The Power of Observation and How It Improves SP Operations

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1. Describe what observation by Sterile Processing leaders means for the department and how observing differs from watching
2. List the primary benefits of observation in the Sterile Processing department
3. Learn effective observation skills

The most powerful tool Sterile Processing (SP) leaders can use to improve departmental operations is observation. This may sound like a bold statement for such a seemingly simple concept but years of experience and practice have underscored its benefits. Observing Sterile Processing department (SPD) operations helps identify standard variances, process waste, and opportunities for performance and process improvement. SP leaders who engage in effective observation coach employees in real time to support good practices, while identifying struggling and high-performing staff members. Like other leadership skills, observational skills require focused attention and practice to gain the most benefits.

Objective 1: Describe what observation by Sterile Processing leaders means for the department and how observing differs from watching

Observation in the workplace is not merely the act of watching people work. Watching is a passive action where an individual looks at work being performed for a specific duration. The watcher may later remember what they saw but does not actively analyze the environment or situation. A manager who watches the decontamination area, for example, will likely see technicians receiving case carts, scanning instrument trays, manually cleaning instruments, and loading washers but will only be able to perform a minimal analysis of what they saw. Leaders focused on throughput may count the number of case carts waiting, calculate the time remaining on washer cycles and consider scheduling upcoming breaks. Still, watchers do not ask about the why behind the situation, which limits their effectiveness.

Conversely, leaders who fully observe—not just watch—the department gather much more actionable information. Oxford Languages defines observation as "the action or process of observing something or someone carefully or in order to gain information." Observation goes beyond watching by adding an essential critical-thinking component. Observers leave all assumptions behind,

questioning every aspect of the process they are observing to gain a deeper understanding. Leaders who observe should ask: Why here and now? Why this way? Why by this person? Why this duration? Watchers and observers may interact with the same scene but have significantly different outcomes, as the following example demonstrates.

The scene: Three case carts with instrument sets wait to undergo the cleaning process. One technician is cleaning quick-turn devices in the handwash sink, while a second technician is cleaning instruments in the cleaning sink. The technician at the cleaning sink rinses the cleaned devices and places them on a rack for the washer-disinfector. He drains, rinses and refills the cleaning sink. Then, he retrieves the next instrument set from the case cart and places it in the freshly filled cleaning sink.

Watcher outcomes: The SP supervisor enters the decontamination space. Upon seeing the three case carts, she approaches the technician at the cleaning sink to confirm that he will be able to complete the device cleaning before staff lunch breaks begin. The technician has work to do but indicates he should be able to finish it in that timeframe. After verbal confirmation, the supervisor feels confident and moves on. She proceeds to the handwash sink and verbally reprimands the technician for cleaning devices in that sink. The second technician stops and moves the instruments to the manual sink area.

The supervisor continues to watch the decontamination area for a few more minutes; during this time, she sees the first technician finish cleaning a set of instruments and then drain, rinse and refill the sink with fresh cleaning solution for the next tray. The supervisor's primary concern was to support the area to ensure that the work was completed on time. She does not pay close attention to the work performed. She discovered a breach in policy and corrected it but did not take the time to ask why the breach occurred. Without analyzing the why, the supervisor did not resolve the underlying problem.

Observer outcomes: The SP supervisor enters the decontamination area. Upon seeing the three case carts, she approaches the technician at the cleaning sink. The supervisor asks why the case carts have not been started, examines the case cart contents, and observes that the technician is having difficulty cleaning the instruments. During this observation and discussion, the supervisor finds that:

- All three case carts arrived at the same time (45 minutes into the shift).
- Point-of-use treatment was not completed in the procedure room.
- The technician incorrectly cleaned some specialty instruments.
- Five trays were processed and placed in the automated washer.
- No "hand-wash only" instruments were cleaned.

The supervisor proceeds to the handwash sink and verbally reprimands the technician for cleaning devices in that sink. The supervisor then asks why the technician is using that sink and discovers that the:

- Backlog of case carts meant that work was held up at the cleaning sink.
- Technician at the sink did not know how to clean the instruments.
- Instruments are needed immediately for another case.

The supervisor continues observing the decontamination area for a few more minutes. The first technician finishes cleaning an instrument set and then drains, rinses and refills the sink with fresh cleaning solution for the next tray. While observing, the supervisor finds that:

- The technician did an excellent job of flushing and brushing cannulated instruments.
- The posted information for filling the sink was outdated and incorrect.
- Soaking requirements were not standardized or documented.
- No devices were processed in the ultrasonic cleaner.

In this example, observation provided a deep analysis with actionable findings; watching did not. Observation typically leads to more questions. In the previous example, the leader could ask: Why did the case carts simultaneously arrive 45 minutes into the shift? How did the posted information become outdated? What does technician education address and how can technician competency be ensured? Is having five trays completed in one hour an acceptable rate of productivity?

Objective 2: List the primary benefits of observation in the Sterile Processing department

Observing is an effective way for SP leaders to become more involved in and aware of the details of their departmental operations. Allocating time for supervisors and managers to perform observations leads to performance improvement. Instead of only "getting work done," the focus can be "performing the work better." The following are some of the key benefits of observation in the SPD.

