

PAEDIATRIC INTENSIVE CARE UNIT (PICU) COVID-19 PANDEMIC RESPONSE PLAN -CHW

PRACTICE GUIDELINE[®]

DOCUMENT SUMMARY/KEY POINTS

- For guidance on standard operating procedures in PICU for COVID -19 pandemic planning
- Purpose: To clearly outline the PICU planning and response in the event of a COVID-19 pandemic. As the number of funded PICU beds have increased over time the surge plan and resource allocation during pandemic planning has evolved.
- Surge plan within PICU COU and Clancy
- Staffing requirements and work flow outlined for COVID -19 model of care
- Parental visitation process for PICU/COU
- PPE guide and checklists to maintain safe practice for staff
- Local COVID resuscitation plans outlined supported by CERS guideline

This document reflects what is currently regarded as safe practice. However, as in any clinical situation, there may be factors which cannot be covered by a single set of guidelines. This document does not replace the need for the application of clinical judgement to each individual presentation.

Approved by:	SCHN Policy, Procedure and Guideline Committee	
Date Effective:	1 st January 2023	Review Period: 3 Years
Team Leader:	Staff Specialist	Area/Dept: PICU CHW

CHANGE SUMMARY

- N/A – New Document.
- Approved by SCHN Policy, Procedure and Guideline Committee on 8/2/23. Republished with updated footer.

READ ACKNOWLEDGEMENT

- PICU staff are to read and acknowledge the document.

This document reflects what is currently regarded as safe practice. However, as in any clinical situation, there may be factors which cannot be covered by a single set of guidelines. This document does not replace the need for the application of clinical judgement to each individual presentation.

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Governance

The Medical and Nursing Directors of PICU report directly to the Critical Care Program Director and the SCHN Executive for all matters related to pandemic response preparedness.

The PICU COVID pandemic response aligns with the SCHN Pandemic Plan (<https://intranet.schn.health.nsw.gov.au/files/attachments/7712/schn-pandemic-response-plan-word-version050620201.pdf>)

Information from governing bodies that inform the plan include:

- Clinical Excellence Commission
- Agency for Clinical Innovation – Intensive Care NSW - Community of Practice
- NSW Health
- Australian & New Zealand Intensive Care Society
- [National COVID-19 Clinical Evidence Taskforce - Supporting Australia's healthcare professionals with consistent, trustworthy guidance on the clinical care and management of COVID-19, based on the best available evidence. \(covid19evidence.net.au\)](https://www.covid19evidence.net.au/)

PICU Surge Capacity Plan

Phase 1 - Beds 5 & 6

Activation Criteria: 0-2 SUSPECTED COVID patients

- Usual PICU operational capacity
- Workflows shown in Figure 1

Phase 2: Beds 1-6

Activation Criteria: 1 COVID confirmed patient

- Escalation of the number of beds available for confirmed or suspected COVID patients
- Capacity for 6 COVID PICU beds + 21 Non-COVID PICU beds
- Workflows shown in Figure 2

Phase 3: Beds 1-10

Activation Criteria: 5 COVID confirmed patients

- Capacity for 10 COVID PICU beds + 17 Non-COVID PICU beds
- Workflows shown in Figure 3

Figure 1

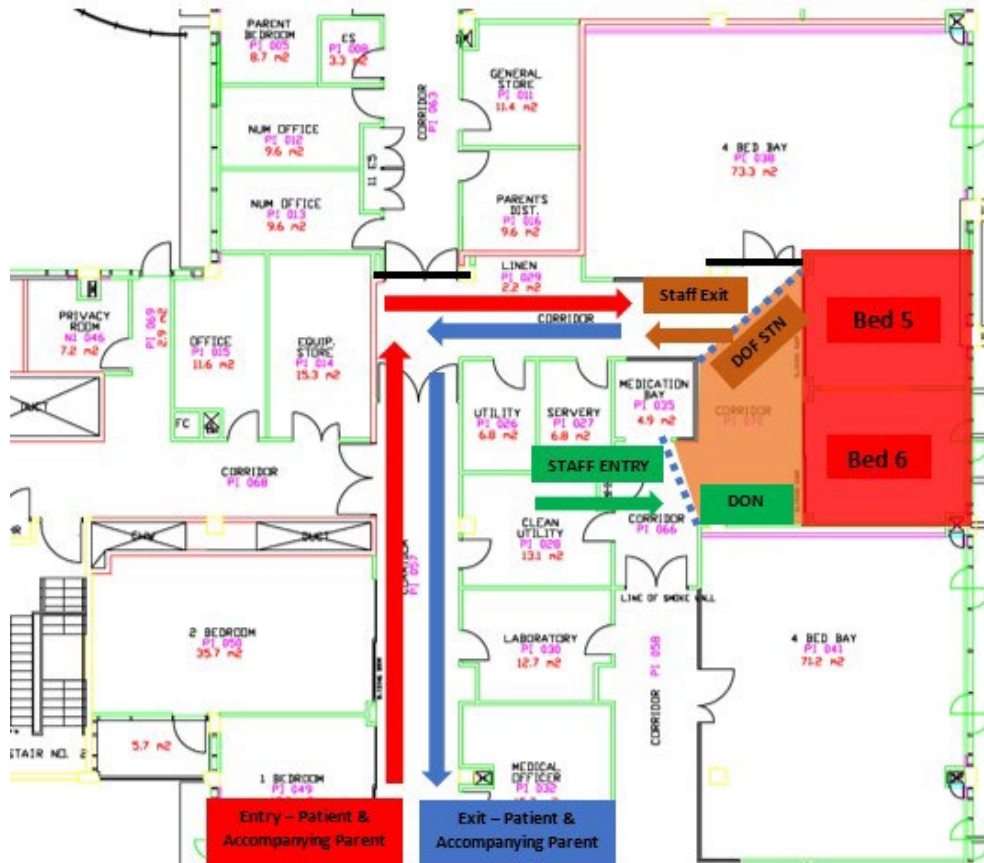


Figure 2

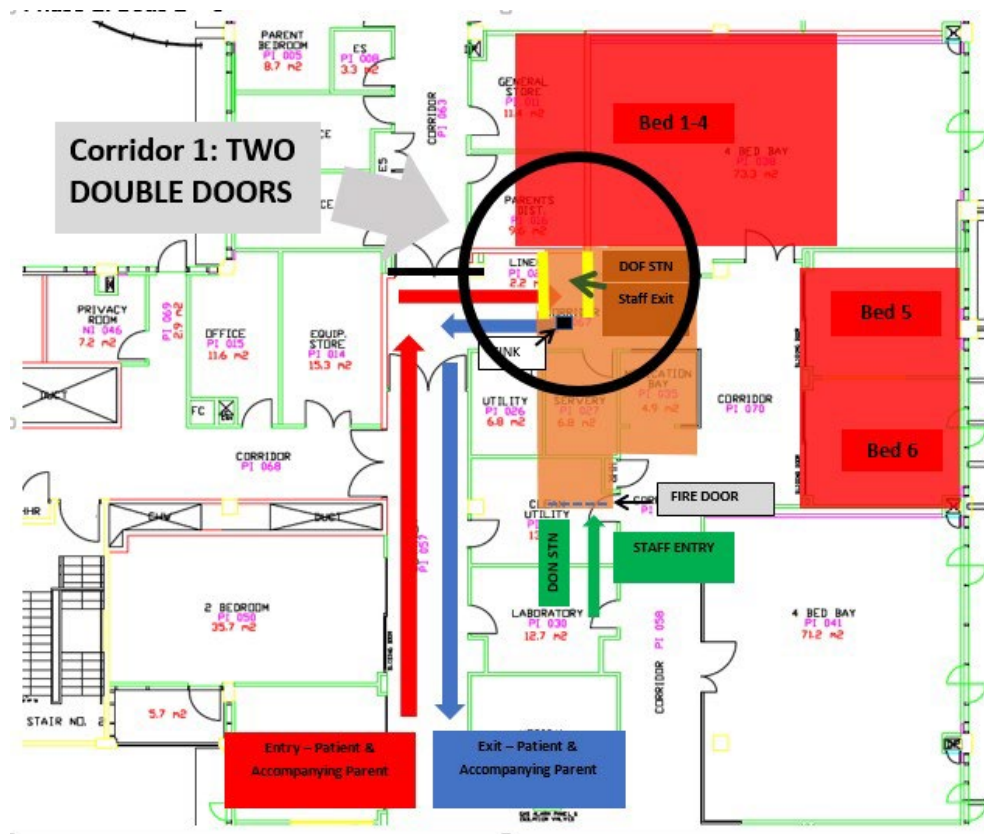
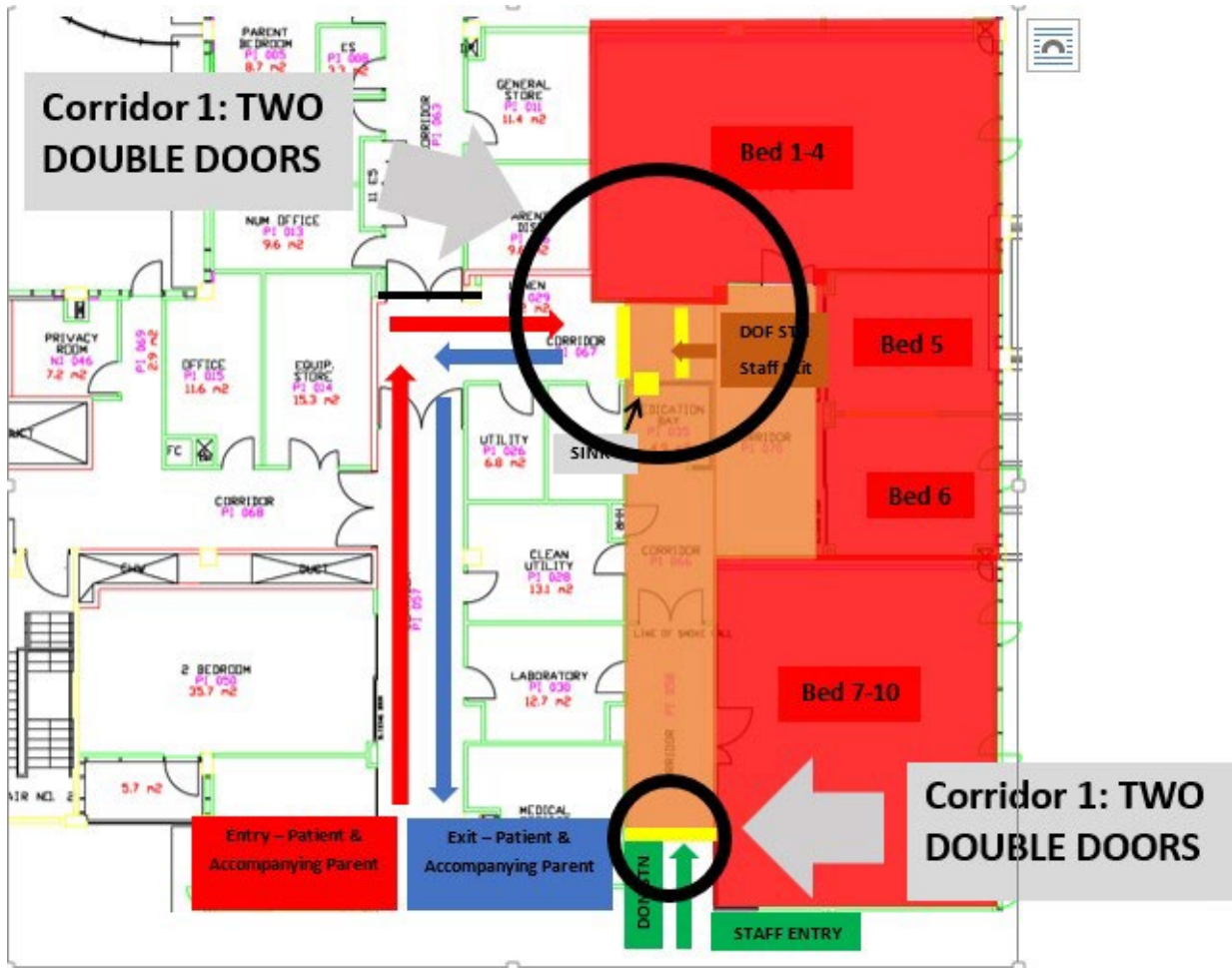


Figure 3



Phase 4: Beds 1-23

Activation Criteria: 9 COVID confirmed patients who require ICU/COU

- Reflects an escalation of the number of confirmed or suspected COVID patients ≥ 10
- Entire PICU has capacity for 23 COVID PICU beds
- Non-COVID PICU beds would be relocated to Clancy Ward (12 beds) and/or Operating Theatres/Todman Recovery (20 beds)
- Requires confirmation from Biomedical engineering that negative air-conditioned flow can be maintained
- See Figures 4- 8 for potential workflows

Figure 4 – Entire PICU footprint as COVID beds



Figure 5 – Middleton footprint as Non COVID beds

Capacity for 10 beds

- Non isolated/infective patients
- Max of 5 ICU beds ■
- 5 beds HDU ■

Additional equipment required:

- 4 outlet power boards x 10
- Oxygen Y outlet x 10
- Air Y outlet x 10]

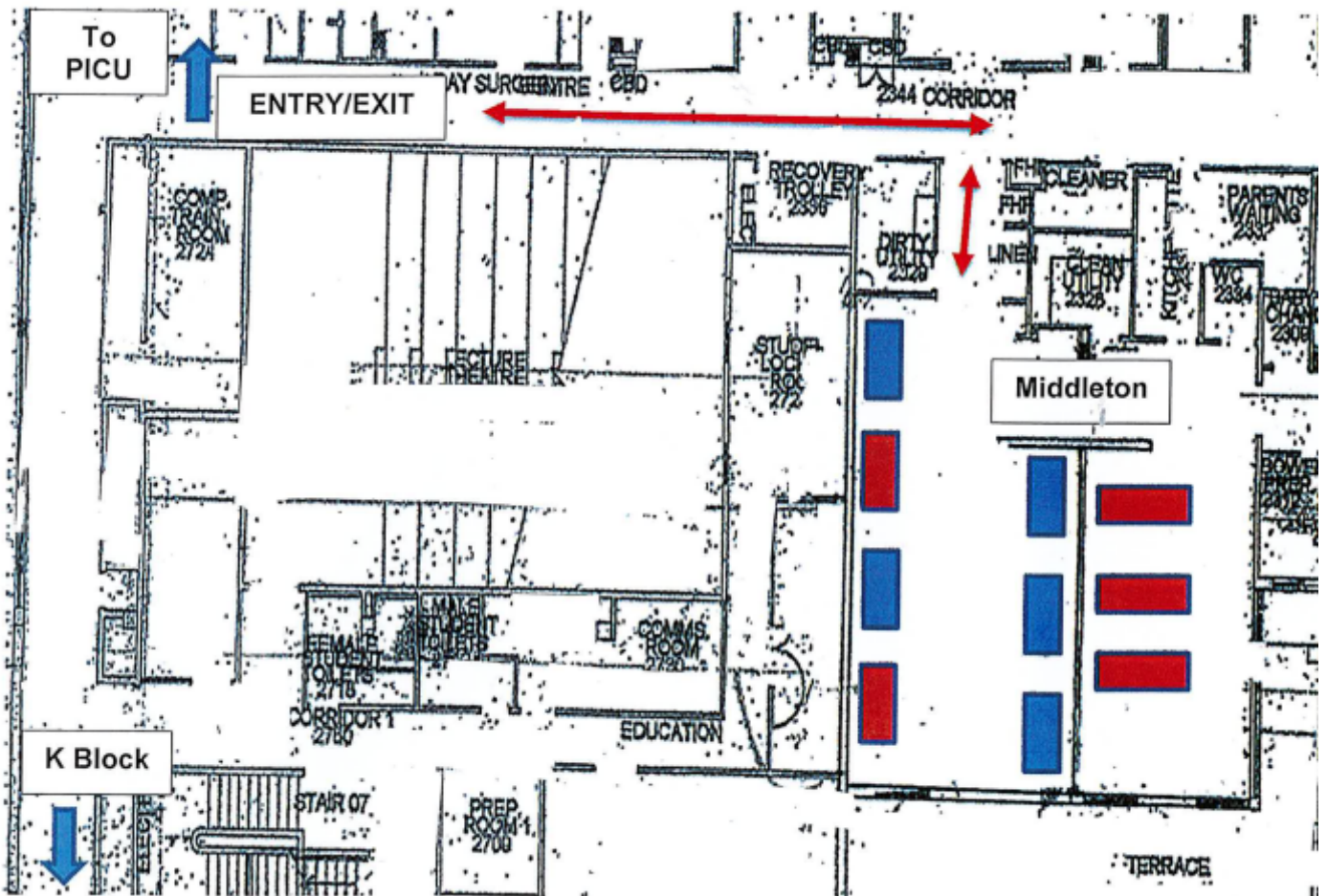


Figure 6 – PICU Non COVID beds surge to Clancy



Green shaded beds = PICU Non-COVID beds x14 White shaded beds = Non PICU beds x11

If just beds 19/20 are used as part of COU, the back to base monitoring is part of Clancy. A PICU Nurse needs to be in this zone.

Biomed can transfer the back to base monitoring to COU, however will take up to one business day. Can only be done in hours Monday-Friday.

