Avera eCARE ______________________________

Time Out for Intubation

Pre-Time Out: Right patient, right procedure, right equipment - then proceed into the room

1. Ensure healthcare staff is in appropriate PPE.

- Recommend respiratory PPE with N95 mask with goggles or PAPR

2. Establish IV access, set up monitor and EtCO2.

- Obtain full set of vitals

3. Ready Video Laryngoscopy. Position bed in room.

- Plug-in cables
- Turn on scope and test
- If no VL, set up bed for better team visualization
- Make sure you have a HEPA filter for use with positive pressure ventilation

4. Preoxygenation and suction set up.

- Preoxygenate with oxymask or nonrebreather for 3-5 minutes. You still should place patient on 6L nasal cannula for passive oxygenation. Nasal cannula should be left on during intubation attempts.
- Try to eliminate use of manual bagging, Bi-PAP and high flow oxygen in order to prevent viral spread.

5. Back-up devices tested and available.

- Direct laryngoscope tested
- Extraglottic (LMA, iGel, Kingtube) available
- Bougie at bedside

6. Obtain 2 sizes of ET tubes with appropriate stylet.

- Rigid stylet if using Glidescope
- Syringe on ET tube – recommend immediate endotracheal tube cuff inflation before PPV

7. RSI medications discussed and drawn up.

- Sedative: Etomidate (0.3 mg/kg) or Ketamine (1.5 mg/kg)
  - Ideal Body Weight dosing; consider lower dose if poor hemodynamics or obese
- Paralytic: Succinylcholine (1.5 mg/kg) or Rocuronium (1 mg/kg)
  - Total Body Weight dosing; consider contraindications for succinylcholine

8. Tube holder, HEPA filter and colormetric EtCO2 at bedside.

9. Roles discussed and clear.

10. Current set of vitals given.

Updated 4.14.20

Special Notes:

- **Pediatrics**: obtain Broselow tape; consider atropine; check BVM pop-off valve.
- **Out of hospital arrest**: do not worry about exchanging an EGD for ET tube until patient stabilized
- Think about **post intubation sedation**.

COVID-19 Special Considerations

- After nasal cannula, advance to Salter or HFNO
- Limit BiPAP due to concern of viral spread.
- Intubate in a negative pressure room and avoid nebulization to prevent viral spread.
- Limit ventilator disconnects.
- Most experienced clinician should intubate.
- Recommend having second clinician (if available) with PPE outside of the room for immediate assistance.
- Limit to a 3-person intubation team when possible (RN, RT and Intubator) to reduce personnel exposure.
- Place soiled equipment in double sealed biohazard bags.
- Proper coached doffing procedure with hand hygiene needs to be performed to limit contamination.