Commence CPR
Minimise Interruptions

ICU VENTILATOR
- Turn off ventilator
- Disconnect DISTAL to HME
- Attach C-circuit and waveform capnography

THEATRE VENTILATOR
- Switch to MAN SPON

Manual ventilation at 10-12/min

Assess Rhythm
Max 10 seconds

VF/pVT
- DC Shock
- Resume CPR x 2mins
  Minimise interruptions

Asystole/PEA
- Resume CPR x 2mins
  Minimise interruptions

Ensure high quality CPR with minimal interruptions
Adrenaline 1mg every 3-5mins
Amiodarone 300mg after 3rd shock
Consider adrenaline infusion

Hypoxia
Hypovolaemia
Hypo/
Hyperkalaemia
Hypotermia
Thrombosis
Tension PTX
Tamponade
Toxins
Inside the room
1. Senior anaesthetist
2. Physician for iv access and airway assistance (may be anaesthetics or other)
3. ICU Nurse to administer medications and energy
4. Staff nurse to do CPR (1)
5. Staff nurse to do CPR (2) – First responder(s)

In anteroom
1. Staff nurse in PPE
   They should:
   - provide support if someone has to leave the room
   - be ready to get whatever the team inside needs
   - facilitate communication
   - observe for breaches in protection
   - relieve personnel inside the room to minimise risk of safety breaches when fatigued

Outside the room
1. RUNNER (staff nurse) to assist with supply/equipment

Donning should be carried out quickly but meticulously
If multiple individuals arrive at the same time, priority for donning and entering the room should be given to senior anaesthetist and ICU nurse
Members of the team initially staying outside the room (e.g., back-up staff nurse and runner), should help with donning (e.g. tie gowns) and assessing for breaches

1. Put personal items (stethoscope, jewellery, clipboard, watch, pagers) in specific bag available in COVID-19 tool bag
2. Don PPE as per guidelines for aerosolized procedures
3. Have member of the code blue team special to assess for breaches prior to entering room

INSIDE THE ROOM / DURING THE CODE
• First responder continues to provide CPR
• First two to enter the room: senior anaesthetist and the ICU nurse with arrest cart (unless already inside the room), unless others already present and properly protected
• ICU nurse immediately connects patient to defibrillator for rhythm analysis if not done already
• Defibrillate if indicated
• No equipment can leave the room until the end of the arrest and without appropriate handling

BEFORE LEAVING THE ROOM.
• Plan transport if needed. Team members who will be in contact with the patient during transport must then put on new, clean PPEs prior to transport.
• All non-disposable equipment must be wiped, placed into a clear biohazard bag in the room and tied
• Disposable equipment must be discarded
• Put arrest record into sleeve sheet and wipe it

• DOFFING
  "DO NOT RUSH.
  "Anyone who is unwell, has had equipment failure, or likely self-contaminated is the first to doff and exit
  "Use doffing guidelines
Commence CPR
Minimise Interruptions

ICU VENTILATOR
- Turn off ventilator
- Disconnect DISTAL to HME
- Attach C-circuit and waveform capnography

THEATRE VENTILATOR
- Switch to MAN SPON

Manual ventilation at 10-12/min

Assess Rhythm Max 10 seconds

VF/pVT
- DC Shock
- Resume CPR x 2mins Minimise interruptions
- DEFIB PADS

Asystole/PEA
- Resume CPR x 2mins Minimise interruptions

HAND POSITION

MODIFIED ACLS - PRONE
Inside the room
1. Senior anaesthetist
2. Physician for iv access and airway assistance (may be anaesthetics or other)
3. ICU Nurse to administer medications and energy
4. Staff nurse to do CPR (1)
5. Staff nurse to do CPR (2) – First responder(s)

In anteroom
1. Staff nurse in PPE
   They should:
   - provide support if someone has to leave the room
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• Disposable equipment must be discarded
• Put arrest record into sleeve sheet and wipe it

