VADA Clinical Guide for COV-1 and COV-2

Anesthesia assistants available to assist with all COVID intubations **EXCEPT Mon-Fri 02:30 – 06:00**

Responsibilities

Weekday Daytime - COV-1 and COV-2 are both in house positions 0700 – 1900

- COV-1 – Anesthesiologist in charge, coordinates COVID response with ICU and ER
- COV-2 – Back up anesthesiologist, assists COV-1, and helps with teaching simulation
- COV1 does not have to perform all intubations. These can be shared throughout the day/night.

Weekend Daytime - D1-D3 and C1 are all in house positions 0700 – 1900

- COV-1 = D3 (no OR responsibility)
- COV-2 = D1 (with day resident to allow attendance at COVID intubations with COV1)
- C1 starts the OR cases at 0900. D1 may help relieve C1 in the OR if C1 is needed in CSICU.

Nighttime - N1 and N2 are both in house positions 1900 – 0700.

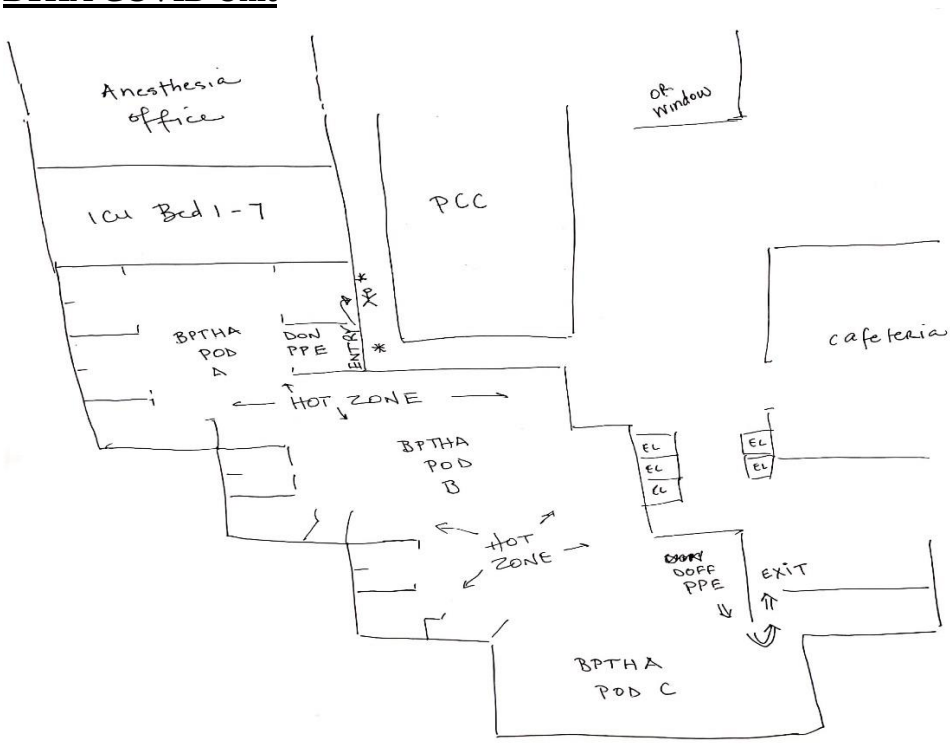
- **The number of anesthesiologists in house must be one more than the number of ORs running.**
- COV-1 = N2 (no OR responsibility)
- COV-2 = N1 (with night resident to allow attendance at COVID intubations with COV1)
- As much as possible, the COV-1 responsibility should not change providers.
    - During the night, N1 may assist as COV-2 provided they are comfortable leaving the resident with the OR case; otherwise, N3 may be called in to be COV-2.
    - If two ORs are running at night, N3 must be called in to leave N2 independent to be COV-1.

