

COVID 19 Intubation Guidelines

Assume all Emergent Airways are COVID-19 until proven otherwise

Preparation

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1. Preparation

- a. PPE=Airborne with Contact= N95/PAPR, Goggles, Gown, Gloves
- b. Leave personal belongings outside.
- c. Prioritize intubation using video laryngoscope as first line
- d. Standard Advanced Cardiac Life Support (ACLS) algorithms apply
- e. Roles in the ACLS protocol include by zone
 - i. Internal Zone (job titles include Physician/APP, RN, RT, NA) - Team Leader; Chest Compressions x 2-3, Airway x2; documentation (maybe asked to go to external zone by team leader) *the most highly skilled person should perform intubation to decrease aerosolization risk
 - ii. External Zone (job titles include Pharmacy, RN, NA) - Medication, Crash Cart Supplies, Runner
 1. Consider a second provider in Airborne with contact PPE outside the patient room in anticipated difficulty with securing the airway or need for complex airway maneuver.
- f. Prepare equipment: video laryngoscope, styletted ETT, suction, ventilator if available, PIV, meds, post-intubation sedation/vasopressors, monitors, and biohazard bag for disposal

Action

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2. Action

- a. Hold chest compression for intubation attempt
- b. Drugs available: paralytics preferred if clinically indicated, pressors, antiemetics, narcotics
- c. Avoid atomized local anesthetic and nebulized medication administration.
- d. Rapid Sequence Intubation (RSI) is recommended avoid Bag-Mask ventilation unless clinically necessary.
- e. Minimize suctioning or other airway manipulation.

Post-Intubation

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3. Post-Intubation

- a. Listen to breath sounds.
- b. Cover laryngoscope blade with outer glove immediately after confirming placement of endotracheal tube (ETT). At end of code, place in appropriate bag to send for reprocessing.
- c. Avoid bag-mask ventilation and connect to ventilator as soon as possible
 - i. if clinically necessary to bag-mask ventilate
 1. Use low volume/high frequency
 2. Bag with viral filter until vent connection
- d. As soon as possible connect directly to the ventilator.
 - i. To reduce the risk of aerosolization, as well as maintain PEEP/oxygenation of patients after intubation, clamping of the ETT with either a Kelly clamp or protected hemostat is recommended.
 - ii. The clamping should be transient and occur after breath delivery just prior to transitioning to mechanical ventilatory support.
 - iii. If the appropriate clamp is not readily available, directing the ETT away from providers during the reconnection process is reasonable.