SUBJECT: Delineation of responsibility for airway management in the Resuscitation Room and roles of Anesthesia Consultation and Emergency Medicine senior residents.

DEFINITION/PURPOSE:
To provide guidelines and policy for management of the airway in patients admitted to the Trauma Resuscitation Suite.

PROTOCOL:
Dr. #1 is responsible for determining the necessity of obtaining an airway by means of intubation or cricothyroidotomy after discussion with the Trauma Attending/Fellow. Anesthesia (covering the code pager) or the senior ED resident on the Trauma Service may intubate the patient depending on the rotation schedules. Anesthesia can be paged by accessing the code blue page beeper for Anesthesia and should respond within five minutes. The senior ED resident will be present with the trauma team prior to the patient’s arrival and will page his ED attending for the procedure. Ultimately the Trauma Attending is in charge of the resuscitation and airway decisions.

SCOPE:
This policy includes all physicians and nurses who practice in the Trauma Resuscitation Room. ED residents do not intubate patients in the SICU as part of this protocol.

PROCEDURE:
Action
1. When a trauma patient arrives, Dr. #1 in conjunction with the Trauma Attending/Fellow is in charge of the patient’s airway including decisions for intubation and adjunctive management. Should Dr. #1 ask for the patient to be intubated, either the ED resident with ED Attending backup or Anesthesia will proceed.

2. ED residents will be scheduled for doing the resus suite intubations only when they are Dr #1 and provided a Trauma Attending is present. The ED attending will be paged stat to the resus suite to supervise the ED resident. The Trauma Attending will be at the bedside supervising patient management and decision making.

3. If Anesthesia is to intubate, the Anesthesia code pager is paged. This code beeper is carried by the in-hospital Anesthesia Resident or Attending 24 hours a day. As a backup in the event that the Anesthesia code pager fails to get a response, the Anesthesia Floor Walker may be accessed by calling the OR front desk at 36040.

4. For the intubation procedure:
   A. All patients should be considered to need C spine precautions and to have a full stomach. Cricoid pressure will be held until the tube placement is confirmed and the cuff inflated.

   B. Placement of the O₂ Sat monitor and EKG leads and suction availability will be a priority for nursing.

   C. A Trauma Attending will be at the bedside for all intubations and is in charge.
D. In order to standardize stocked medications, the following will be used for intubation in the resus suite: Succinylcholine, Morphine Sulfate, Vecuronium, Etomidate, Rocuronium and Ativan. Propofol may be obtained from the SICU pharmacy.

E. Oral intubation attempts should be limited to a total of 3. (For example, in the case of the ED resident intubating, he can attempt twice and his attending could attempt once.)

F. When the intubator finds that the patient has a “difficult airway”, e.g., anterior airway or unable to have a good view due to secretions, he should tell the team immediately. The resus nurse will respond by having the cricothyroidotomy set out and available.

G. The Trauma Attending will make the decision as to whether --
- to page Anesthesia Senior Resident/Attending and request the bronchoscope equipment for oral intubation,* or
- to do a surgical airway/cricothyroidotomy.

(*In some cases the Trauma Attending may decide to await Anesthesia Attending with the bronchoscopy equipment when the patient has acceptable O$_2$Sats and cricoid pressure is well maintained.)

H. After intubation, FEF devices and ETCO$_2$ will be used to assess the adequacy of tube placement.

EFFECTIVE DATE:
APPROVED:

____________________________________
David B. Hoyt, M.D.
Head, Division of Trauma

____________________________________
Raul Coimbra, MD
Division of Trauma

SUPERSEDES: 7/02, 10/98
REVIEW DATES: