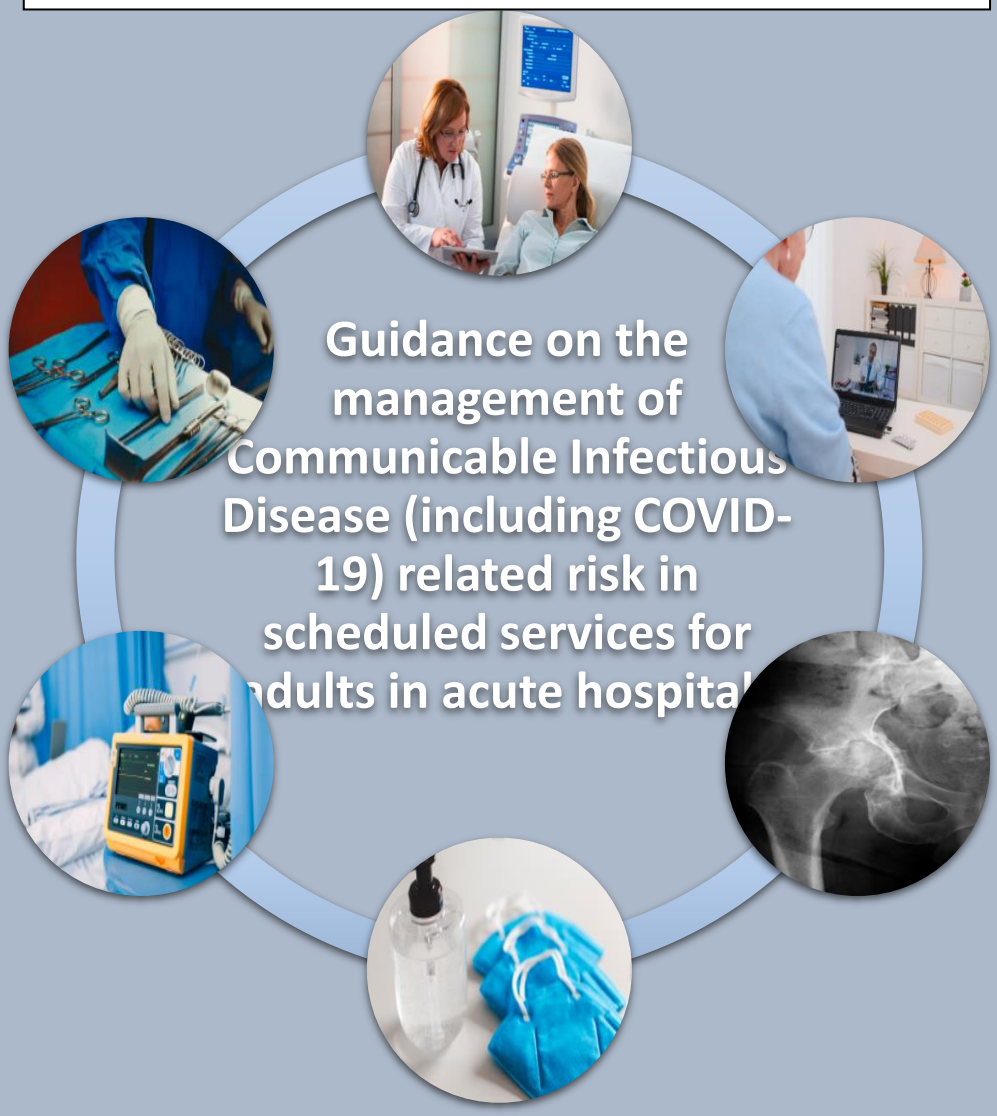
This document replaces "Guidance on the management of COVID-19 related risk in the scheduled services for adults in acute hospitals Version 1.5.



February 2022 V1.5

This document is based on “Guidance on the management of COVID-19 related risk in the scheduled services for adults in acute hospitals”. That document represented collaboration between the following organisations:

- **National Clinical Programme in Surgery**
- **National Clinical Programme in Anaesthesia**
- **National Clinical Programme in Trauma and Orthopaedic Surgery**
- **National Clinical Adviser and Group Lead (Acute Operations)**
- **HSE-Antimicrobial Resistance and Infection Control (AMRIC)**

This document was developed by HSE-AMRIC and Acute Hospital Operations

Table 1: ALERT
Individuals should not be scheduled for elective surgery/procedures during a time when they are subject to a requirement for self-isolation or restricted movements related to SARS-CoV-2 or any other Communicable Infectious Disease (CID)

Contents

Foreword

February 2022

The epidemiological situation with respect to COVID-19 has changed significantly since the most recent version of "Guidance on the management of COVID-19 related risk in the scheduled services for adults in acute hospitals Version 1.5" was issued. While there is a continuing risk of healthcare associated COVID-19 it is now appropriate to place precautions related to COVID-19 in the broader context of other Communicable Infectious Diseases and to support greater flexibility at institutional level regarding how the objectives of managing the risk dissemination of COVID-19 and other communicable infectious diseases is managed at each hospital site. This document reflects that approach.

