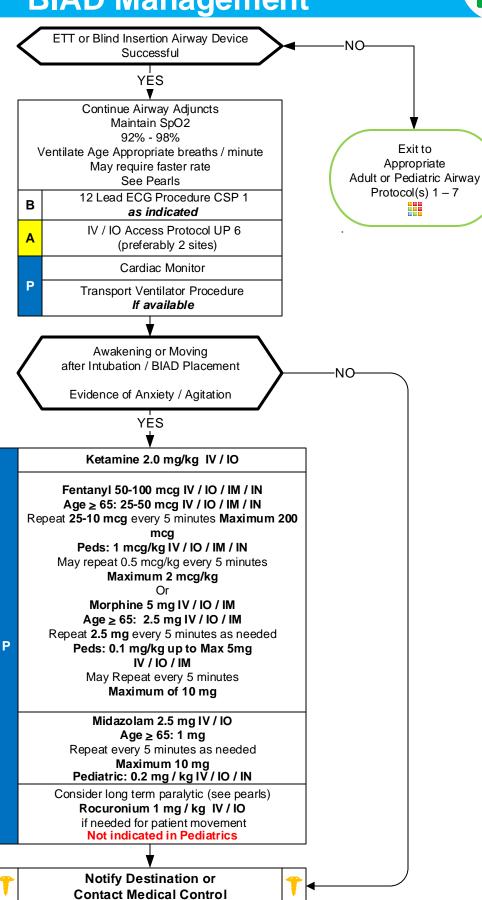
Post-intubation / BIAD Management



Capnography Monitoring

- End-tidal (EtCO2) monitoring is mandatory following placement of an endotracheal tube.
- EtCO2 monitoring is mandatory following placement of a BIAD once available on scene.

Protocols AR 1, 2, 3, 5, and 6 should be utilized together (even if agency is not using Drug Assisted Airway Protocol) as they contain useful information for airway management.



Post-intubation / BIAD Management



** Refer to Length-Based Medication Tape for Medication Doses IF pediatric patients weight is unknown **

Rocuronium may only be administered by technicians who are approved to perform Drug Assisted Intubation by the Harnett County EMS System Medical Director.

Consider Push-Dose Vasopressor Agent for any of the following indications:

1. Indications

- a. Peri-intubation hypotension
- b. Post-arrest (post-ROSC) hypotension
- c. Hypotension requiring initiation of vasopressor drip prior to drip setup
- d. Unstable bradycardia (as a supplement to other therapy)

2. Instructions

- a. Draw up 1mL of 1:10,000 epinephrine
- b. Waste 1mL of saline from a 10mL saline flush
- c. Add the 1mL of epinephrine to the remaining 9mL of saline
 - i. This yields epinephrine in a concentration of 10mcg/mL
- d. Place a medication added label on this syringe to identify it as a vasopressor
- e. Administer 10mcg (1mL) every 2 minutes as needed to achieve desired blood pressure or heart rate

Pearls

- * Continuous pulse oximetry and capnography is **MANDATORY**.
- 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 has tachycardia and/ or hypertension can provide clues to inadequate sedation, however they are not always reliable indicators of a patient's lack of adequate sedation.
- * Sedation strategy:

Pain is the primary reason patients experience agitation and must be addressed first.

Opioids and/ or Ketamine are the first line agents, alone or in combination.

Benzodiazepines may be utilized if patient is not responding to adequate opioid and/ or Ketamine doses.

Paralysis is considered a last resort, only when patients are not responding to opioid, Ketamine, or benzodiazepines.

Patients that have received paralytics may be experiencing pain with no obvious signs or symptoms.

Consider sedation early after giving paralytics, especially in patients receiving Rocuronium.

* Ventilation rate:

Guidelines: 30 for Neonates, 25 for Toddlers, 20 for School Age, and for Adolescents the normal Adult rate of 10 – 12 per minute.

Maintain EtCO2 between 35 - 45 and avoid hyperventilation.

- * Ventilator/ Ventilation strategies will need to be tailored to individual patient presentations. Medical director can indicate different strategies above.
- In general, ventilation with BVM should cause chest rise. With mechanical ventilation a reasonable tidal volume should be about 6 8 mL/kg and peak pressures should be < 30 cmH₂0. Plateau Pressures should be < 30 cmH₂0.
- **★** 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.
- **DOPE:** Displaced tracheostomy tube/ ETT, Obstructed tracheostomy tube/ ETT, Pneumothorax and Equipment failure.