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**Closing Communication Gaps for Unplanned Surgical Patients:
One Pre-Op Checklist at a Time**

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NURS-670: Internship

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Section I. Abstract

Problem: Unplanned, inpatient surgical patients were experiencing poor outcomes and dissatisfaction with their overall care. This surgical patient population also lacked communication from their healthcare teams with regard to plans of care throughout their hospital stays.

Context: This was a quality improvement project for the unplanned, inpatient surgical patient population in the Central Valley of California. Approximately 13% of this hospital's surgical patients required post-surgical care in the inpatient units. These patients, according to unfavorable HCAHPS scores, experienced unsatisfying care and insufficient communication from their healthcare teams, including physicians and nurses.

Intervention: This project implemented an Add-On Communication Tool for the unplanned surgical patients entering the operating room (OR) from the emergency department (ED) or inpatient units. Most importantly, this project reestablished the standard work of completing the pre-op checklist for all surgical patients, which is already part of the patient's electronic medical record (EMR) in Epic HealthConnect.

Measures: Measures for this quality improvement project included the pre-op checklist completion rate for all add-on, unplanned surgical patients of this hospital, including the use of the Add-On Communication Tool. The outcome measure for this project was improved communication among healthcare professionals and patients, as seen in HCAHPS scores for the unplanned, inpatient surgical patient population.

Results: The pre-op checklist completion project for all unplanned, surgical patients achieved successful results over the last 10 months. Since implementation, completion rates from October 2020 to July 2021 averaged 76%, exceeding the original target of 65% for this timeframe.

Additionally, the HCAHPS star rating also increased, from 2.9 stars for the 2020 performance year to 3.6 stars as of June 2021 open data.

Conclusions: This project proved that effective and collaborative communication between healthcare professionals and engaged patients led to better health outcomes following unplanned surgical procedures. Consequently, patients were more satisfied and willing to comply with postoperative care instructions. Moreover, these enhanced interventions shortened hospital stays and expedited post-surgical recoveries.

Keywords: *unplanned surgery, pre-op checklist, surgery checklist, surgical checklist, preoperative surgical care, inpatient surgery, surgery HCAHPS*

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Section II: Introduction

Clara Barton once said, “I have an almost complete disregard of precedent, and a faith in the possibility of something better. It irritates me to be told how things have always been done. I defy the tyranny of precedent. I go for anything new that might improve the past” (Weberg et al., 2019, p. 2). Healthcare has become increasingly complex, requiring all players within a microsystem to collaborate through the journey within the macrosystem, which is the hospital. Healthcare outcomes are not only dependent upon evidence-based practices, determined processes and workflows, and innovative medical technologies, but on the successful working relationships of healthcare professionals within microsystems and among different departments. Healthcare professionals from all different units within the hospital share this common purpose: to return patients to a state of health. Their work must follow established procedures, patterns, and guidelines for the unit and the organization, as a whole. Any deviation from the standards of care can harm desired healthcare outcomes for patients. Professional relationships, system elements, workflows, and processes among other critical elements are subject to accidents and adverse events because human nature tends to find creative ways to get around processes that seem to be unnecessary or that impede the workflow (Harris et al., 2018). As such, healthcare organizations face high risks due to deviance from prescriptive standards or professional expectations. Consequently, healthcare professionals must be steered back to normalcy, where routine activities are once again carried out consistently (Johnson & Sollecito, 2020).

In the Perioperative Department of an acute care hospital setting, there were four different patient stratifications: (a) planned outpatient, (b) unplanned outpatient, (c) planned inpatient, and (d) unplanned inpatient. Each of these stratifications had various touchpoints that determined if someone proceeded through the emergency department (ED) or straight to the

surgical department for surgery. The same was true for when these surgical patients initially recovered. That is, whether they would be discharged home from the post anesthesia care unit (PACU) or be transferred to an inpatient unit.

Because of the frequent transitions of care during hospital visits, communication among physicians, nurses, and patients is vital when establishing plans of care. Engaged patients and their families are better prepared for what is to come, both mentally and emotionally. Communication between physicians and patients and nurses and patients is a measurement of the national Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey that seeks patients' perspectives of care (Centers for Medicare and Medicaid Services [CMS], 2020). When it comes to unplanned surgeries, patients deserve to know what to expect so they can optimize their recoveries. Therefore, it is critical to close the communication gap with surgical patients regarding their plans of care. Step one in this process is to complete the pre-op checklist already embedded in the patient's chart, also known as their electronic medical record (EMR).

Problem Description

When the on-call operating room (OR) nurse goes to the ED or the Inpatient Unit of this hospital to pick up patients for urgent surgical procedures, patients are expected to be completely prepared. However, they are not always ready, especially when they have just been in the ED. Patients who are not fully prepared for surgery face delays in care, inefficiencies, and increased healthcare costs, among other issues, all leading to dissatisfaction (Harris et al., 2018). Too often, surgical nurses contend with the challenge of unsigned surgical consents, uninformed patients, primary nurses without necessary information from the surgeon, and other incomplete critical prep work. Process mapping sessions began in May 2020 and ended in July 2020 (see Appendix

A), along with real-time feedback and concerns provided to this author by the OR staff revealed an excessive number of patients who had not been informed of their transfer times to the OR. Additionally, patients were even unaware of their surgical plans and their overall plans of care during their hospital admissions. Communication gaps were identified between surgeon and patient, surgeon and primary nurse in the ED, ED nurse and patient, and ED nurse and OR nurse.

Seeking pertinent information from the surgeon was also almost nonexistent for the primary ED nurse caring for the surgical patients preoperatively. This behavior represented poor interprofessional relationships among healthcare workers, especially when it involved health professionals from different microsystems who did not fully understand one another's workflows. A classic example was portrayed in the lack of professional collaboration among healthcare professionals in the ED and Perioperative Services. So, the below-target HCAHPS scores with regard to RN Communication and MD Communication were not surprising. If healthcare professionals lacked effective communication amongst each other, it would be expected that communication with patients would also suffer, further necessitating a focus on patient care experiences relating to communication. Organizations must fully and carefully examine data received from HCAHPS surveys for areas needing improvement.

For the 2020 performance year, this medical center's HCAHPS score for inpatient surgical patients was 2.9 stars, while the Northern California region overall achieved 3.3 stars. Thoughtful evaluation and analysis on the obvious gap resulted, but review of this specific latent data must occur regularly until the group has accomplished sustained improvements. Key stakeholders, including CNLs, physicians, frontline nurses, project managers, and a care experience leader must participate in the process, for together they have the ultimate power to drive implicit data, review identified gaps, and implement the Plan-Do-Study-Act (PDSA)

cycles, as needed, to attain favorable outcomes for the organization and, most importantly, for the patients, who should always be the epicenter of care (Johnson & Sollecito, 2020).

A common scenario is the patient who presents into the ED for a specific ailment. If a surgical consultation finds that surgery is the right course of action, the patient then transitions to the Perioperative Department for the procedure. Postoperatively, the patient will either discharge home or transfer to an inpatient unit for further care. Throughout this journey, the patient will necessarily have both positive and, unfortunately, negative experiences. However, due to insufficient transparency and a delayed receipt of HCAHPS surveys and results, it was difficult for CNLs to properly and immediately implement appropriate corrective actions to improve performance and care experiences, as reflected in the data. To close communication gaps and offer evidence to prompt accountability by the ED care team, this author began auditing unplanned surgical patients' charts for completion of pre-op checklists done by ED nurses who cared for these patients.

Chart audits were reviewed for pre-op checklist completion between May and August 2020 to determine a baseline average completion rate. Pre-op checklists were completed at a mere 13.4% for patients going into the OR from the ED. During this 4-month period, there were 247 add-on surgical cases from the ED. Of these cases, only 33 had fully completed pre-op checklists, meaning all 14 essential line items were addressed with the patients by their primary ED nurses. The most prominent fallout was missing informed surgical consent. Less common was NPO status not being addressed. This discovery was an accurate depiction of the concerns brought forward by the OR nurses. The 14 key elements that justify a completed pre-op checklist include:

1. Patient allergies reviewed,
2. Surgical consent completed and signed,
3. Advance directives acknowledged,
4. History and physical present in patient's chart,
5. NPO status,
6. Carbohydrate supplement given,
7. Last time patient voided,
8. Pre-op skin prep with Chlorhexidine,
9. Skin protection,
10. Pre-op hair removal,
11. Pre-op labs,
12. EKG results,
13. X-Rays available, and
14. Existing implants

These standard items should be addressed line-by-line for optimal safety for surgical patients.

This pre-op checklist is part of the patient's EMR built in by Epic HealthConnect. It is not a newly-developed checklist, but a standard of care. However, deviation from this standard work is the ultimate chasm that has been tolerated long-term, leading to significant patient dissatisfaction, hostile work environments, and substandard patient outcomes.

HCAHPS also revealed the need for doctors and nurses to communicate in terms that are easily understood by patients, i.e., "explaining things in a way I understand." These data spoke volumes from the unplanned surgical patients' perspectives requesting improved work, prompting the following question: How can the leaders and frontline care teams of this hospital

leverage HCAHPS data, which are a metric-that-matters, to improve healthcare communication, especially with unplanned surgical patients who need to be admitted following surgery? When comparing this hospital's HCAHPS data on Inpatient Surgical Care Experience to the organization's Northern California Region, consisting of 21 acute hospitals, this hospital's performance was at the same baseline star rating of 2.9 (see Appendix B).

Available Knowledge

The PICOT question used for the literature search and synthesis of evidence in closing RN communication gaps in the preoperative care of unplanned surgical patients asked: For the unplanned inpatient surgical patients (P), will the completion of the pre-op checklist in HealthConnect by the ED nurse (I) as compared to incomplete pre-op checklists (C) improve RN communication in HCAHPS scores (O) over a period of 6 months (T)? These data were gathered after completing a comprehensive search through various databases, including CINAHL, Joanna Briggs Institute, Cochrane Database of Systematic Reviews, DynaMed, PubMed, and Scopus. The following keywords were used in each of the database: *surgical communication, hospital communication gaps, patient surgical preparation, unplanned surgery outcomes, hospital hand-off communication, AND improving communication*. Limitations were set to peer-reviewed journal articles in English with all articles published during/after 2016. From the copious searches, five articles were deemed valuable and relevant to the current study (see Appendix C). These studies were then evaluated using the Johns Hopkins Nursing Evidence-Based Practice Research Evidence Appraisal Tool (Dang & Dearholt, 2018).

