Intubation in Confirmed/Suspected COVID 19

Risks
- High risk for staff & patients (In setting of resp failure 20% desaturate to < 80%, 2% cardiac arrest)
- Aerosol generating procedure
- High risk of environmental contamination

Goals of technique
- 1st pass success
- Minimise aerosol generation (Manual ventilation/Intubation/extubation/suction/circuit disconnections)
- Minimise contamination of environment

1. Personnel (max 4) all in AGP PPE
Two doctors with intubation skills
- **Intubator 1 (most experienced)**
- **Intubator 2 (core role: drugs, reconfigure circuit post intubation, FONA if required)**

Anaesthetic assistant /ODP
Outside runner (in AGP PPE in airlock/outside)

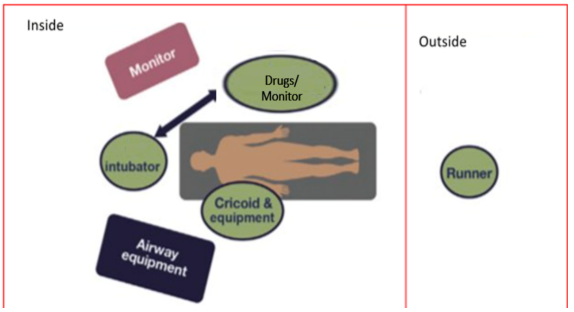
2. Equipment
Negative pressure room (ideal)
Metal trolley
Aim to have everything you might need to avoid need to leave room (See appendix 1)
Consider need for diagnostic tracheal aspirate
Consider planning to insert NGT, CVC & art line prior to leaving room

3. Team brief
Introduce/Allocate roles
Weight, allergies, anticipated difficulties,
Role of runner, Sugamadex/FONA location
Plan A: RSI with VL (minimal ventilation)
Plan B/C: 2 person BVM / Igel (minimise leak)
Plan D: FONA

4. Don PPE for AGP (see local guidance)
Fluid repellent gown, gloves x2, FFP3 mask, visor
Get buddy to check
Write name/identifier on gown

*****ENTER ROOM NOW*****

5. INSIDE ROOM
Apply monitoring
IV access, Art line (if appropriate)
Optimise position, ramp etc
Identify cricothyroid membrane (in case FONA)
Check ventilator/tubing set up
Assemble Mapleson C with HMEF patient side of capnography (always ensure HMEF in place)
Remove facemask if in situ
Pre-oxygenate low flow 6L/min O2, good seal
Orange waste bag near at hand



*****TIME OUT*****

6. INDUCTION
Minimal/no facemask ventilation, 2 person technique
Place used equipment in orange waste bag
Wait for muscle relaxant to work. No coughing!
No ventilation prior to cuff inflation
Clamp tracheal tube prior to each disconnection
Connect closed suction & HMEF (Intubator 2 key role)
Connect ventilator, check cuff pressure
Ensure all twist connections tight to avoid disconnect
Commence sedation etc..
NOTE TIME (when 20mins starts) & tube length

7. ANCILLARY PROCEDURES
Tracheal aspirate viral PCR/micro
NG tube
CVC insertion if required

8. AFTERWARDS
Dispose of used disposables
Decontamination of re-usable equpment
After 20 minutes aerosolised droplets will have settled and okay to enter with standard mask PPE
Can decontaminate environment at this point.
Meticulous doffing procedure with buddy
Wash your hands

