

Recommendations for the Perioperative Management of Patients Requiring Enhanced Respiratory and Contact Precautions

Booking of Emergency Procedures

All patients will be screened with the Febrile Respiratory Illness (FRI) Screening Tool at time of admission. The FRI Screening tool will remain on the patient's medical record.

The attending surgical service and anesthesiologist must maintain a high index of suspicion when booking patients for surgical procedures. The attending service must communicate the following information about their patients at the time of booking and on the day the procedure is to occur:

1. Does the patient have a febrile respiratory illness (FRI)?
 - Does the patient have any SARS risk factors?
 - Does the patient have a SARS contact history?
2. Is the patient designated as SARS probable or suspect or does the patient fit the criteria for SARS person under investigation
3. Does the patient require **enhanced respiratory and contact precautions** (E-RCP) for any other reason?

If a patient requires enhanced respiratory and contact precautions and the procedure is of an elective nature it will be delayed until the patient no longer requires these precautions.

If a patient requires enhanced respiratory and contact precautions and the procedure must proceed due to medical reasons the patient will be treated according to the recommendations set out below.

The surgical service will identify the need for **enhanced contact and respiratory precautions** by checking the appropriate check box on the **Emergency OR Booking Form**. If applicable, the patient's current status or diagnosis (eg. probable SARS, suspect SARS, SARS person under investigation, pandemic influenza, etc.) will be written in the comments section of the Emergency OR Booking Form.

Communication

Communication is essential. All members of the perioperative team must be aware of the patient's need for enhanced respiratory and contact precautions. Mechanisms must be in place to ensure that communication occurs. The individuals that must be informed of the patient's status include:

- OR receptionist
- Anesthesiology attending and resident staff
- Surgical attending and resident staff

- Intensive Care Unit attending and charge nurse
- Hospital infection control practitioner
- Nursing staff in the OR and PACU
- Respiratory therapist (Doug Bodie during business hours. On-call RRCP at other times)
- Anesthesia technicians (during business hours)
- PA1 staff
- Environmental Services staff
- Maintenance and Plant Services staff

The OR communication flowsheet is included in Appendix B.

Transport to OR

Follow KGH “ENHANCED” CONTACT AND RESPIRATORY PRECAUTIONS policies and procedures item 3.6 and 3.12.

During transport the patient must wear a surgical mask unless not tolerated or contraindicated. The patient will continue to wear a surgical mask until they are induced.

Reception

Follow KGH “ENHANCED” CONTACT AND RESPIRATORY PRECAUTIONS policies and procedures item 3.12.

The patient should not be placed in the patient holding area. They should proceed immediately to the designated OR. Preoperative checklists, etc. should be completed either prior to patient arrival or in the designated OR

Suggested patient traffic pattern to the designated OR is shown in Appendix C

Specific perioperative management

Room designation

When designating which OR is to be used for a patient requiring enhanced respiratory and contact precautions the following factors must be addressed:

- Location of the OR to be used for the procedure
- Distance the patient will have to travel through the OR corridors during arrival to the OR suite

- Distance the patient will have to travel through the OR corridors for departure from the OR suite
- Presence of an area that can serve as a makeshift “anteroom” adjacent to the OR used for the procedure
- The designated OR will be out of service for several hours post procedure for appropriate cleaning and disinfection
- The fact that all OR’s are positive pressure environments

I OR has been designated as the room to be used for patients requiring enhanced respiratory and contact precautions.

Room preparation

This will be the only case in “I” OR for the day. Plant Services will provide plastic sheeting and duct tape to OR. This sheeting and tape will be stored in the OR and will only be used for cases requiring enhanced respiratory and contact precautions.

The Triage Nurse or their delegate will ensure that all unnecessary equipment is moved from the room to the Kidd core and the north peripheral corridor. They will also ensure that any required equipment is placed in the designated OR. This includes the anesthesia equipment listed below.

Linen bags will be in the room. Garbage and biohazard bags will be in the room. All OR cupboards will be taped shut, covered with plastic sheeting and taped again. All the doors from the OR except for the west double door and the scrub sink door will be covered with plastic and taped shut – especially over the floor/door space. The door to the Kidd wing core from the west peripheral corridor will be shut and remain shut while “I” is being used and the room is cleaned and appropriate time has expired to reopen the room.

No personal equipment should enter the designated OR. This includes, briefcases, personal digital assistants, etc.

A stethoscope, pens, and clipboard will be provided on the “anesthesia isolation precautions” cart. These items are not to leave the room until they have been disinfected.

A bacterial/viral filter must be placed between the endotracheal tube and the patient breathing circuit and in the expiratory limb of the breathing circuit.

The anesthesia drug cart will be removed from the room. It will be replaced with the “**anesthesia respiratory and contact precautions**” cart. This cart will be positioned in the OR in the location currently occupied by the anesthesia drug cart. See Appendix D for a detailed list of contents for this cart.

The drawers of the anesthesia machine must be emptied of all equipment. An “**anesthesia machine drawer contents**” tote and prep table will be provided. An equipment list for this tote is attached. See Appendix E for a detailed list of contents for this tote.

The use of supplementary anesthesia equipment (fluid warmers, forced air warmers, etc.) should be kept to the absolute minimum.

