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COVID-19: PLANNING CONSIDERATIONS WHEN RESTARTING ELECTIVE SURGERIES

Healthcare facilities, physicians, nurses, and the entire healthcare team need to plan for, and be prepared to safely deliver care as elective surgeries are permitted to resume. There are many facilities in various levels of preparation as well as having already reopened for elective surgery.

Generally, the ability to resume electives cases safely will depend on the presence of a sustained reduction in COVID-19 for at least 14 days, a facility's availability of Personal Protective Equipment (PPE), COVID-19 testing supplies as well as staff and hospital/ICU bed capacity. It is important to always check with the specific guidance issued by your local health authorities and/or professional perioperative organizations.

The following eight principles are summarized below as recommendations from several primary professional organizations within perioperative practice areas.[1, 2, 3, 4] These planning considerations will help you formulate strategies for resumption of elective surgeries and/or could identify potential gaps in a current strategy.

1 Sustained Reduction and Timing for Reopening

There should be a **sustained reduction in the rate of new COVID-19 cases for at least 14 days** and the facility should have the appropriate number of intensive care unit (ICU) and non-ICU beds, PPE, ventilators and trained staff to treat all non-elective patients without resorting to a crisis standard of care.

2 Testing Availability and Turnaround Results

Testing availability and rapid result turnaround time is a key aspect of resumption of electives. Having both **diagnostic testing capabilities and capacity** as well as anti-body testing are crucial to protect staff and patient safety. Facilities should implement a policy addressing requirements and frequency for patient and staff testing.

3 Adequate Supply of PPE and Medical Supplies

Assessment of PPE supplies should include current usage, increased demand due to resumption of elective surgery and procedures, as well as the potential of a second COVID-19 wave after restrictions are relaxed and until a vaccine is available.

4 Case Prioritization and Scheduling Strategy

Establishing a policy to prioritize elective cases and procedures will require **collaboration between key stakeholders** including surgery, anaesthesia and nursing leadership to develop a strategy appropriate to the immediate patient needs. Consider the use of a priority scoring tool[5] to facilitate decision-making and triage for Medically-Necessary, Time-Sensitive (MeNTS) procedures while weighing in on individual patient risks.

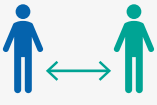
5 Policies for 5-phases of Surgical Care

Facilities should adopt policies addressing all phases of the patient care journey, from **perioperative to immediate preoperative, intraoperative, postoperative and post-discharge care planning** that are specific to COVID-19 and the postponement of surgical scheduling.

6 Data Collection and Management

Facilities should collect and utilize relevant facility data, enhanced by data from local authorities and government agencies. Considerations should cover **COVID-19 related data** (such as number of positives, intubated patients and deaths), **resource tracking** (such as PPE, ICU/non-ICU beds and ventilators) and **quality of care metrics** (such as mortality, complications and re-admissions).

7 Risk Mitigation and Safety



Facilities should have and implement a **social distancing policy for staff, patients and patient visitors** in non-restricted and restricted areas which will meet local and national recommendations for community isolation practices. In the more challenging surgical and procedural areas defined screening and PPE requirements should be considered.

8 Additional COVID-19 Related Needs

COVID-19 related needs must be front and center of planning to ensure patient and staff safety. Considerations, to name a few, include the well-being of staff, trainees and students; patient messaging and communication; case scheduling processes; facility and/or procedural safety for patient and staff; environmental cleaning according to evidence-based information in each phase of patient journey; operating/procedural rooms should meet engineering and facility standards for air exchanges.

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Listen to an Ansell-sponsored webinar that covers these planning considerations in greater detail:
Reopening Surgery: Navigating Through Unchartered Waters.

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Peter has also presented internationally as part of several medical-surgical related venues and national associations.

For any queries on this webinar, please contact ansellcares@ansell.com

Some examples of surgical case types stratified by indication and urgency during the COVID-19 pandemic[6]:

EMERGENT	URGENT	ELECTIVES		
		URGENT	ESSENTIAL	DISCRETIONARY
• Life-threating Emergencies • Acute Exsanguination / Hemorrhagic Shock • Trauma Level 1 Activations • Acute Vascular Injury or Occlusion • Aortic Dissection • Emergency C-section • Acute Compartment Syndrome • Necrotizing Fasciitis • Peritonitis • Bowel Obstruction / Perforation	• Appendicitis / Cholecystitis • Septic Arthritis • Open Fractures • Bleeding Pelvic Fractures • Femur Shaft Fractures & Hip Fractures • Acute Nerve Injuries / Spinal Cord Injuries • Surgical Infections	• Cardiothoracic / Cardiovascular Procedures • Cerebral Aneurysm Repair • Vascular Access Devices • Skin Grafts / Flaps / Wound Closures • Scheduled C-section • Closed Fractures • Spinal Fractures & Acetabular Fractures	• Hernia Repair • Hysterectomy • Reconstructive Surgery	• Cosmetic Surgery • Bariatric Surgery • Joint Replacement • Sports Surgery

Please Note: Given the novelty of this coronavirus, recommendations from the source references are interim and advisory in nature and are based on current knowledge of the situation. Always ensure compliance with your local public health authorities regulations surrounding conservation, usage, and selection guidance of PPE to combat the COVID-19 pandemic.

References: ***1.*** *Joint statement by American College of Surgeons, American Society of Anesthesiologists, Association of perioperative Registered Nurses and American Hospital Association (https://www.facs.org/-/media/files/covid19/joint_statement_resuming_elective_surgery_after_covid19.ashx)* ***2.*** *American College of Surgeons: Local Resumption of Elective Surgery Guidance (https://www.facs.org/-/media/files/covid19/local_resumption_of_elective_surgery_guidance.ashx)* ***3.*** *Australian Health Protection Principal Committee (AHPPC) statement on restoration of elective surgery (https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-restoration-of-elective-surgery)* ***4.*** *The Royal Australian and New Zealand College of Obstetricians and Gynaecologists: Reintroduction of Elective Surgery (https://ranzcog.edu.au/news/covid-19-reintroduction-of-elective-surgery)* ***5.*** *Prachand V, Milner R, Angelos P, et al. Medically-Necessary, Time-Sensitive Procedures: A scoring system to ethically and efficiently manage resource scarcity and provider risk during the COVID-19 pandemic. JACS in press (https://www.journalacs.org/article/S1072-7515(20)30317-3/pdf)* ***6.*** *How to risk stratify elective surgery during the COVID-19 pandemic? Published online 31 March, 2020 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7107008/)*

For more information on infection prevention and control of COVID-19, please visit:
www.ansell.com/us/en/the-new-coronavirus

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