Figure 7 – PICU Non COVID beds surge to OT Phase 1



Figure 8 – PICU Non COVID beds surge to OT Phase 2

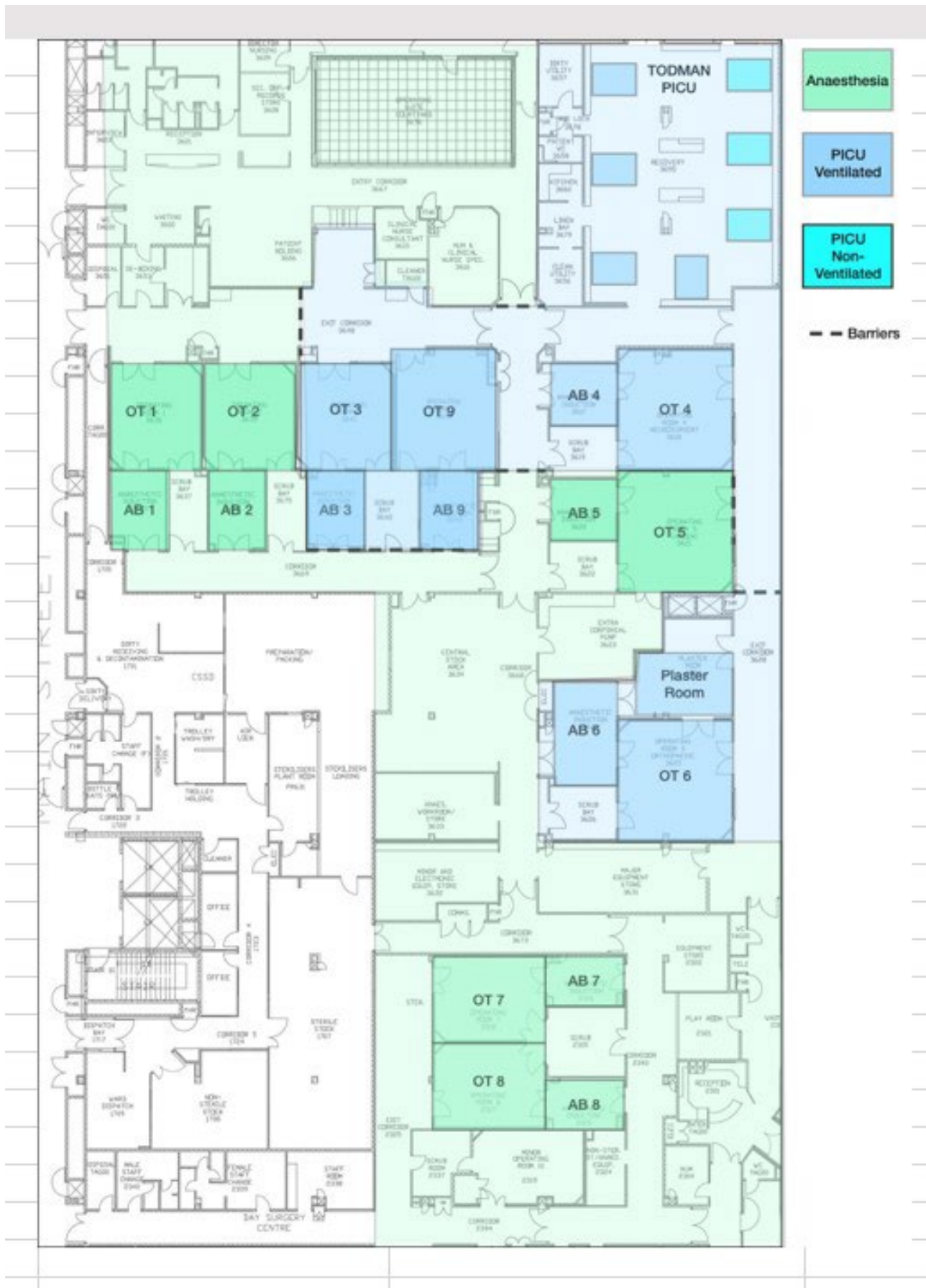


Figure 9 – PICU Non COVID beds surge to OT Phase 3



COU Suspected and/or Positive COVID Patients



COU for COVID Patients

For suspected or positive COVID patients that need to be admitted to COU, first use bed 24.

Ensure the air conditioning is changed from Standard to Negative. PIN: 0317

The room pressure for negative will be around -30mmHg and anti room -10mmHg.

Air Conditioning Panel Control

Standard



Negative



Pandemic Short Term Escalation Plan (STEP)

Level	Impact	ICU surge plan strategies	Triggers to escalate to next level				
0	Minimal impact on daily operations.	<ul style="list-style-type: none"> Funded ICU beds in use: 25 +PICOS ICU surge plan developed recorded in patient flow portal Other critical care staff identified, workforce surge plan being developed 	<table border="1"> <tr> <td>Capacity</td> <td>PICU approaches maximal operational capacity and/ or</td> </tr> <tr> <td>Staffing</td> <td>Insufficient ICU staff to meet current demand</td> </tr> </table>	Capacity	PICU approaches maximal operational capacity and/ or	Staffing	Insufficient ICU staff to meet current demand
Capacity	PICU approaches maximal operational capacity and/ or						
Staffing	Insufficient ICU staff to meet current demand						
1	Moderate impact on daily operations. ICU approaching maximal operational capacity.	<ul style="list-style-type: none"> Funded ICU in use: 25 + PICOS COVID Access Nurse every shift, escalate additional staffing resources Upskill medical and nursing staff from non-critical care areas Maintaining paediatric statewide services (cardiac surgery, burns, liver transplant) Discuss strategy for external PICU/ED referrals (NETS) transferring to other paediatric intensive care units (JHH/SCH) Discuss transfer CHW trauma admissions to other paediatric intensive care units (JHH/SCH) 	<table border="1"> <tr> <td>Capacity</td> <td>ICU demand exceeds operational capacity, >=1 COVID bed + 21 non-COVID beds occupied and/ or</td> </tr> <tr> <td>Staffing</td> <td>Reduction in medical staff and/or Reduction in Nursing workforce</td> </tr> </table>	Capacity	ICU demand exceeds operational capacity, >=1 COVID bed + 21 non-COVID beds occupied and/ or	Staffing	Reduction in medical staff and/or Reduction in Nursing workforce
Capacity	ICU demand exceeds operational capacity, >=1 COVID bed + 21 non-COVID beds occupied and/ or						
Staffing	Reduction in medical staff and/or Reduction in Nursing workforce						
2	Severe impact on daily operations. Overall demand for critical care exceeding ICU operational capacity.	<ul style="list-style-type: none"> Care delivery for ICU1 and ICU2 in other areas (if other PICU in state are at capacity) refer to SOP Maintaining paediatric statewide services (cardiac surgery, burns, liver transplant) Transfer critically ill patients to other paediatric intensive care units as appropriate (JHH/SCH) Activate level 2 workforce strategies (refer to SOP) Non-standard workforce staffing model = additional non-PICU staff (anaesthetics, OT nursing staff); critical care resources from other facilities Review PICOS model of care alternative team composition (anaesthetics, advanced trainee) modify call/triage structure 	<table border="1"> <tr> <td>Capacity</td> <td>ICU demand significantly exceeds operation capacity (10 COVID beds +17 non-COVID beds occupied) and/or</td> </tr> <tr> <td>Staffing</td> <td>Insufficient staff to meet current demand with non-standard critical care staffing model</td> </tr> </table>	Capacity	ICU demand significantly exceeds operation capacity (10 COVID beds +17 non-COVID beds occupied) and/or	Staffing	Insufficient staff to meet current demand with non-standard critical care staffing model
Capacity	ICU demand significantly exceeds operation capacity (10 COVID beds +17 non-COVID beds occupied) and/or						
Staffing	Insufficient staff to meet current demand with non-standard critical care staffing model						
3	Overwhelming impact on daily operations. Demand for critical care services significantly exceeds organisation-wide	<ul style="list-style-type: none"> Directed by the State Health Emergency Operations Centre (SHEOC) Escalate additional resources Non-standard workforce staffing model 					

Hospital ICU Pandemic STEP to align with the NSW ICU Pandemic STEP

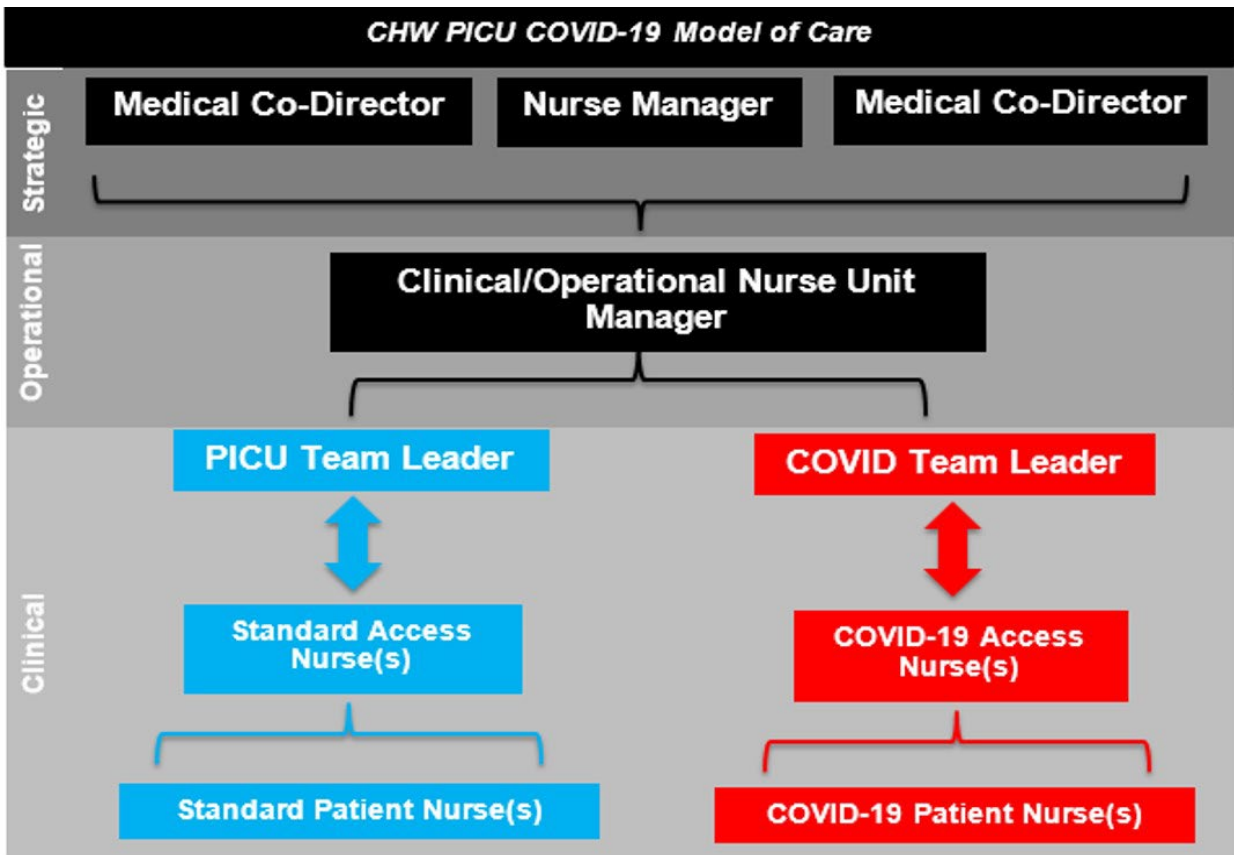
Enter STEP level in the Patient Flow Portal (PFP) as changes occur and at least every 4 hours

All STEP levels > 0 are to be discussed with hospital patient flow and executive

Ventilator Capacity

Model	Number	Category
Servo U	27	Category A (ICU Ventilator)
Servo Air	3	Category B (ICU Transport Ventilator)
Trilogy Evo	15	Category B (ICU Transport Ventilator)
Trilogy 202	5	Category B (ICU Transport Ventilator)
3100B (High Frequency Oscillator)	4	Category A (ICU Ventilator)
SiPAP (nCPAP)	4	Category C (ICU NIV)
Total	58	Cat A Cat B Cat C
<i>Note: this does not include Theatre Anaesthetic machines, or ICU transport ventilators in ED</i>		31 23 4

Model of Care



Staffing Requirements

Medical & Outreach

Level	Impact	JMO + Outreach Workforce	Workforce plans	
0	Minimal impact on daily operations.	<ul style="list-style-type: none"> 4 PICU Regs day and night Outreach team as per normal operations 	Strategy for insufficient staff	Escalation to Step 1 of Pandemic Plan
			Surge Staff	
1	Moderate impact on daily operations. ICU approaching maximal operational capacity.	<ul style="list-style-type: none"> 4 PICU Regs day and night Outreach team normal composition if registrar numbers sufficient 	Strategy for insufficient staff	PICU outreach team to only respond to screened rapid response calls from ward staff Outreach continue to respond to Code Blues/Trauma Attend NPs to help out on Registrar roster to maintain 4 on day and night
			Surge Staff	PICU NPs
2	Severe impact on daily operations. Overall demand for critical care exceeding ICU operational capacity.	<ul style="list-style-type: none"> 5 PICU Regs day and night Outreach team restructure: to only respond to Code Blues, Trauma Attend and triaged rapid response calls by ward team 	Strategy for insufficient staff	PICU Fellows and NPs to slot into Registrar pool JMOs from external departments deployed into PICU Reg roster
			Surge Staff	PICU NPs PICU Fellows External JMOs from Anaesthetics / with critical care experience
3	Overwhelming impact on daily operations. Demand for critical care services significantly exceeds organisation-wide capacity	<ul style="list-style-type: none"> Number of Registrars per day dictated by location and number of surge beds Outreach to only respond to Code Blues, Trauma Attend and screened rapid response calls by ward team 	Strategy for insufficient staff	PICU Fellows and NPs to slot into Registrar pool JMOs from external departments deployed into PICU Reg roster
			Surge Staff	PICU NPs PICU Fellows External JMOs from Anaesthetics / with critical care experience PICU / Anaesthetic consultants

Nursing

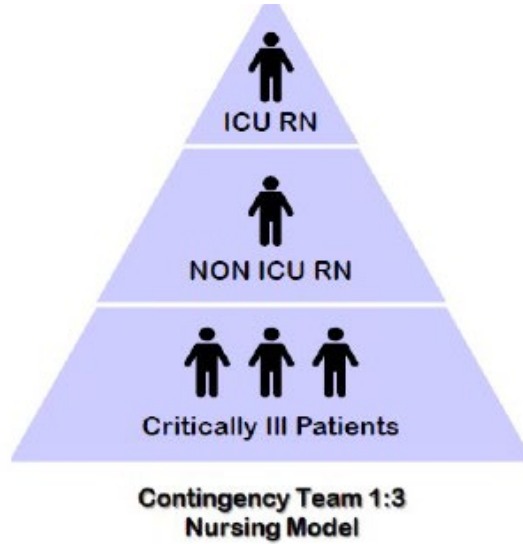
The following table outlines the number of ICU Registered Nurses required to safely care for isolated COVID-19 patients:

COVID Surge Stage	No. of COVID Patients	No. of COVID Patient RNs	No. of COVID ACCESS RNs	No. COVID Team Leader(s)	Total No. Registered Nurses
1	1	1	1	1*	3
	2	1			4
2	3	1	1		6
	4	1			7
	5	1	1		9
	6	1			10
3	7	1	1		12
	8	1			13
	9	1	1		15
	10	1			16
4	11	1	1	1	19
	12	1			20
	13	1	1		22
	14	1	1		24
	15	1			25
	16	1	1		27
	17	1			28
	18	1	1		30
	19	1			31
	20	1	1		33
	21	1			34
	22	1	1		36
23	1	37			

Team Leader(s) may have both COVID and non-COVID patients in stage 1 & 2

[Surge staffing reserve table](#)

Contingency & Crisis Nursing Team Models



Personal Protective Equipment (PPE)

These resources have been developed to provide guidance when patients require combined contact, droplet and airborne precautions

Information and resources are continually evolving - the NSW Health Protection resources and Clinical Excellence Commission (CEC) resources are linked below.

- <http://cec.health.nsw.gov.au/keep-patients-safe/COVID-19/Personal-Protective-Equipment-PPE>
- <https://www.health.nsw.gov.au/Infectious/diseases/Pages/coronavirus.aspx>

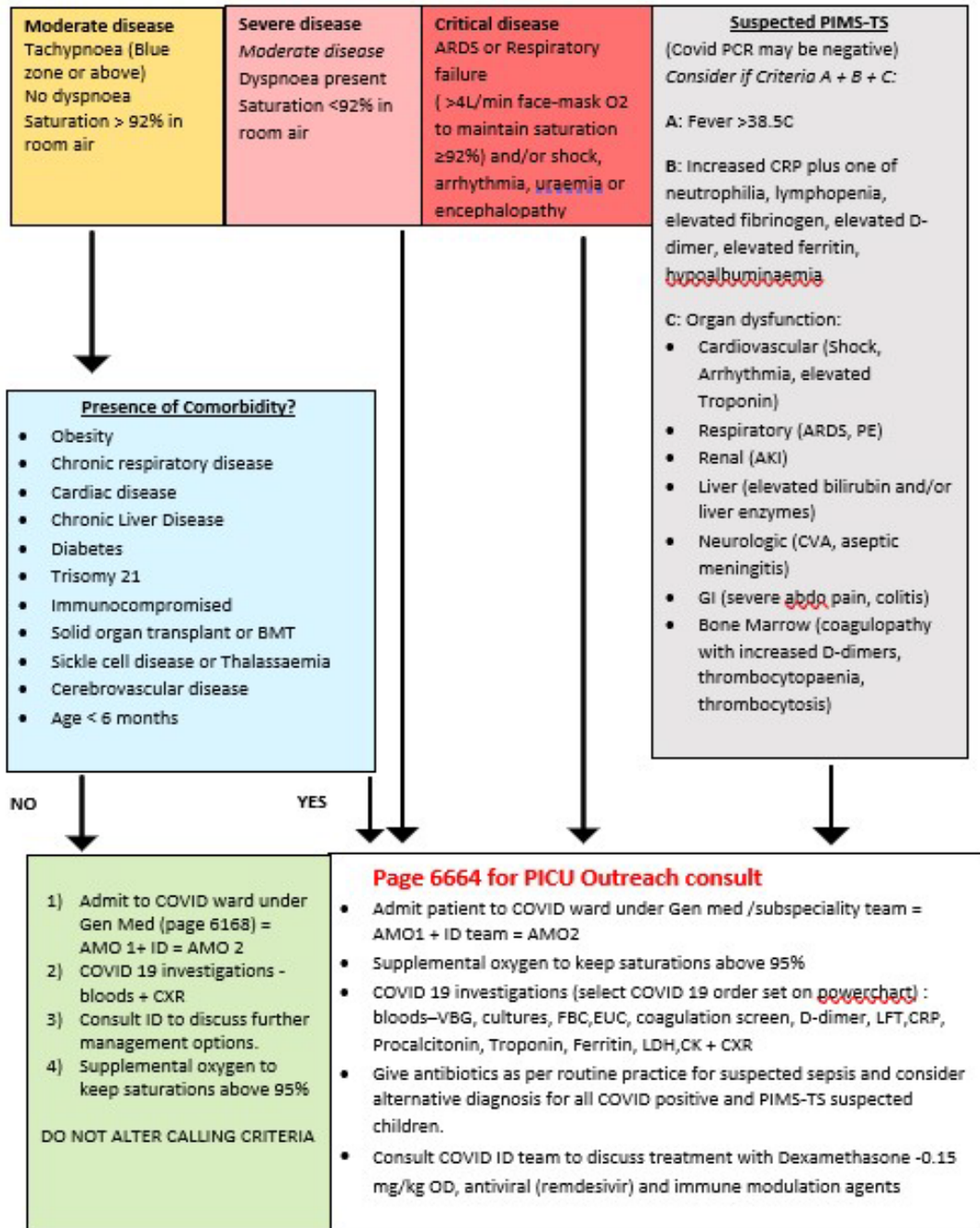
Workflows and Checklists

- PPE checklists for entering and exiting room – [Appendix 1](#)
- Room and bed set up checklists – [Appendix 2](#)
- PICU COVID Access Nurse checklist – [Appendix 3](#)
- COVID Safe Start Huddle – [Appendix 4](#)
- X-ray workflow/checklist – [Appendix 5](#)
- Clinical Logistics Quick Reference Guide – [Appendix 6](#)
- Proning checklist – [Appendix 7](#)
- Sedation and analgesia algorithm – [Appendix 8](#)
- COVID Intubation Medication Kit – [Appendix 9](#)
- COVID Intubation Starter Pack – [Appendix 10](#)
- Food Services – [Appendix 11](#)
- Communication IPADs contact information – [Appendix 12](#)
- Parent/Carer visitation and testing – [Appendix 13](#)
- Patient and Carer resources – [Appendix 14](#)
- Wellbeing – [Appendix 15](#)
- COVID links – [Appendix 16](#)
- Care and transfer of deceased patient – [Appendix 17](#)
- EHM storage and handling – [Appendix 18](#)