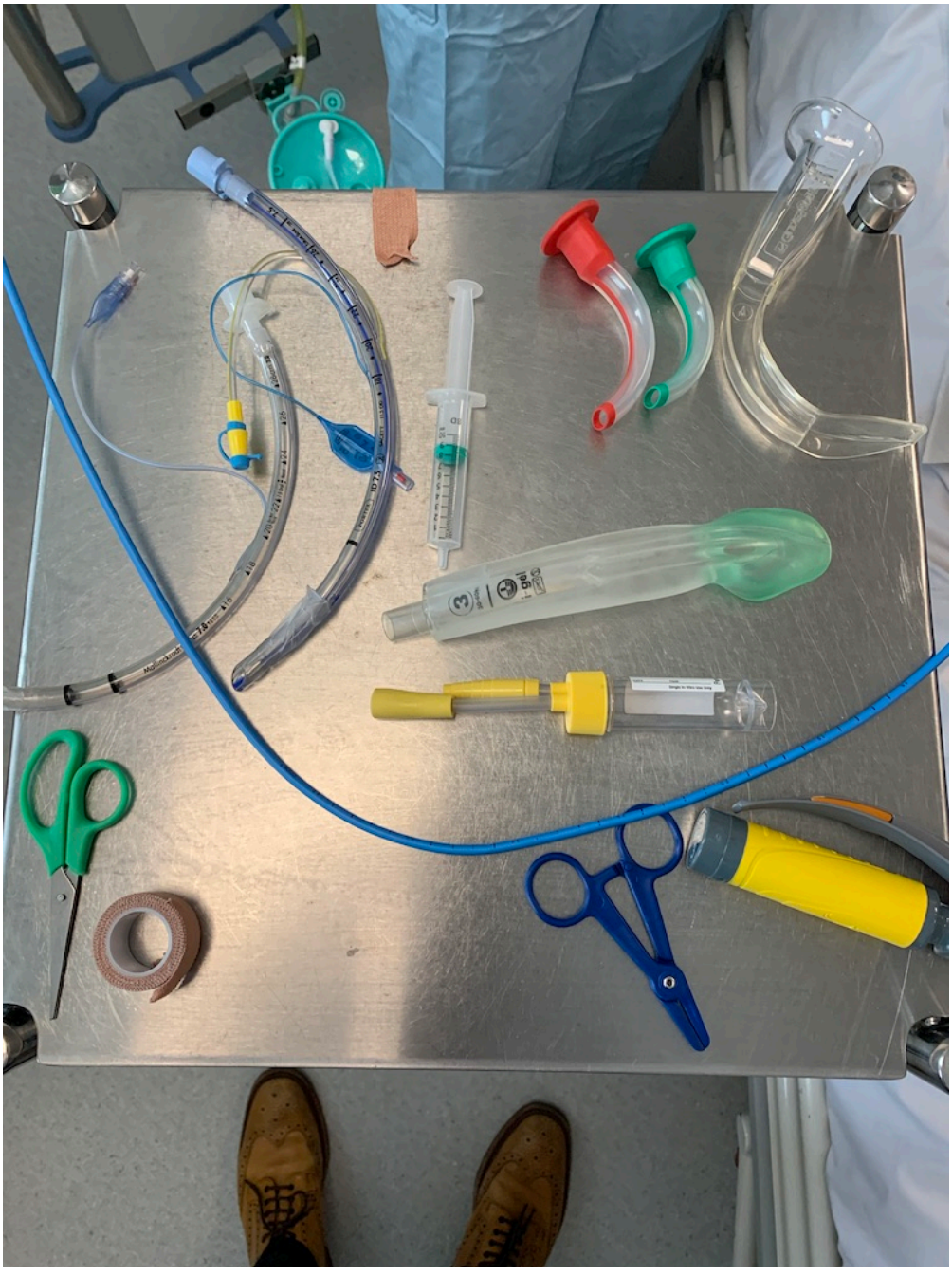
CONTAMINATION
If any significant contamination of a HCW occurs they must wipe the area with a Clinell sanitising wipe and have a decontamination shower in the nearest shower, changing clothing

