COVID-19: Key PRM Messages

- Use appropriate PPE for <u>all cases</u> regardless of COVID status

- Suspected / Confirmed COVID-19 Cases
  - Manage in LW Rooms 9-12 / specified areas of ward 68
  - Use Theatre 1 for operative delivery

- RA is default in ***all*** situations
  - RA *even* in Cat 1 CS
  - No time benefit for GA
  - Reduces maternal & staff risk

In ALL patients regardless of COVID status

Summary guidance from PHE/RCoA/AAGBI/RCOG relevant to obstetric anaesthetists

Antenatal /postnatal ward /clinic	Consultation/assessment >2 m distance from patient	FRSM, eye protection
Labour ward	Consultation/assessment if not in labour/1st stage labour e.g. consent for epidural analgesia	Apron, gloves, FRSM, eye protection
	Consultation/assessment in 2nd/3rd stage labour e.g. attending PPH	Apron, FRDG, gloves, FRSM, eye protection
	Epidural insertion	Apron, sterile FRDG, sterile gloves, FRSM, eye protection
Theatre	Caesarean section with neuraxial anaesthesia[1] (low risk of GA, e.g. elective CS for breech)	Apron, sterile[2] FRDG, sterile gloves, FRSM, eye protection
	Caesarean section with neuraxial anaesthesia (but higher risk of GA[3] e.g. Category 1 CS)	Apron, sterile FRDG, sterile gloves, **FRSM or FFP3**, eye protection
	Caesarean section with general anaesthesia	Apron, FRDG, gloves, FFP3, eye protection
Non-CS obstetric theatre cases	Trial of instrumental delivery in theatre, removal of retained placenta (with regional anaesthesia)	Apron, sterile FRDG, sterile gloves, FRSM, eye protection
	Any other case requiring general anaesthesia	Apron, FRDG, gloves, FFP3, eye protection

1. Neuraxial anaesthesia refers to epidural, spinal or combined spinal-epidural analgesia/anaesthesia.
2. Sterile only if de novo procedure, otherwise non-sterile acceptable.
3. Predictors of higher risk of GA conversion include:

- *Top up of pre-existing poorly functioning epidural, missed segments, unilaterality, breakthrough pain (consider removing and performing spinal).*
- *Anticipated difficult or prolonged surgery or haemorrhage, previous abdominal surgery, adhesions, classical incision, placenta praevia, multiple procedures, uterine structural abnormalities.*

11 April 2020 | Dr Nuala Lucas, Dr Jim Bamber, Dr Fiona Donald, Dr Felicity Platt | icmanaesthesiacovid-19.org

In ALL patients regardless of COVID status

Donning PPE for obstetric anaesthesia

Labour epidural

Prior to entering room:
- Put on theatre hat, FRSM & eye protection
- Scrub up
- Put on disposable fluid resistant sterile gown, sterile gloves
- Perform epidural procedure and ensure epidural is working

Prior to exit of room:
- Remove gloves, clean hands with gel
- Remove gown & turn inside out
- Remove eye protection.
- Dispose of all items in clinical waste bin
- Gel hands

Outside room:
- Remove FRSM (avoid touching outside) & hat
- Dispose of in clinical waste bin
- Wash hands with soap and water

Caesarean delivery spinal anaesthesia

Theatre:
- Put on sterile PPE as described, in an area at least 2m away from patient
- Perform spinal procedure
- Wear this PPE throughout case.

Prior to transfer from theatre:
- Ask patient to put on FRSM after cleaning hands with gel prior to transfer back to room

After transfer:
- Move at least 2m away from patient

Staff transferring patient from theatre to doff FRDG and gloves, perform hand hygiene and replace with apron and fresh gloves

Caesarean delivery general anaesthesia

Theatre:
- Put on AGP PPE in an area at least 2m away from patient prior to induction https://youtu.be/kKz_vNGsNhc
- Undertake induction and intubation
- Keep AGP PPE on until after extubation

Prior to transfer from theatre:
- Put well fitted oxygen mask on patient
- Wait in theatre till patient's airway is safe before transfer of patient to room
- Hand over to clean team who will be wearing standard PPE (midwife looking after patient + someone to push bed)
- Patient transferred to room by clean team
- Remove AGP PPE as per doffing procedure https://youtu.be/oUo5O1JmLH0
- Wash hands with soap & water

11 April 2020 | Dr Nuala Lucas, Dr Jim Bamber, Dr Fiona Donald, Dr Felicity Platt | icmanaesthesiacovid-19.org

General Anaesthesia

Key points

In ALL patients regardless of COVID status

- **Consultant decision**
- **Perform GA checklist outside theatre**
- **All staff** must don full PPE including FFP3 mask & are in theatre **prior to induction** for **duration** of case
- Non-anaes staff wait in Th 1 ante-room
- Avoid theatre entry/exit wherever possible within **20 mins** of intubation/extubation

- All drugs prep'd before GA
- ***No*** sodium citrate
- Have Sugammadex in theatre
- Avoid NSAIDs & Dex in suspected / confirmed COVID-19 cases

- Pre-oxygenate with tight fitting mask
- Avoid manual ventilation (low vols if essential, consider 2-person technique)
- Turn off gas flow before intubation

- **NO** first breath until ETT balloon inflated
- Check position *without* auscultation (chest wall expansion, $ETCO_2$)
- Avoid breaking breathing circuit (clamp ETT if required)
- **Non-anaesthetic staff leave before extubation** (need one runner outside theatre)
- **All staff present at extubation remain in theatre for 20 mins afterwards**
- **Patient recovered in theatre for 20 mins**

- Clean team in fresh PPE (surgical mask adequate), receives patient & takes to room)
- Theatre team doff
- Remove mask in bin outside theatre door
- Wipe neck and wipe down shoes

Ventilated transfer to ICU

In ALL patients regardless of COVID status

- Request MICU (24225)
- Pre-oxygenate with 100% O_2
- Ensure patient paralysed
- Turn off gas flow **before** switching ventilators
- Turn APL valve to fully open
- Clamp ETT
- Detach anaesthetic circuit

- Connect to transport ventilator
- Unclamp ETT
- Clean team to transfer patient to ICU
- Usual transfer checks
- Call ICU to inform of transfer pre-departure
- Theatre team doff PPE after patient has left

COVID-19 APPROVED GUIDANCE

OFFICIAL SENSITIVE

Note: This guidance has been fast-tracked for approval for use within NHSGGC

Covid-19 Use Appropriate PPE for ALL Cases, Quick Guide, PRM, Obstetrics

This guidance is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guidance, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following guidance, it is good practice to record these and communicate them to others involved in the care of the patient.

Version Number:	8
Does this version include changes to clinical advice:	N/A
Date Approved:	29th April 2020
Approval Group:	Covid-19 Tactical Group

Important Note:

The version of this document on the Clinical Guideline Directory is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.