CAPSCO Infection control coronavirus statement

CAPSCO

CONSORTIUM OF AESTHETIC PLASTIC SURGEON CLINIC OWNERS

Introduction and Purpose

CAPSCO is the Consortium of Aesthetic Plastic Surgery Clinic Owners and is a group of plastic surgeons who own their own clinics or have positions of responsibility in such clinics or hospitals. This document has been produced to provide reasoned consensus based on current evidence that has been produced over the past few weeks since COVID-19. As a group of consultant plastic surgeons, CAPSCO members have safety at the forefront of clinical practice.

This document is a guide to reopening of clinics and hospitals owned and run by CAPSCO members. It should be used in conjunction with clinic infection control policies that already exist. Guidelines are produced as reference documents and are different to clinic operating policies (COPs) and standard operating policies (SOPs). These guidelines are relevant to surgical procedures performed in the UK. Knowledge of SARS-CoV-2, Coronavirus and COVID-19 is changing and evolving. SARS-CoV-2 is a type of Coronavirus which causes a disease called COVID-19. Any document produced in relation to COVID-19 should be open to adjustment and modification by appropriate people at appropriate times.

Controlling COVID-19 infection in clinics that perform surgery is of vital importance to protect both staff and patients. Infection transmission can take place at several points in the patient journey. At all these touch points, we should try and limit infection transmission.

CAPSCO members provide private medical services. The implementation of the following guidelines will have an impact on the cost of all surgical procedures. Testing for coronavirus and antibodies will incur additional costs, as will computer software licenses for teleconsultation and communications with patients.

CAPSCO does not endorse or recommend any particular brands or companies for the services that may need to be initiated by clinics. Some services are mentioned in this document and this should not be taken as an endorsement of that particular product or service. We have noted, though, that PPE is widely available for private clinics and there is no shortage. The costs of PPE is currently higher than in the past, but the equipment is available.

This document will not consider when it would be appropriate for clinics to start performing aesthetic surgery, either in a consultant owned clinic or in a private hospital setting.

Testing

There are two types of tests currently available: PCR testing and Antibody testing. PCR tests for the RNA present within the virus. PCR tests are performed with swabs of the nasopharynx and oropharynx and are approximately 70% sensitive and 100% specific. Currently, The Doctors Laboratory is performing these tests for private clinics.

Antibody tests take two forms: lateral flow tests, and ELISA tests that take place in a lab. They look for the presence of IgM and IgG. There are several lateral flow tests available, and are variable in the sensitivity and specificity. the best performance data from these bedside fingerprick tests show sensitivities of around 95% and specificities of around 100%. The performance data from the manufacturers show large confidence intervals, however, given the small number of patients tested in the relevant categories.

ELISA tests performed in a lab are said to be more accurate and testing manufacturers have produced results that show slightly higher levels of accuracy than the bedside lateral flow tests.

If a clinic decides to perform testing, then they should do so in the context of ensuring patients will not make changes to government advice based on results. The only decisions made from such tests should be whether a clinic will proceed with or cancel a patient's surgery. Testing should be performed in the context of the statement from the Department of Health and Social Care, through the Chief Medical Officer in March 2020. A private cosmetic clinic may not be the best place for coronavirus testing and such a service is better suited to a private general medical clinic.

Clinics may wish to consider testing their staff on a regular or occasional basis. Antibody tests will answer one question: "have I recovered from a recent coronavirus infection", PCR tests will answer one question: "am I currently infected with SARS-CoV-2". No test is ever likely to be 100% accurate.

All patients undergoing GA surgery in a private clinic should be considered for PCR testing and self-isolating after the test takes place. For example, a clinic may ask a patient to self-isolate for two weeks prior to surgery and have PCR testing performed 48-72 hours prior to surgery. At some stage in the future, clinics may wish to make use of the NHS contact tracing app to help determine a decision on self-isolation and progression with surgery.

