



DRAFT POLICY GUIDELINES FOR THE BOOKING OF SURGICAL CASES ON THE EMERGENCY SLATE



INTRODUCTION

With the aim of improving emergency surgical case access to emergency theatre services the following areas were identified:

- The introduction of emergency surgical case categorization (triage colour coding- see Emergency Case Categorization Chart)
- Assessment of all booked cases by an anaesthetic Triage Registrar – still to follow in the future
- The establishment of a 24 hour emergency theatre.

The focus of this policy is to

- Identify and prioritise surgical emergencies according to acuity and to then
- Process them accordingly;
- The goal being to improve surgical outcome,
- To prevent avoidable morbidity and mortality,
- To reduce the turnaround times in the operating unit
- To reduce the length of hospital stay.

OBJECTIVES OF POLICY

1. Primary objective:
 - To introduce a method of categorisation (triage) of acute surgical cases that would serve to prioritise them for surgery according to their surgical acuity.
2. Secondary objective:
 - To improve communication and team work between anaesthetic, surgical and nursing personnel involved in the care of these patients
 - To improve data capturing and audit capabilities for emergency theatre

DEFINITIONS:

- **Emergency surgical case:** An emergency surgical case is admitted to a health institution in an ***unplanned and unscheduled*** manner, either via the emergency unit, from an outpatient clinic or as a transfer from another health institution. Patients usually present with ***acute surgical conditions*** that require ***prompt and focused*** treatment in order to avoid increased ***morbidity and mortality***.
- **Elective surgical case:** An elective surgical case is admitted to the hospital from home for a scheduled surgical procedure.
- **Triage/Categorization:** Triage is the process of determining the priority of patients' treatment based on the severity of their condition ***and*** the availability of resources (as regards this policy initiative, the available resource is ***prompt access*** to emergency theatre).

TRIAGE REGISTRAR: (Still to be implemented in the near future)

See the changes made in sent document

The triage registrar's role is to assess all emergency surgical cases as they are booked on the emergency slate. Their function is to primarily ascertain anaesthetic risk and to suggest optimisation strategies on patients with co-morbid conditions that may have an effect on the conduct of anaesthesia.

Triage registrars must communicate their suggestions directly to a member or members of the surgical team caring for the patient concerned. It is the surgical team's responsibility to carry out treatment or further investigations suggested by the triage registrar.

BOOKING OF CASES ON THE EMERGENCY SLATE:

The surgeon may book cases on the emergency slate by calling extensions 2140 or 2476 after hours.

Information required by the person taking the booking is as follows:

- Patient's full name
- Folder number
- Age
- Sex
- Procedure to be performed with the
- Diagnosis
- Case categorization (according to case categorization guidelines-see below)
- Date and time of the booking to be captured on the slate
- Name and contact details of the surgeon

Emergency cases cannot be 'pre-booked' to be operated on at a particular time or date of the surgeon's choosing.

Emergency case categorization chart:

Icon	Case Category	Parameters
Red	Immediate	Immediate life-saving operation, resuscitation simultaneous with surgical treatment e.g. resuscitative laparotomy, ruptured aortic aneurysm, threatened airway, cord prolapse, foetal bradycardia
Orange	Hot emergency	Operation as soon as possible after resuscitation (within 1 to 2 hours) - e.g. ruptured ectopic pregnancy, leaking aortic aneurysm, cranial decompression, positive DPL in multiple trauma, threatened limb, emergent foetal concern
Yellow	Cold emergency	Operation within 6 hours of booking e.g. compound fractures, appendicitis, incarcerated hernia/intestinal obstruction, EUA for non-accidental injuries

Green	Urgent	Operation not immediately life or limb saving but to be done within 24 hours of booking e.g. ORIF of simple fractures, bleeding haemorrhoids, I&D abscess
Blue	Scheduled	Semi-urgent cases, to be done within 72 hours. Operation during in-hours on next available slate if possible

All cases booked on the emergency slate must be categorised using the guidelines set out in the emergency surgical case categorization chart above. Categorization is a surgical judgement call and is the sole responsibility of the surgeon booking the case.

Red cases:

Cases categorised as red need immediate access to theatre in order to avoid significant morbidity or mortality, or where surgery is part and parcel of a resuscitation strategy. The booking of a red case mobilises the emergency team to ensure that the patient is operated on as soon as possible, with every effort made to open an additional theatre if required.

Orange cases:

Cases booked as orange should be operated on within two hours of booking.

Yellow cases:

Cases booked as yellow should be operated on within 6 hours of booking.

Green cases:

Cases booked as green should be operated on within 24 hours of booking.

Blue cases:

These are cases where the surgical pathology is stable and non-emergent but where the patient cannot or should not leave hospital without an operation. Blue cases should be operated on within 72 hours.

The booking of a blue case for longer than 72 hours is strongly discouraged as this has far reaching implications for the function of emergency theatre as well as patient safety and comfort (viz patients being kept nil per mouth repeatedly in expectation of surgery).

Cases booked on the emergency slate are prioritised according to their colour coding and not the date and time of booking. Because of this the potential for a blue case to linger on the emergency slate is high and therefore these cases *must be prioritised on the booking disciplines next elective slate if there is no prospect of the patient being operated on within 72 hours.*

Elective cases will *not* be accepted for booking on the emergency slate, particularly if they have “fallen off” the end of an elective slate due to lack of time. These cases must be prioritised to the surgical discipline’s next elective slate.

MANAGEMENT OF THE SYSTEM

Esme, I don’t think this stepup should be automatic – as stated in the guidelines, the system is not set up to upgrade automatically. Reassessment by the surgical discipline is the key, so that there is a method to ensure pts are seen frequently. For example, if more Red cases come in, these will probably still take clinical

precedence over a matured Orange case; often the Orange case will still be Orange, not Red. This might definitely be the situation if the new Red case is from a different discipline. This principle will hold even more so for the lower categories.

