Facility Case Study

TRANSITION STRATEGY

Client Description

Our client, a 300-bed hospital located in the Northeast region, serves as a regional referral, teaching hospital and provides quality care for women and infants, trauma, and cardiac patients. The facility was housed at the 4th floor of hospital space and received the Award for Excellence in Performance.

Challenge

The local anesthesiology group presented the hospital with a 90-day notice of non-renewal. Sheridan was asked by the hospital to build a new team to provide full anesthesia coverage without any interruption of service.

Success Story

With less than 60 days of lead time, Sheridan’s Transitional Leadership Team successfully worked with hospital leadership to create a seamless service transition.

Achievements Included:

- Fully covered the facility on day one with select retained staff plus Sheridan contract providers
- Recruited a permanent Chief of Anesthesia to provide leadership
- Colonized the anesthesia team through recruitment of staff anesthesiologists, ERAS 2 and "Veteran" Level 4 CDC Certified Anesthesiologists
- Partnered with hospital to improve efficiencies, increase size of service and grow service volume by 37% within year two of service contract

The hospital was in a critical position due to an overwhelming management crisis that would have required significant time and resources to resolve. Through its selection of a strategic partner, Sheridan was able to quickly and effectively enhance service and maximize patient safety.

Further, Sheridan’s Transitional Leadership Team successfully transitioned the anesthesia team from the current group to a new management model. This ensured a smooth transition and maintained patient safety throughout the process.

Safety Through IT Solutions

When a hospital-based management company offers IT solutions, it is better positioned to adjust to the changing needs of today’s health care system. Whether improving patient safety through innovative EHR technology, streamlining scheduling with RIS productivity management, or incorporating health care analytics to track quality metrics, Sheridan strives to ensure that technology integration is second to none with strategic alliances, according to Jim Wilder, Chief Information Officer for Sheridan Healthcare.

Process Improvement to Correct Safety Issues

According to Mitchell Eisenberg, MD, Chairman and CEO of Sheridan Healthcare, all of Sheridan’s corporate and clinical process improvement leadership teams are involved with the company’s current safety initiatives, and clinical management solutions offer a glimpse into how its vast infrastructure positively impacts safety. Kaizen requires the members of the process improvement team to identify and correct safety issues, including this hazards, missing or unclear labels, or misuse of equipment.

While Kaizen strives to reduce chaos and improve processes, its first rule before any assessment is to observe patients and staff. To effectively reduce errors and improve outcomes, Kaizen, is utilized to evaluate and improve both clinical and non-clinical operations.

According to Jim Wilder, Chief Information Officer for Sheridan Healthcare, Inc.

Quality metrics, Sheridan strives to ensure that its technology sophistication is second to none in its industry, according to Jim Wilder, Chief Information Officer for Sheridan Healthcare.

While providing efficient and cost-effective management solutions for anesthesia, radiology, medical informatics, and neonatology departments, Sheridan has grown into the leading provider of comprehensive, or healthcare management and hospital-based physician services in the country. Due to its partnerships that span from the state of Washington to Florida to Vermont, Sheridan can share best practices to improve patient safety in the OR. It is, thereby, helping its partners achieve their goals related to quality, productivity and growth while maintaining a healthy balance between clinical and operational excellence.

Achieving Patient Safety in the OR

New advances in patient safety have transformed the operating room over the past several generations. And rightly so. In the late 1800s, when a group of surgeons stood around the OR table, they believed they were delivering world-class medicine. We now know otherwise. More than a hundred years later, the United States still struggles to ensure patient safety as the Institute for Healthcare Improvement estimates that 10 million incidents of medical harm occur in U.S. hospitals each year. Patients have continuously championed for innovation, efficiency and safety in the surgical arena, but we’ve never had a solution.

For nearly 60 years, Sheridan Healthcare has been dedicated to quality patient care and value-producing efficient and cost-effective management solutions for anesthesia, radiology, medical informatics and neonatology departments. During this time, Sheridan has grown into the leading provider of comprehensive, or healthcare management and hospital-based physician services in the country. Due to its partnerships that span from the state of Washington to Florida to Vermont, Sheridan can share best practices to improve patient safety in the OR. It is, thereby, helping its partners achieve their goals related to quality, productivity and growth while maintaining a healthy balance between clinical and operational excellence.

