



September, 2009

1st Annual OR Excellence Awards

Profiles of the 6 facilities that have taken surgical care to the next level.

In a few short weeks, we will gather with many of our loyal readers at the Hilton San Francisco for our inaugural OR Excellence Conference (go to www.orexcellence.com to register). In celebration of excellence in surgical care, this issue of *Outpatient Surgery Magazine* profiles some of the outstanding facilities that have achieved excellence in several critical areas.

A few months ago, we sent out an online survey inviting you to nominate your facility for an OR Excellence Award in 1 of 6 categories: patient safety, pain control, SSI prevention, patient satisfaction, employee safety and financial management. We were gratified — but hardly surprised — by both the quantity and the quality of the nominations that we received and by the great pride you our readers take in your life's work.

Selecting the winners wasn't easy. We had to choose from among many compelling success stories whose lessons are worth emulating. In the end, though, we feel we've recognized the very best surgery has to offer today. Turn the page and join us in saluting OR excellence.

Patient Safety

Kaiser Permanente West L.A. strives to be "second to none" in patient safety by building Highly Reliable Surgical Teams.

— *Irene Tsikitas*

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When it comes to patient safety, the perioperative team at Kaiser Permanente West Los Angeles Medical Center doesn't believe in setting modest goals. "We want to have the safest ORs in the country, to be second to none in OR safety," says F. Ronald Feinstein, DMD, MD, FACS, assistant medical director and physician manager of the facility's surgical service line. That means zero never events — every surgery performed on the right patient, at the right site, every time.

A little more than a year ago, the hospital set out to achieve this ambitious goal by becoming one of the first southern California Kaiser facilities to implement the Highly Reliable Surgical Team, a safety initiative modeled after the aviation industry and renowned for exceptional levels of teamwork and communication. So far, the program has paid off, says Perioperative Director Victoria Coon, CRNA, MS. Between the first quarter of 2008 and the first quarter of 2009, the facility reported improvements in antibiotic prophylaxis protocols, normothermia, site markings, surgical team briefings and the prevention of retained objects. Outpatient Surgery Magazine recognizes Kaiser Permanente West L.A. and its safety model with its first OR Excellence Award for Patient Safety.

Highly reliable

Before you can improve surgical safety, you've got to know where you stand. Kaiser West L.A. started by having perioperative staff fill out the Safety Attitudes Questionnaire, a survey developed by University of Texas researchers to assess facilities' climates of safety by asking staff to agree or disagree with statements like, "In the OR, it is difficult to discuss errors," and "I am encouraged by my colleagues to report any patient safety concerns I may have." Ms. Coon says Kaiser West L.A. actually scored "among the highest in the country" in the SAQ before starting the HRST program.

The Highly Reliable Surgical Team is modeled after the aviation industry's Crew Resource Management training, which addresses the human factors that contribute to safety: open communication among team members, and the identification and management of potential errors before they occur. After administering the SAQ, Ms. Coon and other HRST leaders at Kaiser West L.A. began holding 4-hour human factors training sessions for all perioperative team members: pre-op and PACU nurses, circulators and scrub techs, anesthesia personnel and surgeons. These sessions employed various tactics to secure buy-in for the new processes that were put into place, such as standardized pre-op briefings, time outs and post-op debriefings. Some presentations focused on how these measures would improve efficiency as well as safety.

"A lot of energy and effort was put into convincing people of the merits" of the Highly Reliable Surgical Team, says Dr. Feinstein, who notes that it's important to foster commitment to patient safety, not just compliance, particularly when you're trying to convince surgeons who may "bristle" at being told what to do. "If people really believe in what you're doing, it requires a lot less monitoring than when you're dealing with the compliance approach." To foster nurse-physician collaboration, HRST leaders handpicked 1 nurse and 1 surgeon — both highly respected — to champion the effort. The hospital also launched a multimedia communication effort, including e-mails, posters and even podcasts, to get the message across.

Sustaining a Culture of Safety

Why do mistakes still occur in well-equipped, expertly staffed ORs? That's the question leaders at Oakwood Hospital and Medical Center in Dearborn, Mich., found themselves asking after a reportable adverse event occurred in their OR a few years ago. "We didn't think our existing processes could prevent a similar event from occurring," says Gregory Bock, chief operating officer of inpatient services at the 24-OR facility, which implemented Crew Resource Management techniques in 2008, with help from LifeWings Partners (www.saferpatients.com), to improve safety across the spectrum of care. CRM centers on building effective teams, standardizing communication during critical processes and training team members to recognize red flags. "A key component is that everyone is empowered to stop the process at any time," says Surgery Manager Wayne Mattern, RN, CNOR. Though data on the program's effectiveness is still coming in, Mr. Bock says having 100% of staff trained in CRM techniques has "improved communication, reduced errors and increased the level of safety awareness."

