

Trauma Center Practice Management Guideline

Iowa Methodist Medical Center — Des Moines

Rapid Sequence Intubation (RSI) Protocol

ADULT Practice Management Guideline	Effective: 06/2014
Contact: Trauma Center Medical Director	Last Reviewed: 07/2016

PURPOSE

To provide guidelines for definitive airway placement in Trauma patients.

PROCEDURE STATEMENTS

1. Indications for RSI
 - A. Airway obstruction
 - B. Hypoventilation (i.e. spinal cord injury)
 - C. Severe hemorrhagic shock
 - D. Severe hypoxemia (despite supplemental O₂)
 - E. GCS ≤ 8
 - F. Smoke inhalation or face/upper airway burns with impending airway obstruction
 - G. Cardiac arrest
2. Orotracheal intubation (OTI) guided by direct laryngoscopy is the procedure of choice for trauma patients.
 - A. When the patient's jaws are not flaccid and OTI is indicated, a drug regime should be given to achieve the following clinical objectives:
 - Neuromuscular paralysis
 - Sedation, as needed
 - Maintain normal hemodynamics
 - Prevent vomiting and aspiration
 - Prevent increases in the ICP
 - Prevent increases in intraocular pressure (especially if globe injury)
 - B. To provide the best opportunity for successful emergent airway control the following are recommended:
 - The most experienced personnel available at that time
 - Pulse oximetry
 - Continuous end tidal CO₂ monitoring with waveforms.
 - Cricoid pressure (Sellick's maneuver)
 - C-Spine neutrality

- C. Cricothyrostomy is appropriate when OTI fails.
King LT is appropriate if expertise in cricothyrostomy is unavailable.

Success rates of OTI without drug assistance	80%
Complication rates of OTI without drug assistance	19%
Success rates of OTI with drug assistance	96%
Complication rates of OTI with drug assistance	4%

Revised and approved by Trauma Committee, July, 2010

Revised and approved by Trauma Committee, June 20, 2014

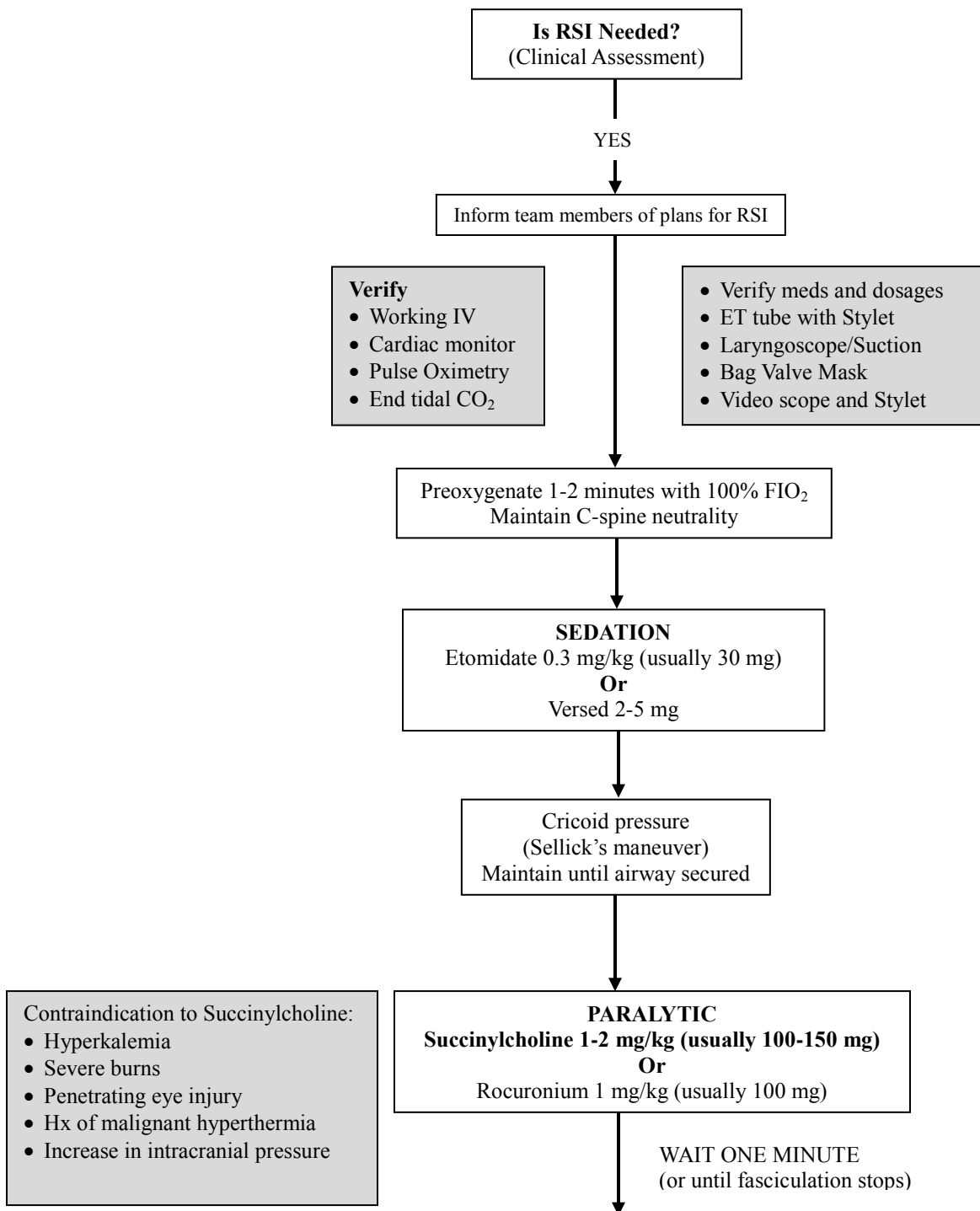
Revised and approved by Trauma Committee, July 2016

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Rapid Sequence Intubation (RSI) Algorithm

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(Continued) Rapid Sequence Intubation (RSI) Algorithm

