Consensus Statement:
ADULT Rapid Sequence Intubation and Post-Intubation Analgesia and Sedation for Major Trauma Patients
July 2018

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Evidence considered in reaching the consensus statements:

8. A.E. Blair, R.Walls, J.Grayzel, UptoDate. Rapid sequence intubation for adults outside the operation room, section on 'Preoxygenation' June 28 2016
10. B. Pudelek Geriatric Trauma: Special needs for a special population. AACN Adv Crit Care February 2002 vol.13 No.1 61-72
Background:
- Major trauma patients frequently require advanced airway control.
- Endotracheal intubation is the preferred advanced airway intervention in major trauma patients.
- Intubated trauma patients also need significant post-intubation pharmacological support.
- Specifically, these patients require analgesia and sedation. This is particularly true when transfer to another facility is required, during which ICU level support is not available unless transfer occurs via Air Ambulance.
- In New Brunswick, there is significant variation in the approach to both advanced airway control and post-intubation analgesia and sedation practices for major trauma patients.
- Physicians in smaller centres in particular have asked for standardized, evidence-based guidance for both Rapid Sequence Intubation (RSI) and post-intubation pharmacological support in preparation for (and during) ground-based interfacility transfer.
- Rapid Sequence Intubation (RSI) is a method to achieve airway control that involves rapid administration of sedative and paralytic agents, followed by endotracheal intubation.
- The purpose of RSI is to affect a state of unconsciousness and neuromuscular blockade, allowing for increased first pass success of endotracheal intubation.
- Post-intubation analgesia and sedation is a method of controlling pain, agitation and medically induced amnesia for major trauma patients.

Consensus Statements:
- A provincially standardized, evidence-based guideline for Rapid Sequence Intubation should be available in all NB Trauma Centres (Appendix A).
- Similarly, a provincially standardized, evidence-based guideline for Post-Intubation Analgesia and Sedation should be available in the Emergency Department of all NB Trauma Centres (Appendix B).
- In addition to standardized, evidence-based guidelines, a provincially standardized equipment layout is recommended to optimize the preparation for RSI (Appendix C).
- Ambulance New Brunswick should ensure consistency with the provincially standardized guidelines for RSI and Post-Intubation Sedation and Analgesia in procedures for Ambulance New Brunswick’s Air Medical Crew.
- RSI should not be considered or applied for trauma patients who are in cardiac arrest or who are apneic.
- RSI should not be considered in patients with a predicted difficult airway.
- RSI should be considered for all trauma patients meeting the following:
  - GCS < 8, quickly deteriorating GCS or loss of airway protection
  - Facial trauma with poor airway control
  - Burns with suspected inhalation injury
  - Respiratory failure
  - Hypoxia
  - Persistent or uncompensated shock (reduction of respiratory efforts)
  - Agitation with possible injury to self or others
  - Potential for eventual respiratory compromise
  - Possible respiratory and/or neurological deterioration during prolonged transport
  - Transport in a confined space with limited resources
- In addition to the above, RSI Guidelines should include
  - Assessment of the possibility of a difficult intubation
  - Troubleshooting
  - Immediate reference to post-intubation analgesia and sedation
- In addition to standardized, evidence-based guidelines, a provincially standardized pre-induction checklist is recommended to optimize the preparation for RSI (Appendix D)
Special Patient Populations:

- **Pediatrics (age less than 16 years):** These guidelines are written for the adult patient population; use in pediatric patients is not recommended.

- **Geriatrics:** Age-related changes need to be addressed during the assessment, treatment and evaluation of care. Particular attention should be given to the resuscitation phase because the elderly do not have the physiologic reserve necessary to respond to hypoxia and shock.

- **Patients with high Body Mass Index (BMI):** BVM ventilation is more difficult as the soft tissue of the pharynx collapses under anesthesia or sedation. When spinal injury is not suspected, appropriate positioning (ramped position) improves the adequacy of mask ventilation therefore eases intubation. The redundant tissues in the upper airway make visualization of the glottis by direct laryngoscopy more difficult.

