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Welcome to your September 2013 Guide

05 Airway management
07 Airway management – be prepared
11 Difficult airways
12 Airway management in post anaesthetic care
15 Theatre nurses design ‘dignity bra’
16 Is your difficult airway trolley fit for purpose?

Contents

Journal of Perioperative Practice Procurement Guide

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NHS Supply Chain, Independent Hospitals, Higher Education, Medical Device Companies.

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Airway management

Airway management is the medical way of ensuring there is an open pathway from the patient’s lungs to the outside world. Airway management is a primary consideration in cardiopulmonary resuscitation, anaesthesia, emergency medicine, intensive care medicine and first aid.

Basic airway management is a skill that must be mastered by any clinician/professional working in anaesthesia as it enables them to provide a certain degree of protection to the patient’s airway.

Triple airway manoeuvre
1. Two hands are used to tilt the head in order to open the airway.
2. A jaw thrust moves the tongue anteriorly with the jaw, minimising any obstruction. Lifting from under the angle of the jaw from both sides causes the jaw to thrust up and forward. This position is often maintained with the assistance of an oral airway device.
3. The tips of the thumbs are used to open the mouth to visualise the oropharynx.

N.B. In patients with potential spine injuries the procedure is modified to include only jaw thrust and open mouth components.

Oral Airways
There are a variety of artificial airways which can be used to keep a pathway between the lungs. It is only possible to insert an oral airway when the patient is completely unconscious or does not have a gag reflex. If the patient begins to gag after inserting the artificial airway, remove it immediately. The correct size is chosen by measuring against the patient’s head from the nostril to the ear lobe.

Airway Assessment
A difficult airway may present a difficult ventilation, difficult laryngoscopy, difficult intubation or a combination of all these. Thirty to forty per cent of anaesthetic related deaths are due to the inability to manage the airway, resulting in hypoxia. The definition of all difficult intubation is greater than three attempts or greater than 10 minutes of attempted intubation. Fifteen per cent of difficult intubations were also associated with difficult mask ventilation.

A difficult airway may present a difficult ventilation, difficult laryngoscopy, difficult intubation or a combination of all these. Thirty to forty per cent of anaesthetic related deaths are due to the inability to manage the airway, resulting in hypoxia. The definition of all difficult intubation is greater than three attempts or greater than 10 minutes of attempted intubation. Fifteen per cent of difficult intubations were also associated with difficult mask ventilation.

Post anaesthetic recovery – core skills:
- Assessment of vital signs and overall patient status
- Competence in all aspects of basic life support
- Assessment of fluid balance
- Administration of appropriate drugs
- Administration of analgesia
- Initiation of appropriate investigations – using local policy.

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Awake intubation Journal of Perioperative Practice 18 (3) 96-104
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Airway management – be prepared

According to the 4th National Audit Project of the Royal College of Anaesthetists (NAP4) report (2011) approximately three million general anaesthetics are administered in our health service hospitals each year with patient airways secured with a supraglottic airway device, a tracheal tube or a small percentage (5%) with face mask only.

The report highlighted that poor patient outcomes were linked to poor patient assessment, poor planning, failing to plan for failures and not having strategies in place when unexpected airway difficulties presented. They concluded that many of the reported deaths and critical incidents were unnecessary. Therefore the importance of individual patient airway assessment, re-evaluation of unfolding events and open and frank communication within the perioperative team is vital if lessons from events like the tragic case of Elaine Bromley are to be avoided. This was an airway management scenario that deteriorated to a ‘can’t intubate can’t ventilate’ situation and reminds us of the importance that human factors play in safe delivery of anaesthesia.

Airway management is the ability of the anaesthetist to ventilate the patient, as the skill of intubation alone will not save lives. If the patient is apnoeic then the patient must be ventilated using the bag and mask technique. If the airway is obstructed then the airway must be opened. Not only is airway evaluation in the pre-operative period essential but the skills of the anaesthetic assistant in the maintenance of a clear airway and adequacy of ventilation in the semi-unconscious or unconscious patient is paramount. These patients’ airways are at risk due to the tongue obstructing the oropharynx and the relaxing effects of anaesthetic drugs on the jaw muscles. Using head tilt, chin lift will position the tongue clearing it from the back of the oropharynx with jaw thrust as an additional manoeuvre in cases when head tilt, chin lift is not fully effective. The jaw thrust is achieved by downward displacement of the chin with the thumbs with the jaw being lifted forward by placing the fingers behind the angles of the lower jaw whilst applying steady upward and forward pressure. This manoeuvre with the insertion of an oropharyngeal adjunct improves airway patency preventing the tongue from falling backwards and obstructing the airway. Anaesthetic assistants must make themselves familiar and competent in maintaining a clear airway for the patients in their care.

In the emergency situation you may not have the privilege of time to carry out a lengthy pre-intubation assessment and/or a situation where you have been unable to pre-assess the patient you will not have the appropriate information to hand for that individual patient it would be important on the arrival of the patient to implement a very quick yet detailed assessment allowing you to prepare the necessary equipment and provide skilled assistance in an anticipative manner. Patient safety is paramount and time is always of the essence.

