

Process improvement

Winning the battle for accurate, updated surgeon preference lists

The preference list is wrong! How often have you heard that from surgeons or the OR staff? It is a constant battle—assuring that the preference list is right, updated, and available for the case. A collaborative effort between surgeons and OR managers can make it better for everyone involved.

The definition of the preference list depends on your point of view. For surgeons, it's a productivity issue. If you can't make the preference list accurate, the surgeon wastes time waiting for the appropriate supplies and equipment. Wasted time means the surgeon is less productive, and that means less revenue and poor patient satisfaction. Having the wrong supplies or not having the necessary items for a case also jeopardizes patient safety. Plus, surgeons may doubt the organization's credibility if it can't seem to get this most basic "recipe" right.

To the OR staff, an accurate preference list means the surgeon will have everything needed to make the case go well. To the administration, the preference list is a tracking and reporting mechanism, a way to ensure patient safety and regulatory compliance, inventory accuracy, and revenue.

Top 5 problems

If preference lists are so important, why are they always wrong? The top 5 answers managers hear are:

- "The computer changes it."
- "I don't need a preference list because I know what my doctor needs."
- "It's not up to date. I don't have time to change it, and that's not my job."
- "They change so much that I can't keep up with them."
- "The card's not really wrong—I didn't read it, but I'll never admit that!"

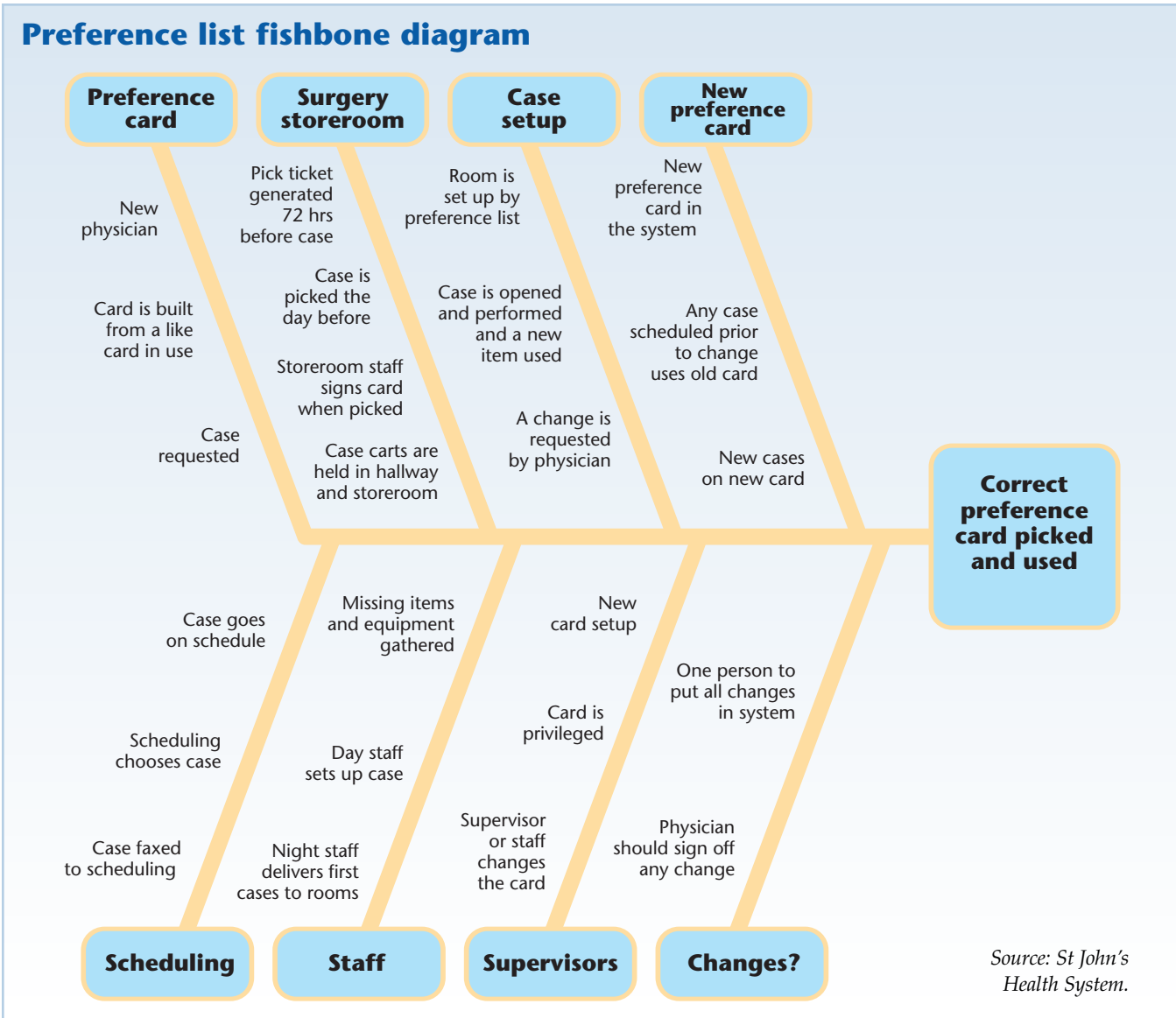
The bottom line: No matter why the preference list is wrong—the wrong stuff is in the room. When the preference list is wrong, material and human resources are wasted. If the wrong items are picked and opened for the case, these items have to be wasted, often without reimbursement for the cost. It means rework to pick a new case and set it up again. It means a dissatisfied surgeon, staff, and administration. Most of all, it means patient safety has been put at risk.