The goals of the literature review were strategized into three different phases: (a) communication gaps that exist in hospital settings, (b) hand-off communication tools that are currently being used in hospitals, and (c) recommendations to close communication gaps,

especially during hand-off of surgical patients as they traveled through different microsystems of the hospital.

In search of significant communication gaps that take place during the care of surgical patients from pre- to post-surgical, a PubMed literature by Jones et al. (2017) concluded that communication gaps between healthcare professionals and patients existed, especially in the emergency surgery patient population. This was a prospective study of emergency abdominal surgical patients and the need for healthcare professionals to involve patients in their plans of care. The authors noted that confidence and trust in healthcare providers was realized when patients perceived that good communication and the hand-off of pertinent information occurred. This study was rated at level III-B.

The second goal was to search for current tools being implemented in hospitals during hand-off communication to the receiving nurse and from healthcare professionals to the surgical patient. A CINAHL search found a level III-A, expert opinion study by Methangkool et al. (2019) that reviewed 419 anesthetic incident reports. This study concluded that having consistent, standardized, and effective perioperative handoffs and communication among different units, beginning with the ED to the perioperative team and between the PACU team to the inpatient unit, reduced patient harm, mitigated potential errors, and improved patient outcomes. Utilizing standardized tools provided by EHR systems through different software offered by hospitals was the initial phase to improving handoff communication and mitigating issues in real-time.

On another note, Ghunimat et al. (2020) found in their prospective study that methods of communication mattered greatly in conveying critical surgical information to patients. Therefore, soliciting patients' communication preferences in the form of conventional letters, emails,

telephone calls, and text messages could lead to better understanding of the surgical plans of care for the patients. This study concluded that most patients preferred telephone calls and sometimes text messages for less urgent communications. Forty-eight of the 111 patients between the ages of 17 and 88 preferred telephone calls. Limiting the relevance to this project, the study focused on the planned surgical patients' communication preferences rather than those of the unplanned surgical patients who were awaiting their surgical procedures while in the ED. This study was rated at level III-B.

The final literature search phase sought recommendations that could help close the communication gap within acute healthcare settings, especially for the unplanned surgical patient population. Cooper et al. (2016) was an expert opinion rated at level V-A. Twenty-three acute care surgeons convened at a 1-day conference to review the current breakdown in communication skills prevalent among surgeons and causing misunderstanding among the elderly emergency surgical population. At the end of this conference, the surgeons produced a communication framework that included nine key elements to be carried out with the patients: (a) share the prognosis, (b) connect and elicit relevant information, (c) share the current status and plans, (d) summarize the findings, (e) pause for the patient to absorb the information, (f) give options, (g) share the goals and expected outcomes, (h) recommend the best pathway, (i) and support the patient. While this study focused on surgeon communication, nurses can certainly utilize this framework and model to connect with their patients when preparing them for unplanned surgeries.

Continuing with the above literature search during the final phase, an additional study was analyzed. Ojuka et al. (2019) completed a consensus paper-interpretive analysis on patient-centered care involving preferences of communication, especially when engaging over surgical

care decisions and allowing for informed choices. This learning can be implemented by the surgeon and the nurse caring for the patient, especially because the surgery is an unplanned event. Patients learn better through different means and there are different resources in the hospital that can be used to best inform patients of their plans of care. Soliciting patient communication preferences can be implemented throughout the acute care hospital. This study summated that better-informed patients enjoy better outcomes by acting as key players in their journeys from illness to health. This study was rated at level V-A.

The literature review pointed to a resounding need for better communication throughout the different microsystems within acute care hospitals between physicians and patients and nurses and patients, particularly with unplanned surgeries among the elderly population. The challenge of this project was collaborating with healthcare professionals from another unit, the ED, and encouraging best practices in completing the pre-op checklist that was already considered standard work, as evidenced by the 100% completion rate on the inpatient units. Properly preparing patients for surgery in the ED prior to the arrival of the OR Call Crew closes the communication gap between physicians and patients and nurses and patients. In so doing, patients are better-informed, make more educated decisions, and subsequently enjoy improved care experiences, which also improves outcomes for everyone.

Rationale

“Person-centered care” is a conceptual framework with origins in humanistic psychotherapy, as suggested by Carl Rogers (1951), who proposed that human beings develop their self-views in childhood based on interactions with their loved ones (Chapman, 2017). Under this framework, patients who feel genuinely loved, valued, and respected with unconditional and positive regard, will trust their healthcare professionals. This framework also

encourages collaboration in the hospital setting, where patients feel heard and respected, thus leading to better outcomes and more satisfaction. Applying “person-centered care” to unplanned surgical patients, especially during the initial encounter, fosters trust and eases anxiety.

Specific Project Aim

The specific aim of this communication gap project at this medical center was to improve the completion rate of the pre-op checklist by ED nurses caring for unplanned surgical patients. The result should yield higher HCAHPS scores with RN communication, better-informed surgical patients, close the communication gaps between nurses and patients, and raise the completion rate of pre-op checklists from the current baseline of 13.4% to the target of 65% or higher by August 2021.

Section III. Methods

Context

The typical Perioperative Services Unit provides surgical care to both inpatient and outpatient populations. However, 83% of the patients come for outpatient procedures and are later discharged to home the same day, whereas the inpatient population represents just 17%. Scheduled surgical patients come from home on a well-planned basis. Urgent, unplanned surgical patients, on the other hand, are transferred into the OR from the ED, or other inpatient units in the hospital. After surgery, transfer is made to the Medical-Surgical Unit, Telemetry Unit, or Intensive Care Unit (ICU), depending on the level of care required postoperatively. The core perioperative care team consists of a preoperative nurse (prepares patients for surgery), an intraoperative nurse (circulates the OR assisting the anesthesiologist and sterile surgical team, including the surgical technologist and the surgeon), and the post-anesthesia care nurse in the recovery room. To effectively and efficiently run three main operating rooms requires 20.35 full-time equivalent (FTE) pre-operative, intraoperative, and postoperative nurses and 8.6 FTE surgical technologists, along with 1.2 FTE patient care technicians.

A “metrics that matter” to the perioperative microsystem, as well as other units within this hospital, is the HCAHPS survey concerning patient satisfaction during inpatient hospital stays. For July 2020, the patient satisfaction average composite score for unplanned inpatient surgical patients, according to HCAHPS, decreased drastically from 4.0 to 3.3 stars. The easily identified indicators were three-fold: physician communication, nurse communication, and care transitions.

After process mapping with key stakeholders regarding low patient satisfaction scores, gaps in communication were identified as early as when patients reported to the ED for

treatment. Once the ED physician determined that a surgical consult was needed, the surgeon reviewed the patient's chart from wherever they were and put in other orders and workups, as needed, to obtain a diagnosis. A diagnosis then led to the patient needing surgery. The surgeon made the next communication to the House Supervisor regarding the need to call in the OR Call Crew to complete the surgery. However, through this process, surgeons inconsistently informed patients of their pending surgeries. Patients often became aware only when the intraoperative nurse arrived to the ED to transport them to surgery. This poor preparedness often delayed care, wasted resources, and produced poor outcomes.

However, even more gaps were found in communication by physicians and the remaining ED care team, as well as deficient processes. Learning and understanding patterns, whether efficient or inefficient, helps the Clinical Nurse Leader (CNL) to prioritize neglected processes for improved patient outcomes (Johnson & Sollecito, 2020). The flow of the perioperative department from start to finish for planned surgical patients is seamless and highly favored by outpatients and the entire perioperative care team. For these planned outpatient surgical procedures, the process flows and advances with care and efficiency, from the moment of admission to the hand-off to a loved one for the ride home. Patient satisfaction scores for the outpatient surgical population were impressive, with an average of 95%. The success of this culture provides a clear structure from which to promote similar outcomes among the unplanned surgical patients on all fronts.

A SWOT analysis was performed and revealed key opportunities and threats (external factors) in addition to strengths and weaknesses (internal factors) that could dissuade the frontline care team from thoroughly completing the pre-op checklist when preparing patients for surgery. For this pre-op checklist project, the main strength was the staff's willingness to voice

their concerns regarding add-on surgical cases. Their eager feedback on frustrations with direct managers and this author regarding inefficiencies, delays in care, and gaps within surgical cases allowed the intended leaders to see the need for improvement among unplanned surgical patient care. Low HCAHPS scores for the 2020 performance year in inpatient surgical patient care confirmed the need to improve experiences among this patient stratification.

Staff concerns regarding the proper preparation of urgent surgical patients was the main weakness identified as an opportunity for improvement. Deeper examination discovered that poor communication among healthcare professionals and patients was hindering timely and efficient patient preparation. Consequently, patients felt ill-informed and dissatisfied, resulting in lower HCAHPS scores for the 2020 performance year.

Regarding return on investment, the pre-op checklist project was expected to improve patient satisfaction, as reflected by improved HCAHPS scores for the inpatient surgical patient population. The focus was to increase the successful and timely completion of the pre-op checklist for unplanned surgical patients from the baseline of 13.4% to 65% by August 2021. A cost-benefit analysis assessed the project's relative benefit to the actual cost of the project. There was no added cost to implementing the planned interventions, as the checklist itself was already integrated into EPIC HealthConnect, the EMR system used at this hospital. The benefits of the project were difficult to quantify or measure; however, implementing the project only boosted "metrics-that-matter," giving the hospital better funding and reimbursements from Medicare, and increasing the likeliness of patients preferring to have surgery at this hospital, if given a choice. Additionally, when patients felt informed and included in their plans of care, they were more agreeable and cooperative, resulting in fewer complications, shorter stays, better adherence to postoperative instructions, and ultimately, better outcomes.

