Tracheostomy Adult Care Policy
(Guidelines for Best Practice)

This procedural document supersedes: PAT/T 20 v.4 – Tracheostomy Adult Care Policy
(Guidelines for Best Practice)

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<table>
<thead>
<tr>
<th></th>
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<tr>
<td>Date revised:</td>
<td>November 2015</td>
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<tr>
<td>Approved by (Committee/Group):</td>
<td>Policy Approval and Compliance Group on behalf of the Patient Safety Review Group</td>
</tr>
<tr>
<td>Date of approval:</td>
<td>23 March 2016</td>
</tr>
<tr>
<td>Date issued:</td>
<td>6 April 2016</td>
</tr>
<tr>
<td>Next review date:</td>
<td>November 2018</td>
</tr>
<tr>
<td>Target audience:</td>
<td>Clinical Staff involved in Tracheostomy Care</td>
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(Guidelines for Best Practice)

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed without change, this information will still need to be recorded although the version number will remain the same.

<table>
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<th>Version</th>
<th>Date Issued</th>
<th>Brief Summary of Changes</th>
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| Version 5 | 6 April 2016  | - New Tracheostomy Nurse  
- Contact details updated  
- Suction guidelines and equipment updated  
- Training and education updated  
- Roles and Responsibilities updated | Janet Ryles/Lucy Brooks |
- New Tracheostomy Nurse  
- Clarification of where to get help and from whom  
- Contact details updated  
- Suction guidelines and equipment updated | Janet Ryles |
| Version 3 | December 2011 | Sister McConachie retired now replaced by Sister T Edmondson.  
- Revised introduction.  
- New title, now changed to Adult Tracheostomy Policy.  
- Roles and responsibilities redefined.  
- Additional items on essential equipment check list.  
- New section – Tracheostomy complications including algorithm for blocked tracheostomy tubes as appendix.  
- Minor wording alterations re swallowing section.  
- References to children removed.  
- Weaning protocol as per IPOC.  
- Names removed, relevant personnel referred to by title. | Janet Ryles |
| Version 2 | December 2008 | - Title change to Tracheostomy Care Policy  
- Bleep system changed  
- Updating of staff  
- Introduction of Tracheostomy Care IPOC  
- Ward names updated  
- Referral clarification of different tube types and their management  
- Assessment and clarification of where and from whom to get help | Janet Ryles |
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1. INTRODUCTION

**Tracheostomies** – are becoming increasingly common place both within the acute setting and the community (Serra 2000). As a result of this there is an expectation of increased knowledge and more advanced nursing and healthcare skills in ward staff caring for these patients. Nurses caring for patients with tracheostomies should have the appropriate knowledge and skills. (NMC 2008)

**Risk Management** – there is always the risk that a tracheostomy tube may become blocked, dislodged or removed completely or that the patient’s condition may deteriorate rapidly. All of these are emergency situations for which the patient must be closely observed. Skill mix and staffing levels should reflect these intensive nursing requirements. If a Nurse is asked to deliver care they consider unsafe or harmful to a person in their care, they should carefully consider their actions and raise their concerns to the appropriate person.

The Tracheostomy Policy aims to promote safe and effective care for patients. Staff involved should provide evidence based practice as outlined in this document.

2. PURPOSE

The purpose of this policy is to improve the quality of care given to patients with a tracheostomy under the care of Doncaster & Bassetlaw Hospital NHS Foundation Trust. Inappropriate/inexperienced attempts at decannulation have led to sudden upper airway obstruction resulting in emergency re-intubation at significant risk to the patient’s life. It is written to ensure safety of all patients within the Trust who have undergone the procedure of having a Tracheostomy.

**The Collaborative Approach** – aims to educate professionals in aspects of anatomy and physiology, cleaning and securing tracheostomy tubes, maintaining the patency of tracheostomy tubes, providing adequate and effective humidification for the tracheostomy patient and being able to carry out suctioning techniques both competently and confidently. It is also important to ensure everyone has the knowledge and understanding of the weaning process through to decannulation. The team involved in producing these guidelines are available 9am – 5pm during the working week, out of hours advice should be obtained from Ward S12/ENT Consultant/Registrar on-call/Anaesthetist/Physiotherapist on-call/CNS/Tracheostomy Nurse.

The Tracheostomy Care IPOC has been piloted, audited and introduced, in order to improve patient safety throughout the Trust. The policy has been revised to prevent complications and in response to critical incident reports and sharing good practice.

