

Endotracheal Intubation**FOR USE IN PATIENTS >34 KG****BLS**

Universal Protocol #601

Pulse Oximetry – O₂ administration per Airway Management Protocol #602**ALS Standing Orders**

- Indications:
 - Patients with a respiratory compromise.
 - ROSC patients requiring airway stabilization
 - Situations where the airway cannot be adequately maintained by BLS techniques.
- Contraindications:
 - Intact gag reflex
- If patient presents with an easily accessible airway (able to visualize the patient's vocal cords), ETI will be indicated.
- Prepare, position, and oxygenate the patient with 100% Oxygen. Ideal positioning is keeping the ears in line with the sternal notch.
- Consider use of video laryngoscopy when available.
- Select appropriate size ET tube and consider the need for endotracheal introducer (Bougie); have suction ready.
- Using the laryngoscope, visualize vocal cords.
- Determine how accessible the patient's airway is. If the patient has a complex airway (unable to visualize the vocal cords due to surrounding anatomy) which would be difficult and time consuming to intubate, consider the use of a supraglottic airway device Procedure # 718.
- Visualization of vocal cords will take no longer than 10 seconds.
- Visualize tube/bougie passing through vocal cords.
- Inflate the cuff with 3-10mL of air.
- Apply waveform capnography (reference Policy #701).
- Auscultate for bilaterally equal breath sounds and absence of sounds over the epigastrium.
- If ET intubation efforts are unsuccessful after the 1st attempt, continue with a BLS airway, re-evaluate the airway positioning before the 2nd attempt. After first failed attempt, consider use of Supraglottic Airways (reference Procedure #718).
- If ET intubation efforts are unsuccessful after the 2nd attempt, continue with a BLS airway and proceed to Supraglottic Airway Procedure #718.
- Patients who have an advanced airway established shall have that airway secured with tape or a commercial device. Devices and tape should be applied in a manner that avoids compression of the front and sides of the neck, which may impair venous return from the brain.

- If the patient has a suspected spinal injury:
 - Open the airway using a jaw-thrust without head extension.
 - If airway cannot be maintained with jaw thrust, use a head-tilt/chin-lift maneuver.
 - Manually stabilize the head and neck rather than using an immobilization device during CPR.
- Following placement of the Endotracheal Tube, if the patient is noted to have an ETCO₂ less than 10, the ALS Provider shall extubate the patient and oxygenate prior to an additional attempt.

Base Hospital Orders Only

As needed

Notes

- During the initial visualization of the patient's airway if the ALS provider determines the airway to be difficult (unable to visualize the patient's vocal cords), ETI will not be utilized and ALS providers will reference Procedure 718 for SGA.
- After placement of the Endotracheal Tube, providers shall verify placement of the ETI by waveform capnography and a minimum of one additional method. This additional method can be any of the following:
 - Auscultation of lung and stomach sounds.
 - Colorimetric CO₂ Detector Device.
 - Esophageal Bulb Detection Device.
- During placement of an ETI, apneic oxygenation is recommended to be utilized when available. If appropriate, providers shall place a nasal cannula onto the patient prior to the intubation attempt and continue use of the nasal cannula during placement in order to assist in oxygenation.