CENTRAL CALIFORNIA
EMERGENCY MEDICAL SERVICES
A Division of the Fresno County Department of Public Health

Manual:	Emergency Medical Services Administrative Policies and Procedures	Policy Number: 510.37 Page: 1 of 3
Subject:	Basic Life Support (BLS) Protocols **SUPRAGLOTTIC AIRWAY**	
References:	California Administrative Code, Title 22, Division 9, Chapter 3.1	Effective: 07/01/2026

I. PURPOSE

A. To establish the standard for the Optional Scope of Practice for EMT Supraglottic Airway Placement in the Central California EMS Agency.

II. POLICY

1. Only EMTs employed by an agency that has received approval for Optional Scope of Practice for EMT Supraglottic Airway Placement by CCEMSA may use this protocol.
2. An electronic patient care record that meets CCEMSA Policy # 811 must be completed by the provider performing the procedure.
3. Emergency Medical Technicians must meet the following requirements to maintain the optional scope of practice for supraglottic airway insertion:
   a. 5 hours of initial training in accordance with Title 22 and approved by the EMS Agency.
   b. Completion of the CCEMSA competency based written and skills examination on the use of supraglottic airway devices and basic airway equipment.
   c. Additional refresher and skills competency demonstration every 2 years.
4. Documentation of initial and ongoing training and skills competency must be maintained by the ambulance provider and available to the EMS Agency upon request.
5. The placement of supraglottic airways by Emergency Medical Technicians is limited to the following category of patients:
   a. Adult patients ≥ 15 years of age in cardiac arrest.
6. The following supraglottic airway devices are approved for use:
   a. i-gel®

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7. Contraindications for Supraglottic Airway insertion:
    a. Intact gag reflex.
    b. Trismus or inability to open the mouth.
    c. Complete airway obstruction (i.e. Foreign body, severe edema, tumor).
    d. Laryngectomy or tracheal stoma.
    e. Caustic ingestion or burns involving the airway.
    f. Significant oropharyngeal trauma.

8. Two attempts at supraglottic airway placement are permissible. Ventilations should be interrupted no more than 10 seconds per attempt.

III. PROCEDURE

1. The priority in medical cardiac arrest is high quality chest compressions and defibrillation. **The supraglottic airway should NEVER be placed prior to initiating chest compressions or AED analysis.** Chest compressions should never be paused to place the supraglottic airway.

2. Airway obstruction is an absolute contraindication to the use of a supraglottic airway. Prior to placement, confirm that the patient can be ventilated with a bag valve mask and begin preoxygenating the patient.

3. Estimate the patient's weight and select appropriate size i-gel

Tube Size	Patient Size	Patient Weight
3	Small Adult	30-60 kg
4	Medium Adult	50-90 kg
5	Large Adult	90+ kg

4. Suction airway as needed. Remove dentures, if present.

5. Lubricate the back of the supraglottic airway with water-based lubricant taking special care to avoid the lumen of the tube.

6. Place the head in a sniffing or neutral position. Maintain spinal motion restriction, if indicated.

7. Introduce the device into the mouth and advance the tip of the device along the hard and soft palate with a continuous but gentle pressure.

8. A slight give-way resistance may be felt during insertion as the device passes into the oropharynx. It is important to continue to insert the device until definitive resistance is felt. Do not apply excessive force on the device during insertion.

9. The i-gel integral bite block has a horizontal line to indicate optimal position of the tube in relation to the teeth.

10. Confirm placement with all the following:
    a. Auscultate breath sounds
    b. Evaluate for chest rise
    c. Continuous waveform capnography should be applied immediately when available

11. If there is any concern about proper placement, remove the device and ventilate with BVM for one minute. Do not make more than two attempts to establish an i-gel.

12. Secure the tube using the manufacturer included strap and ventilate with a BVM and 100% O_2.

13. The device position should be reevaluated frequently and at minimum:
    a. Every time the patient is moved.
    b. When there is a change in patient status.
    c. When there is difficulty ventilating the patient.

14. If there is a change in patient status after placement of the supraglottic device and continued ventilation using a supraglottic airway is no longer possible (i.e. patient combativeness, ineffective ventilation, intact gag

reflex), the device should be removed. Be prepared to suction the patient on removal and assist ventilations with BVM as appropriate.

15. Supraglottic airway insertion is to be documented in the electronic Patient Care Record and must include the following:

    a. Name of individual performing the procedure.
    b. Size of device used.
    c. Technique(s) used to confirm placement.
    d. Complications, if any.