**INTUBATION SEQUENCE**

**PREOXYGENATION 100% FIO₂ X 3-5 min WITH WELL FITTED MASK.**

**RSI DRUGS PROPOFOL + ROCURONIUM / SUCCINYLCHOLINE**

**VIDEOLARYNGOSCOPY WITH STYLET / BOUGIE**

**ETT CUFF 1-2 cm BELOW VOCAL CORDS & Inflate BEFORE VENTILATION, CONNECT CIRCUIT**

**CONFIRM BY ETCO₂ & CHEST-RISE, SECURE WITH TAPE**

**DIFFICULT AIRWAY MANAGEMENT**

**Plan A : Tracheal intubation**
- Laryngoscopy
- Max 3 attempts
- Full NM blockade
- VL +/- Bougie / Stylet
- External laryngeal manipulation

**Plan B/C : Rescue Oxygenation**
- Second generation SAD and ventilate
- Face mask (use 2-person technique / adjuncts)
- Max 3 attempts each
- Change device / size / operator
- FONA set to be opened

**Plan D : Emergency Front Of Neck Access (FONA)**
- Use FONA set : Scalpel
- Cricothyrotomy
- Extend Neck
- NM blockade

**INTUBATION**

**DOs**
- Consider in all cases : High Risk Procedure
- Full PPE with Face Shield/ Goggles + Hand Hygiene
- Limit Personnel during Intubation
- Most Experienced Anaesthetist to Intubate
- Patient enters with Mask On
- Use Acrylic Aerosol Box with Transparent Sheet
- Keep Appropriate Size Lubricated Cuffed ETT Ready (if using Bougie, Prefload on ETT)
- 2-Handed 2-Person Mask Ventilation With VE-grip, not CE-grip
- Use HME Viral filter

**DON’Ts**
- Avoid BMV to reduce aerosols, if required use small TV & low flow
- Do not intubate before complete NM blockade
- Do not ventilate before cuff inflation
- Do not ventilate before cuff deflation

**EXTUBATION**

**Preparation**
- Assess patient’s risk & suitability for extubation, Minimize staff exposure, Staff involved should don PPE
- Analgesia, prophylactic anti-emetics, Xylocard / Fentanyl to minimize bucking / coughing / agitation
- Use aerosol box, perform Ryle’s tube suction and oral suction with caution

**Procedure**
- Use nasal prongs for O₂ supplementation, place a surgical mask on the patient, Staff members should confirm integrity of PPE
- Patient should be handed over to another member outside the room and the personnel involved in extubation should proceed to doffing, not accompany the patient
- Ventilation circuits, humidifiers, and CO₂ absorbent should be discarded after single use
- All anesthesia equipment & surface should be decontaminated before and after each procedure
- The room requires 30 min holding time after extubation
- When the anesthesia circuit needs to be disconnected from patient end, disconnect leaving HME filter attached to ET tube and clamp ET tube
- If laryngospasm occurs consider early use of drugs and minimize positive pressure ventilation by bag-mask
- If apnea occurs give bag-mask ventilation holding mask with 2 hands, assistant should do bagging, delivering low tidal volume & low pressure

**Post-Extubation Concerns**
- Airway Management Protocols during COVID

**CHECKLIST**
- Facemask – 2, 3, 4 & 5
- VL - CMAC / McGrath
- Direct Laryngoscope
- All blades including D
- Stylet and bougie
- ET (PVC) sizes – 5.5 to 8.5 mm ID
- Guedels and Nasal Airways
- I-gel, Proseal LMA
- HME / Viral filter
- Catheter mount
- Tube fixation
- Plastic cover/acrylic box
- Suction catheters : 12/14/16
- Closed suction catheter
- Suction machine
- Check ventilator settings
- Clamp for ET
- Monitoring : ECG, NIBP, SpO₂, ETCO₂
- Cricothyrotomy set : Scalpel, Bougie, size 6 cuffed ETT
- Ambu bag
- Nasal prongs

**DRUGS REQUIRED**
- Induction : propofol, etomidate, ketamine, fentanyl
- Muscle relaxant : Succinylcholine, rocuronium
- Atropine : 5 ml of 0.12 mg/ml
- Adrenaline : 10 ml of 1:100 conc.
- Vasopressors : Mephentermine / Norad
- 2% lignocaine jelly
- MDI – Asthalin inhaler
- Xylocard, Ondansetron