PICU Outreach Service

Initial patient management & criteria for PICOS review

Initial Management of COVID patients



See links:

- [Paediatric Inflammatory Multisystem Syndrome – Temporally associated with SARS-COV-2 \(PIMS-TS\)](#)
- [SCHN Pharmacological treatment approach for children and young people with COVID](#)

PICOS team to don N95/P2 mask + eye protection for ALL Outreach calls

PICOS to ED Workflow

- Don PPE (minimum of P2/N95 mask and goggles or visor) PRIOR to entering ED
- PPE station immediately available on right hand side through second set of automatic swipe door entry to K Block, via critical care lifts
- PICOS PPE backpack available in ED
- Rapid SARS-CoV2 testing is required for all patients and their accompanying parent/carer requiring admission to PICU – ED have process in place for accompanying parent/carer rapid testing

CODE BLUE ARREST

STAY CLEAN - do not enter patient zone unless directed to by ED Medical T/L
Liaison role as per usual – communicate with PICU consultant/fellow and PICU T/L

TRAUMA ATTEND

STAY CLEAN – do not enter patient zone unless directed by ED Medical T/L
Liaison role as per usual – communicate with PICU consultant/fellow and PICU T/L

DETERIORATING PATIENT

Remove pagers & phones – designate to accompanying PICU colleague, or ED Nursing T/L in absence of former, to answer phone & pager – if CERS call activated during this time, then designated person to send delegate from PICU (fellow/consultant or registrar)
Ensure full PPE correctly donned – contact + droplet + airborne

PATIENT TRANSFER OUT OF ED

Patient will be moved with 3 x donned staff
A guide staff member is to be utilised to clear corridors; stop foot traffic, swipe open doors leaving ED and to enter PICU rear doors

EXITING ED

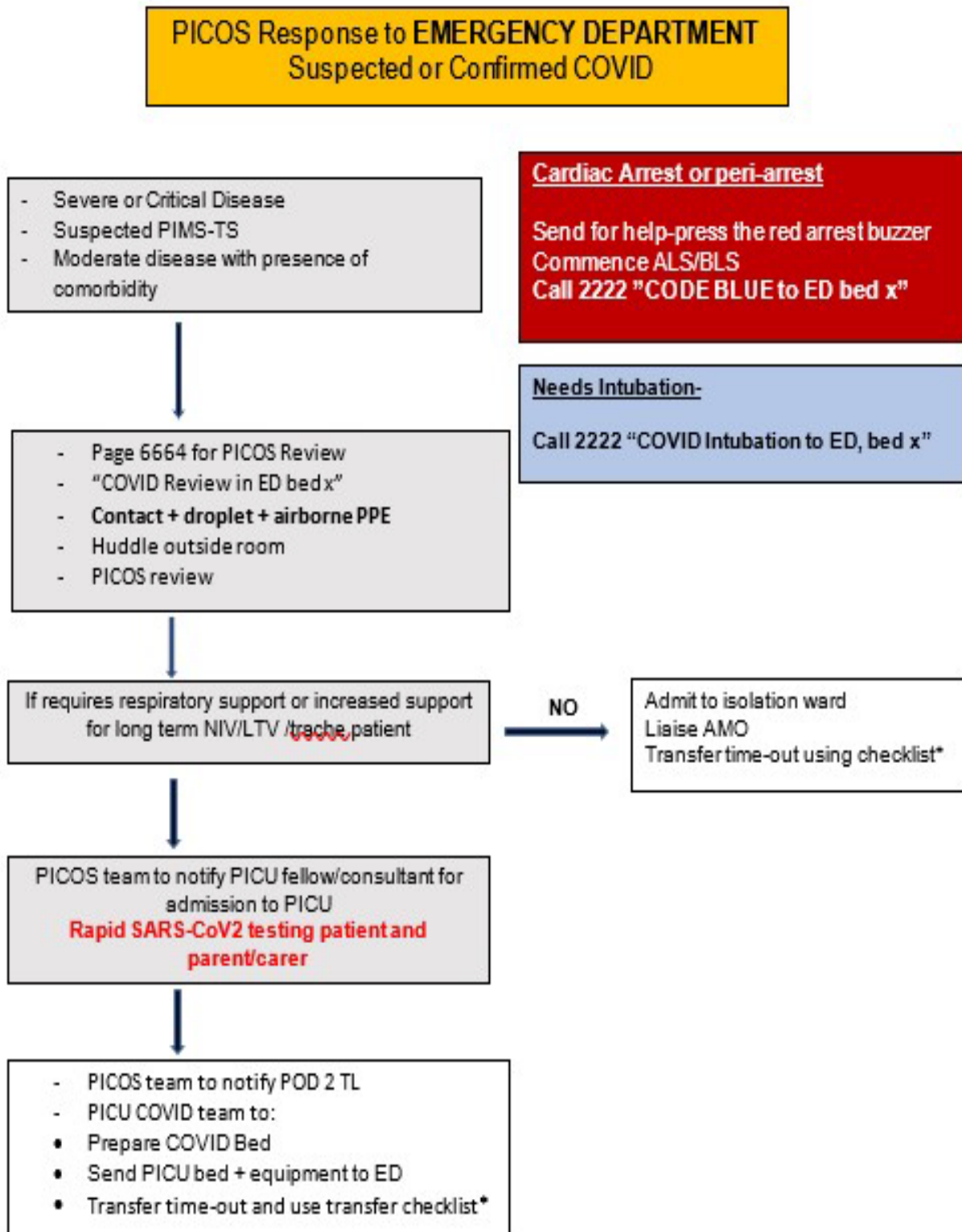
Doff PPE in ED after patient contact completed as necessary
Re-don clean PPE of P2/N95 mask and eye protection to remain in ED/transfer patient/leave ED

ED Floor Map



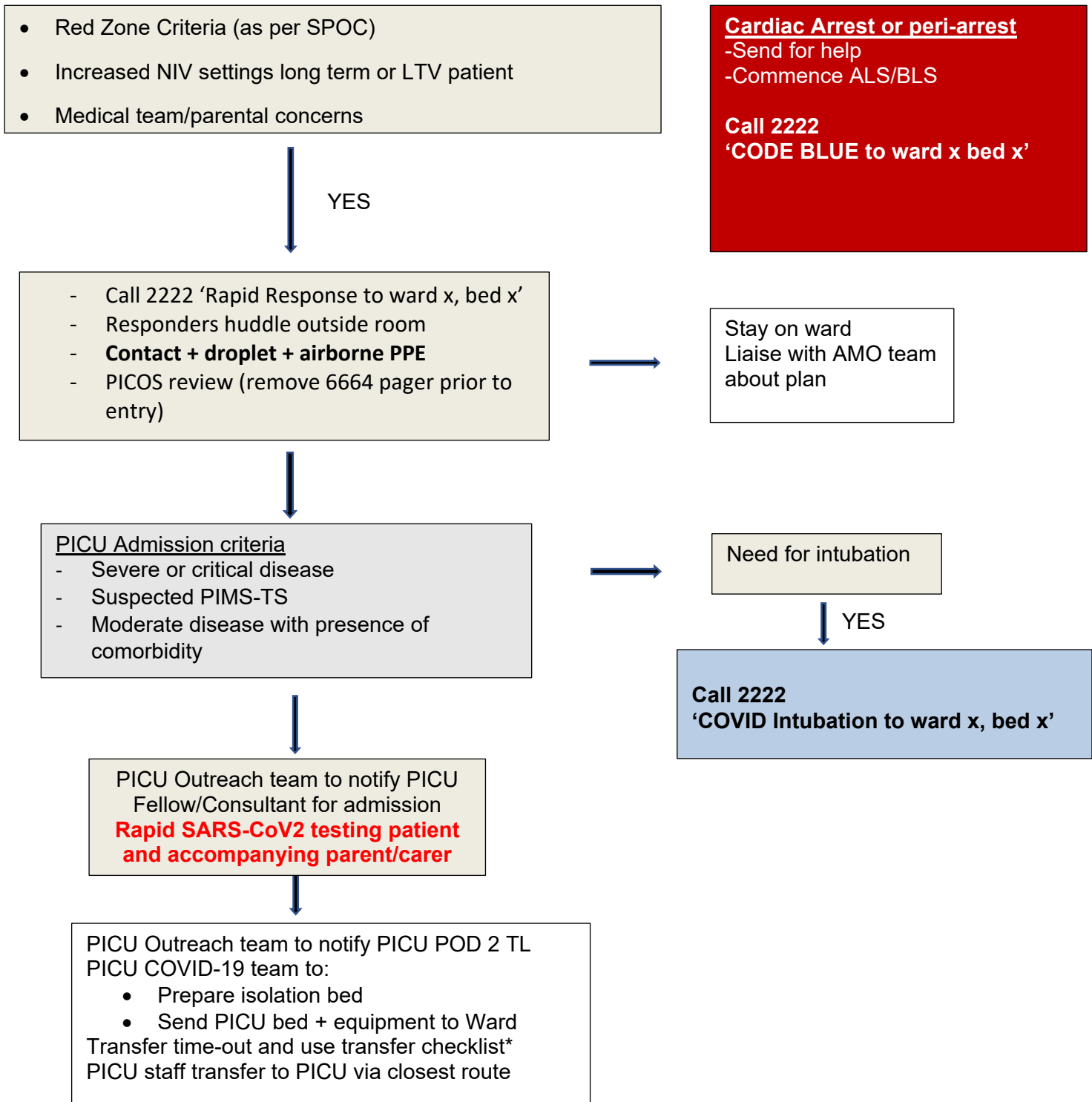
Deterioration of Suspected/Confirmed COVID Patient in ED

Deterioration of Suspected/Confirmed COVID Patient in ED



*Patient mask, transfer staff contact + droplet+ airborne PPE, escort for clearing path, accompanying parent/carer with mask- refer to transfer checklist

Deterioration of Suspected/Confirmed COVID Patient on Ward



*Patient mask, transfer staff contact + droplet+ airborne PPE, escort for clearing path, accompanying parent/carer with mask- refer to transfer checklist

Rapid Response Team

Rapid Response team to DON N95/P2 mask + eye protection for ALL calls

- **Rapid Response Team huddle** outside room:
 - Cause of deterioration
 - Risk assessment
 - Allocate roles - PICU Outreach or senior JMO on site are fresh set of eyes to review
- Stay calm and take appropriate precautions
- Minimise number of responders in the room
- Resuscitation trolley brought to door outside room if required -> utilise drop trolley or staff member to take equipment into room as necessary
- Door can be open for communication purposes, as long as no aerosol generating procedures


Trauma Care

Trauma Attend team to DON N95/P2 mask + eye protection for ALL calls

- Trauma care should follow the usual principles with appropriate precautions to protect staff and resources - trauma patient evaluation **should not** be delayed to determine COVID status
- Ensure all trauma team providers wear PPE for ALL patients
- Allow personnel with specific critical skills to concentrate on those skills
- Minimize the number of personnel at the bedside to only those required for direct patient care - anticipate a maximum of 5 staff members for direct patient contact
- All staff with direct patient contact within 1.5m to DON Airborne + Contact + Droplet PPE

Transfer of Patients


Patient Transfer Checklist




COVID-19 Patient Transfer Checklist


Aims:

- The right protection around the patient.
- The right protection for all the staff.






SET UP



DO




NEXT

- Allocate key roles:
 - Doctor
 - Nurse
 - Porter
 - Parent
 - Escort
- Don PPE (refer to back)
- Patient barrier (surgical mask for non-intubated patient)
- Equipment check:
 - Monitor
 - Suction
 - Oxygen
 - Face-mask, filter, breathing circuit
 - Respiratory support device
 - Resuscitation medications
 - Documentation
- Clinical Recap (ABCDEF)
- Patient safe to leave

- Confirm destination ready: *"This is [identify self and location]. We are ready to transfer [patient name] who is a suspected/confirmed COVID-19 patient. Is the receiving team ready and in PPE?"*
- Transfer via shortest route
- Escort walks 2 metres ahead and summons lift if needed

- Clinical handover inside the room:
 - Transfer doctor and nurse in PPE
 - Receiving doctor and nurse in PPE
- Clinical recap from receiving team
- Transport team doff PPE
- Transport team debrief



COVID-19 Patient Transfer Checklist

Additional pointers

For transfer team member PPE:

- Clinical staff and porter - airborne PPE
- Parent - surgical mask.
- Escort - specific PPE not required as stays outside 2m zone.

Note that if patient is intubated an additional doctor to manage the airway may be required.

Neonatal Transfers

Midwifery staff to send a notifying connected page (10112) to NUMs AND CNCs in Grace for:

- COVID (suspected or confirmed) positive woman in labour or preparing for C-section
- Delivery has occurred
- Transfer is imminent

"COVID Mother" is to be stated at the start of each text page message

Grace TL/ NUM notifies PICU POD 2 TL (mob 0428431316) of the woman in labour

- On-call Intensivist/Fellow notified by PICU Pod 2 TL
- GNN TL/NUM provides PICU with antenatal information
- On-call Intensivist/Fellow to contact the relevant Specialty Consultant/Fellow to inform them of the impending arrival
- If it is a preterm infant requiring admission, the COVID NICU team is to bring COVID backpack, medication and fluid charts to PICU

PICU CSA to create MRN

PICU staff to set up bedspace for COVID neonatal admission

NICU staff arrive in PICU to set up bed space if neonate <37 weeks or neonate is term and needs to be cared for by NICU team

Transfer from Birth Unit to PICU COVID-19 Pod (beds 1-6)

Westmead Medical staff present on the transfer to give handover to the receiving team

Documentation required for ALL transfers:

2x Patient ID band
 Medication chart
 Document if hepatitis B vaccination and vitamin K administered
 2 tubes of maternal bloods for crossmatch sent with signed pathology request form
 NB: Expressed breast milk to be sent with the neonate

Neonate ≥37 weeks*
Cared for by PICU nursing staff

Neonate <37 weeks
Cared for by NICU nursing staff

PICU staff don PPE and prepare for arrival

NICU nursing staff + Fellow don PPE and prepare for arrival

Vascular access, CVL inserted **by PICU staff**-
 neonatal support available for procedures and advice

Vascular access, central lines inserted **by NICU staff**
 -Developmental considerations such as reducing lights, noise
 -Giraffe omni- bed to stay with neonate to minimise handling

Parents telephoned by bedside nurse or doctor to notify them of their baby's arrival to PICU
 Parents given local phone number to call for updates
 Expressed breast milk collection encouraged

Newborn screen test (NBST) to be attended at 48hrs of life unless going to for surgery prior or requiring blood products
 Parental consent via telephone for the test and documented in eMR & blue book

***If a neonate is ≥ 37 weeks and has a complex surgical condition requiring specialist neonatal care, this may be provided by NICU nursing and medical staff at the discretion of PICU Intensivist/Grace Neonatologist**

NETS Retrievals

- Patients will be swabbed at referring hospital (results may not be available prior to transfer)
- If accompanying parent/carer not swabbed at referring hospital then rapid parent test to be attended by PICU staff on admission to PICU and sent to lab at Westmead Hospital
- NETS team will call POD 1 TL on arrival to Westmead Hospital campus
- POD 1 TL will delegate PICU staff member to meet NETS team at the Ambulance Bay Level 1 K Block
- To access the Ambulance Bay Level 1 K Block, use any lift in the critical lift foyer where staff enter K Block ED
- PICU delegate opens the door of critical care lifts and presses level 2 button then gets out of lift and lets NETS team into lift
- PICU delegate takes the general lifts up to level 2 and meets NETS team
- PICU delegate escorts the NETS team to PICU via most direct route through rear PICU doors
- Receiving PICU nurse and doctor to DON PPE and be in room awaiting arrival
- Handover in room with receiving PICU nurse and doctor and NETS team
- NETS team will DOFF after handover of patient to PICU team

