### INTENSIVE CARE UNIT - INTUBATION AND TRACHEAL TUBE MANAGEMENT

<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>1. Purpose</strong></td>
<td>The aim of this guideline is to direct staff working in ICU, ICU2 and CICU in the process of intubation and the post intubation care of patients with endotracheal, submental, nasotracheal and bifurcated tracheal tubes.</td>
</tr>
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</table>
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2.0 Intubation
Intubation is a form of invasive airway management whereby an artificial airway is placed into a patient's trachea. Three types of intubation styles are managed at STG ICU, oropharynx, nasopharynx, and submental.

2.1 Endotracheal
Most preferred approach at STG ICU, which allows for protection from macroscopic aspiration and for either spontaneous or positive pressure ventilation.

2.2 Equipment:

2.2.1 The Airway Trolley includes C Mac:
Located in centre of the ICU (Note: CICU have an “Emergency airway box” situated on the bottom of the chest reopean trolley)
- Checked at least once every 24 hours
- Re-checked and cleaned after each use

2.2.2 Preparation for intubation of the ICU patient
It is the responsibility of a designed Registered Nurse to prepare the airway trolley with the appropriate equipment prior to intubation. A re-usable mat can be used as a guide for laying out appropriate equipment on top of the airway trolley.

It is crucial that only the appropriate equipment is opened/placed in the intubation field.
2.2.3 Equipment and Specific Use

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Specific Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laryngoscope handle and blade</td>
<td>clarify what size required and that the light is working</td>
</tr>
<tr>
<td>2 Endotracheal tubes</td>
<td>Size as requested and a full size smaller. Cuff to be checked for faults.</td>
</tr>
<tr>
<td>Water Soluble Lubricant</td>
<td>Apply to end of ETT</td>
</tr>
<tr>
<td>Magills Forceps</td>
<td>Can be used to facilitate the advancement or direction of ETT.</td>
</tr>
<tr>
<td>Bougie and introducing stylet</td>
<td>Confirm with medical staff which (if any) they would prepare.</td>
</tr>
<tr>
<td>10ml Syringe</td>
<td>To inflate ETT cuff.</td>
</tr>
<tr>
<td>White Tape</td>
<td>To secure ETT.</td>
</tr>
<tr>
<td>ETCO2</td>
<td>Connected to monitor. Requires warming up approx 10 minutes</td>
</tr>
</tbody>
</table>

As a general size rule (depending on size, presumed difficulty of airway):

- **Women**: Size 7-8 (size 3 blade)
- **Men**: Size 8-9 (size 4 blade)

At Patients bed space:
- Suction with yankuer sucker attached and placed on the right hand side of the bed.
- Laerdal Bag and appropriate size mask connected to oxygen 15L/min.
- PEEP valve should be accessible if required.

2.2.4 Drugs and fluids

- It is the responsibility of the medical staff to request the medications required.
- The person who will be administering the intubation medications should reconstitute medications and label syringes with concentrations.
- Intravenous (IV) Infusions should be rationalised. Non-essential infusions should be ceased and all lines should be appropriately labelled.
- A dedicated drugs line should be established and assessed by the person allocated the role of drug administration. The bedside nurse may be required to assist in this process.

2.3 Patient:

- Bed positioned out from the back wall and bed area cleared of unnecessary equipment to allow adequate access.
- Ensure adequate lighting.
- Monitoring attached and minimum ECG monitoring, SPO2, ETCO2, and Blood pressure (Bp)
- Position patient in supine position and pre-oxygenate with 100% Oxygen.
- Personal Protective Equipment (PPE) for all staff involved.
- Ensure privacy and dignity is maintained for the patient at all times, if necessary ask visitors to leave from surrounding bed areas.
2.4 Team: **Follow the pre-intubation checklist below**

- Roles should be allocated from both a nursing and medical perspective. Allocation should depend on available skill mix/support and other concurrent activity within the unit. All members of the team should be made aware of the subsequent plans if difficulty is faced with the first attempt at intubation.