The critical roles of the CNL in leading the aforementioned change included being the client advocate, an outcomes manager, and a team manager (King et al., 2019). The CNL advocates for patients by partnering with them in their plans of care through education, active listening, and collaborative decision-making, which improves the recovery phase. CNLs also supervise surgical patient outcomes, which are measured by HCAHPS scores, lengths of stay post-surgery, and postoperative experiences. The CNL can scrutinize HCAHPS data and other quality metrics to determine areas of deficit. Lastly, the CNL must collaborate with leaders in other units who have touchpoints with the perioperative department to provide seamless care transitions, along with other critical aspects to continuity of care to surgical patients. Unity must be paramount among the various microsystems of the hospital to achieve successful clinical outcomes for patients who need urgent surgical care.

Intervention

Based upon the process mapping sessions for surgical care, pre-op checklist completion was identified by the committee as a key leading indicator with HCAHPS surveys. As patients are prepared for surgery in the pre-operative outpatient phase, preliminary safety checks and patient engagement occurs via the pre-op checklist, including assessing for critical factors, such as NPO status, surgical site preparation, pre-op labs relevant to the whole wellbeing of the patient, etc. All the items listed are part of the pre-op checklist for patients going into the OR from the ED that primary ED nurses miss, leading to delayed care and inadequately prepared patients. Therefore, pre-op checklist completion was identified as the initial area to improve for patient care and optimized health outcomes.

The precursor to pre-op checklist completion is a generated add-on communication tool detailing pertinent information to the planned surgical procedure, most importantly, the

approximate time of transference to the OR from the unit. This tool was created by a SmartPhrase on Epic HealthConnect and implemented by this author in the beginning phases of this project to close the communication gap between the OR team and the frontline primary nurse caring for the patient preoperatively. Initially, it was not received well by the OR charge nurse, who perceived it as another work item. However, within a week, the OR charge nurse could see that it was closing communication gaps via closed-loop communication relevant to the procedure. Active discussion between the surgical care team and the primary nurse took root in preparation for unplanned surgical patients. This led to sustainable improvements in pre-op checklist completion.

The next immediate intervention to the implementation of pre-op checklist completion was the sharing of knowledge with the frontline staff in the ED and Surgical Services through huddles by the respective managers. Plans and explanations of the purpose of this intervention, to ensure that pre-op checklist completion process was a standard task, were discussed during team huddles. Through huddles, briefings, and staff meetings, managers assessed the understanding of processes by their staff members.

The next step was implementation, which began with job-aid on how to complete the pre-op checklist to guarantee that all line items were acknowledged. Additionally, the perioperative manager was invited to speak to the frontline nurses at the ED Staff Meeting on the importance and technique of pre-op checklist completion. Another step within this implementation was the hand-off of the patient from the ED nurse to the OR nurse, where the pre-op checklist was reviewed together, allowing the OR nurse to provide real-time feedback at the bedside. For example, if the OR nurse discovered that a consent was signed by the patient and the nurse, but still had a line item unacknowledged, the OR nurse could ensure that the ED nurse had made the

necessary correction(s). After weekly chart audits, steady improvements were made to pre-op checklist completion for all add-on cases going into the OR from all other units of the hospital. Where fallouts persisted, this author created a case note upon auditing surgical add-on charts to complete a coach and counsel with the OR nurse who had accepted the handoff with an incomplete checklist. Additionally, this same case detail was shared with the ED or Inpatient Nurse Managers for review with the specific nurses involved. While this implementation required the primary nurse caring for the preoperative patient to complete the checklist, the OR nurse was still required to ensure completeness of the checklist prior to transferring the patient to the OR.

Study of the Intervention

Pre-op checklist completion for the unplanned surgical patients or add-on surgeries were audited weekly and reported to the ED and inpatient managers for review and subsequent coach and counsel sessions with individual staff nurses, as appropriate. Often, staff nurses reported having completed the necessary steps of engagement with the patients, but also having overlooked documenting them. The managers could then reemphasize that undocumented care was nonexistent care; therefore, documentation was nonnegotiable.

After this initial review, the Plan-Do-Study-Act (PDSA) cycles were used to immediately address the completion of pre-op checklists, as the weekly audits were lagging indicators for review. The next test of change implemented was preoperative nurses transferring patients from the unit instead of sending the OR nurses to retrieve them. The reason being that preoperative nurses from the surgical department were experts on completing the checklist. Therefore, they could be present for the handoff and provide real-time feedback and corrections to the primary

nurses, as needed. This test of change brought no significant improvement in terms of pre-op checklist completion, as feedback indicated coverage by the preoperative nurse was not 24/7.

Another PDSA cycle implemented after learning that the previous test of change was not quite successful was to require the OR nurse transferring patients from the ED to the OR to review the pre-op checklist together, as part of the handoff. Afterhours, when there are add-ons, the first surgical nurse to arrive is the OR nurse. Therefore, it made more sense to implement another PDSA cycle requiring the OR nurse to review the pre-op checklist upon handoff prior to transfer. This latest PDSA cycle remained successful after initial implementation in early April 2021. When fallouts occurred, the Assistant Nurse Manager (ANM) performed a coach-and-counsel with the responsible OR employee.

Weekly audits of pre-op checklist completion on surgical add-ons have allowed managers to hold their staff accountable and educate them, as needed. It has encouraged managers to review the orientation process for their new hires and travelers from outside of the organization to ensure that this checklist was part of the competency sign-off by frontline nurses in preparing surgical patients. As long as the committee and the managers factored in the variables and risks that lead to fallouts, according to the feedback they received from the staff members, completing pre-op checklists for all surgical patients while prepping them should be manageable.

Measures

The outcome measure was completion of the pre-op checklist for all unplanned surgical patients. The goal was a target completion rate of at least 65% by August 2021 from a baseline of about 13%, between May 2020 through August 2020. The data source for this measure was chart reviews on Epic HealthConnect and audits completed immediately after add-on case completions (see Appendix D). Another outcome measure was the HCAHPS scores on this

hospital's unplanned inpatient surgical patient surveys. The performance baseline for the 2020 performance year for this patient stratification was close to 3 stars. To get to a target rating of 4 out of 5 stars, there needed to be significant effort in interventions and monitoring to ensure that this patient stratification received exceptional care. Though HCAHPS was a lagging indicator, implementations on the front-end as soon as patients checked into the ED helped boost overall HCAHPS scores. However, this committee should not rely heavily on this outcome measure as an indicator for success; therefore, it would be advisable to also consider and monitor related process measures in this implementation.

Process measures include the completion of the created Add-On Communication Tool via Secure Chat in Epic HealthConnect as soon as the surgeon communicates to the OR Charge Nurse or House Supervisor on the need for surgical time in the OR. This tool allows for real-time communication to the frontline nurse as to the time offered for surgery. This notification allows the primary ED or inpatient nurse to prioritize and prepare the patient as appropriate. This process measure and tool surfaced when frontline nurses in the ED and Inpatient Units offered reasons for poor preparation going into surgery, even after the surgeon had decided on urgent surgery. To ensure that primary nurses were receiving communication, the House Supervisor and OR Charge Nurse generating this communication tool included the entire care team in the conversation within the Secure Chat Message in HealthConnect. This system indicates who has seen or read a message. Upon reciprocal communication, the initiator of this conversation can see that all key members have read the plans for surgery. If there has been a delay in receipt of communication by the primary nurse, the House Supervisor or Charge Nurse calls the nurse to ensure awareness of surgical plans.

Balancing measures that surfaced after requiring the completion of pre-op checklists by frontline nurses included patient and family engagement, huddle progress with frontline care teams on a consistent basis, and coach and counsels with individual nurses who had fallouts in preparing their patients for surgery. These balancing measures were expected, but could not be ignored because all aspects needed to be reviewed, acknowledged, and addressed accordingly to see positive outcomes and results among the unplanned surgical patient population. Through chart audits of common fallouts, managers adjusted their huddle messages as appropriate in terms of what elements the nurses needed to know when engaging with their patients and preparing them for surgery.

Ethical Considerations

As healthcare continues to grow, change, and fluctuate due to its complex and multidimensional nature, the profession of nursing will also continue to adjust itself efficiently and seamlessly. The role of a nurse is more complex, versatile, and specialized than ever; therefore, employing *Cura personalis* is even more vital. This theory focuses on the human experience, social justice, and ethics within spirituality, while including all religions. This is the foundation and the focus of the University of San Francisco, whose characteristics rise from the Ignatian-Jesuit faith (Otto, 2013). *Cura personalis* demands that nurses care for the entire individual—body, mind, and soul. Adhering to this framework while caring for all patients, especially those who anticipate emergent surgery, can lead to only positive outcomes. This project was reviewed by the USF Faculty and approved as an evidence-based change in practice project; therefore, Institutional Review Board (IRB) approval was not required (see Appendix E).

Section IV. Results

Outcome Measure Results

The job-aid (see Appendix F) on how to complete the pre-op checklist provided to the frontline Perioperative, ED, and inpatient staff was well-received. It was especially useful to new hires within different departments. The department managers added this job-aid to the New Hire Orientation binders so new hires could review and sign-off on instructions in preparing patients for unplanned surgeries. For the patients who had journeyed from the ED to the OR, better-than-expected improvement came in terms of pre-op checklist completion, as the target was exceeded by over 10%, with a running average of 76%, year-to-date (see Appendix G).

Another success of this intervention was improved closed-loop communication among healthcare professionals that was marked by professionalism and respect. This was not expected since these units worked in silos before this project began. The interdepartmental culture was also quite toxic, based upon this author's subjective observation, since fallout too often prompted blame among staff versus steps toward improvement and collaboration. Therefore, the Add-On Communication Tool (see Appendix H) opened channels for communication that was productive and useful to the entire care team. This tool was the preliminary means of communication to the primary RN caring for the patient, prompting them to prep their patients for surgery via the completion of the pre-op checklist. The use of this tool through Secure Chat was initiated by the OR Charge Nurse or the House Supervisor, who received a call from the surgeon requesting to add on the case to the surgical board. This Secure Chat Messaging system sends a critical message to the key players regarding the who, what, when, where, and why for surgery. This piece of the intervention has seen 100% adherence and has led to timely inquiries and responses among health professionals regarding the care of the surgical patient.

The use of Secure Chat Messaging to discuss unplanned surgical plans has been so successful that other services within the hospital have adopted it, particularly for simple communication related to pharmacy, lab, and admitting. Feedback from frontline staff at a Nursing Quality Forum (NQF) described how communication with other health professionals is easier because individual patient information can be attached to non-urgent messages, enabling the receiving end to know whom the communication is about. Frontline staff thanked this author for this simple, yet useful communication tool.

