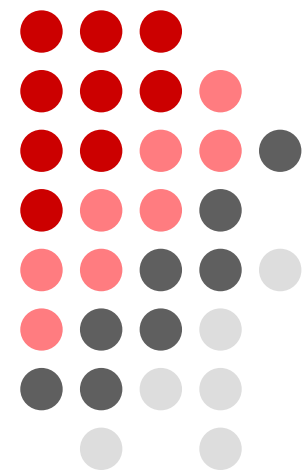


Strathroy Middlesex General Hospital

Surgical Services Review
Presentation

Randy Heiser

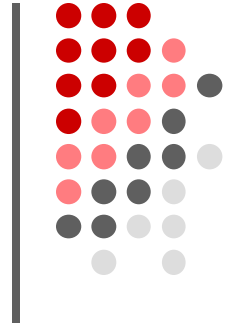


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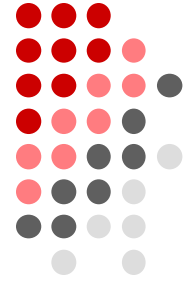
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Agenda



- Background
- Data Analysis
- Operational Findings
- Recommendations
- Next Steps



Background

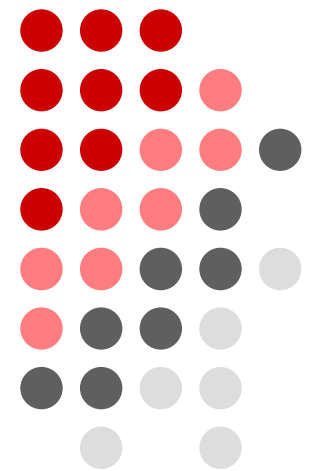
- Objective – Review the surgical program at a high level with particular emphasis on scheduling and OR access to:
 - Improve efficiency
 - Identify opportunities for improvement
 - Create a “marketing” story for surgeons in London and elsewhere



Background

- Interviewed surgeons and anesthesiologists
- Interviewed managers and staff
- Reviewed ORBC data
- Compared this program against similar 1-4 theatre suite hospitals
- Developed recommendations

Data Analysis



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Review of ORBC Data

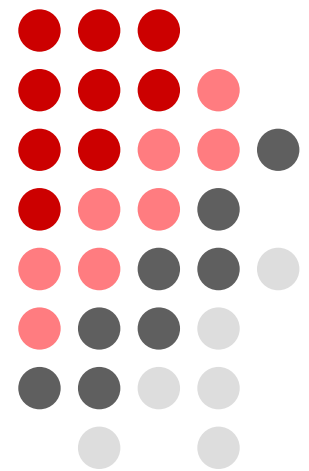
- Start time accuracy appears low; however, SMGH uses a different definition than other hospitals
 - SMGH – incision at 0800 and patient in the room 0745 or earlier
 - Not everyone at SMGH uses this definition
- Case times are longer than expected with the exception of turnover



Review of ORBC Data

- Utilization is low, despite long case times
- Average productivity
 - Eye room – 626 cases were performed last year (same pace this year)
 - Main two theatres – 1,100 cases per year per theatre
 - Staffed productivity is approximately 1,400 cases per year per staffed theatre
 - Benchmark – 1,500 cases per year per theatre, with 2,000 per year per staffed eye room

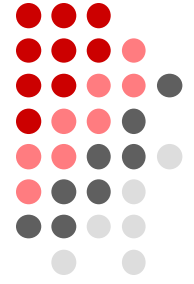
Findings



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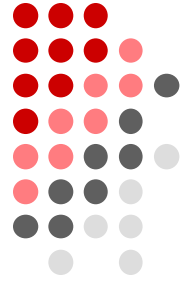
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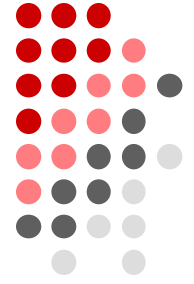
Governance

- No true governance structure for the OR, typical of programs of similar size
- New Chief of Anesthesiology is working well and making positive change occur
- Future changes will require a more formal governance structure in place

