PHASE I (Pre-Operative)

Inclusion Criteria
- Children undergoing new tracheotomy placement

Exclusion Criteria
- Revision tracheotomy
- Recannulation after open airway surgery

Appropriate Use Criteria
- Multiple failed extubations ≥ 2 or prolonged non-invasive support
- Congenital or Acquired Muscular Weakness
- BPD requiring chronic invasive respiratory support
- Uncorrectable upper airway obstruction
- Craniofacial anomalies
- Severe neurological compromise

Provider & Family Discussion
- Family dialogue
- Provide "When a tracheostomy is recommended for your child" - PE2082
- Involve anticipated SCH medical home (Cranio-Facial, Pulmonary)

Discharge RT Consult
- "What is a trach?"
- "What is life at home with a trach?"
- Tracheotomy Road Map - PE2351

OTO Consult
Discuss with family other non-tracheotomy surgical interventions

Trach Y/N
- Yes
  - Primary Team to initiate evaluation for tracheotomy
  - Enter Nutrition & Care Coordination Consult

- No
  - Non-Tracheotomy Option(s)

Nutrition Consult
Assess nutritional status for surgery

Care Coordination RN
Provide Care Notebook

Wound Care RN Consult
- Pre Trach Insertion Trach Assessment
- Assess need for pressure reducing surface

OTO
Schedule & Complete OTO Trach Prep-Checklist
PHASE II (Until 1st Trach Change)

**Inclusion Criteria**
- Children undergoing new tracheotomy placement

**Exclusion Criteria**
- Revision tracheotomy
- Recannulation following failed airway surgery

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OR

- Trach placement with labeled stay sutures, protective dressings to stoma, neck, chin and chest, and Velcro ties
- Patient to get flex bronchoscopy in neutral position without shoulder roll to check position of trach in the OR
- Use OP note template
- OTO to initiate CIS Tracheotomy Pathway and fill out Critical Airway Sign
- OR to ICU with back up trach (one size smaller); Surgeon to pick back up trach

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**OR to ICU Handoff**

- Critical Airway Sign
- Suction Depth FormPosted
- Chest xray upon admission to ICU

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**ICU Care**

Sedation per ICU Comfort Protocol

Ok to start feed within 4 hrs if medically appropriate

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**RT**

- Check fluid filled cuff volume or air filled cuff pressure Q12 hours to ensure minimal cuff inflation with minimal leak technique.
- Also check trach ties for proper tightness.

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**RN/RT**

- Q4* hours, Assess insertion site and peri-stomal area for odor, drainage, or concerning skin findings.
- Q4* hours, shift vent tubing alternating each side to reduce risk pressure injury.
- Clean site with normal saline and Q-tips Q12 hours and PRN
- Job Aid: Tracheotomy Phase 2 (Until 1st Trach Change)
  *Notify ICU provider if concern with vent tubing repositioning
  *Notify OTO if odor, drainage, or skin concerns

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If appropriate, schedule care conference to outline transition to acute care (Accepting acute team, social work, care coordination)

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**OTO**

Provide at least 24 hour notice of timing of first trach change

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**POD 5 to 7**

- First trach change
- OTO, RN, RT, ICU Provider (Fellow/Attending) Present +/- Family

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*Do not change trach dressing under trach tube and/or ties until after 1st trach change without OTO present. Protective dressings in other areas may be changed as needed.*

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**!**

Tracheotomy is not an indication to delay feeds post-op

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**!**

Trach placement is not a contraindication for cough assist but therapy vest is not recommended.

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**For questions concerning this pathway, contact:** Tracheotomy@seattlechildrens.org

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Last Updated: January 2019
Next Expected Review: September 2022
**PHASE III (After 1st Trach Change)**

**Inclusion Criteria**
- Children undergoing new tracheotomy placement

**Exclusion Criteria**
- Revision tracheotomy
- Recannulation following failed airway surgery

**<1 Year**
- Consult OT
- Assess oral skills

**1 Year or Older**
- Consult Speech Therapy
- Assess oral skills and communication after first trach change
- Consider speaking valve

Continue ICU Care as per "trach policy + procedure" by RN/RT

Transfer criteria met

Transfer to Acute Care

RN Care daily +/- RT as per "trach P&P"

**OR Trach safe evaluation**
- Caregiver education
- Discharge planning
- Home care

**ICU Discharge Criteria**
- 1st trach change complete
- Stable vital signs with respiratory care and suction
- Acceptable gas exchange on home-capable respiratory support with no adjustment in ventilator settings in previous 48 hours
- No greater than 50% oxygen support
- ‘Inpatient Trach’ or ‘Inpatient Difficult Airway Trach’ signage at bedside and up to date
- Sedation wean in place, if appropriate
- ICU and Acute Care attendings have discussed transfer plan of care

