

The Role of the Surgical Champion: Effective Engagement of Colleagues, Staff, and Institutional Leaders To Improve Patient Outcomes

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Objectives:

- Discuss characteristics and qualities of a Surgical Champion
- Examine the maturation of Quality Improvement in health care
- Review tactics for success as a Surgical Champion
- Test the strategy as a champion with a case study in process improvement.

The Role of the Surgical Champion:
Effective Engagement of
Colleagues, Staff, and Institutional Leaders
To Improve Patient Outcomes

Colleagues,
Staff, and
Institutional
Leaders

Effective
Engagement

Improve Patient
Outcomes

Who

What

Why

A “Surgical Champion”
Need not be a Surgeon

Personal Traits:

- Engaging
- Collegial
- Inspired
- Committed

1914



Ernest Codman, M.D.

End Result Idea

Every hospital should follow every patient it treats long enough

to determine whether the treatment has been successful, and

then to inquire “if not, why not?”

with a view to preventing similar failures in the future.

DATA
COLLECTION

PEER
REVIEW

CLINICAL
ANALYTICS

QUALITY
IMPROVEMENT

Characteristics of a Champion

- Maintains a wide peer and social network, with extensive insight into how colleagues interact with each other.
- Credible and respected.
- Highly knowledgeable and current through a variety of sources.
- Shares knowledge generously with others.
- Supports and advocates for process changes.
- Engages new guidelines and serves as a resource for others.
- Welcomes contact and attends to issues.
- Demonstrates an interest in a spectrum of viewpoints.
- Flexible and controlled in the face of stress.
- Leads by example.
- Advocates for issues while respectful of other viewpoints.

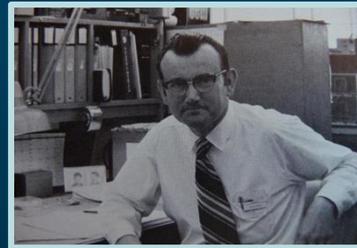
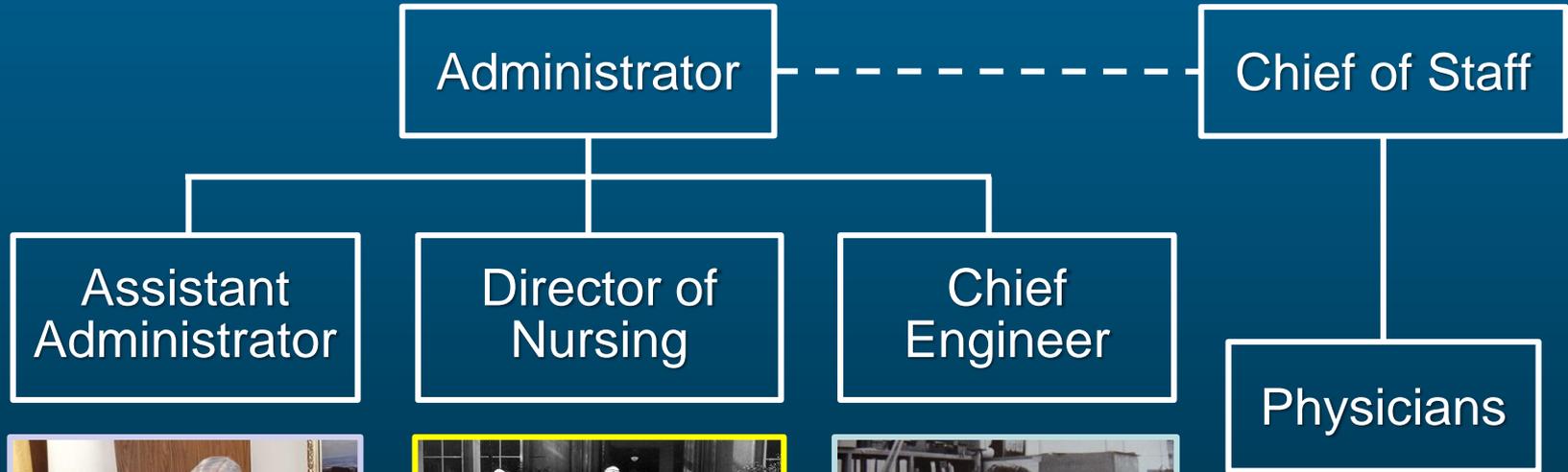
How is a Champion successful?

