Operating room time

It is estimated that 70% of hospital revenue is generated in the operating room (OR) [1)]

Operating room time includes patient stay, from arrival to exit.

Although cost reduction increases for implants in surgery when prices are known, this appears to have little or no effect on the overall costs of care. Length of stay and operating room time have greater effects on global costs. Future efforts to encourage efficient cost savings should focus on practice patterns/pathways for similar conditions rather than limiting the use of certain implants [2)].

For the operating room management, the basis is the surgical suite, and evaluation can be divided into duration of anesthesia, operative time, operating room time, and operating room preparation time.

Duration of anesthesia

The lengthiest stage during a procedure is anesthesia.

Anesthesia duration is divided into four moments: anesthetic induction, maintenance, awakening, and recovery.

Operative time

The operative time consists of dieresis, hemostasis, exeresis, and suture.

Operating room preparation time

Operating room preparation time

Operating room time in public hospitals

Public hospitals provide free healthcare but suffer from poor management and misgovernance, negatively impacting service provision. One aspect of this is operating room time utilization.

Fifty-six percent of operating room time was utilized operating. Sources of delay included the delayed arrival of the anesthesia team (4.7%) and the delay in transferring patients to OT (9.7%). Anesthesia intubation and preparation time accounted for 23% of OT utilization and was significantly longer than comparable international studies. Extubation time accounted for 5.7% of OT utilization

Gross delays relatively simple in nature were identified due to poor management and less than ideal inter-specialty coordination. Most delays were avoidable and can be addressed by proper planning,

optimization of patient transfer and resources, and, most importantly, improved communication between surgeons, anesthetists, and ward staff. This can ensure optimal use of theater time and benefit all specialties, including ancillary staff, and, most importantly, the patient [3].

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