Virtual consultations

- The prefix "tele" means "distant" and has Greek origins.
- Teleconsultations should be used when possible to minimise risk of transmission of infection
- Virtual consultations using video conference software should be considered as an alternative to a face to face consultation when appropriate.
- If the surgeon considers it appropriate, a further face to face consultation either on the day of surgery or prior to surgery may be required.
- Virtual consultations may be recorded and if that is the case, the patient should be made aware of the recording at the start of the consultation. The verbal consent of the patient should be recorded as part of the consent to record.
- All patient records, including video recordings form part of the clinical records and should be stored according to clinic IT policies which will include the ability to export all records for patient access.
- Electronic signing of documents should be encouraged using legally binding systems such as Adobe E-sign.

Clinic cleanliness:

- Consider deep cleaning the clinic before commencing clinical work if the clinic has been closed for a protracted period of time and has not been cleaned as a result of coronavirus lockdown.

Reception area

- Consider keeping the windows and doors of the clinic open for better ventilation apart from the theatre complex.
- Clinics should consider using sticky pads for shoe hygiene or shoe coverings to reduce outdoor contamination.
- Clinics should consider one way systems of patient flow to minimise risks of personal interaction
- Patients should be encouraged to use hand sanitising facilities on entry to the clinic.
- A clinic may choose to only allow patients to enter the clinic using masks provided by that clinic and may consider its own patient mask policy implementation procedure.
- The aim will be to minimise patient presence in reception

- If patients arrive early for their appointments, they should be politely asked to leave and to return at the time of their appointment
- Screening forms must be completed and checked prior to every face to face appointment
- Patients should wear face coverings during their time in the clinic as far as possible
- If seating required, patients should be directed where to sit, aiming to ensure 2m distancing
- A perspex screen should be in place to act as a barrier for patient interaction
- Additional wearing of mask and eye protection (reusable PVC glasses or face shields) may be recommended by receptionist
- All seats should be wiped after patients have left
- Reception desk, door handles, computer keyboard to be wiped (as above) at regular intervals throughout the day
- Patients should be advised of personal hygiene including that related to masks
- Deliveries: these should be received wearing gloves and signed for as required. Ideally the delivery item should be removed from its box as soon as possible and put away as appropriate. The box should be disposed of as well as the gloves used to handle it.

Toilets

- Toilet seat and handle should be wiped with wipes before and after use
- In addition, sink taps should be wiped after use
- Patient toilet to be inspected and toilet seat, flush, taps and door handles to be wiped down three times during the day with wipes by Front of House
- Patients should minimise the use of public toilet facilities to reduce the risk of cross infection and contamination.

Additional end of day cleaning

A cleaning rota will be created to assign each staff member to be responsible for a particular area of the clinic or items of equipment every day

- Plastic goggles – wash in warm soapy water in a clinical sink
- Face shields – wipe down with appropriate antiseptic wipes
- Scrubs to be put on a high temperature wash and then air dried

Clinic attendance at the non-operative area of the clinic

- Patients should
    - answer a screening questionnaire.
    - be encouraged to complete questionnaires online.
    - wash their hands or use hand sanitiser on entering the clinic.
    - be encouraged to attend wearing their own masks or cloth facial coverings.
    - be able to see a health and safety poster entitled “Staying COVID-19 secure in 2020” produced by the health and safety executive
- The clinic may wish to take the surface temperature of all personnel that enter the clinic, but the value of this approach is open to scientific criticism.

- All activities should be performed to limit queues. All personnel within the clinic should try and remain at least 2 meters apart.
- Hand shaking and hugs should be avoided.
- Coughing should be performed into the elbow or into a disposable tissue.
- Patients should distance themselves from one another.
- Clinics should consider placing 2 meter marks on the floor to help patients maintain social distancing.
- To reduce the risk of infection spread through surfaces, clinics should consider removing items that patients can touch, such as magazines, coffee machines, etc.
- Clinic personnel may wish to consider wearing type IIR masks, surgeons' masks or FFP2/N95 masks. There is no need to wear FFP3 masks although any staff member wishing to wear such a mask should not be discouraged.
- Where possible, personnel should be shielded from close patient speech with masks, visors, or barriers at appropriate places.
- Some clinics may wish to test patients with PCR swabs or antibody tests at an appropriate time prior to surgery to ensure results are available on the day of surgery.
- Clinics should constantly be mindful of cleaning hard surfaces with antiseptic wipes at frequent and regular intervals. Some busy clinics may wish to employ cleaning staff.
- Clinics should consider having multiple hand sanitising dispensers around the clinic.
- Universal masking is currently recommended by the CDC in hospitals as well as general masking in public when social distancing is not feasible/possible..

