RSCH / PRH Appendices

Appendix 8: Tracheostomy Care Pathway

TRACHEOSTOMY CARE PATHWAY

PATIENT DETAILS, ASSESSMENT AND CARE PATHWAY FOR PATIENTS WITH TEMPORARY OR PERMANENT TRACHEOSTOMY

Patient Name: Or *attach PAS label* Trust ID Number: Date of birth:	*Date of Tracheostomy insertion:* *Reason for insertion:* *Size & Type of tube:* *Date of Last Tracheostomy change:* *Known complications (including infection status):* *Grade of intubation:*

On-going Tracheostomy tube change record

The tracheostomy tube should be changed every 28 days (medical device). It may be required earlier depending on patient's clinical needs.

(Device sticker must be placed in health records)

Type and size:	Date inserted:	Subglottic / Cuff / Fenestration / extendable flange
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Goals of care for a patient with a tracheostomy

1. To prevent occlusion or accidental decannulation of tracheostomy
2. To be able to manage occlusion or accidental decannulation of tracheostomy
3. To ensure effective secretion management and identify early onset of complications
4. To ensure effective stoma care and identify early onset of complications
5. To ensure the patient has the ability to communicate

6. To implement a successful weaning strategy for decannulation
7. To plan for discharge of patient

SBAR handover from critical care/ specialist area to ward

Date:

S	**Situation:** Tracheostomy inserted on : Size: Type: Reason for insertion :
B	**Background:** SLT assessment : Yes /No Date: Nutrition: NGT ☐ PEG ☐ RIG ☐ Other: Dietician assessment : date Feeding prescription: Yes /No
A	**Assessment:** **Oxygen requirements**: Target Saturations: **Chest Secretions** : • "Cough" quality:…… • Frequency of suction: …… • Suction catheter size required: …… Fg • Subglottic: Frequency of aspiration…… • Amount last aspiration:……..mls **Cuff status:** Inflated / Deflated **Stoma:** Intact, Red, Excoriated, Other (state)…… **Communication**: How is the patient communicating their needs? **Speaking valve**: Passy Muir Time ……Frequency……
R	**Recommendation:** Date of next tracheostomy change: Weaning plan: Cuff deflation: Speaking valve: Nutrition: Oral intake:

Weaning Plan 1

This should be an MDT decision to proceed with weaning. **Ensure patient is in an upright position, suction trachea & oropharynx, oral hygiene before commencing weaning**

Date of MDT	
MDT members present	
Start weaning	**Y / N**

Action (tick relevant action)	**Time / duration**
☐ Cuff deflation trial	
☐ Capping	
☐ Decannulate	
☐ Change tube	
☐ Continue same care / size/ type of tracheostomy tube	
☐ Other	

Progress report

Action	Time	A -if planned care achieved Document any reason for variance / failure

Weaning Plan 2

This should be an MDT decision to proceed with weaning. **Ensure patient is in an upright position, suction trachea & oropharynx, oral hygiene before commencing weaning**

Date of MDT	
MDT members present	
Start weaning	**Y / N**

Action (tick relevant action)	**Time / duration**
☐ Cuff deflation trial	
☐ Capping	
☐ Decannulate	
☐ Change tube	
☐ Continue same care / size/ type of tracheostomy tube	
☐ Other	

Progress report

Tracheostomy daily care chart

KEY for suction: Record + for each suction
1= Minimal, 2=Moderate, 3= Profuse
M= Mucoid B= Blood, P= Purulent
(consider physio, saline nebs, sample for microbiology)

Anticipated outcomes:
To care appropriately for a pt with a tracheostomy
To support weaning from the tracheostomy
To prevent secondary complications

Daily checks	Day	Night
Bedside equipment contents		
Bedhead sign present / correct		
Suction working		
Correct size suction catheters		
Oxygen working		
Spare inner tube available		
Initials of staff checking		

Pt sticker

DATE:	08	10	12	14	16	18	20	22	24	02	04	06
Oxygen : Check system delivery												
Humidification: Check adequacy												
Inner tube : change & clean *(at least 4 hrly)*												
Assess **need** for **Tracheal** suction. Using key Record quantity & type of secretions												
Yankuer suction: use key to record quantity & type of secretions												
Subglottic suction, record amount in mls 4hrly *(record nil if completed but no aspirate)*												
Tapes: check they are secure												
Cuff : record if inflated (I) or deflated (D) If inflated check cuff pressure: Adjust to 20–25 cm H_2O & record pressure *(if no cuff present or cuff deflated record X)*												
Speaking valve (SV): Check & record use: **S**=SV insitu, N=no SV insitu *(remove when patient is asleep)*												
Initials of staff completing checks												

	Day	Night
Dressing and Tapes: Change as required *(At least every12- 24 hrs using ANTT)*		
Stoma : Record condition each shift : 1. Clean and dry 2. red /excoriated 3. Mucky (consider infection) 4. Broken down 5. Other e.g. sutures		
Initials of staff completing checks		