Optimization and Standardization of Doctor Preference Cards for Laparoscopic Cholecystectomy at Lehigh Valley Hospital Network

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Laparoscopic cholecystectomy is one of the most common surgical procedures performed routinely and at LVMH. After reviewing previous protocols to standardize patient care for cases including laparoscopic cholecystectomy, several different approaches have been successful. Some of these approaches focus on surgical technique; some preoperative care and others are a more broadly based systems approach.1-3 There are two main accepted techniques for completion of laparoscopic cholecystectomy specifically, a four port site procedure and a single port site procedure. Information regarding both of these surgical procedures are outlined in short summary form. All of the high volume surgeons at Lehigh Valley Health Network (LVMH) perform laparoscopic cholecystectomy using a four port procedure. This fact identifies an opportunity for cost savings such that instrumenting for the common, fairly basic technical approach was completed for each surgeon and designated as surgeon 1-8 were used. Previous development of a standardized DPC was revised and further scrutinized with the input of the surgical team. The following surgical DPCs were then compared with this standard card. The items in plain black font are items that are present on the DPC and on the standard card. The goal of the project is to move as many items to this standard table. Highlighted in blue are items that are not in the surgical DPC but were agreed upon and included on the standard DPC. We found that in many cases those were similar items. These items are considered by the core surgical staff to be "non" items either not necessary or a duplicate of a more widely accepted instrument or material used in common 4 port laparoscopic cholecystectomy. This is where the majority of time was spent compromising with individual surgeons whose preference, often evidence based, was discussed. Certainly the quantums of emotion intelligence after agreeing from surgeons to surgeon. In meeting with the core, the variation in DPCs nearly 20% from 21.5% to 2.1% operating room ordering, streamlining care by creating a tangible standard to clinical practice. By cutting the pre-standardization of surgeons would not match the current timeline from the hospital administration. After receiving input from several clinicians and house staff from hospital departments including the Emergency Department, Post Anesthesia Care Unit (PACU), operating room staff, sterile supply, operating room scheduling and patient transport the order of the project would not match the current timeline from the hospital administration. Other obstacles included the variation of selection of patients by different surgeons and the coding classifications of the procedures, meaning, were these cases actually just or recorded as just through? Through this experience I have learned that during the process of change, from a change management perspective, it is far more acceptable for individuals to be included than not to be so off set at discussion and be surprised by the change. In coming to an understanding of my own personality traits exhibited by my Meyers Briggs personally analysis I have found that this approach suits me quite well. As an ESTJ I am comfortable in helping out conversations and enjoy the complexities of conflict and resolving conflict, I have learned that I need to be more cautious and a better listener in order to grow into a leader capable of influencing a wide spectrum of people.

Background

Methods

The following sets of DPCs demonstrate the variability of instrumention and other materials used by the surgical staff at LVMH. To maintain surgeon anonymity simple designations as surgeon 1-8 were used. Previous development of a standardized DPC was revised and further scrutinized with the input of the surgical team. The following surgical DPCs were then compared with this standard card. The items in plain black font are items that are present on the DPC and on the standard card. The goal of the project is to move as many items to this standard table. Highlighted in blue are items that are not in the surgical DPC but were agreed upon and included on the standard DPC. We found that in many cases those were similar items. These items are considered by the core surgical staff to be "non" items either not necessary or a duplicate of a more widely accepted instrument or material used in common 4 port laparoscopic cholecystectomy. This is where the majority of time was spent compromising with individual surgeons whose preference, often evidence based, was discussed. Certainly the quantums of emotion intelligence after agreeing from surgeons to surgeon. In meeting with the core, the variation in DPCs nearly 20% from 21.5% to 2.1% operating room ordering, streamlining care by creating a tangible standard to clinical practice. By cutting the pre-standardization of surgeons would not match the current timeline from the hospital administration. After receiving input from several clinicians and house staff from hospital departments including the Emergency Department, Post Anesthesia Care Unit (PACU), operating room staff, sterile supply, operating room scheduling and patient transport the order of the project would not match the current timeline from the hospital administration. Other obstacles included the variation of selection of patients by different surgeons and the coding classifications of the procedures, meaning, were these cases actually just or recorded as just through? Through this experience I have learned that during the process of change, from a change management perspective, it is far more acceptable for individuals to be included than not to be so off set at discussion and be surprised by the change. In coming to an understanding of my own personality traits exhibited by my Meyers Briggs personally analysis I have found that this approach suits me quite well. As an ESTJ I am comfortable in helping out conversations and enjoy the complexities of conflict and resolving conflict, I have learned that I need to be more cautious and a better listener in order to grow into a leader capable of influencing a wide spectrum of people.

Conclusions

For complete transparency I have included the cost analysis of how each DPC changed throughout the process. With a closer look it can be seen that the new standardized card has increased the cost of the procedure when strictly observing this data. However, this cost data is unable to account for the instances when, for example, surgeon 1 was scheduled for a case and due to influence from another surgeon was unable to have their particular surgeon 2 perform the operation. In those instances, which were described by the surgical staff as quite unique, the only surgeon they would be represented and the correct tray of instrumention would be needed to be brought in and prepared for the upcoming surgeon. This cost increase can be seen as another cost of the procedure. With the presence of the standard card this is no longer an issue with the exception of 1 surgeon requiring approximately 15% of new instruments to be brought up. He needed supplies for the procedure. Thus the actual cost savings is something that is very difficult to track however it can be assumed that this standardization will offer significant cost savings to the department of surgery going forward.

References