

# Add-On Team

## I. Background

Unscheduled cases that unexpectedly require surgery and must be added on to the OR schedule represent both a high priority and a dilemma to the OR care team. How should cases of varying levels of urgency and emergency be classified and handled while continuing to provide optimal care to all surgical patients? How can the needs of urgent, complex surgical patients be met, particularly when resources are constrained on nights and weekends? How can a communication system be instituted to serve all team members in a timely and reliable way? This team will benchmark other institutions that have re-designed perioperative flow and test best ways to improve access, safety, and efficiency as well as clinician satisfaction regarding add-on cases at BIDMC.

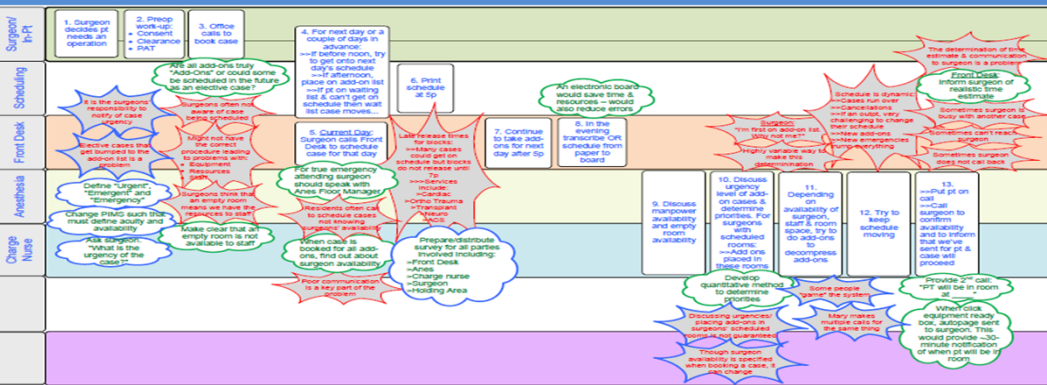
- GOALS:**
1. Develop and implement a priority-based system to define the order of cases. Concerns include:
    - When booked?
    - Urgency?
  2. Make resources evident and ensure that they are communicated early
  3. Optimize matching of resources and expectations
  4. Improve the communication system between the anesthesia floor manager, front desk, surgeon and resident

**Project Team**

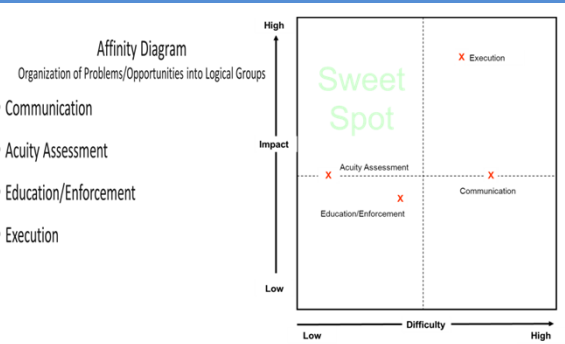
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|------------------------|----------------------------|--------------------------|--------------------------------|
| Mary Austin            | Alok Gupta, MD (Co-Leader) | Verna Rettagliati        | Jason Wakakuwa, MD (Co-leader) |
| Seema Chowdhury, MD    | Stephanie Jones, MD        | Edward Rodriguez, MD     |                                |
| Jane Cody              | Pete Panzica, MD           | Dottie Sarno             |                                |
| Jonathan Critchlow, MD | Beth Person (Co-Leader)    | Ross Simon (Facilitator) |                                |

