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System-wide Recovery Guidelines

Team: **Operating Room (OR)**
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Introduction

This document offers a set of guidelines and tools to help BILH hospitals plan for the resumption of elective surgical care.

The OR guidelines are organized into the following categories:

I. Prioritization of Clinical Services

II. Operationalization of Infection Control Guidelines
   a. Staff Education
   b. Pre-operative Testing and Screening

III. Operational Requirements for Resumption of Elective Surgeries
   a. Assess Readiness
   b. Assess Staff Availability

IV. Patient Pathway
   a. Pre-operative Care
   b. Intraoperative Care (Day of surgery)
   c. Postoperative Care

The following checklists are provided to facilitate assessment of facility readiness to resume elective surgical care (*forthcoming).*

- Screening and testing
- Operational readiness

I. Prioritization of Clinical Services

A. Each facility should adopt a cogent patient prioritization system for the purpose of OR scheduling to maximize efficient use of limited resources while preserving patient equity. This prioritization system may be an existing external algorithm adopted by the institution or internally created and agreed upon by local OR leadership. The adopted model should be described in writing and transparent to all providers within the perioperative area. Scoring systems should consider and provide ranges across the principles listed below.

Prioritization Principles

i. Risk to patient condition if surgery is further deferred
ii. Post-surgical risk of physiological complications secondary to COVID-19 infection
iii. Use of limited hospital resources
    a. PPE in OR suite
    b. PACU stay
    c. ICU bed/stay
    d. Med/Surg bed/stay

b. Each elective surgical case should be scored according to the prioritization system in place. These scores should be maintained in a tracking database. Each hospital should measure and monitor the percent utilization of the prioritization scoring system within each surgical division.

c. It is recommended that service line blocks are adopted in place of individual surgeon blocks and distributed to specific services by hospital OR leadership. This will maximize resource utilization.

d. The utilization of each service line block will become the responsibility of the surgical division chief using the agreed-upon prioritization model.

e. Hospitals should focus on achieving a very high percent utilization of the service blocks with a clear surgical division-specific plan to allow backfilling of cases if cancellations occur. This will be the responsibility of each surgical division chief.

f. Each hospital should engage in simultaneous and parallel models for outpatient ambulatory and inpatient surgical cases.

g. Utilization of all BILH ambulatory resources within the system will be considered to allow cross-pollination of available ambulatory centers to be matched to patient demand and needs.

h. There is an expectation that surgeons will have constant communication with their patient list to understand patients' desire and readiness to proceed with surgery.

II. Operationalization of Infection Control Guidelines

BILH's Infection Control Guidelines related to OR procedures can be referenced here. The guidelines below outline recommendations for operationalizing these guidelines in the perioperative setting.

A. Staff Education

i. To optimize patient care within locally implemented symptom-screening and testing workflows, BILH hospitals must:
   a. Educate staff on COVID-19 symptom and exposure screening questions to be asked of patient, the location of the screening information, and follow-through steps for screen-positive patients
   b. Educate staff on testing including preferred timing of tests, testing locations, counselling PCR-positive patients, indications and process for rapid testing, and follow-up for PCR-positive patients

B. Pre-Operative Testing and Screening

i. To minimize the number of visits patients must make to the hospital prior to surgery, hospitals should, when possible:
   a. Consolidate pre-operative testing needs (e.g., COVID-19 PCR testing, blood bank testing, etc.)
   b. Facilitate the availability of testing at ambulatory sites rather than the hospital, and
   c. Use virtual care to collect and discuss information.

ii. To maximize symptom and exposure-screening and testing of patients, hospitals should:
   a. Centralize screening and test scheduling processes through use of Pre-Anesthesia Testing (PAT) Clinics or similar mechanisms,
   b. Identify who is responsible for:
      - Ordering the test,
      - Communicating with the patient regarding the need to be tested and the process, and
      - Following up on test results, including

- Communicating with the surgical team regarding positive test results, and
- Communicating with the patient regarding test results and whether to proceed with surgery.

iii. Adopt best-practice telehealth models in use by fellow BILH hospitals. For example, some organizations are conducting pre-operative symptom screening via text-messaging-based system while others are collecting this information via telephone.

iv. To streamline communication around reduction of risk of nosocomial COVID-19 infection, hospitals will use BILH-developed FAQs and talking points about transmission risk and the preventive measures in place to ensure the safety of patients undergoing elective surgery.

v. To ensure consistency of messaging to patients and the community, BILH requires hospitals to educate surgical, PAT, and anesthesiology staff across BILH on how to access and use the aforementioned communication tools.

