BAAPS

Planning for the Resumption of Elective Aesthetic Plastic Surgery – BAAPS Guidance

18th May 2020 – Version 1

In order to focus healthcare resources on managing the COVID-19 pandemic, aesthetic plastic surgery and non-surgical treatments have been stopped. With the COVID-19 rates beginning to decline and the UK Government lockdown restrictions entering a phased period of relaxation, the current focus for an increasing number of BAAPS members and facilities is to prepare for the resumption of elective procedures. The timing of the resumption, which is also likely to be staged, will vary between members depending on the type of workload and available facilities. However, members are advised to closely adhere to any national and local NHS guidelines which continue to evolve and be updated.

This document offers a set of principles to help surgeons and minor operating facilities plan for the resumption of elective aesthetic plastic surgical care. Whilst many different models of working for our members exist in the UK private healthcare sector, we suggest members use this checklist as a guide to ensure these principles and issues have at least been considered. Understanding both the local facility capabilities (e.g., beds, testing, operating theatres) as well as potential constraints (e.g., workforce, supply chain), while monitoring the potential for subsequent waves of COVID-19 will continue to be important.

We have focused on the return of non-surgical treatments and local anaesthetic (LA) minor operations in predominantly outpatient facilities, which are often under the direct control of BAAPS members. However, we are aware that many members can influence their local hospital operational framework and hence much of this could be used to impact on the longer-term horizon of a return to elective general anaesthetic (GA) procedures in aesthetic surgery. The document is separated into three distinct sections with five subsections in each, based on the patient journey. Each subsection should be considered before elective treatments and surgery may be safely resumed. Evaluating and addressing each of these will help members and facilities to not only optimally provide safe and high-quality surgical patient care, but also to ensure that aesthetic plastic surgery resumes, and does not stop again.

We have also provided a number of potentially useful documents and templates as appendices. These documents are provided as examples and are for reference purposes only. They have not been produced with any legal or indemnity company approval and, as such, it is vital that any BAAPS member who wishes to use a version of these documents seeks specialist advise.

Finally, many national and international organisations have produced similar guidance on how to safely return to surgical activity. These resources continue to be updated and we would urge all members to also utilise these combined resources where possible. We have summarised many of these resources and provided links in Appendix 1.

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Document Sections

1. PREPARING TO RESTART

1.1 Timing, contact tracing & testing

At the time of writing, the UK Government has begun to relax some elements of 'lockdown'. However, different regions of the UK vary in their exact instructions and confusion exists in different business sectors, not least non-COVID-19 elective healthcare such as aesthetic plastic surgery. What is clear is that our sector will not return to normal for several months and this is expected to be a phased return. Some elements of practice, such as face-to-face consultations in low risk groups will be possible before high risk procedures may be contemplated. You must ensure compliance with UK Government regulations and local healthcare provider recommendations. Many members work within private healthcare providers with their own clinical governance structures in place. The Royal College of Surgeons of England have also produced guidance (Appendix 1) to help with the planning and prioritisation of cases. These resources will be updated regularly and it is vital that all members frequently monitor these publications to keep their patients safe.

You should establish and publish (written or emailed documentation given to all patients and added to your website where possible) a plan for your practice moving forward so that patients are aware of the risks and the procedures that you have put in place to mitigate them. This plan should include your policy on testing and the triage of patients.

All patients coming to the practice should be screened for COVID-19 symptoms and an obvious contact. This should be recorded and will normally consist of a simple questionnaire (an example is given in Appendix 2). Such questionnaires should be completed by the patient before travelling to the practice and should be stored in the patient's paper or electronic files.

The NHS is currently trialling a contact tracing App for the post lockdown period. This is likely to form an integral component of your planning. For example, your local policy might include the compulsory use of this App and for all patients to be symptom and contact-free for 7 days prior to consultation, treatment or surgery.

