MAYO
CLINIC

Extubation Protocol (OR/Procedural) for COVID-19 Positive or PUI Patient

1. If appropriate, consider transferring patient intubated to next care location (e.g., ICU).
2. Adult patients transferring to ICU should ideally have 7.5 ETT or larger.
3. If extubation is indicated, ideally perform in negative-pressure (AAIR) room.
4. Only essential people should be in the room.
5. Don appropriate PPE, including N95 or PAPR, and double glove prior to extubation. A second anesthesia provider is helpful to assist, and control disposal of used equipment. Team members check each other for safety.
6. Turn off ventilator and depressurize circuit, removing any PEEP.
7. Place a towel around the ETT and mouth, deflate cuff, pull ETT through towel keeping mouth covered.
8. Place anesthesia mask over the patient's mouth and nose until patient is stable.
9. Note the time when air circulation will turn over at least 7 times (see Air Exchange Turnover Summary) following AGP. If staff need to enter before this time, they should also wear a N95 or PAPR.
10. Staff may exit the room if necessary assuming they do not plan to return. The risk of discharging aerosol into the hallway is minimal.
11. Physiologic coughing is not an AGP and does not restart the waiting period.
12. Transition to placing a surgical mask over the patient's mouth and nose.
13. Patients should not be taken out of the room earlier than 5 minutes following extubation. It is often appropriate to stay in the room longer while the patient's condition stabilizes. Minimize the time the door is opened to transport the patient.
14. Exit room and remove PPE. Help each other with good technique to avoid self-contamination.
15. Patient wears procedure mask.
16. After the patient leaves the room, keep the door closed until the 7 air exchanges are concluded. Remember that the clock started at the end of the last AGP, not when the patient leaves the room.