Critical Lift Foyer L2



Foyer- Level 1



Entrance to Bay



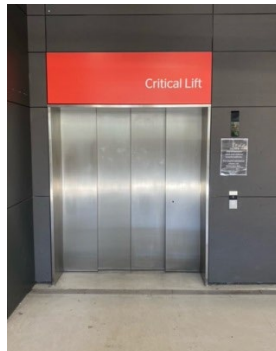
Doors into Bay



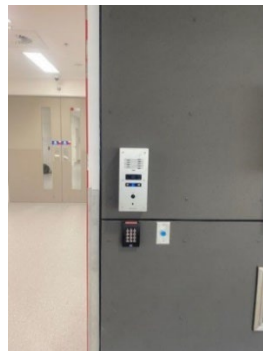
Ambulance Bay



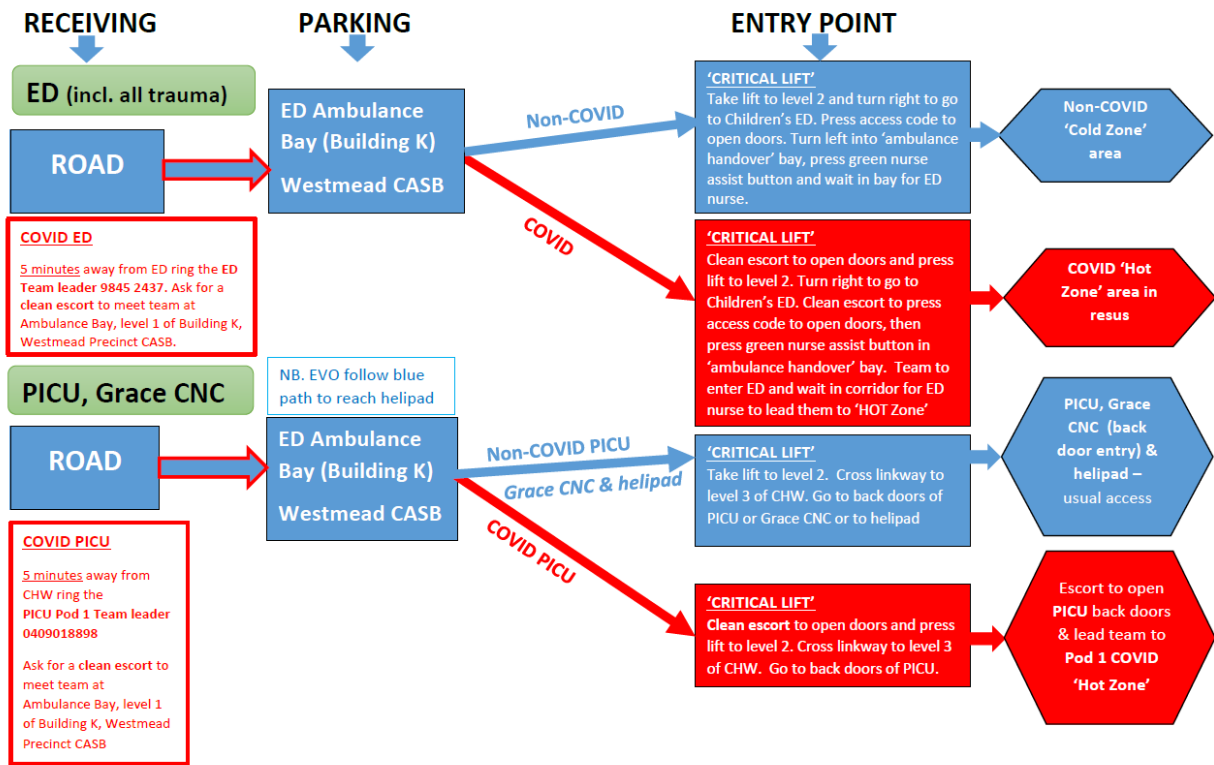
Critical Lift



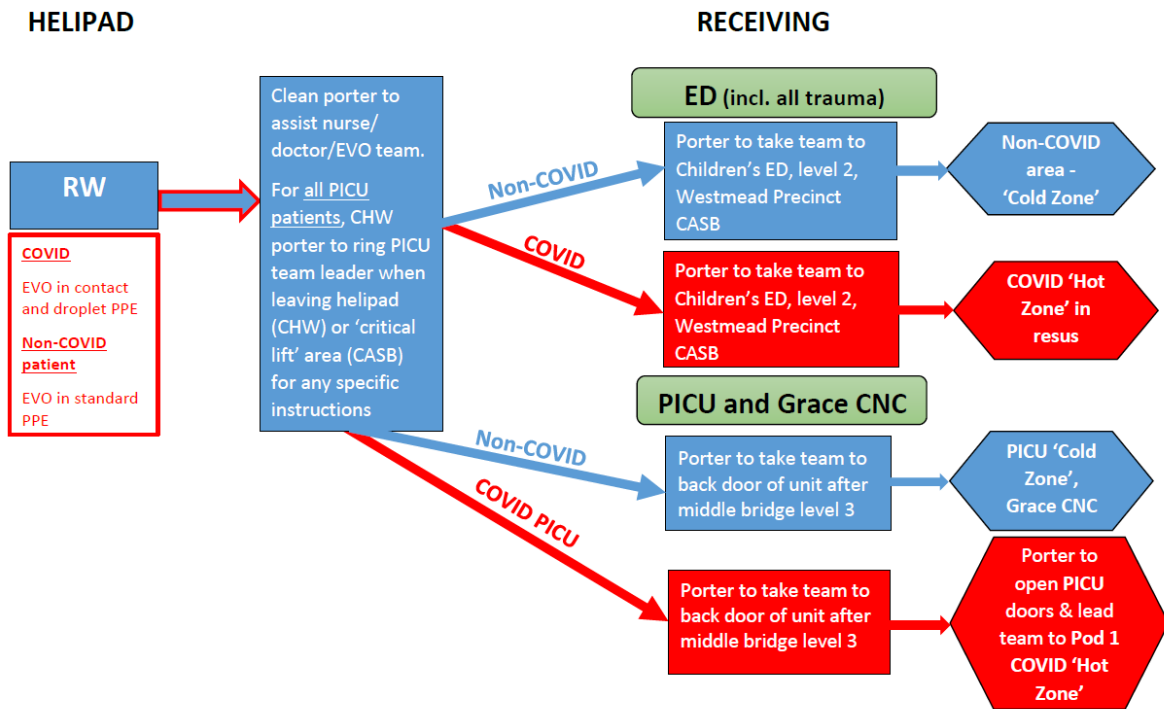
Intercom to get back in



NETS ROAD TRANSFERS TO CHW FOR ALL PATIENTS RE: COVID 19



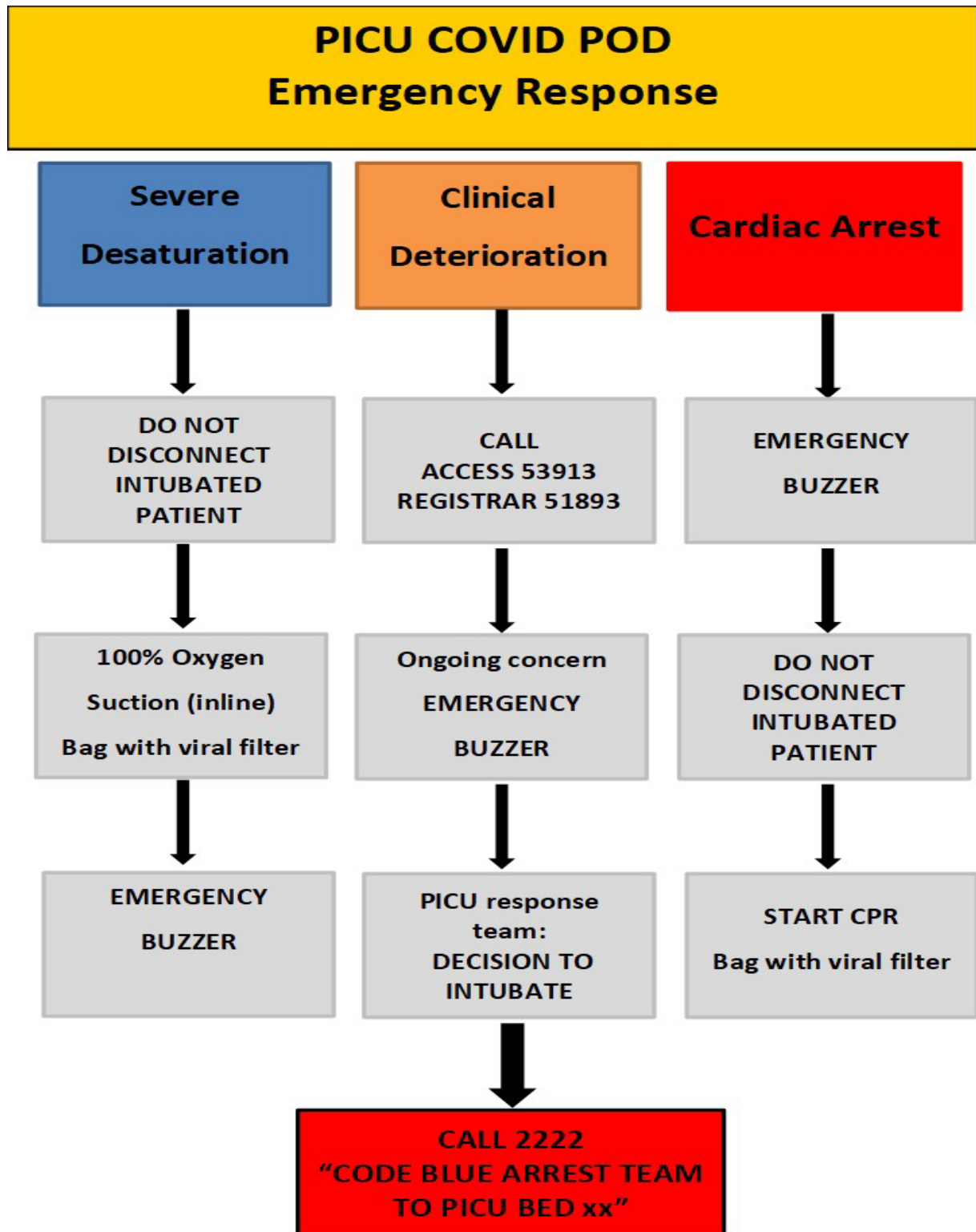
NETS RW TRANSFERS TO CHW FOR ALL PATIENTS RE: COVID 19



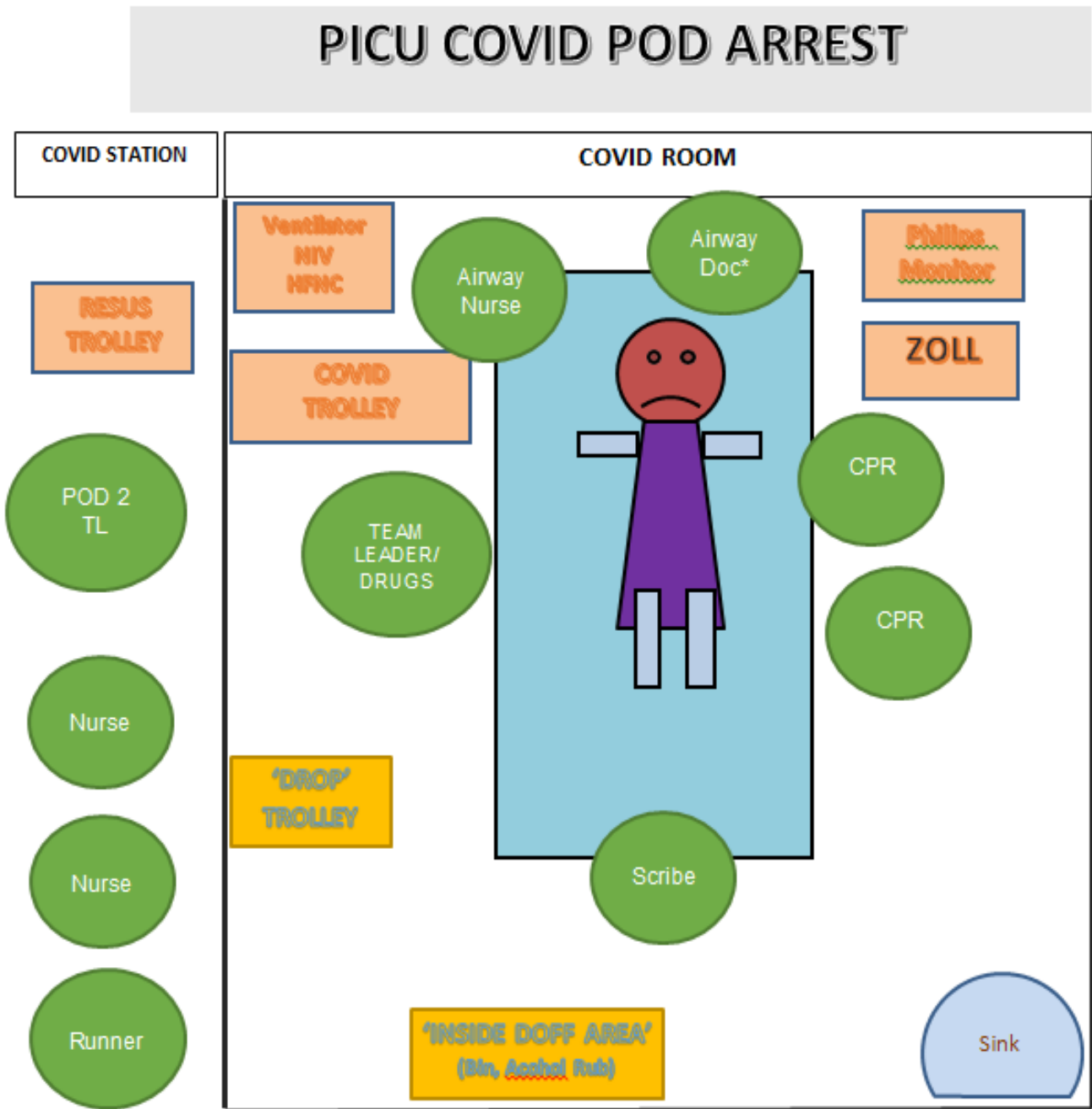
Deterioration & Resuscitation in PICU

Recognition of deterioration and early escalation of support continues to be priority

COVID POD Emergency Response Algorithm

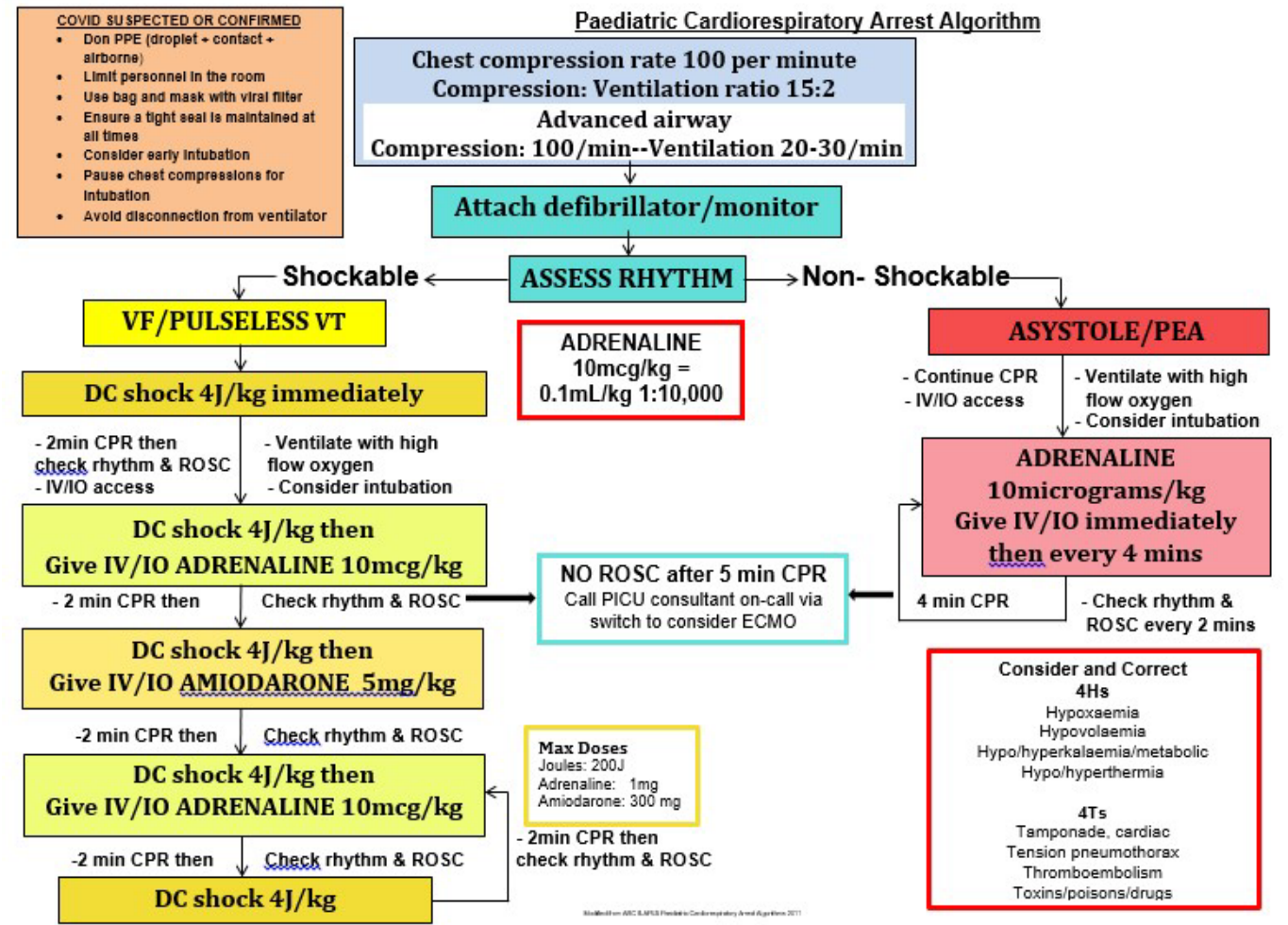


COVID POD Arrest Team Diagram



*First response Airway Doctor replaced by anaesthetic doctor when arrives.

Paediatric Cardiorespiratory Arrest Algorithm



C.O.A.C.H.E.D.

C

Compressions Continue

Person in charge of the defibrillator to say, 'compressions continue'

O

Oxygen away

Person in charge of the defibrillator to say, 'Oxygen Off'.
TURN OFF WALL OXYGEN, then remove mask.

A

All else clear

Person in charge of the defibrillator to say, 'everyone else stand clear'
Everyone other than the person doing compressions is to stand clear of the patient.

C

Charging

Charge the defibrillator to the appropriate joules

H

Hands off/ I'm safe

Person in charge of the defibrillator to tell the compression person 'hands off'. At this point the person doing compressions is to stop compressions step away from the patient raise their hands in the air and respond 'I am safe'

E

Evaluate rhythm

Evaluate the patient's rhythm. Is this a shockable or non-shockable rhythm and vocalise this to the team

D

Defibrillation or disarm and dump

Either defibrillate the patient if they are in a shockable rhythm or **disarm** and dump the shock if the child is in a non-shockable rhythm, **prior to pulse check for return of spontaneous circulation**

REAPPLY FACE MASK AND TURN OXYGEN BACK ON



Non- Invasive Ventilation

Important Principles for managing suspected or confirmed COVID-19 requiring NIV

- Use single room in COVID POD and appropriate PPE (contact + droplet + airborne)
- Trial of CPAP should precede BiPAP when initiating new support
- If utilising home NIV device, ensure bacterial/viral filter is in circuit
- Use a barrier to minimise dispersion of aerosol whenever tolerated: DO NOT obstruct the expiratory port of the NIV device/mask
- NIV masks should be selected and fitted to minimize leak
- Device flow should always be **TURNED OFF** prior to removing mask

Moderate disease

Respiratory illness and unable to maintain SaO₂ > 92% on room air
 A. Use HFNC at 2l/kg, do not exceed FiO₂ 0.4
 B. Awake prone if possible (benefits min 3 hours/day)

Severe disease

Unable to maintain sats > 94% on 2L/kg HFNC at FiO₂ 0.4
 A. Start CPAP
 B. Prone (may need sedation)

Critical disease

CPAP 10 with FiO₂ 0.5 and unable to maintain sats > 92%
 A. Consider NIV
 B. Prone
 Failure of NIV-
 1. Increasing work of breathing with increasing RR, thoraco-abdominal dysynchrony
 2. Failure to maintain sats > 92% with S/F ratio < 221 or P/F ratio < 150.