In the first instance, Antigen testing will form a vital element of any patient journey. Rapid testing for COVID-19 infection through real-time reverse transcription polymerase chain reaction (RT-PCR) testing is likely to be mandated for all patients undergoing planned surgery with or without mandatory pre-operative self-isolation. You should develop a local diagnostic testing policy for your symptom-free patients. For example, you may recommend testing 48 hours before procedure, interval self-isolation and then repeat testing at the point of care (day of treatment or surgery). An example of a pre-treatment schedule is given in Appendix 3, although you should comply with local policies if you are working within a private healthcare facility not under your own management and governance. Currently most pre-assessment guidelines in private hospitals contracted to the NHS including pre-operative reported CXR and subsequent spiral CT if suspicious, plus baseline bloods and CRP.

You should also develop or be aware of the diagnostic screening testing policies for health care workers. With near-future relaxation of physical distancing, local incidences may increase particularly among health care workers. Therefore, as we return to more normal working patterns, screening and

testing policies and planning for staff should be considered in greater detail. For example, you may wish to test your office and theatre staff once per week and this should be included in your policy.

Consider false negative test rates and the need for retesting. False negatives have been reported as high as 30 percent. Guidelines for potential retesting in negative patients might be considered. A particular challenge to health care worker safety is our current lack of understanding of duration for transmissibility of the virus in either asymptomatic COVID-19-positive patients or individuals who have recovered from a COVID-19 illness. There is evidence that even after respiratory samples are negative in patients who have recovered from a COVID-19 illness, viral RNA remains in the stool for >30 days. The clinical significance of faecal RNA is not well understood.

Although several antibody tests are now becoming available in the UK, it is unlikely that there will be a highly sensitive and specific antibody test available for several weeks. When available, this should aid in patient selection moving forward. In the interim, reasonable methods of determining risk versus benefit to the patient and public health in all facilities, inpatient and outpatient, will be required in order to progress the care of patients waiting for surgery.

Surgeons should also be involved in institutional policymaking since risk to patients and staff varies with the type of procedure, the patient's condition, local circumstances, and over time. Some surgeon discretion is necessary and should be permitted.

1.2 Documentation, consent and indemnity

It is vital that all providers communicate their up to date policies with respect to COVID-19. Clear messaging and communication will be essential. In particular this should set out patient triage, testing, PPE use and other risk-reduction steps in place, and post-treatment care pathways, including what to do in the event of a new COVID-19 diagnosis on arrival at your practice or in the post-operative period. This documentation should be sent to all patients at the time of new patient registration or before established patients return to your practice. Where possible it should also be displayed on your website and link to the local policies of the institution within which you are working.

It is also important to consider sending all communication, including advice leaflets and procedure information sheets, to patients electronically, thus reducing physical paperwork as much as possible to avoid the potential spread of the virus from these common contact surfaces.

Specific COVID-19 consent should be gained prior to face-to-face contact and prior to any invasive treatment. This should be separate from any procedure-specific consent, should be documented in the patient records and a copy given to the patient. If you do not have access to a local institutional consent form then you should create your own. An example is provided in Appendix 4 of this document.

You must also consider adjusting your procedure-specific consent and pre-operative information in light of the altered circumstances that the current situation forces upon our activities. For example, there are practical issues to wearing PPE during a procedure, and if you feel that you could carry out the procedure to a higher standard without PPE, then your patient should be aware of this and given the opportunity to delay the procedure.

It is vital that you check with your indemnity company to ensure that you are covered to assess and treat patients during the pandemic and whether there are any limitations to this cover. If you have created your own consent forms or used the example given in Appendix 4, you should also communicate this with them to gain approval for its use.

1.3 Setting up your practice and training staff

Before restarting work, you should consider the physical layout of your practice and the patient flow. Consider waiting room spacing, common areas, link corridors and toilet facilities. Where possible, social distancing should be maintained at 2m. There should be separate access and spaces for administrative staff if possible. You should also consider providing only clinical care within the practice and running all administrative work remotely away from the physical healthcare space.

Not only should you consider the layout but you should also consider additional protective steps to aid patient care including plastic screens for some staff areas, new hands-free dispensers of sanitising alcohol gels, easy access to masks for patients and floor markings to demonstrate clear distancing. You should schedule more time between patients and consider only having one patient in the practice at a time. You should also instruct patients to attend alone where possible and to avoid bringing a family member or friend into the patient areas.

