UMassMemorial Health Care

COVID-19 Clinical Care Council

CONSENSUS ON TRACHEOSTOMY PROCESS MARCH 31, 2020

This document was also approved by CCOC.

The following guidance incorporates CDC recommendations, Professional Society guidelines, and data that are available at this time. This guidance document is subject to change as published guidelines and evidence evolve.

This document is a guideline for all adult patients with the potential need of a tracheostomy, open, and percutaneous.

Pediatric patients are not included in this document, yet this is subject to addendum.

The guidance is the result of a multidisciplinary process involving Thoracic Surgery, Trauma Surgery, Pulmonary Critical Care, Interventional Pulmonology, Anesthesia Critical Care, and Quality.

There are three areas for consensus:

1. Timing of the tracheostomy
2. Needed PPE to perform a tracheostomy
3. Location to perform the procedure
4. Anesthesia and paralysis

1. Timing of the tracheostomy:
    a. **For SARS-CoV-2 positive/rule-out** patients, the proceduralist will determine the time of surgery in conjunction with the critical care team, strongly recommending <u>not</u> to perform the procedure in less than two weeks.
    b. **For NON-SARS-CoV-2 patients,** the proceduralist will perform the tracheostomy electively, under current non-pandemic guidelines. Each independent case will have to be discussed with the critical care team for agreement on the safest time after at least one week of intubation.

2. PPE for tracheostomy:

a. For **ALL** patients, the whole team will wear an approved fitted N95 mask (3M, Wilson, Gerson) **AND a** PAPR system. This is applicable throughout the organization, Operating room as well as in the ICU.

b. <u>During this pandemic, the PPE is limited</u>; therefore, the team will be formed by one representative from each group. (Strongly discourage inviting trainees unless extremely necessary for the procedure on SARS-CoV-2 positive patients)

- In <u>the OR:</u> One surgeon/IP, one anesthesia, one OR tech, one nurse, +/- one assistant (5 PAPR packs maximum)

Modified: 3/31/2020 6:36 PM

By: Dr. Karl F. Uy
Dr. Bruce Simon
Dr. Nicholas Smyrnios
Dr. Paulo Oliveira
Drs. Matthias Walz, Khal Faris, and Aaron Scott
Dr. Ulises Torres

CONSENSUS ON TRACHEOSTOMY PROCESS MARCH 31, 2020

- In the ICU: One- Surgeon/IP, one respiratory therapist, one Nurse, one bronchoscopist (4 PAPR packs maximum)

3. Location to perform the procedure.
   For **ALL** patients
   a. During an open or percutaneous tracheostomy, there is a large amount of aerosolized particles released in the environment; this factor exposes the staff at extreme risk for infection. Therefore, this procedure will be performed in a negative pressure environment or HEPA filtered rooms only.

   b. The proceduralist will decide the location to perform the tracheostomy, taking into consideration: the restriction mentioned above, his/hers best clinical judgment and the new scheduling restrictions in the operating room, which allows no more than ONE airway case to be done at any given time due to the lack of PAPR packs.

      The proceduralist will assure that:
      a. Adequate number of PAPR packs are available for all members of the team
      b. Personnel in the room must be PAPR trained and N95 mask fitted
      c. The case must be booked with enough time in advance to allow the OR schedulers to hold a slot with available PAPR packs. In the ICU, the same planning should occur.

4. Anesthesia and paralysis:
   For **ALL** patients
   a. Consider paralyzing the patient and ceasing ventilation when the trachea is opened to diminish chances for high pressure aerosolization of the virus.
   b. When the case is performed in the ICU, and there are enough PAPR packs available, consider the assistance of a colleague from anesthesia to handle the ventilation, anesthesia and paralysis for you

Modified: 3/31/2020 6:36 PM

By: Dr. Karl F. Uy
Dr. Bruce Simon
Dr. Nicholas Smyrnios
Dr. Paulo Oliveira
Drs. Matthias Walz, Khal Faris, and Aaron Scott
Dr. Ulises Torres