

| TEAM | PATIENT | IV DRUGS MONITORS | EQUIPMENT |
|--|--|--|--|
| <ol style="list-style-type: none"> 1. Notify senior ED doctor 2. Verbalise indication for intubation 3. Allocate roles 4. Confirm intubation plan* <ol style="list-style-type: none"> A. Initial tracheal intubation attempts x 3 B. Final tracheal intubation attempt C. Rescue plan to maintain oxygenation D. Rescue plan for front of neck access 5. Assign lead for post-intubation debrief <p>* see Emergency Intubation Algorithm</p> | <ol style="list-style-type: none"> 1. Optimise haemodynamics, consider: <ul style="list-style-type: none"> • Fluid bolus • Inotrope/vasopressor • Bolus dose vasopressor drawn up 2. Optimise pre-oxygenation, consider: <ul style="list-style-type: none"> • 100% FiO₂ • PEEP via t-piece • Apnoeic oxygenation (NP) 2 L/kg/min (15L/min) • Elevate head of bed 3. Optimise position, consider: <ul style="list-style-type: none"> • <1 year: towel/trauma mat under shoulders • >8 years: towel/pillow under head <p>If any difficulties anticipated CALL FOR HELP</p> | <ol style="list-style-type: none"> 1. IV access functioning 2. Intubation drugs/dose chosen and drawn up 3. Cardiac monitoring 4. BP (2 minute cycle) 5. SpO₂ 6. EtCO₂ 7. Post intubation sedation drawn up | <ol style="list-style-type: none"> 1. T-piece/face mask checked for leak 2. Suction functioning (yankauer and flexible) 3. Airway equipment template complete 4. Glidescope at bedside/turned on |

Emergency pre-intubation checklist. Endorsed by the Paediatric Improvement Collaborative.

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LARYNGOSCOPY →

ANY PROBLEM AT ANY TIME →

CALL FOR HELP

- Anaesthetist **ext 52000**
- Operating Theatre **ext 52001**
- PICU **ext 52324**
- NICU **ext 52211**
- ED **ext 52169**
- MET **ext 2222**

| Preparation | Assess | Check | Help | Plan | Optimise |
|--|--|---|--|--|--|
| | <ul style="list-style-type: none"> • Airway • Severity of condition • Your skills • Get help if difficulty anticipated | <ul style="list-style-type: none"> • Equipment • Monitors • Drugs for anaesthesia • Resuscitation | <ul style="list-style-type: none"> • Who? • Availability? • Inform consultant | <ul style="list-style-type: none"> • Discuss Plans (A, B, C and D) with your team • Nominate a timekeeper • Can this patient be woken up if intubation fails? | <ul style="list-style-type: none"> • Optimise position of the head and neck • Complete checklist |
| <p>REMEMBER: successive attempts at intubation must have different personnel, position, or technique.</p> <p>MAINTAIN: oxygenation, sedation and paralysis between each attempt.</p> | | | | | |

| | | | |
|--|--|------------------------------------|-----------------|
| Plan A: Up to 3 intubation attempts | <p>Pre-oxygenate. Sedate then paralyse. Remove collar and stabilise C-spine.</p> <p>Perform video assisted direct laryngoscopy. If unable to see vocal cords:</p> | | |
| | Manipulate larynx | Remove cricoid pressure if applied | Consider bougie |
| | <p>If unable to oxygenate, go to plan B after a single intubation attempt. Proceed to Plan B if not successful within three minutes.</p> | | |

To optimise oxygenation

- Correct mask size
 - Oral guedel airway
 - Two hands to hold mask
- If still unable to oxygenate, remove guedel and insert laryngeal mask



| | | | |
|----------------------------------|--|---|---|
| Plan B: Insert laryngeal mask | <p>Re-oxygenate. Check heart rate and blood pressure.</p> <p>The best intubator in the hospital at the time to perform a final attempt at intubation</p> | | |
| | Get anaesthetist ext 52000 | Prepare hyperangulated blade videolaryngoscope or flexible/fibreoptic scope | Revert to guedel if unable to ventilate |
| | <p>If unable to oxygenate, go to Plan D immediately. If intubation is unsuccessful, but can oxygenate, do not persist with further attempts, go to Plan C.</p> | | |

