Emergency Department Intubation Checklist

☐ Consider the indication for intubation
- Is NIPPV an option?
- Is the patient DNI status?
- Has patient/family consented, if applicable?

☐ Preoxygenate with high-flow oxygen
- Look externally, Evaluate 3-3-2 rule, Multispati score, Obstruction, Neck Mobility Board, Obese, No teeth, Elderly, Sleep Apnea / Snoring
- Surgery, Hematoma, Obesity, Radiation distortion or other deformity, Tumor

- If suspected difficult airway, use awake technique
- If suspected difficult airway (blood, vomitus, secretions), suction under each shoulder

☐ Check for dentures
- Dentures in for bag-valve-mask, out for laryngoscopy

☐ Position patient
- Patient alignment: External auditory meatus to suprasternal notch
- Bed height: Patient's head to operator's lower sternum

☐ Monitoring equipment
- Continuous electrocardiogram
- Pulse oximetry
- Blood pressure
- End-tidal capnography (continuous or colorimetric)

☐ IV access
- Two lines preferable

☐ Equipment
- Use Broselow tape for sizes in pediatrics
- Ambu bag connected to oxygen
- Verify that source is oxygen and not room air
- Laryngoscopy handles - verify power
- At least two
- Laryngoscopy blades - verify bulbs
- Curved and straight
- One size larger, one size smaller
- Suction under patient's shoulder - verify function
- If suspected soiled airway (blood, vomitus, secretions), suction under each shoulder
- Oral airways
- At least two
- Nasal airways
- At least two
- Colorimetric capnometer (If continuous capnography not available)
- Endotracheal tubes - verify cuffs
- Variety of sizes
- ETT stylet
- ETT securing device (tape if no device available)
- Gum elastic bougie
- Difficult airway equipment
- Cricothyrotomy tools / LMA / Combitube / Glidescope / Fiberoptics
- Magill forceps if suspected foreign body

☐ Drugs
- Pretreatment agents, if applicable
- Atropine: 0.02 mg/kg for children <10y if using Sux
- Lidoine: 1.5 mg/kg for reactive airways or increased ICP
- Fentanyl: 3 mcg/kg if high BP a concern
- Roc: 0.08 mg/kg or Vec: 0.01 mg/kg if increased ICP and using Sux
- Propofol: 1.5 - 3 mg/kg
- Ketamine: 1-2 mg/kg
- Midazolam: 0.2-0.3 mg/kg
- Thiopental: 5-8 mg/kg
- Succinylicholine: 2 mg/kg IV or 4 mg/kg IM
- Propofol and succinylcholine:
  - History of malignant hyperthermia
  - Burn or crush injury > 5 days old
  - Stroke or spinal cord injury > 5 days old
  - Multiple sclerosis, ALS, or inherited myopathy
  - Known hyperkalemia (absolute) / Renal failure or suspected hyperkalemia (relative)
- Rocuronium: 1 mg/kg
- Vecuronium: 0.3 mg/kg

☐ Normal saline flushes
- 100 mcg IV push

☐ Personnel
- MD / RN / RT
- Post-intubation ventilator settings discussed
- A/C
- FiO2 100%
- RR 10 [Asthma/COPD: 6-10]
- TV 8 mL/kg [work down to 6 mL/kg if prone to lung injury] use ideal body weight
- VE 1.2 [Asthma/COPD 1.4 - 1.5] Inspiratory Flow Rate 60-80 L/min [Asthma/COPD 80-100 L/min]
- PEEP 5 cm H2O [CHF 6-12 > watch blood pressure] [PEEP 0 in Asthma/COPD]

☐ RSI vs. Awake Technique
- Verify tube placement
- End-Tidal CO2 / Auscultation / Esophageal Detector Device
- Secure tube with appropriate device
- Portable chest radiograph
- Sedative and opioid drips
- Propofol: 5 mcg/kg/min
- Midazolam: 0.25 mg/kg/hour
- Fentanyl: 25 mcg/hour
- Ketamine: 1 mg/kg load then 1 mg/kg/hour

☐ Head of bed to 30-45 degrees
- 15-25 mm Hg by cufflator

☐ Nasogastric or orogastric tube
- Reduce cuff pressure to minimum required to abolish air leak
- In-line heat-moisture exchanger and in-line suction

☐ Arterial blood gas within 30 minutes post-intubation
- Adjust RR (not TV) to appropriate pH and pCO2 [keep pH > 7.1 for permissive hyperCO2]
- Use incremental FiO2/PEEP chart for oxygenation; keep plateau pressure < 30 cm H2O
- Unfractionated Heparin 5000 units SQ bid
- Enoxaparin 30 mg SQ bid

☐ DVT Prophylaxis
- ICU vs. Transfer / Tube Dislodgement, Obstruction, Pneumothorax, Equipment failure
- Arrange for patient disposition, watch for post-tube complications

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