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As the centrepiece of the technical platform, the operating theatre represents one of the major and certainly the most complex processes in hospitals. It is a place where highly technical acts are performed, but where the associated costs imply notions of profitability to which are added unavoidable safety imperatives. Thus, operating room management must meet three unavoidable imperatives: profitability, quality and safety. In this respect, numerous regulatory texts/recommendations/referentials have been drawn up. On the methodological level, analysis methods (FMEA, RPA, Checklist) aimed at risk prevention have been published. These methods require advanced expertise and require the availability of players often phagocyted by business imperatives and the technical nature of tasks. Based on this observation, the objective of our Working end of study Project is to develop, validate and test a systemic diagnostic tool to identify, a priori, organizational dysfunctions likely to have an impact on patient safety and the quality of surgical management. Inspired by the Gap Analysis approach, our tool aims to measure the gaps between the actual functioning of operating room process activities and the standards/best practices recognized as such by international standards, guides and specialized literature. Once developed and validated by professionals, we tested the tool in the operating room of a private clinic in Casablanca. From a systemic perspective, we have divided the reference items into four of the most critical areas of operating room : patient care, management, flow and hygiene. For each axis, we have developed a repository of specific items distributed over the pre, per and postoperative processes. The calculated data presents the variance rates between the items and the actual process activities. Over a period of 3 months, data collection was carried out by the patient-traceur technique, direct observation and by questioning professionals. Our study shows that the most significant differences are due to shortcomings linked to overwork, lack of managerial training, sub-optimal management of IT applications involved in internal management and poor logistics management (materials, equipment and linen). In order to overcome these shortcomings, we have proposed an integrated action plan to reduce these gaps and ultimately bring activities into line with the corresponding items.