Group, which consults on service excellence (www.studergroup.com) (sidebar).

One step is to introduce the patient to the caregiver for the next phase of care; in this case, the circulating nurse. To aid in this step, managers ask all team members to fill out brief bio sheets with information such as their name, title, years of experience, years of work at the hospital, and clinical strengths.

The preop nurse would use the bio to introduce the patient to the circulating nurse (sidebar).

This is more sensitive and reassuring to the patient than just saying, “We have x-rays, we have lab results, and we have an operative permit,” Foster notes.

**PACU handoff**

After surgery, the handoff between the circulating nurse and PACU nurse complements the report given by the anesthesiologist. The anesthesiologist gives the main report, including medications given, type of anesthesia, allergies, blood loss, and opening and closing times for the procedure. The circulating nurse adds information such as which family members or friends are in the waiting room, preoperative medications that were given, and whether the patient wears dentures or glasses or uses a hearing aid.

“Our handoffs include so much more detail than they did before, and that is a good thing for the staff and for the patients,” Foster says.

—Judith M. Mathias, RN, MA
Joint Commission

Handoff procedures

Preop ➔ OR

- Planned surgical procedure
- Planned anesthesia type
- Allergies
- Last void
- Medications received preop
- Antibiotics to be given
- Significant medical history (cardiac, elevated blood pressure, asthma, etc)
- Rh (if delivery or termination)
- Gestational age if pregnancy related
- Family waiting/contact information?
- Belongings?
- Equipment needs (sequential compression device, blood warmer, etc)
- Other issues (blood products available, STAT postop orders, etc)

OR ➔ OR

On coming on or going off of a case, the scrub or circulator verifies:

- Procedure
- Surgeon plan/preferences (Where are we in the case?)
- Anesthesia type
- Allergies
- Significant medical history
- Count
  - Laps
  - Ray-Tecs
  - Needles
  - Knife blades
  - Miscellaneous
- Irrigations
- Medications
- Instrumentation on and off field
- Specimens on and off field
- Equipment needs

OR team ➔ PACU

Anesthesiologist/OR RN:

- Surgical procedure
- Anesthesia type
- Estimated blood loss
- Input & output (Foley, straight catheter)
- Allergies
- Medications received in OR (antibiotics or others)
- Significant medical history (cardiac, elevated blood pressure, asthma, etc)
- Rh (if delivery or termination)
- Family waiting/contact information?
- Belongings?
- Equipment needs (sequential compression device, blood warmer, etc)
- Other issues (blood products, STAT postop orders, etc)

Source: Sharp Mary Birch Hospital, San Diego.
A SHARED tool strengthens handoffs

To strengthen communication, Northwest Community Hospital (NCH), Arlington Heights, Ill, has developed a handoff method based on Kaiser Permanente’s model, SBAR (Situation, Background, Assessment, and Recommendation).

The method, termed SHARED, involves these steps:
- S—Situation
- H—History
- A—Assessment
- R—Request
- E—Evaluate
- D—Document.

The goal is for nurses to share the same information in the same order when transferring care of patients.

Staff input is key
The surgical services shared governance staff leadership council at NCH has used the SHARED model to create a communication tool for handoffs as part of its effort to improve interdepartmental communication (form, p 16).

“It was helpful for us to have our shared governance council involved in creation of this tool because the staff perceived it as an extension of their own ideas rather than just another form to fill out,” says NCH’s director of surgical services, Judith Knupp, RN, MA.

The entire council had input into the tool, and input was gathered from other staff as well, notes Jill Moscato, RN, APN, OR advanced practice nurse.

Important to acceptance, along with staff input and buy-in, was having nurses and other staff members explain the tool to each other, rather than just putting the form on the chart, says Knupp.

Filling out the SHARED tool is not the same as documenting in a chart. “The SHARED report is simply a work sheet to help the staff organize their report to other caregivers and not a permanent part of the patient’s record,” she emphasizes. The report is discarded at the end of the patient’s surgical experience.

“It’s important to understand that we don’t separate each part of this report to a certain surgical department—nurses in each department fill out as much as possible,” she adds. “The purpose is to communicate information that is significant or of interest about the patient and share a unified report.”

Sharing information
Use of the SHARED report begins when the patient enters the system.

Most surgical patients are first seen in the preadmission testing area 5 to 7 days prior to the day of surgery. Nurses begin the SHARED report, filling in as much as they can. They circle specific orders from the physician’s order sheet that need to be completed in the surgical prep area (SPA), such as giving antibiotics and removing hair.

“For example, we don’t write in the type and dosage of antibiotic; we just circle ‘antibiotic,’” explains Rhonda Lane, RN, BSN, coordinator of the presurgical area. “This circle is a prompt for the SPA nurse to make sure the antibiotic is received from the pharmacy and placed at the patient’s bedside.”

The SPA nurses complete the History, Assessment, and Request sections of the form so this information is available for report when the patient is handed off to OR personnel. The Evaluate section is a prompt for nurses participating in handoffs to ask nurses receiving the patient whether they need more information. All nurses participating in handoffs sign the Document section.

ER involvement
Surgical services is involving the emergency room in the SHARED report.

