Name of Policy:	**Surgical Services Policy**
Policy Number:	3364-100-53-27
Department:	Hospital Administration
Approving Officer:	Chief Operating Officer - UTMC
Responsible Agent:	Director, Operative Services
Scope:	The University of Toledo Medical Center and its Medical Staff

THE UNIVERSITY OF TOLEDO MEDICAL CENTER

Effective Date: 09/27/2023
Initial Effective Date: 05/11/2021

_______ New policy proposal
_______ Major revision of existing policy
___x___ Minor/technical revision of existing policy
_______ Reaffirmation of existing policy

(A) Policy Statement

Provide a uniform practice for scheduling elective and emergent surgical procedures in the operating room.

(B) Purpose of Policy

To provide administrative guidelines for safe and efficient operational management of the operating and procedural rooms to promote positive patient outcomes by monitoring key performance metrics.

(C) Procedure

Will ensure provision of reasonable operating room capacity and timely access to services for elective and emergent surgery cases. Leadership will strive to maximize operational efficiency through implementation of processes and procedures that optimize efficient use of time, personnel, supplies and equipment.

1. The definition of surgical or other invasive procedures for application of Universal Protocol Policy-Comprehensive Surgical Checklist are located in the appendix.

2. The circulating RN is responsible for the documentation and completion of the UTMC Comprehensive Surgical Checklist.

(D) Critical Definitions and Requirements for Efficient and Safe Management of the Operating and Procedural Rooms:

1. **Add-on Cases**. Those cases that are scheduled after schedule closes at 2:00 PM previous day from day of surgery. Needs approval from anesthesia in charge (AIC/board runner) in collaboration with OR supervisor.
    a) **First Available Room (FAR) prior to day of surgery** – Case to be scheduled through scheduling office up until 2:00 PM prior to day of surgery.
    b) **Day of surgery** – Cases to be scheduled through Anesthesia in charge and OR desk lead. Cases to be scheduled from close of previous day (2:00 PM) to day of surgery.
2. **Anesthesiology Staff Arrive Time**. Anesthesia Staff arrives to see the first patient of the day in Pre-Op holding early enough to ensure an on time start for the procedure. Non-regional block patients need to be seen by Anesthesia between 6:40-7:10 am.
3. **Anesthesia Start.** The time when a member of the anesthesia team begins preparing the patient for an anesthetic.
4. **Surgeon/Proceduralist Arrival Time:** Attending physician who will perform a procedure arrives prior to patient admission to the operating or procedure room. Surgeon completes site marking, conversation with patient, and pre-op update by 10 minutes prior to scheduled start time. Exception of this expectation is when a regional block has to be given (surgeons need to have all chart elements and site marking completed 30 minutes prior to scheduled start time).
5. **Block Time Utilization**. A percentage that measures the total number of block minutes used versus the total

number of block minutes available on a given day including turnover time.

