Orotracheal Intubation 5.6

PARAMEDIC STANDING ORDERS – ADULT & PEDIATRIC

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INDICATIONS

- Apnea/respiratory failure, impending respiratory failure, impaired or absent gag reflex. Only after basic procedures are deemed inappropriate or have proven to be inadequate should more advanced methods be used. Use a graded approach for treatment by using least invasive method first. NRFM → BVM → SGA → ETT → Cric.

CONTRAINDICATION

- Epiglottitis.
- Facial or neck injuries that prohibit visualization of airway anatomy (relative).

PROCEDURE

1. Prepare all equipment and have suction ready.
2. Pre-oxygenate the patient.
3. Open the patient's airway. While holding the laryngoscope in the left hand, insert the blade into the right side of the patient's mouth, sweeping the tongue to the left. Use video laryngoscopy, if available and trained.
4. Use the blade to lift the tongue and the epiglottis, either directly with the straight (Miller) blade, or indirectly with the curved (Macintosh) blade.
5. Once the glottic opening is visualized, insert the tube through the vocal cords and continue to visualize while passing the cuff through the cords.
6. Remove the laryngoscope and then the stylet from the ETT.
7. Inflate the cuff with 5 – 10ml of air.
8. Confirm appropriate proper placement by quantitative waveform capnography, symmetrical chest-wall rise, auscultation of equal breath sounds over the chest and a lack of epigastric sounds with ventilations using bag-valve-mask and condensation in the ETT.
9. Secure the ETT, consider applying a cervical-collar and securing patient to a long backboard (even for the medical patient) to protect the placement of the ETT.
10. Reassess tube placement frequently, especially after movement of the patient.
11. Ongoing monitoring of ETT placement and ventilation status using waveform capnography is required for all patients.
12. Document each attempt as a separate procedure so it can be time stamped in the ePCR. **An attempt is defined as placement of the blade into the patient's mouth**. For each attempt, document the time, provider, placement success, pre-oxygenation, airway grade, ETT size, placement depth, placement landmark (e.g. cm at the patient's lip), and confirmation of tube placement including chest rise, bilateral, equal breath sounds, absence of epigastric sounds and end-tidal CO_2 readings.

Protocol Continues

5.6 Orotracheal Intubation

Protocol Continued

PARAMEDIC STANDING ORDERS – ADULT & PEDIATRIC

If intubation attempt is unsuccessful, ETT placement cannot be verified or ETT becomes dislodged:

- Monitor oxygen saturation and end-tidal CO_2 **AND**
- Ventilate the patient with 100% oxygen via a BVM until ready to attempt intubation again.

If continued intubation attempts are unsuccessful (maximum of 3 attempts) consider Cricothyrotomy. See Cricothyrotomy Procedure 5.2 OR 7.4.

POST INTUBATION CARE – ADULT

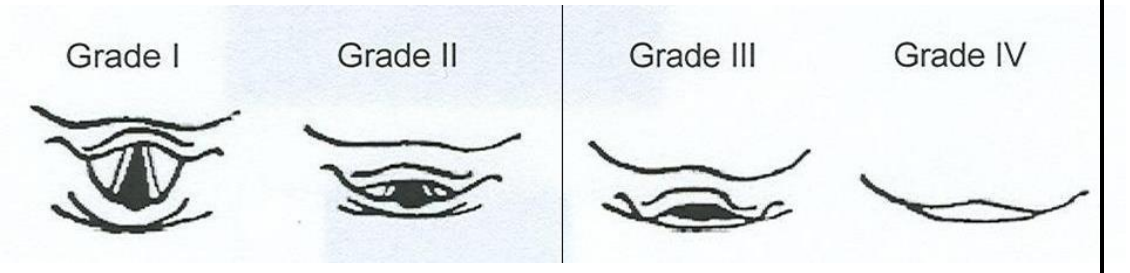
Sedation:

- Midazolam 2 – 5 mg IV, every 5 – 10 minutes as needed, **OR**
- Lorazepam 1 – 2mg IV every 15 minutes as needed (maximum: 10mg). **AND**
- Fentanyl 50 – 100 micrograms slow IV push.

POST INTUBATION CARE – PEDIATRIC

Sedation:

- Fentanyl 2-3 micrograms/kg IV.



Classifications for Laryngoscopy Views