Airway Bundle Checklist (FRONT and BACK)

Date: ______________ **[Place patient sticker/stamp here]**

Time: ______________

Front page completed (check all that apply):

☐ On admission ☐ During rounds ☐ After Rounds ☐ Just prior to intubation ☐ Prior to Extubation

By ____

Assessment for ANTICIPATED Airway Management

Intubation Risk Assessment

Difficult Airway	**History** of difficult airway?	YES	NO
	Physical? (e.g. small mouth, small jaw, large tongue, or short neck)	YES	NO
At Risk For:	High risk for rapid **desaturation** during intubation	YES	NO
	Increased ICP, pulmonary hypertension, need to avoid **hypercarbia**	YES	NO
	Unstable hemodynamics (e.g. hypovolemia, potential need for fluid bolus, vasopressor, CPR)	YES	NO
	Other risk factors? ______________________________	YES	NO

Planning (all risk noted above should be considered in plan)

Who will intubate? (Specify primary provider who will perform **first** laryngoscopy):

☐ Resident ☐ Fellow ☐ NP ☐ Attending ☐ Anesthesiologist ☐ ENT physician ☐ RT ☐Other - Specify below:

____

Who will bag-mask? ☐ Resident ☐ Fellow ☐ NP ☐ Attending ☐ RT ☐ Other (Specify) ______________

How will we intubate? **Method:** ☐ oral vs.☐ nasal **ETT Type:** ☐ Cuffed ☐ Uncuffed

ETT Size: ☐ 3.0 ☐ 3.5 ☐ 4.0 ☐ 4.5 ☐ 5.0 ☐ 5.5 ☐ 6.0 ☐ 6.5 ☐ 7.0 ☐ 7.5 ☐ 8.0 ☐Other: ____

Device: ☐ Laryngoscope ☐ LMA _____ ☐ Glidescope _____ ☐ Other: ____________

Blade: ☐ Mac ______ ☐ Miller _______ ☐ Wis-Hipple _______

Meds: ☐ Atropine ____mg ☐ Glycopyrrolate ____mcg

☐ Fentanyl ____mcg ☐ Midazolam ____mg ☐ Ketamine ____mg ☐ Propofol _____mg

☐ Rocuronium _____mg ☐ Vecuronium ____mg

Apenic Oxygenation: YES / NO _____ L/min (<1y = 5L; 1-7y = 10L; $\geq$8y = 15L)

Other: ____

When will we intubate? (describe the timing of airway management):

☐ Prior to procedure at:_______ ☐ Mental Status Changes ☐ Hypoxemia refractory to CPAP: SpO2 < _____%

☐ Ventilation failure refractory to NIV ☐ Loss of Airway Protection ☐Other: ______________________

____

Backup? Advanced Airway Provider: ☐ Attending ☐ Anesthesia ☐ ENT ☐ Fellow ☐Other: ____________

☐ Difficult Airway Cart ☐ Difficult Airway Emergency Page ☐ Other:______________________________

____

☐ **Front page not filled out: Why?** ____

ver. 5

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Immediate Pre-Intubation Procedure TIME OUT

Date: ____________
Time: ____________
(Complete immediately before intubation)

☐ **Right Patient**: Confirm 2 identifiers and allergy status. Did the patient eat or drink in the last 6 hours?
☐ **Right Plan**: Review and revise the FRONT PAGE plan
☐ **Right Prep**: Patient accessible and positioned correctly, bed cleared for intubation, working IV?
☐ **Right Equipment**: SOAP (e.g Suction, Oxygen, Airway, Personnel), IV fluid bolus readily available?
☐ **Right Monitoring**: BP cycling frequently, different extremity from pulse ox, pulse ox volume?
☐ **Right Rescue plan**: Difficult Airway cart/kit and equipment available? Who can we call for assistance? ***Double press ASCOM Alert Button, or call Emergency# 4CODE*** ***State: "Stat Airway Emergency" (Provide Location)***
☐ **Right Attitude**: State out loud: **"IF anybody has a concern at any time during the procedure please SPEAK UP."**

Other PATIENT SPECIFIC preparation:

Post-Procedure TIME OUT

☐ **All team members performed well without technical/communication challenges.**

Or

Briefly describe below (comments by provider)

	What did we do well?	What can we improve upon?
1. RT		
2. Nurse		
3. Resident		
4. NP/PA		
5. Fellow		
6. Attending		

ETT Cuff adjusted to minimal leak: YES / NO

Goal SBS ______ (- 3 to +2)

Was the patient difficult to ventilate? YES/NO

Was the Patient difficult to Intubate? YES/NO

If Yes to either question please remember to put an ALERT in Epic and a SIGN at the bedside.

Back page completed by (PRINT): ____

Intubated by: ____

☐ **NEAR4Kids data form completed after intubation?**

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