Performance improvement

Turning around the culture of an OR

In 2001, the ORs at Banner Baywood Medical Center were struggling—physicians were dissatisfied, case volume was down, and 13 staff positions were vacant. “There was a general lack of urgency. There just was no culture of efficiency,” says Christine Halowell, RN, MS-HSA, CNOR, director of perioperative services for the Mesa, Arizona, hospital.

Seven years later, things are looking up. Surgical case volumes have risen from under 8,000 a year to close to 10,000. Gross revenue is up by 62%. Staff retention rose to 94% in 2007, up from 90% in 2004. The 10 ORs perform about 10,000 cases a year, with about two-thirds of those in general surgery and orthopedics.

Banner Baywood’s ORs are now considered to be among the most productive in Banner Health’s network of 20 hospitals. The improvement project was described in a poster abstract at the 2008 AORN Congress in Anaheim, California.

When Halowell took her position 6 years ago, she knew changes were needed. These are steps she and her team took to turn the culture around.

Talked to the physicians

Soon after she arrived, Halowell began forming relationships with the physicians and staff.

“I would ask, ‘How can we better serve you and your patients?’” she recalls. She found they were eager to talk. “I don’t know that anyone had ever asked them before.”

Formed OR Logistics Committee

From the most vocal physicians, she enlisted volunteers and formed the OR Logistics Committee.

“We are a multidisciplinary operational team. We handle things the Surgery Committee doesn’t have time for,” she explains. Members include 2 surgeons, an anesthesiologist, an administrator, Halowell, and staff from the preoperative area, OR, postanesthesia care unit (PACU), and sterile processing department (SPD).

Developed an issue list

The committee started by developing a list of issues it wanted to tackle.

“We looked at everything from turnover times to late starts to block utilization,” she says. “We looked at how the H&Ps (histories and physicals) were getting on the charts.”

Early on, the committee was assisted by a management engineer in flow charting some processes it wanted to improve.

“This was a tremendous help,” Halowell says. “It allowed us to have a critical eye for flaws and make improvements.”

The next step was to prioritize the problems.

“We looked at what we could fix immediately—the low-hanging fruit—and what needed medium-term and long-term fixes,” Halowell says.

Started with the easy fixes

One of the easier fixes was improving the preadmission testing (PAT) process and getting the H&Ps into the patients’ charts before surgery.

The PAT staff and management team started by inviting surgeons’ office person-
nel to a hospital-sponsored “lunch and learn.” They requested that H&Ps be faxed to a specific number. “Once the H&Ps arrived, they were placed on patients’ charts by PAT staff, and this issue was resolved,” she says. About 90% of surgical patients are seen 3 to 7 days prior to surgery by nurses in the PAT department. The remainder receives at least a phone call, which has minimized cancellations on the day of surgery.

For H&Ps that are not on the chart by the day of surgery, a short form was developed, which is placed on the chart with the original H&P. This form satisfies the Joint Commission’s requirement to document an update to the patient’s condition prior to surgery or within 24 hours for inpatients.

‘Kamikaze squad’ for turnover

A more complex problem was tightening up turnover time, which in 2001 averaged 35 minutes from patient out to patient in for to-follow cases. A key step was defining and choreographing roles of team members, including a new “kamikaze squad” of OR assistants and housekeepers.

This is the way a turnover is conducted now:

• **Circulating nurse.** At the end of the case, the circulator takes the patient to the PACU, gives report, finishes the documentation, and goes to the preop area to assess the next patient and bring the patient to the OR.

• **Surgical technologist (ST).** The ST, who is still gowned and gloved, ties the trash and linen bags, sets them in the hallway, takes the used instruments to the SPD, and may take a short break.

• **Kamikaze squad.** OR assistants have been taught how to check the preference lists and open sterile supplies. Before the previous case finishes, an OR assistant checks the preference list for the next case, checks the case cart for completeness, and places equipment for the next case outside the OR door.

As soon as a case ends, a housekeeper does the heavy cleaning while the OR assistant cleans the flat surfaces. The OR assistant then brings in the case cart, spreads the supplies, and begins opening them. The ST joins in the setup and counts with the circulator. The circulator then helps the anesthesiologist bring the patient to the OR, and the case is ready to begin.

**OR assistants part of team**

When Halowell introduced the idea of OR assistants opening sterile supplies, she got some pushback from the RNs. “Then I had the nurses teach them so they would feel comfortable,” she says. “Once
they saw that the OR assistants learned well, everybody was fine with it.”

It’s also a plus for OR assistants’ job satisfaction. “They feel more like part of the team. It promotes teamwork in the OR, and you have the right person doing the right job,” she says.

