A. Severe respiratory distress (as evidenced by apnea, severe dyspnea with tachypnea, oxygen saturation less than 90% for greater than 30 sec., or difficulty bagging.

B. Lateralizing exam (decreased breath sounds on one side, or tracheal deviation away from the affected side, or asymmetric chest wall rise).

C. Hemodynamic compromise (BP less than 90)

Procedure:

A. Use a 10 or 12 gauge IV catheter at least 2 inches long
B. Insert the catheter immediately above the third rib (second intercostal space), slightly lateral to the mid-clavicular line on the side of decreased breath sounds.
C. When air returns, advance the catheter and remove the needle.
D. Attach a one way valve to the catheter hub.
E. Stabilize the catheter securely to the chest.
F. Reassess the patient, including breath sounds and vital signs every time the patient is moved.

TRANSTRACHEAL JET INSUFFLATION:

Indications:

A. Complete airway obstruction not relieved by manual procedures and airway visualization with laryngoscope.
B. Inability to intubate and inability to successfully ventilate using BVM ventilation.

Procedure:

A. Locate cricothyroid membrane.
B. Insert 10 gauge IV catheter through the membrane at a 45º angle, directed toward the feet. Aspirate for air return with a syringe to check placement. Remove needle.
C. Stabilize catheter securely to neck.
D. Attach the three way stopcock to catheter.

E. Supply 100% 02 to the three way stopcock attach the oxygen tubing from the jet ventilator to the three way stopcock.
F. Close stop cock and administer a one second breath. Open stock and allow patient to exhale for two seconds. And repeat.

NOTE: In children less than 12 years of age ventilate with Bag-Valve-Catheter with 100% oxygen, if unable to ventilate via anesthesia adapter.

G. Check for proper placement in the following order:

1. Assess chest rise.
2. Check absence of gastric sounds.
3. Check adequacy of breath sounds.
4. Assess for complications, including subcutaneous air.
5. Reassess placement every time patient is moved. Sometimes proper placement is difficult to assess, do not just relay on the indicators listed above. Continual clinical reassessment for adequate oxygenation is essential.

NOTE: SURGICAL CRICOTHYROTOMY IS NOT A LOCALLY APPROVED PARAMEDIC SKILL.

DETERMINATION OF DEATH:

Medical Arrest: See "Asystole" protocol on Page 3.

Traumatic Arrest: See "Traumatic Arrest" protocols, Page 22.