



Airway, Drug Assisted (OPTIONAL)

Indications for Drug Assisted Airway
Failure to protect the airway
and/or
Unable to oxygenate
and/or
Unable to ventilate
and/or
Impending airway compromise

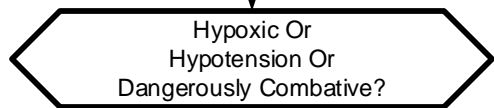
Procedure will remove
patient's protective
airway reflexes and
ability to ventilate.

You must be sure of
your ability to intubate
before beginning this
procedure.

Must have two (2)
Paramedics on scene

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.

	Preoxygenate 100% O ₂
A	IV / IO Procedure (preferably 2 sites)
P	Assemble Airway Equipment Suction equipment Alternative Airway Device

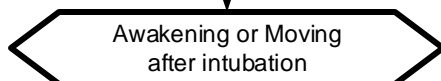


YES

P	Airway Management Ketamine 1.5 - 2 mg/kg IV / IO
	Airway Management + Dangerously Combative Ketamine 300 - 400 mg IM Ketamine 1.5 - 2 mg/kg IV / IO
	Correct Hypoxia and / or Hypotension
	Adult Airway Adult Failed Airway Protocol(s) AR 1, 2 as indicated
	Hypotension / Shock Protocol AM 5 as indicated

P	Etomidate 0.3 mg/kg IV / IO Or Ketamine 1.5 - 2 mg/kg IV / IO May repeat x 1
	Succinylcholine 1.5 mg / kg IV / IO Or Rocuronium 1 mg kg IV / IO (if Succinylcholine contraindicated) May repeat x 1
	Intubate trachea
	Placement Verified Continuous Capnography

	Consider Restraints Physical Procedure
P	Consider Gastric Tube Insertion Procedure



NO

YES

Exit to
Post-intubation /
BIAD Management
Protocol AR 8



Notify Destination or
Contact Medical Control



Red Text
are the key
performance indicators
used to evaluate
protocol compliance.

An Airway Evaluation
Form must be
completed on every
patient who receives
Rapid Sequence
Intubation.



Airway, Drug Assisted (OPTIONAL)

• Pearls

- Agencies must maintain a separate Performance Improvement Program specific to Drug Assisted Airway.
- See Pearls section of protocols AR 1 and 2.
- This procedure requires at least 2 Paramedics. Divide the workload – ventilate, suction, cricoid pressure, drugs, intubation.
- Patients with hypoxia and/or hypotension are at risk of cardiac arrest when a sedative and paralytic medication are administered. Hypoxia and hypotension require resuscitation and correction prior to use of these combined agents. Ketamine allows time for appropriate resuscitation to occur during airway management.
- This protocol is only for use in patients who are longer than the Broselow-Luten Tape.
- Ketamine may be used during airway management of patients who FIT on the Broselow-Luten Tape with a DIRECT, ONLINE MEDICAL ORDER, by the system MEDICAL DIRECTOR OR ASSISTANT MEDICAL DIRECTOR ONLY.
- **KETAMINE:**
 - Ketamine may be used with and without a paralytic agent in conjunction with either a OP, NP, BIAD or endotracheal tube.
 - Ketamine may be used during the resuscitation of hypoxia or hypotension in conjunction with airway management. Once hypoxia and hypotension are corrected, use of a sedative and paralytic can proceed if indicated.
 - Ketamine may be used in the dangerously combative patient requiring airway management IM. IV / IO should be established as soon as possible.
 - Ketamine may NOT be used for purposes of sedation only – it must be used only during airway management procedures.
- Continuous Waveform Capnography and Pulse Oximetry are required for intubation verification and ongoing patient monitoring, though this is not validated and may prove impossible in the neonatal population (verification by two (2) other means is recommended in this population.)
- Before administering any paralytic drug, screen for contraindications with a thorough neurologic exam.
- If First intubation attempt fails, make an adjustment and try again: (Consider change of provider in addition to equipment)
- Different laryngoscope blade
 - Change cricoid pressure; No longer routinely recommended and may worsen your view.
- Different ETT size
 - Align external auditory canal with sternal notch / proper positioning.
- Change head positioning
 - Consider applying BURP maneuver (Back [posterior], Up, and to patient's Right)
- Paramedics / AEMT should consider using a BIAD if oral-tracheal intubation is unsuccessful.
- During intubation attempts use External Laryngeal Manipulation to improve view of glottis.
- Protect the patient from self-extubation when the drugs wear off. Longer acting paralytics may be needed post-intubation.
- Drug Assisted Airway is not recommended in an urban setting (short transport) when able to maintain oxygen saturation $\geq 90\%$.
- Consider Naso or orogastric tube placement in all intubated patients to limit aspiration and decompress stomach if needed.
- **DOPE:** Displaced tracheostomy tube / ETT, Obstructed tracheostomy tube / ETT, Pneumothorax and Equipment failure.