The staff hallway and dressing area / anteroom

If an anteroom is not available: If an anteroom is not available the hallway outside “I” OR will be considered clean and will ONLY be used for donning protective equipment. Outer layers of protective clothing must be removed in “I” OR and not in the hallway.

Refer to Appendix F for location of the staff hallway and dressing area.

If conditions permit the construction of an anteroom: If conditions permit, Plant Services will be notified by the OR manager of the date an anteroom will be required to be built outside “I” OR. When available, the anteroom will facilitate the process of donning protective equipment. The anteroom will be considered clean and will ONLY be used for donning protective equipment. Outer layers of protective clothing will not be removed in the anteroom

“I” OR will be considered contaminated. Outer layers of protective clothing will be removed in “I” OR.

Personnel and protection

The number of personnel in the OR should be kept to a minimum. Personnel in the OR should be limited to the following: **OR RN circulator, scrub tech, staff anesthesiologist, staff surgeon, and surgical assistant** (preferably another staff surgeon).

At times other than high-risk procedures protective apparel consisting of N95 mask, gloves, gown, hair covering, and eye protection must be worn for patient care or room/equipment cleaning. See Appendix G for instructions for donning and removing this protective equipment

Instructions for donning and removing protective apparel will be available with the suits and also in the “anesthesia isolation precautions” cart. These instructions must be clearly posted in the area where personnel will be donning and removing protective equipment.

Other personnel:

The RT/coach: Their responsibility will be to assist with donning and removal of protective apparel and with room entry/exit procedures. This individual will also be responsible for assisting the anesthesiologist during the intubation. Once the intubation and circuit check are complete the RT/coach will remove their PAPR and will remain in the anteroom/hallway.

An additional RN/RPN: This person will remain available in the anteroom/hallway.

The equipment passer: This person should not circulate in the surgical suites. This person should be dressed in protective apparel (N95 mask, goggles/faceshield, gloves,

hair covering and gown) and remain immediately available to deliver equipment from the outside the OR to the OR RN circulator.

The runner: A second individual may be required to deliver equipment from the surgical suites to the equipment passer outside the OR.

Patient transport into the designated OR

Suggested patient traffic pattern to the designated OR is shown in Appendix C

The patient checklist will be completed in the OR. The patient chart will remain outside the OR.

Page 1 and 4 of the anesthesia record will be completed prior to the patient arriving in the OR. The anesthesia record will remain outside the OR with the patient's chart.

The patient will be brought to OR from south peripheral corridor. The team accompanying patient to OR will remain at OR doors. OR staff will take patient into I OR.

Patient induction, maintenance, and emergence

General goal is to minimize patient coughing at the time of intubation and/or induction of anesthesia and during emergence/extubation.

Choice of Airway:

- Cuffed endotracheal tubes.
- Laryngeal mask airways are permitted if appropriate considering patient's respiratory status.

Choice of Anesthetic:

- Tailor to the patients' needs.

Monitoring:

- Use axillary temperature probes. Avoid nasal or esophageal probes.

ETT suctioning:

- If airway suctioning is required in-line suction catheters should be used.

Breathing circuit disconnections and management:

- All circuit disconnections will be made on the machine side of the patient bacterial /viral filter. This will maintain isolation of the patient's respiratory tract and respiratory secretions.

Documentation:

- The **main anesthesia record** will remain outside the anteroom
- A supplementary anesthesia record will be available in the designated OR for recording vital signs and medications administered. This information will be entered on page 2 of the supplementary anesthesia record. This record will be considered contaminated and will not leave

the designated operating room. The information on this record will be transferred to the patient's main anesthesia record at the end of the procedure.

Protection during the intubation

The personal protective system (i.e. PAPR) will be worn during the intubation by the anesthesiologist and their assistant (the RT/coach described below). Protective apparel (N95 mask, gloves, impermeable gown, hair covering, and eye protection) will be worn underneath the PAPR: See Appendices G and H for instructions for donning and removing this protective equipment

Both the anesthesiologist and the RT/coach will remain in their protective apparel for the period immediately following the intubation. During this period all circuit connections will be double checked in order to minimize the possibility of inadvertent circuit disconnections.

Once the circuit has been checked the OR RN circulator can enter the room. The anesthesiologist and the RT/coach will then remove the PAPR as set out in Appendix H.

Removing the PAPR is a two-person procedure. While the anesthesiologist and the RT/coach are removing the PAPR the OR RN circulator will monitor the patient.

The anesthesiologist will then don N95 mask, gloves, impermeable gown, hair covering, and eye protection for the duration of the procedure. The RT/coach will remain in the anteroom/hallway to assist with donning and removal of protective apparel and with room entry/exit procedures.

Patient recovery

The majority of patients requiring enhanced respiratory and contact precautions will recover in the ICU.

If the patient is to proceed back to their ward or to an isolation unit both extubation and recovery will occur in the OR. Patient recovery will occur in the OR following KGH "ENHANCED" CONTACT AND RESPIRATORY PRECAUTIONS policies and procedures item 3.12.