### St George ICU Pre – Intubation Checklist

#### Patient:
- Indication for intubation reviewed (Alternatives to RSI)
- Difficult airway anticipated? (for each of BVM, laryngoscopy, rescue techniques)
- Patient position optimised (occipital pad, ear to sternal notch, ramped?)
- Preoxygenation optimised (consider PEEP valve, NIPPV, apnoeic NPIG)
- Haemodynamics optimised (consider fluid loading, pressors)

#### Team:
- Team Leader & Scribe (ICU Senior Nurse or RN)
- Airway Doctor (ICU/anaesthetic Registrar)
- Airway Assistant (RN)
- Drug administration (RMO)
- Cricoid/ELM? (RN)
- Manual in Line Stabilisation (MILS if required RN)
- Consider calling anaesthetics if difficulty anticipated (Page 999)

#### Equipment:
- Suction on
- BVM / PEEP valve (connected to O₂ filter ETO₂)
- JVC x 2, fluids running/drugs
- OPA/NPA
- Laryngoscope x 2 (consider MAC)
- ET correct size ( cuff checked and lubricated, alternative size available)
- Bougie/Stilet
- Tube tie / tape
- Drug doses confirmed (induction agent, paralytic, ongoing analgesia and sedation, pressor)
- Ventilation set up
- Failed airway/intubation equipment sighted and plan discussed

#### Plans Activated:
- Difficult laryngoscopy plan:
  - Release cricoid, ELM, change position, change blade, change operator)
- Resusc BVM plan:
  - Threshold SPO₂ (consider extend OPA, NPA, two person technique)
- Can’t Intubate, Can’t Ventilate plan:
  - (Do you need help?)
  - (Who shall I call?)
- ICU Senior Registrar
- Anaesthetics 999
- ED Registrar 31661
- ENT Registrar

#### Team Leader/Scribe:
- The Team leader is the Nurse in Charge or Medical Officer who is separate from the airway doctor.
- Follow intubation proforma (see appendix1) instructions and relay to team, ensuring hear back and closed communication loop techniques. Complete proforma.
- Monitors vital signs, relays any deviations from baseline to team, including SpO₂ <20% of baseline pre oxygenation level, and haemodynamic status.
- Prompts the intubating medical officer to abort after second attempt at intubation if the patient desaturates or shows signs of haemodynamic instability and/or need to escalate to second airway operator.
- Place complete intubation proforma in patients notes and copy to be placed on airway trolley.
Airway /Intubating Medical Officer:
- Ensures roles are allocated to appropriate team members
- Ensures there is available senior backup available in-case of unanticipated difficulty
- Checks with appropriate team members that equipment is available/functioning
- Ensures appropriate drugs are available
- Positions the patient correctly:
  - For patients with suspected spinal injury manually maintain in-line stabilisation and remove cervical collar during intubation.
  - For obese patients, they will need to be elevated so that the tragus is at the level of the sternal notch.
- Articulates plans to the Airway Assistant.
- Instructs scribe of the parameter aims to prompt the re-oxygenation between attempts at intubation.

Airway Assistant:
- Sets up intubating equipment
- Communicates directly with intubating medical officer that the equipment and appropriate size is ready for use
- Check suction and places it within close reach.
- Passes the intubating medical officer the equipment as requested in a manner which allows the intubating medical officer to maintain his/her view at all times. For example, placing the laryngoscope handle in the palm of the hand in the position of insertion, handing suction and ETT directly into the palm of the hand in the direction of insertion.
- Stabilisation and removal of bougie/introducer (see figure 1 page 8), ETCO$_2$ adaptor introduction, inflation of cuff, auscultation of patients chest to validate placement
- Secure ETT with white tapes.
- Ensure connection to a preconfigured and checked ventilator and patient ventilating within normal parameters.

