

**PURPOSE:** The purpose of this policy is to authorize paramedics to perform pediatric endotracheal intubation.

**AUTHORITY:** Division 2.5, California Health and Safety Code, Sections 1797.220

**POLICY:**

- I. Pediatric endotracheal intubation is an advanced life support procedure that is indicated for use in the unconscious, apneic or near apneic, patient without an intact gag reflex when the use of BLS Airway techniques are insufficient for ventilation/oxygenation.
  
- II. **PROCEDURE:**
  - A. Position patient in supine position. If infant under 12 months, the larger head may require the use of a shoulder towel roll to maintain a neutral spine position.
  - B. Do not overextend the neck as this can occlude the airway. The larynx is more anterior and superior than in the adult. The tracheal orifice is small and may be easily obstructed by incorrect positioning.
  - C. Perform BVM ventilation for 1-3 minutes with 100% oxygen
  - D. Select a proper type and size of ETT; use length based resuscitation tape.
  - E. Insert stylet.
  - F. Ensure suctioning equipment is available.
  - G. Select proper sized blade and visualize the larynx.
  - H. Suction as needed.
  - I. Apply cricoid pressure as needed to prevent passive regurgitation.
  - J. Insert ETT 2-3cm past the cords under direct visualization.
  - K. Remove stylet and ventilate with BVM.

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Medical Director

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EMS Administrator

- L. Confirm tube placement using bilateral chest and epigastric auscultation and either an esophageal detection device or end tidal CO<sub>2</sub> detector. Document all confirmation methods on the patient care record.
  - M. Secure the tube.
  - N. Reassess tube placement after each patient movement.
  - O. Do not sacrifice good ventilation and oxygenation with repeated attempts at intubation.
  - P. Do not delay transport with repeated unsuccessful intubation attempts.
- III. CONTRAINDICATIONS:
- A. Adequate spontaneous respirations are present.
  - B. Patient is awake with an intact gag reflex.

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