Before seeing your first patient you should personally undertake a walk-through with the staff to experience the patient flow and understand the potential areas of danger.

It is likely that during the lockdown, members of your team will have been seconded to the NHS and will be trained in the principles and procedures involved in treating patients during this time, including the appropriate use of PPE equipment. You must check that all members of the team that will come in contact with patients are trained before the restart. This training may be offered by your institutional healthcare provider. If it is not, then you should carry out your own training or gain access elsewhere.

1.4 Procuring supplies, setting up your treatment areas & minor theatres

In the early phases of the pandemic, the availability of PPE became a significant logistical and political issue. It highlighted the fact that at such times, none of us can work in isolation and we need to consider that all local, national and international healthcare services will have increased demands simultaneously. During the restart and ramping up similar demands will be made on all areas in which we practice and we need to prepare for this. This includes medications, equipment, implants and adequate staffing. Ensure a supply of products is available from traditional or new vendors as well as vendor support as necessary. We must also consider the demands on the local supply chains and logistic facilities such as delivery services. Hence, the BAAPS recommend that all equipment should be in place with a 14-day reserve, before any treatments or procedures are scheduled. Members should also be aware of their local PPE availability for their associated healthcare workers and procedures. You should also review on a regular basis, the needs of the local NHS services in the event of a second wave of COVID-19 infections as it would be inappropriate to prioritise aesthetic surgical procedures above COVID-19 care should the situation change.

Few members will manage their own theatre for sedation or general anaesthetic use. As such, this guidance will not go into detail regarding the need for pre-surgery admission, anaesthetic support, and post-operative hospital stay. Please refer to your local private hospital for advice in this area and ensure your local contract agreement with your NHS provider is still valid during these times of stress to the entire service.

However, many members will run their own minor theatre or treatment area for non-surgical injectables and procedures under local anaesthetic. As with the practice set up, you should consider all spaces and patient flow. You must ensure the same processes are applied and undertake a dummy run-through with your staff. Ideally you should allow for a recovery period in the same area as the procedure and allow for additional time in your scheduling for this.

1.5 Prioritisation & triage

The NHS in combination with the surgical colleges have produced a prioritisation scheme (Appendix 1) dividing patients into four categories. Aesthetic plastic surgery procedures fall into the non-urgent category that could wait for at least 3 months. Given the increasing demand for surgical services as we return to elective surgery and the limited facility resources available, it is unlikely that elective aesthetic plastic surgery will take place in the near future in private hospitals that provide a broad range of specialities. However, focused aesthetic plastic surgery units may be in a different position. As long as all additional risks have been communicated with patients and resource implications in terms of equipment and support staff such as nurses and anaesthetists are considered, then the BAAPS supports restarting minor treatments and local anaesthetic procedures when it is considered safe to do so by the surgeon member.

There is limited data available but it does appear that patients who test negative pre-operatively but go on to develop COVID-19 in the post-operative period have less good outcomes (see section 3.3). Careful patient and procedure selection are therefore vital and it is unlikely that simply working through a waiting list will provide a safe approach during the return to a more normal working pattern.

Consideration should be given to deferring treatment in the higher risk patient groups, beyond the normal risks considered for the particular treatment or procedure. These high-risk patient groups include the elderly, patients with diabetes, malignancy, respiratory disorders such as severe asthma, and the immunocompromised.

Finally, consideration should be given to the anatomical region and type of procedure. Procedures around the aero-digestive tract and those that produce an aerosol (aerosol generating procedures or AGPs) are particularly high risk for virus transfer and should be avoided if possible. Although we recognise that some surgeons around the World have already started rhinoplasty procedures based on functional indications, we advise waiting until accurate data is available for these areas before commencing aesthetic surgery procedures. Similarly, it is important to reduce the complexity of aesthetic procedures where possible and reduce the operative time, hospital stay and recovery period. We therefore do not recommend carrying out complex multiple-site combined operations such as breast and abdomen concurrently.

