COVID-19 Guidelines for ECT in Shared Health - FINAL

In addressing a unique clinical situation arising as a result of the COVID-19 pandemic, a balanced approached to the utilization of ECT is required. Recognizing the unique therapeutic role that ECT can play in mental health treatment, a plan to continue offering ECT must also acknowledge and mitigate the associated risks of COVID-19 transmission arising from the fact that airway management (e.g. bag-mask ventilation) for ECT is an aerosol generating medical procedure (AGMP). AGMPs result in sustained risk of exposure to the virus in the treatment room, until adequate air exchanges and cleanup have been completed.

Selection criteria for patients for ECT need to be applied with caution and diligence:

Psychiatrists who are proposing maintenance ECT should consider:

1. Whether the patient has received a trial of other evidence-based maintenance treatments (e.g. lithium plus nortriptyline).
2. Whether maintenance ECT is being used at the lowest frequency consistent with maintaining benefit.
3. Whether concurrent pharmacologic treatments could be used in conjunction with maintenance ECT to increase the interval between maintenance treatments.

Psychiatrists who are considering acute ECT treatment should fully consider and offer clinically appropriate alternative treatments before proceeding to offer ECT.

Additionally:

1. The following patients will not receive ECT therapy:
   - Those who screen positive for COVID-19 based on the most up to date Shared Health screening questionnaire
   - Those who are under investigation for COVID-19
   - Those who have tested positive for COVID 19
   - Those who have been asked to self-isolate and monitor for COVID-19

2. The physician requesting ECT and physicians responsible for the treatment may reserve the ECT only for a select group of people i.e. for the people at risk of physical deterioration or deterioration of psychiatric illness despite receiving other treatments.
3. Considering the increased time and personal protective equipment (PPE) demands of delivering ECT during the COVID-19 pandemic, the volume of treatments will need to decrease substantially

4. Outpatient ECT treatment will only be permitted under exceptional circumstances, and be approved by both Mental Health and Anesthesia medical site leadership.
5. To conserve PPE, only the minimum number of individuals should be in the room during the treatment. The recommendation is 3 individuals.
6. PPE should include gloves, level II gowns, eye protection, and N95 mask for all clinicians in the room at the time of the procedure.
7. Ambu bag/anesthesia circuit should have an attached HEPA filter.
8. At least 3 minutes pre-oxygenation and the minimum amount of bag mask ventilation throughout the procedure.
9. The ECT treatment area is considered contaminated until after 99% air filtration has occurred. Please refer to the attached table from CDC. Note the air changes per hour may be augmented with the use of additional HEPA filters. The door of the ECT treatment area should remain closed until 99% filtration has occurred. After that period of time, individuals in the room may leave and the area can be entered without N95 masks.
10. After the required time has elapsed, patient will be transported to a separate recovery area. In the recovery room, protection equipment will revert back to pre-procedure.

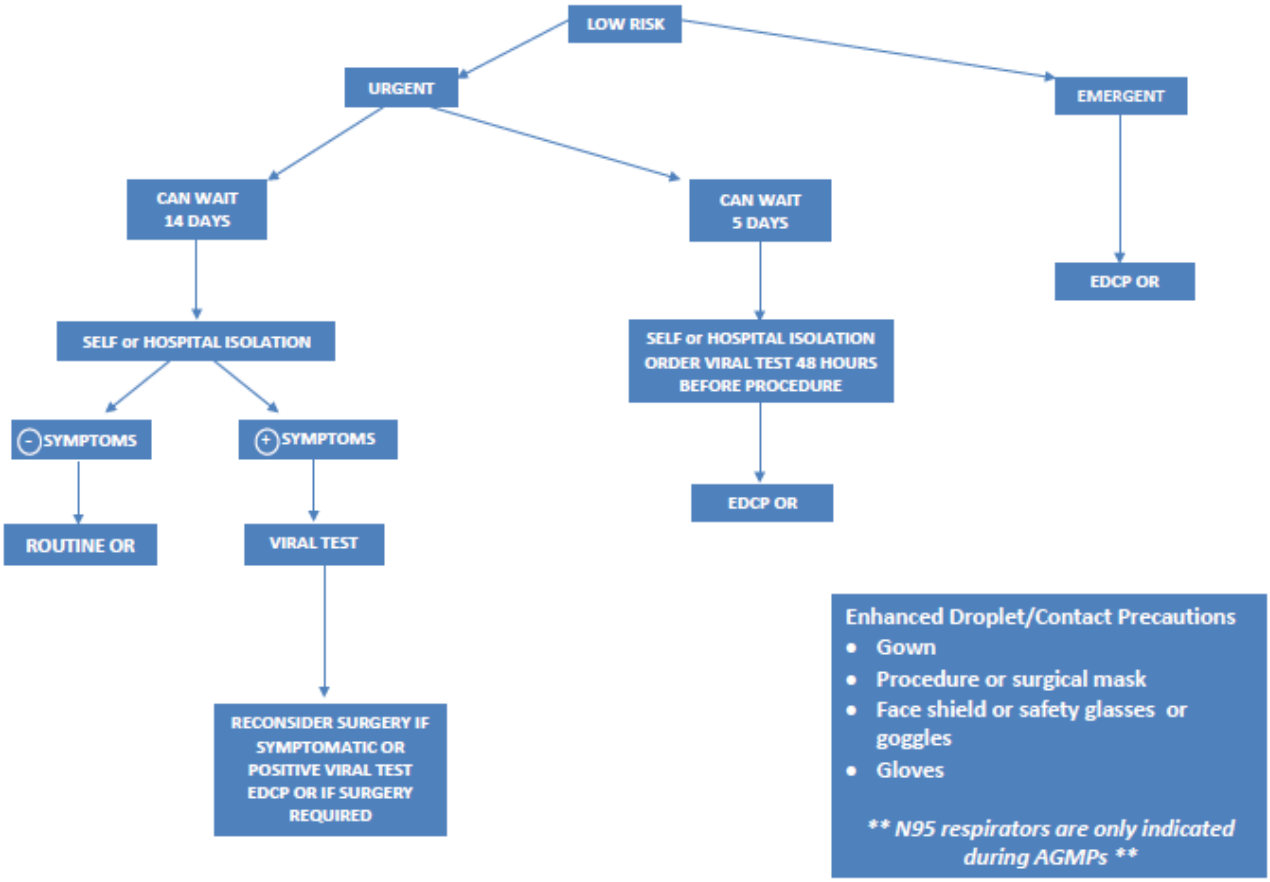
The decision to treat ECT patient as COVID-19 suspects is based on the Shared Health Manitoba Algorithm for low risk operative procedures, dated April 3rd, 2020. See figure below.