“We are in the beginning stages of implementing it in the ER, but the idea is that when a patient presents in the ER who needs surgery, the SHARED report will be filled in as much as possible by the ER nurse. The report will then be faxed to all 3 surgical areas—the SPA, OR, and PACU,” notes OR clinical coordinator, Karen Reynolds, RN.

That way, all 3 areas will get the information early so they can prepare for the patient, and information can be given immediately to the anesthesiologist. The ER nurse will give the final handoff report by phone to either the SPA or OR nurse, depending on the time of admission and the urgency of surgery. Then a transporter will take the patient from the ER to surgery.

PACU prompts
When a patient is transferred to the PACU, the OR/PACU section on the form guides the OR nurse to give a precise, organized report to the PACU nurse, says Maggie Luber, RN, manager of PACU.

The PACU Orders section is often started by the SPA nurse because many internists and cardiologists, for example, leave postoperative orders in the chart to be started immediately after arriving in the PACU, notes Luber.

When an inpatient leaves the PACU for the surgical unit, the PACU nurse uses the SHARED tool when calling the unit. The PACU is working with unit nurses to expand the report to include information they need that isn’t present on it.

The SHARED report is a comprehensive, concise way to see patient information on one page. ✴

—Judith M. Mathias, RN, MA

Reference

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**SHARED Report — Surgical Patient**

| **Situation** | Hello, this is __________________________ RN
| | from __________________ (unit) Ext __________
| | I am calling to give report on: ________________________________
| | Age ____ Sex ____ Language ___________________ Doctor __________________

| **History** | **Diagnosis:** Admitting: __________________ Current: __________________
| | **Allergies:** __________________
| | **Meds:** __________________
| | **History:** Medical/psych/soc __________________
| | **Isolation:**  yes  no  Type: __________ Site: __________________
| | **Recent:** Narcotics __________________
| | **Antibiotics:** __________________
| | **Treatments/procedures:** __________________

| **Assess** | **Last oral intake:** __________________
| | **H & P on chart:**  yes  no  **Preop health history completed:**  yes  no  **Consent signed:**  yes  no  **Power of Attorney or Surrogate Form on chart:**  yes  no  n/a
| | **Vitals:** T____ P____ R____ BP____ SAO₂____
| | **Neuro:** __________________ Mental status: __________________
| | **Resp:** __________________
| | **Cardiovascular:** __________________
| | **Skin:** __________________ Dressing: __________________
| | **Renal/fluids:** IV: Solution_______ Site_______ Gauge_______
| | **Blood products:** __________________
| | **Foley** __________________
| | **Pain:** _______/10 Location __________________
| | **Abnormal labs:** __________________
| | **Pregnancy test:** __________________ (menstruating females)
| | **Dentures/jewelry/underclothes removed:**  yes  no

| **Request** | **Surgical Prep Area (SPA) needs:**
| | • Test results __________________ From __________________
| | • Anesthesia interview  yes  no  Consent  yes  no
| | • Old chart  yes  no  Requested  yes  no  Received  yes  no

| **SPA orders:** | • TEDs knee/thigh  Size _______  SCD knee/thigh  yes  no
| | • Incentive spirometry  yes  no  AV impulse  yes  no
| | • Antibiotic  yes  no  Hair removal  yes  no
| | • Blood sugar  yes  no  Nutrition evaluation  yes  no

| **Evaluate** | **Labs** __________________
| | **Other** __________________

| **Document** | Report given to ** __________________________ RN.  **
| | **This form is not part of the medical record.**

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Source: Northwest Community Hospital, Arlington Heights, Ill.
the block schedule pattern will identify peaks and valleys in available elective block time. Thus, the OR schedule is a key driver to inpatient capacity—or lack thereof.

Most surgery departments have peak days in the surgery schedule, usually on Tuesday and Wednesday. This is primarily because surgeons who perform complex cases with longer lengths of stay want to perform them earlier in the week so patients can be discharged before the weekend when an on-call physician might have to assume their care. Also, ancillary services often aren’t available on weekends. As a result, inpatient bed capacity is filled early in the week, leaving fewer beds for urgent and emergent patients. This taxes the hospital’s resources and creates competition between the OR and the ED for inpatient beds. When inpatient beds are full, the ED becomes overcrowded, and patient safety is compromised.

Peak days also require more expert OR staff and equipment, which can lead to resource conflicts and excessive flash sterilization. The peaks may also result in longer turnover times, case delays, and cancellations. Patients may be held up in the postanesthesia care unit waiting for beds.

A hospital in this situation must make tough decisions. Patient, staff, and physician satisfaction plummets. The elective surgery schedule must be delayed or cancelled, and/or the emergency department must divert ambulances. In some communities that have only a few hospitals, as in our community, diversion may not be an option. Then the surgery schedule suffers because canceling elective cases is the only alternative for decompressing the bed crunch. Limiting or canceling cases may permanently damage referrals, managed care contracts, and the hospital’s financial viability. To avoid canceling or delaying cases, patients may be placed in the first available bed. Surgical patients may be placed on cardiology floors, orthopedic patients on pediatric units, and so forth. Placing patients on inappropriate units leads to extended stays and compromises safety.

