

Oxygen Therapy with Limited Resources

COVID-19 Severe Acute Respiratory Infection (SARI) and Pneumonia

Key points

1. Practical oxygen therapy.
2. Prevent infections in hospital staff.

Suspect and confirm diagnosis of COVID-19 infection

- Case definition, clinically or if available by laboratory test.
- Start infection prevention and control (IPC) measures¹. Put a simple surgical facemask on the patient. Leave it in place to reduce the spread of the virus to staff and other patients.
- Consider IPC issues of staff personal protection equipment (PPE), medical equipment and COVID-19 hospital areas⁵.

Suspect (severe) pneumonia and confirm need for oxygen²

- Adult or adolescent with fever or suspected respiratory infection, plus one of: respiratory rate > 22 breaths/min; severe respiratory distress; altered mental status or SpO₂ ≤ 90% on room air.
- Child with cough or difficulty in breathing, plus at least one of the following: central cyanosis or SpO₂ < 90%; severe respiratory distress (e.g. grunting, very severe chest indrawing); signs of pneumonia with a general danger sign: inability to breast feed or drink, lethargy or unconsciousness, or convulsions. Other signs of pneumonia may be present: chest indrawing, fast breathing (in breaths/min): < 2 months ≥ 60; 2–11 months ≥ 50; 1–5 years ≥ 40.

Confirm hypoxia with pulse oximeter²

- Start oxygen therapy if SpO₂ < 90%. Use oxygen delivery device: nasal cannula (prongs) or nasal catheter or face mask.
- Nasal prongs recommended for child < 5 years.
- Keep simple surgical facemask on patient, over nasal prongs and under any type of oxygen face mask. This reduces viral spread to staff and other patients.
- Adjust O₂ flow to target SpO₂ > 90% adults & children. If signs of multi-organ failure including shock or alteration of mental status SpO₂ > 94%. In pregnant patients target SpO₂ > 92 - 95%.
- If the target SpO₂ > 90% cannot be achieved, or if SpO₂ << 90%, suspect Acute Respiratory Distress Syndrome (ARDS). Consider nursing patient in the prone position for periods with a pillow under the chest. This may avoid the need for mechanical ventilation³.
- If the SpO₂ does not improve, advanced oxygen therapy and mechanical ventilation are required. If possible these patients should to be moved to another ward for management of intubation, oxygenation and ventilation. IPC measures with intubation, airway nursing care and ventilation are vital.

Oxygen delivery devices⁴

Titrate O₂ flow with SpO₂. Do not waste oxygen.

Nasal prongs O ₂ 1 – 5 L/min	→	Fi O ₂ 28% - 40% child and adult
Nasopharyngeal catheter O ₂ 1 – 2 L/min	→	Fi O ₂ 45% - 60% infant and child
Oxygen face mask O ₂ 6 – 10 L/min	→	Fi O ₂ 44% - 60% child and adult
Oxygen face mask reservoir bag O ₂ 10 – 15 L/min	→	Fi O ₂ 60% - 95%
Venturi oxygen face mask O ₂ 4 – 15 L/min (for Venturi O ₂ flow rate Fi O ₂ device specific)	→	Fi O ₂ 24% - 60%

Caution: ↑ aerosolised droplet spread with high flow O₂ from all devices. Keep simple surgical facemask over prongs or under oxygen mask at all times.

Humidification should never be used: ↑ viral spread and equipment may be contaminated.

The resource limitations are oxygen supply or availability of oxygen delivery devices

- Assess and monitor oxygen supply.
- Consider disinfection of nasal prongs, catheters and face masks. Infection prevention and control (IPC) measures are very important with contaminated medical equipment⁵.

Oxygen supply⁴

Oxygen concentrators produce 4 – 10 L/min O₂.

Cylinders may not easily be refilled. Consider IPC measures if cylinder is at the bedside.

Bulk supply may not be available.

Decontamination and Disinfection^{5, 6}

Decontaminate by mechanically cleaning oxygen delivery devices of secretions and mucus. Disinfect with 70% (ethyl or isopropyl) alcohol or soak in 0.1% sodium hypochlorite solution (1000 ppm available chlorine) for 30 minutes.

Preparation of 0.1% sodium hypochlorite solution⁴

Dilute household bleach (widely available), usually 5% = 5g sodium hypochlorite /100ml 1:50 with tap water. Add 1 measure of bleach to 49 measures of tap water. 5% sodium hypochlorite contains 50,000 ppm available chlorine, and the dilution contains 1000 ppm.