- Establishes vision
- Engages support
- Asks questions
- Makes decisions
- Introduces skepticism
- Avoids foolishness
- Runs interference
- Encourages the troops
- Celebrates success



1970

James Decker Munson Hospital
Traverse City, Michigan



Surgical Quality – A Nursing Responsibility

1972

Detroit General Hospital Surgical Quality – A Physician Responsibility



The **chief resident** rotating on emergency surgery worked a night shift and was required to document all cases performed in the daily logbook.

An excerpt from the logbook records the cases performed on March 10, 1972.

- Gunshot wound to the neck with holes in the esophagus and thyroid cartilage
- Gunshot wound to the left femoral artery
- Perforated duodenal ulcer treated with a vagotomy and pyloroplasty
- Gunshot wound to the shoulder involving the veins and nerve

The staff that evening was Dr. J. C. Rosenberg, and he was in the hospital and available if needed.

1972

Surgical Quality – A Physician Responsibility



The **chief resident** would also document in the logbook any problems. This included such items as:

- Suction in OR not working
- Pharmacy out of KCl times two days
- Bed check at 8 p.m. found five beds not on the admitting list
- There was no psych resident and ER filled with psych patients including the Governor's son on drugs
- A third-year medical student on Medicine exhibited psychotic behavior. The surgery residents restrained, sedated and transferred him to the Detroit Psychiatric Institute.

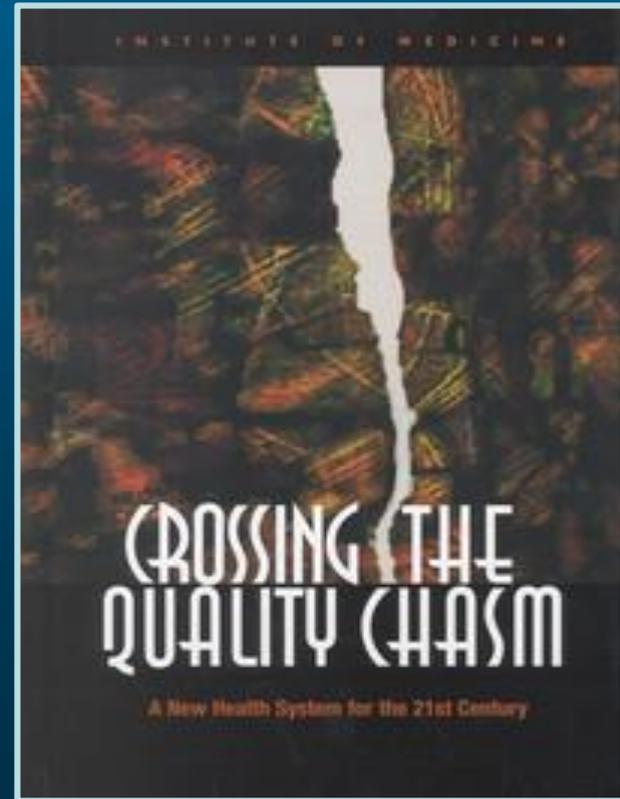
Presidential Address – American Surgical Association
Ledgerwood. What happened to surgical leadership?
Ann of Surg. 262 (3) Sept 2015.

Surgeon as the
“Captain of the Ship”

