

*Indications: Chronic respiratory failure and need for ongoing mechanical ventilation.*

*Consent: Given patient's intubation and sedation, the patient was unable to provide consent.*

*Discussed the procedure with the patient's decision maker, including the indications, risks, benefits, and alternatives. All questions were answered. Written consent was obtained and placed in the chart.*

*Preprocedure: Universal protocol was followed for this procedure. Prior to the initiation of sedation or the procedure, a timeout/"Pause for the Cause" was performed. The patient's identity was verified by confirming the patient's wrist band for name, date of birth, and medical record number. Everyone in the room was in agreement with the patient identify, the procedure to be performed, consent was in place and matched the planned procedure, and the procedure site. The area was cleaned with a CHG scrub and draped with large sterile barrier. Hand hygiene was performed, and cap, mask, sterile gown, and sterile gloves were worn. The patient was covered by a large sterile drape. Sterile technique was maintained for the entire procedure.*

*Anesthesia: The patient was intubated and sedated prior to the procedure. Additional midazolam and fentanyl was given for deep sedation. Please refer to the accompanying procedural sedation form for additional details. Once the patient was adequately sedated and with continuous BIS monitoring, vecuronium was administered for paralysis.*

*Procedure: The patient was placed in the supine position. The anterior neck was prepped and draped in usual sterile fashion. 1% lidocaine was administered approximately 2 fingerbreadths above the sternal notch for local anesthesia. A 1.5-cm horizontal incision was then performed 2 fingerbreadths above the sternal notch. Using a curved Kelly, blunt dissection was performed down to the level of the pretracheal fascia. At this point, the bronchoscope was introduced through the endotracheal tube and the trachea was properly visualized. The endotracheal tube was then gradually withdrawn within the trachea under direct bronchoscopic visualization. Proper midline position was confirmed by bouncing the needle from the tracheostomy tray over the trachea with bronchoscopic examination. The needle was advanced into the trachea and proper positioning was confirmed with direct visualization. The needle was then removed leaving a white outer cannula in position. The wire from the tracheostomy tray was then advanced through the white outer cannula. The cannula was then removed. The small, blue dilator was then advanced over the wire into the trachea. Once proper dilatation was achieved, the dilator was removed. The large, tapered dilator was then advanced over the wire into the trachea. The dilator was removed leaving the wire and white inner cannula in position. A number 6 percutaneous Shiley tracheostomy tube was then advanced over the wire and white inner cannula into the trachea. Proper positioning was confirmed with bronchoscopic visualization. The tracheostomy tube was then sutured in place with two nylon sutures. It was further secured with a tracheostomy tie.*

*Estimated blood loss: Less than 5 mL.*

*Complications: None.*