AIRWAY MANAGEMENT

Effective: January 1, 2022
Replaces: February 12, 2019
Review: January 1, 2024

1. Airway Interventions (BLS)

1.1. The LMA Supreme should be used as the preferred method for securing an adult patients airway. Use of the LMA Supreme is not approved for pediatric use for BLS providers.
  1.1.1. Contraindications for the LMA Supreme for BLS application:
    1.1.1.1. Responsive patients with a gag reflex
    1.1.1.2. Pediatric patients

1.2. Oropharyngeal Airway (OPA) can be used to secure a patient's airway if LMA Supreme placement fails or prior to LMA Supreme placement to establish the presence of a gag reflex. OPAs will be indicated in patients that are unresponsive without the presence of a gag reflex. The provider will ensure appropriate sizing prior to placement.

1.3. Nasopharyngeal Airway (NPA) can be used as the last BLS method to secure a patient's airway if both methods (LMA Supreme and OPA) placement fail or the patient has the presence of a gag reflex. The provider will ensure appropriate sizing prior to placement. Contraindications of the NPA are facial trauma.

1.4. Bag Valve Mask (BVM) Ventilations will be delivered in the range of 10-12 respirations per minute for adults, 20-30 per minute for infants/children, and 40-60 per minute for neonates achieving a tidal volume adequate for chest rise and fall (attached to oxygen), regardless of established airway adjunct.

1.5. All BLS airways will be monitored for patency by capnography, if equipped (ALS providers).

2. Laryngoscopy (Airway Visualization, non-intubation attempt)

2.1. Visualization will consist of the introduction of the laryngoscope by itself or video laryngoscope without the endotracheal tube introducers (Bougie) and endotracheal tube loaded into the channel, into the oral cavity for the purpose of visualization, and/or the intent to:
  2.1.1. Visualize a foreign body airway obstruction and/or remove the foreign body using McGill's forceps
  2.1.2. Visualize and/or physically manipulate the tongue, for the purpose of suctioning secretions, blood or emesis from the pharynx

3. Adult Intubation

3.1. Intubation will be indicated for the treatment of patients with a Glasgow Coma Scale rating of less than eight (8) and one (1) or more of the following:
  3.1.1. Hypoxia and/or hypoventilation
  3.1.2. Securing the airway from aspiration of a foreign substance in patients with a sustained level of altered consciousness
  3.1.3. Insufficient BLS airway patency, verified by capnography
  3.1.4. Airway edema resulting from respiratory tract burns or anaphylaxis

3.2. The Bougie will be used for every intubation attempt for the adult patient when performing direct laryngoscopy.

3.3. The Bougie will be loaded for every intubation attempt for the adult patient when utilizing video laryngoscopy. It, however, is only mandatory to be used if the provider cannot place the ET tube in the trachea.
3.4. A direct intubation attempt will consist of the introduction of the laryngoscope and endotracheal tube with Bougie or Bougie by itself, into the oral cavity with the intent of intubation.
3.5. A video intubation attempt will consist of the introduction of the video laryngoscope loaded with an endotracheal tube and Bougie, into the oral cavity with the intent of intubation.
3.6. One intubation attempt will be completed on patients in cardiac arrest before a provider can attempt placement of a supraglottic airway (LMA Supreme).
3.7. If the first attempt fails, the provider may either elect to make a second attempt at intubation or elect to place the LMA Supreme or return to the BLS airway.
3.8. A combined total of two (2) attempts to successfully intubate will be allowed per patient.
3.9. After two (2) failed intubation attempts, the provider(s) will place either a supraglottic airway (LMA Supreme) or return to a BLS airway.

4. Endotracheal Tube Placement Confirmation

4.1. Endotracheal Tube Placement Confirmation will consist of three steps before placement may be considered confirmed. The provider must complete all of the steps along with properly documenting each step on the patient care report.
4.1.1. Visualize the endotracheal tube pass through the patient's vocal cords (if the vocal cords are visible)
4.1.2. Confirm the presence of bilateral lung sounds with the absence of epigastric sounds through auscultation
4.1.3. Have the presence of continuous capnography waveform while ventilating the patient

5. Capnography

5.1. Capnography will be used to confirm every presumed successful intubation regardless of the provider's confidence of placement. After application of the capnography sensor/device the provider will ventilate the patient. If there is development of a continuous capnography waveform then the placement of the endotracheal tube can be confirmed. The target range will be between 35-45 mmHg, in patients with a pulse, while providing adequate ventilation.
5.2. Additionally, capnography will be used with all supraglottic and BLS airways adjuncts (ALS providers).

6. Adult and Pediatric LMA Supreme (Supraglottic Airway)

6.1. The LMA Supreme will be indicated in the treatment of unconscious patients with absent gag reflex, who require assisted ventilation or airway securement when endotracheal intubation cannot be accomplished. This includes poor visualization resulting in a partial glottic view. In such cases intubation may be bypassed and the LMA Supreme may be placed.
6.2. Contraindications of the LMA Supreme:
6.2.1. Responsive patients with a gag reflex (ALS and BLS)
6.2.2. Pediatric patients (BLS)