2. TREATMENT & OPERATIVE CONSIDERATIONS

2.1 Patient logistics

You must consider the patient pathway for any treatment or minor surgery and protect your patients from any possible exposure to COVID-19. This should even include transport to and from the practice and advice to wear a face mask at all times if on public transport and during the practice / facility visit.

Advice given to patients will depend upon the nature of your outpatient or surgical facility and intended treatment or procedure. For example, if you are carrying out a procedure in the main theatre area of a hospital in which COVID-19 patients are being treated, then consider different entrances, registration centres and separate staffing. These additional steps may not be needed if you are working in an outpatient facility considered to be free of viral contamination.

Members should also review established team briefs and surgery checklists to consider the inclusion of additional steps such as the appropriate PPE availability and COVID-19-specific discharge plans. New documentation for these checklists may need to be created.

Although covered by most large hospital protocols, you should consider specific guidelines for those personnel who need to be present during intubation. Consider also the additional time needed for safe intubation and recovery in your surgical planning, typically adding another hour to any procedure.

2.2 Essential staffing

Members should ensure adequate staffing for their practice, treatment areas and minor theatre facilities. Due to the increased time needed to treat most patients, you may need to consider extended hours of working including evenings and weekends. You may need additional back up of staff to cover for illness and care provision. You should also consider contingency planning in the potential situation of newly diagnosed COVID-19 healthcare workers. This should include a new diagnosis in yourself and which potential colleagues will cover your absence from the practice.

All of these concerns are likely to create workforce staffing issues. You must therefore ensure coordination among surgery, nursing, administrative, cleaning and other staff members. You must also regularly review PPE policies to protect workers from a new infection.

Whilst having adequate staffing resources to run your practice safely, it is vital that only essential staff are present for the treatment or procedure. You should therefore review who is present at all times and clarify their roles. Excessive numbers of staff, such as trainees not needed to assist, should be asked to leave as they pose an unnecessary risk to patients and other members of staff.

Consider levels of stress and fatigue in otherwise healthy workers. Workers returning to work following a COVID-19 infection may especially be at risk of physical and emotional exhaustion. Additional staff may need assistance with childcare, particularly if working extended hours. Institutions may consider mitigating workforce shortages through creative staffing, which could affect the skill-mix of those present to help with the treatment or procedure.

2.3 Appropriate PPE

BAAPS supports the guidance already published by Public Health England (PHE), Public Health Wales (PHW), Health Protection Scotland (HPS) and the BAPRAS Guideline Interpretation (links to all are provided in Appendix 1). All procedures and appointments within larger private hospitals should also conform to their local protocols. Procedures undertaken within facilities owned by private individuals should have PPE policies written and available to patients. This advice is continually changing as new information becomes evident and with changes in the availability of PPE. It is important to maintain PPE levels sufficiently to deal with unexpected complications without unnecessary stockpiling (e.g., 14 days supply). All current PPE guidance assumes the provider to be susceptible to infection and asymptomatic patients to be potential sources of infection given high false negative antigen test rates. This advice may well change completely as antibody tests and potential vaccines become available. Equally as FFP3 masks become more readily available, their use may be recommended more widely. An example of the current suggested PPE for all clinical situations is given in Appendix 5.

Face-to-face clinic consultations that can be conducted at a professional distance of >2m require a water-resistant surgical mask (Type IIR) to be worn with a visor or appropriate alternative eye protection. Masks can be used for multiple patients during the same session. Visors/eye protection should be cleaned with anti-viral solutions between patients. Manufacturer guidelines should be followed specific to the eyewear available as some are not designed to be reused. Overshoe covers are appropriate to consider as an additional precaution.

Face-to-face consultations where 2m professional distance is not practical or where a physical examination is necessary, require a disposable plastic apron and disposable gloves, both for single use only. Masks and eye protection can still be for sessional use.

Non-surgical and minor local anaesthetic procedures above the clavicle should be considered higher risk of increased viral load similar to that of aerosol generating procedures (AGPs). The minimum PPE required would be a disposable plastic apron, disposable gloves, water-resistant surgical mask and appropriate visor/eye protection. FFP3 masks may provide better protection in these situations and should be considered. Procedural asepsis should not be compromised and sterility of protection should be maintained as usual. FFP3 masks may be appropriate for sessional use for procedures when covered with a single use water-resistant surgical mask.

