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EDITORIAL

# Perhaps operating room governance is our largest impact area?

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Although it may not seem intuitive, the most valuable contribution most anaesthetists make to a health system daily, regardless of their grade, is the governance of operating room utilisation. It is well known that one of the most expensive resources in any hospital is the operating suite. This area requires expert leadership, most commonly provided by nurses, anaesthesiologists, or surgeons. In South Africa, this role is usually fulfilled by nursing professionals in the private sector, or as a shared responsibility between anaesthesiologists and nursing colleagues in the state sector.

Peer-reviewed South African operating room performance metrics, describing either efficiency or quality, are scarce. The work by Crew and Venter in this edition of SAJAA makes a significant contribution to this area.[1] Their group compared procedure duration data, captured retrospectively, from a large number of cases from a single centre. They then captured a smaller prospective data set of surgeon-predicted durations for five common procedures, demonstrating that surgeons had a considerably aspirational mindset in their institution. The study findings were highly statistically significant, confirming a major underestimation across most disciplines. However, the actual difference was significant enough that in a practical sense, any operating room nurse or anaesthesiologist would immediately appreciate the impact of booking operating theatre slates with underestimated durations for most procedures.

It would have been interesting if the authors had explored the impact of this underestimation and resultant overbooking of theatre slates in the prospective part of the paper. This study could have examined whether the underestimation resulted in patients having their procedure cancelled on the day of surgery due to a lack of theatre time or whether surgical lists were permitted to overrun and finish late. Patients who are admitted for surgery but do not undergo surgery on the allocated theatre list places an enormous burden on the facility, particularly on the wards and available ward beds, a precious resource in any hospital.

The underestimation of procedure duration when planning theatre slates not only has significant implications for operating room staff, medical facilities, and health systems; but most importantly for patients. Theatre overruns or case cancellations not only affect the patient's healthcare system experience but may also have serious consequences for their personal circumstances, including their transport, employment and financial considerations, particularly in a developing country. Although the exact nature and impact of poor theatre time estimation is likely to differ between state and private facilities, it is undeniable that the effect will be negative in both sectors.

Allowing theatres to overrun is the most common strategy modern theatre managers use to deal with over-booked slates. However, as Tyler and colleagues highlight, although a theatre slate that overruns is perceived to be more efficient, it is economically twice as expensive.[2] In real terms, it is better to complete a theatre list an hour early and redeploy staff to perform other duties than to overrun by 30 minutes and have additional staff payments at a significantly higher overtime rate. When a case overruns, it must be profitable enough that doubling staff costs will still permit a cost-effective procedure. The impact on staff morale and satisfaction was not included in the economic modelling of end-of-list management as described above; however, the model clearly demonstrated that adjusted theatre utilisation of 85–90% is the sweet spot when considering economic viability.

It is vital that the South African healthcare community adopts a standardised set of perioperative times and performance indicators. This would allow a more coherent approach to published South African operating room studies, including those by Crew, Asmal and Hartman.[1,3,4] All these authors employed different definitions for both theatre times and theatre metrics, many unique and defined by the authors themselves. This lack of standardisation hampers any comparison between their findings and also limits comparison with international studies that utilise performance metrics that are well described and have been available for almost five decades. The Association of Anesthesia Clinical Directors (AACD) published the benchmark Procedural Times Glossary in 1998 and revised it in 2018.[5,6] Healthcare Improvement Team South Africa (HITSA) adapted this document to the South African context and published the South African Procedural Times Glossary in 2023.[7] The use of established definitions for theatre times and performance metrics will allow benchmarking against established international metrics, as well as enable individual facilities to understand their own performance. None of the South African theatre efficiency works have used established theatre times or metrics, specifically not for block utilisation, and although the turnover time was described in one study, the acceptable value was exceedingly long.[1,3,4]

During periods of economic austerity, judicious resource utilisation and stewardship is crucial. This is particularly pertinent within the state sector at present. These challenging times provide the perfect moment for anaesthesiologists across Southern Africa to show true leadership in the perioperative space and to invest purposefully in operating room governance.

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