CCRC
OSLER COVID CLINICAL RESPONSE COMMITTEE

Intubation Teams

6 April 2020
15 May 2020

The COVID Clinical Response Committee (CCRC) has been asked to comment on the utility of intubation teams.

1. **The consultant on call for critical care can be paged for intubations. If available, they will attend for the intubation. If not, they will attempt to find an alternate. If the critical care consultant does not respond, contact the Emergency Airway Physician (anesthesiologist) on call and failing this, call a CODE AIRWAY if you need assistance.**
2. **If you need to proceed, use the "Intubation of Patient Under Investigation or with Confirmed COVID-19 Infection" checklist for every applicable intubation.**
3. **Take your time and proceed with staff and patient safety in mind. Many patients can wait to be intubated for some time even if mildly hypoxic on high concentrations of oxygen.**
4. **Where an anesthesiologist is available in the Emergency Airway Physician role, they should attend all code events where airway management may be required. The Emergency Airway Physician may also be called for urgent or elective intubations if assistance is required.**

This decision will be revisited as requested.

Rationale

In order to create an intubating team for COVID clinical care, at least one or more of the following conditions would need to be clearly satisfied:

1. Increases patient safety due to a greater skill set of the provider
    a. There is no good specific evidence of this at this time.
    b. It creates a situation in which experience, skill and comfort is restricted to a small group of providers. Non-providers will be poorly prepared.
    c. With a single intubating team, if simultaneous intubations are required, individuals with little experience or preparation may be required to intubate the second patient.
2. Increase staff safety
    a. There is no good specific evidence of this at this time.
    b. We are currently not using PAPRs so there is no specific skill set that is required to protect staff except appropriate donning and doffing of personal protective equipment (PPE).
    c. We are not convinced that this outweighs the risk of creating a smaller group of additionally skilled and experienced providers when more than one patient may require intubation at the same time.
3. Conserve personal protective equipment
    a. Given that the providers would don and doff as they now do, it would not conserve PPE.
    b. Currently, we do not need to move to PAPRs because of lack of appropriate PPE.
4. Increase efficiency
    a. No evidence that this would be true.
    b. Volume is low enough at this time that it is insufficient to create a team for this purpose at the moment.