

All patients with an ALTERED AIRWAY will be nursed in designated ward areas across the Trust:

Head and Neck for surgical patients at WRH
Acute Respiratory Unit for respiratory patients at WRH
Medical High Care for medical patients at WRH
Ward 5 for patients at Alexandra Hospital

MANAGEMENT OF PATIENTS WITH TRACHEOSTOMY TUBES

Key Document code:	WAHT-KD-022
Approved by:	<i>Intensive Care Forum</i>
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Key Amendments

Date	Amendment	Approved by
8 th April 2019	Notes for Alexandra Hospital Wards	ICM Forum
14 th October 2019	Designated ward area information	ICM Forum

Introduction

A Tracheostomy is the creation of an opening into the trachea via the neck, with the insertion of an indwelling tube. [Balliere, 1989]. It is placed in the trachea just below the 2nd or 3rd tracheal rings, below the level of the vocal cords, thus rendering the patient temporarily without a voice.

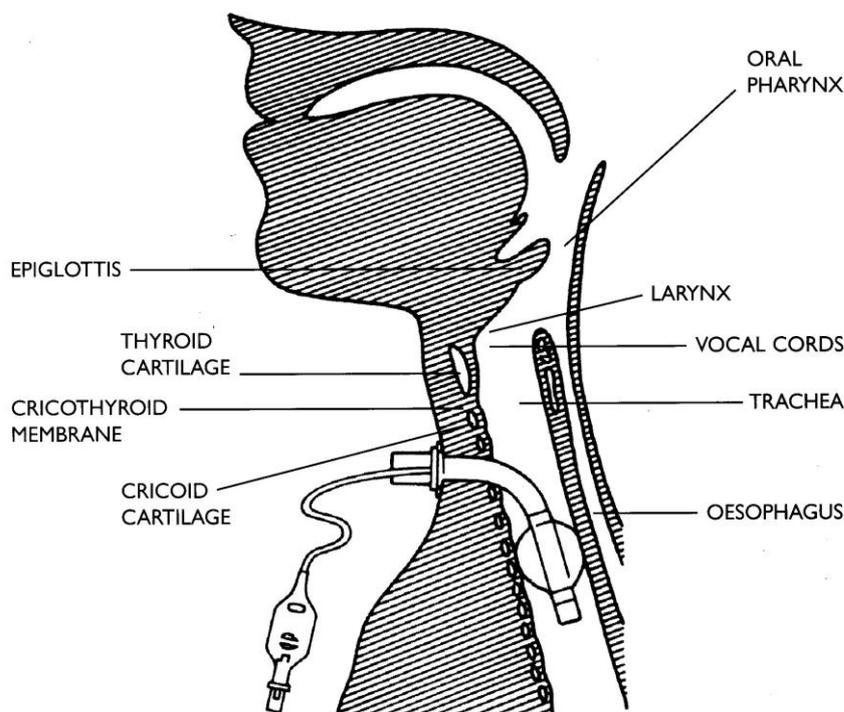


Figure 3: The Anatomical Position of a Cuffed Tracheostomy Tube.

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Types of Tubes

All are made of non-irritant material, curved; approximately 4 inches long and have a flange for the attachment of tapes/tube holder enabling the tube to be secured.

- Single lumen (cuffed or uncuffed)
- Tubes with inner cannulas (cuffed or uncuffed)
- Fenestrated, (cuffed or uncuffed)
- Adjustable flange
- Tubes with sub glottis suction port

How a Tracheostomy Is Formed

Cricothyroidotomy – an opening is made into the cricothyroid membrane and a temporary tube is inserted in an emergency or a minitracheostomy tube (single uncuffed lumen) in a planned procedure.

- Not suitable for conventional ventilation
- Not suitable for patients with no gag or cough reflex
- Is often used as a weaning measure
- Good access for suctioning
- Ideal in patients who are breathing but where sputum retention is a problem

Surgical Tracheostomy- performed in theatre, an incision is made between the 2nd and 3rd tracheal rings. The muscle is divided and the tracheal cartilage is cut and often a small piece is removed to make way for the formal tube. A cuffed, fenestrated or unfenestrated tube is used.

