Guidance for Management of Anesthesia & Airway Devices
Using Enhanced Infection Control Measures

1. **Preparation of OR**: Preoperative preparation of the OR should be carried out as usual, with the addition of the following items:
   a. **Sealed specimen bag** (for used laryngoscope & facemask), this will be on your anesthesia tray. Use either 1 or 2 bags depending on the size. See pictures below.
   b. **Large cassette/plastic bag** (for used items that come into contact with the airway, e.g.: oropharyngeal airway, temp probe, bite block, OG/NG tube, suction, used ETT) – this needs to be fixed to the head of the bed (with tape if needed) on the sheet, not on the metal frame of the bed. See pictures below.
   c. **Pre-prepared long pieces of tape to secure the ETT**. Please do not use a roll of tape as this cannot be placed back afterwards.

2. **PPE during Airway Management**:
   a. For intubation
      i. PPE for anesthesia provider: N95 respirator + eye protection + double gloves
      ii. PPE for nursing staff/assistant: N95 respirator + eye protection + double gloves
   b. For insertion of LMA/i-gel®
      i. PPE for anesthesia provider: N95 respirator + eye protection + double gloves
      ii. PPE for nursing staff/assistant: N95 respirator + eye protection + gloves

3. **Induction of Anesthesia**:
   a. For intubation
      i. **RSI for every patient**, no mask-ventilation, preoxygenate as usual
      ii. **Immediately** following intubation
         - Used laryngoscope should be placed into a specimen bag and sealed.
         - ETT cuff inflated BEFORE applying PPV
      iii. Outside/dirty gloves disposed of immediately after securing ETT
   b. For insertion of LMA/i-gel®
      i. **RSI for every patient**, no mask ventilation, preoxygenate as usual
      ii. Insert LMA as usual
      iii. Outside /dirty gloves disposed of immediately after securing LMA

4. **Post-Intubation**:
   a. Please ensure drugs/syringes are not placed onto the anesthesia workstation/tray, these should remain separate from possible contamination of used airway equipment.

5. **End of case & Extubation**:
   a. Plan routine extubation/removal LMA planning
   b. Ensure full NMB recovery
   c. Antiemetics recommended
   d. Consider using a blue chuck or towel to cover the patient’s mouth during extubation (as a barrier for aerosolization)
   e. Dispose of used disposable supplies (ETT, temp probe, bite block, OPA, NG/OG tube, suction) using the dirty contaminated bag
   f. The bag can then be rolled up and discarded.
   g. Do NOT throw away laryngoscopes, keep in sealed specimen bag in OR for anesthesia technician collection. If anesthesia technician not available, please follow decontamination guidelines for McGrath:
      i. Lay out a clean towel for drying; have Alcohol based wipes available (Purple Top, Super Sani-Cloth)
      ii. Remove the Battery
      iii. Wipe every bit of handle, blade, and lens; then the battery
      iv. Place on towel to air dry for at least 2 minutes
      v. Re-insert battery & test
      vi. BIDMC policy and procedure:
         1. Add a Mac-3 Blade, keeping cover over disposable blade
         2. Place into clean, clear bag and tie to indicate ready for use

Suggested set up & disposal
Place used laryngoscope & facemask into specimen bag during the case. They can be retrieved intra-operatively if needed. If you have a single large bag, place the laryngoscope inside the bag and the facemask in the outer pocket.

Set up cassette bag at the end of the bed pre-op. Place used suction, temp probe, OPA, bite block, OG/NGT & facemask into specimen bag at the end of the case.

At the end of the case, the cassette bag & contents can be rolled up and discarded.

Please note!
These steps are in an effort to minimize transmission of oral secretions which can spread across the entire anesthesia workstation within 6 minutes of starting a case. Image from https://www.apsf.org/article/hca-infections-can-the-anesthesia-provider-be-at-fault/. Invisible fluorescent dye (secretly painted in the “patient’s mouth”) was traced to an alarming multitude of anesthesia work surfaces within six minutes of the start of anesthesia (each star indicates contamination by the oral tracer). Birnbach DJ, Rosen LF, Fitzpatrick M, et al. Double gloves: a randomized trial to evaluate a simple strategy to reduce contamination in the operating room. Anesth Analg 2015;120:848–52.