Airway Management (3 of 3)

CICO - Can't Ventilate & Can't Oxygenate

Confirm ventilation by observing chest rise and monitoring RR and $EtCO_2$ via capnography

- If not already done, attempt intubation ONCE by the most experienced provider
- Reinsert OPA/NPA; perform maneuvers to open airway
- Continue oxygenation via BVM (+/- PEEP valve)

Contact **Medical Control** for additional orders or consultation

Facial Trauma or Swelling?

No

Insert supraglottic airway (SGA) according to manufacturer guidelines

- Confirm adequate ventilation
- Return to using BVM if SGA insertion fails

Continue to appropriate protocol
Transport patient in line with routine procedures

Yes

Perform surgical airway (needle or surgical cricothyroidotomy) as outlined in **Advanced Practice** protocol if approved by agency's Medical Director

- Confirm adequate ventilation
- Continue to appropriate protocol

Transport patient to the nearest Emergency Department for definitive airway management

Post-Intubation Advanced Airway Management

DOPES Mnemonic[1]

Displacement of ETT

Obstruction (e.g. mucus plug, kinked tube)

Pneumothorax, PNA, pulmonary edema, PE

Equipment failure

Stacked breaths (e.g. asthma, hyperventilation)

Provide post-intubation analgesia & sedation as needed

(1) Fentanyl 25-50mcg IV/IO q 2 min prn (max 200mcg)

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Midazolam 5mg IV/IO/IM q2min prn (max 20mg) or

Diazepam 5mg IV/IM q2min prn (max 10 mg)

- Deliver ventilations with only sufficient volume to achieve chest rise (i.e. avoid hyperventilation); initial RR = 12 bpm
- Adjust ventilations based on patient's SpO_2 & $EtCO_2$
- Manage ongoing or sudden hypoxia using the DOPES mnemonic[1]

- Continuously monitor ETT placement during treatment & transport
- Document $EtCO_2$ value and record capnography waveform with each set of vital signs, when the patient is moved, and just prior to patient transfer in the ED