6. **Bumped Case**. A scheduled case that is moved to another time on the OR schedule due to emergency and every effort will be made to move the case to another room ASAP.
7. **Cancelled Case**. A case that will not be performed for reasons specified by the surgeon or anesthesiologist, or because of a no-show by the patient. The case will be cancelled only after communication and agreement between the surgeon and anesthesiologist.
8. **Elective Case**. A surgical procedure that is not critical from a time perspective and is usually scheduled greater 72 hours in advance.
9. **Immediately Available**. Surgeon is physically present on-site within the operative suite area.
10. **Late or Delayed Case**. Occurs when a patient is not in the operating room at the printed time on the operating room schedule.
11. **On Time Start**. A patient that is in the operating room at or before the printed time on the operating room schedule. All members of the surgical, OR and anesthesia teams are prepared to receive the patient in the OR prior to the scheduled start time. All key personnel are required to be present at this time: circulator, scrub, anesthesiologist and surgeon.
12. **Open Time**. Time available on the surgery schedule on a first-come, first-serve basis. A goal is to keep 20% of total OR minutes available as Open Time for surgeons to schedule cases.
14. **OR Utilization**. Measured by the sum of total hours of elective cases performed within the block time (includes patient preparation in the OR, anesthesia induction and emergence) plus total turnover time divided by total hours available and multiplied by 100. Utilization goal is 75% with turnover time included. **Of note:** Block is scheduled based on four and half or two and half (07:30-12:00 or 12:30-1500), seven and half (07:30-1500) or nine and half (07:30-1700) hours blocks. All block schedules are made based on block utilization assessment, OR staffing and Anesthesia staffing.
15. **OR Efficiency**. Measures operational performance: a) On Time starts: case starts at or before scheduled surgery time in ≥ 85% of cases; b) Main OR turnover time is ≤ 30 minutes and ≤ 20 minutes in George Isaac Surgery Center (GISC) on ≥ 85% of cases where surgeon follows self.
16. **Procedure/Surgery Start Time**. The time of initial surgical incision for a surgical procedure, or application of drapes in a procedure that does not require a surgical incision, or insertion of a scope for a diagnostic procedure.
17. **Turnover Time**. The time from when one patient leaves the operating room until the next patient arrives in the operating room when a surgeon is available and scheduled to follow immediately.
18. **Automatic Released Block Time.** Hours of OR time that are released from Block time and converted to open time.
19. **Block Time.** Surgical time reserved for a designated surgeon, group or service within a defined cut-off period. This is time into which only the designated surgeon, group or service may schedule.
20. **Surgeon Released Block Time.** Reserved time that a specific surgeon, group or service releases to open scheduling time. Self-release must occur 14 days prior to scheduled block to prevent negative utilization time.
21. **Scheduled Start Time.** The time on the printed operating room schedule. The patient should be in the OR and ready for anesthesia induction.
22. **In Room Time.** Actual time patient enters OR.
23. **Emergent Case. (Class X) (**Case to start within 30 minutes). A patient needing immediate intervention when any delay poses a threat to life, limb, organs, or critical surgical illness; stable patient (any delay could potentially cause adverse clinical outcomes and requires immediate attention) as determined by the surgeon. The surgeon will document this designation in the record and promptly communicate such to the AIC. The goal is to have the patient in the OR as soon as possible, ideally within 30 minutes of surgeon request.
24. **Urgent Case** (case to start within 1-6 hours). Time-sensitive surgical illness; stable patient (not immediately life threatening but surgeon assessment of the patient determines that significant delay may be clinically detrimental). Added to the OR schedule for the same day.
    Class 1A (Case starts within 1 hour)
    Class 1B (Case starts within 2-3 hours)
    Class 1C (Case within 6 hours)
    Long Bone Fracture (LBF) (Case starts within 24 hours)

Upon re-evaluation by the attending surgeon and anesthesiologist, may be reclassified.

(E) Surgery Hours of Operation

1. There are 12 main operating rooms at UTMC and 4 operating rooms in the GISC. The number of operating rooms available for cases may vary depending on availability of resources (staff, anesthesia, equipment/supplies).
2. On-call response time from notification to in-hospital is 30 minutes.
   a) During on-call times, the goal is to set up the OR and begin surgery as soon as possible after staff arrives.
   b) Elective surgery is not scheduled on all observed holidays.

(F) Pre-Admission Process

1. Pre-operative health evaluation of patients undergoing elective surgery should be completed between 3-30 business days prior to day of surgery.
2. Pre-operative testing guidelines and NPO status must be consistent with anesthesia driven protocols.
3. Pre-op test results are acceptable for up to 30 days before the day of surgery, or greater where applicable.
4. The History and physical (H&P) must be written within 30 days prior to the procedure and be updated immediately prior to the procedure on the date of service. A new H&P must be provided if the H&P is outdated. H&Ps can be performed by the surgeon/ or his/her designee.
5. All chart documentation must be completed and received by the pre-admission office within 72 hours prior to scheduled elective cases. PAT will make every effort to contact the surgeon's office to retrieve missing or incomplete information.
6. Charts for next day surgery are made by the pre-admission testing department for UTMC. Surgical cases may be removed from the schedule or postponed when the pre-op evaluation and correct chart documentation are incomplete.
7. The surgeon will be notified of abnormal pre-op testing results, which may potentially affect the surgical case. The surgeon may postpone or delay elective surgery if further testing is required. The anesthesiologist may postpone or delay elective surgery only after consultation with the surgeon.
8. All equipment and implants required by a non-facility vendor or source, must be in Sterile Processing Department at least 48 hours prior to the procedure's scheduled start time or the procedure may be subject to cancellation. Attending surgeon is responsible for coordinating all vendor resources (non-facility resources include equipment and implants).

