State of Kuwait
Ministry of Health

Title: The Surgical Suite Operational Policy	
Policy Owner: MOH committee on hospital clinical services and policies	**Policy Code:** ADM-009
Section location: Administrative/General	**Effective Date:** 01 Aug 2024
Applies to: 1-Preoperative clinics, the wards, the intensive care unit, and the operation rooms 2- All physicians performing emergency and elective procedures in the surgical suite (e.g., surgical specialties, gastroenterologists, interventional radiologists, anesthetists, etc.) and the supportive nurses & technicians	**Revision Date:** 31 July 2026
Approvals:	**Signature/Date**
Approved by: MOH committee on hospital clinical services and policies	
Approved by: Director of Technical Affairs	
Approved by: Assistant undersecretary of technical affairs	
Notes:	

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1. Purpose

1.1. This policy aims to maintain optimal and safe standards for the perioperative care of patients undergoing interventional procedures to result in the best outcomes for those patients ultimately. Implementing a surgical suite operational policy aims to outline all personnel's duties and responsibilities to provide the safest and best standards of care.

2. Preoperative Stage

2.1. All patients planned for elective interventional procedures (surgical, endoscopic, or radiological) must be seen and assessed by the respective specialized treating physician (surgeon, gastroenterologist, urologist, interventional radiologist, etc.) prior to booking for the planned elective intervention/procedure in the operating room.

2.2. In the aim of providing optimal and safe standards of care, it is imperative that the patient MUST ultimately be acknowledged and/or assessed by the attending physician (specialist or above rank) prior to booking the case in the operating room (even though a registrar or a senior registrar may initially assess the patient in the clinic or the ward). Therefore, The booking of the case must ALWAYS be under an attending's name in addition to the name of the assisting or operating physician performing the procedure.

2.3. All patients planned for elective interventional procedures (regardless of specialty) must have - before booking – a file, file number, a complete documented history and physical examination, a plan of management by the treating physician and any assessing physician preoperatively (e.g., anesthesia, internal medicine, etc.). The file must also contain the necessary preoperative investigations and blood product requirements.

2.4. All patients planned for electives, interventional procedures requiring general anesthesia (GA), sedation, or regional/spinal anesthesia in the main operation suite (regardless of specialty) should ensure a documented clearance for the procedure by anesthesia department preoperatively (in the ward or anesthesia preoperative clinic accordingly).

2.5. When booking patients for an elective intervention, the following must be documented on the operation room elective surgery list:

- 2.5.1. Patient's name
- 2.5.2. Patient's civil ID number
- 2.5.3. Patient's file number
- 2.5.4. Ward and bed number
- 2.5.5. Admitting unit
- 2.5.6. Attending doctor name
- 2.5.7. Diagnosis and intended procedure
- 2.5.8. Category of booking (category 1, 2 or 3)
- 2.5.9. Infectious conditions (e.g., TB, MRSA, ESBL, etc.) to prepare the necessary settings
- 2.5.10. Expected duration of the procedure
- 2.5.11. American society of anesthesia acute score
- 2.5.12. Type of anesthesia used (general or local)

3. Consent Forms

3.1. The consent for the procedure (noting Intervention-related risks, benefits, and complications) must be signed by the patient (or the legal representative of the patient) and the treating/operating physician (or a member of their team). The consent for anesthesia (noting anesthesia-related risks and perioperative anesthesia-related complications) must be signed by the patient (or the legal representative of the patient) and the assessing anesthetist. Each consent must contain the risks and benefits of the respective services signing the consent with the necessary two witnesses cos-signatures (Please refer to the medical responsibility law 70/2020 and relevant MOH circulars regarding the legalities of consent in patients under the legal age of 18 years and minors of divorced parents/widowed)

4. Cancellations

4.1. Cancellations of any surgical procedure depend on patient-related factors (e.g., the patient's preoperative clinical condition) or surgery-related factors (e.g., the absence of the treating physician, lack of the necessary instruments, etc.). When THE ANAESTHETIST decides to cancel the surgical procedure, it is the professional duty of THE ANAESTHETIST to inform the patient of the reason for the cancellations and the plan thereafter and document this information in the file. If THE TREATING SURGEON decides to cancel the surgery, it is the professional duty of THE SURGEON to inform the patient of the reason for the cancellations and the subsequent plan thereafter and document it in the patient's file (Please refer to the operation cancellation form in your department)

4.2. As per law, elective intervention procedures must be done regardless of the official time of day, as long as they -the patient and procedure -are officially documented on the list for that day with the patient (consented and clinically fit/cleared), the treating physician, the anesthetist, nursing staff and operating room all available on site. This is considered by the Civil Service Commission as an extension of the professional duties and set and reimbursed responsibilities of such specialized teams to their patient population. Any unnecessary cancellations or delays are subject to the rules of MOH and the Commission of Civil Services law.

