Airway management is an essential part of the care of all patients. It is an ongoing process which requires assessment of many different signs and symptoms. Evaluating and recognizing respiratory distress, respiratory failure, and respiratory arrest are critical in determining what level of intervention is required to properly treat the patient. The key areas to be assessed include: general impression, patency of airway, presence or absence of protective reflexes, and adequacy of breathing.

This protocol is designed to guide the paramedic through the sequence of airway management and is to be used in conjunction with other treatment protocols for specific conditions.

A. Assess airway for patency and protective reflexes.

B. Determine adequacy of breathing by assessing the rate, depth, effort, and adequacy of ventilation by inspection and auscultation.

C. If airway is patent and spontaneous breathing is adequate, and:

   1. No or mild to moderate distress, then administer oxygen at 2-6 LPM nasal cannula to maintain pulse oximeter >94%.

   2. Severe distress, then administer oxygen at 15 LPM non-rebreather mask to maintain pulse oximeter >94%.

D. If airway is not patent, then:

   1. Attempt to open airway by using head tilt/chin lift if no spinal trauma is suspected, or modified jaw thrust if spinal trauma is suspected.

   2. If foreign body obstruction of airway is suspected, then refer to **Airway Obstruction Protocol 5305.**

   3. If anatomical obstruction is occurring and airway cannot be maintained with positioning and the patient is unconscious, consider placing an oropharyngeal or nasopharyngeal airway adjunct.

E. If breathing is inadequate, ventilate with 100% oxygen.

F. If airway cannot be maintained by above means, including attempts at assisted ventilations or if prolonged assisted ventilation is anticipated, or if protective mechanisms are absent:

1. Perform endotracheal intubation.

2. Confirm endotracheal tube placement using clinical assessment and end-tidal CO2 monitoring.

G. If unable to intubate because of increased muscle tone and patient clearly has compromised airway requiring intubation, **consult Medical Command** and consider administration of diazapam 5 mg IV **per MCP order.**

H. If endotracheal intubation is not possible, insert esophageal-tracheal combitube and confirm placement.

I. Continue ventilation with 100% oxygen.

J. If unable to secure airway by any of the above methods utilize basic airway adjuncts and contact Medical Command. Consider EMT-P intercept.

Special Notes:

1. Do not use nasal route for airway if maxillofacial trauma is present.

2. Any patient with suspected spinal trauma needs in-line stabilization with any airway procedure.

3. Consider nasogastric tube placement if patient intubated and no facial trauma.