



# Airway, Rapid Sequence Intubation (OPTIONAL)



**Indications for RSI**  
 Failure to protect the airway  
 Unable to oxygenate  
 Unable to ventilate  
 Impending airway compromise

	<b>Preoxygenate 100% O2</b>
I	IV Procedure (preferably 2 sites)
P	Assemble Airway Equipment Suction equipment Alternative Airway Device

Protocols 1, 2 and 3 should be utilized together (even if agency is not using RSI) as they contain very useful information for airway management.

Evidence of Head Injury / CVA or Reactive Airway Disease?

NO  
 P [ ]

P **Etomidate 0.3 mg / kg IV / IO**  
 P **Succinylcholine 1.5 mg / kg IV / IO**  
 or  
**Rocuronium 1 mg / kg IV / IO**  
 (if Succinylcholine contraindicated)

Procedure will remove patient's protective airway reflexes and ability to ventilate.  
 You must be sure of your ability to intubate before beginning this procedure.

P **Intubate trachea**

P **Placement Verified**  
**Continuous Capnography**

NO → P May Repeat One Time

Consider Restraints Physical Procedure  
 P Consider Gastric Tube Procedure

**Red Text** are the key performance indicators used to evaluate protocol compliance. An Airway Evaluation Form must be completed on every patient who receives Rapid Sequence Intubation.

NO  
 YES  
 Awakening or Moving after intubation with sedative and paralytic

P [ ]

After 2<sup>nd</sup> cycle

Exit to Failed Airway Protocol

🚑 **Notify Destination or Contact Medical Control** 🚑

General Protocols

## Protocol 3



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## Pearls

- Agencies must maintain a separate Performance Improvement Program specific to Rapid Sequence Intubation.
- This protocol is only for use in patients with an Age 12 or greater or patients longer than the Broselow-Luten Tape.
- Once a patient has been given a paralytic drug, **YOU ARE RESPONSIBLE FOR VENTILATIONS** if desaturation occurs.
- Continuous Waveform Capnography and Pulse Oximetry and are required for intubation verification and ongoing patient monitoring
- Before administering any paralytic drug, screen for contraindications with a thorough neurologic exam.
- If First intubation attempt fails, make an adjustment and try again:
  - Different laryngoscope blade
  - Change head positioning
  - Different ETT size
  - Continuous pulse oximetry should be utilized in all patients.
  - Change cricoid pressure
  - Consider applying BURP maneuver (Back [posterior], Up, and to pt's Right Pressure)
- This procedure requires at least 2 EMT-Paramedics. Divide the workload – ventilate, suction, cricoid pressure, drugs, intubation.
- Protect the patient from self extubation when the drugs wear off. Longer acting paralytics may be needed post-intubation.
- Consider Naso or orogastric tube placement in all intubated patients to limit aspiration and decompress stomach if needed.