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

**Head and Neck for surgical patients at WRH**
**Laurel 2 for respiratory patients at WRH**
**Medical High Care for medical patients at WRH**
**Ward 5 for patients at Alexandra Hospital**

# MANAGEMENT OF PATIENTS WITH A LARYNGECTOMY

This guidance does not override the individual responsibility of health professionals to make appropriate decisions according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

## Introduction:

This guideline is to be used in conjunction with the **"**Acute Care Pathway for all patients with a Laryngectomy.**"** It is designed specifically for clinical staff working with patients who have undergone a laryngectomy. Users are also directed to the "Management of patients with tracheostomy tubes within the Worcestershire Acute Hospital Trust" guideline where appropriate.

## This guideline is for use by the following staff groups:

For all WAHT staff working with patients who have undergone laryngectomy surgery.

### Lead Clinician(s)

| | |
|---|---|
| Mr Chris Ayshford | Consultant ENT Surgeon |
| Guideline reviewed and approved by Head and Neck Directorate meeting on: | 13th November 2024 |
| Review Date:<br>This is the most current version of the document and should be used until a revised version is available | 13th November 2027 |

## Key amendments to this guideline

| Date | Amendment | Approved by: |
|---|---|---|
| August 2013 | New Guideline | |
| 08/11/2013 | Guideline approved for publication | Head & Neck Directorate meeting |
| 06/01/2015 | Guideline reviewed with minor amendments made to content. Care pathway added as appendix to document | Liz Gould |
| 15/12/2017 | Document approved for two years - PG 2 – Return to Head and Neck ward (not Chestnut)<br>PG 3 – Day 3 – contents of laryngectomy equipment bag<br>PG 8 – Day 1 – Following cuff deflation change tracheostomy<br>tube to non-fenestrated laryngectomy tube providing there is no bleeding/fistula or other cause for airway compromise. Diameter to be agreed on a case by case basis, but default; length 55 with Xtra-Moist HME cassette (or buchanan bib if unable to tolerate cassette).<br>PAGE 1: - Addition for "Approved at ENT Directorate Meeting: 15th December 2017<br>And PAGE 8 – Following cuff deflation change tracheostomy tube to non-fenestrated laryngectomy tube providing there is no bleeding/fistula or other cause for airway compromise. | Head and Neck Directorate Meeting |
| January 2018 | Change wording of 'expiry date' on front page to the sentence added in at the request of the Coroner | |
| November 2019 | Guideline review with amendments & additional appendices | |
| November 2024 | Guideline review and amendment to appendices adding in SOP, letters and out of hours guidance for SVR service. | ENT governance No 2024 |

**Contents page:**

## Introduction:

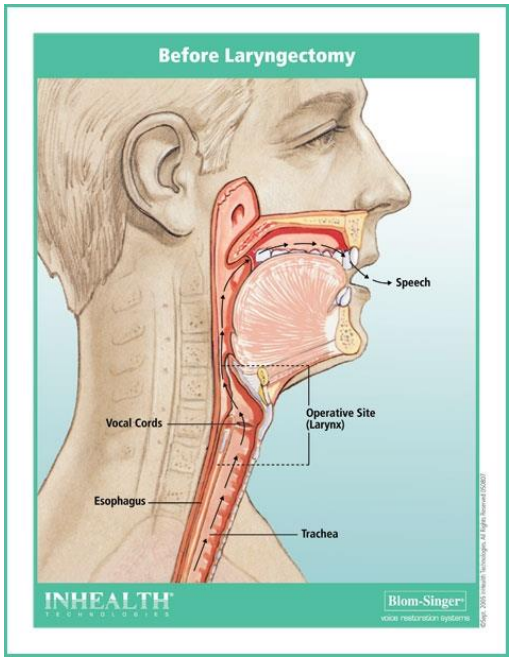
This guideline has been produced in order to enable Trust staff to manage patients, who present to the Trust, including:

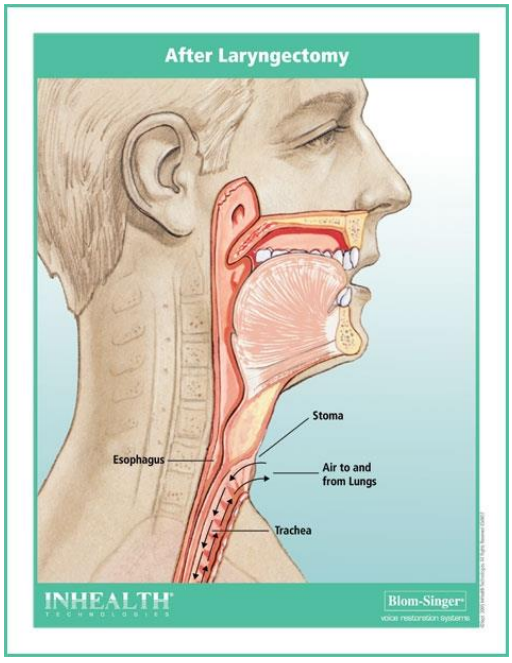
- New laryngectomy patients
- Established laryngectomy patients

In conjunction with other WAHT documents it serves to educate and raise awareness for staff on what laryngectomy surgery means for the patient, the differences between laryngectomy and tracheostomy and the necessary medical procedures required to ensure the best quality of care for this patient group. It is to be used in conjunction with a detailed acute care pathway highlighting the role of members of the Multidisciplinary Team (MDT) during the immediate and early post-operative period. It supports the National Tracheostomy Safety Project's (NTSP) work in ensuring that this patient group is cared for safely in our hospital environment.

## What Is a Laryngectomy?

A laryngectomy is the complete surgical removal of the larynx (voice box) which disconnects the upper airway (nose and mouth) from the lungs. The trachea is cut and then the open end is stitched onto the front of the neck. This is an irreversible operation and once it has been performed, the patient will never be able to breathe or be oxygenated or ventilated through the upper airway again.