III. Operational Requirements for Resumption of Elective Surgeries

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 surgeries 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, anesthesiology lead, surgeons, inner core lead, and Preop and PACU leads

b. Daily multidisciplinary Recovery Huddles assessing hospital capabilities specific to elective care re-opening, including anesthesiology and nursing resources, PPE counts and distribution, PACU 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
   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 perioperative teams should work with their Facilities colleagues to identify signage needs to facilitate patient wayfinding and patient cohorting strategies.

vi. Local perioperative 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 perioperative 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 Availability

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 OR time.

ii. Each surgical specialty division or department should have a designated contact to coordinate with other hospitals regarding physicians who may practice at more than one facility.

IV. Patient Pathway – Recommendations by Perioperative Stage

A. Preoperative Preparation

i. During the scheduling process, hospitals should assess patient readiness to come into the organization and address safety concerns.
   a. Educate all members of the care team on BILH-provided talking points to ensure consistency of messaging to patients.
   b. If patients decline to schedule surgery, record their reason for doing so.

ii. As noted in Section II, hospitals should minimize the need for in-person visits prior to surgery by:
   a. Consolidating testing requirements,
   b. Identifying opportunities to use tele-health:
      - Pre-registration by phone, including any financial clearance conversations,
      - Symptom and exposure screening via telephone or text-based system 48-72 hours prior to surgery, and,
      - Virtual patient education, including information regarding what to expect the day of surgery and the need to arrive at the facility wearing a mask or cloth face covering. For patients who do not have a mask or face covering, one will be provided upon arrival.

iii. Local perioperative teams should work with their Facilities Department to identify pathways for patients to enter the facility and to follow throughout the perioperative visit.
   a. When appropriate, consider having patients wait in car (rather than the waiting room) and call or text when patient should enter the facility. (Hospitals will need to consider

cellular reception in areas such as underground parking garages.)

b. For short procedures, consider having visitors wait in car rather than entering facility. Visitors may be limited to essential escorts during early phases of recovery.

iv. Perioperative leaders should educate the team on physical distancing considerations (e.g., waiting areas) and determine how these guidelines will be enforced

v. To adhere to BILH visitor policies, perioperative teams should:
   a. Educate patients regarding the BILH visitor/escort symptom/exposure policy in advance of the day of surgery. Visitors and essential escorts should arrive at the facility wearing a mask or cloth face covering; a mask will be provided to those who arrive without one and should be worn at all times in the facility.
   b. Inquire during pre-registration who will accompany patient, and
   c. Determine where visitors/escorts will wait during surgery.

vi. Hospitals should assess post-discharge care needs as early in the process as possible to ensure patients' care needs across the continuum are met.
   a. Surgeon (or designated clinical provider) should complete a checklist to frontload coordination of postoperative services needed
   b. Involve case management in conversation prior to surgery
   c. Prior to booking case, the care team should determine the likelihood that a patient will need to go to a post-acute care facility and understand the patient's geographic preference.
      - Ensure case management understands facility testing requirements and capacity to accept patients.

B. Intraoperative Care Day of Surgery

i. Hospitals should have a plan for enforcing compliance with masking, screening, social distancing, visitor protocols, and other Infection Control policies. Hospitals should explicitly identify staff responsible for enforcement.

ii. Providers are encouraged to use regional anesthesia, when appropriate, to avoid intubation and expedite recovery.

iii. A suggested workflow tool including intraoperative PPE and post-case cleaning is available on the BILH website.

C. Postoperative Care

i. Hospitals should identify opportunities to use tele-health for postoperative care and teaching to minimize need for patient to return to facility.
    a. If a patient needs to return to facility for an imaging study, for example, the provider can conduct the post-op visit via tele-health, if clinically appropriate.

ii. The care team should identify ways to enhance post-op teaching (e.g., reinforce during post-op phone call), especially as family members might not be with patients during in-person post-op instruction.

iii. The care team should utilize home health services to eliminate visit(s) to hospital (e.g., VNA nurse to remove stitches/sutures) when clinically appropriate.