Strengthening the team

The Highly Reliable Surgical Team requires collaboration among all members, regardless of rank or title. "We created a flat hierarchy so, for example, a surgical tech, nurse or anyone can call for site verification if the surgeon forgets to do it," explains Ms. Coon. Every OR is outfitted with a whiteboard that displays the names of everyone in the room and spells out the responsibilities of each. "We try to call everyone by name so it creates more of a team feeling in the room."

Each case involves a standardized, documented pre-op briefing, which includes the time out and a review of SCIP measures such as antibiotic protocols, and a post-op debriefing to review how the case went. "After the case, we talk about what could

be done better, what could be fixed next time," says Ms. Coon. Problems are recorded in "glitch books" located in each OR. Unit-based teams of representatives from pre-op, PACU, anesthesia and the surgical staff meet regularly to go over the processes in their units, reviewing glitch books, safety audits and briefing records to identify areas in need of improvement.

Getting results

Because the HRST system involves a lot of repetition, checking and re-checking information to ensure no errors slip through the cracks, patients are educated about the process ahead of time. "We've put together a fairly detailed packet for each patient that explains why we're doing these things, why they're being asked 5 times which body part we're going to be operating on, so they understand there's a real method to this and they're a partner in the process," says Dr. Feinstein. Ms. Coon says they've already gotten positive feedback from patients. "One of our urologists had a patient who happened to be a lawyer. This patient came to him post-operatively and said he felt comfortable that he was in a safe environment," says Ms. Coon. "He noticed all the checks and balances that occurred every step of the way."

Pain Control

Bay Park Community Hospital in Oregon, Ohio, sets itself apart with its peripheral nerve block program. Learn how you can do the same.

— *Sean McKinney*

Mr. McKinney (mckinneycom@gmail.com) is a Philadelphia-based medical writer.

Pain among total joint replacement patients recovering at Bay Park Community Hospital was out of control. These patients rated their post-surgical discomfort in the 7 to 8 range, even after pre-operative treatment with COX-2 inhibitors and opioids and a full range of post-op IVs, needles and capsules.

"We had to try something new," explains Marti Turney, RN, BS, director of surgical services at the 5-OR, 72-bed facility in Oregon, Ohio, winner of this year's OR Excellence Award for Pain Control. "We wanted to set ourselves apart."

And that they did, turning to continuous peripheral nerve blocks (CPNB) for total knee replacements. The new approach, resisted initially by the head of anesthesiology, has been expanded to other orthopedic procedures. They now offer a single-shot nerve block to patients who are undergoing shoulder surgeries, wrist fractures and complicated arthroscopic repairs and are being discharged. Ms. Turney says she's looking to expand to using CPNB in ACL repairs and letting patients go home with a pain pump.

Bay Park infuses bupivacaine HCL continuously through the femoral nerve, providing sensory anesthesia of the anterior thigh, knee, and medial aspect of the calf, ankle and foot. Pain scores are dropping off the charts. Gone are the nausea and dizziness of IV narcotics as well as the peaks and valleys of inconsistent relief. Average length of stay has dropped from 4.2 days to 3.2 days. Interested in giving it a try? Read on to find out how to incorporate the Bay Park solution into your setting.

1. Sell your anesthesia providers.

You'll probably meet with some resistance. "At first, our head of anesthesiology was reluctant to try this. He cited how time-

consuming it was to insert the catheters and that he wouldn't be able to cover the rest of the OR when he was tied up with this," says Ms. Turney. The top 3 complaints you're likely to hear: The CPNB catheter will take long to insert; blocks will steal time from the OR; and they'll require tons of follow-up. It wasn't until Ms. Turney went on a site visit to a nearby ortho hospital that she was able to see how blocks were managed without interfering with daily operations.

CPNB ends bothersome calls for increased intrathecal PCA dosage in the middle of the night. Meanwhile, surgeons need to know that CPNB can free patients of dizziness and nausea, minimize pain and encourage them to get out of bed quickly. During a 3-month study, Bay Park found average pain scores dipped as low as 1.34 for patients on CPNB and spiked to as high 10 for those whose CPNB catheters had been inadvertently dislodged — even though all were on supplementary oral narcotics.

2. Find a 'mentor center.'

Visit a center that uses CPNB and copy how it's done. Ms. Turney says a dedicated team is important initially so that you don't need to repeatedly educate staff. Do blocks in PACU to avoid slowing turnaround in the OR. Anesthesia techs can prepare the insertion site and assist with ultrasonography to locate the femoral nerve. Insertion takes about 20 minutes. Start with motivated and relatively healthy patients and expand your candidates from there. You can soon provide 12 to 18 hours of relief with a single shot of nerve block after extensive shoulder arthroscopy, surgical repair of wrist fractures and anterior cruciate ligament operations.

3. Educate patients.

Tell patients that the nerve that causes post-op pain will be numbed, providing continuous relief for 48 hours, but that they'll still be able to move. "Once they hear that," says Ms. Turney, "they all want the pain block."

