Post-intubation / BIAD Management

ETT or Blind Insertion Airway Device Successful

Yes

No

Exit to Appropriate Adult or Pediatric Airway Protocol(s) AR 1-7

Continue Airway Adjuncts and BVM
Maintain SpO2 ≥ 90%
Preferably ≥ 94%
EtCO2 35 – 45
Ventilate 8-10 breaths / minute
or age-appropriate ventilatory rate for pediatric pt.

12 Lead ECG Procedure
as indicated

IV / IO Procedure
(preferably 2 sites)

Cardiac Monitor

Awakening or Moving after Intubation / BIAD Placement
Evidence of Anxiety / Agitation

No

Yes

Continue Ventilation / Oxygenation
Maintain SpO2 ≥ 90 % EtCO2 35–45
Ventilate 8-10 breaths / minute
or age-appropriate ventilatory rate for pediatric pt.

Adult
Fentanyl 50 – 75 mcg IV / IO
Repeat q 5 minutes PRN
Maximum Dose 300 mcg
OR
Midazolam 2 – 2.5 mg IV / IO
Repeat q 3-5 minutes PRN
Maximum Dose 10 mg

Pediatric
Fentanyl 1 mcg / kg
IV / IO / IN
May repeat 0.5 mcg / kg q 5 minutes PRN
Maximum Dose 2 mcg / kg
OR
Midazolam 0.1 – 0.2 mg/kg IV / IO / IN
Maximum Dose 0.5 mg / kg

Notify Destination or Contact Medical Control

All ventilated patients must be monitored by continuous capnography and pulse oximetry.
**Pearls**

- **Recommended Exam:** Mental Status, HEENT, Heart, Lungs, Neuro
- Patients requiring advanced airways and ventilation commonly experience pain and anxiety.
- Unrelieved pain can lead to increased catecholamine release, ischemia, immunosuppression, and prolonged hospitalization.
- Ventilated patients cannot communicate pain / anxiety and providers are poor at recognizing pain / anxiety.
- Vital signs such as tachycardia and / or hypertension can provide clues to inadequate sedation, however they both are not always reliable indicators of patient’s lack of adequate sedation.
- Pain must be addressed first, before anxiety. Opioids are typically the first line agents before benzodiazepines.
- Ventilator / Ventilation strategies will need to be tailored to individual patient presentations.
- In general, ventilation with BVM should cause chest rise. With mechanical ventilation a reasonable tidal volume should be about 6 mL/kg (using ideal body weight) and peak pressures should be < 30 cmH20.
- Continuous pulse oximetry and capnography should be maintained during transport for monitoring.
- Head of bed should be maintained at least 10 – 20 degrees of elevation when possible to decrease aspiration risk.
- With abrupt clinical deterioration, if mechanically ventilated, disconnect from ventilator to assess lung compliance. Search for dislodged ETT or BIAD, obstruction in tubing or airway, pneumothorax, or ETT balloon leak. Verify tube position and suction for secretions as needed.
- **DOPE:** Displaced tracheostomy tube / ETT, Obstructed tracheostomy tube / ETT, Pneumothorax and Equipment failure.