Transport from OR to inpatient unit or ICU

A separate team should be available for patient transport. Staff should not wear the same protective suits that were worn in the OR for patient transport. Protective clothing must be removed prior to leaving the OR to minimize droplet spread during transport and contamination of other hospital areas.

If the patient requires disposition to a critical care setting they should remain intubated. The ICU should be notified well in advance. A **transport team from ICU** will be responsible for transporting the patient from the OR to the ICU. Patient report will be telephoned to the ICU team prior to patient transport. The ICU transport team should be dressed in appropriate

protective equipment and will meet the OR team to receive the patient at the designated OR door.

The patient will be transported to the ICU following KGH “ENHANCED” CONTACT AND RESPIRATORY PRECAUTIONS policies and procedures item 3.6.

Disposable resuscitator bags will be used for ventilation during transport of intubated patients. All circuit disconnections will be made on the machine side of the patient bacterial /viral filter. This will maintain isolation of the patient’s respiratory tract and respiratory secretions.

A **separate team** should be available for patient transport to other in-patient units. This team will follow KGH “ENHANCED” CONTACT AND RESPIRATORY PRECAUTIONS policies and procedures items 3.6 and 3.12.

Anesthetic Equipment Cleaning and Disposal

Airway equipment:

Oral or nasal airways, LMAs, and endotracheal tubes will be discarded after use. Used laryngoscopes (blade AND handle) will be placed in the provided sealable receptacle and sent to Central Processing Services (CPS) for cleaning.

Anesthetic Circuits:

Bacterial/viral filters, patient breathing circuit, reservoir bag, and end-tidal CO₂ sample line with trap will be discarded at the end of the case.

Anesthesia Machine:

Particular attention should be focused on the exterior surfaces of the anesthesia machine (including dials / vaporizers) and ventilator. Disinfection with a hospital-approved agent should be used. The machine should be wiped down as opposed to having cleaning agent sprayed directly onto its surfaces. Five minutes of contact time should be achieved with the hospital approved agent.

Other anesthetic equipment:

Surfaces of the “**anesthesia isolation precautions**” cart will be disinfected with a hospital-approved agent. The stethoscope, clipboard, and all totes (interior and exterior) will be disinfected with a hospital-approved agent.

All unused disposable items contained in totes on the “**anesthesia isolation precautions**” cart and “**anesthesia machine contents**” tote will be placed in sealed plastic bags and quarantined for a period of time specified in the KGH “ENHANCED” CONTACT AND RESPIRATORY PRECAUTIONS policies and procedures item 3.12.

If fluid warmers or blanket warmers have been used for the case disinfection with a hospital-approved agent, should be used. The equipment should be wiped down as opposed to having cleaning agent sprayed directly onto their surfaces.

All equipment that cannot be disinfected or disposed will be quarantined for the period of time specified in the KGH “ENHANCED” CONTACT AND RESPIRATORY PRECAUTIONS policies and procedures item 3.12.

OR cleaning and shut-down

Follow KGH “ENHANCED” CONTACT AND RESPIRATORY PRECAUTIONS policies and procedures item 3.12.

Environmental Services staff will be called to clean the designated OR, the hallways through which the patient travelled, and the staff hallway/dressing area. The designated OR and hallways will be sealed off to all other personnel.

All reusable equipment that requires high level disinfection or sterilization will be placed in a hard shell container and sent directly to CPD. This equipment must be disinfected with a hospital-approved disinfectant prior to going to CPD.

All other equipment in the OR and in the staff hallway/dressing area will be disinfected with a hospital-approved disinfectant and placed in bags for quarantine for the next seven days in the equipment quarantine room.

Connell 2-219 has been designated the equipment quarantine room.

If an anteroom has been constructed it will be cleaned at the same time as the OR then dismantled by Plant Services. Reusable equipment will be reprocessed appropriately once sufficient time (7 days) has passed.

All the linen in the designated OR will be double bagged (in a water soluble linen bag then an isolation bag). All used linen will be quarantined for seven days in the equipment quarantine room.

All unused and uncleanable equipment will be bagged and quarantined for seven days.

All disposables, garbage, and biohazardous waste will be double bagged and placed in a green bin. These items must be quarantined for seven days prior to disposal.

APPENDIX A: CRITERIA AND DEFINITIONS

Refer to appendix 1 Directive HR03-12 (22 October 2003) for definitions of the following terms:

Febrile Respiratory Illness (FRI): temperature greater than 38°C and new or worsening cough or shortness of breath. During non-outbreak conditions this includes a fever of greater than 38°C **and** new or worsening cough or shortness of breath to increase the specificity of this designation. During outbreak conditions, to maximize the sensitivity to potential SARS infection, this includes a fever of greater than 38°C **or** new or worsening cough or shortness of breath. The context in which FRI is determined must take the outbreak vs. non-outbreak conditions into account.

Non-Outbreak: *Non-outbreak* refers to the conditions once a SARS Outbreak is declared over by the local Medical Officer of Health (MOH) or in a region where no SARS outbreak has occurred. Facilities within the region may have one or more SARS patient(s), either local cases or those imported through travel activity, provided there has been no transmission within the hospital population.

