

## CMG 3(a) – RAPID SEQUENCE INTUBATION (RSI)

(Revised: January 2014)



**ALL INTUBATIONS (EXCLUDING PATIENTS IN CARDIAC ARREST) WILL FOLLOW THIS PROCEDURE**

~ THIS IS AN ICP ONLY CMG ~

### INDICATIONS:

the patient with unequivocal, life threatening airway compromise and clinical evidence of severe hypoxia where the airway cannot be managed by less aggressive means

OR

the patient with potential airway compromise where extrication will make it impossible to maintain adequate airway control, where the airway cannot be managed by less aggressive means and more than 10 minutes (including extrication, load and transport time) from hospital

### CONSIDERATIONS IN APPLYING THE INDICATIONS

The following must be considered prior to utilisation of this guideline:

Response to basic treatment: ability to oxygenate, ventilate and protect the airway by less aggressive means.

Remember the primary goals of airway management.

Consider the risks and benefits of intubation.

Clinical needs are influenced by the following:

- clear and obvious airway compromise
- significantly decreased level of consciousness (GCS <9 / abnormal response to painful stimuli)
- hypoxia – SpO<sub>2</sub> <90% *OR* centrally cyanosed
- time to hospital (including extrication, load & transport time)

Apparent difficulty of intubation:

- anatomy
- acquired and situational factors
- confidence and experience of operator

Caution:

- hypothermic patient
- fitting patient
- patient with reversible pathology

**continues over**



**PROCEDURE**

**DRUG SEQUENCE**

**IF INTUBATION FAILS**

**Basic airway management –**  
Posture, suction, oral/nasal airway, LMA

**Oxygenation –**  
Aim for the highest SpO<sub>2</sub> by the most efficient method.  
*High flow oxygen by nasal prongs is mandatory throughout this procedure.*

**IV / IO access –**  
Establish a fast flowing line that is reliable and secure.  
A second line is sound insurance.

- Prepare patient –**
1. correct any hypotension / hypovolaemia prior to / concurrently with this procedure (10ml/kg normal saline unless in pulmonary oedema)
  2. pre-oxygenate
  3. monitor patient: ECG, SpO<sub>2</sub>, EtCO<sub>2</sub>
  4. execute Intubation Algorithm (CMG 3b)

**Adult:**

- ketamine 1mg/kg fast push
- suxamethonium 1.5mg/kg over 30 – 60 sec

**Post intubation to maintain tube and level of sedation:**

- ketamine 1mg/kg at one to five minute intervals, titrated to effect.
- if adequate sedation not achieved after second post-intubation ketamine dose, consider midazolam 0.05mg/kg

Suxamethonium may cause bradycardia, if patient is bradycardic once ETT is tied in, consider a dose of atropine.

**If suxamethonium is contraindicated:**

- reconsider the need for intubation
- if intubation is required, administer 2mg/kg ketamine IV and attempt intubation.

*Note:* laryngospasm following ketamine is rare, but may occur. Also, intubation conditions will be less than ideal – consider carefully if other airway management options are appropriate.

Re-oxygenate / re-ventilate the patient – utilise basic techniques

There is **no second dose** of suxamethonium

Execute Intubation Algorithm (CMG 3b)

**FOLLOW UP**

1. All relevant details will be carefully documented on the PCR. This especially applies to details concerning the need for sedation, the checks on correct placement of the ETT and the results of the procedure.
2. An incident report must be sent to QSRM by the end of the shift. **There are no exceptions.**
3. All pharmacologically facilitated intubations will be subject to routine, mandatory review.