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SURGICAL PATIENT FLOW DURING COVID-19 EPIDEMIC

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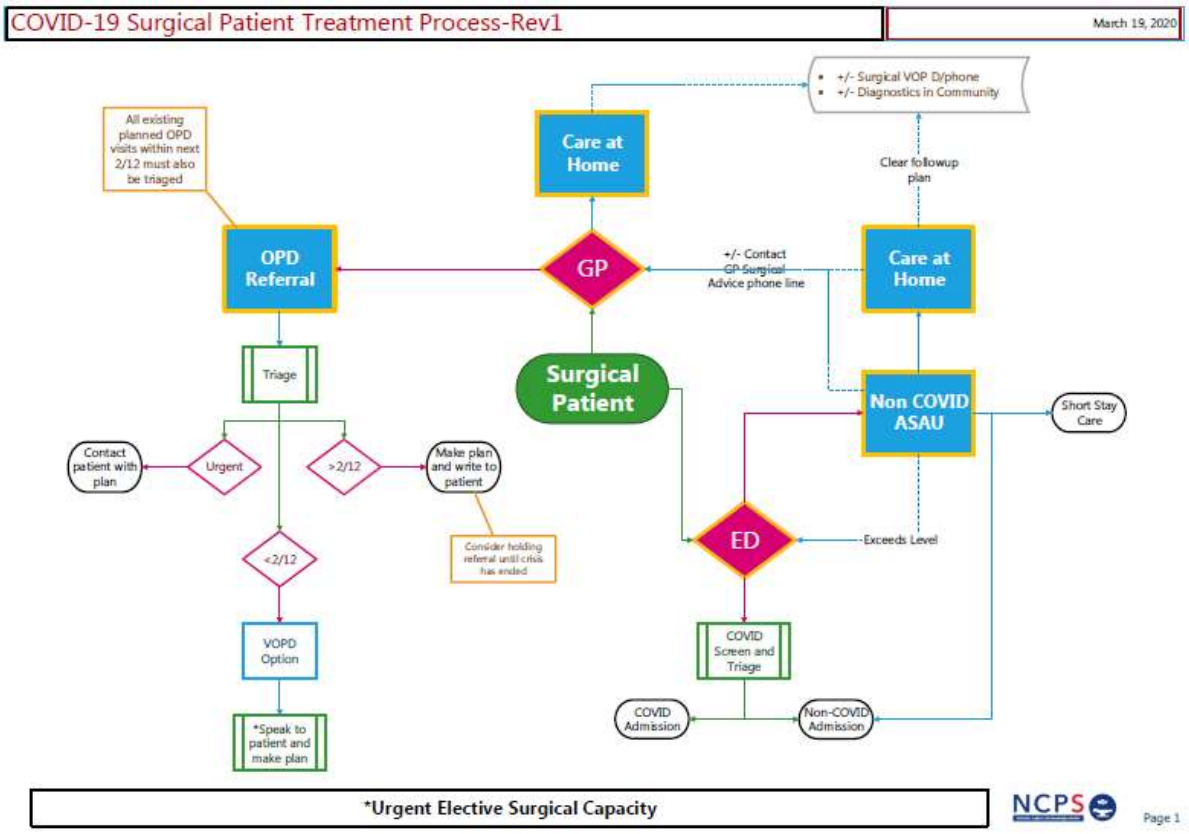
CONTEXT

The current outbreak of COVID-19 has already resulted in significant disruption in surgical practice in Irish hospitals. Based on international experience, this is anticipated to increase. If our public health efforts are successful, the duration of the outbreak will last several months at least. During this time many patients will still require emergency or urgent surgery. Other patients may be able to be safely deferred in the community if additional surgical and diagnostic support is available to GPs. The HSE plans that parallel COVID and non-COVID hospital services will operate during this period.

SURGICAL PATIENT FLOW MODEL DURING COVID-19 EMERGENCY



ACTION 1: ESTABLISH A GP SURGICAL ADVICE PHONELINE (complete)

Aim: To rapidly connect GPs and others in primary care with surgical experts to increase the number of patients with surgical conditions who can be managed in the community by providing doctor-to-doctor advice.

