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Restructuring the surgical service during the COVID-19 pandemic: experience from a tertiary institution in Singapore

Editor

The COVID-19 pandemic has overwhelmed healthcare institutions, even in developed countries[1–3]. As one of the earliest countries to experience the outbreak, Singapore has had the advantage of refining and reflecting on its response so far. Key considerations were self-sufficiency, safety, scalability and sustainability to: mobilize resources and free up hospital infrastructure; decrease staff infection rates; and maintain essential surgical services for as long as possible. High-risk patients were admitted to general medicine for evaluation and transferred to surgery only after clearance. With the exception of cancer and emergency cases, all surgical, endoscopic and outpatient appointments were postponed. All meetings were shifted online via video-conferencing and overseas leave was cancelled.

Designated pandemic wards managed confirmed or high-risk cases, providing natural segregation among nursing staff. Within clean wards, further spatial segregation was implemented with extra 'floater' nurses caring solely for unconfirmed low-risk patients. Central to the plan was the reorganization of medical staff into three independent teams to avoid the complete shutdown of outpatient services should any team become infected. On a weekly rotational basis, one team took a turn to perform inpatient duties, while the other two teams performed outpatient tasks. After one cycle, we conducted a staff survey using the Professional Quality of Life Measure (ProQOL 5)[2] and examined patient safety data. Staff reported moderate burnout rates, with administrative staff and nurses expressing a higher level of burnout and traumatic stress than clinicians. No impact on adverse event or incident reporting was found. Looking forward, we need to transition back to routine care to ensure sustainability, especially once the curve is flattened and the national strategy switches to the mitigation rather than containment phase. This is a fine balance as prolonged suspension of elective surgery would result in patient morbidity and mortality[3,4].

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