This guidance should not supersede clinical judgment and should be adapted to local or specialty requirements under the governance of the local risk assessment team.

Executive Summary

Maintaining functional scheduled surgical services is a core responsibility of a health service and critical to public health in our country. Surgery has many vital benefits: alleviation of pain and other symptoms; treatment of injury; improvement of quality of life; curing disease and prolonging life. Everything possible must be done to ensure that patients have access to the surgery they need in a timely fashion.

Delivering surgical services in the safest possible manner in an environment where there is a significant risk of COVID-19 or other CID is challenging... This document provides guidance to assist hospitals in the implementation of pathways of care that are safe for patients undergoing scheduled surgery and safe for healthcare workers. It is important to note that vaccination against COVID-19 and other CIDs is a central element of any programme to protect patients and healthcare workers against healthcare associated infection. However, vaccination does not eliminate the requirement for other measures including adherence to good infection prevention and control practice at all times.

Table 1: Definitions of Terms & Summary of actions required

Communicable Infectious Disease Assessment	Communicable infectious patient assessment is a hands off assessment to identify if patients have clinical features that indicate that they are suspect cases for COVID-19 or other CID.
Covid-19 testing for current infection	An appropriately sensitive test for detection of the SARS-CoV-2 virus in a respiratory sample. If testing is required, swabbing should take place as soon as practical after the decision to admit is made. The result should be available as soon as is practical and in any case within 12 hours of sample collection for a patient with a clinical suspicion of COVID-19 and within 24 hours of sample collection for all other patients who require testing. Urgent decisions on patient placement or treatment should not be delayed until the test result is reported.
Surveillance testing	This refers to testing for infection in people with no clinical suspicion of COVID-19 and who are not COVID-19 contacts. It may be required to control the risk of introduction of asymptomatic infection in certain higher risk settings.
Virtual clinic:	This refers to a method of clinical review that can either be by telephone or video, where the patient does not attend the clinical setting in person. An information technology platform can be used which allows for video interaction between health care worker and patient. It is imperative to document the platform used in the patients' clinical notes and that consent has been obtained for this type of consultation. As with face to face clinics, for required diagnostics including phlebotomy and SARS-CoV-2 testing, it is essential to ensure patient follow up has appropriate clinical governance and follow-through within the hospital services.

Purpose

This document will act as guidance for healthcare managers and staff to deliver care to patients in the peri-operative setting.

Scope

This guidance document applies to all patients including:

- Adult patients undergoing scheduled surgery in the operating departments
- All patients receiving general, regional, local anaesthesia or sedation
- All HCWs working within the peri-operative pathway

Introduction

Delivery of scheduled care on the peri-operative pathway must take account of the risks associated with COVID-19 and other CIDs. This requires assessing the risk of COVID-19 and other CIDs in patients in advance of scheduled care and adherence to good Infection Prevention and Control practice both in general and for COVID-19. Please see Infection Prevention and Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/InfectionPreventionandControlPrecautionsforAcuteSettings.pdf

Vaccination of staff and patients has transformed the COVID-19 risks associated with delivery of scheduled care. Vaccination against other communicable infectious disease including Influenza virus and Hepatitis B virus are also important in reducing risk.

There should be clear prioritisation protocols that reflect local and national needs, alongside availability of local resources. The National Clinical Programme for Surgery has developed clinical guidance for surgeons on prioritisation of urgent scheduled surgical conditions, which can be accessed at the RCSI website here.

Scheduling modifications may help to increase hospital capacity, including extending hours of elective surgery later into the evening and on the weekends where this is possible.

It is expected that surgeons will work with hospitals and patients to prioritise their patients' needs for surgery, accounting for risk factors and co-morbidities, while having regard also for the safety and availability of health care workers and hospital facilities. The professional judgment of surgeons can be relied upon to balance risk and to prioritise their patients. Continuing audit of process and outcomes is important in each unit. Processes to review cases with adverse outcomes are required reflecting the HSE Incident Review Process https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/. All serious adverse incidents should be recorded on the National Incident Management System (NIMS).

