NWC EMSS Skill Performance Record

DRUG-ASSISTED VIDEO LARYNGOSCOPY INTUBATION

Name:	1st attempt:	☐	Pass	☐ Repeat
Date:	2nd attempt:	☐	Pass	☐ Repeat

Instructions: An awake adult has severe dyspnea and exhaustion from HF or asthma. Prepare equipment and intubate using DAI procedure.

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique , no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
* Takes or verbalizes BSI precautions: gloves, goggles, facemask		
Prepare patient ☐ **Position** patient for optimal view and airway access ☐ Open the airway manually; *insert BLS adjuncts: NPA or OPA unless contraindicated		
Assess for signs suggesting a difficult intubation: neck/mandible mobility, oral trauma, loose teeth; F/B; ability to open mouth, Mallampati view, thyromental distance; overbite		
Assess SpO_2 on RA if time and personnel allow; auscultate breath sounds for baseline		
Preoxygenate 3 minutes: ☐ **Apply $ETCO_2$ NC 15 L**; maintain during procedure – PLUS: ☐ IF RR ≥10; good tidal volume: O_2 15 L/NRM (need 2nd O_2 source) ☐ IF RR <10 or shallow: O_2 15 L/BVM ; (need 2nd O_2 source); squeeze bag over 1 sec providing just enough air to see visible chest rise (~400-600mL); avoid high airway pressure (≥25cm H_2O) & gastric distention. Ventilate at 10 BPM (1 every 6 sec) to SpO_2 94% (Hx asthma/COPD: 6-8 BPM to SpO_2 92%). If SpO_2 does not meet this goal, contact OLMC. ☐ If only 1 O_2 source; sense $ETCO_2$ through NC (no O_2); deliver O_2 through BVM until procedure starts. Then switch O_2 source to NC and run throughout ETI insertion.		
Selects, checks, assembles equipment		
Have everything ready before placing blade into mouth ☐ Prepare suction equipment (DuCanto rigid and 12-14 Fr flexible catheters); turn on to ✓ unit ☐ King Vision device & blade (curved channeled) ☐ ETT 7.0 & 7.5 (must fit into channeled blade) ☐ Bougie; 10mL syringe, water-soluble lubricant ☐ $EtCO_2$, SpO_2, ECG monitor; commercial tube holder, head blocks or tape, BP cuff; stethoscope ☐ Have alternate airway selected, prepped, & in sight (i-gel)		
* Check ETT cuff integrity while in package; fill syringe w/ 10 mL of air; leave attached to pilot tubing		
Place lubricant inside channel of King vision Blade		
* Assemble King Vision; ensure it is operational. Load ET tube into lubricated channel; load bougie inside tube. Ensure tube and bougie do not extend past channel in blade.		
Premedicate if applicable Fentanyl per SOP for pain (not necessary if ketamine used for sedative)		
Sedate: Optimum sedation must be achieved prior to ETI (absence of gag reflex suggested by lack of eyelash reflex or response to a glabellar tap; easy up and down movement of the lower jaw, no reaction to pressure applied to both angles of the mandible). Allow for clinical response to sedative prior to inserting airway. ☐ ***Ketamine** (preferred) 2 mg/kg slow IVP (over one min) or 4 mg/kg IM or IN ☐ ***Etomidate** 0.5 mg/kg IVP (max 40 mg) if ketamine contraindicated or unavailable		
Pass tube:		
☐ Maintain O_2 15 L/$ETCO_2$ NC during procedure ☐ Assistant or examiner stops ventilating pt; withdraw OPA (NPA remains) ☐ Monitor VS, level of consciousness, skin color, $ETCO_2$, SpO_2 q. 5 min. during procedure; time elapsed		
START TIMING tube placement after last breath_____ ☐ Open mouth w/ cross finger technique ☐ *Insert King Vision blade midline over tongue (holding blade just above channeled portion, not on large handle portion below screen) until epiglottis is visualized		

