Correction

to ORNAC's
Recommended Standard #8
"Scrub, Gown, Glove"
Section 8.13 should read:
If a glove becomes contaminated or sustains a pin hole, the glove shall be changed as soon as the situation permits **by one member of the sterile team regloving the other member.** If not possible, **by open glove method.**

Rationale:
Once the original gloves are donned, the gown cuffs are considered contaminated.

Vija Hay
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tions in range of motion due to the fractured right wrist. (This documentation is on Perioperative Flowsheet II, see Appendix 2).

The Operating Room nurse acting as the patient's advocate continued to ensure that these goals were met in the interoperative phase. Any goals that were still active were communicated to the PAAR nurse.

Summary

The flowsheet was trialed and assessed by staff. Valuable input for several revisions was received and incorporated into each new version.

The current form is the result of trials and revisions of the original format developed three years ago. The process of developing this type of documentation was an enriching experience for all involved. This Perioperative Flowsheet now reflects the nursing care provided in the Operating Room.

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Seifert, P. & Grandusky, R. (1990). Nursing diagnoses: their use in developing care plans. AORN Journal, 51(4), 1008-1021, 1023-1026.

Stanfield, V. (1987). Perioperative documentation: Integrating nursing diagnoses on the patient record. AORN Journal, 46(4), 699-701, 703-704.

Note:
The complete documentation is available on request. Please send a self-addressed enveloped (and 88¢ postage) to:
Laurel Hopwood-Jones
Hamilton Civic Hospitals
Henderson General Division
Operating Room
711 Concession Street
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L8V IC3

OR Booking Policy:
Development and Implementation

By Margot Kontak-Forsyth, RN,BSc,BN,MEd & Anne E. Grant, RN, LL.B

Surgical bookings are integral to the optimal functioning of any operating room facility (OR).[1] Ideally, the goals and strategic planning of the organization should be reflected in surgical block scheduling. For example if an institution has identified that it intends to increase outpatient procedures or day surgery, it only follows that an appropriate amount of elective surgical time be allocated to any service or physicians who perform such procedures. Unfortunately this is not always recognized and often the process of booking OR lists is designated as merely a clerical function. In actual fact, bookings are the force that drives the OR. The authors will examine development and maintenance of a policy for this important area, and outline criteria which should be included in an optimal OR booking policy.

There are two general methods of allocating operating room time: block scheduling and open bookings.[2] Block scheduling utilizes a master schedule which defines the number and types of rooms available, the hours that rooms will be open and the service or surgeons who are allocated the operating time.[3] While a master scheduling system has been observed to be potentially more efficient, this is dependent, on whether the scheduled block accurately reflects the actual patterns of usage and whether mechanisms are in place to release unreserved blocks in a timely manner.[4] For example, if a surgeon has been allocated a weekly block and over three months has demonstrated 70% utilization of this time, it would be appropriate to assess whether to decrease the length of the block. Under the open bookings system, also known as first come first served (FCFS), surgery is allocated to the first physician making the request. While FCFS systems are simple to implement and widely used, it has been observed that this system is associated with high levels of cancellations, low resource utilization, excessive overtime and friction between surgeons.[5]

Whatever type of surgical scheduling system is in use, an OR's bookings determine the surgical operational budget. In other words, the surgical schedule directly impacts staffing, hours of work, and utilization of supplies and equipment. As a key cost centre of any hospital, it is imperative that bookings be run smoothly and consistently. Further, the OR bookings significantly impact many other departments in the hospital including: Radiology, Haematology, Housekeeping, Pathology, and Biomedical Engineering to name but a few. Perhaps most significant is the impact of OR surgical block time on the utilization of that

1. Booking policies are utilized in many clinical areas such as endoscopy, cystoscopy, day surgery and out patient clinics. The criteria identified in this article would apply equally to other areas, but for ease of reading, the authors have chosen to refer solely to the operating room.
2. Breslawski, S. & Hamilton, D., Operating Room Scheduling, *AORN Journal.* (1991) 53(5),1229-1237.
3. Blake, J. T., *Strategic and Administrative Aspects of Advance Surgical Process Scheduling* (1994) Department of Industrial Engineering, University of Toronto (unpublished), at page 11.
4. Blake, supra at page 12.
5. Breslawski, supra.