The risk of undiagnosed COVID-19 in patients presenting to hospitals for scheduled surgery continues at present. A brief clinical evaluation of all patients is required on presentation for scheduled care. Guidance on when testing is required is provided in Infection Prevention and Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/InfectionPreventionandControlPrecautionsforAcuteSettings.pdf

There are risks to patients in having surgery during or in the weeks after SARS-CoV-2 infection, whether the disease was mild or otherwise. The COVIDSurg and GlobalSurg Collaborative has published a peer reviewed paper in Anaesthesia, accepted 26th February 2021, which quantifies the risks at different time intervals subsequent to the infection and the findings are summarized in the table 4. This data is based on 140,231 patients across 1674 hospitals and 116 countries and the majority of patients were asymptomatic at the time of surgery. Of note, patients with ongoing symptoms of COVID-19 had higher 30-day mortality than those whose symptoms had resolved or who were asymptomatic.

Ref: COVIDSurg Collaborative and GlobalSurg Collaborative; Anaesthesia 2021 doi:10.1111/anae.15458

This document provides guidance and key considerations in order to maintain surgical services in the context of COVID-19.

High Level Principles for Patients/Staff:

1. There should be a well-defined management team in place (with multi-professional and multi-disciplinary clinical input), to provide coordination and oversight of relevant policies and communications at a local level and to adapts to changing pressures related to COVID-19 demand.
2. As far as practical, scheduled care facilities should be demarcated from unscheduled surgery facilities.
3. Ring-fenced beds for elective surgery can be expected to sustain service and reduce risk arising from all healthcare-associated infections
4. Scheduling modifications to increase hospital capacity, including extending hours of scheduled surgery later into the evening and on the weekends remains an important consideration subject to resources and sustainability.
5. Pre-procedure testing for SARS-CoV-2 should be performed as per Infection Prevention and Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting
6. Patients should be assessed for features of COVID-19 on arrival and this should be documented in the case notes on admission.
7. Patients who are required to self-isolate or restrict their movements for any reason should have planned admissions deferred until the period of self-isolation or restricted movement is completed.

Chapter 1: Pre-Admission Unit Services

1.1 Background

Pre-operative assessment allows the opportunity to identify existing comorbidities, carry out required investigations and help ensure all patients are in optimum health when presenting for surgery. This requires a collaborative approach with multidisciplinary teams within the perioperative clinical governance structure (NCPA, 2014).

Whether face to face or virtual clinics, required diagnostics including phlebotomy and SARS-CoV-2 testing, should be performed and followed up within the hospital services, unless by

prior agreement with a third party i.e. the third party agrees to deliver this service for the hospital.

Cancellation of scheduled surgery may occur for many reasons, including the COVID-19 related pressures on the hospital service. Patients should understand that there is no guarantee that their procedure will be carried out on the proposed date and that such decisions are dependent on hospital prioritization and capacity.

1.2 Pre-Admission Unit (PAU) Recommendations

- Hospitals should identify a prioritisation list of patients for pre-operative assessment from the various surgical specialties available in the hospital. This will enable timely pre-assessment of patients who can have their surgery completed within the available limits
- Consideration should be given to a pre-operative exercise programme, particularly for people who may have become physically deconditioned due to long periods of limited physical activity. of The Joint Schools (HSE, 2015)
- An estimate of available operating theatre session times will also have to be provided to establish what can be scheduled. This available resource should be matched to the number of patients that require pre assessment
- It will be important to know the current address of the patient and to confirm that this is where they will be residing in the pre-attendance period.
- Local protocols should be established to allow for sharing of records between hospitals. This will assist in facilitating the option for a patient to have pre-operative assessment conducted by staff in a local site and surgery carried out in a different site, thus helping to reduce travel in current restrictions.
- If a patient resides in a residential care facility (RCF) then the hospital should establish if there are any specific COVID-19 or other CID related risks in the in the RCF at the time.
- If a patient's surgery is deferred cancelled due to issue within their RCF then communication should be made with the surgical team for appropriate follow up and management plan, this should be clearly documented in the patient record

- A review of patient notes should be carried out, as cancelled or deferred surgeries may lead to an expiration of pre-assessment
- Patients with expired pre-assessment should have re-assessment organized and this should be virtual where appropriate
- For patients who are immunocompromised, it is important to check with them if they have been offered and availed of extended primary immunisation and booster. Particular care is required in relation to preoperative assessment and measures to reduce risk of exposure of the patient in advance of attendance for the procedure and while in the healthcare setting.