Drugs Administrator:
- Responsible for requesting medications and the reconstitution/labelling of medications
- Responsible for administering drugs in closed loop communication with airway Medical Officer, and audible for team, team leader/scribe

**Common RSI (Rapid Sequence Induction) Drugs**

<table>
<thead>
<tr>
<th>PRE MEDICATION</th>
<th>One of the following in patient specific dose.</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIDAZOLAM</td>
<td>Benzodiazepine</td>
</tr>
<tr>
<td>Morphine</td>
<td>Opioid analgesic</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>Opioid analgesic</td>
</tr>
<tr>
<td>Ketamine</td>
<td>Opioid analgesic</td>
</tr>
</tbody>
</table>
INDUCTION: One of the following in patient specific dose.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Category</th>
<th>Concentration</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROPOFOL</td>
<td>Non Barbiturate Hypnotic</td>
<td>200mg/20ml = 2mg/ml</td>
</tr>
<tr>
<td>THIOPENTONE</td>
<td>Ultra short acting barbiturate</td>
<td>500mg/20ml Water = 25mg/1ml</td>
</tr>
</tbody>
</table>

MUSCLE RELAXANT: Given post premedication and induction agents.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Type</th>
<th>Concentration</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUXAMETHONIUM</td>
<td>Depolarising neuromuscular blocker</td>
<td>100mg/2ml = 50mg/1ml</td>
</tr>
<tr>
<td>VECURONIUM</td>
<td>Non depolarising neuromuscular blocker</td>
<td>10mg/10ml = 1mg/1ml</td>
</tr>
<tr>
<td>ROCURONIUM</td>
<td>Non depolarising neuromuscular blocker</td>
<td>50mg/5ml = 10mg/1ml</td>
</tr>
</tbody>
</table>

VASOPRESSOR: Ready to be given if any haemodynamic instability occurs

<table>
<thead>
<tr>
<th>Drug</th>
<th>Type</th>
<th>Concentration</th>
</tr>
</thead>
<tbody>
<tr>
<td>METARAMINOL</td>
<td>Vasopressor</td>
<td>10mg/20ml = 0.5mg/1ml</td>
</tr>
</tbody>
</table>

• **PLANS ARE ARTICULATED AND CONFIRM RECEIPT**

Cricoid:

• Cricoid is used only at the request of airway/ intubating medical officer
• Maintain a downward force of approx 30 – 40 Newtons (3 -4 kg)\(^\text{16}\) (will need to be less if patient has cervical spinal injury) this pressure may not be released until asked by the Airway MO.
• Alternatively you may be asked to use BURP- Backwards Upwards Right of the patient Pressure.

Manual in line Stabilisation (MILS):

• Consider whether patient requires from a spinal precaution perspective

Runner:

• May be required to collect equipment, contact senior support etc.
Figure 1. Photographs to demonstrate handling of bougie and ETT by Airway Assistant.

**NOTE: ONLY TO BE CARRIED OUT BY TRAINED PERSONNEL**

Step 1: Hand bougie to airway doctor

Step 2: Feed ETT over bougie

Step 3: Stabilise bougie

Step 4: When instructed remove bougie

2.5 Post intubation:

1. Maintain ETCO₂ monitoring with adequate capnography readings.
2. ABG sample should be collected with ventilatory aims documented by medical staff to allow for timely weaning from ventilatory support.
3. Medical staff should order analgesia and sedation as well as a desired RASS score.
4. ETT should be checked on CXR by the ICU medical team.
5. The intubation, airway/laryngeal grade and confirmed position must be documented by medical staff in the patient’s notes.
6. Post correct placement secure with adhesive tapes.
7. Size of ETT and position at lips must be recorded in the insertion section by nursing staff.
9. Cuff pressure re-checked and recorded on the CIS ², ⁵

3.0 Alternative Intubation Equipment in the case of a difficult airway--
3.1 Laryngeal Mask Airway: LMA +/- Intubating LMA

Used as an airway adjunct to provide a temporary airway patency in an emergency situation. Size selection is weight dependant with a Size 5 being appropriate for patients >70kg.
The ‘cuff’ is inflated with 20ml of air.
The intubating LMA (iLMA) should only be used by those trained to do so. It is situated in the second draw of the airway trolley.

3.2 C-MAC

A blade with an attached light source/camera to allow for easier visualisation. This is sometimes used in the first instance if difficulty in visualisation is predicted.