(With permission from InHealth Technologies and Severn Healthcare)

## Indications for a laryngectomy

- For cancer of the larynx
- To manage chronic aspiration of gastro-intestinal contents
- For airway protection in the case of life threatening chronic aspiration and airway compromise

## Complications of a Laryngectomy:

Immediate:

- Risk of blockage of the trachea with secretion or blood
- Loss of normal warming and humidification through upper airway
- Fistulae
- Wound breakdown
- Infection
- Haemorrhage

Delayed:

- Risk of blockage of the trachea with secretions
- Infection – pulmonary or stoma
- Tracheal instability
- Ulceration of trachea
- Fistula development
- Tapes/holder too tight
- Stomal stenosis

## Care of the Patient with a new Laryngectomy Stoma:

All staff are required to refer to the "Acute Care Pathway for all patients with a Laryngectomy" in conjunction with this guideline. All laryngectomy patients should have a bed head sign (Appendix 1)

At WAHT it is usual practise for the patient to return to the designated head and neck ward with a double lumen, non- fenestrated, cuffed tracheostomy in-situ, the size may vary. This can be changed to a laryngectomy tube the following morning unless there is still bleeding from the wound or stoma. During the time in which the tracheostomy tube is in place, all aspects of tracheostomy care will need to be addressed including secretion management, inner tube changes, cuff pressure monitoring, humidification and oxygenation, dressings and stoma care.

**If the tracheostomy tube appears blocked**:
Refer to **"**MANAGEMENT OF PATIENTS WITH TRACHEOSTOMY TUBES WITHIN THE WORCESTERSHIRE ACUTE TRUST**"** guidelines for greater detail.

- Let down the cuff
- Reassure the patient
- Apply oxygen via tracheostomy mask
- Remove inner cannula
- Suction the patient
- Remove the tube if still blocked. Refer to emergency laryngectomy algorithm

A decision as to how long the cuffed tracheostomy tube should stay in place following surgery is usually made by the ENT surgical team after 24 hours once the patient is on the head and neck ward.. Multi professional contributions will help to direct the need for a laryngectomy tube and the decision around the length and size on a case by case basis. Those involved include:

- Consultant
- Ward Staff
- Clinical Nurse Specialist
- Physiotherapist
- Speech and Language Therapist

A laryngectomy tube is inserted and held in place initially by tube holders. These should be checked at a minimum of twice per day to ensure they are clean and effectively secure. The holders are positioned around the patient's neck with the soft side to the patient. The tapes or tube holder should be attached tight enough to keep the laryngectomy 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.

**Post-operative stoma:**

- Check that the sutures remain intact and secure
- Check skin integrity is maintained.
- The stoma site must be monitored for signs of infection or wound breakdown at least twice a day.

**Longer term stoma care**:

- Should be kept clean and dry.
- Crusts of secretions removed with forceps
- Humidification & nebulisation

## The Laryngectomy tube:

Laryngectomy tubes should be worn until an agreed weaning process can begin following discussion with all staff involved. Trial of baseplates, laryclips, tracheostomy tapes, stoma bib should commence. Gradual weaning towards complete removal of laryngectomy tube, should occur if the patient is not to undergo further treatment. If the patient is expecting radiotherapy treatment, full weaning from tube wear should be delayed until after this is completed.

Tubes should be changed routinely; a minimum of twice per day or more regularly if required, when there are excess secretions.

Secretions can stick to the internal lumen of a laryngectomy tube and greatly reduce the inner lumen diameter, increasing the work of breathing and may, in severe cases block the airway altogether. Any blockages can be easily dealt with by removal and replacement with a clean tube. If airway still appears blocked, refer to emergency algorithm,

**Indication for extended wear of the laryngectomy tube:**

- If further radiotherapy treatment is planned
- Lymphoedema causing airway obstruction
- Need to suction (i.e. tracheal mucosa is protected during suctioning)
- Viscosity of secretions (i.e. thick secretions can be removed on removal of the laryngectomy tube if restricting airway)
- Tracheomalacia
- Stoma stability/microstoma
- Posterior tracheal wall condition/movement

## Tracheal Suctioning:

Patients are taught to cough and clear their own secretions. Tracheal suctioning should not be carried out routinely but only if the patient is unable to cough and clear secretions independently, which may occur in the first 48 hours or emergency situations. Refer to emergency algorithm.

## Primary puncture:

On return to the ward, some patients may also have had a primary puncture at time of surgery, otherwise known as TEP (tracheo-oesophageal puncture). These patients will have a 14fr foley catheter in position which is used to commence enteral feeding post operatively as guided by dietitians. See 'care of TEP' section for further information.

## Humidification and airway resistance:

Following a laryngectomy, the air that patients breathe is no longer warmed, humidified and filtered by the nasal passages as they now breathe directly in and out via the stoma. Drying of the airway impairs mucus flow and cilia function resulting in thickened airway secretions. (RMH pg 815) Therefore some form of humidification must be provided to prevent the patient's secretions from becoming dry and crusty.

There are several methods available:

- Humidified oxygen administered via a tracheostomy mask if required.
- Humidified Moisture Exchange (HME) cassettes should be applied to the tube once the patient is maintaining their saturation rates satisfactorily and can tolerate the airway resistance introduced
- Nebulised saline x4 a day
- A laryngectomy stoma cover which ties around the neck protecting and humidifying the area in front of the tube by trapping and recycling the patients expired moisture.

## Patient self-care

- As soon as is realistic the patient should be encouraged to self-care for their stoma and maintain the hygiene of their laryngectomy tube.
- Provision of an equipment bag (provided by a prescription delivery company) containing mirror, light and other equipment should be provided in the first week following surgery.