1.3 Staffing in PAU

- In order for the safe and effective delivery of pre-assessment services, experienced staff must be available
- If these recommendations require expansion of the role of the staff in PAU, education and training should be provided

1.4 Virtual PAU Clinics

- Experienced PAU nurses should review referrals alongside patient's medical notes to decide on appropriate method for pre-assessment
- Pre-assessments should be undertaken virtually where appropriate to the needs of the patient
- Local sites should ensure accuracy of completed referral forms to PAU which is essential to deliver safe, effective and quality patient flow
- Patient education classes should be carried out virtually where appropriate
- Local agreement should be made on the expiration date of pre-assessment validity
- In cases where a consultant anaesthesiologist review is required after preoperative assessment by the PAU nurse, this review initially should be carried out virtually where appropriate
- COVID-19 risk assessment and vaccination status should be documented in the patient's case notes.

1.5 Pre-operative Investigations

- Local protocols should be established to assess the requirement for tests/investigations to ensure only what is necessary is undertaken. National Institute for Health & Care Excellence (NICE) guidelines 2016 provides recommendation for routine preoperative tests for elective surgery
- If a patient requires any tests/investigations, every effort will be made to have these done on a single patient visit to the hospital
- All investigations should be determined by patient's medical condition, co morbidities and procedure requirements

1.6 Patient Information for PAU

- Patients and their carers, should be actively encouraged to have the seasonal influenza vaccine and the COVID-19 vaccine and booster vaccination when eligible.
- Patients who are not vaccinated against COVID-19 should be cautioned regarding the risk of hospital acquired COVID-19 and advised that despite great care in the acute hospital system this remains a significant risk for non-vaccinated patients.

Patient information for Virtual Clinics

- Patients should be sent an appointment with instructions and support on how to have a virtual consultation. Information for patients on virtual consultations is available to download from here [check link]
- The patient should be given the option of having a carer/relative present on all virtual appointments
- **As with face-to-face clinics, required diagnostics including phlebotomy and SARS-CoV-2 testing should be performed within the hospital system with appropriate clinical governance and follow-up.**
- For more information on virtual clinic operation and governance, please visit the link here [check]

Patient information when attending in person

- Note there is specific guidance regarding facilitating nominated support partners attending maternity services.

- All patients who need support should be facilitated in having a person accompany them on arrival and while booking in
- Patients should be sent an appointment time and, if they travel by private car they may be asked to wait in their car until just before their appointment time if there is limited space in the hospital waiting area
- A patient information leaflet should accompany the appointment letter indicating any necessary instructions pertaining to the procedure. General patient information leaflets for patients attending hospital can be downloaded from here.
- Patients using public transport should follow current public health guidance and try to arrive at the clinic as close as possible to their allocated appointment time, as there will be limited seating available in many waiting areas.
- If the patient has been brought by car, the accompanying adult/support person can accompany them is they need physical or emotional support but if this not necessary it reduces football if the accompanying person remains in the car.
- All those entering the building should follow IPC recommendations for their safety and the safety of others

1.7 COVID-19 Risk assessment in PAU

- Patients who are required to attend PAU in person should be assessed on arrival for features of COVID-19 or other CID. This should be documented in their cases notes.

1.8 Distancing in PAU

- In relation to distancing, a patient and accompanying person can be considered as a unit and they do not need to maintain distance between them. In the following when the term patient is used this refers to an unaccompanied patient or a patient and an accompanying person.
- To the greatest extent practical, a distance of 1m should be maintained between patients in PAU waiting areas and at any rate patient should have sufficient space to avoid direct contact.
- Maintaining reasonable distance may require staggered scheduling of in hospital appointments

1.9 Personal Protective Equipment (PPE) in PAU

- See Infection Prevention and Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting

1.10 Pre-Attendance Work Up

- See Infection Prevention and Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting

Chapter 2: Day of surgery admission (DOSA) in COVID-19 era

2.1 Background

A Day of Surgery Admission or DOSA refers to an elective, stay-case, surgical patient who is admitted on the day of their surgical procedure, all necessary work-up having been carried out prior to admission. It does not include day cases or minor operations. The ability of an institution to provide DOSA for multi-day stay elective surgery patients is dependent upon maximising quality and efficiency in pre-operative patient management and hospital bed management (NCPS, 2011)

During the Orthopaedic Prospective Funding pilot in 2011–2013, DOSA rates increased from practically zero to over 70% in the 12 orthopaedic hospitals participating in the pilot (case mix unit review, 2012), with a subsequent reduction in average length of stay (AvLoS). Since then the models of care for Elective surgery (NCPS, 2013), Pre-Admission units (NCPA, 2014) and Trauma and Orthopaedic Surgery (NCP TOS 2015) all advocate for the concept of admitting a patient on the morning of surgery, to a dedicated day of surgery admission area. DOSA patients must have appropriate pre-admission assessment and discharge planning arrangements as this avoids unnecessary same day cancellations. DOSA provides an increased level of patient satisfaction and outcomes as well as an increase in theatre productivity and has produced significant savings on bed days. It is now a routine part of the surgical care pathway. Admission on the day of surgery is now more important to limit the total in-patient journey.

