

# Care pathway for the management of day case Laparoscopic Cholesystectomy during COVID pandemic

National consultation - draft only

## 1 Contents

1. Purpose .....	3
2. Scope .....	3
3. Responsibility .....	3
4. Over-arching principles for the reintroduction of safe day-case surgery in the COVID era.....	3
5. Guideline Procedure .....	4
5.1. Patient referral .....	4
5.2. Consent .....	4
5.3. Pre admission .....	4
5.4. Nursing assessment .....	5
5.5. Booking .....	5
5.6. Post booking COVID call .....	5
5.7. Pre-procedural testing .....	5
5.8. Symptom check phone call .....	5
5.9. Admission .....	5
5.10. Intra operative care .....	6
5.11. Post-operative care .....	6
5.12. Discharge .....	6
5.13. Post discharge support .....	7
6. Guideline review .....	7
7. References .....	7

National consultation - draft only

## Care Pathway for the management of Day Case *Laparoscopic Cholecystectomy during COVID pandemic*

### 1. Purpose

To provide clear guidelines for all staff in the management of *day case laparoscopic cholecystectomy patients during COVID pandemic*.

### 2. Scope

Applies to all staff involved in the care and management of patients undergoing *day case laparoscopic cholecystectomy during COVID pandemic*.

### 3. Responsibility

It is the responsibility of all staff involved in the care and management of patients *undergoing day case laparoscopic cholecystectomy during COVID pandemic* to be familiar with and practice within these guidelines.

NOTE. These guidelines do not over rule the independent clinical autonomy of doctors and nurses involved in the treatment of patients undergoing day case surgery.

### 4. Over-arching principles for the reintroduction of safe day-case surgery in the COVID era.

During the writing of this guideline the following principles were assumed:

A.	Robust clinical governance to oversee patient and staff safety to include:
----	--

i.	Audit of patient outcomes - including COVID and Surgical Site Infection rates
ii.	Monitoring and adherence to COVID-free/light day-case pathway
iii.	Monitoring prevalence of staff COVID rates
B.	Adequate PPE for all staff.
C.	Capacity for patient COVID testing pre-surgery and regular staff COVID testing (agreement needed with NCAGL and HPSC).
D.	Administrative system to allow booking from virtual clinics and validation of historical waiting lists.
E.	Revised patient consent process to include patient understanding of COVID risks and incorporation into Surgical Check List.
F.	Appropriate theatre design and technical standards for safe surgery in the COVID era.

## 5. Guideline Procedure

Day case laparoscopic cholecystectomy has been shown to be clinically safe, effective and efficient for appropriately selected patients

### 5.1. Patient referral

Patient referrals in the COVID era are likely to be received from a number of sources:

- Consultant outpatient clinic
- Following an acute presentation
- Tele or virtual health clinic

### 5.2. Consent

Consent for the surgical operation is best taken at initial face to face visit.

5.2.1. If patient has been referred in from a telephone or virtual clinic then signed consent will not be able to be taken at this stage, however a discussion around consent can be had with the patient on tele/virtual health platform and documented in the patient notes.

5.2.2. Time will need to be set aside on the morning of surgery for the consent process to happen at this stage, if this is the first face to face contact with a patient.

5.2.3. Guidelines for consenting during COVID pandemic can be found here

### 5.3. Pre admission

5.3.1. All patients for *day case laparoscopic cholecystectomy patients during COVID pandemic* should have a pre admission triage performed to ascertain their ASA score.

5.3.2. Patients with ASA grade I & II should be pre assessed using a telehealth platform or questionnaire where appropriate.

5.3.3. Patients with ASA grade III & IV should be telephone pre assessed but likely to require further diagnostics to ensure suitability for surgical intervention. Patients who require face to face assessment should follow the OPD pathway

#### 5.4. Nursing assessment

- 5.4.1. For either face to face or virtual assessment, nursing assessment is completed according to local Pre-Admission unit protocols and the nursing documentation forms part of the relevant Day Case record.
- 5.4.2. Time should be allocated on the morning of surgery to take a patient's observation if patient pre-assessed on telephone.
- 5.4.3. For patients who have been pre-assessed on the telephone, time should be allocated on the morning of surgery to carry out the admission clerking from medical team.

#### 5.5. Booking

Following assessment and review of all investigations, both senior nursing and anaesthetic sign off is required for confirmation of surgery scheduling.

#### 5.6. Post booking COVID call

Once a patient has completed the preadmission process and has a date for day surgery, a post booking COVID call is required. The pre admission staff are required to call the patient with the following information

- a. Time and date of the procedure
- b. Inform patient that cocooning is required for 14 days prior to the admission
- c. Inform patient that they will receive a compliance check 7 days pre admission, checking that they are following cocooning guidelines

A record of this should be made within the patient notes.

