

PEDIATRIC PROTOCOL

AIRWAY

3-5 kg	6-7 kg	8-9 kg	10-11 kg	12-14 kg	15-18 kg	19-23 kg	24-29 kg	30-36 kg
6-11 lbs	13-15 lbs	18-20 lbs	22-24 lbs	26-31 lbs	33-40 lbs	42-51 lbs	53-64 lbs	66-81 lbs
18-24 in	24-26 in	26-29 in	29-33 in	33-38 in	38-43 in	43-48 in	48-52 in	52-57 in

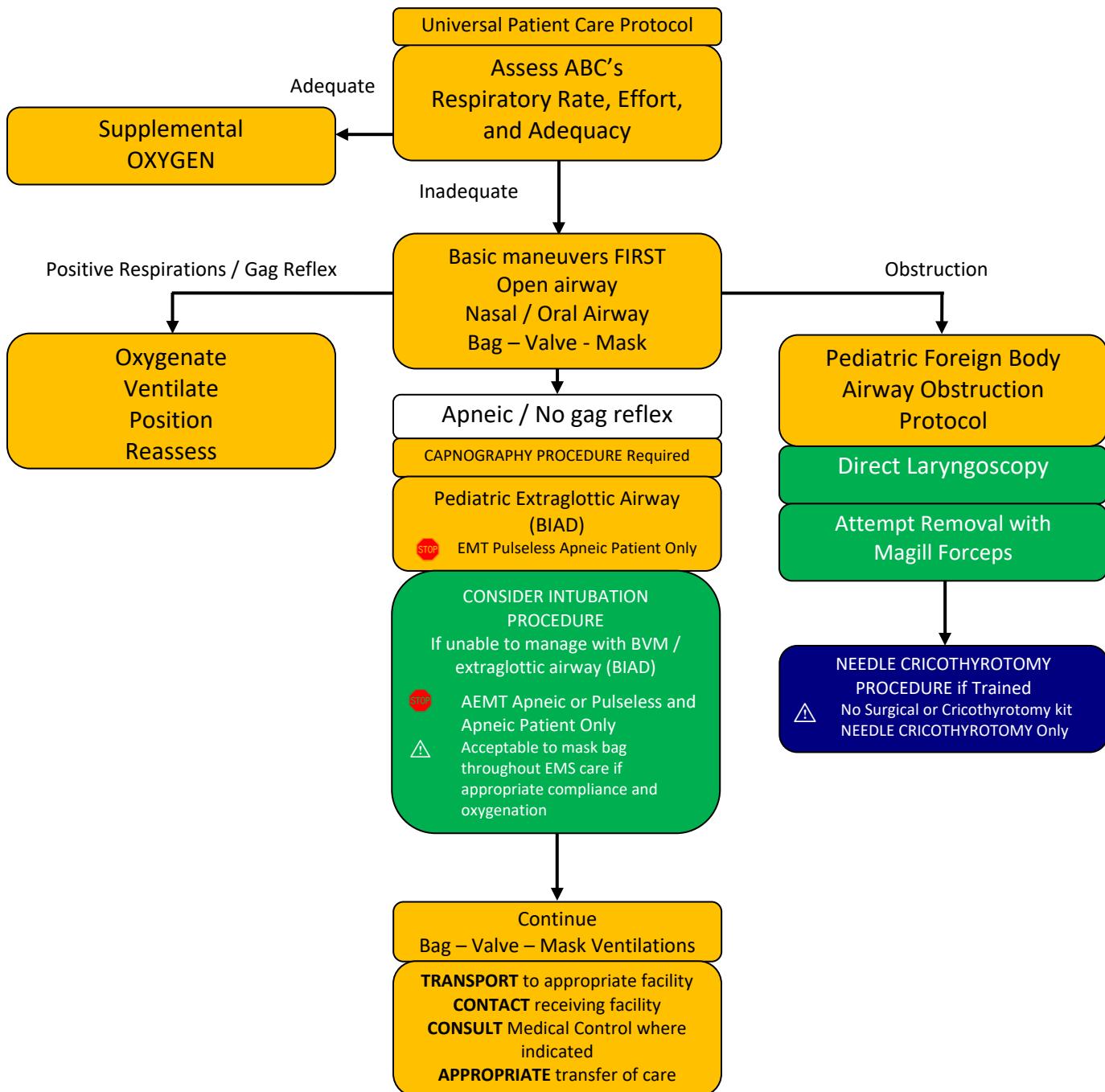
Airway / Breathing

Circulation / Shock

Cardiac

Medical

Trauma



EMT Intervention

AEMT Intervention

PARAMEDIC Intervention

Online Medical Control

AIRWAY

INDICATIONS	SIGNS AND SYMPTOMS	DIFFERENTIAL DIAGNOSIS
<ul style="list-style-type: none"> • Apnea • Coughing • Choking • Inability to speak • Unresponsive • Burns • Trauma 	<ul style="list-style-type: none"> • Witnessed aspiration • Sudden episode of choking • Gagging • Audible stridor • Change in skin color • Decreased LOC • Increased or decreased Respiratory rate • Labored breathing • Unproductive cough 	<ul style="list-style-type: none"> • Cardiac arrest • Respiratory arrest • Anaphylaxis • Esophageal obstruction

Extraglottic airway device / BIAD (Blind Insertion Airway Device)

Examples (not limited to); King Airway, LMA, iGel, Etc.

Differentiate airway obstruction from esophageal obstruction.

If esophageal obstruction, place patient in position of comfort, suction as needed and treat pain.

MANAGEMENT OF TRACHEOSTOMY PATIENTS**Tracheostomies come in 2 types**

- Cuffed tracheostomy – has a distal cuff to create seal in patient trachea. Necessary for patients requiring mechanical ventilation. There is a ET tube like pilot balloon to verify cuff patency once placed in the tracheal stoma. Select devices may be filled with saline rather than air, this is device specific. Nearly all will be filled with air.
- Uncuffed tracheostomy – does not have distal cuff and does not seal in the trachea. This type is used for spontaneously breathing patients who require an alternate airway due to upper airway defect. These patients may be able to speak with the use of special tracheostomies or valves.

Tracheostomies have 2 essential parts

