Booking, scheduling and efficient management (including escalation and de-escalation plan) of emergency surgery cases

Reference No:	***16***	**Version No:**	3	**Previous Trust / LHB Ref No:**	N/A

Documents to read alongside this Policy , Procedure etc (delete as necessary)	

Classification of document: Departmental

Area for Circulation: Peri-Operative Care Directorate

Author/Reviewee: Bindu Ajimon – clinical leader
Jayne Thain – theatre manager

Executive Lead: Jon Barada (Lead Nurse)

Group Consulted Via/ Committee: Directorate governance forum

Approved by: Directorate governance forum

Date of Approval: September 2017

Date Procedure Was Reviewed: March 2022

Date of Next Review: February 2025

Disclaimer

When using this document please ensure that the version you are using is the most up to date either by checking on the UHB database for any new versions. If the review date has passed please contact the author

OUT OF DATE POLICY DOCUMENTS MUST NOT BE RELIED ON

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	Sept 2017	Sept 2017	For ease of access the following procedures have been combined; 1 = Procedure for the booking of emergency procedures in the operating theatre environment 2 = Procedure for the management & scheduling of emergency surgery patients 3 = Protocol for effective management of the 'out of-hours' CEPOD service
2	Sept 19	Sept 19	Section added to reflect the booking of trauma / MTC and CEPOD cases onto the list
3	March 22	March 22	Updated top reflect current practice

INTRODUCTION

This procedure provides guidance for staff within the Perioperative directorate to manage the emergency stream efficiently and improve communication between shifts in order to minimise risk to patients and staff.

SECTION 1 = BOOKING EMERGENCY CASES AT MAIN THEATRES - UNIVERSITY HOSPITAL OF WALES

	ACTION	RATIONALE
1(a)	All emergency cases must be booked using the Emergency Booking programme on TheatreMan. This should be done by the operating surgeon / doctor / nurse practitioner. This can be accessed by typing '//theatreman' into the browser from any PC in the UHB.	All patients must be booked correctly using the approved method.
1(b)	After booking the patient for surgery the operating surgeon / doctor / nurse practitioner must contact the Emergency Consultant anaesthetist and the Duty Manager to discuss the case. (41179/41178)	To ensure effective lines of communication are maintained.
1(c)	It is the responsibility of the surgical team booking the Emergency case to contact the following members of the multidisciplinary team (if required); • Anaesthetist • Duty Manager • Critical care (if ITU / HDU bed is required post operatively) • X-ray and radiographer • Endoscopy staff	To ensure that the patient is treated in a timely manner.

1(d)	It is the responsibility of the surgical team booking the Emergency case to ensure that the following tasks are completed prior to booking when practicable; • That the patient has been consented using the appropriate consent form • **Recent Covid 19 test** • Notify the ward that the patient requires surgery and should remain nil by mouth • Notify the ward that the patient requires surgery and must be prepared for theatre • **Females – pregnancy test** • Laboratory requirements • Any speciality requirements e.g. medical illustration • Availability of post op beds.	To ensure that the patient is treated in a timely manner.
1(e)	The following categories apply to all Emergency stream cases; • Category 1 – Within 2 hours • Category 2A – Within 6 hours • Category 2B – Within 18 hours • Category 3 – Within Days	To ensure that the patient is treated in a timely manner based on clinical need.
1(f)	When a patient is postponed by the ***surgical*** team, they must re-book the patient if surgery is still required. Unless delay due to surgeon unavailability.	This will ensure that there is no confusion over the priority of patients requiring surgery.

1(g)	All patients who require surgery will be scheduled as above. In the event that there is no post- operative ward bed available • The site manager must be informed in order to locate a bed. • The patient will remain in recovery area until a bed is available.	This is in line with the Clinical Governance Guidelines that all patients must receive their operation regardless of the bed situation.