For local anaesthetic procedures below the clavicle the patient should be asked to wear a surgical mask and a screen should be erected between the patient and the operative field. A water-resistant surgical mask for the surgeon and assistant/scrub nurse would then usually be considered sufficient.

Where possible, AGPs should be avoided and alternatives used. Examples of AGPs relevant to aesthetic surgery are given in Appendix 6. All AGPs require FFP3 or above filtered face mask protection with a mask that has been formally fit tested to that individual in addition to a fluid-resistant gown, two pairs of gloves and single use visors/eye protection. This should be worn by every individual in the treatment room or theatre at the time of the AGP. Individuals failing mask fit tests for all masks available should either use full-face respirators or not be present during these procedures. Those not wearing the appropriate PPE should remain out of the room for two air changes (20mins standard theatre ventilation, 4-6mins faster ventilation systems).

Surgeons and theatre staff should therefore either wear full PPE for GA procedures including FFP3 masks and be present in theatre at the time of intubation or wait for two air changes before entering theatre in a water-resistant surgical mask. PPE should otherwise be as previously described unless further AGPs are planned during the procedure.

Where contamination with fluids is considered likely, a fluid resistant surgical gown should be worn. Examples where this might be appropriate include liposuction with wet techniques or larger procedures with more bodily fluid exposure such as abdominoplasties and bilateral breast reductions. It should be noted that most FFP3 masks are not considered waterproof so need to be worn with an additional water-resistant surgical mask if body fluid splashing is anticipated.

All ward reviews require a water-resistant surgical mask for sessional use, visors/eye protection to be cleaned between patients, and single use gloves and a plastic apron. Nebulisers and high flow nasal oxygen are considered AGPs, so additional protection is required to review patients whilst receiving these.

All members of staff should be trained in donning and doffing techniques and should adhere to local protocols for performing this safely to minimise risks of desterilisation during donning and self-contamination during doffing.

2.4 Wide-ranging approach

Before restarting you must consider all steps in the treatment and minor surgery pathways being provided and take a more wide-ranging approach to reducing risk of both patient and healthcare worker exposure to COVID-19. Whilst we are lacking data in many areas, and until this data becomes available, it is prudent to act with caution. This includes:

- Changing of scrubs (not only PPE) for all staff following a procedure
- Increasing use of disposable equipment
- Consideration of the gas plume from cautery – the use of smoke evacuation with inline filters even in outpatients
- Suction devices with complete disposal containers rather than re-fillable inserts
- Consider air flow of the room and if possible use laminar flow (this must be considered against the risk of moving into a major hospital where such theatres exist but are more likely to be adjacent to COVID-19 positive patient areas)
- Specimen packing and pick-up protocol

2.5 Cleaning & decontamination

Thorough cleaning of the treatment area and minor operating facility will be required after each treatment episode. This will affect the type and amount of cleaning materials needed, the staffing allocation and the turnaround time between patients. Your treatment room and surgery schedule will need to be adjusted to account for this. Indeed, it may be safer to start with partially filled lists in the initial stages to assess turnaround time and capacity. The added turnaround time will help reduce the risk of more than one patient being in the practice at a time.

Along with standard decontamination cleaning of obvious contact areas such as operating table/chair, worksurfaces and floors, don't forget the need to more frequently clean other surfaces, such as cables, keyboards, monitors and machinery. There will also be a need to declutter the operating theatre although this may mean that procedures requiring specialist dressings or machinery, will require additional time.

3. POST-TREATMENT CONSIDERATIONS

3.1 Recovery

As noted in 1.4 above, it is preferable that most patients recover in the same area their treatment or surgery took place. If this is not possible then consideration should be given to the additional risk of moving a patient to a recovery area. The layout of the recovery area should be reviewed in a similar way to the main practice and /or operating theatre with an emphasis on increased distancing, e.g., the removal of alternate bays. Although covered by most large hospital protocols, it is vital that in general anaesthetic cases, specific guidelines exist for those personnel who need to be present during extubation which should happen in theatre, even if patients are to be transferred to a recovery area.