Outbreak: for the purposes of SARS activity, an *outbreak* is defined as local transmission of SARS. The local Medical Officer of Health is responsible for declaring a SARS outbreak. An outbreak may be setting-specific (e.g., a hospital with transmission) or health unit wide (e.g. transmission in more than one setting or significant community exposure).

SARS Contact History: SARS contact history in a patient with febrile and/or respiratory illness is defined as any one of:

- Unprotected contact with a person with SARS in the last 10 days prior to the onset of this illness
- Were present in a healthcare facility closed due to SARS before the onset of symptoms, 10 days prior to the onset of this illness
- Instructed by Public Health to be in quarantine or isolation.
- Travel to a SARS affected area in the 10 days prior to the onset of illness

SARS Risk Factors: SARS risk factors in a patient with febrile and/or respiratory illness are defined as:

- Travel (patient or household/close family) to a former or current SARS affected area in the last 30 days.
- Admission to a hospital* or nursing home* in the 10 days prior to the onset of this illness.
- Household members or other close contacts with fever or pneumonia.
- Health care worker with direct patient contact in a healthcare facility.
- (*Only facilities in Toronto, York, Durham regions of Ontario or Taiwan, Singapore or Hong Kong are considered as positive Risk Factors.)

Febrile Respiratory Illness Screener

Screening Questions to be Asked of Patients as Part of an Active Screening Process

1. Do you have new / worse cough or shortness of breath?

- if 'no', stop here (no further questions)
- if 'yes', continue with next question:

2. Are you feeling feverish, have you had shakes or chills in the last 24 hours?

- if 'no', take temperature; if >38 C, continue with next questions, otherwise stop (no further questions)
- if yes, take temperature and continue with next questions:

Initiate droplet precautions if "yes" to 1 and 2.

3. Is any of the following true?

- Have you lived in or visited China, Taiwan, Hong Kong, Vietnam, Thailand, Japan or South Korea within the last 30 days?
- Have you had contact in the last 30 days with a sick person who has traveled to these same areas?

Patients with FRI (fever and respiratory symptoms) and answered 'yes' to any of these exposures / conditions may potentially have severe respiratory illness (SRI).

Initiate droplet precautions and notify infection control if "yes" to 1, 2 and 3.

Infection control to notify public health.

Additional questions to be asked of all admitted patients:

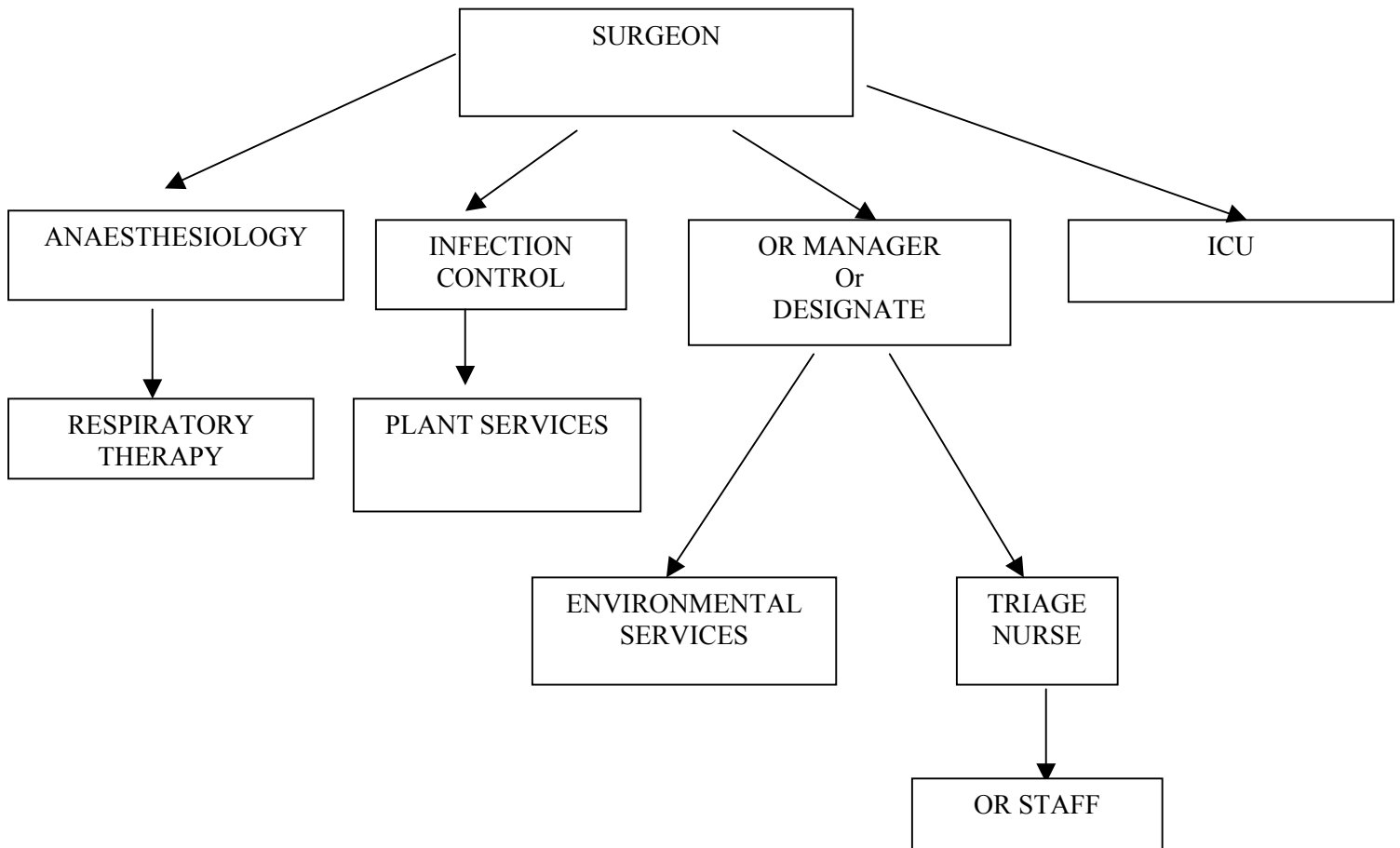
4. Do you work for a healthcare agency or organization?