C-MAC 3 and 4 blades – normal sized blades  
C-MAC D blade – D blade used for short necks and larger patients. 
Note: the black plug should be removed from the handle to connect to machine and then sent with the blade to SSD once used.

3.3 McCoy Blade

Hinged tip is used to lift the epiglottis if it is obscuring good view of the vocal cords. This has the same nursing requirements as the simple laryngoscope and handle.

4.0 Securing Endotracheal tubes

4.1 Adhesive Tape
1. Two nurses must always be present to change the method of securing an ETT or renew the current method securing the ETT. One nurse to change the tape and one nurse to secure the ETT.  

2. Of the two nurses, at least one nurse must be an experienced member of the ICU team.
When changing tapes PPE should always be used by both nurses as there is a high risk for contact with potentially contaminated secretions. This includes goggles/facemask, gloves, gown, and mask (if respiratory precautions).  

3. When tapes should be changed/applied:
- Once in a 24hr period.
- Tapes must be changed even if there is an expected extubation that day.
- When visibly soiled.
- Once ETT position in confirmed in a newly intubated/admitted patient – especially neurosurgical patients
- Identified as not being secure and ETT is able to migrate or move more than 1cm.
- If CXR is done and ETT is not in an ideal position – the medical team are responsible for documenting these orders in the patient’s clinical notes.
- Tapes should ideally be changed while a patient is sedated, if unsure of tube safety inform Nurse in charge or Registrar before attempting to change tapes.
- Tapes should be done during daylight hours with shave if male patient - as per orientation manual. ICU registrar should be present on the unit. **This is essential if grade 3 or 4 airway.** Unplanned extubation's occur more frequently during night shifts.  

4. Adhesive tapes are the standard method for securing ETT at St George ICU.  
Tape should not wind up the ETT which may limit the visibility of centimetre markings
4.2 White cotton tapes -

- Can be used on patients with impaired facial skin integrity, extreme diaphoresis, patients with beards.
- If patients are expected to be intubated for a prolonged period of time, it may be necessary to shave facial hair. Permission must be sought from the patient's next of kin prior to shaving patient.
- White tapes are required if a patient is being ventilated using the High Frequency Oscillator (HFOV) or Prone positioning.

Note: If using cotton tapes you should be able to insert two fingers between tape and skin to prevent pressure injuries.  

5. The ETT should alternate from side to side every 24 hours. Ensure the placement of ETT during tape change to be placed in line at oropharynx and corner of mouth. Tube not to be situated diagonally across oropharynx. This causes patient discomfort and which can lead to an increase in ETT intolerance and a more agitated patient. The changing of sides and the reapplication of tapes should be documented in the insertion tab on the CIS.
5.0 Alternative Intubation/Artificial Airways:

5.1 Nasotracheal Intubation

5.1.1 Indication
Those patients who are unable to open their mouth due to injury to the mandible or a rigid temporomandibular joint pathology. Patients with cervical spine injury as well as facial fractures may have their airway obscured with blood or oedema, therefore they are more suitable for nasotracheal intubation. Patients with upper airway obstruction may also be more easily intubated using a blind nasal technique.

5.1.2 Where does the procedure take place?
This practice is not routinely carried out in the ICU and would be performed by the Anaesthetics team in the Operating Theatres.

5.1.3 Equipment and Nursing Care
Reinforced ETT's are sometimes used in this application.
The measurement should be taken in centimetres from the tip of the nare to the blue ET connector and should be marked on the ETT with a permanent marker at the nare.
Depending on the grade airway or medical orders, the airway may need to be held by an ICU Registrar for repositioning/tape changes.
5.2 Bifurcated (double lumen Endotracheal tubes)

5.2.1 Indication
Inserted when there is a need to isolate one lung in ventilation. Indications for a Bifurcated ETT are to protect one lung from contamination from the opposite side (bronchopleural fistula), pulmonary haemorrhage or to provide different lung strategies to either side post trauma or transplant. It is also possible to suction and lavage each lung separately.