Physician is responsible for
patient outcomes and quality

National Academy of Sciences
Institute of Medicine

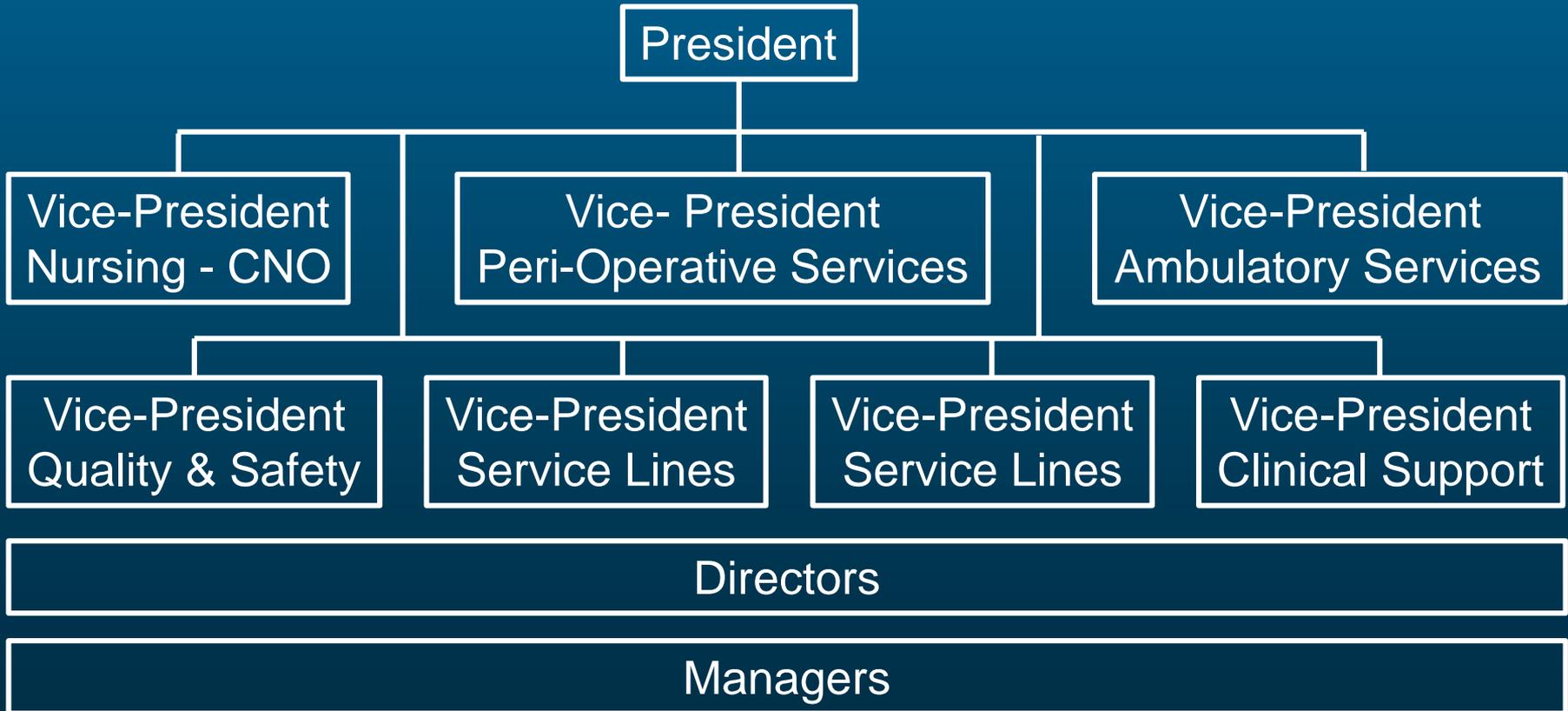
Non-Physician stakeholders
define, measure, report
Healthcare Quality