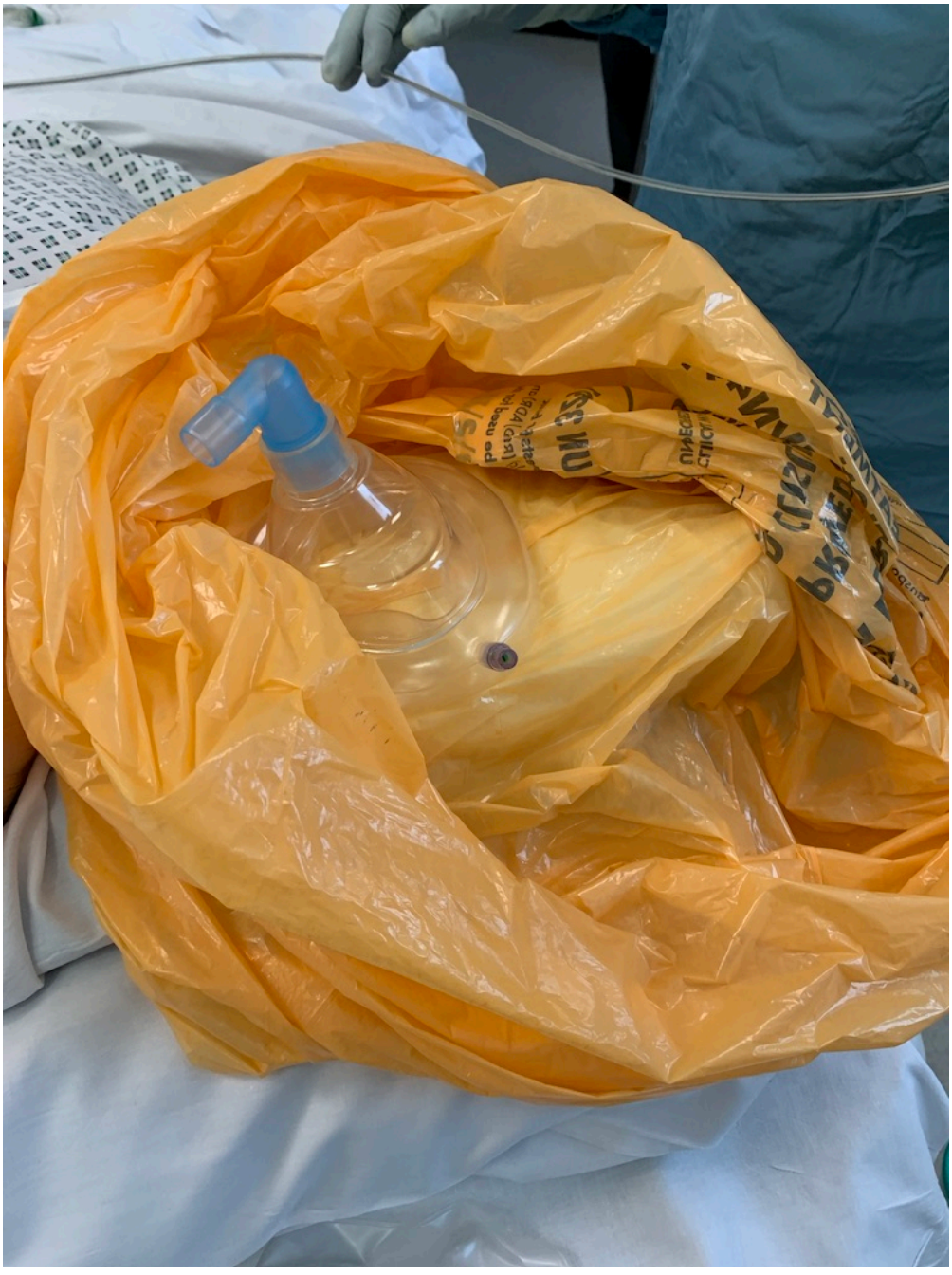
Appendix 1 – Pre Intubation Kit Checklist

- ***Drugs:***
- Prepare drugs outside room in tray (induction, ongoing sedation, CV support)
  - Eg Ketamine 1-2mg/kg
  - Rocuronium 1.2mg/kg
  - 2% propofol infusion/opioid
  - Metaraminol
- Ensure the red portable drug bag is available in the room. This contains all necessary drugs.

- ***Equipment (available pre-assembled on Metal Trolley) [Guide only]:***
- Anaesthetic facemask (s)
- Videolaryngoscope & stylet
- Disposable laryngoscope - size 3 and 4
- Guedel airways – green/orange
- Subglottic ET tubes - 6, 7, 7.5, 8
- 10ml Syringe x 12
- Bougie
- Igel
- Scalpel (FONA kit)
- Tape & scissors
- Lubricant *
- Mapleson “C” circuit (green bag)
- **HME/Filter (dual function eg Intersurgical Filter-therm)**
- Capnography
- Yankeur suction
- Closed suction
- 20ml 0.9% Saline & yellow tracheal aspirate trap (if diagnosis unclear)
- Ventilator tubing (dry circuit)
- Blue tube clamp
- NG tube & bag
- Magills forceps
- CVC kit – see separate SOP (+/- US machine)
- Art line kit
- Clinell wipes
- Orange bag for waste on bed


PROPOFOL






Single Patient Use
INTERSURGICAL