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**Medication Assisted Airway (RSI)**

**Clinical Indications**

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| * This procedure provides guidelines for successful rapid sequence endotracheal intubation (RSI).
* Patients requiring RSI may include those where the paramedic expects difficulty in securing the airway, status epilepticus (seizures unresolved with anticonvulsants and inadequate respirations), isolated head trauma, CVA, multiple system trauma, overdose, acute pulmonary edema, respiratory failure, and severe burns.
* RSI is utilized for patients unable to maintain a patent airway when there is adequate manpower and equipment.
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**TREATMENT GUIDELINES**

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| **R-EMR** | **E–EMT** | **A-AEMT** | **P-PARAMEDIC** | **\*\*M-Medical Control \*\*** |

**\*\*\*Higher level providers are responsible for lower level treatments\*\*\***

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| * Pre-oxygenate (9006) with bag-valve-mask while assembling equipment (2-3 min).
* Have secondary airway immediately available. Evaluate for difficult BVM ventilation (MOANS), and indicators for difficult intubation (LEMONS) or Cricothyrotomy (DOA).
* Consider Lidocaine 1 mg/kg IV/IO for evidence of head injury or stroke or suspected increased intracranial pressure (ICP).
* Before administration of a paralytic drug, screen for contraindications, do neurologic exam.
* Administer Etomidate 0.3mg/kg IV/IO, or Ketamine 1-2 mg/kg IV/IO. Ketamine is preferred in the settings of hypotension or clinical indicators for shock.
* After 30 seconds assess patient and consider intubation via sedation only.
* Consider Fentanyl particularly in pediatrics and trauma (note: Fentanyl may increase ICP in head trauma patients) 0.5-2.0 mg/kg- IV/IO.
* Administer Rocuronium 1.0 mg/kg -IV/IO, or Succinylcholine 1.5 mg/kg IV/IO.
* Apply cricoid pressure to occlude the esophagus.
* As fasiculations stop jaw relaxes and resistance to ventilations diminishes, proceed with intubation. Attempt intubation up to 3 times; oxygenate between attempts.
* If unable to intubate after 3 attempts, utilize secondary airway such as a King Blind Insertion Airway device (BIAD-9007).
* Confirm endotracheal tube placement and inflate cuff.
* Measure ETCO2 (9002), and Pulse Oximetry (9001). Ventilate at a rate to maintain ETCO2 at 35-45 mmHg. For obvious head injury with possible increased ICP, ventilate as needed to an ETCO2 of 30-35 mmHg.
* Consider restraints and C-collar placement to help reduce dislodgement.
* Document procedure, ETT size, time, result and placement location in PCR.
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Pearls:

**MOANS: Difficult Mask seal, Obese or airway obstruction, Advanced age, No teeth, Sleep apnea or Stiff lungs. LEMONS: Look externally, Evaluate 3-3-2, Mallampati score, Obstruction, Neck mobility, Scene or Situation. DOA: Disruption or Distortion, Obstruction, Access problems. The paramedic must be prepared to deal with and prevent complications while placing an endotracheal tube. These include: airway trauma, laryngospasm, hypoxia, aspiration and Failed Airway (4002). Patient outcomes are directly related to the promptness and competency with which a paramedic moves through appropriate options while maintaining ventilation. Premedicate pediatric patients with Atropine 0.01-0.02 mg/kg IV/IO. Don’t be a D.O.P.E.- Reassess for complications: Displacement, Obstruction, Pneumothorax, and Equipment failure.**

**QA Parameters: 100% of patients receiving RSI with attention to frequency of Capnography.**