COVID-19 / Suspected COVID-19 SOP– Ward 20

Pre-referral Communication:

- Daily 9am phone call between consultant on call for RIDU and Ward 20 ICU.
  - Update: number of patients with suspected/proven COVID-19 infection and clinical status of these patients
  - Record on COVID safety board
  - If patient at high risk of deterioration is identified, discuss with nurse in charge re nursing staffing levels.
  - If practical, assess patients at risk of deterioration for suitability for escalation to Level 3 care. If unsuitable, anticipatory care planning is appropriate.
  - Two COVID-19 nurses will be identified at every shift change – should be experienced at assisting with emergency intubations.

Communication at time of referral:

- Contact Ward 118 consultant on call – bed availability
- Inform anaesthetic team on call

Staff involved in RSI:

- ICU consultant – intubator/drugs administrator
- ICU nurse 1 and 2 – intubator's assistants
- Runner (outside room) – RIDU nurse
- PPE buddy (supervising donning/doffing) – RIDU nurse

Equipment list for RSI in RIDU – Equipment stored in Ward Clerk's office. See Kit List

- Laminated COVID-19 Emergency Intubation Checklist
- Facemasks – size 3 and 4
- C-circuit
- Monitor with ECG, Sp02, EtC02 and BP monitoring
- Oxylog ventilator and tubing
- HME
- ETT x 2 (7 and 8)
- IGel Size 3, 4, 5
- Lubricating jelly, scissors, Anchorfast
- 10ml syringe
- Cuff manometer
- Guedel airways size 2,3 and 4
- Bougie
- Aintree intubating catheter
- Front of neck access kit
- Metal tube clamp
- Closed suction units
- Suction equipment include bottle, tubing and Yankaeur suction catheters
- Stethoscope
- NG tubes – 14 and 16F
- Ambu monitor and Ambu scopes x2 one slim, one wide
- Sonosite US machine

Critical Care Guidelines
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Drugs list for RSI in RIDU – to be made up before departure

- IV fluids primed through B Braun pump
- 3 x syringe drivers – propofol, alfentanil, metaraminol
- Induction drugs of choice
- Emergency drugs – atropine, 1:100 000 and 1:10 000 adrenaline

PPE for RSI

- Follow current HPS guidance
- Donning/doffing videos can be found on front page of critical care intranet

Conduct of RSI

- See Covid-19 intubation guideline – aim is to minimise risk of aerosolization of respiratory secretions

Post-RSI on RIDU

- Ventilation – maintain on Oxylog plugged in on charge, and piped oxygen
- Monitor Etc02 via Oxylog if not measuring through monitor
- Arterial line insertion – use sterile gloves but full scrub not required
- CXR for tube position check
- ID consultant will convene PAG (Problem Assessment Group) to confirm arrangements for transfer
- Ward 20 NIC to contact SAS to arrange transfer (when confirmed by PAG) and to communicate progress of transfer to Ward 118 team

CPR in suspected or proven Covid-19 infection

- Perform compression-only CPR with oxygen mask in situ on face.
- Establish definitive airway with cuffed ETT during pause in compressions

Severe hypoxia post-intubation

- Anecdotal evidence from China indicates severely hypoxic Covid-19 patients respond well to proning.
- The ICU consultant should use clinical judgment to determine if a patient is too unstable for transfer
- If patient remains hypoxic post intubation and proning is indicated, the patient can be moved to Ward 20 and nursed in a side room with door closed and PPE precautions, as per HPS guidance.

Transfer to RIE – see Covid Interhospital transfer SOP

- Transfer team will consist of ICU nurse and appropriately trained medical staff (ICU/anaesthetic consultant or anaesthetic specialty trainee)
- Restock and take RIDU RSI and transfer box
- Exit RIDU through their dedicated lift
- Phone Ward 118 immediately prior to leaving WGH
- Transfer team will be met by the receiving critical care team at RIE at the Primary PCI entrance and escorted to Ward 118.
- Ward 118 NIC will supervise doffing of PPE after handover of patient, and will arrange for cleaning of transfer equipotent before transfer back to WGH
- Transfer back to WGH may be by taxi or by ambulance

Critical Care Guidelines
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