(Note that the figure below will be updated for ECT as it is updated for other operative cases – See April 5th, 2020 memo - attached). Social distancing is no longer adequate for assuring the patient is disease free. ONLY verified complete isolation for 14 days will now be adequate. This means all persons in an isolated home CANNOT have any contact with any person outside of the isolated home.

Version Date, April 7, 2020.
Primary Authors: Drs. Marshall Tenenbein, Murray Enns, Craig Haberman

PROTOCOLS FOR OPERATIVE CASES

Low Risk Procedure (Non Upper Aerodigestive Tract) - Low Risk Patient



April 3, 2020 COVID-19 Protocols for Operative Cases – Low Risk Procedure (Non Upper Aerodigestive Tract) Low Risk Patient

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MEMO

Date: April 5th, 2020

To: Site Anesthesia and Surgery Leads
WRHA Surgical Service Leads
Site Chief Medical Officers
Surgery Site Program Directors

CC: Nancy Dixon, Chief Medical Officer, WRHA
Krista Allan, Chief Health Operations Officer, WRHA
Lanette Siragusa, Provincial Lead, Health System Integration, Quality/Chief Nursing Officer, Shared Health

From: WRHA Surgery/Anesthesia Programs

Subject: **REVISED - Supplemental information regarding guidelines and algorithms for screening of COVID-19 for urgent/ emergent surgical cases**

As the COVID-19 situation is evolving there are changes to the way patients need to be treated when going to the OR and algorithms for surgery.

Social distancing is no longer adequate for assuring the patient is disease free. ONLY verified complete isolation for 14 days will now be adequate. This means all persons in an isolated home CANNOT have any contact with any person outside of the isolated home. (At this time this may only apply to cancer patients needing surgery).

The 5 day pathway mentioned in the previous algorithms only now applies to Upper Aerodigestive Tract Surgery (high and low risk) cases.

The need for viral swab testing pre-operatively will only be done on Upper Aerodigestive Surgery cases, and those patients who are displaying respiratory symptoms. This is to be done 48 hours prior to surgery. (Following the protocol outlined by Dr. Buchel on April 1, 2020).

At this time ALL other surgery, at ALL sites are to use Enhanced Droplet/Contact PPE this means: gowns, gloves, surgical mask and eye protection. N95 masks are only required during AGMP.

For ALL surgery under a general anesthetic the guidelines for intubation and extubation remains the same:

1. Anesthesia team **ONLY** present during Intubation: Enhanced Droplet/Contact PPE using N95 respirator and full face shield.

2. Wait 30 minutes before the Surgical team can enter the theater - Enhanced Droplet PPE using a gown, surgical mask and eye protection (face shield or safety goggles), and gloves.

3. Anesthesia team **ONLY** present during extubation: Enhanced Droplet/Contact PPE using N95 respirator and full face shield.

4. After 30 minute wait time, patient transferred out of the OR using Enhanced Droplet/Contact PPE - gown, surgical mask, eye protection (face shield or safety goggles), and gloves.