DOFFING
• DO NOT RUSH.
• Anyone who is unwell, has had equipment failure, or likely self-contaminated is the first to doff and exit
• Use doffing guidelines
Commence CPR
Minimise Interruptions

Intubate ASAP - no compressions during intubation
Preoxygenate - BMV/C-circuit with HME filter
Apnoeic oxygenation with nasal prongs
Videolaryngoscope
Connect HME filter Immediately
Waveform Capnography

Manual ventilation at 10-12/min

Assess Rhythm Max 10 seconds

VF/pVT
DC Shock
Resume CPR x 2mins Minimise interruptions

Asystole/PEA
Resume CPR x 2mins Minimise interruptions

Ensure high quality CPR with minimal interruptions
Adrenaline 1mg every 3-5mins
Amiodarone 300mg after 3rd shock
Consider adrenaline infusion

Hypoxia
Hypovolaemia
Hypo/
Hyperkalaemia
Hypotermia

Thrombosis
Tension PTX
Tamponade
Toxins

MODIFIED ACLS - WARD
**Inside the room**
1. Senior anaesthetist
2. Physician for iv access and airway assistance (may be anaesthetics or other)
3. ICU Nurse to administer medications and energy
4. Staff nurse to do CPR (1)
5. Staff nurse to do CPR (2) – First responder(s)

**In anteroom**
1. Staff nurse in PPE
   - provide support if someone has to leave the room
   - be ready to get whatever the team inside needs
   - facilitate communication
   - observe for breaches in protection
   - relieve personnel inside the room to minimize risk of safety breaches when fatigued

**Outside the room**
1. RUNNER (staff nurse) to assist with supply/equipment

**Donning should be carried out quickly but meticulously**
If multiple individuals arrive at the same time, **priority for donning and entering the room should be given to senior anaesthetist and ICU nurse**.
Members of the team initially staying outside the room (e.g., back-up staff nurse and runner), should **help with donning (e.g. tie gowns) and assessing for breaches**.

1. Put personal items (stethoscope, jewellery, clipboard, watch, pagers) in specific bag available in COVID-19 tool bag
2. Don PPE as per guidelines for aerosolized procedures
3. Have member of the code blue team special to assess for breaches prior to entering room

**INSIDE THE ROOM / DURING THE CODE**
- First responder continues to provide CPR
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- Defibrillate if indicated
- No equipment can leave the room until the end of the arrest and without appropriate handling

**BEFORE LEAVING THE ROOM**
- **Plan transport** if needed. Team members who will be in contact with the patient during transport must then put on new, clean PPEs prior to transport.
- All **non-disposable equipment must be wiped, placed into a clear biohazard bag** in the room and tied
- **Disposable equipment must be discarded**
- **Put arrest record** into sleeve sheet and wipe it

**DOFFING**
- **DO NOT RUSH.**
- **Anyone who is** unwell, has had equipment failure, or likely self-contaminated is the first to doff and exit
- **Use doffing guidelines**
COVID-19 ACLS CHECKLIST

REVIEW of PPEs
- Review appropriate PPEs available

DONNING
- Review donning steps (consider reviewing video and posters available)
- Providers directly participating in intubation must wear 1) goggles AND full face shield; 2) double gloves
- Personal items (e.g., stethoscope, jewellery, watch, pagers) should be left outside room
- Priority for donning and entering the room: senior anaesthetist and ICU Nurse
- Discuss “donning buddy” strategy
- Do not enter patient’s room without another member of the team having assessed for PPE breaches

DOFFING
- DO NOT RUSH
- Review doffing steps (consider reviewing video and posters available)
- Discuss “doffing buddy” strategy

EQUIPMENT
- Check COVID-19 ACLS tool bag (C-circuit with HME filter, selection of Guedel airways, laminated copy of guidelines, disposable stethoscope, arrest record, pen, stop watch, clear bag for personal belongings to be left outside room)
- Travelling arrest cart not to be brought inside patient’s room (will stay outside available if other equipment needed – e.g., IO supplies)
- Discuss need for videolaryngoscope and who will be responsible of bringing it to the room
- Review ETT/inline suction/filter/ETCO2/BMV correct set-up
- Review importance of using appropriate mechanical HEPA filters

