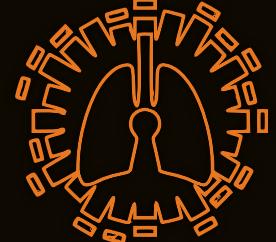


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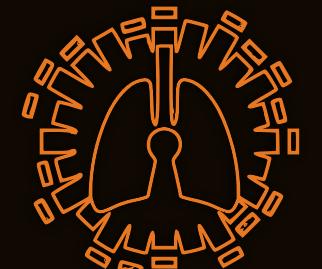


OWN THE HEAD OF THE BED

HOW TO BE COMFORTABLE IN THE AIRWAY OPERATOR'S HOME BASE

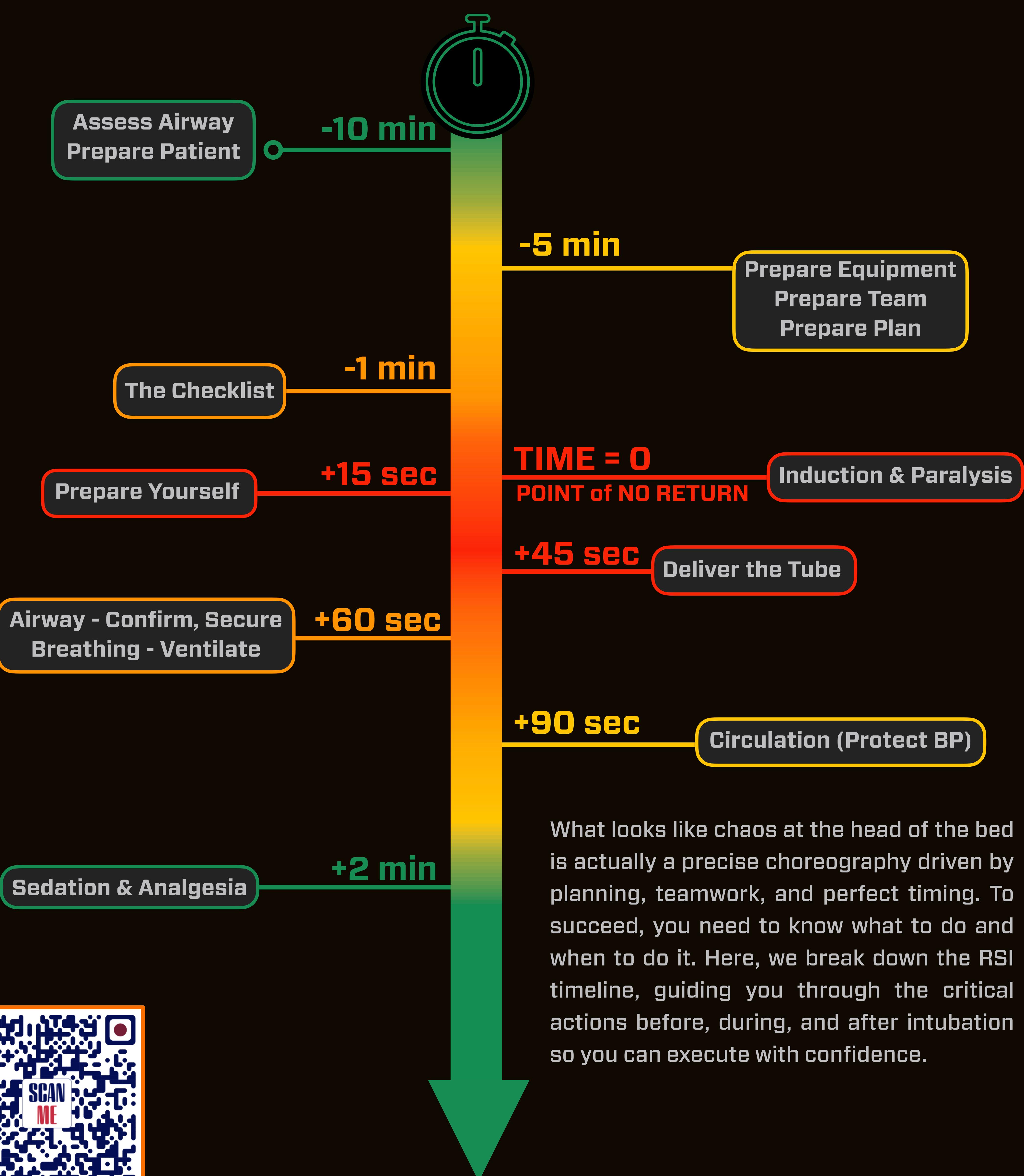
The ability to step into the airway operator's home base with confidence requires a set of vital skills. You have one primary goal, and it's not to perform intubation, but to protect your patient from the consequences of hypoxia. To do this you will need to be comfortable using all three upper airway lifelines; with the concepts of safe apnea time and RSI, and you will need to be able to come up with a plan to secure the airway, all while preparing your patient, your equipment and your team. It's a lot. Which is why we designed this space to prepare you to **own the head of the bed**.





