Anesthesia Patient Safety Foundation

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Recommendations for Airway Management in a Patient with Confirmed or Suspected COVID-19 Infection

YOUR personal protection is **THE** priority. Personal protective equipment (PPE) should be available for all providers to ensure droplet/contact isolation precautions can be achieved. Review protocols for donning and doffing PPE. Careful attention is required to avoid self-contamination.

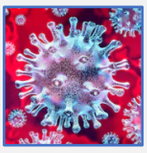
Patients with confirmed or suspected COVID-19 infection:

- Should **NOT** be brought to holding or PACU areas
- Should be managed in a **designated OR**, with signs posted on the doors to minimize staff exposure.
- Should be **recovered in the OR** or **transferred to ICU** into a negative pressure room.
- Should have a high-quality HME (heat and moisture exchanging) filter, rated to remove at least 99.97% of airborne particles 0.3 microns or greater, placed between the ETT and circuit/reservoir bag at all times.

Plan ahead:

- For time to allow all staff to apply PPE and barrier precautions
- Consider intubation early to avoid the risk of a crash intubation when PPE cannot be applied safely.

During Airway Manipulation



Apply:

- PPE: N95 mask (or equivalent), eye protection or a face shield, an impermeable fluid resistant gown, disposable head cover, protective footwear, and **2 sets of gloves**.
- Standard ASA monitoring should be applied before induction of anesthesia.

Assign:

- The most **experienced** anesthesia professional available to perform intubation, if possible. Avoid trainee intubation for sick patients.

Discuss:

- The plan for an unanticipated difficult intubation and ensure that desired **rescue equipment** is immediately available, including a supraglottic airway and a surgical airway kit.

Avoid:

- Awake fiberoptic intubation, unless specifically indicated. Atomized local anesthetic will aerosolize the virus. Consider alternate topicalization methods if indicated.

Prepare to:

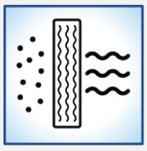
- Preoxygenate for 5 minutes with 100% FiO_2, or until a desired target EtO_2 is achieved.
- Use equipment most familiar to the intubator; a **video-laryngoscope** is recommended as the primary intubating device to improve intubation success.

Perform a Rapid Sequence Intubation (RSI):

- Perform a RSI to avoid manual ventilation of patient's lungs and potential aerosolization of virus from airways.
- Depending on the clinical condition, the RSI may need to be modified.
- If manual ventilation is required, apply small tidal volumes, ensure an HME filter is in place.
- Immediately post intubation, inflate the ETT cuff **before** applying positive pressure ventilation

Ensure:

- A high quality HME filter is in place between the ETT/facemask and breathing circuit/reservoir bag at all times



Dispose:

- Resheath the laryngoscope immediately post intubation (**double glove technique**) or place within sealed bag. Seal all used airway equipment in a double zip-locked plastic bag. It must then be removed for decontamination and disinfection.

Extubation:

- Should occur under strict adherence to PPE. Consider the use of a protective cloth barrier to cover the mouth during extubation. Carefully dispose of contaminated equipment.

Remember:

- After removing protective equipment, avoid touching hair or face before washing hands.

Track:

- Symptoms of health care providers involved in airway manipulation, consider using an online registry such as IntubateCOVID at https://intubatecovid.knack.com/registry#add-intubation/

Updated May 12, 2020