NCPS
NATIONAL CLINICAL PROGRAMME IN SURGERY

Resumption of Outpatient Activity for Otolaryngology and Head and Neck Surgery in Ireland

Rev 1

RCSI DEVELOPING HEALTHCARE LEADERS WHO MAKE A DIFFERENCE WORLDWIDE

NCPS GUIDE FOR RESUMPTION OF OUTPATIENT ACTIVITY FOR OTOLARYNGOLOGY AND HEAD AND NECK SURGERY IN IRELAND

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1. Overview

In the time of COVID-19, resumption of outpatient services in Otolaryngology Head and Neck Surgery (hereby referred to as ORL-HNS) will require new ways of working in order to deliver safe, timely, accessible, cost-effective and efficient care. The guidance detailed in this document should be followed in order to ensure the safety and wellbeing of the patients receiving care, as well as clerical and clinical staff involved in the delivery of ORL-HNS outpatient services in Ireland.

2. Purpose

The interim guidance for the return of non-COVID outpatient activity issued on 29 April 2020 by the Acute Hospitals Division of the HSE suggested service redesign, with the application of lean principles and a robust quality improvement process. New ways of working are required to support the delivery of care in a setting appropriate to the patient's needs with the potential for virtual clinics and distance consultations. Vigorous safety requirements must be followed, which clinicians must take into consideration upon planning OPD attendance, pre-reviewing and pre-assessing patients, for scheduling clinics, and workforce planning. Patients will also have safety instructions to follow in advance of, during and following their appointments. This document provides guidance for the new ways of working, in order to support safe and effective reopening of ORL-HNS outpatient services in Ireland.

3. Authorship

This document was authored by Mr Nash Patil, President of the Irish Institute of Otorhinolaryngology, Head and Neck Surgery, and Mr. Michael Walsh, Clinical Advisor for ENT to the National Clinical Programme of Surgery, with consensus from a major majority of the members of the IIORLHNS

4. Target Audience

The target audience for this document is all clinical and clerical staff involved in the delivery of ORL-HNS outpatient services.

5. Introduction

The interim guidance for the return of non-COVID outpatient activity issued on the 29th April 2020 by the Acute Hospitals Division of the HSE suggested a requirement for service redesign (systems engineering) to ensure that lean principles/flow processes are applied. There is a need for risk management, and a robust quality assurance and improvement process to underpin service reconfiguration.

There is a requirement for clinicians to:

1. Review all planned attendances to OPD in the context of option for care provision in Primary Care settings or integrated care.
2. Review all planned OPD attendees for the option to triage to a virtual clinic review.
3. Consider mechanisms to support single patient visits where the patient is attending multiple providers or having laboratory and radiological tests undertaken ("One Stop Shop").
4. Deliver OPD services by appointment only, with patients remaining in their car until just before the appointment, as there will be a minimal seating area.
5. Pre-review and cohort all required OPD attendees (per specialty criteria) to a designated provider (Consultant, SpR, SHO, Intern, Student, AMP, CNS, SN). Clearly record in the OPD appointment system, a designated clinician per patient and other staff per clinic. Update if changes occur on the day of the clinic.
6. Pre-assess all OPD attendees (with appropriate supports for vulnerable groups) for symptoms – fever, cough, shortness of breath or lethargy, confusion, loss of appetite, unexplained change in the baseline condition (also require symptomatic members or close contact with confirmed cases amongst social circle).
7. Consider split clinics, extended days, extended working hours and workforce planning. (Contractual implications to be agreed with individual Consultants).

Patients will be required to:

1. Commence social distancing two weeks in advance of OPD visit with attention to hand hygiene.

2. Comply with requirements for assessment for signs and symptoms of COVID-19 to minimise spread.
3. Hand sanitise and wear a face mask during the visit, if tolerated.

All staff should have their temperature checked and assessed for symptoms when coming on duty, and wear surgical masks and appropriate PPE according to Health Protection Surveillance Centre (HPSC) healthcare worker PPE guidance (Reference 1).