- Outer cannula – This is the base that secures in the tracheal stoma. If it is cuffed tracheostomy, the cuff is on this section. There are “wings” that allow for attachment of a tie around the patient’s neck. Some recently placed devices may be sutured in place.
- Inner cannula – is removable for cleaning / replacement. Usually clips or is locked in with a quarter turn detent.

Management of tracheostomy patients

- Have suction equipment on hand throughout all phases of treatment and transport suction to maintain patency as required.
- If a tracheostomy becomes dislodged and cannot be reinserted, use a ET tube sized to the stoma size.
- If a tracheostomy comes out and can be reinserted or needs changed, utilize a bougie (tube changer) if available to insert into stoma and “railroad” the tracheostomy over the bougie into place.
- Check all cuffed tracheostomy cuffs for patency, add additional air if an air leak can be appreciated around stoma.
- If a tracheostomy patient cannot be bagged effectively, suspect mucous plug. Alternate trachea lavage with saline, suction, and bagging until resolved.
- If a tracheostomy patient presents with increased work of breathing, remove, and inspect inner cannula.
- Pediatric tracheostomies may not have inner cannulas due to their size
- Take an extra tracheostomy kit or inner cannula with you during transport if available at pickup location
- Patients and their care givers are frequently very adept at managing these devices, utilize them as a resource.
- See procedures section for stoma and tracheostomy care procedures

KEY POINTS

- EtCO₂ measurement is mandatory with all methods of intubation. Document results of SpO₂.
- Limit intubation attempts to 2 per patient max.
- BVM and oral airway is acceptable means of airway control and ventilation during prehospital care.
- If unable to intubate, continue BVM ventilations, transport rapidly, and notify receiving hospital early.
- Provide Spinal Motion Restriction for patients with suspected spinal injury.
- Do not assume hyperventilation is psychogenic - use oxygen, not a paper bag.
- Continuous pulse oximetry should be utilized in all patients with inadequate respiratory function.
- Consider c-collar to help maintain ETT placement for all intubated patients.