UConn Health Endotracheal Intubation

**PRE-PROCEDURE**

1. The decision to intubate a patient must be carefully considered. Early intubation is preferable. Weigh the risks and benefits of early intubation.
   a. If patient is hypoxemic despite conventional oxygen therapy can trial with well-fitting HFNC (in negative pressure room and all staff wearing PPE).\(^{1,2}\) HFNC should be considered over NIPPV (CPAP, BIPAP). (Weak evidence based on surviving sepsis campaign/ANZICS/WHO guidelines). CPAP likely better (higher mean airway pressure) in certain situations including requiring FiO2 50-60%, DNR/DNI, single organ failure, no resp distress.
   b. No peak flow monitoring, avoid nebulization of medications, bronchodilator delivery via MDI using spacers.

2. Personnel:
   a. Intubator (most experienced provider) (Surviving Sepsis-best practice statement)—Likely anesthesia or pccm attending/fellow; No residents to limit exposure/attempts and decrease PPE use
   b. Respiratory therapist
   c. Patient’s RN
   d. If a difficult intubation is expected another trained provider should assist.

3. The equipment needed to place and secure the endotracheal tube should be assembled prior to entering the HOT room (including intubation tray, MAC video laryngoscope). Video-guided laryngoscopy is preferred over direct laryngoscopy (weak recommendation, low quality evidence Surviving Sepsis) and capnography. The intubation cart is located in the North Doc Box. The intubation cart will be moved to outside the patients’ room and should only be taken into the room if needed. Any reusable equipment should be sequestered for decontamination and risk assessment prior to reuse with guidance from Infection Control.

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1 Alhazzani W, Moller M, Arabi Y et al. Surviving Sepsis Campaign: Guidelines on the Management of Critically Ill Adults with Coronavirus Disease 2019 (COVID-19).
4. Drugs for induction, paralysis and resuscitation will be available in the ICU. Provided by nursing or nursing supervisor

5. The pre-procedure checklist should be performed in the warm/cold room. This occurs with the intubating team and the Charge Nurse / Stat Nurse who will assist with ensuring that all necessary drugs and equipment are available.

6. PPE MUST be applied!

Minimum PPE is:

- N95 mask +/- PAPR* (especially facial hair)
- Face shield or and goggles
- 2 Gown
- 2 pair Gloves

* At this time we are recommending PAPR for procedures involving airway management. The intubator, nurse and RT assistant should have PAPR.

7. A ventilator should be in the room with settings preset prior to intubation.

**PROCEDURE**

- Assign roles
- Most experienced staff intubates
- Limit people in the room to 4-6
- Calculate predetermined ETT depth
- Preoxygenate with non-rebreather (or high flow) 100%
- Ensure hemodynamics are stable. If not, administer fluid/drugs to improve hemodynamics.
- Perform RSI
- AVOID positive pressure ventilation with the face mask because this increases the risk of aerosol dispersal. If IPPV is essential use the least possible pressure and avoid leakage around the mask.
- Perform Video scope
- Inflate cuff PRIOR to any breaths given, check for color change and / or ETCO2. DO NOT AUSCULATE. Confirm tube position during laryngoscopy, bilateral chest rise, distance from teeth.
- Clamp tube with hemostats for disconnects
- Attach preset ventilator. Use LPV to minimize cuff leak. Check cuff pressure and prevent over or under inflation.
• AVOID LMA unless it is part of a failed intubation drill. If essential, minimize pressure to prevent aerosol dispersal.
• AVOID awake intubation as this increases aerosol dispersal.
• See COVID Intubation image summary

DOFF PPE with observer to avoid contamination

Leave all personal items out: ID, phone, stethoscope, pens etc.