Clinical Advisory Subcommittee
of the Emergency Medical Care Committee

Meeting Agenda
10:15 A.M., Tuesday, August 9, 2022

Virtual Meeting Only

https://slohealth.zoom.us/j/95400099601?pwd=MDl5cXZYNjZUaVQvYzNYbkhMMmZiUT09

Meeting ID: 945 0009 9601
Passcode: 452699
Call In Number: 1-669-900-6833

Members

CHAIR: Dr. Stefan Teitge, *County Medical Society*
Dr. Heidi Hutchinson, *ED Physician Tenet*
Dr. Kyle Kelson, ED Physician Tenet
Dr. Lucas Karaelias*, ED Physician Dignity*
Vacant, *MICNs*
Rob Jenkins, *Fire Service Paramedics*
Nate Otter, *Ambulance Paramedics*
Paul Quinlan, *Fire Service EMTs*
Lisa Epps**,** *Air Ambulance*
Luke Riley*, Air Ambulance*
Arneil Rodriguez*, Ambulance EMTs*
Casey Hidle, *Lead Field Training Officer*
Tim Benes, *Medical Director Appointee*

Staff

STAFF LIAISON: Kyle Parker, *EMS Coordinator*
Vince Pierucci*, EMS Division Director*
Dr. Tom Ronay, *Medical Director*
Michael Groves, *EMS Coordinator*
Rachel Oakley*, EMS Coordinator*
David Goss, *EMS Coordinator*
Sara Schwall, *EMS Admin Assistant III*

AGENDA	ITEM	LEAD
Call to Order	Introductions	Dr. Teitge
	Public Comment	
Summary Notes	Review of Summary Notes April 12th	
Discussion	**Review of Draft Procedures:** • Endotracheal Intubation # 717 • Supraglottic Airway Device #718	Kyle
Adjourn	**Declaration of Future Agenda Items**	Dr. Teitge
	Next meeting date – October 11, 2022 1015 hrs - 2nd floor Conference Room, Health Agency	

Clinical Advisory Subcommittee of the Emergency Medical Care Committee

Meeting Minutes
10:15 A.M., Tuesday April 12th, 2022

Health Agency Campus, 2nd floor large conference room
2180 Johnson Ave., San Luis Obispo

Members

☐CHAIR: Dr. Stefan Teitge, *County Medical Society, ED Physician Dignity*
☒ Dr. Heidi Hutchinson, *ED Physician Tenet*
☒ Dr. Kyle Kelson, *ED Physician Tenet*
☒ Dr. Lucas Karaelias, *ED Physician Dignity*
☐ Lisa Epps – *Air Ambulance*
☒ Luke Riley – *Air Ambulance*
☒ Rob Jenkins, *Fire Service Paramedics*
☒ Nate Otter, *Ambulance Paramedics*
☐ Arneil Rodriguez, *Ambulance EMTs*
☐ Casey Hidle, *Lead Field Training Officer*
☐ Lori Tobey RN, *MICNs*
☒ Tim Benes, *Medical Director Appointee*
☐ Paul Quinlan, *Fire Service EMTs*

Staff

☒ STAFF LIAISON: Kyle Parker, *EMS Coordinator*
☐ Vince Pierucci, *EMS Division Director*
☒ Tom Ronay, *Medical Director*
☒ Michael Groves, *EMS Coordinator*
☐ Rachel Oakley, *EMS Coordinator*
☒ Sara Schwall, *EMS Admin Assistant III*

AGENDA	ITEM	LEAD
Call to Order 1015	Introductions	Dr. Teitge
	Public Comment – No public comment	
Summary Notes	None	
Discussion	**Review of Draft Procedures:** - Endotracheal Intubation #717: - 2021 success rates of ETI 80-85% - First pass success about 55% - 30% of patients who ROSC are not intubated - Skill level/experience of medics play a role in attempt of ETI N. Otter asks if there are any issues with patients arriving to the hospital with BLS airway. Dr. Karaelis – In STEMI hospital, there is no issue with BLS airway (OPA/bag valve mask) but would need to remove supraglottic (SGA) in ER before moving to cath lab. It is more likely to resuscitate someone who is intubated. Dr. Kelson – In Trauma hospital, agrees that SGA is a good backup to BLS. R. Jenkins responds that transport time is no issue as intubations can occur in the ambulance. Dr. Ronay suggests to ED physicians to inquire with colleagues regarding potential downstream effects of patients arriving with SGAs. Discussion of airway scoring system and the importance of teaching airway technique.	Kyle Parker

	In Policy #717 draft, should include definitions of intubation "attempts." **Future Items:** - Monitor SGA use across the state - Demo SGA at June Airway Lab - Look at refining draft SGA policies	
Adjourned – 1110	**Next meeting date –** June 14, 2021, 1015 a.m.	

Endotracheal Intubation

FOR USE IN PATIENTS >34 KG

BLS

Universal Protocol #601

Pulse Oximetry – O_2 administration per Airway Management Protocol #602

ALS Standing Orders

- Adult Patients with respiratory compromise or in cardiac arrest/ ROSC or where the airway cannot be adequately maintained by BLS techniques.
- 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.
- *Blank Fill in Time Frame*
- Visualize tube passing through vocal cords.
- Inflate the cuff with 3-10mL of air.
- Apply waveform capnography.
- 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.
- If ET intubation efforts are unsuccessful after the 2nd attempt, continue with a BLS airway, procced to Supraglottic Airway Procedure # 718.
- Patients who have an advanced airway established should be 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.

Base Hospital Orders Only

As needed

Notes

Supraglottic Airway Device

FOR USE IN PATIENTS >34 KG

BLS

Universal Protocol #601

Pulse Oximetry – O_2 administration per Airway Management Protocol #602

ALS Standing Orders

- Patients who meet indications for **Endotracheal Intubation Procedure #717**
- Patients, who after two (2) attempts with an ETT, have not been successfully intubated**.**

I-GEL

- Monitor End-tidal capnography throughout use.
- Select appropriate tube size.

	3	Small Adult	30-60kg
	4	Medium Adult	50-90kg
	5	Large Adult	90+kg

- While preparing tube, have assistive personnel open the airway, and clear of any foreign objects. Pre-oxygenate with 100% oxygen.
- Apply water soluble lubricant to the distal tip and posterior aspect (only) of the tube, taking care to avoid introduction of the lubricant into or near the ventilatory openings.
- Grasp the lubricated i-gel firmly along the integral bite block. Position the device so that the i-gel cuff outlet is facing towards the chin of the patient.
- Position patient into “sniffing position” with head extended and neck flexed. The chin should be gently pressed down before proceeding to insert the i-gel.
- Introduce the leading soft tip into the mouth of the patient in a direction towards the hard palate.
- Glide the device downwards and backwards along the hard palate with a continuous but gentle push until a definitive resistance is felt.
- At this point the tip of the airway should be located into the upper esophageal opening and the cuff should be located against the laryngeal framework. The incisors should be resting on the integral bite-block.
- Attach a BVM. While gently bagging the patient to assess ventilation, carefully withdraw the airway until ventilation is easy and free flowing (large tidal volume with minimal airway pressure).
- Confirm proper position by auscultation, chest movement and verification of ETCO2 by waveform capnography.
- The i-gel should be taped down from maxilla to maxilla
- Patients who have an advanced airway established should be 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.

Base Hospital Orders Only

As needed

Notes

Contraindications

•Gag reflex. •Caustic ingestion. •Known esophageal disease (e.g., cancer, varices, or stricture).