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PCS Guidelines on Post-ECQ Resumption of Elective Surgeries and Outpatient Clinics

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Since March 16, 2020 of the Enhanced Community Quarantine (ECQ), all elective surgeries were put on hold primarily to contain the spread of COVID-19 and to conserve hospital resources and manpower. With the pending lifting (partial or total) of the ECQ, questions now arise whether to resume elective surgical procedures at this time. "It really depends on when the COVID-19 curve is flattened. We don't think it is going to be cured and go away."[1]

As the curve begins to flatten, there is a demand to gradually resume elective surgical care for the increasing number of non-COVID-19 cases postponed and unduly delayed in the past 6 weeks.

With this mindset, we recommend the following guidelines for hospitals preparing to resume elective surgeries and out- patient clinic schedules. To ensure safety as well as facility and personnel readiness in operating rooms and all other procedural areas involved, the following conditions should be met before the resumption of elective surgeries:[2,3]

- Timing of Resumption: There should be a sustained reduction in the rate of new COVID-19 cases for at least 14 days in your geographic area
- Availability of rapid RT-PCR testing kits for patient and staff
- Appropriate number of trained staff to enable treatment of all patients without compromising patient and staff safety and well-being
- Adequate supply of PPE and availability of all medical surgical supplies for the planned surgical procedures
- Comprehensive facility policies to minimize risk of transmission to patients and the surgical team

General Guidelines For All Hospitals

I. Preoperative Preparation

1. Scheduling of Cases[3]
   a. OR schedules should be designed to accommodate the influx of postponed cases during the ECQ lockdown. Consideration should be given on extending hours of elective procedures including weekends if feasible.
   b. Staff availability commensurate with the increased volume and extended hours should be ensured.
   c. There should be ample supply of PPEs in storage and a reliable supply chain to ensure availability of all supplies needed for the planned procedures especially for high risk aerosol generating procedures.

2. Screening of patients for elective surgery
   a. Guideline for timing of surgery
      - Any patient who has returned from travel outside the country or a high density COVID-19 community, should not have their procedure in the first 14 days following their return even if asymptomatic.
      - Any patient who has been in direct contact with a known confirmed COVID-19 positive patient should not have their procedure within 14 days of the contact even if asymptomatic.
      - Any patient who has been in direct contact with a person who is undergoing test for COVID -19 should not have their procedure until the results are confirmed negative even if asymptomatic.

- Any patient who has an influenza-like illness at the time they show up for their procedure should not have their procedure until they have recovered.
- Any patient who has an unexplained new cough should have their procedure delayed until it has been investigated.[3]

b. Pre-operative screening for COVID-19.
   - Consider testing all patients with RT-PCR prior to their scheduled procedure. If there is a discrepancy between clinical findings and testing or if RT-PCR is indeterminate, or negative in an asymptomatic patient with a history of contact with COVID-19, a CT scan of the chest can be a quick adjunct to detect early and subtle lung changes; or diagnose pneumonia that may warrant further testing of these patients.[4]
   - Patients with RT-PCR COVID (+) test result: Defer the planned elective surgery until patient becomes COVID (-). This is due to the reported high morbidity and mortality rates in patients undergoing surgery during the incubation period of COVID-19 infection.[5]
   - Stringent screening of patients is most important, especially knowing whether a patient had been in contact with any COVID-19 confirmed, probable or suspect in the community because of reported high morbidity and mortality in a subset of asymptomatic patients who were operated during their incubation period.[5]

c. Patients should undergo cardiac and pulmonary risk assessment. Consider Infectious Disease Specialist (IDS) evaluation as needed prior to surgery.
d. Explicit patient consent should be secured for the procedure including the possible risk of hospital-acquired COVID-19 infection during the duration of hospital stay.

II. Concerns During Operation

1. Proper OR attire for the personnel[7,8]
   As part of the continued precaution, the appropriate PPEs for the whole OR staff should be worn.[7] The rationale use of the PPEs in the hospital must be in place.