THE RSI TIMELINE

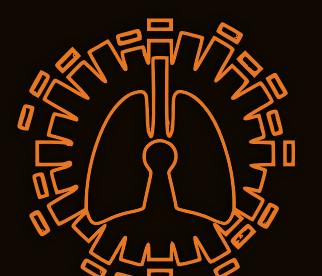
UNDERSTAND THE TIMING OF KEY ELEMENTS OF INTUBATION



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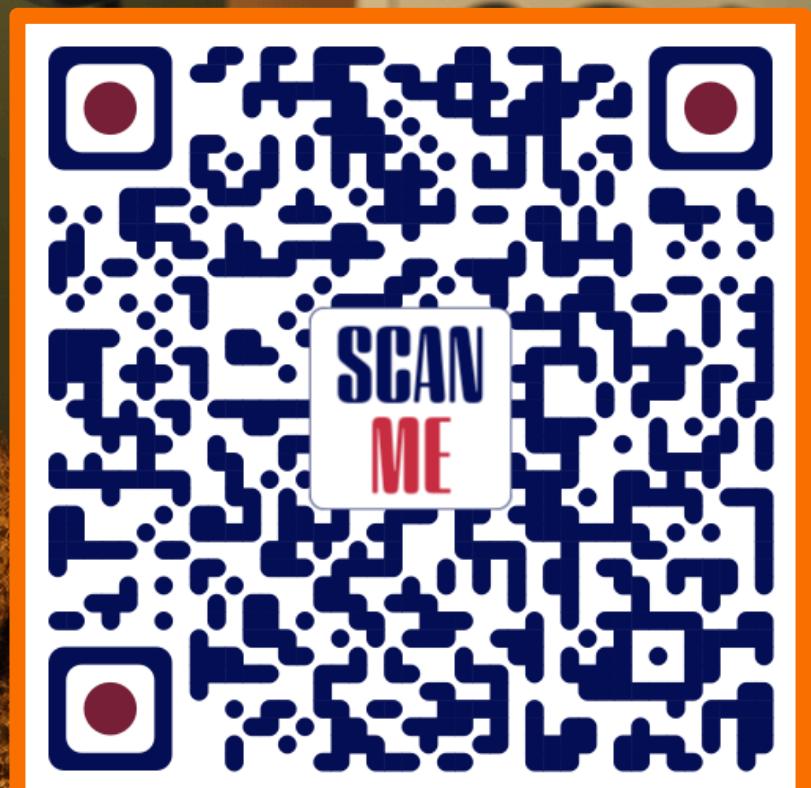
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ASSESS THE AIRWAY

PREDICT DIFFICULTY & AVOID **PREDICTABLE COMPLICATIONS**

Airway surprises are the last thing you want. Avoid trouble by *assessing the airway* first the moment you step up to the head of the bed. In a fast-moving emergency, there's often no time for a full formal assessment, but in under 60 seconds, you can gather nearly all the critical information you need with a few simple steps. So don't skip an airway assessment. It could be the difference between a smooth intubation and a disaster you could have avoided. *We'll show you how here.*



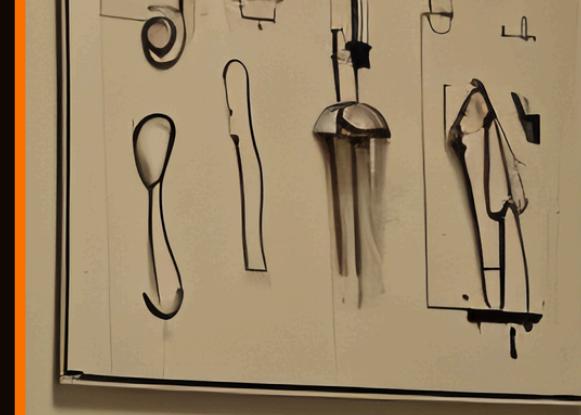


PREPARE YOUR PATIENT

WONDERING WHERE TO START? FOCUS ON YOUR PATIENT

When you first step up to the head of the bed, it's good to remember that your first priority is not intubation, but always the safety of your patient. You can do that by supporting them physically and psychologically. Are they breathing? Do they need an immediate intervention to restore oxygenation and ventilation? If they're conscious, then start by telling them who you are, and what you're going to be doing. Enlist their co-operation if possible, and then get to work with pre-oxygenation, access and, connection to a monitor. Now it's time to learn the details of how to do all of this well [here](#).