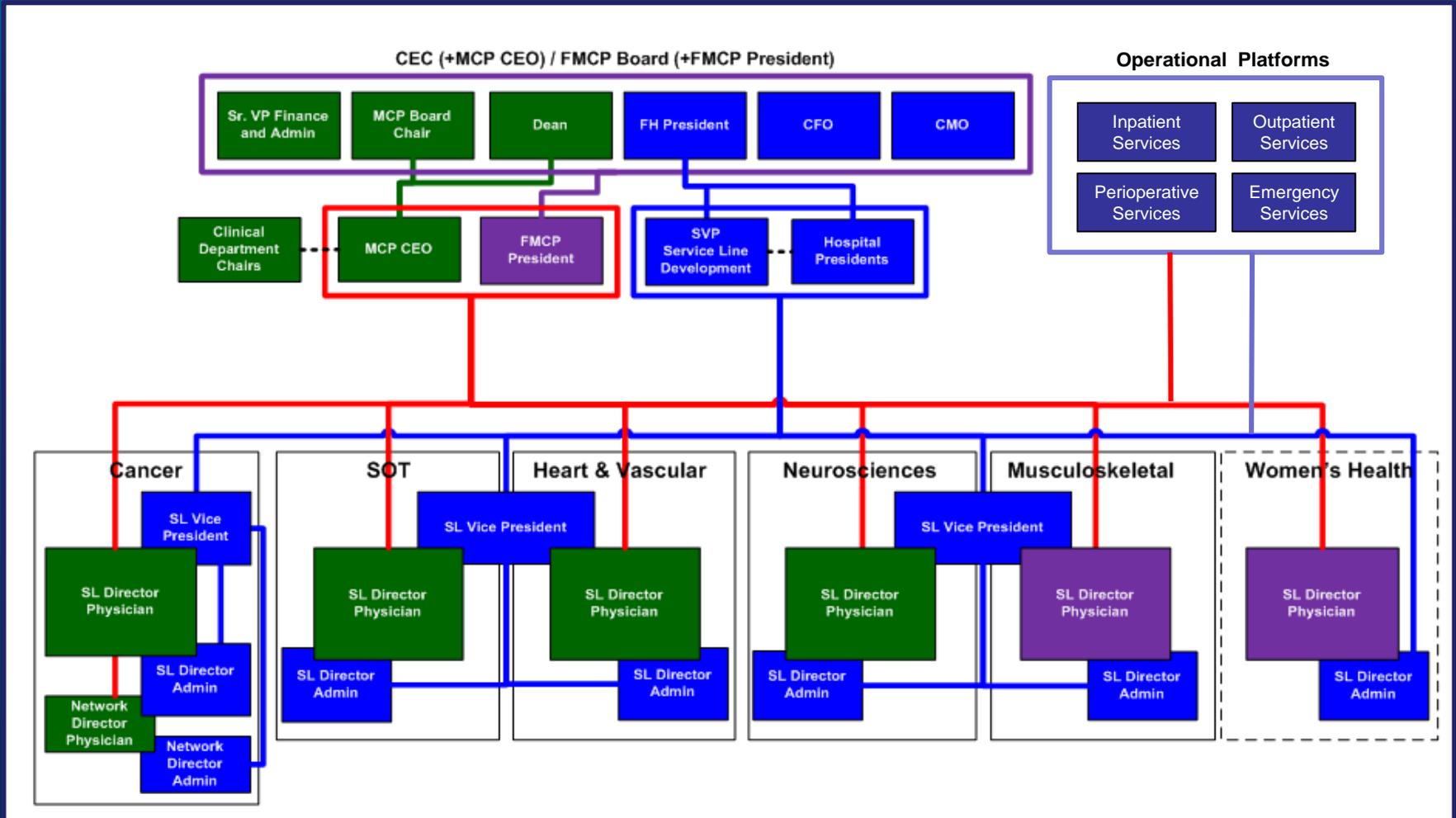


2016

Froedtert Health Froedtert Hospital



Surgical Quality – A Matrixed Responsibility



Operational Excellence



Pillars:

- Knowledge
- Expertise
- Analytics
- Informatics

Foundation: Operational Leadership

A Champion:

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Establishes Vision

Mission of Froedtert Surgical Services

We are committed to the highest standards of excellence to bring the value proposition to our patients:

Outstanding quality in patient care and safety, with reduced cost.



Core Values

Patient Centered Care

Thoughtful planning for every patient will be conducted so their experience and safety is optimized, including uncompromised care, pain management, protection of privacy, emotional support and alleviation of anxiety , empathy , technical excellence, and adherence to quality initiatives.

Excellence

We will strive to provide outcomes that meet or exceed national benchmarks with a continual commitment to quality improvement.

Respect

We will create and maintain an environment of care, where communication is highly valued; individual initiative is appreciated; resources are conserved; programs are created and administered with contributions and critiques welcomed from all participants; and all members of the patient care team are mutually respected and valued.

Safety

Because human life is fragile, we will create and maintain a workplace and systems of care to maximize the safety of our patients and health care workers. We will maintain a proactive reporting system for process improvement that encourages caregivers to provide information that will enhance our working environment.

Compassion

We will maintain the highest level of empathy for our patients, their families and loved ones. We will extend an equal level of concern to our colleagues and those with whom we collaborate to deliver patient care.

Stewardship

We will optimize use of resources and increase the value (quality/cost) of the care we provide.

Mission of Mortenson Construction

We are inspired by a compelling purpose:
Building structures and facilities for the
advancement of modern society.®

Our purpose is fulfilled through our Mission:
To create an exceptional customer
experience.



Mortenson Values

Trust

We place trust at the center of every relationship—with customers, subcontractors, suppliers, architects, engineers and fellow team members.

Teamwork

People are our greatest strength. Mortenson people work with customers and business partners in a spirit of collaboration and trust to tackle the challenges of construction.

Responsibility

We are responsible to team members, customers, subcontractors, suppliers, architects, engineers and the communities in which we live and work.

