Neonatal failed intubation protocol (* denotes equipment in emergency airway bag)

Plan A: Successful intubation

Failed intubation

CAN ventilate

→

Plan B

<u>Optimise face mask ventilation</u>

- Call for senior help early
- Titrate oxygen to SpO_2
- Attach monitoring, use Pedicap

→

Neutral head position, correct mask size, optimise seal

- Check gas flow, consider increase PIP, 2 person jaw thrust
- Consider oropharyngeal airway*
- Consider airway suction **(Yankauer/Meconium Aspirator)***
- Plan any further intubation attempts with senior support
  - Is intubation still required?
  - Max 4 attempts, ventilate between
  - Use optimal cricoid pressure
  - Consider use of cold ETT or stylet*

If suxamethonium has been given for intubation, consider allowing this to wear off

Babies with significant micrognathia may benefit from prone positioning, AND/OR nasopharyngeal airway insertion

Failed intubation

CAN NOT ventilate

→

Plan C

<u>Priority - OXYGENATION</u>

- Call neonatal consultant if not already present
- Help from a second consultant may be sought
- Consider paediatric anaesthetic/ENT support

→

As Plan B plus;

- Insert laryngeal mask airway (Size 1.0)*
  - Confirm adequate ventilation
- Consider indirect intubation using Glidescope
  - Kept in neonatal unit store room
  - Blades in airway bag*

CAN NOT VENTILATE

CAN NOT INTUBATE

WORSENING HYPOXAEMIA

AND/OR BRADYCARDIA

→

Plan D

<u>RESCUE TECHNIQUES – CRITICAL AIRWAY</u>

Call for paediatric anaesthetic/ENT support

→

As Plan C plus;

Option 1: Neonatal emergency tracheostomy

Option 2: Percutaneous tracheal puncture with 16G (grey) cannula connected to 3 way tap, and green oxygen tubing connected to high flow supply (10lpm+) *