April 2020

St.Thomas Elgin General Hospital

PROTECTIVE INTUBATION

- Limit staff in room
  - Ideally Code Pink Lead Physician, W&C RN, RT, and staff for compressions (if needed)

- Intubation Pause
  - Ensure all staff in the room have donned AIRBORNE PPE
  - Ensure manual resuscitator has a filter attached
  - Patient is being preoxygenated with 2 person BVM technique or filtered NRB
  - Patient has an IV access – IO recommended for quick access
  - Ensure patient is sedated and paralyzed with a RSI strategy
  - Most skilled intubator is at the head of the bed
  - MD verbalizes sequence of intubation and roles during intubation (ie. equipment, etc)

- Prepare intubation equipment
  - Appropriate ETT size
  - ETT stylet inserted and syringe attached to cuff (if applicable)
  - End tidal CO2 detector prepared
  - Appropriate laryngoscope blade and handle prepared (DL only)
  - Kelly clamps (if required)

- Intubation Sequence
  - Stop compressions for intubation (ideally perform intubation on pulse/ rhythm check)
  - Removed Filtered Non-Rebreather → Place laryngoscope in patient's mouth
  - Assistance will pass the ETT to intubator → once ETT is passed the vocal cords → stylet out → ETT clamped with kelly clamps → ETT cuff inflated (if applicable) → ETCO2 detector placed on end of ETT → BVM attached → unclamp ETT → confirm placement
  - If BVM is required 2 person technique must be used – 1 person holding mask on patient's face for seal and another person is squeezing the bag
  - If able, place patient on ventilator for transport
  - Hand tighten all connections from ETT to ventilator and secure with water-proof tape (to prevent accidental disconnect) – NOTE: uncuffed do not tape connections to prevent accidental extubations

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