Respiratory

Airway Management

Patient Care Goals
1. Maintain a patent airway
2. Provide effective oxygenation and adequate ventilation using the least invasive possible method to achieve those goals paired with pulse oximetry and end-tidal capnography (EtCO$_2$) data
3. Anticipate, recognize, and alleviate respiratory distress
4. Provide necessary interventions quickly and safely to patients with the need for respiratory support
5. Anticipate, identify, and plan for a potentially difficult airway
6. Optimize the patient for any advanced airway attempts

Patient Presentation

Inclusion Criteria
1. Patients with signs of severe respiratory distress/respiratory failure
2. Patients with evidence of hypoxemia or hypoventilation with medical or traumatic etiology
3. Patients with tracheostomies (See Tracheostomy Management Guideline)
4. Patients with acute foreign body airway obstruction

Exclusion Criteria
1. Chronically ventilated patients
2. Newborn patients

Patient Management
Implement emergent interventions and monitoring [Refer to Universal Care Guideline]

Assessment
1. History – Assess for:
   a. Time of onset of symptoms
   b. Associated symptoms and triggers for dyspnea (e.g., exertion, exercise, lying flat)
   c. History of asthma or other breathing disorders
   d. Choking or other evidence of upper airway obstruction
   e. History of trauma
   f. Prior similar episodes (e.g., prior intubation, prior ICU stay, prior airway surgery including tracheostomy, anaphylaxis, angioedema). If prior episodes, what has helped in the past (meds, interventions) Home interventions for symptoms (e.g., increased home oxygen, nebulizer)
   g. Severity of shortness of breath, sensation of dyspnea
2. Physical Examination – Assess for:
   a. Abnormal respiratory pattern, rate and/or effort
   b. Use of accessory muscles
   c. Ability to speak words/sentences
   d. Quality of air exchange, including depth of respiration and equality of breath sounds
   e. Abnormal breath sounds (e.g., wheezing, rhonchi, rales, or stridor)