SCGH ED Intubation Confirmed or Suspected COVID-19 v1.3

General

Outside room

Plan

Inside Room

Post

Timing

Prevent ED intubation by referral and transfer BEOFRE deterioration

Consider intubation early
- Minimise staff exposure
- Maximise preparation

Location

Isolation Room

If this is not available

Fast Track with doors closed

Decision to intubate

- Senior Medical assessment – Documented
- Call anaesthetics
- Inform ICU

Information for DA

- For full escalation of care?
- COVID-19 positive or suspected?
- ICU aware?
- Pertinent medical history for intubation
  - Airway risk / physiology risk

Call the Special Airway Service 24 hours via Duty Anaesthetist ext. 71242

Don Personal Protection Equipment (PPE)

Aerosol precautions
Be Thorough, don't rush

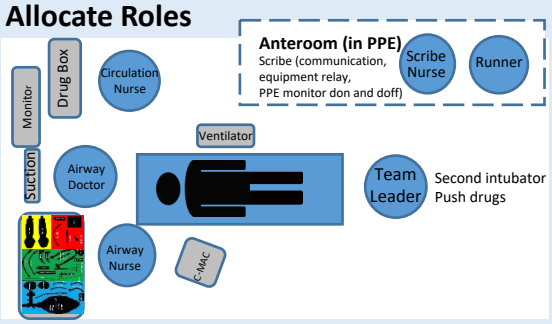
Leave personal items outside: phone, stethoscope etc

Follow don and doff flowchart

- **Wash Hands (soap & water)**
- **Gown** – Back covered
- **N95 mask** – with fit test
- **Hat**
- **Face Shield**
- **Gloves**

Buddy Check

Allocate Roles



SAS Anaesthetic Team will take handover and replace

- **ED Airway Doctor with Anaesthetist**
- **ED Team Leader with Anaesthetist**
- **ED Airway Nurse with Anaesthetic tech**

Get and Check Equipment

Kit Dump Equipment
- Prepare on trolley outside room
- Use dump sheet to lay out equipment
- Kit dump equipment should remain outside isolation room unless required - anaesthetic team will bring their own equipment

Check BVM Circuit
- Mask>Filter>ETCO2>BVM>PEEP valve
- PEEP valve set to 10cmH20

C-MAC + VL Blades
- Cover with plastic bag in basket
- Ensure appropriately sized VL blade fitted and screen working
- Hyperangulated D blade & GlydeRite stylet available in anteroom

Ventilator Pre-set for ARDS
TV = 6ml/Kg IBW I:E = 2:1 RR = 14 PEEP 10-15

Check Drugs

Ketamine 2mg/Kg (reduce dose if haemodynamically unstable)

Paralytic agent Use higher mg/kg dose of muscle relaxants rapid onset and reduced coughing.

Rocuronium 1.6mg/Kg (IBW)
or
Suxamethonium 1.5mg – 2.0mg / kg (TBW)

What is the plan for difficult intubation? Confirm agreed plan. Does anyone have any concerns?

Plan A – Primary Plan

RSI

Most experienced operator

Use Video Laryngoscope

Plan B/C – Rescue Oxygenation

2-Handed BVM
- **Adjuncts**

2nd Generation LMA

Plan D – Front of Neck airway

Scalpel-bougie-tube

Required equipment should be in the room for intubation

Patient Prep

- Apply monitoring
- Assess Airway
- Check IV access
- Optimise position
- Check Suction
- Check 02

Pre-oxygenation

45 degree head up position

5 minutes 2 hand technique
BVM + Filter + PEEP valve
(10-20cmH2O) with 15L/min 100% O2

Low Flow NP 4L/min concurrent with BVM – remove for intubation

- Do not ventilate
- Do not use NP for apnoeic oxygenation
- Do not use NIV

Modified Rapid Sequence Intubation for COVID-19

- **Avoid Cricoid pressure** (avoid cough)
- **Avoid BVM ventilation** during apnoeic period unless life-threatening refractory hypoxaemia
- **Videolaryngoscope – indirect (screen) view** to maximise distance from patients airway
- **Inflate cuff** prior to ventilation
- **Clamp ETT** when changing from BVM to Vent
- **HMEF Filter** should always be connected to patient

Airway management post intubation

- Confirm ETT position with ETCO2
- Use closed suctioning systems
- Monitor Cuff Pressure to avoid leak
- Keep 45 degree head up position

Organise Transport of Patient

- Activate COVID-19 transfer protocol
- Ensure receiving location aware

Disposal, Decontaminate, Doff, Debrief

- Gloves > HH > Gown > HH > Eyeware > HH > Hat >HH >Mask > Wash Hands
- Buddy check
- **Debrief**