Interim Guidance on the Management of Day Case Procedures – non-aerosol generating procedures (AGPs) e.g. non-invasive radiology, colonoscopy, minor procedures

This document does not supersede clinical judgment and describes methods to mitigate risks associated with delivering non-COVID care in an environment where SARS-CoV-2 is prevalent. It provides a framework for services that will need to be tailored to local conditions and specialty needs.

Pre-admission: All patients should have a pre-procedural engagement that is virtual, by telephone or other suitable means, to ascertain that they are not

1. Suffering from any symptoms or signs of COVID-19
2. Restricting their movements due to being a close contact
3. Suffering from acute illness of any nature other than that related to the procedure
4. In contact with any member of their social group who is suffering from the symptoms or signs of COVID-19.

In addition, they need means to get to the hospital and a designated individual to stay with them for 12/24 hours after any procedure involving sedation. It is preferable if the accompanying adult remains in the car but recognised that this may not always be possible. No children are to accompany individuals for procedures.

Pre-sedation assessment:
As much as can be should be assessed virtually and additional investigations and/or in person history and examination should be scheduled to occur on the same day to minimize the number of hospital visits.

Prior to admission, patients should be sent an appointment time and asked to wait in their car, where possible, until shortly before their appointment time. Included in this communication should be a patient information leaflet indicating the requirements pertaining to the procedure. Facemasks, one for the patient and one for the individual, accompanying them can be included in this communication.
These masks are to be put on prior to entering the facility, if tolerated, and hands sanitized. Individuals are asked not to touch their face whilst wearing their masks. If masks are inadvertently touched, sanitize hands immediately after.
Once delivered, the accompanying adult will be asked, where possible, to return to their vehicle and to leave contact details for patient collection.
Patients will be asked to keep their facemask in place for the entire hospital/ clinic visit, if tolerated. Should it become wet or soiled a replacement will be offered.

On admission the patient will be screened for the symptoms and signs of COVID-19. If any are present the procedure will be cancelled. If the patients has signs of COVID-19 within 14 days of the procedure they are asked to phone and will be offered an alternate appointment. This applies up to the day of the procedure.

Dr Vida Hamilton, NCAGL Acute Operations, Approved EAG, 29th April 2020

Interim Guidance on the Management of Procedures that are Day Case – Involving anaesthesia or aerosol generating procedures (AGPs).

This document does not supersede clinical judgment and describes methods to mitigate risks associated with delivering non-COVID care in an environment where SARS-CoV-2 is prevalent. It provides a framework for services that will need to be tailored to local conditions and specialty needs.

Pre-admission: All patients should have a pre-procedural engagement that is virtual, by telephone or other suitable means, to ascertain that they are not

1. Suffering from any symptoms or signs of COVID-19
2. Restricting their movements due to being a close contact
3. Suffering from acute illness of any nature other than that related to the procedure
4. In contact with any member of their social group who is suffering from the symptoms or signs of COVID-19.

In addition, they need means to get to the hospital and a designated individual to stay with them for 12/24 hours after any procedure involving sedation or anaesthesia. It is preferable if the accompanying adult remains in the car but recognised that this may not always be possible. No children are to accompany individuals for procedures.

Pre-sedation, anaesthesia assessment:
As much as can be should be assessed virtually and additional investigations and/or in person history and examination should be scheduled to occur on the same day as pre-procedural COVID-19 testing to minimize the number of hospital visits.

Pre-procedural testing: Within 48 hours of the procedure, the patient should attend for a COVID-19 test. They should not proceed to the hospital/ clinic until it has been confirmed that their test is negative.

Prior to admission, patients should be sent an appointment time and asked to wait in their car, where possible, until shortly before their appointment time. Included in this communication should be a patient information leaflet indicating the requirements pertaining to the procedure. Facemasks, one for the patient and one for the individual, accompanying them can be included in this communication.
These masks are to be put on prior to entering the facility, if tolerated, and hands sanitized. Individuals are asked not to touch their face whilst wearing their masks. If masks are inadvertently touched, sanitize hands immediately after. Once delivered, the accompanying adult will be asked, where possible, to return to their vehicle and to leave contact details for patient collection.

Patients will be asked to keep their facemask in place for the entire hospital/ clinic visit, if tolerated. Should it become wet or soiled a replacement will be offered.

On admission the patient will be screened for the symptoms and signs of COVID-19. If any are present the procedure will be cancelled. If the patients has signs of COVID-19 within 14 days of the procedure they are asked to phone and will be offered an alternate appointment. This applies up to the day of the procedure.

The patient will be admitted to a dedicated elective pre-operative area.

Post procedurally, the patient will be admitted to an area dedicated to planned care and including only patients who have had similar pre-procedural screening and testing.

On discharge the patient will be given an information leaflet including the means to contact the hospital or attend for unplanned care due to an unforeseen complication of the procedure e.g. G.P., a virtual clinic, the ASAU or AMAU for clinical examination rather than attending an undifferentiated care pathway (ED).

Dr Vida Hamilton, NCAGL Acute Operations, Approved EAG, 29th April 2020

Interim Guidance on the Management of planned Hospital Admission for non-COVID care.

This document does not supersede clinical judgment and describes methods to mitigate risks associated with delivering non-COVID care in an environment where SARS-CoV-2 is prevalent. It provides a framework for services that will need to be tailored to local conditions and specialty needs.

