Intubation Protocol COVID-19/PUIs/Unknown Cases

GOAL: Protecting health care providers is the first priority. Ensure adequate time for reviewing the intubation plan, and for PPE.

PPE Requirements

- Enhanced PPE is required for aerosol-generating medical procedures
- A fit-tested N95 respirator or powered air-purifying respirator (PAPR) device, if available and trained

- Face shield
- Gown
- Double gloves (preferably long gloves)

Intubation Plan

1. Minimize the number of staff in the room to the number required to provide safe intubation.
2. The most experienced clinician should perform the intubation.
3. Avoid awake fiberoptic intubation (due to risk of coughing and aerosols).
   If possible, recommend/consider using video laryngoscopy to minimize close exposure.
4. Plan for rapid sequence induction (RSI). → RSI may need to be modified to ultra-rapid:
   If patient has very high alveolar-arterial gradient and is unable to tolerate a short period of apnea, or has a contraindication to neuromuscular blockade.
5. If manual ventilation is required, apply small tidal volumes only.
6. Five minutes of pre-oxygenation with 100 percent oxygen and RSI in order to avoid manual ventilation and potential aerosolization of infectious respiratory droplets.
7. Ensure high-efficiency, hydrophobic filter placed between face mask and breathing circuit or between face mask and Laerdal bag.
8. Intubate and confirm correct position of tracheal tube.
9. Institute mechanical ventilation and stabilize patient.
10. Use high-flow nasal oxygenation with caution and avoid mask CPAP due to greater risk of aerosol generation.

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