

AIRWAY AND TRACHEOSTOMY MANAGEMENT

UPDATED 1/2024

ALL PROVIDERS

- ❑ Focused history and physical exam
 - Assess ABC's for evidence of current apnea, airway reflex compromise or difficulty in ventilatory effort.
 - Assess medical conditions, burns or traumatic injuries that may have or will compromise the airway.
- ❑ Continuous cardiac, ETCO₂, blood pressure, and pulse oximetry monitoring.
- ❑ Obtain a 12 Lead EKG when available.
- ❑ **Treatment Plan**
 - Provide basic airway maneuvers to all compromised airways, i.e. jaw-thrust, airway adjuncts, and oxygen.
 - Identify and treat underlying reversible medical conditions (narcotic overdose, hypoglycemia, etc.).
 - Provide supplemental oxygen and assisted ventilation as needed for the patient to maintain an oxygen saturation 90-94% and ETCO₂ of 35-45.
 - Ensure proper documentation of ETCO₂ level and waveform as well as lung sounds.
 - Always ensure proper care of the C-spine during airway treatment per the *Spinal Motion Restriction Guideline*.
 - Keep NPO. Stop any GI Feedings and do not use GI tube during resuscitation except to vent tube if assisted ventilations being delivered
 - Infants and young children are primary nose breathers. Suction oral and nasal passages as needed to keep clear.
 - Use a 8fr soft tip catheter and suction for no less than 10 seconds per nare. If in distress, use 1 drop of saline and suction the length measured from the tip of the child nose to their ear lobe.
 - BVM is the preferred method of ventilation below the age of 10 years old.
 - Tracheostomy/Home Ventilator
 - Primary caretakers and families are your best resource for understanding the equipment they are using.
 - Disconnect the ventilator and assist ventilations with BVM if the patient is apneic, unresponsive, or has severe respiratory distress. (Disconnecting a vent poses a very HIGH risk for body fluid exposure and can be dangerous to the patient if done incorrectly, see appendix for more details)
 - If unable to ventilate, suction the tracheostomy, then reattempt ventilatory efforts.
 - If still unable to ventilate, attempt traditional BVM
 - If there is difficulty ventilating a tracheostomy patient, consider "D.O.P.E." (Dislodged? Obstruction? Pneumothorax? Equipment failure?)

ADULT

PEDIATRIC (<15 years of Age)

NOTE: Pediatric weight based dosing should not exceed Adult dosing.

EMT

EMT

- ❑ Ventilate with BVM when apneic or exhibiting respiratory distress. Consider a nasal or oral airway when not contraindicated (facial fractures, intact gag response, etc).
- ❑ Avoid hyperventilation and maintain a ventilatory rate of 10-12 breaths per minute

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- ❑ Avoid hyperventilation - recommended pediatric ventilatory rates:
 - Infant (0-12 month): 25 breaths per minute
 - 1-3 yrs: 20 breaths per minute
 - 4-6 yrs: 15 breaths per minute
 - >6 years: 12 (Same as adult)

AEMT

AEMT

- ❑ Consider an appropriately sized supraglottic airway device if unable to ventilate with BVM
- ❑ Document confirmation via ETCO₂ waveform capnography and lung sounds.

- ❑ Consider an appropriately-sized supraglottic airway device if unable to ventilate with BVM.
- ❑ Document confirmation via ETCO₂ waveform capnography and lung sounds.

- ❑ **CPAP/BiPAP** – Consider when the patient is awake but needs assistance with oxygenation and ventilation such as in a CHF/pulmonary edema patient or COPD patient.
 - Explain the procedure to the patient
 - Initially apply the mask and begin the CPAP or BiPAP according to manufacturer instructions.
 - If unable to adequately ventilate return to BVM and consider insertion of supraglottic airway and bag ventilation.

- ❑ **CPAP/BiPAP** – Only use when the patient is on the machine at home. Maintain home settings and bring machine with the patient. If unable to adequately ventilate return to BVM and consider insertion of a supraglottic airway.