It applies to planning for a hospital stay or planned interventions that will impact the patient's immune system. Surgery and immunosuppressant treatments such as chemotherapy or radiotherapy co-inciding with acute COVID-19 may be associated with increased mortality. [1,2]

1. Modelling by Williams et al suggests that mortality from chemotherapy is doubled in presence of COVID 19 infection, in the > 50 age group (https://www.medrxiv.org/content/10.1101/2020.03.18.20038067v1.full.pdf).
2. S. Lei et al., Clinical characteristics and outcomes of patients undergoing surgeries during the incubation period of COVID-19 infection, EClinicalMedicine (2020), https://doi.org/10.1016/j.eclinm.2020.100331

14 days prior to admission:

In order to mitigate the risk of having surgery or in-patient medical therapy whilst incubating COVID-19, it is recommended that each individual, in so far as possible, minimizes their risk of exposure to others who maybe asymptomatic or presymptomatic or indeed be symptomatic with COVID-19.

The most effective strategy is to cocoon for 2 weeks in advance of admission. Where this is not possible, it is recommended that contact is minimized with people outside of your immediate social group to the greatest possible extent and that social distancing, mask wearing and hand washing/ sanitizing is used to minimize infection risk.

If an individual is in a residential care setting, establish if there is COVID-19 transmission in the RCF and if so defer surgery or remove to another setting two weeks prior to admission.

7- days prior to admission:

Call or text patient to confirm they are cocooning/ physical distancing
Check that they and their social circle have no clinical features suggestive of COVID-19

Anaesthesiology pre-assessment clinic:

As much as is possible should be assessed virtually and efforts made to bundle tests and investigations, including COVID-19 test, that require hospital attendance into as few episodes as possible.

48 hours pre-admission:

All patients should have a pre-procedural engagement that is virtual, by telephone or other suitable means, to ascertain that they are not

1. Suffering from any symptoms or signs of COVID-19
2. Restricting their movements due to being a close contact
3. Suffering from acute illness of any nature other than that related to the procedure
4. In contact with any member of their social group who is suffering from the symptoms or signs of COVID-19.

The patient should attend for a COVID-19 test within 48 hours of scheduled admission. Patients (and individuals accompanying them) should wear facemasks to and from testing, if tolerated.

At this time the patient's medical file can be made up and sent to their admission ward which should only care for patients with planned admission who have spent 2 weeks preparing and have had pre-screening and test results with 'VIRUS NOT DETECTED'. This gives clinicians the opportunity to review the chart on the day before, if required.

In addition, the patient needs means to get to the hospital. It is preferable if the accompanying adult remains in the car but recognised that this may not always be possible. No children are to accompany individuals for admission.

Prior to admission, patients should be sent an appointment time and asked to wait in their car, where possible, until shortly before their appointment time. Included in this communication should be a patient information leaflet indicating the requirements pertaining to the procedure. Face masks may be used during hospital visits, if tolerated and hands sanitized. Individuals are asked not to touch their face whilst wearing masks. If masks are inadvertently touched, hands should be sanitized immediately after.

Day of admission:

Patients should not attend unless they have been informed that their COVID-19 test indicates "VIRUS NOT DETECTED" and given an attendance time.

On admission the patient should be screened for the symptoms and signs of COVID-19. If any are present the procedure will be cancelled. Patients should be admitted on the day of surgery/ intervention whenever possible to minimize the length of hospitalization and directly to the specialist planned care ward

occupied only by patients who have similar pre-procedural planning, screening and testing.

Post procedurally, the patient should be admitted to an area dedicated to planned care and including only patients who have had similar pre-procedural planning, screening and testing.

On discharge
The patient should be given an information leaflet including the means to contact the hospital or attend for unplanned care due to an unforeseen complication of the procedure whether it be the GP, a virtual clinic or the ASAU/ AMAU rather than attending an undifferentiated care pathway.

If being discharged to another healthcare or long stay residential centre (LSRC) after a stay case the patient should be tested for COVID-19 within 24 hours of discharge and consideration given to 'cocooning' on return to the LSRC for 14 days.

Surveillance:
It is recommended that patient are reviewed for infection, including COVID-19 and surgical site infection occurs between 2 to3 weeks post discharge. In so far as possible this should be done virtually.

Dr Vida Hamilton, NCAGL Acute Operations, Approved EAG, 29th April 2020

Interim Guidance on the Peri-Procedural Period

Patient having a planned procedure should have had 2 weeks 'cocooning' or social distancing, pre-screening for symptoms and signs and a COVID test with 'virus not detected' within 48 hours of the procedure as outlined in '**Guidance on the Management of planned Hospital Admission for non-COVID care'**.

These patients should not be situated near undifferentiated patients. For theatres that are delivering on scheduled and unscheduled care, procedures should be put in place to avoid the mixing of these patient cohorts.

The patient should wear a facemask going to theatre, if tolerated and the staff attending should wear mask, apron and gloves (MAG).

Induction: may occur in the anaesthetic room, suggest minimum staff present. Face shield gloves, gown and respirator mask (FGGRM) suggested for

- Bag, mask ventilation
- Intubation/ extubation
- LMA insertion/ removal
- Flexible optical intubation
- Bronchoscopy
- Nasal and guedal airway insertion and removal
- Naso-gastric tube insertion

Transfer to theatre may occur as soon as the patient is ready due to the pre-admission risk mitigation actions.

For regional techniques a surgical mask is suitable, with sterile gown and gloves for sterile procedures.

In the theatre, depending on the procedure, goggles/ face shield, surgical mask and gown is suitable, with respirator mask used when aerosol generation is possible.
Theatre staff should have facemasks in place prior to the patient being brought into theatre and until the patient has left.

Extubation should occur in the theatre and the patient transferred to a non-COVID recovery area

LMA removal may occur in recovery with a barrier or FGGRM.

Post-operatively patients should be transferred to a dedicated non-COVID post-op ward.

Dr Vida Hamilton, NCAGL Acute Operations, Approved EAG, 29th April 2020