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9:00 AM - 11:00 AM

Room Hall E, Area D

A Good Start to a Good Day: Increased Percentage of On-Time First Starts in the Operating Suite

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Introduction:

Operating room efficiency is a much-discussed topic in recent anesthesiology literature. In our operating rooms, first cases were frequently delayed. This contributed significantly to an overall decrease in efficiency for the rest of the day; start times for subsequent cases were unpredictably pushed back, which often resulted in the cancellation of cases scheduled for later in the day. Our situation was further complicated in that 30 % of our patients are prisoners who require additional security measures. In this prospective study we report on our operating room initiative to increase the frequency of on-time first case starts.

Methods:

A core group composed of the OR medical director, the OR administrator, the chairman and vice chairman of the anesthesiology department and the head nurse of the operating rooms reviewed current statistics for first time starts. All personnel whose jobs influenced first time starts were identified and specific improvements were mandated. For example, nurses and guards were instructed to bring all patients into the operating rooms by 7:15 am. All consent issues, surgical issues and final preoperative evaluations were to be finalized in the operating room. Nurses were instructed to bring patients directly to the operating room and by-pass holding whenever possible. The numbers of prison hospital guards available for transportation was also increased. We then selected a "go live" date of August 1, 2005. The percent of on-time starts was posted daily in public spaces throughout the operating room. There was daily reinforcement by the OR medical director and nurse manager, and personal were required to account for all delays.

Results:

Analysis of On-Time First-Case Starts:[table1]* $p < 0.05$

Discussion:

Our data show that we were successful in our initiative. The percent of on-time first case starts tripled to comprise 78% of all first cases. Instead of a typical quality improvement team, we used a "top-down" management approach of a leadership group that later solicited feedback from component groups. Although our study was not randomized, the control interval immediately preceded the intervention. When combined with a subsequent initiative to improve global turnover times, we improved operating room efficiency and decreased monetary outlays for late rooms while maintaining the same case load.

References:

1. Friedman DM, Sokal SM, Chang Y, Berger DL. Increasing operating room efficiency through parallel processing.[see comment]. *Annals of Surgery* 2006; 243:10-4.
2. Sandberg WS, Daily B, Egan M, et al. Deliberate perioperative systems design improves operating room throughput.[see comment]. *Anesthesiology* 2005; 103:406-18.
3. Prough D, s, Dana J, Yancey V, Duncan R. Improving Operating Romm Efficiency: A Sisyphean Task? *Problems in Anesthesia* 1998; 10:373 - 394.
4. Overdyk FJ, Harvey SC, Fishman RL, Shippey F. Successful strategies for improving operating room efficiency at academic institutions.[see comment]. *Anesthesia & Analgesia* 1998; 86:896-906.

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On Time Starts

Period	Yes On Time	No On Time	Total	% change
7/01-7/29	100 (28%)	258 (72%)	358	
8/01-12/07	462 (61%)	294 (39%)	756	+33% *
12/08-12/31	174 (78%)	49 (22%)	223	+ 17% *
1/01-1/17	127 (75%)	43 (25%)	170	- 3%
Total	863			