CCEMSA Fresno Kings Madera Tulare

Central California Emergency Medical Services Agency

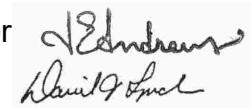
A Division of Fresno County
Department of Public Health

SPECIAL MEMORANDUM

FILE #: F/K/M/T #02-2020

TO: All Fresno/Kings/Madera/Tulare EMS Providers, Hospitals, First Responder Agencies, and Interested Parties

FROM: Jim Andrews, M.D., EMS Medical Director
Daniel J. Lynch, Director



DATE: April 7, 2020

SUBJECT: Suspension of Endotracheal Intubation

To limit the possible droplet exposure to COVID-19, effective immediately, the use of endotracheal intubation has been **SUSPENDED UNTIL FURTHER NOTICE**.

In addition to the King Airway (King LT(S)-D), the i-gel Supraglottic Airway has been approved for use as an advanced life support airway in Fresno, Kings, Madera, and Tulare Counties. It is the intent of CCEMSA to replace the King Airway with the i-gel over the coming months. Attached are general procedures for the use of i-gel which will replace the King Airway in Policy 530.02.

It is the recommendation of the EMS Agency for providers to either use up their supply of current King Airway devices or have them exchanged for the i-gel Supraglottic Airway with their vendor(s).

In addition, the EMS Agency advises all providers to make sure that proper technique along with a good seal is acquired when ventilating a patient using a bag valve mask to limit the possible droplet exposure to COVID-19.

Please contact Mato Parker, EMS Coordinator at (559) 600-3387 if you have any questions.

JA:DJL:mkp

VII. i-gel Supraglottic Airway

A. Indications:

The i-gel Supraglottic Airway is performed only on a patient who meets all of the following:

1. Unconscious (no purposeful movement), with an absent gag reflex.
2. Apneic or agonal respirations less than 8 per minute.
3. Appears to be at least 5 feet tall.

B. Contraindications:

1. Patients under 5 feet tall.
2. Suspected caustic ingestion.
3. Suspected narcotic overdose, until after the administration of Naloxone.
4. Laryngectomy or tracheal stoma.

C. Procedure:

1. Use in-line immobilization if a C-spine injury is suspected.
2. Have suction equipment immediately available.
3. Prior to placing the i-gel Supraglottic Airway, hyperventilate the patient with 100% oxygen for a minimum of one minute, if possible.
4. Do not interrupt ventilation for more than 20 seconds while inserting the airway. If unable to insert and ventilate in 20 seconds or less, stop, hyperventilate and reattempt. Lubricate the gel-filled cuff on all sides with H_2O soluble lubricant.
5. Insert tube and advance until a definitive resistance is felt. Do not use excessive force. Sniffing position is the optimum position.
6. If unsuccessful, ventilate for one minute before trying again.
7. Do not make more than two (2) attempts total per patient to establish an i-gel Supraglottic Airway. If BVM ventilations cannot be adequately performed, a third attempt of the i-gel Supraglottic Airway would be appropriate prior to the use of the TTJI.

8. The i-gel Supraglottic Airway has a horizontal line to indicate optimal position of the teeth.

9. Check for proper placement:

    a. Check adequacy of breath sounds.

    b. Check absence of epigastric air entry.

    c. End-Tidal CO_2 Detector (for patients that are mechanically ventilated, *with or without* a pulse, i-gel/trach, and BVM).

        NOTE: THIS DEVICE IS TO BE USED AS AN ADJUNCT TO ASSESS I-GEL SUPRAGLOTTIC AIRWAY PLACEMENT. ITS PURPOSE IS NOT TO ELIMINATE CLINICAL JUDGMENT.

    d. Assess chest rise.

    e. Reassess the placement of i-gel Supraglottic Airway every time the patient is moved.

10. Secure the i-gel Supraglottic Airway as soon as possible.

11. After placement, ventilate with bag-valve and 15 liters/minute of oxygen with reservoir.