***Patients with confirmed COVID-19 that are deteriorating with hypoxemic respiratory failure, consider early escalation of respiratory support and modalities
 Don't delay intubation as increasing PEEP nor NIV is unlikely to help**

Intubation

COVID Intubation Activation

1. POD 2 TEAM LEADER or delegate
 - Call **2222** & state: "COVID INTUBATION TEAM TO PICU BED ___"
 - Call anaesthetic consultant on call - via switch
2. PICU ACCESS to retrieve:
 - Intubation medication kit from ADC in PICU fluid room – see [Appendix 8](#)
 - Appropriate size ventilator circuit (if not already in room)
 - Alert Registrar/NP to chart medications

COVID-19 Intubation Trolley

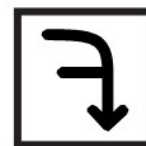


COVID Intubation Checklist



COVID-19 PICU Intubation Checklist

*Aims: — Minimise aerosolisation of pathogens
— Minimise staff exposure to pathogens*



→ SET UP

- Don PPE
- Five core roles:
 1. Most experienced airway proceduralist
 2. Airway assistant
 3. Medical team leader/drugs administrator
 4. Ventilator manager
 5. Outside scribe/timekeeper
- Equipment:
 - COVID Airway Trolley
 - From inside trolley:
 - COVID Airway Pack
 - CMAC Blade
- Drugs drawn up and doses discussed
- Airway strategy (big picture) and plan (small details) shared

▶ DO

- Position
- Pre-oxygenation
- Give drugs
- Device flow OFF
- Intubate
- Cuff up
- Close circuit
- Device flow ON
- Confirm ETCO₂
- Secure ETT

➡ NEXT

- Dispose of all non-reusable equipment in clinical waste bin
- Pack reusable equipment for CSSD
- Doff PPE
- Handover and document
- Team debrief

COVID-19 PICU Intubation Checklist

Additional pointers

The most **experienced airway practitioner** should be the nominated airway proceduralist - the aim is intubation on the first attempt

A **filter** should be between the face-mask and the chosen breathing circuit

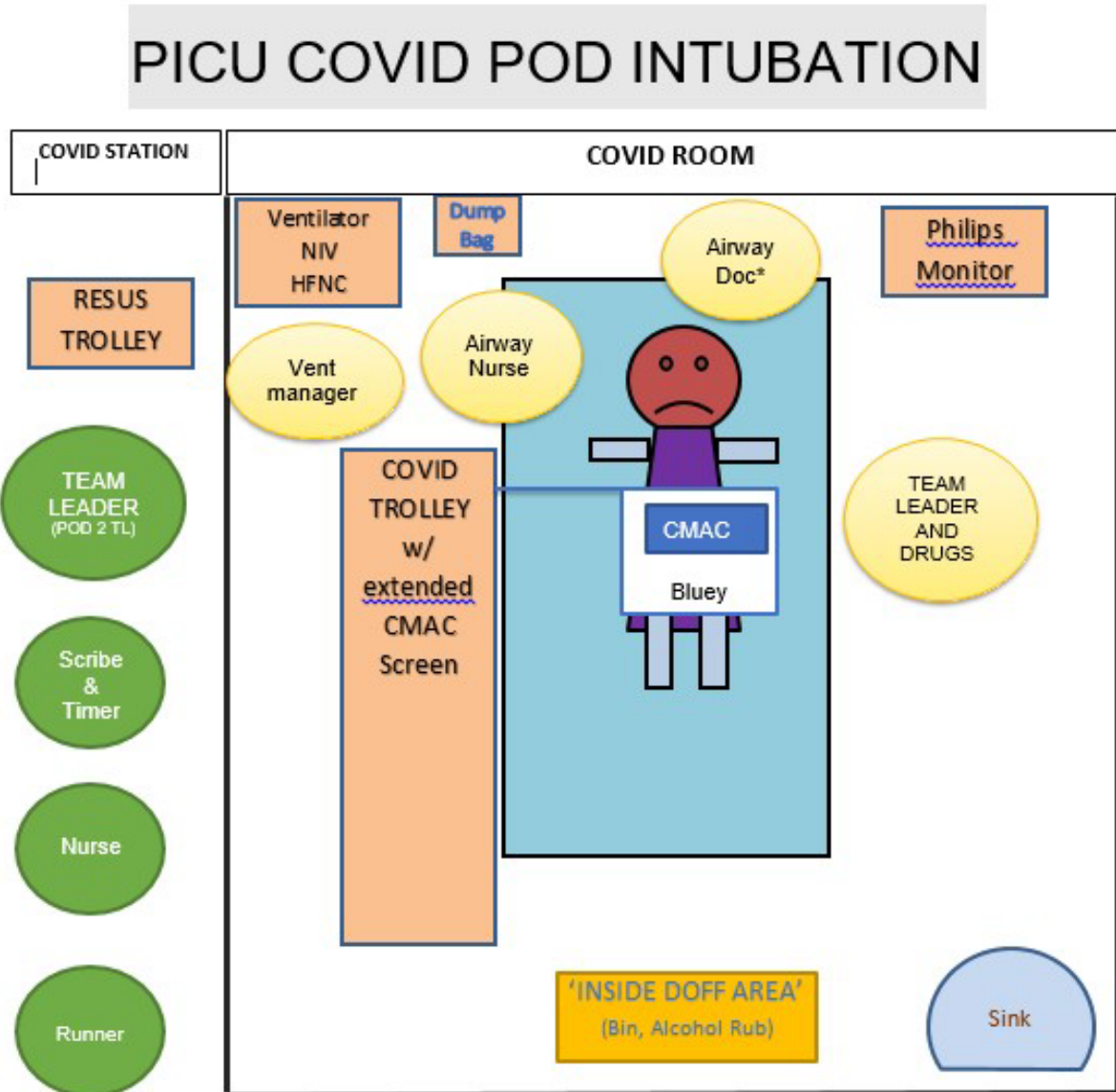
Aim for no manual face-mask ventilation (i.e. traditional RSI) once medications are given

- **Optimise preoxygenation** with ideally at least 3 minutes of preoxygenation with a continuous seal maintained and a spontaneously ventilating patient
- **Maintain the seal** after administration of the chosen induction agent and muscle relaxant—If the patient is unable to tolerate brief apnoea then consider gentle face-mask ventilation & if undertaking face-mask ventilation then consider maintaining the seal with a **2-hand maskhold** technique while a second person squeezes the bag
- Start ventilating **only after the cuff is inflated**

Attach inline suction immediately

Clamp the tube for any required disconnection

COVID POD Intubation Team Diagram



*First response Airway Doctor replaced by anaesthetic doctor when arrives.

COVID POD Intubation Team

**** Avoid aerosolisation whenever possible ****

The most experienced airway operator should do the intubation

The whole team must work closely together to be as quick and safe as possible for both the patient and staff

Key points of practice deviation

- Cease all device flow *BEFORE* removing patient interface
- Place patient interface on patient *BEFORE* commencing device flow
- T-piece flow recommended to be 4-6L/min
- Aim to connect patient directly to ventilator with Inline suction, ETCO₂ *IMMEDIATELY* after cuff is inflated post intubation
- Await ETCO₂ on monitor and assess chest rise & fall rather than auscultation for ETT position confirmation. Do not listen for cuff leak.

Key Roles

3. Airway proceduralist

- Read through script
- Airway plan – A, B, C
- Airway strategy – finer details to communicate to airway assistant re passing of equipment/use of stylet or bougie
- After completion – place reusable equipment for CSSD cleaning into clear plastic bag and tie (bags kept in intubation trolley side drawer with CMAC blades); place disposables in appropriate bins

4. Airway assistant

- Select appropriate COVID Intubation Starter Pack from intubation trolley - see [Appendix 9](#)
- ETT clamp from side drawer
- Inline suction, ETCO₂ (connect in that order from ETT end) from side drawer ready to be connected to ventilator circuit
- CMAC blade connected and turned on
- *TURN OFF/STANDBY* device flow prior to removing patient interface
- Set ventilator to invasive mode with planned settings during pre -oxygenation phase
- Attach Inline suction, ETCO₂ & filter to vent circuit

- Hand intubation equipment to airway proceduralist as requested
- Inflate ETT cuff when instructed by proceduralist
- Connect closed ventilator circuit to ETT after cuff inflated
- Commence ventilation
- Secure ETT with tapes

5. Medical team leader/medications

- Overall patient management, giving medications/fluid bolus as required
- Give RSI medications
- Turn flow to T-piece on and off as directed by airway proceduralist
- PROMPT airway proceduralist where necessary following script

6. Scribe

- Follow script and PROMPT proceduralist where needed
- Scribe timings of key points of script on scribe sheet
- Call out time from rocuronium administration in 10 second intervals
- Transcribe documentation in to Power Chart notes after completion

7. Outside runner

- Be available to pass in any additional equipment & medication requests
- Take bag of used equipment to CSSD for cleaning (after hours leave in room)

8. POD 2 Team Leader

- Activate COVID-19 Intubation team 2222 'COVID INTUBATION PICU BED --'
- Remain CLEAN outside room, direct traffic into room, and watch progress of intubation
- Activate Code Blue (2222) for airway emergency if becomes 'can't intubate, can't ventilate' situation. Via switch call the Consultant Anaesthetist and ENT fellow/consultant; use the following script:

'COVID Airway emergency in PICU Bed-- NOW. Please advise ETA to PICU'

Extubation

COVID Extubation Checklist



COVID-19 Extubation Checklist



Aims:

- Minimise aerosolisation of pathogens.
- Minimise exposure of pathogens to airway operators.



- Key roles identified
 1. Most experienced airway proceduralist
 2. Experienced airway assistant
 3. Co-pilot
- Extubation strategy (including reintubation plan) defined and shared
- Respiratory support plan after extubation defined
- Essential equipment - additional mask with filter, reintubation equipment
- Anti-emetic
- Adequate reversal of neuromuscular blocking drugs

EXTUBATE TO MASK WITH FILTER

- Consider "mask over tube" technique
- Suction of oropharynx +/- inline suction of ETT if needed
- Gas flow OFF
- Deflate cuff and extubate without positive airway pressure
- Gas flow ON

- Dispose of all non-reusable equipment in clinical waste bin
- Reusable equipment bagged and sent to CSSD
- When leaving, doff PPE using standard process
- Exit room
- Airborne precautions to continue for 30 minutes after cleaning
- Handover and document
- Team debrief



Additional pointers: mask over tube extubation

Anaesthetic mask with 2nd HME filter with good seal - two hand technique

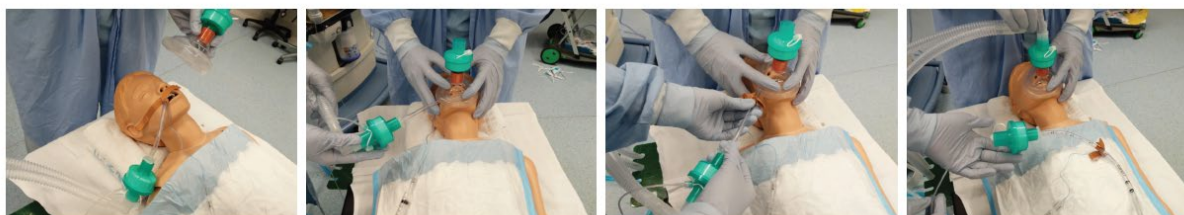
Position ETT to side of mouth exiting under anaesthetic facemask

Gas flow OFF - no positive airway pressure during extubation

Deflate ETT cuff and remove ETT maintaining good mask seal

Disconnect circuit from ETT filter and connect to mask filter

Gas flow ON



Accidental Extubation

To minimise the risk of accidental extubation:

- Identify if patient is at high risk using Risk Matrix and COVID Safe Start Huddle
- Ensure adequate sedation
- Ensure ETT cuff is inflated to correct pressure
- Ensure ETT is secure
- Have an appropriately size non-invasive mask taped to the ventilator to use in case of emergency.

In the event of accidental extubation:

- Press emergency buzzer
- Attach ventilator circuit to mask
- Using two hands, place non-invasive mask over patients face
- Do not change from Invasive Ventilation(IV) to Non Invasive Ventilation(NIV) until there are more than 2 people in the room and a decision has been made whether to leave on NIV or to be reintubated
- Adjust FiO2 as clinically indicated

*****Decision to be made to trial the patient on NIV based on clinical condition***

*****If not, then proceed to re-intubation***

ECMO

ECMO Initiation

All suspected or confirmed COVID-19 patients should have their ECMO status established proactively by the team on admission and daily rounds

Case scenarios where suspected COVID19 patient might need ECMO:

- Patient with ARDS who is deteriorating
- Suspected or confirmed COVID-19 patient who has a cardiac arrest
- Suspected or confirmed Paediatric Inflammatory Multisystem Syndrome - temporally associated with SARS-CoV-2 (PIMS-TS) or Multisystem Inflammatory Syndrome-related to SARS-CoV-2 virus (MIS-C) with arrhythmia, conduction disturbances or ventricular dysfunction

****Team agreed that currently we will provide ECPR for these patients however; providing ECPR for COVID-19 patients remains an ongoing point of discussion and currently is a case-by-case decision, bearing in mind patient comorbidities etc. Hence the importance of having an early conversation****

Cannulation strategy

- VV ECMO- Avalon wherever possible
- VA or ECPR- neck cannulation (unless postop cardiac and suspected COVID-19)

Who and where to cannulate

- Semi-elective VV ECMO:
 - in PICU by Cardiothoracic Surgeons
 - cannula position to be confirmed on ECHO by cardiologist
- VA/ECPR:
 - in PICU (unless patient arrested in OT or Cath Lab) by Cardiothoracic Surgeon

Team composition for initiation (in PICU)

Overall aim is to minimize exposure to team members

Minimum team members required in PICU:

- Perfusionist
- Cardiac Surgical Consultant and Fellow
- Theatre nurse X 3 (2 in hot zone, 1 in warm zone)
- PICU Consultant/Fellow
- ECMO nurse
- ICU patient nurse
- Anaesthetics - PICU consultant can decide whether anaesthetics assistance required

PPE for initiation

- OT nurses will always bring the COVID specific ECMO pack on their trolley (which contains appropriate PPE stock - protective eyewear, P2/N95 masks and disposable fluid-repellent surgical gowns)
- For surgeons - 'Surgeon Elite' face shields (on right hand side wall of ECMO equipment alcove) to clip on and wear their magnifying loupes during the initiation process

Additional Information

- Activate ECMO as per the usual pathway with the addition of contacting cardiology for semi-elective VV ECMO
- Team to scrub and don in warm zone
- Doffing as per COVID doffing checklist – PICU team to assist with 'spotting'
- Essential equipment for hot zone entry:
 - diathermy/suction unit
 - surgical head light
 - ECMO procedure trolley
- Leave additional equipment in warm zone
- Prepare ECMO circuit drugs in warm zone

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Appendix 1: PPE Checklists for Entering and Exiting Room

CHW PICU COVID-19 PPE Checklist

ENTERING ROOM

- Remove jewellery/other items/mobile
- Perform hand hygiene
- Don **yellow gown**
- Don **mask**
- Perform **mask fit check**
- Don **protective eye wear** (if not using visor)
- Don **visor** (if not using protective eye wear)
- Don **hat** (optional)
- Perform hand hygiene
- Don **gloves – ensure cuffs tucked in**
- Check in mirror or with colleague
- Enter room

CHW PICU COVID-19 PPE Checklist

EXITING ROOM

- Doff **gloves**
- Perform hand hygiene
- Doff **gown**
- Perform **hand hygiene**
- Exit** room
- Perform **hand hygiene**
- Doff **hat** (with fingers and minimal touch) (optional)
- Perform **hand hygiene**
- Doff **visor**, discard (if not using protective eye wear)
- Perform **hand hygiene**
- Doff **protective eye wear** and clean using Isowipe
(if not using visor)
- Doff **personal glasses** and clean
- Perform **hand hygiene**
- Doff **mask**
- Perform **hand hygiene**

Appendix 2: Room & Bed Set-up Checklists

Bed Set Up Checklist

Send PICU bed (Consider cot if older than 6 months but < 2.5 years) to referring area with following equipment:

- Monitor and leads (SaO₂, ECG + dots, BP, ETCO₂)
- Portable suction machine
- Suction equipment (2x 8FG for NIV)
- T Piece with filter
- Small Laerdal bag with filter & PEEP valve (regardless of weight)
- 2 x Oxygen cylinders with regulators & flow meters
- COVID Patient Transfer Checklist

Room/Bedspace Checklist

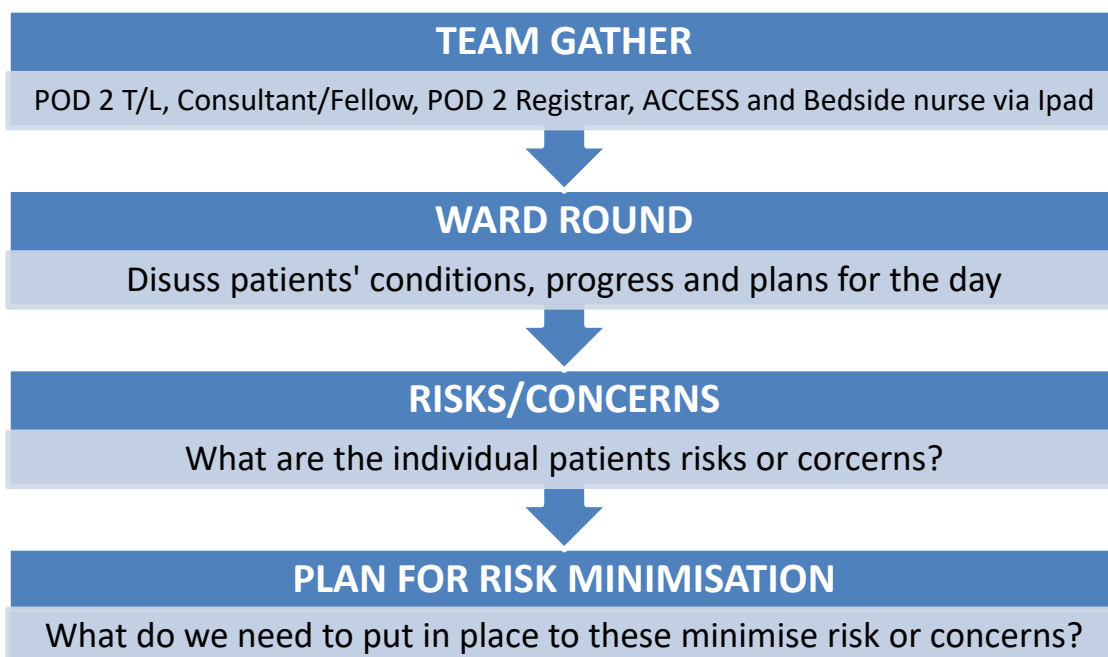
- Pumps - 3 x infusion 2 x volumetric
- Contact numbers on bedside white board – registrar & ACCESS nurse
- Suction canister assembled with tubing
- Stethoscope
- Scribe sheet and clipboard
- Small whiteboard and marker
- Drop trolley
- PPE Doffing Bin (x2 per room for 4 bedded room)
- Rubbish bin & contaminated waste bin
- Parent chair, bottle of water, box of tissues
- Bedside wire drawers:
 - Mouth care containers + eye care ointment
 - Appropriately sized disposable nappies & 2 x appropriately sized arm boards
 - Bluey x 2 + wash bowl + towel
 - Appropriately sized gastric tube
- Airway trolley:
 - Tongue depressor + appropriately sized airway adjunct
 - 2 masks (1 round and 1 clear cushioned) + Hudson face mask with O₂ tubing
 - ETT and oral suction catheters & sterile gloves & spare visor
- Bottom drawer of medication trolley outside room
 - IV Cannulation packs x 6 minimum
 - Fluid bolus packs x 6 minimum

Appendix 3: PICU COVID Access Nurse Checklist

- Check resus trolley
- Check intubation trolley
- Check ZOLL trolley
- Check bed space set ups (checklists in COVID resource folder)
- PPE donning trolley stock (escalate to NUMs for additional items)
- Doffing bin empty and station clean
- Phone charged and ready for use
- Ipads Charged and ready for use
- Isolation Room Entry Log forms
- Confirm resource folder in warm zone
- Restock warm zone
- Ensure COVID Safe Start Huddle is attended to AM and PM

Appendix 4: COVID Safe Start Huddle

The aim of this huddle is to ensure that individual patient concerns or risk are discuss and potential mitigation strategies are discussed/implemented.