- Suitable for all types of patient
- Maintains a patent airway
- Facilitates the delivery of conventional ventilation

Percutaneous Tracheostomy- may be performed in the Intensive Care Unit. A small incision is made in the patient's neck and a guide wire is inserted into the trachea under fibre optic guidance. The incision site is dilated up to a diameter that will allow a tube to be inserted over the guide wire. Doctor requires training in the technique.

- Less traumatic than a formal tube
- No theatre time, and avoids moving the patient.
- Fewer complications

Indications for a Tracheostomy

- To bypass an obstruction in the upper airway
- To optimise weaning by reducing the requirement for sedation required to facilitate tolerance of an endotracheal tube
- To facilitate weaning by permitting intermittent periods of discontinuation of mechanical ventilatory support
- To optimise access for tracheal suction

Complications of Tracheostomy Insertion

Immediate:

- Haemorrhage
- Surgical emphysema
- Pneumothorax
- Accidental disconnection from ventilator

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- Acute loss of airway patency
- Cricoid cartilage damage

Delayed:

- Blockage with secretions
- Infection – pulmonary or stoma
- Tracheal stenosis
- Ulceration of trachea
- Sinus development
- Airway obstruction
- Tapes/holder too tight
- Mucosal ischaemia caused by over inflated cuff
- Poor stoma closure

Competencies Required

A Qualified Nurse/Physiotherapist who has undergone appropriate training using the Tracheostomy Competency Package.

Patients Covered

Any patient in any area with a tracheal tube.

DETAILS OF GUIDELINE

Care of the Patient with a Tracheostomy

The nursing care of a patient with a tracheostomy tube in situ can be divided into six sections:

1. Maintaining the airway
2. Tracheal suctioning/subglottic suctioning
3. Care of the stoma
4. Removal of the tracheostomy tube
5. What to do if things go wrong
6. Psychological support and education
7. Speech and Swallowing

These will be described in more detail and specific procedures for care will be highlighted. All care must be documented in the Tracheostomy Care Pathway.

Maintaining the airway:

Tube holder

The tracheostomy tube must be secured with tube holder to ensure that the airway is maintained.

Movement can result in:

- Traumatic extubation
- Displacement of the tube
- Loss of cuff seal
- Oesophageal intubation
- Patient discomfort

The tube holder should be checked once per shift to ensure that it is clean and effectively secured. It should be changed if visibly soiled. This should be recorded on the Tracheostomy Observation Chart.

The procedure should involve two nurses, as there is a risk of decannulation. Both nurses should decontaminate their hands by performing hand hygiene and apply gloves and aprons. The assisting nurse should maintain the security of the tube whilst the other nurse carries out the procedure.

Securing with Tracheostomy Holder. The holder is positioned around the patient's neck with the soft side to the patient. The attachment pieces are threaded through the flanges on the tube and folded back to connect with the Velcro.

The tube holder should be attached tight enough to keep the tracheostomy tube firmly in place but loose enough to allow two fingers to fit between them and the patient. This will help to minimise the risk of reduced cerebral blood flow from the carotid arteries due to external pressure.

Cuff Pressure Measurements:

Increased pressure inside the cuff may cause damage to the tracheal mucosa reducing the perfusion, which itself may lead to tracheal damage. [St Georges Healthcare NHS Trust, 2012] However, if the cuff is not adequately inflated it will allow the tube to move in the trachea causing erosion, ulceration and loss of airway patency.

The cuff pressure must be measured and recorded at least once per shift on the Tracheostomy Observation Chart.

The tracheostomy cuff may be considered for deflation but this decision needs to be made by the attending physician or competent practitioner (see Removal of the Tube)

A hand pressure manometer is used to check the pressure in the cuff and indicates the pressure exerted by the cuff on the tracheal wall. Pressure should not exceed 25cmH20.

Safety Equipment:

Within the patient's bed space there should be certain equipment readily available when caring for a patient with a tracheostomy tube (Wilkinson et al 2014):

- Oxygen supply and appropriate delivery system, e.g. tracheostomy mask
- Humidification and nebulising device/equipment
- Ambubag and mask
- Hyperinflation bag (Waters circuit)
- Suction unit and appropriate sized suction catheters
- Patient sign indicating Altered Airway – green
- Tracheostomy Box - this will accompany the patient to the ward on transfer from the Critical Care Unit and will contain
 - Tracheal dilators
 - Replacement tube of the same size and one a size smaller
 - Tracheostomy dressing
 - Tapes/Velcro holder
 - Gauze
 - 10 ml syringe
 - Disposable inner cannulas
 - Occlusive dressing
 - Stitch cutters
 - Cuffed tracheostomy tube of same size for resuscitation
 - Carbon Dioxide detector
 - Aquagel

This equipment should be checked at least once per shift and documented on the Tracheostomy Observation Chart.