Optimize Position



PREPARE YOUR PATIENT!
ACCESS
OXYGEN
MONITOR



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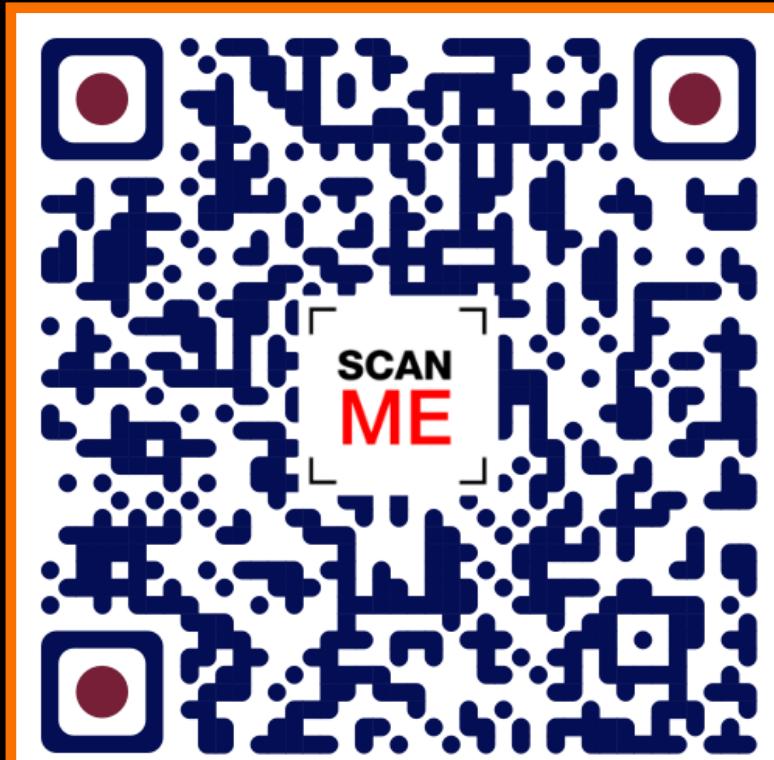
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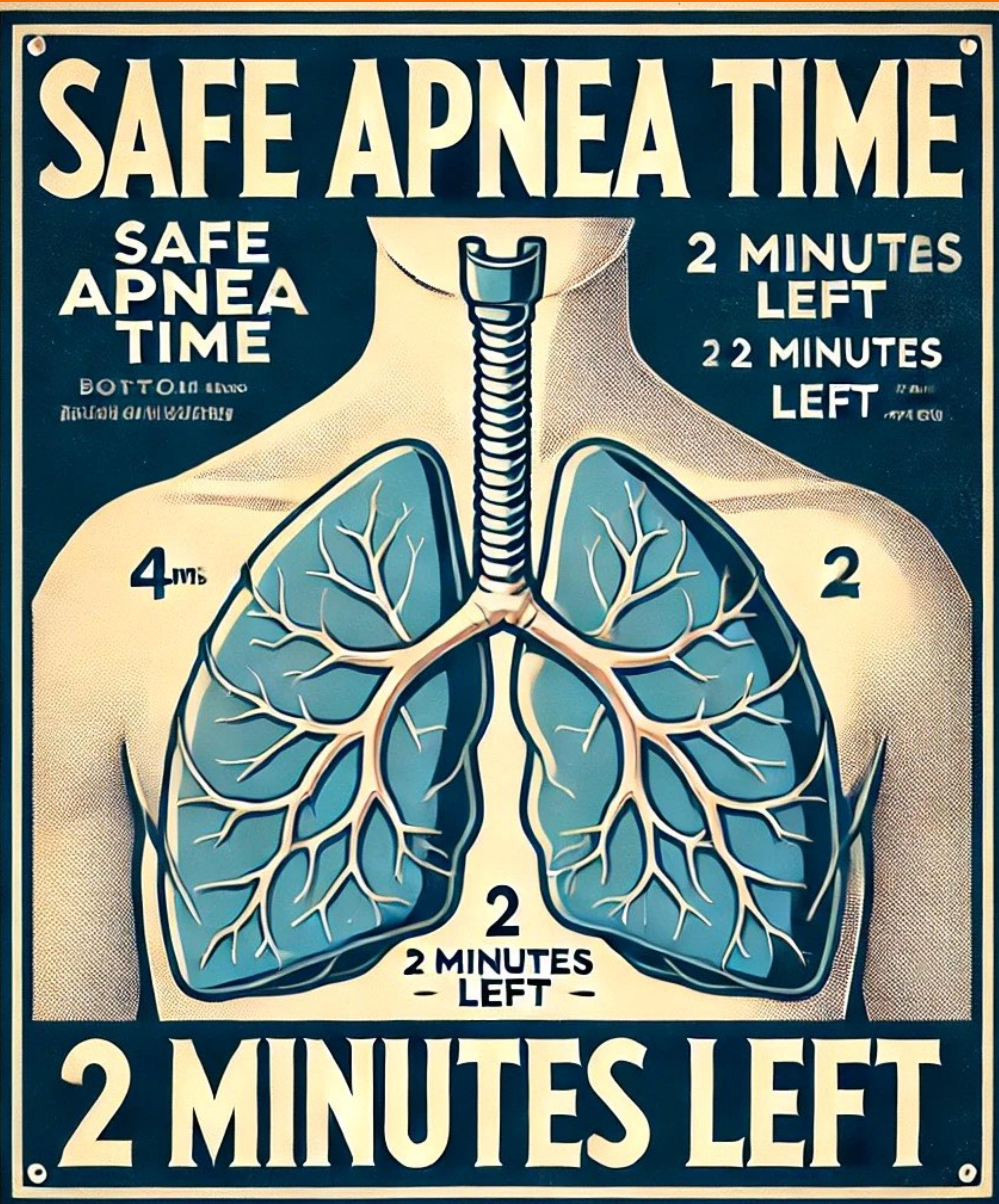


GIVE YOURSELF A BUFFER

FILL THOSE LUNGS WITH OXYGEN!

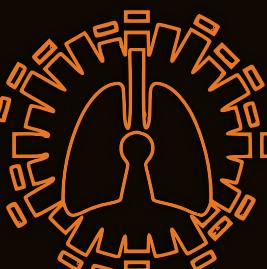


Safe apnea time is a cornerstone principle of airway care. The more time you have to intubate, the less potential harm you will cause your patients. It is defined as the time from the cessation of breathing or ventilation until the peripheral arterial oxygen saturation (SpO₂) declines to 90 percent, after which it falls precipitously, and oxygen must be restored immediately.



205 OHB

- 10 MIN



PRE-OXYGENATION

ITS ALL ABOUT EXTENDING SAFE APNEA TIME

Once RSI medications are in, the clock is ticking, and how much time you have to intubate depends entirely on how well you pre-oxygenated your patient before they became apneic. The twin concepts of **pre-oxygenation & safe apnea time** are cornerstones of RSI and safe airway management. More oxygen means more time to intubate, a higher success rate, less patient harm, and fewer stress-induced wardrobe changes over your career. At this station, we'll cover everything you need to know about this foundational skill so you can do it effectively. Let's get started.