4. Meet the clinical challenges.

Secure the catheter so it doesn't become dislodged when you're moving patients. "We stopped having this problem once we started using TinCoBen, steri-strips and Tegaderm dressings," says Ms. Turney. During the first 48 hours of CPNB, pain may be reported in the back of the knee after total knee cases. Manage it with oral narcotics and monitor the dressing closely. The moist and covered groin is prone to infection. "That is why we don't use pain block for more than 48 hours," says Ms. Turney.

5. Take advantage of the first 48 hours.

Patients can recover and rehab faster by climbing out of bed for PT within hours of surgery. Self-administered bolus infusions provide relief that makes post-op activity much easier than usual. "By the time we remove the catheter, pain scores average 4 to 5," says Ms. Turney.

6. Manage for success.

Each loaded CPNB pump costs about \$500. The procedure adds nearly an hour in staff time — 20 minutes for an anesthesia tech and up to 30 minutes for the PACU nurse. But Ms. Turney says Bay Park expects reimbursement for the procedure and

earlier discharges to boost the bottom line while improving the surgical experience. Nonetheless, strive for efficiency and keep a lid on costs. For example, all of the pump kits can be sent to the pharmacy to be filled when they are delivered, instead of one by one.

Bay Park now offers all total knee replacement patients the choice of having a CPNB. Only a few refuse. "The patients who've had a knee replaced without a CPNB, then come in for the other side and get the CPNB, state that it's like night and day," says Ms. Turney. "Patients are up in the chair the night of surgery. No more IV narcotics with all of their side effects. I truly do believe we are improving the care of our patients by offering [nerve blocks] as an alternative to IV pain medications. It's worth any extra cost or effort in the long run. Patients have told us that they've come to us over competitors because of our pain-block technique."

SSI Prevention

Getting "Back to the Basics" was just what West Virginia University Hospitals in Morgantown, W.Va., needed.

— *David Bernard*

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In the field of infection prevention, there is always room for improvement. So when the administrators of West Virginia University Hospitals in Morgantown, W.Va., noticed in 2007 that their surgical site infection rate had been increasing and that their staff's compliance with AORN guidelines, APIC standards and hospital policies could have been tighter, they took action. Outpatient Surgery Magazine recognizes WVUH and its "Back to the Basics" Program for Perioperative Services with its first OR Excellence Award for SSI Prevention.

The goal of prevention

According to Mary C. Wilson, BSN, RN, CNOR, clinical preceptor for the hospitals' Ruby Day Surgery Center, and Dawn M. Yost, RDH, RN, BSN, CNOR, manager of nursing operations and the sterile processing department, who led the program, its goal was multifaceted and broad in scope. "Back to the Basics" set out to identify and implement the clinical practice changes necessary to boost compliance and decrease SSIs, they describe, while also continually maintaining that standard through staff education focusing on areas of improvement.

The first step toward that goal was the creation of a multidisciplinary team to define the efforts needed. "This group brought other people into the process who hadn't necessarily been a part of this before," says Ms. Wilson. In an attempt to engage as many parties as possible, the team included representatives from administration, surgical services and infection control; the hospitals' surgeons, anesthesia providers and Center for Quality Outcomes; sterile processing, laundry services and housekeeping; biomedical and facilities engineering; radiology and information technology. "If you had business in the OR, you were at our meeting," says Ms. Yost.

During the weekly meetings, each participant tapped on his own experience and had a voice at the table. "Don't just put it on an administrative level," Ms. Wilson advises. "Listen to your people in the trenches. They can identify areas of improvement

and can have an impact, too." They reviewed hospital operations and government and accreditor patient safety initiatives as they brainstormed over possible causes of SSIs and infection prevention strategies to counter them.

5 key areas

Over the course of many meetings, their focus closed in on 5 areas: proper handwashing methods, cleaning and processing of instrumentation, surgical attire, environmental cleaning and upkeep and traffic control in the OR. Then the real work began, as proposed solutions were put into practice. Highlights of the "Back to the Basics" program included:

- **Proper handwashing methods.** Hand hygiene rules and expectations were posted for employee notification and hand sanitizer dispensers were placed in ORs (for personnel who weren't scrubbed in), in restrooms and at patient bedsides in pre-op and recovery. Managers conducted audits of handwashing compliance and technique. Patients and their families were educated on the importance of hand hygiene — how and why to do it when they visited the hospitals — and were even encouraged to ask their providers if they'd washed their hands.
- **Cleaning and processing of instruments.** "Our sterile processing room was 1986 or 1987 vintage," says Ms. Yost. "Not a whole lot had been done since it was first installed." A renovation brought reprocessing services up to date with new machinery offering larger capacities, the availability of de-ionized and filtered water, and rearranged sinks and counters for improved ergonomics and workflow.