Safety

We are committed to eliminating all worker injury. Every Mortenson team member and every customer, subcontractor, supplier, architect and engineer can expect that our work sites place their personal safety as our highest priority.

Service

We embrace a customer service culture. We believe our future is secured by advancing the interests and success of our customers.

Stewardship

We will perpetuate our business for future generations and support the communities in which we live and work

Froedtert Values

Mortenson Values

Compassion	Trust
Patient Centered Care	Teamwork
Respect	Responsibility
Safety	Safety
Excellence	Service
Stewardship	Stewardship

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Engages Support

Management by Walking Around (MBWA)

Popularized by Bill Hewlett and David Packard
Considered applicable to hospitals



- Stopping by to talk with people face-to-face
- Get a sense of how they think things are going
- Listen to whatever may be on their minds

Tucker, A.L. and Singer, S.J., 2015. The Effectiveness of Management-By-Walking-Around: A Randomized Field Study. *Production and Operations Management*, 24(2), pp.253-271.

Management by Walking Around (MBWA)

- 1. Make MBWA part of your routine.**
 - Most effective if you don't do it on any fixed schedule.
 - Do plan for MBWA on your own calendar
- 2. Don't bring an entourage.**
 - MBWA works best as a continual stream of one-on-one conversations with individual employees.
- 3. Visit everybody.**
 - Try to spend roughly the same amount of time – over the long run – with each person involved in the unit.

4. **Ask for suggestions, and recognize good ideas.**
 - Ask each employee for thoughts about how to improve processes or service.
 - Track suggestions to recognize contributors.

5. **Follow up with answers.**
 - Return with an answer.
 - Besides being common courtesy, it builds trust.

6. **Don't criticize.**
 - You're on a fact-finding mission.
 - The secondary purpose is building rapport.
 - Don't attempt to solve problems on the spot.

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Asks Questions

What are the most useful questions?

Responsible

- The person who actually carries out the process or task assignment
- Responsible to get the job done

Accountable

- The person who is ultimately accountable for process or task being completed appropriately
- Responsible person(s) are accountable to this person

Consulted

- People who are not directly involved with carrying out the task, but who are consulted
- May be stakeholder or subject matter expert

Informed

- Those who receive output from the process or task, or who have a need to stay informed

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Makes Decisions

Making decisions requires a structured approach.



A Decision Diagnostic

Review a meaningful decision you've made.

Ask yourself the following questions:

1. Was the decision correct?
2. Was the decision based on appropriate facts?
3. Was it made with appropriate speed?
4. Was it communicated and executed well?
5. Were the right people involved, in the right way?
6. To the extent that there were divergent facts or opinions, was it clear how the decision was made?

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Introduces Skepticism

Clinical Review & Education

From The JAMA Network

Does Rigorous Quality Process Reporting Guarantee Superior-Quality Health Care?

Gary R. Seabrook, MD

JAMA SURGERY

Timing of Surgical Antibiotic Prophylaxis and the Risk of Surgical Site Infection

Mary T. Hawn, MD, MPH; Joshua S. Richman, MD, PhD; Catherine C. Vick, MS; Rhiannon J. Delehol, MPH; Laura A. Graham, MPH; William G. Henderson, MPH, PhD; Kamal M. F. Itani, MD

IMPORTANCE Timing of prophylactic antibiotic administration for surgical procedures is a nationally mandated and publicly reported quality metric sponsored by the Centers for Medicare and Medicaid Services Surgical Care Improvement Project. Numerous studies have failed to demonstrate that adherence to the Surgical Care Improvement Project prophylactic antibiotic timing administration measure is associated with decreased surgical site infection (SSI).

OBJECTIVE To determine whether prophylactic antibiotic timing is associated with SSI occurrence.

DESIGN Retrospective cohort study using national Veterans Affairs patient-level data on prophylactic antibiotic timing for orthopedic, colorectal, vascular, and gynecologic procedures from 2005 through 2009.

SETTING National Veterans Affairs Surgical Care Improvement Project data from 112 Veterans Affairs hospitals and matched Veterans Affairs Surgical Quality Improvement Program data.

PATIENTS Patients undergoing hip or knee arthroplasty, colorectal surgical procedures, arterial vascular surgical procedures, and hysterectomy.

INTERVENTION Timing of prophylactic antibiotic administration with respect to surgical incision time.