TEAM TO DISCUSS:

- Level of Support required from the POD 2 Registrar
(E.g. Should they stay in WARM ZONE today? Check ins)

COVID ACCESS

- Discuss meal reliefs/drink breaks for the shift
- If help required from POD 2 T/L

Please note: The POD 2 T/L and an ACCESS Nurse is allocated each shift to responds to the COVID Zone in case of an emergency

Appendix 5: X-ray Workflow/Checklist

Entering room

Machine

- Remove **unnecessary items** from machine
- Put **disposable plastic cover** over plate

Human

- Remove jewellery/other items/mobile/pager
- Don **lead gown**
- Perform hand hygiene
- Don **yellow gown**
- Don P2/N95 mask
- Don **protective eyewear**
- Perform hand hygiene
- Don **gloves**
- Check in mirror or with colleague
- Enter** room
- Position **tube head** above patient
- Position **plate** underneath patient
- Take **X-Ray**

Exiting room

Machine

- Bring **tube head** back
- Remove **plate** from under patient
- If assistant available, remove **cover** from plate and hand to assistant
- If no assistant available, remove **cover and let plate** slide back into plate holder
- Remove **gloves**
- Perform hand hygiene
- Don **gloves**
- Remove lead gown**
- Wipe down the mobile X-ray machine, tube head and equipment using Isowipes™
- Doff **gloves**
- Perform **hand hygiene**
- Doff **gown**
- Perform hand hygiene**
- Leave room
- Perform **hand hygiene**
- Doff **protective eyewear** without touching face and clean using Isowipe™
- Perform hand hygiene**
- Doff **mask** without touching face
- Perform hand hygiene
- Put items back onto X-Ray machine

Appendix 6: Clinical Logistics Quick Reference Guide

FOR STAFF

COVID Huddle for Clinical deterioration/Safety Planning

- To occur at commencement of each shift
- Present: POD 2 COVID Registrar, POD 2 Team leader and COVID Zone Staff
- Allocation of roles in the event of a deterioration
- Discuss individual patient risk and requirements

Uniforms

- You can wear your own uniform/scrubs
- You may shower post your shift

PPE

- Contact + droplet + Airborne precautions
- HOT ZONE: yellow gown, gloves, goggles and P2 or N95 mask
- WARM ZONE: P2/N95 and goggles
- You do not need to wear a head cover unless intubating the patient or doing CPR on the patient
- You do not need to double glove
- You do not need to wear shoe covers
- Change your N95 or P2 mask every 4 hours

Personal Belonging storage

- Leave all bags, water bottles, phones and stationary outside the COVID Zone

Contamination Management

- Inform T/L of any breaches in PPE
- Inform ID team – Obtain risk assessment based on individual circumstances

Example 1: Donned a N95 mask that you haven't been fit tested for? (low risk)

- DOFF PPE following the sequence
- DON correct mask and PPE
- Obtain a COVID swab 72 hours later

Example 2: Bodily fluids Splash (low risk)

- DOFF PPE as per sequence
- DON NEW PPE
- If clothes are soiled, Shower and change into clean scrubs

Surveillance COVID Testing

- Obtain a COVID test within 72 hours of working in the COVID Zone or as Outreach
- Continue surveillance testing every 72 hours

FOR PATIENTS

Paperwork and Notes

- Leave all paperwork outside the room in the WARM Zone
- If paperwork was in the HOT Zone, Hand hygiene is essential when dealing with this paperwork

Pathology Samples

- Staff inside the room to take the sample and label tubes
- Staff outside the room to DON gloves, open a specimen bag, open the door
- Staff inside the room places the specimen into the bag without touching the bag
- Send sample as per normal

COVID Testing of Patients

- Viral swabs (red swabs) are taken of the nose and throat
- Double bagged
- This will need to be walked to virology and marked as URGENT-PICU.

Food trays

- Dispose of all rubbish and food scraps in room
- Pass tray to staff member in WARM ZONE
- Wearing gloves, Wipe over tray with 70% Alcohol
- Place at the bottom of the food trolley

Disposing of Milk bottles

- Rinse bottle in the HOT ZONE
- Drop into a bag in the WARM Zone
- Tie bag when full and place in the kitchen.
- Place in the bottle bags in kitchen

Ventilator Return process

- Place bag over test lung filter
- Disconnect all ventilator probes
- Disconnect ventilator circuit and humidifier – place in clinical waster bag
- Dispose of bag into clinical waste bin
- Cover ventilator including arm with a plastic bag
- Label with marker – “COVID”
- During hours: Phone ahead before you take out to inhalation, ring bell and wait for someone to take it from you
- After hours: Leave it the sluice room until inhalation is present

Patient Waste

The use of disposable bedpans and urinals are recommended for use in the COVID Zone.

Pan

- Place pan liner insert into pan
- Place one moisture absorbing gel pack in liner (will absorb approx. 500mls)
- After use, place pan liner in clinical waste
- If not soiled, non-disposable pan can be reused for the same patient

Urine Bottle

- Urine bottle can be used as is
- Place one moisture absorbing gel pack into bottle
- After use, dispose of bottle into clinical waste

If disposables are not available, then please use the following processes

Disposing of urine

- While wearing FULL COVID PPE
- Cover pan with pan cover or cover urine bottle with a glove
- Pass it to a person outside the HOT ZONE who is dressed in FULL **CLEAN** COVID PPE
- Exit via Doffing area**
- Take to dirty utility room
- Pour urine down the dirty sink and flush
- Place pan or bottle in the washer on cycle 3
- Doff Gloves, Hand hygiene
- Doff Gown, Hand hygiene
- Keep mask and eyewear on

Disposing of faeces

- While wearing FULL COVID PPE
- Place a clear plastic bag to line the bedpan
- Tie bag and place in clinical waste bin
- Cover pan with pan cover
- Pass it to a person outside the HOT ZONE who is dressed in FULL **CLEAN** COVID PPE
- Exit via Doffing area**
- Take to dirty utility room
- Place pan in the washer on cycle 3
- Doff Gloves, Hand hygiene
- Doff Gown, Hand hygiene
- Keep mask and eyewear on

FOR ENVIRONMENT

Please keep doors closed at all times

PPE in the HOT ZONE

- Change Gloves and perform hand hygiene in between patients
- DON a second Gown when dealing bodily fluids
- If contaminated always EXIT the HOT ZONE and DON clean PPE

Equipment out of the HOT ZONE

- Drop equipment on the Drop Trolley in WARM ZONE
- Clean with a minimum of 70% ethanol
- Return to storage
- E.g. Equipment such as ECG machine can enter WARM Zone with patient attachments being cleaned thoroughly once exiting the HOT ZONE
- If cannot be cleaned then needs to be exposed of in the room*

General Waste Management

Disposing of White Gown bin in the room?

- Lid can remain open while in room
- If full, Tie the bag
- Close lid and remove from HOT Zone.
- Place in DOFFING area and advise cleaner
- Obtain a new white bin

Disposing of general waste (Clear bags) in the room?

- Tie the bag in the room
- Pass to the cleaner or support person outside HOT ZONE
- Take Waste through the DOFFING area to waste collection point
- NOTE: Only Gloves are required when dealing with non-clinical waste

Disposing of Clinical Waster from the room?

- Tie the bag in the room
- Pass to the cleaner or support person outside HOT ZONE
- Take Waste through the DOFFING area to waste collection point
- NOTE: Only Gloves are required when dealing with clinical waste

Sink in DOFFING Area





- Cleaner will replace the water drums (under the sink) at 0800 and 2100 every day
- If drums need to be replaced overnight, 2 spare drums are located in the PICU dirty utility room under the right corner bench (below CSSD/Inhalation boxes)
- Clean drum → fill with tap water
- Wearing FULL PPE, empty the waste drum in the dirty sink

If tap does not work after replacing, there is a switch under the sink to the right when you open the doors

Appendix 7: Proning checklist

PRONING CHECKLIST

Preparation Phase (Prior to getting help into room)	
	If < 8 years of age: Create pillows using egg crate material (head, chest, pelvic, distal femoral, & lower limb). No pillows necessary if ≥ 8 years of age
	Check ETT on CXR - tip should be in the lower 1/3 of the thoracic trachea
	Assess the security of the ETT, vascular lines, SpO ₂ probe and reinforce as necessary Retape the ETT to the upper lip on the side of the mouth if required
	Protect eyes if chemically paralysed &/or open (polyvisic, hydrocel pad)
	Move ECG electrodes to the lateral aspects of the upper arms and hips
	Remove clothing surrounding thorax and abdomen
	Coil then secure bladder catheter to inner thigh
	Suction the patient's oropharynx
	Temporarily cap nonessential vascular lines and the patient's NGT/JT
	Final Check: Review the start and end point of all that is left attached to the patient Arrange the remaining vascular lines and Foley catheter tubing to prevent tension
	Adequately sedated for proning? Give sedation bolus if required
Planning Phase	
	<p><i>Pre-plan responsibility:</i></p> <p>Infant/toddler: RN1 or DR- Head/ETT; RN2 - chest/arms; Nurse RN3 - hips/legs. Child: RN1 or DR- Head/ETT; RN2/3 - chest/arms; Nurse RN4/5 - hips/legs.</p>
	<p><i>Review technique:</i></p> <ul style="list-style-type: none"> • Infants/toddlers: Levitate = levitate up, turn 45 degrees, pause/reassess, turn prone, to place pillows under the patient. • Children: Mummy = using all bed linens - slide patient to the edge of the bed away from the ventilator, place bed sheet over patient • (If < 8 years: position chest and pelvic pillows over draw sheet); place full sheet over entire patient; create a mummy effect by tucking the edges of the full sheet under patient; turn patient 45 degrees toward ventilator, pause/reassess/change hands if needed, position patient prone on new linen and pillows/remove old top linen

Turning Phase	
<p>STEP 1 – SLIDE AWAY Slide the patient away from the Ventilator to the edge of the bed</p> 	<p>STEP 2 – ROLL ONTO SIDE Roll the patient onto their side towards the ventilator</p> 
<p>STEP 3 – SWAP HANDS Rollers on either side of bed swap hands in staggered fashion</p> 	<p>STEP 4 – Complete Roll Complete roll to prone, unroll sheets, ensure ETT and all lines secure.</p> 
<p>Remember:</p> <ul style="list-style-type: none"> - Keep head in alignment with body, avoid hyperextension, keep arms next to torso, point toes of the upper leg in the direction of turn - Turn toward the ventilator without disconnecting. (FiO₂ may be manipulated to maintain target SpO₂) - Talk the patient throughout the turn 	

Returning to the supine Position	
	The same mummy wrapping technique should be used
	Do not place pillows on patient back
	<p>The 4-Step sequence is reversed with some significant differences. The most significant difference is the patient rolls away from the ventilator</p> <ul style="list-style-type: none"> • Step-1 – Slide towards the ventilator – patient face should be pointed towards the ventilator through the maneuver • Step 2 – Turn 45 degrees away from the ventilator • Step 3 – pause/reassess/change hands if needed • Step 4 – Complete the maneuver

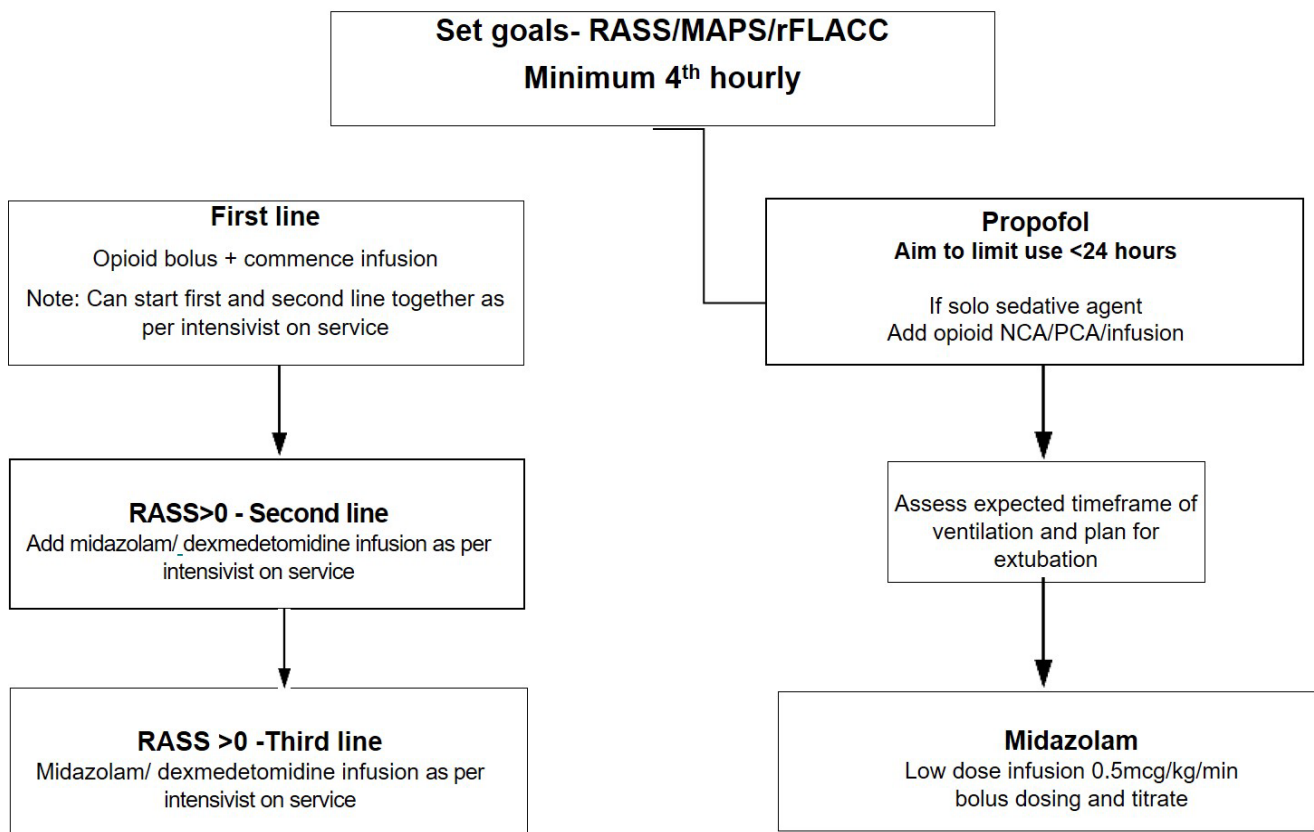
Cardiac Arrest and Unplanned Extubation

In the event of cardiac arrest and/or unplanned extubation the patient must be immediately returned to the supine position to allow for cardiopulmonary resuscitation and/or