PRE-OX YOUR PATIENT

The Rule of 15

All patients get NC @ 15 LPM and NRB at ≥ 15 LPM (the higher the better) If 100% O₂ sat is not achieved, replace NRB with CPAP up to 15 cm H₂O

VINTAGE
1940s

1940s & MILITARY

1940s & MILITARY

1940s & MILITARY



GREEN ZONE O₂ >90%

SAFE APNEA TIME

MARGIN OF SAFETY

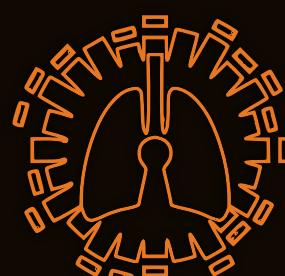
WITHOUT PRE-OX

GREEN ZONE O₂ >90%

SAFE APNEA TIME

MARGIN OF SAFETY

WITH PRE-OX



PREPARE YOUR EQUIPMENT

EVERYTHING YOU NEED AND NOTHING YOU DON'T

Standing at the head of the bed with the clock ticking is no time to realize you're missing an essential piece of equipment. On the other hand, you need to temper your desire to bring everything and the kitchen sink to the bedside. Preparation for intubation is the art of gathering everything you need and nothing you don't. Proceeding safely also requires knowing how to retrieve that backup equipment at a moments notice. **We explain all this here.**

- ✓ BAG VALVE MASK
- ✓ CONNECTED TO O₂
- ✓ NPA & OPA
- ✓ PEEP VALVE
- ✓ LARGE BORE SUCTION

- ✓ LARYNGOSCOPE
- ✓ ETT X 2
- ✓ STYLET
- ✓ 10CC SYRINGE
- ✓ END TIDAL CO₂

- ✓ BOUGIE
- ✓ SUPRAGLOTTIC
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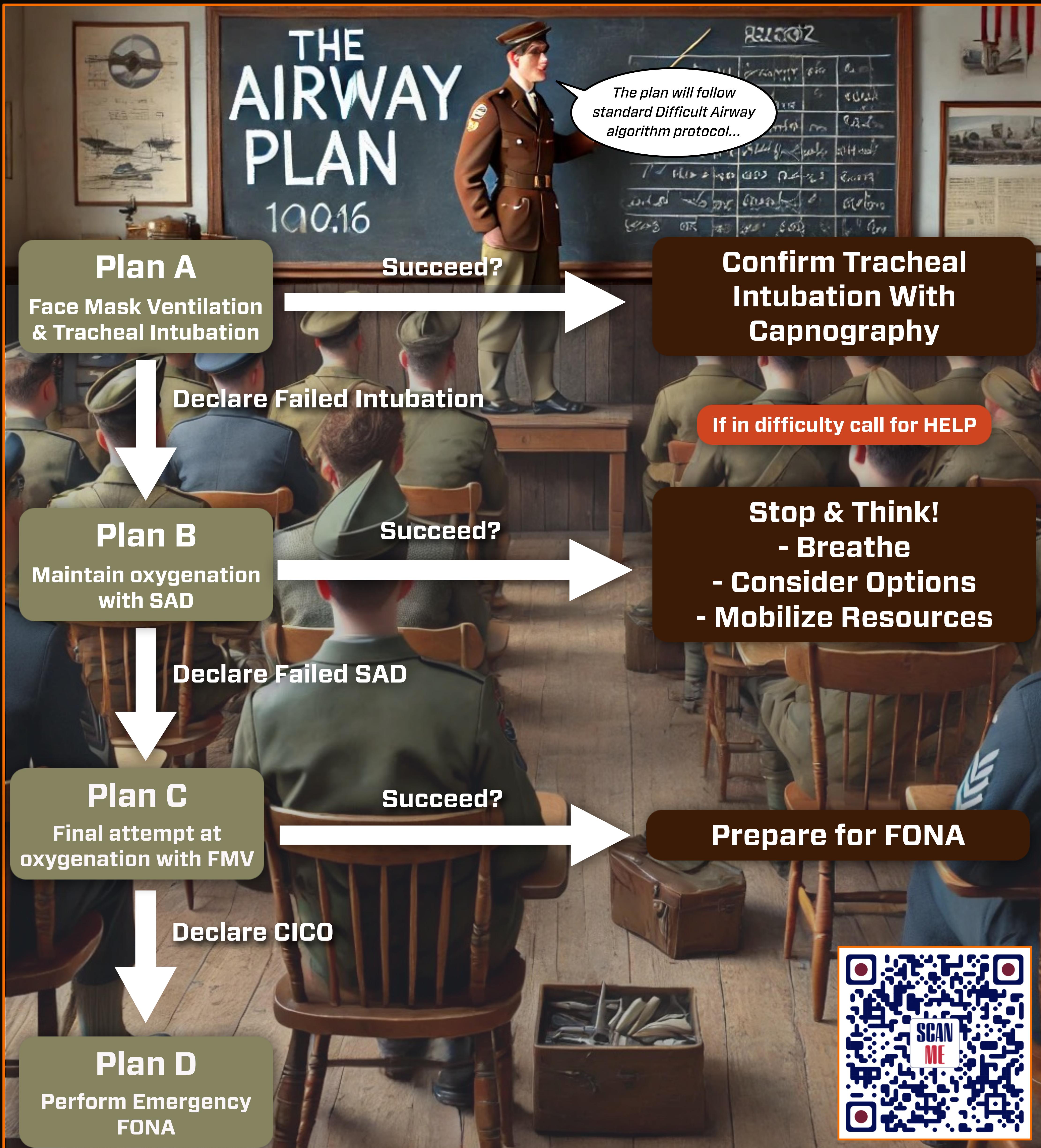


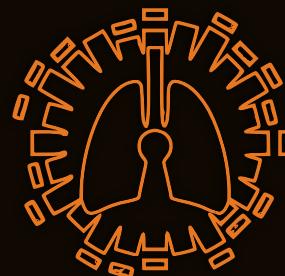


WHAT'S YOUR PLAN

MAKE IT SIMPLE, MAKE IT **COMPLETE**

Every part of your intubation plan needs to be followed by the question, what if that plan fails? To be complete every intubation plan should have these four parts. Do this for every intubation, and you will never be caught off guard by an unexpected failed airway!



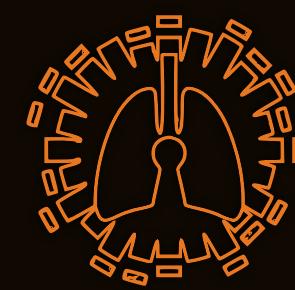


PREPARE YOUR TEAM

IT'S ABOUT PERFORMANCE SUPPORT & SAFETY

Resuscitation is a team sport. Your role at the head of the bed needs to be co-ordinated with the rest of the resuscitation efforts and with your team members. To do that effectively means keeping the quarterback at the foot of the bed informed, it means assigning roles, communicating a plan, allowing for shared decision making, feedback, and closed loop communication. All of these skills require practice. This learning space is designed to help.