## Safety Equipment:

- Each patient should have an altered airways emergency box containing tracheal dilators, tracheostomy tube, tracheostomy tapes, gauze, by their bed space. Available from critical care outreach team or head and neck ward.

## Procedure for Cleaning a Laryngectomy tube in hospital:

Appendix 2

## Changing the laryngectomy tube:

Appendix 3

**Care of the stoma:** see Appendix 4

### Care of the Tracheoesophageal Puncture (TEP) :

(With permission from University Hospital Birmingham, Queen Elizabeth Hospital; Laryngectomy Care Plan)

- Ensure the TEP feeding catheter is secured to the patient's skin with tape ensuring a skin barrier is applied with choice of tapes – transpore/micropore
- Ensure the length of the feeding catheter i.e. stoma to catheter junction remains unchanged and this is documented.
- Inflate the balloon with 2 mls water
- Alternate the position of TEP feeding catheter every 24 hours
- Monitor for any leakage of saliva or refluxed feed around the feeding catheter in the TEP

### Care of the Voice Prosthesis:

See Appendix 5

### What to do if things go wrong:

Careful monitoring of the laryngectomy 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 NEWS (National Early Warning Score) are recorded 4 hourly or more frequently as required.
In the event a patient needs resuscitation, remove the laryngectomy tube if this is in place. Replace this with a cuffed tracheostomy tube with cuff inflated. Start ventilation with ambubag. Follow emergency algorithm.

### Communication:

Not being able to communicate is extremely difficult for the patient with a laryngectomy. Each patient will have an agreed method of communicating following surgery. Not all patients are suitable for speaking valve placement therefore other modes of communication can be utilised alongside a speaking valve or independently. These include:

- Low tech communication: pen and paper or whiteboard
  - Mouthing
  - Oesophageal voicing
- High tech communication: text to speech app
  - Electrolarynx
  - Liaise with the specialist speech and language therapist for advice.

### Psychological Support and Education:

Laryngectomy surgery is life altering and requires the patient and their family to adjust to a new normal. Team members involved to support psychological health include a Head and Neck Counsellor and wider psychological service, CNS, SLT, Physiotherapist, ward nursing staff.

## Care of the established laryngectomy stoma:

Long term laryngectomy patients when admitted to the trust should be nursed on a designated altered airways ward: respiratory, medical short stay or head and neck ward.
Established laryngectomy patients are usually independent in their stoma care and not all patients will have a laryngectomy tube insitu. Refer to appendix 4 for stoma care and page (7) for humidification advice.
If a patient has a Tracheo-oesophageal voice prosthesis in situ, this will need cleaning and checking for leaks (see appendix 5). If a voice prosthesis is not in situ then there is no risk of aspiration as food pipe and airway are totally separated (unless a post-operative fistula is present).

## Discharge Planning:

Refer to:

- **"Adult patients going home with an altered airway - Guidelines for the care and training required for carer/patient prior to discharge from hospital"**
- **WAHT "Altered Airway Discharge Pathway"**
- **Adult Laryngectomy Patient Information/Assessment Booklet**

Encouraging independence as soon as possible and throughout their admission will facilitate earlier discharge & avoid Hospital Acquired Functional Decline (HAFD).

All laryngectomy patients will have seen a SLT prior to discharge and will have an outpatient follow up arranged before leaving hospital and provided with spare equipment tailored to their individual needs. All patients will have been registered with a supply company.
Those who have a voice prosthesis will have completed the competencies for self-management and will have been provided with:

- spare foley catheter tube – 14 fr and 8 fr, spigot, syringe, tape, aqua gel, contact numbers in case of an emergency, dilator, valve cleaning brush, voice prosthesis record card
- Their valve will have been checked for leakage when drinking and a tub of thickening powder will have been provided.

## Monitoring Tool

| | |
|---|---|
| How will monitoring be carried out? | Audit |
| Who will monitor compliance with the guideline? | ENT Directorate meetings<br>Ward meetings |

| STANDARDS | % | CLINICAL EXCEPTIONS |
|---|---|---|
| Documentation fully completed | 100% | None |
| Staff Knowledge ? Staff undertaking care of laryngectomy have relevant knowledge / have undertaken training in the care of laryngectomy | | Staff who have not attended training |
| All appropriate Equipment Available | | Supply Issue |

## References


- National Tracheostomy Safety Project (NTSP) http://www.tracheostomy.org.uk/Resources/Printed%20Resources/NTSP_Manual_2013.pdf


### CONTRIBUTION LIST

**Key individuals involved in developing the document**

| Name | Designation |
|---|---|
| Catherine Ball | Clinical Nurse Specialists |
| Mirjana Rasovic | Speech and Language Therapists |

**Circulated to the following individuals for comments**

| Name | Designation |
|---|---|
| Emma Boffey /Emma Jameson | Physiotherapists |
| Alison Spencer | Lead Critical care Outreach Nurse |
| Rebecca Morgan/Rebecca Allies/Megan Wright/Abigail Currie | Ward Manager & Sisters Head and Neck Ward |

**Circulated to the following CD's/Heads of dept for comments from their directorates / departments**

| Name | Directorate / Department |
|---|---|
| Mr Chris Ayshford | Consultant Head and Neck Cancer and Thyroid Surgeon and Clinical Lead for Head and Neck Cancer |
| Mr Graham James | Consultant Oral and Maxillofacial Surgeon and Director of Surgery |
| Julie Briggs | Directorate Manager |
| Steve Graystone | Associate Medical Director – Patient Safety |
| Chris Doughty | Senior Resuscitation Officer |