- **Pregnant patients:** For optimal outcome of mother and fetus, clinicians must assess and resuscitate the mother first. Management of the pregnant patient should be consistent with ATLS guidelines (eg. patient positioning and consideration of potential difficult airway). Early consultation with an obstetrician is recommended.

GRADE Level of Evidence:

- **Level A:** recommendation

- Generally, clinicians should follow the recommendations but should remain alert to new information and be aware of contraindications.
Optimize Resuscitation: BLS airway and ventilation

Is urgent airway control indicated?

Yes

Prepare Kit Dump and Required Medications

Assess Airway Anatomy

Predicted difficult airway?

Yes

Consider awake intubation

Consider fibreoptic intubation

Consider set up for Plan C and/or D

No

Complete NB Trauma Program RSI Checklist

Plan A: Best Look Laryngoscopy – Direct or Video

Max 1-2 attempts

Successful intubation?

Yes

Plan B: Alternative intubation technique – Direct or Video Laryngoscopy

Max 1-2 attempts

Successful intubation?

Yes

Plan C: Rescue Device

LMA, King LT or i-gel

Max 1 attempt

Successful Placement?

Yes

Plan D: Surgical Airway

Cricothyrotomy

No

Is urgent airway control indicated?

No

Appendix A: Rapid Sequence Intubation

This is not an order sheet

Last revised July 2018

- Colorimetric and quantitative CO₂
- Confirm ETT Placement
- Secure Tube
- Vital Signs q3 minutes peri-intubation
- Orogastric Tube
- Repeat Primary Survey
- Sedation and Analgesia
- Portable chest X-Ray (consider pelvis)
Goal in Emergency Phase of Care and During Interfacility Transfer:
RASS -4: Pain Management and Deep Sedation
(see RASS Scale below)

Starting dosages for infusions 1 and 2

1. Analgesia
   FentaNYL 1-2 mcg/kg/hr

2. Sedation (choose only one; Ketamine preferred in hypotensive patients)
   - Propofol 5 mcg/kg/min
   - Ketamine 0.05-1.2 mg/kg/hr
   - Midazolam 0.02-0.1 mg/kg/hr

IV PRN boluses

Analgesia
FentaNYL: 1 bolus of ½ infusion dose q15 min PRN
Consider prior to moving patient

Sedation (choose only one)
- Propofol 0.3mg/kg q10 min PRN
- Ketamine boluses not recommended; proceed directly to titration
- Midazolam ½ dose of continuous infusion q10 min PRN

If 3 boluses of any one drug is required within 30-60 minutes, titrate that infusion

Analgesia
FentaNYL: increase rate by 25mcg/hr

Sedation (choose only one)
- Propofol: increase rate by 5 to 10 mcg/kg/min
- Ketamine: increase rate by 10 mg/hr q5-10min PRN
- Midazolam: increase rate by 1 mg/hr

If sedation lightens, return to PRN boluses

RASS -4?

Yes

Critical Guidance
Refer to local policy for guidance on propofol infusion age restrictions
Call sending physician if:
- Patient becomes acutely agitated or presents a safety concern
- Patient becomes hypotensive, hold sedation (continue analgesia)

No

Appendix B: Post Intubation Analgesia and Sedation Prior to Transfer
This is not an order sheet. Obtain written transfer orders prior to departure

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Other Clinical Guidance
- Refer to local policy for minimum and maximum infusion dosage limits
- Regularly repeated ABCDE assessments are recommended
- Vital signs are recommended prior to the administration of all medications