AIRWAY CHECKLISTS

HOW THIS SIMPLE COGNITIVE TOOL SAVES LIVES

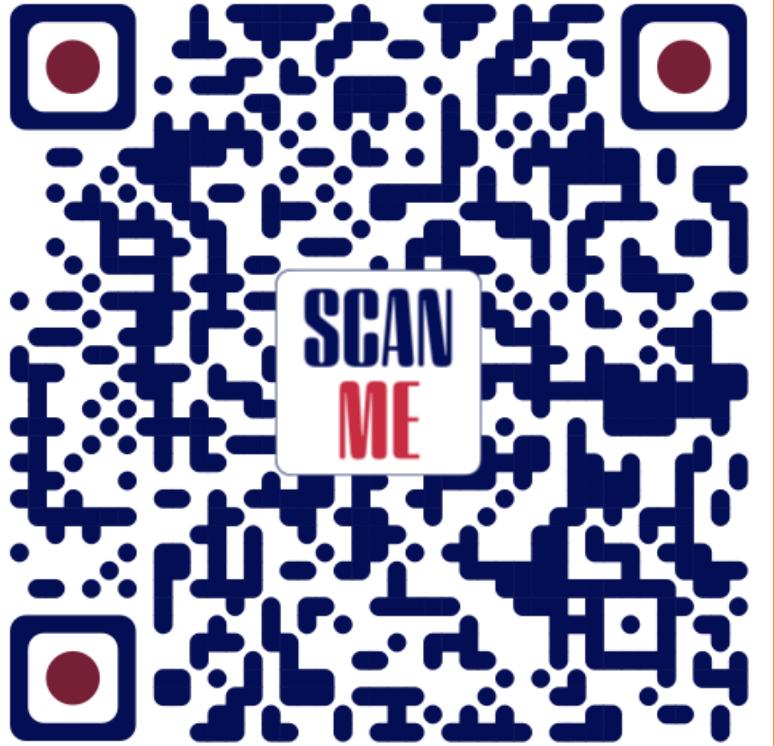
In the 1930s, the quality of aircrew performance was improved by a simple, effective form of standardization: the checklist. Like a recipe, a checklist consisted of written, step-by-step procedures that ensured Airmen performed their duties in the correct manner and sequence. Even experienced pilots benefited from this tool, and its use has expanded into other applications. Use this space to discover the power of the intubation checklist.

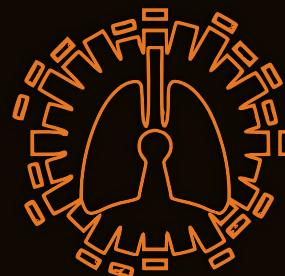


“The volume and complexity of what we know has exceeded our individual ability to deliver its benefits correctly, safely, or reliably.”

— Atul Gawande

The Checklist Manifesto





RAPID SEQUENCE INDUCTION

LAST EXIT BEFORE TOLL

Rapid Sequence Intubation (RSI) is the structured approach to quickly and safely securing a definitive airway in critically ill patients who need oxygenation, ventilation, airway protection, or urgent diagnostics. By using sedatives and paralytics, RSI optimizes conditions for first-pass success, giving you the best chance to intubate efficiently when time is critical. But before you give the meds, this is your last chance to confirm you're ready to take over your patient's oxygenation. Once the drugs are pushed, there's no turning back. Are you ready? Make sure you are by spending time here.



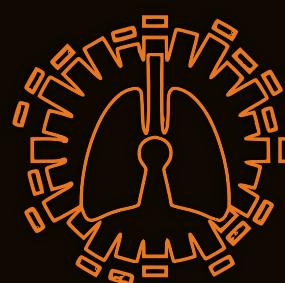


PREPARE YOURSELF

TO ENHANCE PERFORMANCE UNDER PRESSURE

The moment before those RSI medications are pushed is a great time to stop and take a moment for yourself. Uncontrolled stress can impair your performance in several ways. So take a deep breath. Visualize yourself performing the procedure and tell yourself, "You got this." As you insert the blade, you use a trigger word and feel your heart rate slow and the focus return. These essential techniques are used by athletes and other professionals where performance under stress is required. In this space, we show you how to pause before you take the plunge.





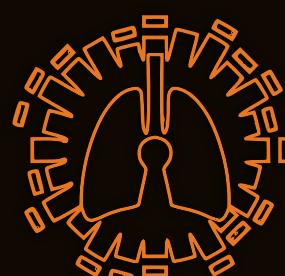
TIME TO INTUBATE

SLOW DOWN, TAKE A BREATH, YOU GOT THIS

The fasciculations have finished, and the chest is no longer rising. Your patient is apneic, and the baby blue 100% on the monitor makes you glad that you took the time to pre-oxygenate your patient. The 45 seconds that led up to this moment felt like infinity, but you were able to slow your breathing and visualize success. You are ready, and there is only one thing left to do...

You did it! But the game is not over. What follows are some of the most crucial and dangerous moments for patient resuscitation. The following posters explain the essential actions after successfully intubating.





POST-INTUBATION CARE

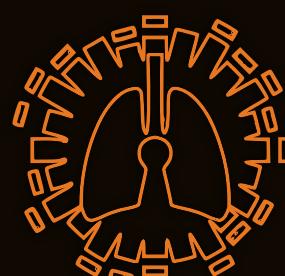
DON'T LEAVE THE BEDSIDE, YOU'VE GOT WORK TO DO

You've intubated your patient. Now the real work begins. After all, a **patent and protected airway is only step one!** Now it is time to double check your work and ensure correct tube placement, time to place your patient on the ventilator with the proper settings, and ensure that your patient is comfortable and sedated and not aware of the plastic you just inserted into their trachea. Once that is all done it is time to start the task of addressing the underlying pathology and mobilizing the resources you will need to continue this patient's care. Lets get into it.



