Donning of PPE for COVID-19 Intubation

- ☐ Remove all personal items (personal stethoscopes, watches, phones, jewelry, etc)
- ☐ Shoe covers placed
- ☐ Gown placed
- ☐ Mask placed (N95 OR PAPR)
- ☐ Eye protection placed (your personal glasses are inadequate)
- ☐ Double Gloves
  - Gloves should cover gown cuffs and sleeves
- ☐ Head Covering placed over ears (disposable)
- ☐ Second mask placed over N95 (regular surgical mask) and over your head covering.
- ☐ Before you go into the room, double check all team members to ensure proper PPE

What to bring in the room for the intubation

- ☐ Video laryngoscope with nothing in drawers or on the back of the tower
- ☐ Amber box that laryngoscope blade will go in and black cap if needed for particular blade
- ☐ Kleenz spray
- ☐ ETT, opened, checked for cuff leak, syringe attached
- ☐ Stylet, lubricated and placed into the ETT
- ☐ Induction drugs
- ☐ Emergency drugs likely to be used
- ☐ Sedative gtt for after the intubation
- ☐ Flush syringes
- ☐ Suction catheter and tubing if not already in the room
- ☐ Laminated Doffing checklist

What to leave in the hallway with the resident and/or anesthesia technician

- ☐ Other emergency airway supplies: Bougie, LMA, ETTs, trach kit, etc. unless you think you are likely to use them
- ☐ Ultrasound and kits for arterial line, central line, etc.
- ☐ Zoll and crash cart

Airway Management Checklist

- ☐ Anesthesiologist preoxygenates with 100% O2 for 5 minutes
  - o Mask seal on patient is tight and not lifted
  - o Use bag-valve mask with HME filter
  - o Use flutter or slight squeeze to keep valve open if patient is not breathing deeply on own
- ☐ Anesthesiologist directs RN to give induction medications and flush with 20 mL Saline
- ☐ Anesthesiologist performs laryngoscopy with videoscope
  - o RT or RN holds cricoid pressure as directed by anesthesiologist
- ☐ Tube is Placed
  - o RT or RN removes stylet slowly
  - o RT inflates cuff
  - o RT attaches HME filtered circuit (or can use bag valve mask with filter and portable capnography indicator)
  - o RT auscultates breath sounds
  - o RT takes control of tube
- ☐ Anesthesiologist disassembles laryngoscopy blade from power supply cords and places laryngoscope blade in the amber box after placing black cap (CMACs) onto port.
    - ▪ RT to hold ET tube during this time
- ☐ Anesthesiologist and RT secure tube together using established device

- Additional procedures are done by anesthesiologist as needed by primary team (This is the same team that intubated the patient)
  - Central Line
  - Arterial Line
  - Additional IV access
  - NGT or OGT placement
  - Chest Tube Placement

☐ RT confirms cuff pressure maintained between 25-30cm H20.

☐ RN sprays laryngoscope blade (with cap if needed) and closes box. Wipes down box with wipe and hands to personnel outside for transport to SPD

☐ RN or anesthesiologist wipe down the video laryngoscope tower and then pass to personnel on outside where a second wipe down occurs. Bleach wipe on wheels.

Doffing of PPE for COVID-19 Intubation

- ☐ Staff members will begin doffing near the doorway giving each other enough room to avoid contaminating each other
- ☐ Use hand sanitizer on last set of gloves
- ☐ Remove gloves and gown together, slow downward motion out in front of your body, rolling it in a ball
- ☐ Hands, wrists and forearms are sanitized
- ☐ Put on clean gloves (optional)
- ☐ Eye protection is removed and wiped down
- ☐ Shoe covers removed
- ☐ Sanitize hands or gloves
- ☐ Head cover is removed
- ☐ Sanitize hands or gloves
- ☐ Outer mask is removed and discarded
- ☐ Remove gloves if wearing them
- ☐ Hands are sanitized
- ☐ Leave the room and close the door
- ☐ The N95 is removed and placed in a Ziploc bag, not completely sealed to avoid moisture trapping, labeled with your name and saved. If the mask is wet from sweat or secretions, discard it.
- ☐ Wash hands with soap and water to your elbows.
- ☐ If you feel you have contaminated through or around your PPE, please wash with soap and water (shower if necessary) and change into clean scrubs.