

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	8830.06
	<u>PROGRAM DOCUMENT:</u> Supraglottic Airway (King® Tube or i-Gel®) Paramedic Skill Only	Initial Date:	02/18/09
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Signature on File

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EMS Medical Director

EMS Administrator

Purpose:

- A. To serve as the emergency medical services (EMS) system standard for the establishment of a supraglottic airway.
- B. To describe the situations where a supraglottic airway device may be established.

Authority:

- A. California Code of Regulations, Title 22, Division 9
- B. California Health and Safety Code, Division 2.5

Indications:

- A. As a secondary advanced airway device after failure of OTI, in respiratory failure in an unconscious patient, age ≥ 8.
- B. As a primary advanced airway in cardiac arrest airway management, for age ≥ 8.
- C. As per Respiratory Distress: Airway Management Policy PD# 8020 and Pediatric Respiratory Distress: Reactive Airway Disease, Asthma, Bronchospasm, Croup, or Stridor PD# 9003.

Approved Superglottic Airway Devices:

- A. King ®Tube
- B. I-Gel®

Contraindications:

- A. Responsive patients with intact gag reflex
- B. Patients with known esophageal disease
- C. Ingestion of caustic substance
- D. Difficulty in advancing the King® tube or i-Gel® due to resistance upon insertion attempt
- E. Presence of tracheostomy or stoma
- F. Burns involving the airway
- G. Patient height less than 4 feet for King® Tube.
- H. Foreign body airway obstruction

Relative Contraindications:

- A. Anatomical disruption of the oropharynx

Procedure:

King Tube

- A. Inflate cuff to test for leaks
- B. Deflate cuff
- C. Lubricate King® tube with water-soluble lubricant
- D. Ensure gag reflex is not intact
- E. Place patient's head in sniffing or neutral position. Maintain cervical spinal precautions if indicated
- F. With the King® tube rotated laterally 45-90 degrees such that the blue orientation line is touching the corner of the mouth, introduce tip into mouth and advance behind base of the tongue. Never force the tube into position
- G. Advance the tip behind the base of the tongue while rotating tube back to midline so that the blue orientation line faces the chin of the patient
- H. Advance tube until base of connector aligns with teeth or gums
- I. Fully inflate cuff using manufacturers guidelines
- J. Confirm placement by auscultating bilateral breath sounds and end tidal CO2 detector. Response to confirmation may be slower than endotracheal intubation
- K. Secure the tube using approved device and ventilate with a BVM and 100% oxygen.
- L. The tube's position shall be reevaluated after moving the patient
- M. No medication is administrated through the supraglottic device

I-Gel

- A. Lubricate i-gel® with manufacture lubricant
- B. Ensure gag reflex is not intact
- C. Place patient's head in sniffing or neutral position. Maintain cervical spinal precautions if indicated
- D. Introduce i-gel into mouth and advance behind base of the tongue. Never force the tube into position
- E. Advance tube until base of connector aligns with teeth or gums
- F. Confirm placement by auscultating bilateral breath sounds and end tidal CO2 detector. Response to confirmation may be slower than endotracheal intubation
- G. Secure the tube using approved device and ventilate with a BVM and 100% oxygen.
- H. The tube's position shall be reevaluated after moving the patient
- I. No medication is administrated through the supraglottic device

Potential Complications:

- A. Subcutaneous emphysema
- B. Perforated trachea or esophagus
- C. Retropharyngeal perforation

Precautions and Special Considerations:

- A. Emergency Removal:

In situations where patient combativeness makes continued intubation with a supraglottic airway device dangerous, presence of a gag reflex or inadequate ventilation with the supraglottic device, the tube may be removed.

- 1. Have suction and BVM for assisted ventilations

2. Position patient to minimize risk of aspiration
3. Deflate cuff
4. Remove tube
5. Suction and assist ventilations as necessary

B. Airway Management:

The Paramedic is responsible for all airway management and must frequently reassess advanced airway placement. Bilateral breath sounds are to be checked after each move of the patient, e.g. placing patient on gurney, moving patient to ambulance, loading patient into ambulance and unloading patient at the hospital.

Cross Reference:	Respiratory Distress: Airway Management Policy	PD# 8020
	Pediatric Respiratory Distress: Reactive Airway Disease, Asthma, Bronchospasm, Croup, or Stridor	PD# 9003