

- Ensure appropriate volume of each ventilation. Too much volume can divert air into the stomach.

- If unable to ventilate, ensure the correct size was chosen and placement is correct with adequate lubrication. If continued inability to ventilate, revert to BVM ventilations.

7. Ongoing Use

- End-tidal CO₂ detector, if available, shall be attached and used with every supraglottic airway device insertion.

- Secure the device with tape, endotracheal tube holder or supplied securing straps.

- If gastric lumen present, insert lubricated nasogastric tube through the gastric lumen and connect to suction to evacuate air and contents from the stomach.

- Any patient who meets field termination requirements (other than intubation with an endotracheal tube) who can be successfully ventilated with a supraglottic airway device can be considered for field termination.

F. One-Person Bag-Valve-ET Tube/Supraglottic Airway Ventilation [BLS/ALS]

1. Attach valve of bag-valve device to end-tidal CO₂ sensor adapter.

2. Verify position of endotracheal tube by noting depth of incisor teeth according to centimeter (cm.) markings on tube.

3. Tube should be secured in place.

4. Ventilate the patient by using a one second ventilation which produces visible chest rise.

5. Adjust the rate of ventilations as per in-charge paramedic.

6. Constantly monitor depth of endotracheal tube, and oxygen supply. Replace oxygen supply when ¼ or less of tank is available.

7. Immediately notify paramedic of any changes in airway (e.g., bag becoming difficult to squeeze, blood/fluid visible in the tube, etc.).

8. Monitor for air leakage which may require repositioning or replacement of ET Tube or Supraglottic airway.

G. Airway Foreign Body Removal (Adult/Adolescent) [BLS/ALS]

1. Partial Airway Obstruction in Responsive Patient

- If the patient can cough, speak or breathe – allow the patient to attempt to clear the obstruction by forceful coughing.

- If the patient demonstrates a weak, ineffective cough, high pitch noise while inhaling, extreme respiratory difficulty, and/or cyanosis, treat the patient as having a complete airway obstruction.

2. Complete Airway Obstruction in Responsive Patient

- Use abdominal thrust maneuver with standing patient. If the patient is in late stages of pregnancy or the rescuer is unable to encircle the abdomen with arms, utilize chest thrusts.

- Stand behind the victim with your arms wrapped around the patient's waist.

- Place the thumb side of your fist against the patient's abdomen, in the midline slightly above the navel and well below the xiphoid process.

- Grasp the fist with the other hand and press the fist into the patient's abdomen with a quick inward and upward thrust.

- Repeat the thrusts until the object is expelled or the patient becomes unresponsive.

3. Complete Airway Obstruction in an Adult Patient Who Becomes Unresponsive

- Carefully support the patient to the ground.

- Without a pulse check, immediately begin chest compressions followed by ventilations at a 30:2 ratio.

- Each time the airway is opened in CPR, look for an object in the patient's mouth and remove

it if seen.

- Position the airway and attempt to ventilate; if unable to ventilate, continue chest compressions.
 - Repeat cycles of chest compressions and ventilations at 30:2 ratio until either ventilation is successful or advanced life support measures become available.
4. Airway Obstruction if Adult Patient Found Unresponsive
- If an adult patient is found unresponsive and with no breathing or no normal breathing (only gasping), then CPR shall be started immediately.
 - If the patient is unable to be ventilated with the BVM or supraglottic airway, then airway obstruction should be considered.
 - Chest compressions should be continued, and each time the airway is opened in CPR, look for an object in the patient's mouth and remove it if seen.
 - Position the airway and attempt to ventilate; if unable to ventilate, continue chest compressions.
 - Repeat cycles of chest compressions and ventilations at 30:2 ratio until either ventilation is successful or advanced life support measures become available.
5. Airway Obstruction in Unresponsive Adult Patient by Advanced Life Support
- Perform a progressive laryngoscopy until foreign body is visualized.
 - Insert closed Magill forceps into oral cavity, open forceps, grasp foreign body and remove.

H. Airway Foreign Body Removal (Child/Infant) [BLS/ALS]

1. Partial Airway Obstruction

- If the patient can cough, speak or breathe – allow the patient to attempt to clear the obstruction by forceful coughing.
- If the patient demonstrates a weak, ineffective cough, high pitch noise while inhaling, extreme respiratory difficulty, and/or cyanosis; treat the patient as having a complete airway obstruction.

2. Complete Airway Obstruction

-Child : Use abdominal thrust maneuver with standing child patient.

- Stand behind the victim with your arms wrapped around the patient's waist.
- Place the thumb side of your fist against the patient's abdomen, in the midline slightly above the navel and well below the xiphoid process.
- Grasp the fist with the other hand and press the fist into the patient's abdomen with a quick inward and upward thrust.
- Repeat the thrusts until the object is expelled or the patient becomes unresponsive.

-Infant / Neonate : Use a combination of back blows and chest thrusts in an infant or neonatal patient.

- Deliver five back blows between the infant's shoulder blades with the heel of the hand while the infant is supported in the prone position straddling the rescuer's forearm, with the head lower than the trunk.
- After delivering the back blows, place your free hand on the infant's back, holding the infant's head. Turn the infant over while the head and neck are carefully supported, and hold the infant in the supine position draped on the thigh. The infant's head should remain lower than the trunk.
- Give five quick downward chest thrusts in the same manner and location as chest compressions.

3. Complete Airway Obstruction in a Pediatric Patient Who Becomes Unresponsive

- Carefully support the patient to the ground.
- Without a pulse check, immediately begin chest compressions followed by ventilations at a