

ADVANCED AIRWAY PROCEDURES

This procedure includes the following:

- Endotracheal intubation (plus use of Supraglottic Airway Laryngopharyngeal Tube (S.A.L.T. device), gum elastic bougie assisted tracheal intubation, video laryngoscopy)
- Non-Visualized Airways (King, LMA, iGel)
- Cricothyroidotomy (needle and surgical)
- Medication Facilitated Advanced Airway
- Advanced Airway Device Removal

GENERAL CONSIDERATIONS

1. In general, airway interventions should gradually progress from least invasive to most invasive: Start with nasal cannula or non-rebreather oxygen (unless apneic) → CPAP/BiPAP (unless apneic) → bag-valve mask with OPA/NPA → supraglottic airway (iGel, King, LMA) → endotracheal intubation.
2. Rescuers must be aware of the risks and benefits of advanced airway management techniques. In cases of cardiac arrest, the insertion of an advanced airway often requires interruptions in chest compressions which worsens survival outcomes. The preferred method of ventilation is *not* an endotracheal tube unless in the paramedic's judgment, ventilation can occur by no other means (BVM, iGel, LMA, King). Such potential situations could include cases of significant airway obstruction (anaphylaxis with pharyngeal swelling, angioedema, obstructing mass or foreign body) or failure of BVM or supraglottic airways. Rescuers may defer insertion of an advanced airway until the patient fails to respond to initial CPR and defibrillation attempts or demonstrates return of spontaneous circulation.
3. Providers should have a second (back-up) strategy for airway management and ventilation if they are unable to establish the first-choice airway adjunct. Bag-mask ventilation may provide that back-up strategy.

SUPRAGLOTTIC AIRWAYS (SGAs)

A. Indications:

1. Basic EMT: Advanced airway management option for apneic and pulseless patients.
2. Advanced EMT: First-line advanced airway device for apneic patients. Exceptions where endotracheal intubation could be considered first-line include cases of significant airway obstruction (anaphylaxis with pharyngeal swelling, angioedema, obstructing mass or foreign body).

3. Paramedic: First-line advanced airway device for apneic patients. Exceptions where endotracheal intubation could be considered first-line include cases of significant airway obstruction (anaphylaxis with pharyngeal swelling, angioedema, obstructing mass or foreign body).

B. Device options:

1. King LT-D™ Airway
2. Laryngeal Mask Airway (LMA)
3. iGel

C. Contraindications:

- a. AEMT: Patient has a gag reflex
Paramedic: Patient has a gag reflex despite use of ketamine or versed.
- b. Appropriately sized airway is unavailable.
- c. In cases of known esophageal disease or cirrhosis, history of esophageal injury or trauma
- d. In cases of caustic poison ingestion
- e. Foreign body in trachea
- f. Tracheostomy or laryngectomy
- g. Respiratory depression / arrest due to suspected narcotic overdose or hypoglycemia **prior** to administration of Narcan and/or glucose.

D. **King LT-D™**

1. Always begin artificial ventilation immediately using an oral or nasal airway and positive pressure ventilations via BVM.
2. General consideration: If patient has gag reflex or exhibits significant dyssynchrony with ventilations, consider ketamine or versed to assist advanced airway management. *See Medication Facilitated advanced airway below.*
3. Select appropriately sized tube and test cuff inflation by injecting the maximum recommended volume of air (listed in table below) into the cuffs. Remove all air prior to insertion.

Size	Patient description	Connector Color	Inflation Volume
2	35 – 45 inches tall	Green	
2.5	41 – 51 inches	Orange	
3	4 – 5 feet tall	Yellow	45-60 ml
4	5 – 6 feet tall	Red	60-80 ml
5	Greater than 6 feet tall	Purple	70-90ml

4. Apply water-based lubricant to beveled distal tip and posterior aspect of the tube, taking care to avoid introduction of lubricant in or near the ventilator openings.
5. Remove dentures; suction secretions from mouth and oropharynx
6. Position the patient's head. The ideal position is the "sniffing position". If this contraindicated due to suspected spinal injury, the tube can be inserted with the head in a neutral position.
7. Hold the tube at the connector end with the dominant hand. With the non-dominant hand, hold mouth open and apply chin lift>
8. With the tube rotated laterally 45-90° such that the blue orientation line is touching the corner of the mouth, introduce tip into mouth and advance behind the base of tongue.



