Tracheostomy in Covid19 Patients – top tips for Anaesthetists

Booking procedure

Please see also the document from the local Tracheostomy Steering group, the ENT UK document, NTSP document and the SOP. There is a daily rota of which surgeon is available from ENT and MaxFax.

These patients will be booked onto Cepod for Theatre 14 for (in the first instance) Monday, Wednesday and Friday. A meeting will take place at 1pm the day before with Consultant Surgeon, ITU Consultant and Consultant Anaesthetist (Cepod) in Critical Care Unit office A3-B3 corridor. Consent form 4 will be done by ITU. The surgeons will not have reviewed the patients. Patients in Llandough can also be discussed. A tracheostomy care plan/anaesthetic chart will be completed by ICU, and left out for us in the Cepod hub. There are clear criteria regarding fitness for procedure.

Planning on the Day of Procedure

Team brief by theatre 14 first thing in the morning.

Identify your team: minimum of 1 Consultant Anaesthetist and 1 OPD, 1 more person also in PPE to help collect the patient is helpful to push the bed and red trolley but you can do it with two. You need 1 additional "clean" person to come and open the doors and guide down corridor. We cannot use the porters. You need an anaesthetic trained runner in the anaesthetic room. Identify how to call for help from the rest of the team (whose bleep, which phone number).

The patient already has a tube in, so the staff can be in the theatre when you arrive, in full PPE. No "20 minute pause" required.

Plan whether to use the operating table or the bed. Talk through the plan of how to change the airway, in order to minimise aerosol generation (see below).

Phone ICU to confirm the patients are ready and check they have/can be put onto their transport trolley with monitor and oxylog to prevent us using ours which are currently on MERIT trolleys. They do have a dedicated "covid +" trolley.

Kit and Set up in Theatre

Bring some Trache tubes with you back from ICU, and keep the existing an in-line suction set and straight purple catheter mount. (These are in short supply, so only bring a new set if the nurse tells you it is due to be changed.) The suction tubing can be disconnected, and leaves a sealed port down which you can insert an ambuscope, should you need to.

Usual kit that you would want, plus drugs (Muscle relaxant, fentanyl etc)

Have a direct laryngoscope and new ETT, ambuscope and cmac available nearby on standby (in anaesthetic room is ok).

Head near anaesthetic machine (normal length tubing). Shoulder roll and head ring, neck extended.

Sully clamp and bougie (surgeon may need)

Tessa Bailey v4 14/4/20

Procedure

Scrub team: connect in-line suction, straight purple catheter mount and filter ready to be attached to the trache, and syringe to inflate cuff to hand/attached

Prior to starting: Muscle relaxant on board. Ensure you can get to the tube ties with the drapes on the head (?remove tube holder device attached from ICU, and replace with ties/tapes).

Preoxygenate. Advance the tube a little further (caution re right main bronchus), this is so the cuff is distal to the trache site. Ensure cuff is inflated and no leak. This should be ok even with ETTs cut to 27cm. Watch the PAW/VT for signs of endobronchial intubation.

Suction the oropharynx with yankauer, and trachea with in-line suction. Consider bronchoscopy with ambuscope to check for clots/plugs existing in the tracheal tree (but take aerosol reduction precautions).

During surgical procedure:

Once surgeons are ready to open the trachea they will inform you. They may ask for a Valsalva to check the area is dry.

Switch off the ventilator with the APL valve open, allow passive expiration.

The surgeons can then open the trachea, which may have damaged the cuff, without risking aerosol leak. If you need to resume ventilation you can, by gentle manual ventilation first if the cuff is intact.

When the trache is ready to insert – Stop ventilation, Deflate the cuff. Pull the tube back slowly until they say stop (just proximal to the tracheal hole). The surgeons should suction the trachea to ensure no clots/bleeding.

Surgeons insert the trache and inflate its cuff. Clamp your tube, disconnect the circuit and pass it to them, with in-line suction and catheter mount pre-prepared. Confirm ventilation.

Remove the tube (careful with the secretions, you may wish to attach the yankauer to the tube and seal with your hand so that you suction as you come out)

End of procedure:

Suction via the in-line suction catheter. Carry out an additional check with the ambuscope, with the surgeons.

Consider steps required carefully when reattaching the oxylog for transfer, same process of switching the ventilator off, going onto manual to allow exhalation, then attach oxylog tubing. You can clamp the catheter mount as avoids risk of damaging the suction catheter.

Phone ICU once ready to go back.