2.2 Day of Surgery Admission area

- See Infection Prevention and Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting
- A dedicated area within the hospital should be allocated for patients to be admitted on the day of surgery. This may be an area of the pre admission unit, an area of the elective ward or a separate area entirely
- All patients admitted on the day of surgery must be assessed for clinical features that suggest COVID-19 or other CID
- A specific time for attendance should be given to the patient in advance to assist with maintaining distance between patients
- If patients have travelled by car, they should wait in the car until just before their appointment time
- If accompanied by a friend or relative, this person can accompany the person on arrival and check if they require physical or emotional support. If the person does not need to be accompanied this helps to maintain space between people.
- If the procedure is deferred due to the patient having symptoms of COVID-19 or other CID, then any immediate care for COVID-19 required should be arranged and appropriate follow up from the surgical team must be arranged
- Where possible, the patient should walk to theatre from DOSA
- Time needs to be allocated on the morning of surgery for a final anaesthesia review if required

2.3 Staffing in DOSA

- Every effort should be made to reduce footfall of healthcare workers through DOSA to minimise patient exposure
- Nurses working in DOSA must have relevant skills and knowledge specific to the clinical area i.e. pre-operative surgical patient assessment
- Daily access to clerical/administrative support for the DOSA unit is required. The amount of time will depend on the throughput of patients

2.4 Consent

Obtaining informed consent from patients should be performed in line with the Irish Medical Council Guide to Professional conduct & Ethics (1), the Code of Practice for Surgeons (2) and the HSE National Consent Policy (3).

Clinicians should consider, and provide patients with, information on how COVID-19 or other CID might alter the risks and benefits of their treatment.

- Doctors consenting must know where to access the latest guidance and should be aware of up-to-date data on COVID-19 for the hospitals where they operate to consent patients, as well as to risk assess each procedure.
- Doctors consenting patients should refer to RCSI guidance on consenting in COVID-19 era

2.5 Personal Protective Equipment in DOSA

- See Infection Prevention and Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting
- It is important that each patient's infection or colonisation status with respect to multi-drug resistant organism is incorporated into every evaluation and not limited to COVID-19, for example patients for whom transmission-based precautions, such as contact precautions are required because of carriage of antimicrobial resistant organisms (e.g., MRSA, CPE, VRE)
- Patients vaccination status should be documented

2.6 Distancing in DOSA

- In relation to distancing, a patient and accompanying person can be considered as a unit and they do not need to maintain distance between them. In the following when the term patient is used this refers to an unaccompanied patient or a patient and an accompanying person.
- To the greatest extent practical, a distance of 1m should be maintained between patients in PAU waiting areas and at any rate patient should have sufficient space to avoid direct contact.
- Maintaining reasonable distance may require staggered scheduling of in hospital appointments

Chapter 3: Operating Theatre

3.1 Operating department

The principles of routine infection prevention and control during scheduled surgery should be strictly adhered to, including avoidance of unnecessary entry and exit from the operating theatre during surgery

- The number of people in the theatre should be limited to those required for clinical or education purposes
- Appropriate measures are required at entrances to operating department to prevent unauthorised access

3.2 Prioritisation, Capacity and Scheduling

Careful evaluation of the likely throughput and factors affecting successful surgery are needed in order to plan effective delivery of scheduled surgical services. The National Clinical Programme for Surgery has developed clinical guidance for surgeons on prioritisation of urgent scheduled surgical conditions, which can be accessed at the RCSI website here.

- Delivery of scheduled surgery requires ongoing management in each hospital.
- Review of patient flow through the operating department will be required on an on-going basis
- Scheduling modifications to increase theatre capacity, including extending hours of elective surgery later into the evening and on the weekends should be considered
- In the event of further surge requiring an expansion in critical care capacity and utilisation of operating department areas, this will reduce capacity and impact the provision of surgical services
- Communication to waiting list patients in each hospital regarding the local situation is essential
- Communication to GP's of changes in patient pathways and variation in local practice is essential
- Pathways should be implemented to allow General Practitioners contact the surgical/orthopaedic service if their patient's condition deteriorates or red flag symptoms occur

