



PROCEDURE CHECKLIST

Basic airway management

Opening, clearing and maintaining the airway with simple manoeuvres, adjuncts, bag-mask ventilation and a supraglottic airway, as a bridge to recovery or a definitive airway.



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Patient reference

Date

Time

Completed by

Equipment ready

- ☐ High-flow oxygen with non-rebreather mask
- ☐ Rigid wide-bore suction (Yankauer) and flexible suction catheters
- ☐ Oropharyngeal airways (range of sizes)
- ☐ Nasopharyngeal airways (range of sizes) and water-based lubricant
- ☐ Self-inflating bag-valve-mask with reservoir, masks of several sizes, PEEP valve
- ☐ Supraglottic airway (second-generation) in appropriate sizes
- ☐ Waveform capnography
- ☐ Pulse oximetry and monitoring
- ☐ Magill forceps and laryngoscope

Before · Recognise and call for help

- ☐ Look, listen and feel for airway obstruction and breathing
- ☐ Call for help early and ask for the airway trolley and suction
- ☐ Attach monitoring: SpO₂, ECG, blood pressure, and waveform capnography once ventilating
- ☐ Give high-flow oxygen 15 L/min via non-rebreather mask if breathing spontaneously

Before · Assess for trauma and difficulty

- ☐ **If cervical spine injury is suspected, do not use head tilt; open the airway with jaw thrust and maintain manual in-line stabilisation**

If jaw thrust fails to open the airway, a small amount of head tilt is acceptable: the airway takes priority.

- ☐ Predict difficult bag-mask ventilation
- ☐ Inspect the mouth for blood, vomit, secretions or a foreign body

During · Open and clear the airway

- ☐ Position supine; in the non-trauma patient place the head in the sniffing position
- ☐ Perform head tilt–chin lift
- ☐ Perform jaw thrust if head tilt–chin lift fails or trauma is suspected
- ☐ Suction the oropharynx with a rigid wide-bore sucker under direct vision

- ☐ **Do not perform blind finger sweeps; remove a foreign body only if it is visible**

Use Magill forceps under direct laryngoscopy for a visible foreign body.

- ☐ Reassess patency after every manoeuvre

During · Oropharyngeal airway

- ☐ Size: flange at the incisors, tip at the angle of the jaw
- ☐ Insert in adults upside down, then rotate 180° as it passes the hard palate; in children insert the right way up using a tongue depressor

- ☐ **Remove the oropharyngeal airway if the patient gags or strains; do not force it**

Gagging can provoke vomiting and laryngospasm.

During · Nasopharyngeal airway

- ☐ Size: length from nostril to tragus; choose a diameter that passes the nostril without force
- ☐ Lubricate, insert bevel toward the septum along the floor of the nose, directed backwards not upwards, with a gentle rotating motion
- ☐ If resistance is felt, withdraw and try the other nostril
- ☐ Consider a nasopharyngeal airway in the semi-conscious patient who will not tolerate an oropharyngeal airway, or with trismus

During · Bag-mask ventilation

- ☐ Choose a mask that covers the bridge of the nose and the chin without covering the eyes
- ☐ Use a two-person technique whenever possible
- ☐ Keep an oropharyngeal and/or nasopharyngeal airway in place while ventilating
- ☐ Give each breath over about 1 second, enough to see the chest rise
- ☐ Confirm ventilation with chest rise, SpO₂ and a capnography trace
- ☐ If ventilation is difficult, optimise: reposition, two-person technique, adjuncts, suction, check for leaks, add PEEP

During · Supraglottic airway

- ☐ Insert a second-generation supraglottic airway if bag-mask ventilation fails or for prolonged ventilation
- ☐ Lubricate the back of the device, insert along the hard palate until resistance, and secure
- ☐ Confirm with capnography, chest rise and auscultation; pass a gastric tube through the drain port if present

- ☐ **If you cannot oxygenate by face mask, supraglottic airway or intubation, declare a can't-intubate-can't-oxygenate emergency and proceed to front-of-neck access**

Follow the difficult airway guidance; see the surgical airway procedure.

After · Ongoing care

- ☐ Place the spontaneously breathing, unconscious non-trauma patient in the recovery position once the airway is maintained
- ☐ Titrate oxygen to target saturation: 94–98% for most, 88–92% if at risk of hypercapnic respiratory failure
- ☐ Decide early whether the patient needs a definitive airway and involve a senior airway clinician
- ☐ Decompress the stomach with a gastric tube after prolonged bag-mask ventilation
- ☐ Treat the cause of the reduced conscious level (hypoglycaemia, opioid toxicity, seizure)
- ☐ Document the manoeuvres and adjuncts used, the ease of ventilation and the response



A drafted procedure checklist, awaiting senior review. Perform procedures only within your training, competence and local policy. It does not replace your clinical judgement.

EM Orbit · Emergency medicine, in one orbit · proc-basic-airway · red rows are the steps that must not be missed