وزارة الصحة
Ministry of Health

Ministry of Health of Kuwait

Title: Emergency Operating Room Categories and Booking Policies	
Policy Owner: MOH committee on hospital clinical services and polices	**Policy Code**: ADM-010
Section location: Administrative/General	**Effective Date**: 1 Jan 2024
Applies to: 1-The Emergency Operating Room 2-All physicians performing emergency procedures in the surgical suite (e.g., surgical specialties, gastroenterologists, interventional radiologists, anesthetists, etc.) and the supportive nurses & technicians	**Revision Date:** 1 Jan 2026
Approvals	**Signature/Date:**
Approved by: MOH committee on hospital clinical services and polices	
Approved by: Director of technical affairs	
Approved by: Assistant undersecretary of technical affairs	
Notes	

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1. Purpose

1.1. It is the objective of this policy to achieve improved patient care, by organizing and ensuring delivery of optimal emergency surgical intervention in a timely fashion by establishing a framework and template for emergency operation categorization and booking. The framework of the policy is based on designating categories by which cases would be triaged based on urgency and the patients' clinical states rather than by a "first comes first served" basis.

2. The Categories

2.1. **Category 1 – Emergent Intervention**

2.1.1. **Background** The patient population belonging to this category include those suffering from any general surgical (or other specialty as urological, neurosurgical, ENT, OMF etc.) pathology that is immediately life, limb or organ threatening, **and/or** with ***hemodynamic instability*** (or impending hemodynamic instability), **and/or** with airway compromise secondary to a surgically or endoscopically correctable cause.

2.1.2. Timing

2.1.2.1. Surgeries and procedures booked as category 1, should start within the hour (**< 60 min from diagnosis & decision to intervene**).

2.1.2.2. Surgeries and procedures in this category should **not** be delayed pending blood availability, file availability or administrative admission procedures

(admission procedures may be completed by the admitting team and nurses while the patient is being managed accordingly in the operating room).

2.2. Category 2 – Urgent Intervention

2.2.1. Background

2.2.1.1. The patient population belonging to this category include those suffering from any general surgical (or other specialty as urological, neurosurgical, ENT, OMF etc.) pathology that will need urgent intervention, and that on whom a few hours delay is **not** expected to adversely affect the general clinical outcome. They are hemodynamically **stable** at the time of the decision for intervention.

2.2.2. Timing

2.2.2.1. Surgeries and procedures booked as category 2 are surgeries that should be done **within 4 -8 hours** of the decision to intervene.

2.2.2.2. Surgeries and procedures in this category should **not** be delayed pending blood availability, file availability or administrative admission procedures (admission procedures may be completed by the admitting team and nurses while the patient is being managed accordingly in the operating room).

2.3. Category 3 – Semi-Urgent

2.3.1. Background

2.3.1.1. The patient population belonging to this category include those suffering from any general surgical (or other specialty as urological, neurosurgical, ENT, OMF etc.) pathology that will need semi urgent/expedited intervention that on whom hours to days of delay with medical management is **not** expected to adversely affect the general clinical outcome and who are hemodynamically **stable** at the time of the decision for intervention. It should be acknowledged that patients booked on the emergency list are either medical inpatients in need of diagnostic or therapeutic procedures or surgical patients admitted through the emergency room and eventually in need of an intervention prior to discharge -such as persistent biliary colic or acute cholecystitis.

2.3.2. Timing

2.3.2.1. Surgeries and procedures booked as category 3 are surgeries that should be done **within 24-72** hours of the decision to intervene.

2.3.2.2. Cases that are category 3 for more than 72 hours (but are not operated on due to other category 1 or 2 cases) maybe be:

2.3.2.2.1. Upgraded to category 2 ***within*** those 72 hours for urgent intervention based on the clinical situation.

2.3.2.3. Upgraded to category 2 ***after*** those 72 hours based on the clinical situation and resources.

2.3.2.3.1. Deferred- by the treating surgeon - to be done the next elective list of the week and If possible, to be accommodated without elective cases cancellation.

