University of Colorado – Northern Region

Business Rules - Perioperative Services and Medical Staff

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Last Updated Date:	April 13, 2015
Originating Department:	UCHealth North, Perioperative Services

TITLE: Operating Room Procedures and Protocol for Medical Staff

PURPOSE: To establish procedures and protocol for Perioperative Services to improve patient care and room utilization.

POLICY: It is the policy of UCHealth North which includes Poudre Valley Hospital (PVH), Medical Center of the Rockies (MCR) including MCR Surgery South (MCRSS) and Greeley Ambulatory Surgery Center (GSC), to assure reasonable and timely surgery capacity where emergencies receive the highest priority. It is the goal of the Perioperative Services department to provide optimal surgical care as well as physician and staff satisfaction, by incorporating a system for the efficient use of personnel, time, and equipment resources.

Procedures:

1. Start time (time posted on master schedule) is the time the patient is to be in the OR and the initiation of anesthesia induction. All key personnel are required to be present at this time. Nursing personnel are completing room set up, anesthesia personnel are starting induction, and the surgeon is physically on the premises and must be immediately available to start the operative procedure.
2. For pediatric cases (12 years and under), the surgeon and anesthesia provider must be present prior to transporting the patient to the OR.
3. The primary surgeon and anesthesiologist are responsible for the pre-operative, intra-operative, and post-operative care.
4. Turnover time is measured from patient exit to the next patient entrance.

A. Hours of Operation, by location:

Greeley Ambulatory Surgery Center Hours of Operation:

The GSC has two procedure rooms, one of which is used as a GI procedure room. Evaluation of opening the second room as a GI room will occur by Periop administration, as volume continues to increase.

GI procedures may be scheduled Monday through Friday beginning at 0700 and will be scheduled consecutively whenever possible. Patients must be in the PACU by 1600. Additionally, a minimum of four cases must be booked consecutively in order to warrant

opening a room at any time. If this is not met, surgery scheduling will work to either move the case to MCR or to reschedule on a day with additional volume at GSC.

Medical Center of the Rockies Hours of Operation:

MCR schedules 7 of 8 rooms, Monday through Friday beginning at 0700. Seven rooms are staffed appropriately to run until 1500. 5 ORs are staffed until 1700, 3 ORs are staff until 1900, 2 ORs until 2300, and one room for overnight. The eighth room is held for trauma cases unless there is an overflow from the other ORs, then the trauma surgeon may be called to release the eighth room, if appropriate. In addition to the eighth room being held for Trauma, a two hour orthopedic trauma block does exist from 0700 to 0900, and will be assigned on a first come, first serve basis, and per section E guidelines.

On Saturdays, MCR runs 1 to 2 elective rooms based on volume from 0700 until 1500. On-call staff are available for cardiac and trauma emergency coverage 24/7 so that cardiac and trauma cases can be run in addition to the elective rooms.

MCR GI Lab Hours of Operation:

MCR GI Lab schedules outpatient elective procedures in one room Monday through Friday 0700-1600. The second procedure room will be available for urgent/emergent procedures.

On-call staff are available for emergency coverage after hours on week days and on weekends 24/7 with a 30 minute response time.

Activation of the On-Call team is initiated by the on call GI physician.

MCR Surgery South Hours of Operation:

Surgery South has 4 ORs. Cases can be scheduled beginning at 0700 and must be in the PACU by 1700, with an estimated departure from the facility by 1900, Monday through Thursday. On Fridays, cases must be to PACU by 1200 until volume requires additional hours be added. Patients needing additional recovery time are transferred to the MAIN PACU or admitted to an observation room.

Poudre Valley Hospital Hours of Operation:

PVH schedules 10 rooms, Monday through Friday beginning at 0700, staffed appropriately to run until 1500. 5 rooms are staffed until 1700 pm, 4 ORs until 1900, and one room overnight. Trauma cases are run in first-available room. Additionally, a two hour orthopedic trauma block does exist from 1400 to 1600, and will be assigned on a first come, first serve bases, and per section E of these guidelines.

