Departmental Policy Title: Surgical Scheduling Case Policy - Perioperative Services

<table>
<thead>
<tr>
<th>Keywords</th>
<th>Policy ID</th>
<th>8002</th>
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<td>or, mor, osc, late, close schedule, block time, bed management, add ons, not before, elective, weekends, holidays, late rooms, allocated, cancel, outpatient elective, change, urgent and emergent, case grade, eswl, consent, hours of operation</td>
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Department
Perioperative Services

I. Purpose of Policy

The purpose of this policy is to define the scheduling policies and functions of Perioperative Services at Dartmouth-Hitchcock (D-H).

II. Policy Scope

This policy is inclusive of the staff of the Main Operating Room (MOR), the Center for Surgical Innovation (CSI), the Outpatient Surgery Center (OSC) and all surgical scheduling staff of D-H Lebanon.

III. Definitions

- **Block Time**: Block(s) of time in the MOR and OSC that are allocated to surgical services for the scheduling of elective surgical cases/procedures; surgical services then assign their services blocks of time to their surgeons for individual use.
- **Case**: Surgical case or procedure.
- **Combo Case**: Surgical case that requires more than one primary attending surgeon.
- **Case Grade**: A guide to assigning priority and urgency from A to G to a case, with “A” being urgent/emergent requiring critical care.

### Grade, Classification, and Example of Case Chart

<table>
<thead>
<tr>
<th>GRADE:</th>
<th>CLASSIFICATION</th>
<th>EXAMPLE OF CASE</th>
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<tbody>
<tr>
<td>“A”</td>
<td>A patient who requires surgical intervention in the next 30 to 60 minutes</td>
<td>Rupturing aortic aneurysm with hypotension and ST elevation</td>
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<tr>
<td>“B”</td>
<td>A patient who requires surgical intervention in the next 2 hours</td>
<td>Appendectomy</td>
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<tr>
<td>“C”</td>
<td>A patient who requires surgical intervention in the next 6 hours</td>
<td>Fractured humerus with no neurologic or vascular compromise</td>
</tr>
<tr>
<td>“D”</td>
<td>A patient who requires surgical intervention in the next 24 hours</td>
<td>Fractured hip</td>
</tr>
<tr>
<td>“E”</td>
<td>Elective inpatient ‘work ins’ in the next 1 to 3 days</td>
<td>Non-inpatient</td>
</tr>
<tr>
<td>“F”</td>
<td>Elective outpatient in the next 1-3 days</td>
<td>Non-inpatient</td>
</tr>
<tr>
<td>“G”</td>
<td>All other elective cases</td>
<td>Non-inpatient</td>
</tr>
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</table>
• **CPT Code**: Current Procedural Terminology for a specific procedure; can be used to review a surgeon’s cases, or a group of CPTs can be used to review an area of surgical cases. This could be used to see trends in scheduling.

• **Late Room**: MOR only; specific room(s) assigned to departments and so noted on the MOR block only, allocated to run later than 1700 end of block time.

• **Schedulers**: there are three types of schedulers:
  - Centralized Scheduler: Master OR Schedulers who are embedded within MOR, OSC and CSI.
  - Decentralized Scheduler: Master OR Schedulers who are embedded within the individual surgical sections.
  - Procedural scheduler: Off-site scheduler for non-OR procedural areas; such as NORA, IR, Cath Lab, etc.

• **AFR**: Anesthesia Floor Runner.

• **Designated Perioperative Authority**: (in order of preferred contact) Manager of Surgical Scheduling, Nursing Daily Operations Manager, AFR, Clinical Director, V.P. of Perioperative Services.

### IV. Policy Statement

#### A. Commitment to Scheduling that Ensures Quality, Efficiency, and Sustainable Patient Care

- This policy guides management, surgeons, schedulers, and all staff involved in case scheduling in holding the highest standards and providing high quality patient care.
- All scheduling procedures and job aids reflect direction within this policy. For particular types of scheduling, procedures inform staff of the actual process used to maximize resources and optimize utilization.