9. The key to insertion is to get the distal tip of the tube around the corner in the posterior pharynx, under the base of the tongue. Use of the lateral approach in conjunction with a chin lift will facilitate tube placement.

As tube passes under the tongue, rotate tube back to midline (blue orientation line faces chin).



10. Without exerting excessive force, advance tube until base of connector is aligned with the teeth or gums.
11. Inflate cuffs with the minimum volume necessary to seal the airway at peak ventilator pressure employed (just seal volume).
12. Attach BVM to tube connector. While gently bagging the patient to assess ventilation, simultaneously and slowly withdraw the tube until ventilation is easy and free-flowing (large tidal volume with minimal airway pressure).
13. Adjust cuff inflation, if necessary, to obtain an airway seal at peak ventilation pressure.
14. Confirm tube placement by auscultation of lung sounds, chest rise, and waveform capnography.
15. Device placement must be confirmed with end-tidal CO₂ waveform capnography. If no waveform obtained, after taking less than 10 seconds ensure equipment is appropriately connected, you **MUST** assume device is improperly placed and failing to ventilate appropriately. Remove device and ventilate with BVM until supraglottic airway can be attempted again. If supraglottic device fails, paramedic or AEMT may escalate to endotracheal intubation.
16. Document the procedure by noting the following:
 - a. Number of attempts
 - b. Person(s) making attempts
 - c. Presence of lung sounds, absence of epigastric sounds, and chest rise and fall immediately after insertion and minimally every 10 minutes or after each significant movement of the patient.
 - d. SpO₂ / end-tidal CO₂ / capnography reading every 10 minutes.
 - e. Any complications.

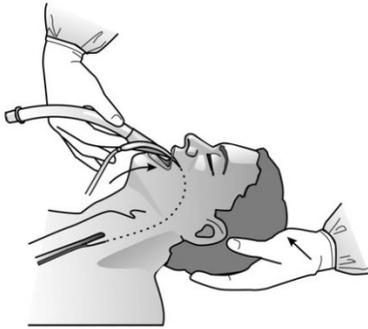
E. Laryngeal Mask Airway (LMA)TM

1. Always begin artificial ventilation immediately using an oral or nasal airway and positive pressure ventilations.
2. General consideration: If patient has gag reflex or exhibits significant dyssynchrony with ventilations, consider ketamine or versed to assist advanced airway management. *See Medication Facilitated advanced airway below.*
3. Select appropriately sized tube:

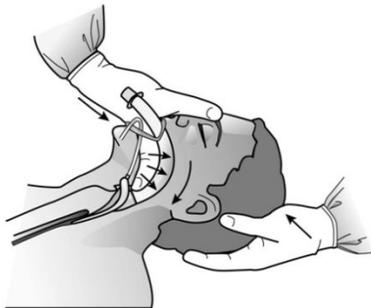
LMA TM Size	Patient Description	Maximum Inflation Volume
1	Neonates/Infants up to 5 kg	4 ml
1 ½	Infants 5-10 kg	7 ml
2	Infants/Children 10-20 kg	10 ml
2 ½	Children 20-30 kg	14 ml
3	Children 30-50 kg	20 ml
4	Adult 50-70 kg	30 ml
5	Adult 70-100 kg	40 ml
6	Adult > 100 kg	50 ml

