Bradford Teaching Hospitals NHS
NHS Foundation Trust

Theatres

SOP

Standard Operating Procedure

Subject	Safe staffing in the Operating Theatres
Background	Effective organisation by all members of the perioperative team is essential for the safe and efficient management of operating sessions. This SOP will ensure clear guidance to all theatre users on what are agreed staffing numbers for theatres and recovery and what is deemed safe to run a list. It will outline the decision making and escalation process for safe and unsafe staffing levels.
Assessment	Although there is a generic recommendation for the staff required in the operating theatre for each session which should be followed, there will be times when due to absence of staff or appropriate skills it will be necessary to run a session with reduced staff. This will largely depend on the specialty, complexity of the case-mix and the number of cases on the operating list. Therefore a risk assessment will have to be made on each occasion to ensure safe staffing to manage that operating session. In addition to staffing numbers it is also necessary to take in to account the competency of staff to ensure that staff have the right skills to undertake the roles allocated to them
Rule	1. **It must be clear for all areas where invasive procedures take place what minimum staffing levels are** 2. **The skills and qualifications of staff required must be agreed and stated.** 3. **Agreed staffing levels for a theatre lists reflecting recommendations by the Association for Perioperative Practice, AfPP**. <u>Theatre</u> ODP Scrub 1 (registered nurse or ODP) Scrub 2 (registered nurse, ODP or ATP) Circulator (HCA) If an LA list it may not be necessary to have an ODP this should be risk assessed against the cases on the list.

	Ophthalmic LA lists require an ODP or a member of the team to have the ILS training (See ophthalmic SOP) If cell salvage is required it may be necessary to have an additional member of staff to run this. <u>Recovery</u> One recovery practitioner per list (RN recovery trained or ODP) In areas where there is only 1 list running there should be a second member of staff in recovery (RN, ODP, ATP or HCA) or readily available in the department if required. The anaesthetist should remain in recovery until the 2nd staff member is present. **4. No staff, no start: A procedure can only begin when the agreed minimum number and skill mix of staff for that procedure are present.** There may be times when this level of staffing is not required or it is possible to run a list safely with less than the optimum staffing levels. This should be risk assessed taking into account the number and complexity of the cases on the list, the experience of the staff in theatre and the location of the list. E.g. a single big case that requires only 1 scrub practitioner. This risk assessment should be undertaken by the theatre coordinator in collaboration with the Theatre Matron. Allocations should reflect a risk managed mix of substantive and non substantive staff. **5. Day and night: The same minimum standards apply both inside and outside normal working hours.** **6. Surge management: All professional groups must have clear plans for escalation when clinical demand overwhelms resources and a risk management plan for monitoring the frequency of these events.** **7. Escalation process for staffing concerns raised is in place and these should be documented as a safety issue.** We should not plan to staff lists with less than the agreed staffing levels but situations such as on the day sickness may necessitate a compromise to those agreed levels but maintaining patient safety. This should be escalated to the Theatre coordinator in the first instance who will escalate to the Theatre Matron. Following risk assessment if it is believed to be unsafe to run the list with the staffing numbers or skills that will be escalated to the Directorate manager to support the decision to cancel. **8. Scheduling should take into account all workloads and the time**

	needed to follow all required five steps to safer surgery. It should also include specific safeguards and clear responsibility for ensuring that patients are not deprived of oral nutrition or hydration for unnecessarily long periods due to delays or list changes Theatre staffing allocations should be completed a minimum of 2 weeks in advance as per 6-4-2 protocol. This allows time to review any gaps in numbers or skills and put in place arrangements to bring levels up to safe agreed levels. **9. On rare occasions that it is necessary to perform an emergency procedure with a workforce that does not comply with the BradSSIP this should be reported as a safety incident and should be should be reviewed through local governance processes.**