YOU'RE RESPONSIBLE FOR POST-INTUBATION CARE

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GEEL701



POST-INTUBATION CARE

“A” is for AIRWAY

The first and most crucial step you need to take immediately after you intubate is to confirm that the tube is, in fact, in the trachea and not in the esophagus. Once you are confident that it is, you must ensure the tube is secured. It is also an excellent practice to suction the tube and clear any secretions or mucus plugs. After all, **a patent and protected airway is our primary objective**. Use the content in this poster to explore the various skills and tools used to confirm tube placement, learn how to secure the tube, and perform in-line suction.





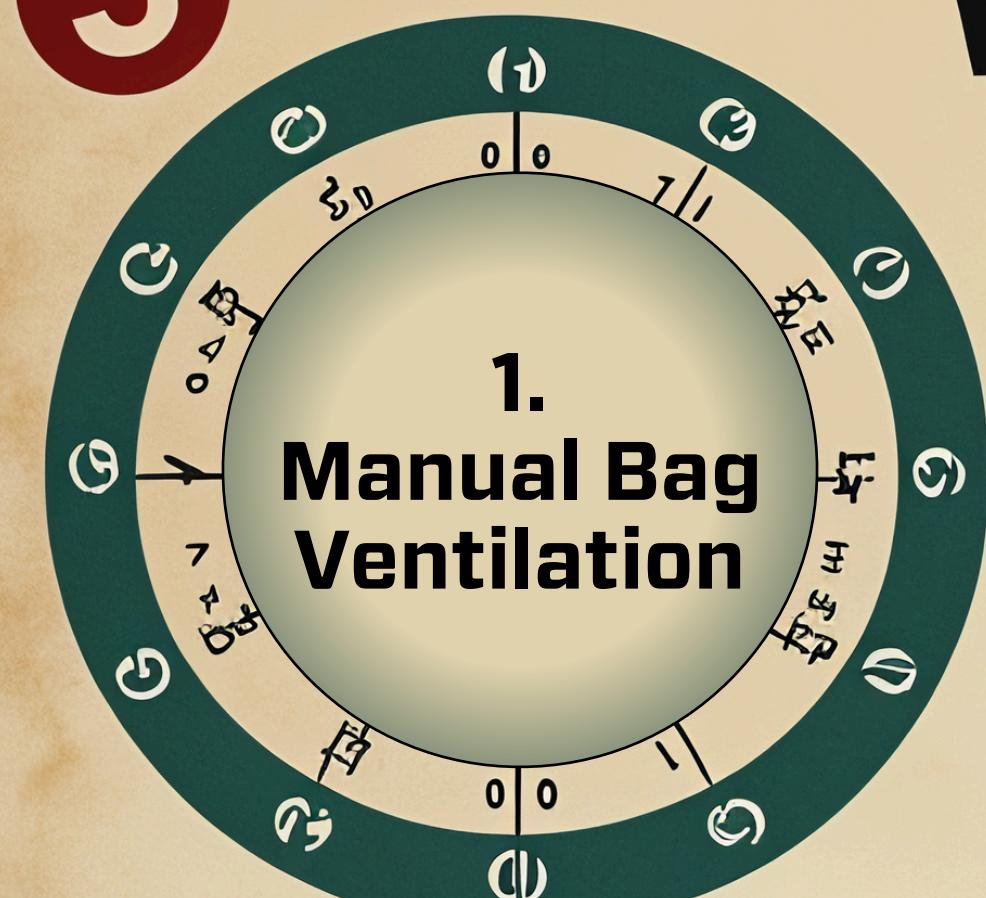
POST-INTUBATION CARE

“B” is for BREATHING

While the mechanical ventilator is being set up nearby, we begin by manually delivering breaths via a Bag Valve Mask. Using this to deliver the first few breaths after we inflate the balloon gives us tactile control of each breath as we listen for breath sounds, look for color change, and observe the end tidal waveform. But remember the rate! One breath every 6-8 seconds. Bag too fast, and you risk hyperinflation of the chest and hemodynamic collapse.

Once the tube is secured, we can now connect the patient to a mechanical ventilator and tailor the settings to our patient's specific resuscitation needs. Ventilator settings are a vast topic outside of the scope of this installation, but we invite you to use the content in this poster to learn about the fundamentals needed to ventilate your patient.