Turnover time statistics are shared with the staff monthly. Initially, Halowell says teams were recognized and rewarded for short turnover times when no corners were cut. Teams and individuals that did not comply with turnover expectations were coached, and some were disciplined for noncompliance.

“In this way, the staff realized we held everyone accountable to our standards,” she says. “Now good turnover times are part of our culture.”

Turnover times for 2007 averaged 22.6 minutes from patient out to patient in for to-follow cases, including total joint replacements, which average about 25 to 30 minutes between cases.

**Improved on-time starts**

Another major focus was improving on-time starts for the first case of the day, which Halowell says was “really bad” at 21% and affected the rest of the day’s schedule.

The first step was to define an on-time start. The OR Logistics Committee consulted the surgeons and decided to define “start time” as the time the patient enters the OR. The committee decided surgeons and anesthesiologists would be considered late if they had not seen the patient at least 15 minutes before the scheduled start time.

In the beginning, a patient entering the OR even a minute past the scheduled time was considered late. Now there is a 5-minute grace period.

Preop nurses record when surgeons and anesthesiologists arrive, and the time is correlated with the time the patient enters the OR. Data showed lateness by physicians was the major issue. Staff lateness was not a problem, Halowell says.

Steps to improve on-time starts included:

- Sending a reminder letter to all surgeons to heighten awareness. That step alone brought on-time starts to about 45%.
- Sending individual monthly “report cards” to surgeons with their on-time records (illustration).
- Posting a list showing physicians’ records for on-time arrival. At first, the report was posted without names. “Now we post it with names, with the blessing of the chairman of surgery,” Halowell says. These steps brought on-time starts to more than 60%.
- Putting teeth into on-time expectations. With the agreement of the chairman of surgery and chair of the OR Logistics Committee, a policy was implemented stating that surgeons who are consistently late cannot schedule cases until 9 am. “We did that for a couple of surgeons, and that is all it took,” she says.

Physician lateness is defined as the patient in the room 4 or more minutes late, averaged over 4 cases in a quarter. Physicians who exceed this criterion receive a warning letter telling them their 7 am and 7:30 am case-scheduling privileges may be rescinded for 3 months. If a physician exceeds the lateness criterion for 2 consecutive quarters, the data is shared with the surgery committee with a recommendation to rescind early-case scheduling privileges for 3 months. This policy is carried out at the discretion of the chairman of surgery and/or the OR director.

Together, these steps have raised on-time starts to 70% to 75%.
Changing the culture

How was Halowell able to change the culture among the nursing staff? Recognition is part of the answer, she notes.

“One thing I do every day is to recognize and build up the staff,” she says. “I tell them how good they are.”

She sent the staff a survey to ask how they want to be recognized. Interestingly, while some liked to be recognized in front of their peers, others weren’t comfortable with that, so she plans recognition accordingly (sidebar).

Time is provided before every staff meeting and report for staff to recognize peers.

“That’s built into our culture now,” she says. “Even if you don’t ask at report, they’ll raise their hands and say, ‘I just want to say thank you to this person who did this for me yesterday.’”

If the OR’s performance is slipping, she shares that, too.

“Our dashboard and financials are posted,” she says. “I find if I share that data with the staff, they are more in tune and ready to work for you.”

Staff also participate in the OR’s efforts to improve quality and operations. An example is peer review meetings to discuss root cause analyses and near misses. The group discusses the near miss, analyzes what parts of the system or process failed, and proposes improvements.

Halowell finds positive reinforcement goes a long way in building morale.

“If you continually tell the staff they’re the best and celebrate your accomplishments, one day it just clicks for them. They realize they are good and strive to be better,” she says.

Ways to recognize staff

Ideas from Banner Baywood Medical Center, Mesa, Arizona:

• Start all meetings, reports, and huddles with formal or informal recognitions.
• Write and send thank you cards.
• Give lunch (meal) tickets or coffee coupons.
• Give Banner Bucks (good at the gift shop, cafeteria, or on- line store).
• Acknowledge the good work of our employees to administrators who send a thank you card to the employee’s home.
• Place high-performing staff on facilitywide and corporate teams and give them time to do a good job.
• Have shared leadership or unit-based council announce an Employee of the Month and an Employee of the Year, with monetary awards.
• Reward and recognize certifications in all disciplines, many times with salary increases.
• Recognize employees who attend national conferences by allowing them to present what they learned.
• Give extra time off for good attendance.
• Celebrate world-class patient satisfaction and Gallup staff engagement scores with pizza parties for all perioperative departments. Share in each other’s successes.
• Give thank you cards with meal tickets and/or car wash coupons to physicians for their good work.
• Leaders round with staff and give recognition during rounds.
• Recognize clinical practices and behaviors publicly that the organization wants replicated, reinforcing correct behaviors.
• Deliver recognition in a timely fashion.