SECTION 2 – OPHTHALMIC EMERGENCIES

	ACTION	RATIONALE
2(a)	Within office hours, the operating surgeon should: • Contact the pre-assessment nurse (Ophthalmic Emergencies) • Liaise with Senior Practitioner for Ophthalmic surgery • Contact the duty manager from SSSU. Out-of-hours the process outlined in section 1 should be followed.	To ensure that the patient is treated in a timely manner. To ensure effective lines of communication are maintained.

SECTION 3 - BOOKING EMERGENCY CASES AT UNIVERSITY LLANDOUGH

3(a)	At UHL all emergency cases must be booked by medical staff, Nurse Practitioner or Surgical Assistant: □ In person or by telephone with the Senior Practitioner in charge of the department	All patients will be booked correctly and the Senior Practitioner in charge of the department (Llandough) will coordinate the booking process.
3(b)	It is the responsibility of the surgical team booking the emergency to contact and arrange the following • Anaesthetist • Patients consent for surgery • Notify the ward nil by mouth and prepare the patient for theatre □ X - ray facilities. • Laboratory requirements • Any speciality requirements e.g. medical illustration • Critical care bed if needed	This will ensure availability of the patient and medical team requirements
3(c)	The following details must be submitted at the time of booking: • Patients full name • Address • Date of birth • Hospital number • Ward • Procedure details • Booking of category • Name of consultant • Contact bleep number and name of surgeon performing the procedure. • If patient is starved. • Any relevant medical condition, known allergies, blood results or high risk factors. • Post operative destination i.e. CCU/HDU and bed availability. • Immediate availability of surgical team.	This will provide all details required by the team are available, ensuring availability of equipment and staff. This will ensure all available time is used for the emergencies and prevent any delays

	• Whether the patient is suitable for surgery at SSSU at UHW	
3(d)	When a patient is postponed by the ***surgical*** team they must re-book the patient if surgery is required.	This will ensure that there is no confusion over the priority of patients requiring surgery.
3(e)	All patients who require surgery will be scheduled as above. In the event that there is no post operative ward bed available • The Site Manager or bed manager must be informed in order to locate a bed. • The patient will remain in post anaesthetic care unit until a bed is available	This is in line with the Clinical Governance Guidelines that all patients must receive their operation regardless of the bed situation.

4 – BOOKING TRAUMA PATIENTS ON THE CEPOD LIST

	ACTION	**RATIONALE**
4 (a)	All patients requiring emergency surgery should have equitable access to the Emergency list. This includes trauma/MTC patients. All patients booked onto the Emergency list (including trauma) must follow the agreed booking process.	To treat patients in a timely manner. To ensure that all patients follow an agreed pathway.

5 – MANAGEMENT & SCHEDULING OF EMERGENCY SURGERY PATIENTS

	ACTION	RATIONALE
5(a)	Identify a golden patient to be first on the list for every emergency theatre. Patients should be as well prepared for emergency surgery as for elective surgery wherever possible. Theatres should be informed of any inconstancies and the reasons why.	To minimise time wasting at the beginning of the day and improve the efficiency of the emergency lists. To minimise the risk of peri-operative complications
5(b)	Consultation with the medical team may be required	To establish the optimisation of patient treatment and outcomes.
5(c)	Extreme cases will necessitate admission to high dependency/high care area	Central venous pressure monitoring may be required to optimise the medical condition rapidly safely and effectively
5(d)	Rapid correction of dehydration and/or hypovolaemia	Some patients may have • associated vomiting and diarrhoea • leakage of fluid out of the circulation due to sepsis, perforation of viscera etc • other medical conditions such as diabetes may be difficult to control due to surgical problems and this may lead to hypovolaemia • limited ability to eat or drink adequately

5(e)	Optimal scheduling of surgery to be decided following discussion between relevant surgical and anaesthetic teams and the Theatres duty manager.	Where there are limitations such as resources or other patient needs, the needs of the patients should be the guiding principle and not based on a “first come, first served” philosophy
5(f)	In cases of dispute the on-call Consultant anaesthetist will make the final decision	Scheduling of emergency cases should be organised on the category basis on the background of time the case is booked
5(g)	In the event of failure to reach an agreement at this level, the advice of the clinical or medical director should be sought	To establish optimal patient care

