



<b>Performance Standard</b>		<b>7313</b>
Effective <b>April 1, 2018</b>	Expires <b>March 31, 2019</b>	
Category I Skill – Low Frequency/High Risk: <b>King Airway</b>	Approval: Medical Director <b>Reza Vaezazizi, MD</b>	Signed
Applies To: <b>AEMT, PM, MICN, BHP, EMS System</b>	Approval: REMSA Director <b>Bruce Barton</b>	Signed

**PURPOSE**

This performance standard is intended to be supplemental to the Performance Standard for Rescue Airway Insertion and delineates specific criteria based upon the manufacturer’s recommendations for use of the King Airway.

**Terminal Performance Objective**

Secure placement of the King Tube to facilitate positive pressure ventilation.

**Before performing insertion of a Rescue Airway, AEMTs and paramedics must:**

1. Determine BLS airway adjuncts are inadequate for effective positive pressure ventilation (PPV) and confirm the need for ALS airway placement.
2. Recognize signs of a difficult airway and select, prepare and employ the appropriate rescue airway and techniques.
  - a. A difficult airway is defined as the presence of anatomic conditions which preclude direct visualization of the patient’s glottic opening (e.g. airway edema, arthritis, scoliosis of the spine, significant overbite, small mandible, short neck, morbid obesity, cervical spine immobilization, face or neck trauma).
3. Correctly assemble all equipment required for rescue airway insertion within 60 seconds.
4. Ensure optimal ventilation and oxygenation of the patient while rescue airway equipment is prepared.

**Procedure**

1. The King Airway is an alternate airway for use by properly trained AEMTs and paramedics in Riverside County, when the placement of an ET tube is not possible or not prudent.
2. Each first response agency, or combined first response and transport agency, or EMS transport service, as required by the REMSA Drug and Equipment List, must stock all three sizes for appropriate patient fit, based on patient height:

4 ft - 5 ft	-	Size 3 (yellow cap)
5 ft - 6 ft	-	Size 4 (red cap)
Over 6 ft	-	Size 5 (purple cap)

3. Indications for use of this airway:
  - a. Unresponsive patients without a gag reflex **and**
  - b. Adjunctive airway protection and positive pressure ventilation is required **and**
  - c. Airway protection and/or positive pressure ventilation is inadequate or ineffective by BLS means

**Note: When all of the above indications are met and signs of difficult intubation are present, the King Airway should be considered as the initial ALS airway adjunct.**

4. Contraindications for use include patients with:
  - a. an intact gag reflex
  - b. known esophageal disease
  - c. probable ingestion of caustic substance(s)

5. Procedure for insertion:
  - a. Select the proper tube size.
  - b. While preparing tube, have assistive personnel open the airway, and clear of any foreign objects. Pre-oxygenate with 100% oxygen.
  - c. Test cuff inflation system by injecting the maximum recommended volume of air into the cuffs (size 3 – 60 mL; size 4 – 80 mL; size 5 – 90 mL). Remove all air from both cuffs prior to insertion.
  - d. 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.
  - e. Position patient into “sniffing position” if possible, otherwise head may be in a neutral position.
  - f. Hold the tube at the colored connector with the dominant hand. With the non-dominant hand, hold open the patient’s mouth and apply a tongue-jaw lift (thumb into oral cavity, index finger under chin).
  - g. Rotate the tube 90° laterally, so that the blue orientation/x-ray line on the inside curve of the airway is touching the outer corner of the mouth, with the tube curving out.
  - h. While advancing the tip of the tube across the tongue to its base, rotate the tube an additional 90° back to midline, so that the blue orientation line now faces the chin.
  - i. Without exerting excessive force, advance the tube until the base of the connector is aligned with the teeth or gums. Be sure to maintain the tip of the tube midline so as to advance it into the upper esophagus and not into the piriform fossa (blind pocket).
  - j. Using a syringe, inflate the cuffs with the minimum volume necessary to seal the airway at the peak ventilatory pressure employed (“just seal” volume). Typical inflation volumes are as follows:
    - Size 3: 45-50 mL
    - Size 4: 60-70 mL
    - Size 5: 70-80 mL
  - k. 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).
  - l. Confirm proper position by auscultation, chest movement and verification of CO<sub>2</sub> by waveform capnography (paramedics). CO<sub>2</sub> monitoring device shall remain in place for continuous monitoring.
    - i. If the waveform capnography monitor malfunctions, a colorimetric CO<sub>2</sub> detector shall be used, and the malfunction reported to the organization’s QI Coordinator.
6. Readjust cuff inflation to new “just seal” volume, taking care not to exceed maximum cuff volume - 60 mL, 80 mL, 90 mL (see 5c above).
7. Stabilize the patient’s airway and prevent tube migration by using a device to prevent rotation, flexion, or extension of patient’s head.
8. Document time of placement, recording the final volume of air used and the depth markings (cm) on the tube.
9. Procedure for removal:

Removal of the airway in the field will only occur if the airway malfunctions or the patient’s condition changes so as to make an airway adjunct unnecessary (ex - a deeply hypoglycemic patient becomes conscious).

  - a. Have suction and additional intubation equipment ready.
  - b. Deflate tube cuffs completely.
  - c. Remove in a smooth, swift motion.
  - d. Reassess the patient’s airway to ensure it is protected.
  - e. Ensure the patient has adequate minute volume and apply supplemental oxygen as needed.
  - f. Record time, reason for tube removal, and how removal was tolerated by the patient.
10. As part of the quality assurance process, all placements or attempted placements of a King Airway will be documented on the patient care report (PCR) / electronic patient care report (ePCR). The PCR/ePCR will be submitted to the AEMT or paramedic’s QI coordinator for internal review. The QI coordinator will then forward the PCR/ePCR to the EMS Agency.