4. Prior to insertion of the LMATM airway, the cuff should be tightly deflated so that it forms a smooth “spoon-shape” without any wrinkles on the distal edge. Press the mask with its aperture side down on a flat surface with the fingers being used to guide the cuff into the desired shape.
5. In order to ensure airway is completely deflated, the “flip-test” should be performed. When the tip of the deflated cuff is inverted, it should flip back to its original position. If it does not, there may be air inside the cuff or the mask may be incorrectly deflated.
6. Lubricate posterior surface with water-soluble lubricant. Avoid blockage of the aperture with the lubricant.
7. Remove dentures; suction secretions from mouth and oropharynx
8. Position the patient’s head. The ideal position is the “sniffing position”. If this contraindicated due to suspected spinal injury, the tube can be inserted with the head in a neutral position.

9. Hold LMA™ airway like a pen, with the index finger placed at the junction of the cuff and the tube. Mask aperture must face posteriorly and the black line on the airway tube should be oriented anteriorly toward the upper lip.



10. Press the tip of the cuff upward against the hard palate and flatten the cuff against it.
11. Using the index finger to guide the LMA™ airway, press backwards toward the ears in one smooth movement. Do NOT use force. Advance LMA™ into hypopharynx until a definite resistance is felt.



12. Check to ensure that the black line is oriented anteriorly toward the upper lip.
13. Inflate the cuff with just enough pressure to obtain a seal. The airway may move during inflation. Do NOT overinflate.
14. Signs of correct placement may include one or more of the following: the slight outward movement of the LMA™ airway with inflation, presence of a smooth oval swelling in the neck around the thyroid and cricoid area, or no cuff visible in the oral cavity.
15. Adjust cuff inflation, if necessary, to obtain an airway seal at peak ventilation pressure.
16. Confirm tube placement by auscultation of lung sounds, chest rise, and waveform capnography.
17. Device placement must be confirmed with end-tidal CO₂ waveform capnography. If no waveform obtained, after taking less than 10 seconds ensure equipment is appropriately connected, you MUST assume device is improperly placed and failing to ventilate appropriately. Remove device and ventilate with BVM until

supraglottic airway can be attempted again. If supraglottic device fails, paramedic or AEMT may escalate to endotracheal intubation.

18. Document the procedure by noting the following:
 - a. Number of attempts
 - b. Person(s) making attempts
 - c. Presence of lung sounds, absence of epigastric sounds, and chest rise and fall immediately after insertion and minimally every 10 minutes or after each significant movement of the patient.
 - d. SpO₂ / end-tidal CO₂ / capnography reading every 10 minutes.
 - e. Any complications.

F. iGel Airway

1. Contraindications:
 - a. Patients with an ASA or Mallampati score of III and above.
 - b. Trismus, limited mouth opening, pharyngo-perilaryngeal abscess, trauma or mass.
 - c. Do not allow peak airway pressure of ventilation to exceed 40cm H₂O.
 - d. Do not use excessive force to insert the device.
2. As with all supraglottic airway devices, particular care should be taken with patients who have fragile and vulnerable dental work

Procedure:

- a. Always begin artificial ventilation immediately using an oral or nasal airway and positive pressure ventilations
- b. General consideration: If patient has gag reflex or exhibits significant dyssynchrony with ventilations, consider ketamine or versed to assist advanced airway management. *See Medication Facilitated advanced airway below*
- c. Always wear appropriate PPE.
- d. Open the I-Gel package, and on a flat surface take out the protective cradle containing the device.
- e. In the final minute of pre-oxygenation, remove the I-Gel and transfer it to the palm of the same hand that is holding the protective cradle, supporting the device between the thumb and index finger. Place a small bolus of a water-based lubricant, such as K-Y Jelly, onto the middle of the smooth surface of the cradle in preparation for lubrication. Do not use silicone-based lubricants.
- f. Grasp the I-Gel with the opposite (free) hand along the integral bite block and lubricate the back, sides and front of the cuff with a thin layer of lubricant. This process may be repeated if lubrication is not adequate, but after lubrication has been completed, check that no BOLUS of lubricant remains in the bowl of the cuff or elsewhere on the device. Avoid touching the cuff of the device with your hands.