**What’s the solution?**

The solution? Smooth the flow of elective admissions to the hospital. Although not easy, this is a long-term solution. One way to accomplish smoothing is to provide consistent block availability by surgical service throughout the week based on utilization. This requires accurate data for surgeon and surgical service utilization of the OR. Data should include patient-in-room to patient-out-of-room time plus associated turnover time. Once the number of hours utilized in a given time frame is determined, the result can be divided to obtain the average number of hours needed every week; this is further

A high degree of collaboration is critical.
divided equally for every day of the week. This smoothing provides a service or surgeon with consistent block time throughout the week. The advantage to the surgeon is more consistent placement of patients in the appropriate inpatient beds.

A project to smooth the flow
Learning about the research on variability led the physician and hospital leadership at St John’s Regional Health Center in Springfield, Mo, to embark 2 years ago on the difficult task of smoothing the flow of elective surgical admissions. Prior to the smoothing project, block time was allocated according to surgeons’ preference and utilization. As a result, variability in elective admissions was largely a result of a surgeon’s scheduling availability (Graph 2).

Fortunately, at St John’s, collaboration, leadership, and a willingness to improve through change are deeply cemented. Since 1995, blocks have been changed every 4 to 6 months based on block utilization, with 70% utilization required to maintain block time. Block scheduling rules apply to all surgeons regardless of their “rank” or seniority.

Surgeons participate in the governance of perioperative services through the Perioperative Services Guidance Team, co-chaired by the chair of the department of surgery (a surgeon) and the director of perioperative services. Five surgeons from resource-intensive, high-volume services; an anesthesiologist; perioperative managers; and materials management round out the committee, which meets twice a month at 6 am. Meeting attendance is 100% because it is well known that this group “gets things done.” This committee reports to the larger Surgical Executive Committee and, ultimately, to the hospital board. Without fail, every 4 months, the block schedules for both the hospital OR and surgery center are reviewed for utilization, adjusted, and approved for recommendation to the Surgical Executive Committee.

Creating an add-on room
Smoothing began with creation of an add-on room in 2002. An add-on room reduces variability by separating the predictable, scheduled cases from unpredictable, unscheduled cases to improve the flow of scheduled cases. The add-on room provides the flexibility to improve throughput and allow scheduled cases to proceed in a more predictable manner. No longer is bumping necessary to make room for unscheduled add-on cases.

The Perioperative Services Guidance Team began by clearly defining add-ons as:
- emergent (next room available, threat to life or limb)
- priority (requires a room within 2 hours)
- urgent (needs a room within 6 hours)
- to follow (needs to be done in the next 24 hours).

It is the surgeon’s responsibility to designate the patient’s acuity and prioritize the case to be placed on the add-on list, and the case will be done accordingly. The OR staff is no longer responsible for determining patient or case priorities.

If the case is not started within 30 minutes of the surgeon-defined time, the case becomes an emergency and receives the next room available. If a patient’s condition does not warrant surgery within 24 hours, the case should be scheduled into the next available block or open time.

An add-on room is not intended to be utilized more than 60% of the time available. If utilization is more than 60%, the room’s flexibility may be lost. Staff can be reassigned to ensure expert staff for the add-on case being performed. Cases that are not prioritized appropriately are

Continued on page 20
OR Business Management Conference

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- OR Design and Construction
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Photo: Travis Jennings
Surgical scheduling

Add-on room results

- Surgical case volume increased by 5.1% between 7:30 am and 1:30 pm.
- Overall volume has increased by at least 7% every year for the past 3 years with associated revenue growth.
- Need for operating rooms at 3 pm, 5 pm, 7 pm, and 11 pm decreased by 45%.
- Overtime overall was reduced to 2.9%.
- Trauma surgeon revenue increased by > 4.6%.
- Nursing floors are able to better predict staffing.
- Patient, physician, and staff satisfaction increased.

Continued from page 18

taken to the Perioperative Services Guidance Team for review and disposition. (Results are in the sidebar.)

Smoothing the elective schedule

After the success of the add-on room, the next step was to smooth the flow of elective surgical admissions. Even after creation of the add-on room, peaks and valleys in the block schedule were still creating bed capacity issues as well as cancellations, delays, and ED diversion.

Because of their strong physician leadership, the orthopedic surgeons were approached in 2004 about smoothing the flow of their elective admissions by evening out their elective block time. The Perioperative Services Guidance Team agreed that orthopedics as a specialty would be provided with an additional 19 hours of block time in return for changing their schedules in the office and the hospital to smooth their elective OR time. The average weekly orthopedic surgical volume was calculated over the previous quarter and distributed evenly throughout the week.

The orthopedic surgeons then distributed this allotted time among themselves, working closely with the OR management team. The result was a block schedule that reduced resource conflicts for orthopedic staff and equipment in the OR. The new schedule also reduced the overflow of postoperative orthopedic patients to nonorthopedic floors by at least 12%, with 96% now placed in the appropriate bed.

The success in orthopedics fueled the further implementation of smoothing of the schedule across all services. In August 2005, all of the sections were allocated block time evenly across the week (Graph 3). They were asked to review their block utilization and distribute the time among their sections. Graph 4 shows the result—the peaks and valleys of inpatient admissions were smoothed; 27% fewer procedures were performed on the peak day of Tuesday, and the case volume was spread throughout the week.