Humidification:

As the tracheostomy tube bypasses the body's own humidification and filtering system, some form of humidification must always be provided to prevent the patient's secretions from becoming dry and crusty. [Choate and Barbetti 2003]

There are several methods available:

- Aerosol therapy, via oxygen and elephant tubing attached to a tracheostomy mask, may be used alone or in conjunction with a warming element, i.e. an aquapak motor.
- A Buchanan bib is a foam bib that lies around the neck protecting and humidifying the area in front of the tube by trapping and recycling the patients expired moisture.
- A Swedish nose is a small connector that fits onto the tube and may be appropriate as long as the patient is well hydrated and the secretions are minimal. A clip on device can be used in conjunction with this device to deliver oxygen.
- Nebulised saline may be given if prescribed to reduce the viscosity of secretions.
- It should be noted here that systemic hydration is paramount, as no amount of humidification will assist a dehydrated patient whose mucous membranes will be drier, reducing mucocillia transport causing retention of secretions.

The humidification device should be recorded on the Tracheostomy Observation Chart.

Inner Cannula Tube Maintenance:

Two-piece tracheostomy tubes have an inner tube that can be either removed and cleaned if reusable or replaced if disposable. Secretions can stick to the internal lumen of a tracheostomy tube and greatly reduce the inner lumen diameter, increasing the work of breathing and may, in severe cases block the airway altogether.

A tracheostomy with an inner cannula has the advantage that the inner cannula can be changed frequently reducing the risk of occlusion.

The inner tube must be replaced or cleaned and replaced at least once per shift depending on the secretions and recorded on the Tracheostomy Observation Chart.

**Procedure for Cleaning a Reusable Inner Cannula:
(Backup Measure – non disposable 2 piece tube in situ only)***Equipment required:*

Tracheostomy Box
Sterile dressing pack
Catheter tip syringe
2 sterile normal saline sachets
Patient own clean temporary inner tube
Sterile water
Plastic storage pot with lid and patient label
Sterile gloves and an apron must be worn

Method:

- Prepare the patient and explain the procedure. Apply PPE and perform hand hygiene
Sit the patient up and perform tracheal suction if necessary.
- Check contents of tracheostomy box and ensure that tracheal dilators are to hand but not opened.

- Loosen lid on pot containing clean temporary inner tube and check that the pot is labelled with the patient's name and the date the tube was opened. If the pot is uncovered or you have any doubt about the efficacy of the tube, discard and use a new temporary inner tube, pot and re-label.
- Assemble equipment on the trolley, opening the catheter tip syringe and dressing onto the sterile field. Place normal saline into the larger side of the lotion tray and sterile water into the smaller side.
- Wearing procedure gloves from the pack, twist the permanent inner tube to unlock it and remove. Place in the normal saline solution.
- Insert the clean temporary inner tube and lock into position. N.B: This should only be left in situ for 15 minutes.
- Attach the catheter tip syringe to the inner tube and keeping the other end of the tube immersed in the saline gently suck through and depress the plunger repeatedly until all secretions are cleared. Use a gauze swab to wipe clean the outside of the tube.
- Rinse the tube in sterile water and dry using a clean piece of gauze.
- Remove the temporary inner tube and place in lotion tray in sterile water. Immediately replace with the clean, dry permanent inner tube.
- Rinse the temporary tube in sterile water and dry with gauze.
- Return the tube to the labelled pot replacing the lid firmly.
- Remove PPE and decontaminate hands by performing hand hygiene
- Ensure the patient's comfort and safety and document procedure in the patient's notes or care plan.