4.3. Nevertheless, due to the occasional shortages in the surgical suite staff (e.g., anesthetists, scrub nurses, technicians, etc.) that may result in a lack of manpower in certain shifts of the day or after official working hours, it is imperative that cooperation between the departments exists and is enforced and maintained to ensure the performance of all the elective booked procedures on the list within the working hours to optimize the efficiency of the flow of cases on the elective list and operation rooms.

(Please see the MOH legal department letter on June 18th, 2017, serial number 2229/21 & referenced Civil Service Commission law paragraph 2, article 24, code 15 from the year 1979)

5. Surgical Suite Front Desk Nursing Responsibilities

5.1. The operation room front desk/station nurse is responsible for calling the patients from the ward to the operation room waiting area.

5.2. The operation room front desk/station nurse must ensure the following is met BEFORE calling for the patient:

5.2.1. The presence of the operating physician and anesthetist.

5.2.2. Confirmation by the treating/operating physician that he/she will be performing the stated procedure as planned.

5.2.3. The patient is physically present and ready for transfer from the ward.

5.2.4. The patient's file, including signed consent forms, laboratory investigations, and blood products (if indicated), is ready.

5.2.5. The patient has been cleared by anesthesia for surgery as stated on their preop anesthesia sheet, and the consents (anesthesia and procedure) completed by the respective physicians and signed by the patient (or the patient's legal representative)

5.3. Upon receipt of the patient from the ward, the receiving operation room nursing team must confirm the patient's identity and planned procedure, patient's file, signed consent forms, files, and blood product availability (if indicated), and the presence of the respective physicians (anesthetist and physician performing the intervention)

5.4. Prophylactic medication must be given according to the standard perioperative guidelines of the index MOH hospital and respective departments.

5.5. The patient must NOT BE placed under General anesthesia UNTIL the preoperative safety or TIME OUT form and checklist have been completed by the physician performing the procedure, the responsible anesthetist, and the circulating nurse of that room.

6. Operation Room Management and Case Flow

6.1. The flow of cases in the operating rooms is subject to anesthesia time, surgical procedure times, nursing communication, and transport to and from the wards. Thus, members of both departments must cooperate to ensure an efficient flow of cases and that all patients are provided with the procedures they have been planned for in a safe and time-efficient manner.

6.2. NO surgeon, unit, or department (regardless of specialty) is to restrict use of an operating room(s) or limit its function to its department

6.3. Operating rooms are the property of the MOH and must be utilized efficiently to ensure timely care is delivered to ALL patients in need of surgical intervention.

6.4. Implementation of the following is mandatory to ensure efficient utilization of operation rooms and case flow:

6.4.1. Using operating rooms that have cancellations (and vacant time slots) to perform procedures for patients waiting for procedures in other rooms if

applicable and possible (from the personnel and instrument point) to maintain and expedite the flow of the cases.

6.4.2. Delegating gatekeepers (organizers) from the anesthesia, surgical, and nursing departments to communicate and organize the case flow within and between the operation rooms (both elective and emergency rooms).

6.4.3. Allocating AT LEAST one emergency surgery room (or more depending on the hospital setup and capabilities) where only emergency procedures are to be performed in this room(s).

6.5. No elective cases can be referred from the elective list to the emergency surgery room list.

*(Please refer to the emergency surgery room category and booking policies by visiting the following link: https://www.moh.gov.kw/en/Technical/Pages/Policies.aspx).

7. Perioperative ICU Consults and Admissions

7.1. Admission of Emergency Surgical cases to the ICU

7.1.1. For cases planned for emergency surgery and determined—on presentation, during anesthesia assessment, or even intraoperatively—to require postoperative ICU admission, the ICU team must be informed and consulted to allow time for planning and resource allocation by the ICU on-call team.

7.1.2. After the procedure is completed, the respective patient will be admitted to the ICU if deemed necessary by the anesthesia and or surgical team. If the patient is in the recovery room pending bed allocation or assessment, the ICU team will not be involved in the patient care and management unless officially consulted (until then- i.e., ICU consult and care- the care of the patient in the recovery room is the responsibility of the respective anesthetist).

7.1.3. To ensure efficient bed management and proper resource allocation, communication between the ICU team and the operating /anesthesia team must be maintained intra- and postoperatively to determine whether the monitored bed is still required for the respective patient postoperatively.

