Utilisation of redundant time on trauma list for carpal tunnel decompression

B Theruvil, R K Choudhary, V Kapoor, D G Hargreaves, D J Warwick

RESULTS

Initial audit

Of the 141 trauma lists audited, the mean start time was found to be 9.40 am despite a scheduled start time of 8.30 am. The main reasons for the delay were the time required for the anaesthetist to see the patient (58%) and the other staff to set up the necessary equipment (28%). Surgeons were implicated in 14% of the delays.

Re-audit

The trauma theatre time utilisation was re-audited after the introduction of the CTR. We studied 140 lists and found that the start time for CTR was 8.44 am (mean). The start time of the first trauma case was 9.46 am (mean). After we started performing CTR as the first case, we were able to reduce the start delay from 70 minutes to 14 minutes. Therefore, despite performing an additional surgery on the list there was a delay of only six minutes (p < 0.05) to the start of the first trauma case.

CTR had to be cancelled on three occasions in the one year period we audited, once because of medical reasons, and twice as the theatre was being used to perform emergency operations on patients with multiple injuries.

DISCUSSION

Operating sessions are an expensive and limited resource. Throughput in operating theatres is often used as an index of surgeon’s performance. In the first audit our aim was to determine the use of trauma list time and the causes for delayed starts.

CTR is among one of the most commonly performed procedures by orthopaedic surgeons. By performing CTR as the first case, we felt, we could tackle the common three causes of delays to the trauma list. This is a short procedure that can be performed by a junior grade surgeon giving time for the senior surgeon to complete post on-call ward rounds. As this is commonly performed under local anaesthetic, the presence of an anaesthetist is not required. Thereby the anaesthetist has sufficient time for assessment of patients on the trauma list. This also gives the theatre staff ample time for preparing complex instrumentation, if required, for the first trauma case.

After an extensive literature search we could only find one study where the orthopaedic theatre times were studied. Ricketts et al. found that 60% of elective theatre time was used for operating and 21% for turnover. No useful activity occurred during the remaining 19% of the time. There was an average start delay of 26.5 minutes. In contrast with the study by Ricketts et al., we audited the timing of trauma lists that are well known for their unpredictability.

Ineffective use of expensive capital resources, such as theatre time, should not be acceptable to those responsible for the provision of health care. Since this audit, a third of carpal tunnel decompressions done in our hospital are now performed on trauma lists. This has also had a huge impact on reducing the waiting times required for CTR in our hospital. Better organisation and predictability of the start of the trauma list has improved the staff morale and working practices.

In the NHS, where pressures on waiting lists keep growing, we feel that simple and effective ideas like this can help make a big difference.

Authors’ affiliations

B Theruvil, R K Choudhary, V Kapoor, D G Hargreaves, D J Warwick, Department of Orthopaedics, Southampton University Hospital, Southampton, UK

Funding: none.
Clinical Evidence—Call for contributors

Clinical Evidence is a regularly updated evidence-based journal available worldwide both as a paper version and on the internet. Clinical Evidence needs to recruit a number of new contributors. Contributors are healthcare professionals or epidemiologists with experience in evidence-based medicine and the ability to write in a concise and structured way.

Areas for which we are currently seeking authors:
- Child health: nocturnal enuresis
- Eye disorders: bacterial conjunctivitis
- Male health: prostate cancer (metastatic)
- Women’s health: pre-menstrual syndrome; pyelonephritis in non-pregnant women

However, we are always looking for others, so do not let this list discourage you.

Being a contributor involves:
- Selecting from a validated, screened search (performed by in-house Information Specialists) epidemiologically sound studies for inclusion.
- Documenting your decisions about which studies to include on an inclusion and exclusion form, which we keep on file.
- Writing the text to a highly structured template (about 1500–3000 words), using evidence from the final studies chosen, within 8–10 weeks of receiving the literature search.
- Working with Clinical Evidence editors to ensure that the final text meets epidemiological and style standards.
- Updating the text every six months using any new, sound evidence that becomes available.
- To expand the topic to include a new question about once every 12–18 months.

If you would like to become a contributor for Clinical Evidence or require more information about what this involves please send your contact details and a copy of your CV, clearly stating the clinical area you are interested in, to Klara Brunnhuber (kbrunnhuber@bmjgroup.com).

Call for peer reviewers

Clinical Evidence also needs to recruit a number of new peer reviewers specifically with an interest in the clinical areas stated above, and also others related to general practice. Peer reviewers are healthcare professionals or epidemiologists with experience in evidence-based medicine. As a peer reviewer you would be asked for your views on the clinical relevance, validity, and accessibility of specific topics within the journal, and their usefulness to the intended audience (international generalists and healthcare professionals, possibly with limited statistical knowledge). Topics are usually 1500–3000 words in length and we would ask you to review between 2–5 topics per year. The peer review process takes place throughout the year, and our turnaround time for each review is ideally 10–14 days.

If you are interested in becoming a peer reviewer for Clinical Evidence, please complete the peer review questionnaire at www.clinicalevidence.com or contact Klara Brunnhuber (kbrunnhuber@bmjgroup.com).
Utilisation of redundant time on trauma list for carpal tunnel decompression

B Theruvil, R K Choudhary, V Kapoor, D G Hargreaves and D J Warwick

Postgrad Med J 2005 81: 613-614
doi: 10.1136/pgmj.2004.029769

Updated information and services can be found at:
http://pmj.bmj.com/content/81/959/613

These include:

References
This article cites 3 articles, 0 of which you can access for free at:
http://pmj.bmj.com/content/81/959/613#BIBL

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/