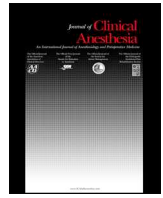




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## Correspondence

## Preoperative assessment organization in the time of the outbreak COVID-19



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The 2019 novel coronavirus disease (COVID-19) is an acute respiratory disease caused by SARS-CoV-2 that is spread from human-to-human through close contact and via respiratory droplets. Due to lack of sufficient awareness in the early stages of the pandemic, some healthcare providers have been infected [1,2]. To protect staff and non-infected patients from potential COVID-19 cross-infection, traditional work routines were reviewed and modified in our anesthesiology department and urgent measures were implemented. We summarize our organizational planning experience in the preoperative-assessment clinic (PAC) while continuing to maintain a service under difficult circumstances.

Besides general infection control preparedness in the hospital (triage of all patients at entrance outside the hospital wards, risk stratification for hospital areas, designated COVID-19 wards, separation of entrances and passageways between patients and healthcare providers...), special arrangements have also been made for PAC.

Currently, about 90% of all patients who undergo programmed surgery in our main operating rooms are first seen face to face with a Consultant Anesthetist (CA) in the PAC. Usually 60–65 patients are evaluated daily, 5 days a week. It was quickly determined that an additional CA was necessary in order to reduce the waiting time in the PAC patient-waiting area. Thus, a second box was dedicated for preoperative assessment.

All patients are required to wash hands with 70% alcohol solution before admission to the patient-waiting area. Alcohol dispensers were installed in different zones throughout the PAC and infographics are currently displayed on walls as reminders to perform hand washing regularly.

To reduce the density of patients in the patient-waiting area, only five patients are allowed to be present at the same time with a minimum-security distance of 1.5 m between each one. The patients who cannot be roomed immediately, are asked to wait outside the facility (preferably in a personal vehicle), and are contacted by mobile phone when a waiting seat becomes available. Prior to facility entry, they are provided with a surgical mask to wear. Accompanying persons are not allowed until necessary.

Since the PAC was designated as a moderate risk area in our hospital, we recommend that staff-members wear surgical masks and a hat. For members who may be in close contact with the patient, disposable gowns, single-use latex gloves and if available, goggles or reusable face visors are also used.

When the patient has to be examined on the examination bed, he is asked to turn his face to the opposite side of the CA. Airway assessment is a risky time for the CA as he can be in close proximity to the patient's airway. In order to keep the patient's and CA's faces apart, we have opted for projecting the airway examination via a mirror placed in front of the patient (Fig. 1). This assessment was the last one to be made for the patient. After completion of the examination, the CA removes their gloves and gown, washes their hands, and uses an alcohol-based hand sanitizer to kill any remaining microorganisms.

Hazardous waste bags have been placed in dedicated containers in the common areas and in each consultation box. The patient chair, examination bed and non-disposable medical equipment are systematically disinfected.

Additional measures were taken to eliminate the spread of the virus including turning off air conditioning and opening windows for good ventilation, and thoroughly cleaning and disinfecting all floors, surfaces and computers at least three times a day, using a broad-spectrum disinfectant of proven antiviral activity. All staff monitored and reported their temperature twice a day.

By following extraordinary measures, the risk of cross-contamination for both staff and non-infected patients could be greatly reduced while continuing to provide high levels of care. Projecting the airway assessment via a mirror placed in front of the patient can be a useful idea to minimizing viral contamination.

## Role of authors

Abdelghafour Elkoundi: This author helped in drafting manuscript, collecting data and giving final approval.

Abdelhamid Jaafari: This author helped reviewing manuscript and collecting data.

Mourad ababou and Ayoub Boubekri: The two authors helped in acquisition of data.



**Fig. 1.** The patient (represented here by a member of the medical staff) is placed in front of a mirror. The consultant anesthetist, placed behind the patient, performs a preoperative airway assessment. For a better view, a light source can be used.

Abdelouahed Baite: This author helped in reviewing critically the manuscript and giving final approval.

Mustapha Bensghir: This author helped in the conception of the idea, drafting manuscript and giving final approval.

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#### Declaration of competing interest

The authors declare no conflicts of interest.

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