

Principles for resuming elective surgery

Advice for NSW health services

This document outlines the key principles for resuming non-urgent elective surgical procedures to safely increase access to services, while maintaining service capability to respond should a surge in pandemic activity occur.

In response to COVID-19 preparedness, the NSW Ministry of Health directed all local health districts (LHDs) and private operators on 26 March 2020 to suspend all non-urgent elective surgery, operating only on Category 1 and stratified Category 2 cases.

This suspension was supported by professional societies and colleges, as well as by clinicians within NSW LHDs.

Since this time, the slowing of the spread of COVID-19 has shifted the focus of health services and clinical teams to preparing to resume some elective surgery.

There are a number of issues that must be addressed at the state, district and local level when recommencing elective surgery. Readiness and ability to resume elective surgery will vary across states.

It is imperative that resuming elective surgery in any health facility does not impede that facility's capacity to manage current COVID-19 pandemic activity or its capacity to respond to a potential surge in COVID-19 levels in the future.

Evaluating and addressing each of the principles below will support health facilities provide safe, high quality patient care and ensure that surgery resumes in a gradual manner that can be sustained in the longer term.

This will allow flexibility for the health system to respond dynamically should a second wave of COVID-19 infections occur, while balancing the risk to patients of delaying planned surgery against the risks of undergoing non-urgent elective surgery.

This document provides advice on surgical service delivery during the COVID-19 pandemic. For advice on LHD response to changing risk profiles and appropriate infection prevention and control measures, please refer to the CEC [COVID-19 Infection Prevention and Control Response and Escalation Framework](#).

Given the rapidly changing conditions of both the COVID-19 pandemic and the NSW health system, this advice will be regularly updated to reflect contemporary evidence and current advice from relevant health authorities.

Key principles

1. Awareness of local COVID-19 prevalence, surgical demand and hospital capacity
2. Ensuring facility readiness to resume elective surgery
3. Sufficiency of resources and consumables
4. Safety and continuity of the workforce
5. Prioritisation of elective surgery cases
6. Patient preparedness for elective surgery

More detail is outlined below for each key principle.

1. Awareness of local COVID-19 prevalence, surgical demand and hospital capacity

The NSW Ministry of Health is aiming to gradually resume theatre and endoscopy lists, previously closed in response to the pandemic, in line with local circumstances and capacity.

Clinical review of urgency and risk of continued delay for all waitlisted patients must inform the decision to proceed to surgery.

Selection of patients suitable to undergo elective surgery during the resumption period should be based on clinical need and guided by the following, as [identified by the Commonwealth National Cabinet](#).

- Low risk, high value procedures
- Patients at low risk of post-operative deterioration
- Children awaiting procedures for which they have exceeded the clinically recommended wait time
- Assisted reproductive procedures
- Endoscopic procedures
- Procedures associated with screening programs
- Critical dental procedures.

2. Ensuring facility readiness to resume elective surgery

Consider which sites across a hospital or LHD are suitable and ready to resume elective surgery.

Review critical care requirements for elective surgery, including intensive care and close observation unit capacity.

Be aware of changes to patient flow in facilities, particularly where the creation of COVID-19 positive zones in wards, theatres and intensive care units, may limit unit availability and capacity.

Consider which patients and procedures are suitable to be undertaken as ambulatory or day only cases to minimise the impact of elective surgery on inpatient bed capacity across the hospital.

Ensure sufficient staff and equipment are available to provide safe care to surgical patients across all phases of their hospital journey.

Ensure sufficient capacity in medical imaging, allied health and hospital corporate services to support increased surgical service requirements, ensuring staff safety or the hospital's ability to address a potential surge in local COVID-19 cases are not compromised.

To promote equity of access, theatre lists may be allocated to departments rather than individual surgeons. Regular review of resources, waiting list urgency and composition should inform allocation of theatre time.

Strategies to address increased volumes of patients waiting for elective surgery should be developed.

