**NEAR4KIDS QI Collection Form**

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| --- | --- |
| ENCOUNTER INFORMATION |  |
| **Patient Information □ Airway Bundle/Pink sheet Completed – front AND back**  **Date:** {date\_placeholder} **Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_**  **Patient Gender: M F Patient Dosing Weight (kg): \_\_\_\_\_\_\_\_\_\_\_\_**  **At the time of intubation, did this patient have a suspected or confirmed diagnosis of an emerging epidemic/novel lung disease?** *(i.e. COVID-19, SARS, Pandemic Flu, EVALI)* **YES / NO**  **Form Completed by (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pager #:\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Family member present? Yes / No Attending physician present? Yes / No**  **CHANGE-OF-TUBE**  **Type of Change:**  **From:** □ Oral □ Nasal □ Tracheostomy  **To:** □ Oral □ Nasal □ Tracheostomy  **Nature of Change:**  □ Clinical Condition  □ Immediate after Previous Intubation (Exclude routine Trach Change)  **Check as many as apply:**  □ Tube too small  □ Tube too big  □ Tube changed to cuffed tube  □ Tube changed to uncuffed tube  □ Previous tube blocked or defective  □ For more stable airway management  □ For procedure (e.g. bronchoscopy, etc.)  □ Others:  **INITIAL INTUBATION**  **Check as many as apply:**  □ Oxygen Failure  (e.g. PaO2 <60 mmHg in FiO2 >0.6 in absence of cyanotic heart disease)  □ Procedure  (e.g. IR or MRI)  □ Ventilation Failure  (e.g. PaCO2 > 50 mmHg in the absence of chronic lung disease)  □ Frequent Apnea and Bradycardia  □ Upper Airway obstruction  □ Therapeutic hyperventilation  (e.g. intracranial hypertension, pulmonary hypertension)  □ Airway Clearance  □ Neuromuscular weakness  (e.g. Max. negative inspiratory pressure > -20 cm H2O; vital capacity < 12 – 15 ml/kg)  □ Emergency drug administration  □ Unstable Hemodynamics (e.g. shock)  □ ongoing CPR  □ Absent protective airway reflexes  (e.g. cough, gag)  □ Reintubation after unplanned extubation  □ Others:  **INDICATIONS** | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Diagnostic Category (Check as many as apply):** | | | | |
| Cardiac - Surgical | Respiratory – Upper Airway | | | Neurological (excluding Traumatic Brain Injury) |
| Cardiac - Medical | Respiratory – Lower Airway/Pulmonary | | | Trauma (including Traumatic Brain Injury |
|  | Sepsis/Shock | | | Others (Specify): |
| **Co-Morbid Condition Presence:** | | | | |
| Trisomy 21 –  Yes  No | | If Trisomy 21 is **Yes**, then: | Congenital Heart Disease:  Yes  No | |
|  | |  | If Congenital Heart Disease = **Yes**, Was it:  already repaired or  resolved at the time of this intubation encounter? | |
| Atlantoaxial instability -  Yes  No  Unknown | | If yes or unknown: | Any C-spine protection technique used during intubation? Yes  No | |

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**.

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| --- | --- |
| 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) Yes / No / Not applicable** (bag-mask ventilation not given) |

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

|  |  |  |
| --- | --- | --- |
| 1. Evaluation done **before** or **after** this course is completed? | **BEFORE** | **AFTER** |
| 2. Known prior history of difficult airway? | YES | NO |
| 3. Any Limited Neck Extension or (Maximal with or without sedation/paralytics)  Severe Reduction (e.g. trauma patient with collar) | YES | NO |
| 4. Widest Mouth Opening – How many *Patient’s* fingers between gum/incisors | 0 – 2 | ≥ 3 |
| 5. Thyromental space – Patient’s fingers between chin and thyroid cartilage | 0 - 2 | ≥ 3 |
| 6. Evidence of Upper Airway Obstruction or Anatomical Barrier to visualize glottic opening (Subjective assessment before looking)? | YES | NO |
| 7. Midfacial Hypoplasia? | YES | NO |
| 8. Any other signs of difficult airway exist? | YES | NO |
| If **YES** Please Explain: | | |