Authors

Margot Kontak-Forsyth RN, BSc, BN, MEd, is the Associate Director of Perioperative Services, Mount Sinai Hospital, Toronto.
Anne E. Grant RN, LL.B, is a registered nurse, a lawyer and a trained mediator. Currently, she functions as a health care legal consultant.

scarce resource, hospital beds. A poor booking policy, as with a poor system of surgical time block allocation, results in surgical staff circumventing the rules in order to get their cases done. This triggers other problems with staffing, inconsistent application of the rules and inefficient use of OR time, which may result in increased costs and a system clearly out of control.

Source of Problems

Possible problems with booking policies include:

- over utilization and under utilization of surgical block time;
- chronic overtime of nursing and support staff;
- last minute changes to the list resulting in inefficiencies for other departments such as Radiology, Haematology, Pathology, Housekeep ing, CSR, PAR etc. Late changes to the list also increase nursing staff costs due to changes in set-up and assignment of staff;
- perception of favoritism re allocation of time;
- inappropriate scheduling of emergency cases;
- unavailability of equipment;
- cancellations; and,
- dissatisfied and unhappy clients.

The authors would also like to point out that the location of the booking office functions should be physically near the surgical suite. Booking functions are part of the day to day operations of the OR. In order to ensure efficiency, ready access by all OR personnel is necessary, for anaesthesia assignments, surgeons making changes, checking on lists, etc. Each institution will have to consider what works best in their own setting in the context of space restrictions and other limiting factors.

Problems with the OR list impact nursing staff, anaesthesia, surgeons' clinics and support staff as well as numerous departments outside the OR. Booking changes may contribute to increased change-over time and increased over-time worked by nursing staff.

Development of Booking Policies

Having identified problems, the procedure to amend and implement any policy should be collaborative. The process must consider hospital goals and objectives as well as the requirements of the staff physicians. The review should be conducted by the OR Management Team which consists of three individuals representative of Anaesthesia, Surgery and Nursing.[6] It has been the experience of the author that a smaller working group accountable to the larger OR committee structure is most efficient. The process should allow for the head of the Surgical and Anaesthesia departments as well as the heads of various surgical services to be consulted separately. This promotes collegiality as well as providing an opportunity to assess the impact of the policy on various staff. Other hospital commitments for physicians must also be factored in. These commitments include coverage in: labour and delivery; ICU; the emergency department; clinics; and pre-admission units. All adjustments to the policy should be reviewed once more by these stakeholders before the draft goes to a full OR Committee. Multidisciplinary consensus is essential to ensure on-going compliance.

Criteria to be Considered for an Optimal Booking Policy

The criteria which should be considered for an optimal booking policy have been subdivided into three sections: elective bookings; emergencies; and semi-emergencies.

Elective Bookings:

An optimal effective booking policy should address the following:

- A standard booking request form and process for all services and areas serviced by the booking office;
- Onus on the surgeon for providing timely, accurate and complete booking information including need for X-rays, type of anesthetic, equipment requirements, etc.;
- Complete and continuously updated list of procedures for each surgeon;
- Procedural time for each booked case based on objective data as provided by the data collection system in use (for example: an average of the times of the last ten (10) procedures done in the particular OR);
- Changes to the procedural times should require nursing management approval and consent;
- Pre-designated deadline for bookings. For example, elective bookings may be done months in advance but in a large urban teaching hospital the list should be finalized 48 hours prior to surgery, (for example, by 1200 on the second working day preceding surgery.) For out-patient surgery it may be prudent to close bookings one week in advance. Likewise, in a rural setting the cutoff time may be a week to a month prior to surgery. This provides anesthesia and nursing with adequate time to prepare and determine staffing requirements as well as time to notify and confirm the booking with the patient. Surgical time is removed and/or reallocated at this point if not booked;
- Exceptions to the designated deadline should be spelled out. Examples of such exceptions could include, neuro surgery, some vascular cases and retinal surgery, due to the urgent and emergent nature of the patient population. This assists in decreasing utilization of emergency time for these types of surgery;
- Bookings should close and the OR lists should be published at some consistent time such as at 1400 hours on the second working day preceding surgery;
- Distribution of the list should be consistent and predictable. Circulation is important as the Pre-Admission Unit relies on the list to re-affirm date and time of surgery with their clients;
- There should be a target of 100% utilization of various departments/division's surgical time. This can be enforced by designating one clerical individual per surgical specialty to ensure that any unused time is distributed to others in the department first and then to other departments. When allocated time is not used, this should be documented and sent to a designated individual who has a responsibility to ensure appropriate future action; (The authors recommend a member of the OR Management Team who is in turn accountable to the OR Committee.)
- It should be specified that longer cases go first unless there is a documented exception. This ensures that major cases are done when the team is "freshest", that major cases are not cancelled at the end of the day and prevents major cases from running late into the evening;
- Responsibility for re-arrangement of the list and notification of surgeons etc. should be spelled out;
- There should be specified procedures for dealing with cancelled and delayed cases, such as a delayed cases list;
- It should be specified that staff surgeons must remain in the OR with any case which is running late to minimize over-time and other additional costs;
- There should be procedures for dealing with remaining time if a surgeon's elective list finishes early;
- There should be a form and a process to address OR booking irrigulatities. This situations should be documented and submitted to the same designated individual responsible for enforcing utilization of surgical time, (Member of OR Management Team, accountable to OR Committee);
- There should be a specific protocol to deal with Emergencies.

Emergencies:

Emergency cases need specific treatment which should be clearly spelled out.

Procedures should be in place to determine priority of cases and to resolve potential conflicts. This is generally done through the use of a policy and procedure for emergencies and an Emergency Request list. An optimal policy should include:

- A clear definition of an Emergency Case;
- A list of cases defined as emergencies, according to the emergency case list submitted by each surgical service;
- Requirement that only surgeons or house staff may book such cases utilizing the appropriate form;
- Prescribed procedure for dealing with situations where a surgeon books a case which is not on the emergency list;
- The surgeon and the patient must both be available or the nurse does not take the booking;
- Provision for contacting the surgeon should OR time become available;
- Provision for documenting inappropriately booked Emergency Procedures. Such documentation should be submitted to the OR Management Team for action;
- Designation of the order in which emergency cases will be done;
- Provision for the resolution of any conflict as to the order of emergency cases;
- Clear direction as to what cases are to be done on what shift. For example, only emergency cases to be done on nights or weekends;
- Procedures as to who may call in nursing staff to do emergencies; and
- Define the number of emergency rooms to be run

6. The authors note that later references to the "OR Management Team" refer to the three person multidisciplinary structure described. This team is the working arm of and is accountable to the OR Committee.

and ensure anesthetic and nursing coverage.

• Clear procedure establishing how to bump elective cases.

• Provision that emergency cases should bump within their own service whenever possible.

Semi Emergencies:

The issue of "semi" emergencies generally applies to ORs with a high volume of orthopaedic surgery. Often cases such as fractures are "bumped" and the patients are left NPO waiting while other emergent cases take priority. A surgical service may need to assess its waiting list to determine whether allocation of fracture time for example, should be placed into Orthopaedic Surgical Blocks or the general elective block. Booking procedures need to be amended to include a limited time frame in which a fracture can be bumped. This could be 48 hours, before the case is automatically slotted into the assigned surgeon's elective list.

Implementation

The implementation of a booking policy builds on the same processes used for its development: collaboration; consensus; and multi-disciplinary cooperation. It is imperative that the policy be widely circulated, approved and enforced to foster credibility. Generally the policy will be determined by all major OR stakeholders and after consultation, presented to the main OR committee for approval. Institutional circulation should include the Surgical Nursing Directors, Post-Anesthetic Care Unit, and the Pre-Admitting Department. Such a policy should not only be accepted within the OR, but should be supported by all levels of the organization. As previously stated the goals and strategic plan of the institution should be reflected in this and all policies.