- g. Place the I-Gel back into the cradle in preparation for insertion. The I-Gel must always be separated from the cradle prior to insertion. The cradle is not an introducer and must never be inserted into the patient's mouth.
- h. Grasp the lubricated I-Gel firmly along the integral bite block. Position the device so that the I-Gel cuff outlet is facing towards the chin of the patient.
- i. The patient should be in the 'sniffing the morning air' position with head extended and neck flexed. The chin should be gently pressed down before proceeding to insert the I-Gel.
- j. Introduce the leading soft tip into the mouth of the patient in a direction towards the hard palate.
- k. Glide the device downwards and backwards along the hard palate with a continuous but gentle push until a definitive resistance is felt.
- l. At this point the tip of the airway should be located into the upper esophageal opening and the cuff should be located against the laryngeal framework. The incisors should be resting on the integral bite-block.
- m. The I-Gel should be taped down from 'maxilla to maxilla', or secured using an appropriate available commercially made
- n. Adjust positioning forwards or backwards, if necessary, to obtain an airway seal at peak ventilation pressure.
- o. Confirm tube placement by auscultation of lung sounds, chest rise, and waveform capnography.
- p. Device placement must be confirmed with end-tidal CO₂ waveform capnography. If no waveform obtained, after taking less than 10 seconds ensure equipment is appropriately connected, you **MUST** assume device is improperly placed and failing to ventilate appropriately. Remove device and ventilate with BVM until supraglottic airway can be attempted again. If supraglottic device fails, paramedic or AEMT may escalate to endotracheal intubation.

3. Documentation:

- a. Indications for I-Gel use.
- b. Number of attempts to insert I-Gel
- c. Size of I-Gel
- d. Steps taken to verify tube placement.
- e. Repeat assessment and vital signs every five minutes.
- f. Changes from baseline that may have occurred, if any.
- g. Attach a Capnography waveform print out the ePCR

ENDOTRACHEAL INTUBATION

- A. Indications for emergency endotracheal intubation are:
1. Inability of the rescuer to adequately ventilate the patient with a bag-mask device or supraglottic airway
 2. The absence of airway protective reflexes (coma and cardiac arrest)
- B. In most cases, endotracheal intubation provides definite control of the airway. Its purposes include:
1. Actively ventilating the patient
 2. Delivering high concentrations of oxygen
 3. Suctioning secretions and maintaining airway patency
 4. Preventing aspiration of gastric contents, upper airway secretions or blood
 5. Prevented gastric distention due to assisted ventilations
 6. Administering positive pressure when extra fluid is present in alveoli
 7. Administering medications during resuscitation for absorption through lungs as a last resort
- C. Endotracheal intubation is an Advanced EMT and Paramedic skill. Per the State of Ohio Scope of Practice, Advanced EMTs are able to use endotracheal intubation for **APNEIC** patients only.
- D. Hazards:
1. Esophageal intubation
 2. Tracheal rupture
 3. Right mainstem bronchus intubation
 4. Broken teeth
 5. Laryngospasms
 6. Trauma to oropharynx
 7. Trauma or puncture of trachea due to misplacement of stylet
- E. Technique**
1. Always begin artificial ventilation as soon as possible using positive pressure ventilations. Deliver each breath over on second with sufficient volume to cause chest rise. Rescue breathing rate for adults is one breath every 5-6 seconds and one breath every 3-5 seconds for children and infants.
 2. If patient has gag reflex or exhibits significant dyssynchrony with ventilations, Paramedics may consider ketamine or versed to assist advanced airway management. *See Medication Facilitated advanced airway below.*
 3. Assemble and prepare equipment
 4. Check cuff on ET tube for leaks and lubricate tube. Introduce stylet and assure that the tip is at least ½” from the end of the tube.

