

AIRWAY OBSTRUCTION

ALWAYS USE BODY SUBSTANCE ISOLATION PRECAUTIONS

INDICATION

- Presence of upper respiratory infection, sore throat, fever, stridor or drooling
- Mechanical upper airway obstruction with history of food aspiration (especially if elderly)

CRITICAL INFORMATION

- Ability to speak
- Ability to manage secretions

TREATMENT

- ALS RMC
- Visualize airway
- Suspected mechanical upper airway obstruction; Conscious patient- able to speak:
 - Suctioning if needed to control secretions
 - Transport in position of comfort, avoid agitating patient
- Suspected mechanical upper airway obstruction; Conscious patient-unable to cough or speak:
 - Ask the patient if he/she is choking
 - Administer abdominal thrusts/Heimlich maneuver until the foreign body is expelled or the patient becomes unconscious
 - After obstruction is relieved, reassess airway, lung sounds, skin color and vital signs
- Unconscious patient:
 - Perform a tongue-jaw lift followed by finger sweep to remove object
 - Begin CPR
 - Prepare to use Magill forceps if BLS not effective
- Suspected epiglottitis
 - Transport in an upright sitting position
 - If patient deteriorates or the airway becomes completely obstructed, attempt positive pressure ventilation via BVM. Endotracheal intubation should be performed only if BVM is inadequate.
 - Prepare for cricothyroidotomy if unable to ventilate with customary BLS or ALS adjuncts

DOCUMENTATION- ESSENTIAL ELEMENTS

- Frequent pulse oximetry recordings

RELATED POLICIES/ PROCEDURES

- Cricothyroidotomy Procedure ALS PR 5