7.2. Admission of ELECTIVE surgical cases to the ICU:

7.2.1. If a patient is considered possibly or definitely to require admission to the ICU ***after*** an elective procedure, the ICU team on service will be required to be notified at least 48 to 72 hours ***before*** the designated date of the procedure.

7.2.2. Notifications and bed requests must ***not*** be considered confirmations of availability or admission, as the ICU patient flow, bed capacity, and availability are dynamic processes. Thus, the ICU bed availability must be reconfirmed on the morning of the procedure to avoid miscommunication.

7.2.3. The service requesting the postoperative ICU admission is responsible for communicating with the ICU team accordingly before admission (e.g., surgery for surgical-related reasons, internal medicine for medical-related reasons, or anesthesia for anesthesia-related reasons).

7.2.4. After the procedure has been completed, the respective patient will be admitted to the ICU if deemed necessary by the anesthesia and/or surgical team. If the patient is in the recovery room pending bed allocation or assessment, the ICU team will not be involved in the patient care and management unless officially consulted (until then- i.e., ICU consult and

care- the care of the patient in the recovery room is the responsibility of the respective anesthetist).

7.2.5. To ensure efficient bed management and proper resource allocation, communication between the ICU team and operating /anesthesia team must be maintained intra-/postoperatively to determine whether the monitored bed is still required for the respective patient postoperatively.

7.2.6. If the ICU team receives multiple requests for postoperative ICU beds simultaneously for a specified operative date(s), the requests must be triaged based on medical/clinical urgency.

7.3. Patients requiring postoperative ICU admission despite lack of bed availability

7.3.1. If it is determined a patient is a candidate for ICU admission pre/intra/ or postoperatively. At the same time, the ICU lacks the necessary resources and bed capacity, the patient is to be temporarily transferred to the recovery room (postoperatively). An official consult must be issued by the treating physician requesting the ICU admission (anesthesia or surgeon accordingly) to the ICU, who will, in turn, evaluate the patient and determine candidacy for ICU care and admission. The management plan and care for the patient will be established by the ICU team until either (a) an ICU bed is made available and the patient is admitted to the ICU, (b) the patient's condition has been deemed not in need for ICU admission and is transferred to the respective ward (with or without follow up).

7.3.2. While in the recovery room the ICU team and the recovery room nursing staff are responsible for care and management (if deemed so by the ICU team).

8. Elective Surgery Categories

8.1. All Surgical departments and units (including subspecialties such as orthopedics, ENT, plastic surgery, etc.) must allocate their respective cases/patients to categories according to their surgical care service needs.

**Please refer to the ministerial circular no.79 for the year 2020 issued by the undersecretary of the MOH on the 1st of July,2020 (regarding elective procedure prioritization p.4)*

**Please refer to the Accreditation Standards for Hospitals in Kuwait 2019, version 6*

8.2. The following categories are to be used as a framework and designated accordingly, as seen fit, by each specialty to ensure the patients are provided the necessary interventional procedures at the most appropriate time, with undue delay depending on the respective pathology. (Please refer to the emergency surgery room category and booking policies by visiting the following link: https://www.moh.gov.kw/en/Technical/Pages/Policies.aspx).

8.2.1. **Category 1:** procedures that are clinically indicated within 30 days of diagnosis and plan of surgical intervention, which delays beyond the mentioned timeline are likely to be associated with increased morbidity, mortality, or poorly affected outcome *(e.g., malignant conditions, cholecystectomy with history of biliary pancreatitis, etc.)*

8.2.2. **Category 2:** procedures that are clinically indicated within 90 days of diagnosis, and plan of surgical intervention *(e.g., thyroidectomy, cholecystectomy with history of biliary colic, anal fissure, etc.)*

8.2.3. **Category 3**: procedures that are clinically indicated within 120-240 days of diagnosis and plan of surgical intervention (e.g., morbid obesity, nonincarcerated hernia, etc.)

8.3. The urgency category listed in this guide must be used to assign an urgency category unless a patient's clinical indications require earlier treatment.

8.4. The treating surgeon (unit /department) is responsible for assigning the urgency category.

8.5. The urgency category must be appropriate to the patient and their clinical situation and not influenced by the availability of hospital or surgeon resources.

8.6. The department must perform an audit on a 6-12 monthly basis on waiting time and adherence to category allocation.

9. Monitoring Procedure

9.1. The Department chairs of the respective surgical specialties and The ICU & anesthesia departments are responsible for ensuring adherence to this policy and efficient case flow, which ensures patients receive the necessary surgical intervention in the appropriate allocated time.

9.2. The MOH committee in hospital clinical services and policies will monitor the above policy.

9.3. Senior doctors of the related team can email the above-mentioned committee in case of any incidence.

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