Appendix 8: Sedation and analgesia algorithms

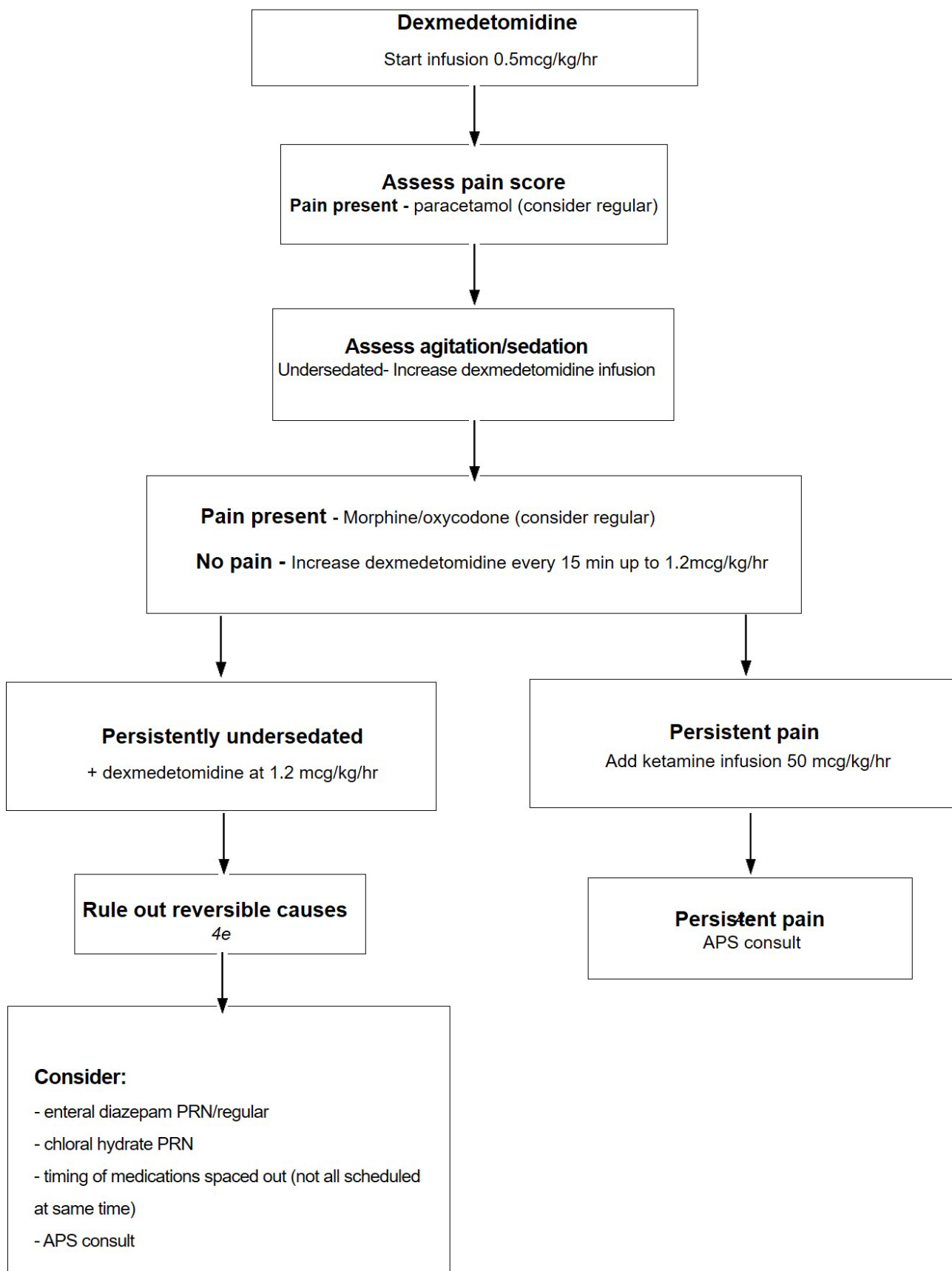
Intubated patients

Daily	<ul style="list-style-type: none"> RASS/MAPS/rFLACC scores every 4 hours + after every bolus Goals - RASS 0 to -2; MAPS: 3; rFLACC:0-1 Rule out reversible causes: <ul style="list-style-type: none"> Secretions or ventilator dyssynchrony Constipation Uncomfortable position Pain Non pharmacologic delirium prevention done every day CAPD delirium scoring every shift
Analgesia & Sedative infusions (bolus + initial doses)	Bolus dose & infusion starting rate <ol style="list-style-type: none"> Morphine – 20mcg/kg bolus & 20mcg/kg/hr Fentanyl – 1 mcg/kg & 1mcg/kg/hr Midazolam – 50mcg/kg & 0.5mcg/kg/hr Dexmedetomidine – 0.5mcg/kg/hr (no bolus)
Every 15 minutes if required Reassess RASS/MAPS/rFLACC	Bolus dose + incremental increase in infusion rate: <ol style="list-style-type: none"> Morphine – 20mcg/kg & 10mcg/kg/hr Fentanyl – 1 mcg/kg & 0.5mcg/kg/hr Midazolam – 50mcg/kg & 0.5mcg/kg/hr Dexmedetomidine – 0.2mcg/kg/hr (no bolus)
Maximum infusion dose limit	<ol style="list-style-type: none"> Morphine – 40mcg/kg/hr Fentanyl - 4mcg/kg/hr Midazolam – 2mcg/kg/hr Dexmedetomidine – 1.2mcg/kg/hr
PRN Medications & doses	Agent selection is based on pain score Pain present: 1 st line – Paracetamol 2 nd line – Opioids if not already on 3 rd line – Ketamine No pain: Consider enteral: - chloral hydrate - clonidine (if not on dexmed) - diazepam CAPD >9: Consider atypical antipsychotics (risperidone or olanzapine)



Non Invasive Ventilation patients

Daily	<ul style="list-style-type: none"> • RASS/MAPS/rFLACC scores every 4 hours + after every bolus • Goals - RASS 0 to -2; MAPS: 3; rFLACC:0-1 • Rule out reversible causes: <ul style="list-style-type: none"> - Secretions or ventilator dyssynchrony - Constipation - Uncomfortable position - Pain • Non pharmacologic delirium prevention done every day • CAPD delirium scoring every shift
Initial sedative infusion of choice	<p>Dexmedetomidine infusion - 0.5 mcg/kg/hr</p> <p>Increase by 0.2 mcg/kg/hr every 15 min to a maximum 1.2mcg/kg/hr</p>
Initial pain management and escalation	<p>Paracetamol PRN - consider regular doses</p> <p>Opioids PRN (morphine/oxycodone) - consider regular doses</p> <p>Opioid infusion - morphine/fentanyl</p> <p>Adjunct to analgesia - ketamine infusion starting rate 50mcg/kg/hr</p>
Maximum infusion dose limit	<p>Morphine – 20mcg/kg/hr</p> <p>Fentanyl – 1.5mcg/kg/hr</p> <p>Dexmedetomidine – 1.2mcg/kg/hr</p> <p>Ketamine – 200mcg/kg/hr</p>
Assessment/Titration	<p>Pain scores (MAPS/rFLACC)</p> <p>Assess every 4 hrs</p> <p>Reassess 30 minutes after PRN doses</p>
PRN Doses	<p>Agent selection based on pain score</p> <p>Pain present: As above</p> <p>No pain: Consider enteral:</p> <ul style="list-style-type: none"> - chloral hydrate - clonidine (if not on dexmed) - diazepam <p>CAPD >9: Consider atypical antipsychotics (risperidone or olanzapine)</p>



Appendix 9: COVID Intubation Medication Kit

ADC COVID Intubation Medication Kit

Contents

- Fentanyl 100mcg/2ml
- Ketamine 200mg/2ml
- Propofol 200mg/20ml
- Adrenaline 1:10,000 (1mg/10ml)
- Atropine 600mcg/1ml x 2
- Metaraminol 500mcg/10ml
- Rocuronium 50mg/5ml x 4



Instructions to remove Kit from ADC

- Scan finger
- Select Patient
- Select Remove Meds
- Type & Select – Intubation Kit
- Witness prompt & count checks
- Remove Kit

Instructions to return/restock

- Unused S8s must be placed in DD safe for pharmacy witness and disposal – usual S8 process applies
- Pharmacy will replace used kits as per ADC process

Appendix 10: COVID Intubation Starter Pack

	ETT	LMA	Guedel	Airway Syringe	Inline suction	Stylet	Bougie
0-5kg	3 (uncuffed and cuffed) 3.5 – cuffed	1	00 + 0	5ml	6 FR	6 FR	Infant
5-10kg	3.5 + 4 cuffed	1.5	1	5ml	6 FR	6 FR	Infant
10-20kg	4+4.5+5 cuffed	2	1 + 2	5ml	8 FR	10 FR	Paed
20-30kg	5 + 5.5 (cuffed)	2.5	2	10ml	10 FR	10 FR	Paed
30-50kg	6 +6.5 (cuffed)	3	3	10ml	10 FR	14 FR	Adult
50kg+	6.5+7 (cuffed)	4 + 5	4 + 5	10ml	10 FR	14 FR	Adult

DO Phase of Intubation Checklist

- Appropriately sized cuffed ETTs
- Airway syringe
- Bougie
- Stylet
- Gauze for introducer control
- Lubricant
- Inline suction
- ETCO2 line
- ETT clamp (if using metal clamps ensure oxygen tubing on the ends of clamps)
- Yankeur sucker
- “Remember the ETT tape” sign or cut ETT tapes

Lifelines

- Guedel's Airway
- AuraGain LMA

Note - viral filter, face mask, and anaesthetic T-piece should already be in room

Appendix 11: Food Services

Guidelines for all patients in isolation requiring meals:

- CSA to enter correct diet code into patient management system
- CSA/nursing staff to call Diet Office (ext 52238) to inform (can leave message):
 - Patient is in isolation
 - If guest tray / parent meal required
 - When the patient is no longer in isolation
- Nutrition Assistant to leave the menu with CSA to give to Nursing staff
- Nursing staff to take menu order verbally (menu is not to enter patient room)
- Mid-meal items will be sent with main meals as well as water bottles & cups
- Nutrition Assistants and Food Service staff are not to enter patient room
- Nursing staff to deliver and collect tray from patient room & place on lowest shelf of trolley

Food Service for all patients in isolation requiring meals

- Normal meal tray service
- Standard cleaning procedures for trays, cutlery, crockery, bottles.
- Hand hygiene procedures to be followed (**major preventative measure**):
 - Alcohol hand rub on entry and exit of wards
 - Wash hands on return to kitchen and put on gloves
 - Wear gloves when stripping trays
 - Washing of hands after removal of gloves

Dept. Nutrition & Dietetics page # 6069 / Food Services / Infection Control

<https://www.health.gov.au/sites/default/files/documents/2020/03/interim-recommendations-for-the-use-of-personal-protective-equipment-ppe-during-hospital-care-of-people-with-coronavirus-disease-2019-covid-19.pdf>

Appendix 12: Communication IPADs contact information

IPAD 1 - XMK1150

Email: SCHN265@gmail.com

IPAD 2 - XMK1149

Email: schn2050@gmail.com

IPAD 3 - XMK1148

Email: Schn259@gmail.com

IPAD 4 - XMK1151

Email: SCHN252@gmail.com

IPAD 5 - XMK1152

Email: SCHN251@gmail.com

Appendix 13: Parent/Carer Visitation and Testing

Visitor guidelines

TEMPORARY VISITOR GUIDELINES:

CHANGES DUE TO COVID-19

In response to COVID-19 and the increased number of cases in the community, we have temporarily changed our visitor guidelines to protect vulnerable patients, families and staff.

- Only one parent/carer can visit their child per day.
- In most areas, two parents/carers can accompany their child upon admission and discharge for 15 minutes.
- A 15 minute 'handover' period per day is also supported while the child is in hospital, to allow parents/carers to discuss their child's care. To find out more, please speak to your child's health care team.
- Unfortunately, siblings are not able to visit at this time. We encourage virtual visits using platforms like Facetime or WhatsApp. If you need access to a tablet for video conferencing, please speak to your child's Nurse Unit Manager.
- All visitors will be screened upon entry and must stay home if sick or if they have visited a COVID-19 case location.
- All visitors over the age of 12 need to wear a mask in all areas of the hospital.
- Hand washing and physical distancing guidelines should be maintained at all times, to help protect vulnerable patients and families.

We know these changes may be challenging. If you have any questions or concerns, please speak to your child's Nurse Unit Manager or health care team.

Thank you for your patience and understanding, as we work hard to keep everyone safe.

the children's
hospital at Westmead



Parent Testing Process

Child rapid swab:

- Usual process - send to CHW lab
- Call CHW lab to process as a Rapid swab after approval by COVID ID team

Parent/carer requires a routine swab if not tested in past 72hrs:

- Ward clerk to generate CHW MRN (ED/ward)
- Exception - approved by COVID ID team for parent's rapid swab to be done at CHW
 - Public health request
 - Impacting ICU capacity/patient flow

Do not delay clinical treatment for child that needs admission to PICU pending a COVID test result

Parent visitation

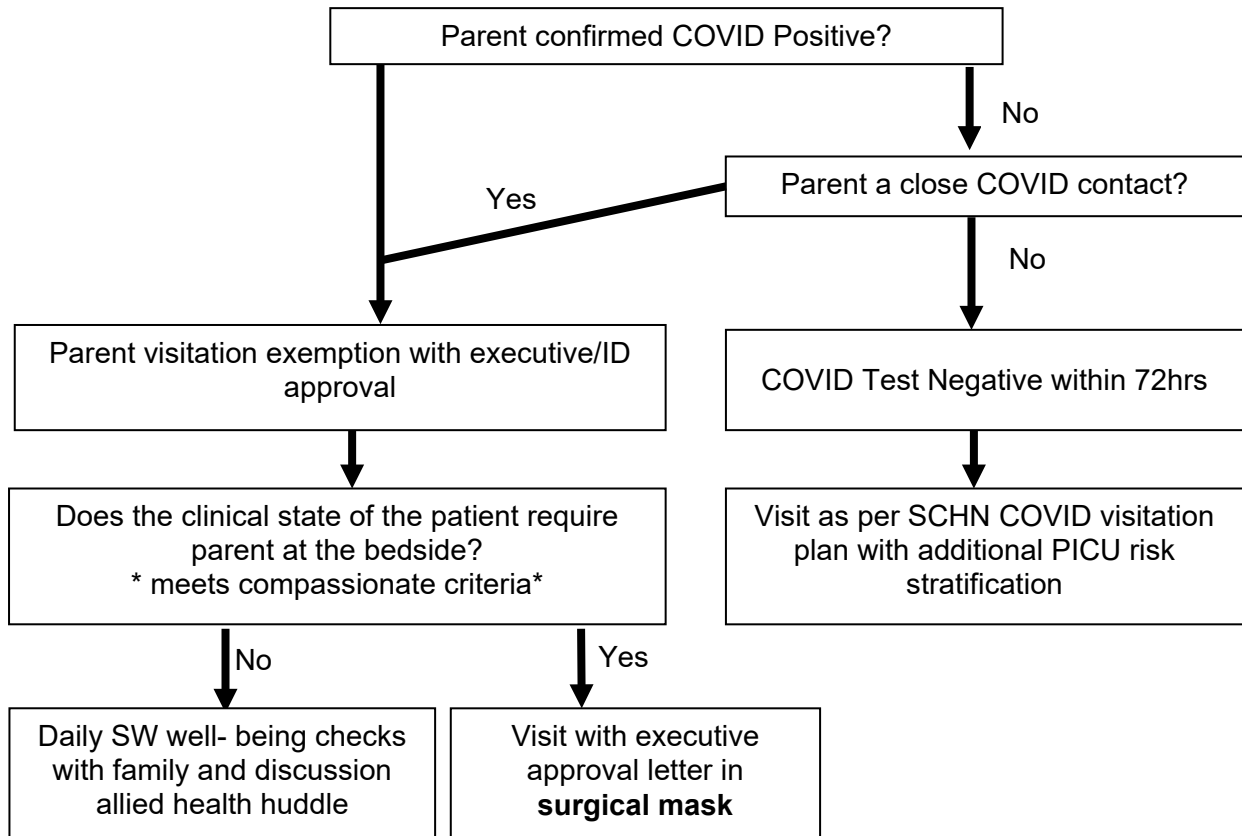
Patient and parent test result pending:

- Step 1 - Bed 5, 6, 7 (8-10 need to be vacant)
- Step 2 - Bed 24
- If the above rooms are occupied then request parent rapid PCR test

Patient test negative and parent test pending:

- Step 1 - Bed 24
- Step 2 - Bed 7 (8-10 need to be vacant)
- If the above rooms are occupied then request parent rapid PCR test

COVID Positive Parent Visitation Guideline



***Compassionate criteria**

- having parent at bedside for behavioural management
- Parent/carer mental health/distress
- Acute clinical deterioration, ECLS, cardiac arrest, end of life care

1. Process for obtaining parent/carer visitation:

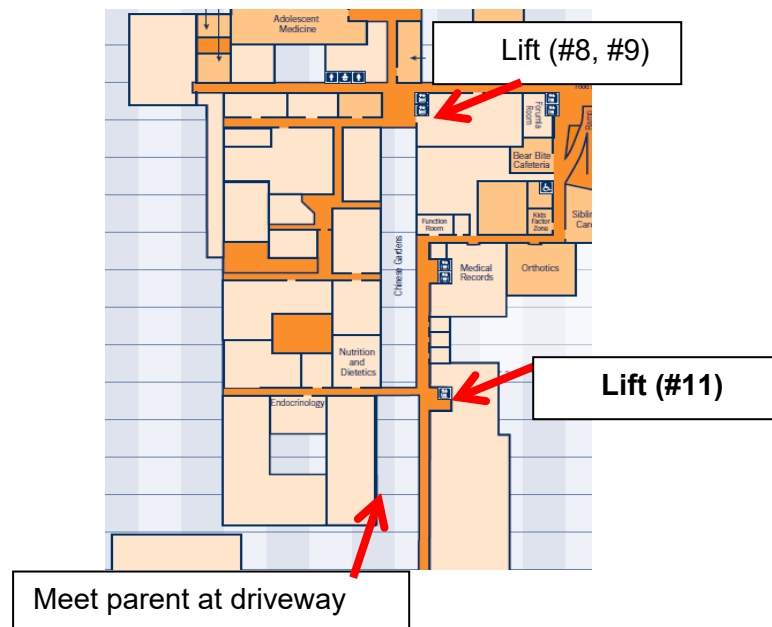
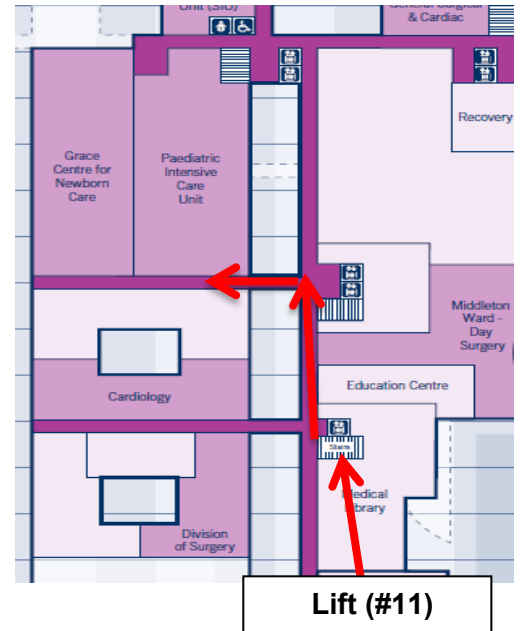
- a. Discuss requirement for visitation with POD2 Intensivist and TL
- b. Identify representative to notify and discuss this with Infectious Diseases and Executive on-call to obtain approval for visitation
- c. Once parent/carer visitation status obtained, liaise with parent/carer to plan visit
- d. Advise parent/carer to call PICU when they arrive into the bay

2. Entry of Parent/Carer into the Hospital:

- a. Confirm the arrival time and location of parent/carer (If arriving via personal car or being dropped off, use the Chinese Gardens (directions below)
 - i. Notify Security of plan and ETA (location car will be parked)
 - ii. Parent/carer to be met by PICU escorting team at set location
- b. TL to notify POD2 Intensivist and team that parent/carer has arrived
- c. Allocated escort to bring a surgical mask for parent/carer and min 70% isopropyl alcohol wipes in case buttons pressed/surface touched by parent/carer
- d. PICU parent escort team to wear :
 - i. 1 x parent escort to wear contact + droplet + airborne PPE
 - ii. 1 x PICU clean escort to wear P2/N95 mask and eye protection
- e. Escort parent/carer to PICU via designated route (directions below)