Check the concentration of the bleach sodium hypochlorite on label (in g/100ml) and adjust dilutions accordingly. For example: 2.5% sodium hypochlorite bleach contains 2.5g sodium hypochlorite /100ml. To 1 measure of bleach add 24 measures tap water. 4.2% sodium hypochlorite bleach contains 4.2g sodium hypochlorite /100ml. To 1 measure of bleach add 41 measures tap water. The dilutions all contain 1000 ppm available chlorine.

Prepare a container of solution in a well ventilated place. Avoid direct contact with eyes. Store covered, cool and shaded. Discard at 24 hours. Do not mix with detergents. Thoroughly rinse the oxygen delivery devices before reuse.

References:

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2. Clinical management of severe acute respiratory infection (SARI) when COVID-19 disease is suspected. Interim guidance 13 March 2020 WHO
3. Lower mortality of COVID-19 by early recognition and intervention: experience from Jiangsu Province. Sun, Q., Qiu, H., Huang, M. et al. *Ann. Intensive Care* 10, 33 (2020). <https://doi.org/10.1186/s13613-020-00650-2>
4. WHO UNICEF technical specifications and guidance for oxygen therapy devices. WHO Medical Device Series 2019. ISBN 978-92-4-151691-4 (WHO)
5. Infection prevention and control of epidemic–and pandemic–prone acute respiratory infections in health care. WHO Guidelines 2014. ISBN 978 92 4 150713 4
6. Persistence of coronaviruses on inanimate surfaces and their inactivation with biocidal agents. G. Kampf, D. Todt, S. Pfaender, E. Steinmann. *Journal of Hospital Infection* 104 (2020) 246-251. <https://doi.org/10.1016/j.jhin.2020.01.022>

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KEY POINTS

- Practical oxygen therapy
- Prevent infections in hospital staff

Suspect and Confirm Diagnosis of Covid-19 Infection

- Diagnose by case definition, clinically, by laboratory test
- Put a simple surgical facemask on patient
- Start infection prevention and control (IPC) measures
- Consider staff personal protection equipment (PPE), disinfect medical equipment and dedicated Covid-19 hospital spaces

Suspect Severe Pneumonia and Confirm Need for Oxygen

- Respiratory signs and symptoms
- Adult or adolescent SpO₂ ≤90%
- Child SpO₂ <90%



Confirm Hypoxia by Pulse Oximeter

- Start oxygen therapy if SpO₂ <90%
- Nasal cannula (prongs) or nasal catheter or face mask
- Nasal prongs for child < 5 years
- Adjust O₂ flow to target SpO₂ >90%
- Try prone position - pillow under chest
- If SpO₂ not ↑ or <<90% → advanced oxygen/ventilator care needed



Cautions

- Keep surgical facemask over prongs/under oxygen mask
- Droplet spread with high flow O₂ from all devices
- No humidification to be used

Oxygen Delivery Devices

- Nasal prongs O₂ 1–5 L/min
- Nasal catheter O₂ 1–2 L/min (infant & child)
- Oxygen face mask O₂ 6–10 L/min
- Oxygen face mask reservoir bag O₂ 10-15 L/min
Make sure reservoir bag inflates
- Venturi oxygen face mask O₂ 4–15 L/min
O₂ flow rate device specific



Resource Limitations

- Oxygen supply or the availability of oxygen delivery devices
- Assess and monitor oxygen supply
- Consider disinfection of prongs and masks



Decontamination and Disinfection

- Physical cleaning
- Soak in 0.1% sodium hypochlorite solution for 30 minutes
Contains 1000 ppm available chlorine



Preparation of 0.1% Sodium Hypochlorite Solution

Check concentration of sodium hypochlorite in household bleach contains 5% or 5g/100ml sodium hypochlorite (= 50,000 ppm chlorine). Dilute bleach 1:50 with tap water. One measure of bleach to 49 measures of tap water makes 0.1% solution = 1000 ppm chlorine. If bleach concentration is less, dilute accordingly to give 0.1% solution = 1000 ppm chlorine. Prepare a bucket in a well ventilated place. Store covered in a cool shaded place and discard at 24 hours. Do not mix with detergents. Avoid contact with eyes.

Thoroughly rinse the oxygen delivery devices before reuse.



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