Facility



- Overall a good facility, with some exceptions
 - PACU is poorly designed and does not meet standards for a first stage recovery area
 - Pre-op/second stage area is not patient friendly with open bays, but is appropriately sized for the OR volume
 - Observed patients waiting on stretchers in the hallway outside of the OR unattended
 - CPD is well designed and with good equipment



Staffing Findings

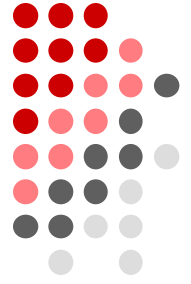
- Staff start at 0700 for a 0745 patient in the room time; other hospitals have staff start 30 minutes prior to patient in the room
- All rooms are staffed the same
 - Reported that eye room has three staff members plus a physician. Typical staffing is either three staff members (2 RN, 1 RPN) or two staff members and a physician
- CPD requires 2.75 FTEs to support surgery; some additional investment in staffing may be required
- OR and pre/post areas are appropriately staffed
- Some issues were voiced with overtime



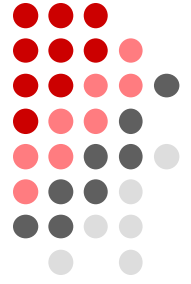
Throughput Findings

- Site marking was reported to be done by nurses or in the hallway. This should always be done by the surgeon prior to patient going to the room
- Joint program is a best practice nationally and compares favorably with Holland O&A

Preoperative Clinic (POC) Findings

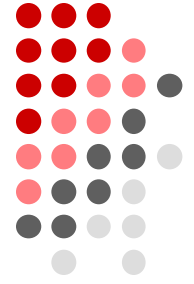


- Very little phone screening
- Low acuity, low complexity patient population, and the POC visit target is 100%
- Testing is ordered by the surgeon
- No anesthesiology protocols in evidence
- Progress is being made in improving this function
 - ENT cases, for example



PACU Findings

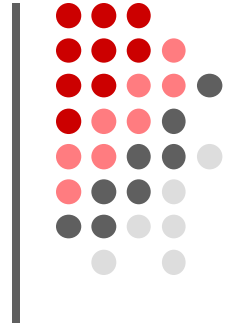
- PACU appears to have a long length of stay
- No bypass protocols reported to be in place
- Only local patients bypass PACU
- Facility is not typical of a first stage recovery unit
- Reported length of stay is longer than expected



Scheduling Findings

- Blocks are not aggressively managed; surgeons who want and would use more time are unable to get it
- Low utilization blocks are maintained
- Re-allocation does not occur
- Duration estimates are unreliable and not believable. Cerner has a reputation of being very inaccurate
- Cases scheduled with ICU bed post-op were observed, atypical of similar sized programs
- Lack of guaranteed coverage plan due to anesthesiology staffing

Scheduling Findings



- OR time is dedicated to cosmetic cases, which could be decanted to “leased” time on weekends if necessary



Materials Findings

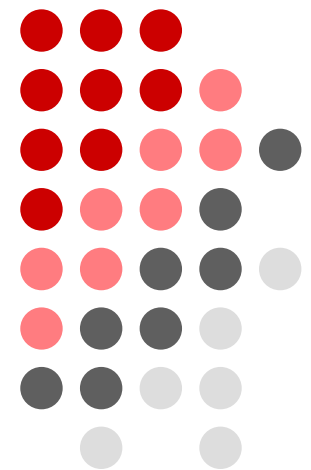
- Appears to be a good program
- CPD technicians were reported to be all certified – a best practice
- Cases are not always picked the night before



Overall Conclusions

- Excellent program with opportunity for growth
- One of the highest efficiency joint program seen by SHC in Canada
- Opportunities to improve in:
 - Pre-surgical screening (more screening and less testing)
 - Balancing demand and capacity
 - Block management and scheduling improvements

Recommendations

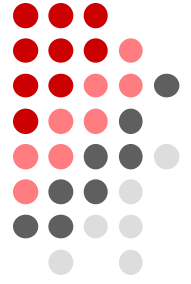


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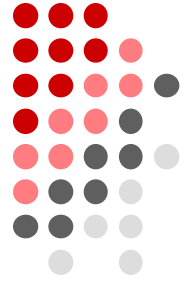
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Governance Recommendations