📞 Contact OLMC for further assistance as needed.

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PARAMEDIC

- ❑ **Endotracheal Intubation** - Consider orotracheal intubation using an endotracheal tube (ETT) when indicated
 - Video laryngoscope is the preferred method of achieving first pass intubation.
 - Document confirmation via ETCO₂ waveform capnography and lung sounds
 - Secure the ETT for transport
 - Consider NG/OG tube placement or opening active G-tubes for all intubated patients
 - Consider sedation after intubation
 - If endotracheal intubation is unsuccessful revert to a supraglottic airway device or BVM with appropriate oral/nasal airway. Avoid multiple attempts at intubation.
- ❑ **Surgical Airway - Cricothyrotomy** - Consider only when all other methods of oxygenation, ventilation and securing the airway have failed.
 - Document confirmation via ETCO₂ waveform capnography and lung sounds.
 - Gather all equipment before beginning the procedure
 - Once the procedure is done insert a 5.0 or 6.0 cuffed ETT, inflate cuff, and secure.
- ❑ **Tracheostomy Assistance**
 - Provide supplemental oxygen
 - Suction the patient appropriately (use in-line suction if available)
 - Replace Tracheostomy tube if needed
 - IF unable to ventilate, pass an appropriately sized ETT through the stoma 1-2 inches
 - IF unable to pass a tracheostomy tube or endotracheal tube use BVM, orotracheal intubation or Supraglottic device to ventilate the patient.

PARAMEDIC

- ❑ **Endotracheal Intubation** - Consider orotracheal intubation using an endotracheal tube (ETT) when indicated
 - BVM ventilations are the preferred method of ventilation in children, even for long transports. However, if oxygenation or ventilation is inadequate with BVM, a trial of a supraglottic airway is indicated. In the rare instance that a supraglottic airway is ineffective, then proceed to ETT.
 - Video laryngoscope is the preferred method of achieving first pass intubation.
 - For longer transports, be aware of gastric distension during BVM, which may limit ventilation. An NG/OG tube can be placed to decompress the stomach
 - Pediatric ETT's are sized according to age and are in mm:
 - Premie: 2.5
 - 0-3 months: 3.0
 - 3-7 months: 3.5
 - 7-15 months: 4.0
 - 15-24 months: 4.5
 - 2-15 years: Formula is (age+16) | 4
 - Document confirmation via ETCO₂ waveform capnography and lung sounds.
 - Secure the ETT for transport
 - Consider NG/OG tube placement or opening active G-tubes for all intubated patients
 - Consider sedation after intubation
 - If endotracheal intubation is unsuccessful revert to a supraglottic airway device or BVM with appropriate oral/nasal airway. Avoid multiple attempts at intubation.
- ❑ **Surgical Airway – Cricothyrotomy** - Consider only when all other methods of oxygenation, ventilation and securing the airway have failed.

☐ **Ventilator Management**

- Work with the family to troubleshoot the machine
- Address tracheostomy as above
- If you need to disconnect for transport provide adequate BVM ventilations similar to home respiratory rate settings.

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- Open Surgical Cricothyrotomy is contraindicated in ages < 12 years old.
- Needle Cricothyrotomy patients < 12 years of age.
- Document confirmation via ETCO₂ waveform capnography and lung sounds.
- Gather all equipment before beginning the procedure.
- Once the procedure is done insert an appropriately sized cuffed ETT and secure.

☐ **Tracheostomy Assistance**

- Provide supplemental oxygen
- Suction the patient appropriately (use in-line suction if available)
- Replace tracheostomy tube, with patient's back up tracheostomy tube if needed
- IF unable to ventilate, pass an appropriately sized ETT through the stoma 1-2 inches
- IF unable to pass a tracheostomy tube or ETT use BVM, orotracheal intubation or SGD

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- Address tracheostomy as above
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