

RESUMPTION OF OPD ACTIVITY, IN HSE HOSPITAL GROUPS. **OTOLARYNGOLOGY HEAD AND NECK SURGERY**

Introduction

The interim guidance for the return of non-COVID Outpatient activity issued on the 29/04/2020 by the Acute Hospitals Division of the HSE suggested a requirement for service redesign (systems engineering) to ensure lean principles/flow processes are applied. There is a need for risk management and quality assurance/improvement process to underpin service reconfiguration.

There is a requirement for clinicians to:

1. Review all planned attendances to OPD in context of option for care provision in Primary Care settings or integrated care.
2. Review all planned OPD attendees for option to triage to a virtual clinic review.
3. Consider mechanisms to support single patient visits where patient is attending multiple providers or having laboratory and radiological tests undertaken (“One Stop Shop”).
4. Deliver OPD services by appointment only, patient to remain in their car until just before appointment, as there will be minimal seating area.
5. Pre-review and cohort all required OPD attendees (per specialty criteria) to a designated provider (Consultant, SpR, SHO, Intern, Student, AMP, CNS, SN). Clearly record in the OPD appointment system, a designated clinician per patient and other staff per clinic. Update if changes occur on the day of clinic.
6. Pre-assess all OPD attendees (with appropriate supports for vulnerable groups) for symptoms – fever, cough, shortness of breath or lethargy, confusion, loss of appetite, unexplained change in baseline condition (also require symptomatic members or close contact with confirmed cases amongst social circle).
7. Consider split clinics, extended days, extended working hours and workforce planning.
(Contractual implications to be agreed with individual consultants). (IIORL/HNS)

Patients will be required to:

1. Commence social distancing two weeks in advance of OPD visit with attention to hand hygiene.
2. Comply with requirements for assessment for signs and symptoms of COVID-19 to minimize spread.
3. Hand sanitise and wear a face mask during visit, if tolerated.

All staff should have their temperature checked and assessed for symptoms when coming on duty. All staff to wear surgical masks and appropriate PPE according to HPSC, HCW, PPE guidance.

The Model of Care for Otolaryngology and Head and Neck Surgery published in February 2019 recommended to improve Outpatient services, there was a requirement to institute new ways of working such as the introduction of: One Stop Clinics, by delivery of services by Health and Social Care Professionals (HSCPs), Advanced Nurse Practitioners (ANPs), Clinical Nurse Specialists (CNSs), Vestibular Physiotherapists and Speech Therapists.

The NTPF waiting list data published on the 02/04/2020 revealed that there are approximately 65,000 patients on the waiting list for Otolaryngology Head and Neck Surgery.

In order to cope with this workload and the unmet need of patients not yet put on the outpatient waiting list since the commencement of the COVID-19 pandemic, introduction and support of these new ways for working is imperative.

Health Care workers, in general have a three times higher risk of infection than the general public, based on data from China and Italy. (Ref 1).

The viral load is concentrated in the upper airway in the early stage of the disease (Ref2) Otolaryngologists, are at risk, and were among the most affected Health care workers in Wuhan (Ref 3)..

Safety recommendations for each intervention should be based on risk analysis and safety recommendations published in the literature which are peer reviewed and guidelines recommended by specialty groups.

Outpatient activity in Otolaryngology /HNS has a large procedure base (table1). This Ambulatory care is not recorded on the HIPE coding system, 1 in 3 patients require some form of intervention.

TABLE 1.

1. Functional Endoscopic Swallowing Test.
2. Stroboscopy.
3. Nasendoscopy.

4. Insertion of Nasal Pack.

5. Reduction of Nasal Fracture
6. Drainage of Peritonsillar Abscess.
7. Microdebridement of ears
8. Myringotomy and grommet insertion in adults
9. Removal of foreign body from the ear canal
10. Fine Needle Aspiration of lymph node/Thyroid nodule
11. Drainage of neck abscess
12. Change of Tracheostomy Tube.
13. Insertion of voice prosthesis.
14. Nasal electro-cautery.

SCHEDULING OF OUTPATIENT ATTENDEES.

Outpatient infrastructure

Scheduling will be dictated by the space available in the outpatient waiting area, which varies from hospital to hospital. ENT services are provided in thirteen hospital sites, plus the two Paediatric hospitals in Dublin. Satellite clinics are held in ten separate sites. The facilities vary from large units that have designated rooms for procedures, with separate consulting rooms, to satellite clinics, frequently held in small poorly ventilated rooms, not suitable for endoscopic procedures.

If infrastructure permits, it is preferable to designate a space/room where potential AGPs are performed and if possible a separate area designated for donning and doffing.

The number of patients scheduled per session will be dependent on the clinical case mix (one third of workload in general ENT is in children), the number requiring endoscopy, the availability of PPE's and facilities to decontaminate scopes in the outpatient area.