#### B. Documentation of Patient Information & Consent, Required to Schedule a Surgical Procedure

- Date of procedure and preferred time of day, if applicable
- Patient name
- Medical Record Number (MRN)
- Date of birth (DOB)
- Requesting surgeon
- Patient status day of surgery: (Outpatient, Inpatient, Day of Admit)
- Surgical Consent
  - A plan must exist for all elective cases to have an executed and accurate consent in eD-H in time for the patient to enter the OR without any delay.
  - Obtaining a signed consent should preferably be accomplished at least the day before surgery, except in the instance of emergency add-ons, or for patients who were referred urgently without being seen in clinic.
- Pre-op diagnosis (description)
- Case Grade
  - If urgent add-on, please see “Case Scheduling and Management” for required additional steps
- Procedure(s) to be performed with CPT codes
• Request for technical support and/or special equipment
• Post-op bed reservation
  o If the patient is an outpatient but is to be admitted post-operatively or is an inpatient who needs a change in location after surgery (e.g., now in ISCU but requires an ICU bed after surgery).

C. Scheduling of Cases Based on Hours of Operations in Perioperative Services (MOR and OSC)

• The MOR is staffed to run 24 rooms until 5:00 pm, Monday through Friday except for holidays.
  o The elective schedules in the MOR, CSI and OSC all begin at 7:30 am Monday through Thursday, 8:30 am on Fridays.
  o Each day, the MOR allocates a few late rooms to run until 6:30 pm. Service allocation and number of late rooms changes daily.
• The OSC is staffed to run six rooms until 1600, Monday through Friday except for holidays.
  o No case involving sedation or anesthesia is to be scheduled to extend past 1600.
  o All OSC patients are expected to be discharged by 1800.
• No elective case may be scheduled if it causes the OR to run past the room’s assigned time, unless prior approval by designated Perioperative Services authority.

D. Staffing Impact on Nights, Weekends and Holidays for Surgical Scheduling

• Weeknights (Mon-Fri): 9:00 pm to 7:30 am, the MOR staffs with one on-site team for urgent and emergent cases
  o Two RNs and one CST; one charge RN with on OR team
  o One staff person on call for same shift; can be called in to run second room with charge RN should the need arise
• Weekends: 7:00 am to 7:30 pm, the MOR staffs with three on-site teams for urgent and emergent cases
  o Four RNs and three CSTs; one charge RN with three OR teams
  o Two person call team available
    ▪ Can be called off by 8:30 am if low predictive demand
    ▪ Can be kept on call or brought in on shift if demands increase or to cover weekend sick calls
• Weekends: 7:00 pm to 7:30 am, the MOR staffs with one on-site team for urgent and emergent cases
  o Two RNs and one CST; one charge RN with one OR team
  o Two person call team available from 7:00 pm until 7:00 am if second room is needed for emergent cases
  o Perioperative Services also recognizes the Friday after Thanksgiving as part of the holiday; creating a four day holiday weekend
• On these days, the OR is staffed to the weekend staffing pattern. If the holiday falls directly on a Saturday, then the “holiday” is observed on the day before – Friday; if the holiday falls directly on a Sunday, then the “holiday” is observed on the day after – Monday

• Specialty team on-call coverage for nights, weekends and holidays includes:
  o One on-call Neurosurgical RN or CST to scrub emergency Neurosurgery cases
  o One on-call Vascular RN or CST to scrub emergency Vascular cases
  o Two on-call Cardiothoracic RN to circulate and scrub any emergency Cardiac cases

• All cases for weeknights, weekends (day and night) and holidays will be put on the Pending List and will be added to the schedule on day of according to priority and urgency, and as staffing and demands are assessed.

E. Case Scheduling and Management

• Elective surgical procedures are scheduled through surgeon clinics by the decentralized schedulers.
  A. The centralized scheduling offices confirm and manage the coordination of the final OR schedules.

• The decentralized scheduler and the centralized scheduling office collaborate to finalize case orders by 12noon two days prior to date of surgery.
  A. Preferred case order should be:
    ▪ All outpatients first.
    ▪ All inpatients/admissions to follow.

• The elective OR schedule ‘soft closes’ at 12noon the day prior in order to assure minimal changes once patient phone calls begin.
  A. Switching case order/substitutions after the closing of the schedule is not allowed except by permission, which must be obtained from the designated Perioperative Services authority.
  B. Add-on cases are allowed after this soft closure.
    ▪ Any add-on case must fit into the room’s block schedule, or it should be put on the pending list.
    ▪ Add-on cases must go at the end of the day unless case order change approval has been received as noted above.
  C. A surgeon must be available to perform an add-on procedure at the time offered or another case may be placed in front of that case at the discretion of the AFR.
  D. The AFR makes every effort to place all add-on cases on the schedule, but that cannot be guaranteed.

