**MWLCEMS Skill Performance Record**

**OROTRACHEAL INTUBATION w/ KING VISION & Bougie**

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**Instructions:** An adult is found in bed with apnea. No trauma is suspected. Prepare the equipment and intubate the patient.

**Performance standard**

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- **Not yet competent:** Unsuccessful; required critical or excess prompting; marginal or inconsistent technique
- **Successful:** competent with correct timing, sequence & technique, no prompting necessary

* Takes or verbalizes BSI precautions: gloves, goggles, facemask

**Prepare patient**

- Open the airway manually
- *Elevate tongue, insert BLS adjuncts: NPA or OPA unless contraindicated

**Assess SpO₂ on RA if time and personnel allow; auscultate breath sounds for baseline**

* **Preoxygenate**/ventilate for 3 min w/ O₂ 12-15 L/BVM with O₂ reservoir; at 10 BPM unless asthma/COPD (6-8 BPM); squeeze bag over 1 sec with sufficient volume to see chest rise (~400-600mL) – avoid high pressure & gastric distention. Ventilate with room air until O₂ source available.

**Assess for signs suggesting a difficult intubation:** neck/mandible mobility, oral trauma, loose teeth; F/B; ability to open mouth, Mallampati view, thyromental distance; overbite

**Selects, checks, assembles equipment**

- Have everything ready before placing blade into mouth
- Prepare suction equipment (DuCanto rigid and flexible catheters); turn on to ✓ unit; suction prn
- King Vision & Blade (curved channeled)
- Select ETT 7.0 & 7.5 (must fit into channeled blade)
- Bougie; 10mL syringe, water-soluble lubricant
- Capnography, commercial tube holder, head blocks or tape, stethoscope
- Have alternate airway selected, prepped, & in sight (King LT) & Salem sump tube

* Check ETT cuff integrity while in package; fill syringe w/ 10 mL of air; leave attached to pilot tubing

**Pass tube:** * (Allow no more than 30 sec of apnea)

- Maintain O₂ 6 L/NC during procedure
- Assistant or examiner stops ventilating pt; withdraws OPA (NPA remains)
- Monitor VS, level of consciousness, skin color, ETCO₂, (SpO₂ if perfusing rhythm) q. 5 min. during procedure; time elapsed

**START TIMING tube placement after last breath**

- Open mouth w/ cross finger technique
- *Insert King Vision blade directly midline holding the blade right above the channeled portion, not on large handle portion below screen
- *Insert the blade down the midline of the tongue until you reach the back of the tongue and you can visualize the epiglottis
- *Seat blade in the vallecula, or pick up epiglottis. Do not lift blade-it is a non-displacing device. Look to visualize epiglottis, posterior cartilages, and/or vocal cords

**Visualization**

- Bougie may be advanced through the glottis if needed. You may twist the bougie, like a pencil, to the left or right to guide between the cords.

**Insertion of ET tube**

- Intubator maintains view with King Vision in place and then advances the ETT
- Counterclockwise rotation of ETT facilitates insertion through vocal cords into trachea if met with resistance at the glottic opening.

*If > 30 sec of apnea:* remove king vision, reoxygenate X 30 sec. If pt remains good candidate for ETI, change position, blade, or PM and attempt again. May go straight to King LT if unable to visualize anything.
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* Once ETT is inserted to proper depth (3X tube ID at teeth), firmly hold ETT in place, remove tube from channel by taking tube to corner of the mouth. Carefully remove blade from mouth and bougie from ETT.

* Confirm tracheal placement:
  - Ensure adequate ventilations & oxygenation: 15 L O₂, ventilate as needed at 10 BPM unless asthma/COPD (6-8 BPM)–observe chest rise; auscultate over epigastrium, both midaxillary lines and anterior chest X 2.
  - Definitive confirmation: monitor ETCO₂ number & waveform.
  - 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; repeat from insertion of blade with new tube
- *If ETT cannot be placed successfully (2 attempts) or nothing can be visualized; attempt extraglottic airway.

**If tube placed correctly**

- *If breath sounds present and equal bilaterally, inflate cuff w/ up to 10 mL air to proper pressure (minimal leak) & remove syringe
- Note ET depth: diamond on ETT level w/ teeth or gums (3 X ID ETT)
- *Insert OPA as needed; align ETT with side of mouth; secure ETT with commercial tube holder apply lateral head immobilization.

**If secretions in tube or gurgling sounds with exhalation: suction prn**

- Select a flexible suction catheter
- Preoxygenate patient
- Mark maximum insertion length with thumb and forefinger
- Insert catheter into the ET tube leaving catheter port open
- At proper insertion depth , cover catheter port and applies suction while withdrawing catheter
- Ventilate/direct ventilation of patient (NO SALINE FLUSH)

* Reassess: Frequently monitor SpO₂, EtCO₂, tube depth, VS, & lung sounds enroute to detect displacement, complications (esp. after pt movement), or condition change
  If intubated & deteriorates, consider: Displacement of tube, Obstruction of tube, Pneumothorax, Equipment failure (DOPE)

Post-intubation sedation: If pt remains unconscious but begins to bite the ETT, give midazolam in 2 mg increments IVP as needed up to total of 20 mg for post-intubation sedation

**State complications of the procedure:**

- Post-intubation hyperventilation: Use watch, clock, timing device
- Barotrauma: pneumothorax & tension pneumothorax; esophageal perforation
- Trauma to teeth or soft tissues
- Undetected esophageal intubation
- Hypoxia, dysrhythmia

*Critical Criteria: Check if occurred during an attempt (automatic fail)*

- Failure to initiate ventilations within 30 seconds after applying gloves or interrupts ventilations for greater than 30 seconds at any time
- Failure to take or verbalize body substance isolation precautions
- Failure to voice and ultimately provide high oxygen concentrations [at least 85%]
- Failure to ventilate patient at appropriate rate
- Failure to provide adequate volumes per breath [maximum 2 errors/minute permissible]
- Failure to pre-oxygenate patient prior to intubation and suctioning
- Failure to successfully intubate within 2 attempts without immediately providing alternate airway
- Failure to disconnect syringe immediately after inflating cuff of ET tube
- Uses teeth as a fulcrum
- Failure to assure proper tube placement by capnography and auscultation of chest bilaterally and over the epigastrium
- Inserts any adjunct in a manner dangerous to the patient
- Suctions patient excessively or does not suction the patient when needed
- Failure to manage the patient as a competent paramedic
- Exhibits unacceptable affect with patient or other personnel
- Uses or orders a dangerous or inappropriate intervention
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. **Score 40-44**
- **Competent:** Satisfactory performance without critical error; minimal coaching needed. **Score 35-39**
- **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. **Score below 35**

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