These may include:

- extending hours of theatre operation, where safe and feasible to do so
- pooling lists for increased efficiency
- coordinating waitlist management at the LHD level
- concentrating high complexity work in tertiary hospitals
- designation of COVID-19 and non-COVID-19 theatres to minimise transmission risk and reduce turnover time between patients.

Where operating theatres have been converted to negative pressure environments, these should remain preserved for confirmed COVID-19 surgical cases or aerosol generating non-operative procedures such as endoscopy and bronchoscopy.

In recent months new ways of working have also evolved, particularly where public and private facilities enter into agreements to provide care collaboratively. While these arrangements increase health system capacity, it is important to ensure the same standards and quality of care is delivered, regardless of the facility in which care is provided.

3. Sufficiency of resources and consumables

Sufficient stock of surgical supplies, implants and equipment must be secured prior to resuming elective surgery, including confirmation of ongoing supply chains with vendors.

Adequate cleaning and sanitation products, including environmental cleaning products, must be available and not detract from the ability of the facility to address a potential surge in local COVID-19 cases.

Personal protective equipment

Facilities should not resume non-urgent elective surgery until adequate PPE and other supplies are available. Sufficient stored inventory to support operating theatre activity should be confirmed by the LHD and continuously monitored against planned surgical service activity.

Reliability of equipment and consumable supply chains should also inform plans to resume elective surgery.

Monitor and map the use of PPE and surgical consumables to ensure adequate supply, being aware that usage profiles may change for some procedures as advice on personal protection evolves.

Mapping the use of PPE for individual surgical procedures may further inform which procedures and case volumes can safely recommence.

4. Safety and continuity of the workforce

Elective surgical cases must be consultant surgeon and anaesthetist led.

Multidisciplinary staffing coverage for routine hours and extended hours, if required, must be confirmed prior to resuming elective surgery.

Staff should be routinely screened for symptoms of COVID-19 using the most up-to-date [clinical and epidemiological criteria](#), and if symptomatic, should be tested and quarantined.

Contingency plans should be in place for the potential situation of newly diagnosed or vulnerable healthcare workers.

[Vulnerable staff undertaking essential work](#), who are most at risk of acquiring COVID-19, should undertake risk assessments and implement mitigation strategies. Where necessary, these staff may be redeployed to alternative duties.

Training and educational activities in the operating theatre should be thoroughly risk-assessed prior to recommencing.

Hospitals should have social distancing policies in place for staff, patients and visitors.

5. Prioritisation of elective surgery case

In planning to resume elective surgery, a multidisciplinary committee should be established within the hospital or LHD to develop a prioritisation strategy based on clinical need and facility capacity.

A prioritisation strategy should consider:

- volumes of postponed patients
- prioritisation across and within specialties
- care teams required and available for clinical work
- a phased approach to re-opening dormant operating theatres
- plans to increase the time available for surgery
- coordination of local strategy with those developed in peer and LHD facilities.

6. Patient preparation for elective surgery

Risk assessment

Patients with confirmed COVID-19, or those in a [high risk category, or from a high risk setting](#) for COVID-19, should not undergo elective surgery unless postponing the procedure creates a greater risk to life.

Patients should meet NSW Health [release from isolation criteria](#) prior to surgery.

COVID-19 testing must be undertaken in line with [NSW Health testing criteria and prioritisation guidelines](#), which does not recommend routine COVID-19 testing pre-operatively for elective surgery patients.

Assessment of clinical urgency and local capacity to safely undertake the case should be made by a multidisciplinary team.

[If a decision is made to go ahead with elective surgery, patients should not be instructed to self-isolate prior to admission.](#)

Patients who are significantly immunocompromised are required to have two negative swabs prior to being released from isolation. If these patients subsequently require surgery, seek advice regarding readmission to hospital.

