Specialty guides for patient management during the Coronavirus pandemic

Clinical guide for the management of patients requiring plastics treatment during the Coronavirus pandemic

20 March 2020

“…and there are no more surgeons, urologists, orthopaedists, we are only doctors who suddenly become part of a single team to face this tsunami that has overwhelmed us…”
Dr Daniele Macchine, Bergamo, Italy. 9 March 2020

As doctors we all have general responsibilities in relation to the Coronavirus response and for these we should seek and act upon national and local guidelines. We also have a specific responsibility to ensure that essential Plastic and Reconstructive Surgery care continues with the minimum burden on the NHS. We must engage with those planning our local response. We may also need to work outside of our specific areas of training and expertise and the GMC has already indicated its support for this in the exceptional circumstances we may face.

Plastic and Reconstructive Surgery may not seem to be in the frontline in the Coronavirus response but we do have a role to play and this must be planned. In response to pressures on the NHS, the elective component of our work may be curtailed. However, the non-elective patients, who are predominantly trauma-related, will continue to need care. We should seek the best local solutions to continue the proper management of these patients whilst protecting resources for the response to the Coronavirus.

In addition, we need to consider the small possibility that surgical facility for emergency surgery may be compromised due to a combination of factors including staff sickness, supply chain and the use of theatres and anaesthetic staff to produce ITU pods. This is an unlikely scenario but plans are needed.

Plastic and Reconstructive Surgery patients can be considered in a few categories:

1. **Obligatory in-patients:** Continue to require admission and surgical management e.g., open fractures, significant extremity soft-tissue trauma, major burns. We must expedite treatment to avoid pre-op delay and expedite rehab to minimise length of stay.
2. **Non-operative**: Patients with injuries that can reasonably be managed either operatively or non-operatively e.g. closed hand fractures. We must consider non-operative care if that avoids admission.

3. **Day-cases**: Surgery can be safely undertaken for a large number of conditions. Provision for day-case surgery must be made.

4. **First contact and clinics**: Outpatient attendances should be kept to the safe minimum.

When planning your local response, please consider the following:

**Obligatory in-patients.**
- A consultant must be designated as “Lead Consultant”. This duty can be for 1 day, a few days or even 5 days in small units. This is an essential role during crisis management. It cannot be performed by the consultant “on-call” or the consultant in clinic or the consultant in theatre. They must be free of clinical duties and the role involves coordination of the whole service from ED through to theatre scheduling and liaison with other specialties and managers.
- It can be very stressful during a crisis. Support each other and share the workload. Do not expect the Clinical Director to do all of the coordination!
- Establish a daily situation report (sitrep) and dashboard with critical data to share across the workforce. That should include patient flows, workforce issues, stock levels and other key messages (eg state of Coronavirus response and personal protective equipment (PPE) requirements).
- Use elective theatre capacity and surgeons to ensure minimum pre-operative delay.
- Use elective rehab services to minimise post-operative stay.
- An anaesthetic guideline for patients requiring surgery and who are positive for Coronavirus will be required.
- Contingency plans for supply chain issues.

**Non-operative management**
- A number of injuries can be managed either operatively or non-operatively. Clinical decisions during a serious incident must take into account the available facility for the current patient and also the impact this may have on the whole community.
- As the system comes under more pressure, there may be a shift towards non-operative care.
- Non-operative care may reduce the in-patient and operative burden on the NHS.
- It may also protect the individual from more prolonged exposure in a hospital setting.
- It may free up beds for more urgent cases

**Day-cases**
- Many emergency procedures are clinically suitable to be performed as a day-case.
- During the Coronavirus response, an increase in day-case emergency surgery will:
  - Avoid unnecessary admission
  - Reduce exposure of the individual to a hospital environment
  - Free-up beds for more urgent cases
  - Allow staff from elective theatres to continue working in a familiar environment
• During the Coronavirus response, it is likely that the only elective day-case surgery occurring will be urgent cases. Careful prioritisation of day-case patients will be needed across both the elective and non-elective patients based on theatre/staff capacity.

