Guidelines for Restarting Elective Surgery Post-COVID-19

These principles apply to all practitioners performing these types of procedures regardless of scope of practice or setting.

(Applicable to hospital, ambulatory surgery center and office-based settings)

PRACTICE RE-OPENING CONSIDERATIONS

The Northeast region is fairly diverse in how it has been impacted by COVID-19. With that said:

Non-COVID-19 care should be offered to patients as clinically appropriate and within a state, locality, or facility that has the resources to provide such care and the ability to quickly respond to a subsequent surge in COVID-19 cases, if necessary. The recommendations outlined here are a working document and are subject to change and will be updated as the COVID-19 situation continues to evolve.

Maximum effective utilization of facilities to meet elective surgery patient needs requires that each practice setting (hospital, ASC or office-based) independently develop prioritization plans within the scope of its individual capabilities and conforming to all state and local regulatory safety standards as outlined in this document.

To begin this process, certain principles must be considered:

Gating criteria (Local / Regional hospital epidemiologic data):

- 14-day downward trend in number of cases and deaths
- The 14 days shall begin when the 3-day rolling average shows a downward trend
- Must know your local hospital current circumstances
    i. Are ICU beds/ventilators available?
    ii. Are hospital beds available?
    iii. Staff capacity at the hospital

Must know COVID-19 testing capacity and capabilities (all levels)

Your facility/office must have a transfer policy with receiving acceptance hospital in place

COVID-19 TESTING/SCREENING CONSIDERATIONS

DRIVING PRINCIPLE: WITHOUT NEGATIVE PREOP COVID19 TEST (RNA/PCR), NO SURGERY SHOULD BE PERFORMED

Screening

Screening should be done immediately upon entering facility for patients and staff (temperature and a focused history).

- Symptomatic patients should be referred home, self-isolate, and discuss options with primary care physician
- Symptomatic staff should self-isolate and expeditiously be tested for COVID-19

Testing for COVID-19

- COVID-19 testing required prior to surgery AND as close to surgery as possible (RNA/PCR)
- Consider **self-isolation of all preop patients** from the time of testing until the time of the procedure
- If everyone is tested, the likelihood of still operating on an asymptomatic COVID-19 positive patient is:

LOCAL PREVALENCE OF COVID-19* X *FALSE NEGATIVE RATE OF COVID-19 TEST

Given these numbers, it is impossible to recognize all asymptomatic Covid19 patients preoperatively, so all surgical patient should be treated as if they are Covid19 positive patients.

At this point in time, antibody serology testing is not considered reliable and does not address the needs of these guidelines. Further, a link between a positive antibody serology test and immunity has not been established

Patients/Staff Screening / Testing Positive for COVID-19

- Acutely ill patients/staff should be immediately sent to the emergency room at a COVID-19 ready hospital / facility
- Symptomatic patients/staff that are not acutely ill (sniffles, congestion, cough etc.) or asymptomatic positive testing patients/staff should be referred home, self-isolate, and discuss options with their primary care physician

Preoperative Clearance

- Strict adherence to 30-day limitation for H&P and for standard preoperative testing
- **Informed Consent** - Consider either additional COVID-19 language in existing consents (or a separate consent) to address potential for exposure to COVID-19, limitations of testing and other mitigating measures, as well as the risk of undetected infection at the time of procedure leading to potential increased morbidity and mortality.
    - **ASPS Sample COVID-19 Informed Consent**

PERSONAL PROTECTIVE EQUIPMENT (PPE) CONSIDERATIONS

DRIVING PRINCIPLE: WITHOUT APPROPRIATE PPE REOPENING AT ANY LEVEL CANNOT AND SHOULD NOT OCCUR

PPE Supply Level

Each facility/practice should ensure that it has enough and appropriate PPE supplies. These supplies should include, but are not limited to:

- N95 Masks (FDA or NIOSH approved)
  - N95 masks are form fitting masks designed to fit and create a seal on the user's face
- KN95 Masks (only use those specifically FDA certified through a single exemption)
  - While some KN95 masks have been certified, these masks are not typically considered approved by the FDA or NIOSH
- Surgical Masks
- Surgical or Isolation Gowns
- Face Shields
- Gloves
- Caps
- Eye Protection

How often do you change PPE/Ability to Reuse or resterilize PPE

- Refer to CDC and NIH guidelines for often to change, reuse or resterilize PPE
- **CDC Guidelines**
- **NIH Guidelines**

OFFICE/FACILITY CONSIDERATIONS

DRIVING PRINCIPLE: EXPEDITED TESTING FOR POSTOPERATIVE SYMPTOMATIC PATIENTS

Screening

- Screening at entry for temperature, focused history including symptoms for patients and staff

Social Distancing

- Implement social distancing guidelines throughout office operations
- Consider staggered schedule (examples)
    - One patient at a time
    - Limit family members
    - Direct family members to wait in the car/outside of the office/facility until called
- Consider separate timing for potentially high-risk patients
- Limit all non-essential visitors
- No sales representatives should be allowed in the office/facility
- Strongly consider telehealth where feasible
- Consider as minimal staffing levels as possible

Cleaning

- Reassess cleaning protocols in your office and facility
    - Have a plan for terminal cleaning of perioperative/OR areas and enhanced maintenance cleaning of entire facility, especially in high-touch areas. Show patients that this is being performed.
    - Have multiple hand sanitizing dispensers available throughout the office have signs encouraging patient and staff use.

