VHA, Inc, the hospital alliance, has launched an OR project to address the cultural and communication gap between surgeons and nurses. Studies show the gap can contribute to errors and poor patient outcomes.

In a survey of the 20 participating hospitals in September, VHA found surgeons and nurses have a wide difference of opinion on whether communication problems exist in the OR, says Kathy Irvin, RN, VHA’s program director for the Transformation of the Operating Room (TOR) project.

“VHA uses this assessment to gauge OR staff perceptions and develop a baseline for improvement,” Irvin says.

For example, the survey found that while 85% of surgeons said they believe “physicians and nurses here work together as a well-coordinated team,” only 60% of nurses agreed with the statement.

Physicians’ initial reaction to communication problems in the OR is denial, says Peter Plantes, MD, a VHA vice president. “Surgeons begin by being pessimistic and doubting when presented with the information. Then they look at the data, acknowledge it, and become the leaders of positive change,” he says.

“We presented the findings at our OR Council meeting, and the surgeons were humbled when they learned that staff felt they weren’t part of the team,” says Faith Schaffer, RN, BSN, MHA, director of perioperative services at Billings (Mont) Clinic, an integrated delivery system with a 200-member group practice, and a 272-bed hospital.

“Surgeons immediately decided they didn’t like the results of the survey. They felt we worked in a much better place than that,” Schaffer says. “They took responsibility for their part and agreed they could make a difference. The survey was a catalyst for the surgeons to discuss this with their partners.”

Hospitals participating in the TOR project also are striving to improve clinical processes and financial performance.

“If you have fewer patients developing symptoms (such as) heart attacks and pneumonia, and you get better clinical outcomes, you spend less money,” Dr Plantes says.

But because VHA’s survey found such a wide variation in responses between surgeons and OR staff, he says, VHA decided to start work simultaneously on the cultural and clinical issues.

**Cultural gaps**

Faulty communication is cited in 60% of sentinel events reported to the Joint Commission on Accreditation of Health-care Organizations.

Mirroring similar studies, VHA’s survey found 55% of OR staff and physicians agreed that the “culture of the OR here makes it easy to learn from the errors of others.” More than 25% agreed with the statement: “In the ORs here, it is difficult to speak up if I perceive a problem with patient care.”

“It is a universal problem and not specific to one hospital,” Dr Plantes says. “It is based on one of the cultural foundations of how physicians have been trained and how ORs have been run for the last 50 years. Once surgeons understand the tie to quality and poor outcomes, they quickly realize they are responsible for the care of patients. They do not want that culture to continue.”

**How to improve OR culture**

VHA suggests 4 strategies to improve OR communication:

* executive rounding
designating a physician champion

• conducting preoperative and postoperative briefings
• picking a team to identify and solve 1 problem per month.

“Some hospitals implement just one strategy, and some tackle multiple ones, depending on needs and situations,” says Teresa Carter, RN, BSN, MBA, vice president of surgical services for the Triad Region of Novant Health, a 7-hospital system based in Winston-Salem, NC. “You have to look at what is best for your particular hospital.”

In October, for example, Billings Clinic started preoperative briefings for orthopedic surgery. The briefings, which take about 5 minutes, cover issues such as supplies and equipment availability and possible complications. The staff are asked to share any concerns they have. (An article about preoperative briefings was in the December 2003 OR Manager.)

“We expect this will prevent near misses and errors because it sets a different tone and creates an environment that enhances teamwork,” Shaffer says.

The VHA program also suggests safety pauses and time-outs to encourage any member of the OR team to delay or even suspend surgery if there is a concern.

Seeking an executive champion

VHA’s survey also discovered that nursing staff feels hospital administration could play a larger role in improving communication, Irvin says. Executive rounding and designating a physician champion help address these issues.

“You have to have a physician champion, an executive champion, and a supportive OR council,” Shaffer adds. “We found from our own surveys that staff don’t feel supported by administration. We had worked hard to create a positive culture, but when the chips were down, (negative or disruptive) physician behavior was not attended to in a timely manner, and staff didn’t feel the administration was involved enough.”

