SECTION: **ADMINISTRATIVE**

SUBJECT: **OPERATING ROOM SCHEDULING POLICY**

APPROVED BY: _____
OPERATIVE SERVICES, NURSE MANAGER

POLICY

To ensure optimal utilization of the scheduling process and the use of Operating Rooms (OR). To establish clear guidelines and procedures for the efficient and safe scheduling of surgical procedures within Arrowhead Regional Medical Center (ARMC.)

PROCEDURES

I. SCHEDULING PROCESS

A. Elective procedures scheduling request shall be made at least but not limited to 1 week in advance.
B. Scheduling requests for urgent or emergent procedures are made with the Anesthetist in Charge (AIC) and Charge Nurse (CN).

Covered Room Plan

A. Block-time Scheduling will be established by the Perioperative Executive Committee (PEC) and utilized as the basis for OR staffing and anesthesia coverage. This will be the model that establishes the parameters defining capacity by specialty for surgery scheduling (Setting Block Schedules.)
B. Block-time Scheduling will be reviewed periodically by the PEC to determine whether adjustments are required to:
    1. Meet changing demands within services.
    2. Provides opportunity for growth.
    3. Meet the desired utilization target of 75%
C. No rooms will be closed without mutual agreement between OR leadership and Anesthesiology.
D. Cases will be booked first within surgeons/groups blocks; surgeons will be directed to schedule elective procedures within their established blocks. Consideration for scheduling outside of the established block will occur. If the case has been classified as urgent/emergent and will follow urgent/emergent scheduling process.

Elective Case Scheduling

A. Elective cases will be scheduled during hours of operation established by the PEC and according to subsequent guidelines addressing block scheduling.
B. All first cases will have a scheduled start time of 7:45 AM (8:45 AM Wednesday) unless approved otherwise by the Anesthesiologist in Charge (AIC) or surgical services leadership.
C. When scheduling cases into the electronic health record (EHR), clinic staff will complete “Procedure Pass”

Add-On Case Scheduling

A. The OR schedule will finalize at 9:30 AM, the business day prior to surgery for elective case scheduling. Any inpatient urgent/emergent case added to the OR schedule after 9:30 AM is considered an add-on, and placement of the case onto the schedule may require coordination with the AIC.
B. Any emergent/urgent case requests after 9:30 AM for the day of or the next day will be considered add-on's and must be made with AIC and CN
C. If conflict over sequencing of cases occurs; the AIC will refer the surgeons to each other to resolve the sequence of cases based on the patient acuity.
D. Requested time for an add-on case will never be considered a guaranteed time.

II. URGENT/EMERGENT CASE SCHEDULING

Urgent/Emergent Scheduling Goals

A. The following guidelines will support:
   1. Prioritizing or triaging add-on cases and patients based on clinical urgency and in a fair and consistent manner.
   2. PEC will review and evaluate data related to the care of patients with time sensitive disorders so that improvements to this process can be assessed.
   3. Urgent cases cannot wait to be scheduled electively, and by nature must be done as soon as possible depending on diagnosis and acuity.
   4. Emergent cases must come immediately to OR, or to the next available room as determined by the attending surgeon.
   5. Urgent cases, but not emergencies, must follow in order of request unless the surgeon requests to bump another. It is the responsibility of the surgeon doing the bumping to personally inform the surgeon being bumped. Documentation of "bumping" will be completed on the appropriate form and be available for review by the PEC**.**

   NOTE: Only emergent/urgent cases may be scheduled on nights/weekends/holidays.

   6. One operating room available for trauma covered by staff on call.

III. POSTPONING CASES

A. In cooperation with the OR charge nurse and attending surgeon, the responsible anesthesiologist may postpone a case in the event of the following:
   1. Patient condition
   2. An urgent or emergency situation must take precedence.
   3. Practitioners privileges are not appropriate for scheduled surgical procedure.

Process to Request Two Scheduled ORs for One Surgeon

A. Formal request (verbal or written) must be made to the Operative and Invasive Service Committee for review of Appropriateness and resource availability and forwarded to the PEC for approval. This request will be reviewed and either approved or denied via the PEC and communicated back to the requesting surgeon.

REFERENCES: **Regulatory Standards Surgical Services**

DEFINITIONS: 1. Start Time: The time that the patient is wheeled into the operating room

2. Two Scheduled ORs for one surgeon: One (1) surgeon assigned to two (2) OR's with two (2) separate teams.
3. First Case: A procedure that is not first for physician and room
4. Subsequent Case: a procedure that is not first for physician and room
5. PEC: Perioperative Executive Committee-OR governance composed of the medical director of surgical services, medical director of anesthesia, VP of clinical operations, director of patient care surgical services, and director of perioperative services patient care
6. Anesthesiologist in Charge (AIC)

ATTACHMENTS: **N/A**

APPROVAL DATE:	**N/A**	**Policy, Procedure and Standards Committee**
	03/26/2024	**Operative & Invasive Procedures Committee** Applicable Administrator, Hospital or Medical Committee
	04/16/2024	**Nursing Standards Committee** Applicable Administrator, Hospital or Medical Committee
	04/30/2024	**Patient Safety and Quality Committee** Applicable Administrator, Hospital or Medical Committee
	05/02/2024	**Quality Management Committee** Applicable Administrator, Hospital or Medical Committee
	05/23/2024	**Medical Executive Committee** Applicable Administrator, Hospital or Medical Committee
		Board of Supervisors Approved by the Governing Body

