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Tier 1: Tracheostomy Guidelines During COVID-19

Scope

These guidelines apply to all HFHS providers performing tracheostomies during the COVID-19 pandemic.

Background

These guidelines are for the performance of the high risk procedure of tracheostomy as more and more patients require prolonged ventilation. This would be applicable to ALL patients needing tracheostomy regardless of current COVID-19 status (COVID positive, COVID status pending or suspected, COVID negative)

Definitions

None

Guidelines

Tracheostomy Procedure Classification and Prioritization

Procedure Classification	Descriptions	Policy
Emergent	Acute airway with oxygen desaturation, unable to intubate, unable to bag mask	Proceed with tracheostomy. Airborne Plus Precautions.
Urgent	Acute airway no oxygen desaturation, able to bag mask only, unable to intubate.	Proceed with tracheostomy. Airborne Plus Precautions.
Elective	Patient intubated.	Staff Physician to Staff Physician discussion. Decision to trach confirmed by two intensivists.

COVID-19 Testing

- For patients with low clinical suspicion and admitted for reasons other than COVID19:
 - Obtain one NP swab sample, followed by tracheal aspirate if negative
 - If NP swab is positive, tracheal aspirate sample is not indicated
 - These patients do not need to be moved to a COVID area for testing and do not need to be placed in isolation pending results.
 - If result is positive, then follow recommendations for COVID positive patients and place in Droplet Plus precautions
 - When both tests are negative, proceed with tracheostomy placement using standard precautions
- For COVID19 positive patients (by test or clinical suspicion), consider tracheostomy after 14-21 days of mechanical ventilation. Note that viral shedding is likely to be significantly decreased 21 days after symptom onset. No repeat testing is required

ICU or OR Tracheostomy

- A. When possible and clinically appropriate, percutaneous tracheostomy at bedside in a negative pressure room is preferable to minimize aerosolization, transport and resource utilization.
- B. If decision is made to perform a tracheostomy, the following applies to all COVID positive or suspected patients:
 1. **Minimal staff to be present in the room:**
 - a. Bedside Trach: Respiratory therapist, surgeon and surgical assistant/APP/Resident, RN.
 - b. OR Trach: anesthesia provider, surgeon, circulator, surgical scrub and surgical assistant/APP/Resident.
 2. The procedural staff will speak directly to the ICU Attending Staff to confirm need for and timing of tracheostomy (as noted in the grid above, two intensivists must have previously agreed to the need for tracheostomy; if the proceduralist is also an intensivist, they may serve as secondary confirmation).
- C. All tracheostomy performed will use Airborne Plus precautions: N95 mask (or equivalent masks approved by infection control), face shield, head covering, moisture barrier gown, and gloves. Proper removal of PPE will be followed.
- D. All bronchoscopy procedures (including percutaneous tracheostomy), will be performed using disposable bronchoscopes unless a life-threatening airway issue exists.
- E. For more information regarding proper removal of PPE refer to: [Personal Protective Equipment for COVID 19](#)

Tracheostomy Recommendations for COVID + Patient

- A. Day before or day of procedure, consider performing “apnea test”: pre-oxygenate patient, then hold ventilation for 60 seconds to test tolerance of apnea time during surgery, thus predicting likelihood that ventilation will be required while airway is open.
- B. Paralyze patient

- C. Pre-oxygenate and hold ventilation when entering airway or manipulating any device within the airway (i.e., endotracheal tube, tracheostomy tube, or bronchoscope)
- D. Maintain cuff inflation whenever possible: as applicable, advance tube prior to creating window, inflate cuff promptly upon insertion of tube, ensure cuff is inflated prior to resuming ventilation
- E. Cuffed non-fenestrated tracheostomy tubes should be used to avoid aerosolizing the virus
- F. Confirm placement with end-tidal CO₂ rather than suction catheter or bronchoscope through trach
- G. Filter (HEPA or HME) should be placed on the tracheostomy to reduce shedding of the virus should the anesthetic tubing be disconnected
- H. Avoid disconnecting filter, but if necessary, disconnect distal to the filter

Post Tracheostomy Care Recommendations

- A. No tracheostomy tube exchange unless clinically indicated
- B. Cuff to remain inflated and check for leaks
- C. Make every effort not to disconnect the circuit
- D. Only closed in line suctioning should be used
- E. When weaned from ventilator, use HME rather than humidification via trach collar
- F. For transport
 - 1. On ventilator: ensure circuit is closed and avoid any disconnection of circuit outside negative pressure room
 - 2. Off ventilator: HME to be placed on trach if tolerated, with a surgical mask covering the trach

Related Documents

[Tier 1: Airborne Plus Precautions](#)

References/External Regulations

<https://www.entuk.org/tracheostomy-guidance-during-covid-19-pandemic>

<https://journals.lww.com/annalsofsurgery/Documents/Tracheotomy%20in%20ventilated%20patients%20with%20COVID19.pdf>

<https://www.entnet.org/content/tracheotomy-recommendations-during-covid-19-pandemic>

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
VP, Regulatory & Infection Control Compliance	Jacqueline Chesney: VP-Reg&InfectnControlComplianc	4/24/2020
System Policy Management Office	System Policy Management Offic	4/24/2020
Document Owner	Carol Mcquery: Mgr-HFHS Policy Mgmt Office	4/24/2020

Applicability

Henry Ford Allegiance Health, Henry Ford Allegiance Specialty Hospital, Henry Ford Behavioral Health Services, Henry Ford Community Care Services, Henry Ford Health System, Henry Ford Hospital, Henry Ford Kingswood Hospital, Henry Ford Macomb Hospital, Henry Ford Medical Group, Henry Ford West Bloomfield Hospital, Henry Ford Wyandotte Hospital

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