# Advanced Airway Management Policy, Emergency Department, St John's Hospital

# An Emergency Department and Anaesthesia Joint Guideline

## This policy recognises that:

- Airway management in the ED has a relatively high incidence of complications (NAP4). Tracheal intubation is likely to be difficult and patients requiring anaesthesia/advanced airway management are frequently critically ill and/or physiologically compromised.
- In St John's, a Consultant Anaesthetist and/or Intensivist will almost always be available to attend the ED within a few minutes. Out of hours, however, the most immediately available Anaesthetist will most likely be a trainee.
- Good communication is essential for optimum outcomes in airway management, especially when circumstances are difficult. The airway management plan must be discussed and understood by the team well before intubation. Airway management will follow the most recent DAS guidelines.

## Advanced Airway Management Guidelines

As soon as the ED have assessed that a patient requires/potentially requires drug-assisted intubation, they should contact the both the anaesthetist on call for ITU carrying bleep 3561 **and** the on-call ODP on bleep 3656.

The most senior anaesthetist available will go to the ED as soon as possible. If earlier intubation is required, the EM doctor may proceed **if** they have the appropriate skills and experience.

When the anaesthetist arrives, they should liaise with the EM Team Leader to discuss who will lead the intubation. EM clinicians who are ST3 and above may be the primary intubator if they are happy to do so. If this is the case, the plan for airway management should be clear about whether and at what point the Anaesthetist/Intensivist/senior EM clinician should take over.

Situations may arise in which it is more appropriate for the senior Anaesthetist to be the primary intubator, including;

- They predict significant challenges in managing the airway itself
- They feel they are not confident "supervising" another unknown doctor
- The plan is for the intubation to be carried out in theatre

If the anaesthetist feels any/all of these to be the case, they should be the primary intubator. They should also consider whether they should request more senior support e.g. Consultant Anaesthetist on-call.

## Before RSI

- The RSI checklist should be completed
- The team should introduce themselves and verbalise their roles
- The drugs and doses to be given should be verbalised
- The airway plan A, B, C and D should be stated as per the DAS guidelines and, in particular, decide who is going to carry out front of neck access (FONA), should that be required

## Essential Documentation

1. Complete Trak entry detailing method, drugs used, direct/indirect laryngoscopy views, number of attempts at intubation required, and any complications arising.
2. Complete an RSI audit form (ED Intubation Registry on Trak; found under EPR – Clinical Audit/QI – New – Emergency Department Intubation Registry)
3. Fill in a proper anaesthetic form (available within the ED) to record airway management and drug therapy, along with physiological observations.

## This guideline has been developed by the Emergency Medicine, Critical Care and Anaesthesia Directorates in St John's Hospital

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