5. **Tube Sizing: Adult**– the size of tube that can be passed easily into most adults is 8.0 mm. Therefore, this tube should be tried first on the average adult. The size of the tube is judged by the size of the adult, not by age.

Tube Sizing: Children a length-based tape (i.e., Broselow tape) can be used to determine proper size. Generally, the proper tube is usually equal to the size of the child’s little finger. The following guide will also help determining the proper sized tube:

Premature.....3 mm	18-24 months.....5-6 mm
14-24 weeks.....4 mm	2-4 years.....6 mm
6-12 months.....4-5 mm	4-7 years.....6-7 mm
12-18 months....5 mm	7-10 years.....7 mm

All the above sizes are still dependent on the child’s size in consideration of age.

Children younger than 8 years of age should have an uncuffed tube, or if the tube has a cuff, it should not be inflated after insertion

6. Assemble laryngoscope and check bulb.
7. Put the patient’s head in sniffing position if cervical spine injuries are not suspected. Do not allow the head to hang over the end of the cot; the occiput of the head should be on the same horizontal plane as the back of the shoulders with the neck somewhat elevated.
8. Holding the laryngoscope in the left hand, insert the blade to the right of the midline, moving the tongue up and to the left, with the blade ending up in the midline, giving clear visualization of the glottis opening.
9. Remove dentures; suction the mouth and pharynx as necessary.
10. Visualize the epiglottis and identify the trachea, using the vocal cords and/or arytenoid cartilages as a guide.
11. Holding the ET tube in the right hand, insert the tube from the right side of the mouth, starting at the corner of the mouth down into the trachea. Advance tube so the cuff is 1.5 inches beyond cords (or glottis marker is at the cords for pediatric tubes).
12. Remove laryngoscope and stylet (if used), holding the tube securely with the right hand.
13. Attempt to ventilate with bag-mask. Check for bilateral chest rise and auscultate for breath sounds over BOTH lung fields and for absence of sounds over epigastrium.
14. Tube placement must be confirmed with end-tidal CO₂ waveform capnography. If no waveform obtained after taking less than 10 seconds to ensure equipment is appropriately connected, you MUST assume ETT is improperly placed or in the esophagus. Remove device and ventilate with BVM until supraglottic airway can be placed. May repeat attempt with ETT only if ETT is the only possible means of ventilation in cases of significant airway edema or obstruction.

15. When placement confirmed, inflate cuff (for patients > 8 years of age) and secure the tube in place with oropharyngeal airway used as a bite block.
16. Maintain ventilation until adequate respirations resume or the victim is transferred to the emergency department.
17. Recheck lung sounds and verify tube placement each time the patient is moved and every 10 minutes. Document these checks.
18. Document the intubation by noting the following:
 - a. Number of attempts
 - b. Person(s) making attempts
 - c. Size of tube
 - d. Type and size of laryngoscope blade
 - e. Lung sounds before intubation
 - f. Lung sounds after intubation and time of each check
 - g. Presence of confirmatory ETCO₂ waveform capnography
 - h. Measurement on tube at lips of the patient when lung sounds are present
 - i. Any complications

F. **Gum Elastic Bougie Assisted Tracheal Intubation**

1. Can be used for the difficult orotracheal intubation.
2. The bougie can accommodate ET tubes > 6mm
3. Perform direct laryngoscopy and maintain adequate laryngoscopic force to optimize the glottic view. External pressure over the cricoid cartilage can also be employed to improve the view.
4. Introduce the bougie into the patient's mouth and gently advances it through the glottic opening (Grade II view) or anteriorly under the epiglottis (Grade III view) until clicks against the tracheal rings or hold up is felt.
5. With the first rescuer still maintaining laryngoscope and bougie control, a 2nd rescuer then threads a tracheal tube over the bougie and advances it to a depth of 20-24 cm at the lip while maintaining proximal control over the 60 cm long bougie. Occasionally, the bougie and tracheal tube may need to be rotated 90° for the tube to pass.
6. Attempt to ventilate with bag-mask. Check for bilateral chest rise and auscultate for breath sounds over BOTH lung fields and for absence of sounds over epigastrium.
7. Tube placement must be confirmed with end-tidal CO₂ waveform capnography. If no waveform obtained, after taking less than 10 seconds to ensure equipment is appropriately connected, you MUST assume ETT is improperly placed or in the esophagus. Remove device and ventilate with BVM until supraglottic airway can be placed. May repeat attempt with ETT only if ETT is the only possible means of ventilation in cases of significant airway edema or obstruction.