If needed, weekly trach stoma rounds with OTO NP, OTO resident, and wound RN (place wound consult to initiate)

If needed, monthly trach rounds with speech, RT, OTO NP, and OTO resident

No contraindication for oral stimulation

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Tracheotomy Approval & Citation

Approved by the CSW Tracheotomy team for September 20, 2017 go live:

CSW Tracheotomy Team:

CSW Pathway Owner                     Sanjay Parikh, MD
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Surgical Clinical Nurse Specialist     Rebecca Engberg, RN, BSN, CPN
ICU Clinical Nurse Specialist          Hector Validivia, MN, RN, CCRN
Certified Wound Consult                Leslie Newell, RN, BSN, CWCN, CCRN
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Pediatric                              Zeenia Billimoria, MD
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Librarian:                             Sue Groshong
Program Coordinator:                   Kristyn Simmons

Executive Approval:

Sr. VP, Chief Medical Officer          Mark Del Beccaro, MD
Sr. VP, Chief Nursing Officer          Madlyn Murrey, RN, MN
Surgeon-in-Chief                       Bob Sawin, MD

Retrieval Website: http://www.seattlechildrens.org/pdf/tracheotomy-pathway.pdf

Please cite as:
This pathway was developed through local consensus based on published evidence and expert opinion as part of Clinical Standard Work at Seattle Children’s. Pathway teams include representatives from Medical, Subspecialty, and/or Surgical Services, Nursing, Pharmacy, Clinical Effectiveness, and other services as appropriate.

When possible, we used the GRADE method of rating evidence quality. Evidence is first assessed as to whether it is from randomized trial or cohort studies. The rating is then adjusted in the following manner (from: Guyatt G et al. J Clin Epidemiol. 2011;4:383-94.):

Quality ratings are downgraded if studies:
- Have serious limitations
- Have inconsistent results
- If evidence does not directly address clinical questions
- If estimates are imprecise OR
- If it is felt that there is substantial publication bias

Quality ratings are upgraded if it is felt that:
- The effect size is large
- If studies are designed in a way that confounding would likely underreport the magnitude of the effect OR
- If a dose-response gradient is evident

Guideline – Recommendation is from a published guideline that used methodology deemed acceptable by the team.

Expert Opinion – Our expert opinion is based on available evidence that does not meet GRADE criteria (for example, case-control studies).

Quality of Evidence:
- ⭐⭐⭐⭐ High quality
- ⭐⭐⭐ Moderate quality
- ⭐⭐ Low quality
- ⭐⭐⭐⭐ Very low quality
- Guideline
- Expert Opinion
Summary of Version Changes

- **Version 1.0 (09/20/2017):** Go live
- **Version 1.1 (10/12/2018):** Updated citation due to error
- **Version 1.2 (1/18/2019):** Added job aid to phase II.
Medical Disclaimer

Medicine is an ever-changing science. As new research and clinical experience broaden our knowledge, changes in treatment and drug therapy are required.

The authors have checked with sources believed to be reliable in their efforts to provide information that is complete and generally in accord with the standards accepted at the time of publication.

However, in view of the possibility of human error or changes in medical sciences, neither the authors nor Seattle Children’s Healthcare System nor any other party who has been involved in the preparation or publication of this work warrants that the information contained herein is in every respect accurate or complete, and they are not responsible for any errors or omissions or for the results obtained from the use of such information.

Readers should confirm the information contained herein with other sources and are encouraged to consult with their health care provider before making any health care decision.
Search Methods, Tracheotomy, Clinical Standard Work

Studies were identified by searching electronic databases using search strategies developed and executed by a medical librarian, Susan Groshong. Searches were performed in March, 2017, in the following databases – on the Ovid platform: Medline and Cochrane Database of Systematic Reviews; elsewhere: Embase, CINAHL, National Guideline Clearinghouse, TRIP, Nursing+, Cincinnati Children’s Evidence-Based Recommendations and Registered Nurses’ Association of Ontario Best Practice Guidelines. In Medline, Embase and CINAHL, appropriate Medical Subject Headings (MeSH), Emtree headings and CINAHL headings were used respectively, along with text words, and the search strategy was adapted for other databases using text words. Concepts searched were tracheotomy and tracheostomy. Retrieval was limited to humans, English language, 2007 to current and further limited to certain evidence categories, such as relevant publication types, index terms for study types and other similar limits.

Susan Groshong, MLIS
August 16, 2017

Identification

316 records identified through database searching
0 additional records identified through other sources

Screening

258 records after duplicates removed

258 records screened
234 records excluded

Eligibility

26 records assessed for eligibility

18 full-text articles excluded,
12 did not answer clinical question
3 did not meet quality threshold
3 outdated relative to other included study

Included

7 studies included in pathway

Flow diagram adapted from Moher D et al. BMJ 2009;339:bmj.b2535


