

PEDIATRIC RSI PROTOCOL

Paramedic

Predictors of Difficult Intubation

HEAVEN

- Hypoxemia
- Extremes in size
- Anatomical challenges
- Vomit/ blood/ fluid
- Exsanguination / anemia
- Neck Mobility Issues

Verify Placement

ETCO₂, auscultation, chest wall movement, condensation in tube, chest x-ray if possible

UTILIZE RSI CHECKLIST

High Flow NC @ 15LPM & NRB @ 15 LPM

Ensure IV/IO patency
Suction equipment
Rescue Devices immediately accessible
HEAVEN Airway assessment

Consider Atropine 0.02 mg/kg if bradycardic during intubation (Max dose 1 mg)

Ketamine 2 mg/kg IVP
Consider smaller doses for critically ill or hypotensive patients

Vecuronium 0.1 mg/kg IVP

Airway, Orotracheal Intubation

- Video Laryngoscope for 1st Attempt

ET tube placement verified by:

- ETCO₂ (continuously monitor)
- Auscultation
- Chest wall movement

Successful Tube

- Pediatric Intubated/Mechanical Ventilation Guideline
- Post-intubation pain and sedation medications immediately following intubation.
- Consider Gastric Tube Procedure

Use Broselow tape to assist with pediatric drug doses and equipment sizes

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

Unsuccessful Tube

May Repeat 1 x

Failed Airway Guideline

Pearls:

- This guideline is only for use in pts <37 kg (81.4 lbs), Age < 12 years, or pts that fit the Broselow tape
- Once a patient has been given a paralytic drug, **YOU ARE RESPONSIBLE FOR VENTILATIONS!!**
- This procedure will take away the patient's airway, so you must be sure of your ability to ventilate/oxygenate before giving drugs.
- **Continuous ETCO₂ and SPO₂ are required for advanced airway verification and ongoing patient monitoring.**
- Prior to RSI, conduct a neurologic assessment including LOC and extremity movement
- It is preferable to have 2 providers complete this procedure – ventilate, suction, drugs, and intubation.
- 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)