Targeting Operating Room Inefficiencies in the Complex Management of Vision-Threatening Diseases in Children

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Objective: To review the effect of interventions designed to decrease turnover time in infants and children (median age, 2.6 years; range, 1 month to 10 years) who required examinations under anesthesia.

Methods: Five efficiency interventions (3 anesthesia providers for 2 rooms, digital remote communication, change in patient scheduling, standardization of case order, and streamlining administration of preoperative medications) were implemented during a 4 1/2-year period from January 2003 to July 2007. Using data from our in-house operating room information system, we analyzed turnover times (time it took 1 patient to leave the operating room and the next to enter).

Results: The mean turnover times decreased from 12.1 minutes to 3.8 minutes. The 90th percentile of longest turnover times decreased from 14.5 minutes in 2003 to 5.8 minutes in 2007, despite a progressive increase in the number of cases per day.

Conclusion: Caring for children who require extensive examinations under anesthesia can be efficiently achieved in nonpediatric environments.

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Methods

We retrospectively reviewed OR data for all infants and children (median age, 2.6 years; range, 1 month to 10 years) who underwent examinations under anesthesia for retinoblastoma or other vision-threatening conditions (that require a thorough indirect ophthalmoscopic examination) at the Bascom Palmer Eye Institute from January 2003 and July 2007. All examinations were performed by a single ophthalmologist. Using Structured Query Language reports, we extracted data from our in-house OR management system. Data collected included date of procedure, date of birth, time patient was in room, time patient left OR, time patient entered OR, OR room number, and Current Procedural Terminology codes. Cases were sorted by date, OR number, and the time patient was in the room. Turnover times were calculated as the difference between the time a patient left the OR and the time the next patient entered. For each calendar year of the study, we calculated the following: number of cases per day and per year, number of turnover events between cases, duration of each turnover, and time of day the last case was completed.

Deidentified data from our OR information management system were analyzed. Our
morning. Starting in 2005, all families were asked to be at the
instructed to arrive at various designated times throughout the
quirements (third intervention). In prior years, families were
purchased.

a communication device (Vocera Communications Inc, Cupertino,
Meninges, removal of cataracts, and enucleations. This strategy
proved efficiency by minimizing the need to move large equip-
mog, up to a maximum dose of 12 mg) before arriving to the hold-
were carried out simultaneously in 2 adjacent ORs to

No. of turnover turnover cases, % 84 86 87 87 89
Turnover time, mean (SD), median, min 12.1 (18.2), 8 11.7 (21.9), 8 7.2 (10.3), 5 5.7 (7.0), 5 3.8 (3.2), 3
Latest time last child left operating room 6:15 PM 4:31 PM 7:19 PM 3:10 PM 2:32 PM
Mean time last case finished 12:40 PM 12:34 PM 12:17 PM 11:58 AM 12:18 PM

Table. Operating Room Efficiency Data for Examinations Under Anesthesia in Children With Vision-Threatening Diseases

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of cases</td>
<td>338</td>
<td>387</td>
<td>359</td>
<td>535</td>
<td>336</td>
</tr>
<tr>
<td>No. of turnovers</td>
<td>283</td>
<td>331</td>
<td>312</td>
<td>465</td>
<td>300</td>
</tr>
<tr>
<td>No. of turnovers/No. of cases, %</td>
<td>84</td>
<td>86</td>
<td>87</td>
<td>87</td>
<td>89</td>
</tr>
<tr>
<td>Turnover time, mean (SD), median, min</td>
<td>12.1 (18.2), 8 11.7 (21.9), 8 7.2 (10.3), 5 5.7 (7.0), 5 3.8 (3.2), 3</td>
<td></td>
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</tr>
</tbody>
</table>

a Projected estimate of 576 cases for 2007 based on the rate at the time of manuscript preparation.

institution has determined that institutional review board ap-
approval is not required when no direct identifying patient in-
formation is obtained. This study was evaluated under the aus-
pices of our patient care and quality assurance review to assess
trend analysis in our OR facilities. During the 4½-year period,
a number of interventions were implemented to improve the
case flow.