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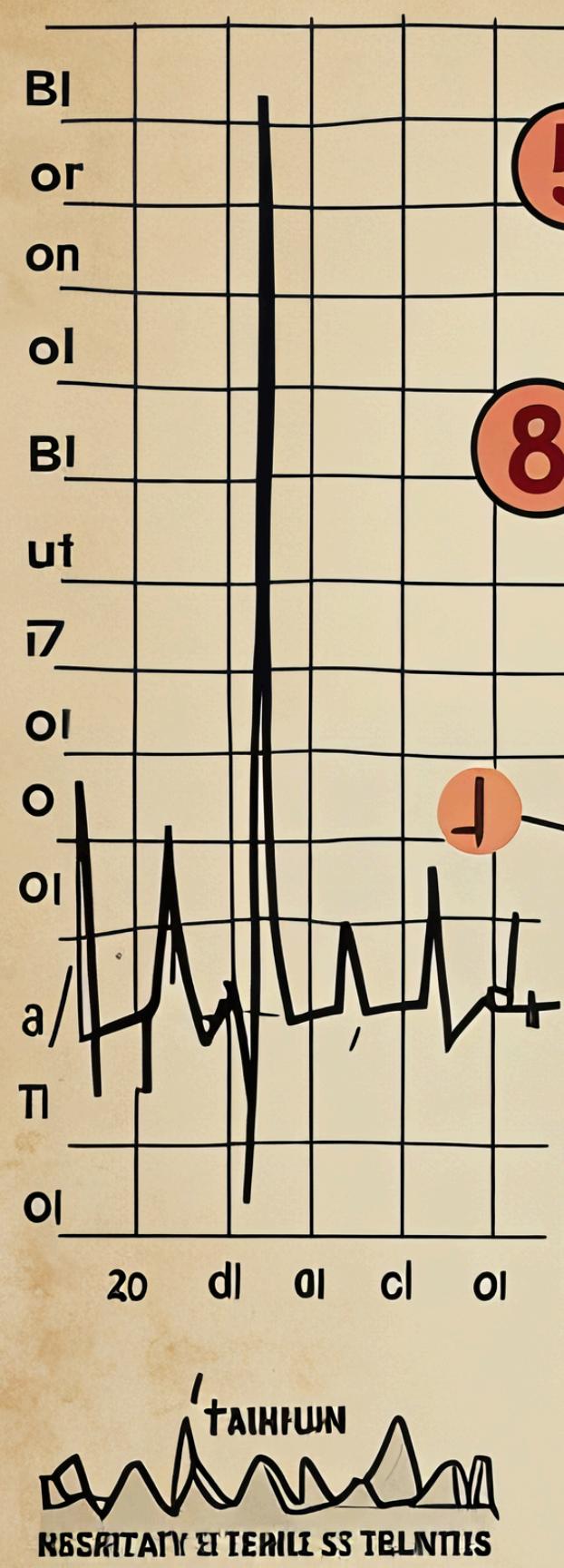


VENTILATOR GUIDELINES

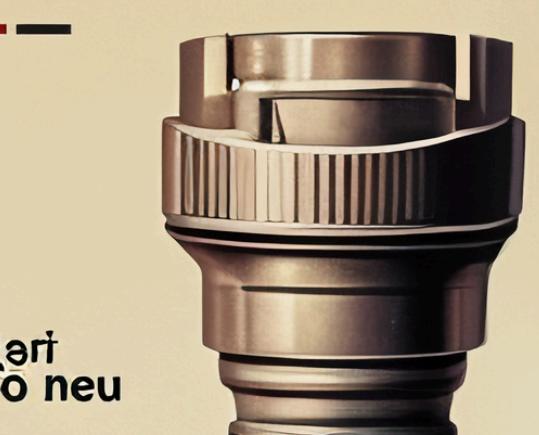
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VENTILATOR GUIDELINES



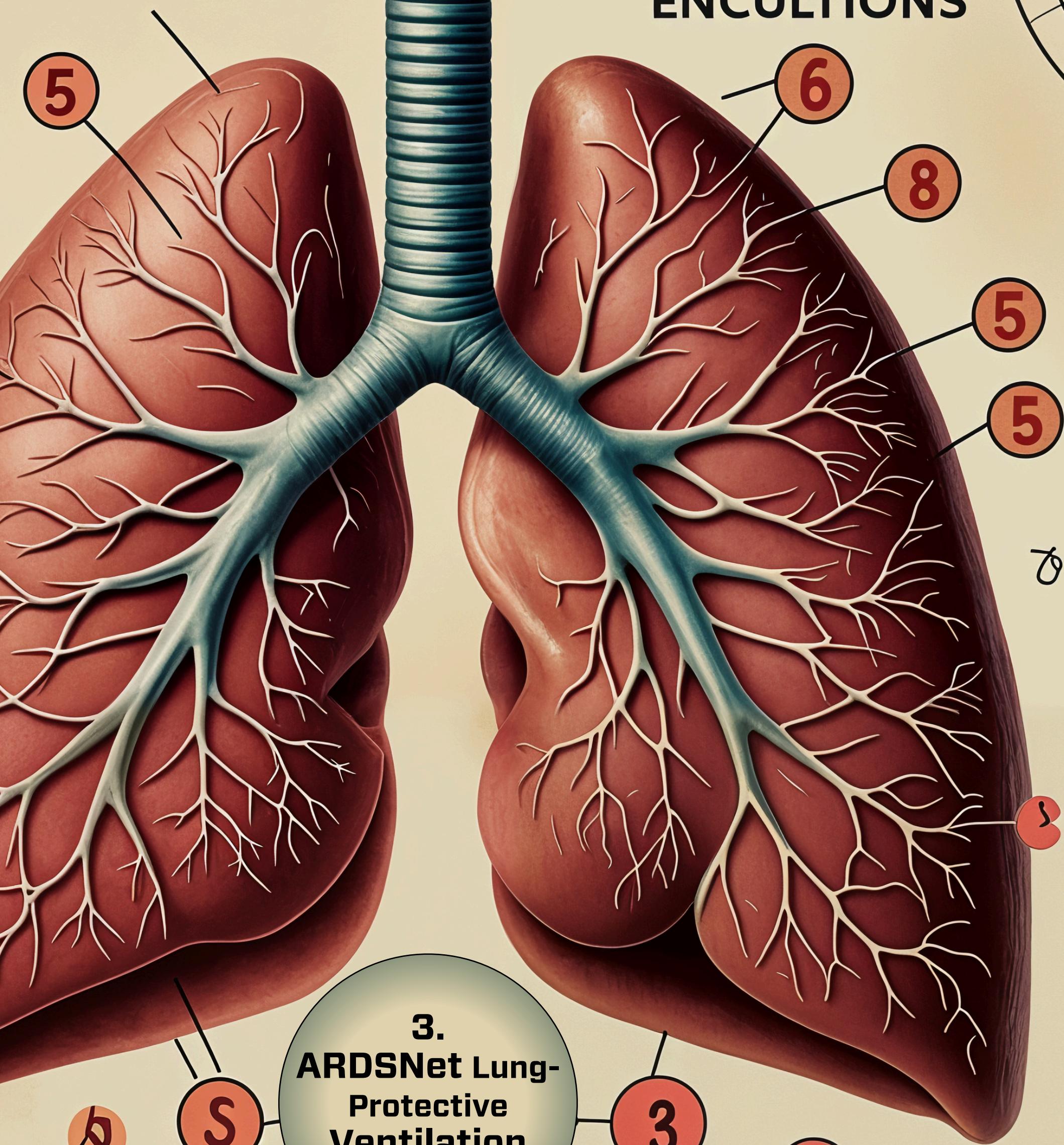
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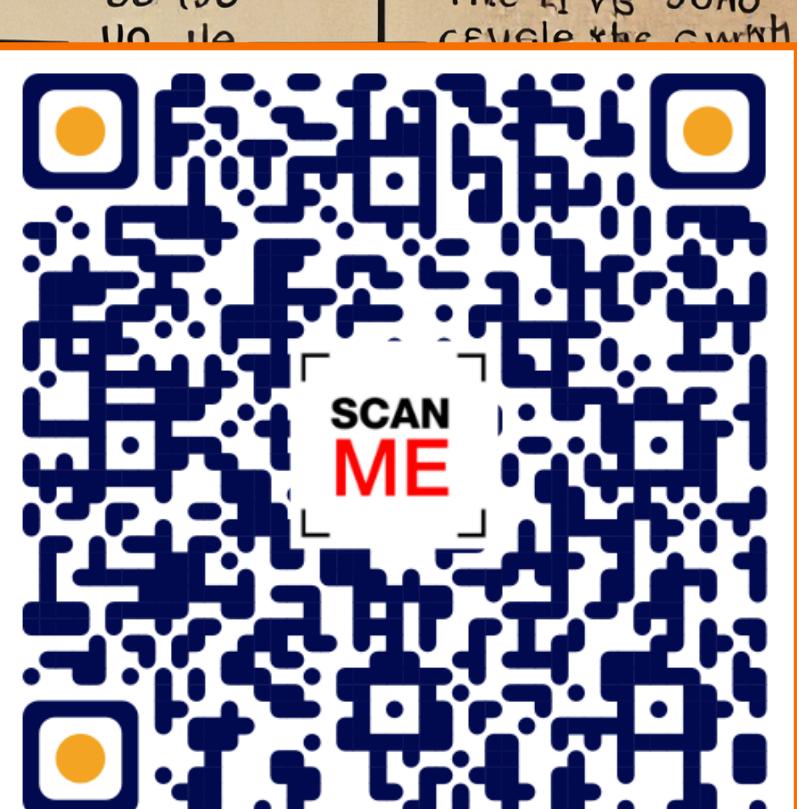


