

Integrated Care Pathway for Patients with a Tracheostomy

Information for patients' admitted to a ward area with a tracheostomy

Patients Name		Hospital Number	
D.O.B.		Consultant	

Date of Tracheostomy Insertion		Reason for Insertion	
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Dates of tracheostomy tube changes	Type & Size:	Date changed:	Fenestrated yes/no	Cuff yes/no
	Type & Size:	Date changed:	Fenestrated yes/no	Cuff yes/no
Size of Current Tracheostomy	<input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> Other.....			
Type of Tracheostomy	<input type="checkbox"/> Portex <input type="checkbox"/> Shiley <input type="checkbox"/> Silver Negus <input type="checkbox"/> Other <input type="checkbox"/> Fenestrated <input type="checkbox"/> Non-fenestrated <input type="checkbox"/> Uncuffed (only uncuffed tubes on dedicated ward areas)			
Current Humidified Requirement	<input type="checkbox"/> Humidified oxygen - O2% ... <input type="checkbox"/> Bib <input type="checkbox"/> HME / Swedish nose <input type="checkbox"/> Other.....			
Suction Requirements i.e. frequency				
Secretions (colour, viscosity, airway clearance routine)				
Communication Adjuncts- e.g. one way valve				
Plan (short and long term)				

Critical Care Outreach: Bleep 1428
Out of hours: On-call critical Care registrar Bleep 1300 **Respiratory Physio:** Bleep 1286

Continuation of Care Information

Patients Name		Hospital Number	
D.O.B.		Consultant	

Weekly MDT Reviews / Weaning Recommendations

Medical Team:	
Signature	Date
Critical Care Outreach:	
Signature	Date
 	
Signature	Date
Speech and Language Therapist:	
Signature	Date

Name sticker

Tracheostomy documentation of care

Date:		Tracheostomy		Size		
Weaning Plan:						
	Inner tube checked 2-4hourly (Y / N)	Cough effort / sputum / suction (colour/volume/ consistency/odour)	Tracheostomy secure / clean (Y / N)	Stoma dressing checked / changed (Y / N)	Humidification present (Y / N) e.g. humidified O2	Signed
00:00						
01:00						
02:00						
03:00						
04:00						
05:00						
06:00						
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Tracheostomy Discharge Information

To ensure safe discharge from hospital, the following people require education on the principles of tracheostomy management to ensure safe discharge from hospital:

- The patient (if applicable)
- The patient's relatives / next of kin / carers
- The district / community nursing team

Planning their discharge is a complex process, involving close liaison with the community team and ensuring the correct specialist equipment is provided for the patient.

This document lays out the core skills required by the patient or carer prior to discharge from hospital. It lists the essential equipment to ensure a safe discharge from hospital.

Contents of pack:

- 1. Tracheostomy Skills Prior to discharge** - skills required by the patient and/or carer/ community nursing team prior to discharge from hospital
 - These skills should be signed off, and filed in the patient's medical notes.
 - A copy should be given to the patient/carer/community nursing team.
- 2. Essential tracheostomy equipment required for discharge** - List of essential tracheostomy equipment required for home / community placement and where this can be ordered from.
- 3. Tracheostomy Discharge Information** – Documentation / emergency and useful contacts

Tracheostomy Skills Prior to Discharge

Patient Name _____ Hospital Number _____

Skills required prior to discharge	Patient	Carer / community nursing team	Comments / Date
Understanding of basic altered neck anatomy and physiology			
Identifies the type and different parts of the tracheostomy tube.			
Understands importance and frequency of stoma cleaning			
Demonstrates effective cleaning of stoma site			
Demonstrates understanding of the importance of inner tube			

cleaning and frequency			
Demonstrates removal and cleaning of inner tube			
Demonstrates a dressing change and when dressing change required			
Demonstrates the awareness of the indications for suction			
Demonstrates the awareness of the indications for suction			
Demonstrates an effective suction technique			
Demonstrates awareness of the indication for humidification			
Demonstrates what to do if the tracheostomy becomes blocked			
Demonstrates what to do if the tracheostomy becomes displaced / emergency			

Essential tracheostomy equipment required for discharge

Patient Name _____ Hospital Number _____

Item	Requirements	To be ordered from:	Signed /Date
Suction Machine	Battery and mains operated		
Suction Catheters			
Yankeur Suction Catheter	If applicable		
Tracheostomy Tubes	One same size and		

	one smaller and all appropriate inner tubes		
Tracheostomy Dressings			
Tracheostomy Holders			
Humidification System / Nebuliser chamber and tubing			
Oxygen	If appropriate		
Cleaning tips			

Information for patients - caring for your tracheostomy and what to do in an emergency

- Check the inner tube three times a day
 4. When you wake up
 5. In the middle of the day
 6. Before you go to bed

Clean it with running warm water and a cleaning swab or brush. You may need to check and clean the inner tube more frequently if you are producing a lot of secretions (phlegm)

- Always have a clean inner tube ready to put in while you're cleaning the dirty one.
- Change the tracheostomy dressings at least once a day or more often if they become dirty.
- The securing tapes must be changed at least once a week or more often if they become dirty. This is a two person job – one person to hold the tracheostomy tube in place and the other person to remove and replace the holder.
- To keep your secretions loose and prevent blocking of the tube, you will need to use humidification and suction as instructed by your nurse.

What should I do if the tracheostomy becomes blocked?

3. Remove the inner tube and replace with a clean one.
4. If you are still in difficulty, try to suction down the tracheostomy tube
 - a. If your symptoms are relieved → have a nebuliser
 - b. If you are still in difficulty, call **999** immediately

What should I do if the tracheostomy falls out?

5. Keep calm as you will still be able to breathe, but immediately:
6. Try to put the whole tube back into the hole. It goes in the same direction as when you put the inner tube into the outer one. Use some water based gel e.g. Aquagel or KY jelly, to make this easier.
7. If this is difficult, try to put the next size down tube in the hole.
8. If you can't do this, call **999** immediately.

Tracheostomy Discharge Information

On discharge from hospital, this document should be filed in the patients' medical notes.

If the patient is to be transferred to another hospital/ nursing home with the tracheostomy in place, the following should be sent with the patient:

- A photocopy of the front sheet
- Photocopies of the MDT record sheets
- A photocopy of the most recent equipment check
- A photocopy of the Skills required before discharge from hospital
- List of essential tracheostomy equipment and ordering details
- Patient information sheet/ Emergency guidelines
- Important Contact Numbers
 - Atos Supplies: 0800 783 1659
 - <https://www.atosmedical.co.uk>
 - GP Telephone Number:
 - District Nurse Number:
 - Critical care outreach contact number: 01903 205111ask for Bleep 1428
 - Ward number
 - Speech Therapist Number:
 - 01903 20511 ext 85582

Speech and Language Therapy (SLT) - The role of a Speech & Language Therapist (SLT) is to assess, manage and provide therapy to patients with a tracheostomy / laryngectomy who may have dysphagia (swallowing difficulties) and may have difficulty communicating.

Speech & Language Therapy can provide specialist assessment and advice in the following areas:

- 1) **Communication** - The presence of a tracheostomy will usually limit the ability of the patient to produce voicing, as a cuffed tracheostomy will divert airflow through the tracheostomy that would otherwise go up through the larynx where voicing is produced.
 - Promote communication by any appropriate means, especially if voicing is impaired.
 - Provide specialist assessment and management, as part of the multi-disciplinary team, to facilitate communication and voicing including when the cuff is deflated, the use of finger occlusion to elicit voicing on outward breath and suggest when best to place and use a speaking or one-way valve so the patient can communicate with their own voice.
 - Provide advice and information to the patient, their carers' and those professionals involved, tailored to the needs of the patient.

2) **Dysphagia (Swallowing Difficulties)**

- Provide a detailed assessment of the patient's swallowing and the impact that the tracheostomy may or may not be having on swallow function.
- Having assessed whether able to eat, drink and swallow, will contribute to discussions about nutritional support, as led by Dietetics. This may involve non-oral nutrition if a patient is not safe to swallow or may not meet their nutritional needs.
- Regular review and re-assessment will be completed, including post-decannulation. Eating and drinking normally is the preferred outcome. Aiming to maximize or rehabilitate swallow function where this is not possible

3) **Communication – What to consider:**

- What is your experience of voice loss or communication difficulties?
How would you communicate your needs if:
 - You were experiencing increased pain
 - You were unsure if your cat was cared for at home
 - You were exhausted but couldn't sleep
 - Have no voice
 - Have no hand movements
- What can we do?
 - Attempt to establish a means of communicating as early as possible
 - Allow time for the patient to respond
 - Use speaking valves for key times in the patient's day, e.g. ward rounds, relatives visits, therapy sessions and when most alert
 - Think/ act as a team~ involve/liaise with others
 - Use communication aids - being flexible:

- Alphabet board
- Call buzzer
- Eye pointing frame
- Word/picture chart
- Mouthing should be encouraged
- Apps are available for mobile phones or tablets to help with producing a message – this should only be attempted with patients who are fully aware and can choose this means of communication.

4) Swallowing: What to consider - It is important to consider the normal swallow, as it acts automatically to protect the airway from the bolus.

- Importantly during the swallow reflex the:
 - Larynx rises
 - Epiglottis lowers over laryngeal inlet
 - Cricopharyngeal sphincter opens oesophagus
 - Inspiratory cycle halts
 - Muscular contraction of the pharynx and oesophagus occurs
- The placement of a tracheostomy may effect these essential actions causing:
 - Reduced laryngeal elevation
 - Poor cricopharyngeal opening
 - Oesophageal compression
 - Disrupted airflow
 - Poor sensation
 - Reduced subglottic pressure – so unable to swallow effectively
- At risk groups include:
 - Acquired or progressive neurological conditions
 - Head and Neck surgery
 - Poor co-ordination of respiration and swallowing
 - Patient who have signs of food/fluid secretions on suctioning
 - Patients with weak voice or cough (when capped or using speaking valve and fenestrated tracheostomy tube with cuff deflated)

It is important to note that swallowing function can fluctuate so appropriate assessment, management and review by SLT can be beneficial.

Speech & Language Therapy will not attempt a swallowing assessment if the patient is not sufficiently alert, is too agitated or medically unstable. However, a severe cognitive impairment may not exclude a swallowing assessment though this would be at the discretion of the SLT advising the MDT.