G. **Video Laryngoscopy** - Follow specific manufacturer's recommendations

CRICOTHYROIDOTOMY

Paramedic Only

A. Indications – unable to manage airway by other methods. This may be seen with:

1. Cervical spine injuries
2. Maxillofacial trauma
3. Laryngeal trauma
4. Oropharyngeal obstruction from:
 - a. Edema due to infection, caustic ingestion, allergic reaction, and/or inhalation injuries
 - b. Foreign body
 - c. Mass lesion
5. All other advanced airway management options are contraindicated

B. Complications:

1. Hemorrhage or hematoma formation
2. Aspiration
3. Creation of false passage into the tissues
4. Subglottic stenosis/edema
5. Laryngeal stenosis
6. Laceration of esophagus or trachea
7. Vocal cord paralysis / voice change

C. Manufactured Tracheostomy Kit

Cricothyrotomy with a manufactured tracheostomy kit (follow manufacturers guidelines) such as the QuickTrach is preferred, unless anatomy of the cricothyroid membrane is obscured by excessive amounts of soft tissue, significant traumatic disruption of landmarks, presence of neck mass, or paramedic cannot reliably in their judgment palpate landmarks without scalpel dissection. In those cases, a surgical cricothyroidotomy is preferred.

D. Surgical Cricothyroidotomy

Remember, manufactured cricothyroidotomy kits such as the QuickTrach are the preferred method of performing a cricothyroidotomy. Follow manufacturer's recommendations for technique. However, if a manual surgical cricothyrotomy is necessary:

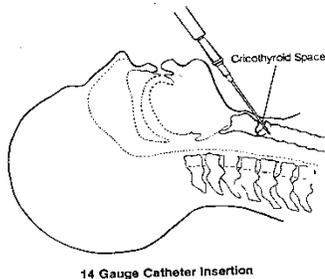
1. Place patient in supine position with neck in neutral position.
2. Palpate thyroid notch, cricothyroid membrane, and sternal notch for orientation.
3. Prep area with antiseptic solution.
4. Stabilize thyroid cartilage with one hand and maintain stabilization until trachea is intubated.
5. Make vertical skin incision over the cricothyroid membrane, and carefully incise through membrane vertically.
6. Use a hemostat or tracheal spreader to create a wide enough gap to pass an endotracheal tube. Only if these tools are not available should you insert the

- scalpel handle into the incision and rotate it 90-degrees horizontally to create a gap large enough for an endotracheal tube
7. Insert appropriately sized cuffed endotracheal tube into the incision, directing the tube distally into the trachea.
 8. Inflate the cuff and ventilate the patient.
 9. Observe lung inflation and auscultate the chest for adequate ventilation, as well as an absence of sounds over the epigastrium
 10. Confirm placement with ETCO₂ waveform capnography and secure the tube

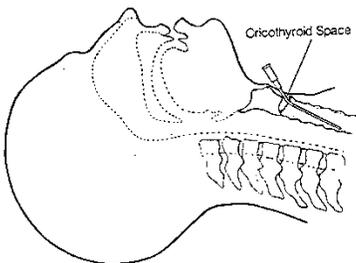
E. Needle Cricothyroidotomy

- Use only if adult manufactured tracheostomy kit (e.g. QuickTrach) AND surgical cricothyroidotomy are not an option.
- May be necessary in children < 8 yo, whose cricothyroid membranes are too narrow for the placement of an adult-sized manufactured tracheostomy kit:

1. Place patient in supine position
2. Prep area with antiseptic solution
3. Attach a 12–14-gauge, 8.5 cm, over-the-needle catheter to 5-10 ml syringe
4. Palpate cricothyroid membrane, anteriorly, between the thyroid and cricoid cartilages.
5. Stabilize the trachea with the thumb and forefinger of one hand to prevent lateral movement of the trachea.
6. Insert the needle into the cricothyroid membrane at a 45-degree angle caudally, while applying negative pressure with the syringe.