**Circulated to the chair of the following committee's / groups for comments**

| Name | Committee / group |
|---|---|
| Clinical Management Board | |

## Appendix 1

This patient has a

# LARYNGECTOMY

and CANNOT be intubated, oxygenated or resuscitated via the mouth

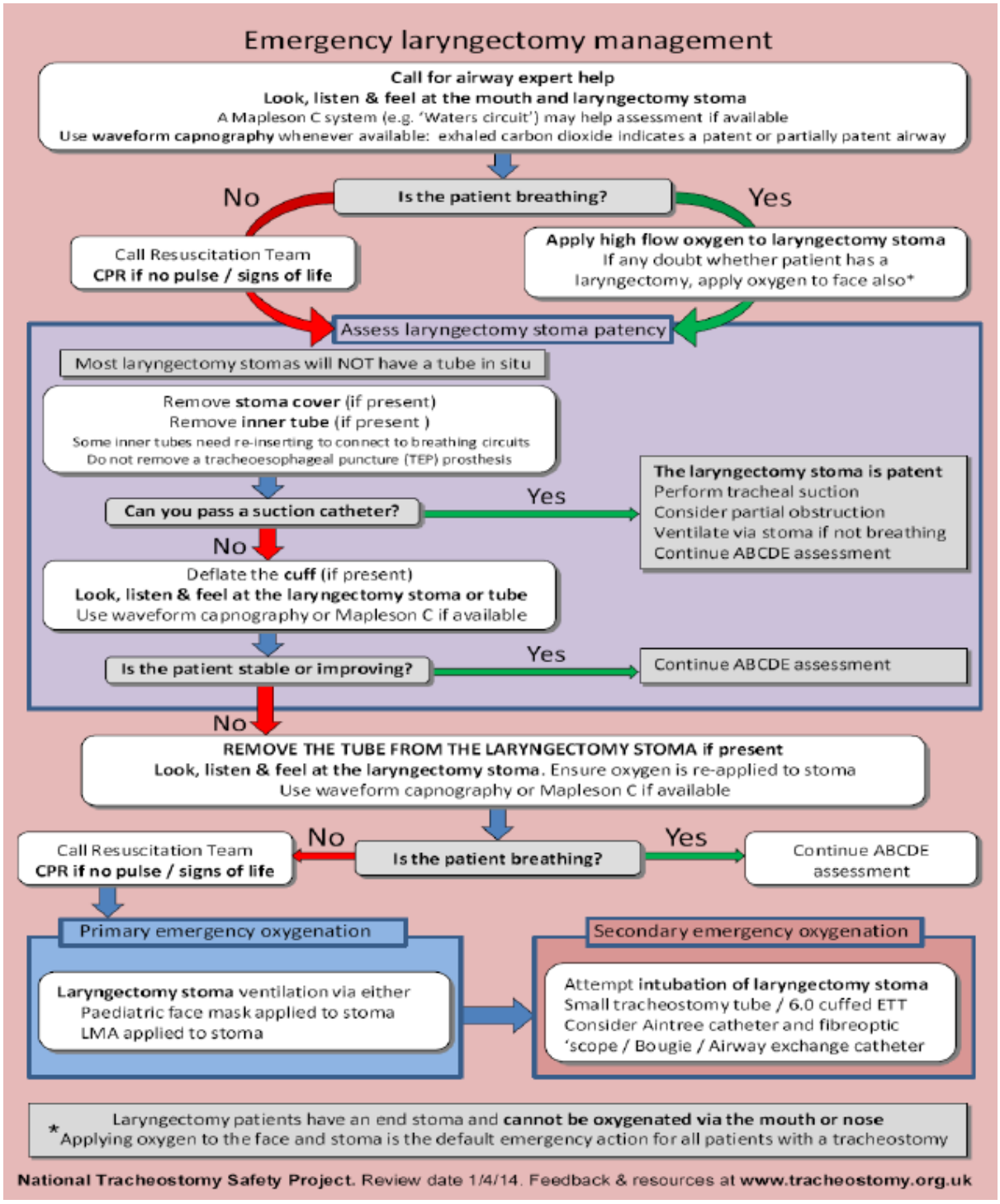
Follow the LARYNGECTOMY algorithm of breathing difficulties

Performed on (date) .....

Tube size (if present) .....

Patient Name .....

Worcestershire Acute Hospitals NHS Trust


Emergency laryngectomy management
Call for airway expert help
Look, listen & feel at the mouth and laryngectomy stoma
A Mapleson C system (e.g. 'Waters circuit') may help assessment if available
Use waveform capnography whenever available: exhaled carbon dioxide indicates a patent or partially patent airway
Is the patient breathing?
No
Yes
Call Resuscitation Team
CPR if no pulse / signs of life
Apply high flow oxygen to laryngectomy stoma
If any doubt whether patient has a laryngectomy, apply oxygen to face also*
Assess laryngectomy stoma patency
Most laryngectomy stomas will NOT have a tube in situ
Remove stoma cover (if present)
Remove inner tube (if present )
Some inner tubes need re-inserting to connect to breathing circuits
Do not remove a tracheoesophageal puncture (TEP) prosthesis
Can you pass a suction catheter?
Yes
The laryngectomy stoma is patent
Perform tracheal suction
Consider partial obstruction
Ventilate via stoma if not breathing
Continue ABCDE assessment
No
Deflate the cuff (if present)
Look, listen & feel at the laryngectomy stoma or tube
Use waveform capnography or Mapleson C if available
Is the patient stable or improving?
Yes
Continue ABCDE assessment
No
REMOVE THE TUBE FROM THE LARYNGECTOMY STOMA if present
Look, listen & feel at the laryngectomy stoma. Ensure oxygen is re-applied to stoma
Use waveform capnography or Mapleson C if available
Call Resuscitation Team
CPR if no pulse / signs of life
No
Is the patient breathing?
Yes
Continue ABCDE assessment
Primary emergency oxygenation
Laryngectomy stoma ventilation via either
Paediatric face mask applied to stoma
LMA applied to stoma
Secondary emergency oxygenation
Attempt intubation of laryngectomy stoma
Small tracheostomy tube / 6.0 cuffed ETT
Consider Aintree catheter and fibreoptic 'scope / Bougie / Airway exchange catheter
* Laryngectomy patients have an end stoma and cannot be oxygenated via the mouth or nose
Applying oxygen to the face and stoma is the default emergency action for all patients with a tracheostomy
National Tracheostomy Safety Project. Review date 1/4/14. Feedback & resources at www.tracheostomy.org.uk

