What’s the problem?

- Anesthesia residents receive no pertinent patient information prior to arrival at the bedside for emergent airway management
- Lack of advance information can lead to delays in mobilizing equipment and backup support in patients with critical airways
- No easily accessible, aggregated source of relevant anesthetic information exists for most patients
- Retrieval of information from multiple EHR menus may delay care or lead to incomplete understanding of critical comorbidities

**Root causes of this problem:**

- Prior use of pager did not allow for advance communication
- Teams often do not know what to ask or what to report

**Project goal:** Improve response time from airway alert to intubation while ensuring pertinent critical patient information is communicated to the airway team to reduce negative patient outcomes and better mobilize anesthesia resources.

**Acuity (What’s the O2 sat?)**

**Indication (Why are we intubating?)**

**Induction concerns (Cardiac history? NPO status? Last K?)**

**Reason for admission**

**Weight (in kg)**

**Allergies**

**Airway exam/history (intubation note, history of difficult airway, cervical spine fusion, etc.)**

**Years (age)**

**Improvement strategy**

- Create standardized emergent airway signout smartphrase in Epic to be completed by primary team and reported to anesthesia team over airway phone at first point of contact
- Implement smartphrase into Medicine Department’s signout
- Provide laminated reference cards with airway signout tool for primary and anesthesia teams to serve as a cognitive aid
- Plan to measure time from call to intubation, number of intubation attempts, and intraprocedure events (ex. hypoxia, aspiration, etc.)
- Plan to measure team satisfaction