CRITICAL AIRWAY GUIDELINES FOR PATIENTS IN THE RCNIC

Date: 5/08

Approval:_____

A critical airway is defined as an anticipated difficult intubation, history of difficult intubation, history of quick decompensation with extubation or an airway requiring reconstructive surgery.

Management of Critical Airway Upon Admission

- Staffing is 1:1 ratio
  - Any deviations from 1:1 staffing ratio must be approved by the medical team
  - Continuous observation and assessment with documentation of activity level and tolerance of care by RN or RT
- Time frame: until operative procedure or the airway is deemed "not critical"
- The need for "Critical" status will be assessed, discussed, and documented (in the plan of care) during rounds each day
- Sign placed at bedside "Critical Airway: Do not manipulate or replace ETT without physician order" and "Page (what service-such as surgery, ENT) at phone/pager number with any emergencies, concerns, or problems"
- All infants with a "Critical Airway" require a patent IV
- Titrate pain and sedation medications
- All ventilated patients will have their vent tubing secured by a halo
- Appropriate sized emergency ETT/tracheostomy tube secured to head of the bed
- Maximum suctioning depth must be identified and documented in IPOC by RT
- Continuous observation and assessment with documentation of activity level and tolerance of care by RN or RT
- Individualized needs of patient clearly identified in the patient orders/IPOC. These needs will be based on patient's gestational age using a family-centered care approach.
  - Infant may only be held with physician order and approval of care team under special circumstances.

Immediate Post Operative Protocols for Critical Airways

- Time frame: the first 48-72 hours post operative
- Staffing is 1:1 ratio
  - Any deviations from 1:1 staffing ratio must be approved by the medical team
  - Continuous observation and assessment with documentation of activity level and tolerance of care by RN or RT
- All infants with "Critical Airway" require a patent IV
- Maximize the sedation and pain control
- Paralytics used **only if** absolutely necessary (rarely used after 24 hours post-op). Necessity for continued use of paralytics must be assessed and addressed on an ongoing basis.
- All ventilated patients will have their ventilator tubing secured by a halo
- Sign placed at bedside "Critical Airway: Do not manipulate or replace ETT without physician order" and "Page (what service-such as surgery, ENT) at phone/pager number with any emergencies, concerns, or problems
- Appropriate sized emergency ETT/ tracheostomy tube at the head of the bed
- Maximum suctioning depth must be identified and documented in patient orders/IPOC by RT
- Infant may not be held during this time
- Individualized needs of patient clearly identified in IPOC. These needs will be based on patient's gestational age using a family-centered care approach.
- Activity level will be assessed, including a NIDCAP observation, if applicable; a developmental plan of care will be developed and documented

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Continued Management of Critical Airway

- Time frame: until follow up evaluation and the patients airway is deemed "not critical" by the Attending Physician
- The need for "Critical" status will be assessed, discussed, and documented (in the plan of care) during round each day
- Staffing is 1:1 ratio
    - Any deviations from 1:1 staffing ratio must be approved by the medical team
    - Continuous observation and assessment with documentation of activity level and tolerance of care by RN or RT
- All infants with "Critical Airway" require a patent IV
- Adjust pain medication and increasing sedation as needed
- Ventilator tubing remains secured by halo
- Sign placed at bedside "Critical Airway: Do not manipulate or replace ETT without physician order" and "Page (what service-such as surgery, ENT) at phone/pager number with any emergencies, concerns, or problems
- Appropriate sized emergency ETT/tracheostomy tube at the head of the bed
- Maximum suctioning depth must be identified and documented in IPOC by RT
- Patient can be awake and responsive with adequate pain and sedation control
- Individualized needs of patient clearly identified in the patient orders/IPOC. These needs will be based on patient's gestational age using a family-centered care approach.
    - Infant may only be held with physician order and approval of care team under special circumstances
- Activity level will be assessed, including a NIDCAP observation; a developmental plan of care will be developed and documented