**A Practical Guide for Anesthesia Providers on the Management of COVID-19 Patients in the Acute Care Hospital**

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Appendix.

Appendix 1. **A Practical Example of an Airway Team at our Institution**

At Stony Brook University Hospital, the anesthesia department created a dedicated airway team that provided around-the-clock coverage divided into 12-hour day and night shifts. Each shift the airway team consisted of an attending anesthesiologist paired with two additional providers from a pool of senior anesthesia residents or certified registered nurse anesthetists. Team members were paired together and maintained as a group to provide shift coverage for 4-7 days at a time. Maintaining the same group of team members permitted development of a familiar team workflow and utilization of providers highly trained in donning and doffing PPE. Providers on the airway teams were preferentially protected from also covering operating room anesthesia services with the goal to minimize viral transmission from healthcare provider to the patient.

Given the high viral exposure risk during endotracheal intubation of COVID-19 patients and repeated exposure risk to the airway teams covering multiple shifts per week, PPE configuration was optimized with redundant protective measures. Airborne precautions were achieved via an N95 mask covered by a multi-use PAPR hood. Contact protection was achieved with a surgical gown, double gloves, and a transparent patient-belonging bag placed over the PAPR hood. The use of a belonging bag to cover the PAPR hood facilitated protection of the hood from soiling and showering to permit higher rates of PAPR hood reuse. Though an N95 was not necessary with a PAPR hood, the use of the N95 provided a redundant protection measure should the PAPR units fail given its high usage volume. Additionally, the N95 masks afforded protection when the PAPR hood was off in clean zones. The PAPR hood protected the N95 and thereby permitted ongoing reuse of the N95 respirator.

A checklist was developed for the patient’s covering nurse to facilitate prompt and complete setup of standard equipment. This included discussion with the patient and consent for intubation, gathering necessary equipment (wall oxygen flow meters, ambu-bag, PEEP valve, HEPA filter, Yankeaur suction catheter, propofol and norepinephrine infusions) and contacting respiratory therapy to set up a ventilator. Conduct of intubation occurred with 1-2 anesthesia providers at the bedside with an additional team member on standby outside the room to assist with passing supplies into the room or entering to assist with an unanticipated difficult airway.

In addition to routine intubation requests, the airway team expanded to assist with common ancillary tasks including tube exchanges for inspissating secretions causing tube obstruction, or cuff leaks from loss in cuff integrity after prolonged use. Additionally, the airway team provides assistance with turning patients prone by ensuring airway securement, providing guidance on the logistics of prone repositioning, or remaining on standby for an unplanned extubation.