- Pathways must also be in place that allow the post elective care patient attend for acute review via an alternate pathway to ED such as ASAU
- Given the potential risks associated with carrying out elective surgery in an uncertain environment, patients must be made aware of conservative self-management options available to them compared to operative intervention

3.3 Staffing and skill mix in the operating department

- Should be appropriate to the nature of the surgery performed. .
- Should these recommendation require additional workforce, then local consideration needs to be given to this as appropriate

3.4 Availability of Interdependent Services

- Access to and availability of interdependent services e.g. critical care occupancy/ high dependency unit (HDU) bed availability, radiography, laboratory testing & processing, pathology etc. intra-operative spinal monitoring, sterile services is essential for the delivery of surgery
- Five working days' notice is required for loan sets, in order to ensure Sterile Services Departments have adequate time to process them, without endangering whole hospital decontamination capacity
- The blood transfusion committee should be notified of planned surgeries with a potential requirement for blood in advance, as part of the supply demand management process, acknowledging that scheduled surgeries may be subject to last minute cancellations

3.5 Distancing in the operating department

- To the greatest extent practical, a distance of 1m should be maintained between patients and staff in the operating department at any rate patients and staff should have sufficient space to avoid direct contact.
- At all times footfall in operating departments must be minimised

3.6 Documentation

- A review of the perioperative checklist documents should be conducted to include the assessment for COVID-19 or other CID.

3.7 Personal Protective Equipment in the Operating Department

See Infection Prevention and Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting

- If it is necessary for an accompanying person to be with the patient in the holding bay/for induction of anaesthesia for example prison officers, patients with special needs the accompanying person should be supported in adhering to good IPC practice.
- The Safe Site Surgery briefing should be used as an opportunity for the whole theatre team to agree appropriate IPC practice
- Please be aware that surgical helmets are not protective against aerosols and droplets. (Parvizi et al. 2020)
- For guidance on bronchoscopy, visit the HSE Repository at : https://hse.drsteevenslibrary.ie/c.php?g=679077&p=4874377 or click here

3.8 Anaesthesia in operating department

- Local/regional anaesthesia should be the preferred choice to invasive airway management whenever possible for elective surgery
- Patients assessed as low risk for COVID-19 or other CID can be anaesthetised in an anaesthetic room
- Patients ,assessed as low risk for COVID-19 or other CID can be extubated in theatre or recovery
- The use of perspex barriers/boxes are not supported by evidence and are not recommended.

3.9 Cleaning and decontaminating in operating department

- No supplementary cleaning is required in addition to standard cleaning and decontamination procedures for COVID, COVID-pathway or non-COVID cases
- There is no requirement to remove equipment from the operating theatre for patient on the non-COVID-19 pathway
- Perioperative staff should receive on-going education on the principles and standards for cleaning required in the operating department

3.10 Ventilation air changes in operating & anesthetic rooms

See Infection Prevention and Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting

Chapter 4: Elective Surgical Beds

4.1 Background

The National Clinical Programme in their Elective surgical model of care 2013 discussed the separation of elective and emergency surgical care to improve quality of patient care and facilitate the effective use of facilities.

Furthermore, the Trauma and Orthopaedic surgery Model of Care (2015) outlines the importance of infection prevention and control in orthopaedic patients and recommended that orthopaedic patients should be cared for in designated orthopaedic wards.

It is recommended that separation of elective and emergency beds take place to the greatest extent practical to enable surgical services to be safely conducted with lowest practical risk of exposure to COVID-19.

4.2 Ring Fenced Surgical Beds

- The number of beds should be determined locally based on type of surgery being undertaken and AvLOS
- The beds should be equipped with piped oxygen and suction equipment
- The ward should remain open 24/7 for the post-operative stay of elective surgical in-patients
- The ward should be clearly marked and footfall of staff be reduced to a minimum
- All patients must meet the admission criteria
- System of bed management should support short stay care
- Where possible, patients should walk to theatre from the designated elective surgical area

4.3 Staffing in Scheduled Surgery Ring Fenced Area

- Health care workers moving between clinical areas should be avoided where possible unless they have significant vaccine protection

- Every effort should be made to reduce footfall of healthcare workers through scheduled surgery ring fenced area to minimise patient exposure
- Nurses staffing scheduled surgery ring fenced area must have relevant skills and knowledge specific to the clinical area i.e. pre and post-operative surgical patient care
- An appropriate number of clerical staff should be only assigned to scheduled surgery to oversee the administration and smooth running of the ward
- A full complement of Health and Social Care Professionals (HSCP) must be available
- Staff should have had appropriate training in Infection Prevention and Control

4.4 Distancing in Scheduled Surgery Ring Fenced Area

- Maintain a minimum distance of 1m between patients. See Infection Prevention and Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting

4.5 Personal Protective Equipment in scheduled surgery ring fenced area

- See Infection Prevention and Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting

4.6 Visitor restrictions

- Please seen national guidance on access to acute hospital for visitors and other people.

