

Guideline for intubation and initial management of COVID-19 patients

Indication for mechanical ventilation

Early intubation in the deteriorating patient

- Hypoxia despite increasing O₂ therapy and signs of respiratory decompensation (↑RR, fatigue, ↑PCO₂)
- Use NRBM, but NO HFNP or NIV

Location

- Intubation should occur in a negative pressure room in CT ICU if clinical state allows transfer
- If clinical state requires intubation in ED, proceed in R2 as per COVID ED RSI plan
- If there no space availability in CTICU or ICU to facilitate intubation, intervention is to proceed in ED
- Patients should not be transferred on HFNP or NIV. Surgical masks to be placed over the patient's oxygen device during transport

UCGH Intubation team

Call 2222 ask for "Code Blue ED Resus – Anaesthetics ONLY"; ED consultant present/aware

Intubating doctor: ICU SpR/ED Senior (only if anaesthetic availability is overwhelmed)

Airway assistant: ED Reg/ED Nurse

Drug administrator/ team leader: ICU Specialist/Senior Registrar/Registrar or ED

Specialist/Senior Registrar

Drugs Pack in Resus Fridge: Propofol 200 mg, Suxamethonium 200mg, Rocuronium 100 mg, Metaraminol 10 in 20mls, Adrenaline 1mg/1ml, Midazolam 10mg, Phenylephrine x2 (500mcg/10mls), Ephedrine (30mg/10mls), Adrenaline 1mg/10mls

Personal Protection Equipment (PPE)

Airborne precautions are used because intubation is an aerosol-producing procedure

Theatre/disposable scrubs

Long-sleeved waterproof gown

Gloves: double glove technique

Avoid gap between gloves and gown – tuck gown into gloves

Immediately remove and dispose of outer gloves after airway manipulation

N95 mask + face shield or goggles

Pairs of two team members to check each other donning/doffing of PPE

Donning occurs outside the ambulance doors. Doffing occurs in the patient's room, except for the N95 masks which remain on until you exit through ambulance