Capping a service’s hours

The other method of smoothing the schedule is to cap the number of cases or hours of surgery a service is able to perform based on destination and bed availability, providing consistency in utilization throughout the week. An example of this method, used by Boston Medical Center, was described in the December 2004 OR Manager.

St John’s is currently using this strategy to smooth the cardiothoracic elective admissions primarily to the ICU. In March, St John’s plans to allocate 12 hours of elective surgical block time to this group based on its historic utilization by week. The rest of the service’s 16 hours will be available for urgent, emergent, and inpatient cases, which now are frequently performed after hours.

Research on smoothing patient flow

Eugene Litvak, PhD, of Boston University, has studied the effect of variability in patient flow on hospital operations. Interestingly, a major source of what he terms “artificial” variability is elective surgery.

In a study published in 2003, Litvak and colleagues found that during the hospital’s busiest times, nearly 70% of the diversions from the ICU were associated with variability in the scheduled caseload—when elective surgery peaked, so did the number of patients diverted from the ICU.

For example, the cardiac surgeons have block times on Wednesdays and Thursdays. When those patients come out of surgery, they go to the ICU. Soon those beds are full. There is no more room for patients who come in as emergencies, and the emergency department is placed on diversion. If the demand for ICU beds is high enough, some surgical patients may need to be held in the postanesthesia unit.

“When you have a peak in elective surgical demand, all of a sudden, your resources are being consumed by those patients. You don’t have enough beds to accommodate the medical demand,” Litvak said in a 2003 interview with OR Manager.

Smoothing the elective surgical schedule can avoid these peaks and valleys. Moreover, Litvak has demonstrated that when the schedule is smoothed, surgeons can get more cases done. Nursing costs are reduced because there are fewer surges and less overtime. There also are likely to be fewer errors because clinicians are not as stressed.

References


Smoothing OR schedule can ease capacity crunches, researchers say. OR Manager. November 2003;19(11):1,9-10.

Hear Eugene Litvak, PhD, at a breakout session on smoothing patient flow at the Managing Today’s OR Suite conference Nov 8 to 10 in Orlando, Fla.
A combination

A combination approach is also an option, providing flexibility and smoothing simultaneously. Flexibility and open time for add-on cases must be ensured and are critical for success with smoothing the schedule. Utilization of block time must be consistently evaluated and adjusted regularly based on utilization (at least every 6 months—quarterly is best). In addition, at least 10% to 15% of open unblocked time should be available daily to accommodate cases that are not scheduled. Having a defined block release policy for every service also ensures optimal utilization of available elective time.

Collaboration, trust crucial

Because surgeons must change operating days and office or clinic days to smooth the schedule, a high degree of physician and hospital collaboration and trust are crucial. These are a few keys to success based on our experience:

- Trials are encouraged to cement the collaborative relationship, address issues, and enable rapid-cycle improvements.
- The hospital administration must be fully aware and supportive of this initiative.
- Choosing the right physician champion is important.
- Providing the surgeons with incentives like more block time in exchange for participating in a trial of a particular option may allow for a smooth trial and transition. At St John’s, each time a section was asked to participate in a trial of a scheduling change, the service was given extra block time and the promise that if the trial was not successful, the previous schedule would be reinstated with no reduction in time.

This collaborative approach is the only method for implementing this strategy successfully. The gains in quality, patient safety, improved revenue, capacity, and throughput are tangible and irrefutable. ✴

—Christy Dempsey, RN, BSN, MBA, CNOR
Vice President
St John’s Regional Health Center
Springfield, Mo

OR Business Management Conference offers practical supply chain strategies

Looking for ideas on improving the surgical supply chain? OR leaders and business managers can gain practical strategies for materials management at the OR Business Management Conference May 10 to 12 in Austin, Tex. Attendees can choose from 2 all-day seminars and 7 breakout sessions that focus on topics like technology acquisition and value analysis.

Preconference seminars

Two all-day seminars, to be held Wednesday, May 10, have a materials management focus:

A Systems Approach to Materials Management
A team from a health system in the Midwest will describe how the system saved $9.4 million in the past year using innovative approaches to vendor negotiations, standardization and consolidation, and physician-determined best practices.

Crossing the Clinical Technology Chasm
Anthony J. Montagnolo, MS, of the nonprofit agency ECRI, will take the audience through the essentials of evidence-based technology assessment using case studies. He will discuss key strategies for assessing and planning for new technologies.

Breakout sessions

Breakout sessions will give attendees take-home ideas for the selection, purchasing, and management of OR supplies and equipment:

Patient and Asset Tracking Systems
The session will cover types of tracking systems, how they work, and what gains can be expected. Advantages and disadvantages of each type of system will be discussed.

Best Practices for Managing Medical Device Hazards and Recall Notices
The audience will hear about best practices for managing these notices, which can be critical to patient safety, including defining responsibilities, having a consistent naming convention, and organizing the process.

Implementing an Automated Inventory Control System in the OR
A hospital system’s team will talk about lessons learned from rolling out an automated system that is interfaced with the enterprisewide inventory system. They will discuss how the system improves logistics and provides data for management decision making.

Managing the High Cost of Technology
This session will cover 10 tips for managing technology costs and purchasing effectively. Among topics are staying within the capital budget, new product entry committees, value analysis teams, and where to get information about new technologies.