2. Proper facility
   For Non-COVID 19 patients, a specific OR theater should be designated.

3. Precautionary measures to be observed during procedures:[9]
   a. A separate set of OR staff shall handle the non-COVID 19 cases.
   b. During surgery either open, laparoscopic or robotic, the same protective measures are strictly employed for OR staff safety and to maintain a healthy, functioning workforce.
   c. For MIS procedures, use of devices to filter released CO_2 for aerosolized particles should be strongly considered. (Please refer to PALES Position Statement dated April 2, 2020 and PAHPBSI Advisory dated April 9, 2020)
   d. Since there is enhanced risk of viral exposure from endoscopy and airway procedures, strict use of PPEs should be considered for the whole team, following Centers for Disease Control (CDC, https://www.cdc.gov) or WHO (https://www.who.int) guidelines for droplet or airborne precautions. This likely includes, at a minimum, Level 3 PPE.
   e. Smoke evacuation for diathermy / other energy sources should be available.
   f. Prioritizing procedures of short duration should be done at this time.
   g. Prolonged procedures are discouraged for now but if necessary, careful planning should be done, to include OR team substitution/ changes.
   h. When patients are for intubation and extubation in the OR theatre, staff immediately present should be at a minimum (Anesthesiologist and nurse only).

III. Postoperative Safety

1. Care of the facility and equipment and PPE used After each procedure, proper and thorough disinfection of the operating room and all devices should be done.[8]

2. Transport of patient
   Patient transit to and from the non-COVID-19 operating suite must be as quick as possible. A pre-planned dedicated transport route for non-COVID-19 patients should be used. This path must be kept as short as possible and separate from COVID patients' transport route to prevent breach of infection control during transport.

Specific Guidelines For Hospitals

1. For hospitals that never admitted probable and confirmed COVID 19 positive patients during the ECQ period and instead transferred such patients from their ER Triage area to other COVID 19 hospitals, restart of elective procedures is allowed after proper screening of patients.

2. For hospitals with suspected, probable and confirmed COVID 19 patients, elective procedures may resume as long as the following are available:
   a. Designated OR suites within the same OR complex for non-COVID patients separate from suspected, probable and confirmed COVID-19 patients.
   b. Dedicated OR staff to handle non-COVID patients only
   c. Dedicated OR instruments, anesthesia machines, and other devices for non-COVID 19 patients only

3. For COVID-designated centers seeing a high volume of severe and critical COVID-19 patients, elective procedures may recommence as long as the following are available:
   a. Dedicated OR Suites preferably in a separate OR Complex for non-COVID patients
   b. Dedicated OR staff to handle non-COVID patients only
   c. Dedicated OR instruments, anesthesia machines, and other devices for non-COVID 19 patients only

Surgical Care In The Out-Patient Department

1. All clinics, including post-operative follow ups need to be scheduled with the principles of social/physical distancing. Consultations should be by appointment basis to appropriately space patients' schedule and avoid crowding at the clinic and corridors. Optimize use of telephone/telehealth/virtual visits where possible.
2. Establish a Triage system at the out-patient department to screen patients before they enter the appropriate clinic. Patients who are COVID suspects shall be referred to the hospital's Main Triage area for further evaluation.
3. No mask, no entry policy should be implemented.
4. Only one companion should be allowed for patient requiring assistance, otherwise patient should come alone
5. Patients and companions should be required to have hand washing or disinfection at the designated area at the entrance.
6. The waiting areas and the clinic itself should be redesigned to provide physical barriers, distancing, a safe flow of people and installation of visual alerts providing needed reminders at the waiting area. Setting up appropriate plastic or glass barrier between doctor/clinic staff and patient during interview is recommended.
7. The clinic staff should be trained on all precautionary measures done to avoid the risk of infection.
8. All clinic personnel involved in direct patient care should wear disposable gloves, surgical mask, face shield or goggles. To minimize disease transmission, avoid wearing medical gown, necktie, watch and other pieces of jewelry. Wearing of short sleeves is advised for easy hand washing.
9. Hand washing or the use of alcohol-based disinfectant should be done after examining the patient and after each consult

10. Disinfection and change of linen should be done after every patient.
11. Consultation time should be minimized (less than 15 mins per patient) as warranted.
12. Extreme care should be exercised when doing oral, rectal, internal examination or minor surgical procedures, ensuring proper disposal of the contaminated gloves and adequate disinfection of the reusable instruments or devices.
13. Physicians with multiple clinics are advised to see patients in only one clinic.

These recommendations are designed to serve as a constant reminder that even when we feel that we are winning the battle against COVID-19, we should not be complacent as we continue to deliver our much-needed services.

Disclaimer

The aforementioned guidelines are based on our current concept of COVID-19 and are not intended to replace clinical judgment. These recommendations can change as our understanding of COVID-19 evolves.

References

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