

## **Interim Guidance on the Management of planned Hospital Admission for non-COVID care**

This document does not supersede clinical judgment and describes methods to mitigate risks associated with delivering non-COVID care in an environment where SARS-CoV-2 is prevalent. It provides a framework for services that will need to be tailored to local conditions and specialty needs.

It applies to planning for a hospital stay or planned interventions that will impact the patient's immune system. Surgery and immunosuppressant treatments such as chemotherapy or radiotherapy co-occurring with acute COVID-19 may be associated with increased mortality.<sup>1,2</sup>

1. Modelling by Williams et al suggests that mortality from chemotherapy is doubled in presence of COVID-19 infection, in the > 50 age group (<https://www.medrxiv.org/content/10.1101/2020.03.18.20038067v1.full.pdf>).
2. S. Lei et al., Clinical characteristics and outcomes of patients undergoing surgeries during the incubation period of COVID-19 infection, *EClinicalMedicine* (2020), <https://doi.org/10.1016/j.eclinm.2020.100331>

### **14 days prior to admission:**

**In order to mitigate the risk of having surgery or in-patient medical therapy whilst incubating COVID-19, it is recommended that each individual, in so far as possible, minimises their risk of exposure to others who maybe asymptomatic or presymptomatic or indeed be symptomatic with COVID-19.**

The most effective strategy is to cocoon for 2 weeks in advance of admission. Where this is not possible, it is recommended that contact is minimised with people outside of your immediate social group to the greatest possible extent and that social distancing, mask wearing and hand washing/ sanitising is used to minimise infection risk.

If an individual is in a residential care setting, establish if there is COVID-19 transmission in the RCF and if so defer surgery or remove to another setting two weeks prior to admission.

### **7 days prior to admission:**

Call or text patient to confirm they are cocooning/ physical distancing  
Check that they and their social circle have no clinical features suggestive of COVID-19

### **Anaesthesiology pre-assessment clinic:**

As much as is possible should be assessed virtually and efforts made to bundle tests and investigations, including COVID-19 test, that require hospital attendance into as few episodes as possible.

### **48 hours pre-admission:**

All patients should have a pre-procedural engagement that is virtual, by telephone or other suitable means, to ascertain that they are not

1. Suffering from any symptoms or signs of COVID-19
2. Restricting their movements due to being a close contact
3. Suffering from acute illness of any nature other than that related to the procedure
4. In contact with any member of their social group who is suffering from the symptoms or signs of COVID-19.

The patient should attend for a COVID-19 test within 48 hours of scheduled admission. Patients (and individuals accompanying them) should wear facemasks to and from testing, if tolerated.

At this time the patient's medical file can be made up and sent to their admission ward which should only care for patients with planned admission who have spent 2 weeks preparing and have had pre-screening and test results with 'VIRUS NOT DETECTED'. This gives clinicians the opportunity to review the chart on the day before, if required.

In addition, the patient needs means to get to the hospital. It is preferable if the accompanying adult remains in the car but recognised that this may not always be possible. No children are to accompany individuals for admission.

Prior to admission, patients should be sent an appointment time and asked to wait in their car, where possible, until shortly before their appointment time. Included in this communication should be a patient information leaflet indicating the requirements pertaining to the procedure. Face masks may be used during hospital visits, if tolerated and hands sanitised. Individuals are asked not to touch their face whilst wearing masks. If masks are inadvertently touched, hands should be sanitised immediately after.

### **Day of admission:**

Patients should not attend unless they have been informed that their COVID-19 test indicates 'VIRUS NOT DETECTED' and given an attendance time.

On admission the patient should be screened for the symptoms and signs of COVID-19. If any are present the procedure will be cancelled. Patients should be admitted on the day of surgery/ intervention whenever possible to minimise the length of hospitalisation and directly to the specialist planned care ward occupied only by patients who have similar pre-procedural planning, screening and testing.

Post procedurally, the patient should be admitted to an area dedicated to planned care and including only patients who have had similar pre-procedural planning, screening and testing.

**On discharge:**

The patient should be given an information leaflet including the means to contact the hospital or attend for unplanned care due to an unforeseen complication of the procedure whether it be the GP, a virtual clinic or the ASAU/ AMAU rather than attending an undifferentiated care pathway.

If being discharged to another healthcare or long stay residential centre (LSRC) after a stay case the patient should be tested for COVID-19 within 24 hours of discharge and consideration given to 'cocooning' on return to the LSRC for 14 days.

**Surveillance:**

It is recommended that patients are reviewed for infection, including COVID-19 and surgical site infection occurs between 2 to 3 weeks post discharge. In so far as possible this should be done virtually.

**Dr Vida Hamilton, NCAGL Acute Operations, Approved EAG, 29 April 2020 & NPHEt 1 May 2020**