In addition, the decontamination room no longer doubled as the trash room. "We used to put everything on a case cart after surgery and move it to the sterile processing room to offload it," says Ms. Yost. Clean trash, biohazard trash and linens all came down with the instruments. "By

3 p.m., there would be 8 full trash trucks in the room," she recalls. The team found a room closer to the OR that could be used for the separation of trash, linens and instruments, which ensured that the only thing going to decontamination was soiled instruments in covered case carts. This not only made space in the room, but also reduced incidents of instrument loss and damage.

- **Environmental cleaning and upkeep.** The team assigned staffers to conduct a thorough cleaning of all surgical suites, including their ceilings, walls, air vents, lighting fixtures, cupboards and storage structures. An outside company was hired to power-wash all moveable equipment at the hospitals' loading docks, a process that included wheel cleaning (since equipment wheels tend to collect discarded suture, says Ms. Wilson) and replacement, rust removal and repainting. The cleaning's completion was no time to rest on laurels, though. The team established a routine timeline for cleaning, ongoing maintenance and replacement, including a contract that would bring the equipment cleaning company back every 6 months.
- **Surgical attire.** The dress code for entry into the hospitals' surgical suites got stricter under the infection prevention efforts. Staff were not allowed to wear scrubs from home into the OR and were required to change their scrubs if they left and returned to the hospital in mid-shift. Masks were worn at all times

behind the sterile line ("It helps you to remember where you are," says Ms. Wilson) and disposable head coverings became the standard. "Bacteria shed from the body on your hair and skin," says Ms. Yost, who notes that some staffers wore cloth caps for days at a time without laundering them. "So maybe they like the cloth because it holds their hair better. But we make them wear a disposable cap or bouffant over top of it, too."

The team drew the line on which bags and backpacks anesthesia residents, vendors' representatives and IT staff were allowed to bring into the surgical suite. Cloth bags weren't permitted, but bags that could be wiped down with disinfectants in the same manner as an OR table's surface were. A staging area was designated in which visitors could leave unapproved bags. The team also targeted some of the contents of visitors' bags: Eating and drinking in the surgical suite was forbidden after OR personnel mentioned that they'd seen anesthesia residents dipping into potato chips or other snacks during some cases.

Also Busting the Bugs

Surgical site infection rates at the Grand Valley Surgical Center in Grand Junction, Colo., were "well below" national benchmarks, says Lori Sterbenk, RN, CNOR, clinical resource manager. With a re-accreditation survey on the horizon, however, and an increasing focus by government agencies and surgical industry organizations on infection control and surveillance efforts, the center kicked off a quality improvement project in fall 2008 to bolster its SSI prevention program.

A team of employees examined each of the center's departments: pre-op, PACU and the OR; central sterile and environmental services; administrative and admitting/business offices; even the pharmacy. They identified the infection risks existing in each area as well as the factors that could increase or decrease those risks. Then they identified personnel in each department to reinforce the positive effects of prevention efforts. An environmental rounds checklist helps clinical staff to keep tabs on identified risks and to address newly discovered ones.

Discharged patients are sent home with information on the prevention and symptoms of and the recommended response to infections; and post-discharge SSI report forms are forwarded to patients' physicians so they can fax data to the infection control team on any resulting infections detected during follow-up visits. Given the wealth of regulations, standards and recommendations guiding the field, says Ms. Sterbenk, "one of the biggest challenges for a busy surgery center is finding time for infection prevention." She credits the support of her center's board and leadership, which allowed staff the time and resources to meet, plan, educate themselves and carry out preventive efforts. "So often we go to meetings, but have no time to follow up on action items," she says. "We can't be so busy not to be able to dedicate ourselves to this task."

The word on surgical attire was spread to all departments who occasionally required access to the surgical suite. Sitting in on IT staff meetings, for instance, team leaders provided insights on infection control basics and clinical behavior when entering the OR and patient rooms, such as dressing in scrubs or "bunny suits" and shoe covers and bringing only approved bags. "And they appreciated the guidance, so they wouldn't be discourteous after we'd drummed it into our people," says Ms. Yost.

- **Traffic control in the OR.** "Every open door means people are going in and out," says Ms. Wilson, "and the dirtiest thing in an operating room is people. More people in and out of an OR means more risk of bacterial contamination, since the air currents are floating bacteria around instead of them just lying there." Infection prevention staff counted how many times OR doors were opened during cases, placed culturing plates around the ORs and cultured instruments and fluids used in a case to build a baseline of data. Then they stationed hall monitors to limit OR entries and exits during surgeries. Attending anesthesia providers and residents were equipped with wireless phones to reduce the traffic created by their frequent

communications, questions and checking on residents' needs for breaks.

