



PROCEDURE CHECKLIST

Rapid sequence induction

Emergency tracheal intubation using near-simultaneous induction and neuromuscular blockade, planned around a shared difficult-airway strategy (Plans A to D) and confirmed by waveform capnography.



EM Orbit

Patient reference	Date	Time	Completed by
Equipment ready		☐ Avoid bag-mask ventilation during apnoea unless SpO2 falls; if needed, ventilate gently with low pressures	
☐ Airway trolley checked against a challenge-response checklist		☐ Wait for full relaxation before laryngoscopy (about 45–60 seconds)	
☐ Two working laryngoscopes (videolaryngoscope and direct), blades of two sizes		During · Plan A: laryngoscopy and intubation	
☐ Tracheal tubes (adult typically 7.0–8.0 mm), one size smaller available, 10 mL syringe		☐ Perform laryngoscopy with the device most likely to succeed first time, usually a videolaryngoscope	
☐ Bougie and/or stylet		☐ Optimise the view: suction, external laryngeal manipulation, head position, change of blade	
☐ Second-generation supraglottic airways		☐ Pass the tube (over a bougie if the view is limited) and watch the cuff pass through the cords	
☐ Front-of-neck access kit: scalpel with number 10 blade, bougie, 6.0 mm cuffed tube		☐ Inflate the cuff and connect to capnography and the ventilation circuit	
☐ Waveform capnography connected before induction		☐ Confirm placement with a sustained waveform capnography trace; no trace means wrong place, even in cardiac arrest Remove the tube unless there is a clear alternative explanation; in cardiac arrest, a flat trace with good CPR still means oesophageal placement until proven otherwise.	
☐ Suction x2, working and under the pillow		☐ Check bilateral chest movement and auscultate both axillae and the stomach	
☐ Nasal cannula for apnoeic oxygenation, bag-valve-mask with PEEP valve		☐ Stop laryngoscopy and oxygenate if SpO2 falls below about 93% or the attempt is prolonged Each attempt should be optimised; do not persist with repeated identical attempts.	
☐ Drugs drawn up and labelled: induction agent, neuromuscular blocker, vasopressor, post-intubation sedation		☐ Limit to 3 laryngoscopy attempts (a fourth only by a more experienced operator); then declare failed intubation and move to Plan B	
☐ Ventilator set up and tested, tube tie		During · Plan B and C: rescue oxygenation	
Before · Team and plan		☐ Insert a second-generation supraglottic airway (up to 3 attempts) and oxygenate	
☐ Assign roles: airway operator, airway assistant, drug administrator, team leader and a runner		☐ If supraglottic airway fails, attempt face-mask ventilation with two-person technique and adjuncts	
☐ Perform an airway assessment and predict difficulty		☐ Ensure full neuromuscular blockade before declaring can't-intubate-can't-oxygenate	
☐ Mark the cricothyroid membrane before induction (palpation or ultrasound)		During · Plan D: front-of-neck access	
☐ Verbalise Plans A, B, C and D to the whole team		☐ If you cannot intubate and cannot oxygenate, declare it aloud and perform scalpel cricothyroidotomy immediately Scalpel, bougie, tube technique; see the surgical airway procedure. Do not delay while SpO2 falls further.	
☐ Run the emergency intubation checklist aloud		After · Post-intubation care	
Before · Patient preparation		☐ Secure the tube and record its length at the teeth	
☐ Secure two working intravenous or intraosseous accesses		☐ Set lung-protective ventilation: tidal volume 6–8 mL/kg of predicted body weight, PEEP 5 cmH2O initially, rate for target CO2	
☐ Resuscitate before induction: fluids or blood and a vasopressor ready or running if hypotensive		☐ Start post-intubation sedation and analgesia promptly to prevent awareness, especially after rocuronium	
☐ Position: head up or ramped with ear level with the sternal notch; manual in-line stabilisation in trauma, removing the collar front		☐ Anticipate and treat post-intubation hypotension	
☐ Pre-oxygenate for at least 3 minutes with a tight-fitting mask, or until end-tidal oxygen is above 85%		☐ Insert a gastric tube and request a chest X-ray to check tube position	
☐ Apply nasal cannula oxygen for apnoeic oxygenation and keep it running through laryngoscopy		☐ Send an arterial blood gas and adjust ventilation	
☐ Choose drugs and doses for the patient's physiology		☐ Continue waveform capnography throughout the patient's stay and transfer	
Before · Drugs (adult)		☐ Document airway grade, device, number of attempts, adjuncts, drugs and doses, and any complications; record a difficult airway alert if relevant	
☐ Induction: ketamine 1–2 mg/kg IV, reduced (for example 0.5–1 mg/kg) in shock; alternatives per local protocol		☐ Debrief the team	
☐ Neuromuscular blocker: rocuronium 1.2 mg/kg IV or suxamethonium 1.5 mg/kg IV			
☐ Optional opioid co-induction, e.g. fentanyl 1–3 micrograms/kg, in haemodynamically stable patients			
☐ Have sugammadex available when rocuronium is used			
During · Induction			
☐ Give the induction agent followed immediately by the neuromuscular blocker and flush			
☐ Apply cricoid pressure only if your local practice uses it, and release it if it impairs the view or mask ventilation			



A drafted procedure checklist, awaiting senior review. Perform procedures only within your training, competence and local policy. It does not replace your clinical judgement.

EM Orbit · Emergency medicine, in one orbit · proc-rsi · red rows are the steps that must not be missed

