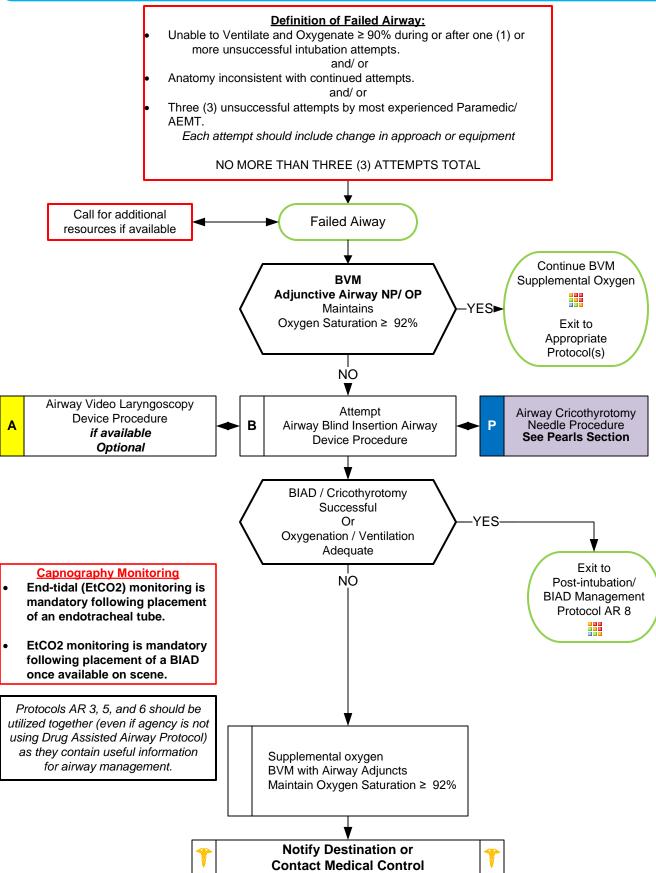


Pediatric Failed Airway





Pediatric Failed Airway

Pearls

This protocol is for use in patients who FIT within a Pediatric Medication/ Skill Resuscitation System Product.

- For the purposes of this protocol, a secure airway is when the patient is receiving appropriate oxygenation and ventilation.
- If an effective airway is being maintained by BVM with continuous pulse oximetry values of ≥ 90%, it is acceptable to continue with basic airway measures.
- Ventilation rate

30 for Neonates, 25 for Toddlers, 20 for School Age, and for Adolescents the normal Adult rate of 10 - 12 per minute. Maintain EtCO2 between 35 - 45 and avoid hyperventilation.

Capnography Monitoring (EtCO2)

Continuous waveform or Quantitative Capnography and Pulse Oximetry are required for intubation verification and ongoing patient monitoring.

Intubation:

Attempt defined as laryngoscope blade passing the teeth or endotracheal tube passed into the nostril.

Use of a stylet is recommended in all pediatric intubations.

Endotracheal tube: Depth = 3 x the diameter of the ETT. Estimated Size = 16 + age (years) / 4. Term newborn = 3.5 mm.

If First intubation attempt fails, make an adjustment and try again: (Consider change of provider in addition to equipment)

• NC EMS Airway Evaluation Form:

Fully complete and have receiving healthcare provider sign confirming BIAD or endotracheal tube placement.

Complete online in region specific ReadyOp and upload completed form.

Complete when Ketamine, Etomidate, Succinylcholine and/ or Rocuronium or used to facilitate use of a BIAD and/ or endotracheal intubation. Paramedics/ AEMT should consider using a BIAD if endotracheal intubation is unsuccessful.

- Secure the endotracheal tube well and consider c-collar in pediatric patients (even in absence of trauma) to better maintain ETT placement.

 Manual stabilization of endotracheal tube should be used during all patient moves / transfers.
- Airway Cricothyrotomy Percutaneous Needle Procedure:

Indicated as a lifesaving / last resort procedure in pediatric patients < 10 years of age.

Very little evidence to support it's use and safety.

A variety of alternative pediatric airway devices now available make the use of this procedure rare.

Agencies who utilize this procedure must develop a written procedure, establish a training program, maintain equipment and submit procedure and training plan to the State Medical Director/ Regional EMS Office.

≥ 10 years: Surgical cricothyrotomy or commercial kits based on agency preference recommended.

• DOPE: Displaced tracheostomy tube/ ETT, Obstructed tracheostomy tube/ ETT, Pneumothorax and Equipment failure.

Airway Respiratory Protocol Section