## Appendix 2 – Established Laryngectomy Checklist

**Established Laryngectomy Checklist: neck stoma and Surgical voice restoration monitoring**

For use on hospital admission or out of hours (please circle)

1. Stoma size:

micro standard macro

2. Does the patient use a larytube? Yes no
3. Is candida present on the tube or on viewing inside the stoma? Yes no

4. Is voice prosthesis present? Yes no

If yes, follow out of hours flow chart section 5 in laryngectomy guidelines to check for leak
See CLIP outpatient notes for information on SLT/ CNS reviews and voice prosthesis type and size

5. Check Tracheo-oesophageal puncture health

stable granulation embedding overlong other

6. Equipment used: Baseplate (type)_____

Laryclips Tapes HME filters (type) larybib nothing

7. Comment on secretion load

_____

8. Are any the following used?

Humidification nebulising suction

9.Dysphagia status: nil chronic acute problem

9. Tube fed? yes no

If yes, type

_____

10. Pain assessment

## Appendix 3

### Procedure for in hospital laryngectomy tube cleaning

**Equipment required:**

PPE – gloves, apron facial protection visor or goggles
Sterile receiver/bowl
Sterile saline
Single use pink sponges/laryngectomy tube brushes
Sterile Gauze
Waste bag
Dressing trolley

1. Prepare patient and explain procedure - set up equipment on dressing trolley
2. Wash hands and don apron, gloves and facial protection if required
3. Remove laryngectomy tube and cleanse outside of tube with gauze to remove all residual visible secretions.
4. Pour sterile saline into receiver/bowl and submerge tube
5. Clean through the tube with sponges or brush so that all secretions are removed and the tube is visibly clean. (You may need to change the solution if there are a lot of secretions)
6. Rinse off with sterile saline
7. Check tube for any signs of perishing or splits – if tube found to perished discard
8. Dry tube thoroughly inside with clean dry pink sponge outside with gauze
9. Store tube in labelled pot with lid on patient's trolley or bed space.
10. Remove gloves apron and eye protection/visor in that order, wash hands
11. Discard all waste into the appropriate waste bag & dispose into the correct waste stream bin
12. De-contaminate hands with hand sanitizer.

## Appendix 4

### Procedure for Laryngectomy Tube change

| **Equipment Required:** |
| --- |
| Spare clean tube<br>Tracheostomy tapes<br>Cleaning equipment as appendix 2 |

1. Prepare Patient explain procedure
2. Remove tube, inspect and clean stoma as required (Appendix 4)
3. Apply tapes to new tube
4. Aquagel applied to end of tube to aid insertion
5. Ask patient to breath in and insert tube into stoma in smooth action, following the shape and direction of the trachea
6. Apply tapes with two finger width from skin.

## Appendix 5

### Procedure for in hospital Stoma cleaning

Equipment Required:
Dressing trolley
PPE
Gallipot/dressing pack
Sterile Saline
Sterile Gauze
Waste Bag

1. Remove Laryngectomy tube as above
2. Inspect stoma, clean with sterile gauze soaked in saline with one wipe technique to remove any secretions.
3. Any dried secretions soften and remove with gauze and saline or Tilleys forceps.
4. Ensure stoma is clean dry and check for skin damage or soreness, can use skin barrier protection if required.
5. Replace with clean laryngectomy tube or baseplate as per individual patient equipment use.

## Appendix 6

### Procedure for checking voice prosthesis function in hospital

| |
|---|
| Torch<br>Voice prosthesis cleaning brush<br>Milk or coloured water<br>Suction |

1. Make sure patient is sat upright and you are able to view stoma and voice prosthesis easily.
2. Ask patient to clean the valve or support them with this if they are unable to do so. Aim for the centre of the voice prosthesis with the brush and apply gentle pressure until fully inserted, then rotate the brush 360 degrees in one direction.
3. Gently remove the brush and clean with sterile water and sterile receiver. Dry with a paper towel. Repeat procedure until brush is clean on removal from voice prosthesis.
4. Ask the patient to take a sip of fluid, hold it in their mouth and then swallow. Be ready with light source and suction whilst viewing the voice prosthesis during the swallow.
5. If the voice prosthesis is leaking fluid will be seen from either the centre or around the voice prosthesis.
6. Provide patient with thickened fluids and re-assess whether this stops the leak
7. Contact SLT or ENT for further assistance if out of hours.

## Appendix 7

Standard Operating Policy: Surgical Voice Restoration (SVR) service for laryngectomy patients

| **Policy Overview:** |
|---|
| This Standard Operating Procedure (SOP) describes the correct processes and procedures of delivering SVR (surgical voice restoration) service for laryngectomy patients under the Head and Neck Cancer pathway, by SLT & CNS. |

**Key amendments to this Document**:

| Date | Amendment | By: |
|---|---|---|
| 22/01/2021 | Addition of appendix 10: ADMINISTRATION PROTOCOL (Lidocaine hydrochloride 5% w/v and phenylephrine hydrochloride 0.5%) | Morag Inglis SLT Manager |
| 08/11/2024 | Update to remove Covid-19 processes. | Mirjana Rasovic/ Catherine Ball |

### Content

## 1. Scope of document

### 1.1 Background

Patients are empowered to be as independent in their SVR management as possible. This may include the use of exdwelling valves. However there is a cohort of patients who cannot change their own prosthesis, and who would be at risk of harm and / or poorer outcomes if face to face SVR changes are not provided. The inability of a patient to access timely SVR changes can have a profound impact on their physical wellbeing, leading to avoidable complications including hospital admissions, inability to participate in life.