ACLS MODIFICATIONS
- Review code blue special ACLS modifications (see back of this document and ACLS COVID-19 Card)

INTUBATION/Mechanical Ventilation
- If you need to disconnect ETT (e.g., air trapping):
  - 1) clear, loud announcement
  - 2) leave filter connected to ETT
- If possible, don’t perform manual bag-mask ventilation (BMV) before intubation.
- Consider videolaryngoscopy as first intubation technique

TRANSPORT
- You need to doff and re-don before transport of patient
- Review checklist for transportation of airborne droplet contact patient
Make sure that every patient gets **Fast Hugs in Bed Please** at least once per day

**F**luid therapy and feeding  
**A**nalgesia, antiemetics  
**S**edation and Spontaneous breathing trial  
**T**hromboprophylaxis - Enoxaparin 40mg OD SD (20mg if renal failure, BD if >100kg)

**H**ead up position (30-45 degrees) if intubated  
**U**lcer prophylaxis (if not enterally fed)  
**G**lucose control (5-10mmol/L)  
**S**kin/eye care and suctioning

**I**ndwelling catheters - are they needed?  
**N**asogastric tube

**B**owel cares  
**E**nvironment (e.g. temperature control, appropriate surroundings in delirium)  
**D**e-escalation (e.g. end of life issues, treatments no longer needed)

**P**sychosocial support (for patient, family and staff)

Ref Dr Chris Nickson https://litfl.com/fast-hugs-in-bed-please/

@bryan_reidy
**Target MAP >65mmHg**

**Noradrenaline**

If noradrenaline >25mcg/min then consider adding a second agent to achieve MAP
- Adrenaline
- Vasopressin

A higher target may be needed if underlying hypertension or raised ICP

**Fluids**

Do not routinely prescribe maintenance fluids if tolerating NG feeds.

Aim for neutral or negative fluid balance every 24 hours.
Diuretics as required

**Haemodynamic Assessment**

Formal TTE on day 3-4

Clinical signs - tachycardia, hypotension
Cardiac output monitor (if available)
  - Stroke volume variation >10%
  - Pulse pressure variation >10%

Passive leg raise
  - Sit patient at 30-45°
  - Tilt whole bed head down until legs at 30° to body
  - Monitor for increase in CO, decrease in SPV/SV

If signs of fluid responsiveness then consider bolus of 250mls crystalloid (CSL or NaCl) and observe for clinical effect

---

**Semirecumbent position**

**Passive leg raising**
## PREPARE

### PREPARE PATIENT
- Preoxygenate
- Paralyse
- Increase vasopressors
- Lubricate and tape eyes
- Remove ECG
- Aspirate NG
- Disconnect and cap arterial line

### PLACE PILLOWS
- 1 X SHIN
- 1-2 x THIGH (ensure genitals and catheter free)
- 1-2 x CHEST

### PLACE SHEET OVER PATIENT
- Ensure 4 corners match
- Roll edges close to patient

## REVIEW AND CONFIRM PLAN

### COMMAND READY - BRACE - MOVE
- Move to edge of bed
- Move 1/2 body width off bed
- Move up so head clear of top of bed
- Remove pillow/head-ring
- Ensure lines and tubing free

### COMMAND READY - BRACE - MOVE
- Turn paint 90 degrees
- Turn patient prone
- Turn head into position
  (face ventilator on first turn)

### COMMAND READY - BRACE - MOVE
- Move down bed
- Head-ring/pillow into place
- Move arm up to side of tube
- Check head position, eyes, lines and tubes

### CHECK CONNECTIONS
- Ensure tube secured opposite side to ventilator - sleek and IOBAN
- Ensure all ventilator connections secure
- Ensure lines free

## PROCEDURE

### COMMAND READY - BRACE - MOVE
- Reattach monitors
- ABG 30 mins post proning and 4 hourly thereafter
- Commence feed once stable
- Check eyes hourly