Falling SSI Rates

Laminectomy

2006: 3.24% (24 of 739)

2007: 3.67% (29 of 790)

2008: 2.06% (16 of 775)

Hernia

2006: 9.09% (6 of 66)

2007: 6.25% (4 of 64)

2008: 6.06% (2 of 33)

Total Hip Arthroplasty

2006: 7.69% (7 of 91)

2007: 2.54% (3 of 118)

2008: 2.16% (3 of 139)

Total Knee Arthroplasty

2006: 6.84% (5 of 73)

2007: 1.06% (1 of 94)

2008: 0.87% (1 of 115)

Total Hip Arthroplasty Revision*

2007: 6.67% (3 of 45)

2008: 4.65% (2 of 43)

Total Knee Arthroplasty Revision*

2007: 3.45% (1 of 29)

2008: 0.00% (0 of 44)

*Arthroplasty revision surgeries were broken out from first-time surgeries beginning in 2007.

Source: Mary C. Wilson, BSN, RN, CNOR, and Dawn M. Yost, RDH, RN, BSN, CNOR, West Virginia University Hospitals.

Results and lessons

The "Back to the Basics" program sought to reinforce the tenets of infection prevention, particularly those pertaining to the areas of needed improvement, among the hospitals' staff. This education took a variety of forms: posters around the facilities, presentations at staff meetings, direct observation of clinical practices and feedback, even a "Back to the Basics Change Agent" award to periodically honor a perioperative staffer who'd gone the extra mile.

Two years after the program's beginnings, how has getting back to the basics worked? The numbers say it's worked out well. West Virginia University Hospitals' surgical site infection rates have declined (see "Falling SSI Rates"), and while the multidisciplinary team meets only quarterly instead of weekly now, its participants keep monitoring the situation and setting their sights on new goals. This was not a one-time fix, Ms. Wilson and Ms. Yost point out, but instead a culture change.

"It continues to be an ongoing process," says Ms. Wilson. And it's not been without its challenges. Team members have had to face a lack of immediate results, occasional backsliding and resistant employees. "Some of the biggest challenges were personalities," she says. "They've done things for so long that it's difficult to change. They ask, 'Why do I have to change?' We have to explain why we're doing this, what this process means to them and to their patients."

Peer pressure, she says, can play a valuable role in changing a culture. "We point out that everyone else is doing this without any problems," she says. "For long-term effect, get people who really believe in these efforts to talk them up. Then you have positive role-modeling that people will follow."

Patient Satisfaction

The Orthopedic and Sports Surgery Center in Appleton, Wis., features a hotel-like recovery room and unparalleled service for patients and their families.

— *Kent Steinriede*

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The secret to keeping patients and their families happy is personalized attention, from their first contact with the surgery center staff until long after they're back at home recuperating, says Angela Laux, RN, BSN, MSOLQ, director of quality for the Orthopedic and Sports Surgery Center in Appleton, Wis.

Indeed, patients in the center's total- and partial-joint program meet with Ms. Laux and other staffers 2 weeks before their scheduled operation. If necessary, Ms. Laux and her team go to patients' homes. They've traveled as far as 60 miles away.

Family members are always at the first visit, and they get nearly as much attention as the patients. From that day on, patients and their families have cell phone numbers for Ms. Laux and the center's liaison between patients and the home healthcare agency that will help care for patients as soon as they get home. At the meeting, Ms. Laux discusses how to prepare for the procedure and also gathers information that will help make the day of surgery as pleasant as possible for patients and families. She asks them what magazines they like to read and what type of music they like to listen to, and gets recommendations on films to rent for family members who will be waiting during surgery and recovery. The day before surgery, someone from the center goes shopping for the patients and families, rents movies and downloads music from iTunes.

When a patient at West Hartford (Conn.) Surgery Center showed up for a reconstructive procedure with an infection that caused the case to be cancelled, she was disappointed. Not by the cancellation, but in not being able to have a chocolate frosted donut in the PACU. "So one of the staff ran out to Dunkin' Donuts and we turned a negative day into a few laughs for her," says Administrator Louise DeChesser, RN, BSED, CNOR, MS. Just a small example of the ASC's mantra: "We will do anything for our patients. Our patients are like family." ' At discharge, patients at the St. Joseph's Candler Health System eye surgery center get a satisfaction survey with a pre-addressed stamped envelope. More than 30% are returned, says Judith Braun, BS, BSN, BC, director of clinical operations of Dynasty Healthcare in Savannah, Ga., which manages the center. Ms. Braun posts results to give physicians feedback as needed. "We've been able to improve processes from wait time upon arrival to discharge time, patient education to explanation of charges." ' When Bristol (Conn.) Hospital's patient satisfaction coordinator questioned hospital personnel who underwent surgery there, the grades were glowing and consistent with patient satisfaction scores. "They believed that they were treated with respect," says Janet Brown, RN, MN, CNOR, director of clinical operations of perioperative services. "They felt that the staff was very responsive to their needs, engaged them in

their care and were cognizant of their need for privacy." ' Beverly Funseth, RN, MBA, department administrator at KFH Sand Canyon Surgicenter in Irvine, Calif., shares her secrets to patient satisfaction: "The voice of a caring nurse calling pre- and post-op, pleasant greetings in admissions, smiles from all, passion and concern for every patient. Patients love warm blankets, attentive staff and doctors, timely surgeries. Finally, a rose presented to them at discharge puts the final touch on their positive care experience."

