AIRWAY MANAGEMENT

Airway management is an essential part of the care of all patients. It is an ongoing process which requires assessment of many different signs and symptoms. Evaluating and recognizing respiratory distress, respiratory failure, and respiratory arrest are critical in determining what level of intervention is required to properly treat the patient. The key areas to be assessed include: general impression, patency of airway, presence or absence of protective reflexes, and adequacy of breathing.

A. Assess airway for patency and protective reflexes.

B. Determine adequacy of breathing by assessing the rate, depth, effort, and adequacy of ventilation by inspection and auscultation.

C. If airway is patent and spontaneous breathing is adequate, and:

1. No or mild to moderate distress: administer oxygen at 2 - 6 LPM nasal cannula to maintain SpO2 at 94 - 99 %.

2. Severe distress: administer oxygen at 15 LPM non-rebreather mask to maintain SpO2 at 94 - 99 %.

D. If airway is not patent, then:

1. Attempt to open airway by using head tilt/chin lift if no spinal trauma is suspected, or modified jaw thrust if spinal trauma is suspected.

2. If foreign body obstruction of airway is suspected, then refer to **Airway Obstruction Protocol 4305.**

3. If anatomical obstruction is occurring and airway cannot be maintained with positioning and the patient is unconscious, consider placing an oropharyngeal or nasopharyngeal airway adjunct.

E. If breathing is inadequate, ventilate with 100% oxygen.

F. If airway cannot be maintained by the above means, including attempts at assisted ventilations, prolonged assisted ventilation is anticipated:

1. Perform endotracheal intubation.

2. Confirm endotracheal tube placement using clinical assessment and end-tidal CO2 monitoring.

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G. If endotracheal intubation is not possible, insert supra-glottic airway and confirm placement or consider **Rapid Sequence Intubation Protocol 4903,** if approved to do so.

H. Continue ventilation with 100% oxygen.

I. If unable to secure airway by any of the above methods and patient is in impending danger of cardio/respiratory arrest, consider *optional* **Percutaneous Cricothyrotomy - Protocol 8401 per MCP Order.**

J. Post Intubation Management:

1. If patient is intubated and shows evidence of need for sedation/pain management to facilitate tolerating the endotracheal tube, administer:

   a. **Midazolam** (Versed®) 2 mg IV/IO every five (5) minutes to a maximum dose of 10 mg. Hold for systolic BP < 90 mmHg.

   AND/OR

   b. **Fentanyl** (*Sublimaze*®) 1microgram/kilogram – up to 100 micrograms max single dose, slow IV. Additional doses require **MCP order.**

Note: These medications may be given IM if IV/IO not available or becomes dislodged.

K. If patient is still restless and/or combative, contact **Medical Command** for further treatment considerations.

Note:

1. Do not use nasal route for airway if maxillofacial trauma is present.

2. Any patient with suspected spinal trauma needs in-line stabilization with any airway procedure.

3. Consider gastric tube placement if patient is intubated.