6 – EMERGENCY SURGERY ESCALATION AND DE-ESCALATION PLAN

Emergency pressures escalation & de-escalation plan (2012) (Adapted) – IN HOURS (Mon – Fri 8am – 6pm)

	Actions/Trigger	Details	Who does this?
Normal	There is capacity for all patients listed to be operated on.	All patients prioritised. Consultant anaesthetist has seen patients and is happy with list order.	Consultant anaesthetist decides list order CEPOD Co-ordinator facilitates sending of patients
Level 2	Early indication that the number of patients to be operated on exceeds the capacity available.	Emergency and/or Trauma/MTC scrub practitioner with duty manager and consultant anaesthetist review lists and where possible re-direct patients to; ✓ Try and add patients to the end of appropriate elective lists. ✓ Where elective operating theatres look to be finishing early plan to do emergency cases to follow.	Consultant anaesthetist decides which patients can be re-directed. Duty manager re-directs patient and communicates outcome to CEPOD co-ordinator and consultant anaesthetist
Level 3	The available capacity is insufficient to meet the number of patients available for the next 24 hours	As for level 2, plus: ✓ Check to see if with additional staffing an additional theatre which is empty (even if the next day, including a weekend) can be utilised. If so mobilise staff from either hospital sites / units. ✓ Call an urgent capacity meeting in theatres and involve all bed holding directorates ✓ Consider cancellation of an elective patient on an elective list and move staff who are able to work in Amber area to available theatres, slot in emergency patient. ✓ Order of patients in terms of clinical need are; Cancer, urgent, routine. ✓ When there are two or more cases that require urgent surgery and the available capacity allows for one theatre, the operating surgeons will discuss which patient should go first after considering the clinical priority of each case. If a decision cannot be reached the Emergency consultant anaesthetist will make a final decision.	Peri-operative Care Directorate Clinical Director/Service manager/ Senior or lead nurse try and staff an additional theatre. If the above fails a meeting is called and the actions (left) enacted. The following must attend; • All affected directorates send a management representative • Consultant surgeons with patients on the lists affected • Consultant anaesthetist (Emergency/MTC & Trauma) • Practitioner in charge of Emergency/MTC & Trauma • Duty Manager

Level 4	The available capacity is insufficient to meet the number of patients waiting that a backlog situation has occurred where patients are waiting >48 hours for urgent surgery.	As for level 2 & 3, plus: ✓ Cancel elective operating to expand emergency capacity. Order of patients to be cancelled; Routine, urgent, cancer. Move available staff to Amber zone ✓ Think ahead, is a weekend occurring in the next 24 hours? If so plan to staff additional theatres for the weekend to cope with the additional capacity needed. ✓ When there are two or more cases that require urgent surgery and the available capacity allows for one theatre, the operating surgeons will discuss which patient should go first after considering the clinical priority of each case. If a decision cannot be reached the Emergency consultant anaesthetist will make a final decision.	Peri-operative Care Directorate Clinical Director/Service manager/ Senior or lead nurse try will work with the team identified in the above bullet pointed list. If a decision cannot be made the following staff to be called and asked to attend theatre for final decision-making meeting; Clinical Board Director/ Director of Operations/ Director of Nursing of directorates affected.