#### 5.7. Pre-procedural testing

- 5.7.1. Within 48-72 hours of the booked procedure, the patient should attend the hospital for a COVID-19 test. They are to wait in the car until their allocated time of appointment. They should not proceed to the hospital/ clinic until it has been confirmed that their test is negative.
- 5.7.2. Pre admission staff are to check test and carry out a further phone call to the patient to inform them of the results and the decision to proceed or further cocooning required.

#### 5.8. Symptom check phone call

48- 72 hours prior to admission the patient should be called by pre admission staff to carry out a symptom check to ascertain if the patient is experiencing any signs and symptoms of COVID.

#### 5.9. Admission

- 5.9.1. 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. Facemasks, one for the patient and one for the individual, accompanying them can be included in this communication.
- 5.9.2. On arrival at the day unit the patient will be screened for COVID symptoms and a temperature check performed. If the patient is positive for any symptoms at this stage then they will be turned away and surgery will not proceed.
- 5.9.3. The patient will be admitted to a dedicated elective pre-operative area with other patients who have undergone the same rigorous pre arrival screening.
- 5.9.4. Generally patients scheduled for day case surgery should undergo surgery at such a time as to allow sufficient recovery time in the Day Care Unit, and to ensure that they

meet the specified discharge criteria prior to discharge, please refer to local policies on:

- local pain management protocol for patient comfort and expedite discharge
- local anti-coagulation guidelines

#### 5.10. Intra operative care

5.10.1. The anaesthetic type is at the discretion of the individual anaesthetist.

5.10.2. The pneumoperitoneum should be deflated with care via a standard suction device. It is unknown the risk of COVID19 in the pneumoperitoneum, but it is likely to be very small in this prescreened population.

5.10.3. Local anaesthetic (20 mls of 0.5% Bupivacaine) may be applied to the liver bed and infiltrated into the skin around the port sites to reduce post-operative pain.

5.10.4. Analgesia intra-operatively and post-operatively will be prescribed by the anaesthetist. Prophylaxis for prevention of post-operative nausea and vomiting will be administered as per hospital protocol.

5.10.5. The nasogastric tube should be removed at the end of the operation.

Normal guidelines for the discharge of patients from the recovery room to the day ward should be followed.

Note: On occasion, the surgeon may choose to convert to open cholecystectomy and as such, the theatre must be ready for conversion from laparoscopic to open cholecystectomy. If this happens, care is to be delivered appropriately and bed management must be informed to allow for inpatient admission.

#### 5.11. Post-operative care

5.11.1. The patient will be admitted to an area dedicated to planned care and including only patients who have had similar pre-procedural screening and testing providing a COVID 'light' pathway.

5.11.2. Oral fluid, diet and mobilisation should be commenced as soon as tolerated.

5.11.3. Patients who do not meet the discharge criteria are converted to inpatients. Post-operative pre-discharge review by the surgical team must be documented. The patient may be discharged once the discharge criteria have been met (Appendix 3).

5.11.4. Local policy may allow a nurse led discharge process.

#### 5.12. Discharge

5.12.1. Multidisciplinary discharge planning will commence at pre-assessment where the estimated length of stay will be discussed with the patient and documented in the Day Care record.

5.12.2. Standard day care discharge criteria as set out in Appendix 3 will apply.

5.12.3. The nursing staff will document the patient's discharge score every two hours following surgery until the discharge criteria are met. Any potential problems must be acted upon immediately and the relevant team informed.

5.12.4. The National Early Warning Score will be used for patient monitoring.

- 5.12.5. In addition to discharge criteria, clinical and professional judgement should be exercised in relation to all hospital discharges.
- 5.12.6. The patient will 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 e.g. G.P., a virtual clinic, the ASAU or AMAU for clinical examination rather than attending an undifferentiated care pathway (ED).
- 5.12.7. A designated individual is to stay with them for 12/24 hours after any procedure involving sedation or anaesthesia. 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 procedures.
- 5.12.8. Discharge medications will vary depending on local policy. Discharge analgesia may be provided for a 48 hour period and can be dispensed according to local policy. Prescriptions for take home medications should only be allowed if the timing and the patients' circumstances allow dispensing in an appropriate community pharmacy.
- 5.12.9. If a patient fails to meet the discharge criteria, the patient will be admitted under the care of the operating surgeon or a designated nominee. For stand-alone day surgery units transfer to an inpatient facility should adhere to local policies.

