Endotracheal Intubation - Rapid Sequence Intubation

Authorization: Paramedic
Protocol: Paramedic - Standing Order

The use of sedative and paralytic medications to facilitate direct laryngoscopy and orotracheal intubation

Indications:
- In a patient with an intact gag reflex that:
  - Is unable to protect their own airway
  - Will potentially be unable to protect their own airway without intervention
  - Who is at risk for airway swelling and obstruction without intervention
  - Airway compromise with trismus

Contraindications:
- Patients <13yrs
- Patients who can be adequately oxygenated/ventilated by less invasive means with no potential for airway compromise

Precautions:
- RSI is a procedure that has a high potential for significant complications. This procedure should be reserved for patients who have, or will most likely develop, airway compromise that cannot be adequately managed by other means
- A adequate number of personnel should be on hand to assist

Procedure:
- Ensure that indications are present for RSI
- Asses for predicated difficult BVM, intubation, EGD, and cricothyrotomy:
  - Consider an “Awake Look” utilizing atomized Lidocaine
  - Sedation with Versed may be used if needed
- Obtain BP and continuous SPO2, ECG, and ETCO2 (If indicated)
- Place a nasal cannula on patient for apneic oxygenation, even if patient is on a NRB
- Established IV/IO
- Prepare intubation equipment, extra-glottic device, and cricothyrotomy equipment
- Consider premedication with:
  - Fentanyl - 3µg/kg
  - Lidocaine for head injury - 1.5mg/kg
    - For patients with increased ICP, CAD, or vascular disease
- Administer induction agent:
  - Ketamine - 1.5mg/kg
    - If the patient is hypotensive consider 1mg/kg
    ----------OR----------
  - Midazolam - 0.3mg/kg
- Administer paralytic of choice:
  - Succinylcholine - 1.5mg/kg
    ----------OR----------
  - Veccuronium - 0.1mg/kg
- Attempt endotracheal intubation with VL or DL technique
  - Ensure that adequate SPO2 is maintained during/between attempts. If endotracheal intubation is unsuccessful, the patient desaturates with inability to ventilate with a BVM, or after 3 intubation attempts, place extra-glottic device if indicated. (See Failed Airway)
- Verify endotracheal tube placement
  - Continuous ETCO2 monitoring is mandatory and must be uploaded to report
- Secure endotracheal tube
- Maintain sedation: Versed and/or Ketamine
- Maintain pain control: Fentanyl
- The need for re-paralysis should only be considered once adequate sedation and analgesia have been ensured

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- Vecuronium – 0.1mg/kg IV
- Place NG or OG tube
- Complete all documentation per agency and state requirements and submit for review within 24hrs

Notes:
- If the patient is hypotensive or at risk to become hypotensive, have vasopressor of choice available and attempt to correct hypotension prior to induction
- If the patient is hypoxic and unable to correct prior to induction and paralysis, consider placement of an EGD with oral ETI at a later time
- If the patient is acidotic, consider placement of an EGD with oral ETI at a later time. Ensure ETCO2 does not rise from pre-induction value