Sponsor: Richard Whyte, MD

## II. Current Condition

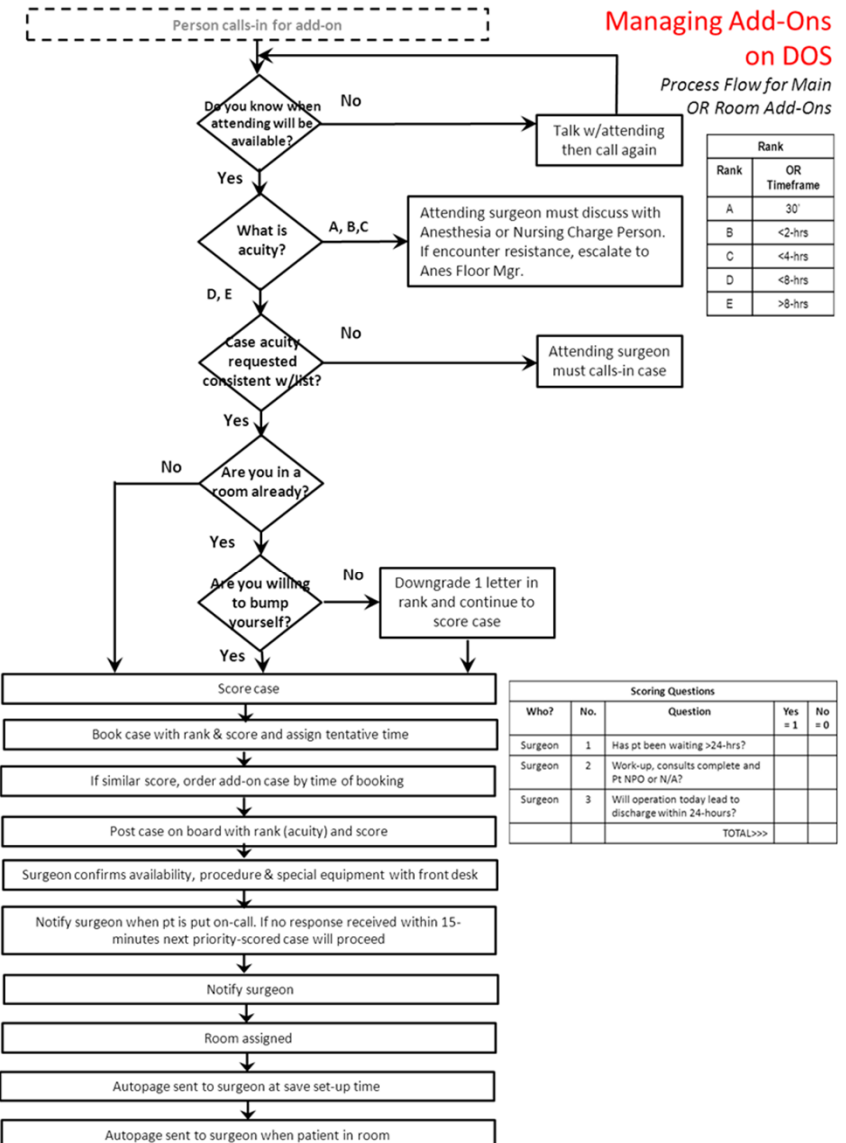


## III. Analysis



Guidelines for Surgical Case Bookings			
Guideline only: medical judgment required			
<b>A</b> Acute life and death emergencies • 30 minutes	<b>B</b> Emergencies, but not immediately life threatening • 2 Hours	<b>C</b> Urgent • 4 hours	<b>D</b> Semi-Urgent • 8 hours
<ul style="list-style-type: none"> <li>• Anxious emergency (upper airway obstruction)</li> <li>• Cardiac surgery postoperative bleeding with tamponade</li> <li>• Cardiopulmonary decompression (bever)</li> <li>• CVC tamponade</li> <li>• Catastrophic emergency</li> <li>• Major hemorrhage</li> <li>• Major trauma</li> <li>• Major vascular occlusion or C.A. revascularization</li> <li>• Neurological condition w/ imminent herniation</li> <li>• Orthopedic emergency</li> <li>• Postoperative severe bleeding</li> </ul>	<ul style="list-style-type: none"> <li>• Anxious emergency (upper airway obstruction)</li> <li>• Cardiac surgery postoperative bleeding with tamponade</li> <li>• Catastrophic emergency</li> <li>• Major hemorrhage</li> <li>• Major trauma</li> <li>• Major vascular occlusion or C.A. revascularization</li> <li>• Neurological condition w/ imminent herniation</li> <li>• Orthopedic emergency</li> <li>• Postoperative severe bleeding</li> </ul>	<ul style="list-style-type: none"> <li>• Anxious emergency (upper airway obstruction)</li> <li>• Cardiac surgery postoperative bleeding with tamponade</li> <li>• Catastrophic emergency</li> <li>• Major hemorrhage</li> <li>• Major trauma</li> <li>• Major vascular occlusion or C.A. revascularization</li> <li>• Neurological condition w/ imminent herniation</li> <li>• Orthopedic emergency</li> <li>• Postoperative severe bleeding</li> </ul>	<ul style="list-style-type: none"> <li>• Anxious emergency (upper airway obstruction)</li> <li>• Cardiac surgery postoperative bleeding with tamponade</li> <li>• Catastrophic emergency</li> <li>• Major hemorrhage</li> <li>• Major trauma</li> <li>• Major vascular occlusion or C.A. revascularization</li> <li>• Neurological condition w/ imminent herniation</li> <li>• Orthopedic emergency</li> <li>• Postoperative severe bleeding</li> </ul>

## IV. Solution



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