Chapter 5: Discharge and surveillance

5.1 Background

When a patient has undergone an inpatient stay and surgical procedure, it is recommended there be a system of follow-up with the patient to ensure they have not developed signs/symptoms or required antimicrobial therapy from their GP for surgical site infection within 30 days of their procedure date.

5.2 Discharge from scheduled surgery ring fenced area

- Every effort should be made to adhere to getting patients discharged home by 11am.

- A summary of the patient's investigations and procedures must be given to the patient on discharge and a discharge letter sent to GP (by Healthlink where possible)
- A patient information leaflet should be provided on discharge and include a relevant contact point for unplanned care due to an unforeseen complication of the procedure e.g. G.P., a virtual clinic, the ASAU or review clinic in the absence of ASAU for clinical examination rather than attending an undifferentiated care pathway (ED)
- Patient requested to notify the hospital in the event they are confirmed to have COVID-19 infection within 14 days of discharge
- Local protocol should determine which cohort of patients are suitable for nurse-led discharge

5.3 Post discharge infection surveillance

- It is recommended that where practical to do so the patient is reviewed for infection, including COVID-19 and surgical site infection between 2 to 3 weeks post discharge
- This information so far as possible this should be collected virtually
- Local agreement should be made around 'who' collects post discharge infection information
- Any creation of surgical site infection surveillance services, should follow existing guidance on Surgical Site Infection (WHO 2016 ; Global guidelines on the prevention of surgical site infection, European SSI surveillance protocol 2017)
- Surgical infection rate data including COVID-19 and surgical site infection should be collected locally and reviewed on a regular basis
- If a patient has reported a post-operative infection then local protocols will apply
- Note that adverse incidents should be recorded on the National Incident Management System
- The patient's post discharge infection status should be documented within the patient's clinical notes
- Appropriate review and follow up should be arranged following virtual consultation if infection present

5.4 Review Clinic

- For sites that do not have an ASAU then consideration should be given to a dedicated space suitable for a daily review clinic for review of scheduled inpatient and day case procedures who run into complications and need to avoid the Unscheduled (ED) route into services
- Clear governance agreements should be arranged locally for a review clinic including admission criteria
- Patients using public transport should follow current public health guidance and try to arrive at the clinic as close as possible to their allocated appointment time, as there will be limited seating available in many waiting areas.
- If the patient has been brought by car, the accompanying adult/support person can accompany them is they need physical or emotional support but if this not necessary it reduces football if the accompanying person remains in the car.
- All those entering the building should follow IPC recommendations for their safety and the safety of others

Chapter 6: Staff Health & Wellbeing

- All staff should be encouraged and supported to be vaccinated for COVID-19 and other relevant CID if not already vaccinated and to avail of booster vaccine when eligible. They should also avail of influenza vaccine and other recommended vaccines.
- At the start of each day, all staff should complete a self-assessment for symptoms of COVID-19 to check that they do not currently have symptoms of COVID-19. For further information on occupational health, please click here.
- If symptoms develop during a shift, staff should immediately report to their line manager/person in charge. A local pathway should be established for management (including testing) of staff who develop symptoms while either on or off duty
- Records should be kept of any close and casual contacts of members of staff/patients/other by the line manager/person in charge to facilitate rapid contact tracing in the event of a positive test. Rapid testing pathways for COVID-19 should be used where available.
- Staff start times, break times and finish times should be staggered to avoid congestion in changing areas or staff rest rooms

- Staff facilities should be adequate to maintain 1m distance between staff when practical to do so
- The healthcare environment has been a particularly stressful workplace over the last two years. Staff members may have feelings of stress and fatigue and may require additional support

Selected Reference Materials

Archer J, Ereidge S, Hosni S, Odeh A, (2020) ***Mortality and pulmonary complications in patients undergoing surgery with perioperative SARS-CoV -2 Infection: an international cohort study****:available from* https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2931182-X

British Orthopaedic Society (2020) **Re-starting non-urgent trauma and orthopaedic care**: Full guidance available from https://www.boa.ac.uk/uploads/assets/ee9cdbed-4427-458c-82d1075edb09945f/BOA-Guidance-for-restart-full-doc-final2.pdf

COVIDSurg Collaborative and GlobalSurg Collaborative (2021**), Timing of surgery following SARS-CoV-2 infection: an international prospective cohort study.** Anaesthesia. https://doi.org/10.1111/anae.15458