5.2.2 Where does the procedure take place?
Either ICU or by the Anaesthetics team in the Operating Theatre. The tubes themselves should be sought from Operating Theatres. Bifurcated tubes are inserted under direct laryngoscopy or may be changed from a simple ETT using an exchange method. The intubation using a bifurcated ETT may be more difficult in patients with already know difficult airways. Bronchial and tracheal cuffs will require minimal occlusion pressures. Orders for management of cuffs must be documented as well as clear orders for management in an emergency.

5.2.3 Equipment and Nursing Care
Securing a bifurcated ETT is the same process as a simple ETT. Given the extra weight of the ventilator circuit, it is crucial nursing staff prevent circuits resting on the patients body which places them at risk of pressure areas. These patient’s will require water base humidification and in some instances may require two ventilators.

5.3 Submental tubes
5.3.1 Indication
Used predominantly for patients with traumatic facial fractures who are deemed not appropriate for a tracheostomy.

5.3.2 Where does the procedure take place?
Submental airways are inserted in the Operating Theatre and are secured with sutures at the site of insertion.

5.3.3 Equipment and Nursing Care
The surgical team will dictate the daily care of the insertion point and are responsible for documenting this in the patient’s clinical notes. Check sutures are intact and document each shift. A Submental tube needs to be held as a new tracheostomy is held for turns and repositioning. It may be necessary for the ICU Registrar to hold the Submental Tube for turns and repositioning. Care should be taken to ensure proper angling of the Submental tube to prevent kinking and/or pressure area development.

6.0 Tracheal Suctioning:
• Closed suction catheter systems are the system of choice in the ICU - this needs to be changed after 72 hours of use.
• Suction catheter should be < half the internal diameter of the ETT
• The suction catheter should be measured so it only just emerges from the ETT lumen prior to suction
• Closed suction systems should be cleaned as per the manufacturers’ instructions to maintain patency and minimize colonization
• Syringes used to flush the suction line should not be left attached to the ventilation circuit. They should be once use only and thrown away.
• Hyperinflation should not be performed on a routine basis prior to suctioning.

Considerations for use of hyperinflation are:
  o Atelectasis
  o Volume loss on CXR
  o Sputum plugging

• Pass suction catheter till resistance is felt or a cough stimulated, withdraw 1-2cm, then apply continuous suction on withdrawal
• Max occluded pressure should be 20kpa for CSS or OSS. Wall outlets should have high pressure gauges attached
• Total procedure time should be <15sec for catheter insertion and suction/withdrawal
• Frequency of suctioning should be performed as clinically indicated condition and sputum load.
• If a patient has high oxygen and PEEP requirements and/or is known to desaturate to clinically significant levels, pre-oxygenation should be considered.
• Pre oxygenation is no longer considered a standard practice. Monitoring oxygen saturation before, during and after suctioning to determine need for hyperoxygenation. Avoid use where not needed. 100% oxygen can have deleterious effects i.e. absorption atelectasis.
• If pre-oxygenating, use the ventilator capacity to deliver 100% oxygen. This maintains positive pressure, the incidence of desaturation is reduced with less haemodynamic effects.
• Bolus instillation of normal saline should not be routinely used prior to suctioning. Consider for tenacious sputum.
• Optimise the following factors prior to considering saline:
  o Adequate hydration
  o Adequate humidification
  o Mucolytics
  o Effective Mobilisation
### 7.0 General Patient Assessment and Documentation for the Intubated Patient

- Grade of airway must be documented by Airway Doctor on intubation in order to inform extubation.

<table>
<thead>
<tr>
<th>1-2 hourly</th>
<th>2-4 hourly</th>
<th>Each shift</th>
<th>Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vitals</td>
<td>Mouth care</td>
<td>Emergency equipment. Ensure breathing circuits are close to minimise risk of contamination and colonisation.</td>
<td>Position of tube on CXR.</td>
</tr>
<tr>
<td>2 /24 confirmation of centimetre measurement (at the lips) Nasotracheal tubes measurement - tip of nose to end of blue connector on tube. Recorded on CIS with respiratory Observations.</td>
<td>2/24 Patient positioning for prevention of the risk of hypostatic pneumonia and pressure area relief</td>
<td>Position of the tube at the lips or tip of nose to end of tube for nasotracheal tubes, cuff pressure.</td>
<td>Change of tapes (more frequently if soiled or otherwise indicated)</td>
</tr>
<tr>
<td>Air Entry.</td>
<td></td>
<td>Assessment of patient skin integrity – including face, teeth, gums, tongue, lips and if pt has cotton tapes back of neck and ears.</td>
<td></td>
</tr>
<tr>
<td>Assess Airway patency and need for suction.</td>
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<td></td>
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</table>

