

RAPID SEQUENCE INTUBATION

OVERVIEW:

Rapid Sequence Intubation (RSI) is used to control/protect the airway of patients who cannot or soon will not be able to control/protect their own airway. RSI combines the use of sedative and paralytic medications with standard endotracheal intubation. RSI is applicable to both trauma and medical patients under the correct circumstance. RSI is complicated by the administration of several different medications, each with their own indications and contraindications. While the skill is authorized for Paramedic providers only, all providers will be involved in the preparation and implementation of this skill.

INDICATIONS:

- ❑ Patient is unable to protect/maintain own airway. **OR**
- ❑ Patient's expected course indicates orotracheal intubation will be necessary and will be more safely established in the out of hospital setting.
- ❑ Patient is expected to exhibit muscle tone, especially laryngeal tone (active gag reflex).

CONTRAINDICATIONS:

- ❑ Extreme caution should be used in situations where intubation is expected to be difficult.
 - If unable to ventilate via BVM, do not intubate, consider placement of "rescue" airway first line.
 - Always consider proximity to definitive care (risk vs. benefit)
- ❑ The use of Succinylcholine as a paralytic is contraindicated in patients with:
 - Major unhealed burn injuries greater than 24 hrs old
 - Crush injuries, or missed dialysis sessions.
 - In cases where Succinylcholine is contraindicated, Vecuronium should be used as the primary paralytic

PROCEDURE:

- ❑ Prepare intubation equipment as per Standard Intubation Procedure.
- ❑ **Etomidate, 0.3 mg/kg IVP.**
 - For patients weighing between 140 and 200 lbs, providers can administer **20 mg IV/IO.**
 - Pediatric dose **0.3 mg/kg IV/IO.**
- ❑ **Succinylcholine, 1.5 mg/kg IVP.**
 - For patients weighing between 140 and 200 lbs, providers can administer **100 mg IV/IO.**
 - Pediatric dose **2 mg/kg IV/IO.** Repeat x 1 if sufficient paralysis is not reached.
 - If Succinylcholine is unavailable or contraindicated - use **Vecuronium, 0.2 mg/kg IVP** for adults and pediatrics.
- ❑ Wait for fasciculation. (if using vecuronium, there will be no fasciculation)
- ❑ Perform Intubation
 - Ensure that SpO₂ does not fall below 90% during intubation attempt
 - A maximum of 2 attempts (defined as attempting to visualize cords with laryngoscopy) is permitted prior to the utilization of alternative airways (e.g., King airway).
- ❑ If intubation is unsuccessful then move immediately to "rescue" airway.
- ❑ Secure & Confirm ETT/"Rescue" airway device
 - Negative EDD, auscultation, no epigastric sounds, misting in tube, chest rise/fall, equal breath sounds, ETCO₂, and etc.
- ❑ Sedation and/or Cont. Paralysis: if BP >80, **Versed 2.5 - 5 mg IV/IO**, repeat as needed to maintain sedation
 - Pediatric dose **0.1 mg/kg** (max single dose 2.5 mg).
 - If not able to maintain adequate sedation with versed **and** transport time is greater than 15 mins: administer **Vecuronium, 0.1 mg/kg IV/IO**, max 10 mg. May repeat if needed, at **0.05 mg/kg** every 30 mins.

PARAMEDIC

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RAPID SEQUENCE INTUBATION CONT.

CONSIDERATIONS:

- ❑ An attempt at ETI is defined as any laryngoscopy with the intent of visualizing airway anatomy and/or passing an endotracheal tube.
- ❑ When faced with a difficult airway situation, providers should consider the use of the following techniques: BURP (back, up, right, pressure); eschmann catheter; two provider laryngoscopy.
- ❑ In the presence of closed head injury and/or increased intracranial pressure, providers should administer:
 - **Lidocaine 1.5mg/kg IV/IO** prior to administration of Etomidate
 - For patients weighing between 140 and 200 lbs, providers can administer **100 mg IV/IO**.