OR/PERIOPERATIVE/POSTOPERATIVE/CLINICAL CONSIDERATIONS

DRIVING PRINCIPLE: ANY SYMPTOMATIC PATIENT FOR OFFICE VISIT, PROCEDURE, OR SURGERY SHOULD NOT ENTER THE FACILITY AT ANY TIME. THIS INCLUDES COUGH, FEVER, RUNNY NOSE, SORE THROAT, ETC.) THOSE THAT NEED EMERGENT OR IMMEDIATE CARE SHOULD BE REFERRED TO THE EMERGENCY ROOM OR OTHER URGENT CARE VENUE WHERE POSSIBLE (COVID-19 READY FACILITY)

Scheduling Considerations / Prioritization of Cases and Procedures:

In the event that scheduling of operations needs to be phased in, the following scoring factors can be considered (MeNTS Instrument), with the recognition that prioritization will be made at a hospital and surgeon level dependent on state/local factors:

- Comorbidities and risk considering COVID-19
    - HTN
    - Pulmonary history
    - CAD
    - Immunosuppression
    - Diabetes
    - Obesity
    - Age
- Risk based upon type and length of procedure
    - Potential need for admission
    - Potential need for a ventilator
    - Case length
        - Less than 1 hour
        - 1 hour – 3 hours
        - Greater than 3 hours
- Necessity of procedure (Facility based considerations)

Surgical Capacity Considerations

- Know the following capacity issues by confirming with your affiliated hospital:
    - Hospital bed census
    - ICU census
    - Ventilator availability

PPE for Surgery Considerations:

What PPE is needed for each type of surgery?

- Above the clavicle
    - Full PPE and Isolation Garments
        - FDA approved N95 masks
        - Face Shield
        - Isolation garments
        - Gloves

- Below the clavicle
    - N95 mask or surgical mask
        - The surgeon at their discretion can use either an N95/K95 (FDA/NIOSH approved) mask or surgical mask
    - Eye protection
    - Traditional surgical gowns
    - Gloves
- Anesthesia
    - Full Isolation PPE recommended at all times

Anesthesia Considerations

- It is recommended that Anesthesia wear full isolation PPE
- In conjunction with your anesthesia team, consider surgical team leaving the room for intubation and waiting a pre-determined amount of time before re-entering (typically 20 minutes)
- Confirm that anesthesia supplies are adequate
    - E.g. Scopes & Medications
- Consider using Anesthesia tents
- Should use **viral HEPA filters x 2**
    - Protects the patient and anesthesia machine
- Crash carts fully stocked and readily available

Operating Room Considerations

- Sales representatives should not be allowed in the operating room
- Medical students should not be allowed in the operating room but recommend conferring with the facility's affiliated medical school
- Visitors should not be allowed in the operating room
- Limit to one circulator
- Only place equipment and supplies for each specific procedure in the room for that time period
- Limit staff movement in and out of the operating room during the surgical procedure
    - Consider timing of breaks and shift relief
    - Reduce unnecessary congregation of staff in hallways

Recovery Room Considerations

- Consider appropriate PPE worn by staff in the recovery room
- Consider availability of respiratory support in the recovery room

MINIMALLY INVASIVE PROCEDURES (e.g. Botox/Fillers/Cool Sculpting/Lasers)

- Screen patients for temperature, focused history including symptoms
- Minimally invasive procedures will require PPE
    - N95 masks
    - Face Shield or Eye Protection
    - Consider surgical gown

ADDITIONAL RESOURCES

- CMS Reopening Guidelines Phase One
- AHA ACS ASA AORN Joint Statement
- ACS Local Resumption of Elective Surgery Guidance
- New York Executive Orders
- New Jersey Executive Orders
- Connecticut Executive Orders

NORTHEAST REGION COVID-19 COALITION SOCIETY MEMBERS

- Connecticut Society of Plastic Surgeons (CTSPS)
- Massachusetts Society of Plastic Surgeons (MSPS)
- New Jersey Society of Plastic Surgeons (NJSPS)
- New York Regional Society of Plastic Surgeons (NYRSPS)
- New York State Society of Plastic Surgeons (NYSSPS)
- Northeastern Society of Plastic Surgeons (NESPS)
- Robert H. Ivy Pennsylvania Plastic Surgery Society (Ivy)

NORTHEAST REGION COVID-19 COALITION ENDORSEMENT

- New England Society of Plastic Surgeons (NESPRS)

NORTHEAST REGION COVID-19 COALITION MEMBERS

Member	Affiliation
Scot B. Glasberg, MD (Chair)	NYRSPS/NYSSPS/ASPS EC
Alan Matarasso, MD	NYRSPS/ASPS EC
Jennifer Capla, MD	NYRSPS
Keith Blechman, MD	NYRSPS
Thomas Sterry, MD	NYRSPS/NYSSPS
Ash Patel, MD	NYSSPS
Steve Fallek, MD	NJSPS
Gregory Greco, DO	NJSPS/ASPS EC
Rick D'Amico, MD	NJSPS
Paul LoVerme, MD	NJSPS
Thomas Sena, MD	CTSPS
Alan Babigian, MD	CTSPS
Joseph Brad O'Connell, MD	CTSPS
Gary Price, MD	CTSPS
Deborah Pan, MD	CTSPS
Jesse Goldstein, MD	IVY Society (PA)
Alexander Spiess, MD	IVY Society (PA)
Charles Long, MD	IVY Society (PA)
Jonathan Winograd, MD	MSPS (MA)
Simon Talbot, MD	MSPS (MA)
Brian Glatt, MD	NESPS (NJ)
John Potochny, MD	NESPS (PA)
Peter Taub, MD	NESPS (NY)
Paul Liu, MD	NESPS (RI)
Joseph Napoli, MD	NESPS (DE)