if available. See Mechanical Ventilation (Invasive) Guideline.

g. Intubated patients should be provided appropriate sedation with sedative or opioid medications, and sedation titrated to an appropriate target level using RASS score or similar scale
h. Consider PEEP adjustment to achieve oxygenation and ventilation goals (see above)

9. **Gastric decompression** can improve oxygenation and ventilation, so it should be strongly considered in any patient with an advanced airway and positive pressure ventilation
10. When patients cannot be oxygenated/ventilated effectively using the above interventions, or when conventional airway approaches are impossible, surgical airway management is a reasonable option if the clinician has competency in the procedure and risk of death for not escalating airway management seems to outweigh the risk of a procedural complication
11. Transport to the closest appropriate hospital for airway stabilization when respiratory failure cannot be successfully managed in the prehospital setting

Patient Safety Considerations

1. Suctioning to limit aspiration is a priority, since it is associated with development of hospital acquired pneumonia and related increases in ICU stay and mortality.
2. Avoid excessive pressures or tidal volumes during BVM ventilation. The goal is to avoid barotrauma as well as overventilation and related reduction of venous return/preload/cardiac output.
3. Routine use of sedation is not recommended for treatment of anxiety in patients on NIV. Anxiety should be presumed due to hypoxia or inadequate minute ventilation and treated primarily with ventilatory support.
4. Endotracheal intubation should only be used if less invasive methods do not meet patient care goals.
5. Once a successful SGA placement or intubation has been performed, obstruction or displacement of the tube can have further negative effects on patient outcome. Tubes should be secured with either a commercial tube holder or tape.
6. Meticulous attention should be paid to avoiding hypoxia and hypotension during intubation attempts to limit patient morbidity and mortality.
7. Waveform capnography should be placed prior to the first breath through an invasive airway to confirm placement.
8. Drug Assisted Airway Management (DAAM) should be reserved for specialized clinicians on operating within a comprehensive program with adequate resources, ongoing training and quality assurance measures, and close EMS physician oversight.
9. Once initiated and patient is tolerating mask, DO NOT discontinue CPAP/BiPAP until patient is on the emergency department stretcher and hospital CPAP/BiPAP is immediately available for patient to be switched over, or physician is at bedside and requesting CPAP/BiPAP be discontinued. Breaking the mask seal causes a significant decrease in airway pressures and may lead to abrupt decompensation due to atelectasis and alveolar collapse.
10. If patient deteriorates on CPAP/BiPAP (e.g., worsened mental status, increasing $EtCO_2$, vomiting), remove CPAP/BiPAP and escalate airway management options as above.
11. If an endotracheal tube becomes dislodged, SGA should be strongly considered.