Procedure for Changing an Inner Cannula:

Equipment required:

Tracheostomy box
Sterile dressing towel
Gauze swabs
New tracheostomy inner cannula
Sterile gloves and apron

Method:

- Prepare the patient and explain the procedure. Sit the patient up and perform tracheal suction if necessary.
- Check contents of tracheostomy box and ensure that tracheal dilators are to hand but not opened.
- Wash hands and don PPE and assemble and prepare equipment on a trolley, opening the gauze swabs, inner cannula and gloves onto the sterile field.
- Wearing the gloves grip the ring pull of the inner cannula and steady the tube as you pull the inner cannula out. Discard.
- Insert the new cannula and lock into position whilst securing the tube.
- Ensure the patient's comfort and safety
- Remove PPE and decontaminate hands by performing hand hygiene.
- Document procedure in the patient's notes or care plan.

Tracheal Suctioning:

Tracheal suction should not be carried out routinely at set times, but only after careful assessment of the patient.

Indications for Suction:

Indications:

- Visible or audible secretions

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- To maintain the patency and integrity of the artificial airway.
- Increased coughing
- A decrease in O2 saturations.
- Course / absent breath sounds on auscultation

Initially the tube will irritate the trachea, thereby increasing the amount of secretions produced. Frequent suctioning may be required at this stage. [Harkin, 1998].

Complications of tracheal suctioning are:

- Hypoxia
- Cardiovascular instability
- Atelectasis
- Mucosal damage
- Bronchospasm
- Introduction of infection
- Raised Intracranial pressure

The lowest effective vacuum pressure should be used when suctioning to reduce the complications.

Recommended suction pressure for adults

13.5-20 Kpa or 80-120mmHg

[Glass and Grap, 1995]

The appropriate suction catheter should always be used according to the size of the tracheal tube. Use the smallest diameter catheter necessary to clear secretions.

Procedure for Tracheal Suctioning:

Equipment required:

Functional suction unit (wall mounted or portable)

Suction tubing

Sterile suction catheters

Y – connector if needed

Sterile disposable gloves

Tissues

Oxygen therapy

Yankauer suction catheter

Sterile water

Apron, gloves

Method:

- Perform hand hygiene and don PPE
- Explain procedure and prepare patient sitting upright in bed. Consider pre-oxygenation of patients prone to desaturation during suction
- Connect appropriately sized catheter to the suction apparatus leaving the catheter in the outer packet.
- Ask the patient to take a few deep breaths to reduce hypoxia.
- Wearing a sterile glove remove the catheter from the outer packet and pass into the tracheostomy tube until there is resistance or the patient coughs.
- Withdraw the tip applying suction as you do so slowly and continuously out of the trachea.

- Only apply suction on withdrawal of the catheter and the suctioning should last no longer than 15 seconds. [Knox, 1993]
- Remove and discard the glove and catheter.
- Allow the patient to deep breathe and recover between suctioning and rinse the tubing through with sterile water
- Repeat the whole procedure until the secretions are cleared and the patient is breathing comfortably.
- Remove PPE and decontaminate hands by performing hand hygiene
- Note the amount, colour and tenacity of secretions and document accordingly.
- Send a sputum specimen for M, C and S if indicated.
- Document the procedure on the patient's Tracheostomy Observation Chart.

Procedure for Subglottic Suctioning:

The suction ports should be aspirated using a 10ml syringe every 1-2 hours (depending on the quantity of secretions)

The port must be suctioned prior to letting the cuff down and before any significant repositioning events.

If the suction lumen appears blocked or secretions are too thick to aspirate 5mls 0.9% Normal Saline may be injected via the suction port to test patency or clear the suction port prior to further aspiration attempts.

N.B It may be possible to achieve 'above cuff voicing' with occlusion of the port

Care of the Stoma:

A tracheostomy stoma is a surgical wound and should be treated as such to maintain patient comfort, promote healing and reduce the risk of infection. Tracheostomy sutures may be removed 4 days after surgery following consultation with the Surgeon / Anaesthetist.

Secretions collected above the tracheostomy cuff may ooze from around the stoma site.

The wetness that results can promote irritation of the skin and can lead to soreness. It may also act as a medium for bacterial growth or prevent the stoma from healing.

The patient will be transferred to the ward from theatre or Critical care Unit with foam-backed dressing in situ and tapes or tube holder securing the tracheostomy tube.

The dressing should be checked at least once per shift to ensure that it is clean and dry.