Finally, HCAHPS scores related to inpatient surgical patients have seen significant improvements, with the current rating of 3.6, as of June 2021, exceeding the target of 3.5 stars from the baseline of 2.9 stars. Though this outcome measure is a lagging indicator, the rollout of this project began in August 2020, allowing sufficient time for surveys to return from patients during implementation, assessments, and PDSA cycles. This outcome measure was not expected, as the n for returned surveys for the inpatient surgical patients has averaged 6 per month for this hospital. Therefore, just one unsatisfied patient can skew the results in a negative direction.

Increased patient satisfaction started trending upwards in January 2021 (see Appendix I). Senior leaders noticed this uptick and suggested applying this project to the sister facility, whose HCAHPS baseline for this patient stratification was at 3.6 stars, and currently at 2.9 stars. Committee meetings on interventions have been ongoing.

Section V. Discussion

Summary

In summary, this quality improvement project sought to improve care experiences among the unplanned surgical patient population by improving overall communication among healthcare professionals and their patients. The main intervention was to reestablish the standard task of completing the pre-op checklist readily available as an integrated component of the EMR system for each patient in Epic HealthConnect. This checklist provides the primary RN with safety checks and detailed preparations for surgical patients. It also buffers a nurse by ensuring that important elements get completed, whose absence would otherwise delay surgical care and cause inefficiencies and patient dissatisfaction. This portion of this quality improvement project exceeded the target of 65% by August 2021. The current completion rate for patients going into the OR from the ED and Adult Services reached 82%, as indicated in July 2021 data (see Appendix G).

During the beginning phases of this project, the most challenging obstacle was gaining the support and partnership of the leaders and staff in other units of this hospital, including the ED and Adult Services. Early collaboration and buy-in from the frontline staff were vital to the initiatives of this project. Through several process mapping sessions of the surgical patients' workflows and journeys through the hospital, communication gaps were identified. From there, successful progression was dependent upon ownership from different leaders from included units. Key gaps included ineffective peer-to-peer communication and physician-to-patient and nurse-to-patient communication regarding care plans. As mentioned earlier, there are four patient classifications within the population of surgical patients. The focus of this project was enhanced engagement between frontline care teams and their patients prior to surgery with regard to

preparation and care of the mind, body, and soul. As with anything unplanned, there can be unspoken anxieties, fears, and worries. Healthcare professionals can and should alleviate these concerns through ongoing engagement and explanation of care. Leaders and frontline staff from all units, including Perioperative Services, Adult Services, and ED Services, acknowledged this critical area of oversight, making possible the launch and successful implementation of this project.

One of the PDSA cycles tested involved sending preoperative nurses, instead of OR nurses, to the ED and inpatient units to pick up patients for surgery when the OR was ready for them. However, this test of change was not as successful as anticipated. Instead of correcting their peers in other units, preoperative nurses ended up completing the checklists themselves due to the resistance encountered from some frontline nurses. This also caused a noticeable decline in collaboration. Additionally, it also made for inconsistent exchanges of knowledge since preoperative nurses from the Surgical Department did not work around the clock. The constant factor in this regard was that OR nurses are consistently available, even after hours, as they are the first frontline staff in the Surgical Unit to report to duty for add-on cases.

After approximately 3 weeks of testing the above PDSA cycle, a second PDSA cycle plan was put in place after much discussion with the frontline staff and committee. The implementation with this next cycle covered handoff communication. This test of change involved the OR nurse reviewing pre-op checklists with primary nurses as part of the handoff to ensure that all items on the checklist had been met and that the patient was fully ready for surgery. This communication was shared with the team members in mid-April 2021 and with perioperative staff and the inpatient and ED's unit managers. All parties agreed to this plan. A read-and-sign sheet was posted with the message and the job-aid for OR nurses. To date, this

PDSA cycle was the most successful one, with few fallouts. From April to July 2021, the running average of completed pre-op checklists for all add-on cases was 88.8% (see Appendix J). The surgical department also experienced misses with per diem OR nurses who did not receive messages first-hand. When returning to work, they were not informed of this implementation for handoffs. Lesson learned. This observation was shared with the ANM, who then began communicating with per diem nurses regarding changes that had taken place in their absence.

With ongoing support and consistent messaging, the frontline nurses from all microsystems accepted this process and responsibility with open minds. Pre-op checklists fail to be fully completed for various reasons; however, through collaboration, ongoing feedback, and support from the managers and OR peers, interventions introduced by this project added value to the positive outcomes of surgical patients. Greater engagement between the frontline primary nurses and their surgical patients was seen and experienced. Furthermore, collaboration among microsystems improved drastically, leading to meaningful working environments.

Conclusions

Patient experiences and outcomes, in general, suffer when healthcare professionals fail to engage and communicate plans of care proactively. The Add-On Communication Tool, generated through Secure Chat in Epic HealthConnect, flips this around and involves unplanned surgical patients in their plans of care. Furthermore, primary RNs can engage better with their patients by fully preparing them for surgery via the pre-op checklist, already a part of the workflow in the patient's EMR. These two interventions were vital to closing communication gaps among healthcare professionals, while paving the way for enhanced engagement with patients.

Recommendations

Further and ongoing audits and reassessments, as completed by the committee and nurse leaders of the respective units, are recommended for sustainability. Active communication, encouragement, and recommendations between the leaders from all units of this hospital are suggested to remain vigilant to the common goal of improved patient care experiences. The core element to care experiences is the intentional effort of healthcare professionals to put patients at the center of care. Inclusion of and engagement with patients during all phases of care are also determining factors in positive health outcomes.

The main factor that connects all of these pieces is the use and completion of the pre-op checklist, which allows the nurse to naturally engage with their patients as they prepare them for surgery. Further explanation as to the importance of knowing the answers to the items listed on the pre-op checklist prompts active engagement between the two parties and instills a standard goal of safety and quality. This also leads to better-informed patients, who, in-turn, comply with self-care instructions postoperatively and enjoy faster and more successful outcomes. When patients and healthcare professionals understand the content on the pre-op checklist, buy-in increases, along with adherence (Johnson & Sollecito, 2020). The target for pre-op checklist completion for surgical patients going into the OR from all areas of the hospital was 80%. With due diligence and influence among peers and by managers and preceptors, this goal is attainable.

Limitations

Some of the barriers to the implementation phase and PDSA cycles included the everchanging COVID-19 guidelines, surges and resurgences, testing requirements for the disease, and COVID-19 restrictions. Additionally, capturing focused education time with new hires, transfers, and travelers on this work and its implied standard work in preparing patients for

surgery through pre-op checklist completion was challenging for hiring managers. Consequently, managers in other units affected by the influx of travelers, along with new hires, were encouraged to add the job-aid for pre-op checklist completion into the New Hires Binder for review during onboarding and orientation week. With regard to the COVID-19 status of urgent surgical patients, this author added this element to the Add-On Communication Tool for members of the team to see on Secure Chat. Knowledge of patient COVID-19 status helped the planning and staffing phase in the Surgical Unit, leading to better efficiency and coverage in caring for COVID-19 patients. With the three different COVID-19 surges this hospital faced during the implementation of this project, travelers were onboarded to accommodate the increase in hospital census. Because of this rigorous task of onboarding travelers, managers struggled to onboard them in a more thoughtful, thorough, and meaningful way. Managers of these travelers were reminded to inform and guide travelers on the Surgical Care Experience initiatives and standard work as they related to surgical patients through positive support from the perioperative leadership team of this hospital.

In conclusion, with enhanced communication through standardized work, as seen in the pre-op checklist completion initiative, other units that were struggling with this same issue or something similar, were encouraged to review care experience gaps in their units. It was recommended that they begin the improvement work with process mapping sessions that involved the broader stakeholders of the hospital. Different perspectives and input from frontline staff and leaders can shed light on key elements that may be overlooked. Simple PDSA cycles are suggested for any quality improvement project to gain better buy-in and support from the frontline staff and key leaders. The other benefit from the use of PDSA cycles is that it allowed for input from the frontline staff as long as nurse leaders solicited feedback with

recommendations; thus, the importance of forming a committee on the quality improvement topic. Additionally, keeping all affected parties involved and in close communication as to the process changes, plans for implementation, and ongoing progress is as critical as identifying gaps and addressing those gaps with the wider group.