5. Are you a resident of a long-term care institution?

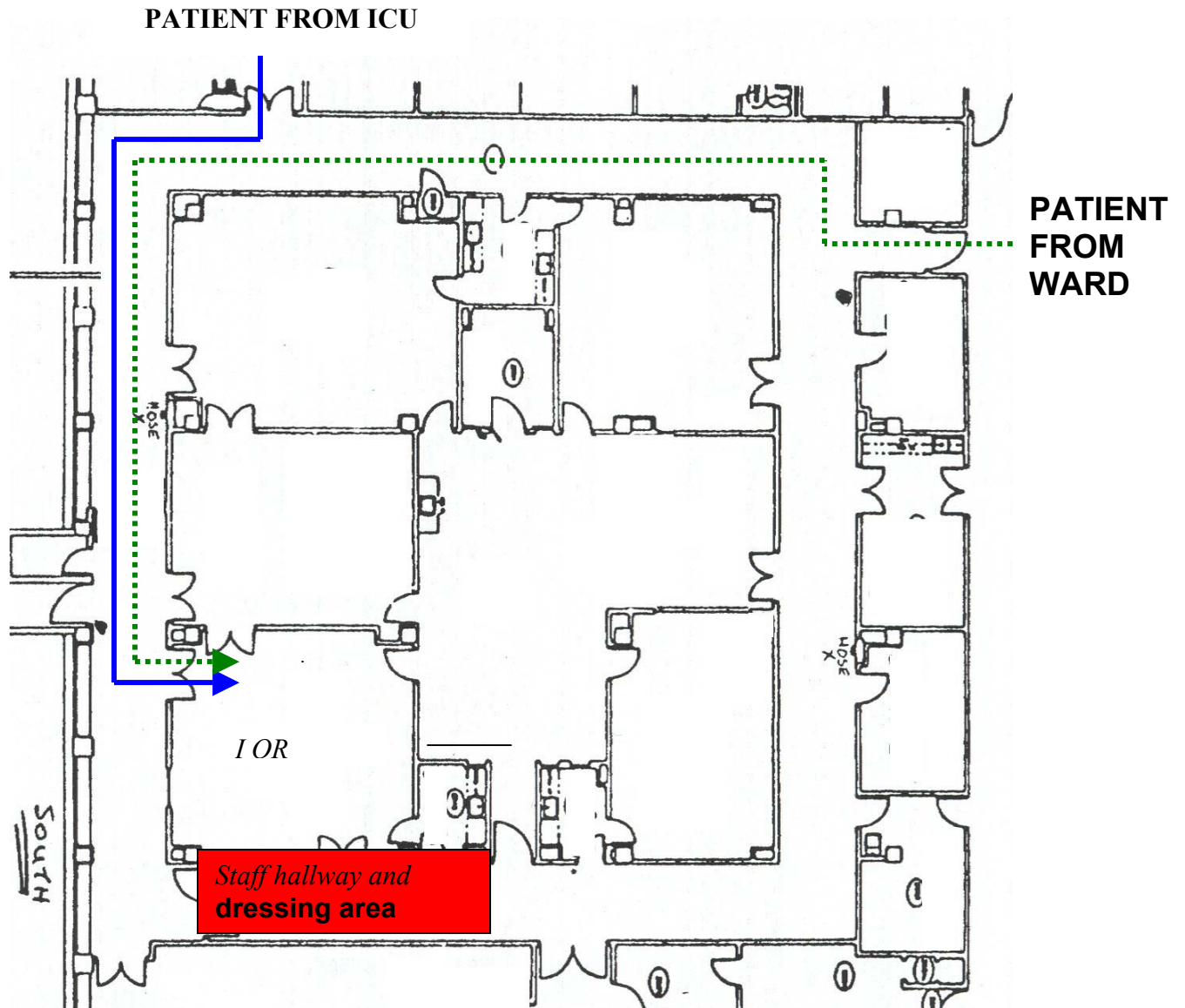
Initiate droplet precautions and notify infection control if "yes" to 1, 2 and either 4 or 5.

Infection control to notify public health.

