SESSION TITLE: Optimizing Patient Flow By Improving Perioperative Communication

SPEAKER NAME: Randy Heiser, MA

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DATE/TIME: Wednesday, March 6, 2013, 3:30-5pm

CONTACT HOURS: 1.5 CH

OVERVIEW:
Optimizing patient flow can significantly increase the quality of patient care and maximize utilization, efficiency, and productivity of the OR, surgeons, anesthesia providers, nursing, and perioperative support staff. A first step toward best practice patient flow is the creation of a multi-level team of perioperative staff members to collaboratively assess current workflows and identify opportunities for improvement. This session will discuss process changes that one facility made to improve and optimize patient flow.

OBJECTIVES:
1. Identify patient throughput flow options for improving perioperative communication.
2. Implement strategies for improving communication among perioperative team members.

BIOGRAPHY:
Randy Heiser, MA, is the president and CEO of Sullivan Healthcare Consulting, specializing in perioperative operational performance. During his 28 years as a hospital consultant, Randy has worked with over 800 hospitals in the US, Canada, Europe, South America, and Asia. For the last 20 years, he has worked exclusively in the perioperative arena with particular emphasis on surgery scheduling, operational improvement, and governance. In his work with perioperative performance data, Mr. Heiser has developed detailed operational benchmarks for hospitals that include not only operational data, but financial and labor productivity, offering a comprehensive view of an OR's performance. He currently leads the largest independent perioperative consulting firm in North America.

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FACULTY DISCLOSURE:
Best Solution – Checklists, checklists, checklists

What Types of Communication Are We Talking About?

- Surgeon/surgeon’s office to patient
- Surgeon office to scheduling
- Patient to pre-surgical screening
- Anesthesiology to pre-surgical screening
- Pre-surgical screening to preop
- Preop to OR
- OR to PACU
Surgeon to Patient Communication

Informed consent
- Complete procedure with most likely possibilities
- Alternative therapies discussed and documented
- Expected benefits
- Risks
- Expectations

Surgery logistics
- Where surgery will occur
- What to expect before surgery and on the day of surgery
- Where to go, park, etc.
- After surgery
  » Therapies, return visits, hospital stay or outpatient, etc.

Surgeon to Patient Communication

Key Impacts on Throughput
- Delays due to missing or inaccurate consents
- Patient safety near misses due to wrong procedure
- Longer preop processes, verifying paperwork
- Higher anxiety levels for patients
Surgeon Office to Scheduling Communication

Procedure and patient information
- Key information should include:
  » Procedure being performed
  » Patient information (including contact information)
  » Needs and concerns that exceed the routine
  - Time/duration
  - Equipment
  - Supplies
  - Patient condition
  - Possible added procedures

Scheduling office should not attempt to replace the admission or registration process

Surgeon Office to Scheduling Communication

Best Practice
- Online requests into block time
  » Phone /fax for non-block holders or after release time
- Reviewed by booking office prior to confirmation
- Copy of informed consent forwarded (electronically) to pre-surgical screening
- Positive confirmation sent back to office with key procedure and special needs documented to ensure nothing is lost or miscommunicated
Surgeon Office to Scheduling Communication

Impact on throughput
- Patient safety
  » Incorrect procedure scheduled
- Necessary equipment and supplies may not be available or else obtained at last minute at higher cost
  » Inappropriate supplies picked
- Reduced ability to plan the day
- Either blocked time due to under-scheduling or overtime/run-over due to overscheduling
- Extended preoperative length of stay

Patient to Pre-Surgical Screening

Pre-surgical screening (PSS) should be responsible for ensuring the patient is medically ready to undergo anesthesia
- Medical direction and control provided by anesthesiology
- Focus on screening and chart completion instead of testing
- Balancing patient need and resources consumed
- 100% of scheduled patients should be screened using a “tool” developed by anesthesiology
- The screening should drive all testing and interventions
Anesthesia to Pre-surgical Screening
Communication

Testing information
Other information to assist with determination of patient being ready for surgery
H&P required
Consent should be available to verify procedure
Definition of a complete chart

Anesthesia to Pre-surgical Screening
Communications

Best Practice
- Testing protocols should be evidence driven
- All testing should be done based on the protocols
  » Surgeons should limit orders to what is needed for the procedure
- If an anesthesiology consult is required, blocks of time should be allocated each day for these consults
  » Typically first off MD does consults
- Standard practice between anesthesia providers
Anesthesia to Pre-surgical Screening Communication

Impact on throughput
- Large volume of testing
- Higher incidence of abnormal values that require follow-up but do not impact the decision to move forward
- Less marketable program
- Surgeons ordering “everything”
- Higher costs
- Longer LOS due to ensure “if it was ordered, it was done”

Pre-surgical Screening to Preop Communication

Ensure that all patients are clinically ready for surgery
Forward a complete chart, for every scheduled patient, that includes:
- Signed consent
- H&P (requires last minute updating)
- Results, if required
- Clearances, if required
- Other items as required by the hospital
Teaching complete and documented
Pre-surgical Screening to Preop Communication

Impact on throughput (areas of greatest opportunity)
- Morning of surgery chaos
- Loss of independent procedure verification
- Increased costs and staffing levels
- Increased patient LOS and dissatisfaction
- Greater opportunity to miss something