The Model of Care for Otolaryngology and Head and Neck Surgery published in February 2019 suggested that to improve outpatient services, there was a requirement to institute new ways of working, such as the introduction of One-Stop Clinics, and delivery of services by Health and Social Care Professionals (HSCPs), Advanced Nurse Practitioners (ANPs), Clinical Nurse Specialists (CNSs), Vestibular Physiotherapists and Speech Therapists.

The NTPF waiting list data published on 2 April 2020 revealed that there are approximately 65,000 patients on the waiting list for ORL-HNS. In order to cope with this workload and the unmet need of patients not yet put on the outpatient waiting list since the commencement of the COVID-19 pandemic, introduction and support for these new ways for working is imperative.

Healthcare workers have three times higher risk of infection than the general public, based on data from China and Italy (Reference 2). The viral load is concentrated in the upper airway in the early stage of the disease (Reference 3). Otolaryngologists are at risk, and were among the most affected healthcare workers in Wuhan (Reference 4, Reference 5) Safety recommendations for each intervention should be based on risk analysis and safety recommendations published in peer-reviewed literature, and guidelines recommended by specialty groups.

Outpatient activity in ORL-HNS has a large procedure base; see list below. This ambulatory care is not recorded on the HIPE coding system; 1 in 3 patients require some form of intervention.

ORL-HNS outpatient procedures

1. Functional Endoscopic Swallowing Test
2. Stroboscopy
3. Nasendoscopy
4. Insertion of Nasal Pack
5. Reduction of Nasal Fracture
6. Drainage of Peritonsillar Abscess
7. Microdebridement of ears
8. Myringotomy and grommet insertion in adults
9. Removal of foreign body from the ear canal
10. Fine Needle Aspiration of lymph node/Thyroid nodule
11. Drainage of neck abscess
12. Change of Tracheostomy Tube
13. Insertion of voice prosthesis
14. Nasal electro-cautery

6. Scheduling of outpatient attendees

a. Outpatient infrastructure

Scheduling will be dictated by the space available in the outpatient waiting area, which varies from hospital to hospital. ENT services are provided in thirteen hospital sites, plus two paediatric hospitals in Dublin. Satellite clinics are held in ten separate sites. The facilities vary from large units that have designated rooms for procedures, with separate consulting rooms, to satellite clinics, frequently held in small poorly ventilated rooms which are not suitable for endoscopic procedures.

If infrastructure permits, it is preferable to designate a space or room where potential aerosol-generating procedures are performed, and if possible a separate area designated for donning and doffing. The number of patients scheduled per session will be dependent on the clinical case-mix (one-third of workload in general

ENT is children), the number requiring endoscopy, the availability of PPE, and facilities to decontaminate scopes in the outpatient area.

It is not advisable to perform nasendoscopy in a non-ventilated room. The minimum requirement is access to an open window. Installation of an air exchange or exhaust system enhances healthcare worker safety and significantly improves patient turnaround time (Reference 6).

Virtual Clinics (telephone/video) should be held in a designated space where privacy is guaranteed; not in an open reception area. Virtual clinics should be set up on the hospital administration systems, similar to the regular outpatient clinics. Electronic links to the Radiology and Pathology reporting/booking systems are crucial for the efficient running of virtual clinics.

The number of patients scheduled per session will also be dependent on the ability of the Audiology service to safely triage patients on the same day of attendance (Reference 7).

To minimise face to face during consultation time and return visits, appropriate diagnostic investigations such as Radiology should be arranged virtually before the scheduled attendance were clinically safe to do so.

b. Microdebridement of ears

According to the National Quality Assurance Improvement System (NQAIS) Clinical system, which uses Hospital In-Patient Enquiry (HIPE) data from the Healthcare Pricing Office (HPO), this procedure was performed 3,701 times in 2019. This procedure is carried out utilising a binocular microscope.

Stimulation of the ear canal can induce a secondary cough reflex with a possibility of aerosol generation. To date, there is no data in the literature to determine this risk. The patient should wear a face mask.

Microsuction of the external ear canal (for wax removal or treatment of otitis externa) is not considered an aerosol generating procedure as the skin of the canal does not harbour virus.

