ICU Extubation Huddle / Airway Risk-Assessment Tool

Risk Stratification *(Check One)*			Intervention
☐ **High**	No/Poor Leak Around ETT (< 110 mL) Traumatic Intubation Difficult Intubation Cormack-Lehane Gr III/IV view Fiberoptic intubation	Upper Airway Mass Severe glottic edema Unstable midface fracture Mandibular fracture with trismus High Cervical Spine (C4 and above) Injury/Fusion	**REQUIRED:** Leak test **REQUIRED:** Anesthesia attending present for extubation
☐ **Moderately High**	3 or More Moderate Suspicion Factors Inhalation Injury Major Burns (> 30% TBSA)	Anasarca Morbid Obesity BMI > 40 Resolving Upper Airway Infection	**REQUIRED:** Leak test **CONSULT:** Anesthesia attending consulted prior to extubation
☐ **Moderate**	Mechanical Ventilation > 4 days Neurologic Injury with diminished airway & pharyngeal reflexes Female or Small stature	Significant + Fluid Balance >10L Anatomic Factors Associated with a Difficult Airway: small chin, large tongue, short neck	**N/A**
☐ **Low**	Absence of any risk factors		**N/A**

EXTUBATION HUDDLE - DISCUSSION POINTS

☐ The patient continues to meet extubation criteria and orders placed in Epic	☐ Code Status ☐ This is extubation attempt #
☐ Primary team and ICU team agree with plan to extubate	☐ Upcoming scans/procedures/OR that affect extubation timing?
☐ Anesthesia attending present (Red) or aware (Orange) per risk level	☐ Is a surgical airway team necessary at bedside?
☐ NMBA (paralytic) given in the last 4 hours? ○ If yes, consider reversing or check for twitches	☐ Airway equipment and medications (e.g. Racemic epi) at bedside PRN ○ Previous equipment used for successful intubation
☐ RN ○ Stop propofol ○ Pause tube feeds just prior to extubation & resume within 30 minutes ○ Assist with extubation	☐ Extubate patient to HFNC, NIV, FM, NC ☐ Post extubation surveillance/care: CXR, ABG, RCS interventions
☐ Is this patient at risk of withdrawal from any substances? If yes, what is the plan to prevent/treat withdrawal?	
☐ Orders to be placed by provider: ○ Extubate patient ○ D/C propofol ○ D/C other sedatives and opioid gtts unless otherwise appropriate to continue based on patient's condition ○ Opioid gtts may be continued for pts in whom sudden discontinuation would be inappropriate or detrimental. Consider risk for withdrawal	

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Post Extubation HFNC/NIV Considerations

Consider the following conditions for post extubation initial HFNC support:

1. FiO2 requirement > 40%
2. High Secretion Burden
3. Impaired ability to cough, clear secretions and/or take deep breaths. Patients at high risk of this include:
    a. Malnourished or decreased muscle tone
    b. Significant deconditioning of critical illness
    c. Frailty - Limited or complete dependence on others for instrumental activities of daily living such as food preparation, housekeeping, and laundry prior to admission.
4. Post laparotomy or thoracotomy in the following groups:
    a. Age > 65
    b. Class III obesity (BMI ≥ 40 kg/m^2)
6. Presence of rib fractures and one of the following:
    a. Flail chest
    b. > 5 displaced rib fractures
    c. > 3 rib fractures and age > 65

Consider the following conditions for post-extubation initial NIV (BiPAP/CPAP):

1. Cardiogenic pulmonary edema (may also consider pre-extubation T-piece trial)
2. Obstructive lung disease (COPD or asthma)
3. Obstructive Sleep Apnea
4. Neuromuscular weakness (Notify ICU Attending if using NIV for this indication after extubation)

For additional High Flow Therapy or NIV indications/contraindications, refer to the RCS P&Ps:

High Flow Therapy - Adult

Non-Invasive Ventilatory Support Protocol

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