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 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

Note: Local infectious control team's discretion is advised, especially the classification of HFNC.

Reference: SCC- COVID 19-Critical Care Guidelines