REQUEST FOR APPROVAL of UNDEFINED SCOPE OF PRACTICE

Check One: X **Local Optional Scope of Practice** ☐ **Trial Study**

EMS Medical Director: _____ **Date:** _____

Local EMS Agency: _____

Proposed Procedure or Medication: Supraglottic Airway Device

Please provide the following information. For information provided, check "yes" and describe. For information not provided, check "no" and state the reason it is not provided.

Yes	No	
X	☐	**1. Description of the procedure or medication requested:** Use of a Supraglottic Airway Device to assit in oxygenation and ventilation of appropriately selected patients
X	☐	**2. Description of the medical conditions for which the procedure/medication will be utilized:** Obtunded patients suffering medical or traumatic emergencies
X	☐	**3. Patient population that will benefit:** Adult and Pediatric obtunded patients with absent gag reflex unable to maintain oxygenation, ventilation and/or airway protection
☐	X	**4. Description of proposed study design including the scope of the study, research question, method of evaluating the effectiveness of the procedures or medications and the expected outcome.** This is not a study, nor a research question.
X	☐	**5. Alternatives (Please describe any alternate therapy(ies) considered for the same conditions and any advantages and disadvantages.** Endotracheal intubation or BVM ventilation. In pediatric patients, ETI is not an option starting in 2018, and perilaryngeal airways are not available in pediatric sizes. Perilaryngeal airways are implicated in diminished cardiac survival.
X	☐	**6. Estimated frequency of utilization:** ☐ <10 cases/year ☐ 11 - 25 cases/year ☐ 26-50 cases/year ☐ 51-100 cases/year ☐ >100 cases/year
☐	X	**7. Other factors or exceptional circumstances:**

Please attach the following documents. Check "yes" for each document attached; for documents not attached, check "no" and state the reason it is not attached.

Yes	No	
X	☐	**8. Any supporting data, including relevant studies and medical literature:**

1. "Higher insertion success with iGel in out of hospital Cardiac arrests", *Resuscitation* 2014; 85(7): 893-7. 2. "A comparison of three supraglottic airway used by healthcare professionals during pediatric resuscitation", *Emerg Med J*, 2013; 30(9): 754-7. 3. "Emergency airway management by paramedics: comparison between ETI, LMA and iGel" *Eur J Emerg Med*, 2014 Oct; 21(5): 371-3. 4. "Performance of iGel during pre-hospital cardiopulmonary resuscitation", *Resuscitation*; 2013; 84(9): 1229-32.

X	☐	**9. Recommended policies/procedures to be instituted regarding:**
X	☐	**Use**
X	☐	**Medical Control**
X	☐	**Treatment Protocols**
X	☐	**Quality assurance of the procedure or medication**
X	☐	**10. Description of the training and competency testing required to implement the procedure or medication:**

Refer to attached "SAD Competency Evaluation" form. Training is device specific.

X	☐	**11. Copy of the local EMS System Evaluation and Quality Improvement Program plan for this request:**

See attached documentation (LEMSA specific)

☐	X	**12. Make up of local medical advisory committee, appointed by the medical director, to assist with the evaluation of the trial study:**