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☐ *Seat blade in vallecula; DO NOT LIFT! (non-displacing device) Visualize epiglottis, posterior cartilages, and/or vocal cords.		
***Insert bougie into trachea** Advance bougie through glottis under direct visualization. If needed, twist bougie, like a pencil, to left or right to guide between cords. Avoid forceful insertion – can cause tracheal trauma/perforation. ***Confirmation of bougie placement into trachea** ☐ Clicking/vibration sensation felt (60-95% of cases) when bougie tip rubs against anterior tracheal rings (tip must be oriented anteriorly) ☐ If inserted into esophagus, no clicking/vibration is felt and tip easily advances well beyond 40 cm		
***Insertion of ET tube** ☐ Maintain view with King Vision in place and advance ETT over bougie and through glottis ☐ Rotate ETT to facilitate insertion through cords into trachea if resistance met at glottic opening or cricoid ring.		
***If > 30 sec: of apnea**; remove King Vision, reoxygenate X 30 sec. If pt remains good candidate for ETI, suction, and attempt again. May go straight to alternate airway (i-gel) if unable to visualize anything.		
*Once ETT inserted to proper depth (3X tube ID at teeth), firmly hold ETT in place, remove from channel by taking tube to corner of mouth. Carefully remove blade from mouth and bougie from ETT.		
* **Confirm tracheal placement:** ☐ Ensure adequate ventilations & oxygenation: 15 L O_2 /BVM; ventilate at 10 BPM (asthma/COPD 6-8 BPM); volume & pressure just to see chest rise; auscultate stomach, both midaxillary lines and anterior chest X2 ☐ **Definitive confirmation**: **monitor $ETCO_2$** number & waveform. ☐ **Time of tube confirmation**: (Seconds of apnea)_____		
Troubleshooting ☐ *If breath sounds only on right, withdraw ETT slightly and listen again. ☐ *If in esophagus: remove ETT, reoxygenate 30 sec; repeat from insertion of blade with new tube ☐ *If ETT cannot be placed successfully (2 attempts) or nothing can be visualized; attempt extraglottic airway.		
If tube placed correctly ☐ *If breath sounds present and equal bilaterally**, inflate cuff** w/ up to 10 mL air to proper pressure (minimal leak - avoid overinflation); & remove syringe ☐ Note ETT depth: diamond level w/ teeth or gums (3 X ID ETT) ☐ * Insert OPA; align ETT with side of mouth; secure with commercial tube holder; apply lateral head immobilization ☐ Continue to ventilate at 10 BPM (asthma 6-8); $ETCO_2$ 35-45; O_2 to SpO_2 94% (92% COPD)		
If secretions in tube or gurgling sounds with exhalation: suction prn per procedure ☐ Select a flexible suction catheter; mark maximum insertion length with thumb and forefinger ☐ Preoxygenate patient; insert sterile catheter into the ET tube leaving catheter port open ☐ At proper insertion depth , cover catheter port and apply suction while withdrawing catheter ☐ Limit suction application time to 10 sec. Ventilate patient (NO SALINE FLUSH).		
* **Reassess**: Frequently monitor SpO_2, $EtCO_2$, tube depth, VS, & lung sounds to detect displacement, complications (esp. after pt movement), or condition change. If intubated & deteriorates, consider**:** **D**isplacement of tube, **O**bstruction of tube, **P**neumothorax, **E**quipment failure (DOPE)		
Post-intubation sedation and analgesia (PIASA): Assess RASS (below) ☐ If inadequate sedation & SBP ≥ 90 (MAP≥ 65): **KETAMINE** 0.3 mg/kg slow IVP every 15 min or MIDAZOLAM standard dose for sedation ☐ If pt restless, tachycardic, consider need for pain medication (if ketamine not used to sedate).		
State complications of the procedure: ☐ Post-intubation **hyperventilation**: Use watch, clock, timing device; titrate to $ETCO_2$ ☐ **Barotrauma:** pneumothorax & tension pneumothorax; esophageal perforation ☐ Trauma to teeth or soft tissues ☐ Undetected esophageal intubation ☐ Mainstem intubation ☐ Hypoxia, dysrhythmia ☐ **Over sedation**		
***Critical Criteria: Check if occurred during an attempt (automatic fail)** ☐ Failure to initiate ventilations w/in 30 sec after applying gloves or interrupts ventilations for >30 seconds at any time ☐ Failure to take or verbalize body substance isolation precautions ☐ Failure to voice and ultimately provide high oxygen concentrations [at least 85%] ☐ Failure to ventilate patient at appropriate rate, volume or pressure: max 2 errors/min permissible		

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☐ Failure to pre-oxygenate patient prior to intubation and suctioning		
☐ Failure to successfully intubate within 2 attempts without immediately providing alternate airway		
☐ Failure to disconnect syringe **immediately** after inflating cuff of ET tube		
☐ Failure to assure proper tube placement by capnography and auscultation of chest bilaterally **and** over the stomach		
☐ Inserts any adjunct in a manner dangerous to the patient		
☐ Suctions patient excessively or does not suction the patient when needed		
☐ Failure to manage the patient as a competent paramedic		
☐ Exhibits unacceptable affect with patient or other personnel		
☐ Uses or orders a dangerous or inappropriate intervention		

Factually document below your rationale for checking any of the above critical criteria.

_____

_____

Scoring: All steps must be independently performed in correct sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the person to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Rating: (Select 1)

☐ **Proficient**: The paramedic can sequence, perform and complete the performance standards independently, with expertise and to high quality without critical error, assistance or instruction.

☐ **Competent:** Satisfactory performance without critical error; minimal coaching needed.

☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

CJM 4/19

_____

Preceptor (PRINT NAME – signature)

The **Richmond Agitation Sedation Scale (RASS)** assesses level of alertness or agitation
Used after placement of advanced airway to avoid over and under-sedation

Combative	+4	Agitated	+2	Alert and calm	0	Light sedation	-2	Deep sedation	-4
Very agitated	+3	Restless	+1	Drowsy	-1	Moderate sedation	-3	Unarousable sedation	-5

Goal: RASS -2 to -3. If higher (not sedated enough) assess for pain, anxiety. Treat appropriately to achieve RASS of -2.