Staff require access to specialist equipment, and be competent in voice prosthesis management. For SLT this includes completion of RCSLT competency framework. CNS/ENT colleagues will be competent by completing in house and external training courses.

A two person approach is favoured for this procedure to ensure staff and patient safety, holistic patient care and equitable service provision. This can be a combination of SLT and CNS is at the discretion of staff to account for staffing levels.

### 1.2 Scope

This Standard Operating Procedure provides guidance on how to provide patients with SVR interventions at WRH whilst working within the legal, regulatory and professional frameworks that govern Speech and Language therapy.

### 1.3 Procedure

It is the responsibility of all employed by the Trust and those that have a contract with the Trust to provide a service to remain up to date with Trust infection control and PHE advice. All staff must also remain up to date with mandatory training including, infection control policies and procedures and PPE guidelines.

It is the responsibility of all registered health professionals to work within the legal, regulatory and professional frameworks that guide the safe management of patients, the safety of the wider public and everyone who works in the Trust.

## 2. Location/Facilities:

### 2.1 Worcestershire Royal Hospital, Linden Suite

SVR changes require a suitably equipped room and to be appropriate for AGPs. Access to suction, lighting, a treatment chair which enables safe positioning of the patient.
Support from ENT colleagues should be readily available.

## 3. Operational Hours

1
All SVR changes are delivered within core hours of 9:00 – 4:30 in clinics on Mondays-Fridays.
Provision of daily SVR slot at 13:00 on trial basis.

## 4. Process

### 4.1 Prior to appointment

1. Patients must contact the SVR team as per letter in Appendix 11 to discuss the need for a valve change. At the time of the contact, the clinician should ascertain the urgency of the need. Patients with persistent saliva leaking through or around the valve; unmanageable leaks are considered high priority.

2. Patients should initially be advised to try the following to manage the leak prior to the valve change:

    - Use a plug if supplied by SLT/CNS to provide a temporary bung to the centre of the valve.
    - Use thickener in all drinks to reduce the flow of the leak (trial sachets & prescription request letter will have been sent to all patients).

3. Appointment made through H&N Support worker on PAS and patient and ENT department advised.

### 4.2 Appointment

1. Patient checks in to ENT OP.
2. Room and equipment prepared by SLT/CNS/SLTA as appropriate including:
    a. Equipment trolley
    b. Suction
    c. 100mls water
    d. Lighting, headtorch and/or STACK.
    e. Trays
    f. Lubrication gel
    g. Gauze
    h. Correct valve
    i. Dilator
    j. Sizer
    k. Spencer wells/crile forceps
    l. Lidocaine spray (If required)
    m. PPE Must include apron, gloves, mask and eye protection.
3. Patient history/baseline obtained of presenting problem.
4. Assess Valve for leak or voicing.
5. Conduct Valve change if required/ use of Lidocaine if required following administration protocol.
6. Arrange follow up with ENT if appropriate.
7. Signpost to Laryngectomy group or Buddy if appropriate.
8. Documentation and GP letter if appropriate.

**5.Out Of Hours SVR Management.**
Follow flow chart Appendix 10.

**6 - ADMINISTRATION PROTOCOL (Lidocaine hydrochloride 5% w/v and phenylephrine hydrochloride 0.5%)**

administration protocol for Lidocaine

## Governance Structure

This Standard Operating Procedure forms part of the Laryngectomy guidelines and will be signed off by ENT directorate.

## Review

This Standard Operating Procedure will be reviewed alongside laryngectomy guidelines.

## Appendix 8

Worcestershire NHS
Acute Hospitals NHS Trust

Ref:
NHS No:

Worcestershire Royal Hospital
Charles Hastings Way
Newtown Road
Worcester
WR5 1DD
Reception: 01905 760212
Medical Secretary: 01905 760215

West Midlands Ambulance Trust
Waterfront Business Park
Waterfront Way
Brierley Hill
West Midlands
DY5 1LX

Dear cad.admin@nhs.net

**RE :-**

**Address:-**

**Date of birth**

**Altered airway: - Laryngectomy**
**Tracheostomy**

**Could it be a silent call Yes /No**

**Is there a telephone aid used Yes /No**

Please contact me as soon as possible if there are any concerns regarding this.

Yours Sincerely

Macmillan CNS Head and Neck
Worcester

## Appendix 9 – Laryngectomy/Tracheostomy Trolley

**To be checked & topped up as necessary daily**

**Top Drawer: Laryngectomy/Tracheostomy care**

- Spare laryngectomy tube in sealed pot
- Tube holding tapes
- Tracheostomy dressing (if applicable)
- Lubrication jelly x2
- Saline solution 10ml ampoules x5
- Dressing Pack/gauze/cleaning sponges
- Sterile kidney receiver

**2nd Drawer: Feed Equipment (if applicable)**

- Purple 60ml syringes x3
- Medicine pots/purple syringes 10ml/20ml
- Plastic cups
- Feed giving set x1
- Bag of feed

**3rd Drawer: Miscellaneous**

- Gauze swabs x2 packs
- Pink sponges x2 packs
- Sterile field x 1
- Yankeur suction catheter x2
- Single use suction gloves

**4th Drawer: Basic Surgical Voice Equipment if applicable/Miscellaneous**

- 14fr foley catheter8fr feeding catheter
- Spigot
- Syringe
- Cleaning brush
- Micropore/Transpore tape
- Torch
- Optiderm base plates
- HME cassettes
- Tilleys forceps
- Spare water bottle x1
- Spare saline bottle x1

**Basket:**

- Tracheostomy box (complete as per equipment list)

**Trolley Top:**

- Bottle water (in use, open dated & timed)
- Bottle saline for suction (in use open dated & timed)
- Tracheostomy inner tubes (if applicable)

**Trolley to be cleaned daily & only equipment as stated above stored on it in line with infection control policies.**

**Appendix 10 out of hours SVR flowchart**

## OUT OF HOURS VOICE PROSTHESIS TROUBLE SHOOTING AND CHANGE PROCESS

This is to be followed when Speech and Language Therapy (SLT), Clinical Nurse Specialist are unavailable either as an outpatient or inpatient.

