NWC EMSS Skill Performance Record

VIDEO LARYNGOSCOPY INTUBATION w/ ProVu®

Name:	1st attempt:	☐ Pass	☐ Repeat
Date:	2nd attempt:	☐ Pass	☐ Repeat

Instructions: An unconscious adult is found in bed with gasping respirations. There is still a pulse. No trauma is suspected. Prepare the equipment and intubate the patient.

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique, no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
* Takes appropriate BSI precautions: gloves, goggles, mask | HEPA filter for ventilating w/ BVM		
Verbalize indications for procedure: ☐ Actual or potential airway impairment or aspiration risk not mitigated by other interventions ☐ Actual/ impending hypoxic or hypercarbic ventilatory failure (SpO_2 ≤90; $EtCO_2$ ≥60) ☐ Increased WOB (retractions, use of accessory muscles) resulting in severe fatigue ☐ GCS ≤ 8 due to an acute condition unlikely to be self-limited ☐ Unable to ventilate/oxygenate effectively with BLS airways and BVM ☐ Need for ↑ inspiratory pressure or PEEP to maintain gas exchange & CPAP contraindicated		
Prepare patient ☐ **Position** patient for optimal view and airway access (head up to 45° unless contraindicated) ☐ Open the airway manually; *insert BLS adjuncts: NPA or OPA unless contraindicated		
Assess for signs suggesting a difficult intubation (LEMON): neck/mandible mobility, oral trauma, loose teeth; F/B; ability to open mouth, Mallampati view, thyromental distance; over/under bite		
Assess SpO_2 on RA if time and personnel allow; auscultate breath sounds for baseline		
***Preoxygenate 3 minutes:** ☐ **Apply $ETCO_2$ NC 15 L**; maintain before and during procedure – If 2 O_2 sources add: ☐ RR ≥10 / AWAKE / good ventilatory effort: Consider CPAP at 5-10 PEEP if not contraindicated ☐ RR <10 or shallow: O_2 15 L/BVM squeeze bag over 1 sec providing just enough air to see visible chest rise (~400-600mL); avoid high airway pressure (≥25cm H_2O) & gastric distention. Ventilate at 10 BPM (1 every 6 sec) to SpO_2 94% If Hx asthma/COPD: 6-8 BPM to SpO_2 92%. If SpO_2 does not meet this goal, contact OLMC. ☐ If in cardiac arrest & apneic preox (ApOx) indicated: Apply O_2 -DO NOT VENTILATE ☐ *If only 1 O_2 source; sense $ETCO_2$ through NC (no O_2); deliver O_2 through BVM until procedure starts. Then switch O_2 source to NC and run throughout ETI insertion.		
Prepare (select, check, assemble) equipment		
BLS airways; O_2 sources; size appropriate BVM + Have below ready before placing blade into mouth ☐ **Suction equipmen**t (DuCanto rigid and 12-14 Fr flexible catheters); turn on to ✓ unit ☐ ProVu Display (reusable; inspect for S&S of damage) ☐ ProVu disposable blade (curved non-channeled) | ETT 7.0 & 7.5 ☐ Stylet; 6 mL syringe, water-soluble lubricant ☐ $EtCO_2$, SpO_2, ECG monitor; commercial tube holder, head blocks or tape, BP cuff; stethoscope ☐ Alternate airways prepped, & in sight (iGel; cricothyrotomy)		
* Check ETT cuff integrity while in package; fill syringe w/ 6 mL of air; leave attached to pilot tubing		
☐ ***Assemble ProVu**: Insert display into disposable blade. Ensure that the display is fully seated. Turn on the device and verify imaging function. ☐ *Tilt screen forward for optimal viewing if necessary. ☐ *Place lubricant on the end of endotracheal tube. ☐ *Load stylet inside ET tube. Ensure that the stylet is inserted fully and loosely seated.		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique, no prompting necessary	Attempt 1 rating	Attempt 2 rating
Intubate: *(Allow no more than 30 sec of apnea)		
☐ Maintain O_2 15 L/$ETCO_2$ NC during procedure ☐ When ready to perform procedure: stop ventilating pt.; withdraw OPA (NPA remains) ☐ Monitor VS, level of consciousness, skin color, $ETCO_2$; SpO_2 during procedure; time elapsed		