Following the recruitment of an additional pediatric anesthesiologist (in the fall of 2003), 1 of 2 pediatric anesthesiologists supervised all examinations under anesthesia for children at risk of retinoblastoma. In 2004, we optimized anesthesia staffing in each of the 2 dedicated ORs. The pediatric anesthesiologist supervised 3 residents or certified registered nursing assistants who were collectively assigned to 2 ORs (first intervention). Previously, the pediatric anesthesiologist supervised 2 providers (1 in each room). This modification enabled each room to have anesthesia coverage while the third anesthesiologist completed the documentation and prepared for the next patient (eg, reviewed the preanesthesia history and physical examination results and prior OR anesthesia records, confirmed/reiterated informed consent with responsible adults, established rapport with the child and parents, provided anxiolytic medications as indicated, and consulted with the attend ing anesthesiologist).

Patients next in line were seated with their parents in a holding
area less than 15 feet from both ORs. Such closeness makes it possible for the attending anesthesiologist to re-evaluate the patient once the previous case has begun. Depending on whether or not the children received oral anxiolytics, they were either carried or walked into the OR. We standardized our turnover process. We typically wiped the OR table down with an antiseptic cleaning agent, placed fresh sheets, and changed the anesthesis circuit.

In late 2004, we instituted the use of a digital remote communication device (Vocera Communications Inc, Cupertino, California) to be carried by each member of the anesthesia team (second intervention). These devices enabled continuous communication among the anesthesiologist, OR control desk, and transporters, thus facilitating the steady flow of patients to the holding area. Operating on our institution’s existing wireless network, this communication process requires a site license and a number of communication “badges,” which cost approximately $200 to $300, depending on the number purchased.

In early 2005, we changed our method of scheduling require-
ments (third intervention). In prior years, families were instructed to arrive at various designated times throughout the morning. Starting in 2005, all families were asked to be at the hospital in time for a 7:30 AM start. This intervention elimi-
nated unnecessary delays in the schedule owing to patient trans-
portation problems. We realized that delays of even 15 min-
utes in a patient’s arrival could have significant effects, with
the OR being free but no child ready.

Basic OR case efficiency data are presented in the Table. The total number of examinations under anesthesia was 1955. The number of examinations performed daily and yearly increased steadily during the study period (Figure 1). During most operative days, procedures were carried out simultaneously in 2 adjacent ORs to minimize the number of turnover events. The mean time per turnover decreased during the study period. There was also a steady improvement in the cumulative frequency distribution of turnover times (Figure 2). For example, the 90th percentile for turnover times decreased each year (2003, 14.5 minutes; 2004, 13 minutes; 2005, 10 minutes; 2006, 8.5 minutes; and 2007, 5.8 minutes).

This study examined the efficacy of 5 efficiency-related inter-
ventions that were implemented in our ORs during a 4½-year period. During the study, the number of ex-
Examinations under anesthesia increased per day and year, while the mean turnover time and number of cases with lengthy turnover times decreased.

Changes in health care structure have imposed increasing pressure on health care facilities to improve their efficiency in inpatient and outpatient, and clinical and operative settings. Many highly specialized freestanding outpatient surgical centers have become facile in the completion of a large number of rapid surgical cases in a short time with minimal turnover times. This level of efficiency is typically more difficult to achieve when administering anesthesia to children in nonpediatric settings. We sought to define specific interventions that could improve efficiency in such a hospital setting without compromising patient care or safety.

Our data indicate that these interventions were effective. In addition to the economic benefits of improved OR efficiency, our anecdotal experience indicates that the children’s families were more satisfied with the care, as the amount of time their children spent on a nothing-by-mouth protocol was minimized and discharge from the hospital was hastened. We recommend these interventions to all large eye or general inpatient hospitals attempting to accommodate a full day of examinations under anesthesia for children with retinoblastoma or other vision-threatening ocular diseases.

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