First contact and outpatient clinics
• Emergency Departments (ED) are likely to come under intense and sustained pressure and Plastic and Reconstructive Surgeons can make an important contribution by reducing the ED workload so that clinicians in ED can focus on medical patients.
• **Emergency Departments will change their system and will use senior clinician triage at the front door and stream patients directly to Clinic before examination or diagnostics.** Outpatient clinics are likely to be asked to take all patients presenting as emergencies (including wounds and minor injuries) straight from triage. It is possible that this temporary service will need to be expanded to provide a 12-hour service, 7 days per week. Consider combining with fracture clinic.
• Consideration should be made to use videoconferencing platforms to enhance this process.
• ED will continue to take patients requiring resuscitation, Trauma Team etc.
• We should avoid unproductive attendances at hospital.
• Senior decision making at the first point of contact should reduce or even prevent the need for further attendances.
• A decrease in elective work will allow for a greater senior presence at the front door.
• Clinicians may need to work in unfamiliar environments or outside of their sub-specialist areas. They will need to be supported.
• Consider, where appropriate, the use of splints rather than plaster casts for hand injuries to allow for removal without hospital re-attendance.
• Protocols to identify those injuries that require no follow up should be reviewed.
• No patient should be scheduled for surgery without discussion with a consultant.
• Outpatient clinics will need to be open-access at least 09.00-17.00 depending on volume.
• Using Virtual Clinic will not reduce ED workload. Hospitals using this system may need to switch during the crisis to the system outlined above.
• Can a follow-up video conferencing be developed with your facility?
• Consider postponing long-term follow-up patients until the crisis has passed.
• A temporary minor operating theatre and dressings clinic may need to be set up in outpatient areas to allow for suturing of wounds etc.
• CT scanning may be limited as it is the investigation of choice for coronavirus pneumonitis. Consider delaying post-operative surveillance scans.

Plastic Surgery Escalation Framework

The Coronavirus pandemic is expected to put UK Health services under escalating pressure. Initially decision making may be within current ethical/practice standards. However, if conditions continue to escalate as has been seen in other countries decision making may be more extra-ordinary. **In these circumstances it is important that when decisions are made both the decision process and decision made is well documented.** At more
normal working levels the decision making may seem easy, at extraordinary working levels these decisions are difficult, staff will be under severe stress and it is well recognised that this will impact on staff mental health and resilience.

This framework is designed to support that decision-making process. The decision-making process should bring together available information, assess the risks, legal position, policies and procedures and then recommend and support shared decisions (individual clinician, organisation and (where appropriate patients).

The phases of any incident response will overlap. Different hospitals and units may be at different stages at different times (although all decisions made should take account of the wider local, regional and national position). The table below should not be considered rigid (columns may overlap) and these are not mandatory instructions.

<table>
<thead>
<tr>
<th>Prevalence</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
<th>Very high</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact</td>
<td>Normal Winter Pressure</td>
<td>Limited ITU</td>
<td>No ITU Theatre ITU pods</td>
<td>Emergency surgery limited isolation limited</td>
</tr>
<tr>
<td></td>
<td>Business as usual</td>
<td>Limited beds</td>
<td>No Beds Emergency Discharges</td>
<td></td>
</tr>
</tbody>
</table>

| Phase       | Prepare to respond  | Stop routines            | Prioritise Urgent           | Major Incident             |

<table>
<thead>
<tr>
<th>Trauma Operating</th>
<th>Normal</th>
<th>Increase day-case</th>
<th>Maximise day-case</th>
<th>Further increase non-op</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant Surgeon Trauma Coordinator</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early surgery to decrease LoS (using elective capacity) – No pre-op delays</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Elective Operating</th>
<th>Normal except no vulnerable patients e.g. ASA 1 only</th>
<th>Urgent and cancer only</th>
<th>All elective surgery stops</th>
</tr>
</thead>
</table>

| Emergency Clinic  | Normal new patient Start reducing follow-up           | Increase use of non-surgical techniques Virtual follow-up where possible | All ED injuries triaged to outpatient clinic except resus cases Urgent minor ops in outpatient clinic |
|                   | All-day open access new pt Start designing virtual clinic follow-up |                          |               |
|                    | Elective surgeons to support 7 day, 12h service |

| Elective Clinic | Normal new patient Start reducing follow-up | Urgent only No follow-up | Urgent diverted to clinic |