On Saturdays, PVH runs 1 to 2 elective rooms based on volume from 0700 until 1500. On-call staff are available for trauma emergency coverage 24/7 so that trauma cases can be run in addition to the elective rooms.

* Activation of the On-Call team is determined by the On-Call Trauma surgeon

PVH GI Lab Hours of Operation:

PVH GI Lab has three rooms available, Monday through Friday, staffed appropriately to run 0700-1600.

On-call staff are available for emergency coverage after hours on week days and on weekends 24/7 with a 30 minute response time.

Activation of the On-Call team is initiated by the on call GI Physician.

B. Pre-Operative Preparation

For all patients admitted to inpatient or for observation, a medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration. This must be completed prior to surgery or a procedure requiring anesthesia services, provided that an interval admission note is recorded that includes all additions to the history and any changes in the physical findings subsequent to the original report per Med Staff by-laws. Effective July 13, 2013, all pre-op orders are entered in Epic.

C. Case Scheduling

1. Scheduling Process
    a. The scheduling office is open Monday through Friday 0800-1700.
    b. Elective cases for the next day may be scheduled until 1700, provided time is available during hours of operation.
    c. All cases submitted after 1700 prior to the day of surgery, will be considered add-ons for block schedule purposes.
    d. After 1700, the OR Front Desk may accept add-on cases for the next day based on an availability of access and appropriate staffing. Add-on cases will be taken in the order that they are booked. Exceptions will be made for pediatric cases 12 years of age or under, which will take priority.
    e. Emergent and urgent cases will be scheduled according to the protocol, as detailed in Section E below.

    All add-on cases submitted after 1700, will be scheduled no earlier than 0730 the following morning. Cases may be added earlier with Anesthesia and department director approval.
2. Pediatric Cases
    a. PVH: Pediatric patients of all ages and health statuses will be allowed to be scheduled. Trauma peds will continue to be treated and transferred.
    b. MCR and MCRSS: Elective outpatient procedures will be allowed to be scheduled for healthy pediatric patients between 2 and 6 years of age. At MCRSS, an exception could be made for a healthy elective outpatient procedure for a patient between 1 and 2 years of age, with pediatric anesthesia approval. Trauma peds will continue to be treated and transferred. Elective cases for children under the age of 2 shall be scheduled at PVH.
    c. GSC: No pediatric cases will be allowed to be scheduled.

3. MCRSS
    a. Procedures for patients with an ASA between 1 and 3 can be performed at MCRSS.
    b. Patients with an ASA of 4 can be scheduled at MCRSS, providing that the procedure is low-risk (i.e., carpal tunnel, cataract, and injections) and with Anesthesia approval. Pre-admit will call to discuss with Anesthesia and seek approval.
    c. Procedures for patients with a BMI greater than 50 will not be performed at MCRSS.
    d. Procedures for patients with significant sleep apnea history will not be performed at MCRSS.
4. GSC
    a. Procedures for patients with an ASA greater than 3 will not be performed at GSC.
    b. Procedures for patients with a BMI greater than 50 will not be performed at GSC.

D. Elective Cases

1. Cases which can be electively scheduled in the future.
    a. All cases, block and non-block, will have case times assigned at the time the case is scheduled, based on historical data.
    b. A minimum of 20 minutes will be allocated to each case for room turnover time.

E. Urgent and Emergent Cases

1. **Priority Class A Emergencies:**
    a. Life, limb, airway, or organ threatening conditions requiring immediate attention.
    b. Take precedence over any other case.
    c. Performed in the first available operating room (will bump pre-scheduled cases during regular hours).
    d. Requires the on call team during off hours.
2. **Urgent Class B Emergencies:**
    a. Emergencies that are not life threatening but may lead to severe complications if surgery is not performed within 8 hours of classification.
    b. Time posted will be noted on the schedule board. All Class B emergencies that have waited 8 hours will be reclassified as Class A emergencies.
3. **Expedited Class C Emergencies:**
    a. Cases which are not life threatening, but which may lead to complications if surgery is not performed within 24 hours.
    b. Class C cases are to be worked into the existing urgent/emergent schedule or performed during evening hours.
    c. The cases will be queued, based on the time posted. Time posted will be noted when case information is received.

