OR CASES IN ASYMPTOMATIC PATIENTS WITHOUT SUSPECTED COVID-19

ROOM SETUP:
- Wear masks tightly fitted on face
- Wear eye protection, especially during intubation and extubation
- Wear gloves at all times; change or clean gloves often
- Minimize equipment that is out. Try to get everything out that you will need for a basic case to minimize possible contamination of supplies
- Only have essentials of what you may need near field/on vent table; keep any potential equipment needed (oral airways, LMAs, extra DL blade, tape, etc) back on omnicell to avoid aerosol contamination
- Have an upper body warmer on patient for later use
- Keep the glide and other equipment 6 ft away from intubating field if not being used to avoid aerosol contamination
- Have a designated plan for your dirty airway equipment (placing in ETT packing, double glove, placing on blue towel) vs placing dirty blades on bed, patient, or back on ventilator
- Have clear roles of personnel assisting, prior to intubation
- Maintain separated clean and dirty spaces
- Place filter between mask and elbow prior to case
- Consider having all eye tape already dispensed and tape allotted for ETT securing needs so as to not touch rolls of tape that are being re-used for other patient care
- Wear gloves throughout patient care and change/or sanitize (up to 20 times) when contaminated.

INTUBATION:
- All personnel in the room for intubation and extubation must wear airborne PPE, including N95 mask / PAPR and eye protection. Do not wear the blue plastic gown unless it is a high risk case (aerodigestive surgery, ENT, or thoracic procedure).
- Have only essential people around bed during intubation; others must stand at least 6 ft away or immediately available outside room
- After induction, consider using “plastic drape” method, unfolding plastic drape of upper body warmer as a see-through barrier between airway and anesthesia provider
- Minimize positive pressure ventilation by mask and suctioning; perform RSI when feasible
- If masking is required, consider two-handed mask with a tight seal
- Use muscle relaxant for intubation
- Check twitches prior to intubating
- Hook up filter and circuit as soon as intubation complete; inflate cuff and then give breaths; do not give breaths without cuff up
- Make sure airway helpers change gloves after assisting with intubation
• Consider Glidescope to keep face away from patient’s face

POST INTUBATION:
• Change gloves after managing airway and prior to touching any equipment (including vent); or double glove and remove top layer after intubating; keep garbage immediately available to dispose of gloves.
• Wipe down equipment after intubating (ventilator, bag, vent table, blade handle) to clean off any aerosolization that may have occurred.

EXTUBATION:
• All personnel in the OR must be in airborne PPE, including N95 / PAPR and eye protection.
• Minimize personnel within 6 ft of bed during extubation.
• At extubation make sure filter is on ETT at all times if circuit is disconnected and pull ETT with filter on; place garbage can close, easily accessible, and away from other equipment to dispose of ETT tube with minimal transport and contamination involved
• Have someone available to either place face O2 mask on immediately after extubation or to replace circuit mask with filter over mouth (do not throw away filter at extubation)
• Be aware of where your gloves have been and what you are touching with them (omnicell, supply drawers, gauze stacks, syringes, omnicell screen); wipe down anything that may have been touched or contaminated
• Change or clean gloves and perform hand- or glove-hygiene after extubation

CLEANING:
• Techs need to be diligent and methodical about cleaning between cases:
  -omnicell: drawers and pulls, outside of storage bins, touch screen, waste drawer handle
  -ventilator: screen, arm where bag goes, pop off valves, Inhalational agent vaporizers, vitals monitors
  -medfusion pumps
  -IV polls
  -epic charting computers and mouse
• The HEPA filter on the expiratory limb may be re-used during the day.