

Airway Bundle Checklist (FRONT and BACK)

Date: _____

Time: _____

Front page completed: ☐ On admission ☐ During rounds ☐ After Rounds ☐ Just prior to intubation
☐ After intubation ☐ Prior to Extubation

By _____

☐ Front page not completed - emergent intubation (within 1st hour of admission)

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**Apneic Oxygenation:** Yes No _____L/min (<1 y = 5L; 1-7y = 10 L; > 8 y = 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: _____

Immediate Pre-Intubation Procedure TIME OUT

Date: _____

Time: _____

(Complete immediately before intubation)

<input type="checkbox"/> Right Patient: Confirm 2 identifiers and allergy status.
<input type="checkbox"/> Right Plan: Review and revise the FRONT PAGE plan
<input type="checkbox"/> Right Prep: Patient accessible and positioned correctly, bed cleared for intubation, working IV?
<input type="checkbox"/> Right Equipment: SOAP (e.g Suction, Oxygen, Airway, Personnel), IV fluid bolus readily available?
<input type="checkbox"/> Right Monitoring: BP cycling frequently, different extremity from pulse ox, pulse ox volume?
<input type="checkbox"/> Right Rescue plan: Difficult Airway cart/kit and equipment available? Who can we call for assistance?
<input type="checkbox"/> Right Attitude: State out loud: "IF anybody has a concern at any time during the procedure please SPEAK UP."

Has the patient had anything to eat or drink in the last 6 hours? YES / NO

Other PATIENT SPECIFIC preparation:

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Post-Procedure TIME OUT

What did we do well? What can we improve upon?

☐ No CQI Issues

Feedback:

1. RT	
2. Nurse	
3. Resident	
4. NP/PA	
5. Fellow	
6. Attending	

ETT Cuff adjusted to minimal leak: YES / NO

Sedation Goal _____

Was the patient difficult to ventilate? YES/NO

Was the Patient difficult to Intubate? YES/NO

Back page completed by (PRINT): _____
Intubated by: _____
<input type="checkbox"/> NEAR4Kids data form completed after intubation?