

AIRWAY – NASOTRACHEAL INTUBATION

1. Level: Paramedic, RN
2. Clinical Indications:
 - 2.1. A spontaneously breathing patient in need of intubation (risk for failure of airway maintenance or protection, risk for failure of oxygenation or ventilation; deteriorating clinical course expected) where orotracheal intubation is difficult.
 - 2.2. Respiratory failure with trismus (clenched jaws)
 - 2.3. Patient must be 13 years of age or older.
3. Contraindications:
 - 3.1. Apnea
 - 3.2. Patients receiving anticoagulants
 - 3.3. Patients with upper airway hemorrhage, significant mid-facial trauma, or laryngeal trauma
4. Adverse Effects/Complications:
 - 4.1. Epistaxis
 - 4.2. Intubation of the esophagus
 - 4.3. Trauma to the oropharynx, vocal cords, esophagus, or trachea
 - 4.4. Right mainstem bronchus intubation
 - 4.5. Vomiting
 - 4.6. Increased intracranial pressure, as result of increased vagal stimulation
 - 4.7. Pneumothorax or tension pneumothorax from high pressure ventilation or underlying pre-existing trauma
 - 4.8. Intracranial tube placement through basal skull fracture
5. Procedure:
 - 5.1. Pre-medicate the patient with oxymetazoline HCL 0.05%.
 - 5.2. Select the largest and least obstructed nostril and insert a lubricated nasal airway to help dilate the nasal passage.
 - 5.3. See **PRE-OXYGENATION Procedure**
 - 5.4. Remove the nasal airway and gently insert the tube keeping the bevel of the tube toward the septum.
 - 5.5. Continue to pass the tube listening for air movement and looking for vapor condensation in the tube. As the tube approaches the larynx, the air movement gets louder.
 - 5.6. Gently and evenly advance the tube through the glottic opening on the inspiration. This facilitates passage of the tube and reduces the incidence of trauma to the vocal cords.
 - 5.7. Upon entering the trachea, the tube may cause the patient to cough, buck, strain, or gag. Do not remove the tube! This is normal, but be prepared to control the cervical spine and the patient, and be alert for vomiting.
 - 5.8. The 15mm adapter usually rests close to the nostril with proper positioning.
 - 5.9. Inflate the cuff with 5-10 cc of air.
 - 5.10. Confirm tube placement using electronic end-tidal CO₂ monitoring and two other confirmation methods.
 - 5.11. Secure the tube.
 - 5.12. Document the procedure, time, and result (success) in the electronic Patient Care Record (ePCR).