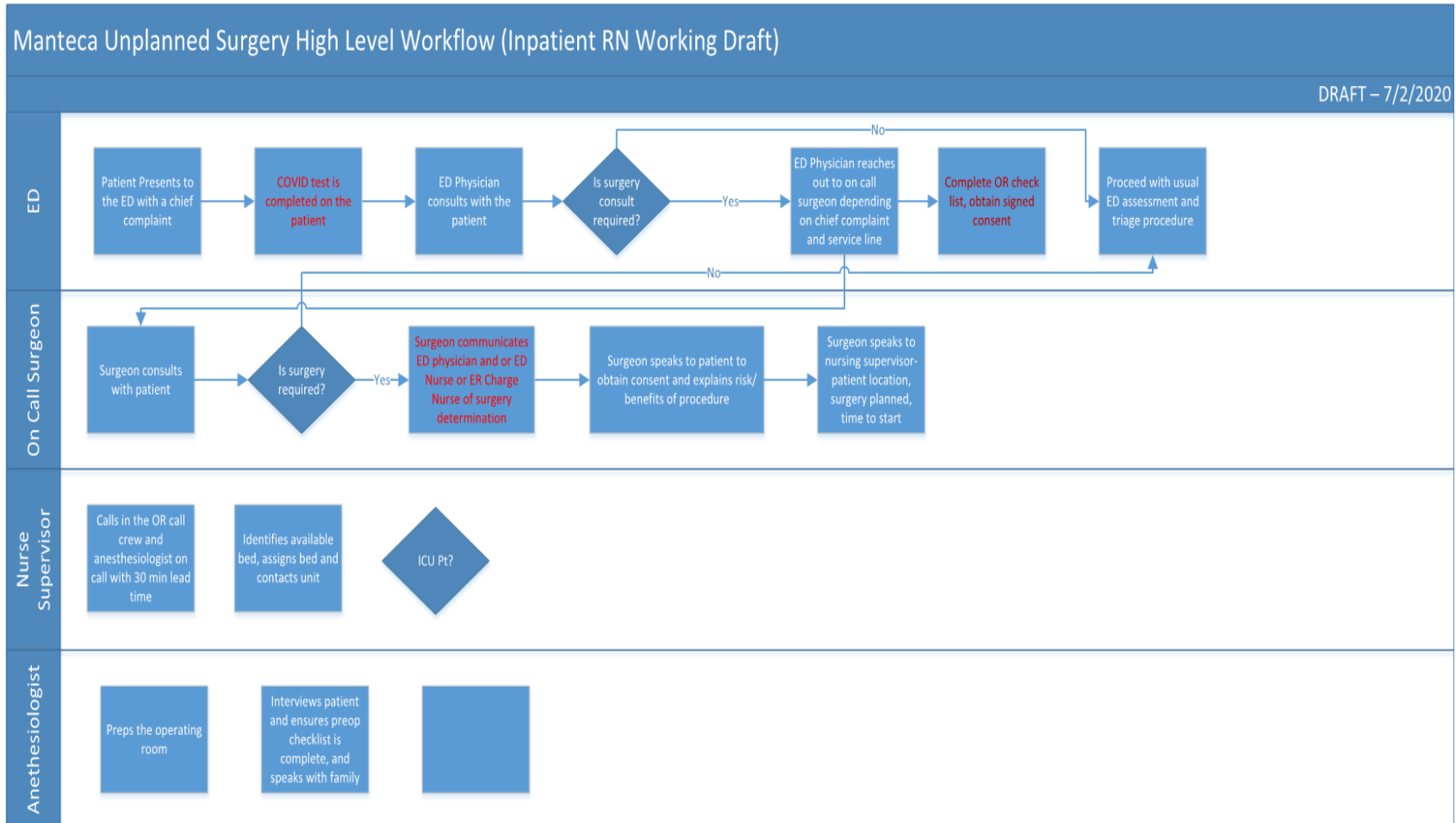
Section VI. References

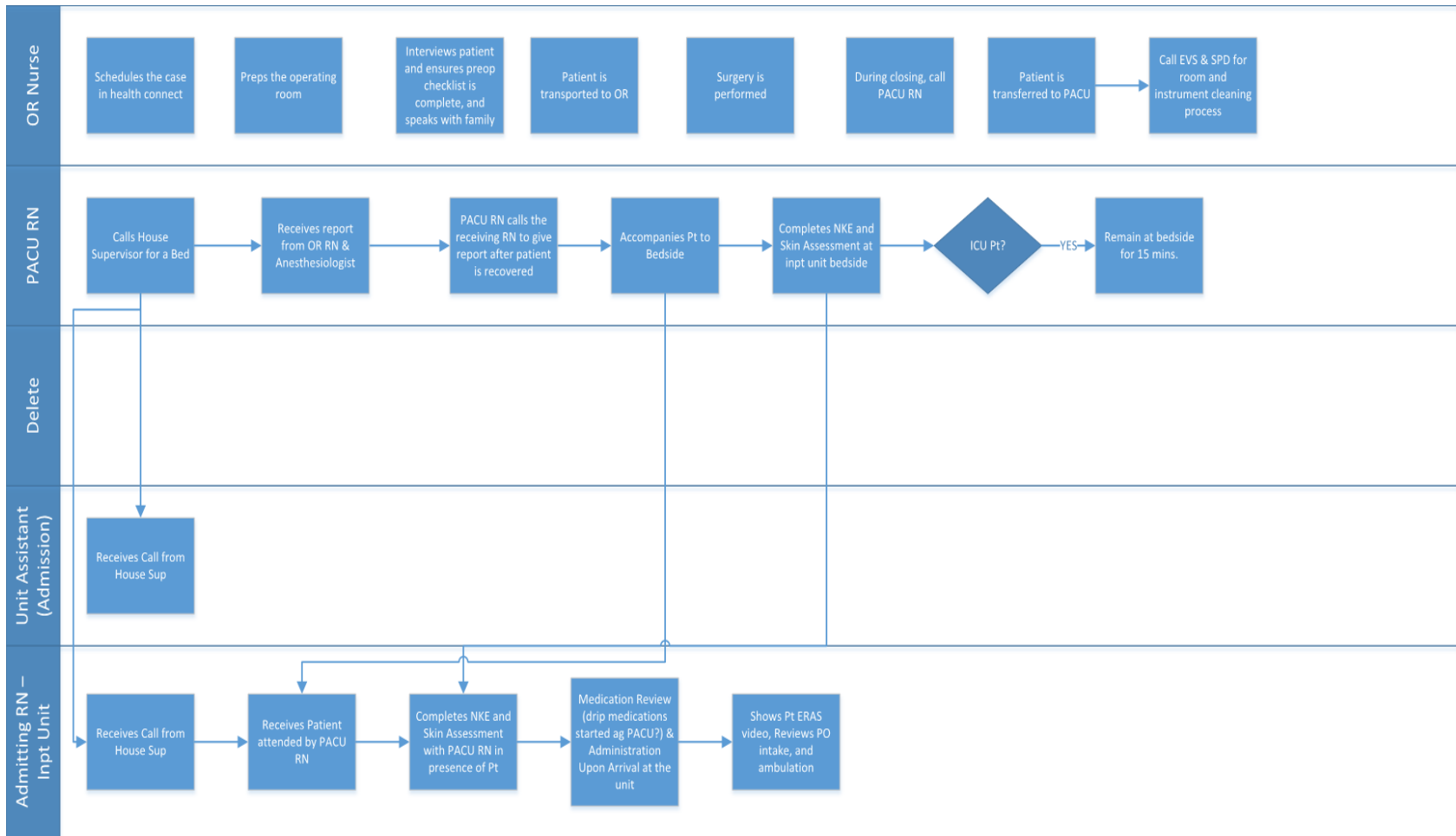
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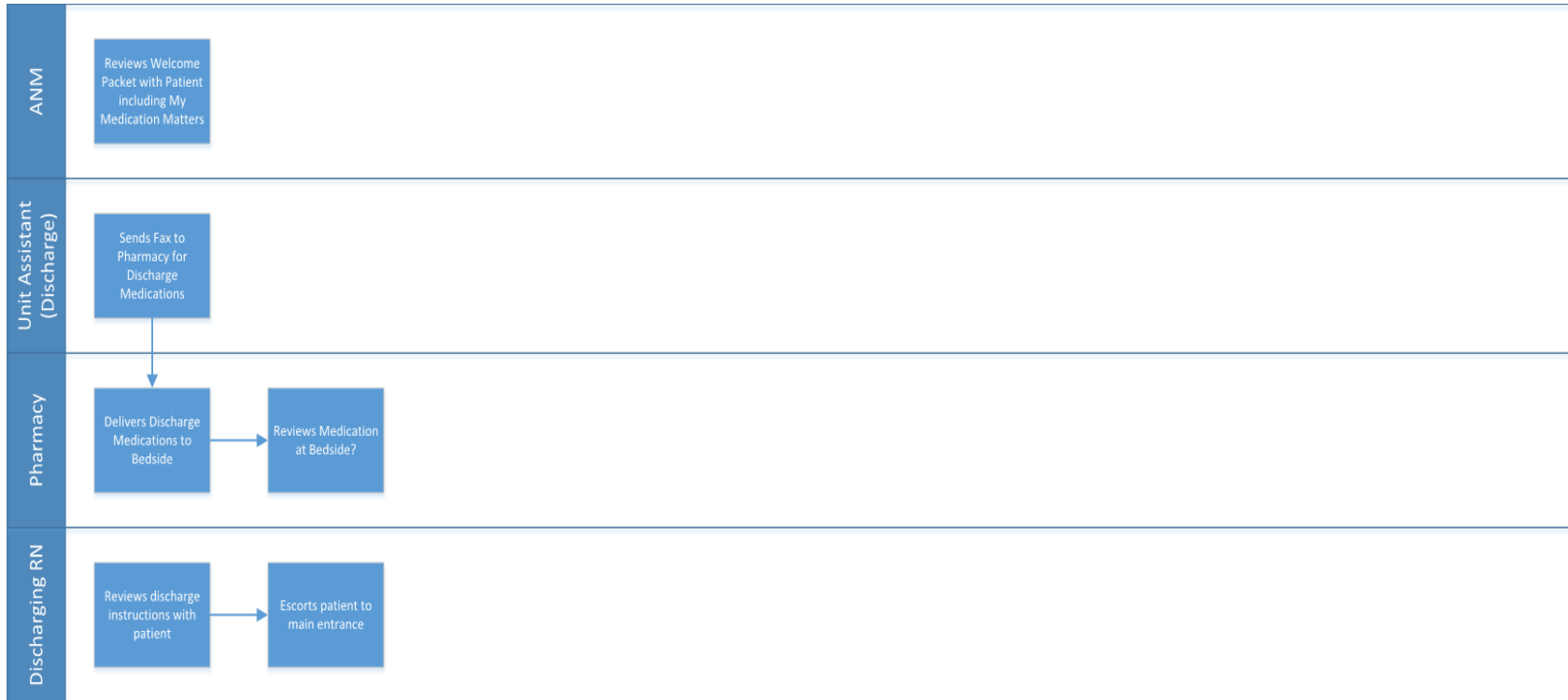
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Section VII. Appendices

Appendix A. Process Map







Appendix B. Northern California Regional HCAHPS Scores IP Surgery

Service Line	IP Surgery													
Facility	NCAL Region													
Unit	All Units													
Open Data	Yes													
Target Trigger	Yes													
Data As Of	7/14/2021													

