[Please place patient sticker here]

To be completed by study team:
days (age)_____(intubated) _____ (PICU)_____
Center Unique Identifier: _____Encounter # _____ PIM2:_____
Course #(s):_____

NEAR4KIDS QI Collection Form

ENCOUNTER INFORMATION

Patient Information

Airway Bundle/Pink sheet Completed – front AND back: _____

Date: _____ **Time:** _____ **Location:** _____

Patient Gender: _____ **Patient Dosing Weight (kg):** _____

Form Completed By (please print): _____ **Pager #:** _____

Family Member Present? **Attending Physician Present?**

INDICATIONS

INITIAL INTUBATION

Check as many as apply:

CHANGE-OF-TUBE

Type of Change:

From: _____

To: _____

Nature of Change:

Check as many as apply:

Diagnostic Category (Check as many as apply):

(Not part of medical record call x5193 if found)

An "**ENCOUNTER**" of advanced airway management refers to complete sequence of events leading to a placement of an advanced airway
A "**COURSE**" of advanced airway management refers to ONE method or approach to secure an airway **AND** ONE set of medications (including premedication and induction).
Each course may include one or several "attempts" by one or several providers.
An "**ATTEMPT**" **is a single advanced airway maneuver (e.g. tracheal intubation, LMA placement), beginning with the insertion of a device, e.g. laryngoscope (or LMA device) into patient's mouth or nose, and ending when the device (laryngoscope), LMA or tube is removed**.

COURSE INFORMATION

Attempts for this COURSE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Who intubated (Fellow, Resident, etc)								
Discipline (ICU, ENT, Surgery, etc)								
PGY level (3rd year resident = PL3, 1st year fellow = PL4, NP=yrs as NP, etc.)								
ETT (or LMA) size								
ETT type: cuffed/uncuffed/ NA								
Immediately prior to this attempt was cricoid pressure/external laryngeal manipulation provided?								
During this attempt, was cricoid pressure/external laryngeal manipulation provided?								
Attempt Successful: Yes / No								

Difficult to Bag – Mask Ventilate? (Circle ONE only):	

(Not part of medical record call x5193 if found)

Difficult Airway Evaluations (Choose/Circle one in each category):

1. Evaluation done **before** or **after** this course is completed?	
2. Known prior history of difficult airway?	
3. Any Limited Neck Extension or (Maximal with or without sedation/paralytics) Severe Reduction (e.g. trauma patient with collar)	
4. Widest Mouth Opening – How many *Patient's* fingers between gum/incisors	
5. Thyromental space – Patient's fingers between chin and thyroid cartilage	
6. Evidence of Upper Airway Obstruction or Anatomical Barrier to visualize glottic opening (Subjective assessment before looking)?	
7. Midfacial Hypoplasia?	
8. Any other signs of difficult airway exist?	
If **YES** Please Explain:	

Known cyanotic heart disease (R to L shunt)?: **(Circle ONE only)**	

Medications:

☐ NO DRUGS USED (If no drugs used, select box and go to next section)

Pretreatment Dosage	**Paralysis Dosage**	**Induction Dosage**
[_____] **mg** Atropine (check unit!)	[_____] mg Rocuronium	[_____] mg Propofol
[_____] mcg Glycopyrrolate	[_____] mg Succinylcholine	[_____] mg Etomidate
[_____] mcg Fentanyl	[_____] mg Vecuronium	[_____] mg Ketamine
[_____] mg Lidocaine	[_____] mg Pancuronium	[_____] mg Midazolam
[_____] mg Vecuronium	[_____] mg Cisatracuronium	[_____] mg Thiopental
Others:	**Others:**	**Others:**

Atropine Indication: _____

Glycopyrrolate Indication: _____

Method: Begin NEW course if NEW method / device used (please use new form):

Airway Management Technique and/or Corresponding Medication Protocol:

Apneic Oxygenation Use:

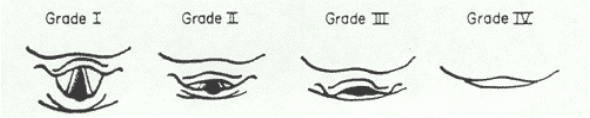
1. Was Oxygen provided **DURING** any TI attempts for this course?	
2. If Yes, How was the oxygen provided:	

		Liter Flow	**FiO2**
	NC without nasal airway		
	NC with nasal airway		
	Oral airway with oxygen port		
	Through LMA		
	HFNC		
	NIV with nasal prong interface – provide PEEP/PIP		
	Other (device, FiO2, Setting):		

(Not part of medical record call x5193 if found)

Device (Check only ONE) Begin NEW course if NEW method / device used.

Tracheal Intubation Confirmation [Check ALL that apply]



Glottic Exposure During Intubation [Check only ONE]:	

Tracheal Intubation Associated Events (Check ALL that apply: LINK it to attempt #):

	EVENTS	ATTEMPT #		EVENTS	ATTEMPT #
	NONE			Epistaxis	
	Cardiac arrest – patient died			Dental trauma	
	Cardiac arrest – patient survived			Lip trauma	
	Main stem intubation			Laryngospasm	
	Esophageal intubation, immediate recognition			Malignant hyperthermia	
	Esophageal intubation, delayed recognition			Medication error	
	Vomit with aspiration			Pneumothorax / pneumonmediastinum	
	Vomit but No aspiration			Direct airway injury	
	Hypotension, needs intervention (fluids/pressors)			Dysrhythmia (includes Bradycardia<60/min)	
	Hypertension, requiring therapy			Pain/Agitation, req'd additional meds AND delay in intubation	
	Other (Please describe):				

Monitoring Of Vital Signs (Confirm with telemetry / monitoring records):

Pulse oximetry (%):	Highest Value immediately prior to course of intubation (e.g. **after pre-oxygenation**)	**%**	Lowest value during the course of intubation, even transiently	**%**

Course Success:

Successful tracheal intubation/advanced airway management:
If course failed, please explain briefly:

Disposition:

	Stay in PICU/NICU/CICU/ED		Transferred to □ PICU □ NICU □ CICU
	Died – due to failed airway management		
	Died – other causes		Others (Specify):

Other Comments (e.g. the use of higher dose of vecuronium, choice of drugs used) please explain:

(Not part of medical record call x5193 if found)