PHC Airway Management - Update on Multidisciplinary involvement of airway management, PPE during intubation, and mobile airway bins:
March 14, 2020

Target audience:

- Emergency Medicine
- Critical Care
- Anesthesiology

1. **Multidisciplinary approach to airway management in all patient care areas**
    - Heavier viral exposure to clinicians from prolonged airway management or multiple intubations seems to be associated with increased morbidity to the provider if they become infected. Goal is to "share the burden/risk" of intubating between the departments of ED, ICU, and Anesthesia.
    - The default airway operators in the ED and in the ICU will be attending physicians from those departments.
    - Physicians in ED and ICU should manage intubations according to regional COVID-19 airway guidelines. An airway checklist will be provided in the airway box.
    - Anesthesia will have a physician in-house whose dedicated role is to respond to COVID-19 related intubations during the daytime, if needed. They will carry a COVID phone. If the MRP from ED/ICU anticipates any difficulty or requires assistance, anesthesia can be called on the Anesthesia COVID phone for an airway planning discussion to decide who should fulfill the intubator role.
    - Meticulous donning/doffing is necessary, so there will be delays in the usual speed at which extra help can be provided. If assistance from anesthesia is anticipated, call the COVID phone as early as possible to allow time for donning PPE.
    - If airway assistance is needed while already donned/doffed, ***"CODE AIRWAY"*** should be activated. This will trigger an overhead call and call to anesthesia COVID phone to notify the designated anesthesiologist to arrive for assistance. ***Note about Code Airway:*** *this code is to only be used in the potential scenario where the MRP is donned and actively resuscitating a COVID patient in isolation room who needs immediate airway assistance from Anesthesia.*

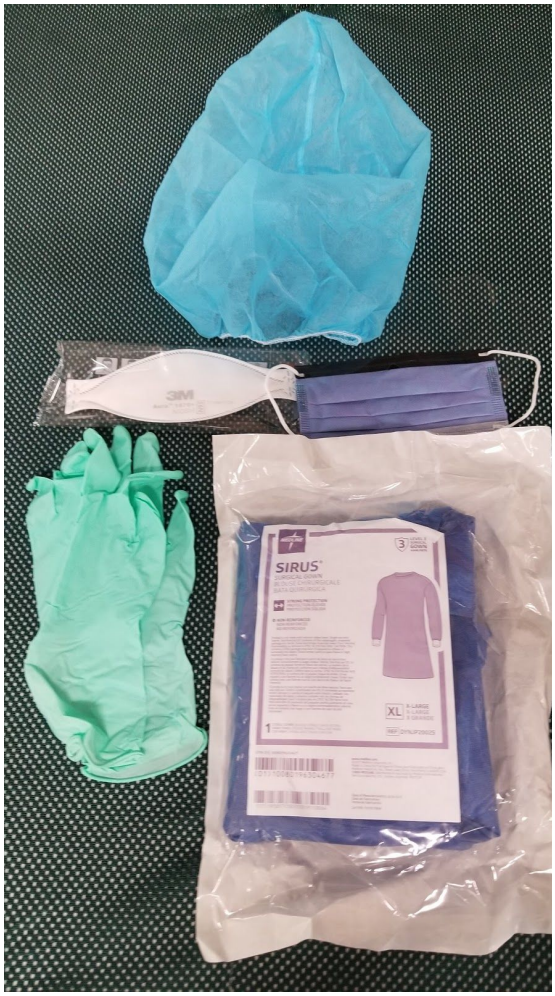
2. **<u>Intubation-specific PPE:</u>**
    - Each intubation team should have **4 total team members** who are donned.
        - Only **3 people** who are involved in Direct Airway Management should be inside the room during the intubation. 1 MD, 1 RN, 1 RT
        - An additional **1 person** donned outside will be an “external circulator” and will wear the lower level of PPE required for routine bedside care.

    - **PPE for Direct Airway Management:**
        - Disposable surgical gown
        - Surgical hood
        - N95
        - Surgical mask with visor
        - Non-sterile long cuff gloves (single pair of gloves, ***not double gloved***)
        - Example in **Appendix #1**
    - **External Circulator (A.K.A. “the runner”):**
        - Disposable Yellow Versagown
        - N95
        - Surgical mask with visor
        - Non-sterile long cuff (single pair of gloves)
        - Example in **Appendix #2**
    - Rooms with specific ante room -- Take everything off in ante room
    - Rooms without ante room -- Take off all droplet/contact PPE (gowns and gloves) in the corner of the room. Hand hygiene before exiting room. Upon exiting the room, remove surgical mask/N95 mask with hand hygiene between removal of each piece. Hand hygiene as final step.
    - ***PPE GUIDELINES WILL CHANGE AS SUPPLIES ARE DEPLETED OR SITUATION EVOLVES***
    - Airway PPE carts with these supplies will be available for airway management:
        - SPH: 2 for ED, 1 for ICU, 1 for Anesthesia/OR
        - MSJ: 1 for ED, 1 for ICU, 1 for Anesthesia/OR

3. **COVID-19 Airway Bins:**
    - Mobile airway bins will be used specifically for the COVID-19 pandemic for ease of transport
    - Contents of the bins have been standardized across all locations in the hospital for both SPH and MSJ
    - Contents of the bin are in **Appendix #3**
    - Each bin will have an empty tray inside of it, along with all of the airway equipment. Physicians should leave the airway bin ***outside*** of the patient room. Load necessary equipment onto the empty tray for transfer into the isolation room. Equipment on this tray will be discarded after airway management (regardless if it is used or not), so ***choose wisely!***
    - Quantity of airway bins:
        - SPH: 3 in ED, 2 in ICU, 2 for anesthesia/OR (to be stocked by Anesthesia Assistants at SPH)
        - MSJ: 2 in ED, 1 in HAU, 1 for anesthesia/OR (to be stocked by RTs at MSJ)

Appendix #1:

Example of donned team member involved in Direct Airway Management:



Appendix #2:

Example of donned team member who is assigned the role of "External Circulator/Runner"

Appendix #3:

Airway Bin Content List:

1. Oral airways x3 (one of each)
2. 8.0, 7.5, and 7.0 EVAC ETTube
3. DL MAC 3 and MAC 4 blades (DL handle ***not*** in kit)
4. McGrath disposable MAC 3, 4 and X3 (McGrath VL ***not*** in kit)
5. iGel LMA size 3 and 4
6. Classic LMA size 4 and 5
7. Gum elastic bougie
8. Cric kit (6.0 ETT, scalpel, pocket bougie)
9. ETT ties
10. 10 cc ETT syringe
11. Flexible stylet
12. Rigid stylet
13. Quantitative EtCo2 monitoring
14. HEPA filter
15. Disposable scissors
16. Suggamadex (1 vial)
17. Surgical hood x 4
18. Biobag for contaminated disposables (VL blade, stylet) to go in garbage in room
19. Biobag for VL to take out of room
20. Kimwipes for McGrath decontamination