Ms. Laux spends about an hour educating patients about what will happen on the day of surgery and what to expect after the operation. "It's good to make them comfortable with what's coming," she says.

Most patients receive enoxaparin sodium (Lovenox) for prophylaxis of deep vein thrombosis. The patients' out-of-pocket cost for enoxaparin sodium can range from nothing to \$400, depending on their type of insurance. During pre-op screening visits, Ms. Laux gets the patients' insurance information and then contacts pharmacies to figure out how much each patient is going to have to pay. That way, there's no big surprise for the patient. If the cost of the drug is going to be a hardship, Ms. Laux checks to see if a patient is eligible for a program sponsored by the drug's manufacturer that allows some patients to receive enoxaparin sodium for free.

When patients or family members come from out of town, they stay in the spa-like hotel across the street from the center the night before surgery and the night afterward. The surgery center pays for the hotel, including anything they want from room service. This saves family members from having to get up early in order to arrive at the center at 6 a.m. Staying the night after surgery lets nervous family members get a good night's rest before hitting the road again.

Between the pre-op screening and the day of surgery, the liaison between patients and the homecare nursing company visits patients at home to make sure that it is safe for patients when they return. Often it's a matter of moving a few pieces of furniture and throw rugs, says Ms. Laux.

Hotel-like service

On the day of surgery, total- and partial-joint patients check in to the Fox River Room, a hotel-like recovery suite where family members will spend most of the day. Each patient is assigned a nurse who will accompany them throughout the perioperative process and speak with family members several times during their visit. Patients and family appreciate the attention. "They have said they feel like they're the only ones in the building," says Ms. Laux.

The deluxe recovery suite has a large television and recliner, flowers, snacks, takeout menus from nearby restaurants and the magazines, music and films that the patient and family requested. "We try to make their stay here more individualized," says Ms. Laux. When they arrive, patients find a gift basket along with a duffel bag for their personal items, a coffee mug and a blanket that they can take home.

Supplying personalized entertainment for family members helps relieve some of the anxiety that they may experience while their loved one is in surgery. It makes passing the time much more pleasant than the typical waiting room experience that most people have. "We feel that that family's experience counts as much as the patient's," says Ms. Laux.

Total- and partial-joint patients appreciate the hotel-like atmosphere of the Fox River Room because sometimes they stay up to 23 hours at the center. Most joint patients stay 5 to 6 hours, but there's no rush to discharge them. "We leave it up to the patient," says Ms. Laux.

At the same time, patients are encouraged to start moving around. "We have a very aggressive program," says Ms. Laux. "We're focused on getting them up and around."

Just how bad was it?

When patients are ready to go home, the same nurse that has taken care of them all day gives the discharge instructions. When patients and family members get home, a homecare nurse is already there, ready to help with the transition. Patients are also discharged with 5 frozen dinner entrees from a home-meal replacement service.

The next morning, Ms. Laux or a staff member calls patients to see how the first night went. Although patients are also in contact with surgeons and the home healthcare agency, someone from the surgery center calls every couple of days. By the time patients have their sutures removed, about 2 weeks after surgery, a staffer will have called at least 5 times. Patients appreciate the continued attention, says Ms. Laux. "The goal is that the patient isn't left 'out there.'"

Employee Safety

Easton Hospital in Easton, Pa., is a model facility when it comes to protecting surgeons and staff from the OR's dangers: surgical smoke, scalpel cuts and latex.

— *Dan O'Connor*

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David Kasprzak, RN, MSc, RNFA, is the winner of Outpatient Surgery Magazine's inaugural OR Excellence Award in Employee Safety not because he did the impossible (got his surgeons at Easton Hospital in Easton, Pa., to use safety scalpels in 90% of their cases!), but because his passion for keeping his staff safe is unstoppable.

"I'm a safety buff and one of these people who grab things and go and want it done yesterday," says Mr. Kasprzak, the director of surgical services at the 369-bed hospital, who considers himself a father figure watching over the staff. "I want to have every safety measure in place so that we have the safest place for our employees to work."

You might say that Mr. Kasprzak, a former EMS worker, is obsessive about keeping his staff safe. Everywhere you look, there's a safety device — respirators for organic vapor protection during bone cement usage, water-mist fire extinguishers, safety scalpels, smoke evacuators on all cautery machines. In addition, Mr. Kasprzak has updated the hospital's fire manual and is spearheading a latex-free campaign.

