Duke protocol ensures right level of screening

Four years ago, Duke Health’s Preop Screening Unit was facing challenges. The unit had a full schedule, some appointments were double-booked, and some patients had long wait times. There was no system for separating healthy patients from complex ones. Meanwhile, surgery centers were asking the unit to provide screening for all of their patients.

Duke, based in Durham, North Carolina, had tried a “fast track” process for healthy patients, but that didn’t solve the problem.

“We were still seeing healthy 18- to 40-year-olds, including healthy people with sports injuries, along with heart surgery patients and patients having major abdominal or cancer surgery,” says Anthony Basil, RN, clinical nurse IV and charge nurse for the unit.

Phone screening protocol
The answer is a nurse phone screening protocol guided by criteria that identify healthy ASA 1 and 2 patients having low- to moderate-risk surgery (referring to American Society of Anesthesiologists physical status).

ASA 3 and 4 patients having more complex surgery are screened in person by a physician assistant (PA) or nurse practitioner (NP), with oversight by a medical director.

The only surgical patients not seen by the unit in this 924-bed academic medical center are those coming in through the emergency department or already in-house. The annual surgical volume is about 30,500.

Patient satisfaction
The unit screens 110 to 130 patients a day, with about 30 to 45 of those assessed by a nurse using the phone screening guidelines. In December 2011, 3 to 4 RNs screened about 800 patients by phone. The Preop Screening Unit is staffed by 11 RNs (10.7 FTEs), all of whom rotate through phone screening. On a typical day, 3.5 RNs perform phone screening.

The screening includes, in addition to the patient’s health history, patient teaching and medication reconciliation.

Patients are just as satisfied with the phone screening as with a clinic visit, Duke’s data shows. A year-long project is underway to collect data on the impact on OR delays and cancellations.

So far, says Basil, there have been no physician complaints about cancellations due to the phone screening process. He notes that the preop process meets all Joint Commission requirements.

Key documents
Two key documents guide the phone screening protocol:

Request for preop phone screening form
The front of the form lists basic information about the patient, including contact information. On the back are criteria to determine which patients are eligible for the protocol. The criteria were developed in consultation with Duke’s anesthesiologists and surgeons.

**Preanesthesia screening questionnaire**
The questionnaire, completed by the patient, covers the health history.

“The patient questionnaire is the crux of what we do,” Basil says. “We have found it is the best source of information because it comes right from the patient.”

**Phone-screening process**
This is how the phone screening process works.

**Surgeon’s office**
After the decision for surgery is made, the office uses the Duke criteria to determine if the patient is eligible for phone screening. If so, the office sends the completed request-for-phone-screening form and patient questionnaire to the Preop Screening Unit.

**Preop screening unit**
When the unit receives the information, an appointment is scheduled in the information system, which generates the preop documentation forms. A preop nurse assembles a 3-ring binder for the patient, which is filed by surgery date.

**Phone screening**
One to two weeks before surgery, a preop nurse calls the patient to conduct the phone screening. On average, screenings take 48.8 minutes, according to 2010 data. This includes:

- preparation: 12.7 minutes
- interviewing: 19.2 minutes
- charting: 16.9 minutes.

Screening patients by phone rather than face-to-face still takes quite a bit of time, says Basil, because teaching and medication reconciliation take about as much time on the phone as in person.

The assessment is entered in the electronic record, printed, and placed in the binder, which is sent to the surgical location.

**Day of surgery**
On the day of surgery, in the holding area, the patient’s anesthesia provider reviews the preop binder. All phone screening charts are tagged with a green label. That way, anesthesia providers know they still need to do a physical and have the patient sign an anesthesia consent on the day of surgery. There is also a place where the attending surgeon can sign off on the history & physical (H&P).

The completed phone screening record is identical to the PA/NP workup except for documentation of the physical, which is completed on the day of the procedure, Basil notes.

**A face-to-face ‘phone screen’**
At times, healthy patients who meet the phone screening criteria still arrive in the Preop Screening Unit. In that case, if a patient meets the criteria, the nurse conducts an in-person “phone screening,” avoiding the need for assessment by an NP or PA.
“We call this a ‘conversion,’ and it usually takes less time than a full assessment,” Basil notes.

**Lessons learned**

Getting buy-in was critical, particularly from surgeons’ nursing staffs, says Basil.

The surgeons’ staffs didn’t warm to the phone screening protocol initially “because we weren’t saving them any time,” Basil explains.

“It was easier for the nurses to call and make a preop clinic appointment than to make sure all of the paperwork was there, and the patient met the criteria.”

One way to overcome this hurdle was to explain to the nurses, “I know it’s a little more work for you, but it’s easier for the patient.”

A second challenge was convincing senior leaders that without additional personnel, the unit couldn’t screen more patients, even using the phone protocol.

The data, showing that one nurse could complete about 10 phone screenings a day, demonstrated that. Once the message was heard and staff added, phone screenings, which had been at 100 to 200 a month, accelerated, hitting 800 in December 2011.

With the phone-screening protocol, lower-risk patients can be screened in an abbreviated manner without missing patients who have significant health issues, Duke researchers note. The protocol ensures all patients receive education and produces a consistent H&P similar to the one conducting during an in-person assessment. That has streamlined the process while ensuring that all patients receive the right level of preop preparation.

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**Duke’s criteria and preoperative screening questionnaire are in the OR Manager Toolbox at [www.ormanager.com](http://www.ormanager.com)**

**References**

