Adult Airway

Assess Respiratory Rate, Effort, Oxygenation
Is Airway / Breathing Adequate?

YES → Supplemental oxygen
Goal oxygen saturation ≥ 90%
Preferably ≥ 94%
Exit to
Appropriate Protocol(s)

NO

Basic Maneuvers First
-open airway chin lift / jaw thrust
-nasal or oral airway
-Bag-valve mask (BVM)

Spinal Motion Restriction
Procedure / Protocol TB 8
if indicated

Altered Mental Status Protocol UP 4
if indicated

Respiratory Distress with a
Tracheostomy Tube
Protocol AR 10
if indicated

Protocols AR 1, 2, and 3 should be utilized together (even if agency is not using Drug Assisted Airway Protocol) as they contain useful information for airway management.

Airway Obstructed

YES →

	Airway Foreign Body Obstruction Procedure
A	Direct Laryngoscopy
P	Airway Cricothyrotomy Surgical Procedure ***if indicated***

NO

Breathing / Oxygenation
Support needed?

YES →

	Supplemental Oxygen BVM Maintain Oxygen Saturation ≥ 90 % Preferably ≥ 94 %
B	Consider Airway NIPPV Procedure
	Airway BIAD Procedure ***if indicated***
A	Oral / Nasotracheal Intubation Procedure ***Optional***
P	Chest Decompression Procedure ***if indicated***
	Consider Airway Drug Assisted Protocol AR 3 ***if available***
	Post-intubation / BIAD Management Protocol AR 8 ***if indicated***

NO

Monitor / Reassess
Supplemental Oxygen
if indicated

Exit to
appropriate protocol(s)

Unable to Ventilate and Oxygenate ≥ 90% during or after one (1) or more unsuccessful intubation attempts .
and/or
Anatomy inconsistent with continued attempts.
and/or
Three (3) unsuccessful attempts by most experienced Paramedic/ AEMT.

Exit to
Adult Failed Airway
Protocol AR 2

Notify Destination or
Contact Medical Control

Airway Respiratory Protocol Section

Adult Airway

Pearls

- **See Pearls section of protocols AR 2 and 3.**
- **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.**
- **Intubation Attempt is passing the laryngoscope blade past the teeth or ETT inserted into the nasal passage.**
- **Capnometry or capnography is mandatory with all methods of intubation. Continuous capnography (EtCO2) is strongly recommended for the monitoring of all patients with a BIAD and mandatory with monitoring of an endotracheal tube.**
- **Ventilatory rate should be 8-10 per minute to maintain a EtCO2 of 35-45. Avoid hyperventilation.**
- **Anticipating the Difficult Airway and Airway Assessment**
  - **Difficult BVM Ventilation (MOANS): M**ask seal difficulty (hair, secretions, trauma); **O**bese, obstruction, OB – 2d and 3d trimesters; **A**ge ≥ 55; **N**o teeth; **S**tiff lungs or neck
  - **Difficult Laryngoscopy (LEON): L**ook externally for anatomical problems; **E**valuate 3-3-2 (Mouth opening should equal 3 of patients finger's width, mental area to neck should equal 3 of patient's finger's width, base of chin to thyroid prominence should equal 2 of patients finger's width); **O**bese, obstruction, OB – 2d and 3d trimesters; **N**eck mobility limited.
  - **Difficulty BIAD (RODS): R**estricted mouth opening; **O**bese, obstruction, OB – 2d and 3d trimesters; **D**istorted or disrupted airway; **S**tiff lungs or neck
  - **Difficulty Cricothyrotomy / Surgical Airway (SMART): S**urgery scars**; M**ass or hematoma**, A**ccess or anatomical problems**; R**adiation treatment to face, neck, or chest; **T**umor.
- **It is strongly encouraged to complete an Airway Evaluation Form with any BIAD or Intubation procedure.**
- **Nasotracheal intubation: Procedure requires spontaneous breathing and may require considerable time, exposing patient to critical desaturation. Contraindicated in combative, anatomical disrupted or distorted airways, increased ICP, severe facial trauma, basal skull fracture, and head injury. Orotracheal route is preferred.**
- Maintain spinal motion restriction for patients with suspected spinal injury.
- AEMT and Paramedics should consider using a BIAD if oral-tracheal intubation is unsuccessful.
- During intubation attempts use External Laryngeal Manipulation to improve view of glottis.
- Gastric tube placement should be considered in all intubated patients if available or time allows.
- It is important to secure the endotracheal tube well to better maintain ETT placement. Manual stabilization of endotracheal tube should be used during all patient moves / transfers.
- **DOPE: D**isplaced tracheostomy tube / ETT, **O**bstructed tracheostomy tube / ETT, **P**neumothorax and **E**quipment failure.