To address the problem of inaccurate preference lists, we have to start at the beginning. A preference list is rarely "made from scratch." More often, it is taken either from another surgeon's list and adapted, or the previous hospital sends the surgeon's list to the new facility. Less often, the surgeon simply uses what the staff provides. Then the changes begin.

At our institution, there had been no real process for changing a preference list. There was no ownership of the process, and anyone could make changes at any time. The result was more than 8,000 messed-up cards.

The OR management team agreed to fix the problem. Slowly, we worked with the surgeons who brought issues and inaccuracies and attempted to correct each issue.

As the list of issues and surgeons with them grew, however, the problems returned, and momentum was lost. The problem, we found, was that none of us really knew what a preference list is. It's not just supplies and instruments. The preference list drives much more than just the supplies and equipment in the room. It also specifies location in the room, positioning, specimen collection, surgeon idiosyncrasies, charting, charging, and adherence to quality and regulatory measures.



Defining a new process

Understanding all the pieces of the preference list and what it drives are the first steps to process improvement. But putting a process in place to ensure accuracy, accountability, and consistency requires a collaborative effort. Our organization has a track record of hospital and physician collaboration. Using the Institute for Healthcare Improvement's methodology of small tests of change and rapid cycle improvement, we formed a team with frontline staff and physicians to define the new process.

A current-state analysis was performed using the fishbone technique (sidebar). After completing this process, the team came to a surprising realization: The surgeon owns the card! In other words, though the hospital maintains the preference list, the surgeon is the one who actually owns the "recipe."

Before we presented the surgeons with this fact, we had to ensure we had addressed the issues we could control. This meant first analyzing the information system and how it works with respect to the preference lists:

- How, when, and where does the preference list print?
- How are items listed and identified?
- When does the inventory decrement?

- How does the list drive the charging process?
- How long does it take for changes to appear on the next case?
- What are the access and accountability issues?

Who owns the change process?

Once these issues were addressed, we needed to determine the method for making changes and who would own the change process. Who tracks changes, and how are they communicated to room staff, storeroom staff, and surgeons?

A major issue identified was that the staff wasn't really reading the preference list. Because of a history of inaccuracies, the staff no longer trusted the lists. Many also thought that because they worked with a surgeon day in and day out, they no longer needed to read the card because they knew what the surgeon wanted.

It took a great deal of effort to change this culture. To change it, staff were required to have the surgeon sign any change before it was made. Only the specialty supervisor was permitted to make the change in the system. Finally, every first scrub person was required to sign that the preference list had been read every time. These signatures ensured that the staff were accountable, and issues could be tracked to the exact case where the issue originated.

The "scheduling bible"

These changes helped improve the accuracy of the preference lists. Even so, we had just as much waste and rework. The preference lists were better, and the staff were reading them and signing off, but there was still a problem: It was often the wrong list!

We traced the issue back to the scheduling process. The preference list is chosen when the surgical case is scheduled. Cases are scheduled in most information systems based on a defined procedure from the procedure file. The procedure file is tied to the preference list file. Unless the case scheduled is exactly the same as the case in the procedure file, the scheduler must guess at the correct procedure based on the surgeon's order. If the guess isn't accurate, the wrong preference list is generated, and the wrong supplies, equipment, patient prep, etc, are chosen for the case.

Our team, with significant surgeon involvement, developed the "scheduling bible," a book containing the procedure file for each surgeon.

The surgeons and their office personnel were educated in what a preference list is, what processes the list drives, and how to choose the right procedure. The fax scheduling form was amended to include 2 lines for case scheduling—one line for the actual procedure to be done according to the surgeon and one line for the procedure from the procedure file that would generate the most appropriate preference list for that case. Cases were not scheduled without completing the last line.

Seeing the benefits

We saw several benefits from improving the preference list process. Turnover time was reduced by more than 8 minutes per case. Returns from the room also were reduced by at least one item per case, reducing rework. In a department with 30,000 procedures annually, this reduction is significant. More accurate charge capture allowed for more accurate inventory and revenue enhancement.

The secondary gain was that even though the current information system is unable to link actual cost and utilization to a particular case accurately, we were finally able to link the surgeon's cost to the preference list. Because the surgeons signed off on every change to the preference list, they agreed that the preference list was correct. Once trust in preference lists was re-established, the organization was able to cost out the preference lists and share this information with the surgeons. This information was used to drive standardization and consolidation, leading to a cost reduction of over \$150,000 for laparoscopic cholecystectomy alone. In addition, because the surgeons now trusted the preference lists, they were able to move more items from an "open" to a "hold" status so fewer items were opened, and less waste occurred.

Ensuring preference list accuracy is a difficult process, but it can be done. There is no cookie-cutter approach. But by understanding current processes and using a collaborative approach with surgeons and staff, a new process may be developed

that drives accountability, ownership, and trust. ❖

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