Laryngeal mask airways (LMA) provide a safe adjunct for both emergency situations and anaesthesia. They are usually single use, latex free and supplied in a variety of sizes. Some styles integrate a bite block. Whilst others are specifically designed as aids to endotracheal intubation in difficult airway scenarios. Reusable LMAs are also available but require traceability, decontamination and re-sterilisation with a life of approximately 40 uses. LMAs are not suitable for the non-fasting patient.

Endotracheal tubes are the ‘gold standard’ for securing the patient’s airway and are provided sterile and latex free in a variety of sizes.
Airways

Risk management is essential in all airway assessment and management situations if the anaesthetic assistant is to provide the level and quality of care vulnerable patients require at induction of anaesthesia and in the post anaesthesia care unit.

LMAs are not suitable for the non-fasting patient.

- Oropharyngeal airways provide instant patency of the patient airway without intubation. An essential on all airway management trolleys, they are supplied colour coded and in a variety of sizes.
- Nasopharyngeal airways providing instant patency when the oropharyngeal route is not available. Again a variety of sizes and materials provide choice depending on the individual patient situation.

In conclusion safety is paramount therefore all equipment should be gathered together prior to the patient arriving and checked through to ensure perfect working order. When endotracheal intubation is indicated the laryngoscope should be checked for bulb, electrode points, blade fit and type dependent on individual patient assessment, a McCoy blade should be ready for use if required. The face mask should be chosen for comfort of fit, good skin to mask seal, preferably single use and latex free. The endotracheal tube should be checked for effectiveness of balloon and cuff and if using an introducer/stylet ensure it is lubricated. Other essential equipment such as cuff pressure monitor, suctioning equipment, anaesthetic machine and monitors are in full working order and have been checked as per AAGBI guidelines (2012).

- Have at hand cotton tape, syringe, connecting tube, oxygen supply and oral and nasal airways with a pair of Magill forceps for nasal intubation. A difficult airway trolley should be easily attainable and the location and decontamination status of the fibre-optic scope known. Anaesthetic assistants should also be knowledgeable and trained to assist with emergency cricothyroidotomy in ‘can’t ventilate, can’t intubate’ airway situations. In all airway management situations the patient should be monitored throughout for oxygen saturation, end tidal carbon dioxide, blood pressure and pulse (AAGBI, 2007, 2009). Airway management training is essential, ongoing and good practice would include the use of simulation for all patient situations even those familiar and daily occurring.

Daphne Martin
Nurse Lecturer, Pathway Leader, Specialist Practice in Anaesthetic Nursing, School of Nursing and Midwifery, Queen’s University Belfast

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The important point being that all staff need to know what they say and how to use the kit. There is no point in having equipment if staff cannot use it!

Regular training with the kit and inter-professional discussions are vitally important to keep skills up to date.

Staff will find regular informal training sessions and presentations around difficult airways really useful.

Paul Dawson  RGN,Sgt. Operating Theatres  Peterborough & Stamford Hospitals NHS Foundation Trust

Useful sources of reference:

Association of Anaesthetist of Great Britain and Ireland (AAGBI)  www.aagbi.org

Clinical Human Factors Group  - http://www.chfg.org

Difficult Airway Guidelines (DAG)  www.das.uk.com

The case of Elaine Bromiley  - www.chfg.org/articles-films-guides/elaine-bromiley-report


The Difficult Airway Society 2007 recommended some steps which represent good practice in airway management and are easily downloadable from their website, which are a whole range of scenarios including both predicted and unpredicted difficult airways which also lead into CICV (can’t intubate, can’t ventilate) guidelines.

They state that all perioperative anaesthetic practitioners should be competent in a number of airway skills and that all anaesthetists work with trained assistants with access to a range of airway devices and techniques.

Critical decision making in a tense environment such as when dealing with a difficult airway, depends on many non-technical skills comprising team leadership, situational awareness, team membership, task distribution and above all, communication amongst team members. These processes make up the “human factors”.

A difficult airway could be defined as the clinical situation in which a conventionally trained anaesthetist experiences difficulty with face mask ventilation of the upper airway, difficulty with tracheal intubation, or both.

The difficult airway represents a complex interaction between patient factors, the clinical setting and the skills of the practitioner.

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What do we mean by a “difficult airway”? Basically, it is an airway that is hard to manage due to anatomy or medical conditions that make ventilations or intubation more difficult than normal.

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A good example was the case of Elaine Bromiley, a healthy young mum, who died after problems occurred during attempted anaesthesia before a routine operation in March 2005.
Airway management in post anaesthetic care

Davey and Ince (2004) describe airway management as the cornerstone of effective post anaesthetic management.

