COVID-19 Safe Return to Care: Resumption of Elective Procedures

Frequently Asked Questions

Testing

What procedures will require a COVID test?

In general, for a non-urgent procedure to be conducted at a Texas Health wholly owned hospital, COVID-19 testing two to three days in advance of the procedure is required if:

- The procedure is or can be expected to be aerosol generating
- The procedure is invasive (here defined as anything beyond a local injection, administration of imaging contrast, or a peripheral needle biopsy)
- The procedure requires intubation or systemic sedation.

Why aren't we doing serology testing in the asymptomatic, elective surgery patient population?

Physician leaders across multiple specialties considered this option, but currently feel that routine serology testing in an asymptomatic population would be of limited value in the clinical decision-making process for procedure timing.

Will offsite COVID-19 tests be accepted? How old can the test results be?

Texas Health will accept COVID-19 molecular testing results performed by an external entity, provided the result is within the appropriate time frame. THPG also has testing centers if patient testing is not done during pre-assessment testing (PAT) at the hospital. Likewise, patients can go to neighboring Texas Health entities who offer testing.

Testing 2-3 days before the procedure is the recommended timeframe. Longer than that interval could be acceptable, for example, a Friday test for a case on the subsequent Tuesday. In special situations, such as a nursing home patient with a send out test, or a staged procedure with multiple hospital visits over a short time span, we will accept results as old as seven days. Any interval beyond seven days necessitates a repeat test.

Will long-term care, assisted living, and residential facility patients be required to come to PAT for their COVID testing?

If possible, patients coming from such settings should obtain pre-procedural testing through their referring facility. These settings have been identified as higher risk environments, and knowledge of COVID status prior to patient transport to the hospital is important.

Intubation Workflow and Case Start Guidance

What are the recommended processes for OR workflow around intubation and case starts during the COVID-19 pandemic?

The guiding principle for current workflow is safety of patients and the care team. It is also important to recognize that health systems are resuming non-urgent procedures at a time when there is still ongoing spread of COVID-19 in the DFW area and state regulations on social

distancing and business operations have very recently been relaxed. Texas Health will continue to evaluate and modify these recommended workflows based on community prevalence of COVID-19, experiences of the frontline care teams, and procedure case volume.

To minimize care team exposure and optimize patient safety, only essential individuals should be in the OR during the intubation and the subsequent procedure. Intubation is aerosol generating, and the OR door should remain closed until a full air exchange has occurred (21-minutes is typical for most Texas Health hospitals, but please check with your OR leader as there is some variation across facilities). Within that post-intubation air exchange window**,** any members of the care team in the OR should be wearing N95 masks. Any remaining surgical team members outside of the OR at the time of intubation can enter following completion of the air exchange window (again, generally 21 minutes in ORs). After the air exchange period, if the procedure being performed is not aerosol generating and the pre-procedural COVID testing was negative, for team members who are not proximal to the surgical field, OR PPE for COVID-Negative patients is appropriate.

In the event N95 masks are needed by the full OR team throughout the procedure due to the nature of the case (e.g., high risk for aerosol generation), we recognize that waiting 21 minutes after intubation to start may not be necessary, as long as the OR team members needed to begin the case are not entering and exiting the room during that post-intubation time window.

Are you allowed to prep the patient during the minimum air exchange timeframe hold?

Patient preparation during the minimum post-intubation air exchange time period is allowed as long as the prep team is present for intubation (to avoid having to open the OR door in the immediate post-intubation window) and they are wearing N95 masks.

Can the surgeon begin the case and make an incision during the minimum air exchange time post-intubation?

Yes. The surgeon can begin the case and make an incision within the minimum air exchange timeframe post-intubation, provided the operative team is wearing N95's during the air exchange window AND the appropriate portions of the Safe Surgery Checklist have been completed.

Laryngoscope Blades

As a contingency, are we considering a process for re-using laryngoscope blades?

Yes, we are working with your hospital leaders to develop a standard procedure for re-using this particular supply, should it become necessary.

Laryngeal Mask Airways (LMAs)

What is Texas Health's position on LMAs?

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The National Patient Safety Foundation for Anesthesia suggests that LMA use may carry greater risk of generating aerosols when compared to tracheal intubation, but further notes LMA can be an acceptable option with particular patients because of the lower risk of coughing.

Accordingly, we are taking a conservative position during the COVID pandemic. LMAs can be used as a bridge to intubation, and in other selected cases based on clinical judgment when risk/benefit analysis makes sense for the patient in favor of LMA (e.g. ability to perform deep extubation, ability to ventilate spontaneously, avoidance of airway irritation). LMA should be switched for ETT if an adequate seal cannot be attained.

Extubation Guidelines

What is the process for extubation, specifically the timing of when staff can leave the OR and patients can go to the PACU?

Extubation is also an aerosol generating process, and ideally, the OR door should remain closed for 21 minutes (in general) post-extubation to allow an air exchange. OR team members could leave the room immediately prior to extubation as appropriate. Any personnel in the room post-extubation within the air exchange window should be wearing N95 masks. The patient can go to the PACU per usual procedures at the end of the 21-minute window.

In hospital procedural areas other than operating rooms, what are the PPE and room turnover recommendations?

If it is an asymptomatic, COVID-Negative patient undergoing an average risk procedure, then standard precautions and room turnover intervals are appropriate.

For asymptomatic, COVID-Negative patients undergoing a procedure with high-risk of aerosol generation, the recommendation is to wear PPE for COVID-PUI status (including an N95 mask). Standard room turnover intervals are appropriate.

If it is a COVID-Positive patient (which should be a very rare exception as an elective case), all personnel should wear N95 for all aerosol generating procedures, and if possible, the case should be conducted in a negative pressure room. Allow an appropriate time interval to complete an air exchanges for that procedural room following the case. If a negative pressure room is not available, consider scheduling these patients as the last case of the day.

PPE Recommendations

What are the PPE recommendations for procedures where cautery is used?

The smoke evacuator is the first line of defense when using electrocautery. When it is not available, N95 masks may be considered for personnel in the operating room or procedural area, particularly those in the surgical field. Where possible, electrocautery and restricting the

number of people in the OR should be minimized. Laparoscopic cases should use a filter on a port.

Radiology Procedures

Can you provide clarification on what radiology procedures need COVID testing?

Based on additional feedback from radiology and laboratory medicine, we have updated the recommendations for pre-procedural radiology testing as indicated below:

Procedures requiring testing *regardless* of sedation/anesthesia (due to potential for stimulation of coughing, forceful expiration or otherwise exposure to aerodigestive tract droplets/aerosols):

- Esophagrams
- Video/"modified" barium swallows*
- Upper GI studies
- Contrast enemas
- Nasogastric or nasoenteric tube placement
- Thoracentesis
- Lung biopsy
- Lung V/Q scan
- *New* placement of percutaneous feeding tubes (gastrostomy, gastrojejunostomy).

*(In pediatric GI tract studies, testing not required as these cases are often time sensitive. Current recommendation is for staff to use an N95 mask during those procedures).

Procedures NOT requiring testing UNLESS deep sedation or general anesthesia utilized:

- Diagnostic CT/MRI, X-ray, and ultrasound
- Small bowel follow-through
- Paracentesis
- Abscess/seroma/biliary/nephrostomy drain evaluation including exchange
- Joint aspiration
- Percutaneous feeding tube evaluation/replacement
- Abscess drainage
- Nephrostomy placement
- Biliary drainage
- Lumbar puncture
- Vascular access (port, dialysis, etc.)

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- Angiography/arteriography/venography with or without intervention
- Biopsies (*except* for lung biopsy)