Guidelines for Intubation in the 3 West Surgical Intensive Care Unit

- All intubations in the 3WSICU will be performed under the **DIRECT** supervision of a Trauma/SICU Attending

- If a Trauma/SICU Attending is not immediately available, the Airway Management should be notified

- EARLY Airway Management involvement should also be considered in the following circumstances:
    - Documented cervical spinal cord injury or patients who are immediately postop from cervical surgery
    - Morbidly obese patients
    - Presence of stridor
    - Previously documented "difficult" airways
    - Active airway hemorrhage

- Prior to any attempt at intubation, the following should be performed:
    - Provision of supplemental oxygen
    - Ensuring adequate IV access
    - Notification of Trauma/SICU Attending and Respiratory Therapy
    - Maintain airway patency
        - Jaw-thrust vs. head-tilt chin lift
        - Insertion of an appropriately sized airway adjunct
    - Airway assessment
        - **T**eeth
        - **U**vula
        - **M**andible
        - **S**pine
    - Pre-oxygenation
    - For patients receiving gastric tube feeds, feeds should be immediately held and the gastric tube placed on suction
    - Patient and provider positioning
        - Remove headboard
        - Move patient bed away from wall

- Roles and Responsibilities (see Table)

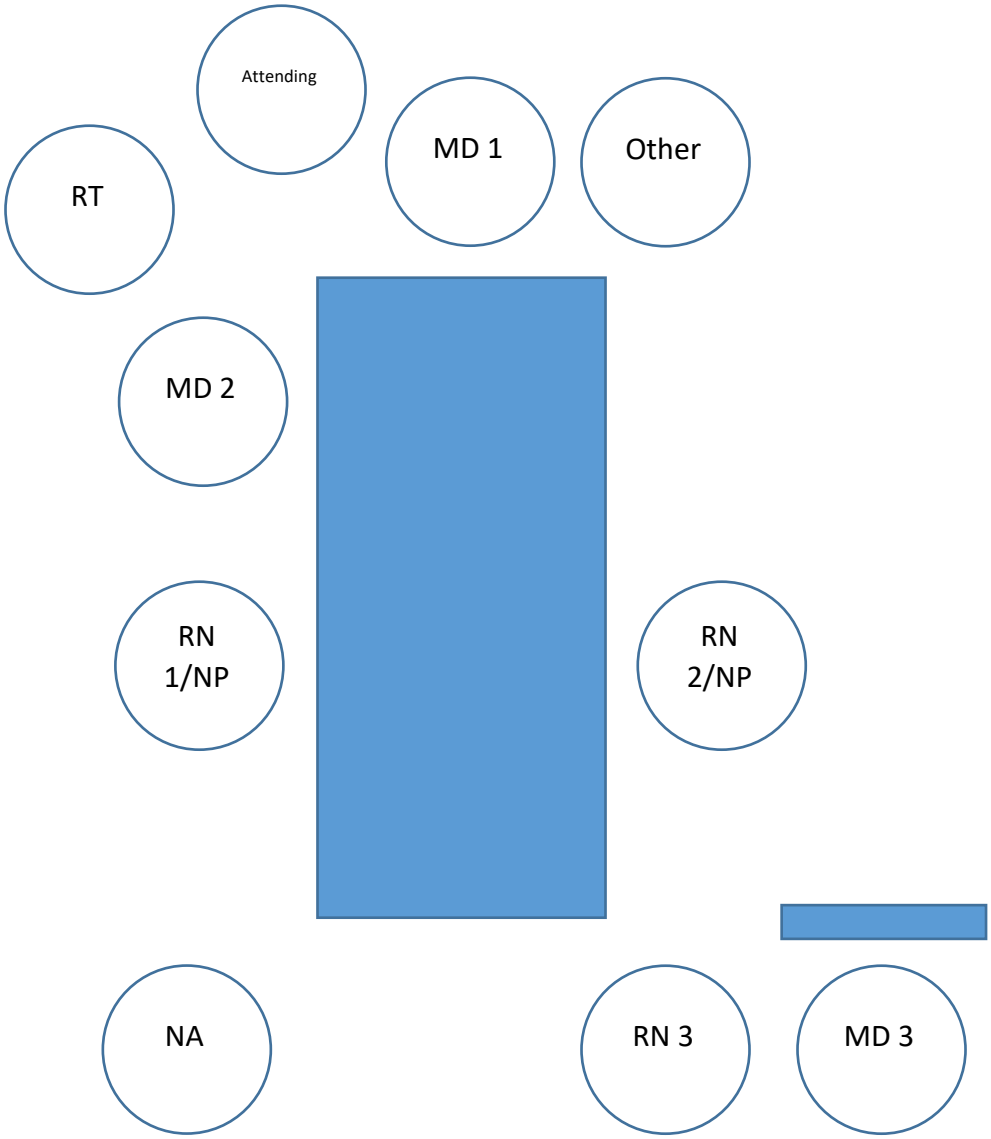
- A rescue or backup device MUST be present for all attempted intubations

- Rapid Sequence Intubation (RSI) will be performed in patients requiring a definitive airway

- Commonly used medications include:
    - Etomidate (0.3mg/kg IV)
    - Succinylcholine (1.5 mg/kg IV) *UNLESS contraindicated*
        - Severe burns or electrical injuries
        - Severe crush injuries/rhabdomyolysis
        - Hyperkalemia
        - Chronic renal failure
        - Chronic paralysis or neuromuscular disease
    - In such cases, rocuronium (1mg/kg IV) or vecuronium (0.1mg/kg) should be considered

- Following successful intubation and securing of the airway, the following should be performed:
    - Debrief with team members
    - Insertion of an orogastric (OG) or nasogastric (NG) tube
    - Order a chest x-ray
    - Confirm ETT and gastric tube placement
    - Orders for mechanical ventilation
    - Orders for sedation, analgesia, and neuromuscular blockade
    - ABG analysis (adjust ventilator setting based on results)
    - Appropriate documentation
        - Indication for intubation
        - Supervising attending
        - Grade of airway
        - Number of attempts
        - Mode of intubation (ie. Direct laryngoscopy, Bougie-assisted, etc.)
        - Size of ETT
        - Depth of tube
        - Mode of confirmation
        - Complications
        - Position of ETT on CXR

3W SICU/CTU Intubation Protocol



Roles and Responsibilities

Title	Role	Responsibilities
Physician/NP		
Attending	Team Leader/Airway	Organize team Ensure R&R understood Supervise intubation Lead debriefing
MD 1	Intubator/Airway	Assess airway Provide assisted ventilation Ensure proper setup and equipment availability Communicate findings to team
MD 2/NP	Airway	Perform cricoid pressure or BURP prn
MD 3	Scribe	Assess PMHx, weight, most recent labs Input orders
Nurses/NP		
RN 1/NP	Primary/Bedside Provider	Patient and bed positioning Ensure adequate IV access Push RSI meds Insert NG/OG tube post-intubation
RN 2/NP	Secondary Provider	Obtain RSI medications Assist with meds (vasopressors, fluids, sedation, and analgesia)
RN 3	Scribe	Document timing of meds, doses, and sequence of events
Respiratory Therapist	Airway	Assist with airway management Provide assisted BVM Setup nasal cannula for apneic O2 EtCO2 Secure ETT In-line suctioning Ventilator setup
Nursing Attendant	Runner	Obtain airway tray Ensure availability of backup devices
Other	Airway	Perform in-line C-spine immobilization