It is not possible to view through the microscope lens with a visor or goggles. The examiner's eyes can be protected during this procedure by the availability of transparent plastic drapes to cover the microscope and the patient. The examiner should wear gloves and a standard fluid-resistant surgical mask.

If the tympanic membrane (eardrum) is not intact, there is a potential risk of transmission because the middle ear mucosa can be virus bearing, The filtering status of the suction equipment should be checked to ensure aerosol is not been vented into the room. A fenestrated suction tube should not be used.

7. Virtual clinics

a. Telephone Contact

Telephone contact has been utilised by the majority of departments in the country since the commencement of the COVID-19 pandemic, mainly for triaging patients who are already on the outpatient waiting list, and it can be readily availed of for follow-up of post-discharge patients and discussion of test results.

- Triaging of new referrals is possible; validated questionnaires improve consistency nationally. The guidelines regarding virtual clinics advised by the RCSI, HSE, ENT UK, and Medical Protection Society (MPS) should be followed (Reference 8, Reference 9, Reference 10).

b. Challenges to distance consultation

The virtual clinic needs to be structured and well supported by hospital administration, with the availability of Radiology, Pathology, and secretarial support. These clinics can be either dedicated sessions or run parallel to a face to face clinic. A proportion of the workload could be taken over by Advanced Nurse Practitioners or Clinical Nurse Specialists, provided it is within their scope of practice.

c. Telehealth

Using internet-based technologies to support remote consultations has the potential to provide an alternative to clinic-based visits in Otolaryngology. Potential areas in the specialty include:

- **Assessment of the dizzy patient**
  - Video consultation can be used to an advantage when combined with a validated questionnaire. As outlined in the Model of Care and demonstrated in projects in the Mater Misericordiae University Hospital Dublin and Beaumont Hospital, consultation and treatment can be carried out by a vestibular physiotherapist with specific expertise in balance disorders following guidelines under the governance of a Consultant (Reference 11).
- **Hearing loss or tinnitus**
  - When combined with the "Sound Scouts" app (Reference 12), which has been validated by the Australian government for hearing screening in children and adults, a significant proportion of patients may not require face to face consultation and can be directly referred for rehabilitation, appropriate investigation, or consultation with the surgeon, if "Red Flag" symptoms are present. This strategy is in keeping with the recommendations in the Model of Care for a direct referral to Audiology, which is proof of practice studies has proven to be safe, efficient and cost-effective
- **Neck lump or swelling**
  - A teleconference would determine the anatomical site of the lump and facilitate the Consultant to make the decision regarding the appropriate radiological investigations before attendance at the clinic for face to face consultation.
- **Sino-nasal disease**
  - Patients referred with nasal obstruction or discharge, facial pain or anosmia can be sent a validated questionnaire (sino-nasal outcome test "SNOT") and at the consultation, their radiological findings can be explained, information brochures and surgical information sheets discussed, and treatment options outlined.
- **Swallowing disorders**
  - Swallowing disorders are assessed by Fiberoptic Endoscopic Evaluation of Swallowing (FEES). Telecommunication can be utilised to liaise with the speech therapist in the community to facilitate the patient's rehabilitation locally.
- **Head or Neck Cancer**
  - Video recording of the tumour site can be relayed to allied health professionals for MDT conferences, and decrease the necessity of the patient attending multiple sites (Reference 10a: The quality and integration of the IT network are essential (e.g. integration of PACS, McKesson). Allowance for the patient's IT skills, people with disabilities especially hearing impairment, and patients for whom English is not the first language, will pose a challenge. Latency in speech and overlapping conversation can be overcome by user training. Use of patient information brochures, validated questionnaires and procedure-specific consent forms greatly enhance the use of distance consultation. (Reference 13).

A very large proportion of patients in Otolaryngology require face to face consultation, however telehealth systems will minimise outpatient visits and decrease significantly the return and non-attendance rates.

