

Specialty guides for patient management during the coronavirus pandemic

Clinical guide for management of patients requiring Oral and Maxillofacial Trauma Surgery during the coronavirus pandemic

20 March 2020 Version 1

“...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 coronavirus and for these we should seek and act upon national and local guidelines. We also have a specific responsibility to ensure that essential Oral and Maxillofacial surgical 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.

<https://www.gmc-uk.org/news/news-archive/how-we-will-continue-to-regulate-in-light-of-novel-coronavirus>

Oral and Maxillofacial surgery may not seem to be in the frontline with coronavirus, but we do have a key 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 Trauma patients whilst protecting resources for the response to 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.

Trauma and acute musculoskeletal patients can be considered in a few categories:

1. **Obligatory in-patients:** Continue to require admission and surgical management e.g., significant mandibular and mid facial fractures and serious cervicofacial infections. *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. condylar 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. **Outpatient LA clinics:** Lacerations other suitable trauma, cancer surgery and biopsies
5. **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 consultant of the week. This is an *essential* role during crisis management. It cannot be performed by the consultant in routine theatre or clinics. 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!
- **A leadership team should support the lead and include relevant members of the MDT**
- Establish a daily sitrep and dashboard with critical data to share across the workforce. That should include patient flows, workforce issue, stock levels and other key messages (e.g. state of coronavirus response, PPE requirements).
- Use elective theatre capacity and surgeons to ensure minimum pre-operative delay.
- Use elective rehab services to minimise post-operative stay.
- An anesthetic guideline for patients requiring surgery and who are coronavirus positive 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 trauma-related procedures are clinically suitable to be performed as a day case.
- During the coronavirus crisis, an increase in day-case trauma 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 emergency, 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.

Outpatient LA clinics

- Lacerations other suitable trauma
- Urgent cancer surgery and biopsies
- Acute dental emergencies treatable under LA

First contact and OMFS triage clinics

Emergency Departments (ED) are likely to come under intense and sustained pressure and OMFS 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 triage at the front door and stream patients directly to OMFS Clinic before examination or diagnostics. OMFS clinics are likely to be asked to take *all* patients presenting with trauma (including wounds and minor injuries) straight from triage. It is possible that this temporary service will need to be expanded to provide an 9-5.00 service, 7 days per week.

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.

If referrals of suitable screened facial trauma patients transferred from spoke hospitals can be re-directed away from the ED direct to and OMFS clinic this will be helpful.

- 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.
- 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.
- OMFS Triage clinic will need to be open-access at least 09.00-17.00 and potentially
- The longer hours will allow ED access and help reduce crowding in waiting rooms.
- The possibility of a 7-day service may need to be considered.
- Using Virtual Review Clinics (VRC) will not reduce ED workload. Hospitals using this system may need to switch during the crisis to the system outlined above.

- The patient information used in VRC will be very effective in reducing follow-up visits.
- Consider postponing long-term follow-up patients until the crisis has passed.
- Can a follow-up VRC be developed with your facility?
- A temporary minor operating theatre and dressings clinic may need to be set up in the OMFS Triage Clinic to allow for suturing of wounds, Incision and drainage and provision of IMF etc.
- CT scanning may be limited as it is the investigation of choice for coronavirus interstitial pneumonia.

Staffing Issues

Impact of self-isolation, illness and burn-out

Statistics from other nations suggest that as the coronavirus situation gets worse, it impacts on staff in

many ways. You should plan for up to 30% of your staff not to be available to work. You might wish

to consider:

- Speaking to your staff about their personal and family co-morbidities and risks.
 - Staff who are not suitable to work in the front line can be used for telephone clinics, triage of referrals, education and support.
- Keeping some staff out of the front line initially to be available later
- Rotating staff into and out of the front line acute/emergency services
- Staffing spoke hospitals with senior staff to support SAS grades.
 - In person or with telephone/video support of decision making
 - Undertaking urgent LA procedures in spoke/non-coronavirus hospitals
 - Undertaking daycase semi-elective surgery in spoke/non-coronavirus hospitals

Dental Core Trainees (DCTs) and SAS and Locally Employed

- Make sure your hospital understands that this group of hospital workers are not doctors. This sounds obvious, but it does not harm to remind them.

Specialty Trainees and DCTs

- Remember that they have training needs
- Review advice from Deaneries/HEE/NES etc
- Recruitment and Exams are completely disrupted for trainees. This will have an impact on them and may caused problems after the summer.

Oral and Maxillofacial Surgery Escalation Policy

Prevalence	Low	Medium	High	Very High
OMFS Personnel	Normal	Normal except acute/trauma OMFS team (if not already) Plan for High and very high	Limit staff exposure/work Rotate acute team (30% may be isolated/sick) Staff spokes to shield hub	Skeleton staff only Assist / Reallocation to other specialities
Impact	Normal Winter Pressure Business as usual	Limited ITU Limited Ward beds	No ITU beds No Ward beds	Surgery limited Isolation limited
Trauma Operating	Normal	1. Increase day-case 2. Maximise day-case 3. 23 hour ambulatory care if available	Increase non operative treatment options	Delay all but essential surgery
Acute Care Leadership	Normal	1. Consultant OMFS Surgeon Acute Care lead/Trauma Coordinator (with no other clinical commitments) 2. Triaging with junior team. Patient directed home, or to OMFS triage clinic 3. Fractures, infections and facial lacerations - early surgery to decrease LoS utilising elective capacity 4. On day admission for Non elective Trauma Operating 5. Consultant led ward rounds x 2 daily		
Elective Operating – GA	Normal	Urgent only	All elective surgery stops except cancer	All elective surgery stops including cancer
Elective Operating – LA	Normal	Urgent only	Urgent only	Cancer and Trauma
OMFS triage Clinic	Normal new patient Procure IMF screws/ adhesive IMF arch-bars for 'see and treat	Increased used of all day OMFS triage clinic Ensure 'see and treat' option available for suitable patients	All ED injuries triaged to OMFS triage clinic except RESUS cases Elective Surgeons to Support including minor ops/non- GA treatment in Triage Clinic/OMFS see and treat	All ED injuries triaged to OMFS triage clinic except RESUS cases Elective Surgeons to Support including minor ops/non-GA treatment in Triage Clinic/OMFS see and treat
OMFS Trauma review clinic	Normal (start designing Virtual Follow up Clinic (VFC)	Use VFC where possible	Use VFC where possible	Use VFC where possible
Elective Clinics	Normal new patient Start reducing follow-ups	Urgent only No follow-up	Urgent diverted to OMFS Triage Clinic	Urgent diverted to OMFS Triage Clinic
Spoke Clinics and AEDs	Normal new patients Start reducing follow-ups Write support protocol for spoke OMFS staff for when pressures increase	1. Urgent only – consider keeping patients in spoke hospital with Virtual input from Hub 2. Consider consultant input into spoke trauma clinics to triage/'see and treat' patients who have been 'patched and planned' in ED to avoid transfer to the hub. Cancelled elective activity in the hub may facilitate this approach. 3. Clear written referral pathways should be shared with EDs across network	Urgent discussed with OMFS Triage clinic(s). Transfer only if essential	Urgent discussed with OMFS Triage clinic. Transfer only if essential