THE CLIENT'S ISSUE

A major medical center performing complex orthopedic, spine and cardiovascular procedures was experiencing significant case delays and surgeon and staff frustration due to instrument issues (missing instruments, dirty instruments), case cart issues, lack of appropriate staff training and education, and lack of collaborative planning. Furthermore, a significant staff retention problem resulted in heavy reliance on expensive traveler SPD technicians.

SHC'S CHALLENGE

The medical center's perioperative leadership engaged SHC to identify potential causes for service gaps, review and revise instrument handling protocols, develop a comprehensive SPD training and education program, recommend optimal organizational and staffing needs for SPD, and re-implement the instrument tracking system for optimal use. In addition, SHC provided interim management services covering the SPD Manager and SPD Educator positions.

WHAT WE FOUND

SHC consultants found noncompliance with national standards for instrument care, cleaning, and reprocessing. An assessment of the sterile processing department management team's experience, expertise, and span of control revealed a need for organizational changes and staffing adjustments. The previous management style was ineffective. The hospital's productivity measurement system was inaccurate, showing the SPD to be less productive than it was. Staff morale was low. The IUSS percentage was over 15% of cases performed. Error rates on instrument trays was greater than 4%, and case cart errors exceeded 5%.

WHAT WE DID

SHC addressed staffing, organizational, and procedural needs by making the following improvements:

- Devising an organizational plan to ensure clinical and managerial expertise and educational support within the sterile processing program
- Developed a career ladder within SPD (Lead Technicians) to utilize available expertise and provide leadership back-up.
- Developed and implemented a formal, competency-based orientation and education program. Assessed all staff and trained to fill skill gaps and ensure consistency of practice. Utilized the new training plan to onboard new permanent staff and bring them up to optimal practice in a reasonable timeframe.
- Empowered staff to make decisions, and take ownership in their work.

- Developing a new staffing plan to optimally support the current volume and workload demands of the medical center, and revised the productivity measurement system to accurately reflect the impact of activity on staffing.

- Streamlining instrument flow through the decontamination and assembly process, improving instrument organization and productivity.
- Re-implementing the instrument tracking system making it more accurate and user-friendly. Maximized utilization of functionality of the current version (upgrade requested)
- Establishing postoperative instrument care protocols, and educated OR staff to proper care in accordance with AORN and AAMI standards.

RESULTS

- OR staff and surgeon satisfaction improved
- SPD staff morale increased significantly
- Traveler staffing eliminated in less than 5 months
- Instrument tray error rate reduced to less than 1%
- Case cart error rate reduced to less than 2%
- Productivity in SPD assembly area increased by 25%
- IUSS occurrence rate reduced to under 4%, remaining occurrences due to instrument inventory issues to be addressed in the next capital budget process
- Professional, clinically knowledgeable sterile processing leadership secured
- SPD reprocessing protocols elevated to achieve compliance with national standards
- Quality of patient care improved
- Postoperative instrument loss and damage significantly reduced