In staffing terms, it is desirable to use the same theatre staff to recover the patient rather than using an alternative dedicated recovery team. This will affect scheduling and allocation rotas.

Consider discharging patients directly from the treatment area or minor surgery facility rather than moving them to a waiting area. The principle here is to reduce patient movement as much as possible in order to reduce the chances of contamination.

During the recovery phase, it is also important to plan where the patient's family and friends should be and how they will be communicated with. Ideally, they should remain away from the building, perhaps outside in a waiting car. The patient can then be discharged from the treatment area directly to their car without additional members of the family entering the building and without the patient waiting unnecessarily in other areas. The administrative and nursing team will therefore need to record all contact numbers and will need to plan discharge (Section 3.4 below) prior to the treatment episode. If a patient needs assistance to leave the building this should be provided by nursing staff rather than the family.

3.2. Hospitalisations

For members undertaking general anaesthetic procedures, this is likely to be in larger private hospitals with their own guidelines and treatment pathways for the restart. You must therefore comply with these local guidelines. However, if you have influence, where possible you should aim to use areas of the hospital not occupied by COVID-19 patients. This should include dedicated theatres and wards that are on a different floor or even a different building. You must again consider recovery facilities and the transfer of patients from one area to another. This should all be published and freely available to staff and patients.

Where possible, you should adhere to standardised care protocols (e.g., enhanced recovery protocols) for increased reliability in light of potential different personnel. These, as standardised protocols, optimise lengths of hospital stay and efficiency and are associated with decreased complication rates.

You should aim for the shortest hospital stay practicable given safety parameters and discharge as soon as possible following surgery. This may mean that some procedures are altered in complexity as detailed in section 1.5.

Family and friend visitors should not routinely be permitted to visit patients in clinical areas. For compassionate reasons, patients requiring prolonged hospital stay or who are critically ill, should be allowed visits by family members protected by PPE. This, however, must be the exception rather than the rule.

3.3 Post-treatment COVID-19 positives

Even after several months of the pandemic, we are still seeing up to 30% false negative antigen tests and we know that at least 25% of positive individuals are asymptomatic, so it is inevitable that members will see some COVID-19 positive cases after an aesthetic plastic surgery treatment episode. The outcomes from post-operative COVD-19 positive patients have varied with some early studies suggesting a 20% mortality after complex major surgery. However, the validity of this data has been questioned and this patient group is likely to have many co-morbidities, unlike the typical patient cohort undergoing elective aesthetic plastic surgery. Indeed, more recent studies after minor surgery have shown very little impact on the outcome of a subsequent COVID-19 positive diagnosis. Nevertheless, members should establish a clear protocol for the post-treatment investigation and management of a potential COVID-19 positive patient.

You should arrange easy access to a post-operative COVID-19 testing facility and you should consider the management of symptomatic patients, including patients with a post-operative pyrexia. Atelectasis, fevers, etc., are not uncommon in the post-operative course and establishing operational guidelines for COVID-19 testing in these patients and concurrent testing results should be established.

It is clearly inappropriate for BAAPS members to manage the care of post-treatment COVID-19 positive patients, even if the patient remains at home. You should therefore establish a pathway of access to COVID-19 care and potentially how this could be escalated to admission and even ITU care.

In the event of a COVID-19 positive test result following a treatment episode, members should review the patient contacts within the practice and staff should be screened for symptoms and retested. The NHS Contact Tracing team should also be informed via the new App.

3.4 Discharge planning

Given the inflexibility of current healthcare systems, it is vital that accurate discharge planning is carried out prior to the treatment episode. Updated protocols should be communicated with all members of the team and patient-specific plans should be documented and communicated (preferably electronically) to each patient. This should include emergency contact numbers, post-acute care facility availability for treatment site concerns (e.g., bleeding from wound) and post-acute care facility availability for potential COVID-19 concerns.