2.4. **Procedures to be performed by specialties without elective operative room privileges** (*e.g., gastroscopy under GA, VATS by a thoracic surgeon or bone marrow biopsy by hematology*).

2.4.1. To be booked in the ELECTIVE list of the operating team after permission of the surgical team of that day (to be done either as first case on 7:30 am, or last case on the elective list as deemed fit by the accommodating unit) otherwise they are considered and booked as category 3 and subject to the rules of category 3.

3. Booking Process, Priorities and Case Flow

3.1. Booking Process

3.1.1. The physicians (or members of their team) planning to perform an emergency procedure in the emergency operation room, must book the case by assistant registrar level and above either in writing in a logbook/or booking form in the front desk of the OT (or electronically depending on the respective hospital set up), with the following information provided (otherwise the booking will not be processed):

3.1.1.1. Patient's name
3.1.1.2. Patient's civil ID number
3.1.1.3. Patient's file number
3.1.1.4. Ward and bed number
3.1.1.5. Admitting unit
3.1.1.6. Attending doctor name
3.1.1.7. Diagnosis and intended procedure
3.1.1.8. Category of booking (category 1, 2 or 3)
3.1.1.9. Infectious conditions (e.g., TB, MRSA, ESBL, etc.) to prepare the necessary settings
3.1.1.10. Operating doctor name and/or booking Registrar/senior registrar name and stamp
3.1.1.11. Contact number of the person performing and/or booking the procedure
3.1.1.12. Booking date and time
3.1.1.13. Expected duration of the procedure
3.1.1.14. Type of anesthesia used (general or local)

3.2. Priorities

3.2.1. **NO** elective cases should be booked in the emergency room.

3.2.2. Cases that are booked on the emergency list will be called for and operated on based on the following:

3.2.2.1. **Category of the booking.**
(*Category 1 before category 2 category 2 before category 3, unless no booked category 1 or 2, then category 3 is called*)

3.2.2.2. **Time of booking** that's written in the booking form, (*i.e., category 2 booked at 7 am goes before category 2 booked at 9 am from another team*

unless the treating physicians agree otherwise, or the anesthetist sees urgency of one over the other)

3.3. Case Flow

3.3.1. **Booking** is made by the treating team.

3.3.2. **Informing** the emergency operating room anesthetist is to be by the treating team, and the operating room reception nurse should ensure that she/he (the anesthetist) has been informed.

3.3.3. **Prioritizing, calling** the respective teams and **directing** the flow of the cases as per category/timing without any delay is the responsibility of the anesthetist and reception nurse covering the emergency operating room.

3.3.4. **Patients requiring ICU care** (perioperatively) should have an ICU Bed ready or, at least, the ICU team should be informed preoperatively for planning of post op care (*please refer to the surgical suite policy ADM-009*).

3.3.5. if the treating surgeon/physician is ***not*** available for the procedure at the allocated time for the booked category, the next case on the list is called based on priority. That treating surgeon/physician is informed of the changes.

3.3.6. Categories 1 & 2 should **not** be booked over night to be done in the morning.

3.3.7. A representative from the anesthesia department and the respective surgical units (senior registrar and above rank) should be delegated on a daily, weekly, or monthly basis by each department to facilitate the flow of emergency cases, resolve issues and case priorities and verify appropriate adherence to the policy by the respective units and departments.

3.4. It is the responsibility of the anesthetist attending on call (or designee) to designate the necessary resources that would ensure the flow of the cases as per category/timing without any delay. This includes calling back up and opening further operating rooms at times of mass incidents, multiple category one emergencies and same category cases overlap that extend to 1.5-2 times beyond the defined category waiting timeline (e.g., category 2 cases with one case extending beyond 4-8 hours).

4. Monitoring procedure

4.1. It is the duty of the chairs and members of the respective anesthesia, ICU and surgical departments to monitor adherence to the emergency room booking policy and audit the performance of their teams ensuring no dereliction of duty arises resulting in delayed patient care.

4.2. MOH committee in hospital clinical services and polices will monitor the above policy.

4.3. Senior doctor of the related team can email the above-mentioned committee, in case of any incidence.

4.4. The email address will be: incident@moh.gov.kw