### 8.0 Physical Obstruction of Airway:

- Biting – which is prevented by adequate sedation to facilitate tube tolerance or the use of a bite-block
- Herniation of the cuff – which is prevented by ensuring the cuff is not over inflated
- Kinking of the tube
- Blood or mucous obstructing the tube – may be avoided by using humidification.

### 9.0 Dislodgment:

- Ensure tube is securely positioned.
- Artificial airways must be supported during turning or repositioning.
- Observe patient for anxiety, agitation and manage this to prevent accidental dislodgment.
### 3. Network file location/reference, if applicable

<table>
<thead>
<tr>
<th>4. External References / Further Reading</th>
</tr>
</thead>
</table>

9. ICCMU- Intensive Care Coordination and Monitoring unit,
Intensive Care Collaborative, Stabilisation


<table>
<thead>
<tr>
<th>Date</th>
<th>Revision number</th>
<th>Contact Officer (Position)</th>
<th>Date for revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/02/2014</td>
<td>0</td>
<td>Ashleigh Ralph ICU RN</td>
<td>02/2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dr Doris Lam ICU Staff Specialist</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Dr Swapnil Pawar ICU Senior Registrar</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Jessica Keady CNS ICU</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Sarah Jones CNC ICU</td>
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<tr>
<td></td>
<td></td>
<td>Wendy Chaseling ICU Physiotherapist</td>
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## DEPARTMENT OF INTENSIVE CARE
### INTUBATION PROFORMA

<table>
<thead>
<tr>
<th>PATIENT</th>
<th>TEAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>INDICATION:</td>
<td>IV ACCESS:</td>
</tr>
<tr>
<td>POSITIONING:</td>
<td>NG ASPIRATE:</td>
</tr>
<tr>
<td>FASTING:</td>
<td>VITALS:</td>
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<table>
<thead>
<tr>
<th>EQUIPMENT</th>
<th>DRUGS</th>
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<tr>
<td>SUCTION:</td>
<td>OXYGEN:</td>
</tr>
<tr>
<td>EVM:</td>
<td>ARTERIAL</td>
</tr>
<tr>
<td>LARYNGOSCOPE:</td>
<td>BOLUSE/ NIVLET</td>
</tr>
<tr>
<td>ET:</td>
<td>ECO2</td>
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<tr>
<td>VENTILATOR:</td>
<td>NIPP/VEN/ BIP</td>
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<table>
<thead>
<tr>
<th>CALL FOR HELP: YES/NO</th>
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<tbody>
<tr>
<td>PLAN A:</td>
</tr>
<tr>
<td>PLAN B:</td>
</tr>
<tr>
<td>PLAN C:</td>
</tr>
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</table>

### DRUGS

<table>
<thead>
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<th>DOSE:</th>
<th>TIME:</th>
<th>FLUSH:</th>
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<tbody>
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<td>PROPOFOL:</td>
<td>DOSE:</td>
<td>TIME:</td>
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<td>FLUSH:</td>
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<tr>
<td>METHAIRON:</td>
<td>DOSE:</td>
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### CALL FOR HELP REQUIRED

<table>
<thead>
<tr>
<th>NAME &amp; POSITION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIME CALLED:</td>
</tr>
<tr>
<td>TIME ARRIVED:</td>
</tr>
</tbody>
</table>

*PLEASE PHOTOCOPY THIS FORM WHEN FILLED & KEEP COPY IN PATIENT'S FOLDER & AIRWAY TROLLEY.*

Intubation Protocol, 25 Feb 2014
Dr Swapnil Pwar/Tene Kalonda/Dr Doris Lam

Approved by: ICU Nursing Practice Committee, J Cosgrove February 2014