Advanced Value Analysis for Managing Perioperative Operations
A medical center will share dramatic results gained from its multidisciplinary approach to value analysis, which has improved product flow, screened out nonvalue-added products, and improved revenue capture.

Supply Chain Management to Reduce OR Inventory
A team from a health system will discuss how they exceeded a goal of reducing inventory by $2 million, or 25%, and increased the turn rate from 4.8 to 7.6. They will talk about processes they used to achieve the savings.

Understanding and Managing Orthobiologics
Orthobiologics—bone pastes, crunches, and bone morphogenic protein, to name a few—can benefit patients but add as much as $5,000 to a case. The speaker will talk about the different orthobiologics and their uses and describe one health center’s experience in collaborating with surgeons to ensure products are available, but costs are not forgotten. ✴

Download the conference brochure and register online at www.ormanager.com.

Check our web site for the latest news, meeting announcements, and other practical help. www.ormanager.com
Despite evidence that proper use of antimicrobials prevents postoperative infections, it’s a challenge to set up a system to ensure antibiotics are used properly. Christiana Care Health System in Newark, Del, formed an interdisciplinary committee to develop an antimicrobial prophylaxis protocol in January 2004. The goal was a protocol that made it easy for surgeons to order the appropriate antibiotics based on national standards.

At first, a generic order based on the recommended antibiotics seemed like the answer. The surgeons could just check a box that said: “Institute surgical prophylaxis.”

A nurse and pharmacist would then use a checklist to identify the planned procedure and which antibiotics should be given according to the protocol.

But this approach didn’t improve compliance. Many surgeons were opposed because they thought someone else was ordering their antibiotics for them.

Leaders went back to the drawing board and came up with an approach using standard orders, which has been more successful.

The project started with formation of an interdisciplinary team to develop the antimicrobial prophylaxis protocol.

Choosing the appropriate drug

“We did not have an official protocol in writing on prophylactic antibiotics before this group started meeting,” Mary Cay Curran, MSN, RN, CAPA, perioperative clinical practice coordinator, told OR Manager.

The committee developed the protocol as part of the hospital’s Care Management Guidelines, which are care paths followed by physicians and nursing staff.

In writing the protocol, the committee used the surgical procedures suggested by the National Surgical Infection Prevention Project, as described by Bratzler and colleagues.

Christiana later expanded the protocol to include all patients undergoing surgery. “We realized that if we were going to have the same standard of care for all patients, we had to expand the protocol,” says Curran.

The infection control department and pharmacy developed recommendations for the appropriate antibiotics and sent them to the surgical specialty sections. They also asked the surgeons what they were routinely using and what their professional organizations recommended.

Because the protocol is a care path, it doesn’t supersede individual surgeon’s decisions. “If for some reason, the surgeon disagrees with the drug selection for a patient, the surgeon can prescribe the drug he or she thinks is best,” says Judith Townsley, RN, MSN, CPAN, perioperative director of clinical operations.

For the most part, the surgeons went along with the recommendations, but some specialties made changes because of recommendations from their professional societies.

Beta-lactin allergies

The biggest issue was use of vancomycin and clindamycin for beta-lactin allergies. Many of the surgeons used clindamycin as the drug of choice. But the infection control department recommended vancomycin instead because of the number of patients with methicillin-resistant Staphylococcus aureus (MRSA).

“The surgeons thought they were doing a good thing by not overusing vancomycin, but infection control pointed out that because the organization had a number of patients with MRSA, it is best overall to use vancomycin,” says Curran.

Garnering surgeon support

Based on feedback about the generic order approach, the committee chose

Making headway on SCIP measures

This article is the first in a series focusing on the Surgical Care Improvement Project (SCIP). Cosponsored by 10 national organizations, SCIP targets 4 areas:

- surgical site infections
- adverse cardiac events in patients having noncardiac surgery
- venous thromboembolism
- perioperative ventilator-related pneumonia.

SCIP measures

Surgical site infection

SCIP has 7 measures for preventing surgical site infections. This article addresses the first 2:

- Prophylactic antibiotic received within 1 hour prior to surgical incision
- Prophylactic antibiotic selection for surgical patients

SCIP has 7 measures for preventing surgical site infections. This article addresses the first 2:

- Prophylactic antibiotic received within 1 hour prior to surgical incision
- Prophylactic antibiotic selection for surgical patients

For more information on SCIP is at www.medqic.org/scip.

instead to use a 1-page sheet of standing orders, which lists the drug of choice and drugs to substitute if the patient is allergic to the drug of choice for each specialty. There is a space to write an alternative drug if the surgeon chooses.

There has been more support for the new protocol since the standing-order form was developed. About 90% of the
surgeons now order prophylactic antibiotics according to the protocol guidelines, says Townsley.

She sent thank you letters to the physicians who comply with the protocol and order set.

“It is important to recognize those physicians who are dedicated to delivering excellent care to patients receiving services at Christiana Care Health System,” she says.

Outliers are surgeons who have been using the same antibiotic for years, say they have not had any infections, and do not want to change.

Start & Chart

For timing and duration of administration, the committee followed the Centers for Medicare and Medicaid Services (CMS) recommendations that antibiotics be:

• given 0 to 60 minutes before surgery
• discontinued within 24 hours after surgery. The committee came up with the phrase “Start & Chart,” to help ensure the antibiotic is started before the patient leaves the holding area. A bright orange laminated sign on the wall of the holding area reminds anesthesia providers to start the antibiotic and chart the time.