Maintaining the airway is vital as the patient's life depends upon it (Dolenska et al 2004). Ineffective airway management will lead rapidly to hypoxaemia, organ failure and ultimately death. Most patients experiencing a general anaesthetic will be recovered in the post anaesthetic care Unit (PACU), and will require airway management and close monitoring to prevent post operative complications. It is essential that adequate standards of care are maintained in order to prevent serious complications (AAGBI 2009).

Intubated and ventilated patients' care is complex and it is important that any complications arising can be diagnosed and managed accordingly, in order to provide individualised care.

Airway

An inadequately maintained airway may result in hypoxaemia (Robinson & Hall 2007). Of primary concern is airway obstruction, of which there are several causes. Yournker (2008) states that central nervous system depression resulting from drugs such as opioids, is the primary reason for airway obstruction post anaesthesia. The tongue falling back against the posterior pharyngeal wall (Davey & Ince 2004), foreign bodies, teeth, crowns and throat packs all pose a threat of airway obstruction to the unconscious patient. The latter was highlighted in an audit conducted into critical incidents (NPSA 2007).

Obstructions not only reduce the intake of air into the respiratory system, but also create a more turbulent flow of air in the trachea and upper airway. This turbulence disturbs the laminar airflow required in the lower respiratory tract to facilitate efficient exchange of gases (Davis & Kenny 2006).

Monitoring of the airway

Close monitoring of respiratory function is required to provide appropriate treatment (Jevon & Ewens 2007) and should be continued until the patient has recovered from anaesthesia (AAGBI 2002). Monitoring is used to supplement clinical observations and is considered essential to the safe conduct of anaesthesia (AAGBI 2007). However some respiratory conditions, such as respiratory acidosis, cannot be clearly diagnosed by observation. Accurate blood gas monitoring is required.

The intubated and ventilated patient

A patient that is both intubated and ventilated may be unable to self-ventilate, or maintain their own airway. This may be due to respiratory depressant drugs or muscle relaxants (McArthur-Rouse & Prosser 2007). In the author's experience most intubated and ventilated patients are cared for in the intensive care unit (ICU).

Suction

Suction can be used to ensure a clear airway. This can be undertaken in the upper airway with a yankeur sucker, preferably under direct vision. A suction catheter can be used through the ETT to remove secretions below the cuff of intubated patients (Lancaster 2007). Care needs to be taken when suctioning. Excessive use may lead to trauma and oedema. Irritation of the vocal cords may lead to laryngospasm (Davey & Ince 2004).

Discharge criteria

Patients must be fully conscious, able to maintain their own airway and displaying adequate respiratory effort and oxygenation, before discharge from the PACU can be considered (AAGBI 2002). Postoperative pain must be under control; patients must be normothermic and displaying a stable cardiovascular state before being discharged to the ward. A ward handover explaining perioperative complications and postoperative care instructions must be conducted upon discharge (Davey & Ince 2004).

Conclusion

Patients in the perioperative environment require a great deal of care. At the forefront of this care is airway management. Postoperatively, airway management is affected by a number of concepts. An understanding of respiratory physiology is necessary in order to understand how various factors affect homeostasis, the patient’s airway and the ability to breathe. Clinical observations and supplementary, mandatory monitoring are used to assess the influence that these concepts place on a patient’s ability to maintain their own airway and to breathe spontaneously. Control and monitoring of these
Airways

Patients in the perioperative environment require a great deal of care. Postoperatively, airway management is affected by a number of concepts. An understanding of respiratory physiology is necessary in order to understand how various factors affect homeostasis, the patient’s airway and the ability to breathe.

Concepts facilitates homeostasis, good airway management and a successful recovery.

This is an extract from Airway management in post anaesthetic care by Bevan Scott published in the Journal of Perioperative Practice, Vol 22, issue 4, pages 135 to 138. The full article is available from: www.afpp.org.uk/books-journals/journal_archive

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Theatre nurses design ‘dignity bra’

Fiona Cartwright and Natalie Reid, Registered Nurses working within the theatre environment, observed that female patients’ breasts often become exposed in preparation for surgery. They conducted an initial audit of 40 women, which was then extended to 100 women, to gauge patients’ opinions. Of the 100 women questioned, 95% of them were unaware that they may become exposed in preparation for surgery and 99% stated that they would like to wear a dignity bra if it was offered to them.

Fiona and Natalie designed and created the ‘Digni’ Bra to protect patients while they are at their most vulnerable. They designed a bra that met MHRA Regulatory Standards, was cost effective, hygienic (disposable, single use), easily removable (paper that can be cut/torn if access to the chest is deemed necessary), minimalistic (strapless so as not to interfere with surgery of the shoulder/neck area along with essential cardiac monitoring), latex free, and non-transparent (a deep royal blue colour was selected of grade 35gsm paper thickness to protect patient modesty). The Digni Pants are unisex to protect the male patients also.

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When we spoke with many hospitals we found that although there was typically an airway management lead within a department, there was little standardisation across a hospital trust for the actual airway trolley itself.

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