Highlights for Surgeons from PHE COVID-19 IPC guidance

This document outlines the recommendations for infection prevention and control for COVID-19 from PHE that may be most relevant for surgeons. All are encouraged to read the full guidance if they are unsure about any of the parts of this document. This document reflects PHE guidance as of 16/3/2020.

Please check local/PHE guidance as it is changing on a day to day basis at:
https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

2.2 Incubation and infectious period
- Patients will not be infectious until the onset of symptoms

- Individuals are usually considered infectious while they have symptoms

- The median time from symptom onset to clinical recovery for mild cases is approximately 2 weeks and is 3-6 weeks for severe or critical cases

5. Standard infection control precautions (SICPs)

5.1 Patient placement/assessment for infection risk
- Patients must be promptly assessed for infection risk

- Patients with symptoms of COVID-19 should be segregated from non-symptomatic patients

5.4.1 Disposable apron/gown
- Disposable plastic aprons must be when providing direct patient care
- Fluid-resistant gowns must be worn when a disposable plastic apron provides inadequate cover when there is a risk of extensive splashing of blood and/or other body fluids.
- If non fluid-resistant gowns are used, a disposable plastic apron should be worn underneath.

5.4.3 Eye protection/Face visor
- Eye/face protection should be worn when there is a risk of contamination to the eyes from splashing of secretions (including respiratory secretions), blood, body fluids or excretions.

- Disposable, single-use, eye/face protection is recommended.

- Eye/face protection can be achieved by the use of any one of the following:
    - surgical mask with integrated visor
    - full face shield/visor;
    - polycarbonate safety spectacles or equivalent

5.6 Staff uniforms/clothes
-Organisations may consider the use of theatre scrubs for staff who do not usually wear a uniform but who are likely to come into close contact with patients e.g. medical staff.

6.4 Personal protective equipment (PPE)

6.4.1 Fluid resistant surgical face masks (FRSM)

- A FRSM must be worn when working in close contact (within 2 metres) of a patient with COVID-19 symptoms.

- In an area where pandemic COVID-19 patients have been cohorted together or outpatient settings**,** it may be more practical for staff to wear a FRSM at all times

- A FRSM for COVID-19 should:
    - be well fitted covering both nose and mouth;
    - not be allowed to dangle around the neck of the wearer after or between each use;
    - not be touched once put on;
    - be changed when they become moist or damaged; and
    - be worn once and then discarded as healthcare (clinical) waste (hand hygiene must always be performed after disposal).
    -single use (disposable) and fluid-resistant

- The provision of a FRSM for patients with suspected/confirmed COVID-19 should be considered if the patient can tolerate it

6.4.2 Filtering face piece (class 3) (FFP3) respirators

- Filtering face piece (class 3) (FFP3) respirators should be worn whenever there is a risk of airborne transmission of pandemic COVID-19 i.e. during aerosol generating procedures (AGPs) and at all times in intensive care unit (ICU), intensive therapy unit (ITU), high dependency unit (HDU) where COVID-19 patients are cohorted.

- All tight fitting respiratory protective equipment (RPE) (i.e. FFP3 respirators) must be:
    - single use (disposable) and fluid-resistant*;
    - fit tested and fit checked (according to the manufacturers' guidance) every time an FFP3 respirator is donned
    - compatible with other facial protection used i.e. protective eyewear
    - regular corrective spectacles are not considered adequate eye protection;

6.5 Aerosol-generating procedures (AGPs)

Aerosols generated by medical procedures are one route for the transmission of the COVID-19 virus. The following procedures are considered to be potentially infectious AGPs:

● Intubation, extubation and related procedures
● Tracheotomy/tracheostomy procedures
● Manual ventilation
● Open suctioning
● Bronchoscopy
● Non-invasive ventilation (NIV) e.g. Bi-level Positive Airway Pressure (BiPAP) and Continuous Positive Airway Pressure ventilation (CPAP)
● Surgery and post-mortem procedures in which high-speed devices are used
● High-frequency oscillating ventilation (HFOV)
● High-flow Nasal Oxygen (HFNO)
● Induction of sputum (see glossary)
● Some dental procedures (e.g. high speed drilling)

Table 1: Transmission based precautions (TBPs): Personal protective equipment (PPE) for care of patients with pandemic COVID-19

	Entry to cohort area (only if necessary) no patient contact*	General ward *	High risk unit ICU/ITU/HDU	Aerosol generating procedures (any setting)
Disposable Gloves	No	Yes	Yes	Yes
Disposable Plastic Apron	No	Yes	Yes	No
Disposable Gown	No	No	No	Yes
Fluid-resistant (Type IIR) surgical mask (FRSM)	Yes	Yes	No	No
Filtering face piece (class 3) (FFP3) respirator	No	No	Yes	Yes
Disposable Eye protection	No	Risk assessment	Risk assessment (always if wearing an FFP3)	Yes

*Personal protective equipment (PPE) for close patient contact (within 1 metre) also applies to the collection of nasal or nasopharyngeal swabs.

8.7.4 Theatres

- Theatres must be informed in advance of a patient transfer of a confirmed or possible COVID-19 positive case

- The patient should be transported directly to the operating theatre and should wear a surgical mask if it can be tolerated

- The patient should be anaesthetised and recovered in the theatre. Staff should wear protective clothing but only those at risk of exposure from aerosol generating procedures, ie during intubation need to wear FFP3 respirators and full gowns.

- Considerations about the use of respiratory/anaesthetic equipment are addressed in the critical care section above

- Instruments and devices should be decontaminated in the normal manner in accordance with manufacturers' advice

- Both laryngoscope handle and blade should either be single use or reprocessed in the Sterile Supply Department. Video laryngoscope blades should be single use and scope/handle decontaminated as per manufacture instructions.

-The theatre should be cleaned as per local policy for infected cases, paying particular attention to hand contact points on the anaesthetic machine

- Theatres should not be used by staff or patients for 20 minutes after the patient leaves if conventionally ventilated, or 5 minutes if ultraclean ventilation is used

- Possible or confirmed cases of COVID-19 should be placed at the end of the list where feasible

Appendix 6: Facial hair and FFP3 respirators

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