Name of organisation: 

Subject: Management of operating sessions for elective and scheduled surgery

Date of implementation: 

Date of review: 

Person responsible for policy implementation and review: 

Policy location:

1 Introduction
Effective organisation by all members of the perioperative caring team is essential for the efficient management of elective and scheduled operating sessions. This template policy has been devised to facilitate the effective use of resources in order to enhance clinical efficiency within the operating department. Adherence to this policy should prevent the overrunning of elective and scheduled operating lists and will provide guidance to all theatre users.

2 Aims of the policy
2.1 To optimise the effective use of human and physical resources through proactive coordination, in order to facilitate the delivery of high quality patient care to patients admitted for elective and scheduled surgery.
2.2 To reduce and prevent the cancellation of elective and scheduled surgery by ensuring that allocated theatre time is planned effectively and that perioperative personnel are deployed appropriately to meet the identified service demand.

3 Objective of the policy
To ensure that all theatre users are aware of the optimal means of utilising allocated theatre time, and its associated resources, for the delivery of an elective/scheduled operating session.

4 Definitions used
THEATRE COORDINATOR/TEAM LEADER: The most senior Registered Nurse/Operating Department Practitioner. The theatre coordinator/team leader is in charge of the theatre team on a particular shift.
ELECTIVE: Operating list organised and delivered at a time that is planned within the operating schedule/contract as agreed by the Theatre Users’ Committee or relevant forum.
EMERGENCY: The requirement for an operative procedure or collection of procedures that is judged to be life threatening, or requires prioritising over and above meeting the needs of patients scheduled for a designated elective list.

5 Times of operating sessions
5.1 The operating session should allow for three and a half hours of operating time, and half an hour for the postoperative recovery of a patient and the effective decontamination of the operating theatre.
5.2 The morning session may be defined as:
09:00–12:30 hrs operating time
12:30–13:00 hrs recovery and cleaning time.

5.3 The afternoon session may be defined as:
13:30–17:00 hrs operating time
17:00–17:30 hrs recovery and cleaning time.

AfPP acknowledges that many operating departments, especially within the independent sector, are managing three operating sessions a day where capacity permits. AfPP also acknowledges that all day operating lists with the same operating consultant are becoming increasingly popular due to increasing efficiency of theatre utilisation. In this situation the principles of indicators stated in 5.1 will still apply.

5.4 In the case of a planned all day operating list the allocated sessions may be from 09:00–16:00.
5.5 It is the responsibility of the consultant operating surgeon or nominated theatre scheduler when planning elective and scheduled operating lists to ensure that as far as is reasonably practicable, allocated operating session times are not exceeded. Theatre resources can then be utilised appropriately.

6 Cancellation of elective/scheduled patients
6.1 In situations where the operating surgeon is about to, or has actually run out of allocated session time, the coordinator or designated team leader of the theatre concerned, in collaboration with the consultant anaesthetist should cancel any further cases to prevent the operating list from overrunning.
6.2 The surgical team responsible for the operative list should ensure that all patients affected by the decision to curtail the list receive an explanation as to why it was deemed necessary to postpone or cancel their planned surgery.
6.3 The appropriate clinical incident form must be completed by the coordinator or designated team leader, stating the reason for cancellation and who was involved in making this decision.
6.4 In the absence of a coordinator or designated team leader the anaesthetic assistant should seek advice from the most senior member of staff on duty within the operating department.
6.5 To ensure effective management of perioperative resources it must be accepted by all staff that only the coordinator or designated team leader have the authority to authorise the collection of/sending for patients.
6.6 All cancellations should be audited monthly to determine whether theatre scheduling has been effective. This process should include Anaesthetic and Surgical Directorates, the main coordinator/scheduler and medical secretaries, as recommended by the National Confidential Enquiry into Perioperative Deaths (NCEPOD 2001).

