Calgary Zone Department of Emergency Medicine COVID GR
Q&A - April 30th

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1. Just to clarify, the doors can be left open except for the actual intubation, for example.

   Correct, done can be open except when AGMP's are being performed.
   Until there is an AGMP - so bagging, suctioning, NIV, intubation etc.

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2. What about the prone position any room in ER for this?

   This will be addressed by Andrew McRae next week.

   I assume you are referring to the usage in the nonintubated patient (as proning is routinely done in the ICU in intubated patients but usually not required in the ED). The summary is that there is currently no-good evidence to support its usage at this point. As mentioned - Andrew will discuss this next week including a clinical trial that may be coming. My understanding (correct me if I'm wrong is that proning is NOT being recommended in the ED)

   From Andrew - Correct re: proning. Current evidence does not guide on which patients its likely to help vs. possible to harm. This will likely be an inpatient ward/ICU intervention for non-intubated patients as it takes practice/nursing resources to do correctly. The paper in Academic EM this week does not give us enough to go on to try to make this an ED intervention. More next week.

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3. RTs at the PLC have taken to putting a surgical mask on COVID patients and then NRBM O2 over this. Anyone aware of any literature supporting this ridiculous practice?

   Not aware of any supporting literature, there is some literature post SARS that looked at surgical masks with NC showing that there is some rebreathing of CO2 and increased dead space, flow rates of > 6L negated this effect. Surgical masks overtop of simple masks also was evaluated showing no effect to oxygen delivery

   Most recent Calgary EMS guideline suggests mask over NC and NRB not under

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4. I don't understand the recommendation for the "W" fold as this seems to contradict our long time teaching of molding mask to face and NOT pinching as pinching creates gaps. Are we looking to phase out these masks as soon as other masks are available? They also smell and are thick. I find I can't keep these masks from slipping up or down.

   The "W" is more of a pre-folding technique and you should still ty to mold the nose piece when donning. We/AHS hears all the concerns re: Vanch masks. I don't have a time frame

of a phase out of these masks but the manufacturer has sent new shipments of these masks with changes to aeration for the smell and lengthened masks for better fit.

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5. White cloth tape to help seal the top of those shitty masks on your face works really well to secure them and to keep them from falling down all the time.

   Agree. Be conscientious of hand hygiene when “doffing” the taped part.

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6. Are buttons on scrub cabs still ok for patient care? (ie: is it the concern over the fit or the contamination of the ear savers?)

   Check the stability of the buttons if using.

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7. Correct re: proning. Current evidence doesn't guide on which patients it's likely to help vs. possible to harm. This will likely be an inpatient ward/ICU intervention for non-intubated patients as it takes practice/nursing resources to do correctly. The paper in Academic EM this week doesn't give us enough to go on to try to make this an ED intervention. More next week.

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8. New Vanch masks seem to be significantly more “irritating” with skin irritation and red eyes. Are we sourcing the original mask?

   I don’t have any information about what stocks AHS has coming in for masks - more Vanch or more PriMed/Primagard/“original” masks. The existing number of older masks is dwindling and the Vanch masks are here for several weeks at least

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9. Early on, an intubation early strategy was advocated. From the podcasts I have listened to, places with high volumes have moved away from this in patients with the “happy hypoxemic” phenotype (ie tolerating a lower oxygen saturation - high oxygen requirement). Can you comment on this from a local perspective?

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10. I’m concerned the Vanch masks are at significant risk of self contaminating yourself given the multitude of “hacks” we need to do to make them remotely usable. What are the plans for getting rid of these?

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11. I would agree with Eileen, and I would encourage everyone to email ppe@ahs.ca with their concerns. I can only wear them with the loops twisted, otherwise there is a huge gap between my face and the mask, but this increases the risk of them getting hooked on my glasses and

several times doffing it flips towards my face. Does anyone have any tips for those with glasses? Especially if we cannot wear the ear savers in droplet/contact rooms.

Chat

1. COVID related admission ONLY correct?

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2. That is great news and very reassuring

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3. Herculean effort by the sim team (kudos Gord et al.)

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4. Yes graphs relate to COVID admissions the 22% drop in admissions means 35-40 a day less for the zone. COVID admissions are only 3-5 per day

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5. The cheat sheet will be available on the website later today!

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6. Over 1200 views of the video!

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7. Green tubing nasal cannula are for high flow (≥6L) and still provide dry O2.
