COVID-19 POSITIVE AND PRESUMED POSITIVE CPR PROTOCOL

General Principles:

- All patients should have a clear designation of COVID-19 positive, COVID-19 suspected, COVID-19 not suspected, COVID-19 negative made clear on their chart.
- If CPR appropriate, **EARLY ICU consult for COVID-19 positive or presumed positive and clinical deterioration**
- ACLS with outlined modifications below
- Recognition that **intubation, bag mask ventilation and chest compressions** are aerosol generating and **require airborne PPE**
- If cardiac arrest **during intubation** secure airway prior to starting CPR; otherwise chest compressions and rapid identification of VT/VF take precedence

Assessment

Initial exam to confirm if a code blue should be activated	• **DON Airborne precautions prior to patient contact** • Visually inspect for absence of signs of life (respiratory effort/chest rise) • Do not auscultate for breath sounds or listen/feel for breath sounds by approaching patient's airway • Palpate femoral or brachial pulse to confirm cessation of cardiac activity • Do not bag mask ventilate patient • Cover airway with BVM plus high efficiency hydrophobic filter or clear plastic cover or facemask **THEN** initiate chest compressions • Communicate CODE status and COVID-19 status to code team

Code Team

Team Members/Role	• 1 RT, 2 Code RN, Physician team leader, Airway expert • Airway to be managed by best possible operator (Staff Anesthesia first choice, ICU staff/Fellow/Clinical Associate if Anesthesia unavailable) • Code team to wear airborne PPE prior to entering room • If available, one additional physician to be outside the room donned in PPE as backup if needed • Minimize code team personnel

ACLS Management

Considerations to protect against virus transmission	• Early defibrillation may prevent need for airway and ventilator support • Place BVM with high efficiency hydrophobic filter interposed between mask and Ambu bag on patient ASAP→ **do not ventilate patient** • Airway management by expert, video laryngoscopy preferred • **Pause** CPR for intubation • Consider **early application of LUCAS device** to limit staff exposure • Clamp ETT prior to circuit disconnect/connecting to ventilator

Transport/Return of Spontaneous Circulation (ROSC)

Post ROSC care	• Communication with ICU regarding disposition and timing of transfer • Avoid CXR/ECG until ICU • Team to DOFF, then DON new PPE prior to transfer of patient as assumed to be heavily contaminated following resuscitation • Ensure all contaminated equipment disposed of or cleaned • Ensure a clear path to ICU destination

Authors: Sonny Thiara, Ruth MacRedmond, George Isac, Mypinder Sekhon, Erik Vu, Craig Fava, Kali Romano, Adam Thomas