CARE EXPERIENCE - STAR Rating	Baseline	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	2021 PYTD	↑ Star	↓ Star	Gap to ↑ Star	Gap to ↓ Star	Imp. from Baseline
		Close	Close	Close	Close	Close	Close	Open	Open	Open	Open	Open	Open						
HCAHPS: Overall Hospital Rating	4	4	3	3	3	3	3	4	4	3				3	4	2	0.9	4.1	-1.0
HCAHPS: Recommend Hospital	4	4	4	3	4	4	3	4	4	4				4	5	3	4.1	0.9	0.0
HCAHPS: RN Comm.	3	3	2	3	4	3	2	3	3	3				3	4	2	1.5	1.5	0.0
HCAHPS: MD Comm.	4	4	4	4	4	3	3	4	4	5				4	5	3	1.8	1.2	0.0
HCAHPS: Cleanliness	3	3	2	2	2	2	2	2	3	3				2	3	1	1.0	4.0	-1.0
HCAHPS: Quiet	1	1	1	1	1	1	1	1	1	1				1	2		3.3		0.0
HCAHPS: Staff Responsiveness	3	3	2	3	2	2	2	3	3	2				2	3	1	1.0	4.0	-1.0
HCAHPS: Comm. about Med	3	2	4	2	3	3	2	3	2	3				3	4	2	4.0	1.0	0.0
HCAHPS: Discharge Info.	4	4	5	3	4	3	3	4	4	5				4	5	3	2.3	1.7	0.0
HCAHPS: Care Transitions	3	3	3	3	2	3	2	3	4	3				3	4	2	1.7	1.3	0.0

5 Star
4 Star
3 Star
2 Star
1 Star




CARE EXPERIENCE - Summary Star	Baseline	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	2021 PYTD	Gap to ↑ Star	Gap to ↓ Star	Target	Variance to Target	Imp. from Baseline
		Close	Close	Close	Close	Close	Close	Open	Open	Open	Open	Open	Open						
HCAHPS: Summary Star	2.9	2.9	3.0	2.8	2.8	2.8	2.9	2.9	2.9	3.0				2.8	0.2	1.8	3.1	-0.3	0.0



***NOTE: Summary Star at the unit level is not a mandated form of measurement, rather it's an example to provide you with an overall sense of the units performance.

CARE EXPERIENCE - N Size	Baseline	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	2021 PYTD
		Close	Close	Close	Close	Close	Close	Open	Open	Open	Open	Open	Open	
HCAHPS: Overall Hospital Rating	10,330	976	717	720	659	763	1,006	949	752	195				6,737
HCAHPS: Recommend Hospital	10,320	969	715	721	658	759	1,003	945	750	196				6,716
HCAHPS: RN Comm.	10,374	979	721	726	659	763	1,009	951	756	198				6,763
HCAHPS: MD Comm.	10,310	971	718	719	654	759	1,001	943	746	197				6,708
HCAHPS: Cleanliness	10,297	971	712	713	651	757	1,004	942	752	195				6,697
HCAHPS: Quiet	10,201	967	706	707	646	755	984	937	753	190				6,645
HCAHPS: Staff Responsiveness	7,652	754	539	530	471	542	755	710	565	147				5,010
HCAHPS: Comm. about Med	6,906	659	489	493	444	506	651	627	509	130				4,506
HCAHPS: Discharge Info.	9,921	943	698	700	628	728	968	912	717	189				6,481
HCAHPS: Care Transitions	10,011	942	691	694	632	730	973	919	724	188				6,493

Appendix C. Evaluation Table

PICOT Question: Will the use of a Surgical Add-On Communication Tool via Secure Chat in HealthConnect (I) as compared to no communication regarding surgical plans to the patient and frontline care team (C) improve HCAHPS scores (O) for the unplanned inpatient surgical patients (P) over a period of 6 months (T)?

Study	Design	Sample	Outcome/Feasibility	Evidence Rating
<p>Cooper, Z., Koritsanszky, L. A., Cauley, C. E., Frydman, J. L., Bernacki, R. E., Mosenthal, A. C., Gawande, A. A., & Block, S. D. (2016). Recommendations for best communication practices to facilitate goal-concordant care for seriously ill older patients with emergency surgical conditions. <i>Annals of Surgery</i>, 263(1), 1-6. https://doi.10.1097/SLA.0000000000001491. PMID: 26649587.</p>  <p>Cooper Article.pdf</p>	Expert Opinion	None	<p>Surgeons need to build on their communication skills especially when it comes to providing emergency surgical care to the elderly population factoring different factors into the communication. Twenty-three acute care surgeons convened at a 1-day conference to review the current situation and produced a communication framework involving 9 key elements.</p> <p>Useful resource for surgeons to communicate to elderly surgical patients.</p>	V A
<p>Ghunimat, A. A., Hind, J., Abruelela, A., Sidhu, G. A. S., Lacon, A., & Ashwood, N. (2020). Communication with patients before an operation: Their preferences on method of communication. <i>Cureus</i>, 12(11). https://doi.org/10.7759/cureus.11431</p>  <p>Cureus Communication 2020</p>	Prospective Study	111 patients aged 17-88	<p>Methods of communication regarding surgical procedure preferences include conventional letters, emails, phone calls, and phone text messages. 45 patients preferred phone calls while 44 patient preferred text messages and letters.</p> <p>Useful for determining which type of communication patients prefer regarding their health care according to their age groups.</p>	III B
<p>Jones, C. H., O'Neill, S., McLean, K. A., Wigmore, S. J., & Harrison, E. M. (2017). Patient experience and overall satisfaction after emergency abdominal surgery. <i>BMC Surgery</i>, 17(1), 76. https://doi.org/10.1186/s12893-017-0271-5</p>  <p>Jones Communication 2017</p>	Prospective Study	97 patients	<p>This study concluded that providing patients with pertinent information regarding their diagnosis, plans, and discharge teaching is crucial to increasing patient satisfaction.</p> <p>Useful for encouraging better communication from the care team (nurses and physicians) regarding the patients' surgical plans along with inpatient and discharge care.</p>	III B

Study	Design	Sample	Outcome/Feasibility	Evidence Rating
<p>Methangkool, E., Tolinche, L., Sparling, J., & Agarwala, A. V. (2019). Communication: Is there a standard handover technique to transfer patient care? <i>International Anesthesiology Clinics</i>, 57(3), 35-47. https://doi.org/10.1097/AIA.0000000000000241</p>  <p>Methangkool Article.pdf</p>	Expert Opinion	419 Anesthetic Incident Monitoring Study (AIMS) reports	<p>Standardized and effective perioperative handoffs and communication between different units beginning with the ER to the perioperative team to the PACU team to the inpatient unit can reduce patient harm, mitigate potential errors, and improve patient outcomes.</p> <p>Useful for different healthcare teams to utilize in the care and handoff of surgical patients.</p>	III A
<p>Ojuka, D. K., Okutoyi, L., & Otieno, F. C. (2019). Communication in surgery for patient safety. <i>Vignettes in Patient Safety</i>, 4. https://doi.10.5772/intechopen.79740</p>  <p>Communication IntechOpen.pdf</p>	Consensus paper – interpretive synthesis	None	<p>Patient-centered care involves their preferences of communication especially when it comes to involving them in surgical decisions and making informed choices.</p> <p>Utilize the models and tools provided in the study for effective and efficient communication.</p>	V A

Appendix D. Project Charter

Global Aim: Improve RN communication scores with unplanned inpatient surgical patients.

Specific Aim: Increase the percentage of pre-op checklist completion on unplanned inpatient surgical patients from a baseline of 13.4% in August 2020 to 65% by August 2021.

Background: Completion of the pre-op checklist on surgical patients is a standard work that needs to be addressed by the primary RN caring for the patient pre-operatively before patients go into the operating room (OR) for surgery. Prior to going into the OR, patients have several avenues to which they begin their pre-operative care for surgery: from home or the surgeon's clinic to the preoperative area of the surgical department, the emergency room, or the inpatient unit. Varying interpretations of whose responsibility it is to complete the checklist has led to inconsistent nursing practice that leads to less than optimal patient care outcomes for those surgical patients (Methangkool et al., 2019). Studies have proven that optimizing patients for surgery reduces complications, length of stay, health care spending, and overall patient experience and satisfaction (Jones et al., 2017). Within this specific organization's Northern California Region, the baseline for HCAHPS score for nurse communication when it comes to the inpatient surgical patient stratification is at 90.8% or 3 stars from the March 3, 2021 report with a performance year-to-date of 90.4%. Therefore, much work still needs to be done in terms of optimizing nurse communication throughout the hospital visit of that of a surgical patient. Aiming small with incremental increase through the completion of a pre-operative checklist is not just another checklist for the nurse to complete. This is the tool to which nurses can utilize to guide their communication regarding surgery along with other plans of care with their patients and their families.

Sponsors:

Assistant Physician in Chief (APIC)	Dr. MJ
Associate Chief Nurse Executive	CN
Perioperative Services Director	JM
Care Experience Practice Leader	VL

Goals: The overarching goal of this project is to improve engagement and communication with unplanned surgical patients and their families from the health care team as a whole. The initial

process to share with patients the plan of care for surgery is through the use and completion of the pre-op checklist by the primary nurse which addresses all medical factors that prepare patients for surgery. By completing the checklist, the nurse has the opportunity to engage with their patients, answer any questions they may have related to the surgical procedure they are about to undergo and provide emotional support and further education as needed. Therefore, the pre-op checklist is the star of this project when it comes to closing communication gaps as experienced by the unplanned surgical patient population.

Measures:

Measure	Data Source	Target
Outcome		
Summary Star Rating – HCAHPS: Manteca IP Surgery	HCAHPS Analytics Tool provided by CEL	4.0 Stars by July 2021 Closed Data
Pre-Op Checklist Completion Rate	KP HealthConnect/EPIC Query	65% by August 2021
Process		
Add-On Communication Tool between HS to frontline care team	KP HealthConnect/EPIC Secure Chat Query	90% by August 2021
SBAR Generation – MD Communication regarding Surgery	Frontline RN Escalation to Charge RN and Manager	100% by August 2021
Balancing		
Patient and family engagement through the preoperative phase	KP HealthConnect/EPIC Flowsheets → PreOp Checklist	100%
Huddle Progress with Frontline Care Team daily	Visual Huddle Boards	100%
Chart Audits and Coach/Counsel with Individual RNs	KP HealthConnect/EPIC Flowsheets → PreOp Checklist → Identification of Primary RN	100%

Team:

Perioperative Services Department Manager	SV
Emergency Room Department Managers	TJ and KM
Adult Services Director and Interim ASD	LW and SV
Perioperative Service Director	JM
Project Manager	TI
Care Experience Practice Leader	VL

References:

- Cooper, Z., Koritsanszky, L. A., Cauley, C. E., Frydman, J. L., Bernacki, R. E., Mosenthal, A. C., Gawande, A. A., & Block, S. D. (2016). Recommendations for best communication practices to facilitate goal-concordant care for seriously ill older patients with emergency surgical conditions. *Annals of Surgery, 263*(1), 1-6.
<https://doi.10.1097/SLA.0000000000001491>. PMID: 26649587
- Methangkool, E., Tollinche, L., Sparling, J., & Agarwala, A. V. (2019). Communication: Is there a standard handover technique to transfer patient care? *International Anesthesiology Clinics, 57*(3), 35-47. <https://doi.org/10.1097/AIA.0000000000000241>

Measurement Strategy:

Background (Global Aim): Improve RN communication among unplanned inpatient surgical patients in a hospital in the Central Valley through completion of the pre-op checklist by the primary nurse caring for the surgical patient, preoperatively.