### COMMAND READY - BRACE - MOVE
- Rotate head and arms every 5 hours
  - Contact prone team 30mins ahead of time
  - Ensure all equipment available

### COMMAND READY - BRACE - MOVE
- Turn supine after 16 hours
  - Stop feed 1 hour ahead of time
  - Contact prone team 30mins ahead of time

## ONCE PATIENT STABLE

DOFFING PROTOCOL AS REQUIRED

EXIT ROOM
**PREPARE**

Ensure PPE correctly applied  
Airway and Lines staff to wear visors

**PREPARE PATIENT**

Preoxygenate  
Paralyse  
Increase vasopressors

**CHECK CONNECTIONS**

Ensure all ventilator connections secure  
Ensure lines free

**REVIEW AND CONFIRM PLAN**

**PROCEDURE**

**COMMAND READY - BRACE - MOVE**

Move up so head clear of top of bed  
Remove pillow/headring  
Ensure lines and tubing free

**COMMAND READY - BRACE - TURN**

Turn head into position (1)  
Ensure lines free

**COMMAND READY - BRACE - MOVE**

Move down bed  
Head-ring/pillow into place  
Move arm up to side of tube  
Check head position, eyes, lines and tubes

**PREPARE**

Team (6)
(1) Airway - Anaesthetist/Intensivist  
(2) Lines - Anaesthetic/ICU nurse  
(3-6) Turning - 4 staff members

**CHECK CONNECTIONS**

Ensure all ventilator connections secure  
Ensure lines free

**REVIEW AND CONFIRM PLAN**

**PROCEDURE**

**COMMAND READY - BRACE - MOVE**

Move up so head clear of top of bed  
Remove pillow/headring  
Ensure lines and tubing free

**COMMAND READY - BRACE - TURN**

Turn head into position (1)  
Ensure lines free

**COMMAND READY - BRACE - MOVE**

Move down bed  
Head-ring/pillow into place  
Move arm up to side of tube  
Check head position, eyes, lines and tubes

**ONCE PATIENT STABLE**

DOFFING PROTOCOL AS REQUIRED  
EXIT ROOM

**PROCEDURE**

**COMMAND READY - BRACE - MOVE**

Move up so head clear of top of bed  
Remove pillow/headring  
Ensure lines and tubing free

**COMMAND READY - BRACE - TURN**

Turn head into position (1)  
Ensure lines free

**COMMAND READY - BRACE - MOVE**

Move down bed  
Head-ring/pillow into place  
Move arm up to side of tube  
Check head position, eyes, lines and tubes

**ONCE PATIENT STABLE**

**DOFFING PROTOCOL AS REQUIRED**  
**EXIT ROOM**

ABG 4 hourly  
Check eyes hourly  
**Rotate head and arms every 5 hours**

- Contact prone team 30mins ahead of time  
- Ensure all equipment available

**Turn supine after 16 hours**

- Stop feed 1 hour ahead of time  
- Contact prone team 30mins ahead of time  
- Ensure all equipment available

**ONCE PATIENT STABLE**

**DOFFING PROTOCOL AS REQUIRED**  
**EXIT ROOM**
PROCEDURE

COMMAND READY - BRACE - MOVE
Move to edge of bed
Move 1/2 body width off bed
Move up so head clear of top of bed
Remove pillow/headring
Ensure lines and tubing free

COMMAND READY - BRACE - TURN
Turn paint 90 degrees
Turn patient supine

COMMAND READY - BRACE - MOVE
Move down bed
Head-ring/pillow into place
Un-tape eyes
Check lines and tubes

CHECK CONNECTIONS
Ensure all ventilator connections secure
Ensure lines free

PLACE SHEET OVER PATIENT
Ensure 4 corners match
Roll edges close to patient

PREPARE PATIENT
Preoxygenate
Paralyse
Increase vasopressors
Remove ECG
Aspirate NG
Disconnect and cap arterial line