7. Aspiration of air signifies entry into the tracheal lumen.
8. Advance the catheter downward and remove the needle and syringe.



9. Intermittent positive pressure ventilations can now be provided with jet ventilator or place the connector from a size 3 ET tube on the catheter and ventilate with BVM.
10. Continue to observe lung inflations and auscultate the chest for adequate ventilation.

MEDICATION FACILITATED ADVANCED AIRWAY MANAGEMENT

Paramedic Only

General Considerations:

- A. While attempting advanced airways, patients may have persistent gag reflex or exhibit significant dyssynchrony with ventilation attempts. In these cases, the paramedic may elect to facilitate advanced airway management with Ketamine or Versed.
- B. Ketamine is a dissociative agent, causes less hypotension than Versed, and helps with bronchodilation in patients with COPD or asthma where bronchospasm may be contributing to respiratory distress. Therefore, consider it early in advanced airway management for cases of Asthma, COPD, severe anaphylaxis or in patients with systolic blood pressures < 100 mmHg prior to attempt.
- C. Versed may also be used to facilitate advanced airway management. Versed should be strongly considered over ketamine if concerned for acute coronary syndrome.

Procedure:

A. Begin advanced airway management procedure per particular device protocol above

B. If patient has gag reflex or significant dyssynchrony with ventilation attempts, may facilitate advanced airway with ketamine or versed

C. Administer medication to achieve dissociation:

Midazolam (Versed): Adult Dose: 2.5 mg slow IVP or Intranasally (IN). Do NOT give if SBP < 100 mmHg. May repeat dose once in 5 minutes as needed.

Midazolam (Versed) Pediatric Dose: 0.1 mg/kg slow IVP or IN (maximum dose 2.5 mg)

OR

Ketamine Adult & Pediatric Dose: Administer 1 mg/kg Ketamine slow IVP. May repeat dose once if dissociative effect not achieved.

Ketamine Geriatric dose: Administer 0.5 mg/kg slow IVP. May repeat dose once if dissociative effect not achieved.

D. Record vital signs including blood pressure after medication administration and q5 min en route.

E. Contact Medical Control for additional doses if needed

ADVANCED AIRWAY DEVICE REMOVAL

If the patient begins to breathe spontaneously and effectively and is resisting the presence of the advanced airway device, is conscious and following commands, removal of the device may be necessary. The following procedure should be followed if indicated:

1. All equipment and medications necessary to provide advanced airway management should device removal fail must be readily accessible.
2. Explain procedure to patient
3. Prepare suction equipment and suction secretions from device, mouth and pharynx
4. The lungs should be completely inflated so that the patient will initially cough or exhale as the device is taken from the larynx. This can be accomplished in two ways:
 - a The patient is asked to take the deepest breath they possibly can and, at the peak of the inspiratory effort, the cuff(s) is deflated and the device rapidly removed; or
 - b Positive pressure ventilation is administered with bag-mask and, at end of deep inspiration, the cuff(s) is deflated and the device rapidly removed.
5. Prepare to suction secretions and gastric contents if vomiting occurs
6. Apply pulse oximeter and administer oxygen via NC or NRB as indicated.
7. The patient's airway is immediately evaluated for signs of obstruction, stridor, or difficulty breathing. The patient should be encouraged to take deep breaths and to cough.
8. The patient is not to be left unattended until there is no doubt of their ability to function without the artificial airway.