UROLOGICAL SOCIETY OF AUSTRALIA AND NEW ZEALAND

Guidelines

Principles of Urological Healthcare Management in the COVID Era

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Subject:	Patient Care	**Distribution:**		Members Only	
Authorised by:	Board of Directors	**Approved Date:**	30.9.2021	**Review Date:**	As needed

Purpose and Scope

This document aims to assist individuals and units in the decision-making process in holistic healthcare provision in the COVID-19 era. COVID-19 has posed a challenge to paradigms of patient care and prioritisation in the context of rapidly evolving changes in resources. Not only do we have to be concerned of the individual patient and their condition(s), but there are now additional responsibilities to healthcare providers, the healthcare system, and the population in general.

This is not designed to replace established local guidelines. The effect of COVID-19 on health care provision is variable depending on the extent of disease penetration into the community, vaccination, government response, preparation of the health systems and available resources. Expect the situation to change, affecting the underlying priorities. Individuals, units, and processes must be ready to adapt and accommodate to the fluidity and rapidly changing conditions. There must also be consideration of all clinical needs within a healthcare precinct.

Principles

Treatment of patients and their health issues have to more than ever be prioritised against these competing factors:

- Potential of the condition to deteriorate and cause harm to the patient.
    - Taking into account disease process and impact on life / organ damage
- Opportunity cost of treating one patient over another.
- Limitation in health service resources
    - Availability of appropriate personal protective equipment and materials
    - Treating clinicians and staffing
    - Hospital and ICU beds available in the system
- Potential for the patient and treatment staff to be exposed to COVID as a result of interventions.

This document does not seek to impose rigid standards of which conditions rank as higher or lower priorities. When resources are more plentiful, routine categorisation can be applied. However, when resources are extremely limited, individual cases and their merits may have to be assessed. This must be done in a collegiate manner.

Tools for decision making and patient weighting (not limited to):

- Established hierarchy of conditions / protocols
- Discussion with senior or experienced colleagues
- Multidisciplinary forums

- Bear in mind these standards and conditions of triage will change depending on resources and impact of COVID
- To communicate available resourcing or limitations in the system
- To ensure fair and objective decision making

- Hospital executive input where relevant

  Further resources may be available for elective treatment in private hospitals or hospitals designated to treat non COVID patients. Good communication across hospitals and units to load share may be necessary to spread workload and resources equitably.

Processes to re-evaluate or review the status of patients

Processes should exist to re-evaluate or review the status of patients who have been deferred. These may include:

- Review by treating and triaging team.
- Education of patient and self-referral
  - Patient aids such as fact sheets
- Evaluation by other practitioners such as GP's according to an interim plan or framework.
  - Keeping aware that patient access to these resources may be limited.
- Establishment of pathways to feedback deterioration such as an email or telephone number
- Maintenance of a recall system
  - A process for reintegration of patients from the COVID waitlist into a post COVID environment as resources normalise (which may include)
  - Principles of first-on first-off.
  - Continuing to adhere to "needs first" principle
  - Education of patients that it may still take time to revert to "normality"

Limitation of travel and potential for exposure

- Limit patient face to face interaction
  - Use of telephone and telehealth where possible
  - Units and practitioners may choose to integrate some of these practices even prior to COVID limitations so that they are tested and familiar.
  - Use of online and video aids as an adjunct to in person counselling
  - Language barriers and interpreter services may need to be taken into account
    - Telephone interpreters
    - Patients who require support relatives who cannot be with them may need to have a conference call or separate call / teleconference
  - Re-consider ordering low yield tests to limit potential COVID exposure to patient and hospital.
    - Disclose to patient departure from "normal"

- Consider procedures that reduce hospital stay including day case TURP / HOLEP / robotic prostatectomy
    - Education of patients and family that reducing hospital times are to their benefit
- Consider temporising procedure if it is less resource intensive / shorter stay / reduces acuity of patient.
- Consider the role of screening and pre-admission testing (and self isolation until negative result) for COVID

Health advocacy

- Those surgeons not deployed for operating lists could advocate for non-surgical / medical therapies which would allow remote treatment of patients
- Surgeons not performing operating lists also could be deployed in teaching and supervision
- Advocate vaccination to staff and patients.
- Advocate safe behaviours to reduce contagion
    - Social distancing/isolation
    - Use of PPE/masks

Staffing

- Consider staffing and rostering to reduce staff exposure potential.
    - Staff may be able to deliver service from home or self-quarantine
        - Phone clinics
        - Consultations of inpatients / ED / GP and advice over the phone
        - Teaching and tutorials should be able to continue via videolink
        - Triage of patients and referrals
        - Virtual/remote guidance of junior medical staff
- Consider limiting interactions between staff to reduce potential for transmission
    - Split teams
    - Use of teleconference for teaching ward rounds, radiology, MDT and other meetings
- Consider contingencies if junior medical staff are redeployed to COVID service.
    - Consultant ward rounds may be necessary without junior medical staff available
    - Urologists may need to be re-deployed to COVID care
        - Maintain PPE competencies to protect oneself
        - Be open to upskilling / recognise own prior experience
- Consider internal redundancies (reserve staff for contingencies) to account for staff being unable to work conventionally due to circumstances:
    - COVID infection
    - Co-morbidities / pregnancy
    - Burnout / fatigue

- Staff health and welfare considerations
    - Have formal and informal processes to assess and maintain morale / mental health
    - Advocate for immunisation
    - Prepare by prioritising personal safety measures
        - PPE Fit testing
        - Training in use of PPE
        - Familiarity of patient handling protocols
    - Try to maintain training opportunities / career development for junior doctors
        - Trainees – preparation for exams / tutorials
        - Non-trainees – engagement

Superseded documents

- None

Revision history & Review date

These guidelines will be monitored and reviewed by the Board as the health crisis develops.

Version	Date	Notes	By
1.0	30.09.2021	Approved	Board of Directors

Contact

USANZ President, Email: president@usanz.org.au