St. James's Hospital
Tracheostomy Care Working Group.

COVID-19: Tracheostomy / Laryngectomy Patient Management SOP
SJH:N069.17

This Standard Operating Procedure (SOP) is effective from September 2020 onwards and is due for renewal in September 2023. It will be reviewed during this time as necessary to reflect any changes in best practice, law, and substantial organisational, professional or academic change. This SOP is supplementary to the Tracheostomy Care and Management Guideline (SJH:N069). This SOP describes standards for the practical management for ward non-ventilated Tracheostomy/Laryngectomy patients during COVID-19 outbreak.
Note: Patients with Tracheostomies and Laryngectomies should be considered HIGH RISK.

1.0 Tracheostomy standards for COVID-19 Negative/or not suspected COVID-19 ward patient

1.1 Face mask FFP2 and eye shield, gown and gloves are advised when carrying out mucoid stimulating procedures such as suctioning/ inner cannula checks/changes.

1.2 Reduce frequency of checking and changing the inner cannula unless clinically indicated with decreased saturation and or thick secretions.

1.3 Suction only as needed.

1.4 Due to high transmission risks ideally all tracheostomy patients should be nursed in a side room. If patient is nursed in open bay with other patients, it is recommended **NOT** to use an AIRVO or to administer nebulisers due to the potential aerosol effect. Please use Swedish nose HME instead as shown in the picture. Up to 5L Oxygen (O_2) can be administered via the attached oxygen port.


Swedish nose HME

1.5 If higher concentrates of O_2 is required administer O_2 via tracheostomy mask placed over Swedish nose HME.

1.6 If the patient is tolerating a Passy Muir Speaking Valve (PMV), Sofshield humidification bib must be worn fully covering the tracheostomy tube. Consider reducing duration of PMV placement and apply HME.

1.7 If the patient is not wearing a PMV, it is recommended to use a Swedish nose instead of Sofshield bib for humidification.

1.8 It is advised to reduce and/or eliminate if possible the use of saline nebulisers during the COVID-19 outbreak. Nebulisers should only be administered if the patient is located in a side room.

1.9 Patient can continue to use AIRVO via tracheostomy interface if in a negative pressure room/side room, again it is recommended for staff to wear face mask with eye shield if performing tracheostomy care in the room.

1.10 Speaking valve use for patients requiring AIRVO will be indicated on case by case basis by Speech and Language Therapist (SLT) in consultation with Multidisciplinary team (MDT).

1.11 Routine tube changes will not be carried out during the outbreak period.

1.12 Tracheostomy CNS/SLT/ENT/Anaesthetics team must wear PPE, FFP2/3, eye protection and gown if carrying out any high risk skilled /airway procedures such as emergency tube change/decannulation/swallow assessments.

2.0 Tracheostomy standards for COVID-19 Positive or suspected positive ward patient

2.1 Full PPE as per SJH COVID-19 PPE Guidance must include face mask (FFP3) and eye/face protection.

2.2 If the patient has a cuffed tube, it is recommended to keep the cuff inflated until the patient is free from COVID-19*. *Please remember that the patient will not be suitable for PMV placement whilst cuff is inflated.

2.3 If the patient has a non-cuffed tube this will increase aerosol generation so the patient should either be in a side room or in cohort area with other COVID-19 patients. Staff must ensure full PPE (FFP3).

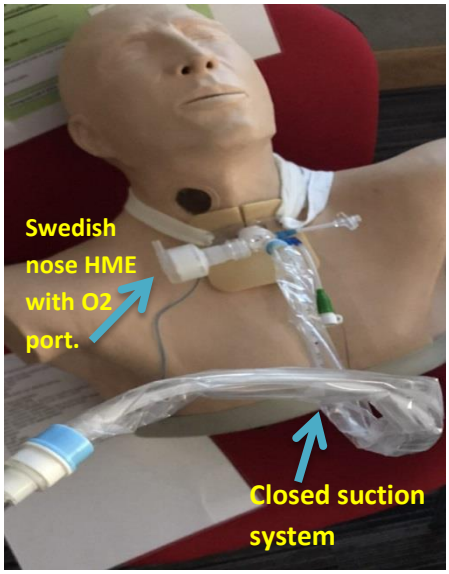
2.4 Speaking valve use for patients with uncuffed tubes will be indicated on a case by case basis by SLT in consultation with MDT.

