### HIGHLIGHTS

- **INTEGRATED COMPETENCIES FOR EVERY PHASE/STEP**
- **AIRBORNE PROTECTION FOR EVERY PHASE/STEP IN CRITICAL CARE SETTINGS IF POSSIBLE**
- **ANTICIPATE NEEDS, MAXIMIZE FIRST-PASS SUCCESS**

### DOUBLE-CHECK INDICATIONS FOR ENDOTRACHEAL INTUBATION

| Adopt Early Warning Scores for intubation/quotidiatum prognosis (consider DNR cases) |
| Identify Isolated room/ negative pressure environment if possible |
| Balance benefits of CPAP/BIPAP/NIV/HFNO versus risks of airborne diffusion |
| IF INTUBATION is required, prefer ELECTIVE procedure (in emergency >> patient risk) |

### TEAM PREPARATION

| Minimize the number of team members: |
| The most expert team member should perform the intubation and advanced airway control/ventilation (with donned PPE) |
| EXPERT assistant on protocols and devices (doctor/nurse with donned PPE) |
| Second doctor with donned PPE if complex maneuver/difficult airway is expected/ planned (INSIDE the chamber) |
| Doctor available with donned PPE (OUTSIDE the chamber) |
| PPE donning/doffing Observer (OUTSIDE) |

### PPE DONNING

Airway Management (including NIV) is considered aerosol generating procedure requiring airborne level protection, or the maximum available level of protection taking account of WHO/ECDC/ISS interim guidance for availability and rational PPE use.

### CLINICAL CHECKLIST (wearing PPE)

- **COMPLETE EVALUATION OF AIRWAYS AND OXYGENATION**
- **HEMODYNAMIC EVALUATION & PRE-EMPTIVE HEMODYNAMIC OPTIMIZATION**

### AIRWAY INSTRUMENTATION

- **HEPA FILTER ON EVERY OXYGENATION INTERFACE**
- **SUCTION: CLOSED SYSTEM**
- **ANTIFOGGING**
- **MEDICATIONS: PREPARED AND DOUBLE-CHECKED**
- **EMERGENCY CART READY (DISPOSABLE devices preferable)**

### AWEAK INTUBATION NOT INDICATED:

- **PREOXYGENATION**
  - 3min’ at TV FiO2=100%
  - or 1min’ at FVC 8 breaths FiO2=100%
  - or CPAP/PV 10 cmH2O + PEEP 5 cmH2O FiO2=100%
- **RII in all patients (limit BMV unless unavoidable and apply Cricoid Pressure only in case of ongoing regurgitation)**
- **NASAL PRONGS 1-3 lt/min FiO2=100% FOR APNOIC PHASE (NODESAT)**
- **FULL DOSE NEUMUSCULAR BLOCK RESPECT onset time for laryngoscopy**
  - 1’ LARYNGOSCOPY:
    - PREFER VIDEOLARYNGOSCOPE with separate screen
    - endotracheal tube pre-loaded on introducer
  - Re-oxygenate with low TV/pressure between attempts - Early switch (after failed second attempt) to supraglottic airway devices (prefer second generation - intubable SADs)
- **INTUBATION THROUGH SUPRAGLOTTIC AIRWAY DEVICES:**
  - flexible endoscope with separate screen (prefer DISPOSABLE)
- **EARLY CRICOTHYRATOMY IF CI-CO**

### AWEAK INTUBATION INDICATED (only if really mandatory):

- **AIRWAY TOPICALIZATION: no aerosol/vaporization**
- **PROTECTIVE SUIT Ø SHOES**
- **DOUBLE GLOVES (possibly in different colors)**
- **PROTECTIVE GOWN**
- **CLEAR SEPARATION OF CLEAN/CONTAMINATED pathways, adequate disposal**
- **DONNING/DOFFING OBSERVER EXTERNALLY CHECKING, INDIVIDUAL DONNING**

### ENDOTRACHEAL TUBE POSITION CONTROL - PROTECTIVE VENTILATION

- **CAPNOGRAPHIC CURVES** repeated and with standard morphology (if in doubt take it out)
- **AVOID useless circuit disconnections**
  - (if needed: ventilator on stand-by/clamp endotracheal tube)
- **CONSIDER indications for advanced techniques: ECMO - experts advise invasive ventilator support, an elective endotracheal intubation should be preferred over anticipated, rather than waiting for an emergency procedure (in the precipitating patient) as to minimize complications of intubation itself and also to reduce both the risks of procedural errors and the contamination of healthcare providers. Adoption of early warning scores (EWS), shared and predefined strategies, multidisciplinary team training and simulation of possible scenarios are highly recommended, taking also into account the available levels of care and feasibility of critical care levels of assistance in a non-ICU environment. The decisional elements for airway management, oxygenation and invasive ventilator support thus include competencies and organization and available human and environmental resources. Vigilance in prevention, strict adhesion of donning/doffing of PPE, preparedness for the care of infected patients remain priority and of utmost importance.**

### PPE DOFFING

- During and after PPE doffing, hands hygiene mandatory
- Donning/doffing observer externally checking, individual doffing
- Waste disposal

### TRANSPORT

- **Follow bio-containment regulations**

### COVID-19

One of the most critical issues regarding 2019 nCoV patients is the transitory phase between initial symptoms and potentially severe evolution requiring critical care, while taking into account the comorbidities. The choice of supplementary oxygen delivery interface and the decision to provide invasive ventilatory support is crucial. These decisions have the potential to determine outcomes and may lead to complications associated with critical care beds. Non-invasive support methods (CPAP, BIPAP, NIV, HFNO) might correct hypoxemia and counterbalance respiratory failure (though univocal data are missing) and may either delay or avoid entotraheal intubation (with potential complications and effects on outcome). Nevertheless, data from the SARS epidemic provide evidence showing that those ventilatory techniques might favor the risk of airborne viral spreading. Given the nature of nCoV-19 in terms of contagiousness, should the patient require, or be expected to necessitate