Beth Israel Lahey Health

System-wide Recovery Guidelines

Team: **Non-Operative Procedures**
Date: **05.14.2020**

III. Operational Requirements for Resumption of Elective Procedures

BILH has put forward an Operational Readiness Checklist (*forthcoming*). Below are recommendations to supplement this checklist.

A. Assess Readiness

i. Hospitals should create teams focused on longer-term and immediate-term planning and corrective action. Hospitals are encouraged to create a multidisciplinary Recovery Governance Committee to develop local policies and protocols, drive local planning efforts, and ensure readiness criteria are met. This Committee should focus on planning over the longer-term horizon, including identifying the phases of recovery and the targeted volume or capacity utilization for each phase. The Committee should outline the processes by which it can attest that adequate supplies, capacity, screening and testing, staffing and other mitigating conditions are present so that elective procedures can resume responsibly.

ii. The local hospital should establish daily huddles focused on immediate-term planning and operational needs. These huddles bring together front-line providers, staff, and managers to focus on more immediate needs. These huddles might include:

a. Daily Safety Huddles with nurse manager/director, anesthesiology lead (where appropriate), proceduralists, technician lead, pre-procedure and post-procedure nursing leads

b. Daily multidisciplinary Recovery Huddles assessing hospital capabilities specific to elective care re-opening, including anesthesiology (if appropriate) and nursing resources, PPE counts and distribution, post-procedure recovery and ICU capacity, and any other “issues of the day”.

iii. Hospitals should share local recovery plans with physicians and staff to allow them to provide input and feedback. Transparency and regular communication will encourage provider and staff engagement and buy-in, while ensuring a more robust recovery plan and unified messaging to patients and the broader community.

   a. Hospitals should evaluate existing communication channels to
   determine whether they need to be adapted or supplemented to meet recovery plan communication needs. Examples of such channels include department meetings, email distribution lists, and intranet sites.

iv. The reclaiming of space and equipment may involve multiple departments and take several days to achieve. To determine whether space/equipment is ready to be reclaimed, and the time required to convert such space, leaders should liaise with colleagues regarding:
   a. Continued need for use by COVID-19 patients,
   b. Cleaning / Environmental services,
   c. Clinical Engineering services, and
   d. Equipment, furniture, and supplies (e.g., will they be cleaned/disinfected and used in space, moved to a COVID-19 care area, or discarded).

v. Local procedural teams should work with their Facilities colleagues to identify signage needs to facilitate patient wayfinding and patient cohorting strategies.

vi. Local procedural teams should work with their Supply Chain colleagues to ensure a robust communication protocol regarding the demand and supply of key supplies, including PPE.

vii. Local procedural teams should work with their Pharmacy colleagues to ensure a robust communication protocol regarding the demand and supply of key medications, including sedatives.

B. Assess Staff Capacity

i. Hospitals are encouraged to build up capacity over time, giving staff time and flexibility to ease into the expanded schedule. Building capacity too quickly may lead to staff

burnout and a subsequent ramp down of available procedural time.

ii. Each procedural area should have a designated contact to coordinate with other hospitals regarding physicians who may practice at more than one facility.