ARRANGING AN ELECTIVE THEATRE LIST

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The date, place and time of operation should be matched with the availability of appropriately skilled personnel. Appropriate equipment and instruments should be made available. The operating list should be distributed as early as possible to all sta ff who are involved in making the list run smoothly (Table 21.12). If this is done electronically , familiarity with the computer system is required. A critical care bed should be prearranged for high-risk cases. Elective list order should prioritise patients who are vulnerable to long starvation times, e.g. children and or a prompt theatre start, planning patients with diabetes. F a straightforward case first can utilise time waiting for preprocedure imaging on the second case, e.g. breast wire insertion, or confirmation of a postoperative critical care bed for a high-risk case. List planning using a surgeon’s average operation times for a procedure rather than generic estimates leads to better list utilisation. Staggering admission times can improve patient satisfaction but reduces flexibility for ‘on the day’ changes to list order. /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF

TABLE 21.12 Perioperative teams. Ward, theatre and specialist nursing staff Anaesthetic and surgical teams Radiology and pathology involvement Rehabilitation and social care workers Administration and scheduling team Speci /f_i c personnel in individual cases, e.g. cardiac devices team

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