Daily add-ons will be managed through the day of surgery schedule management, Anesthesia in Charge (AIC) and the OR and SAC/PACU Nurse Coordinators (NC) or charge nurses.

F. Emergent Surgical Procedure and Displacement Protocol:

1. Class A emergencies bump pre-scheduled cases, first room available. If more than one room is between cases, overall schedule impact will be the primary consideration. Efforts will be made to avoid bumping:
   a. Pediatric patients
   b. Surgeons with the most hours of scheduled surgery remaining
   c. Outpatients
2. The decision of which case to bump will be the responsibility of the AIC and NCs. The Operating Room will run the necessary number of rooms in the afternoon to complete the cases scheduled for that day.
3. The patient displaced from the surgery schedule will be given priority for rescheduling.
4. Per policy when a case must be bumped per this section's guidelines, the surgeon requiring the immediate or earlier start time must communicate when at all possible with the surgeon with the previously scheduled time. When care of patient may be impacted by this, department leadership and AIC will communicate with the surgeon whose case is being delayed.

G. Late Surgeons

1. Late is defined as being greater than one minute after the scheduled start time. The surgeon needs to be in the OR and ready to scrub 5 minutes before the start time. If a surgeon is late more than three times in any one calendar month, or if there is a pattern and/or trend of significant tardiness, these delays will be reviewed by POGG for appropriate action, up to and including removal of first case of day start time. This review will be conducted in collaboration with the surgeon.
2. When a scheduled case is delayed at the request of a surgeon, every effort will be made to accommodate a new, mutually beneficial start time.
3. A case delayed by a surgeon for a significant period of time will not be allowed to interfere with the start time of another scheduled case. In these instances all efforts will be exhausted, but it may be necessary to move the start time of delayed cases to later in the day.
4. If the late start results from the tardiness of an anesthesia provider, it will be documented and reported back to the Director of Anesthesia Services.
5. Delays for first case starts will be reported to POGG for review and any appropriate action.

H. Scheduling Practices

1. Scheduling cases into open time will be on a First Come, First Serve (FCFS) basis.
2. FCFS is available to every surgeon. The FCFS block will be used if the service block is full or there is no service block available for the requesting surgeon on a particular day.

3. Elective cases will be placed on the schedule according to the surgery and anesthesia hours of operation.
4. Any add-ons will be managed through the OR Front Desk in direct consultation with the AIC and the OR and SAC/PACU NCs or charge nurses.
5. The OR commits to provide appropriate personnel (one scrub and one circulator) and resources to meet the needs of all scheduled elective procedures. Any deviation from this practice will be presented to POGG. A First Assistant (RNFA) will be provided on a FCFS basis.

I. Schedule Administration

Schedule Coordination:

1. The responsibility for running the daily schedule is delegated to the NC/charge nurse and AIC.
2. The OR front desk is responsible for notifying the surgeon of any anticipated delay, as soon as it is known.
3. Delays will be classified according to the standardized delay codes in the EHR. The delay code will be entered at the time the patient enters the OR and will be determined by the surgical team (surgeon, anesthesia, and nursing).

BLOCK UTILIZATION REVIEW CRITERIA

J. Purpose:

POGG will review data monthly, or as needed, to:

1. Establish maintain benchmark block time criteria.
2. Reallocate underutilized block time relative to requests for additional or new blocks.
3. Review data for gaps and delays in the schedule with significant downtime of staff and resources.
4. Review/determine volume projections/service needs to maximize resource utilization.