Day of surgery and on the run up to surgery

On the day of surgery, there will be pre-operative, intra-operative and post-operative points of care of the patient.

Pre-operative considerations

- For several days prior to surgery, patients should be encouraged to self-isolate to reduce the risk of infection from their social and professional contacts.
- Patients should avoid taking public transport to the clinic and if they have to do so, they should wear appropriate PPE such as a FFP2/N95 mask.
- Arrival times of patients should be staggered to reduce crowding in waiting areas.
- When attending the clinic, patients should try and maintain the guidelines for attending the non-operative area of the clinic.
- Patient relatives and friends should not attend the clinic unless necessary.
- Patients should be screened with a questionnaire and standard vital sign observations taken, including a temperature after a suitable time for temperature stabilisation, noting that the patient will have entered the building from outside where the ambient temperature may

have an impact on the surface temperature of the patient. If patients have any signs of infection, tests should be repeated and consideration made to reschedule surgery.

- Patients should be consented for risks of COVID-19, using a form similar to that produced by CAPSCO.
- Patients with co-morbidities are more likely to die from COVID-19 compared to otherwise healthy patients. Accordingly, the threshold for performing elective surgery on patients with multiple and significant co-morbidities should reflect the increased risk of COVID-19 sequelae in this population. According to the CDC, risk factors include
    - Asthma - Moderate to severe only
    - Chronic Lung disease – COPD. Pulmonary Fibrosis, Cystic Fibrosis
    - Diabetes
    - Serious Heart Conditions – Heart Failure, coronary artery disease, congenital heart disease, cardiomyopathy,
    - Chronic kidney Disease – Dialysis
    - Severe obesity – BMI > 40
    - Age - > 65 years
    - Immunocompromised – Cancer treatment, transplant including bone marrow, immune deficiency, HIV with low CD4, medication causing immunosuppression including long term steroids.
    - Liver disease – Cirrhosis
- Risk stratification:
    - Low risk: <65 years with no risk factors
    - Medium risk: >65 years with no risk factors
    - Medium risk: <65 years with 1 risk factor
    - High risk: >65 years with 1 risk factor
    - High risk: <65 years with 2 risk factors
    - Very high risk: all patients with 3 or more risk factors
- ASA grades: Aesthetic surgery during the coronavirus crisis should only be performed in patients who are graded ASA I or ASA II
    - ASA I: A normal healthy patient. Healthy, non-smoking, no or minimal alcohol use
    - ASA II: A patient with mild systemic disease. Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30 < BMI < 40), well-controlled DM/HTN, mild lung disease
    - ASA III: A patient with severe systemic disease. Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of

ejection fraction, ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stent
    - ASA IV: A patient with severe systemic disease that is a constant threat to life.
    - ASA V: A moribund patient who is not expected to survive with the operation.
    - ASA VI: A declared brain-dead patient whose organs are being removed for donor purposes.
- Serious consideration should be made by surgeons to split multiple procedures into separate operative procedures. Morbidity significantly increases after 3.13 hour operating time with the exception of facelifts. Surgical complexity needs to be considered in the context of surgical time. (Krista L. Hardy, BS, Kathryn E. Davis, PhD, Ryan S. Constantine, BS, et al. The Impact of Operative Time on Complications After Plastic Surgery: A Multivariate Regression Analysis of 1753 Cases, Aesthetic Surgery Journal, Volume 34, Issue 4, May 2014, Pages 614–622)
- Options for patient screening include: health questionnaire, pre-operative blood workup to include FBC to identify COVID-19 related alterations such as leukocytopenia and lymphopenia, PCR testing, Chest X-ray and low dose chest CT-scan. Realistically, for private clinics in the context of cosmetic surgery, it is likely that a health questionnaire, possibly with the addition of blood work will be used, and this is likely to be sufficient.
- ISAPS recommends that all patients who decide to have surgery should be tested before planning surgery. PCR remains the gold standard for testing for COVID-19 in the pre-symptomatic or asymptomatic patient. However, ISAPS also realises that PCR screening will not be available in every country. CAPSCO therefore advises this to be a consideration for the policies of its members' clinics.