**APPENDIX B: SURGICAL SUITES COMMUNICATION SEQUENCE FOR PATIENTS
REQUIRING E-RCP**



APPENDIX C: PATIENT FLOW PATTERN TO AND FROM I OR



APPENDIX D: CONTENTS OF THE ANESTHESIA RESPIRATORY AND CONTACT PRECAUTIONS CART AND TOTES

Goal of the anesthesia isolation precautions cart is to have an adequate amount of needed equipment available to the anesthesiologist without having to request additional equipment to be brought into the room. All equipment brought into the room will be discarded or cleaned using guidelines as set out above.

These items will be placed on a “**clean case cart**”. The **anesthesia isolation precautions** cart will be placed in the OR in place of the anesthesia drug cart. Multiple totes will be required. These will be labelled sequentially and placed in their designated positions on the clean case cart.

- Anesthesia drug label sheets
- Stethoscope, pen, and clip board
- Copies of:
 - Protective suit and protective clothing donning and removal instructions (laminated)
 - These recommendations
- One anesthesia drug exchange tray
- Angiocatheters: 22ga, 20ga, 18ga (short), 16ga(short), 14ga(short): **all X 3**
- Needles: 21ga, 18ga, 25ga, 30ga: **all X 10**
- Arterial lines
 - Arrow 20ga x2
 - Long 20 ga IV catheter x 2
- Tape
 - 1 inch pink x 2
 - 1 inch clear x2
- Interlink products
 - Vial access cannula x 10
 - Lever lock cannula x 2
 - Blunt access cannulae x 10
- Opsite (small) x 5
- Alcohol swabs x 10
- Tourniquet
- Iodophore swab stick x 2
- Airways
 - Size 10 x 2
 - Size 9 x 2
- Water based lubricant tube x1
- Lidocaine spray and nozzle x1
- Ventolin metered dose inhaler and connector x 1
- Laryngoscope handle x 1
- Macintosh blade
 - Size 3 x 1

- Size 4 x 1
 - 5 cm H2O PEEP valve x 1
 - stopcock, 3-way x 3
 - heplock cap x 3
 - syringes
 - Tuberculin x 5
 - 10cc, 5cc, 3cc: **all X 10**
 - 20cc x 5
 - 60cc x 1
 - endotracheal tubes
 - size 7 x 2
 - size 8 x 2
 - malleable stylet x 1
 - LTA 360 kit x 1
 - LMA
 - Size 3 x 1
 - Size 4 x 1
 - IV tubing
 - Blood sets x 2
 - Extension x 2
 - Nasogastric tube, “Salem” type 14Fr x 2
 - In-line suction catheters x 3
 - Normal Saline fluid bag, 1 litre x 4
 - Normal Saline fluid bag, 100cc x 4
-
- Sharps container
 - Biohazardous waste receptacle

The following items will NOT form part of the equipment list but will be available to be used if indicated

- Double lumen CVP kit
- Percutaneous sheath introducer kit
- Spinal kit
- Epidural kit
- Warming blanket
 - Upper body x 1
 - Lower body x 1

**APPENDIX E: CONTENTS OF ANESTHESIA RESPIRATORY AND CONTACT
PRECAUTIONS MACHINE DRAWER TOTE**

The anesthesia machine drawers will be emptied of ALL contents. The items listed below will be available in a separate tote. **One prep table** will be required for positioning of this tote and for spent respiratory equipment that is not disposable such as laryngoscope blades and handles.

