

## Surgery scheduling

# What's the best way to manage urgent and emergent OR cases?

**A** surgeon calls and says, "I have an emergency." The nurse at the front desk says, "OK, bring the patient to the OR." But then the surgeon replies, "Oh, no. It will be an emergency at 5 pm." The case is added to the schedule, and the surgeon arrives at 4:45 pm. Then another emergency arrives, and the first surgeon refuses to be bumped.

Scenarios like this happen every day in ORs. Too often, nurses end up in the middle of a conflict.

What are effective strategies for managing urgent and emergent cases that help avoid dust-ups at the OR desk?

Two veteran medical directors of ORs offer their suggestions. A researcher outlines the scientific way to order urgent cases (p 12). And a regional trauma center describes how it revised its bumping policy to make it more equitable (p 18).

Offering advice on urgent cases are William J. Mazzei, MD, medical director of perioperative services the University of California, San Diego, and a founder of the Association of Anesthesia Clinical Directors, and Tom Blasco, MD, MS, director of perioperative services at Advocate Lutheran General Hospital, Park Ridge, Ill. Both are founding partners of Surgical Directions, LLC, a Chicago-based consulting firm.

### Manage block time well

The prerequisite to any plan for coordinating urgent cases is to have a fair and equitable system for managing block time, Drs Mazzei and Blasco emphasize.

"If surgeons perceive that block time is not well managed, they'll do anything they can to make it work in their favor," Dr Blasco comments. "Ultimately, the key to success is not so much how you triage the urgent cases but making sure the block scheduling system is functional so surgeons trust it and don't abuse it." (An article on managing block time is in the November 2004 *OR Manager*.)

### Have an urgent room.

One major strategy for handling urgent cases is to build flexibility into the schedule by having an urgent room that is not scheduled until the day before surgery.

"If you routinely—at least once a day—have cases added that don't easily fit into your schedule, you should consider having an urgent room," says Dr Blasco. "If you have gaps in the schedule, this should not be an issue. But if your schedule is packed, and cases are being added on every day, an urgent room will help you handle extra cases without interrupting your elective schedule."

Though facilities with as few as 5 ORs should consider having an urgent room, it becomes critical when a facility has about 10 operating rooms, Dr Mazzei adds. With 20 ORs, there should be 2 urgent rooms. If a specialty, such as orthopedic trauma, has enough urgent cases, then an urgent room can be designated for that specialty.

Though utilization of an urgent room will rarely be more than 50%, "the political goodwill you will buy is probably worth it," he says. OR leaders might decide to keep utilization of the urgent room even lower to allow for greater OR access, particularly if the hospital is trying to attract new surgeons and build market share. They note, however, that greater access for elective cases should not be a driving force for having an urgent room.

### Consider how long to keep the room open.

The norm is to keep the urgent room unscheduled until 24 hours before surgery, Dr Mazzei says.

"You have to watch it very carefully," notes Dr Blasco. The key is to have a strong, fair surgical services executive committee that monitors and enforces how the

urgent room is used and prevents abuse by surgeons.

"The room has to be used for what it was intended for—urgent and emergent cases. If you have a surgeon who is doing elective cases in there because he can't get on the block schedule, you have to do something different," such as addressing issues with blocks.

### **Have a triage team.**

Daily management of urgent and emergent cases is a team effort that involves the surgical scheduler, the OR manager, the medical director of the OR (typically an anesthesiologist), and the nurse at the front desk. The medical director must be perceived as unbiased and not catering to any one specialty. If there is no medical director of the OR, a physician should be assigned daily to manage urgent cases.

"The team needs to develop a relationship and determine how they will work together on a daily basis," Blasco says.

Dr Mazzei adds, "The key is having a good working relationship between the person who is running the schedule, such as the medical director, and the person at the front desk. These leaders will be in frequent contact, so they both need good communication skills." The medical director must also have access to a phone to be able to communicate with surgeons and others throughout the day.

### **Have physicians talk to physicians.**

In making decisions about urgent cases, physicians must talk with physicians whenever possible and keep nurses from being caught in the middle, they advise.

"The medical director or physician running the schedule has to take charge, working physician-to-physician in most cases," Dr Blasco says. As medical director, he tells nurse coordinators: "Never get yourself in the middle of one of these situations. Call me."

### **Should you have definitions?**

Some ORs go to great effort to define urgent cases and list types of cases that will be considered urgent. "I've never seen that work," Dr Mazzei says.

The other option is not to have definitions. Life- and limb-threatening cases generally are obvious and will be done, bumping an elective case if necessary. Urgent cases generally will be done as they can be fitted into the schedule. If there is disagreement about whether to bump a case, the disagreement should be negotiated between the medical director and the surgeons involved.

### **What about bumping cases?**

In smaller community hospitals that can't afford a medical director, a common policy for bumping cases is to have the surgeon with the emergency call the surgeon whose case he would bump.

"That begins to put the surgeons in a situation where they have to make a decision among themselves about the triage," Dr Blasco says. Admittedly, that system doesn't always work. Ideally, the surgical executive committee should decide what to do about cases that are not clear-cut. One possibility for smaller hospitals is to have the medical staff decide who will make the final decision, such as the chief of surgery or the chief of the medical staff.

Dr Mazzei suggests, "This probably should be someone who is so difficult to reach that a surgeon won't attempt to bump a case unless he is convinced it is an emergency."

During the weekend, if a surgeon insists a case is an emergency, a disagreement arises, and the chief of surgery can't be reached, Dr Blasco says he would opt to add the case to the schedule and not to put the patient at risk.

"Later, you can discuss the situation at the surgeon executive committee," he says.

If you can figure out some way to do the case, that's the best solution, whether it's urgent or not, as long as the policies are perceived as fair and consistent, Dr Mazzei notes.

At his facility, there is a policy that for any case booked by noon, enough staff will

be kept on hand to start the case by 5 pm. That way, the surgeons recognize they don't have to declare a case an emergency to have it done by the end of the day, "which means there are a lot less shenanigans in the afternoon." ♦

—Pat Patterson

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## ***Five principles for managing urgent cases***

1. Manage block time in a way that surgeons perceive to be fair.
2. Have a strong surgical executive committee that sets and enforces scheduling policies.
3. Have an open room to provide flexibility.
4. Have a medical director who works with the front desk to coordinate the schedule and mediate any conflicts with the surgeons. If there is no medical director, have a physician assigned each day to work with the front desk.
5. Have the medical staff designate who will make the final decision in case the medical director of the OR can't resolve the issue.

Source: William Mazzei, MD; Tom Blasco, MD, MS.