Local Extubation Pathway After RSI for Status Epilepticus

Refer EARLY to KIDSNTS for advice - 0300 200 1100

Status epilepticus (SE) is a common paediatric emergency that may require RSI and intubation. Once seizures are controlled, most children can be safely extubated locally, avoiding the risks of transfer, prolonged ventilation, family disruption and resource utilisation.

RSI for Status Epilepticus

Aim local extubation if *all* the below conditions are met:

- Normal, uncomplicated airway
- Minimal ventilatory requirements
- Haemodynamically stable without significant support
- CT head done (if indicated):no acute changes
- Well controlled seizures
- No signs of raised ICP
- No indications for neuroprotection
- No preceding encephalopathy
- No immediate surgical intervention required
- Any significant electrolyte or metabolic abnormalities corrected
- Appropriate staff and location for post-extubation care

Stop **ALL** sedation
Aim to assess for extubation within 1 hour

Assess

Airway
- Intact airway protective reflexes (cough & gag)
- No concerns about difficult airway or OSA

Breathing
- Good spontaneous respiratory drive
- End-tidal co_2 normal for age
- Minimal ventilator settings
- Acceptable blood gas (normal pH, CO_2, lactate)

Circulation
- Haemodynamically stable and not requiring inotropic support

Disability
- Seizures terminated
- No focal neurology
- Waking and responding appropriately
- Normal pupillary reactions
- Purposeful movements with normal posture

Exposure
- No signs of septic shock

Normal assessment?

Extubate locally
- Regular neuromonitoring
- Admit to ensure appropriately monitored in ward environment
- Adequate GCS >10/15 & improving
- Check blood gas post extubation

If patient is ***not neurologically*** appropriate at 1 hour allow **further time** to recover and **reassess.** Discuss with KIDSNTS team

Local extubation relatively contraindicated Discuss further with KIDSNTS team :

- Difficult airway
- Significant CXR changes or ventilatory support needed
- Ongoing seizures
- CT head changes (trauma, blocked VP shunt, SOL, cerebral oedema, bleeding, etc)
- Suspected metabolic disorder
- Focal deficit, abnormal pupillary reaction or posturing on sedation hold
- Signs of raised ICP
- Any other immediate surgical interventions warranted

Call KIDSNTS team for further discussions regarding transport & bed availability

- Ensure NG tube insertion and placed on free drainage
- CXR to confirm ET tube and NGT position
- Post intubation gas
- Prepare sedation & paralysis infusions as per the KIDS calculator (Morphine+Midazolam+ Rocuronium)
- Urinary catheter
- Ensure neuroprotection if indicated

Author - VG/RN- Mar '26. Review Mar '30.