K. Definitions:

1. If a case starts and ends within a block, block time used is the total case time.
2. If a case starts before the block start time begins, but ends within the block, block time used equals the total case time.
3. If a case starts within a block but ends after the block end time, block time used equals the total case time.
4. Blocks will be allocated in 4, 8, 10, or 12 hour increments, unless otherwise determined by POGG.
5. Blocks can be granted up to 12 hours in length determined by requestor utilization.

L. OPERATIONAL GUIDELINES

1. Initial block request must be submitted to POGG, via Perioperative Services Business Manager or Director. POGG will obtain the data from the most recent quarter and review for open time based on other surgeons' utilization. A determination will be

made based on that data, based on surgery hours + number of cases + years of service = priority rank.

2. Additional block requests will be submitted to the Perioperative Director.

Mandatory Auto Release of Blocks:

1. Blocks will release at 0900, three business days in advance of block.
2. Certain service lines will maintain release times that allow for timely scheduling of procedures:
    - Cardiovascular x 1 room will not until 1100 the day before
    - Acute Care Surgery/Trauma x 1 room will not until 1100 the day before
3. Block cannot be released in portions; the entire block must be released 7 calendar days prior to day of surgery in order to not be counted towards utilization. If a surgeon/group books into their block and knows additional cases will NOT be scheduled, the entire block can be released. Case minutes completed during open time will be added into surgeons total BIT will not count towards block utilization.
4. If a block is released >=25% of the time in a 3 month period, POGG will review for follow-up with that surgeon/group.
5. Open Time Scheduling shall be on a first come, first serve basis.
6. Surgeons cannot schedule outside of block on the same day until block is full.
7. Block release requests are required in "written format" (i.e., email/fax) and will be acknowledged in like format. To release a block, FAX a message to 970-495-7623 or email a message to: "UCHNPerioperativeScheduling@uchealth.org".

Process for Monitoring Block Time

1. POGG monitors and manages block time.
2. Utilization is based on standard adjusted utilization:

$$\frac{\textit{(Pt in room to Pt out of room) + TOT (turn over time)}}{\textit{Actual Block Time}}$$

3. Calculated monthly, reviewed quarterly, reallocated only after 6 months of trend.

Utilization to Maintain Block Time (for single room)
Until February 28, 2015:

- *50% to maintain block time*
- 40-49% to retain ¾ total block time/month
- 30-39% to retain ½ total block time/month
- <30% will lose block (will use open room to book cases)

From March 1, 2015 until August 31, 2015

- *60% to maintain block time*
- 50-59% to retain ¾ total block time/month
- 40-49% to retain ½ total block time/month
- <40% will lose block (will use open room to book cases)

From September 1, 2015, ongoing

- *75% to maintain block time*
- 60-74% to retain ¾ total block time/month
- 50-59% to retain ½ total block time/month
- <50% will lose block (will use open room to book cases)

In order to receive consideration for the use of a second room (flip/flopping), the following parameters must be met:

- *75% block utilization of a single room must be achieved and maintained for a minimum of 3 months.*
- *70% utilization must be maintained while utilizing 2 rooms.*
- *Dependent on case type and length, a set number of agreed upon cases must be scheduled 72 hours prior to day of surgery, or cases will be stacked in to a single room.*

Note: Reductions are by number of blocks per month and not by length of block (unless a 10 or 12 hour block exists, in which case the block will possibly first be reduced to 8 or 10 hours first.

Beginning in October of 2014 communication regarding underutilization will occur in the following format:

- 1st Communication: Verbal discussion regarding the underutilization of block and possible adjustments

- 2nd Communication: If by January 31, 2015 block remains lower than 50%, a written warning from the Director of Perioperative Support Services will be issued. This leaves one month to meet the requirement of 60% utilization before the March 1st deadline.

- 3rd Communication: If by February 28, 2015, 50% block utilization has not been met, written notification will be sent from the Director of Perioperative Support Services regarding the reduction or removal of block time.

Changes to block schedules will be made by POGG based on a 3 month rolling average.

Reviewed and approved by the Perioperative Governance Group.

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