MEDICAL DIRECTIVE
Neonatal / Infant / Paediatric Intubation

Approved by / Date: February 17, 2009

Authorized To:

This is authorized to any Registered Respiratory Therapists (RRT) of Lakeridge Health Corporation, who is certified in neonatal/infant/paediatric intubations.

Medical Directive Description:

Intubation in the hospital encompasses all care necessary to deal with sudden and life-threatening events affecting the cardio-pulmonary system, and involves the identification, assessment and treatment of patients in danger of or in a cardiac and/or respiratory arrest. The medical directive is applicable to neonatal/infant/paediatric intubation in the hospital setting as well as intra and inter-hospital transports. The condition of the directive is based on the unavailability of a paediatrician/neonatologist or one in which the Respiratory Therapist is the most skilled clinician to perform neonatal/infant or paediatric intubation during a clinical situation where other physician representation may be present.

Patient Description / Population:

This directive encompasses any neonate, infant or paediatric (less than 13 yrs of age) patient found to be in danger of or in cardiac and/or respiratory arrest.

Identify relevant Delegated Control Act or Added Skill associated with this Directive:

Intubation is an entry-to-practice skill (neonatal to adult) and falls under a controlled act regulated to Registered Respiratory Therapists in accordance with Controlled Act #3 "putting an instrument, hand or finger into or beyond the point in the nasal passages where they normally narrow or the larynx" (RHP Act, Bill 64, November 1991).

The College of Respiratory Therapists of Ontario dictates that its members should only practice in the areas in which they have the

necessary knowledge, skill and judgment to perform an act. The CRTO does not require certification for its members to perform procedures such as intubation; instead it possesses an expectation of competency in the areas in which members practice based on that knowledge, skill and judgment. However, there is an understanding that certification is a requirement of individual institutions and this need supersedes the CRTO's stance on certification.[1]

Specific conditions / circumstances that must be met before the Directive can be implemented:

- Cardiac and/or respiratory arrest (impending or actual) or the presence of one or more of the symptoms that may lead to cardiopulmonary arrest as indicated by rapid deterioration in vital signs, decreasing level of consciousness and abnormal blood gas values.
- Meconium Aspiration or any other cause of transient upper airway obstruction where failure to establish a patent upper airway may potentially result in a negative outcome.
- When an endotracheal tube has been accidently displaced and the patient is unable to maintain/protect his/her airway or sustain spontaneous ventilation or maintain adequate oxygenation and/or ventilation (carbon dioxide exchange).

Contraindications to the implementation of the Directive:

- The patient's parents or substitute decision maker (SDM) does not consent to resuscitation. It is either clearly expressed and/or documented in the patient's medical record.
- The Registered Respiratory Therapist who is not or has not maintained competency in neonatal/infant/paediatric intubation.
- Patients with known or suspected cervical spine injury (eg. Trauma)
- Patients with known or suspected fixed airway obstructions (eg. Acute epiglottis, congenital anomalies, oropharyngeal tumours)
- Patients haemorrhaging from the oral or nasopharynx
- If the patient's condition or medical history indicates a potential for a difficult airway to intubate.
- Failure to successfully intubate after 2 attempts will require the Respiratory Therapist to alternately use a Laryngeal Mask Airway (LMA) to establish an airway or bag/mask ventilate the patient until a physician or other clinician (eg. RRT or RN from

Hospital for Sick Children Transfer Team or a physician) who is competent to intubate a neonate/infant/paediatric patient is available.

Documentation requirements:

- The RRTs implementation of the neonatal/infant/paediatric intubation medical directive in a sudden and life-threatening event is documented on the physician order sheet. For all elective intubations, the most responsible physician (MRP) will write an order for intubation to be performed by the RRT.
- The intubation process will be documented in the patient's health record and should include airway management devices used such as: airways, ETT size, tube stabilization, suctioning and any complications. It should also include patient monitoring such as: C02 detectors, pulse oximeters, and airway pressure monitors. Following the event, the Paediatrician or MRP will be notified immediately if not already present.
- The RRT will dialogue with the most responsible physician (MRP) with regard to follow up orders. The Paediatrician, Neonatologist or MRP will assess the patient, the endotracheal tube placement and countersign the medical directive as documented by the RRT on the Physician order sheet.

Review / Evaluation Process (how often / by whom) :

This medical directive will be evaluated annually by the Corporate RRT Practice Council with recommendations going to the Medical Program and Maternal Child Program Council for alterations to this directive.

References:

1. The Exchange - The College of Respiratory Therapists of Ontario Newsletter. Winter 2006-2007, Volume 14, No.2, page 18. http://www.crto.on.ca/pdf/exchange-02-07.pdf

Consultative Resources:

1. Markham-Stouffville Hospital Neonatal Intubation Medical Directive
2. York-Central Hospital Neonatal/Infant Intubation Medical Directive
3. Dr. P. Simantirakis- Anaesthesiologist- Lakeridge Health Corporation

Developed by:	Name	Position/Title	Program
Contact:	Name	Position/Title	Program
(Main Contact – related to the development of the directive)			
Authorized by:	Almadani, Dr. M. Godfrey, Dr. S. Gunawardena, Dr. K. Lai Fatt, Dr. P Mitchell, Dr. M. Montgomery, Dr. C. Rajah, Dr. R.	May 15, 2009 May 21 2009 Date 3/6/09 May 20, 2009 May 22, 2009 May 26, 2009 Date	

Approvals and Signatures:

Department Chief:	Dr. S. Godfrey	Signature	May 21/09 Date
Medical Director:	Dr. M. Almadani	Signature	May 15, 2009 Date
Program Director:	D. Brownlee	Signature	~~MAY~~ June 3/09 Date
Chair of HDAC:	Thom Chambers Name	Signature	June 25/09 Date
Chair of CNAC:	Name	Signature	Date
Chair of P & T Comm:	Dr. I. Lenga	Signature	June 26/09 Date
Final Approval Chair of MAC:	Dr. M. Treloar	Signature	2009 06 29 Date