General COVID-19 related advice should be given to all patients following discharge (an example is given in Appendix 7) along with detailed procedure-specific advice to support them at home. It is vital that the number of post-treatment practice visits are reduced to a minimum. Patients may therefore need to carry out their own wound inspections or dressing changes. Adequate supplies should be given to patients along with clear advice at the time of discharge. You may need to update your standard post-treatment advice sheets to reflect the changes dictated by the COVID-19 pandemic.

3.5 Management of post-treatment non-COVID-19 complications & follow ups

Even with the best preparation and attention to detail during a procedure, complications will still take place. It therefore important to ensure before undertaking any treatment or operation that you have the facilities available to manage a post-procedure complication. For example; to be able to take a patient back to theatre if bleeding or needing a washout or bring a patient back after a filler injection to manage a vascular occlusion. Members should check that these arrangements are in place in their local facilities. Those who own and run their own facilities should ensure that this is included in their protocols and preparations.

Follow up consultations should be kept to a minimum where possible. Members should consider the greater use of telemedicine facilities and postpone longer term follow ups until social distancing guidelines have been relaxed.

APPENDIX 1 – LINKS TO ADDITIONAL SUPPORTIVE INFORMATION & RESOURCES

NHS coronavirus guidance for clinicians and NHS managers
https://www.england.nhs.uk/coronavirus/

Joint Surgical Colleges & NHS guide to surgical prioritisation during the coronavirus pandemic
https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0221-specialty-guide-surgical-prioritisation-v1.pdf

The Royal College of Surgeons of England COVID-19 information hub
https://www.rcseng.ac.uk/coronavirus/

The Royal College of Surgeons of England guidance on recovery of surgical services
https://www.rcseng.ac.uk/coronavirus/recovery-of-surgical-services/

Public Health England (PHE) guidance on PPE
https://www.gov.uk/government/collections/coronavirus-covid-19-personal-protective-equipment-ppe/

Public Health Wales (PHW) guidance for healthcare workers including PPE advice
https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/information-for-healthcare-workers-in-wales/

Health Protection Scotland (HPS) COVID site including PPE advice
https://www.hps.scot.nhs.uk/a-to-z-of-topics/covid-19/

BAPRAS COVID guidance
http://www.bapras.org.uk/professionals/About/member-resources/covid-19-advice-for-members/

ISAPS COVID guidance including sample consent
https://www.isaps.org/covid-19/

APPENDIX 2 – EXAMPLE OF PATIENT SCREENING COVID-19 QUESTIONNAIRE

This document is for reference purposes only. It is intended to provide general guidance, is not legal advice and is not a statement regarding any standard of care. This document has not been produced with legal or indemnity company approval. It is intended as a template and as such, it is vital that any BAAPS member who wishes to use a version of this form seeks specialist advise.

You are considering attending the clinic/doctor for a consultation. We want you to be well. We are doing everything we can to keep you safe. This questionnaire is designed for the safety of you and the clinic staff. If you or we think that you have a high chance of currently being infected with coronavirus, you should delay your attendance until a safer time and we may advise this.

Please answer these questions as honestly as you can.

Have you been tested for coronavirus?	Y/N
Have you had a fever in the past two weeks?	Y/N
Have you had a cough in the past two weeks?	Y/N
Have you had any other symptoms suggestive of a viral infection within the last two weeks, such as muscle pain, lethargy, diarrhoea or vomiting, or loss of smell?	Y/N
Have you been exposed to anyone who has had COVID-19 in the past one month?	Y/N
Have you travelled outside the UK in the past 14 days and if so, where did you travel?	Y/N

If you answer YES to any of these questions we will need to contact you in advance of your attendance.

Today's date:

APPENDIX 3 - EXAMPLE OF PRE-TREATMENT SCREENING REGIME

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In selected patients, members could consider the following schedule prior to any treatment or surgery:

1. Only consider patients in low risk groups (see Section 1.5) who have been symptom free for 14 days and have not been in close contact (family and household members) with anyone demonstrating possible symptoms of COVID-19 for 14 days.

