Intubation Checklist. Scenario Run Sheet

Kunnanurra Workshop

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| Scenario Overview |
| **Estimated scenario time:** | 20 – 30 minutes |
| **Estimated guided reflection time:** | 30 minutes |
| **Target group:** | ED doctors and nurses |
| **Brief summary:** | 55y.o. male intoxicated. Ambulance called by passers by as found him lying on the pavement bleeding from a wound on the back of his head and complaining of neck pain. Bleeding ceased with pressure but patient became agitated and aggressive. Formal GCS of 12 by ambos. Patient swung a punch at the ambulance officer so given 20mg IM midazolam for ease of transport. En route became very sleepy with noisy breathing when airway not supported with a head tilt and chin lift.  |

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| Learning Objectives |
| **General:** |  |
| **Scenario Specific:** | * Identify that patient has a threatened airway due to head injury, intoxication and benzodiazepines
* Recognise the need for urgent CT scanning of the brain/CSpine and requirement for airway protection to facilitate this safely
* Recognise need for definitive airway rather than a manually supported one or LMA due to risk of aspiration
* Identify that patient has a potential cervical spine injury and requires cervical immobilisation during intubation
* Practice the use of the intubation checklist
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| Equipment Checklist |
| **Equipment*** Adult SimMan
* Patient trolley
* Monitoring equipment / ECG/ CO2 monitoring
* IV access
* SIM Resus Trolley
* Guedel and NPA
* CSpine collar
* BVM and various O2 masks
* All invasive airway equipment (bougie, ETT, laryngoscopes, tube tie, syringe, lube
* Difficult airway trolley inc LMA
* Stethoscope
* Video laryngoscope
* Blood pump set for IVF
* NGT
 | **Medications and Fluids*** IV crystalloids
* Induction agent (lower dose thiopentone or ketamine)
* Paralytic agent (Sux or rocuromium)
* Ongoing sedation (Propofol or M&M/F&M)
* Metaraminol
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| **Documents and Forms*** STJA Documentation
* Triage Sheet
* Nursing Assessment Form
* Pathology/Radiology forms
* INTUBATION CHECKLIST FORM
* Ventilation settings guide
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| **Diagnostics available*** ECG: Sinus tachycardia 100 bpm
* VBG: Mild resp acidosis PCO2 60, pH 7.29
* CXR normal pre intubation, ETT and NG appropriate if asked for post intubation
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| Scenario Preparation / Baseline Simulator Parameters |
| **Initial parameters in resus**Temp – 37CPulse – 100Resp – 10(spont – noisy when )BP – 97/60SpO2 – 92% on BVM (assisted ventilation via LMA)GCS E1V2M4 = 7/15 | **Parameters after volume resus/intubation etc**Pulse 110Resp – as set by vent or baggingBP – 110/60SpO2 – 100% |

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| Number of Participants |
| Medical Staff x 3 (TL, airway, assessment)Nursing staff x 4 (Scribe, airway, circulation, meds etc) | **Instructor Roles*** Brief introduction to intubation checklist
* Facilitate scenario
* External communication within scenario
* Debrief participants
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| Additional Information / Medical History |
| **Patient Demographics:**  | 55 year old man, of no fixed abode, known heavy drinker |
| **History of Presenting Complaint:** | No meaningful Hx from patient. Groans and tries to punch you when you ask questions. Hx from passers by that stumbling around outside Woolies then fell over and hit head. Bleeding profusely from occiput. Aggressive when approached.* Tried to punch an ambulance officer so given 20mg midazolam IM for patient and staff safety during TF. Now partically obstructed airway if not supported manually
* Starts to wake up in ED and throwing punches again
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| **Previous Medical History:** | Very heavy alcohol consumption, ALD with previous coagulopathy, multiple presentations with alcohol related trauma. Small subdural previously. |

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| Proposed Correct Treatment (Outline) |
| * ABCDE approach, full set of vitals, x2 IV cannulae
* Urgent FBC, Coags (PT, INR, APTT, Fibrinogen), LFT, U&E, VBG, Glucose, crossmatch
* IV fluids
* Call for senior help, and early involvement of doctor confident to provide definitive airway
* Full non invasive monitoring
* Preoxygenation and nasal prongs for apnoeic oxygenation after induction
* Appropriate CSpine immobilisation during intubation
* +/- cricoid (doctor preference)
* Run through intubation checklist
* Appropriate drugs and doses for induction and paralysis
* Confirmation of ETT placement (fogging, chest rise, auscultation, CO2, CXR)
* Appropriate other post resus care (sedation, head up 30 degrees)
* Demonstrate effective communication
* Demonstrate effective team work
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| Debriefing / Guided Reflection Overview |
| **General opening questions frequently used to start the debriefing session:*** Describe what happened during this scenario
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| **Scenario specific questions:*** What is likely wrong with this patient? (Comprehension) *(clear communication through the team)*
* What medications / investigations maybe required, where do they need to go? (Projection) (*ask one of the junior medical staff)*
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| **General wrap-up questions frequently used to close the debriefing session:*** What did you find most beneficial about this scenario?
* What was the most challenging point within this scenario?
* Do you feel the intubation checklist could become a useful part of your regular practice?
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| Case Considerations: |
| * Recognising which patients are unsafe for transfer to CT without a patent and protected airway
	+ Low GCS
	+ Risk of hypoxia and hypercapnia
	+ Risk of aspiration
	+ Aggressive behaviour risking staff and patients
	+ Inability to lie still/comply with scanning
	+ Risk of unprotected CSpine
* Recognition that the intubation checklist can prevent missing any potentially critical steps that may jeopardise a safe and rapid intubation. Is specific to the particular hospital and best performed when you feel you have everything ready to be able to proceed to intubation. All items are read out by the team leader, all team members listen and respond as to whether they have the necessary equipment or are able to perform the necessary action.
* The safe immobilisation of a patient with an at risk cervical spine. Including removal of collar and in line immobilisation. The intubator is not to more the CSpine unless absolutely necessary i.e NO head tilt or chin lift, avoid the ‘sniffing’ position. A video laryngoscope can improve the view in a patient who’s neck cannot be manipulated.
* Clear communication is essential in the clinical setting; one effective communication tool is ISOBAR. ISOBAR is an easy to remember mechanism that you can use to frame conversations, especially critical ones, requiring immediate attention and action. It clarifies what information should be communicated, and how. It consists of standardised prompt questions within four sections – to ensure concise and focused information, while allowing staff to communicate assertively and effectively, reducing the need for repetition.
	+ Introduce
	+ Situation
	+ Observations
	+ Background
	+ Assessment
	+ Recommendation
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