Intra-operative considerations

- Personnel should avoid entering the operating theatre unless for good reason.
- Clinics should consider taking further advice from air system specialists to evaluate the current air exchange systems in the clinic theatre and to advise on optimum requirements.
- AGPs include: CO2 laser ablation, use of high speed rotating devices, electrocautery, and endotracheal suctioning, CPR, induction of anaesthesia, ventilation, bronchoscopy, open suctioning of airways, piezo-electric saws and burrs, dermabrasion, and so on.
- Coronavirus infects mucous membranes and respiratory epithelium. These two considerations should be taken together when making decisions on PPE requirements for theatre staff. Accordingly, CO2 ablation of the skin will produce an aerosol of skin cells only which will not be infected with coronavirus. However, CO2 ablation of the larynx will produce aerosol which may include any respiratory viruses. Additionally, although electrocautery produces aerosols, again this is highly unlikely to contain coronavirus for most elective cosmetic plastic surgery procedures.

- it is imperative that laser smoke plume is evacuated effectively and to this end filters in smoke evaluators should be changed regularly
- For all aerosol generating procedures (AGP), full PPE should be considered by all theatre staff. This will include a FFP3 or FFP2 mask (or equivalent), eye protection, waterproof gown and gloves. Facial hoods may be also considered. Surgeons will choose their own level of PPE appropriate to risk assessments performed.
- For non AGPs, theatre staff should use appropriate PPE which may be of a lower protection standard.
- During induction and extubation, only personnel absolutely necessary to the procedure should remain in the operating theatre.
- The current CDC guidelines recommend N95s (the UK equivalent being FFP2) and eye protection, gowns, and gloves should be used in AGPs. Procedures "above the clavicle" are particularly noteworthy for increased risk.

The immediate post-operative period

- Patients may cough and produce aerosols during the immediate post-operative period
- Personnel in the Post Anaesthetic Care Unit (PACU) should wear appropriate PPE being mindful of aerosols being generated by the patient being cared for.
- If a patient coughs near the face of a PACU staff member, that staff member should consider changing the potentially contaminated PPE.
- Patients should be discharged from their rooms directly, bypassing reception. All instruction, medications and prescriptions should be available at the time of discharge in the patient's room.
- Clinics should be mindful of limiting multiple personnel changes during the episode of patient care as far as practicably possible to minimise the number of personnel caring for a patient during a single sub-episode of care.

Post-operative patient advice

- After discharge and the patient leaves the clinic, they should receive a post-operative aftercare sheet specific to COVID-19. This document has already been produced by CAPSCO. The principles behind this advice is to try and ensure patients are not infected with COVID-19 at a time when they need to recover from what is usually elective surgery.
- Teleconsultations for post operative consultations should be used when possible.
- Dressing care should be performed in the context of appropriate PPE for dressing staff. Dressings nurses should consider wear masks such as surgical masks, type IIR masks, FFP2, gloves, gowns and/or eye protection, all of which should be available for use by clinical staff.

Conclusion

PPE, social (and professional) distancing, protection of patients and staff are all key aspects of a surgical clinic returning to work, following lockdown from the coronavirus pandemic. This document has laid down certain guidelines that clinics may wish to follow or use as a guide when producing their own policies and documentation.

References

In producing this document, CAPSCO members have provided and have read the following documents and publications. We are grateful to have had sight of these documents (listed in no particular order) and to the demanding work that has been put in, to allow us to read and consider these documents while producing ours: Branch standard proposal for the reopening of aesthetic plastic surgery while containing the spread of covid-19 during the period from April 20th 2020 until normalization, Amin Kalaaji, MD, PhD. President of the Norwegian Society of Aesthetic Plastic Surgery, April 22, 2020

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