Orotracheal Intubation

Clinical Indications:

- Inability to adequately ventilate a patient with a Bag Valve Mask or transport distances require a more advanced airway.
- An unconscious patient without a gag reflex who is apneic or is demonstrating inadequate respiratory effort.
- A component of Rapid Sequence Induction

Procedure:

1. Prepare, position and oxygenate the patient with 100% Oxygen.
2. Select proper ET tube (and stylette, if used), have suction & gum bougie ready.
3. Attach ETCO2 device if available.
4. Using laryngoscope, visualize vocal cords. (Use Sellick maneuver/BURP to assist you).
5. Limit each intubation attempt to 30 seconds with BVM between attempts.
6. Visualize tube passing through vocal cords.
7. Inflate the cuff with 5-10 cc of air.
8. **Confirm and document tube placement using an ETCO2 device if available.**
9. Secure the tube to the patient's face.
10. Auscultate for bilaterally equal breath sounds and absence of sounds over the epigastrium. If you are unsure of placement, remove tube and ventilate patient with bag valve mask.
11. Consider using a Blind Insertion Airway Device if intubation efforts are unsuccessful.
12. Document ETT size, time, result (success), and placement location by the centimeter marks either at the patient's teeth or lips on/with the patient care report (PCR). Document all devices used to confirm initial tube placement. Also document positive or negative breath sounds before and after each movement of the patient.
12. Consider placing an NG or OG tube to clear stomach contents after the airway is secured with an ET tube.
13. **It is required that the airway be monitored continuously through Capnography (if available) and Pulse Oximetry.**
14. **Documentation is required that the receiving physician at the receiving facility confirmed proper tube placement.**

Certification Requirements:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the Survival Flight Medical Director. Assessment should include direct observation at least once annually.