It is not advisable to perform Nasendoscopy in a non-ventilated room. The minimum requirement is access to an open window. Instillation of an air exchange or exhaust system enhances HCW safety and significantly improves patient turnabout time. (Ref 5)

Virtual Clinics (telephone/video) should be held in a designated space where privacy is guaranteed (not in an open reception area).

Virtual clinics should be set up on the hospital administration systems, similar to the regular outpatient clinics.

Electronic links to the Radiology and Pathology reporting/booking systems are crucial for the efficient running of virtual clinics.

The number of patients scheduled per session will also be dependent on the ability of the Audiology service to safely triage patients on the same day of attendance . see. (HSE, Audiology Guidelines.)(Ref6)

To minimize face to face the consultation time and return visits, appropriate diagnostic investigations i.e. Radiology, should be arranged virtually (if clinically safe),prior to the scheduled attendance.

MICRODEBRIDEMENT OF EARS:

3,701 Procedures(NQAIS data 2019).

This procedure is carried out utilizing a binocular microscope.

Stimulation of the ear canal can induce a secondary cough reflex with a possibility of aerosol generation .To date there is no data in the literature to determine this risk . It is advisable for the patient to wear a face mask..

Microsuction of the external ear canal (for wax removal / treatment of otitis externa) is not considered an aerosol generating procedure as the skin of the canal does not harbor virus.

It is not possible to view through the microscope lens with a visor /goggles, the examiners eyes can be protected during this procedure by the availability of transparent plastic drapes to cover the microscope and the patient.

The examiner should wear, gloves , and standard fluid resistant surgical mask.

If the tympanic membrane (ear drum) is not intact, because the middle ear mucosa can be

virus bearing , there is potential risk of transmission , it is advised that a FFP2 or FFP3 mask be worn.

The filtering status of the suction equipment should be checked to ensure aerosol is not been vented into the room . A fenestrated suction tube should not be used.

VIRTUAL CLINICS:

Telephone Contact

Telephone contact has been utilized by the majority of departments in the country since the commencement of the COVID-19 pandemic, mainly for triaging patients who are already

on the outpatient waiting list and it can be readily availed off for follow-up of post-discharge patients and discussion of test results.

Triaging of new referrals is possible ,validated questionnaires improve consistency nationally. The guidelines regarding virtual clinics advised by the RCSI, HSE. ENT UK, and Medical Protection Society (MPS) should be followed. (Ref7).

The virtual clinic needs to be structured and well supported by the hospital administration, with availability of Radiology , Pathology tests, and secretarial support. These clinics can be either dedicated sessions or run parallel to a face to face clinic. A proportion of the workload could be taken over by Advanced Nurse Practitioners or Clinical Nurse Specialists, provided it is within their scope of practice.

TELE HEALTH:

Using internet-based technologies to support remote consultations have the potential to provide an alternative to clinic-based visits in Otolaryngology. Potential areas in the specialty include.

Assessment of the dizzy patient, Video consultation can used to an advantage when combined with a validated questionnaire. As outlined in the Model of Care and demonstrated in projects in the Mater and Beaumont, consultation and treatment can be carried out by a vestibular Physiotherapist with specific expertise in balance disorders following guidelines under the governance of a consultant (Ref8).

Hearing loss/Tinnitus. When combined with the “Sound Scouts” app which has been validated by the Australian government for hearing screening in both children and adults.(Ref 12), a ,significant proportion of patients may not require” face to face” consultation, and can be directly referred for rehabilitation ,appropriate investigation, or consultation with the surgeon, if “Red Flag “ symptoms are present .This strategy is in keeping with the recommendations in the Model of Care of Direct referral to Audiology, which in proof of practice studies has proven to be safe, efficient and cost effective.(Ref9)

Neck lump/swelling.

A tele-conference would determine the anatomical site of the lump and facilitate the Consultant to make the decision regarding the APPROPRIATE radiological investigations prior to attendance at the clinic for face to face consultation.

SINO-NASAL DISEASE, patients referred with nasal obstruction/ discharge , facial pain , anosmia can be sent a validated questionnaire (SNOT) and at consultation their radiological findings can be explained , information brochures and surgical information sheets discussed and treatment options outlined.

SWALLOWING DISORDERS, are assessed by Functional Endoscopic Swallowing Test (FEES),).

Tele – communication can be utilized to liaise with the speech therapist in the community to facilitate the patients rehabilitation locally.

Head /Neck Cancer, video recording of tumor site can be relayed to allied health professionals for MDT Conferences and decrease the necessity of the patient attending multiple sites. (Ref10)

Challenges to distance Consultation.

The quality and integration of the IT network is essential .(integration of PACS , McKesson etc).