Automation

No comment on optimal OR booking would be complete without reference to automation. Automating a poor booking policy will not necessarily correct the problems. So assessment and revision of the booking policy ideally is a pre-requisite to automation. Even where booking offices are automated and equipped with progressive technology, the maximum utilization of these systems is not always realized. Computer systems have great potential to provide important data in a variety of forms and reports. Institutional contracts should be reviewed to determine what modules of the software may be available to upgrade an OR's existing system. Modules exist to deal with various functions and it is imperative that these options be explored, particularly in automated systems which are already installed.

Generally, staff needs for a manual booking system are the same as for a system which is automated. Remember, once additional data is available, more people will want reports. A mechanism should be put into place to filter who receives reports and when.

Those who are considering automation of the booking function should clearly identify their institutional and departmental needs in order to choose the best system for them. In addition to reviewing various companies' products, administrative staff should consider on-site visits to similar facilities to learn from common experience. As with any worthwhile endeavour there should be a plan for implementation. This could include a determination of how much is to be automated and at what point. For example, it may be planned to start with the main OR and expand later to include cystoscopy, endoscopy, etc. Part of the automation plan should be to standardize and streamline the process prior to automating. The technological enshrining of an inefficient and unwieldy system will only result in grief down the road.

Follow-up and Evaluation

As per the nursing process and any good business plan your booking policies and procedures should be evaluated regularly. The Master Schedule should be reviewed, updated and changed on a regular basis. A helpful system is to utilize a regular schedule for general use, and a reduced schedule to be implemented at Christmas, spring break and summer vacation. The utilization of surgical blocks should be assessed regularly (every three months) and administrators should respond to the patterns established by particular surgeons or services. The allocation of surgical beds should be consistent with the allocation of OR time. For example, if it is determined that Orthopaedics requires more time to meet the needs of an additional surgeon, and the total amount of surgical time remains unchanged, surgical beds should be reallocated appropriately.

The emergency case list and elective procedure lists should be continually updated as new procedures and new surgeons come on board. The main booking policy and procedure should be evaluated annually and on a "as needed" basis. The follow-up function can be delegated to the nurses in charge of your surgical specialties. This is an efficient way of handling ongoing evaluation as such nurses are generally among the first to be aware of new procedures and changes.

Summary

The importance of an optimal booking policy which has been reviewed and accepted by all staff cannot be over-emphasised. In these times of re-structuring it is imperative that organizations ensure that key cost centres are run efficiently. Achieving excellence in the utilization of surgical services in any size institution starts with a booking policy that is clear, realistic, accountable at all levels and applied consistently.

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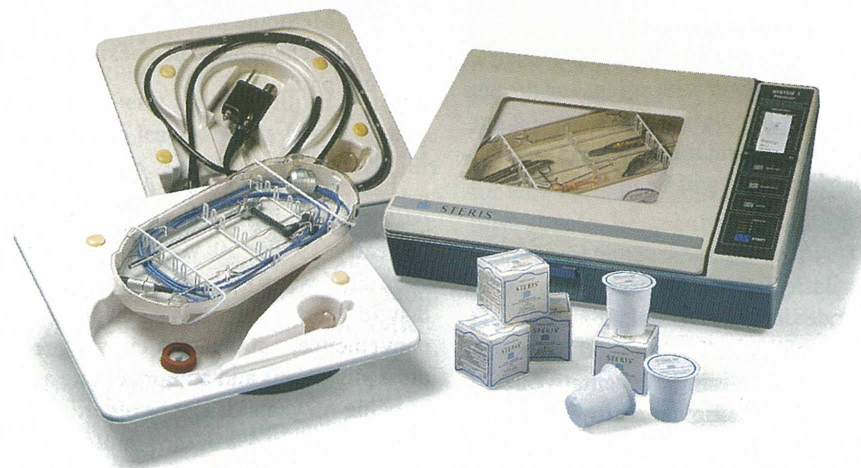

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