Care of the Inpatient COVID-19 positive patient / person under investigation in the Operating Room

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The following process was created referencing sources for guidelines such as AORN, CDC, Anesthesia Patient Safety Foundation and in coordination with IP, SMH Periop, and the URMC COVID-19 Task Force.

(These guidelines apply only to those patients known or suspected to have COVID-19 or influenza are subject to change based upon evolving CDC and hospital recommendations)

Transport to surgical suites

- Do not bring the patient to perioperative anesthesia areas (patients will be intubated in the designated areas of the inpatient units)
- During Transport
    - Clear elevator and corridor in advance of transport
    - Patients will be transported intubated
    - Gloves and a surgical mask are recommended for staff transport
    - Gowns and N95 masks are NOT recommended during transport - All transport team members need to use hand hygiene after patient transport

Personal protective equipment (PPE)

- Post droplet, contact precautions and eye protection signs
- Don PPE prior to entering OR or patient care environment including gowns, goggles and gloves
    - N95 or PAPR/CAPR is only recommended for aerosolizing interventions (e.g. intubation/extubation) with patients that are known or suspected to have transmittable disease
    - Continue to follow the CDC Standard Precautions for patients on contact, airborne and droplet precautions

Intubation

- Intubation and extubation should be performed for suspected or confirmed patients in the designated areas and units using negative pressure rooms whenever possible.
- During laryngoscopy and intubation
    - Double gloves will enable one to shed the outer gloves after intubation and minimize subsequent environmental contamination

    - Avoid awake fiberoptic intubation unless specifically indicated (this will lessen droplet aerosolization)
    - Consider rapid sequence induction to avoid manual ventilation of the patient's lungs and potential aerosolization
        - If manual ventilation is required, apply small tidal volumes
        - Tracheal intubation rather than the use of a laryngeal mask is favored
- Positive pressure shall be maintained in the operating room per guidelines for surgical site infection prevention.
- If general anesthesia is not required, the patient should continue to wear a surgical mask
- If general anesthesia is used
    - Place HEPA filter distal to Y piece.
    - If a pediatric patient who does not tolerate an increase in resistance, place on the expiratory limb
    - Notify anesthesia tech who will ensure machine parts are autoclaved after the procedure
    - High-efficiency hydrophobic filter between the face mask and breathing circuit/airway bag

Extubation

- Patients will be transferred intubated to the appropriate unit and will be extubated in a negative pressure room.
- Patients will be recovered in the appropriate unit.

Cleaning of OR and equipment

- The OR will remain closed for 30 minutes after the patient leaves the room for air exchanges to clear (OR's are 20exchanges/hr)
- After 30 minutes: environmental services will use hospital-approved disinfectant and standard room turnover cleaning protocol
- Glidescope cleaning: leave in OR for 30 minutes close down period and clean following standard procedures after 30 minutes
- Glidescope blade or intubating reprocessed equipment (bronch/batteries) placed in case of a cart for transport.

Sterile instrument cleaning

- Sterile processing will be informed that instrumentation is suspected of or

confirmed to contain gross contamination.

- COVID precautions PPE/handling should be taken when processing instrumentation
- Verbal handoff expected upon drop off of case cart/instruments with sterile processing staff member
- Do not leave contaminated equipment unattended with NO verbal handoff of device/instruments
- All airway equipment, glideslope blades, bronchoscopes, GI scopes need to be cleaned in sterile processing using full PPE for transmittable disease.