Operational improvements: Skilled observation reviews all steps in a process and uncovers unrealized opportunities for improvement. Leaders can confirm how long each step takes, identify education and training needs, and create a list of best practices to

incorporate. Process redundancies, staffing shortfalls, operational waste, and less-than-optimal equipment performance are a few areas that can be addressed. Workflow changes based on observational data lead to improved operational efficiencies.

Error rate reduction: Observation allows supervisors and managers to compare what is happening in the SPD to departmental procedures and policies. Discrepancies between what is occurring and what should be occurring can then be corrected.

Improved employee performance: Observation quickly shows variances to standard work, allowing supervisors to correct technician errors in real time. This improves compliance with standard work and clinical and regulatory requirements.

An engaged team: Through observation, SP leaders and technicians interact and work together, creating an engaging and collaborative environment. The more supervisors and managers improve the employee work environment, the more likely it is that they will see an increase in staff satisfaction and retention.

Objective 3: Learn effective observation skills

As with anything new, the first time a leader observes work may feel awkward. Observation takes practice. It is best to start simply and build upon departmental knowledge. Dedicated observational time can deliver operational benefits to the SPD.

SP leaders should block out time once or twice a week for this important function and select an area of the department to observe. Observing a specific task—such as manual cleaning, set assembly, or case cart picking—can be a good place to start. Area-based observations, such as in the decontamination area, can be overwhelming when just beginning but will become easier as the leader's observational skills and departmental knowledge grow.

To begin performing observations, consider these six steps:

1. Have a purpose. Pick one area and one or two things to watch within that area. Consider decontamination and variances in standard work for manual cleaning.
2. Be transparent with the SP team. Explain the process, what will be observed, and why this will help individual technicians and the department. Allow team members to provide input about how things can be improved and what they need to be more successful. Employees may be nervous or hesitant about being observed initially but, in time, should realize that observations are a beneficial tool for all.
3. Stay focused. Don't start conversations, get distracted, answer the phone, or stray from the observation and its goal.
4. Ask clarifying questions. Be sure to record facts and data, not assumptions.
5. Take notes. This focuses the observer and creates data points for further analysis. Using a prewritten checklist or worksheet is helpful and will standardize the observations between technicians and shifts.
6. Act on the data. Observing staff without taking action is not helpful. Leaders should be ready to begin process improvement efforts based on their observations.

It is worth emphasizing that taking notes and asking clarifying questions are critical to successful observations. Leaders should document everything: the sequence of events or tasks; what work was completed; who did the work; and where and when the work was done. Leaders should then consider asking:

- Why do technicians follow this sequence?
- Do they have the tools needed to be successful?
- Do they have to move or walk to accomplish a task that could have been done at their station?
- Is motion, time, supplies or energy wasted when performing the task? If so, where and when?
- Do the task and workflow follow standards and best practices?
- Where are the standards and work procedures, and do staff have access to them?
- What could make the task easier, more efficient or better?

In some cases, leaders may discover that standard work does not exist—but they needn't worry if operational issues or unknown practices are discovered. The point of observation is to improve beyond where the department is currently. This is called continuous improvement thinking. It is also important to allocate adequate time to ensure the activity is repeatedly performed safely, consistently and effectively and to help identify variances between staff members and across shifts. Watching a technician clean and prepare one instrument tray in decontamination is not a formal observation but rather a spot check on that one tray. Formal observations watch the activity or process for multiple iterations, case carts or trays to monitor technician performance and understand all possible outcomes.

Advanced observation skills allow a task to be performed from different viewpoints, including from that of the patient or surgeon. Observing through the eyes of the patient or surgeon enables

the SP leader to focus on how a product progresses through the process, not on departmental efficiencies and workflow. This can help leaders identify how long a product had to wait to be managed and how the department responds to shifting surgical or patient needs.

Another viewpoint to consider is that of the instrument itself. This may seem strange but looking at the process from the viewpoint of an instrument tray can help leaders and technicians better understand opportunities for improvement. Questions to explore include: How long are instruments exposed to residual soils? Do instruments receive proper point-of-use treatment? How long does it take to transport devices to the decontamination area? Are the proper cleaning chemistries being used on the instruments? Are instrument sets receiving too much exposure to sterilants? How often is an instrument repaired or sharpened?

Yet another viewpoint a leader can consider is that of an accreditation auditor. Observing through the lens of an auditor helps determine whether the process follows documented standard work, instructions for use (IFU), internal policies and procedures, and regulatory requirements.

It is also beneficial for SP leaders to pursue continued knowledge growth and understanding by visiting other departments in the hospital and asking how they manage their work. Often, the insight gained can be adapted to the SPD. Even better, leaders can visit other SPDs to learn from their peers at other facilities. Performing a joint observation with these departments can lead to operational improvements in both organizations.

Conclusion

The power of observation is limitless. By taking the time to stop and formally observe SP operations one area at a time, multiple opportunities for improvement can be identified. Leaders performing the observations will become more knowledgeable of their own operations, allowing them to make process and practice improvements that will benefit the SP team, its customers and the facility. P