START TIMING tube placement after last breath_____ ☐ Open mouth w/ cross finger (standard) technique ☐ *Insert ProVu blade midline over tongue (holding blade just above non-channeled portion, not on large handle portion below screen). Avoid pushing tongue into larynx. ☐ *Watch for the epiglottis; direct blade tip toward vallecula to facilitate visualization of the glottis on the video screen. The blade tip can be placed in the vallecula like a Macintosh blade or can be used to lift the epiglottis like a Miller blade. For best results, center the vocal cords in the middle of the display's video screen. DO NOT LIFT TO LOOK! Tilt blade toward user ☐ If the distal window becomes obstructed (e.g., blood/secretions), remove the blade from the patient's mouth and clear the lens. Suction secretions prn for optimal visualization. Note: Each blade insertion into mouth = 1 attempt | Limit 2 attempts		
***Insert ET tube: Limit 1 attempt at ETT insertion** ☐ Maintain view and advance ETT with stylet through glottic opening. Stop inserting once entered glottic opening. The rigid stylet must be removed prior to further insertion. At this point hold ETT and remove stylet will inserting ETT. Imagine process similar to IV catheter insertion. Never insert fully the ETT with rigid stylet fully inserted in ETT. This process of stylet removal may be a two-person approach. One person holding and inserting ETT, the other removing the stylet, all while maintaining the camera view of the glottic opening. ☐ If trouble passing ETT: Blade tip may have been advanced too far; good image of the vocal cords prevents ETT from advancing because the blade/camera is obstructing ETT passage. Withdraw blade slightly and gently lift in an anterior direction prior to attempting to advance the ETT. ☐ Advance ETT to proper depth (3 X tube ID at teeth)		
☐ ***Remove blade**: Firmly hold ETT in place; remove blade from mouth. ☐ Turn off the display by pressing and holding the POWER button for approximately four seconds for power off. If not fully powered off, the camera will remain in sleep mode which will drain the battery. ☐ Carefully remove stylet from the ETT by pulling up and forward towards the patients chest.		
***Confirm tracheal placement:** ☐ Ensure adequate ventilations & oxygenation: 15 L O_2 /BVM; ventilate at 10 BPM (asthma/COPD 6-8 BPM); volume & pressure just to see chest rise ☐ 5-point auscultation: Confirm absent gastric sounds + bilateral breath sounds (midaxillary and anterior chest) ☐ **Definitive confirmation**: **monitor $ETCO_2$** number & waveform (most reliable) ☐ **Time of tube confirmation**: (Seconds of apnea)_____		
***Troubleshooting** ☐ If breath sounds only on right, withdraw ETT slightly and listen again. ☐ If in esophagus: remove ETT, reoxygenate 30 sec; insert an iGel ☐ **If ETT cannot be placed successfully** (2 attempts to visualize cords/1 attempt to pass tube) or nothing can be visualized; consider alternate airway (BIAD); ventilate & monitor as above		
If tube placed correctly ☐ *Inflate cuff w/ up to 6 mL air to proper pressure (minimal leak or 20 cm H_2O if cuff manometer available | avoid overinflation); remove syringe ☐ *Note ETT depth: diamond level w/ teeth or gums (3 X ID ETT) ☐ *Insert OPA; align ETT with side of mouth; secure with commercial tube holder; apply lateral head immobilization ☐ Continue to ventilate at 10 BPM (asthma 6-8); $ETCO_2$ 35-45; O_2 to SpO_2 94% (92% COPD)		
If secretions in tube or gurgling sounds with exhalation: suction ETT prn per procedure ☐ Select a flexible suction catheter; mark maximum insertion length with thumb and forefinger ☐ *Preoxygenate patient; insert sterile catheter into the ET tube leaving catheter port open ☐ At proper insertion depth, cover catheter port and apply suction while withdrawing catheter ☐ *Limit suction application time to 10 sec (adult). Ventilate/oxygenate patient per SOP.		

