Delayed Sequence Intubation

PROCEDURE

STEPS

1. Prepare equipment; assess the patient (look externally, 3:2:2 rule, Mallampati, obstruction, neck mobility); position
2. Ensure at least 1 secure, running IV; pulse oximetry, capnography, cardiac monitor; assign duties (BVM, cricoid, pulse ox); coach
3. Preoxygenate: NRB with nasal cannula on high flow, CPAP, or BVM
4. Give ketamine 1 mg/kg — preferred: it will not blunt respirations or airway reflexes and allows preoxygenation
5. Improved: let the sedation wear off, reassess, and continue current oxygenation — or proceed if the patient declines again
6. Not improved: paralyze with rocuronium 1.5 mg/kg and intubate
7. Confirm the tube: capnography, direct visualization, vapor in the ETT, SpO2, auscultation, chest rise
8. Post-intubation sedation: fentanyl 50–100 mcg, Versed 2.5–5 mg, ketamine 0.5 mg/kg — frequent doses preferred over re-paralyzation (rocuronium 0.3 mg/kg)

BEFORE YOU START

- Indications: procedural sedation for oxygenation; patient remains hypoxic (<90%) despite attempts to oxygenate
- Impending respiratory failure; combative patients with compromised airway; agitation/anxiety with oxygenation attempts
- Absolute contraindications: cricothyrotomy would be impossible; massive neck trauma/swelling
- Impossible to intubate or ventilate; epiglottitis / upper airway obstruction
- Relative: benefit vs risk; hypersensitivity to medications

KIT YOU NEED

- NRB and nasal cannula (high flow), CPAP or BVM
- Pulse oximetry, capnography, cardiac monitor; secure IV
- Ketamine, rocuronium, fentanyl, Versed

IF IT GOES WRONG

- Respiratory status has NOT improved after oxygenation: proceed with the paralytic and continue to intubation, per the page's pathway

Take Home Message:

DSI buys oxygenation before the tube: ketamine first, reassess honestly, and only paralyze when oxygenation still isn't working.