RUSH ANESTHESIOLOGY - COVID AIRWAY PROTOCOL

March 20, 2020

1. Anesthesia on Call paged Overhead or Call 1/SICU phone called and notified of airway
2. Designated individuals (2 people max) respond with code bag, CAPR equipment, and PPE packs.

This equipment is located in clinical coordinator office by anesthesia board on 5T.

3. Upon arrival to airway, team will be notified of COVID status (rule out versus confirmed).
4. Remove all necessary medications from drug bag and pull up medications in syringes. Keep medications in additional ziplock bag to take into room. Code bag and orange med bag should **NOT** go into patient room.
5. Discuss amongst the 2 airway providers who will be administering medications and who will be intubating. Additional staff entering room should be limited. No ICU fellow intubations allowed in COVID cases. Generally RN and respiratory tech will enter with anesthesia team.
6. Ask respiratory therapist to apply non-rebreather to patient. This minimizes high flows while providing high FiO2. Applying this mask to the patient prior to entry will allow adequate time for pre-oxygenation. In recent airway codes the MICU staff's preferred oxygen modality for these patients seems to be optiflow with high flow nasal cannula. ICU staff has been reluctant at times to exchange optiflow for non-rebreather. We encourage a discussion with the ICU team to see if

they are amenable to switching to non-rebreather. Again good communication is essential. If they are unwilling to change, proceed with current oxygen modality.

7. Ensure respiratory therapist has ventilator ready for use. Prepare glidescope blade and stylet ETT with attached syringe. Open viral filter (ensure viral filter is the filter from our PPE packs, the filter respiratory therapist use for the ventilator is not the same and will not hook into the circuit, picture of proper filter below) and attach to colorimeter capnograph.

8. Don all PPE in appropriate order as follows :
    a. Shoe covers
    b. Yellow Gown (do not tie up yet)
    c. CAPR belt (secured inside of gown) with battery pack
    d. CAPR helmet with mask (turn CAPR on prior to gowning, ensure adequate power and filtration status according to light sensors on headband)
    e. Tie up yellow gown and tuck CAPR power cord into back of gown
    f. Double gloves
    g. Ortho head cover
    h. PLEASE WATCH INSTRUCTION VIDEO :

https://www.youtube.com/watch?v=O4fJitq9pF0&feature=youtu.be

https://www.youtube.com/watch?v=ck_cs9tbxAs&feature=youtu.be

9. Enter the room as a team.
10. Ensure IV is functioning. Ensure all monitors are attached and functioning.
11. Maintain non-rebreather mask or current oxygen modality for patient. Avoid high flows as this can aerosolize the virus.
12. Perform RSI to avoid manual ventilation and potential aerosolization of virus.
    a. Use Succinylcholine 1-1.5 mg/kg (if not contraindicated, ei. >48 hrs bed bound) or Rocuronium 1.2mg/kg for paralysis. If using rocuronium for induction, we recommend bringing Suggamadex in a syringe with your med kit inside the room.
    b. Hypnotics/Sedation administered per anesthesia team's discretion.
    c. Do not attempt bag mask ventilation. Allow for permissive hypoxemia during onset of paralysis. Continue oxygenation with non-rebreather.
    d. Use video laryngoscopy to intubate trachea immediately following onset of paralysis. Minimize airway manipulation and suctioning if possible. It is paramount to avoid intubation prior to onset of paralysis as this will cause patient to cough or buck expelling aerosolized viral load.

e. Once intubated, immediately inflate cuff, and attach capnometry-filter combination device to ETT and then attach ambu bag to ventilate with 100% FiO2 for recovery of oxygenation. (note proper order of : ETT – capnography – filter – ambu)

f. Secure tube and attach to ventilator as quickly and safely as possible. Filter does not need to be applied to ventilator circuit.

g. If inducing with succinylcholine, would recommend giving rocuronium for prolonged paralysis if ICU needs to do any further procedures. Don't forget to give more sedation if patient will be paralyzed for prolonged period of time.

13. Verbalize what medications were given and waste remaining medications with other anesthesia provider. No medications should leave the room that were brought inside.

14. While still in the room remove PPE as follows :

    a. Shoe covers

    b. Ortho head cover

    c. Yellow gown with gloves

    d. Sanitize hands with alcohol sanitizer and EXIT ROOM avoiding hand contact with door handle

e. Once outside of the room, remove CAPR helmet and place gently on ground. Re-sanitize hands.

f. Reapply gloves and wipe down CAPR helmet, shield, cord, and battery with purple SANI-wipes

g. Allow equipment to sit for 2 minutes after wiping down. We are reusing face shields as supply is limited.

15. Wash hands thoroughly and change scrubs.
16. Write airway note (.covidintubation). Can be obtained from smartphrases under any of chief residents (Boguski, Bosman, Kerr, Austell). Make sure to document drugs administered and wasted.
17. Return drug bag to pharmacy or pyxis with proper documentation of drugs administered and wasted.