Verify tracheal intubation

- Verify with capnography and visually
- If in cardiac arrest, capnography can be unreliable — double check visually
- If in doubt, take it out



Failed intubation with successful oxygenation

Failed Intubation and failed oxygenation with bradycardia (SpO2 <80%, or < 50% with cyanotic heart disease)

| | |
|---------------------------------|--|
| Plan C: Maintain oxygenation | <p>Ventilate via face mask with guedel, or laryngeal mask</p> |
| | <p>Wake the patient if possible. Call ENT for urgent tracheostomy.</p> |

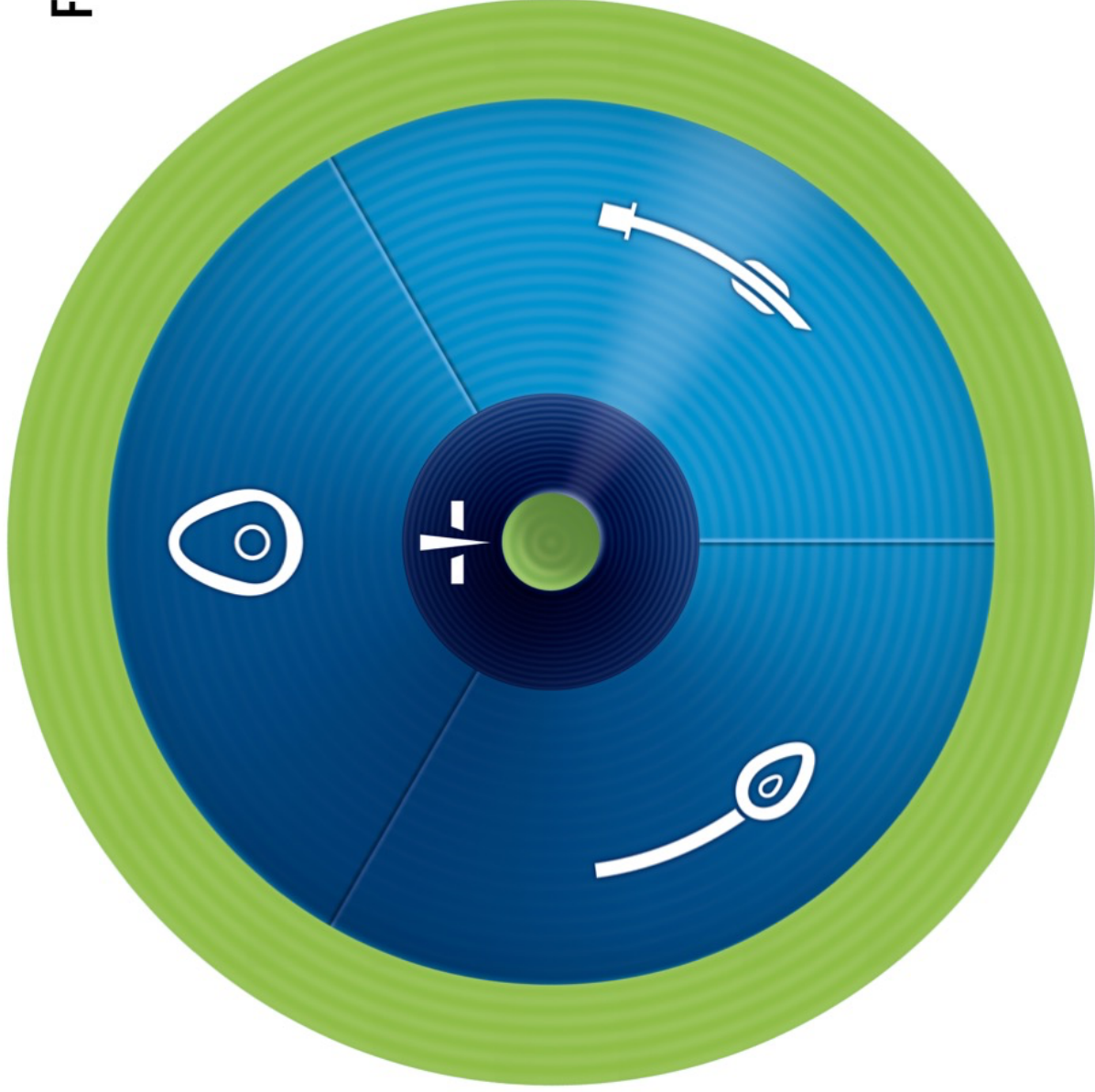
| | |
|---|---|
| Plan D: Rescue cricothyroidotomy/tracheostomy | <p>Revert to face mask with oral and nasopharyngeal airway</p> |
| | <p>Perform rescue cricothyroidotomy or tracheostomy.</p> |

Emergency airway plan. Endorsed by the Paediatric Improvement Collaborative.