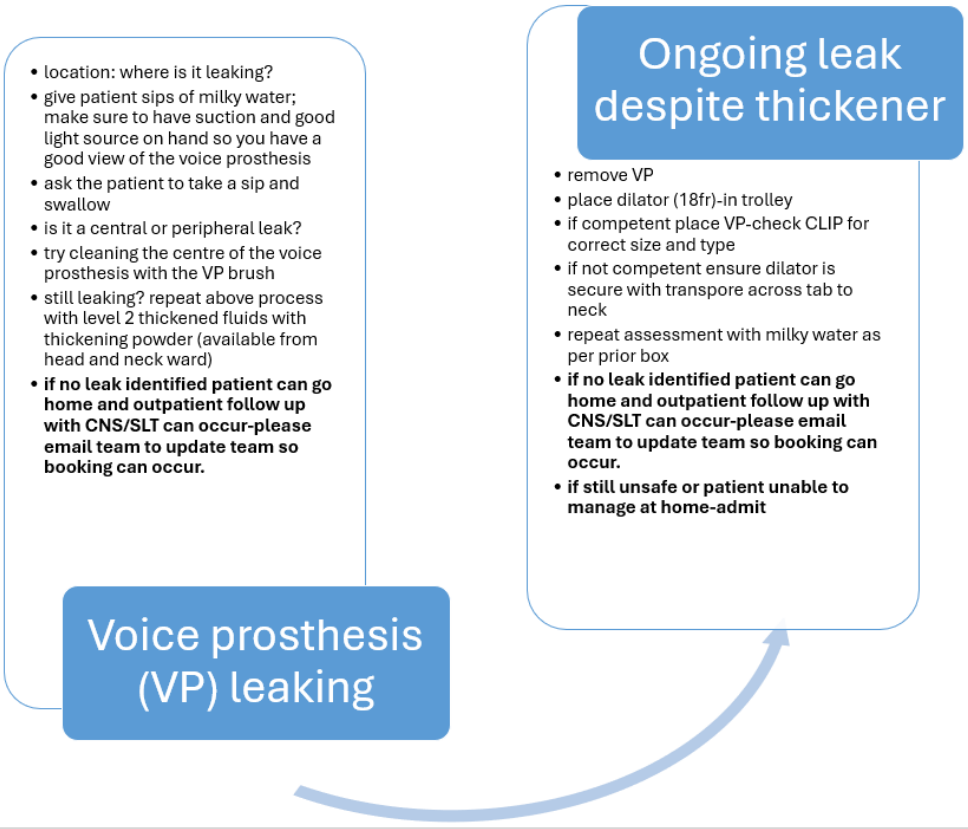
Ask pt if he/she has their own equipment which may include:

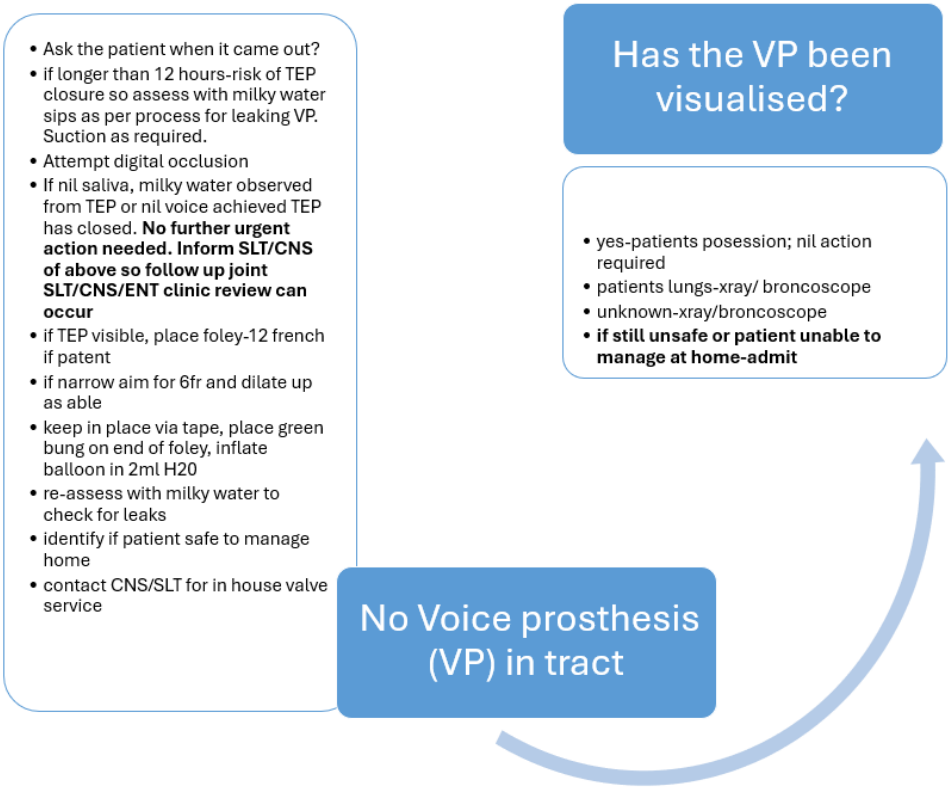
- Sizer
- Dilator
- Spare valve

Equipment for valve changes can be found in the plastic trolley in Linden suite. Valves are kept in Hawthorn Suite.

