BAOMS – Guidance for the care of OMFS and Oral Surgery patients where COVID is prevalent

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Background

Published evidence from China and Italy and current experience in the UK is that surgeons and physicians who, by the nature of their practice, must place their face close to the unmasked face of a patient are at high risk of contracting COVID-19. Some of the most seriously ill UK patients, on ECMO and being ventilated, were fit and well ENT colleagues infected by patient contact. In Italy Ophthalmology and ENT are recognised as high risk specialties. OMFS and Oral Surgery fall within the same high-risk category.

For close patient contact, a standard surgical mask is not sufficient. A FFP3 mask, eye shield, apron and gloves are essential.

Aims

1. To ensure continued care for OMFS oncology patients, trauma and emergencies
2. To ensure staff safety
3. To reduce bed occupancy in line with DoH covid-19 plan
4. Contingency plan for redeployment of staff to other areas as required

BAOMS Four Recommendations - PPE, Avoid, Restrict and Abbreviate.

Personal Protective Equipment - PPE

FFP3 mask, eye screen, apron and gloves are essential for all close face to face contact with patients for exam and treatment. This will remain the case until the current trajectory of COVID has flattened. To do otherwise is to be playing a very high risk health lottery.

For high risk or known COVID patients or invasive procedures, NHSE guidelines should be followed.

The limited supplies of PPE means that any patient who does not need to come to hospital should not.

This is why we must **Avoid, Restrict and Abbreviate.**

Avoid

Avoid clinics: All routine clinics/minor operating should be cancelled. This requires triaging of new and review patients for life or limb threatening conditions, an active decision based on priorities and recording this in the notes. Advice from BAOMS regarding clinics is on the BAOMS website. Head and neck cancer care advice has already been published by BAHNO.

Avoid contact: Telephone reviews for all outpatients who do not need urgent and active treatment should be the first approach. Patients should only come to the hospital for urgent assessment and treatment – emergency care and time limited conditions.

Avoid transfer: where OMFS units link to spoke hospitals, these spokes should not transfer patients without senior discussion. Focussing resources should reduce hospital visits for patients.

Avoid surgery: especially non urgent surgery as much as possible but particularly where aerosols are generated: eg. power tools whether water cooled or not, tracheostomy unless essential.

Restrict

Restrict the number of visits: for patients who must be seen – cancer, emergencies, urgent time limited conditions – the patient pathway should be “see, treat and discharge” where possible. The numbers of visits must be kept to a minimum.

Restrict the generation of aerosols: body fluids contain virus particles. The avoidance or minimisation of aerosols is importance to reduce the transmission of COVID to health care staff.

Restrict staff numbers: so that skeleton staff is available on site with a second tier available to cover for sickness, isolation and tiredness

Abbreviate

The length of contact determines the length of potential exposure of healthcare workers. All clinical episodes and surgery should be as brief as possible.

Abbreviate waiting times: patients should not wait for treatment in waiting rooms. They should be treated promptly. Provision for vulnerable groups (elderly and comorbid pts who DO need care) should be made to maintain social distancing.

Abbreviate treatment: undertake the most efficient, short duration intervention.