AdventHealth Guidance for Surgical Procedures during COVID-19 Mitigation and Surge Phases

AdventHealth

Tuesday April 7, 2020

The incidence of COVID-19 cases is increasing exponentially, with a peak expected in late April through June 2020. In order to prepare for the surge, increase capacity and decrease use of PPE, elective surgical cases across AdventHealth have been cancelled.

Guiding principles for operative intervention during the COVID-19 pandemic are to ensure the safety of patients and staff and appropriate preservation of healthcare resources. AdventHealth has adopted guidance from the CMS Non-Emergent, Elective Medical Services and Treatment Recommendations and the American College of Surgery. Partner with your surgeons, proceduralists, anesthesiologists, intensivists, radiologists and nursing colleagues to implement this change. Please use this guidance and your attending physician's clinical judgment in deferring elective surgeries and procedures. In the event of an urgent or emergent indication for a procedure or surgery, the following guidelines are recommended:

1. **Screening for COVID-19 based on symptoms prior to operative intervention and include the following questions:**
   a. Do you currently have a cough, fever, shortness of breath or difficulty breathing?
   b. Have you had any international, cruise ship or domestic travel to a location with widespread community transmission within the past 14 days?
   c. Have you had close contact with someone with known or suspected COVID-19 in the last 14 days?
   d. Have you been tested for COVID-19 within the past 14 days?

2. **If pre-operative screening identifies the possibility of exposure or infection, COVID-19 testing should precede operative intervention, barring instances in which surgical care is deemed high-acuity/emergent surgery. Thus, minimum PPE requirements (i.e., N95 masks) are required for all operating room (OR) personnel.**

3. **If COVID-19 testing is positive, and barring a medical condition requiring urgent intervention, consider procedure postponement or await a negative COVID-19 test prior to operative intervention. Simultaneous assessment of current and projected facility resources for the procedure is required.**

4. **Surgical patients known to be COVID positive should be cohorted (i.e., dedicated OR and/or post-anesthesia care unit [PACU] area as allowed by individual facility).**

5. **Intubation in advance could be considered in the setting of confirmed or suspected COVID-19. This should be done in the lowest-risk area — dependent on the facility. Consideration should be taken that a negative pressure ventilation room is the most ideal, such as in the ICU or an OR with negative pressure conversion capacity.**

6. For patients who are or may be infected, full personal protective equipment (PPE) is required including a minimum of N95 mask, or powered air-purifying respirator (PAPR) for high-risk, aerosol-generating procedures that have been designated for the OR.

7. During intubation and extubation, limit OR personnel to the anesthesia team only. Then limit OR staff to those essential personnel for the case and avoid unnecessary personnel from entering and exiting the OR throughout the case.

8. Smoke evacuators should be used when energy devices are used, during either open or laparoscopic cases.

9. The Anesthesia Patient Safety Foundation (APSF) has recommendations for safe use of anesthesia machines: FAQ on Anesthesia Machine Use, Protection, and Decontamination during the COVID-19 Pandemic.

10. Upon conclusion of the procedure, the COVID-19-positive patient should be transported directly back to the ICU or to a negative pressure isolation room in the PACU.

ACS COVID-19 Clinical Issues and Guidance

CMS Adult Elective Surgery and Procedures Recommendations