Emergency pressures escalation & de-escalation plan (2012) (Adapted) – OUT OF HOURS 6pm – 8am and 6pm (Fri.) – 8am (Mon or Tues for BH weekend)

	Actions/Trigger	Details	Who does this?
Normal	Ensure there is capacity for all patients listed to be operated on	✓ All patients are prioritised ✓ Consultant anaesthetist has seen patients and is happy with the list order	Consultant anaesthetist decides list order CEPOD Co-ordinator facilitates sending of patients
Level 2	Early indication that the number of patients to be operated on exceeds the capacity available.	✓ Duty Manager in charge of theatre suite and consultant anaesthetist review lists and where possible re-prioritise patients	Consultant anaesthetist decides which patients are re-prioritised and informs CEPOD co-ordinator
Level 3	The available capacity is insufficient to meet the number of patients available for the next 24 hours	✓ Duty Manager in charge of suite to consult with Consultant anaesthetist and Theatre Manager on call to consider mobilising additional teams to cover backlog by opening additional capacity. ✓ Duty Manager in charge of the theatre suite and consultant anaesthetist review lists and where possible re-prioritise patients. Establish whether some ✓ patients can be sent home to return at a later date for surgery (e.g. Trauma, Max Fax patients) ✓ Consider cancellation of an additional planned weekend elective list and slot in emergency patients ✓ When there are two or more cases that require urgent surgery and the available capacity allows for two theatres, the operating surgeons will discuss which patient should go first after considering the clinical priority of each case. If a decision cannot be reached the Emergency consultant anaesthetist will make a final decision.	CEPOD Co-ordinator/Trauma Co-ordinator to try and staff an additional theatre. If the above fails a meeting is called and the actions (left) enacted. The following must attend; • Consultant surgeons with patients on the list affected • Consultant anaesthetist (CEPOD & Trauma) • Practitioner in charge of CEPOD & Trauma
Level 4	The available capacity is insufficient to meet the number of patients waiting that a backlog situation has occurred where patients are waiting >48 hours for urgent surgery.	✓ Duty Manager in charge of suite to consult with Consultant anaesthetist on call and enact mobilising additional teams to cover backlog by opening additional capacity. On call Clinical Leader and Theatre Manager will be contacted to assist. ✓ When there are three or more cases that require urgent surgery and the available capacity allows for two theatres, the operating surgeons will discuss which patient should go first after considering the clinical priority of each case.	Duty Manager and Theatre Manager on call to make every attempt to staff an additional theatre.

		If a decision cannot be reached the Emergency consultant anaesthetist will make a final decision.	

7 – PROTOCOL FOR THE EFFECTIVE MANAGEMENT OF THE EMERGENCY SERVICE

This section of the document will provide staff with guidance to allow the effective management of the CEPOD/ MTC/Trauma / surgery list and to improve communication between shifts in order to minimise risk to the patients and staff.

Roles and responsibilities

1. ***Duty Manager –*** Will co-ordinate the elective workload and support the Emergency team when the demand for emergency surgery exceeds the available capacity
2. ***The lead CEPOD practitioner*** – will be the most senior practitioner on duty during the 'out-of-hours' period and will take responsibility for the effective management of the 'out-of-hours' Emergency list.

Operational guidelines

Two dedicated Emergency theatres are available 24 hours per day. These are located in the Amber Zone in main theatres. Plus one Trauma from 0800 – 1900 seven days a week and one MTC theatre 0800 – 1900 five days a week.

Saturday & Sunday (including public holidays) –2 CEPOD theatres will run 24hours a day alongside Trauma theatre 0800 – 1900 hrs.

Nights - Every effort should be made to clear the backlog of emergency cases before the start of the night shift. During the night 2 theatres may run, however, it is expected that overnight emergency surgery cases will be restricted to life or limb threatening cases. The decision to operate will be made by the anaesthetist and operating surgeon.

The CEPOD theatre is staffed by a full theatre team consisting of;

- 4 x Registered scrub practitioners
- 4x Theatre assistant / Nursing assistant
- 3 x Registered anaesthetic practitioners
- 3 x Registered Recovery practitioners

The Emergency theatre teams are considered a 'protected' resource. At no time should the team be reallocated to support elective activity unless agreed by the Emergency Consultant Anaesthetist and the Clinical Lead for CEPOD.

Handover

Effective handover is essential to ensure that effective communication is maintained and to minimise the risk to patients and staff alike.

