

	Department Name Address	ALS	Paramedic
		Revision #	
		Implementation Date	
Protocol	2.1.2 Airway Management	Last Reviewed/Update Date	
Author / Owner		Medical Director	

Treatment goals in airway management of a patient in the pre-hospital environment include: ensuring adequate oxygenation and safe timely transport to the appropriate care facility.

1. Baseline care standards.
2. Place patient in position of comfort and reassure.
3. Maintain cervical spine control on patients with suspected trauma.
4. Auscultate with stethoscope at least four different areas of the chest and document.
5. In the conscious patient:
 - Administer oxygen by non-rebreather mask at 15 L per minute.
 - Monitor O₂ saturations.
6. For the unconscious patient:
 - Use the head tilt-chin lift or jaw thrust maneuvers to open airway.
 - If trauma is suspected, use the modified jaw thrust maneuver.
 - If positioning doesn't open the airway and foreign body is suspected, follow the obstructed airway guidelines.
 - Monitor O₂ saturation and capnometry.
7. If blood, secretions or vomitus are present, suction airway for no longer than 15 seconds.
 - If airway immediately refills, alternate suctioning with 30 seconds of oxygenation and/or ventilation.
8. If patient has an altered level of consciousness and is without a gag reflex, insert an oral airway.
9. If patient has an altered level of consciousness and a gag reflex, insert a nasopharyngeal airway.
 - Do not use a nasopharyngeal airway if severe head trauma is suspected.

10. Using a bag-valve-mask, assist respirations in any patient with decreased level of consciousness and respiratory rates of < 10 or > 30 per minute.
 - Consider tension pneumothorax.
 - Consider treatment with chest needle decompression.
11. If patient is unresponsive and unable to maintain an adequate airway or without a pulse, intubate using direct laryngoscopy and appropriate size endotracheal tube. If cervical spine injury is suspected, have second person maintain c-spine control during intubation.
 - Inflate ET tube cuff and verify tube placement by auscultation of breath sounds, esophageal detector device, and capnometry.
 - Secure ETT with commercial device.
 - Monitor O₂ saturations with pulse oximeter.
 - If unable to intubate after repeat attempts, consider alternative airway management (Continue BVM, Combi-tube, LMA, or cricothyrotomy) and contact medical control.
12. For a conscious or semi-conscious person in severe respiratory distress, consider Rapid Sequence Intubation (RSI) to assure a patent airway, prevent aspiration, and to oxygenate and ventilate the critically ill or injured patient. Another acceptable indication for the technique is to protect and provide expedient care to the agitated or combative patient. The underlying assumption of RSI technique is that the patient is in a NON-fasting state.
 - Consider administration of adjunctive medication:
 - o *Lidocaine 1.5mg/kg* for suspected head injury and intracranial neoplasm.
 - Induction with sedative/hypnotic:
 - o *Etomidate 0.3mg/kg IV, OR*
 - o *Midazolam 0.1mg/kg IV.*
 - Administer defasciculating dose of paralytic:
 - o *Succinylcholine 0.1mg/kg IV.*
 - Perform cricoid pressure (Sellick maneuver).
 - Administer Neuromuscular blockade:
 - o *Succinylcholine 1-1.5mg/kg IV.*
 - Intubate using direct laryngoscopy.
 - Inflate ET tube cuff and verify tube placement by auscultation of breath sounds, esophageal detector device, and capnometry.
 - If unable to intubate after repeat attempts, consider alternative airway management (Continue BVM, Combi-tube, LMA, or cricothyrotomy) and contact medical control.
 - Maintain neuromuscular blockade as needed using:
 - o *Rocuronium 1mg/kg IV.*
 - Maintain sedation using:

- o *Midazolam 0.05mg/kg IV.*

13. Consider needle or surgical cricothyrotomy if indicated.

Medical Director's Signature

Date

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