Adult CPR Protocol for Suspect and Confirmed Cases of COVID-19

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***For Critical Care Managed Codes (local practice may differ – refer to your local protocol)**

General Principles:

- The charts of **suspect** and **confirmed** cases of COVID-19 should be clearly labelled.
- If CPR is deemed appropriate, **immediately consult ICU team** for all suspect and confirmed cases of COVID-19 with clinical deterioration.
- Perform Advanced Cardiac Life Support (ACLS) with modifications as outlined below.
- Procedures such as **intubation, bag mask ventilation and chest compression** are considered aerosol generating medical procedures (AGMP) and as such require appropriate airborne precautions and PPE. (http://www.bccdc.ca/Health-Info-Site/Documents/Respiratory-protection-COVID19.pdf).
- If a patient suffers a **cardiac arrest during intubation,** secure the airway **prior** to initiating chest compressions and rapid identification of VT/VF.

Assessment	
Initial exam to confirm if a code blue should be activated	• DON appropriate PPE **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 • 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 (where available) • Airway to be managed by best possible operator (staff anesthetist - first choice; ICU staff, ERP, fellow, or clinical associate if anesthetist unavailable) • Code team to don airborne PPE prior to entering room • If available, one additional physician or RN 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 • Team to consider **not initiating resuscitation** i**f concern of futility** • 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 if available • 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

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