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 20 exchanges/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.