Monitoring the protocol

The protocol is monitored in 2 ways.

• Christiana’s OR is required by the state’s Medicare quality improvement organization (QIO) to report on the 3 performance measures of appropriate antibiotic, appropriate timing, and discontinuation of antibiotic within 24 hours.

One person audits all charts after patients are discharged and fills out forms for the QIO, which gives the organization a score. The score is available to the public on the Department of Health and Human Services web site.

• Curran also does her own proactive audit for the OR’s process improvement statistics.

“If I identify an issue, we can make a change quickly and not wait for the QIO audit,” she says. For example, in February 2005, cefotetan, the drug of choice for gynecologic and colorectal surgery, was no longer available. The committee recommended that these specialties change to an alternative, cefoxitin. But the organization’s supplier ran out, so the pharmacy made an automatic substitution to cefazolin and metronidazole. Because Curran was doing her own audit, she was able to communicate the substitutions and administration timing to surgeons and anesthesia providers quickly.

The perioperative services executive leadership is key to implementing the protocol, Townsley says.

“The team is focused on improving clinical excellence for all patients who require our services.”

—Judith M. Mathias, RN, MA

References


Please see the ad for KARL STORZ ENDOSCOPY in the OR Manager print version.
How do physicians determine which cases are safe to perform in the ambulatory surgical setting?

As procedures become safer to perform in ambulatory surgery centers (ASCs) and private insurers and Medicare encourage them, patient selection has become a front-burner issue for anesthesiologists.

“The topic is raised at every ambulatory anesthesia meeting,” says anesthesiologist Raymond Borkowski, MD, medical director of the Carnegie Ambulatory Surgery Center, one of 5 ambulatory surgery centers owned by The Cleveland Clinic Foundation (CCF). “There’s an adage that there is no patient whose surgery can’t be performed in an ASC. I don’t think that’s true. Yes, we are seeing more ASA 3s and even ASA 4s with minor procedures, but there are definitely limitations,” he said, referring to the physical status classification system developed by the American Society of Anesthesiologists.

Cleveland Clinic guidelines

Because there are no hard-and-fast rules for patient selection at ASCs and little research to support decision making, CCF anesthesiologists created their own guidelines. Dr Borkowski convened the medical directors of CCF’s ASCs to write the guidelines. Their overriding safety considerations were the:

- patient’s medical condition
- type of procedure
- type of anesthesia required.

The first CCF guideline is that patients have a thorough preoperative health assessment to determine if they are appropriate candidates for ambulatory surgery.

At the initial surgical evaluation at CCF, each patient takes a computerized presurgical assessment called HealthQuest. HealthQuest is a computerized questionnaire with about 140 interactive questions. Patients can answer the questions on a touch screen in the surgeon’s office or over the Internet. The computer program has built-in algorithms that process the answers to give a summary of the patient’s health status, which is given a score of 1 to 4. (This scale is different than the ASA physical status classification.)

The second step in patient selection is to classify the type of surgery, using the Johns Hopkins Surgical Classification System developed by L. Reuven Pasternak, MD, MBA, MPH. Procedures are classified from category 1—minimal risk, minimally invasive with little or no blood loss, such as a breast biopsy or vasectomy—to category 5—major risk, highly invasive, and blood loss greater than 1,500 mL, such as cardiothoracic or intracranial procedures.

The surgeons or their designee, such as a resident or physician assistant, consult a grid with the HealthQuest score and the surgery classification (grid, page 26). The intersection of these values determines which preoperative evaluations are recommended prior to surgery, Dr Borkowski says.

For example, a patient with a HealthQuest score of 3 or 4 and a procedure that is a category 2 or higher requires an evaluation in both:
- the IMPACT (Internal Medicine Preoperative Assessment, Consultation and Treatment Center), staffed by hospitalists, and
- the PACE (Preoperative Assessment, Consultation and Evaluation Clinic), staffed by anesthesiologists.

For a patient with a HealthQuest score of 1, no evaluations are suggested for any surgical category. These patients

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are placed in an “express group” and have an anesthesia assessment only on the day of surgery. This is also the case if patients need only preoperative evaluations in the IMPACT clinic.

Getting set for day of surgery

The PACE anesthesiologist ensures the anesthesia provider has the necessary information and test results for the day of surgery.

“This greatly decreases, although I can’t say eliminates, cancellations and delays on the day of surgery,” Dr Borkowski says, adding that these evaluations should be performed a minimum of 2 weeks prior to surgery. This allows time to obtain tests from other institutions or for patients to have studies to optimize their medical condition prior to surgery.

“If the evaluation isn’t performed until the day before surgery, we sometimes can’t get the appropriate information, and surgery is postponed,” he says.

CCF has more influence in enforcing patient selection guidelines than other organizations might because the surgeons who operate at the foundation’s ASCs are CCF employees. There have been few if any compliance problems, Dr Borkowski says.

“We told the surgeons this is what we expect, and this is how the patients will be evaluated at our centers,” he says. “I can and will say no to a patient who is not appropriate for the ambulatory surgical setting. Since we’re all Cleveland Clinic employees, the surgeons aren’t taking their business to another center if they don’t like the decision.”