Performance standard 0 Step omitted (or leave blank) 1 Not yet competent: Unsuccessful; required critical or excess prompting; marginal or inconsistent technique 2 Successful; competent with correct timing, sequence & technique, no prompting necessary	**Attempt 1 rating**	**Attempt 2 rating**
* **Reassess**: Frequently monitor SpO_2, $EtCO_2$, tube depth, VS, & lung sounds to detect displacement, complications (esp. after pt movement), or condition change. If intubated & deteriorates, consider**:** **D**isplacement of tube, **O**bstruction of tube, **P**neumothorax, **E**quipment failure (DOPE)		
***After 10 min:** Assess need for **postinvasive airway sedation and analgesia** (PIASA) **– Use RASS** below If SBP ≥ 90 (MAP ≥ 65) (in order of preference)**:** ☐ **KETAMINE** (pain dose**)** 0.3 mg/kg slow IVP (pain relief + sedation) unless contraindicated OLMC NOT needed for ketamine pain dose added to sedation dose that exceeds max total of 300 mg | OR ☐ **MIDAZOLAM** standard sedation dose + **FENTANYL** (standard dose) if restless/tachycardic (S&S pain)		
State complications of the procedure: ☐ *Post-intubation **hyperventilation**: Titrate to $ETCO_2$ ☐ ***Barotrauma:** pneumothorax & tension pneumothorax; esophageal perforation ☐ Trauma to teeth, vocal cords, larynx, trachea, mucosal, TMJ injuries, nerve injury ☐ ***Misplaced tube** (esophagus, hypopharynx, mainstem bronchus) ☐ Over sedation ☐ *Peri-intubation **Hypoxia** (<90% SpO_2), **bradycardia** (per age), **hypotension** (SBP <90 mmHg or lowest age-appropriate SBP) or cardiac arrest Note: Peri-intubation period encompasses time from sedative administration or last PPV to up to 10 minutes post any invasive airway attempt		
Verbalize post-procedure cleaning & disinfection: After the procedure is complete, separate the display and video adapter from the blade. Dispose of blade per standard protocol and clean/disinfect display and video adapter/I-2 policy.		
***Critical error criteria in addition to starred items:** Check if occurred during an attempt ☐ Failure to ventilate w/in 30 sec if pt apneic or hypoventilating after applying PPE/interrupts ventilations for >30 sec at any time ☐ Failure to provide appropriate FiO_2 preox and during peri-intubation period ☐ Failure to ventilate patient at appropriate rate, volume or pressure: max 2 errors/min permissible ☐ Failure to successfully intubate within 2 attempts without immediately attempting alternate airway ☐ Suctions patient excessively or does not suction the patient when needed ☐ Exhibits unacceptable affect with patient or other personnel ☐ Performs in a way that could cause harm to a pt or is inconsistent with competent care		

Factually document below your rationale for checking any of the above critical criteria.

_____

_____

Scoring: All steps must be independently performed in correct sequence with appropriate timing and all starred (*) items must be explained/ performed correctly in order for the person to demonstrate competency. Any errors or omissions of these items will require additional practice and a repeat assessment of skill proficiency.

Rating: (Select 1)

☐ **Proficient**: The paramedic can sequence, perform and complete the performance standards independently, with expertise and to high quality without critical error, assistance or instruction.

☐ **Competent:** Satisfactory performance without critical error; minimal coaching needed.

☐ **Practice evolving/not yet competent:** Did not perform in correct sequence, timing, and/or without prompts, reliance on procedure manual, and/or critical error; recommend additional practice

KAC 8/24

_____
Preceptor (PRINT NAME – signature)

The **Richmond Agitation Sedation Scale (RASS)**

Assesses level of alertness or agitation | Used after placement of ADV airway to avoid over/under-sedation

Combative	+4	Agitated	+2	Alert and calm	0	Light sedation	-2	Deep sedation	-4
Very agitated	+3	Restless	+1	Drowsy	-1	Moderate sedation	-3	Unarousable sedation	-5

Goal: RASS -2 to -3. If higher (not sedated enough) assess for pain, anxiety | Rx appropriately to achieve RASS of -2