At least once per day or more frequently if necessary, the dressing should be changed and this should then be recorded on the Tracheostomy Observation Chart.

Aseptic technique must be employed and the following procedure followed :

Two nurses are required to perform due to the risk of decannulation.

Procedure for the Care of the Stoma:

Equipment needed:

Tracheostomy Box

Sterile dressing pack

2 sachets of Normal Saline

Sterile Tracheostomy Dressing (Lyof foam)

Gloves and apron

Method:

- Prepare the patient and explain the procedure. Don PPE and decontaminate hands by performing hand hygiene
- Sit the patient up and perform tracheal suctioning if necessary.
- Ask the patient to slightly extend their neck as this allows easier access to the stoma site.
- The assisting nurse applies gloves and maintains the security of the tube throughout the procedure.
- Wash hands and assemble equipment on a trolley, opening the normal saline and dressing onto the sterile field.
- Remove soiled dressing and discard.
- Assess the stoma site. If red, inflamed or signs of infection present, take a swab and send for M, C and S.
- Clean area with normal saline and dry with gauze.
- If the skin around the stoma site appears sore a barrier cream may be applied. Contact the Wound Care Team for advice.
- Apply clean dressing and ensure patient's comfort.
- Remove PPE and decontaminate hands by performing hand hygiene
- Document procedure in the patient's notes or care plan.

Removal of the Tube:

A multidisciplinary decision will have been made and documented in the Tracheostomy Care Pathway regarding the plan for removal of the tube. In certain circumstances it may not be appropriate for the tube to be removed at all. In some situations it may be necessary to downsize the tube.

If the plan is to remove the tube then the decannulation guideline may be applied once the patient fits the criteria suggested in the Tracheostomy Care Pathway.

Removal of the tube is only appropriate when the patient has the ability to maintain their own airway and expectorate secretions without the need for tracheal suctioning.

Patients' needs to be assessed individually by the parent team with consultation of the multidisciplinary team involved in their care. [Harkin and Russell, 2001]

There should be adequate staff on duty to closely observe the patient for the first 24 hours. The patient should be fully informed and aware of the intended procedure and help should be readily available if the patient becomes distressed.

Timing of the decannulation should be optimal; when the patient is rested early in the day is preferable, ideally Monday to Friday between 9am and 3pm.

Two Health Care Professionals are required for these procedures who have undertaken the necessary competency in the Tracheostomy Competency Package.

Procedure for removing the tracheostomy tube:

Equipment required:

Tracheostomy Box
Sterile dry dressing
Occlusive film dressing
10 ml syringe
Gloves and apron

Method:

- Prepare the patient and explain the procedure.

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- Don PPE and decontaminate hands by performing hand hygiene. Sit the patient up in bed.
- Prepare the equipment on the trolley, opening the dry dressing and occlusive dressing onto the sterile field.
- Attach the patient to a pulse oximeter to detect any deterioration during the procedure.
- Ensure that the tracheal cuff is fully deflated.
- Remove any sutures present.
- Apply sterile gloves and pass a suction catheter appropriate to the tube size into the tracheostomy and gently but firmly withdraw the tube as you withdraw the suction catheter applying suction as you do so.
- The assisting nurse may dry the stoma and apply the dry dressing covered with the occlusive one.
- Remove PPE and decontaminate hands by performing hand hygiene
- Ensure the patient's comfort.
- Document the procedure in the patient's notes and care plan and in the Tracheostomy Care Pathway.
- Encourage the patient to press on the dressing when he/she coughs to prevent air from escaping.
- Reapply oxygen if appropriate and observe the patient closely for the next 24 hours.
- The dressing should be changed daily until the stoma closes, usually within a few days.
- The tracheostomy box should be kept with the patient for 24 hours and then the nurse can contact the Critical Care Outreach Team to collect it on Bleep 421/422 at WRH or 0216/0217 at the Alexandra Hospital.

Elective Changing of a Tracheostomy Tube:

It is recommended that a tracheostomy tube, without an inner cannula, should be changed every seven to fourteen days to avoid the risk of occlusion with dried secretions. A two-piece tube system should be considered for complete tube change at 4 weeks [EEC Directive 1993]. The decision to change any tracheostomy tube must be made by the attending physician or competent practitioner. This should only be undertaken by a practitioner with the appropriate competency.