<table>
<thead>
<tr>
<th>RASS</th>
<th>Description</th>
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<tbody>
<tr>
<td>+4</td>
<td>Comatose, violent, danger to staff</td>
</tr>
<tr>
<td>+3</td>
<td>Pulls or removes tube(s) or catheters; aggressive</td>
</tr>
<tr>
<td>+2</td>
<td>Frequent nonpurposeful movement, fights ventilator</td>
</tr>
<tr>
<td>+1</td>
<td>Anxious, apprehensive, but not agressive</td>
</tr>
<tr>
<td>0</td>
<td>Alert and calm</td>
</tr>
<tr>
<td>-1</td>
<td>Awakens to voice (eye opening/contact) &gt; 10 sec</td>
</tr>
<tr>
<td>-2</td>
<td>Light sedation, briefly awakens to voice (eye opens/contact) &lt;10 sec</td>
</tr>
<tr>
<td>-3</td>
<td>Moderate sedation, movement or eye opening. No eye contact</td>
</tr>
<tr>
<td>-4</td>
<td>Deep sedation, no response to voice, but movement or eye opening to pain or stimulation</td>
</tr>
<tr>
<td>-5</td>
<td>Unresponsive, no response to voice or physical stimulation</td>
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Appendix C: Sample Kit Dump Layout

For the most current version, suitable for lamination and use in your facility, contact the NB Trauma Program:

NBTrauma@HorizonNB.ca
(506)648-8040
## Do RSI Checklist AFTER initial Primary Survey and Resuscitation

1. Sats probe, 3 lead ECG attached? **Blood pressure** on 3 min cycles?
2. What is the Pulse, Blood Pressure, Respiratory Rate, Oxygen Sats and GCS?
3. Nasal Cannula at 15L, Bag Valve Mask at 30L and Peep valve at 5 cm?
4. IV or IO Access Working?
5. Hypotension YES/NO?  
   - If Hemorrhagic shock start MTP.  
   - If Septic shock start Norepinephrine infusion.
6. Laryngeal Injury or Distortion? **Double Setup** better?
7. In non-trauma is there **Ear to Sternal Notch Alignment**?
8. Why **RSI**? Give a summary to the team.
9. **Bed height** at Intubator’s navel?
10. **Equipment silhouette** items present? **Waveform End Tidal CO2** connected?
11. **Suction on** and Pre-positioned?
12. What is **Plan A** for Best Look Laryngoscopy?
13. What is **Plan B** for Alternative Intubation?
14. What Size **LMA or iGel** for **Plan C**?
15. Is the **Surgical Cricothyrotomy** Kit in the Airway Cart?
16. **C-Collar undone** with manual immobilization from below?
17. Who is giving the **Drugs**?
18. Signs of **Shock**? *If YES halve the induction dose!*
19. Patient **estimated Weight** in Kilos?

## 20. #1 – KETAMINE or ETOMIDATE DOSE?

<table>
<thead>
<tr>
<th></th>
<th>STABLE DOSE</th>
<th>SHOCKED DOSE</th>
<th>Dose?</th>
</tr>
</thead>
<tbody>
<tr>
<td>KETAMINE</td>
<td>2.0 mg/Kg</td>
<td>1.0 mg/Kg</td>
<td></td>
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<tr>
<td>ETOMIDATE</td>
<td>0.3mg/Kg</td>
<td>0.15 mg/Kg</td>
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</table>

## 21. #2 – ROCURONIUM or SUCCINYLCHOLINE DOSE?

<table>
<thead>
<tr>
<th></th>
<th>ADULTS</th>
<th>SHOCKED DOSE</th>
<th>Dose?</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROCURONIUM</td>
<td>1.5 mg/Kg</td>
<td>1.5 mg/Kg</td>
<td></td>
</tr>
<tr>
<td>SUCCINYLCHOLINE</td>
<td>1.5 mg/Kg</td>
<td>2.0 mg/Kg</td>
<td></td>
</tr>
</tbody>
</table>

## 22. Give the Drugs NOW by rapid IV Push! Sedative then paralysis! Start the clock

## 23. Wait for drugs to work! 45 secs for Succinylcholine & 60 secs for Rocuronium

## 24. Bag the patient if the O2 Sat drop below 95%

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