Patent Safety in the OR

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- Medfusion
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PATIENT SAFETY IN THE OR

SAFETY SURVEY 2015 CHECKLIST TEMPLATE

- List & minimize possible errors
- Patient ID: date of birth (all ORs)
- Background info on patient (all ORs)
- Available surgical history (all ORs)
- All medications (all ORs)
- Patient allergies (all ORs)
- Informed consent document completed (all ORs)
- Surgical procedure to be conducted (all ORs)
- Type of anesthesia ordered (all ORs)
- Two IVs/central access and fluids warmed in place
- Risk of hypothermia — for operations longer than 1 hour
- Warming in place
- Preoperative: patient temperature
- Type of cross-match/screen planned

- Surgical team present
- Surgical site mapped
- Surgical site marked
- Surgical safety checklist has been completed
- Surgeon, anesthesiologist, nurse, and surgical tech present
- Scrub tech present
- All present surgical team aseptic
- No patient or equipment errors
- No room for substitutions in place

- Table surgical items:
  - Everyone in surgery knows the plan
  - Patient’s name and room number displayed
  - Team roster present
  - Team protocol for provider identification
  - Percutaneous procedure
  - Unlabeled clear solutions
  - Financial mapping available
  - Surgical equipment available
  - Unprepared items

- Surgical checklist items:
  - Preoperative: patient temperature
  - Preoperative: patient temperature
  - Percutaneous procedure
  - Unlabeledclearsolutions
  - Financial mapping available
  - Surgical equipment available
  - Unprepared items

- Surgical checklist outcomes:
  - Surgical errors reported in order
  - Follow-up, surgical infections
  - Perioperative: patient temperature
  - Follow-up, surgical infections
  - Perioperative: patient temperature
  - Follow-up, surgical infections

- Surgeon & anesthesiologist verify:
  - Patient ID: date of birth
  - Background info on patient
  - Available surgical history
  - All medications
  - Patient allergies
  - Informed consent document completed
  - Surgical procedure to be conducted
  - Type of anesthesia ordered
  - Two IVs/central access and fluids warmed in place
  - Risk of hypothermia — for operations longer than 1 hour
  - Warming in place
  - Preoperative: patient temperature
  - Type of cross-match/screen planned

- Patient & family verify:
  - Patient ID: date of birth
  - Background info on patient
  - Available surgical history
  - All medications
  - Patient allergies
  - Informed consent document completed
  - Surgical procedure to be conducted
  - Type of anesthesia ordered
  - Two IVs/central access and fluids warmed in place
  - Risk of hypothermia — for operations longer than 1 hour
  - Warming in place
  - Preoperative: patient temperature
  - Type of cross-match/screen planned

SUGGESTIONS FOR YOU:
- "Ask if you have anything you don’t understand"
- "You’re here to help"
- "We’re here to help"
- "We’re here to help"
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BOSTON CHILDREN’S HOSPITAL

For the first time in its history, Boston Children’s Hospital is presenting its annual report on patient safety in the operating room. The report, which is the result of a year of data collection and analysis, highlights the progress made in improving patient safety and outcomes in the OR.

MISTAKES CAN BE PREVENTED

Many common types of errors have been identified in the operating room, and efforts to reduce these errors have been ongoing for several years.

While checklists alone may not be enough, experts say, they are an important tool in improving patient safety. In fact, a recent study found that using checklists reduced the number of errors in surgery by up to 30%.

One of the biggest barriers has been getting surgeons to accept the checklist as a tool. “My key to the lock,” says Dr. Sarah Smith, “is to have the surgeons respect to talk with them in one-on-one conversations before you hold large or discipline-specific meetings.”

Another barrier is that many surgeons may not feel comfortable talking about their mistakes. “I personally believe there are a lot of people who actually reflect that we’re being more consistent,” says Dr. Smith.

But checklists alone aren’t enough, experts say. Communication and team building are essential ingredients for maintaining a safe operating environment.

According to the Joint Commission, 80% of adverse events are attributable to failed communication. The Veterans Health Administration’s National Center for Patient Safety found significantly improved communication in ORs that used checklists.

Last year alone, there were 152 cases of surgeons operating on the wrong patient, or wrong site, or performing the wrong procedure, according to the Joint Commission. This number has been steadily increasing over the past few years.

In response to this trend, the Joint Commission has released a number of initiatives aimed at improving patient safety in the OR. One of these is the Surgical Safety Checklist, which includes a series of steps that should be completed before any surgical procedure.

The Check for Knowledge in Surgery (CKS) is another initiative aimed at improving patient safety. The CKS is a set of questions that providers are asked to answer before performing a surgical procedure. The questions cover a wide range of topics, from patient identification to surgical site marking.

Despite these efforts, patient safety remains a persistent topic of conversation in the health care business. Still, experts say, there is hope for improvement.

“In the end, it’s really about making sure everyone feels safe,” says Dr. Smith. “And that means making sure they feel comfortable speaking up.”

The report also highlights the importance of leadership and management in improving patient safety in the OR. “Senior leadership support is key to a successful implementation of a checklist policy,” says Dr. Smith.

Keys to Effective Implementation

1. Service leadership support
2. Nontechnical skills training
3. Education and awareness
4. Communications to staff
5. Follow-up with feedback and coaching
6. Phase-in with small cohorts
7. Encourage input from team members
8. Regular management "walk rounds"
9. Evaluate effectiveness with a benchmarking tool
10. Stakeholders” “buy-in”
For nearly 60 years, Sheridan Healthcare has been dedicated to quality patient care and safety by providing efficient and cost-effective management solutions for anesthesia, radiology, emergency medicine and neurology departments. During this time, Sheridan has grown into the leading provider of comprehensive practice management and hospital-based physician services in the country. Due to its partnerships that span from the states of Washington to Florida to Vermont, Sheridan can better serve local hospitals to improve patient safety in the OR, thereby helping its partners achieve their goal related to quality, productivity and growth while maintaining a healthy balance between clinical and operational excellence.

