COVID 19 Universal Precautions in the IPP
Version 3
4/14/2020

The protection of patients and providers remains our highest concern. All patients undergoing operations are to be treated as potentially being infected with COVID-19, even if testing is negative. We have established the following guidelines for the Integrated Procedural Platform (IPP), recognizing that they may soon change as standards evolve and testing improves.

A negative-pressure "anteroom" has been created in the hallway outside IPP Rooms 15, 16, and 17. When three or fewer rooms are being used, all operations will be conducted in these rooms (unless Hybrid Room 18 is necessary). When more operating rooms are necessary, low-risk operations (e.g., not on the upper aerodigestive tract; unlikely to have aerosolization; COVID-negative, no respiratory symptoms) will be performed in Rooms 14 or 18.

1) Patients will be transported to the anteroom, where the entire team will conduct the usual Universal Protocol (UP). The scrub person may remain in the operating room for the UP, and the circulating nurse will communicate pertinent information to the scrub person. COVID-positive patients will be transported directly to the anteroom without stopping in the preoperative holding area.

2) After the UP, the surgeons and any staff (circulator nurse, scrub person, and others) will move to the positive-pressure operating room while the anesthesiology team anesthetizes and intubates the patient in the anteroom. Because of potential aerosolization of high concentration of COVID-19 in the upper aerodigestive tract, the anesthesiology team will wear PPE, including face shields and N-95 masks. They may also implement a barrier system to minimize dissemination of aerosolized virus. The Neptune system is placed in the anteroom so that suction is available. The anteroom's air and any aerosols will be evacuated via the negative-pressure system.

3) The anesthesia team will move the patient into the operating room following intubation.

4) In high-risk operations, surgeons and staff will wear PPE (either N-95 masks with face shields, or N-95 masks with orthopedic ventilated hoods to protect the face and neck, or PAPRs)*. These **high-risk situations include**:
   a) **Operations that disrupt the upper aerodigestive tract mucosa**. (See document "COVID-19 Protocol for Upper Aerodigestive Operations" version 2 dated 4/5/2020.)
   b) **Operations that are associated with a chance of aerosolization** - including usage of **powered instruments**, insufflation for **laparoscopy or thoracoscopy**, **electrocoagulation with anticipated significant amounts of plume**, and considerable wound irrigation - regardless of COVID status.

*Note: The three PPE options cited above are thought to provide equivalent safety. Because of the limited supply of PAPRs, these respirators must be arranged well in advance of the operation via the Command Center.

5) The number of staff in the operating rooms will be restricted to those who are necessary, limiting changes of staff as much as possible in high-risk situations.

6) Bovie electrocoagulation is to be used with the suction aspirating device for surgical smoke evacuation.

7) Upon completion of the operation, the anesthesiologists will determine when and where the patient should be extubated.
   a) **For COVID-positive or PUI patients, extubation may be performed in PACU Room 27** (negative-pressure), with the anesthetists and PACU staff wearing the same level of PPE as during intubation. (An alternative negative-pressure room for extubation may be IPP Room 20, depending upon its availability.) The negative-pressure room should not be entered for **60 minutes** after extubation of a COVID-positive or PUI patient (due to the number of air exchanges), unless staff members are wearing PPE, including N-95 masks.
   b) **When <u>any</u> patient is extubated in the operating room** - whether COVID-positive, PUI, clinically at low risk for COVID, or COVID-negative - the anesthetists will wear the same level of PPE as during intubation. Members of the operating team who are already wearing PPE, including N-95 respirators, will remain in the room. (In addition to the anesthetists, at least two operating team members wearing PPE with N-95 masks must remain at the patient's side during extubation.) Prior to extubation, the remaining members of the operative room staff will move to the anteroom. **No other staff will enter the operating room for 30 minutes after extubation**. If somebody needs to enter the operating room during that interval, they must wear PPE, including N-95 masks.
   c) If patients came from intensive care units, they will be transported back to the ICU for extubation, ideally in a negative-pressure room.
   d) Each team member's N-95 respirator may be preserved in a Tupperware container while not in use during the shift. The N-95 may be re-used as needed throughout the shift, as long as it has not been significantly contaminated by aerosol or damaged. **N-95 respirators are to be deposited in the recycling bins at the end of the shift or after each highly aerosolizing operation/procedure.** Grossly contaminated or damaged N-95 masks should be discarded.

8) Due to the air exchange rate, **nobody should enter the anteroom for 6 minutes after the intubation of a COVID-positive or COVID-PUI patient**. If anybody needs to enter the anteroom during that interval, they must wear PPE, including an N-95 mask. Also during that interval, the front desk nurse manager will be responsible for directing traffic, alerting staff to stay inside the rooms served by the anteroom and preventing

others from entering the anteroom. The anteroom will be terminally cleaned no sooner than 6 minutes after the intubation of patients who are COVID-positive or COVID-PUI.

Mary Fingliss, RN
David McAneny, MD
Rafael Ortega, MD
Jennifer Tseng, MD