Centre for Prehospital Care
Health Sciences North

STANDARD WORK

KING LARYNGEAL TUBE (LT) INSERTION

Document Owner:	E. Levasseur	**Program/Service Area**:	Centre for Prehospital Care	**Issue Date:** April 2009
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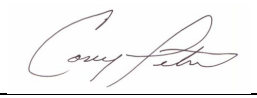
Approval:	Chair, CPC Program Council : Corey Petrie		**Frequency:** As required, in accordance with the Supraglottic Airway Medical Directive.	
Signature:				

Purpose: To ensure a consistent standardized practice for performing King LT insertion.

	Content	Details
1.	Ensure that the patient qualifies for King LT insertion or contact a Base Hospital Physician (BHP) for further direction.	
2.	Communicate the need for King LT insertion, and its effects to the family member whenever possible.	
3.	Wear appropriate PPE & attempt basic manoeuvres as needed: positioning, suctioning, pharyngeal airway insertion, and BVM with Intermittent Positive Pressure Ventilations (IPPV) in addition to application to high-flow high-concentration oxygen. Initiate cardiac monitoring and pulse oximetry (if available).	
4.	Pre oxygenate the patient for 30-60 seconds with high-flow high-concentration oxygen (and IPPV, if required).	
5.	Choose the appropriate size King LT airway based on the patient's height. Inflate and test the cuff for integrity then lubricate only the posterior portion of the tube.	Ensure that the posterior portion only is lubricated. Keep lubricant away from the anterior portion.
6.	Maintain the head tilt chin lift or modified jaw thrust if appropriate.	
7.	Insert the King LT laterally into the corner of the mouth. Advance the tip of the tube under the base of the tongue, while rotating the tube back towards the midline.	
8.	Advance the tube until the base of the connector is aligned with the teeth or gums.	Vigilance during the insertion must be exercised. If resistance is met, withdraw the Airway
9.	Inflate the tube cuffs with the appropriate amount of air. See airway for required amount	

	Content	Details
10.	Ventilate the patient with the BVM; confirm placement via End-Tidal CO2 or in its absence, a 5 point auscultation starting over the epigastrium and chest rise. If air entry is inadequate, the tube might be in too far. Slowly pull back the tube until adequate ventilation is achieved. Recheck pilot balloon for adequacy of air. Note centimetre marking at the teeth or gums. Reconfirm using 5 point auscultation and secure using a tube tie, tape or holder.	
11.	If the King LT placement is unsuccessful after 30 seconds, stop and re-oxygenate. The paramedic may re-attempt insertion beginning at procedure 2 (to a maximum of 2 attempts per patient) and/or initiate immediate transport.	
12.	**Primary Care Paramedics (PCP)**: If a second attempt fails, revert to BVM/pharyngeal airway management. **Advanced Care Paramedics (ACP)**: If a second attempt fails, revert to BVM/pharyngeal airway management or follow endotracheal intubation directive or other advanced airway directive.	
13.	If the patient regurgitates or vomits, deflate the cuffs, turn the head to the side (if no spinal trauma suspected), remove the King LT, suction the airway and either reinsert or manage the airway by alternate means according to paramedic skill level.	
14.	If using a LTS-D model and stomach contents appear within the gastric access lumen, utilize a suction catheter and remove contents.	
15.	Document the procedure on the patient care record as per the Ministry of Health and Long Term Care Emergency Health Services Branch Ambulance Call Report Documentation Standards and your Service Provider policy which includes: • time of attempt • associated equipment used • complications • reasoning for insertion	
16.	Document patient condition before and after King LT insertion.	

Expected Outcome: Successfully performs King Laryngeal Tube (LT) insertion.