(G) Scheduling Procedures

1. The Surgery Scheduling Office is open Monday through Friday 0700-1630, excluding observed holidays.
2. Elective cases will be placed on the schedule according to the hours of operation.
3. Only physicians with surgery privileges granted through the Medical Staff credentialing process may schedule and perform operative procedures. Surgeon privileges and credentials will be verified when cases are first scheduled by a surgeon new to the department. Thereafter, credentials are reviewed and verified if there is a question as to privilege status, or if a surgeon attempts to schedule a case outside of his credentialed surgical specialty.
4. Surgery cases that do not meet these requirements should not be scheduled.
   a) If case is scheduled, the primary surgeon is responsible for identifying another privileged surgeon to perform the surgery. If no privileged surgeon is available, then case will be cancelled.
5. Cases scheduled in open time are on a first-come first-serve basis. Open time may be used by a surgeon who does not have block time on a first-come first-serve basis.
6. Elective cases will be assigned case time at the time the case is scheduled based on historical case time specific to the assigned surgeon. This time may be extended depending on the degree of difficulty or extent of intervention as judged by the surgeon (needs approval by AIC).
7. Surgeons with block time may schedule elective cases by a standardized scheduling form.
8. All scheduling transactions including cancellations, rescheduling, and equipment or supply requests must be uploaded into Athena.
9. Surgeon offices may not fax notice of next day add-on cases, cancellations or other changes. These transactions must be communicated to Surgery Scheduling by telephone; an updated scheduling fax form must be sent as soon as possible following the phone call.
   a) All cancellations must be accompanied by a reason for the cancellation. Reason for cancellation must be documented in the patients' healthcare record.
10. The first scheduled case of the day is expected to begin at the scheduled time.
11. Financial clearance for elective procedures must be obtained by 12:00 PM the day prior to surgery or the case

may be deferred.

12. Scheduled start times after the first case are estimates only. All efforts are made to start cases at or before the time printed on the operating room schedule.
13. Surgery Scheduling will confirm case order and expected surgery start time with the surgeon and/or office day prior to surgery.
14. Surgeons with Blocks may be permitted to schedule up to 100% of the approved hours of block time, (based on historical surgeon data) of elective surgery in operating rooms.

(H) Surgeon Availability

1. The surgeon should notify the OR staff when he/she arrives in the department.
2. The surgeon must see the patient in Pre-Op Holding prior to anesthesia induction to update pre-operative note and mark procedure site. This should be completed sufficiently early to allow for an on-time procedure start. The patient will not be transported to the OR until surgeon documentation is complete.
3. The primary surgeon must be present during all critical portions of the procedure. The case may be delayed or rescheduled if the surgeon is not available as described.

(I) Delays

1. Delays should be discussed during Timeout of the case. Delays will be determined by the surgical team (surgeon, anesthesia, and nursing). Delays will be documented using the standardized delay codes.
2. Delays should be recorded in Intraoperative EPIC chart
3. SSEC will monitor first case on time start rate by surgeon every month. If the surgeon continues to arrive late for scheduled cases during the current timeframe, SSEC will review and determine course of action. For surgeons with assigned block, course of action could include revision of block schedule