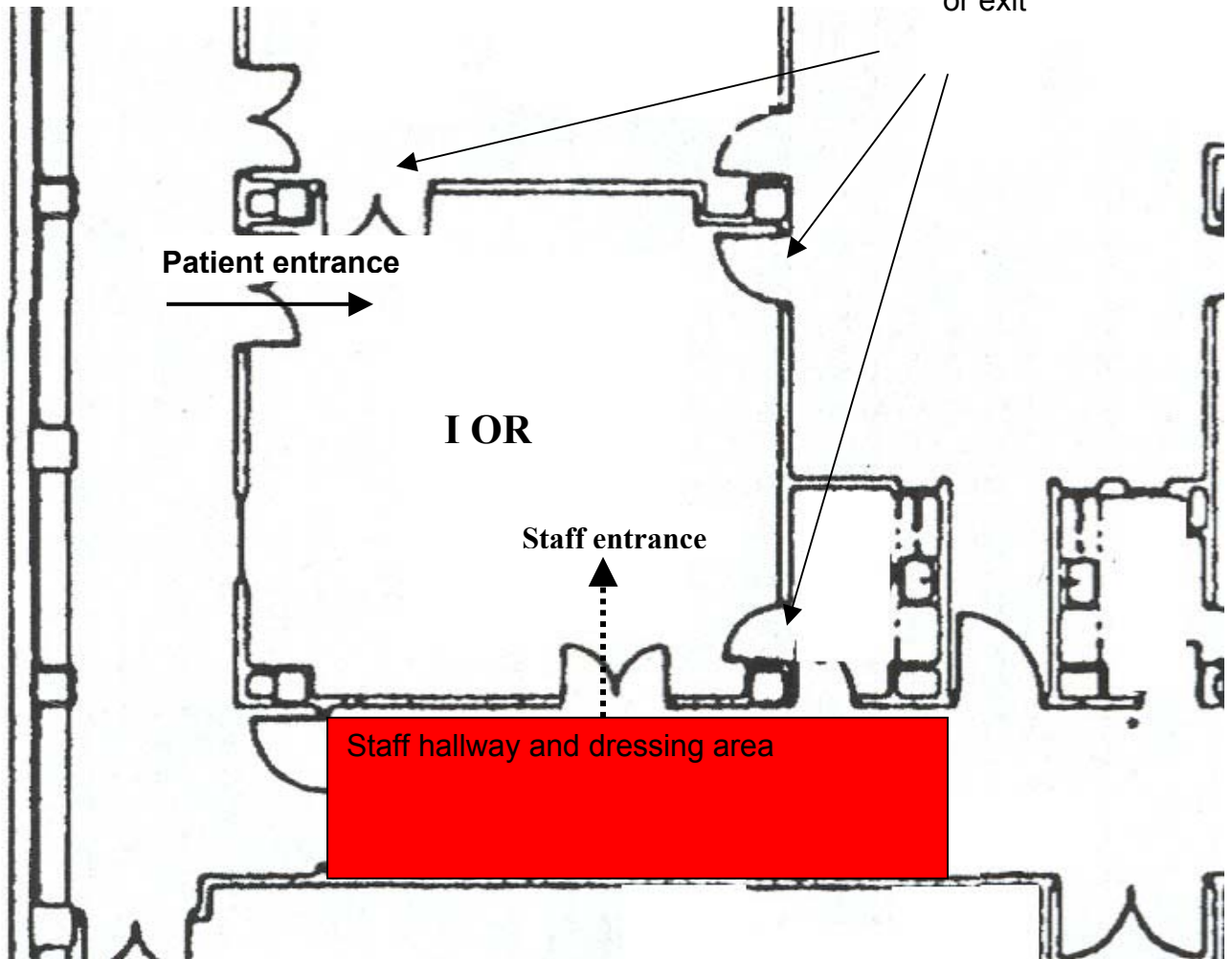
The equipment listed below consists of items over and above the items that are already deployed on the anesthesia work-station for the case.

- Disposable anesthesia clear facemasks (size 3, 4, and 5)
- CO2 sample tubing x 1
- Elbow connector x 1
- ECG leads package x 4
- Flashlight x1
- Oxygen nasal prongs x 2
- Suction tubing x 2
- Bacterial/viral filter x 2
- K-basin x 1

One extra sealable tote will be provided in which to place soiled airway equipment that is not disposable (eg. laryngoscope handle and blades). **THIS CONTAINER SHOULD BE LABELLED “CONTAMINATED EQUIPMENT FOR CLEANING”**

**APPENDIX F: LOCATION OF
STAFF HALLWAY / DRESSING AREA**

Doors
NOT to be
used for
staff entry
or exit



Note:







1. Staff hallway and dressing area will be considered clean and will ONLY be used for
 - a. donning protective equipment
 - b. removing inner protective layer for individuals wearing PAPR
 - c. undressing as outlined in instructions
2. Staff hallway and dressing area will be equipped with
 - a. biohazardous waste receptacles
 - b. dressing and undressing instructions
 - c. appropriate personal protective equipment
 - d. hand rinse
3. Scrub team will scrub in scrub area prior to donning personal protective equipment in staff hallway and dressing area
4. OR side of staff entrance will be equipped with
 - a. biohazardous waste receptacles
 - b. dressing and undressing instructions

APPENDIX G: PROCEDURE FOR DONNING AND REMOVING PERSONAL PROTECTIVE SYSTEM

BARRIER SIGN A - POST OUTSIDE PATIENT ROOM

BEFORE ENTERING OPERATING ROOM:

Put on the following barrier equipment:

- ✓  N95 mask
- ✓  Goggles [optional except for high risk procedures]
- ✓  Disposable hair cover over the hair cover you are already wearing
- ✓  Face shield
- ✓  Gown
- ✓  **Gloves (if providing direct patient care, put on a second pair once inside patient room)**

BARRIER SIGN B - POST ON INSIDE OF PATIENT ROOM DOOR**BEFORE LEAVING PATIENT ROOM
(NO ANTEROOM):*****While still inside the room:***

- ✓ Pass specimens to assistant outside of room, directly into specimen bag. Assistant must wear N95 mask.



- ✓ If wearing two pairs of gloves, remove **outer** gloves after patient contact. Discard in waste.



- ✓ Remove gown by grasping at the neck and bringing it **forward** and off. Discard in linen hamper. If disposable, discard gown in waste.










- ✓ Remove **inner** pair of gloves.



- ✓ Sanitize hands with alcohol hand sanitizer.

- ✓ Have assistant open door to leave room or **open door with clean paper towel.**

BARRIER SIGN C - POST ON OUTSIDE OF PATIENT ROOM**AFTER LEAVING PATIENT ROOM
(NO ANTEROOM):**

- ✓  Apply clean pair of gloves
- ✓  Remove face shield by bringing it **forward** off the face and discard into waste
- ✓  Remove outer hair cover carefully **from front to back**, and discard into waste
- ✓  Remove goggles and place in bag for cleaning
- ✓  Remove mask by holding it in place while releasing straps, grasping mask and pulling **forward**, away from face. Discard into waste
- ✓  Remove gloves
- ✓  Decontaminate hands with alcohol hand sanitizer


BARRIER SIGN D - POST ON INSIDE OF PATIENT ROOM DOOR

**BEFORE LEAVING PATIENT ROOM
(ANTEROOM PRESENT):**

While still inside the room:

- ✓ Pass specimens to assistant outside of room, directly into specimen bag. Assistant must wear N95 mask.



