

**PEORIA AREA EMS SYSTEM
PREHOSPITAL CARE MANUAL**

**Basic Airway Control
Procedure**

Establishing and maintaining an open airway and assuring adequate ventilation is a treatment priority with all patients. Proper techniques must be used to assure treatment maneuvers do not inadvertently complicate the patient's condition.

Basic Airway Control

1. Assure an open airway by utilizing either the head tilt/chin lift maneuver, the modified jaw thrust maneuver or the tongue-jaw lift maneuver. The head tilt/chin lift maneuver is NOT to be used if there is any possibility of cervical spine injury.
2. Expose the chest and visualize for chest rise and movement, simultaneously listen and feel for air movement at the mouth and nose. This procedure will need to be done initially and after correcting an obstruction and securing the airway.
3. If the chest is not rising and air exchange cannot be heard or felt:
 - a) Deliver two positive-pressure ventilations. If resistance continues, follow AHA sequences for obstructed airway rescue.
 - b) Reassess breathing and check for a carotid pulse.
 - c) If spontaneous respirations return and a pulse is present, provide supplemental Oxygen by non-rebreather mask or assist respirations with bag-valve mask (BVM) at 15 L/min.
 - d) If the patient remains breathless and a pulse is present, initiate ventilations with a BVM at 15 L/min at a rate of 12 breaths per minute.
 - e) If the patient remains breathless and a pulse is not present, initiate CPR and institute the appropriate cardiac protocol.
4. If the patient presents with stridor, "noisy breathing" or snoring respirations, render treatment for partial airway obstruction in accordance with AHA guidelines.
 - a) Reassess effectiveness of the airway maneuver.
 - b) If initially unable to resolve partial airway obstruction, suction the airway and visualize the pharynx for any evidence of foreign objects. Perform a finger sweep if a foreign object can be seen.
 - c) If partial airway obstruction persists, treat according to AHA guidelines for resolving a complete airway obstruction.

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Basic Airway Control (continued)

5. Once the obstruction has been corrected:
 - a) Insert an oropharyngeal airway in the unconscious patient (without a gag reflex).
 - b) Insert a nasopharyngeal airway in the conscious patient or an unconscious patient with a gag reflex. *Note:* Do not use if the possibility of head injury exists.
6. Establish the presence and adequacy of breathing by observing the frequency, depth and consistency of respirations. Also, observe the chest wall for any indications of injuries which may contribute to respiratory compromise.
7. Supplemental oxygen should be delivered to any patient who exhibits signs of difficulty breathing, sensation of shortness of breath, respiratory rate > 20 breaths per minute, use of accessory muscles, altered level of consciousness/altered mental status, cyanosis, cardiac symptoms, head injury or any indications of shock.
 - a) Supplemental oxygen should be provided by a non-rebreather mask (NRM) at a rate of 15 L/min (assuring reservoir bag is inflated).
 - b) If patient is unable to tolerate the NRM, administer oxygen via nasal cannula at a rate of 6 L/min.
8. Bag-valve mask ventilation with supplemental oxygen at 15 L/min should be initiated at the rate of 12/min if respirations are absent, there is evidence of inadequate ventilation, respiratory rate is < 8 /min, absent or diminished breath sounds or wounds to the chest wall.

Critical Thinking Elements

- Inadequate maintenance of the patient's airway, inappropriate airway maneuvers, using inappropriately sized airway equipment and/or failure to recognize an obstructed airway will complicate the patient's condition.
- Do NOT use the head tilt/chin lift maneuver on a patient with a suspected cervical spine injury.
- Proper facemask seal during artificial ventilations is imperative to assure adequate ventilation.
- BLS, ILS & ALS providers should establish basic airway and ventilation measures prior to Combitube placement; ILS & ALS prior to intubation.