

OPERATING ROOM FLOW IMPROVEMENT
SEPARATING SCHEDULED AND UNSCHEDULED CASES TO IMPROVE ACCESS, SAFETY, AND EFFICIENCY



Old Concept – Emergencies were unpredictable and just had to be accommodated when they showed up.

INITIAL MODEL

TWO CASE SCHEDULING TYPES

SCHEDULED CASES ■
85-90 % of all Cases

EMERGENCIES ■
10-15 % of all Cases

DAILY SCHEDULE

95 % of all OR time allocated to Doctor Specific Blocks

Emergencies done at end of the day, or forced into slots between scheduled cases.

RESULT

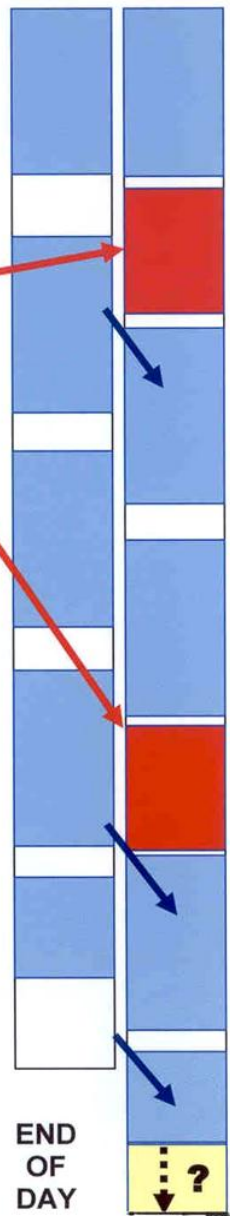
Long Add-On List at the conclusion of the day

Long Waiting Times for parents and children with urgent needs

Often doing complex cases in evening or at night when resources were limited

Not Ideal

OLD
Sched Actual



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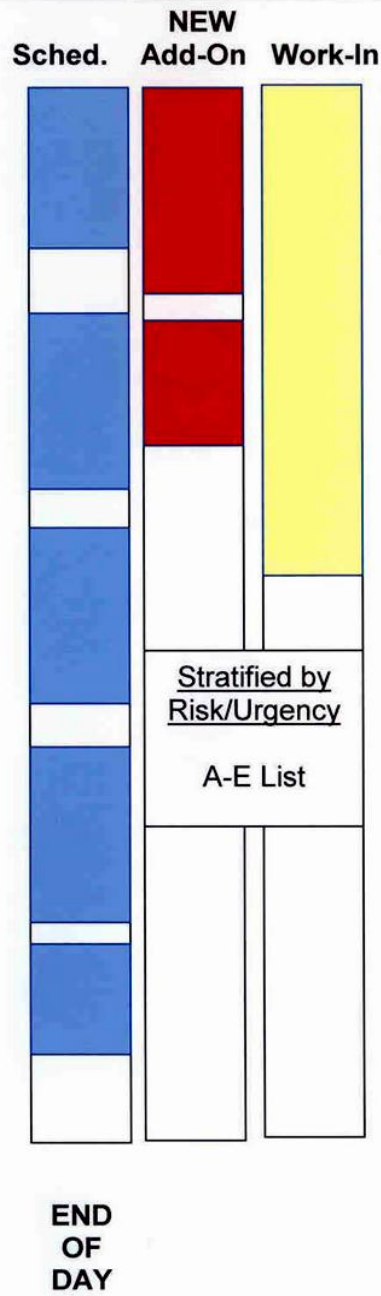
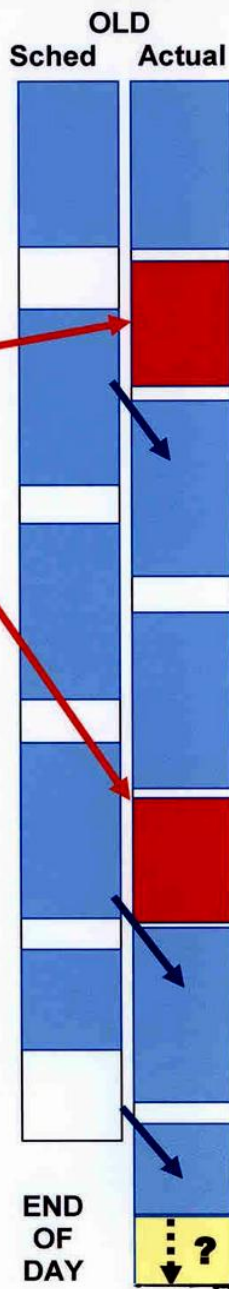
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PRESENT MODEL

TWO CASE SCHEDULING TYPES

SCHEDULED CASES ■ 85-90 % all Cases

UNSCHEDULED 10-15 % of all Cases
Divided into two subgroups

■ **Add-On** – 0-24 hours

■ **Work-In** – 1-7 days

DAILY SCHEDULE

90 % of all OR time allocated to Doctor Specific Blocks

2 Add-On Rooms for Urgent and Emergent cases / day

1 Work-In Room for cases needing access in < 7 days

RESULT

Decreased time to access OR in urgent and emergent cases

Add-On's done during prime operating hours, maximum resources

More predictable end of day