Summary of Anesthesia Management in COVID Positive / Suspected Patients

Operating Room
Ensure all OR doors are closed.
Ensure label of COVID + is visibly displayed on the OR door
Ensure patient is wearing a facemask at all times, including during transport.
OR Personnels
Inside OR: 1) Anesthesiologist; 2) RT / AA; 3) RN (runner/clean); 4) Surgical team (surgeons, scrub nurse)
Outside OR: 1-2 "runners" are available for assistance.
All OR personnels have left non-essential communication devices (e.g. mobile phone, pager) outside the OR
All OR personnel are aware of COVID (+) status, wearing full PPE for aerosol precautions which includes: **1) Fluid resistant long sleeve Gown; 2) Long cuffed gloves (double); 3) Eye protection (goggles); 4) Full face shield; 5) N95 respirator; 6) Hair cover / hood**
Anesthetic Machine
Plastic cover is protecting anesthesia machine & monitors.
An HME filter is in place at the patient's wye.
A second HME filter is in place at the expiratory limb of breathing circuit.
All breathing circuit conections are tightly secured to avoid accidental disconnection
Anesthesia medications
All medications for RSI and case are drawn up and ready for use on a mayo stand.
Spinal anesthesia / peripheral nerve block kits + ultrasound in the room if regional anesthesia to be used.
Full drug cart outside the room if needed.
Airway Preparation
Ensure videolaryngoscope (e.g. C-MAC) is available and ready for use in the OR.
Oropharyngeal airway, bougie and LMA (emergency, rescue only) are available for use inside OR.
Clamp (e.g., Kelly forceps) for ETT tube is available in the room.
Endotracheal tube with shaped stylet is ready + syringe attached to cuff.
Suction (blue Yankauer cannula) ready for use at the bedside pole.
Rebreathing filter mask (e.g., Tavish mask) in the room if regional anesthesia to be used.
Emergency airway equipment / cardiac arrest cart are outside OR.
Induction and Intubation

Ensure surgical team and OR nurses are **outside** the OR before starting anesthetic induction and intubation (only anesthesiologist, AA and nurse are to be present)
Tape for eye protection and securing ETT + bite block are ready before starting induction
Airway Management - Key Points
Avoid high flows (> 5 litres/min) for preoxygenation + APL valve fully open
Two hand facemask with tight seal technique for preoxygenation (aim ETO2 > 87%)
Anticipate rapid oxygen desaturation.
Perform RSI, intubate with video laryngoscope.
Avoid bag-mask ventilation (whenever possible); quickly switch to LMA if anticipate prolonged manual ventilation and prepare for difficult intubation.
After intubation, place video laryngoscope blade inside a glove / biohazard bag.
Place all airway equipment (laryngoscope blade, facemask, syringe) in the plastic airway safety box.
Fully inflate ETT cuff and check airway & circuit connections for tight fit before mechanical ventilation.
Avoid auscultation at all possible.
Extubation
Ensure surgical team and OR nurses are **outside** the OR before starting extubation (only anesthesiologist and nurse are to be present).
Cover patient head and face with a clear plastic drape.
Suction patient while under patient is still anesthetized.
Consider strategies to minimize coughing during extubation.
Remove ETT tube and filter as a single unit. Do not disconnect ETT from filter.
Leave ETT tube under drape.
Apply facemask with tight seal immediately after extubation to minimize aerosolization.
Postoperative Period
If patient does not require ICU postoperatively, recover patient in the OR.
Leaving the OR
All OR staff have removed their contaminated gloves + gowns and applied hand hygiene before exiting the OR.
Doff with utmost care.
All OR staff keep their face shield and N95 respirators on when leave the OR.