Subject: Scope of Practice/Procedure – ALS
Supraglottic Airway Device (SAD) – i-GEL^{02}Airway

Associated Policies:

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

II. Purpose:
The purpose of this policy is to define training standards, criteria, and procedures for the use of the supraglottic airway device (SAD) – i-GEL^{02}Airway.

III. Indications:
   A. Inability to secure an endotracheal tube in a patient who does not have a gag reflex with inadequate or absent respirations.
   B. Appropriate intubation is impossible due to patient access or difficult airway anatomy.
   C. Use for pediatric patients when BVM is not adequate.

IV. Contraindications:
   A. Intact gag reflex.
   B. Esophageal burns from caustics.
   C. Complete airway obstruction.
   D. Trismus
   E. Distorted anatomy preventing placement,
   F. Adequate BVM ventilations.
   G. Esophageal disease.

V. Complications:
   A. Airway trauma
   B. Regurgitation
   C. Aspiration
   D. Direct trauma to the esophagus.

VI. Equipment:
   A. Appropriately sized SAD.
   B. Water based lubricant.
   C. Suction device.
   D. Securing device for SAD.
   E. Bag value mask
   F. Stethoscope
   G. Pulse oximetry device
   H. End Tidal CO2 capnography/colorimetric device***.

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VII. Procedure:
- A. Assure patent airway.
- B. Apply monitor (ECG) and pulse oximetry.
- C. Pre-oxygenate with 100% oxygen.
- D. Apply chin life and introduce the SAD into the mouth.
- E. Attach BVM and ventilate.
- F. Assess lung sounds and secure the device.
- G. Connect the ETCO2 device and pulse oximetry and monitor throughout transport.

VIII. Documentation on ePCR:
- A. Time of insertion.
- B. Reason for device use (Failed intubation, unable to ventilate via BVM, etc).
- C. Successful or unsuccessful placement and number of attempts.
- D. Complications including dislodgement, hypoxia, bleeding/trauma or vomiting.
- E. If dislodgement occurs, was there successful replacement.

*** Please note: As of January 1, 2020, any I-GEL placement of a pediatric patient must be confirmed via waveform capnography.