- ***The Duty Manager (****Amber zone)* will take the Emergency Wi Fi phone (41178) carry it with them at all times
- ***The Duty manager (****Green zone)* will give an overview of the remaining elective work to be completed. At no time should elective activity impact upon the emergency surgery service.
- Ensure that the controlled drug check has been completed and that the count is correct will highlight any issues that are likely to impact on the efficiency of the Emergency service (sickness etc)

Night shift handover – Amber Zone,

- ***The Duty Manager*** will give an overview of the cases remaining on the Emergency list
- Will allocate the available staff to the appropriate theatre, considering case complexity and skill mix in collaboration with the lead CEPOD practitioner
- Will give an overview of the remaining elective work to be completed. At no time should elective activity impact upon the emergency surgery service.
- Will highlight any issues that are likely to impact on the efficiency of the CEPOD service (sickness etc)

Supernumerary staff working 'out-of-hours'

Supernumerary staff may wish to work 'out-of-hours', at all times their Supernumerary status must be respected. They must be allocated a shift mentor and will work alongside this person for the remainder of the shift. This will allow the Supernumerary member of the team to experience emergency surgery whilst being supported by an experienced member of the team.

Expectations of the Duty Manager/ lead CEPOD practitioner

- The lead Duty Manager/CEPOD practitioner will be present in theatre at all times, they should both attend the emergency meeting at 0800 each morning. The CEPOD list will be coordinated from inside the operating theatre. The lead CEPOD practitioner must work as part of the theatre team alongside the Duty Manager. It is not acceptable to co-ordinate the CEPOD list without being a physical presence in the operating theatre.
- The lead CEPOD practitioner will uphold the principle that the CEPOD theatre team is considered a 'protected' resource. At no time should the team be reallocated to support elective activity unless agreed by the CEPOD Consultant anaesthetist and the Clinical Lead for CEPOD. At no time should elective activity impact upon the emergency surgery service. Whenever a CEPOD theatre is working, it is expected that two scrub practitioners and a minimum of one theatre assistant will be present at all times.
- Be expected to scrub and circulate for all Emergency cases
- Be expected to organise and co-ordinate paid and unpaid breaks so that the efficiency of the CEPOD list is maintained.
- Be expected to act as a role model for junior staff and ensure that UHB and theatre policy and procedures are followed at all times
- When appropriate, delegate tasks to other skilled members of the team, however they must ensure that all delegated tasks have been completed to the expected high standard

Duties to be completed by the Duty Manager/lead CEPOD practitioner – Monday – Friday

- Link in with the practitioners in charge of recovery and anaesthetics to discuss any potential problems that will have an impact on the efficiency of the CEPOD list

- Link in with the practitioner in charge of the Trauma list to determine if the Trauma list is likely to over-run. After 1930 only two CEPOD theatres can run, every effort should be made to ensure that only two theatres are working after 1930 hrs.
- Ensure that all sickness calls are logged using the correct paper work, that the staff are marked as sick on the off-duty and the allocation book.

* If only one CEPOD theatre is working then staff may be sent to assist cleaning dirty theatres, cleaning scopes etc, however staff will be expected to return immediately if a second CEPOD theatre is needed. At no time should elective activity impact upon the emergency surgery service.

Duties to be completed by the Duty Manager/lead CEPOD practitioner – Nights

- Link in with the practitioners in charge of recovery and anaesthetics to discuss any potential problems that will have an impact on the efficiency of the CEPOD list
- Ensure that stock levels in the CEPOD theatre are maintained
- Ensure that the CEPOD theatre has been terminally cleaned (including; store room, plaster room and sluice)
- Ensure that the CEPOD equipment checklist has been completed
- Ensure that all sickness calls are logged using the correct paper work, that the staff are marked as sick on the off-duty and the allocation book
- Ensure that the controlled drug check has been completed
- Ensure that the 'CEPOD out-of-hours work schedule' should be completed. The Lead CEPOD practitioner will delegate tasks fairly amongst the team.