- Blue cases become green after 72 hours – blue cases not operated in 72hrs must be booked on an elective slate.
 - Green cases become yellow after 24 hours
 - Yellow cases become orange after 6 hours
 - Orange cases become red after 2 hours
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- Booked cases must be assessed on an ongoing basis and re-categorised as required
 - The surgical team admitting the patient is responsible for the initial triage of the patient
 - The anaesthetic team should be **directly** involved in the triaging of cases with their surgical colleagues
 - Arbitration between surgeons with similarly triaged patients regarding priority on the emergency list to be decided by the Department of Anaesthesia consultant on call.
 - Similarly triaged patients from different disciplines should be operated by the consultant, especially in the red cases.

RE-CATEGORISATION

When a yellow, green or blue case is due in theatre (6, 24 and 72 hours after booking, respectively), and cannot be done the case must be “re-categorised.” At this juncture the anaesthetist in charge of the emergency theatre must contact the surgeon to inform him/her that their case is due but is unable to be processed (giving valid reasons). The surgeon should then re-categorise his/her case appropriately, which may be the same as the original booking categorisation or an upgrade to a more urgent triage category.

Surgeons are encouraged to follow up on their cases at regular intervals to pre-empt any delay in being contacted by the anaesthetist when their case comes up for re-categorisation.

Red and orange cases are not flagged for re-categorisation as almost without exception, true (i.e non-miscategorised) red and orange cases are processed well within the times suggested by their triage level.

INAPPROPRIATE CATEGORISATION OF CASES:

The urgency required for operative treatment of any one case booked on the emergency slate depends exclusively on the acuity of the patient’s surgical condition and not on the convenience or availability of the surgeon. Anaesthetists will engage surgeons if anything in the details of the patient or procedure booked does not match the categorisation given by the surgeon e.g EUA of rectum booked as a red or orange.

Surgeons must desist from inappropriately “up-grading” their case’s category level as this inevitably affects other appropriately classified cases’ timely access to theatre.

PRIORITISATION OF BOOKED CASES:

The triage category (colour code) of a case booked on the emergency slate is the first rung in the ladder of prioritisation of emergency surgical cases. Several factors are taken into account when deciding which case takes precedence over another of similar category. These factors may include:

- Time and date of booking of surgical case.
- The presence of significant co-morbidities.
- The availability of in house specialist surgical or anaesthetic cover.
- The presence of an adequately composed nursing team (numbers and skills mix).
- The type, degree of complexity and duration of the surgical procedure intended.

ARBITRATION:

The consultant anaesthetist on call is generally the best placed individual to make decisions concerning which case is done first before another that has the same triage colour coding.

Surgeons are encouraged to engage with the consultant anaesthetist on call should they feel that their case has been unfairly superseded by another. Should no consensus be reached at this level, contact must be made with the superintendent on call, who would then decide whether to include the heads of department (surgery and anaesthetics) in the discussion if he or she is unable to settle the matter amicably.

NB! The operating theatre can presently manage only one emergency theatre after hours. In the event of two (2) Red category cases simultaneously requiring immediate surgery, the advanced midwives from the Labour Ward (K4) will have to scrub for any emergency the caesarean section so that we can open two (2) theatres in the B6 Main Theatre Unit. (include this paragraph in the final guideline)

CASE CANCELLATION AND POSTPONEMENT:

Surgeons should communicate timeously with the emergency team on call when a decision has been made to cancel a case already booked on the emergency slate. Postponed cases will not remain on the emergency slate. These cases should be re-booked on the day that the surgeon intends operating on them.

Reasons for postponement or cancellation must be communicated verbally and in writing to the nursing and anaesthetic staff in theatre.

AVAILABILITY OF SURGEONS:

Surgeons should be readily contactable and available in theatre within a reasonable period of time (≤ 15 minutes when in the hospital or ± 30 minutes when out of hospital) when informed that their case is ready to be sent for. The surgeon responsible for booking a case must contact the emergency team if their contact details differ from that originally posted on the emergency slate.

OPERATING AFTER MID-NIGHT:

Operating in the early hours of the morning has been shown to increase the incidence of adverse events affecting both patients and health workers. However, it is often unavoidable to operate after mid-night, particularly if the emergency slate is overloaded and it is in the best interests of patients to avoid further delay in accessing theatre.

By booking a case on the emergency slate, the surgeon accepts that he or she may be called to operate on their cases at any time. A refusal to heed a reasonable request to operate on a case late at night will result in the postponement of the case and its removal from the emergency slate.

HAND OVER RESPONSIBILITY OF SURGEONS:

Surgeons must inform the emergency team the moment they are no longer responsible for any cases they have booked on the emergency slate. Contact details of the surgeon taking over responsibility must be communicated timeously so that these can be displayed on the emergency board.

SUMMARY

Emergency case categorization chart:

Icon	Case Category	Parameters
Red	Immediate	Immediate life-saving operation, resuscitation simultaneous with surgical treatment e.g. resuscitative laparotomy, ruptured aortic aneurysm, threatened airway, cord prolapse, foetal bradycardia
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MANAGEMENT OF THE SYSTEM

- Booked cases must be assessed on an ongoing basis and re-categorised as **indicated**.
- The surgical team admitting the patient is responsible for the initial triage of the patient

- The anaesthetic team should be intimately involved in the triaging of cases with their surgical colleagues
- Arbitration between surgeons with similarly triaged patients regarding priority on the emergency list to be managed as described.

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