# Supraglottic Airway Device

## BLS

Universal Protocol #601
Pulse Oximetry – $O_2$ administration per Airway Management Protocol #602

- Optional skills as approved by SLOEMSA

## ALS

- Patients who meet indications for **Endotracheal Intubation Procedure #717**
- ALS provider judgement.

## I-GEL

- Monitor End-tidal capnography throughout use.
- Select appropriate tube size.

| Description | Size | Weight Range | Colour |
|---|---|---|---|
| I-Gel supraglottic airway, large adult | 5 | 90+ kg | Orange |
| I-Gel supraglottic airway, medium adult | 4 | 50 - 90 kg | Green |
| I-Gel supraglottic airway, small adult | 3 | 30 - 60 kg | Yellow |
| I-Gel supraglottic airway, large paediatric | 2.5 | 25 - 35 kg | White |
| I-Gel supraglottic airway, small paediatric | 2 | 10 - 25 kg | Grey |
| I-Gel supraglottic airway, infant | 1.5 | 5 - 12 kg | Light Blue |
| I-Gel supraglottic airway, neonate | 1 | 2 - 5 kg | Pink |

- While preparing tube, have assistive personnel open the airway, and clear of any foreign objects. Pre-oxygenate with 100% oxygen via BLS airway and BVM.
- Apply water soluble lubricant to the distal tip and posterior aspect (only) of the tube, taking care to avoid introduction of the lubricant into or near the ventilatory openings.
- Grasp the lubricated i-Gel firmly along the integral bite block. Position the device so that the i-Gel cuff outlet is facing towards the chin of the patient.
- Position patient into “sniffing position” with head extended and neck flexed. The chin should
- be gently pressed down before proceeding to insert the i-Gel.
- For *pediatrics* consider padding under the shoulders.
- Introduce the leading soft tip into the mouth of the patient in the direction towards the hard palate.
- Glide the device downwards and backwards along the hard palate with a continuous but gentle push until a definitive resistance is felt.
- At this point the tip of the airway should be located into the upper esophageal opening and the cuff should be located against the laryngeal framework. The incisors should be resting on the integral bite-block.
- Attach a BVM. While gently bagging the patient to assess ventilation, carefully withdraw the airway until ventilation is easy and free flowing (large tidal volume with minimal airway pressure).
- Confirm proper position by auscultation, chest movement and verification of ETCO2 by waveform capnography.
- The i-Gel should be secured down per manufacturer recommendation.

- Patients who have an advanced airway established shall have that airway secured with tape or a commercial device. Devices and tape should be applied in a manner that avoids compression of the front and sides of the neck, which may impair venous return from the brain.
- Ensure proper documentation of placement of the i-Gel placement including verification methods.

**Base Hospital Orders Only**

As needed

**Notes**

**Contraindications**

•Gag reflex. •Caustic ingestion. •Known esophageal disease (e.g., cancer, varices, or stricture).

- SGA during cardiac arrest is indicated.
- Once an SGA has been placed, it should not be removed for an ETI.
- If the provider cannot accomplish an ALS airway, they should document in the PCR why an ALS airway wasn't accomplished.
- To verify patency and placement of the SGA Device, providers shall verify placement of the i-Gel device by waveform capnography and a minimum of one additional method. This additional method can be any of the following:
  - Auscultation of lung sounds
  - Colorimetric CO2 Detector Device
  - Esophageal Bulb Detection Device
- During placement of an SGA, apneic oxygenation is recommended to be utilized when available. If appropriate, providers shall place a nasal cannula onto the patient prior to i-Gel placement and continue use of the nasal cannula during placement in order to assist in oxygenation.
- Powered suction is the preferred method of suction while maintaining SGA patency when presented with oral secretions, vomitus, etc.
- When utilizing flexible suction catheter for direct suction do not insert past the end of the device to prevent potential gastric suctioning.
- Suctioning of Supraglottic Airway Devices should be intermittent – suction shall not be attached to airway devices for continuous suction purposes.