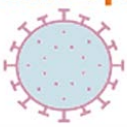
3 STEPS TO INTUBATE SAFELY WITH SUSPECTED COVID-19

Airway Management strategy that protects both patients and staff.

Minimize Aerosolization of Virus

Prevent Spread



- Early Tracheal Intubation instead of Bi-PAP or HFNO.
- Intubate in a negative pressure room and avoid nebulization.
- HEPA filters for positive pressure ventilation (PPV).
- Rapid sequence intubation for apnea and lack of cough. Use higher dose paralytics.
- PPV, high-flow oxygen and manual bagging only if clinically necessary.
- Immediate endotracheal tube cuff inflation before PPV.
- Limit ventilator disconnects. If needed, do so at end-expiration.

Maximize First Attempt Success

Patient Safety

- Use a checklist and closed-loop communication.
- Most experienced clinician should intubate.
- Use video laryngoscopy (VL) if available.
- Have all necessary equipment at the bedside.
- Robust preoxygenation with 100% O2 for 3-5 min.
- Early placement of a supraglottic airway instead of manual bagging for rescue oxygenation.
- Second clinician with personal protective equipment (PPE) outside of the room for immediate assistance.

Reduce Personnel Exposure

Limit Contamination

- Enhanced respiratory PPE with N95 mask or PAPR and observer-ensure donning compliance.
- Use double-glove technique.
- Use VL for indirect tracheal intubation if available.
- Limit to a 3-person intubation team when possible (RN, RT and Intubator).
- Placed soiled equipment in double sealed biohazard bags.
- Proper coached doffing procedure with hand hygiene.