Practical Tracheostomy Assessment

1. Care of the stoma, dressing and Tape holder change

Prepare all equipment needed. Explain procedure to patient and consent gained, two nursing staff present
One nurse holds tracheostomy securely in place throughout the procedure
Used/soiled tube holder & dressing removed by undoing Velcro and dispose of in a yellow clinical waste bag,
Neck slightly extended to allow easier access to the stoma. Assess the stoma site, if red, inflamed or showing signs of infection, take swab and send for MC+S.
Clean area with normal saline and dry with sterile gauze
New Dressing applied and tape positioned around neck
Velcro ties passed through the flanges on the tracheostomy base plate and passed back on themselves to attach to the tape
Tape/Tube Holder loose enough to fit 2 fingers between tape and patient
Patient left safe and comfortable, Document any necessary information in the Tracheostomy Observation Chart/Care Plan/Medical notes

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2. Inner Cannula change

Prepare necessary equipment, explain procedure to patient.
Perform tracheal suction if needed, keeping one hand on baseplate to help stabilise tube removed inner cannula in a downwards then sideways motion.
Dispose in clinical waste.
Clear any excess secretions from around the tube.
Insert new cannula in a side the downwards motion, clicking into position, whilst holding the baseplate securely.
Document in care pathway/medical notes.

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3. Humidification/applying oxygen
Prepare Necessary humidification equipment.
Position HME or Stoma bib on Tracheostomy tube.
Set up Aquapak humidified circuit via 02 using tracheostomy mask.
Documentation in pathway/medical notes.

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4. Tracheal Suctioning
Explanation of procedure given/consent gained, prepare patient and necessary equipment ensuring correct size suction catheter selected..
Monitor Sp02, pre oxygenate if patient likely to desaturate, nebulise prior to suction to help loosen any thick secretions.
Test suction pressure.
Yankeur suction: apply only around stoma and to catch secretions patient is spontaeneously coughing from tube, do not place yankeur inside tracheostomy tube.
Deep Suction: wearing sterile glove over clean glove remove suction catheter from packet and pass down the tracheostomy until meeting resistance or patient coughs. Apply suction and withdraw catheter in continuous motion over maximum period of 15 seconds only applying suction on withdrawal.
Wrap catheter around hand and remove glove keeping catheter within it then dispose of in clinical waste.
Clear any secretions around the tube/stoma with yankeur suction or tissue if required.
Repeat procedure until secretions are cleared and patient breathing comfortably, allowing time to settle in between suctions.

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5. Use of Speaking valve

Prepare necessary equipment, perform tracheal suctioning or encourage coughing out of secretions.
Ensure cuff is deflated and fenestrated inner cannula in position.
Ensure correct speaking valve selected.
Assess glottal patency, occlude tracheostomy with finger tipto ensure air passes around tube to upper airway.
Place speaking valve on end of trachesotomy, observe the valve to ensure it is patent.
Encourage patient to speak.
Monitor observations and check signs of distress/discomfort and remove if necessary.
Ensure patient knows how to remove speaking valve and is left safe.

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6. Use of Passey Muir Speaking Valve (PMSV) in ventilated patient (If applicable)

As above, however attach double ended connector to speaking valve and insert between tracheostomy and catheter mount. Ensure Speaking valve diaphragm opens during inspiration. Adjust ventilator setting as appropriate following discussion with ITU staff.
Encourage patient to speak, monitor for signs of distress/discomfort.

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7. Tracheostomy Decannulation

Completed weaning process and patient deemed ready for decannulation. Explanation of procedure, prepare necessary equipment, two nursing staff present.
Tracheostomy emergency box at bedside.
Perform tracheal suctioning, encourage patient to cough out any excess secretions.
Monitor Sp02, check cuff is fully deflated (if applicable).
Slightly extend neck to improve access, assisting nurse holds onto tracheostomy tube whilst other removes dressing and tapes, disposed of in clinical waste bag.
Advise patient to breathe in and on expiration remove tracheostomy by pulling on it firmly, clear away any excess secretions and cover stoma with gauze to assess whether patient can breathe via upper airway with no reduction in Sp02.
Assess stoma site and clean with saline, cover with occlusive dry dressing, and button for patient to locate pressure point. Show patient how to apply pressure when coughing and talking.
Maintain regular observations to ensure no distress/discomfort post decannulation.

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8. Tracheostomy Changing/Downsizing (established stoma)

Explained procedure and prepared necessary equipment, two nurses present. (If first tube change or unsure of airway ENT present with flexible scope to ensure positioning)
Tracheostomy emergency box at bedside.
Perform tracheal suctioning, encourage patient to cough out any excess secretions.
Monitor Sp02, check cuff is fully deflated (if applicable).
Slightly extend neck to improve access, assisting nurse holds onto tracheostomy tube whilst other removes dressing and tapes, disposed of in clinical waste bag.
Advise patient to breathe in and on expiration one nurse removes tracheostomy by pulling on it firmly, the other nurse inserts a prepared lubricated new tracheostomy tube with introducer in an side and downwards motion removing introducer once in place.
Reinflate cuff (if applicable), apply new dressing and tapes, perform suction if required.
Monitor patient to ensure airway patent and tube comfortable.

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9. Management of Cuff/Subglottic suction port

Ensure equipment available, explain to patient procedure.

Position Manometer onto cuff port to check pressure, between 20-25mmHg, remove air or inflate as required.

Position syringe onto subglottic port and draw off saliva/secretions.

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