Population Criteria: Unplanned Inpatient Surgical Patients

Data Collection Method: Data will be obtained from chart audits using HealthConnect/EPIC to review the PreOp Checklist completion in the charts of all surgical add-on patients going into the OR from the inpatient (IP) unit and the emergency department (ED). Audits will be completed on a weekly basis from the beginning of the implementation on September 2, 2020. Findings and results will be shared with key stakeholders including the ED and IP managers along with the project manager as a mediator. Data will be reviewed during the weekly committee meeting led by the project manager.

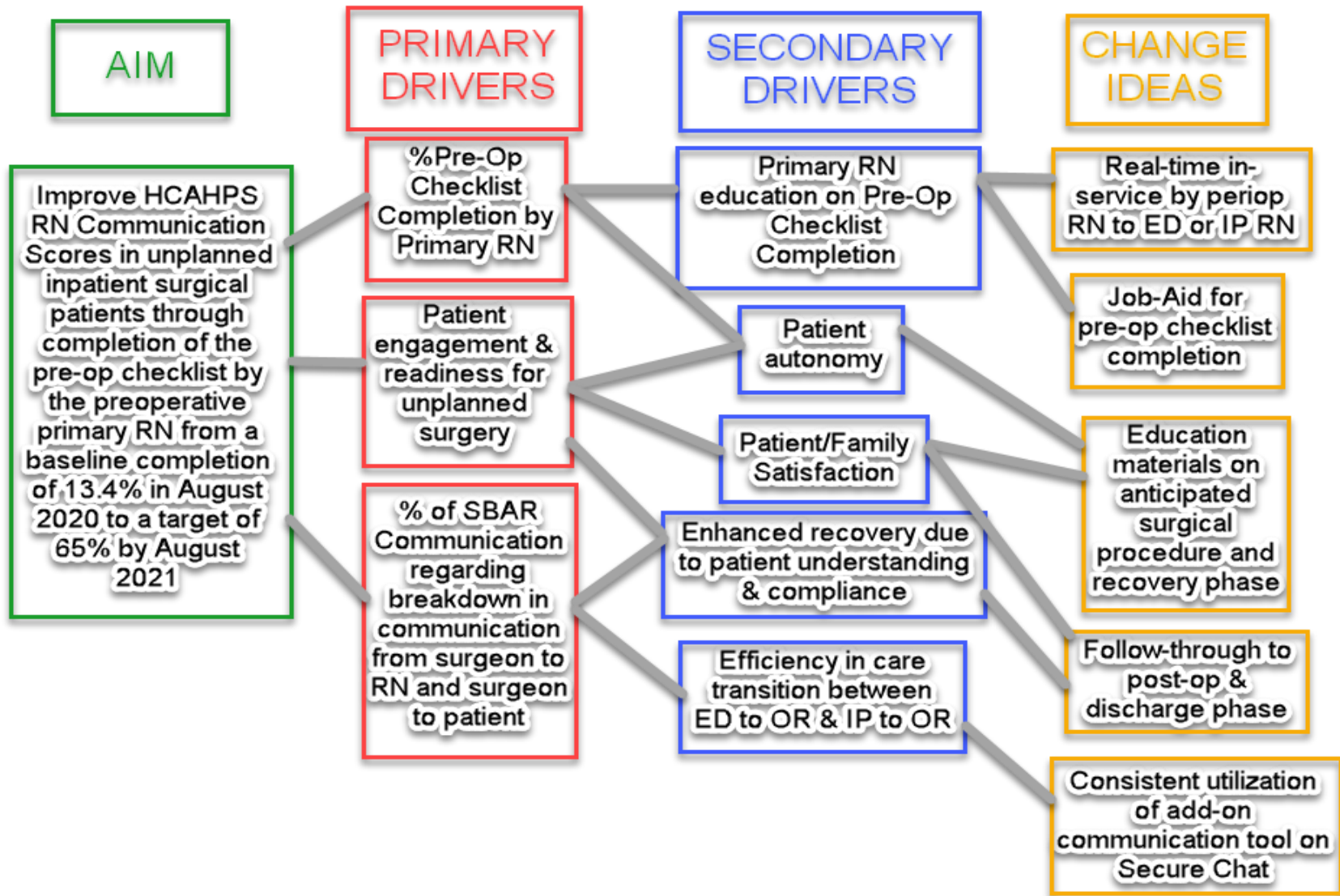
Data Definitions:

Data Element	Definition
Unplanned inpatient surgical patients	This patient stratification includes those who present to the Emergency Department needing surgical consultation and eventually surgery. These patients can also be from the Inpatient Unit prior to immediate surgery.
Pre-op checklist	A checklist to be completed by the primary nurse caring for the patient before surgery addressing all aspects of preparing the patient for surgery including the surgical consent, NPO status, etc.
Handoff communication	A nursing report off from the primary nurse to the OR nurse to resume care of the patient
HCAHPS star summary	Hospital Consumer Assessment of Healthcare Providers and Systems that scores the patients' perspectives of care. Star summary refers to a 5-Star Care experience with 5 being exceptionally the highest level of care as perceived by the patient/consumer
Sbar generation on MD communication	The primary RN will generate a SBAR to notify their immediate supervisor on the lack of communication from the surgeon to the patient and surgeon to primary RN on the plan of care for the patient
Add-on communication tool	A communication tool implemented by the Perioperative Manager for the House Supervisor to generate to communicate to the frontline care team via Secure Chat in Health Connect regarding the surgical time scheduled for the add-on case so the primary RN can anticipate and provide timely preoperative care and engagement with the patient and the family, as needed.

Measure Descriptions:

Measure	Measure Definition	Data Collection Source	Goal
Pre-Op checklist completion rate on add-on unplanned surgical patients	<p>N = Number of add-on surgical patients with completed pre-op checklist</p> <p>D = Number of add-on surgical patients</p>	Chart audit in HealthConnect	65%
Percent of Add-On Communication Tool generated by House Supervisor and others in similar role	<p>N = Number of add-on communication tool generated for all add-on surgical cases</p> <p>D = Number of add-on surgical cases</p>	Secure Chat Messages pertaining to the add-on in HealthConnect	100%
HCAHPS Survey Summary Star Rating for the Unplanned Inpatient Surgical Patients	<p>5 Stars = Highest</p> <p>1 Star = Lowest</p>	HCAHPS Data Analytics Tool as provided by Care Experience Practice Leader	4 Stars

Driver Diagram



Changes to Test:

- 1) Standardize preoperative nursing care throughout the entire macrosystem whether patient is in Pre-Op Department, Emergency Department, or on the Inpatient Unit through the completion of the Pre-Op Checklist.
- 2) As soon as the House Supervisor or the Perioperative Assistant Nurse Manager or the Relief in Higher Class Staff Members receive a call from the surgeon to request to add a case on to the surgery schedule, an Add-On Communication Tool is generated via Secure Chat in HealthConnect communicating to the entire frontline care team of the detailed plans for surgery.
- 3) Nurse Managers on all units to share the Care Experience and HCAHPS Survey scores with the frontline care teams through daily huddles the progress made in terms of closing nurse communication gaps.

Gantt chart:**Pre-Op Checklist Project Timeline**

	5/20	6/20	7/20	8/20	9/20	10/20	11/20	12/20	1/21	2/21	3/21	4/21	5/21	6/21	7/21	8/21	Ongoing
Define the project/process mapping																	
Develop the aim																	
Microsystem assessment																	
Charter development																	
Create measurement, outcomes, processes, & balancing																	
Review literature																	
Identify changes to test																	
Driver diagram																	
Complete charter																	
Evaluation & ongoing performance improvement																	

Appendix E. IRB Non-Research Determination Form

CNL Project: Statement of Non-Research Determination Form

Student Name: Seda Vash

Title of Project: Closing Communication Gaps for Unplanned Surgical Patients: One Pre-Op Checklist at a Time

Brief Description of Project:

A) Aim Statement: Improve RN communication scores with unplanned inpatient surgical patients by increasing the percentage of pre-op checklist completion on unplanned inpatient surgical patients from a baseline of 13.4% in August 2020 to 65% by August 2021.

B) Description of Intervention: Improve RN communication among unplanned inpatient surgical patients in a hospital in the Central Valley through completion of the pre-op checklist by the primary nurse caring for the surgical patient, preoperatively.

C) How will this intervention change practice? The overarching goal of this project is to improve engagement and communication with unplanned surgical patients and their families from the health care team. The initial process to share with patients the plan of care for surgery is through the use and completion of the pre-op checklist by the primary nurse which addresses all medical factors that prepare patients for surgery. This checklist allows the nurse to engage with their patients, answer any questions they may have related to the surgical procedure they are about to undergo and provide emotional support and further education as needed.

D) Outcome measurements: A goal has been set for pre-op checklist completion at 65% by August 2021 on unplanned surgical patients coming from the units of this hospital with a target of 4 stars for RN Communication on HCAHPS Survey for this patient stratification.

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used:

(<http://answers.hhs.gov/ohrp/categories/1569>)

This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

This project involves research with human subjects and must be submitted for IRB approval before project activity can commence.