Preop to OR Communication

Greatest impact on throughput
Often the primary cause of late starts and delays, regardless of root cause
In detailed studies:
- More time is spent in preop resolving chart issues than preparing patients
- Circulators redoing nursing assessments adds 12 minutes to turnover time
  » When one group of nurses does not trust another group, redundancies will be always be introduced
Preop to OR Communication

Fix the problem, and the trust will follow
Set clear expectations about what will be done by whom and when
Require sign offs
Empower nurses to stop the flow if the process is not complete
Identify root causes, not symptoms

Preop to OR Communications – Case Study – Best Practice

16 OR community hospital, 14,200 cases, high complexity case mix
- ALOS in preop: 75 minutes
- Average turnover time: 14 minutes (patient out to patient in)
- Patient satisfaction scores for surgery and preop: 95+
Preop to OR Communication – Case Study

Historical background
- Multiple patient safety incidents in the past, numerous near misses
- Surgeons and anesthesiologists pushed very hard to reduce long turnovers; often moved patients to the room without notifying anyone
  » Average turnover: 32 minutes
- To ensure “quality of care,” circulators redid the full nursing assessment, which increased turnover and pushed physicians to circumvent a safe process

Preop to OR Communication – Case Study

New policies approved by OR committee and senior administration
- All patient movement required a signature by the responsible nurse prior to movement
- Any patient moved without the signature would be returned to the unit
- “T-minus” expectations were set for preop nursing, surgeons, and anesthesiologists
- Percentage of expectations met for each group published weekly and reported hospital wide
- List of individuals not meeting expectations published in the OR each day for the previous day
Preop to OR Communication – Case Study

New Focus

• “What expectations were not met and what can be done to ensure they are met in the future”
• Instead of “whose fault is it?”

Preop to OR Communication – Case Study

Checklist was built for preoperative process
- One for most patients
- One for patients requiring blocks, lines, or other intervention
- After pilot, incorporated into the perioperative information system so that checklists became part of the patient record
- Non-compliance addressed same day by a member of the perioperative executive committee
Preop to OR Communication – Case Study

Result:
- Immediate improvement in on-time starts
  » Now 93% within 10 minutes or early
- Turnover time decreased rapidly
- New sense of collaboration between OR and preop
- Preop nurse and bay now assigned day before
- Three incidents where patients returned or nurses disciplined due to inappropriate patient movement
- Circulators now conduct hand-offs via phone and greet the patient in the hallway
  » Never leave the OR
- SSIP protocols now being met 99% of the time

OR to PACU Communication

PACU needs the ability to plan and anticipate the workload
Adjust staffing assignments based on patient needs
Ensure continuity of care
OR to PACU Communication

Best Practice
- PACU receives the schedule in advance
- Arrival times to PACU estimated based on case durations
- PACU can access the perioperative records to review PSS results, comorbid conditions, etc.
- Anesthesiologist immediately available to support PACU to avoid “finding” the original anesthesiologist
- Nursing hand off and report occurs via phone and the anesthesiologist/CRNA accompanies the patient and provides the detailed report and care plan

Throughput impact
- Shorter LOS
- Difficulties addressed immediately
- Fewer PACU closures or slow downs, resulting in lower cost
Perioperative Communication

Some checklists extend across areas and must have clear, positive communications to work
- Often impact quality and patient safety
Example: Surgical site infection prevention checklist – multiple areas impact this
- PSS
- Preop
- OR
- Anesthesia

Improving Communication

Must start with the governance structure
- Policies are great if enforced
  » Damaging if written and ignored
Surgery Executive Committee
- Membership
  » Surgeon – Chair/Chief/Surgeon Medical Director
  » Anesthesia – Chair/Chief/Perioperative Medical Director
  » Nursing – Director/Manager
Improving Communication

Perioperative Executive Committee
- Responsible for the day-to-day operation of the program
- Responsible for enforcing policy in the moment
- Requires
  » Physician to physician interaction
  » Nurse to nurse interaction

Must be charted and supported by senior administration

Improving Communication

Break down silos between areas
- Tactics used:
  » Rotate staff between areas
  » Interdepartmental task forces
  » Combined report
  » Fun and games
    – “Spend a day with my patients”
    – Shadowing
  » Scorecards and publication of performance
Improving Communication

Scorecards and publishing results and performance has been shown to change performance and behavior in multiple hospitals.

Lahey Clinic experience:
- Monitors throughout the perioperative program, with feeds available on the hospital intranet
- Scrolling display shows:
  » Hospital news/bulletins
  » Positive comments about perioperative staff and physicians taken from satisfaction surveys
    – If names are used on the surveys, included on the display
  » Yesterday’s cancelations – surgeon, service, and reason
  » First case late start – service and reasons
    – Example – Orthopedics: 3 late starts – 2 consent missing, 1 site marking occurred at 7:50 AM
Improving Communications

First case start time
- Prior – 73%
- After – 94%
Patient satisfaction increased and the number of staff mentioned by name increased
- Staff began taking ownership of patient satisfaction

Summary

- Perioperative communications are critical to efficient and effective patient throughput
- Effective communications require a structure
- Checklists provide a communication structure that has been shown to increase trust between groups
- Compliance and change require a strong, balanced and effective governance structure
- Publishing performance and results with names attached is the easiest way to implement and sustain