MAIN OUTCOMES AND MEASURES Data for prophylactic antibiotic agent, prophylactic antibiotic timing with respect to

surgical incision, and patient and procedure risk variables were assessed for their relationship with the occurrence of a composite superficial or deep incisional SSI within 30 days after the procedure. Nonlinear generalized additive models were used to examine the association between antibiotic timing and SSI.

RESULTS Of the 32 459 operations, prophylactic antibiotics were administered at a median of 28 minutes (interquartile range, 17-39 minutes) prior to surgical incision, and 1497 cases (4.6%) developed an SSI. Compared with procedures with antibiotic administration within 60 minutes prior to incision, higher SSI rates were observed for timing more than 60 minutes prior to incision (unadjusted odds ratio [OR] = 1.34; 95% CI, 1.08-1.66) but not after incision (unadjusted OR = 1.26; 95% CI, 0.92-1.72). In unadjusted generalized additive models, we observed a significant nonlinear relationship between prophylactic antibiotic timing and SSI when considering timing as a continuous variable ($P < .01$). In generalized additive models adjusted for patient, procedure, and antibiotic variables, no significant association between prophylactic antibiotic timing and SSI was observed. Vancomycin hydrochloride was associated with higher SSI occurrence for orthopedic procedures (adjusted OR = 1.75; 95% CI, 1.16-2.65). Cefazolin sodium and quinolone in combination with an anaerobic agent were associated with fewer SSI events (cefazolin: adjusted OR = 0.49; 95% CI, 0.34-0.71; quinolone: adjusted OR = 0.55; 95% CI, 0.35-0.87) for colorectal procedures.

CONCLUSIONS AND RELEVANCE The SSI risk varies by patient and procedure factors as well as antibiotic properties but is not significantly associated with prophylactic antibiotic timing. While adherence to the timely prophylactic antibiotic measure is not bad care, there is little evidence to suggest that it is better care.

JAMA Surg. 2013; doi:10.1001/jamasurg.2013.134.

In a recent article in *JAMA Surgery*, Hawn and colleagues¹ report a focused and statistically powerful assessment of outcomes related to measures in the Surgical Care Improvement Project (SCIP). The retrospective cohort study evaluated patient-level data on prophylactic antibiotic administration timing for 32 459 orthopedic, colorectal, vascular, and gynecologic procedures over 5 years and identified 1497 (4.6%) surgical site infections (SSIs). With unadjusted generalized additive models, a significant nonlinear relationship between prophylactic antibiotic

administration timing and SSI was observed; however, when the generalized additive models were adjusted for the patient, procedure, and antibiotic variables, no significant association between timing of antibiotic administration and SSI was demonstrated. In an evaluation of the relative contributions of model covariates (including operation duration, age, diabetes, wound class, dyspnea, American Society of Anesthesiologists class, and chronic obstructive pulmonary disease), prophylactic antibiotic administration timing ranked 15th of 16 variables studied.

The article is timely because the Centers for Medicare & Medicaid Services implemented the Value-Based Purchasing (VBP) program to measure the quality of hospital care and to reward hospitals with better quality scores by redistributing Medicare payments so that higher-performing hospitals receive a greater proportion of the payment compared with lower-performing hospitals.² Timing of prophylactic antibiotic administration for surgical procedures is one of 12 quality measures composing the Clinical Process of Care Domain that accounts for 45% of the VBP assessment.

The SCIP quality measures set a high bar for a hospital to be judged compliant for the timing of prophylactic antibiotic delivery within 1 hour of the surgical incision—the interval identified to provide optimal antibiotic tissue levels. For the 2013 assessment, the expected achievement threshold (set by the hospital's highest level of performance during baseline data collection) for preoperative prophylactic antibiotic administration timing is 98.07%, working toward a perfect benchmark (the mean of the top decile of overall hospital scores) of 100%.³ For a hospital's monthly audit, 1 noncompliant case may drop the quality measure score from a metric at or above the benchmark to one below the achievement threshold. The VBP standards are attractive to hospital and physician leaders because they have become a surrogate marker for organizational excellence.⁴ Patients are encouraged when a measurable standard can be reported, demonstrating a health system's commitment to provide optimal surgical care for every patient every time.⁵