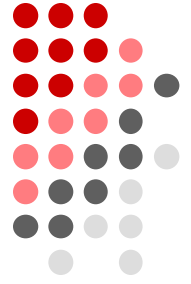
- Establish a Surgery Executive Committee that has responsibility and authority over the surgery program.
 - Set policy
 - All policies should have consequences included for non-compliance
 - Review budgets and be held accountable for performance against budgets
 - Act as the board of directors for the surgery program
 - Should consist of representatives from
 - Anesthesiology
 - Administration
 - Nursing
 - Surgeons

Scheduling Recommendations – Schedule Planning



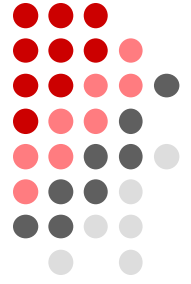
- Revise the block allocation process to include:
 - Utilization requirements
 - Individual block release times
- Reallocate blocks over time based on
 - Utilization
 - Compliance with policy
 - Contributions to hospital
 - Wait list
- Measure and improve first case on-time start accuracy
- Monitor add on cases for appropriateness
- Stop the practice of scheduling cases with planned ICU admissions due to the scope of the program

Preoperative Clinic (POC) Recommendations



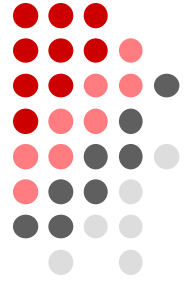
- Organize the POC as an integrated and coordinated presurgical screening function for both nursing and anesthesiology
- Endeavor to screen 100% of surgical patients utilizing anesthesiology determined protocols, telephone interviews, and a patient questionnaire
- Schedule patients for anesthesiology assessments based on protocols and surgeon referrals only and not as a “standard” practice
- Based on complexity of program less than 30% of patients need to come to the hospital pre-operatively

Preoperative Clinic (POC) Recommendations



- Assign POC responsibility for chart assembly, review and retrieval of all tests, consult results, and OR package documentation
- Establish a standard review of charts 72 hours before surgery to ensure chart completion
- Develop a checklist and audit function for chart assembly, verification, and completion activities
- Ensure all first case charts are complete and reviewed by noon day before, if not move the case

Surgical Day Care Recommendations



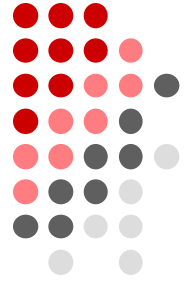
- Adjust the hours of operation to accommodate the OR schedule and patient volume and prevent patient movement if possible
- Utilize lounge chairs for un-medicated and stable preoperative patients, transport with wheelchairs or let the patient ambulate to the OR
- Redesign the preoperative patient flow to include anesthesiology and surgeons visiting the patient prior to the case in the day surgery area, rather than the OR hallway



PACU Recommendations

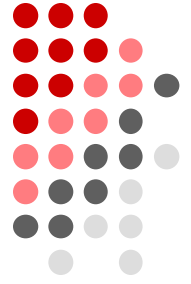
- Investigate facility changes to open up the unit
- Consider eliminating first stage recovery and providing the care needed based on staffing ratio changes and needs of patients

Intraoperative Recommendations



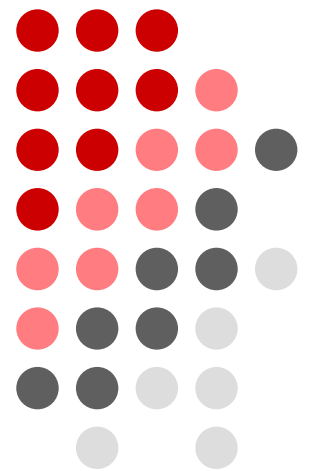
- Develop an agreed-upon definition of start time. Consider staggering first case starts to ensure a 95% on-time start
- Review start time for nursing and anesthesiology to determine the need for change
- Eliminate the practice of leaving patients unattended in the hallway. Transport patients directly into the OR
- Establish a policy of surgeons marking all appropriate patients prior to going to OR

Materials Management Recommendations



- Move one CPD staff member to afternoon shift to pick all cases after 3:00 PM to avoid nursing picking the cases in the morning
- Evaluate staffing levels and backlogs
- Target 0 flash cycles
- Continue the current practices

Questions?



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