(J) Surgical Team responsibilities

1. Attestation of consent and marking procedure site should be completed 10 minutes prior to surgery. If a block needs to be placed, both items need to occur 30 minutes prior to surgery.
2. All required documentation must be completed at least 10 minutes before scheduled OR start time. This timeline will need to be modified for patients needing nerve blocks pre-operatively in conjunction with the surgeon and the anesthesiologist involved in the case:
    a) Signed and dated consent
    b) A History and Physical exam must be performed by a physician or designee within 30 days of surgery, including date, time and signature of the attending physician of record.
    c) If an inpatient, a daily progress note dated within 24 hours of surgery, completed by surgeon or designee.
    d) Antibiotic order
    e) Site marking and any patient questions
3. Marking the procedural site:
    a) Site marking is defined as the attending surgeon or proceduralist's initials at or near the procedure site (E.g., "C.S.R"). The mark will be sufficiently permanent to be visible after skin preparation and draping. This is the unambiguous standard for marking at UTMC.
    b) Only the surgeon or proceduralist can mark the patient
    c) The attending surgeon or proceduralist is ultimately responsible for the procedure and will be present when the procedure is performed will mark the procedure site(s)/side(s) in the preoperative department before the patient is taken to the operating room, procedure area, or before a regional block is performed.
    d) Marking the procedure site will be performed with the active involvement of the patient or his/her representative. The patient will be awake and fully conscious. (Exceptions would be a confused patient).
    e) Site marking applies to all surgeries or procedures that involve laterality (e.g., limb or pair of organs), multiple surfaces or structures (e.g., flexor/extensor, skin lesions, and fingers/toes) or levels (e.g., spinal procedures, in addition to the preoperative skin marking of the general spinal region, special intraoperative imaging techniques may be used for locating and marking the exact vertebral level.
    f) When it is technically or anatomically impossible or impractical to mark the correct site (e.g., mucosal surfaces, perineum, teeth, premature infants and where site marking might permanently discolor the skin), or a patient refuses site marking, the anatomical diagram will be used to mark the correct site.

Site marking on the form will be confirmed by the team during the pre-procedure check in and during the time out.

4. First Case On Time Starts:
   a) Will be evaluated every 2 months.
   b) If there are more than 3 late starts in this 2-month period the surgeon per the direction of SSEC may lose the ability to schedule first case starts for 1 month. The loss of first case start may also result in the loss of block time.
5. Time Out Process:
   a) Each surgeon is required to fully participate in the "WHO Time Out" Process which will include these specific elements:
      - Team member introductions
      - Patient Identity using 2 patient identifiers
      - Procedure and procedure site/side
      - Consent signed
      - Site marked by attending surgeon or proceduralist (i.e., initials) and is visible after draping
      - Patient allergies
      - Antibiotic prophylaxis completed before incision
      - Critical or not routine steps
      - Case duration
      - Anticipated blood loss
      - Site prepped and dry time met
      - Images labeled and displayed
      - Equipment/devices/implants in the OR and concerns addressed
      - Sterilization confirmed
      - Additional surgery specific information & concerns addressed (such as ABO, cross match and UNOS number(s) for transplants, etc.)
   b) Each surgeon or their representative is expected to participate in the "WHO Debrief" Process, which will include these specific elements:
      - Procedure name(s)
      - Wound classification
      - Sponge, sharp & instruments count complete
      - Specimens identified and labeled
      - Equipment problems to address
   c) All team members are required to stop ALL and ANY activity during the Time Out process and the Sign Out process. A verbal agreement to both process by the entire operative team with information shared. If any disagreement, this needs to be address before proceeding further. An incision will not be made before a full Time Out is completed. The patient will not leave an OR before an entire Sign Out is completed. Any questions should be directed to OR supervisor and/or Anesthesia in Charge (AIC).

(K) Block Time Utilization

1. Total Block assignments will not exceed 80% of prime block hours (07:30 – 1500). The intent is to maintain 20% open time at all times, and block time requests will be granted or denied with this ratio in mind.
2. The Block Utilization Goal for the Operating Room is 75%. Individual/Group Blocks are evaluated by SSEC every two months. If 75% utilization is not met, surgeon will be notified by SSEC.
   a) Goal met: >/= 75%
   b) Potential concern: 65% – 74%
      (Blocks that receive potential concern for two consecutive months will be subject to a warning)
   c) Warning: 36% – 64%
      (Blocks that receive warnings for two consecutive months are subject to reduction in assigned block time)
   d) Automatic Adjustment: </= 35% for two consecutive quarters
3. Block time is assigned based on demonstrated volume and compliance with block time utilization rules. Unused block time will automatically release 5 business days prior.

