Surgical Administrative Committee Vision for 2018

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Brief Introduction

"… an amiable servant with some minor personality flaws and a wicked sense of humor."

Role of the SAC

(per Medical Staff Bylaws):

- Coordination of procedures/affairs in Operating Rooms
- Review/approve specialized and new OR equipment
- Review/approve privileges to use equipment
- Coordinate emergency surgical services for Clinical Center
- Coordinate surgical consultative services for ICs without surgeons
- Review justification for surgical procedures
- Review interactions of OR with Lab of Pathology
- Review quality of Pathology services

What is the *real* reason for SAC?

It's about the patient !

In our various capacities, we are here
to ensure the delivery of high-quality surgical care to
patients enrolled in clinical research protocols
at the NIH Clinical Center.

Vision for 2018

Succinctly define the SAC's mission, and

Re-dedicate the SAC as the primary NIH body responsible for:

1. Surgical (Peri-Operative) Quality

2. Efficiency & Utilization

3. Contingency Planning

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- *Critical review of adverse events, near-misses, etc.*
- *Assessment of competency, maintenance of skills (anesthesia & surgery)*
- *Outcomes & peer review processes to support professional development & organizational advancement*

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2. Efficiency & Utilization

- *Improvement of patient-flow, perioperative performance & productivity*
- *Assessment of equipment requests, needs, and actual usage*
- *Standardization of supplies, instrument sets and other equipment*

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3. **Contingency Planning**
   - *Plans for specialized personnel and procedures*
   - *Assessment of case practicality (i.e., what can/should be done at NIH CC)*

How will we do this?

- Re-commitment by SAC members to serve the *patients* of NIH Clinical Center through our work

- Establish "Working Groups" to achieve goals
  - Surgical Quality
  - Efficiency & Utilization
  - Contingency Planning

Renewed Focus

Since January 2018…

- Rounding out of SAC membership with additions:
  - Nurse anesthetist, Physician Assistant (OPSCQ), Surgical Oncology Fellow
- Formation of SAC “working groups”
  - Completed first meetings
  - Identified priorities
- “It’s about the patient” campaign
  - Intended to engage and empower staff
  - Emphasis on teamwork

"Quality" Working Group

Surgical Quality – initial observations

1. Assessment of surgical quality requires precise outcomes data

2. Data capture is inefficient and/or fragmented across CC
   - Individual departments/ICs responsible for collection
   - Data not standardized or readily accessible

3. Current outcomes data reliable, but not comprehensive for the purpose of advancing surgical quality

"Quality" Working Group

Surgical Quality – preliminary corrective actions

1. Regular review of adverse events by peer group able to provide immediate feedback

2. Quarterly review of events with focus on systemic issues
   - Most recent example: Unplanned / After-hours Admissions to CC

3. Explore feasibility of a centralized, standardized documentation system for peri-operative outcomes

Summary

What do we need to succeed?

- Buy-in from stakeholders
  - Surgeons, Anesthesiologists, Nurses, Techs, Transporters, etc.

- Trust the power of data
  - Commitment not only to capture, but to share with the intent to continually improve the quality of patient care

SAC Members

Naris Nilubol
Henry Wiley
Joe Fontana
Theo Heller
Brad Wood
Piyush Agarwal
Theresa Jerussi
David Lang
Armando Filie
Drew Mannes
Rick Sherry
Melissa Merideth
Clint Allen
Prashant Chittiboina
Susan Marcotte
Colleen Hadigan
Kevin Driscoll
Samantha Ruff
Anthony Suffredini
Jeremy Davis

Thank you