PREPARE
Ensure PPE correctly applied
Airway and Lines staff to wear visors

REVIEW AND CONFIRM PLAN

ONCE PATIENT STABLE
DOFFING PROTOCOL AS REQUIRED
EXIT ROOM

TEAM (6)
Airway - Anaesthetist/Intensivist
Lines - Anaesthetic/ICU nurse
Turning - 4 staff members

ONCE PATIENT STABLE
DOFFING PROTOCOL AS REQUIRED
EXIT ROOM

@bryan_reidy

Version 1.0
Initial phase - deep sedation - Target RASS < -4

**Propofol 100mg/hr**
**Morphine 5ml/hr**

**Stable**
**Improving Oxygenation**

RASS -2 - -3

**Unstable**

add/substitute
**Midazolam 5ml/hr**

Review sedation daily

Anticipate Delirium

**Quetiapine**
**Dexmedetomidine**

---

**Richmond Agitation and Sedation Scale (RASS)**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>+4</td>
<td>Combative, violent, immediate danger to staff</td>
</tr>
<tr>
<td>+3</td>
<td>Very Agitated, pulls or removes tube(s) or catheter(s); aggressive</td>
</tr>
<tr>
<td>+2</td>
<td>Agitated, frequent non-purposeful movement, fights ventilator</td>
</tr>
<tr>
<td>+1</td>
<td>Restless, anxious, apprehensive but movements not aggressive or vigorous</td>
</tr>
<tr>
<td>0</td>
<td>Alert &amp; calm</td>
</tr>
<tr>
<td>-1</td>
<td>Drowsy, not fully alert, but has sustained awakening to voice</td>
</tr>
<tr>
<td></td>
<td>(eye opening &amp; contact ≥ 10 sec)</td>
</tr>
<tr>
<td>-2</td>
<td>Light sedation, briefly awakens to voice (eye opening &amp; contact &lt; 10 sec)</td>
</tr>
<tr>
<td>-3</td>
<td>Moderate sedation, movement or eye-opening to voice (but no eye contact)</td>
</tr>
<tr>
<td>-4</td>
<td>Deep sedation, no response to voice, but movement or eye opening to physical stimulation</td>
</tr>
<tr>
<td>-5</td>
<td>Unarousable, no response to voice or physical stimulation</td>
</tr>
</tbody>
</table>
## Standard Admission Orders (all patients)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Concentration/Dilution</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Noradrenaline</td>
<td>6mcg in 100mls 5% Dextrose</td>
<td></td>
</tr>
<tr>
<td>Midazolam</td>
<td>60mg in 60mls 0.9% NaCl</td>
<td></td>
</tr>
<tr>
<td>Morphine</td>
<td>60mg in 60mls 0.9% NaCl</td>
<td></td>
</tr>
<tr>
<td>Propofol</td>
<td>500mg in 50ml</td>
<td></td>
</tr>
<tr>
<td>Dexmedetomidine</td>
<td>1000mcg in 250mls 0.9% NaCl</td>
<td></td>
</tr>
<tr>
<td>Ranitidine</td>
<td>50mg TDS (until enteral feed)</td>
<td></td>
</tr>
<tr>
<td>Enoxaparin</td>
<td>40mg OD (20mg if renal failure, BD if &gt;100kg)</td>
<td></td>
</tr>
<tr>
<td>Senna</td>
<td>10mls OD</td>
<td></td>
</tr>
<tr>
<td>Lactulose</td>
<td>20mls BD</td>
<td></td>
</tr>
<tr>
<td>Potassium Chloride</td>
<td>Max rate 20mmol/hr</td>
<td>Target K &gt;4mmol/L</td>
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<tr>
<td>Potassium Phosphate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Magnesium Sulphate</td>
<td></td>
<td>Target Mg &gt;1 mmol/L</td>
</tr>
<tr>
<td>Chlorhexidine Mouthwash</td>
<td></td>
<td>1 application QDS</td>
</tr>
</tbody>
</table>

