In many surgery departments, schedule management is a daily struggle. Staff work hard to manage case requests, juggle resources, and respond to changes, but errors, inefficiencies, and general frustration persist. The results are frequent case delays and cancellations, low utilization, high costs, low staff morale, and poor surgeon satisfaction.

The key to effective scheduling is to develop solid processes for booking cases, creating a daily operational plan, and responding flexibly to emerging conditions. Well-designed scheduling systems are built on 4 principles of effective information management and workflow planning.

Centralize and standardize
OR efficiency starts with the accurate boarding of the surgical case. In many ORs, however, boarding processes are complex and poorly controlled.

A common problem is that different staff members may handle different phases of the scheduling process, with separate responsibilities for various OR units and out-of-OR areas. This creates disconnects and information gaps.

The solution is to establish a centralized scheduling office staffed by a dedicated nurse coordinator. This coordinator will receive all schedule requests, book cases, assist in managing the daily schedule, and provide clinical oversight of the entire scheduling process.

Another problem in many ORs is that surgeons are allowed to make schedule requests via multiple avenues, including phone calls, emails, faxes, and in-person requests. This leads to inconsistent information capture—some surgeons provide only minimal details about the patient and the procedure.

The solution is to establish a single vehicle for scheduling surgical cases. Many leading ORs have developed a standardized fax form for submitting schedule requests. Typically, the form is developed with multidisciplinary input so that it reflects the information needed by surgeons, anesthesiologists, OR nursing, materials management, and other stakeholders.

Required fields should include full patient demographics and complete procedure information (specifying admission type and anesthesia needs). The form should also include space to specify any special instructions or equipment needs (sidebar, p 22).

We recommend adopting an electronic solution for managing fax requests. Several vendors offer electronic fax management systems capable of receiving scheduling requests, assembling information into organized folders, and facilitating active management of case information.

Well-organized ORs also integrate scheduling with other perioperative processes and functional areas. Booked cases are automatically pushed to preadmission testing (PAT) so staff can immediately initiate patient triage and preoperative testing protocols. Similar links can be created to drive proactive interventions in case management, admissions, and patient financial services.
A good scheduling form includes full patient demographics, procedure information, and space for special instructions. 
Source: Surgical Directions.
Build in accuracy

The first step to improving schedule accuracy is to address problems in the scheduling dictionary. In many ORs, surgical cases are scheduled by procedure name. But this often forces scheduling staff to choose between several similar procedures. Selecting the wrong procedure will create problems downstream.

For example, suppose a surgeon’s office requests OR time for “inguinal hernia repair.” Scheduling staff assume this is a laparoscopic procedure, but the case will actually be an open surgery, with completely different setup, instrumentation, and postoperative needs. The incorrect booking leads to wasted time and resources.

At the minimum, an incorrect procedure in the schedule system will generate the wrong pick list. This can cause delays during surgery, as the circulating nurse may need to leave the OR to obtain missing instrumentation and supplies. Incorrect pick lists also lead to supply waste.

To prevent these errors, the scheduling dictionary should be edited so that staff can book cases by CPT code aliases tied to procedure names. Booking by code ensures that all presurgical processes are focused on the correct procedure. (Be sure to include the CPT code as a required field on the schedule request form.)

The second step to ensuring schedule accuracy is to develop accurate case time estimates. Many ORs allow surgeons to assign case times during scheduling. However, surgeons often underestimate setup time, close time, and turnover time. Low estimates result in delayed start times for following cases and can create large schedule gaps. Some ORs have schedulers review and adjust surgeons’ case time estimates, but this can involve a lot of guesswork.

The solution is to use a historical performance method for calculating case times. When a schedule request comes in, pull case times for the last 12 like procedures for the surgeon, drop the high and low values, and average the remaining 10 case time figures (sidebar, p 23).

Some surgical information systems can be configured to do this automatically, but a dedicated scheduler can become adept at manual calculation. Surgeons may be allowed to request a longer case time, but they must receive special permission from the scheduling office.

Other interventions can make boarding processes more effective:

- Enhance the boarding form to ensure key information flows forward. For instance, the form should specify any sleep apnea or malignant hyperthermia issues.
- Make sure the surgeon block schedule is loaded into the scheduling information system. This helps schedulers book cases correctly, and it helps the entire OR get a good start on strong block time utilization.
- Have staff flag potential problems directly within the schedule. For example, a patient may require a fiberoptic intubation. Noting this in the schedule entry will allow OR managers to prepare accordingly so that the case can start on time.

Clear the runway

Many ORs do not devote adequate attention to the 24 hours before surgery. A common problem is that the schedule never closes. Physicians are allowed to add cases to the schedule up to the morning of surgery, with no regard for the disruption this causes to anesthesia and nursing staff.
We recommend closing the OR schedule at 1 or 2 pm on the afternoon before surgery. This gives OR leadership time to develop an operational plan for the next day. Any later requests should be considered add-ons to be managed at the discretion of the medical director.

The medical director, PAT nurse, scheduling clinical coordinator, and other OR stakeholders should hold a daily huddle every afternoon following the schedule close. The purpose of the meeting is to ensure all next-day patients have medical clearance. Participants should also focus on finalizing the upcoming schedule in terms of room assignments, case times, and case order, and on coordinating staffing and equipment for optimal schedule flow. Daily huddles in many better-performing ORs review the schedule 1 to 5 days in advance.

In many ORs, patients do not receive confirmation of their surgery time until the evening before their procedure. This creates unnecessary stress and inconvenience. By closing the schedule early and finalizing it promptly, many ORs are able to provide patients with arrival time and procedure time confirmation by 3 pm.

**Plan for flexibility**

Starting the day with an operational plan is critical to efficiency, but OR leaders need to be ready to adjust the plan as the day proceeds. To respond to issues “on the fly,” ORs must develop dynamic scheduling processes for the day of surgery.

First, develop strong operational leadership. The OR medical director, chief anesthesiologist, or floor leader must take an active role in daily schedule management. This includes responsibility for maximizing schedule efficiency, not just directing traffic. The medical director’s own case load may need to be adjusted to allow him or her to manage the schedule appropriately.

Medical directors should devote particular attention to managing add-on cases. Add-ons include cases requested after the close of the schedule on the previous day and any urgent/emergent cases. Effective medical directors take advantage of holes in the schedule to accommodate add-on volume while introducing as little disruption as possible. This underscores the importance of having adequate “open rooms” not only for add-on cases but also for case requests from surgeons who do not have block time.

Many ORs lack a culture that supports dynamic scheduling. OR leaders need to set the expectation that the schedule will be actively managed and that flexibility will be viewed as a core competency for staff. The most effective way to attain this culture transformation is to establish true shared governance of the OR through a multidisciplinary Surgical Services Executive Committee.

**An efficiency barometer**

As OR leaders begin to address scheduling problems, it quickly becomes clear that efficiency depends on a range of processes and performance improvement efforts.

For example, efficient scheduling requires active management of block time allocation. Effective block management, in turn, calls for clear block guidelines with appropriate release schedules and utilization thresholds (see OR Manager, May 2013, p 21). Accurate preference cards are key to avoiding time-wasting equipment conflicts. Improving preference card accuracy typically involves a focused effort to consolidate existing cards (the rule of thumb is 20 preference cards per active surgeon).

Ultimately, an effective schedule is the byproduct of strong processes throughout perioperative services. Schedule efficiency can provide an accurate barometer for your ongoing efforts to build a strong surgical services organization. ✤
This column is written by the perioperative services experts at Surgical Directions (www.surgicaldirections.com) to offer advice on how to grow revenue, control costs, and increase department profitability.