

# SKILLS

## ADVANCED AIRWAY MANAGEMENT (S09)

FR/EMR

EMT

PARAMEDIC

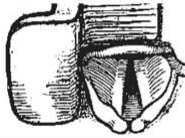
### Indications

1. Cardiac arrest.
2. Respiratory arrest or depression.
3. ROSC without rapidly improving GCS.
4. Severe respiratory distress.
5. Patient cannot control their own airway.

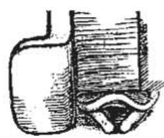
### Considerations

1. If narcotic use is suspected, maximize naloxone administration prior to advanced airway.
2. If the patient's airway is patent and being well managed with BLS airway, the use of advanced airway may be deferred.
3. If oral ET tube has not been successfully placed after two attempts, a Supraglottic Airway should be placed.
4. If the patient's airway is a grade 3 or grade 4 on the Cormack-Lehane scale\*, placement of a Supraglottic Airway is preferred.

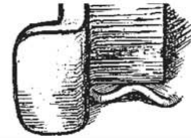
### \*Cormack-Lehane scale



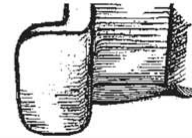
Grade 1



Grade 2



Grade 3



Grade 4

### Equipment:

1. Personal protective equipment.
2. BVM.
3. Appropriately sized ET tube or Supraglottic Airway.
4. Laryngoscope with appropriately sized blade.
5. Tape or commercially manufactured tube holder.
6. 10cc syringe.
7. ET introducer.
8. Suction device.
9. Stethoscope.
10. Pulse oximetry device.
11. End tidal capnography device.
12. Towel or pad (optional).

### Procedures: Oral Tracheal Intubation

1. Don PPE.
2. Assure patent airway, oxygenation & ventilation.
3. Assure ECG & pulse oximetry is applied.
4. Check cuff integrity by fully inflating & deflating.
5. Place ET introducer into ET tube- OPTIONAL
6. Select laryngoscope blade & check laryngoscope light.
7. Place towel/pad under patient's occiput, and place patient in the "sniffing position" (if spinal injury is not suspected).
8. Preoxygenate with 100% oxygen for 2 – 3 minutes, target  $\geq 95\%$  O<sub>2</sub>

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- saturation.
9. Cricoid pressure (Sellick Maneuver) by assistant - OPTIONAL.
  10. Insert laryngoscope blade into the right side of the patient's mouth, advance blade to the base of the tongue, sweep tongue to the left.
    - a. Place straight blade beneath the epiglottis.
    - b. Place curved blade into the vallecula above the epiglottis.
  11. Lift laryngoscope along the long axis of the laryngoscope handle, avoid a rocking motion & contact with the patient's teeth.
  12. Visualize the vocal cords & glottis opening.
  13. Insert ET tube & remove introducer (if used).
  14. Inflate cuff.
  15. Confirm ET tube placement by auscultation, ET tube position makers (21-23 cm at the teeth).
  16. Secure ET tube with tape or commercially manufactured tube holder.
  17. Connect ETCO<sub>2</sub> device.

### Procedures: Supraglottic Airway Placement

1. Don PPE.
2. Assure patent airway, oxygenation & ventilation.
3. Assure ECG & pulse oximetry is applied.
4. Preoxygenate with 100% oxygen for 2 – 3 minutes, target  $\geq 95\%$  O<sub>2</sub> saturation.
5. Place patient in the “sniffing the morning air position” (if spinal injury is not suspected).
6. Hold SGA firmly at the bite block with dominant hand. With non-dominant hand, open the mouth applying a chin lift.
7. Introduce the leading soft tip into the mouth in the direction of the hard palate.
8. Glide the SGA down and back along the hard palate with continuous but gentle pressure until definitive resistance is felt. Does not repeatedly push down or apply excessive force during insertion, a feel of ‘give-way’ may be felt before end point resistance is met as the SGA moves into position.
9. Place so that the incisors rest on the bite block.
10. Secures SGA using commercial holder, or tape.
11. Attach BVM.
12. Confirms absence of abdominal sounds and presence of bilateral breath sounds.
13. Connect ETCO<sub>2</sub> device.

SGA	Patient size	Patient weight (kg)
1	Neonate	2-5
1.5	Infant	5-12
2	Small pediatric	10-25
2.5	Large pediatric	25-35
3	Small adult	30-60
4	Medium adult	50-90
5	Large adult	90+

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