## Additional Orders

<table>
<thead>
<tr>
<th>Drug</th>
<th>Concentration/Dilution</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adrenaline</td>
<td>6mcg in 100mls 5% Dextrose</td>
<td></td>
</tr>
<tr>
<td>Vasopressin</td>
<td>20 Units in 50mls 5% Dextrose</td>
<td></td>
</tr>
<tr>
<td>Milrinone</td>
<td>10mg in 50mls 0.9% NaCl</td>
<td></td>
</tr>
<tr>
<td>Atracurium</td>
<td>500mg in 50mls (neat)</td>
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<tr>
<td>Heparin</td>
<td>25000 Units in 50mls 0.9% NaCl</td>
<td>As per protocol</td>
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<tr>
<td>Metoclopramide</td>
<td>10mg TDS</td>
<td></td>
</tr>
<tr>
<td>Pabrinex</td>
<td>Ampoule 1 + 2 in 100mls 0.9% NaCl</td>
<td>2 ampoules TDS</td>
</tr>
</tbody>
</table>
Hypoxaemic Respiratory Failure P/F <26.6 (200)

Volume Control Ventilation
Male 430mls Female 350mls
PEEP 10cmH₂O
Resp rate <35
I:E 1:2
RASS -4

ABG at 30 mins
4 hourly thereafter

PF ratio < 20 (150)
RASS -4
NMBA infusion*
Prone

PF ratio <26.6 (200)
RASS -4
NMBA infusion*
x 48hours
Reassess 4 hourly

PF ratio >26.6 (200)
RASS -2
Continue ventilation settings

PF RATIO = PₐO₂/FiO₂

POST INTUBATION RECRUITMENT MANOEUVRE
PEEP 40cmH₂O x 40 secs
Repeat 4-6 hourly

TARGETS
Vt 6mls/kg IBW
Plat Pressure <30cmH₂O
pH >7.2
pO₂ >8kPa, SpO₂ >88%

*cis-atracurium or atracurium
## TIDAL VOLUME - 6mls/kg IDEAL BODY WEIGHT

<table>
<thead>
<tr>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Height</strong></td>
<td><strong>Height</strong></td>
</tr>
<tr>
<td>cm</td>
<td>cm</td>
</tr>
<tr>
<td>Feet inches</td>
<td>Feet inches</td>
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<tr>
<td>Tidal Volume (mls)</td>
<td>Tidal Volume (mls)</td>
</tr>
<tr>
<td>153 5'0&quot;</td>
<td>166 5'5&quot;</td>
</tr>
<tr>
<td>280</td>
<td>370</td>
</tr>
<tr>
<td>155 5'1&quot;</td>
<td>168 5'6&quot;</td>
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<tr>
<td>290</td>
<td>390</td>
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<tr>
<td>158 5'2&quot;</td>
<td>171 5'7&quot;</td>
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<td>161 5'3&quot;</td>
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<td>163 5'4&quot;</td>
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<tr>
<td>166 5'5&quot;</td>
<td>178 5'10&quot;</td>
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<td>350</td>
<td>440</td>
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<tr>
<td>168 5'6&quot;</td>
<td>181 5'11&quot;</td>
</tr>
<tr>
<td>360</td>
<td>460</td>
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<tr>
<td>171 5'7&quot;</td>
<td>183 6'0&quot;</td>
</tr>
<tr>
<td>370</td>
<td>470</td>
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<tr>
<td>173 5'8&quot;</td>
<td>186 6'1&quot;</td>
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<td>390</td>
<td>480</td>
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<tr>
<td>176 5'9&quot;</td>
<td>188 6'2&quot;</td>
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<td>500</td>
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<tr>
<td>178 5'10&quot;</td>
<td>191 6'3&quot;</td>
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<tr>
<td>420</td>
<td>510</td>
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<tr>
<td>181 5'11&quot;</td>
<td>194 6'4&quot;</td>
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<tr>
<td>430</td>
<td>530</td>
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<tr>
<td>183 6'0&quot;</td>
<td>196 6'5&quot;</td>
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<td>440</td>
<td>540</td>
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### FiO₂ & PEEP

