

Ward Tracheostomy Management



Western Health

COVID - 19

Be Safe -- Be Smart -- Be Kind

This document is for use within the ward setting only.

Care of the patient with COVID-19 or suspected COVID-19 with a tracheostomy within the ward setting.

The primary reason for tracheostomy insertion for a COVID-19 positive is to wean from ventilation when a primary extubation is not possible or has failed.

The essential principles when caring for patients with a Tracheostomy are based on maintaining patient safety, facilitating communication and preventing complications associated with a tracheostomy. Routine care remains unchanged from the current WH Adult Tracheostomy Management Procedure OP-GC3. The content of this QRG is to highlight the changes to tracheostomy management in the COVID-19 patient on the ward. Please refer to the ICU ventilator weaning management of the COVID 19 positive patient with a tracheostomy QRG for ICU specific management.

1.1 Management of the COVID-19 patient with a tracheostomy on the wards

- Specific medical orders must be adhered to.
- The care of all tracheostomy patients requires AGPs, and thus should be a high priority for a single room if COVID-19 positive or COVID-19 suspected. Please refer to the [De-isolation Guideline](#) for details, please see the [microsite](#) for the latest version.
- All staff entering the bed area must be wearing the recommended PPE as per the Western Health COVID-19 PPE Guidelines, please see the [microsite](#) for the latest version.
- Note all tracheostomy care, including suctioning, Airvo set up, cuff deflation and PMV trials, are considered a high risk AGP. Please refer to the latest PPE Guidelines for details.

1.2 Tracheostomy Safety Equipment that MUST be at the Bedside at All Times

All Tracheostomy safety equipment as per normal practice

- Two spare tracheostomy tubes (one the same size and one a size smaller than the tube in situ);
- Tracheostomy Securing neck tapes (2 cotton ties or 1 Velcro strap);
- Spare inner cannula same size as tube in situ;
- Cuff manometer;

- Tracheal dilator;
- Allevyn foam tracheostomy dressing pack
- 10ml syringe;
- Oxygen source (wall);
- Humidification equipment (heater base set for an artificial airway at 37°C and tubing circuit);
- Water for irrigation of suction catheters;
- Suction catheters of appropriate size for patient's tracheostomy tube (see suctioning section for sizing);
- Suction bottle, tubing and wall suction;
- Yankauer sucker;
- Yellow bag;
- Stitch cutter (for surgical tracheostomy only);
- Bag mask

1.3 Inner Cannula Care

- The inner cannula must be removed and cleaned QID, or more frequently if required, as per standard tracheostomy care
- Changing the inner cannula is considered a low risk aerosol generating procedure and can be attended to at the bedside.
- If excessive secretions or partial blockage found during inner cannula change, consider increasing suction frequency and frequency of inner cannula changes
- Inner cannulas are to be washed and reused unless unable to be cleaned. If for disposal, these should be placed in the yellow waste bins.

1.4 Dressing the Insertion Site

The insertion site of an unhealed tracheostomy should be assessed daily by a medical practitioner to determine if a dressing change is required. The dressing should only be changed if there are frank indications of infection. The dressing change should be clustered to coincide with the inner cannula change.

1.5 Monitoring Cuff Pressure

- Cuff pressure should be maintained between 25-30cmH₂O unless otherwise indicated.
- Cuff pressure measurements should be performed QID or more frequently if required.
- Excessive cuff leaks will be reported to medical staff.

1.6 Suctioning

- Endotracheal suctioning will only be performed via an open suction circuit on the wards and a closed in line suction catheter in ICU for COVID-19 positive patients with a tracheostomy.

- The frequency is determined by individual patient assessment of indications for suctioning and clinical need and not based on a fixed schedule. Limiting the amount of suctioning to a needs only basis minimizes the potential risks and adverse effects of suctioning.
- If resistance or difficulty passing suction catheter consider replacing the inner cannula due to potential risk of occlusion with secretion build up.

1.7 Nebulisation

- The use of nebulisers is not recommended for COVID-19 positive patients and use of metered dose inhalers are preferred where possible.
- A metered dose inhaler may be used in place of a nebulizer with an appropriate adaptor.

1.8 Humidification

- All tracheostomy patients require humidification
- Patients need medical clearance to initiate Airvo set up
- Consider set up of sleek on humidification tubing to minimise leakage
- Once weaned from oxygen consider the use of Swedish nose/Buchanan bib to facilitate ongoing humidification

1.9 Cuff deflation and PMV trials

- Cuff deflation/PMV/use of open circuit (high risk AGP) for suspected or proven COVID-19 trache patients should be limited to single rooms or isolated rooms where COVID-19 positive patients are cohorted together
- Timing of cuff deflation trials and/or PMV trials should be discussed with the treating medical team prior to commencing. Usual care and tracheostomy weaning should not be delayed in COVID-19 patients as sufficient PPE is available and every effort should be made to maintain staff safety whilst ensuring weaning and rehabilitation can occur in a timely fashion.
- Ensure staff wearing appropriate PPE during procedure.
- When performing cuff deflation trial and/or PMV trial, minimize staff in the bedspace to conserve PPE and minimise exposure risk. Discuss with Speech Pathology and Physiotherapy prior to cuff deflation trial and/or PMV trial to maximize assessments completed during trial and to minimize staff exposure.
- Where appropriate, consider alternative models of care, e.g. rather than joint MDT assessments, consider one discipline taking the lead role in tracheostomy wean with other disciplines providing advice via remote consultation.
- Consider shorter period of patient demonstrated tolerance of cuff deflation and PMV than standard practice to guide timing of decannulation,
- Discuss cuff deflation weaning plan with the MDT, and document weaning plan clearly.

2.1 Tracheostomy Review Service

- All non-ENT tracheostomy patients should be referred to the Tracheostomy review service (TRS), including input from Physiotherapy, Speech Pathology, Respiratory or ICU.
- During COVID-Peak ICU liaison may no longer be involved in TRS. In this scenario the ICU physiotherapist will flag patients for transfer to the ward with the Speech Pathology senior on site who will take on coordination of TRS meetings. Speech Pathology will monitor for community tracheostomy patient admissions who require TRS input.

2.2 Weaning the tracheostomy

- The procedure regarding weaning the tracheostomy remains unchanged during the COVID-19 pandemic, and consultation should be sought from all members of the TRS, except for ENT patients.

References:

Austin Health — Tracheostomy Review and Management Service (TRAMS): TRAMS Tracheostomy COVID-19 Update (April 3 2020)

Speech Pathology Australia – Speech Pathology Australia guidance for service delivery, clinical procedures and infection control during COVID-19 pandemic (April 3 2020)

Thomas P, Baldwin C, Bissett B, Boden I, Gosselink R, Granger CL, Hodgson CL, Jones AYM, Kho ME, Moses R, Ntoumenopoulos G, Parry SM, Patman S, van der Lee L (2020): Physiotherapy management for COVID-19 in the acute hospital setting. Recommendations to guide clinical practice. Version 1.0, published 23 March 2020. Journal of Physiotherapy.

WH Adult Tracheostomy Management Procedure OP-GC3.

Western Health COVID-19 PPE Guidelines