Obstruction/Foreign Body

Airway

CRITERIA

- Adult patients where airway and ventilatory support are required
- This includes both medical and trauma conditions

PROTOCOL

EMR	Follow *General – Universal Patient Care/Initial Patient Contact protocol.*	**EMR**
EMT	If suspected obstructed airway, perform obstructed airway sequences in accordance with current American Heart Association guidelines • Continue sequence until obstruction is cleared or patient becomes unconscious • Then perform obstructed airway sequences in accordance with American Heart Association guidelines while preparing airway equipment	**EMT**
A	Perform laryngoscopy and remove any visible foreign bodies with Magill forceps if unable to ventilate	**A**
EMT	Reassess compliance with BVM: • If adequate oxygenation/ventilation, **continue to BVM or NPA/OPA/Blind Insertion Airway Device (BIAD)**.	**EMT**
I	**Attempt Endotracheal Intubation [I- only if patient is over 12 years old]** • **Confirm tube placement and ventilate at 10 breaths per minute** • If unsuccessful after 3 attempts or anatomy inconsistent with intubation attempts, **continue with protocol**	**I**
P	If there is significant facial trauma or airway swelling with inadequate oxygenation/ventilation, **consider Surgical Cricothyrotomy** or **Needle Cricothyrotomy**	**P**
EMT	Consider spinal immobilization	**EMT**

PEARLS

- Ventilatory rate should be 10 breaths per minute to maintain $EtCO_2$ of 35 to 45mmHg
- Use suction to remove blood, secretions and vomitus
- DO NOT suction for more than 10 seconds between ventilations
- An intubation attempt is defined as 30 seconds of non-ventilatory support to include visualization, suctioning of the airway, and tube placement
- Use of a continuous $EtCO_2$ monitoring device is required to monitor correct tube placement