REPLACES: **OR 105.09 Issue 7, Scheduling Additional Cases**

EFFECTIVE: **05/23/2024**

REVISED: **N/A**

REVIEWED: **N/A**

SECTION: **ADMINISTRATIVE**

SUBJECT: **BLOCK SCHEDULING POLICY**

APPROVED BY: _____
Operative Services, Nurse Manager

POLICY

I. To support equal scheduling opportunity for all qualifying services/surgeons and outline processes to maximize schedule access.

   A. Blocks are allocated to a service or group.
   B. Block time is calculated as actual time plus reasonable turnover, divided by allocated block minutes minus voluntary release time.
   C. Block must maintain a threshold of 75% utilization.
   D. Operating Room (OR) Operative Services (OPS) committee will connect with each department at least once per quarter to review OR block time allocation and utilization.

PROCEDURES

I. BLOCK DISTRIBUTION PROCEDURE:

A. The Perioperative Executive Committee (PEC) will allocate block time to departments, services, or surgeons based on recent block utilization, strategic growth, and/or operational efficiencies.

   1. Requests for additional block time or changes will be made to the PEC.
   2. Named block holders are required to maintain at least a 75% on-time rate for their first case of the day or risk loss of the block time.

II. BLOCK UTILIZATION PROCEDURE:

A. Block time is calculated as actual time plus reasonable turnover divided by allocated time minus voluntary release.
B. Blocks begin when the OR begins each day, and cases will be booked sequentially to minimize gaps during the block.
C. Block holders are expected to be available and dedicated to the OR when they have block assignments. Coordination of other hospital activities (clinic, committees, meetings, research) will take a secondary priority to the OR.
D. Surgeons cannot schedule outside their block until they fill their blocks.
E. Any cases a surgeon performs on his/her block day count toward the surgeon's utilization, even if the case is scheduled in the block after the time has been released.
F. Cases done outside of block time will be monitored as out-of-block time and will not be included in block time utilization unless utilization is at 100%.
G. Targeted thresholds for maintaining block time:

1. 75% to maintain block time.
2. 50%-74% at risk for block time adjustment
3. <49%possible loss of block time
4. Utilization greater than 80% will be offered additional block time if available.

H. Blocks will be reviewed and updated on a quarterly basis using a quarterly block percentage average.
I. Reductions in block time will be implemented with adequate lead time to accommodate patients already scheduled in the block.
J. Specialty practice will be assigned reduction in block time or lose underutilized block after two quarters of underutilization.

1. First communication-written notification after one quarter of underutilization
2. Second communication-written notification of block reduction or removal after two quarters of underutilization.

K. Block time is adjusted in 2-hour or greater increments.

III. RELEASE OF BLOCK TIME

A. Unscheduled Block Time will release at 72 business hours and be given no utilization credit with the following exceptions:

1. Cardiac-does not release.

B. Blocks released one (1) week prior to block schedule will receive full utilization credit.
C. Gastroenterology/Plastic and Ear Nose Throat (ENT) blocks released 72 hours prior to the day of surgery will receive full utilization credit.
D. Excessive release of block time is monitored quarterly and will trigger a review if block times are released 15% or more of the time. This may result in a warning letter for loss or modification of block time.

REFERENCES: **Association of Perioperative Practice AORN**

DEFINITIONS:

1. Allocation: Amount of time a group is granted to do elective surgery.
2. Automatic Release: Unused block time that is released at an agreed-upon interval prior to the day of surgery. Released time converts to open time.
3. Blocked Time: Time in Operating Room (OR) reserved for services.
4. Block Scheduling Committee: Perioperative Executive Committee PEC and Perioperative Business Services.
5. Block Utilization: A measure of the use of operating room time by a surgeon or group of surgeons to whom time has been allocated.
6. Correct Time: Amount of time that a surgery takes during the same time as a matching block. First Cases Start Time 7:45 wheels in to OR.
7. Outside Time: Amount of time that a surgery takes outside the time of a matching block.
8. Procedure Time: Time between wheels into OR and wheels out of OR
9. Target Utilization: Expected minimum utilization of assigned block
10. Turnover Time: Patient out to next patient in (wheels in to wheels out).
11. Utilization Calculation: $\frac{\text{Correct + Turnover Time}}{\textbf{Available-}\text{Voluntary Released}}$
12. Voluntary Release: Process in which assigned block holders release their time. Blocks must be released 1 week prior to the day of surgery in order to get credit.

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
03/26/2024	**Operative & Invasive Procedures Committee** Applicable Administrator, Hospital or Medical Committee
04/16/2024	**Nursing Standards Committee** Applicable Administrator, Hospital or Medical Committee
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REPLACES: **N/A**

EFFECTIVE: **05/23/2024**

REVISED: **N/A**

REVIEWED: **N/A**