4. If utilizing 2 rooms, block time needs to be 65%.
5. There are no more than 90-minute gaps between cases.
6. Designated Block Time should be utilized before a surgeon books cases into non- designated or open time. Cases scheduled in open time will not count toward a surgeon's monthly utilization.
7. Any new requests for a Block will be considered for approval at the monthly SSEC meeting:
   a) If there is time available
   b) Demonstrated efficient and professional use of OR time and resources
   c) Approval by Anesthesia/Board Runner
8. For multi-surgeon group blocks, no special preference will be given to one surgeon over another.

(L) Releasing Block Time

1. Block release to open time as follows:
   a) Automatic Block cutoff applies at 7:00 AM 5 business days prior to scheduled surgery date in all surgery locations.
2. All unused Block time will release to open time 5 business days prior to the surgery date.

UNSCHEDULED BLOCK	TIME OF RELEASE AT 1500
MONDAY	PRIOR MONDAY
TUESDAY	PRIOR TUESDAY
WEDNESDAY	PRIOR WEDNESDAY
THURSDAY	PRIOR THURSDAY
FRIDAY	PRIOR FRIDAY

3. Released time will be converted to open time and made available to other surgeons and services on a first-come first-serve basis. Block time cannot be designated to another colleague (unless block time is a group block).
4. When a surgeon releases block time, and then attempts to schedule cases in the now open time, the request will be honored on a first-come first-serve basis.

(M) Flip Rooms

1. Current block time utilization should not be less than 75% to qualify for a flip room block.
2. Case volume should consist of > 250 cases/year or 5 cases/8-hour block.
3. The case length (wheels in – wheels out) for a flipping surgeon should average 60 to 90 minutes.
4. Flip rooms should be awarded to only those surgeons who partner with the hospital to grow the volume, but also demonstrate the mission of the hospital. Surgeons who have the history of disruptive behavior should not be considered for a flip room, even if they meet all other criteria.
5. The SSEC should manage flip room allocation and modification.
6. Changes to block are requested through the "Block Schedule Request Form."

(N) Concurrent or Overlapping Rooms

1. Concurrent or simultaneous surgeries are not supported by UTMC.
2. Concurrent or simultaneous surgeries: When the critical components of the operations for which the primary attending surgeon is responsible are occurring at the same time.
3. Overlapping surgeries: When the critical components of the first operation have been completed and the primary attending surgeon performs critical portions of a second operation in another room.
   a) The primary surgeon must designate another attending surgeon who is immediately available should the need arise. This back-up surgeon must be identified at the time-out and documented in the post-operative checkout form.
4. If there is an anticipation of potential overlapping surgeries, the patients in both surgeries must be informed prior to surgery and documented in the patient consent form.
5. Critical element: The critical element of the surgery to the extent that it is practical, must be identified by the attending surgeon at the time-out prior to the start of surgery.

(O) Daily Operations of the OR

1. The OR Director/Manager, in collaboration with have responsibility for running the daily OR schedule and notifying a surgeon of any anticipated delay.

(P) Surgical Services Executive Committee

1. This committee includes UTMC department chairs, UTMC surgeons, anesthesia, OR supervisors, and administration
2. The Surgery Services Executive Committee will meet every month and as needed.

<table>
<tr><td>Approved by:

/s/
______________________ ________
Christine Stesney- Ridenour   Date
Chief Operating Officer - UTMC

/s/
______________________ ________
Michael W. Ellis, MD   Date
Chief Medical Officer - UTMC
Review/Revision Completed By:

Chief Medical Officer</td><td>Review/Revision Date:
09/2023

Next Review Date: 09/01/2026</td></tr>
<tr><td colspan="2">Policies Superseded by This Policy:
• 3364-87-18 Medical Staff Policy Operative Services Committee
• 3364-87-39 Medical Staff Policy Scheduling of Operating Rooms
• 3364-87-40 Medical Staff, Surgical Provider Operating Room Responsibilities
• 3364-100-53-05 Universal Protocol
• 3364-124-09 Nursing Services (OR Specific) Block Scheduling</td></tr>
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