#### 5.13. Post discharge support

- 5.13.1. Support should be provided by the Hospital/Day Surgery Unit for 24-hours post-surgery with support from primary care. This should include the issuing of contact telephone numbers to patients at the time of discharge including out-of-hours contact information. Patients needing urgent assessment or re-admission should be provided with a fast track care plan. This should also be communicated to their GP.
- 5.13.2. In the event of the patient presenting to the Emergency Department with a post-operative problem the surgical on call team will review the patient and either refer back to the operating surgeon or arrange appropriate care.

## 6. Guideline review

The National Clinical programme in Surgery has collated this pathway and resources for surgeons in practice, trainees and other professional involved in surgical patient care during the current COVID-19 epidemic. This document will be updated regularly over the coming months and many of these resources are themselves dynamic and will change, update or disappear.

Please contact us with other resources you think we should include and to let us know if there are any out of date or incorrect links via email [surgeryprogramme@rcsi.ie](mailto:surgeryprogramme@rcsi.ie).

Knowledge is evolving rapidly and some of the advice may change or expire, so please cross check your sources if you are unclear.

## 7. References

Aldret JA. The post anaesthesia recovery re-visited. J Clin Anaesthesia 1995;7:89-91.

American Society of Anaesthesiologist 2008: ASA Relative Values Guide, Illinois. ISBN: 978-1-93754213-9

British Association of Day Surgery 2000. Guidelines about the discharge process and the assessment for the fitness for discharge. Handbook Series, London. British Association of Day Surgery 2004. Day

Case Laparoscopic Cholecystectomy 2nd Ed. Handbook Series, London.

<http://daysurgeryuk.net/en/shop/handbooks/day-case-laparoscopiccholecystectomy-2nd-edition/>

Clarke M G, et al. 'An Effective Approach to Improving Day-Case Rates following Laparoscopic Cholecystectomy'. Minimally Invasive Surgery. Volume 2011 (2011), Article ID 564587, 5 pages.

<http://dx.doi.org/10.1155/2011/564587>

Gurusamy KS, et al.: 2008. Day Case versus overnight stay for Laparoscopic Cholecystectomy. Br J Surg. 2008 Feb; 95(2): 161-168. Doi: 10.1002/bjs.6105.

HSE National Integrated Discharge Planning Steering Committee 2008. The code of practice for integrated discharge planning. Health Services Executive. Dublin.

[http://www.hse.ie/eng/services/Publications/services/Hospitals/Code\\_of\\_practice\\_for\\_integrated\\_discharge\\_planning.pdf](http://www.hse.ie/eng/services/Publications/services/Hospitals/Code_of_practice_for_integrated_discharge_planning.pdf)

Katz J and Melzack R. 1999 Measurement of Pain: Surgical Clinics of North America, Vol 79(2);23152.

Leeder P C, et al. Routine day-case laparoscopic cholecystectomy. Br J Surg. 2004 Feb; 91(3): 312316. Doi: 10.1002/bjs.4409.

NHS Institute for Innovation and Improvement. 'Cholecystectomy service redesign: Reducing length of stay in hospital'. Last updated March 2012. <http://www.evidence.nhs.uk/qipp> ID: 10/0070

National Hospital Office 2007. The code of practice for healthcare records management. Dublin.

[http://www.hse.ie/eng/about/Who/qualityandpatientsafety/resourcesintelligence/Quality\\_and\\_Patient\\_Safety\\_Documents/HSEHealthcareRecordsManagementIntegratedDischargeGuidanceNotesforAuditTool.pdf](http://www.hse.ie/eng/about/Who/qualityandpatientsafety/resourcesintelligence/Quality_and_Patient_Safety_Documents/HSEHealthcareRecordsManagementIntegratedDischargeGuidanceNotesforAuditTool.pdf)

National Early Warning Score. 2012. Health Services Executive. Dublin.

<http://www.hse.ie/go/nationalearlywarningscore/>

National Public Health Emergency Team (2020) Interim Guidance on the Management of Day Case Procedures – Non aerosol generating procedures (AGPs), e.g. non-invasive radiology, colonoscopy, minor procedures

[file:///C:/Users/jamielogan/AppData/Local/Packages/Microsoft.MicrosoftEdge\\_8wekyb3d8bbwe/TempState/Downloads/NCAGL%20Acute%20Operations%20Interim%20Guidance%20on%20the%20Management%20of%20Day%20Case%20Procedures%20non%20AGPs%20May%202%20\(1\).pdf](file:///C:/Users/jamielogan/AppData/Local/Packages/Microsoft.MicrosoftEdge_8wekyb3d8bbwe/TempState/Downloads/NCAGL%20Acute%20Operations%20Interim%20Guidance%20on%20the%20Management%20of%20Day%20Case%20Procedures%20non%20AGPs%20May%202%20(1).pdf)