Recannulation within 7 days should only be undertaken by trained Medical staff using fibre optic scope. This should include the use of capnography to ensure correct placement.

What to do if things go wrong:

Careful monitoring of the tracheostomy patient will result in the identification of problems at an early stage. A respiratory assessment of the patient should be undertaken when the observations of Temperature, Pulse, Respiration and Blood Pressure and National Early Warning Scores (NEWS) are recorded 4 hourly or more frequently as required.

Emergency tracheostomy management flow chart is available on the reverse of the patients bedhead tracheostomy sign

Signs of Respiratory Distress

- | | |
|------------------------------|------------------------------------|
| • Laboured breathing | • Use of accessory muscles |
| • Sweating | • Anxiety |
| • Increased respiratory rate | • Fall in pulse oximetry readings |
| • Increased blood pressure | • Cyanosis [Cox and McGrath, 1999] |

If the patient is in distress

Don PPE and decontaminate hands by performing hand hygiene

- Sit them up in bed well supported with pillows

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- Reassure the patient
- Ensure that the oxygen therapy is being administered correctly
 - Accurate to prescription
 - Delivery system intact
- Ensure that the humidification system is working effectively
 - Sufficient water in bottle
 - Tubing intact
- Suction the patient
- If patient remains distressed call for help

If the tracheostomy tube appears blocked

- Let down the cuff
- Call for urgent help
- Reassure the patient
- Apply oxygen via facemask
- Remove inner cannula
- Suction the patient
- If necessary remove the tube if still blocked
- Insert tracheal dilators to maintain stoma and airway and wait for help

If the tracheostomy tube falls out or has to be removed due to blockage

- Call for urgent help
- Reassure the patient
- Insert the tracheal dilators to maintain the stoma and airway
- Apply oxygen via facemask
- Monitor patient closely until help arrives
- Remove PPE and decontaminate hands by performing hand hygiene

Who to call for help:

If routine query then contact outreach or ward based maxillo-facial junior doctor

If distressed or rapidly deteriorating patient then fast bleep ICU registrar and ward based maxillo-facial junior doctor.

Psychological Support and Education:

The psychological status of the patient must be considered by the nurse as they may be unable to speak to identify their fears and needs. [Albarran, 1991]

Alternative methods of communication must be employed, for example a pen and paper or Communication charts and a patient call bell must always be readily available.

If the patient has been transferred from a Critical Care Area they may well be sleep deprived and disorientated. It is vital that the nurse spends time with the patient explaining about the tracheostomy itself, the reason for its insertion and the subsequent care that will follow.

The patient may need reassurance and teaching about coughing, deep breathing and oxygen therapy.

Ideally the patient should be nursed in a main ward area where nursing staff can be available and easily summoned by the patient or relatives. The patient's relatives may also need support and education regarding the tracheostomy and its care. They may wish to assist in their relatives care and this should be encouraged as with any other nursing care as it enables the relatives and the patient to feel more involved in the recovery process. Discharge documentation should be used in preparation.

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Speech and Language Therapists (SLT) are involved in the assessment and management of tracheostomised patients who present with swallowing or specific communication difficulties. An assessment of swallowing function by an SLT is required prior to the commencement of oral feeding in patients, identified as being at risk of dysphagia. This is to reduce the risk of aspiration, which may lead to aspiration pneumonia. A multi-disciplinary approach is recommended to ensure appropriate and effective care for the individual patient.

If the complex interrelation between swallowing and respiration is disrupted, significant impairment can result. Additionally, due to the shared functions of the hypopharynx and the larynx, the impact of dysphagia is often heightened in the individual with respiratory compromise. (St Georges Healthcare NHS Trust 2012)

When to consider a referral to the Speech and Language Therapy Department for a swallowing assessment:

Referral would be appropriate for tracheotomised patients with:

- Neurological involvement – bulbar
- Head and Neck surgery
- Evidence of aspiration of food/fluid/oral secretions on tracheal suctioning
- Persistent wet or weak voice when cuff is deflated and speaking valve or decannulation cap in place
- Coughing in relation to oral intake
- Patient anxiety or distress during oral intake

SLTs are able to assess swallowing at bedside or using instrumental assessment such as Fiberoptic Endoscopic Evaluation of Swallowing (FEES) and Videofluoroscopy.

