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LSUHSC-Shreveport, LA
Critical Care

Percutaneous Tracheostomy

Purpose:

To provide a long term airway.

To provide ease in weaning from ventilator and patient comfort.

Policy:

1. The percutaneous tracheostomy shall be inserted by LSUHSC – S house staff and an attending physician with percutaneous tracheostomy privileges.
2. The Registered Nurse assigned to the patient shall be responsible for setting up for the insertion, administering ordered sedation, assisting with troubleshooting and recording of vital signs during the insertion. If conscious sedation used they shall obtain vital signs in accordance to policy
http://www.sh.lsuhs.edu/policies/policy_manuals_via_ms_word/Nursing/P-51.pdf
3. An informed consent shall be obtained prior to the insertion of a percutaneous tracheostomy from the patient or immediate relative. If a life-threatening emergency exists the physician may perform the procedure without consent. If this is done it is documented as such in the progress note.
4. Patient and/or family shall be educated regarding procedure and steps for infection prevention.
5. The physician performing the procedure shall document a procedure note.
6. Bedside percutaneous tracheostomies shall always be done with verifying bronchoscopy. If bronchoscopy unavailable, procedure is delayed or tracheostomy inserted via open technique in the OR

Equipment:

Percutaneous Tracheostomy Introducer Set

Tracheostomy Tube: size is determined by physician

Bronchoscopy Cart

3 - 10cc Syringes

1% Xylocaine

Emergency Tracheostomy Tray

1 – Maximum barrier precaution drape (comes in kit)

2 - Sterile sheet

4 - Sterile towels

Sterile gloves and gown for each MD in procedure (MD performing bronch needs only yellow gown, mask, hat and sterile gloves)

Surgical mask and cap

2 - Chlorohexidine scrub brushes

Procedure:**Responsible Party****Action**

Responsible Party	Action
MD	1. Explain procedure to patient / family.
RN/RT / MDs	2. Obtain consent.
MD	3. Obtain Bronchoscopy cart.
	4. Don cap and mask
	5. Scrub / prep insertion site with antimicrobial scrub brush.
	6. Perform surgical scrub to hands.
RN	7. Don sterile gown and gloves.
	8. Open equipment forming sterile field and maintaining sterility of items.
MD	9. Form sterile field by draping towels and sheets.
RT	10. Place ventilator on 100% FIO ₂ . Increases the rate of ventilation if needed. Increase the Pressure alarms to allow for flow around bronchoscope.
	11. Remove tape from around ETT while holding ETT in position.
RN	12. Administer IV sedation as ordered.
MD	13. Inject local Xylocaine.
Bronch MD	14. Perform bronchoscopy and guide MD performing dilatational trach.
Insertion MD	15. Check the integrity of Introducer set and tracheostomy tube.
	16. Perform cannulation of trachea.
Bronch MD	17. Observe for the needle entering the trachea using the bronchoscope. Instruct the RT to move ETT as needed for needle clearance.
Insertion MD	18. Progressively dilate the trachea opening using the dilators in the kit.
	19. Insert the Air – Cuff trach.
Bronch MD	20. Confirm placement of Air - Cuff trach by visual inspection.
Insertion MD	21. Inflate balloon on trach.
Bronch MD	22. Removes bronchoscope and ETT.
RT	23. Uses trach for ventilation.
Insertion MD	24. Suture trach in place and secure with Velcro trach tie.
	25. Order CXR.
RN and MD	26. Document procedure in patient chart.