Schedule – involve anesthesia assistants on rounds and during intubations
0700 – Zoom meeting and handover with night team
0715 – Give COV-1 contact info (cell#) to BTHA COVID unit (ext. 66991) and ICU (ext. 54275)
0830 – Board meeting with ICU/CCOT staff and Code RT/RN, **exchange contact info**, assessment of potential COVID intubations (bedside walk around)
0845 – Meeting with ERP in charge (EPIC), and RN in charge of isolation rooms A10/11
0900 – Simulation teaching if able
1730 – Board meeting with ICU/CCOT staff
1900 – Handover to night team including **contact info for on call ICU/CCOT staff**
1915 – Give night COV-1 contact info (cell#) to BTHA COVID unit (ext. 66991) and ICU (ext. 54275)
2000 – Board meeting with ICU fellow

Intubations

- COV1 and COV2 should attend all intubations as much as possible
- COV1 and resident to attend all code blues – see "COVID CPR Protocol" on website
- Follow COVID intubation and donning and doffing guidelines – practiced in simulation
- After intubation:
    - Note in chart (brief)
    - Complete "UHN COVID Airway Management Documentation Form" (at slater office window) and leave on patient chart
        - Photocopy into Steven Moore's mailbox (thank you)
    - Billing – write "COVID intubation" somewhere on all pinks (both COV1 and 2)
        - COV1 – 1088 for duration of attendance
        - COV2 – 1015 plus anesthesia standby code 1112 for the duration of attendance
    - Dictation
        - Required to support 1088 billing, see dictation template below

BTHA COVID Unit



Call Rooms Leon Blackmore	
202C	7178
202H	2048
202T	7178
202A	6650

CSICU COVID Unit - See "COVID Cohort Unit Primer" document on website

Dictation template

Use work type 104 for hospital consult or "VGH Anesthesia COVID intubation note" in Fluency Flex (FESR)

At <Enter Time> on <Enter Date>, I responded to a request from ICU to intubate and resuscitate a patient with respiratory failure +/- undifferentiated shock < presumed or confirmed> due to infection with SARS-COV2/COVID-19.

Past medical history includes: <Cardioresp disease, DM, obesity, other>
Initial vital signs were: <BP, HR, O2 sat on how many litres NP/FM, estimated height and weight>

Following team briefing, review of history, and formulation of an intubation plan using the VCH Intubation Checklist for COVID-19 Patients, appropriate PPE was donned, equipment gathered, and the intubation team comprising myself, an RN, and an RT entered the room. <If a second anesthesiologist was donned in the anteroom, please state that "Due to the high risk nature of this airway, a second anesthesiologist, Dr <Insert Name Here>, was donned in the anteroom">. <If additional personnel involved, insert here>.

After entering the room, intubation equipment and medications were prepared. An airway exam was conducted which revealed <insert airway exam here>. The patient was positioned for airway management. Monitors were readied, and IV access was confirmed. A time out was performed to review the intubation plan, address concerns, and reinforce key points.

Pre-oxygenation occurred for ___ min. Before induction, saturation was ____%. An RSI was conducted using ____ mg of ketamine, _____ mg of rocuronium, <___ mcg of phenylephrine, any other drugs and doses here>. A drape was used to cover the patient to prevent aerosolization of the room. After 60 seconds, intubation was performed using a <Glidescope/McGrath/DL and type of blade>. Cormack-Lehane grade _____ VL/DL view was seen and the airway was secured with a a 7.0/7.5/8.0 EVAC ETT. <Initially, a _____ grade was seen, and thus our plan B bag and 2nd RT was activated. ____Describe____). After cuff inflation the ETT was connected to the ventilator. ETCO2 was confirmed. The lowest oxygen saturation peri-induction was <_>, and this recovered to <_> after ventilation with 100% oxygen. <Please comment on any other significant hemodynamic events here>.

<An <OGT/NGT> was placed followed by insertion of a femoral/internal jugular/subclavian central line under appropriate sterile conditions <+/- ultrasound>. A <femoral/radial> arterial line was also placed using sterile conditions <+/- ultrasound>>.
After ensure adequate patient stability, personal protective equipment was doffed, again using a buddy system and a cognitive aide.

Care of the patient was then transferred back to ICU staff.