• For urgent add-on cases for day of:
  A. Surgeon or resident calls Main OR desk to discuss case and urgency.
  B. Surgeon or resident pages the AFR to discuss case, urgency and pertinent medical information.
  C. An accurate Case Grade must be assigned in order to allow the OR to appropriately prioritize all add-on cases.

• The surgeon is responsible for communicating special equipment and/or implant needs, as well as post-op bed management requirements (e.g., at the time the case is reserved (“booked”).
  A. Special equipment and or vendor supplied instruments or implants must be communicated to the decentralized scheduler in the surgeon’s clinic who then will communicate in the case booking for the OR to see.
F. Block Time

- Block time in the operating rooms is a D-H resource and is managed by Perioperative Executive Committee. No permanent/long-term trades can be made directly between sections or departments without approval of the committee.
- Temporary/one-time trades can be made between sections if a section ‘releases’ its block time for use. (Often referred to as selling/purchasing block time).
- If a department or section/service desires a permanent/long-term change (increase, decrease, trade with another group, etc.) in their MOR or OSC block allocation, the department representative must make such request via email sent to their Department Director, V.P. of Perioperative Services and the Manager of Surgical Scheduling.
- All such requests will be considered in light of all D-H resources; including the potential impact on equipment, sterilization, supply chain, nursing, anesthesia and post-op bed capacity, as well as to determine the overall impact to the rest of the block schedule allocation.
- Allocation:
  - Surgical services are allocated block time based on historical utilization data combined with future projected volumes and growth. Blocks are allocated to service; the service then has autonomy to allocate amongst its own surgeons as best fits with clinic and other schedules.
  - Flex/Combo Flex time is block time that is staffed by OR and Anesthesia, but is not allocated to a specific service. This time is utilized on a ‘first come, first serve’ basis. Clinics may request the use of Flex time up to 12 weeks in advance. Combo Flex is managed in a similar fashion except case requests must be for combo cases until 2 weeks prior to date of surgery.
  - ACR (Acute Care Room) – two rooms every day, Mon-Fri, that are staffed by OR and Anesthesia, but cannot be booked into prior to day of surgery. These rooms are utilized on day of surgery at the discretion of the AFR and OR Charge Nurse for urgent and emergent add-on cases.
- Automatic Release of Block Time:
  - A block or any portion thereof that remains unscheduled by the given release time is considered open time and is available to be scheduled by any service on a first-come-first-served basis. Unscheduled block time in non-restricted rooms is released five (5) business days prior to the scheduled block; known as the ‘5-Day Rule’.
    - A ‘3-Day Rule’ applies to Thoracic, Vascular and Ophthalmology services only.
  - Orthopedic surgery, General surgery, Cardiac surgery, and Neurosurgery each have allocated restricted time that will not release under above mentioned rules.
  - Note that two (2) MOR rooms each day (Mon.-Fri.) are declared “ACR” (Acute Care Rooms) and are under the control of the daily charge staff (charge nurse and AFR). They are not available for scheduling by any service in advance and are used day of for urgent and emergent add-on cases only.
- Manual Release of Block Time:
  - If an assigned surgeon is going to be away and cannot use their allocated OR time by their section, the section should first look to see if another surgeon within the section can use the OR time. If another surgeon cannot use the services allocated block time, the decentralized scheduler must send an email to the centralized scheduler as soon as possible to release the block time for another services use.
    - If manual release happens outside of 45 days prior to the impacted date of surgery, the section’s utilization will not be negatively impacted.
If manual release happens inside of 45 days prior to impacted date of surgery, the sections utilization will be negatively impacted.

G. Bed Management - Scheduling Elective Cases to Match Bed Capacity

- Inpatient beds are a scarce resource. In addition, placing patients on the ward most often associated with type of surgery is important to ensure the highest quality of care. For this reason, there are quotas (“caps”) on elective procedure patient beds on each ward for each day of the week that must be observed when scheduling elective procedures that lead to inpatient admission.
- No elective procedure is to be scheduled without first insuring that a bed is available below or at the cap on that day in a location that is acceptable to both the surgeon and the inpatient nursing service.

V. References

N/A