2.5 Patient should be nursed in a side room ideally negative pressure room if requiring AIRVO.

2.6 AIRVO should be avoided (unless the patient is in a side room) due to the potential aerosol effect. Please use Swedish nose HME instead. Up to 5L O_2 can be administered via the attached oxygen port.

2.7 If higher concentrates of O_2 required administer Oxygen via tracheostomy mask placed over Swedish nose HME.

2.8 Closed suction system is advised if the patient is requiring suctioning. Pending availability of stock closed system to be renewed weekly. Swedish nose HME with O2 port can be attached to side of suction system (see picture). Refer to Tracheostomy: Closed Suction Technique SOP (SJH:N069.6) for further information.



2.9 **Important to note*:** If swabbing a tracheostomy patient for SARS-coV-2 (COVID-19), the sites are nasopharyngeal and tracheostomy **NOT** Mouth. The swab should be gently inserted into the tracheostomy tube to the mid-way line until tip of swab meets resistance (this is at the half way mark of the tube where the tube begins to curve) and then the swab is removed. The swab should remain straight for the full procedure and not attempted to manipulate downwards into the airway. The inner cannula should remain in place and if an incident occurred with the swab snapping it would be easily removed via inner cannula.

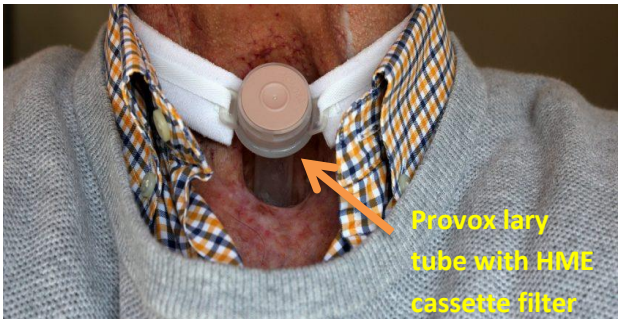
Please note this information is subject to change as new information becomes available.

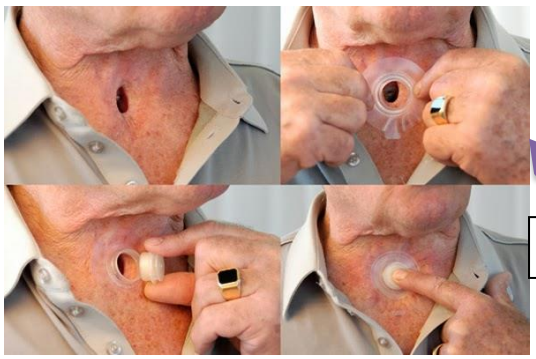
3.0 Laryngectomy standards for COVID-19 Negative/or not suspected COVID-19 ward patient
Note: Patients with Laryngectomies and Tracheostomies should be considered HIGH RISK.

3.1 Face mask, eye shield, FFP2, gown and gloves are advised when carrying out mucoid stimulating procedures such as removing and cleaning lary Provox tube/suctioning via stoma.

3.2 Ask the patient to manage as much of their stoma care and voice prosthesis care as possible using recommended hand hygiene guidelines.

3.3 Due to high transmission risks ideally all laryngectomy patients should be nursed in a side room. If the patient is nursed in an open bay with other patients it is recommended NOT to use an AIRVO or to administer nebulisers due to the potential aerosol effect.Please use Provox HME disc filter instead (as shown in the picture) that is attached to either a lary tube or a base plate.





