7F4 QUICKTRACH

PATIENT CARE GOALS

- Gain control of the airway in patients for whom orotracheal intubation has failed or is not indicated and ventilation by any other means is not possible. (Such as may be encountered in the presence of airway obstruction or severe facial trauma)

PARAMEDIC

1. Place the patient in a supine position. Hyperextend the neck to bring landmarks into view, unless cervical spine injury is suspected (see figure 1, right).
2. Secure the larynx laterally between the thumb and middle finger, pulling tension on the skin to make landmarks more visible.
3. Use the forefinger of the same hand to find the cricothyroid membrane. The membrane is located in the midline between the thyroid cartilage and the cricoid cartilage. This is the puncture site.
4. Clean the site by vigorously scrubbing with alcohol or iodine preps.

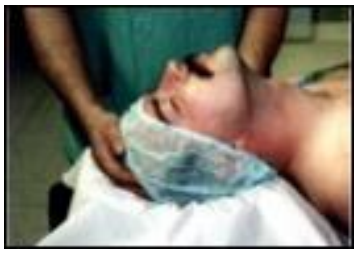

Figure 1

5. Firmly hold the device and puncture the cricothyroid membrane at a 90-degree angle (see figure 2, right). If unable to puncture the skin, use a #10 blade scalpel to incise the skin down to the membrane.
6. After puncturing the cricothyroid membrane, confirm entry of the needle into the trachea by aspirating air through the syringe. If air is present, the needle has entered the trachea.[1]
7. Change the insertion angle to 60-degrees (from the head) and advance the device forward into the trachea to the level of the red stopper (see figure 3, below). The stopper reduces the risk of inserting the needle too deeply and causing damage to the rear wall of the trachea.
8. Remove the stopper (see Figure 4, below). Be careful not to advance the device further with the needle still attached.

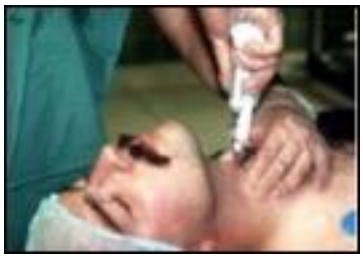

Figure 2

9. Hold the needle and syringe firmly and slide only the plastic cannula along the needle into the trachea until the flange rests on the neck. Carefully remove the needle and syringe (see figure 5, below).

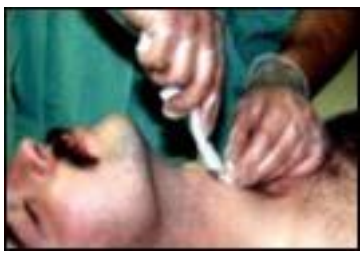

Figure 3

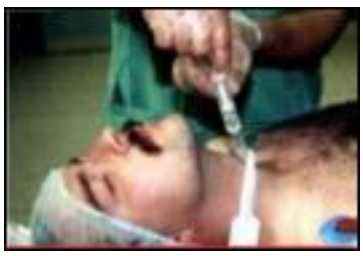

Figure 4

Figure 5

10. Secure the cannula with the neck strap.
11. Apply the larger diameter end of the connecting tube to Quicktrach. Connect the other end to a bag-valve-mask with supplemental oxygen.
12. Ventilate the patient with 100 percent oxygen and periodically reassess the airway.
13. Bleeding from superficial neck veins is very common. Control bleeding with direct pressure once Quicktrach is in place.

DOCUMENTATION KEY POINTS

- Rationale for use of the Quick Trach and complication (if any) encountered.
- Initial confirmation and ongoing assessment of airway patency and change after procedure including breath sounds, oximetry, capnography.

NOTES

[1] If, due to adipose tissue on the neck, the red stopper does not allow for adequate advancement of the needle through the cricothyroid membrane and into the trachea, the red stopper should be removed and the needle slowly advanced until air can be aspirated. If the patient does NOT have a COMPLETE upper airway obstruction, pinch nose and cover mouth during ventilation to prevent air exfiltration.