CMJAH

Theatre Protocol for suspected/confirmed SARScov2 infection

Revision 4 19/3/2020

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REMIND STAFF RE GOOD HAND HYGIENE WITH ALCOHOL CONTAINING SOLUTIONS (>70%)

GOOD COUGH ETIQUETTE AND HEALTH PROMOTION

Elective Patients known with COVID19

Most patients should have been preidentified as positive; If so Similar protocol as per MDR TB

Patient to have surgical mask; Travel route to be cleared of unnecessary equipment and personnel;

Pt to move straight to intended theatre; Theatre procedure and staff protection as below; Recovery in theatre and then secure transport back to destination ward

Unanticipated patient with suspected COVID19 infection

Most likely theatre for unanticipated infected patients will be in obstetrics:

Prior to examination and maintaining distance-

Check if a patient meets NICD case criteria

Fever/URTI sx/Sore Throat/dyspnea AND in the previous 14 days has one of the following

a) Were in close contact with a confirmed or probable case of SARS-CoV-2 infection;

OR

b) Had a history of travel to areas with local transmission of SARS-CoV-2; (NB Affected countries will change with time, consult the NICD website for current updates);
OR

c) Worked in, or attended a health care facility where patients with SARS-CoV-2 infections were being treated
OR

d) Admitted with severe pneumonia of unknown aetiology

If so prior to examining pt don PPE (Surgical mask appropriate for routine exam/Disposable Gown/ Head cover/Goggles/ Overshoes) and get patient to wear normal surgical mask

If elective case – isolate patient and contact Infection Control and your Consultant/HOD

If an emergency isolate pt in theatre and notify Infection Control and your Consultant/HOD

Theatre Preparation and Conduct

Prepare theatre:

Notify all staff to wear PPE – in theatre N95 mask is appropriate

NO PERSONAL ELECTRONIC DEVICES IN THEATRE

Limit staff number to minimum required – with a runner outside in gloves, apron and surgical mask with a trolley to pass items as needed using the trolley through the ante room door; The trolley can move in and out as on the periphery; At end case the transfer trolley will be pushed into the ORT for decontamination

Prepare all drugs outside – preferably in syringe form; Take appropriate fluids into theatre

Remove all unnecessary equipment from theatre to decrease contamination risk

- Unused: Defib/ Drug Trolley/Accessory Trolleys/ Syringe Pumps/Drip stands/Chairs
- Ultrasound – contentious; will have to be wrapped in plastic bag – machine/probe connectors Speak to consultant
- **Electric Suctions should not be used due to risk of aerosolisation from the compressor; Only in event of vacuum failure**

Patients Current Trolley/bed should be pushed to the side inside theatre to prevent further contamination in the corridors

Regional preferable

Surgical mask must remain on patient if regional ; avoid venturi oxygen mask with >8LPM

Do not write an anaesthetic chart in theatre– contamination of pen and paper- must be done postoperatively outside of theatre

Intubation/Ventilation/Extubation

Ensure HMEF on circuit at y piece and on expiratory connection to anaesthetic machine; do not bag the patient without a definitive airway in situ to limit aerosolisation;

RSI recommended to avoid coughing and aerosolisation

LMAS are appropriate if pt has no respiratory sequelae and a good seal

For intubation Videolaryngoscope preferable, particularly with immersable blades (metal cmac/disposoable glidescope) – wrap monitor with clingwrap/plastic bag as a drape

Auscultation will be difficult/impossible depending on PPE and in absence of disposable stethoscopes– use capnography/visualization with the Videolaryngoscope

Ventilator to be started only when cuff up and HMEF in place on airway

Ventilate as per lung protective strategies – 6ml/kg ibw optimal peep lowest fio2 for sats 88-92%

Extubation if appropriate; Risk of aerosolisation

Recovery of the patient is to take place in theatre

Once the patient is deemed recovered arrangements should be made to transport the pt under the control of the Infection Control team to the allocated isolation area; This will require either new staff for transport or redonning of new PPE

Post leaving Theatre Terminal cleaning should take place and PPE removed in theatre under supervision (buddy must onitor for breach of cleanliness) and then discarded as per good Infection Control; All surfaces/equipment to be cleaned as per protocol with solution of minimum of 1000ppm chlorine – we are using Biocide 5000ppm; Immersable laryngoscope blades are to be immersed in an 70% alcohol solution or Biocide with scrubbing of visible vontamination prior to rinsing with water

The theatre should be left vacant for a period of at least 20 minutes as per current evidence if air changes ~10-15; any openable windows should be opened (?concern for dispersion in, limited evidence for dispersion)

The IPC sister will document names and addresses of all staff involved in the procedure as potential contacts; If staff feel unwell in the next 14 days they must self isolate and contact Infection Control to arrange for testing

Numbers will be attached for Infection Control Sister to this protocol