The SCIP measures directed at SSI prevention include delivering prophylactic antibiotics within 1 hour of the surgical incision, selecting antibiotics according to strict guidelines, discontinuing prophylactic antibiotics within 24 hours, controlling serum glucose levels at 6 mm the day after cardiac surgery, and removing urinary catheters on the first or second postoperative day. When a battery of infection control standards is assembled and endorsed by a dominant payer with hospital reimbursement at risk, other effective strategies for controlling SSIs may be set aside, overlooked, or deemed inferior. Currently, hospitals receive no quality credits or financial rewards for embracing other evidence-based strategies to reduce SSIs, including preadmission antimicrobial skin cleansing, perioperative skin antisepsis using chlorhexidine gluconate with 70% alcohol, use of antibiotic-coated sutures, or weight-based antibiotic dosing.⁶⁻⁹

In a highly reliable organization, standardization and checklists have proven to increase quality. However, the variation in human physiology, the spectrum of disease severity, and the unpredictability of a patient's response to interventions may affect certain outcomes. The promulgation of SCIP scores into metrics for the VBP redistribution of hospital reimbursement creates the potential for unintended strategies to meet a benchmark. Hospital managers, to avoid a citation attributed to their unit that could result in substantial financial losses for the institution, might dispatch observers into the clinical arena to confirm documentation of antibiotic administration, monitor midnight serum glucose levels, and check for the presence of urinary catheters.

Institutions might commit excess resources to monitoring and documenting standards that are not always achievable for human care—even when best practices are achieved. When adherence to guidelines cannot be associated with an improved outcome, such as a decreased rate of SSI, the credibility of the initiative comes into question. In a presentation to the American Surgical Association, which demonstrated that adherence to 5 SCIP measures did not reduce the rate of SSI, Hawn et al¹⁰ concluded, "Mandatory SCIP reporting and linkage to performance pay without proven improvement in care may lead to increased skepticism and result in physician fatigue with quality improvement endeavors."

Physicians and hospital leaders, faced with the risk of financial penalties, are seemingly intent on complying with SCIP measures, despite the absence of evidence that quality is improved by most of these guidelines.¹ Leaders involved with setting standards for health care quality should focus attention on strategies that will achieve the desired clinical outcome. Caution must be exercised in linking reimbursement to focused performance scoring, realizing that excessive attention will be applied to standards subject to financial review. Health care resources will be devoted to rigid audit and documentation strategies to avoid negative shifts in reimbursement at the expense of funding other proven quality initiatives that are not associated with a financial penalty. As clinicians and health care systems strive to deliver the most reliable and safest medical care, they also must be accountable for improved health-related outcomes and be mindful that compliance with rigorous process standards reporting does not guarantee superior-quality health care.

ARTICLE INFORMATION

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Conflict of Interest Disclosures: The author has completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

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From The JAMA Network Clinical Review & Education

A Champion:

- Establishes vision
- Engages support
- Asks questions
- Provides reason
- Introduces skepticism
- **Avoids foolishness**
- Runs interference
- Encourages the troops
- Celebrates success

Avoids Foolishness

Parachute use to prevent death and major trauma related to gravitational challenge: Absence of randomised controlled trials

- As with many interventions intended to prevent ill health, the effectiveness of parachutes has not been subjected to rigorous evaluation by using randomised controlled trials.
- Advocates of evidence based medicine have criticised the adoption of interventions evaluated by using only observational data.
- We think that everyone might benefit if the most radical protagonists of evidence based medicine organised and participated in a double blind, randomised, placebo controlled, crossover trial of the parachute.



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Runs Interference

JAMA Surgery

Letters

RESEARCH LETTER

Investigating Teamwork in the Operating Room: Engaging Stakeholders and Setting the Agenda

The operating room (OR) offers a unique opportunity to explore concepts of teams and teamwork. Communication and teamwork contribute to adverse events.^{1,2} Attempts at intervention, such as crew resource management, have had mixed results.³ While survey-based studies have shown discipline-specific differences in perceived teamwork in the operative setting,⁴ we have unique aspects of operative teamwork contribute to these predictions. Studies are insufficient in and behaviors of operative evaluations of surgical care has been minimal. Investigating topics of operative team identity, team member unfamiliarity, engaging stakeholders and critical to setting an agenda design and implementation team training interventions.

Methods | This qualitative study of a quality-improvement program informed consent. We have from 3 disciplines: anesthesiologist assistants and certified registered (including surgical technique) of 23 participants. Both residents participated. Based on the need of hand-offs and communication and safety, we explored topic management of team member hand-offs using a semi-structured questions (Table 1).

