

5.1P Airway Management – Pediatric

EMT STANDING ORDERS

E

- Routine patient care.
- Establish airway patency.
 - Open Airway.
 - Consider patient positioning by placing padding under shoulders to ensure sternal notch and ear are at the same level
 - Suction as needed.
 - Clear foreign body obstructions.
- If patient has a tracheostomy tube see [Tracheostomy Care 5.10](#).
- Consider additional help.
- For respiratory distress:
 - Administer high concentration oxygen (preferably humidified) via mask positioned on face or if child resists, held near face.
 - Titrate oxygen saturation to 94% - 99%; observe for fatigue, decreased mentation, and respiratory failure.
 - For children with chronic lung disease or congenital heart disease, maintain or increase home oxygen level to patient's target saturations.

Note: Pulse oximetry is difficult to obtain in children. Do not rely exclusively on pulse oximetry. If child continues to exhibit signs of respiratory distress despite high oxygen saturation levels, continue oxygen administration.
- For respiratory failure or for distress that does not improve with oxygen administration:
 - Assist ventilations at rate appropriate for child's age. Reference [Pediatric Color Coded Appendix A3](#).
 - If unable to maintain an open airway through positioning, consider placing an oropharyngeal and/or nasopharyngeal airway.
- Determine if child's respiratory distress/failure is caused by a preexisting condition
 - For Allergic Reaction/Anaphylaxis, refer to the [Allergic Reaction/Anaphylaxis Protocol 2.2P](#).
 - For Asthma/Reactive Airway Disease/Croup, refer to the [Asthma/Bronchiolitis/Croup Protocol 2.3P](#).
- For Pediatric Cardiac Arrest: consider insertion of a supraglottic airway; see procedures for [Supraglottic Airways 5.9](#).

ADVANCED EMT STANDING ORDERS

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- For pediatrics in severe respiratory distress due to asthma consider use of CPAP. See [CPAP Procedure 5.4](#).

PARAMEDIC STANDING ORDERS

P

- The appropriate method of airway management should be determined based on patient condition. If basic procedures are deemed inappropriate or have proven to be inadequate then more advanced methods should be used.
- If feasible, place an orogastric tube to decompress the stomach.
- If you cannot establish an airway or ventilate, see [Cricothyrotomy Percutaneous Procedure 5.2](#).

Pediatric Respiratory Distress	Pediatric Respiratory Failure
<ul style="list-style-type: none"> • Child is able to maintain adequate oxygenation by using extra effort to move air. • Signs include increased respiratory rate, sniffing position, nasal flaring, abnormal breath sounds, head bobbing, intercostal retractions, mild tachycardia. 	<ul style="list-style-type: none"> • Hallmarks of respiratory failure are respiratory rate less than 20 breaths per minute for children <6 years old; less than 12 breaths per minute for children <16 years old; and >60 breaths per minutes for any child; cyanosis, marked tachycardia or bradycardia, poor peripheral perfusion, decreased muscle tone, and depressed mental status.
<p>Respiratory distress in children and infants must be promptly recognized and aggressively treated as patient may rapidly decompensate.</p>	