Facility limitations

Another guiding issue in ambulatory surgery patient selection is the type of surgery center—freestanding or freestanding with a relationship to a hospital that is in safe patient-transfer distance. Surgery at an independent, freestanding surgery center may carry more risk for patients with higher ASA classifications, Dr Borkowski says.

“I have a friend who was the medical director of a freestanding surgery center,” he says. “He was the sole anesthesiologist and has no hospital affiliation. He had to be much more careful about the types of cases he was willing to do.”

Another limitation of an ASC is the amount of surgical equipment and instruments on site.

“ASCs are only so big, and that is a surgical and safety constraint,” Dr Borkowski says. “We can’t have everything a hospital has.”

A matter of clinical judgment

Little research has been done to guide recommendations for patient selection in ASCs, Dr Borkowski says.

“This situation reflects the not-uncommon phenomenon of rapid diffusion of a technology without an evidence-based analysis to determine appropriate risk factors,” wrote Dr Pasternak in the Canadian Journal of Anesthesia. “The ability to truly determine the relative risk of ambulatory surgery is, at best, ambiguous despite over 20 years into its rapid growth phase.”

The Canadian Ambulatory Anesthesia Research and Education Group conducted extensive literature reviews on conditions that may make patients unsuitable for ambulatory surgery (side-
**Contraindications for ASC procedures**

Though patients with significant medical histories may undergo surgical procedures at ASCs, there are a few absolute contraindications, according to patient selection guidelines established by The Cleveland Clinic Foundation:

- highly suspected or a history of known difficult intubation
- cases in which blood or blood products may be required
- total care nursing home patients or uncooperative patients
- history of or strong family history of malignant hyperthermia
- patients who may require greater than extended recovery, eg, discharge after 7 am
- patients with automatic implantable cardioverter defibrillators
- duration of surgery greater than 6 hours
- emergency surgery
- body mass index (BMI) greater than 38
- patients with significant cardiac and pulmonary disease
- patients who cannot be discharged to the care of a responsible adult
- patients who plan to use public transportation or drive themselves home
- when the patient’s primary language is not English, and a translator is not available or present.

**Evidence on patient selection**

Canadian researchers reviewed the evidence on the risk of ambulatory anesthesia for patients with significant coexisting diseases. In many cases, there is little evidence on outcomes, and they suggested more trials. Their findings:

- **Elderly patients:** May safely undergo ambulatory surgery but are at increased risk for hemodynamic variation in the OR.
- **Heart transplant recipients:** At increased risk of coronary artery disease and renal insufficiency and should undergo careful preoperative evaluation.
- **Reactive airway disease patients:** At increased risk of minor respiratory complications and should be encouraged to quit smoking.
- **Coronary artery disease and recent myocardial infarction patients:** May undergo ambulatory surgery without stress testing if functional capacity is adequate.
- **Obstructive sleep apnea patients:** At increased risk of difficult tracheal intubation, but the likelihood of airway obstruction and apnea following ambulatory surgery is unknown.
- **Diabetes mellitus:** Has not been linked with adverse events following ambulatory surgery.
- **Morbid obesity patients:** At increased risk for minor respiratory complications in the preoperative period, but these events do not increase unanticipated hospital admissions.
- **Ex-premature infants:** May be considered for ambulatory surgery if postconceptual age is > 60 weeks and hematocrit is > 30%.
- **Children with upper respiratory infection:** At increased risk for perioperative respiratory complications, particularly if endotracheal intubation is required.
- **Malignant hyperthermia patients:** May undergo outpatient surgery but require 4 hours of postoperative temperature monitoring.
- **Meperidine and indirect acting catecholamines in combination with monamine oxidase inhibitors:** Ambulatory surgery is safe if these drug combinations are avoided.


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Morbid obesity is an important issue for patient selection at ASCs, Dr. Borkowski notes.

“A colleague told me his center used to have a limit of 350 pounds because the OR table could only hold 350 pounds,” he says. “Then his surgery center bought tables that could hold 500 pounds. But the issue isn’t how much weight the table can hold. The issue is that obese people have a higher incidence of medical conditions such as diabetes, sleep apnea, cardiac disease, and difficult airways—all conditions that factor into our decision of ASC appropriateness.”

Dr. Borkowski says much of his determination is based on physicians’ clinical judgment.

“We’re not going to do a thoracic aneurysm repair or a colectomy in a freestanding surgery center,” he says. “It’s a patient safety issue, and you need to be able to say to your surgeons, ‘I won’t do it.’”

—Leslie Flowers

Leslie Flowers is a freelance writer in Indianapolis.

**References**


Medicare payments for approximately 280 procedures performed at ambulatory surgery centers (ASC) will be reduced to the rate paid to hospital outpatient departments (HOPD) effective Jan 1, 2007, under legislation passed by Congress.

The provision is part of legislation that cuts about $39 billion from the federal budget to reduce the deficit.

“We knew that effective January 2008, CMS’s new payment system would not provide for ASC rates in excess of those paid hospitals,” says Craig Jeffries, executive director of the American Association of Ambulatory Surgery Centers.

“Congress’s decision to make this change a year earlier is disappointing and will have at least a nominally adverse impact on most ASCs.”

HOPD payments will increase in 2007, so some of these procedures may not be affected, says Kathy Bryant, executive director of the Federated Ambulatory Surgery Association (FASA).

In a related development, the Ambulatory Surgical Center Medicare Payment Modernization Act of 2005 was introduced in October to revise the ASC payment system. The bills (S 1884 and HR 4042) propose that the Centers for Medicare and Medicaid Services pay ASCs and HOPDs comparable rates for procedures performed in both environments and develop a list of procedures that would be excluded from Medicare coverage in ASCs. That’s a departure from the current approach, in which Medicare lists procedures that are included for coverage in ASCs. The ASC industry supports the change, saying the government has not kept the list up to date with current practice.

ASC leader on President’s panel

In other Washington news, an ASC administrator, Jerry W. Henderson, RN, MBA, CNOR, CASC, spoke at a February Department of Health and Human Services (HHS) conference to address transparency in health care pricing. She is vice president of operations for the northeast region of HealthSouth Corp and a FASA board member.

Henderson participated in a panel that advised President Bush during his week-long campaign to draw attention to his health care agenda. During the discussion, President Bush stated that “ASCs are on the leading edge of health care.”

The White House has asked HHS to create a voluntary program that will publicize the charges of hospitals, ASCs, and other providers. The Bush administration says providers need to make pricing and quality information available to consumers in “user-friendly” ways. While so far these efforts are to be voluntary, administration officials say legislation could be coming if the voluntary effort isn’t adequate.

Henderson said, “A lack of information, as well as restrictions on insurance coverage, often keep patients from knowing their options. They can’t make decisions that are truly informed about quality or cost.”

During a panel discussion with President George W. Bush, Jerry Henderson (third from left) advocated more open information about pricing for patients having surgery.

Web calculator for ASCs compares Medicare payments

The American Association of Ambulatory Surgery Centers (AAASC) has developed a web-based calculator that compares Medicare payments to ambulatory surgery centers (ASC) with those to hospital outpatient departments (HOPD).

The comparison calculator provides ASCs with wage index information to compute Medicare ASC payments in specific locations. AAASC developed the calculator to assist ASCs with the anticipated transition to a Medicare payment system based on HOPD payments, says Craig Jeffries, AAASC executive director. He says the calculator addresses the needs of ASCs that want easy-to-use, web-based tools.

The calculator is at www.aaasc.org.
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**Gum chewing reduces ileus after colectomy**

Patients who chewed gum after elective open colon resections had a shorter time to return of bowel motility and shorter hospital stays than a control group (4.3 versus 6.8 days), in a small study of 34 patients randomized to 2 groups. The study group chewed sugarless gum 3 times a day for 1 hour each time until discharge; the control group did not chew gum. The patient groups were equivalent in demographics, intraoperative, and postoperative care, say the researchers.


**Four indicted in tissue plundering scandal**

Michael Mastromarino, owner of Biomedical Tissue Services (BTS) of Fort Lee, NJ, and 3 other men were indicted in Brooklyn, NY, Feb 23 for allegedly operating an illegal body parts ring, the Associated Press reported. The men are accused of conspiring to steal tissue from corpses of persons who never gave permission to be donors, prosecutors said. Among those who had tissue stolen was Alistair Cooke, the British broadcaster.

The 122-count indictment alleges defendants forged death certificates and consent forms to create the impression that the tissue was legally obtained.

Investigators said the suspects profited by selling the tissue to companies that turned the tissue into products used in surgery.

The Food and Drug Administration issued a notice Oct 26 that 5 tissue processors had received tissue from BTS. The firms said they had voluntarily recalled the tissue and were notifying physicians whose patients might have received the tissue.


**MedAssets acquires Shared Services Healthcare, Inobis**

MedAssets Supply Chain Systems, Alpharetta, Ga, said it acquired group purchasing organization Shared Services Healthcare, Atlanta, which will become a MedAssets subsidiary.

The deal is MedAssets’ third of the year. Earlier, the company acquired Inobis, a Knoxville, Tenn-based health care supply chain data management company, and Avega Health Systems, a Los Angeles-based software and consulting firm.

—www.medassets.com

**Medicare to propose refined DRG system**

The Centers for Medicare and Medicaid Services (CMS) is expected to formally propose overhauling the DRG reimbursement system when it publishes new inpatient regulations in April in the *Federal Register*, according to CMS Administrator Mark McClellan, MD. McClellan says the DRG system doesn’t accurately reflect patient acuity and hospitals’ true costs, according to *Modern Healthcare’s* March 8 Daily Dose.

CMS plans to propose an “all-patient refined” DRG system, or APR DRGs, for fiscal 2007. In 2005, McClellan told Congress that APR-DRGs could relate payment rates more closely to patient resource needs and thus reduce the advantage of selecting healthier patients. He said this could have a substantial effect on hospitals.


**Senators request more reports on specialty hospitals**

Senate Finance Committee Chairman Charles Grassley (R-Iowa) and ranking member Max Baucus (D-Mont) in March asked the Health and Human Services Inspector General and Government Accountability Office to review quality of care and financial arrangements at physician-owned specialty hospitals. In February, the senators asked the Medicare Payment Advisory Commission to provide an update on physician-owned specialty hospitals.