Sessions were audio-recorded. A multidisciplinary team independently reviewed qualitative content analysis, and one author (L.L.F.) applied new codes as appropriate.

Results | The 3 disciplines described "team identity" (Table 2). We identified other nurses and anesthesia professionals identified the provision of anesthetic care. Session of the team, including all participants involved in the patient care and working "behind the

jamasurgery.com

Table 1. Proposed Topics and Guiding Questions for Focus Groups

Topic and Goals	Guiding Questions and Prompts
Team	
Explore participants' perceptions about team identity and purpose	Who's on your team? What's the purpose of a team?
Team unfamiliarity	What happens if you begin your day and realize that you'll be working with an unfamiliar team or team member?
Explore the effect of unfamiliar team member(s) at the beginning of the day	What happens when the team composition

RESEARCH LETTER

Investigating Teamwork in the Operating Room: Engaging Stakeholders and Setting the Agenda

The topic of “setting the tone” was not one that we originally set out to explore but arose during data analysis. Clinicians indicated that events in the preoperative phase of the case set the tone of the room for the rest of the case or even the rest of the day. Clinicians remarked that surgeons were key facilitators in setting the tone, as good communication led to an improved OR atmosphere. Conversely, early miscommunication or delays resulted in tension.

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Encourages the Troops

Meaningfulness of Work

Coaching ...

Praise, recognition, and acknowledgement matters a great deal.



But also consider ...

that work is important when the results:

- are important to others.
- have an emotional consequence.
- are focused at an event.
- are examined in perspective.
- are the result of a unique experience.

Transcendence

Poignant

Episodic

Reflective

Personal

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Celebrates Success

THE ROLE OF THE SURGICAL CHAMPION



CASE STUDY

Your hospital identifies an increased incidence of surgical site infections for patients receiving total hip arthroplasty.

The infection prevention team is charged to investigate and create an action plan for process improvement.

Senior Leaders
Champion

Project Sponsor
Team Leader

Quality Improvement Staff

Content Experts

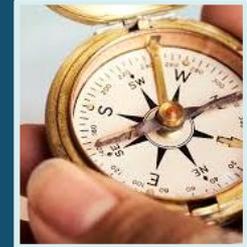
Process Experts

Stakeholders

What is the role of the Surgical Champion for this initiative?

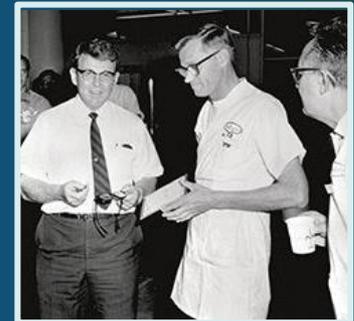
Establishes Vision

Because human life is fragile...
Provide clinical perspective on the implications of the pattern of infection.



Engages Support

Visit the clinic, day surgery, operating room, PACU, nursing unit, sterile processing department.
Initiate conversation with nurses, support staff, surgeons, pharmacy, EVS, managers, vendors.
Create project awareness outside of scheduled meetings.



Asks Questions

Instructions about pre-op shower?
Surgical skin prep?
Implant management / IUSS?
Peri-op antibiotics / timing?
Sequence of the operation?
Post-op wound care?

Responsible	<ul style="list-style-type: none">• The person who actually carries out the process or task as assigned.• Responsible to get the job done.
Accountable	<ul style="list-style-type: none">• The person who is ultimately accountable for process or task being completed appropriately.• Responsible person(s) are accountable to this person.
Consulted	<ul style="list-style-type: none">• People who are not directly involved with carrying out the task, but who are consulted.• May be stakeholder or subject matter expert.
Informed	<ul style="list-style-type: none">• Those who receive output from the process or task, or who have a need to stay informed.

Makes Decisions

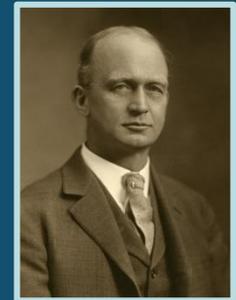
Establish **standard** pre-op teaching.
Add rigor to **protocol** for antibiotics.
Introduce **policy** for dressing changes.



Introduces Skepticism

Suggest unlikely infection sources and vectors.

If **not** lapses in skin prep or surgical technique, **why not?** What else?



Avoids Foolishness

Nix idea to culture every surgical wound every day.

Balance against: *Introduces Skepticism.*