FEES allow direct visualisation of pharyngeal and laryngeal anatomy and physiology before, partially during and after the swallow.

Videofluoroscopy enables radiographic visualisation of the swallow, the triggering of the pharyngeal swallow in relation to the bolus and the motor aspects of the pharyngeal swallow. Videofluoroscopy is available for patients who are appropriate to be assessed in the radiology department.

SLT's can also assess and facilitate communication using non-verbal and verbal communication methods as well as manipulation of the tracheostomy tube to facilitate the voice. Referral to the SLT can be made by telephone via switchboard

The physiotherapist will also visit the patient regularly and is a great source of reassurance and education to the patient and relatives. If the patient has been transferred from a Critical Care Unit to the ward the Outreach Team will follow the patient up at least until the tube is removed.

The team are available during the day seven days a week to support and teach the nurses on the ward, the patient and their relatives about tracheostomy care. Please do not hesitate to contact a member of the team if there are any queries about tracheostomy care.

Discharge Planning

When tracheostomy patients are ready to step down from ICU to the ward they should be identified at the morning safety brief on ICU and discussed with the multidisciplinary team to ensure that they are transferred to one of the designated wards before 5pm

At WRH - Head and Neck Ward for Surgical patients, Laurel 2 or Medical High Care for Medical patients.

At the Alex - Ward 5 (Respiratory Ward)

Critical Care Outreach will liaise directly with Head and Neck ward at WRH following the safety brief and the transfer will be managed directly between the two wards to facilitate discharge as early as possible in the day with Outreach and Physiotherapy support.

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Appendix 1. Bed head sign - Tracheostomy

This patient has a

TRACHEOSTOMY

There is a potentially patent upper airway (Intubation may be difficult)
Oxygen and nebulisation to be given via the neck in the first instance or by both routes if there is uncertainty about tracheostomy patency