5. PPE Acute and Sub-Acute Surgical Inpatient Settings protocol are to be followed for the remainder of the patient stay in hospital.

- If possible, COVID-19 positive patients should be recovered in the OR theater, unless there is an isolation room in PACU.

To help facilitate and to ensure the correct PPE is used for all surgery, Anesthesia will be the lead on the PPE requirements for every surgical case.

Effective Immediately:

1. Prior to the start of each case conduct a briefing which attending Anesthesia and Surgical staff MUST participate in. In addition to the routine briefing, it will be clearly outlined by Anesthesia the appropriate PPE for each health care worker in the OR and the sequence of events for the case. This will be lead by Anesthesia and Anesthesia WILL have the final say on the appropriate PPE for ALL staff involved.

2. With the exception of emergent situations and/or unstable patients, limit the amount of Anesthesia staff in the room to 2 people.

- If possible and safe to do, the favoured approach would be to perform intubation/extubation with an OR Nurse, or OR Assistant, instead of a second Anesthetist.

PPE is in short supply. To do this we MUST limit the number of people involved in every case. Please keep to the following guidelines:

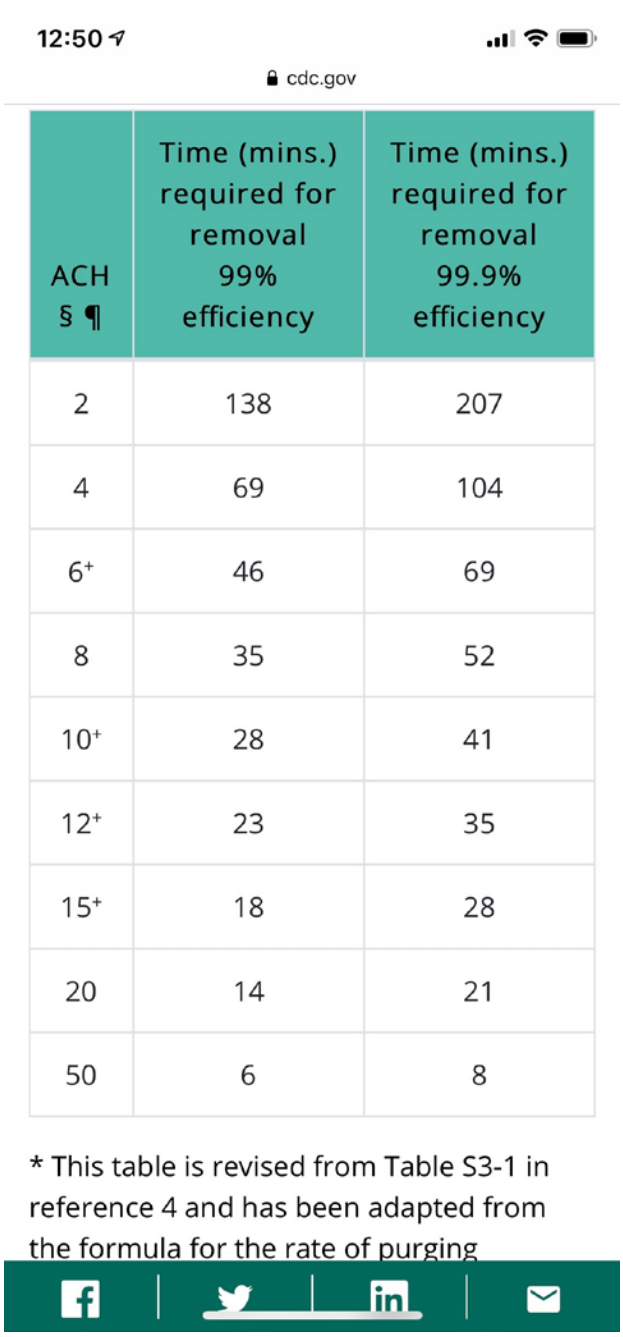
1. The operative surgeon and one surgical assist will be allowed in the case. If more than one is needed to complete the case safely, this needs to be discussed at the surgical time out.

2. Surgeon and surgical assist should NOT switch out during the case unless absolutely necessary.

3. To limit length of cases, closure should be done as quickly as possible and not be delegated to the assist alone.

4. The surgical team (at least one member) must be immediately available to the OR until the patient is transferred to PACU.

Your efforts to conserve PPE and protect patients and all healthcare providers are greatly appreciated.



ACH § ¶	Time (mins.) required for removal 99% efficiency	Time (mins.) required for removal 99.9% efficiency
2	138	207
4	69	104
6+	46	69
8	35	52
10+	28	41
12+	23	35
15+	18	28
20	14	21
50	6	8

* This table is revised from Table S3-1 in reference 4 and has been adapted from the formula for the rate of purging