"When you create a safe environment, you cut down on missing time for employees," says Mr. Kasprzak, a believer in this adage: In safe organizations, safety is rooted in the culture and the system, rather than in the behavior of individuals.

Going latex-free

Of all his safety initiatives, Mr. Kasprzak is proudest of a project he's in the middle of right now: making 13 operating rooms latex-free. We're not just talking gloves, although several staff, including Mr. Kasprzak, had the telltale reaction to latex gloves — red, itchy hand rashes.

"We're going to have to change over so many products," he says. "We're used to using latex: rubber tubings, hoses and catheters — they're all latex-based."

He calls the conversion to latex-free ORs a "long, hard road to travel. You have to research every one of the products in your operating room. That's a lot of phone calls to vendors."

The problem, he says, is that latex is hidden in a lot of products you might not have suspected, such as Ace bandages and hoses you thought were made of other compounds. Finding alternatives takes lots of painstaking research. Easton is 2 years into the conversion and they're still not done getting all of the latex-containing products changed over.

"We want to make latex-free a standard for the OR," says Mr. Kasprzak.

Of course, the simple way to begin a latex-free journey is to switch to latex-free gloves. The goal, he says, is to have different textures of gloves available to try. "We're still in the process of trialing the gloves," he says. During a 3-week trial in the OR, all staff will trial latex-free gloves, paying particular attention to the sensation when they pick up instruments, scalpel blades and suture.

Safety-engineered tools

Here are a few other ways that Easton Hospital is keeping its employees safe.

- **Safety scalpels.** Equal parts education and sales is how to get your surgeons to use safety scalpels, says Mr. Kasprzak. "It's all in how you present it to your surgeons," he says. "You have to present in a positive manner. Stress the positive changes that the equipment will make. Never stress the negative aspect of a piece of equipment. Let the safety aspects of the devices sell them."

His surgeons trialed several brands and narrowed the field down to 2 differently styled safety blades and handles that they're using for 90% of cases (of course, some surgeries, such as nasal, require a bare blade).

They picked a premium blade. "You know the old adage: You only get what you pay for. I always like the Cadillac version," says Mr. Kasprzak. One, for orthopedic cases, comes with a clip-on device that allows for easier popping on and off of blades. The other is a longer blade used for deeper tissue and has a safety slide instead of a hood.

Surgeons enjoy using them and nurses prefer them, too, because "everything is self-contained and safe."

- **Smoke evacuators for use on all cautery machines.** Everybody knows the dangers of surgical smoke. When Easton Hospital purchased new electrosurgery units last year, it bought smoke evacuators for each one. They include a few surgeon-friendly features. One, they're nearly silent. Two, the device is only activated when you activate the pencil. When the surgeon removes his finger from the pencil, the evacuator stops. "We just talked about safety again," says Mr. Kasprzak. "Everybody's safety in the room."
- **Water-mist fire extinguishers.** Inside each of the hospital's 13 ORs you'll find wand-like fire extinguishers that emit a mist — "like a plant mister would, but with more flow," says Mr. Kasprzak. He says they're ideal for paper or electrical OR fires because they can quickly extinguish a fire without the plume of carbon dioxide. "So you're not contaminating the whole field," he says.
- **In case of an OR fire.** Mr. Kasprzak also created a separate fire plan for the surgical services department. A task force came up with a script of who does what at what time in the event of an OR fire. "We rehearsed it a few times so that everybody knows their job duty," he says. "It's simple — only several lines long."

Just Say No to Back Injuries

Lexington Medical Center purchased 6 inflatable mattresses that are used to move patients between stretchers and beds in the OR to prevent back injuries. "Since this purchase 2 years ago, we have had no back injuries attributable to moving a patient," says Maureen Spangler, RN, director of perioperative services at the West Columbia, S.C., surgical facility. "This is a comfortable, secure way to move the patient with no lifting or back strain for the staff." The air mattress is inflated, allowing the patient to virtually glide from one bed to another with minimal effort by the staff, she adds. Lexington also has several motorized stretchers to move bariatric patients with minimal staff exertion.

Perpetual safety seminars

Easton Hospital believes it's never too early to begin preaching and teaching about surgical safety. All surgical students and residents who rotate through the operating rooms get the same comprehensive orientation to employee safety initiatives as the OR staff. The hospital also issues CE credits to new hires who participate in the OR safety orientation program.

"It helps tremendously," says Mr. Kasprzak. "Everybody's on the same page. They know what all the safety devices are for and why we use them." That's a good thing, too, because there are plenty of safety devices to learn how to use.

Financial Management

The Eye Center of Columbus in Columbus, Ohio, was hemorrhaging cash — until this determined executive director stepped in. Follow these 6 strategies to emulate her turnaround success.

— *Sean McKinney*

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Is it possible to pull together the best surgeons from ophthalmology's subspecialties, manage thousands of advanced procedures and still lose your shirt?