- ✓  If wearing two pairs of gloves, remove **outer** gloves after patient contact. Discard in waste.

BARRIER SIGN E - POST IN ANTEROOM**IN THE ANTEROOM:**

- ✓ **Disinfect equipment** with hospital disinfectant and pass to cart outside room



- ✓ Remove inner pair of gloves.



- ✓ Remove gown by grasping at the neck and bringing it **forward** and off. Discard in linen hamper. If disposable, discard gown in waste.



- ✓ Sanitize hands with alcohol hand sanitizer.



- ✓ Apply clean pair of gloves



- ✓ Remove face shield by bringing it **forward** off the face and discard into waste



- ✓ Remove hair cover carefully **from front to back**, and discard into waste



- ✓ Remove goggles and place in bag for cleaning or disinfect with hospital disinfectant



- ✓ Remove mask by holding it in place while releasing straps, grasping mask and pulling **forward**, away from face. Discard into waste



- ✓ Remove gloves



- ✓ Wash hands

APPENDIX H: PROCEDURE FOR DONNING AND REMOVING PAPR

3 M Breathe Easy Hood (Powered Air Purifying Respirator (PAPR)) Gowning and De-Gowning Procedure for the OR

PAPR to be used in OR I unless otherwise notified Entry Preparations

- ❑ Check belt unit / hood to ensure proper assembly and function
- ❑ Remove jewelry, pagers, nametags and stethoscopes
- ❑ Make sure hair is contained (tied back)
- ❑ Scrub shirt/pants only, no T-shirts underneath, tuck long laces into shoes
- ❑ Cleanse hands with alcohol rinse
- ❑ Put on new N95 mask
- ❑ Put on bouffant hair cover
- ❑ Put on goggles
- ❑ Put on high-top shoe covers (to the knee)
- ❑ Put on clean surgical gloves
- ❑ Put on clean body suit, zipped up all the way, with neck covered and hood up
- ❑ Put on 2nd pair of high-top shoe covers
- ❑ Put on 2nd pair of gloves (1/2 size larger than first pair, cuff over suit),
- ❑ Check belt unit for proper function
- ❑ Back into power unit when putting it on, with the black hose up
- ❑ Make sure ON/OFF button is within your reach
- ❑ Tuck extra belt into waist band
- ❑ Put on surgical gown only tying at the side (don't use the inner ties)

- ❑ Place black tubing on outside of blue gown
- ❑ Put on 3rd pair of gloves
- ❑ Put on 3M hood, ensuring it covers ears, with gray headband around head
- ❑ Attach black hose to hood
- ❑ Turn on blower unit
- ❑ Adjust hood, ensure that it hangs over the gown
- ❑ Ensure that the system is working
- ❑ Check each others' systems and gowns
- ❑ Gather equipment needed in the room for the procedure (including 4-6 bags for post procedure)
- ❑ Enter room

- ❑ Post procedure, ensure equipment to be removed from the room is bagged and tied

EXITING ROOM

- ❑ Untie each others' waist ties on blue gowns, don't touch turbo unit belt pack
- ❑ Carefully remove first pair of gloves off
- ❑ Assist each other with removal of black hose from turbo unit
- ❑ Turn unit off through surgical gown
- ❑ Remove black tubing first and place into biohazard bag, then do other persons' black tubings also
- ❑ Remove protective hood from behind and place into biohazard bag, ensuring not to disturb goggles or mask
- ❑ Remove gown, roll inwards into self with a gentle rolling technique and discard into biohazard bag

- ❑ Remove second pair of gloves (leaves one pair on)
- ❑ Undo belt and battery pack and place into transparent biohazard bag and seal it
- ❑ Notify extra person outside that you are ready to leave the room. Don't touch the door
- ❑ Extra person opens the door for you
- ❑ Remove shoe cover in the OR and step onto the decontamination carpet on the floor in the hallway, and then repeat for other shoe cover
- ❑ Remove third pair of gloves
- ❑ You are now outside OR I (designated staff entrance/exit)

In the Hallway

- ❑ Alcohol rinse hands
- ❑ Put on clean gloves
- ❑ Unzip the body suit
- ❑ Remove body suit, touching only the outside, starting by pulling off the hood, then remove the suit from the shoulders down to the feet (do not remove your hands from the inside of the sleeves) and place in biohazard bag
- ❑ Remove 2nd pair of shoe covers and place into biohazard bag; step off the mat
- ❑ Remove gloves and disinfect hands, wrists and lower arms
- ❑ Put on clean gloves
- ❑ Take off goggles
- ❑ Take off cap by pulling front to back
- ❑ Take off mask by pulling forward off the face (cut the straps if scissors are available)

- ❑ Take off gloves
- ❑ Rinse hands
- ❑ Put on new N95 mask

Leave the area