Resuming Elective Surgery after COVID-19

Organizations have developed and executed well-structured plans to respond to the influx of COVID-19 patients. However, hospital and health systems are now challenged with planning for the patients who require care but whose care has been delayed due to the COVID-19 crisis. The delay has made sense, has followed guidelines, and has followed the popular concept used in medicine: “first do no harm.” The healthcare community is faced now with creating a plan that will continue to “do no harm” for patients who need your services.

The US government has developed guidelines and restrictions for states to follow to resume elective surgeries. Clinical organizations have prepared adjunct guidelines to consider when planning the resumption of services. Your organization may have a range of opinions about when and how to begin. Much information is coming your way.

The planning and execution will be key in the process and the resultant outcomes. In 2009, Larry Bossidy and Ram Charan’s Execution: The Discipline of Getting Things Done was updated in response to the crisis of the global recession that was taxing businesses at that time.1 The authors noted, “We now live in a world in which radical change can happen seemingly overnight, and in which many former ‘givens’ will be in flux for a long time.”

COVID-19 has created a crisis, and we are living in a world of radical change, which happened nearly overnight and requires new plans and processes. The resumption of elective cases will require well-developed plans, executed with relentlessness and structured around strategy, people, and operations. The strategy for resuming elective cases will be driven first by governmental guidelines, from the timing of the resumption through the details of the operational requirements. Other strategic considerations may include system strategy, optimizing already over-pressed resources, the balancing of patient needs, and the health of the clinical teams, to name a few.

Perioperative and medical staff leadership will be charged to develop and lead the operational resumption plans. In alignment with the recently published joint statement and roadmap from the AHA, ACS, ASA, and AORN,\(^2\) the operational plans to develop or redesign and execute will contain many components, including:

- The structure to redesign the future state and garner key stakeholder support
- A new (at least interim) block calendar to assure access
- The system used to prioritize patients
- Redesigned processes to address the new state
- Identification of new roles and responsibilities, along with a review of current roles and responsibilities, such as device representatives, and outsourced services
- Updated training needs for new processes and for continued competencies intraoperatively
- Adequacy of supplies (testing, PPE)
- Clear communication channels
- Systems to assure patient and visitor safety
- Systems to support front-line staff to deliver care to patients awaiting surgical procedures

Accountable, clear, and metric-driven goals will assist in the execution of the operational plans. Data and metrics will provide direction to support making decisions based on facts.

Your work as executive leaders, like the landscape, is changing quickly. Communities are relying on healthcare leadership and the services of hospitals to keep patients safe and to help heal communities. Your current work may be some of the most challenging you have encountered in your career. Please be safe and take time to give yourself credit so that you can continue to be energized to lead during the formulation of the future state.

Paula Harms
MBA, BSN, BBA, RN, FACHE
Director

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