

ADULT RSI PROTOCOL

Paramedic

Quick Med Reference

Small Adult (est. 60 kg)
Ketamine 120 mg IVP
Midazolam 6 mg IVP
Vecuronium 6 mg IVP

Medium Adult (est. 80 kg)
Ketamine 160 mg IVP
Midazolam 8 mg IVP
Vecuronium 8 mg IVP

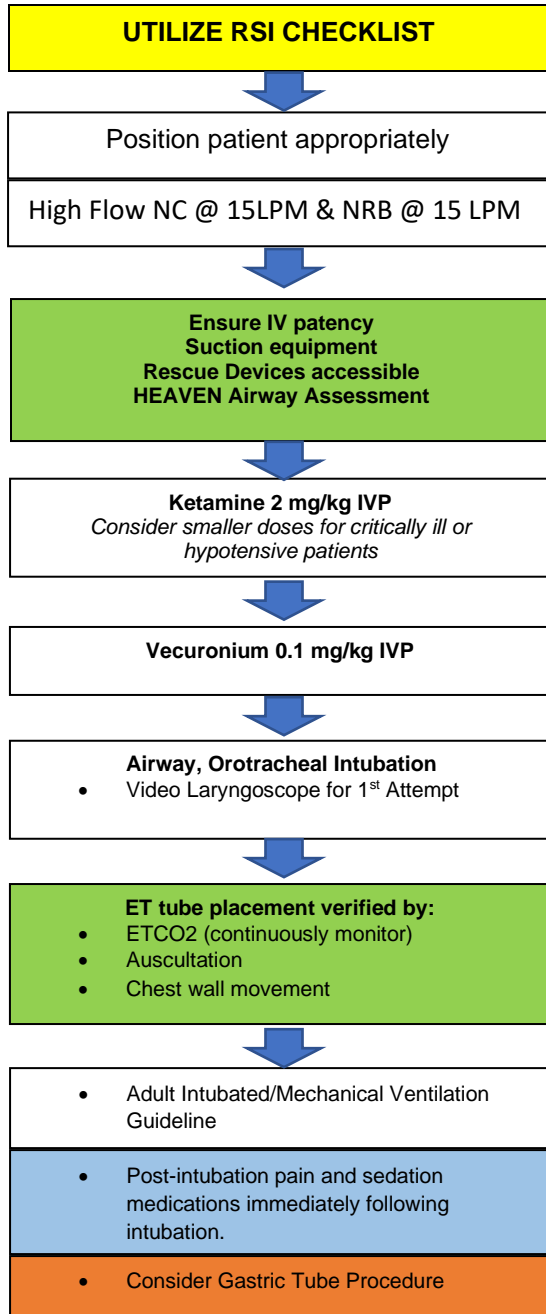
Large Adult (est. 100 kg)
Ketamine 200 mg IVP
Midazolam 10 mg IVP
Vecuronium 10 mg IVP

To prevent HTN in pts with increased ICP, aortic dissection, ICH, etc ... Consider premedicating with **Fentanyl 1 – 3 mcg/kg** prior to intubation.

Predictor of Difficult Intubation:

HEAVEN

- Hypoxemia
- Extremes in size
- Anatomical challenges
- Vomit / Blood / Fluid
- Exsanguination / anemia
- Neck Mobility issues



Resuscitate before you intubate.
Do not undertake RSI lightly!!!

To prevent hypertension in pts with increased ICP, aortic dissection, ICH, etc... consider pre-medicating with Fentanyl 1-3 mcg/kg prior to intubation

Hypotension Pre-Intubation or immediately post-intubation consider: Push-dose Epinephrine

- 5-20 mcg (0.5-2.0 ml) IVP q 2-5 minutes
- Mix 1 ml EPI 1:10,000 with 9 ml NS

OR (Trauma and Hemorrhage) consider Push-Dose Vasopressin

2-4 Units (2-4 ml) IVP q 2-5 min

Mix 0.5 ml Vasopressin (10 units) in 9.5ml NS = 1 unit/mL

May Repeat 1 x

Failed Airway Guideline

PEARLS:

- Once a patient has been given a paralytic drug, **YOU ARE RESPONSIBLE FOR VENTILATIONS!!!**
- Maintain apneic oxygenation via NC during intubation attempt when possible.
- This procedure will take away the patient's airway, so you must be sure of your ability to ventilate/oxygenate before giving drugs.
- Prior to RSI, conduct a neurologic assessment including LOC and extremity movement
- Have all rescue devices immediately available (King Airway, DL blade, Cric kit)
- Preoxygenate with NRB/NC or BVM/PEEP, do not manually ventilate unless absolutely necessary
- All equipment must be in place and ready for use prior to administering RSI drugs.
- Midazolam 0.1 mg/kg IVP should be considered for patients with seizures or ETOH withdrawal
- If first intubation attempt fails, make adjustments and try again:
 - Different laryngoscope blade
 - Change patient head positioning
 - Different ET tube size
 - Consider applying external laryngeal manipulation (ELM)