



## MetroHealth Guidelines for Non-Emergent Tracheostomy during the COVID-19 Pandemic

**Consideration for tracheostomy is to be determined by the primary team caring for the patient.**

Contact Acute Care Surgery (ACS) or ENT to assess patient for possible tracheostomy. ACS should be consulted if other potential procedures such as lines or enteral access are needed/requested at the same time.

### **Contacts:**

Acute Care Surgery (ACS): (pager 207-6348 or the attending on-call)

Otolaryngology (ENT): (pager 207-0224)

If the patient needs other invasive procedures *such as* enteral access, wound-care issues, alternate IV/arterial access, these can be timed to coordinate with the tracheostomy (if patient status allows) and should be on the consent form prior to the day of surgery. These other procedures should be clearly communicated between primary team and ACS team.

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Based on Infection Control recommendations, all patients who will undergo non-emergent tracheostomy will be tested for Covid-19

No *non-emergent* tracheostomy will be performed while Covid-19 status is pending (will await test results before proceeding).

- 1) **Confirmed or suspected COVID positive patients**
  - a) In general, will defer the tracheostomy until at least 14 days from onset of symptoms.
  - b) Consult prior to 14 days acceptable for proper OR scheduling/preparations to be arranged.
  - c) Standard assessment will be performed for medical and pulmonary stability for the surgical procedure (including the degree of ventilator support required)
  - d) Timing of tracheostomy to be determined by primary team together with the ACS team or ENT
  - e) The procedure will be performed in the “COVID OR” (currently OR 14 – subject to change)
  - f) Full COVID PPE precautions instituted (including N95 mask; see Metro OR hospital policy)
  
- 2) **Confirmed COVID negative patients**
  - a) Perform open tracheostomy in a standard operating room
  - b) Timing to be based on patient needs and team availability as well as availability of hospital resources
  - c) Surgical team (including anesthesia, nurses, techs) to **wear normal PPE**



### Standardized Tracheostomy Procedure for Covid Positive Patients\*\*\*

- 1) “Open” tracheostomy to be done in the operating room (subject to change with emerging data)
- 2) Advance ETT so the tip is just above carina (ETT balloon to be distal to surgical site)
  - a) Consider endotracheal tube positioning preoperatively in the unit and confirm location with chest x-ray
  - b) If endotracheal tube positioning is done in the OR: hold ventilation while repositioning the ET tube; verify equal breath sounds to minimize change of right main stem progression
- 3) The patient is positioned for tracheostomy in the standard position, and patient should be preoxygenated well before surgical start. In general, avoid circuit disconnections and suction via closed circuit.
- 4) The trachea is exposed to allow for tracheotomy. Minimize any cautery, especially monopolar cautery. **Do not deflate the balloon.** All stay sutures and incisions can be safely placed without needing to deflate the balloon as it should be safely below the 3<sup>rd</sup> - 4<sup>th</sup> tracheal ring. This will minimize aerosolization of respiratory particles freely into operating room\*.
- 5) Make tracheotomy in the standard fashion while keeping balloon inflated \*\*
- 6) **Stop respirations**, deflate the balloon and have anesthesia retract the ET tube to above the level of the opening in the trachea under direct guidance. Place tracheostomy tube and inflate balloon.\*\*
- 7) Attach ventilator tubing and circuit to the new tracheostomy tube and gooseneck adaptor then commence with ventilation. Clamp ET tube when disconnecting the circuit.

If a patient on the unit becomes stable enough to be off the ventilator or if the patient is disconnected from mechanical ventilation, a heat-moisture exchanger (HME) with a viral filter should be attached to the trach tube.

\*Recommendations subject to change with evolving data, resources, testing procedures

\*\*If at any step there is violation of the balloon or ET tube- hold respirations and proceed rapidly through remaining steps.

\*\*\*These steps and guidelines are for stable situations and only apply in those conditions.

\*\*\*If it is determined that the patient’s pulmonary status will not tolerate a cessation of respiration the surgical and anesthesia team should coordinate a variation in procedure prior to incision to minimize aerosolization as possible. It is also reasonable to consider delaying procedure.

Last updated 4/9/2020 For any questions contact: Jeffrey Claridge ([jclaridge@metrohealth.org](mailto:jclaridge@metrohealth.org))