COVID-19 AIRWAY EQUIPMENT MODIFICATIONS

ADAPTED FROM SAFE AIRWAY SOCIETY GUIDELINES

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- 2-handed vice-grip, with assistant to squeeze bag.
- Minimise ventilation pressure by ramping patient and use of OPA and low tidal volumes.
- Use collapsible bag and ETCO2 trace to rapidly identify leaks.
- Do not ventilate prior to laryngoscopy unless for rescue oxygenation.



- Use video-laryngoscope to maximise first intubation success.
- Use video screen (indirect view) to view larynx to maximise distance between operator and patient's airway.
- Place laryngosopeblade in sealed bag immediately after intubation for sterilisation.



- Inflate cuff prior to ventilation.
- Use cuff manometer to minimise leak.
- Vigilance to ensure correct depth of ETT on first pass to avoid manipulations.
- Full PPE when manipulating ETT depth.



- Remains controversial as a treatment in COVID-19. Risk remains unclear.
- Do not use for pre-oxygenation or apnoeic oxygenation.



- Airway topicalisation is a high risk procedure for aerosol transmission
- Awake fibre-optic intubation only if indicated after airway assessment by senior clinician



- In CICO rescue, use scalpel-bougie to minimise aerosolization.



- Once ETT in situ, all suction should be using an in-line apparatus.
- Suctioning prior to extubation should be done in full PPE with the ETT cuff up.

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