

# 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

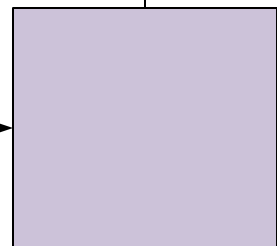
	Continue Airway Adjuncts Maintain SpO2 ≥ 90 % Preferably ≥ 94 % Ventilate Age Appropriate breaths / minute May require faster rate See Pearls
<b>B</b>	Maintain EtCO2 35 – 45 12 Lead ECG Procedure <i>as indicated</i>
<b>A</b>	IV / IO Procedure (preferably 2 sites)
<b>P</b>	Cardiac Monitor Transport Ventilator Procedure <i>If available</i>

Awakening or Moving after Intubation / BIAD Placement  
Evidence of Anxiety / Agitation

NO

YES

<b>P</b>	



Notify Destination or Contact Medical Control



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## 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 as 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 cmH2O.
- 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.**