ARDS COVID-19 Critical Care Intubation Quick Reference Guide – V1

(Use in conjunction with ARDS COVID-19 ventilation + Proning QRG)

- All patients being considered for intubation due to respiratory failure secondary to COVID-19 should be discussed with the Critical Care Consultant via #68751
- Unless peri-arrest, transfer to the Critical Care Unit for Intubation
    - Non-Rebreather Mask via predefined route (state specific route here)
    - Full PPE for transfer
    - Critical Care co-ordinator #68752 will allocate next available level 3 space in trust
- Inpatients suitable for invasive ventilation NIV + Highflow Oxygen delivery devices should not be used
- Patients should not be transferred to CCU until intubation is required
    - Sats <92% on Non ReBreathe Mask @ 15L/min

SETUP

(Use attached Team Member "1-4" + B@ease Checklists to assist rapid + efficient setup)

- ARDS intubation is challenging, minimum of 4 team members in room.
    - 2 Senior doctors
    - Full PPE as per FICM guidance
        - FFP3 Mask, Gown, Double Glove, Hood, Visor +/- Goggles + footwear
    - Extra person in Anteroom in full PPE + non PPE runner out with isolation area
    - Difficult airway + resuscitation equipment/drugs immediately available outside room
- All Equipment setup and checked prior to patient arrival on CCU or prior to entering patient room
- Receive handover (where possible) + Run through B@EASE checklist, allocate roles and confirm airway plans prior to putting on PPE
- Put on Full PPE with a buddy to help and check using posters to assist
- Monitor other team members for potential contamination throughout procedure

EVALUATION

Patient arrives on CCU/Enter Patient room with equipment

- Communication is challenging in Full PPE – use closed loop communication via team leader
- Assess airway + optimise patient position
- Check/Gain IV access
- Connect to full monitoring
- Confirm ventilator + closed suction on standby with appropriate settings
- Confirm team ready – including Anteroom + outside runner

INTUBATION

- Size 8.0 Subglottic ETT – 7.0 too small for ARDS Management + Bronchoscopy
- Airway management by Senior Intensivist/Anaesthetist only – Consider Video 1st
- Two handed mask seal for preoxygenation + Two person technique for manual ventilation
- Use conservative O2 flow via C-Circuit during pre-oxygenation
- Avoid ventilation in apnoeic period where possible
- Ensure Cuff up prior to ventilation - connect straight to ventilator with closed suction

POST INTUBATION/PRONING

- Intubating team to place following prior to leaving room:
  - Arterial line + **LEFT** IJV CVC (+ Vascath if required)
  - NG tube + Urinary Catheter
- Stabilise Cardiovascular and Respiratory parameters –
  - See ARDS COVID-19 Ventilation QRG
  - Manage desaturation via ventilator rather than C-Circuit
  - Avoid disconnection of ventilator circuit
    - Clamp ETT if disconnection unavoidable
    - Ensure ventilator in standby prior to disconnection
    - Disconnect distal to HME when possible
- Consider need for early proning prior to team leaving room
- All unused/unopened items collected at back of bed space

Ketamine/Fent/Roc -Recommended

PLAN A

- Consider Video
- No Cricoid
- -Bougie 1st pass
- -**8.0** subglottic ett

PLAN B/C

- -LMA
- -2 Person Mask Ventilation

Can you Ventilate?

Yes – Consider AMBU scope ventilation +/- Exchange catheter

No – **PLAN D**

- FONA
- Scalpel bougie **6.0** ett

PPE REMOVAL

- Strict adherence to PPE removal instructions
- Ensure thorough cleaning of essential reusable items
  - FFP3 mask/ McGrath/AMBU scope screen
- Remove PPE under guidance of buddy + poster to avoid contamination
- Debrief – improvements for next time

SRFT Critical Care
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safe • clean • personal

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