"Yes," answers Pam Canfield, RN, MPA, executive director of the Eye Center of Columbus in Columbus, Ohio. "We were losing tons of money."

That was late in 2007. Within 8 months, the center began earning hundreds of thousands of dollars and paid distributions to investors for the first time. "Now we have a 401(k) plan and we pay bonuses," says Ms. Canfield. "We went from 13,433 procedures to 18,236 procedures in one year."

The Eye Center is the winner of Outpatient Surgery Magazine's inaugural OR Excellence Award in Financial Management. Read on to find out how she and her colleagues pulled off such a sharp 180.

Just how bad was it?

Cash flow streamed in one direction — toward bill-happy suppliers — and rarely back from patients who owed for out-of-pocket services. Coding for complex procedures was a science no one understood. Some employees specialized in meeting attendance and downtime between procedures. Accounting, legal and other services seemed to have been outsourced to pirates in business suits.

Twenty-six investors, mostly ophthalmologists, had invested in the center, an eye mall that included a pharmacy and a delicatessen, without seeing a dime back in nearly 5 years. Enter Ms. Canfield, a former high school point guard with serious pluck whose parents built a church out of a farmhouse congregation. Here's her advice:

1. Stabilize full-time equivalent (FTE) hours per case. Ask staff to volunteer to learn new skills and give resistant employees walking papers. "Be direct and fair," advises Ms. Canfield. Nobody should be above cleaning carts, escorting patients to the parking lot and completing paperwork between tasks.

Cross-train employees to work pre-op, OR and post-op. Eliminate and consolidate positions, such as putting a clinical director in charge of quality, infection control and surgery reports. Ask laser technicians to do more. Require unpaid or paid time off as needed. Monitor FTEs weekly and adjust schedules accordingly. "Most people will take time off without pay," says Ms. Canfield, who cut ballooning FTEs per case from 11 to 7.95.

2. Sic your surgeons on suppliers. Better deals, consignment inventory and cost cutting await those who can educate surgeons on how much you pay for packs and other materials. Your docs can be effective negotiators, using your center's volume and reputation as leverage. "Ask, ask, ask," advises Ms. Canfield. "You will not know what vendors are willing to do unless you put the questions out there."

3. Code and bill correctly. Hire a certified coder to ensure that 2 or more codes are used when needed, such as after a cataract surgery involving the posterior segment. Keep your charge sheets (CPT codes) updated. Read surgical notes thoroughly and consult with surgeons and their staffs to pinpoint what work has been performed. Comb your files to identify cases that haven't been fully coded. Re-file claims, including those that have been rejected.

Make sure patients cover private payments, co-payments and deductibles before their cases. Use healthcare finance services. Process claims quickly and refund deductibles that have been satisfied by previous procedures or doctor visits. "Word will get around that you take care of patients," says Ms. Canfield.

4. Hire an accounting firm that works for you. You can monitor and adjust medical supplies, overtime, contractual revenue, year-to-date expenses, year-to-year revenue comparisons, cash on hand, FTEs and other key indicators.

5. Eat up your AR. Accounts receivable dropped from more than 38 days to 23 days at the Eye Center. Besides prompt billing and up-front payments, Ms. Canfield attacks deadbeat files with the telephone and collection letters.

6. Negotiate block time tactfully. Not every surgeon can get prime spots, even when you are trying to lure them in. "Be open with surgeons and you can accomplish a lot," says Ms. Canfield. "This is something you always need work on."

Measuring success

The Eye Center has added 5 investors and credentialed 51 surgeons, up from the 45 who were credentialed 2 years ago. "Step by step," says Ms. Canfield, "you can go anywhere if you have an excellent clinical team and superior surgeons — and if you take care of business."

Also Taking Care of Business

Advanced Cosmetic Laser Center of Tamarac, Fla., has developed a spreadsheet (www.outpatientsurgery.net/resources/forms/2006/xls/OutpatientSurgeryMagazine_0609_SurgicalProcedureCost.xls) that helps manage OR costs. "Once you have properly filled out the items, costs per item and quantities, the spreadsheet populates the total cost for each case," says Jay A. Shorr, BA, CMBM, CAC, vice president of operations and practice administrator. "This lets you determine the actual profitability of each case, less the appropriate fixed costs for rent, electricity, laundry, red bag trash, other ancillary labor, etc." "There's a science to the way they monitor savings at Yale New Haven Health in New Haven, Conn. When trialing a product, Nancy Ruby DeRienzo, BSW, RN, clinical utilization specialist, examines all the clinical data — no vendor-sponsored studies, she says — she can get her hands on. "We look for independent research that this product indeed does what it claims to do," she says. "It's all about science, not marketing." After surgeons trial the product and use it for a period, Ms. Ruby DeRienzo monitors cost savings through a clinical quality value analysis approach. "It's ensuring better patient outcomes with better products at the best price," she says. "We compare clinical outcomes to the price of the product and surgeon satisfaction."

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