In response, Billings Clinic CEO Nick Wolter, MD, agreed to become the executive champion.

“He will do rounding in the OR at least once a month,” Schaffer says. “He will be asking the staff, ‘What went wrong yesterday? What equipment do you need?’ It is very powerful to have the CEO participating like this.”

Improving clinical quality

VHA modeled the clinical aspects of its TOR program on the Surgical Care Improvement Project (SCIP), a public-private effort to prevent 4 types of postoperative complications. SCIP’s goal is to reduce surgical complications nationally by 25% by 2010 (www.medqic.org/scip/).

More than 70 hospitals participated in the first phase of SCIP, which includes delivery of antibiotics to patients within 1 hour of beginning surgery and other recommendations. Hospitals participating in VHA’s program are tracking the same clinical data as in the SCIP project and will report results and best practices to the group, Irvin says.

The program focuses on 4 key areas that an estimated 30% of patients face after surgery: Surgical site infections, cardiovascular events, venous thromboembolism, and postoperative ventilator-associated pneumonia.

“These are all preventable,” Dr Plantes says. “There is medical evidence that certain protocols can greatly reduce the numbers of complications in those areas.”

National data indicate that a major surgical complication has an average increased cost of $11,626, according to a 2004 study by Justin B. Dimick, MD, and colleagues.

Patients without complications had a median 4-day length of stay, compared with 9 days for those with minor complications and 14 days for those with major complications.

For prevention, Dr Plantes says all hospitals should monitor and control patient glucose levels, establish firmer guidelines about the timing and dosages of antibiotic and anticoagulant administration, and eliminate the practice of shaving the surgical site.
During 2006, VHA’s hospital teams plan to meet twice annually and engage in monthly telephone conversations moderated by VHA.

“Each hospital tries different things, and in the meetings they tell everyone their successes and failures,” Irvin says. “It is competitive. They share data and approaches and want to be better than the others, but there also is an environment of support and camaraderie because they know they are doing this for better patient care.”

**Tracking financial measures**

VHA's OR project also is addressing financial improvement.

“Most hospitals do not have methods to measure how much money they make or lose in the OR because they don’t have common measurement systems,” Dr Plantes says.

For example, some hospitals start the charge clock when the physician or patient arrives in the OR. Others begin charging when the first incision is made. One of the TOR goals is to help participating hospitals create uniform standards they can use to compare improvements with others.

The OR group chose several variables to track, including orthopedic implants and nurse retention.

“We know the costs of implants are killing us,” Schaffer says. “It is a matter of getting the data on implant costs, talking with the orthopedic surgeons, and coming together on best practices. Then we can negotiate better prices.”

The OR group also plans to track nurse recruitment and retention.

“We know it costs $50,000 or $60,000 to replace an OR nurse,” Schaffer says. “When you create a great culture, you don’t see as much turnover. We can track turnover rates and correlate that with training and orientation costs.”

Dr Plantes says payers are starting to scrutinize OR mistakes and charges. In the past, surgical errors or poor outcomes sometimes translated into higher revenue because more services would be delivered to correct the problem.

As quality measures become more refined, he says, payers are beginning to penalize organizations for poor outcomes.

“Our motivation is to provide superior clinical care, so members get out in front of the wave,” he says.

Hospital officials participating in the VHA project say time spent on quality improvement is worth the cost.

“Implementation takes time, but if you are heading toward best practices, this is a good mechanism to do it,” Schaffer says.

—Jay Greene

*Jay Greene is a freelance writer in St Paul, Minn.*

**Reference**


**Highlights of VHA project**

The project will focus on:

- improving surgical quality by reducing surgical site infections, adverse cardiac events, deep vein thrombosis, and postoperative ventilator-associated pneumonia
- improving and comparing the OR's financial performance
- changing the OR culture to improve communication and safety.