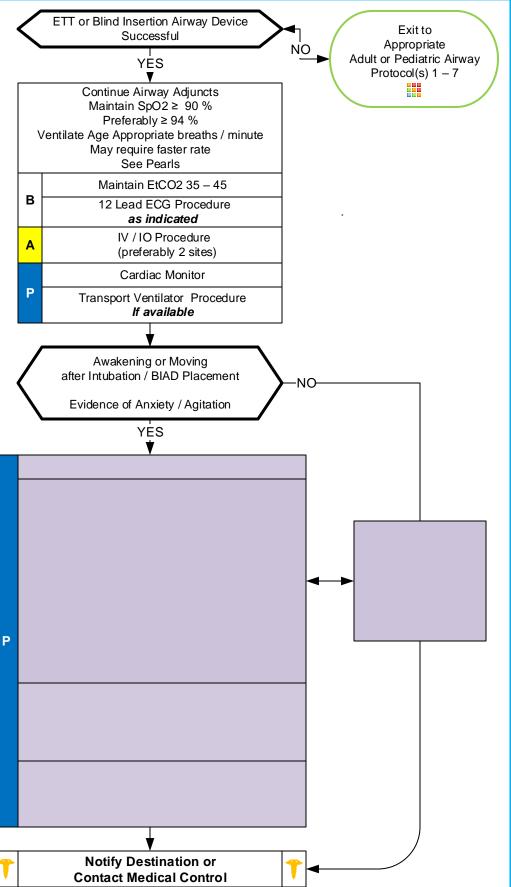


## Post-intubation / BIAD Management

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

## **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 has 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. Ketamine is also a reasonable first choice agent.
- 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 mL/kg 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.
- DOPE: Displaced tracheostomy tube / ETT, Obstructed tracheostomy tube / ETT, Pneumothorax and Equipment failure.