Staffing Policy Template

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:

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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 emergency surgery.

2.2 To reduce and prevent the cancellation of 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 effective surgical service.

4 Definitions used

Theatre Coordinator - The most senior Registered Nurse/Operating Department Practitioner overseeing the whole department.

Theatre team leader - The theatre 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.

NCEPOD/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. (NCEPOD 2001)

5 Times of operating sessions

5.1 AfPP acknowledges that many operating departments are managing locally agreed sessions to fulfil their required demand. AfPP also acknowledges that all day operating lists with the same operating consultant are commonplace in an effort to achieve increased efficiency in theatre utilisation. Some establishments continue to operate on varying allocated session times which may cover morning, afternoon and evening sessions.

5.2 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. Sessions can be decided locally and some theatres operate on a full day session 8-6 or 8-8 for elective patients. This is ideal where there are long cases and where the allocation of breaks can be unpredictable. In this situation the importance of adequate staffing and controls to relieve and support staff are utmost, and should be reflected in the overall operational policy.

6 Cancellation of elective/scheduled patients

6.1 Lists should be realistic for their allocated times. A booking policy should be in place which determines timings allocated for different procedures and consultants. The list should be managed by the theatre manager and agreed in advance. Every effort should be made to avoid overbooking of patients on lists resulting in cancellation which can be very stressful and unsatisfactory for patients.

6.2 In situations where the operating surgeon is about to, or has actually run out of allocated elective session time, the coordinator or designated team leader of the theatre concerned, in collaboration with the consultant anaesthetist should discuss the cancellation of further cases to take into account available resources and patient need.

6.3 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.

6.4 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.

6.5 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 Changes to list orders should not be made except in extreme circumstances and for viable clinical need. The appropriate clinical incident form should be complete each time changes are made indicating the reasons why the change was necessary. In compliance with AfPP Standards and Recommendations 2011 all copies of theatre lists should be amended to reflect the changes, and all parties informed in the interests of patient safety.

6.7 Booking sessions: The scheduling of theatre cases should reflect evidence collected from real time data capture to ensure realistic session timings scheduling of theatre cases and ongoing challenge.

6.8 All cancellations should be audited monthly to determine whether theatre scheduling has been effective. This process should include the theatre management team and local governance arrangements.

7 Varying exceptional circumstances

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 provides a responsive emergency service, then a designated 24 hour operating theatre, managed by trained and competent staff, must be resourced (NCEPOD 1997, 2003).

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 Anaesthetists and surgeons rostered for emergency work should be free from other commitments (NCEPOD 1997, 2003).

9 Cancellation/changes to the operating list

9.1 All operating lists should arrive in the operating department minimum 16 to 24 hours in advance of a scheduled session, in order to ensure patient safety and the effective utilisation of resources (AfPP 2011).

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.

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.

9.7 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 AfPP (see pages 12–17 of *Staffing for Patients in the Perioperative Setting*) are utilised.

The recommendations include as a minimum and after risk assessment of patients' needs and the skills and competencies required of the perioperative team:

- **TWO SCRUB PRACITIONERS** 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 REGISTERED ANAESTHETIC ASSISTANT PRACTITIONER** for each session involving an anaesthetic. 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. 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.

REFERENCES

Association for Perioperative Practice 2011 **Standards and Recommendations for Safe Perioperative Practice** Harrogate, AfPP

Association for Perioperative Practice 2014 **Staffing for Patients in the Perioperative Setting** Harrogate, AfPP

National Confidential Enquiry into Patient Outcome and Death 1997 **Who Operates When? 1 April 1995-31 March 1996** London, NCEPOD www.ncepod.org.uk

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