<table>
<thead>
<tr>
<th>FiO₂</th>
<th>PEEP</th>
</tr>
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<tbody>
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</tbody>
</table>

### ADJUST RR & MINUTE VENTILATION TO pH

1. **pH > 7.2**
   - Increase RR up to max 35/min
   - **pH > 7.2**
     - Continue

2. **Increase VT to 7mls/kg**
Worsening Hypoxia/Hypoxaemia

SpO2 <88%  PaO2 < 8kPa

Intensivist Review (when possible)

Closed Suction

Recruitment Manoeuvre

PEEP @ 40cmH2O x 40 secs

Increase FiO2 and PEEP

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<th>FiO2</th>
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<td>20-24</td>
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</tbody>
</table>

Increase Inspiratory Time

I:E 1:<2

PF ratio <26.6 (200)

RASS -4
NMBA infusion* x 48hours

Sedation

RASS -4

PF ratio < 20 (150)

Consider prone position

ALL IMAGING REQUESTS MUST BE APPROVED BY CONSULTANT INTENSIVIST
PF ratio > 26.6 (200) x24 hours

PEEP < 10
FiO₂ ≤ 40%
Compliance >40ml/cmH₂O

Reduce sedation
Wean to pressure support

COVID-19 NEGATIVE

HFNC/NIV

COVID-19 POSITIVE

Continue ventilation

PF > 33.3 (250) x 12 hours

Facemask O₂ - MAX 6L/min
Nasal prongs <6L/min
**Disconnection**

**In room**

Rapid reconnection by nurse/intensivist  
All non essential staff to stand as far from patient (if safe to do so)

**On transfer**

All non essential staff to stand as far from patient (if safe to do so)  
Intensivist to reconnect as soon as possible

**In CT**

Intensivist to enter room  
Reconnect as soon as possible  
All staff to don full PPE - including FFP3 before re-entering room  
Room to be deep cleaned

**High Airway Pressures**

1. Check ventilator to patient for kinks/obstructions/filter saturation  
2. Closed suction of ETT  
3. Check tube position on CXR  
4. Check for bronchospasm and treat as needed  
5. Check for pneumothorax

**Dyssynchrony**

1. Intensivist review when feasible  
2. Leak or water in circuit?  
3. Closed suction of ETT  
4. Adequate sedation?  
5. Consider neuromuscular blockade
Caring for critically ill patients can be a stressful experience for staff, particularly in new or unfamiliar environments. We have compiled some practical tips and resources to help you, and your colleagues, look after your mental and physical wellbeing during the weeks ahead.

Keep a routine - make sure you eat healthily and stay hydrated. Take your breaks. Try to exercise and get sufficient rest in between shifts.

Stay in touch with friends and family.

Check out www.gov.ie for factual updates, avoid continuously checking news sites or social media as the flow of information may be overwhelming.

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**Employee Assistance Counselling Service**

The Employee Assistance Counselling Service is provided by the HSE to support employees at a time of difficulty in their personal or professional lives.

The service can be accessed confidentially without having to go through HR or occupational health. Between 4 and 6 sessions are provided free of charge.

The service uses trained counsellors based in numerous locations nationwide to ensure it is convenient for staff members.

Contact details and more information available on hse.ie or via QR code

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**YourMentalHealth.ie**

Developed by the HSE yourmentalhealth.ie contains a wealth of information on all things mental health.

Resources include information on mental health conditions and how to support a friend or family member who is struggling with their mental health.

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**Practitioner Health Matters**

The practitioner health matters programme provides support to doctors, pharmacists and dentists who are struggling with stress, anxiety, burnout or other mental health issues such as substance misuse and addiction.

The service is designed specifically to deal with healthcare providers and so is familiar with the common issues they face, and how to support them through these issues.

The service is fully confidential and free at the point of access for staff.

(01) 297-0356 confidential@practitionerhealth.ie https://practitionerhealth.ie/