DESCRIPTION/OVERVIEW

This document describes the steps that UNMH personnel will undertake to (1) identify patients with difficult airways and share this information with other caregivers, (2) standardize steps to be taken with patients who are at high risk for developing a difficult airway, such as post-tracheostomy patients, and (3) identify the steps to be taken when an airway emergency presents.

REFERENCES


AREAS OF RESPONSIBILITY

Medical Staff, Nursing Staff

PROCEDURE

1. **Identification and Documentation of the Difficult Airway**

Some patients, by virtue of anatomy, pathology, or recent surgery (including recent placement of tracheostomy) are at particular risk for losing their airway. If these patients are identified in advance, modifications to airway plans, or mobilization of necessary resources prior to an airway attempt, can be made.

1.1. There are three separate processes for identifying patients with potentially difficult airways:

   1.1.1. Nursing applies a difficult airway bracelet to the patient (once a difficult airway note has been entered into the electronic medical record (EMR))

   1.1.2. A difficult airway note in the EMR

   1.1.3. A formalized system of provider handoffs where airway status is communicated.

1.2. All patients with a history of a difficult airway, or potential for developing a difficult airway, will be flagged as a difficult airway patient. Patients will be identified in the following fashion:

   1.2.1. Patients admitted as inpatients who provide a history of difficult airway during the routine nurse evaluation

   1.2.2. Patients with a known difficult airway by virtue of prior difficult intubations or attempts

   1.2.3. Patients at high risk for developing a difficult airway by virtue of recent airway instrumentation or tracheostomy placement

   1.2.4. Patients at high risk for developing a difficult airway by virtue of illness, such as angioedema, neck masses, and trauma
1.2.5. Patients at high risk by virtue of difficult anatomy, such as cervical spinal deformity or tracheal stenosis

1.3. The treating physician or licensed independent practitioner (LIP) is responsible for initiating and documenting the difficult airway alert via the difficult airway order in the EMR.

1.4. Upon receiving the order, or if a difficult airway alert is present in the EMR, the patient’s nurse will apply the difficult airway bracelet and place a DART sign above the patient’s bed which will describe the airway issue.

1.5. The difficult airway alert can only be removed by the treating physician or LIP once a time-limited illness has resolved and no longer represents a risk for ongoing difficult airway complications. In some patients, the difficult airway indicator should remain on the chart indefinitely.

2. Difficult Airways

2.1. Difficult airways can include the following:
   2.1.1. Difficult face-mask ventilation
   2.1.2. Difficult laryngoscopy
   2.1.3. Difficult tracheal intubation
   2.1.4. Failed intubation
   2.1.5. Failed attempt of ventilation using alternative airway device
   2.1.6. Inability to manage the airway using conventional airway techniques due to anatomic, pathologic, or postsurgical change

3. Activating the DART Team

3.1. When a difficult airway is recognized, the treating physician or LIP should immediately activate the DART by contacting Lifeguard Dispatch through the designated UNMH emergency response number “44”.

3.1.1. Callers need to let the dispatcher know they have a “DIFFICULT AIRWAY EMERGENCY”.

3.2. The dispatcher will then issue a page to all DART pagers indicating patient age, location, and the type of airway issue.

3.2.1. Dedicated DART pagers will be made available to responders and will be tested weekly.

3.3. The DART responders will respond based on patient age:

3.3.1. Newborns (patients generally less than 2 months of age)
   3.3.1.1. Members of the Newborn Rapid Response Team
     3.3.1.1.1. Anesthesia Attending on call
     3.3.1.1.2. Trauma attending on call
     3.3.1.1.3. Pediatric Anesthesia Attending on call, if in house
     3.3.1.1.4. ENT Attending on call
     3.3.1.1.5. ENT Senior Resident on call
     3.3.1.1.6. Respiratory Therapy Supervisor

3.3.2. Children (patients generally between 2 months of age and 18 years)
   3.3.2.1. Members of the Pediatric Rapid Response Team
     3.3.2.1.1. Anesthesia Attending on call
     3.3.2.1.2. Trauma attending on call
     3.3.2.1.3. Pediatric Anesthesia Attending on call, if in house
     3.3.2.1.4. ENT Attending on call
     3.3.2.1.5. ENT Senior Resident on call
     3.3.2.1.6. Respiratory Therapy Supervisor

3.3.3. Adults over 18 years of age
   3.3.3.1. Members of the Rapid Response Team

Title: Difficult Airway Response
Owner: Quality & Patient Safety
Effective Date: 8/20/2013
Doc. #3060
3.3.3.1.1. Anesthesia Attending on call
3.3.3.1.2. Trauma Attending on call
3.3.3.1.3. ENT Attending on call
3.3.3.1.4. ENT Senior Resident on call
3.3.3.1.5. Respiratory Therapy Supervisor

4. **Equipment**
   4.1. Dedicated difficult airway carts are available across the hospital. After activation of the DART pagers, one assigned member of the Rapid Response Team will bring the cart from the dedicated area to the site of the airway emergency.
   4.2. The Rapid Response Team maintains a list of DART cart locations and is responsible for stocking and maintenance of the carts.

5. **Training and Experience**
   5.1. It is an expectation that LIPs undertaking airway management maneuvers are appropriately trained in the management of the difficult airway. This includes either:
      5.1.1. Completion of an ACGME residency in anesthesia or emergency medicine or an ACGME fellowship in critical care medicine
      5.1.2. Satisfactory completion of an approved difficult airway course. This course is encouraged for all LIPs who expect to manage airways routinely.

**SUMMARY OF CHANGES**
New Document initiated 10/2012.

**RESOURCES/TRAINING**

<table>
<thead>
<tr>
<th>Resource/Dept</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNM Batcave (Airway Classes)</td>
<td>Course Scheduling: 272-5476</td>
</tr>
<tr>
<td>Office of Quality and Pt. Safety</td>
<td>Patty Williams: 272-0140</td>
</tr>
</tbody>
</table>

**DOCUMENT APPROVAL & TRACKING**

<table>
<thead>
<tr>
<th>Item</th>
<th>Contact</th>
<th>Date</th>
<th>Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owner</td>
<td>Quality and Patient Safety, Executive Medical Director, Quality and Patient Safety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant(s)</td>
<td>Difficult Airway Task Force, Jonathan Marinaro, MD, Michael Spafford, MD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Committee(s)</td>
<td>Difficult Airway Task Force, NEC, CCC, MEC, Clinical Operations PP&amp;G Committee, Nursing PP&amp;G Subcommittee</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Nursing Officer</td>
<td>Sheena Ferguson, UNMH Chief Nursing Officer</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Medical Director/Officer</td>
<td>David Pitcher, UNMH Chief Medical Officer</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Official Approver</td>
<td>David Pitcher, UNMH Chief Medical Officer</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Official Signature</td>
<td></td>
<td>Date: 8/20/2013</td>
<td></td>
</tr>
<tr>
<td>2nd Approver</td>
<td>Sheena Ferguson, MSN, RN, CNS, CCRN, CNO</td>
<td>Date: 8/20/2013</td>
<td></td>
</tr>
<tr>
<td>Signature</td>
<td></td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>Effective Date</td>
<td></td>
<td>8/20/2013</td>
<td></td>
</tr>
<tr>
<td>Origination Date</td>
<td></td>
<td>10/2012</td>
<td></td>
</tr>
<tr>
<td>Issue Date</td>
<td></td>
<td>Clinical Operations Policy Coordinator</td>
<td>8/23/2013</td>
</tr>
</tbody>
</table>

**ATTACHMENTS**
None