2. Compulsory use of NHS Contact Tracing App for 7 days pre-treatment.

3. Negative antigen test 48 hours pre-treatment.

4. Strict self-isolation following test (including social distancing from household members).

5. Repeat antigen test on the day of treatment (rapid result if possible or to aid in the event of a post-operative complication).

APPENDIX 4 – EXAMPLE CONSENT FOR COVID-19 RISK

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I ……(patient name) understand that I am opting for an elective treatment that is not urgent and may not be medically necessary.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, the UK Government and healthcare agencies recommend social distancing.

I recognise that …….. (doctor name) and all the staff at …… (practice name) and …… (facility name) are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment.

I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment, and I give my express permission for …….. (doctor name) and all the staff at …….. (practice name) and …….. (facility name) to proceed with the same.

I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test.

I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment may result in the following: a positive COVID-19 diagnosis, extended self-isolation, additional tests, hospitalisation that may require medical therapy, Intensive Care treatment, possible need for intubation and ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment, I may need additional care that may require me to go to an Accident & Emergency Department at a different hospital.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment itself.

I have been given the option to defer my treatment to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment.

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE.

Patient or Person Authorised to Sign for Patient Date/Time

Witness_____ Date/Time_____

I have been offered a copy of this consent form (patient's initials) _____

APPENDIX 5 – RECOOMENDED PPE REQUIREMENTS FOR AESTHETIC PRACTICE

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Setting	Context	Gloves	Plastic apron	Surgical gown	Fluid resistant surgical gown	Fluid resistant (Type IIR) surgical mask[1]	FFP3 or full face respirator	Visor/eye protection[2]
Clinic	Discussion[3]					✔		✔
	Examination	✔	✔			✔		✔
Ward	Any	✔	✔			✔		✔
Theatre	AGPs[4]	✔ (2 pairs)			✔		✔	✔
	Non-AGPs (LA or GA)	✔		✔		✔		✔
	Procedures with large volume fluids[5]	✔			✔	✔		✔
	Non-surgical treatments	✔	✔			✔		✔

1. Sessional use in clinic, single use in theatre
2. Recommended where feasible in theatre for single use only. Sessional use in clinic, cleaned between clinic sessions
3. History taking and discussion only >2m from patient
4. Aerosol generating procedures (detailed in Appendix 5)
5. Procedures with anticipated/likely risk of contamination with splashes, droplets of blood, body fluids or surgical fluids including liposuction

APPENDIX 6 – LIST OF POTENTIAL AEROSOL GENERATING PROCEDURES (AGPs)

- Intubation/extubation
- Tracheal suction
- Nebulisers
- High flow nasal oxygen
- Non-invasive ventilation
- Nasogastric tube insertion/removal
- Collecting diagnostic respiratory samples (e.g. nasopharyngeal swabs) in an indoor environment
- CPR
- Procedures involving power tools or pressurised air such as drills, burs, K-wire drivers, dermatomes, pressurised lavage, power assisted liposuction, etc.
- Procedures involving oronasopharyngeal mucosa

APPENDIX 7 – EXAMPLE OF GENERAL COVID-19 POST-OPERATIVE ADVICE FOR PATIENTS

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In order to protect you and the people who surround you after surgery, we have developed these guidelines for your post-operative recovery. The rules to follow are the same as those advised by the Government, but there are some extras specific to your recent surgery. You should follow these instructions for two weeks after your surgery. This is in addition to the standard aftercare following your procedure.

Do's – please try and do the following

Do maintain government guidelines of social isolation even though lockdown is being relaxed.
If you start getting symptoms of a viral infection, consider calling 111 or your GP to inform them and socially isolate from others around you. You should also contact the practice so that we can guide you through the next steps.
If you are instructed by your surgeon, wear a face mask to protect yourself and others around you.

Don'ts – you should avoid the following activities

Avoid visitors unless they need to make an essential visit.
Avoid going out for two weeks unless you need to go on an essential journey.
If you do go on an essential journey then avoid public transport.
Avoid contact and meeting with anyone who has recently suffered a viral illness.
Minimise contact with anyone who has been in contact with large numbers of people.

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