8. Summation of recommendations

- Patients should be contacted before attendance via telephone or teleconference to determine if they have COVID-19 symptoms or COVID-19 contact, require attendance at a face to face consultation and if appropriate investigations are required before the consultation. Every effort should be made to have appropriate investigations performed before the patient attends the clinic, to minimise the time of attendance and the number of visits to the outpatient department.
- Scheduled attendance will be required to ensure social distancing in the outpatient waiting area.
- Protocols for entry, exit and triaging to the appropriate treatment or consultation room should be established for the outpatient area. Ideally, there would be a one-way system.
- Surgical masks and alcohol gel or spray should be available in the waiting area. Where possible, Perspex screens should be established at the reception and consultation desk.
- Parallel sessions can take place where patients are triaged to a consultation area where no invasive procedure is required, or to the treatment or diagnostic area where specific interventions are required which involve the use of PPE. If the treatment room is fitted with an exhaust or ventilation system, aerosol and droplet dispersion will be minimised. This will facilitate a patient turnaround.

- Contagion risk assessments should be carried out for the common outpatient procedures; Microscopic ear examination, Nasendoscopy, Reduction of nasal fracture, Epistaxis control, Fine Needle Aspirate, epley maneuver, and Fiberoptic Endoscopic Evaluation of Swallowing.
- If feasible a protected space should be set aside for the decontamination of fibre-optic endoscopes.
- If practical, a designated area for “donning and doffing” should be assigned.
- It is essential that the clinic is provided with a sufficient number of nasendoscopes and video stack systems to facilitate efficient patient turnover.
- Transparent plastic drapes to help to protect the surgeons when performing microscopic ear examination/treatment are an option.
- Ideally, each outpatient service should have an Advanced Nurse Practitioner or Clinical Nurse Specialist whose duty it is to ensure efficiency and safety in the running of the outpatient triage system.

9. Resumption of surgical activity in the ORL-HNS specialty

Resumption of surgical activity in the ORL-HNS specialty will be contingent on:

- Availability of inpatient and ICU beds
- Availability of anaesthesiologists
- Availability of appropriate PPE
- Availability of appropriately-trained personnel (e.g. nurses trained in tracheostomy care)
- The ability of acute hospitals to triage patients into COVID or non-COVID pathways

If patients are triaged to private hospitals, agreed selection criteria, pre-admission testing, peri-operative and discharge pathways should be established, as should governance structures to ensure continuity of patient care. The pre-admission patient requirements are cocooning for 14 days, negative Smear test within 48 hours and a CT Thorax if ICU admission is required. When obtaining informed consent for the patient, the National Clinical Programme in Surgery’s ‘Consenting in the COVID situation: consenting support briefing document’ should be followed (Reference 14).

10. Surgical prioritisation during the COVID-19 pandemic

The intercollegiate clinical guide to surgical prioritisation (Reference 15) describes levels of surgical priority, and classifies conditions into grouped priority levels, acknowledging that time intervals may vary from usual practice and may possibly result in a greater risk of an adverse outcome due to progression or worsening of the condition.

Level 1a. Emergency (within 24 hours)

- Acute airway obstruction
- Penetrating neck injury
- Button battery ingestion
- Life-threatening middle ear infections
- Life-threatening Sinus infections

Level 1b. Urgent (within 72 hours)

- Severe epistaxis
- Sinus surgery for impending complications
- Acute mastoiditis or middle ear infection not responding to medical management
- Facial palsy secondary to trauma cholesteatoma
- Lymph node biopsy (suspected aggressive tumour)
- Head and neck sepsis not responding to medical therapy

Level 2 (Surgery can be deferred for up to 4 weeks)

- EUA and biopsy for a suspected tumour
- MDT-directed surgical management of head and neck tumours
- Cochlear implant post-meningitis
- Perilymph fistula
- Organic foreign body

Level 3 (Surgery can be deferred for up to 3 months)

- CSF leak
- Sinus mucocoele
- Cochlear implant in pre-verbal profound hearing loss

Level 4 (can be deferred more than 3 months)

- Routine rhinology (nasal polyps)
- Cholesteatoma (not complicated)
- Chronic otitis media (not complicated)
- Vestibular surgery (sac decompression)
- Mentoplasty
- Cochlear implant (other)
- Non-organic foreign body
- Grommets
- Nasal Fracture (uncomplicated)

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