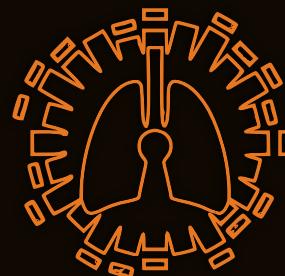
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POST-INTUBATION CARE

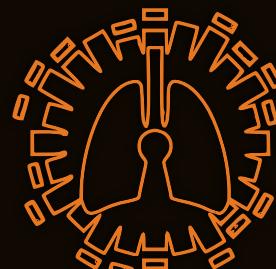
“C” is for CIRCULATION

Always Expect Post-Intubation Hypotension

In the first few minutes after intubation and initiation of ventilation, your patient is at very high risk for hemodynamic collapse. The decrease in blood pressure after intubation can be so profound it can cause cardiac arrest. While the causes are multifactorial, understanding the physiology of post-intubation hypotension will help you prevent it and allow you to treat it more efficiently. Use the content in this poster to learn about preventing hemodynamic collapse in the peri-intubation period.



Post-intubation hypotension occurs in up to 20% of cases and carries a >2x increase in mortality.



POST-INTUBATION CARE

“D” is for DRUGS

Never Paralyze Without Sedation

All intubated and mechanically ventilated patients should receive analgesia and sedation to minimize patient suffering, prevent self-extubation, and optimize ventilator synchrony. This is particularly important in the immediate post-intubation period. In many cases, **the paralytic used during RSI lasts longer than the sedative**. Therefore, sedation should be initiated as soon as possible to avoid a situation where the patient is awake and paralyzed. Use the content in this poster to familiarize yourself with the fundamental goals of sedation in intubated patients, as well as some of the most commonly used medications.

ALWAYS PROVIDE POST-INTUBATION SEDATION

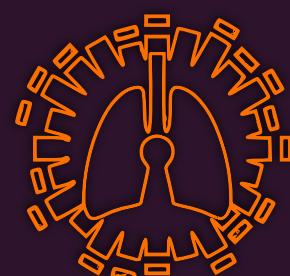
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Attention to to Hustocation Sedation Atetonel sedet! Sedation Atetonel sedet!





OWN THE HEAD OF THE BED

SIMULATION TRAINING PROGRAM

Welcome to the PAC simulation for **own the head of the bed**. To successfully complete the critical actions here, you will need to take some time reviewing the concepts and skills within the learning space, review the pre-brief here, and then work together as a team to achieve your goal of a safe intubation. The simulation starts when the *door opens!*

AMCIENCY MUREENCY

ASSIGN ROLES

THIS IS A SIMULATION

SHARED MENTAL MODEL

TEAM WORK

MUTUAL TRUST

TASK ASSIST

- OBJECTIVE - INTUBATE SAFELY
- LEVEL - FOUNDATIONAL
- PARTICIPANTS 2-5 MAX
- TIME - 10 MINUTES
- DEBRIEF - 10 MINUTES

SCAN ME

BEGIN HERE