Previous COVID-19 infection but now recovered

Evidence is currently emerging that patients undergoing surgery within three months of infection with COVID-19 are at increased risk of post-operative complications. If a patient has recovered from COVID-19, met the criteria for release from isolation and is awaiting elective surgery, they should be informed of the increased risk of adverse outcomes and discuss their individual situation with their surgeon.

Identification of suspected or probable COVID-19 cases

As per the [CDNA guidelines for Public Health Units](#), an individual must meet both clinical and epidemiological risk factors to be considered a suspected or probable case.

Clinical criteria

- Does the patient have a fever ($\geq 37.5^{\circ}\text{C}$)?
- Does the patient have an acute respiratory infection (e.g. cough, shortness of breath, sore throat)?
- Does the patient have a loss of taste or loss of smell?

Epidemiological criteria

In the 14 days prior to illness onset:

- Has the patient had close contact with a confirmed or probable case?
- Have they travelled internationally?
- Were they a passenger or crew member on a cruise ship?
- Are they a healthcare, aged or residential care worker with direct patient contact?
- Do they live, or have they travelled through a [geographically localised area with elevated risk of community transmission](#)?

Patient preparation

Wherever possible, usual preoperative preparation activities should also be maintained, with consideration for alternative methods for conducting face to face appointments to minimise hospital attendance.

Previous COVID-19 infection but now recovered

Evidence is currently emerging that patients undergoing surgery within three months of infection with COVID-19 are at increased risk of post-operative complications. If a patient has recovered from COVID-19, met the criteria for release from isolation and is awaiting elective surgery, they should be informed of the increased risk of adverse outcomes and discuss their individual situation with their surgeon.

In these circumstances, surgery may be deferred where it is clinically safe to do so. If surgery is to proceed, patients may take additional precautions to lessen the risk of complications before and after their surgery, such as:

- physical distancing wherever possible
- voluntary self-isolation before and/or after surgery
- avoiding unnecessary travel and social activities
- wearing a mask when outside their home and physical distancing is not possible
- reporting any respiratory symptoms to their treating team and/or doctor.

Appendix 1: Patient screen questionnaire

Patients must have positive COVID-19 antibody and a compatible clinical illness PLUS at least one epidemiological criteria to be considered a probable case.

Patients must meet at least one criteria from BOTH clinical and epidemiological risk factors to be considered a suspected case.

AFFIX PATIENT STICKER	
Name
MRN
DOB

Clinical criteria

Fever ($\geq 37.5^{\circ}\text{C}$) or history of fever (e.g. night sweats, chills)

OR acute respiratory infection (e.g. cough, shortness of breath, sore throat)

OR loss of smell or loss of taste.

Epidemiological criteria

In the 14 days prior to illness onset:

- close contact with a confirmed or probable case
- international travel
- passengers or crew who have travelled on a cruise ship
- healthcare, aged or residential care workers and staff with direct patient contact
- people who have lived in or travelled through a geographically localised area with elevated risk of community transmission.

Date of surgery / procedure: _____

Surgery / procedure: _____

Has the patient travelled overseas or interstate in the last 2 weeks? YES NO

Has the patient had contact with suspected or known COVID-19 positive person in the last 2 weeks? YES NO

Has the patient been tested for COVID-19 in the last 2 weeks? YES NO

If the patient has been tested for COVID-19, what was the result? POSITIVE **Stop. Escalate as per local process**

NEGATIVE Proceed to next section

Comments: _____

Does the patient have, or have they had in the past 48 hours, any of the following symptoms?

Fever ($\geq 37.5^{\circ}\text{C}$) Shortness of breath Runny nose Nausea / vomiting

Cough Loss of smell Muscle pain Diarrhoea

Sore / scratchy throat Loss of taste Joint pain Loss of appetite

Comments: _____

If the patient answers 'yes' to any of these questions, escalate as per local process to confirm next steps

Completed by: _____

Signature: _____

Designation: _____

Phone contact: _____ Date: _____

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