AIRWAY MANAGEMENT FOR ADULT PATIENTS, CONFIRMED COVID-19 POSITIVE AND PUIs

COVID-19+ or PUI screened in the Emergency Department

Transport using NC O2 is preferred. If additional O2 is needed (> 6L/min), NIV with an expiratory filter can be used provided that there is minimal/no leak around the mask. If NIV is ineffective, consider intubation prior to transport

Place in negative pressure room (if available)
If unavailable, place a portable HEPA filter in the room and keep the door closed

Use supplemental NC O2, up to 6L/min, to maintain O2 sat > 92%

MDI treatments ONLY
NO nebulized bronchodilators

HFNC O2 up to 40 LPM(60-TMH) can be used. Patient must wear a surgical mask when HCW are in the room. If dyspnea/SpO2 do not improve, a trial of NIV may be considered, otherwise a low threshold to intubate

Multidisciplinary collaboration for all imminent Intubations. Anesthesia will perform ALL intubations. In emergent situations, the next most skilled provider should intubate

Intubate using RSI

Place patient on a ventilator with a closed filtered circuit

Extubate to NC O2 or HFNC

Increased O2 demand, work of breathing

N95/face shield MUST be worn for the following:
Intubation, extubation, use of bag mask valve ventilation, NIV, HFNC O2 > 6L/min

* If a CAPR is available, it may be used as a substitute for N95/face shield

Aerosol masks and face tents will NOT be used post-extubation

Essential travel

LTV 1200 (PALL filter)
Triology (PALL filter)
NIV with filtered circuit may be considered

If unable to maintain target O2 sat with 40LPM (60 - TMH) HFNC O2 or significant work of breathing, a trial of NIV may be considered, otherwise low threshold to re-intubate

O2 sat < 92%
LTV 1200 Circuit (PALL Filter Inline at the wye)

Trilogy Circuit (PALL Filter Inline prior to exhalation valve)

Inter-surgical filter application with the Bag