• Insert closed Magill forceps into oral cavity, open forceps, grasp foreign body and remove.

H. Airway Foreign Body Removal (Child/Infant) [BLS/ALS]
1. Partial Airway Obstruction
   • If the patient can cough, speak or breathe – allow the patient to attempt to clear the obstruction by forceful coughing.
   • If the patient demonstrates a weak, ineffective cough, high pitch noise while inhaling, extreme respiratory difficulty, and/or cyanosis; treat the patient as having a complete airway obstruction.
2. Complete Airway Obstruction
   - Child: Use abdominal thrust maneuver with standing child patient.
     • Stand behind the victim with your arms wrapped around the patient’s waist.
     • Place the thumb side of your fist against the patient’s abdomen, in the midline slightly above the navel and well below the xiphoid process.
     • Grasp the fist with the other hand and press the fist into the patient’s abdomen with a quick inward and upward thrust.
     • Repeat the thrusts until the object is expelled or the patient becomes unresponsive.
   - Infant / Neonate: Use a combination of back blows and chest thrusts in an infant or neonatal patient.
     • Deliver five back blows between the infant’s shoulder blades with the heel of the hand while the infant is supported in the prone position straddling the rescuer’s forearm, with the head lower than the trunk.
     • After delivering the back blows, place your free hand on the infant’s back, holding the infant’s head. Turn the infant over while the head and neck are carefully supported, and hold the infant in the supine position draped on the thigh. The infant’s head should remain lower than the trunk.
     • Give five quick downward chest thrusts in the same manner and location as chest compressions.
3. Complete Airway Obstruction in a Pediatric Patient Who Becomes Unresponsive
   • Carefully support the patient to the ground.
   • Without a pulse check, immediately begin chest compressions followed by ventilations at a 15:2 ratio.
   • Each time the airway is opened in CPR, look for an object in the patient’s mouth and remove it if seen.
   • Position the airway and attempt to ventilate; if unable to ventilate, continue chest compressions.
   • Repeat cycles of chest compressions and ventilations at 15:2 ratio until either ventilation is successful or advanced life support measures become available.
4. Airway Obstruction if Pediatric Patient Found Unresponsive
   • If an pediatric patient is found unresponsive and with no breathing or no normal breathing (only gasping), then CPR shall be started immediately.
   • If the patient is unable to be ventilated with the BVM or supraglottic airway, then airway obstruction should be considered.
   • Chest compressions should be continued, and each time the airway is opened in CPR, look for an object in the patient’s mouth and remove it if seen.
   • Position the airway and attempt to ventilate; if unable to ventilate, continue chest compressions.
   • Repeat cycles of chest compressions and ventilations at 15:2 ratio until either ventilation is successful or advanced life support measures become available.
5. Airway Obstruction in Unresponsive Pediatric Patient by Advanced Life Support
   • Perform a progressive laryngoscopy until foreign body is visualized. Insert closed Magill
     forceps into oral cavity, open forceps, grasp foreign body and remove.
   • It is generally advisable to intubate the patient if possible at this time.

I. CPAP - Continuous Positive Airway Pressure [ALS]
CPAP is a method of patient ventilation which provides a noninvasive continuous positive-pressure
ventilation to prevent alveolar collapse. It decreases the work of breathing, enhances oxygen and
carbon dioxide exchange and increases cardiac output.

1. Indications
   Mask CPAP ventilation is indicated for the treatment of impending ventilatory failure in an
   attempt to avoid intubation and standard mechanical ventilation. This non-invasive pressure
   support system seems best applied to patients whose respiratory failure is expected to quickly
   respond to medical therapy, as continuous mask CPAP or ventilation requires close attention.
   The patient shall meet all of the following criteria:
   a. Dyspnea with pulmonary edema or wheezes, or near drowning or submersion with possible
      aspiration
   b. An awake patient, adult or pediatric, who is able to follow commands
   c. The ability to maintain an open and protected airway and handle secretions
   d. Two or more of the following signs:
      • Respiratory rate > 24 / min.
      • Pulse Oximetry of < 94% at any time
      • Use of accessory respiratory muscles

2. Contraindications
   a. Decreased level of consciousness / Unconsciousness
   b. Unable to maintain a patent airway
   c. Pneumothorax (unilateral absence of breath sounds)
   d. Hypotension (SBP < 90 mmHg)
   e. Recent surgery to face or mouth, epistaxis, or other impediment to proper mask placement
      or fitting
   f. Pediatric patient who is too small for the CPAP mask to fit appropriately

3. Usage
   a. Assure patent airway.
   b. Perform appropriate patient assessment, including obtaining vital signs, pulse oximeter
      (SpO₂) reading and cardiac rhythm.
   c. Prior to initiation of the mask CPAP treatment, the patient must be informed of the purpose
      of the mask and cooperation ensured.
   d. The Mask CPAP System components are assembled (CPAP mask, tubing, pressure relief
      valve) and connected to the oxygen cylinder.
   e. Connect the pressure tubing and pressure relief valve to the connection port.
   f. Turn on gas supply.
   g. Verify controls are set (FiO₂).
   h. Hold the mask in place as the patient adjusts to the ventilatory support. With the mask in
      place, modify the CPAP System settings to optimize the patient’s ventilatory status. Titrate
      to effect, generally a range of 5 - 10 cm H₂O of PEEP in adults and 3 - 5 cm H₂O of PEEP
      in pediatric patients.
   i. Encourage the patient to breathe deeply.
   j. Adjust the mask for comfort and to minimize air leak especially about the eyes.
   k. Periodic evaluation of the patient’s status should be coupled with ongoing vital sign and