Unrecognised Oesophageal Intubation

Introduction

Unrecognised oesophageal intubation (UOI) is a potentially fatal, yet avoidable, complication of airway management. It can occur even when patients are cared for by the most experienced clinicians [1,2] A recurring theme of all recent UK UOI cases is that MDT team members either failed to speak up when they believed safety to be at risk or concerns that were raised were not heard or acted upon [1,3]. Following the deaths of Sharon Grierson, Peter Saint and Glenda Logsdail (who all died as a result of irreversible hypoxic brain injury following unrecognised oesophageal intubation), the coroners issued a Regulation 28 Prevention of Future Deaths report [3,4, 5]. Despite this, unrecognised oesophageal intubation and avoidable patient deaths are still occurring, with a further Prevention of Future Deaths report being issued in July 2024 [6].

International consensus guidelines were recently published, focusing on the importance of a sustained capnography trace to confirm intubation and strategies to actively exclude oesophageal intubation if this is not present [1]. To help staff speak up if a steep team hierarchy (or 'authority gradient') is present, the CUSS graded assertiveness tool can be used. It is a framework that team members can use to voice concerns and works best if team leaders use it to "listen down" for critical phrases and realise that 'they are being CUSS'd'. It is used in other safety critical industries to reduce the authority gradient ("flatten the team hierarchy") [2].

Learning Objectives

1) Teach the MDT to recognise and prevent oesophageal intubation
2) Emphasise "Abnormal Trace = Wrong place" rather than "flat trace = wrong place" or "no place = wrong place"
3) Empower all members of the MDT to speak up

References

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