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

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

INITIAL MODEL

TWO CASE SCHEDULING TYPES

SCHEDULED CASES  
85-90% 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

Not Ideal

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
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PRESENT MODEL

TWO CASE SCHEDULING TYPES

SCHEDULED CASES
85-90% of 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