PEDIATRIC ADVANCED AIRWAY MANGEMENT

PURPOSE

The purpose of this policy is to outline the clinically indicated and required steps for airway management and highlight the steps of basic airway management in the pediatric patient.

INDICATIONS

All unconscious, apneic or near apneic patients aged twelve (12) or less require airway management with bag-valve-mask (BVM) preferred in all situations, unless impossible or unsuccessful.

CONTRAINDICATIONS

Patient is awake with intact gag reflex.

GENERAL CONSIDERATIONS

Place patient in optimum position for airway management.

Child must be in supine position, unless extenuating circumstances exist.

Utilize manual cervical immobilization and minimize neck movement in patients with head and/or neck trauma.

In infant and toddler patients, the larger head may require padding under shoulders or torso (i.e. towel roll) to maintain neutral spine and airway alignment.

Use waveform capnography and document findings.

Do not use cricoid pressure.

PROCEDURE

When clinically indicated, a BLS airway should be established and should remain in place, unless unsuccessful or impossible in all patients.

AVOID HYPERVENTILATION

If endotracheal intubation is required:

Place patient in correct position
Instruct partner to place patient on cardiac and pulse oximetry monitors.
Ensure suction equipment is available.
Pre-oxygenation with BVM ventilation with 100% oxygen for one (1) to three (3) minutes.
Ensure adequate chest rise
Note waveform capnography morphology.
WAVEFORM CAPNOGRAPHY is REQUIRED on all intubated patients

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SPECIAL CONSIDERATIONS

If the patient regains consciousness while intubated, do not extubate. Use restraints as necessary to prevent uncontrolled extubation. Consider sedation: refer to sedation guidelines.

If the patient has suspected spinal injury
- Open the airway using jaw-thrust without head extension
- If airway cannot be maintained with jaw-thrust, use a head-tilt/chin-lift maneuver.
  - Manually stabilize the head and neck rather than using immobilization devices during CPR.

All intubated patients must have their head secured, and kept midline (when able).

DOCUMENTATION:

All devices used to confirm tube placement must be documented in the PCR, including:
- Method of confirmation
  - Auscultation of lung sounds/negative epigastric sounds, rise and fall of chest, mist in tube, visualization of the tube passing through the vocal cords, waveform capnography
- Description of waveform (box, shark fin, straight line, bumpy line, ect. .)
- Capnometry number in mmHg
- Depth of insertion
- Method used to secure the tube

CQI:

Pediatric airway interventions will be 100% reviewed by the medical director and included in the CQI Airway report submitted quarterly to the YEMSA for review.