Evaluation Process
Prior to seeking BSQ certification, a resident should be confident in their skills. The “Basic Skills Qualification” is printed and given to the supervising physician, where after, the resident performs the procedure under direct observation of the supervising physician. The competency assessment is completed by the supervising physician with their signature and given back to the resident. The resident then returns the competency assessment to the Academic Coordinator.

Resident: __________________________

<table>
<thead>
<tr>
<th>Competent</th>
<th>Needs Work</th>
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<tbody>
<tr>
<td>Informed consent: can state contraindications and describe risks, benefits, alternatives, and procedure</td>
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<tr>
<td>Positioning: In the sniffing position. Discuss technique for suspected cervical spine injury. Identify anatomy of the airway</td>
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<tr>
<td>Selects proper device, blade and size. Properly sizes endotracheal tube.</td>
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<tr>
<td>Prepares and discusses alternative methods of ventilation, and difficult intubation</td>
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<td>Discuss placement confirmation techniques. Confirms proper placement with at least 3 methods.</td>
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<tr>
<td>Discuss pharmacologically assisted intubation. Discuss rapid sequence intubation</td>
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Faculty: __________________________

Date: __________________________

Orotracheal intubation via direct laryngoscopy. This route is generally favored in most circumstances, including when cervical spine is suspected.
EQUIPMENT

- Bag-mask-valve resuscitation unit with oxygen supplementation
- Medications as selected for analgesia/anesthesia, amnesia, and neuromuscular blockade
- Towel roll or pad for occipital elevation
- Pulse oximeter
- ECG monitor
- Automatic blood pressure device or personnel to provide frequent manual blood pressure monitoring
- Gloves, mask, eye protection
- Laryngoscope handle and blade(s) - usually sizes 3 and 4 curved and 2 and 3 straight Endotracheal tubes (usually 7.0- or 7.5-mm for adult women and 8.0-mm for adult men) Malleable stylet
- Yankauer and tracheal suction catheters, suction device Magill forceps
- 10-mL syringe to inflate cuff
- Qualitative CO2 detector, CO2 monitor, or esophageal detector device
- Tape or tracheal tube stabilization device
- Resuscitation cart

Preparation
1. Don gloves, mask, and eye protection
2. Explain the procedure, if patient is conscious
3. Assure patent airway
4. Assure optimal oxygenation and ventilation
5. Assure IV access
6. Apply pulse oximeter, ECG, and blood pressure device
7. Assemble all equipment and ensure proper working order
8. Prepare the endotracheal tube
9. Check cuff integrity by inflating and fully deflating
10. Insert lightly lubricated stylet into endotracheal tube, bend to configuration predicted to assist glottic entry
11. Apply water-soluble lubricant to the cuff end of the tube
12. Connect laryngoscope blade to handle
13. Blade selection (operator's choice)
14. Straight blade - used to elevate the epiglottis anteriorly
   Curved blade - inserted into the vallecula
15. Select blade length - #3 blade is proper unless patient's neck is very long
16. Assure that light from bulb is bright OR the screen can be easily seen
17. Place pad or towel under occiput if cervical spine injury not suspected
18. Topically anesthetize the patient's oropharynx
19. Preoxygenate with 100% oxygen for 2 to 3 minutes or using 3 to 4 vital capacity breaths if time permits
20. As necessary, proceed with sedation and neuromuscular blockade.

The operator stands at the head of the bed, and the bed is raised to a position of comfort for the operator. The head of the bed may be flat or raised slightly per operator preference.
Regardless of the operator's dominant hand in other contexts, the laryngoscope is always held in the left hand.

Cricoid pressure should be gently but firmly applied by an assistant as soon as consciousness is lost and should be sustained until endotracheal tube placement is confirmed and the cuff inflated.

Insert tip of laryngoscope blade into the right side of the patient's mouth; advance the blade to the base of the tongue. Sweep the tongue to left; proper tongue control is key to laryngeal visualization.

Gently advance the blade further to its proper position. A straight blade is placed beneath the epiglottis; a curved blade is placed into the vallecula above the epiglottis.

Caution! Traction should be applied only along the long axis of the laryngoscope handle as the laryngoscope lifts the tongue upward away from the larynx, revealing the glottic opening. A rocking or rotating motion of the blade and handle may damage teeth, gingiva, or lips. The base of the laryngoscope blade should never contact the upper teeth!
Visualize the vocal cords and glottic opening.

If the vocal cords and glottis cannot be visualized, it may be helpful for an assistant to grasp the thyroid cartilage between the thumb and index finger and exert pressure in the following sequence: Pressure is applied backward against the cervical vertebrae and then in an upward direction to shift the larynx superiorly. Additional pressure is applied to shift the thyroid cartilage no more than 2 cm to the right side of the patient's neck. (This procedure can be remembered by the acronym BURP: backward, upward, and rightward pressure on the thyroid cartilage).

Gently insert the endotracheal tube through the vocal cords, holding the tube/stylet with the right hand. The stylet, if angled, may interfere with passage of the tube into the trachea. Until resistance is encountered as the tube is advanced, consider having an assistant remove the stylet while the operator holds the endotracheal tube firmly in the glottic opening.

Carefully remove stylet and laryngoscope. The operator must continue to firmly hold the endotracheal tube; position the tube such that the external centimeter length markers on the tube show 21 cm (female) or 23 cm (male) adjacent to the front teeth. Inflate cuff.

**To ensure proper position of the tube:**

1. Inspect and auscultate chest to assure equal bilateral gas entry
2. Use qualitative CO2 detector or monitor or esophageal detector device. Lack of color change with a qualitative CO2 detector or low exhaled CO2 may occur with a correctly placed tracheal tube in the patient with poor pulmonary perfusion.
3. Observe for condensation in the endotracheal tube during exhalation.
4. Listen for breath sounds through the endotracheal tube as the patient is breathing spontaneously.
5. Obtain chest radiograph (tube tip 2 to 3 cm above carina)
6. Secure endotracheal tube with tape or endotracheal tube stabilization device.