Follow the TRACHEOSTOMY algorithm of breathing difficulties

Surgical/Percutaneous

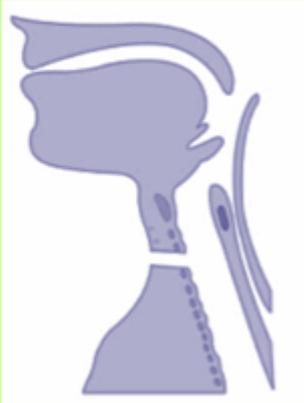
Performed on

Tracheostomy tube type

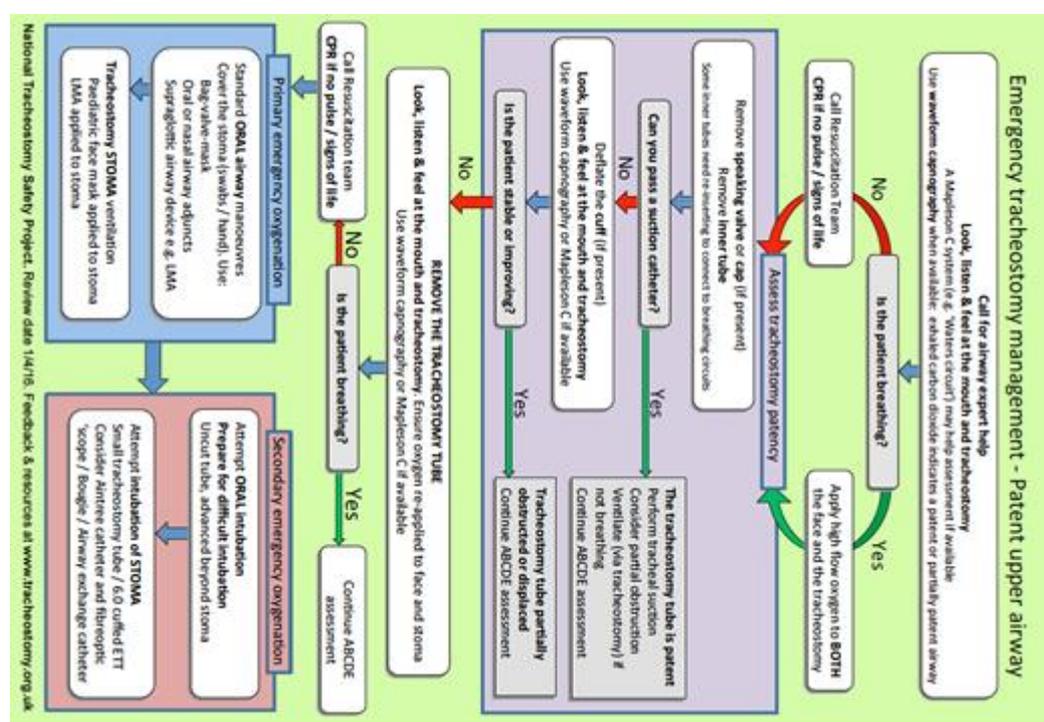
Tracheostomy tube size

Patient Name

Grade of intubation



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Appendix 2. Bed head sign – Laryngectomy

This patient has a

LARYNGECTOMY

and **CANNOT** be intubated, oxygenated or resuscitated via the mouth

Follow the LARYNGECTOMY algorithm of breathing difficulties

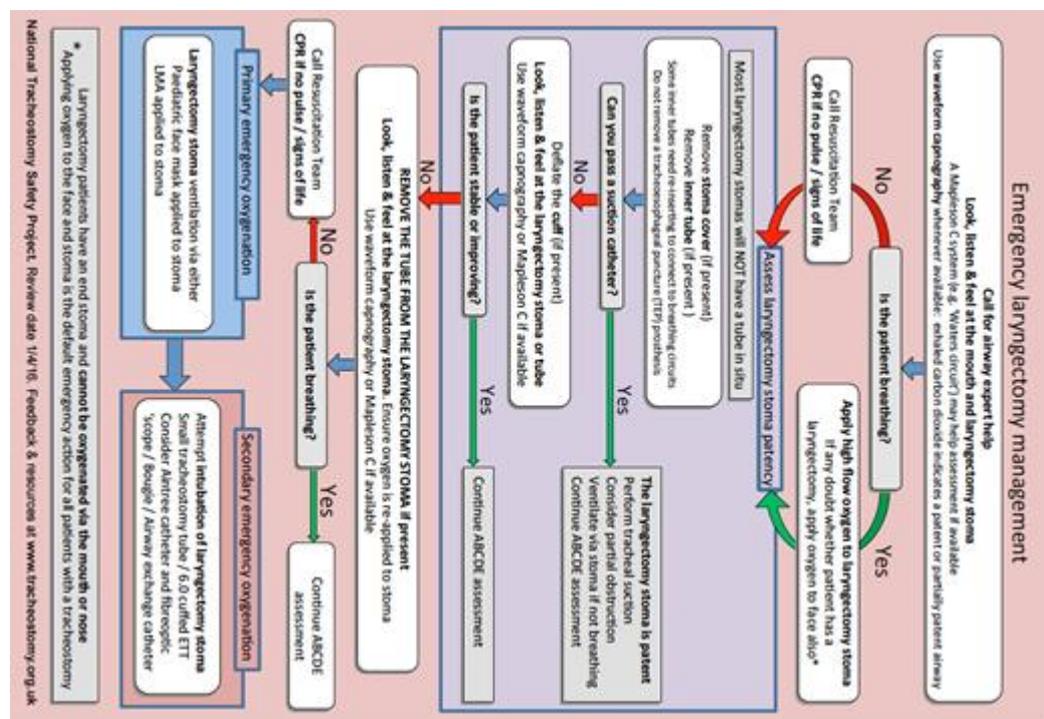
Performed on (date)

Tube size (if present)

Patient Name



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Appendix 3. Emergency box contents

TRACHEOSTOMY BOX CONTENTS:

2 spare tracheostomy tubes:
1 same size as current one
1 size smaller than current one
1 cuffed tube of the same size in case of resuscitation
Tracheal dilators
Tracheostomy tube holder or tapes
Stitch cutters
Lubricating gel
Gauze
Tracheostomy dressing
10ml syringe
Occlusive dressing
Carbon dioxide detector

WITHIN THE BEDSPACE:

Oxygen and humidification device
Waters Circuit
Bag/Valve/Mask
Suction unit, tubing and appropriate catheters
Yankeur suction
Sterile gloves
Tracheostomy care pathway
Bed head sign - Trach/Lary