PICU designated Route for COVID positive Parents**Ground Floor Level 1**

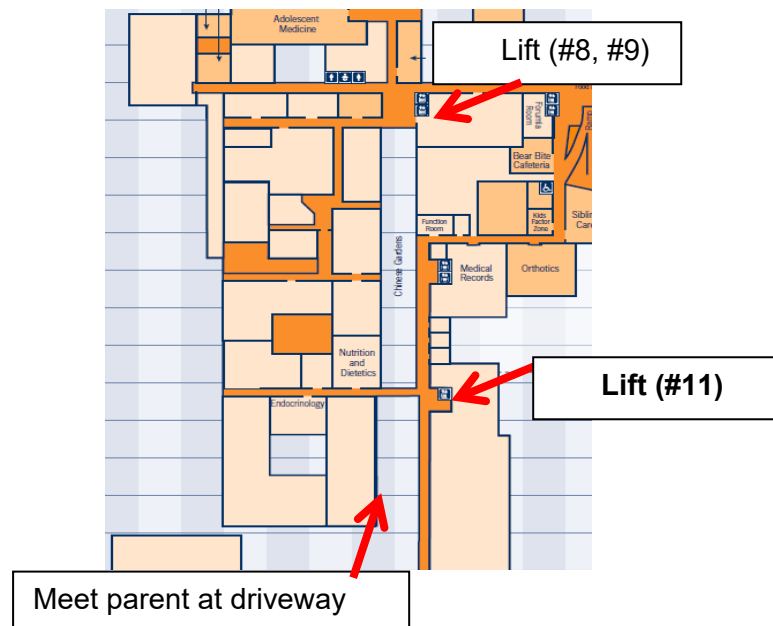
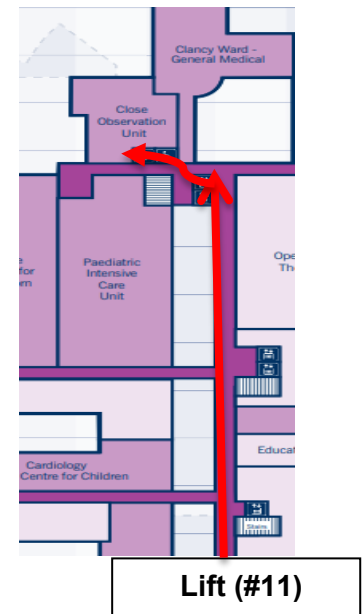
- Parents will enter via 'The Westmead Institute for Medical Research' driveway via Research Lane and park in bay
- Parent/carer must only wear a surgical mask (not P2/N95).

Level 1 (Before Chinese Gardens)**Level 3**

1. Meet at the bay
2. Walk to lift #11
3. PICU clean escort call lift and go straight up to level 3 via lift #8, #9 or the stairs and meets the lift on level 3 (opposite South Bridge – Division of Surgery Department)
4. PPE escort and parent/carer to go to level 3 in the lift (parent/carer not to touch/brush up against anything).
Lift does not need to be cleaned or isolated, unless there is a breach of mask, coughing without a mask or parent/carer touches the lift
5. PPE escort and parent/carer will wait on level 3 in the alcove area outside of the lifts, moving to one side until the clean escort arrives. This may take a few minutes.
6. PICU clean escort to clear walkway in front of PPE escort + parent/carer
7. Out of lift, turn right. Follow corridor to the PICU Biomedical Engineering bridge
8. Turn left and enter back door of PICU. Follow normal PICU flow
9. Follow reverse process when returning to car

COU designated Route for COVID positive Parents**Ground Floor Level 1**

Parents will enter via 'The Westmead Institute for Medical Research' driveway via Research Lane and park in bay
Parents **only need to wear a surgical mask.**

Level 1 (Before Chinese Gardens)**Level 3**

1. Meet at the bay
2. Walk to lift #11
3. COU clean escort call lift and go straight up to level 3 via lift #8, #9 or the stairs and meets the lift on level 3 (opposite South Bridge – Division of Surgery Department)
4. PPE escort and parent to go to level 3 in the lift (parent not to touch/brush up against anything)
Lift does not need to be cleaned or isolated unless there is a breach of mask, coughing without a mask, parent touches the lift
5. PPE escort and parent will wait on level 3 in the alcove area outside of the lifts, moving to one side until the escort arrives. This may take a few minutes.
6. COU clean escort clear walkway in front of PPE escort + parent
7. Out of lift turn right and follow the corridor until reaching COU/Clancy main doors
8. Enter main doors, Turn left and enter the EXIT doors of COU
9. Reverse Process for returning to car

After hours and on weekends

The fire doors outside of the lift on level 1 will need to be opened from the inside (the clean escort will need to go down the lift to level 1 to be able to open the doors). Push to fully open both doors until they lock onto the magnets.

When parent/carer has returned back to the car, the escort will need to release the doors in front of the lifts, off the magnets.

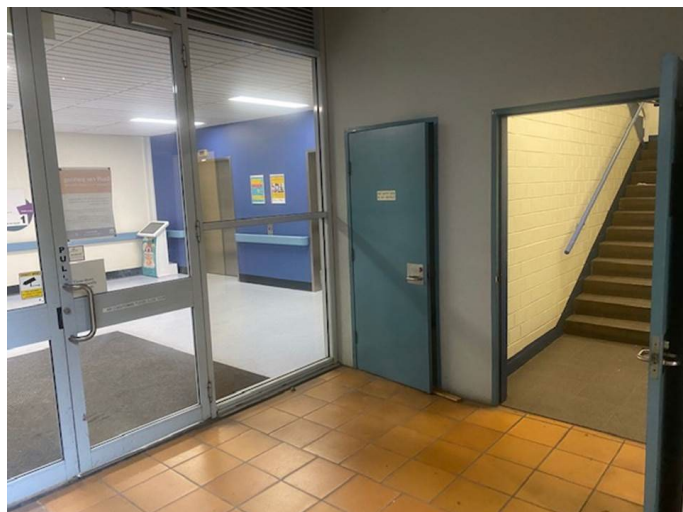
Level 1 - Lift #11 (Access point for access to go to level 3)



Level 3 - Lift #11 (Waiting point while clean escort comes back up to level 3)

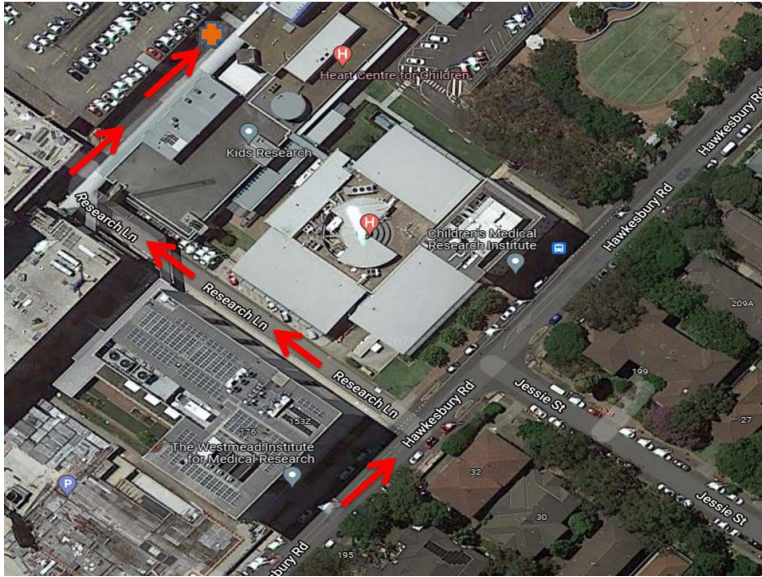


Level 1 - Lift # 8, # 9 and stairs to level 3 (Access point for clean escort to go to level 3)



Directions for PICU Parents to park at The Children's Hospital at Westmead

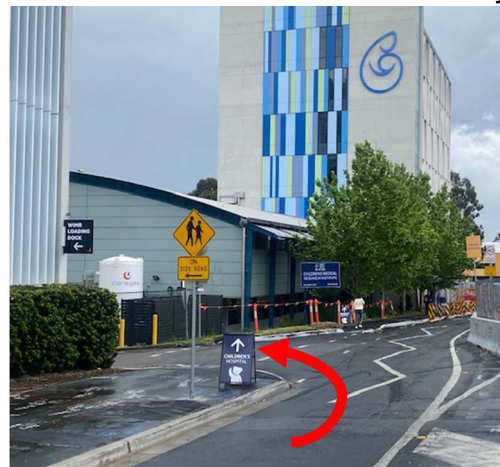
You will not come through the main entrance of the hospital but will enter through the Westmead Institute for Medical Research's driveway via Research Lane.



Aerial view map showing the area where you will enter the hospital

Approaching the Hospital

1. Drive down Hawkesbury Road towards The Children's Hospital.
2. Once you are on Hawkesbury Road, please **call 9845 2002** to let the team know that you are approaching.
3. Turn left into Research Lane. There is a lot of roadwork on this corner at present.
4. You should be turning between two research buildings



5. Follow the road down, **then the road will bend to the right**



6. Park car here - Meeting point



7. Your escort should be waiting for you in the area and will direct you where to park
8. Please remain in your vehicle with a mask on. Communication will be via your mobile.

Appendix 14: Patient and Carer Resources

Explaining Isolation to Your Child

Having a child in isolation is a hard situation for any parent or carer

We understand that you may be experiencing a combination of feelings, including worry, sadness and being overwhelmed. These are all normal feelings, and the hospital staff is here to support you. In particular, as part of your child's care team, you will meet a Social Worker who will provide support to you and your family for the duration of your child's stay.

While your child is with us at the Children's Hospital Westmead, they will be looked after by a team of doctors, nurses, and allied health professionals. All of our staff have a focus on child wellbeing and will work to ensure your child's physical and emotional needs are attended to.

As a parent or carer, we encourage you to ask questions, either in person or over the phone. It is also very important that you look after your own wellbeing and that of the wider family. This includes, making time to eat healthy meals, staying hydrated and getting rest. We encourage you to talk with family and friends so they can support you. Also, please let your child's team know if you feel you would benefit from extra support.

When it is decided by the medical team that your child needs to be in isolation, it's important to try and prepare your child for this. The first step is to explain to your child in age-appropriate language what isolation means.

You can use something simple, such as; *"The doctors and nurses are working to help you get better and also to make sure that no one else gets sick. This means you will need to stay in the hospital in a room called an 'isolation room'. In an isolation room you will have your own bed, and Mum/Dad/carers will be able to come and visit every day. You will have a nurse with you all the time to make sure you are OK and to help when either mum or dad can't be there with you'.*

It's important to encourage your child to ask questions, either of you or their nurse, and that your child knows they haven't done anything wrong. Remember, your child will look to you to know how to react to this news, so try to remain as calm and positive as possible.

Explaining Isolation to Siblings

Unfortunately, in order to help stop contamination, brothers and sisters will not be permitted to visit the hospital to see their sibling.

It can be hard to know how to explain to siblings of a child in isolation what's going on for their brother or sister. What we do know is that it's important to provide them with age-appropriate and honest information about what's happening. Without siblings being given information from an adult they trust, siblings may guess or make up their own stories, and this usually centres on them doing something wrong can create anxiety.

A simple explanation that allows children to ask questions is often best. This might be something like: "Susie is sick and the doctors and nurses are working to get her better. To stop anyone else getting sick, Susie has to be in an isolation room. This means, she has her own room in the hospital, which has all the things she needs. Mum/Dad or Carer can visit Susie every day, but no one else can visit. We can deliver messages to Susie for you."

Some children may need to ask many questions at once; other children may ask questions gradually over the next few days; and some children may not want to talk at all. These are all normal responses. One of the most important things you can do is ensure siblings know there are adults – like you, or family members/friends – they can talk to.

If you would like some support in talking to siblings about having a child in isolation, please don't hesitate to ask your Social Worker.

Commonly Asked Questions

How long will my child be in isolation for?

This is a difficult question and depends on each child. To begin with, your child will be in isolation until test results come back. Once tests results have returned, you and the team will discuss next steps.

Who can visit, and how long for?

Only **one parent** and **no siblings** will be allowed to visit, unless a young sibling is breastfeeding. The maximum visit is for **one visit per day** and the **same parent/carer** will need to visit each day. Unfortunately, no other visitors are allowed while a child is in isolation. COVID19 test results takes about 24 hours to process, so this restriction often applies only for that duration, unless the patient tests positive for COVID19, or there remains a strong clinical suspicion of COVID19 despite a negative test.

Can I touch/hug/hold my child?

When you see your child, you will need to wear a face mask and practice good hand hygiene. You will be allowed to touch your child while you visit them; however it's very important that you wash your hands thoroughly before you leave the room.

Can I bring things in from home for my child?

No, unfortunately nothing from outside the hospital can be brought in for your child in isolation. The hospital will make sure your child has everything they need, and if you feel that something in particular might be helpful, please let your team know.

How can I come to the hospital - and leave the hospital - safely?

Before you come to the hospital, please call the ward to let them know when you will be arriving. When you come to the hospital to visit your child, it is very important that you come straight to your child's room to limit the chance of any contamination. This means you are unable to visit the food outlets, the hospital bathrooms, or spend time in the hospital's common spaces. When it's time to leave the hospital, you must leave straight away with a mask on.

Will my child be alone?

Your child will never be alone in hospital. They will always have a nurse with them. The nurse will be wearing protective equipment, such as gloves, face masks and a gown.

Will the ward give me updates?

Yes, you can call the ward and request updates over the phone when you are unable to be with your child.

Can I speak to my child when I'm not in the hospital?

Yes, your child will have access to an iPad & this will be a way of connecting with your child



Talking to Children About COVID-19

Facing a health emergency can bring up feelings of stress, uncertainty, and confusion, especially for young children. While we don't want to overload them with scary information, we can try to answer their questions honestly. There are simple ways to talk about COVID-19 with young children, and we can *always* offer comfort:

- Ask children what they've heard about COVID-19. This will help you share only the information that they need right now. Answer simply and honestly and provide as much reassurance as you can, assuring them that you know how to keep your family safer.
- Ask them how they feel. Let them know that their feelings are okay and that many other people everywhere are feeling those feelings, too. Use words to share your own feelings (anxious, worried, sad, and so on).
- Be prepared to answer the same question more than once; repeating the same question may be how your child expresses concerns.

Explain that COVID-19 is a virus. It is so small, it's invisible, and it can make some people sick. But there are ways to protect ourselves and others (we can wash our hands with soap and water for 20 seconds, say hello in new ways such as waving from afar, sneeze or cough into the bend of our arm, stay indoors, and keep a safe distance of six feet from other people).

You Might Also:

- Notice and focus on any kindness or cooperation you see around you, no matter how small. Point out that, in every tough situation, there are always people helping.
- Remind children that this situation (and the feelings we're having) will not last forever, and that this experience can make him/her, and your whole family, stronger.

And...

- Be aware of your own feelings. It's normal to feel helpless when you can't protect your child from changing circumstances; keep in mind that children respond to and learn from your reactions.
- Listen to your child. Take the time to listen closely to what question they are asking. Remember, less information is best: they want their question answered, but giving them more information than they are ready for or can handle is overwhelming and may raise more unintended questions and fears.
- It's okay take a moment to think about how to respond before answering. It's also okay to say you don't know and that you can find out the answers together. It's important to be honest with your child so you don't tarnish their trust.
- Trust your instincts. You know your child best. Children of different ages will have different questions and needs, and a wide range of reactions is normal.
- Respect children's concerns. If they tell you they're afraid of something, don't dismiss their fears.



All about me!

Name:

Age:

My favourite things

My family

I am happy when.....

**I sometimes worry
when.....**

You can help me by.....

Other considerations

Appendix 15: Wellbeing

These are challenging times to be working in health care, especially critical care. We would strongly encourage all staff, no matter how robust you are feeling, to call EAP (it's free, confidential and helpful)

- <https://www.accesseap.com.au/>
- <https://intranet.schn.health.nsw.gov.au/employee-need-know/employee-assistance-p...>
- Call: 1800 818 728

Speak to your colleagues, family, friends, GP or leadership team within the hospital.

Try to look after yourself – eat, exercise, rest, relax and sleep as well as you can. Work will be hard, so be more generous in looking after yourself when you are not at work.

By turning up and caring, we are already doing more than enough and exceeding what's needed. Our fears, doubts, our passions, skills and strengths are exactly what are needed in 2021. We have already helped and very specially cared for more people than we know and this will be no different over the next few weeks and months.

When it's a bit unclear what you are doing, why you are doing it and how you are going to do it, "Do all the good that you can, in all the ways that you can, by all the means that you can, to all the people that you can, in all the places that you can for as long as ever you can."*

*Care for the Journey, Gary Maikin and Michael Stillwater 2005,

<https://open.spotify.com/album/5n5DDmp0zuN5qUMqrY5Jwu>

Check out the SCHN staff health & wellbeing page

<https://intranet.schn.health.nsw.gov.au/staff-health>

Appendix 16: COVID Links

[SCHN Intranet COVID19 Webpage](#)

[NSW Health COVID19 Information Page](#)

[ANZICS COVID19 guideline](#)

[WHO COVID19 page](#)

[COVID19 data in Australia](#)

Appendix 17: Care and transfer of deceased patient

As the child has a prescribed infectious disease listed in the Public Health Regulation (NSW) Division 3 -Section 53, the following process must be observed:

- The body must be double bagged in PICU using two standard body bags
 - Body bags are located in the morgue
- The body should not be washed, devices not removed and please ensure that both body bags are labelled with patient identification labels
- Add a 'COVID 19 – HANDLE WITH CARE' label to the outside of the body bag to ensure patient identification for mortuary staff
 - These labels are located in the mortuary
- Circle the infectious illness on the Mortuary Patient Information Form
- The patient cannot be carried to mortuary
- The patient needs to be transferred in a bed with a sheet over the top to the morgue

The deceased's body will not be available for viewing after transfer to the Mortuary

SCHN Policy: <http://webapps.schn.health.nsw.gov.au/epolicy/policy/5090>

CEC / NSW Government COVID-19 Infection Prevention and Control Manual update as of July 2021, page 43 section 2.13

https://www.cec.health.nsw.gov.au/_data/assets/pdf_file/0018/644004/COVID-19-IPAC-manual.pdf

Appendix 18: EHM Storage and Handling

Expressed Human Milk (EHM)