If uncertain the priority is to make the patient safe and to retain the tracheoesophageal puncture (TEP/TOP)

**Refer to the pathway below for management:**






Challenges with voicing have not been outlined in this out of hours pathway as not part of admission prevention. If a patient is having trouble with voicing either on the ward or as an outpatient, please contact SLT and CNS to problem solve within working hours. However, if there are concerns about voicing once new valve is inserted, we would advise ENT scoping, reviewing voicing technique and cleaning the VP with the VP brush.

**Appendix 11**

Adult Speech and Language Therapy
Aconbury West
Worcestershire Royal Hospital
Charles Hastings Way
WORCESTER WR5 1DD
Telephone: DD 01905 760475 or 01905 761440

Dear Valve user,

**Re: Speech and Language Therapy & CNS Laryngectomy support**

We are writing to update you with our new contact information so that you will be able to access our service for valve changes and problem solving.

We are available Monday –Friday, 08.30 a.m - 4.30 p.m.

You can contact us via telephone on: 01905 760475, or CNS 01905 761440 where a member of the team will answer your query or please leave a message on the answer machine and we will get back to you as soon as possible.

You may also email us, but please make sure that we are all included. Failure to do so may mean your email is not answered in a timely manner. We can then offer a planned appointment to see you.

**Jess Sumner** **jess.sumner1@nhs.net**
**Catherine Ball** **catherine.ball5@nhs.net**

**Text option now available via this mobile number 07761329417.**
**(this phone is manned Monday, Tuesday, Thursday and Friday.)**

For any urgent valve problems out of office hours please phone the head and neck ward on: 01905 760545.

Yours sincerely,

The Speech and Language Therapy Team.

## Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Please complete assessment form on next page;

**Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form**
**Please read EIA guidelines when completing this form**

**Section 1 - Name of Organisation** (please tick)

| | | | | | |
|---|---|---|---|---|---|
| Herefordshire & Worcestershire STP | | Herefordshire Council | | Herefordshire CCG | |
| Worcestershire Acute Hospitals NHS Trust | x | Worcestershire County Council | | Worcestershire CCGs | |
| Worcestershire Health and Care NHS Trust | | Wye Valley NHS Trust | | Other (please state) | |

| | |
|---|---|
| **Name of Lead for Activity** | **Mirjana Rasovic** |

| | | | |
|---|---|---|---|
| **Details of individuals completing this assessment** | **Name** | **Job title** | **e-mail contact** |
| | **Mirjana Rasovic** | **Professional Clinical Lead SLT** | **mirjana.rasovic@nhs.net** |
| **Date assessment completed** | | | |

**Section 2**

| | | | | |
|---|---|---|---|---|
| Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.) | **Title:** Management of Patients with a Laryngectomy | | | |
| What is the aim, purpose and/or intended outcomes of this Activity? | | | | |
| Who will be affected by the development & implementation of this activity? | ❑ | Service User | x | Staff |
| | x | Patient | ❑ | Communities |
| | ❑ | Carers | ❑ | Other _____ |
| | ❑ | Visitors | ❑ | |
| Is this: | x Review of an existing activity<br>❑ New activity<br>❑ Planning to withdraw or reduce a service, activity or presence? | | | |

| | |
|---|---|
| What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc. | |
| Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required) | |
| Summary of relevant findings | |

## Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

| Equality Group | Potential positive impact | Potential neutral impact | Potential negative impact | Please explain your reasons for any potential positive, neutral or negative impact identified |
|---|---|---|---|---|
| **Age** | | | | |
| **Disability** | | | | |
| **Gender Reassignment** | | | | |
| **Marriage & Civil Partnerships** | | | | |
| **Pregnancy & Maternity** | | | | |
| **Race including Traveling Communities** | | | | |
| **Religion & Belief** | | | | |
| **Sex** | | | | |
| **Sexual Orientation** | | | | |
| **Other Vulnerable and Disadvantaged Groups** (e.g. carers; | | | | |

| Equality Group | Potential positive impact | Potential neutral impact | Potential negative impact | Please explain your reasons for any potential positive, neutral or negative impact identified |
|---|---|---|---|---|
| care leavers; homeless; Social/Economic deprivation, travelling communities etc.) | | | | |
| **Health Inequalities** (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies) | | | | |

**Section 4**

| What actions will you take to mitigate any potential negative impacts? | Risk identified | Actions required to reduce / eliminate negative impact | Who will lead on the action? | Timeframe |
|---|---|---|---|---|
| | | . | | |
| | | | | |
| | | | | |
| **How will you monitor these actions?** | | | | |
| **When will you review this EIA?** (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation) | | | | |

**Section 5 -** Please read and agree to the following Equality Statement

**1. Equality Statement**

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation
1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.
1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

| | |
|---|---|
| **Signature of person completing EIA** | |
| **Date signed** | |
| **Comments:** | |
| **Signature of person the Leader Person for this activity** | |
| **Date signed** | |
| **Comments:** | |

## Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

| | Title of document: | Yes/No |
|---|---|---|
| **1.** | Does the implementation of this document require any additional Capital resources | No |
| **2.** | Does the implementation of this document require additional revenue | No |
| **3.** | Does the implementation of this document require additional manpower | No |
| **4.** | Does the implementation of this document release any manpower costs through a change in practice | No |
| **5.** | Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff | No |
| | Other comments: | |

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval