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.

ETT or Blind Insertion Airway Device Successful

NO → Exit to Appropriate Adult or Pediatric Airway Protocol(s) 1 – 7

YES

Continue Airway Adjuncts
Maintain SpO2 ≥ 90 %
Preferably ≥ 94 %
Ventilate Age Appropriate breaths / minute
May require faster rate
See Pearls

B	Maintain EtCO2 35 – 45
	12 Lead ECG Procedure ***as indicated***
A	IV / IO Procedure (preferably 2 sites)
P	Cardiac Monitor
	Transport Ventilator Procedure ***If available***

Awakening or Moving after Intubation / BIAD Placement

Evidence of Anxiety / Agitation

NO

YES

P

Ketamine 1.0 mg / kg IV / IO PRN

Fentanyl 50 - 100 mcg IV / IO
Repeat every 5 minutes as needed
Maximum 200 mcg
Pediatric: 1 mcg / kg IV / IO / IN
May repeat **0.5 mcg / kg** every 5 minutes as needed
Maximum 2 mcg / kg
Or
Morphine 4 mg IV / IO
Repeat **2 mg** every 5 minutes as needed
Pediatric: 0.1 mg / kg IV / IO
Maximum single dose 5 mg
Maximum 10 mg

Propofol
Interfacility Transfer Protocol / Policy
If available

Versed 2-2.5mg or Valium 5mg IV/IO
Repeat every 3 – 5 minutes as needed
Maximum 10 mg
Pediatric: 0.1 – 0.2 mg / kg IV / IO

Consider long term paralytic
Vecuronium 10 mg (0.1 mg/kg) IV / IO
If needed for patient movement.
Not indicated in Pediatrics

Notify Destination or Contact Medical Control

Airway Respiratory Protocol Section

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: D**isplaced tracheostomy tube / ETT, **O**bstructed tracheostomy tube / ETT, **P**neumothorax and **E**quipment failure.