Canadian Journal of Surgery | Journal canadien de chirurgie

Editor's view

Continuing the theme of physician resources and access to care from the last 2 editorials in the *Canadian Journal of Surgery*, one barrier for surgical patients has been the lack of operating room (OR) resources. I am sure all of us in surgery today are subject to exhortations to improve OR efficiency to maximize the effective use of available resources. My hospital, like yours, collects statistics regarding OR use, but my hospital reports these publicly to the OR staff through the Perioperative Services Committee. This open attitude about sharing information regarding problems in the OR has allowed us collectively to make changes and to target specific areas of chronic inefficiency to try to improve our performance.

In fiscal year 2006–2007, 11 166 operations were performed. This is comparable to the number of procedures performed over the last several years. Data have been collected from fiscal 2002–2003 to 2006–2007 to allow us to compare our performance across years. This direct comparison was discouraging in the last year because we noticed an increase in surgical delays for 2006–2007, compared with previous years. This was particularly acute in the last 6 months of the fiscal year.

If we turn to the reasons for delay, we find that the single biggest problem is the lack of bed availability; one-third of the patients had a delay because of the lack of a bed in the recovery room, in the intensive care unit or on the ward. On closer inspection, this single notation "no bed available" appears to be multifactorial and not within the purview of any one individual, making solutions difficult.

Other causes of delay are more easily attributable to specific problems. For example, 20% of delays were caused by inappropriate preoperative assessment — the patients had not been seen by anesthesia before their procedure because they had not been referred appropriately in the preadmission facility. A further 13% of delays were caused by surgeons changing the booked procedure either just prior to or during the procedure, necessitating a delay while instruments were retrieved from central processing. Thirteen percent of delays were caused by patients arriving late, which is a byproduct of same-day admission that can only be partially addressed by educating patients — weather and traffic still play a significant role in Canada!

These data have been subdivided to look at delays in starting the first case of the day. This delay seems to be the most crucial; if you start the first case late, you will almost inevitably finish late, causing considerable problems for OR staffing late in the afternoon or leading to the cancellation of the last booked case. When looking at the reasons for first case delay, approximately 75% can be attributed to the surgeon and not the usual whipping boys (in our minds) of anesthesia or nursing. Twenty-five percent of the patients were not appropriately prepared in terms of fasting or intravenous in situ; another 25% were not preregistered and an additional 25% had incomplete paperwork, primarily, no consent or incomplete history.

I don't know how many hospitals in Canada report in detail their perioperative experience. If your hospital does not, I strongly encourage you to request that this type of information be collected and displayed so that people can try to improve their on-time performance and thereby improve OR efficiency. If your hospital does collect this type of information, you should push to ensure that it is widely available for all surgeons, nurses and anesthetists who work in the facility.

Surgery in Canada right now is all about doing more with less. To maximize the physical and human health resources allocated, it is our obligation and responsibility to use resources in the most efficient way possible. To do that, we must share information regarding our performance as surgeons as well as the performance of our colleagues in nursing and anesthesia. This allows us to target specific deficiencies either in personnel or in the process and, thereby, to improve performance. It also allows us to target specific problems that might suddenly arise over the course of the year (for example, bed availability) and develop a strategy to address this by modifying discharge planning and discharge criteria from inpatient wards.

I am interested to hear from you about your experience with this type of information gathering and its analysis and use in your hospitals. Does your experience mirror mine?

James P. Waddell, MD
Coeditor

Competing interests: None declared.