

# Guidelines for Pre-Procedural Testing for SARS-CoV-2 in asymptomatic patients

DOC ID HHCMPA102023

Effective Date: 3.14.2023

Page 1 of 6



<b>Purpose</b>	To provide updated guidance regarding requirements for SARS-CoV-2 testing for asymptomatic patients before elective surgery or procedures.	
<b>Scope</b>	NYC Health + Hospitals	
<b>Guidelines</b>	<b>Standard Measures</b>	<p>All patients should be reminded to wear a well-fitting mask unless alone in a single occupancy room.</p> <p>All staff should adhere to current standard H+H PPE guidelines, along with transmission-based precautions where applicable.</p> <p>All staff and patients to adhere to proper hand hygiene.</p>
	<b>SARS-CoV-2 Testing</b>	<ul style="list-style-type: none"><li>a. Routine pre-procedure SARS-CoV-2 testing is no longer necessary for asymptomatic patients and standard infection control practices should be applied to these patients.</li><li>b. Patients anticipated to have an inpatient admission of &gt; 48-hour duration after the procedure must have a SARS-CoV-2 PCR test done on the day of surgical procedure. Testing can be done post-procedure, but a negative result should be available before deciding to triage to an inpatient shared occupancy space.</li><li>c. Asymptomatic patients who test positive on day of surgery may have procedure/surgery and should follow protocol for operating on COVID positive patients (unless there is medical indication for postponing procedure). See Appendix A.</li><li>d. Inpatients, already admitted to the hospital prior to surgery, who were COVID tested negative on admission and remain asymptomatic do not need to be re-tested prior to day of procedure/surgery.</li><li>e. Testing not recommended for asymptomatic patients who recovered from COVID in the past 30 days.</li></ul>

**Guidelines for Pre-Procedural Testing for SARS-CoV-2 in asymptomatic patients**



**DOC ID** HHCMPA102023

**Effective Date:** 3.14.2023

**Page** 2 of 6

	<b>PACU and other congregate recovery spaces</b>	<ul style="list-style-type: none"><li>a. Ensure social distancing is maintained. Patients should be a minimum of 6 feet apart.</li><li>b. Privacy curtains should be drawn to separate patient areas whenever possible.</li><li>c. Continue Merv 13 HEPA filters in congregate areas.</li><li>d. Any planned or anticipated aerosol generating procedures (AGPs) during recovery should be performed in an Airborne Infection Isolation Room (AIIR) with the door closed. If an AIIR is not available, AGPs may be performed in a single occupancy patient room with the door closed.</li><li>e. Healthcare staff performing AGPs should be using N95 respirators and eye protection regardless of the patient's COVID-19 status.</li></ul>
<b>Reference</b>	<p>CDC: <i>Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic</i>.</p> <p>NYSDOH: Hospitals, diagnostic and treatment centers, physician offices, dental offices, local health departments, and office-based surgery practices. February 28, 2023.</p>	

**APPENDIX A. Peri-procedural guidelines for Covid-positive patients including isolation precautions, patient placement and cohorting**

These guidelines apply to time-sensitive procedures for patients with COVID-19 who are still considered infectious.<sup>1</sup>

1. Patients must wear a surgical mask at all times when outside of their hospital isolation room.
2. Schedule surgery or procedure for end of the day if possible.
3. The number of personnel entering the operating room or procedure room should be kept at a minimum.
4. All staff entering the operating room or procedure room should wear N95 respirator and eye protection.
5. All doors to the operating room or procedure room should be kept closed as much as possible while the patient is inside. This is particularly important during and after intubation, extubation, and other AGP's (**Table 1**).
6. HEPA filter should be used on the breathing circuits and expiratory tubing for intubated patients.
7. Extubation should be performed either in the operating/procedure room or in an airborne infection isolation room (AIIR) with the door closed.
8. Operating rooms should remain positively pressurized in order to minimize surgical site infection risk.
  - a. Negative pressure rooms are not recommended for Operating Rooms when caring for known or suspected Covid positive patients.<sup>2</sup> Ventilation design following current ASHE/ASHRAE standards for operating rooms<sup>3</sup> are adequate for control of airborne spread of COVID-19 in operating rooms and adjacent areas. No supplemental HEPA filtration within the operating room is needed.
9. After any AGP (e.g. extubation), allow enough airing time (**Table 2**) (based on the room's air changes/hour) to allow removal of airborne contaminants with >99% efficiency before allowing COVID-negative patients to enter the same room.<sup>5</sup> If unable to determine the room's air changes/hour, allow at least 60 minutes of airing time.
10. All staff (including EVS) should wear an N95 respirator and eye protection when entering the room prior to completion of the airing time. There is no need to wait to enter the room or to initiate cleaning of the room.