Planned Service:

Doctor to doctor consultation and advice on surgical issues, 8am to 8pm service, 7 days a week

Staffed by panel of expert surgeon volunteers who agree to provide phone advice to GPs (eg retired surgeons; surgeons on maternity leave; surgeons with health conditions precluding clinical duties)

Clinical indemnity scheme coverage for all involved (to be agreed); duty of care remains with GP

Single RCSI point of access to allow GP to phone a dedicated phone number or webpage hosted by RCSI

Central coordination role by RCSI staff with clinical governance oversight (by NCPS Co-Leads Prof Hyland/Prof McNamara).

Surgeons are allocated to a 4 to 6 hour session where they will be available to take calls (either via mobile phones or a virtual RCSI call centre that will field calls, take GP contact details and then send to the available panel member to phone GP back). Aim to respond within the hour.

HSE and ICGP will notify GPs of the availability of the service.

Planned Start Date: 23/3/20

ACTION 2: AVAILABILITY OF COMMUNITY DIAGNOSTICS TO ASSIST SURGICAL TRIAGE AND HOSPITAL AVOIDANCE

Arranging direct-access diagnostic tests instead of a hospital visit would expand the ability of GPs, possibly with the assistance of the surgical advice phone-line, to triage and manage patients in the community. Abdominal CT scan availability with same day reporting is especially important. Such capacity should be identified and protected in each hospital group but could be delivered in smaller hospitals or in private hospitals or private diagnostic centres.

ACTION 3: MAINTAIN A FUNCTIONING ACUTE SURGICAL ASSESSMENT UNIT (ASAU) IN EACH HOSPITAL GROUP

An acute surgical assessment unit allows rapid assessment of possible surgical emergencies by a senior decision maker. Ideally it is linked to short stay surgical capacity to rapidly treat surgical patients in Manchester triage criteria categories 3 and 4 (see table, from ASAU standards document). It is possible that selected patients in category 2 may be appropriate depending on local circumstances.

A detailed description of ASAUs is available here.

Triage Category	Surgical description/example	Management location
1. Resuscitation	e.g. active intraperitoneal bleeding, trauma	ED – surgical team will review in ED/resus
2. Emergent	e.g. incarcerated hernia with bowel entrapment, diffuse peritonitis due to hollow viscus perforation, necrotizing fasciitis, any patient with haemodynamic (HD) instability (e.g. unstable bleeding), all UGI bleeding.	ED – surgical team will review in ED/resus
3. Urgent	Acute appendicitis, uncomplicated cholangitis (not septic and HD unstable), diverticulitis not septic, not HD unstable)	ASAU
4. Less urgent	Uncomplicated cholecystitis requiring admission (not meeting criteria for necrotizing fasciitis), abscess requiring drainage, LGI bleed (not unstable) LBO (not perforated or HD unstable	ASAU
5. Non urgent		Appropriate outpatient referral

At least one functioning ASAU should be maintained in every hospital group. It should be noted that the location of the HG ASAU may need to change from the existing sites, many of which are COVID-receiving hospitals. COVID-triage should take place to ensure that the group's ASAU remains COVID-free for the longest possible duration and if testing capacity and patient condition allows, every patient should be pre-screened.

During the COVID-19 emergency, each ASAU should allow appropriate patients to be booked directly from primary care as well as accepting patients from hospital triage. During this period, the hospital group ASAU is therefore a geographic service, not necessarily linked to any specific hospital. Appropriate sites for each hospital group's ASAU may be in the public or private system. ASAU sites may be an appropriate site for co-location of community diagnostics.

ACTION 4: MAINTAIN EMERGENCY THEATRE ACCESS IN EVERY HOSPITAL GROUP

Availability of COVID and non-COVID emergency theatre availability is required in every hospital group. It may be necessary for patients to be transferred between hospitals if theatre or staffing is not available to deliver this service.

ACTION 5: MAINTAIN URGENT SCHEDULED SURGICAL CAPACITY IN EVERY HOSPITAL GROUP

As the intensity and duration of the crisis increases, the waiting list of patients requiring urgent surgery will expand. Work to clarify the prioritisation and location of such services is being developed through the office of the NCAGL acute hospitals division. Designation of one or more non-COVID elective hospitals nationally may be necessary to maintain urgent surgical services.