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| --- |
| **Known cyanotic heart disease (R to L shunt)**? **(Circle ONE only) Yes / No** |

**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:** □ Premed for TI □ Treatment of Bradycardia

**Glycopyrrolate Indication:** □ Premed for TI □ Treatment of Bradycardia

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

□ Oral □ Nasal □ LMA □ Oral to Oral □ Oral to Nasal □ Nasal to Oral □ Nasal to Nasal □ Tracheostomy to Oral

|  |  |  |  |
| --- | --- | --- | --- |
|  | Standard Sequence (administration of induction meds, PPV, then paralysis) |  | Paralysis Only |
|  | Rapid Sequence requiring positive pressure ventilation (PPV) |  | Awake, topical |
|  | Rapid Sequence without PPV (Classic RSI) |  | No medications |
|  | Sedation & Paralysis (Change of tube or subsequent courses) |  | Surgical – Cricothyrotomy/Tracheostomy |
|  | Sedation Only |  | Others (Specify): |

**Apneic Oxygenation Use**

1. Was Oxygen provided **DURING** any TI attempts for this course? YES / NO / ATTEMPTED but not done (explain on last page)
2. If Yes, How was the oxygen provided:

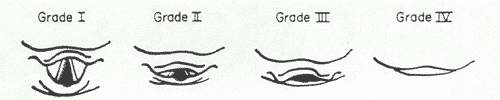
|  |  |  |  |
| --- | --- | --- | --- |
|  |  | Liter Flow | FiO2 |
|  | NC without nasal airway |  |  |
|  | NC with nasal airway |  |  |
|  | Oral airway with oxygen port |  |  |
|  | Through LMA |  |  |
|  | HFNC |  |  |
|  | NIV with nasal prong interface – provide PEEP/PIP |  |  |
|  | Other (device,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

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

|  |  |  |  |
| --- | --- | --- | --- |
|  | Laryngoscope |  | Fiber optic-flex |
|  | LMA (Laryngeal mask airway) only |  | ET tube via trach-stoma |
|  | Intubation through LMA |  | Surgical airway – Percutaneous/Cricothyrotomy Describe: |
|  | Video laryngoscope - Unguided (e.g. Glidescope) |  |  |
|  | Video laryngoscope – CMAC  View FOR INTUBATOR: Direct / Indirect |  | Other (please describe): |

**Tracheal Intubation Confirmation [Check ALL that apply]**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Adequate and equal chest rise |  | Exhaled CO2 – colorimetric |
|  | Appropriate breath sounds heard ( Auscultation ) |  | Chest X-ray |
|  | Humidity seen in endotracheal tube |  | Second independent laryngoscopy |
|  | Exhaled CO2 – capnography |  | Others: |

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**Glottic Exposure During Intubation [Check only ONE]:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | I = Visualized entire vocal cords |  | IV = Non visualized epiglottis |
|  | II = Visualized part of cords |  | V = Not Applicable (e.g. blind nasotracheal) |
|  | III = Visualized epiglottis only |  |  |

**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: Yes / No

**If course failed, please explain briefly:**

□ Cannot visualize vocal cords □ Unstable hemodynamics

□ Cannot place device into trachea □ Other (please explain):

|  |  |
| --- | --- |
| COURSE INFORMATION | (*For Official Use Only)*Encounter #: \_\_\_\_\_\_\_\_ Course #: \_\_\_\_\_\_\_\_ |

**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:**

**To be completed by study team:**

BP: \_\_\_\_\_\_\_\_\_\_\_\_ PICU Admit: (date and time 1st VS) \_\_\_\_\_\_\_\_\_\_\_\_\_

Pupils: \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Mechanical Ventilation 1st hour: \_\_\_\_\_\_ Extubated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FiO2: \_\_\_\_\_\_\_

PaO2: \_\_\_\_\_\_\_ PICU d/c: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Base Excess (art or cap only): \_\_\_\_\_\_\_

HR or LR diagnosis: \_\_\_\_\_\_\_\_\_