7 Planned overrunning of sessions
The Audit Commission (2003) estimated that in about 5% of hospitals in the UK, the majority of operating lists were consistently over running. Some operating lists are predictably over booked which is unacceptable. Research by Pandit and Carey (2006) recommends that when planning the operating list estimates of operating times to plan lists would reduce the incidence of predictable overruns and cancellations.
7.1 In situations where it is anticipated that the complexity of a procedure or the nature of the operative case will result in a longer than scheduled operating time, it is the responsibility of both the consultant surgeon and the anaesthetist to liaise with the coordinator/designated team leader. The priority is to ensure that the appropriate physical and staff resources can be organised and secured.
7.2 In circumstances where a consultant surgeon or anaesthetist may wish to commence the scheduled operating list at an earlier time than that allocated or published, they must liaise with the coordinator or designated team leader to ensure that appropriate human and physical resources are available. If the necessary resources are not available then the coordinator/designated team leader should inform both the consultant surgeon and the anaesthetist as soon as is reasonably practicable.

8 Ensuring an effective response to emergency situations
8.1 If the organisation wishes to provide a responsive emergency service, then a designated 24 hour operating theatre, managed by trained and competent staff, must be resourced (NCEPOD 1997).
8.2 The staff rostered/designated to provide emergency cover must not be used to supplement the staffing establishment that service/support elective or scheduled cases. It must be ensured that they are available to provide an immediate response to emergency incidents.
8.3 In situations where emergency teams comprise a minimum of three registered personnel, and a risk assessment regarding prioritisation of service and patient dependency has been conducted, one individual may, at the discretion of the coordinator or
designated team leader, be directed to assist where a significant staffing problem has occurred. This is acceptable only on the understanding that the individual will be recalled in the advent of an emergency situation.

8.4 Anaesthetists and surgeons rostered for emergency work should be free from other commitments (NCEPOD 1997).

9 Cancellation/changes to the operating list

9.1 All operating lists should arrive in the operating department 16—24 hours in advance of a scheduled session, in order to ensure patient safety and the effective utilisation of resources (AIPP 2007).

9.2 Any changes or cancellations to the operating list must be relayed immediately to the person in charge of the operating list.

9.3 All copies of the operating list or send-for slips must be amended as appropriate by the person making the changes and all appropriate members of staff must be notified (AAGBI 1995).

9.4 The persons making the amendments must sign and add a note to the side of the list: ‘Note change to order’. The appropriate untoward incident form should be completed detailing the reasons why the change in order was indicated.

9.5 All relevant staff should be informed, including the wards, radiological departments and support services as appropriate.

9.6 It must be acknowledged by all staff that to change the order of an operating list creates the potential for error and that changes to a published schedule should only occur in extreme circumstances and only when absolutely necessary. The importance of documenting the circumstances of any change, via the appropriate untoward incident form, should be viewed as fundamental to securing improvements in future scheduling practice.

10 Staffing of elective/scheduled operating lists

It is the responsibility of the coordinator or designated team leader to ensure that every elective and emergency operating list is staffed by a team of appropriately trained and competent personnel who are equipped with the skills and abilities to administer high quality patient care and who are able to identify and minimise any risks to the patient as they journey through the perioperative environment. It is recommended that the formula for calculating staffing establishment advocated by AIPP (see pages 18–22 of this document) are utilised. The recommendations include:

- ONE REGISTERED ANAESTHETIC ASSISTANT PRACTITIONER for each session involving an anaesthetic
- TWO SCRUB PRACTITIONERS as the basic requirement for each session, unless patient dependency and/or clinical service demand more or less. Two practitioners are recommended for a list of major surgery unless there is only one case. Two practitioners are recommended for a list of minor surgery that demands a quick throughput or has several cases on it such as for an elective day surgery list
- ONE CIRCULATING STAFF MEMBER for each session unless there is a requirement for more, i.e. when two cavities are opened, for example anterior and posterior resection.
- ONE PRACTITIONER TO ACT AS ANAESTHETIC ASSISTANT for each session involving an anaesthetist and/or anaesthetist. This includes sessions where local sedation or regional anaesthesia is administered. There may be occasions when more than one assistant is required due to patient dependency/type of anaesthesia.
- ONE RECOVERY PRACTITIONER per patient for the immediate postoperative period. There may be occasions when two recovery practitioners are judged to be required if there is a quick throughput of patients requiring minor procedures, such as in a surgical day unit.
- If the patient is not returning to a special care area such as a High Dependency Unit immediately after surgery, they need to be cared for by practitioners who are trained and experienced in post-anaesthetic care.