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T H E V O R T E X

FOR EACH LIFELINE CONSIDER:



MANIPULATIONS:

- HEAD & NECK
- LARYNX
- DEVICE



ADJUNCTS



SIZE / TYPE



SUCTION / O₂ FLOW



MUSCLE TONE

**MAXIMUM THREE ATTEMPTS AT EACH LIFELINE (UNLESS GAMECHANGER)
AT LEAST ONE ATTEMPT SHOULD BE BY MOST EXPERIENCED CLINICIAN**

CICO STATUS ESCALATES WITH UNSUCCESSFUL BEST EFFORT AT ANY LIFELINE OR WITH UNSUCCESSFUL ATTEMPTS AT ANY TWO CONSECUTIVE LIFELINES



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Emergency Intubation

USE IN CONJUNCTION WITH BASIC LIFE SUPPORT GUIDELINES. SEE RCH AIRWAY MANAGEMENT CLINICAL PRACTICE GUIDELINES.



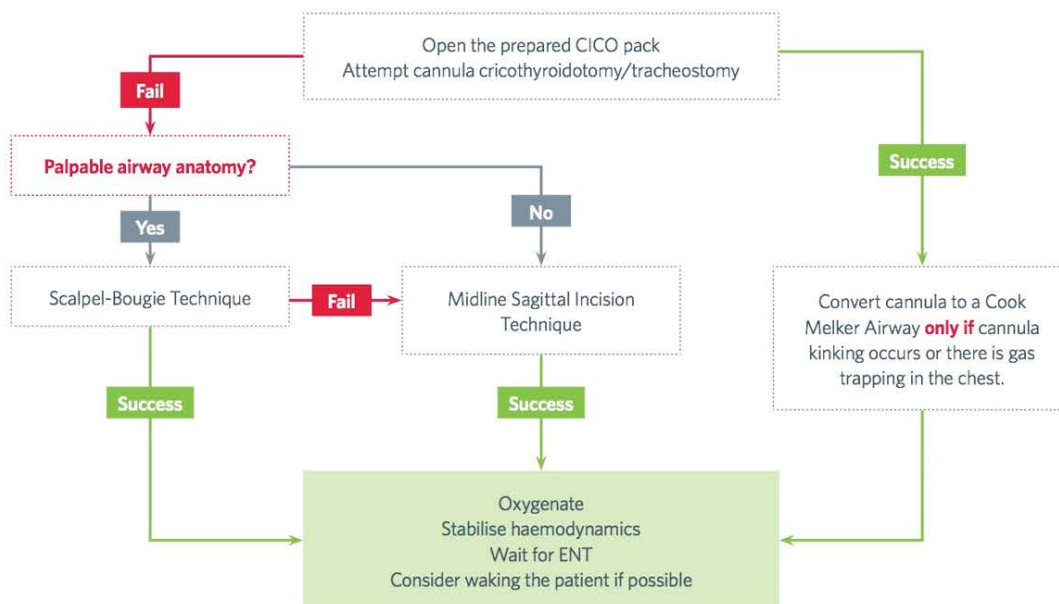
Anaesthesia, PICU, NICU, and Emergency

Plan D: RESCUE CRICOTHYROIDOTOMY/TRACHEOSTOMY

CAN'T INTUBATE, CAN'T OXYGENATE

Perform IF:

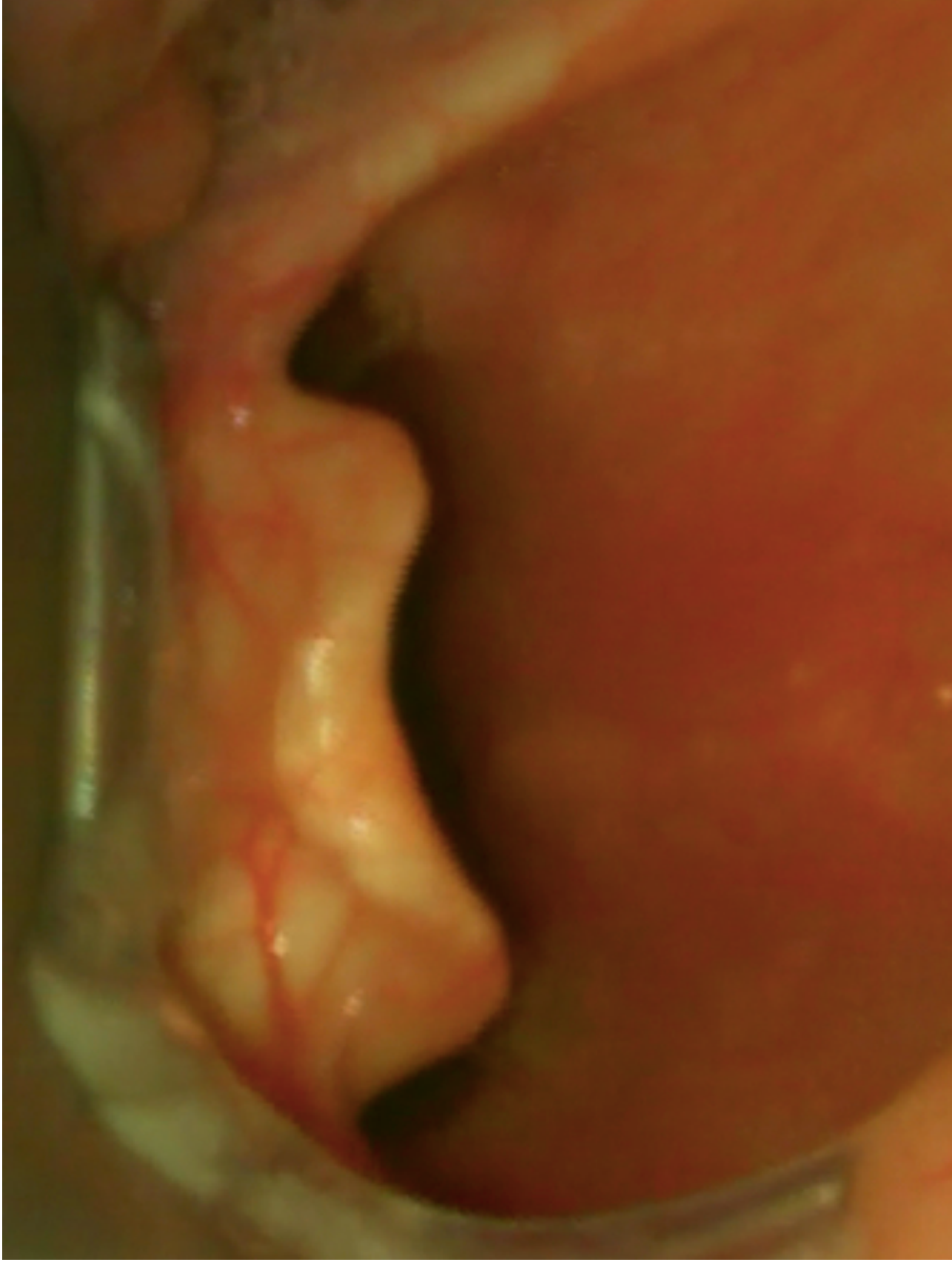
1. Child anaesthetised/unconscious with GCS < 8
2. Unable to intubate patient
3. Unable to oxygenate/ventilate patient with either a guedel airway, a laryngeal mask airway, or a two person ventilation technique
4. Oxygen saturation is <80% (< 50% with cyanotic heart disease) with bradycardia
5. No reversible cause (e.g. laryngospasm) and cricoid pressure has been removed
6. Child cannot be woken up



Airway Group

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Grade 3 larynx, Epiglottitis only



Grade 4 larynx, no structures visualized



Safe emergency airway management APLs

A



B

