Practical guide for airway management for suspected or confirmed COVID-19 patients

(Disclaimer: Local infectious control team, attending physician and the airway team member’s discretion are advised)

Anticipation and planning

Avoid high NIV settings if possible (Note: HFNC is not considered as aerosolizing procedure according to SCC guidelines, but this needs to be clarified with local infection control team)

Clarify the setting when the team considers threshold for intubation

Intubation is an aerosol generating procedure. Please ensure appropriate Personal Protecting Equipment following local infections control rules.

Minimize number of direct providers: however, you will need RN, RT and Physician outside the room to assist documentation and the process.

Use self- or flow- inflating resuscitation bags with a filter between exhalation valve and mask.

Use cuffed endotracheal tube to eliminate any aerosol spread from airway leak

Use video laryngoscopy with video view as a primary approach to maximize the distance between the airway and the laryngoscopist

Consider using pre-oxygenation (3min minimal) with classic rapid sequence intubation without bag mask ventilation when feasible (Note: child with smaller FRC, lung disease, or high O2 consumption may not tolerate classic RSI: rapid sequence intubation).

Use apneic oxygenation to extend safe apneic time (OK to use HFNC with 100% O2 if a child is already on High flow nasal cannula)

Have right size AirQ (intubating LMA) outside the room

Use COVID-19 Airway Bundle to guide intubation planning (attached)

Time Out/Procedure

Ensure 2 additional Personal Protection Equipment (PPE) are available (with donning support outside the room)

Clarify roles: if only 1 physician in the room, the checklist should be read by the RN who will administer medication.

Review the plan on the checklist
Back up medications should be drawn up and readily available at the bedside.

Ensure appropriate size intubating LMA in the room.

Ensure ½ size smaller ETT is prepared with stylet.

Minimize patient’s coughing, use paralytic early (i.e., rapid sequence intubation: simultaneous administration of sedative and paralytic, with or without mask ventilation) when appropriate (coughing is aerosol generating, bag mask ventilation is also aerosol generating).

Ensure the most experienced clinician is performing intubation to minimize attempts and adverse events.

Consider calling Anesthesiologist/ENT for high risk intubation or anticipated difficult airway (Donning Anesthesiologist/ENT may take up to 5 minutes).

After intubation, transition to mechanical ventilation early when feasible (minimize hand bag ventilation).

For failed 1st attempt, consider using LMA to provide rescue ventilation over bag mask system (to reduce aerosolization).

Confirm placement with EtCO₂ first, then X-ray or Ultrasound for confirming depth.

**Post-procedure**

Conduct a quick Hot-debriefing.

Share learned points to your team.

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NOTE:

Local infectious control team’s discretion is advised, especially the classification of HFNC.

Reference: SCC- COVID 19-Critical Care Guidelines