**Recovery space options (prior to return to hospital unit isolation space)**

1. Patients should recover in a single occupancy isolation room with the door closed. If AGPs are anticipated, these should ideally be performed in an airborne infection isolation room (AIIR).
2. If patient came from ICU initially, return to ICU directly for isolation.

**References**

1. ASHE/ASHRAE: Current/Updated Health Care Facilities Ventilation Controls and Guidelines for Management of Patients with Suspected or Confirmed SARS-CoV-2 (COVID-19):  
<https://www.ashe.org/system/files/media/file/2021/02/ventilation-health-guide.pdf>



2. APSF Newsletter. 36(1):30. <https://www.apsf.org/wp-content/uploads/newsletters/2021/3601/APSF3601.pdf>
3. Current ASHE/ASHRAE standards for Ventilation of Health Care Facilities: [https://www.ashrae.org/file%20library/technical%20resources/standards%20and%20guidelines/standards%20errata/standards/170\\_2017\\_a\\_20200901.pdf](https://www.ashrae.org/file%20library/technical%20resources/standards%20and%20guidelines/standards%20errata/standards/170_2017_a_20200901.pdf)
4. <https://www.epa.gov/indoor-air-quality-iaq/what-hepa-filter-1>
5. <https://cdn.dal.ca/content/dam/dalhousie/pdf/dentistry/CDC-%20Appendix%20%20Environmental%20Guidelines%20%20Guidelines%20Library%20Infection%20Control%20%20CDC%20copy.pdf>

**Table 1: List of Aerosol Generating Procedures (AGP)**

The list of AGPs will be assessed on a regular basis for inclusion or exclusion of procedures.

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>• Airway Surgeries (e.g., ENT, thoracic, transsphenoidal surgeries)</li> <li>• Intubation</li> <li>• Extubation</li> <li>• Chest Compressions</li> <li>• Nebulization</li> <li>• High flow oxygen, including nasal cannula, at &gt;15L</li> <li>• Non-invasive positive pressure ventilation (e.g., CPAP, BIPAP)</li> <li>• Oscillatory ventilation</li> <li>• Bronchoscopy</li> <li>• Sputum induction</li> <li>• Pulmonary function testing</li> <li>• Rehab swallow evaluations</li> <li>• Cardiac stress test (Exercise only)</li> </ul> | <ul style="list-style-type: none"> <li>• Open suctioning of tracheostomy or endotracheal tube</li> <li>• Tracheostomy change</li> <li>• Manual ventilation (e.g., manual bag-mask ventilation before intubation)</li> <li>• Disconnecting patient from ventilator</li> <li>• Upper endoscopy (including transesophageal echocardiogram, nasal endoscopy)</li> <li>• Venturi mask with cool aerosol humidification</li> <li>• Ventilator circuit manipulation</li> <li>• Dental surgeries</li> </ul> |
|---|---|

**The following are not considered aerosol-generating:**

- Non-rebreather or oxymask, face mask, or face tent up to 15L
- Humidified trach mask up to 20L with in-line suction
- Routine trach care (e.g., replacing trach mask, changing trach dressing)
- In-line suctioning of endotracheal tube
- Routine Venturi mask without humidification
- Suctioning of oropharynx
- Nasopharyngeal swab
- Proning is not inherently aerosol-generating but aerosols are possible if the endotracheal tube becomes disconnected during the proning process

**Table 2. Airing time needed for airborne contaminant removal**

Air changes/hour (ACH) and time required for airborne-contaminant removal by efficiency

The number of air changes per hour and time and efficiency.

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

Source: <https://www.cdc.gov/infectioncontrol/guidelines/environmental/appendix/air.html>

Guidelines for Pre-Procedural Testing for SARS-CoV-2 in asymptomatic patients

DOC ID HHCMPA102023

Effective Date: 3.14.2023

Page 6 of 6



Reviewed and/or Revised

Prepared  
by:

Mary Fornek *Mary Fornek* System Director, Infection Prevention 3/7/2023  
Name/Signature Title Date

Justin Chan *Justin Chan, MD* Infectious Disease Specialist 3/7/2023  
Name/Signature Title Date

*Machelle Allen* 3/14/23  
Machelle Allen SVP/System Chief Medical Officer 3/14/2023  
Name/Signature Title Date

Previous Versions of this Guidance

Signature	Title	Date
Machelle Allen	SVP/CMO	Version 1 – March 2023