Infection Prevention Precaution Practices for OR Cases in Patients with Confirmed or Suspected COVID-19

Note: These practices apply for patients who are having aero-digestive or thoracic surgery, unless the patient recently tested negative for COVID-19 and remains asymptomatic, with the exceptions noted at the end of the document.

1. Communication
   a. Attending surgeon must communicate with the OR Coordinator and Charge Nurse
   b. OR Coordinator and Charge Nurse will identify the anesthesia and nursing team and notify them to prepare the room.
   c. Identify four-person anesthesia team (not all are required to be anesthetists):
      i. Primary anesthetist: direct care; head of bed; ensure mask seal; intubate; extubate
      ii. In-room assistant: administer drugs, chart, assist as requested by Primary
      iii. Outside assistant: dons Airborne PPE; communicates with Armstrong Cart Assistant; hands off need equipment, supplies, drugs; enters OR if needed; does not leave door or touch anything outside of the OR
      iv. Armstrong assistant: Provides equipment, drugs, and supplies as requested to outside assistant; holds phones for anesthetists inside room; coordinates delivery of additional equipment and supplies from Workroom and drugs from Pharmacy; does not leave cart; has access to upper drawer or identifies individual to call when additional controlled drugs are required.
   d. The primary anesthetist and two assistants will transport the patient to the OR, once the OR is ready. The patient will be taken directly to the designated OR.

2. OR Set-up
   a. Check that blue Airborne Precautions sign is on all doors.
   b. Check that separate donning and doffing stations are set up just outside OR door. This is to ensure doffing does not contaminate clean surfaces and supplies.
      a. If using N95, label a paper bag with first name, last two digits of UNID, date, and “ANES” and set it on the doffing station for easy access.
c. If there is an Omnicell in the room, either remove it from the room or cover it 
with plastic sheeting. Do not access at any time.
d. Check that EPIC computer is covered with plastic, use a 10/10 drape over the 
keyboard. Open the planned case in EPIC before patient arrives.
e. Empty pockets of everything except name badge. No phones, bags, or books in 
OR. No reading in OR. Leave phone on Armstrong cart.
f. All equipment and supplies should be removed from anesthesia machine 
drawers.
g. Set up an Armstrong cart (including controlled drugs) outside OR.
h. Bring only essential drugs, equipment, and supplies into OR. Additional supplies 
that may be needed can be set on top of the Armstrong cart for easier access.
i. Check that HEPA room air purifier is set up near head of bed.
j. Check circuit that one HME airway filter is at distal end of elbow (so air is filtered 
before it is sampled for end tidal gases) and one HEPA airway filter is on 
expiratory limb inlet. Be aware that two filter- resistance can potentially exceed 
ventilator settings and cause alarms.
k. Check that closed suction is available.
l. Set up a Mayo stand inside the door for passing off additional supplies.
m. Complete OR Readiness Huddle. Call nursing staff to inform them team is ready 
to go.

3. Transport to OR
   a. Check in with RN, primary care team for report
   b. Complete preop note.
c. Before transporting, complete a Pre-Transport Huddle and confirm the 
destination is ready.
d. Don PPE: gown, double gloves, N95 or EHMR P100 plus eye protection / face 
shield or PAPR.
   i. If using a new N95, label with your first name, last two digits of UNID, 
date, and “ANES” using a fine point Sharpie.
   ii. Always don and doff with a partner who verifies compliance .
   iii. Consider writing your name and role on your gown or on the top of the 
face shield.
   iv. Keep the inner glove on throughout the case. When the outer glove is 
soiled, remove it, perform hand hygiene on the inner glove, and don a 
new pair of gloves.
e. Clean bed rails and frames with sani-wipe, cover patient with clean blanket.
f. Place surgical ear-loop mask on patient prior to transport.
g. If supplemental oxygen is required, NC or simple FM are preferred; high flow 
nasal cannula (HFNC) and non-invasive positive pressure ventilation (NIPPV)
devices should be avoided. Consider continuing HFNC or NIPPV if already in use; intubation before transport is ideal for those patients.

**h.** During transport, minimize flow rate to maintain SpO2 below 94%. This will reduce aerosol spread. For NIV, ensure a good seal and place a HEPA filter between the patient and the circuit. For other routes, place a surgical ear-loop mask over nose, mouth, and oxygen delivery device prior to transport.

**i.** For patients who will require general anesthesia, the airway should always be secured by intubation. If the patient is in a negative-pressure room and if the conditions for intubation are acceptable, the patient should be intubated before transport to the OR.

**j.** If using BVM/JR or transport ventilator, HEPA filter should be placed between ETT and connector.

**k.** Two individuals should push the bed and provide patient care. One individual should *not* touch the bed, but should serve as a “clean escort” for opening doors/pushing buttons and clearing the hallway. The clean escort should don droplet PPE; airborne PPE is not required.

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### 4. Intraoperative Care

**a.** All personnel must wear airborne PPE to enter the OR.

**b.** When a HEPA room air purifier is available, the HEPA air purifier must be turned on to the maximum setting for intubation and extubation. After intubation and extubation the HEPA room air filter must be on the maximum setting for 14 minutes.

  a. For cases that don’t require (or can’t achieve) a sterile field, for example, airway, dental, and aerodigestive cases, the HEPA room air purifier may be left on throughout the duration of the procedure. If it is too loud for effective communication, it may be turned down to medium or low.

