



Table. Ambulatory Surgical Facility (ASF) Preoperative Screening and Assessment Challenges and Lessons Learned from Participating ASFs

CHALLENGES	LESSONS LEARNED
<p><b>Staffing and Time Constraints</b></p> <p>Limited time to review and approve alignment of the existing checklist with the standardized set of checklist questions</p> <p>Limited staff and staff time to make second preoperative phone calls to patients</p> <p>Alignment of staff and patient working hours, reducing staff's ability to contact or reach patients</p>	<p>Performing preoperative phone calls one to two days prior to the day of surgery (DOS) (when staff are available) showed dramatic improvements as a result of staff clarifying arrival and procedure times with patients and patients asking questions to clarify preoperative instructions. The number of patients who were unable to be contacted on previous calls was reduced.</p> <p>Identifying cancellations more than two days prior to the DOS allowed some ASFs to fill openings in their surgery schedule.</p> <p>Calling patients preoperatively on off-hours (Saturdays) increased patient contact and reduced cancellations. One ASF found that patients are more likely to be home on weekends.</p>
<p><b>Communication Issues</b></p> <p>Difficulty keeping open lines of communication with surgeons' offices</p> <p>Limited information about a patient's health status when collected by clerical staff compared with nursing staff</p> <p>Insufficient or inaccurate contact information, resulting in staff's inability to contact patients</p>	<p>Initiating the checklist improved office staff interactions with patients. The checklist was used to educate staff about the importance of getting more information from the patient. For example, if a patient states they had an angioplasty, the checklist prompts office staff to find out the date when the procedure was done.</p> <p>Educating staff to improve screening skills resulted in improvements in communication between clerical staff and clinical staff.</p> <p>Educating schedulers improved information conveyed to patients and improved the scheduler's sense of team participation and team functioning.</p> <p>Completing preoperative phone calls by a nurse resulted in a decrease in no-show cancellations.</p> <p>Opening up lines of communications between the ASF and referring physician offices improved communication between offices and provided opportunities to obtain additional phone numbers when the ASF was unable to contact patients.</p> <p>Calling patients two weeks prior to the day of surgery when the chart was incomplete due to missing allergy information, missing a history, or questionable history resulted in significant increases in completed charts.</p> <p>Obtaining additional phone numbers from the patient and family or friends, including cell phone numbers, can increase the ASF's ability to contact the patient for the preoperative screening and assessment.</p> <p>Sending letters to patients when an ASF is unable to reach the patient by phone has the potential to improve patient communication and reduce DOS no-show cancellations.</p>

per 1,000 admissions preintervention to 0.77 transfers per 1,000 admissions postintervention. This increase in postoperative transfer rates was not statistically significant. Postoperative transfers consisted of medical conditions that arose during or as a result of the procedure and required further intervention beyond the scope of the ASF (e.g., respiratory monitoring, aspirations, perforations).

Evaluation of time of preoperative screening for patient transfers occurring in the postintervention phase revealed that 100% (n = 8 of 8) of patients transferred preoperatively received a preoperative screening and assessment, whereas 70.8% (n = 17 of 24) of patients transferred postoperatively received a preoperative screening and assessment.

An examination of 12 patients transferred postoperatively with potential contributing

factors revealed that 75% (n = 9) had a preoperative screening and assessment and that 25% (n = 3) had no preoperative screening and assessment. The potential contributing factors for these 12 patients were reported as follows:

- Patient ill on day of surgery (n = 5)\*
- New (i.e., previously undiagnosed) medical issues (n = 2)

\* One patient was not screened preoperatively.

Table. Ambulatory Surgical Facility (ASF) Preoperative Screening and Assessment Challenges and Lessons Learned from Participating ASFs (cont'd)

CHALLENGES	LESSONS LEARNED
<p><b>Educational Issues</b></p> <p>Lacking patient compliance with preoperative instructions (e.g., failing to maintain nothing by mouth [NPO] status, no driver present on the DOS)</p> <p>Changing anesthesiologist group during the collaboration, requiring additional education of physicians</p>	<p>Speaking slowly so patients can comprehend what is said and using plain nonmedical language helped improve patient comprehension.</p> <p>Limiting the amount of information provided to patients aided patient's understanding of the information; too much information at one time can cause information overload, limiting retention.</p> <p>Using the teach-back technique confirms the patient's understanding of preoperative instructions.</p> <p>Lowering the literacy level of the preoperative instructions helped improve patient understanding of the preoperative instructions. For example, telling patients not to drink or eat anything rather than using the word "fast" resulted in improved patient understanding of preoperative instructions.</p> <p>Creating an open environment by phrasing questions in ways that engage patients encouraged patients to ask questions and receive clarifications about their upcoming procedure. For example, asking patients "what questions do you have?" conveys to patients that staff expect and encourage questions.</p> <p>Using simplified explanations to describe to patients the safety reasons for NPO status when receiving anesthesia helped improve understanding. For example, providing a list of clear liquids (e.g., black coffee, water, apple juice) for patients who are allowed to have drinks can reduce ambiguity.</p> <p>Making sure patients understood the importance of having a driver to take them home and that the procedure would be cancelled if they did not have a driver helped improve compliance.</p> <p>Getting feedback from patients about following the preoperative instructions assisted facilities with problem solving when patients were not properly prepped for procedures.</p> <p>Changing the color of the preoperative instructions sheet made the information prominent among the other patient forms.</p> <p>Switching anesthesiologist groups provided an opportunity for the new group of anesthesiologists to incorporate the preoperative checklist into their patient screening and assessments.</p>
<p><b>Checklist Implementation Issues</b></p> <p>Lacking an existing preoperative screening checklist</p> <p>Adding new questions to an existing preoperative checklist</p> <p>Lacking clinical staff compliance with the checklist</p> <p>Difficulty incorporating the checklist into office staff workflow processes to improve preoperative screening</p>	<p>Adding psychosocial questions to the checklist was beneficial in identifying nonclinical issues, such as no ride home or financial difficulties in paying for the surgery or procedure.</p> <p>Completing the checklist resulted in more completed patient charts on the DOS.</p> <p>Collecting information and forms two weeks prior to surgery aided in tracking missing forms; staff tacked notes on the chart identifying the missing forms. A significant increase in completed charts and completed history and physicals was realized.</p>

- Preexisting medical condition (n = 2)\*
- Surgery more difficult than expected (n = 1)\*

\* One patient was not screened preoperatively.

- Patient required additional time to monitor (n = 1)
- Questionable home care (n = 1)

**DISCUSSION**

Omitting a nurse-driven preoperative screening and assessment was associated

with a high percentage of no-show DOS cancellations. The implementation of a nurse-driven preoperative screening and assessment was associated with reductions in clinical (e.g., protocol-related issues) and nonclinical (e.g., transportation-related issues) DOS cancellations. Several ASFs