Department of Health (2018) Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Setting in Ireland available from: https://www.gov.ie/en/publication/2d1198-framework-for-safe-nurse-staffing-and-skill-mix-in-general-and-speci/

European Centre for Disease Control: (2020) **Coronavirus disease 2019 (COVID-19) in the EU/EEA and the UK – eleventh update: Resurgence of cases**. Available from: **https://www.ecdc.europa.eu/sites/default/files/documents/covid-19-rapid-risk-assessment-20200810.pdf/ Accessed 24th August 2020.**

Health Information and Quality Authority (18 June 2020) Evidence summary for care pathways support for the resumption of scheduled hospital care in the context of COVID-19.
Ref Day of Surgery Admission Casemix Ireland. (2012). Case Mix Unit Review of Prospective Funding December 2012.

Health Protection Surveillance Centre (2020) "**Appropriate use of PPE in healthcare settings**" available from https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/webinarresourcesforipc/ Accessed 16th May 2020

Health Service Executive (2013) *Model of Care for Elective Surgery* available from https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/model-of-care-for-elective-surgery.pdf

Health Service Executive (2014) *Model of Care for Pre Admission Units* available from https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/anaesthesia-model-of-care-for-preadmission-units.pdf Accessed 3rd May 2020

Health Service Executive (2019) ***The National Consent Policy*** available from https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/consent/national-consent-policy-hse-v1-3-june-2019.pdf

Health Service Executive (2020) "*PPE guidance for Staff*" available from https://healthservice.hse.ie/staff/news/coronavirus/prevent-the-spread-of-coronavirus-in-the-workplace.html Accessed 14th May 2020

Lei S, Jiang F, Su W, Chen C, Chen J, Mei W, et al. Clinical characteristics and outcomes of patients undergoing surgeries during the incubation period of COVID-19 infection. EClinicalMedicine. 2020:100331.

Health Service Executive (2015**) Model of care for trauma and Orthopaedic Surgery.** Available from https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/national-model-of-care-for-trauma-and-orthopaedic-surgery-2015.pdf Accessed 20th June 2020

Institute for Health & Care Excellence (NICE) guidelines 2016 ***"Routine preoperative tests for elective surgery"*** *available from:* https://www.nice.org.uk/guidance/ng45/resources/routine-preoperative-tests-for-elective-surgery-1837454508997 Accessed 6th May 2020

Parvizi et al. (2020) Current Concepts Review: Resuming Elective Orthopaedic Surgery During the COVID-19 Pandemic Guidelines Developed by the International Consensus Group (ICM), JBJS in press available online at*: https://journals.lww.com/jbjsjournal/Documents/P-FINAL-Parvizi.pdf*

Royal College of Surgeons in Ireland (2018*) Code of Practice for Surgeons* available from http://rcsi.ie/files/surgery/docs/20180212115142_Code%20of%20Practice%20for%20Surgeons%20.pdf

Royal College of Surgeons in Ireland (2020*) Consenting in the COVID situation: consenting support briefing document* available from https://www.rcsi.com/dublin/coronavirus/surgical-practice/clinical-guidance-for-surgeons

The Medical Council (2019) ***Guide to Professional Conduct for Registered Medical Practitioners*** **(8th Ed)** available from https://www.medicalcouncil.ie/news-and-publications/reports/guide-to-professional-conduct-and-ethics-8th-edition-2016-.pdf

World Health Organisation (2016) Global Guidelines on the prevention of Surgical Site Infection available from: https://www.who.int/gpsc/ssi-prevention-guidelines/en/

World Health Organisation (2020) *Maintaining essential health services: operational guidance for the COVID-19 available from* https://www.who.int/publications/i/item/10665-332240

Useful links

https://www.hpsc.ie/a/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/webinarresourcesforipc/

https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/aerosolgeneratingprocedures/AGPs%20for%20confirmed%20or%20possible%20COVID19.pdfhttps://www.hse.ie/eng/about/who/cspd/ncps/https://hselibrary.ie/wp-content/uploads/2020/05/Evidence-Summary-COVID-19-Laminar-Airflow-in-Operating-Theatres.pdf

(HSPC, 15/05/2020) https://healthservice.hse.ie/staff/news/coronavirus/prevent-the-spread-of-coronavirus-in-the-workplace.html

https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/webinarresourcesforipc/
https://www.who.int/infection-prevention/tools/surgical/SSI-surveillance-protocol.pdf

HSE COVID-19 - Clinical Guidance and Evidence

HSE https://hse.drsteevenslibrary.ie/Covid19V2/home