**c.** Additional providers may not enter the room until 14 minutes after the end of intubation. The must wear airborne PPE.

  a. Traffic in and out of the room should be kept to a minimum.

  b. Doors should be kept closed as much as possible.

  iii. Open doors (with button) to make requests of outside assistant (when alternate communication mechanism is not available).

  iv. Outside assistant may open the door to place requested equipment, drugs, and supplies on a Mayo stand inside the door. The stand should be cleaned with sani-wipes by OR staff after the supplies are removed. *Supplies should never be directly handed to anyone in the OR.*

**b.** No observers or students are allowed; aim for minimum required staff

**c.** MAC and regional anesthesia may preferable because intubation is not required. If patient is coughing, intubation may be preferable.
i. If supplemental oxygen is required, minimize flow rate to maintain SpO2 below 94%.

ii. Limit sedation to prevent the need for airway rescue.

iii. Patient should continue to wear ear-loop surgical mask over nose, mouth, and face mask or NC.

d. Before intubation, complete Pre-Intubation Huddle.

e. For intubation, primary anesthetist applies anesthesia mask with straps and holds with two hands to ensure seal. Assistant does other tasks as directed.

f. Place all airway equipment on the plastic bag on the anesthesia machine or directly in the trash. Once induction/intubation complete, discard all airway equipment and supplies except mask. Clean mask with sani-wipe and save for extubation.

g. Once induction complete, do not disconnect circuit unless absolutely necessary.

h. Once induction/intubation complete, wipe all surfaces with sani-wipe, including the front of your face shield.

i. Perform hand hygiene before charting.

j. Hand hygiene can be performed directly on gloves. Remove the outer gloves, perform hand hygiene, and don a new pair of gloves when gloves are visibly or highly soiled (after intubation, after line placement, etc.). Consider triple gloving for intubation and extubation, so the outer layer can be quickly removed immediately after intubation/extubation.

k. Before extubation, complete Pre-Extubation Huddle.

l. Patients who had general anesthesia and will go to a negative-pressure room after surgery should be transported while they are still intubated. Anesthesia and muscle relaxation should be maintained to reduce the risk of coughing.

m. Consider leaving patients who were on supplemental oxygen preop intubated postop, to avoid the need for later reintubation.

n. Patients who had general anesthesia who will not go to a negative pressure room should be extubated in the operating room. The patient should be awake and breathing well prior to transport. This will require a few extra minutes in the room. If possible, take the time to wean them to room air so they can be transported on room air. For patients who were on supplemental oxygen prior to transport, it is reasonable to continue that route. Otherwise, low flow NC or simple face mask should be used. Minimize flow rate to maintain SpO2 below 94%. For NIPPV, ensure a good seal and place a HEPA filter between the patient and the circuit. For other routes or room air, place a surgical ear-loop mask over the nose, mouth, and oxygen delivery device prior to transport.

o. Reconcile controlled drugs in OR with nurse/anesthesia provider & waste in dirty suction canister.

p. Place the anesthesia circuit, suction, water-trap, and soda-lime canister in the trash before leaving the room.
5. **Transport from OR**
   a. Before transport, complete Pre-Transport Huddle and confirm the destination is ready.
   b. The (cleaned) anesthesia mask, a HEPA filter, and bag-valve-mask or Jackson-Rees should be placed on the bed in case of airway emergency during transport.
   c. PPE should be kept on for transport.
   d. Clean bed rails and frames with sani-wipes, cover patient with clean blanket.
   e. Make sure the HEPA air purifier is turned on maximum prior to leaving room.
   f. Two individuals should push the bed and provide patient care. One individual should **not** touch the bed, but should serve as a “clean escort” for opening doors/pushing buttons and clearing the hallway. The clean escort should don droplet PPE; airborne PPE is not required. The clean escort can also transport the labeled N95 paper bag to facilitate doffing and preserving the N95 at the destination.
   g. Place a sign on the door indicating the departure time and whether a HEPA room air purifier was used. *Cleaning must not start for at least 15 minutes if HEPA room air purifier was used and 20 minutes if it was not.*

6. **Cleaning the Anesthesia Work Space**
   a. Wear gown, surgical mask, and eye protection (droplet precautions)

**Exceptions for Aero-Digestive or Thoracic Surgery**

The above practices apply for patients who do not have confirmed or suspected COVID-19 and who are having aero-digestive or thoracic surgery with the following exceptions:

1. If the patient recently tested negative for COVID-19 and remains asymptomatic, follow the **NON COVID OR** procedures.
2. Bring the Armstrong cart into the OR. Place it at least 6 feet from the head of the OR table. As for COVID-19 cases, **do not** access the Omnicell, which should be removed or covered in plastic sheeting.
   a. **Always** perform hand hygiene (use of hand sanitizer on gloves is acceptable) before accessing anything on top of or in the Armstrong cart.
   b. Use the minimum supply blue bins to set up for the case. Place additional items you think might be necessary on the top of the cart to limit drawer opening during the case.