Allowance for the patients IT skills ,those with a disability, especially hearing impairment and patients who do not have English as their first language, will pose a challenge.

Latency in speech and overlapping conversation can be overcome by user training.

Use of patient information brochures, validated questionnaires and procedure specific consent forms greatly enhance the use of distance consultation.

A very large proportion of patients in Otolaryngology require face to face consultation, however telehealth systems will minimize outpatient visits and decrease significantly the return and non - attendance rates.

SUMMATION OF RECOMMENDATIONS FOR PROVISION OF OTOLARYNGOLOGY, HEAD AND NECK SURGERY OUTPATIENT SERVICES IN THE COVID ERA

patients should be contacted prior to attendance, via virtual link (telephone/Tele Health) to determine if they have Covid-19 symptoms/contact or require attendance at a face to face consultation and if appropriate investigations are required prior to consultation.

Every effort should be made to have appropriate investigations performed before the patient attends the clinic to minimize the time of attendance and the number of visits to the outpatients.

Scheduled attendance will be required in order to ensure social distancing in the outpatient waiting area.

Protocols for entry / exit and triaging to the appropriate room,(treatment or consultation) should be established for the outpatient area .Ideally there would be a one way system.

Surgical masks and alcohol gel/spray should be available in the patient waiting area.

Where possible Perspex screens should be established at the reception and consultation desk .

Parallel sessions can take place where patients are triaged to a consultation area where no invasive procedure is required or to the treatment/diagnostic area where specific interventions are required which involve the use of PPE .

If the treatment room is fitted with an exhaust/ventilation system, aerosol/droplet dispersion will be minimized. this will facilitate patient turnabout.

Contagion risk assessment should be carried out for the common outpatient procedures ;Microscopic ear examination,Nasendoscopy, Reduction of nasal fracture, Epistaxis control, Fine Needle Aspirate, Epley Maneuvre Functional Endoscopic Swallowing Test.

If feasible a protected space should be set aside for the decontamination of fibre-optic endoscopes.

If practical , a designated area for “ donning and doffing” should be assigned.

It is essential that the clinic is provided with sufficient number of nasendoscopes and video stack systems to facilitate efficient patient turnover.

Transparent plastic drapes help to protect the surgeons when performing microscopic ear examination/treatment are an option.

Ideally each outpatient service should have an ANP/CNS whose duty it is to ensure efficiency and safety in running of the outpatient triage system.

Resumption of Surgical Activity. Otolaryngology, Head/Neck Surgery.

This will be contingent on.

Prevalence of Covid -19 in the community.

Availability of Inpatient and ICU beds.

Availability of Anaesthiologists.

Availability of appropriate PPE

Availability of appropriately trained personnel (nurses trained in tracheostomy care).

Ability of Acute hospitals to triage patients into Covid , non Covid pathway.

If patients are triaged to private hospitals, agreed selection criteria, pre- admission testing , peri-operative and discharge pathways are established.

Governance structures to be established to ensure continuity of patient care.

Pre – Admission patient requirement, Cocooned for 14 days .Negative Smear test within 48 hrs . CT Thorax if ICU admission required.

Consent; the guideline regarding *Surgical Consent in the Covid – 19* era should be followed.

Surgical Prioritization . Intercollegiate Guidelines April 20.

Level 1a. Emergency (within 24hrs)

Acute Airway obstruction.

Penetrating Neck injury.

Button Battery Ingestion.

Life threatening middle ear infections .

Life threatening Sinus infections.

Level 1 b. Urgent (within 72 hrs)

Severe Epistaxis.

Sinus Surgery for impending complications.

Acute Mastoiditis/ Middle Ear infection not responding to medical management.

Facial Palsy , secondary to Trauma / Cholesteatoma.

Lymph Node Biopsy (suspected aggressive tumor)

Sepsis from Head and Neck not responding to medical therapy.

Level 2. (Surgery can be deferred for up to 4 weeks)

EUA and Biopsy Suspected tumor.

MDT directed surgical management of Head and Neck Tumors.

Cochlear Implant post- Meningitis.

Peri-Lymph Fistula .

Organic Foreign Body .

Level 3 (can be deferred up to 3 months.)

CSF LEAK.

Sinus Mucocele.

Cochlear Implant Profound Pre Lingual Loss.

Level 4 (Can be deferred more than 3 months)

Routine Rhinology, (nasal polyps)

Cholesteatoma (not complicated).

Chronic Otitis Media (not complicated)

Vestibular Surgery (Sac Decompression.)

Meatoplasty.

Cochlear Implant (other)

Non Organic Foreign Body.

Grommets.

Nasal Fracture (uncomplicated)

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Nash Patil.

President Irish Institute of Otorhinolaryngology, Head and Neck Surgery

Michael WALSH

Clinical Advisor , NCPS.