

Airway: Direct Laryngoscopy Intubation

Applies to:	
P	Paramedic

Clinical Indications:

1. Inability to adequately ventilate a patient with a Bag Valve Mask (BVM) and basic airway adjunct.
2. An unconscious patient without a gag reflex who is apneic or is demonstrating inadequate respiratory effort.

Procedure:

1. Prepare, position, and oxygenate the patient with 100% Oxygen.
2. Select proper ET tube and stylette; have suction ready.
3. The use of a Bougie device is strongly encouraged with all ET intubation attempts.
4. Using laryngoscope, visualize vocal cords.
5. Do not stop/pause CPR to intubate.
6. Visualize tube passing through vocal cords.
7. **Confirm and document tube placement using continuous EtCO₂ monitoring.**
8. Inflate the cuff with 3–10ml of air until pilot balloon is softly firm; secure the tube using a commercial tube holder.
9. Auscultate for bilaterally equal breath sounds and absence of sounds over the epigastrium. If you are unsure of placement, remove tube and ventilate patient with a BVM.
10. Apply waveform capnography. After 3 ventilations, EtCO₂ should be >10 or comparable to pre-intubation values. If < 10, check for adequate circulation, ETT placement, equipment, and ventilatory rate. If EtCO₂ remains < 10 without physiologic explanation, remove the ETT and ventilate using an airway adjunct and BVM.
11. If unable to ventilate with a BVM and BLS airway adjunct, consider using a King Airway if intubation efforts are unsuccessful.
12. Monitor EtCO₂ and record readings on scene, en route to the hospital, and at the hospital.
13. Document ETT size, time, result (success) and placement location by the centimeter marks either at the patient's teeth or lips in the EHR. Document all devices used to confirm initial tube placement. Also document positive or negative breath sounds before and after each movement of the patient.
14. **It is required that the airway be monitored continuously utilizing waveform capnography (ALS providers) and pulse oximetry.**

