

RSI Pre-Hospital Checklist MEDICATION

Medication Preparation

- Estimate patient weight
- Choose RSI drugs
- Calculate & verbalize dosages
- Draw up all drugs, confirm dose and label syringes (or leave syringe with needle in vial)

Recommended Pre-Medication

- Fentanyl 1-2 mcg/kg
- Ketamine 2 mg/kg
 - * Etomidate 0.3 mg/kg

Recommended Paralytic

- Succinylcholine 1.5 – 2 mg/kg
 - * Vecuronium 0.3 mg/kg
 - * Rocuronium 1.0 mg/kg

Recommended Post-Intubation Medications

- Ketamine 1mg/kg
- Fentanyl up to 2 mcg/kg
 - * Versed 0.05 - 0.1 mg/kg (max single dose 5 mg q 3-5 min)
 - * Long acting paralytic if needed: Vecuronium 0.1 mg/kg

- * Other medications to consider, based on patient allergies and/or hemodynamics.

RSI Pre-Hospital Checklist PROCEDURE

TIME-OUT: CHECK:

- Heart Rate
- Blood Pressure
- Blood Sugar
- Acidosis (Salicylates, DKA) If RSI is necessary, maintain patients ventilatory rate
- Check for Medical Alert ID's
- Anticipated problems: Any questions or concerns?
- Is patient positioned optimized?

Procedure Continued

- Push pre-Medication(s)
- Push induction Agent
- Push Paralytic
- Allow ApOx (30-45 sec) maintaining O2 sat >93%
- Epiglottoscopy (identification of the epiglottis) pass ETT
- Confirm tube & secure
- Push sedation & analgesia (more analgesia and less sedation)
- Consider long-acting paralytic only if required
- Repeat vitals q 5 min.
- Keep ETCO2 35-45 (30-35 if ICP if suspected)

RSI Pre-Hospital Checklist PREPARATION

- Verbalize Airway Plan
- Assign roles & responsibilities
- Select ETT(s) & Supraglottic Airway
- Select laryngoscope / blades
- Have Bougie, QuickTrach at bedside
- Check all equipment
- Connect ETCO2 to BVM & Monitor
- Turn on suction with rigid catheter
- Optimize patient position
- Pre-Denitrogenate
- Pre-Oxygenate
- Is patient's hemodynamics optimal?
 - Fluid Bolus needed?
 - Pressor Drip or push-dose pressor needed?
- IV Patent: Flushed

Developed by P. Neuwirth, FP-C,

This checklist is not intended to be comprehensive; check your local protocols

This page includes explanations of the checklist for students, residents, and when training with the checklist

De-nitrogenation, Pre-oxygenation, and ApOx: If you anticipate your patient may require a definitive airway, begin denitrogenation ASAP with NC + NRB @ 15L. This will eliminate nitrogen from patients lungs and allow for a higher concentration of O₂. If patient unable to maintain their own airway, the intubator must maintain their airway during this step. If patient can follow directions, have them take 8 vital capacity breaths. Be sure to position patient to increase their full respiratory capacity. After approx. 3 min or 8 vital capacity breaths, pre-oxygenate patient with a goal of 100% O₂ saturation. If patient is shunting, O₂ sat <93%, add passive BVM+PEEP over high flow NC to provide additional oxygen therapy. A tight BVM mask seal is critical. Once the drugs are pushed, allow apneic oxygenation for (30-45 sec) while waiting for patient to become flaccid, maintaining O₂ sat >93% with NC at 15L. If <93% with NC at 15L add passive BVM + PEEP with tight seal (no bagging).

Preparing Team: The most important step in this timed, sequenced, event is **preparation**. The person intubating must evaluate patients hemodynamics and any indications of a difficult airway. Then select their tools, prepare a back-up plan, check and set-up equipment, assign roles and responsibilities and verbalize their airway and post intubation plan. The person administering the drugs needs time to draw up the meds and confirm dosages. BLS and ground ALS must be briefed in their role when assisting.

Verbalized airway plan should sound like this: My first & second attempt I will use a video laryngoscope maintaining an O₂ sat >93%. If at anytime my sat drop below 90%, I will stop my attempt and ventilate patient. If after 3 unsuccessful attempts to intubate, I will place a supraglottic airway. If unable to oxygenate and ventilate patient, I will place a QuickTrach to secure a definite airway. Once airway is placed, I will ask my partner to confirm placement by auscultation. Then note patients ETCO₂ waveform and numeric by printing an EKG strip. Once tube is confirmed, I will ask BLS/ALS to help secure the tube and my partner will administer post intubation medications.

The time-out: This is designed as a last second check before the procedure is initiated. Is the Intubator and their selected equipment ready; Are all meds drawn up and proper dosages confirmed; Does Assistant(s) understand their roles and responsibilities? Is all needed equipment selected and within arm's reach; Are there any contraindications to succinylcholine if being used (e.g. med alert tags for malignant hyperthermia, evidence of hyperkalemia, peaked T waves, evidence or hx of muscle wasting disease). If all clear....push meds and allow approx. 30-45 seconds for the patient to become flaccid. Monitor O₂ sat, HR – only bag during apneic oxygenation if O₂ sat <93%. Maintain HF NC at 15L.