Comments:

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST *

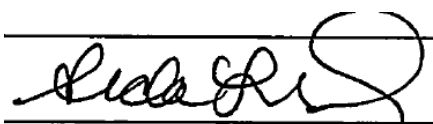
Instructions: Answer YES or NO to each of the following statements:

Project Title:	YES	NO
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	X	
The specific aim is to improve performance on a specific service or program and is a part of usual care . ALL participants will receive standard of care.	X	
The project is NOT designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does NOT follow a protocol that overrides clinical decision-making.	X	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does NOT develop paradigms or untested methods or new untested standards.	X	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does NOT seek to test an intervention that is beyond current science and experience.	X	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	X	
The project has NO funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	X	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., not a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	X	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: <i>“This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board.”</i>	X	

ANSWER KEY: If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. **IRB review is not required. Keep a copy of this checklist in your files.** If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

STUDENT NAME (Please print): Seda Vash

Signature of Student:  _____ DATE 4/10/2021 _____

SUPERVISING FACULTY MEMBER NAME (Please print):

Signature of Supervising Faculty Member _____ DATE _____

Appendix F. Pre-Op Checklist Completion Job-Aid

Flowsheets

File | Add Rows | LDA Avatar | Add Col | Insert Col | Data Validate | Hide Device Data | Last Filed | Reg Doc | Graph | Go to Date | Values By | Refresh | Legend | Link List

PACU FLOWSHEET IO AD LDA's Wound Point of Care Tests A... CRITICAL/EVENT NOTIFI... Patient Belongings **Preop Checklist** VS Pain ICU PEDS PACU Assessment IO PEDS Preop Adult Ass

Search (Alt+Comma) []

Expanded View All []

1m 5m 10m 15m 30m **1h** 2h 4h 8h

ED to Hosp-Admission (Discharged) from 9/23/2020 in HOSPITAL PERI-OP. SERVICES
9/23/20

	1816	1827	1927	1932	1937	1945
Two (2) patient identifiers (ID) verified	PATIENT NAM...		PATIENT NAM...			
ID band applied/in place	ID BAND		ID BAND: ALL F			
Allergy Band Applied/In Place	YES					
Procedure Verification	PROCEDURE ...					
Interpreter Used						
Interpreter Services Used	NO - Patient pr...					
Preop Checks						
Allergies Reviewed	YES					
Consents Complete and Signed	INFORMED O...					
Advance Directives	NO					
Interval H&P on Chart	YES					
Current H&P on Chart	YES					
NPO Status Solids	0800					
NPO Status Liquids	0800					
Carb Supplement	N/A					
Time Carb Supplement Consumed						
Last Time Voided	1817					
Pre Op Prep	N/A					
Chlorhexidine Performed						
Skin Protection						
Pre Op Hair Removal	N/A - No Hair ...					
Pre Op Lab/Test Results Available	YES					
EKG Results Per Policy	NOT APPLICA...					
PreOp X-Rays Available	Yes					
Existing implants	None					
Blood/Products Availability						
Blood Ordered	N/A					
Personal Items						
Patient Meds/Inhalers	NONE					
CPAP/BiPAP/Oxygen	NONE					
Personal Items Removed	REMOVED					
Home Information						
Home with (Name/Relationship)	stacie					
Driver's Phone Number	510-282-8440					
Driver's Location	WILL WAIT ...					
Contact Person's Number	510-282-8440					
Contact Person's Location	on site/main h...					

EXAMPLE OF COMPLETED PRE-OP CHECKLIST

If there is laterality involved i.e. urology patients, the site and laterality needs to be marked prior to patient going into the OR. Select ALL options from the drop-down menu as appropriate.

Interval H&P is almost always N/A for ED patients. The surgeon will need to complete an initial H&P the same day before surgery.

This is part of the ERAS initiative! No need to complete the actual work! Selecting N/A is appropriate. (If there are changes, will update ED Team.)

Skin protection can be left blank. Unless there are abnormalities, then select as appropriate.

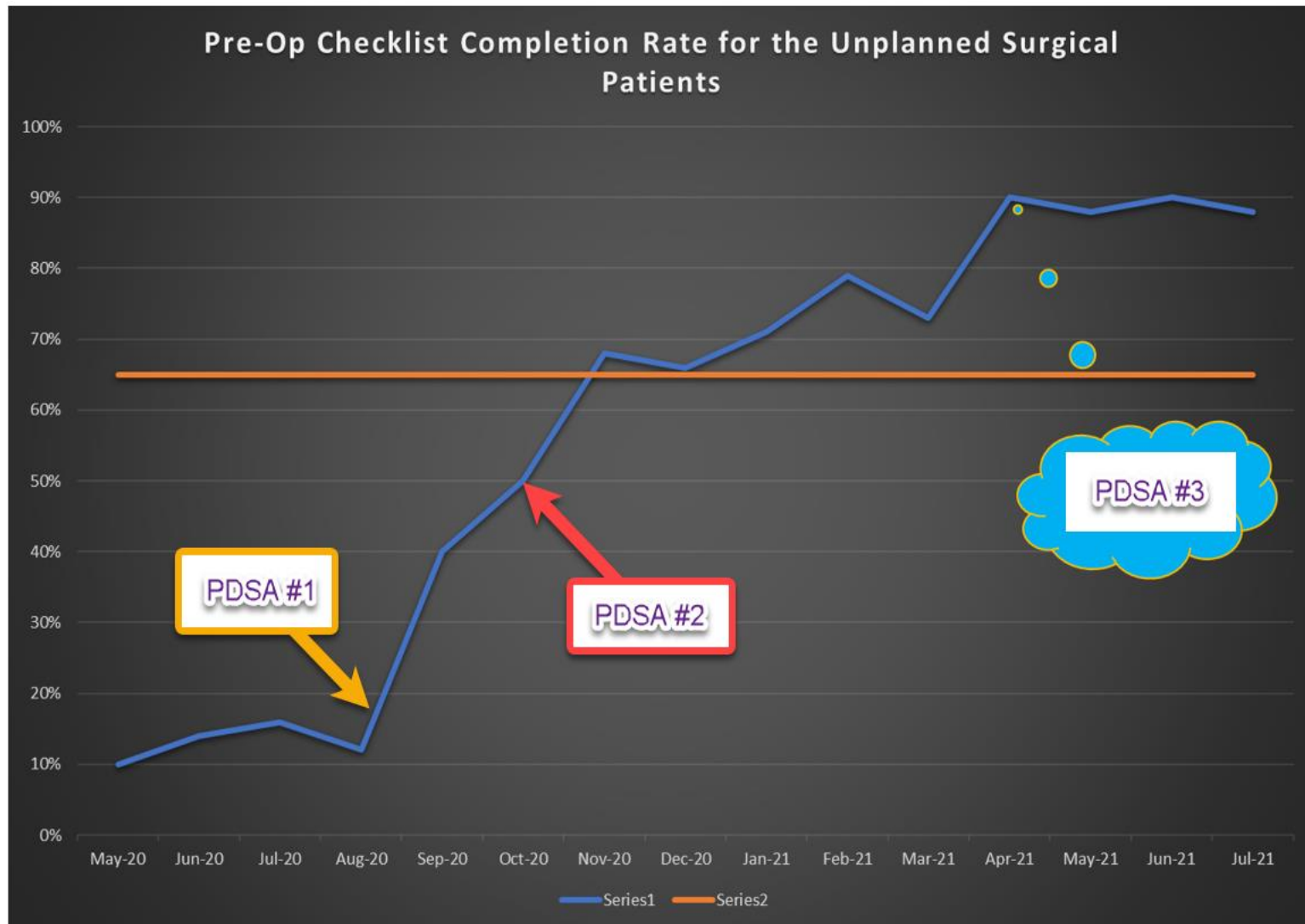
Comment Entry

Comment: []

Always enter name and relationship

Accept Cancel

Appendix G. Run Chart for Pre-Op Checklist Completion by Month



Appendix H. Add-On Communication Tool via Secure Chat

Date: 9/14/20
Patient Location: Manteca ER
Patient Arrival Time if Pre Op is Needed: 1400
Patient Name: Joe Smith
MRN: 12345678
NPO Status: NPO
Time and Date of Last Intake: 2200 on 9/13/20
Surgeon Name: Bitgood
Procedure to Be Performed: Thyroidectomy
Surgeon Available Time: 1500
OR Time Offered: 1530

Notified the Call Team Per Below

Time of Anesthesia Notification: 1330
Time of OR Circulator Notification: 1330
Time of OR Tech Notification: 1330
Time of PACU RN Notifications: 1330
PACU RN's Notified: Jennifer, Lisa, mary

Special Requests

C Arm Needed and Radiology Notified (Yes/No): Yes

Laser Lithotripsy Needed and Agiliti Notified (Yes/No) Yes, contacted Agiliti at number below 1230PM
Agiliti Contact Number 1-800-660-6162 Option 1

Other Requests: None

House Supervisor Taking Information: Joe Smith

Additional Information / Condition of Admission: HAS For monitoring labs and airway.

Now

Appendix J. Pre-Op Checklist Data after PDSA Cycle #2

Week #	Dates:	# of completed checklists (n)	# of cases (d)	Completion %	ED cases completion rate	IP cases completion rate	PreOp completion rate
29	4/28 - 5/4	15	16	94	9/10=90%	3/3=100%	3/3=100%
30	5/5 - 5/11	14	16	87.5	11/13=85%	2/2=100%	1/1=100%
31	5/12 - 5/18	19	21	90.5	11/13=85%	4/4=100%	4/4=100%
32	5/19 - 5/25	19	21	90.5	12/14=86%	5/5=100%	2/2=100%
33	5/26 - 6/1	4	7	57	1/4=25%	3/3=100%	0
34	6/2 - 6/8	15	19	79	10/14=71%	3/3=100%	2/2=100%
35	6/9 - 6/15	14	14	100	9/9=100%	3/3=100%	2/2=100%
36	6/16 - 6/22	15	17	88	9/10=90%	4/5=80%	2/2=100%
37	6/23 - 6/29	14	14	100	5/5=100%	7/7=100%	2/2=100%
38	6/30 - 7/6	11	11	100	7/7=100%	2/2=100%	2/2=100%
39	7/7 - 7/13	13	15	87	9/10=90%	3/4=75%	1/1=100%
40	7/14 - 7/20	13	16	81	9/11=82%	4/5=80%	0
Totals:		166	187	88.80%	102/120=85%	43/46=93%	21/21=100%