Safety Through IT Solutions
When a hospital-based management company offers IT solutions, it is better positioned to adjust to the changing needs of today’s health care system. Whether improving patient safety through innovative EHR technology, streamlining scheduling with MSO productivity management, or incorporating health care analytics to track trends, Sheridan provides IT solutions that are secure and evolve as the industry, according to Jim Wilson, Chief Information Officer for Sheridan Healthcare.

Process Improvement to Correct Safety Issues
According to Michael Crooging, MD, Chairman and CEO of Sheridan Healthcare, all of Sheridan’s corporate and clinical practice management leadership shares a common desire toward “50 – 30 – 20 to 5” which means 50% better quality, 30% faster, with a 20% increase in productivity towards 5% growth overall. Due to its culture of “lean” thinking, Sheridan provides extensive in-house process improvement resources that include the expertise of its state leadership and formal models in creating process improvement and management. This hands-on approach provides IT solutions, Kaizen is ideal to evaluate and report both clinical and non-clinical operations. While Kaizen efforts in reducing chaos and improving processes, its first rule before any assessment is to observe safety. Kaizen requires the members of the process improvement team to identify and correct safety issues, including EHR alerts, missing or unclear labels, or misuse of equipment.

Improve Patient Safety in the OR with Kaizen.

As the state of science and technology continues to expand, patients expect that medical care will improve their health, and we, as hospital partners, should use this performance measurement tool because, although, and while Sheriand’s breadth and depth exceeds what is available now, it offers solutions, process improvement initiatives, and clinical management solutions that are in tune with how we use infrastructure positions contribute to quality clinical care and patient safety.
Client Description

Our client, a 30-bed hospital located in the Northeast region, serves as a regional referral, teaching hospital and provides quality care for women and infants, trauma, and cardiac patients. The facility was honored as the #1 Overall Hospital in 2010 and received the Magnet Award for Nursing Excellence.

Challenge

The local anesthesiology group presented the hospital with a 60-day notice of termination. Sheridan was asked by the hospital to build a new team to provide full anesthesia coverage without any interruption of service.

Success Story

Within the first 60 days of our arrival, Sheridan’s transitional leadership team successfully worked with hospital leadership to create a seamless service transition.

Achievements Included:

- Fully covered the facility on day one with select retained staff plus Sheridan contract providers
- Recruited a permanent chief of anesthesia to provide leadership
- Established the seamless team through recruitment of staff anesthesiologists, ERNs and 2 “Veterinary-trained” CRNA Certified Credentials, Neonatologists
- Partnered with hospital to improve efficiencies, increase slice of service and grow service volume by 37% within year two of our service contract

Improve Patient Safety in the OR with Kaiser.

Process Improvement to Correct Safety Issues

According to Michael E. Corea, MD, Chairman and CEO of Sheridan Healthcare, all of Sheridan’s corporate and clinical site-specific management leadership crises can be divided into two areas—0-25 vs. 25-50 vs. over 50 before中小学, with a 50% increase in productivity towards 5% growth overall. Due to its culture of “Lean” thinking, Sheridan’s process-driven solutions are based on the principles of lean manufacturing and lean thinking in running operations and management. This process improvement methodology focuses on identifying and improving both driving and non-driving critical metrics.

When Lean strives to reduce class and improve processes, its first step before any assessment is to observe hospital processes. For the purpose of process improvement teams to identify and correct safety issues, including the hospital, training in nuclear security, or the use of equipment.

As the state of science and technology continues to expand, certain facts that medical care can improve their patients’ health are limited. Sheridan partners believe that Sheridan’s performance-driven business model, with an immediate benefit to its shareholders, will improve the hospital to build a new team to provide full anesthesia coverage without any interruption of service. Sheridan was asked by the hospital to build a new team to provide full anesthesia coverage without any interruption of service. Sheridan was asked by the hospital to build a new team to provide full anesthesia coverage without any interruption of service. Sheridan was asked by the hospital to build a new team to provide full anesthesia coverage without any interruption of service. Sheridan was asked by the hospital to build a new team to provide full anesthesia coverage without any interruption of service. Sheridan was asked by the hospital to build a new team to provide full anesthesia coverage without any interruption of service. Sheridan was asked by the hospital to build a new team to provide full anesthesia coverage without any interruption of service. Sheridan was asked by the hospital to build a new team to provide full anesthesia coverage without any interruption of service. Sheridan was asked by the hospital to build a new team to provide full anesthesia coverage without any interruption of service. Sheridan was asked by the hospital to build a new team to provide full anesthesia coverage without any interruption of service.