Base plate with HME cassette filter

3.4 Apply dry O_2 (if required) via tracheostomy mask and position over cassette HME filter.

3.5 Sofshield humidification bib if worn must be positioned fully covering the patient's stoma.

3.6 It is advised to reduce and/or eliminate if possible the use of saline nebulisers during the COVID-19 outbreak. Nebulisers should only be administered if the patient is located in a side room.

3.7 Patient can continue to use AIRVO for humidification if in a negative pressure room/side room. It is recommended for staff to wear face mask FFP2/3 and eye protection/apron/gloves when carrying out laryngectomy care in the patients' room.

3.8 Surgical Voice Restoration (SVR) including voice prosthesis insertions & changes are to be avoided where possible as directed by ENT Consultants. SLT will triage these cases and liaise wit ENT.

3.9 SLT must wear full PPE (including FFP2/3 & gown) if SVR task is deemed essential & urgent, and consent is obtained from ENT Consultant/Registrar.

4.0 Laryngectomy standards for COVID-19 Positive or suspected positive ward patient

4.1 Full PPE as per SJH COVID-19 PPE Guidance must include face mask (FFP3) and eye/face protection.

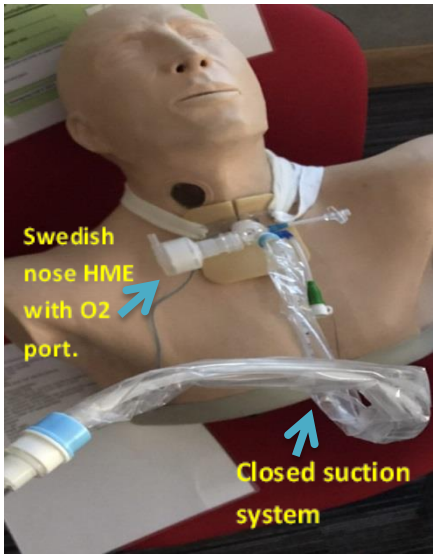
4.2 Cuffed tracheostomy tube inserted into stoma and cuff inflated to better manage infective secretions.

4.3 Patient should be nursed in a side room ideally negative pressure room if requiring AIRVO.

4.4 AIRVO should be avoided (unless the patient is in a side room) due to the potential aerosol effect. Staff should use Swedish nose HME instead. Up to 5L O_2 can be administered via the attached oxygen port.

4.5 Administer O_2 (if higher concentration is required) via tracheostomy mask placed over Swedish nose HME.

4.6 Closed suction system is advised if the patient is requiring frequent suctioning. Pending availability of stock closed system to be renewed weekly. Swedish nose HME with O_2 port can be attached to side of suction system (see picture). Refer to Tracheostomy: Closed Suction Technique SOP (SJH:N069.6) for further information.



4.7 Consider reducing the frequency of checking and changing inner cannulas to avoid disconnecting the closed suction system unless clinically indicated with decreased saturation and or thick secretions.

4.8 **Important to note*:** if swabbing a laryngectomy patient for SARS-coV-2 (COVID-19) the sites are nasopharyngeal and tracheostomy/lary stoma **NOT** Mouth. If swabbing laryngectomy stoma site. Insert swab into the lary stoma and gently swab the posterior wall of the trachea, swab should be kept in a straight position.

*Please note this information is subject to change as new information becomes available.

Links to related PPPGs:

- Tracheostomy Care and Management Guideline (SJH:N069)
- Tracheostomy Care and Management Guideline: Associated Documents
- For information on Additional Precautions for speaking valve placement during COVID-19 outbreak, refer to Tracheostomy: Non-Verbal and Verbal Communication SOP (SJH:N069.10)
- For information on Resuscitation during COVID-19 outbreak, refer to Tracheostomy / Laryngectomy: Emergency Management of Patients' SOP (SJH:N069.15).