	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	8830.07
	PROGRAM DOCUMENT: **Supraglottic Airway i-Gel®**	Initial Date:	02/18/09
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Signature on File	Signature on File
EMS Medical Director	EMS Administrator

Purpose:

A. To establish 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:
Paramedic

A. As a secondary advanced airway device for paramedics after failure of OTI, in respiratory failure in an unconscious patient, age ≥ 8 unless age not known, and then only children who meet or exceed the GREEN length on Handtevy or Broselow length based tapes.
B. As an advanced airway device when non-invasive airway management is inadequate, age 15 and above
C. As a preferred advanced airway for paramedics in cardiac arrest airway management, for age ≥ 8 unless age not known, and then only children who meet or exceed the GREEN length on Handtevy or Broselow length based tapes.
D. As per Respiratory Distress: Airway Management Policy PD# 8020 and Pediatric Respiratory Distress: Reactive Airway Disease, Asthma, Bronchospasms, Croup, or Stridor PD# 9003

EMT

A. As an advanced airway for EMT's in cardiac arrest management, for age ≥ fifteen (15).

Approved Superglottic Airway Devices:

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 i-Gel® due to resistance upon insertion attempt
E. Presence of tracheostomy or stoma
F. Burns involving the airway
G. Foreign body airway obstruction

Relative Contraindications:

A. Anatomical disruption of the oropharynx.

Procedure:

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 spinal motion restriction 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. Remove tube
4. Suction and assist ventilations as necessary

B. Airway Management:

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