3. ROLES AND RESPONSIBILITIES

**Allied Health Professionals** – involved in caring for tracheostomy patients have a professional responsibility to ensure that they can respond to this need and are able to provide competent evidence based care for individual patients. The NMC 2011 states ‘staff should have skills and
knowledge and fitness to practice in relevant clinical procedures’ i.e. Tracheostomy care including suction.

Clinical Site Managers, Matrons, Ward Managers are responsible for ensuring that patients are managed in accordance with this policy and for escalating any situations where safe placement cannot be achieved.

TRACHEOSTOMY CARE SERVICE:
The multi-disciplinary team, comprising of:
- ENT/Head and Neck (H&N) surgeon (Lead Clinician on Ext 642417 or via switchboard)
- Specialist nursing staff (Lead H&N CNS on Ext 642421 or via long range pager- via switchboard)
- Tracheostomy Sister, DRI Ext 642421/ MOBILE 07789654039
- Critical Care Outreach Team, DRI (Bleep 1980)
- Respiratory physiotherapists Team, DRI (Bleep 1311)
- Senior Speech & Language Therapists, DRI (Bleep 1381)
- Bassetlaw Outreach Service (Bleep 1558)
- Consultant Anaesthetist DCC, DRI - ext. 3152 (bleep via Switchboard).

4. PROCEDURE

4.1 Referral
All patients should be referred to the Tracheostomy Care Service by Critical Care Outreach Team, DRI/Bassetlaw Outreach Service on the day of discharge. Referrals should be faxed to Ward S12 fax no 647024/647081. Alternatively post to the Lead Clinical Nurse Specialist/Tracheostomy Nurse. Ward Managers should liaise with the Department of Critical Care for assessment of Tracheostomy patients to ensure needs can be met prior to their transfer.

4.2 Assessment
Patients will be seen either by Lead Clinicians, a middle grade member of the team or ENT specialist nurses within 2 working days.

Each patient’s requirements will be assessed and a tracheostomy tube selected according to the following. The patient will continue to be seen by the Outreach Team/Outreach Service as necessary for up to 7 days.

- Patients who are requiring CPAP/BIPAP via their tracheostomy tube will remain in the Department of Critical Care, DRI/ITU, Bassetlaw.
- Patient not on CPAP/BIPAP and not at risk of aspiration should have an uncuffed Shiley tube with phonation valve or trachephone/Swedish nose attachment.
- Tube size (for adult patients) size 6 (female); if decannulation predicted in the short term, size 8 (male) if long term airway support required (Shiley tube sizes),
4.3 Transfer of Tracheostomy Patients

Refer to transfer sheet (see Appendix 2).

NOTE: COPY OF THE TRANSFER INFORMATION SHEET MUST BE FILED IN THE PATIENTS MEDICAL NOTES.
SECTION 4A - GUIDELINES FOR TRACHEOBRONCHIAL SUCTION

Tracheobronchial suction is the insertion of a suction catheter into the trachea in order to aid removal of secretions.

Determining the need for suction relies on an accurate respiratory assessment and should be carried out only when necessary and not on a routine basis.

Health professionals must use their experience and professional judgement to select a suction technique that meets the specific needs of the patient. This is particularly so where the evidence is inconclusive or contradictory.

It must be remembered that suction is associated with a number of potential problems of which many can be avoided by evidence based practice (see reference list).

The following should be used as guidelines only.

EQUIPMENT REQUIRED:

The following equipment should be available for any patient requiring suction:-

- Suction pump
- Suction tubing
- Yankauer
- Suction catheters
- Sterile disposable gloves
- Sterile distilled water
- Oxygen therapy
- 0.9% Sodium Chloride ampoules and syringes
- Sputum trap
- Protective eye wear (see Standard Infection Prevention & Control Precautions Policy – PAT/IC 19)
- Apron
- Suction Pump – wall source or portable.

See IPOC

Vacuum Pressure
The lowest possible vacuum pressure should be used to reduce complications. Increasing the amount of negative pressure does not improve aspiration efficiency.

Magnitude
Maximum 13-16 kPA
100-120 mmHg (adults) (ICS 2011)

Suction Tubing
- Yankauer Suction
• **Suction Catheters**

  **Size**
  The catheter size should ideally be less than half the diameter of the tracheostomy tube. The following is a useful, simple way of calculating recommended catheter size.

  Add 4 to current tube size e.g. size 8 tube = size 12 catheter.

  **Closed versus Open Suction**
  Closed circuit, multiple use catheters have been developed to negate the need to disconnect from the ventilator, prevent loss of PEEP or leakage of aerosolised secretion. Closed suction requires to be changed every 24 hours or according to manufacturer’s instructions.

• **Sterile/Disposable Gloves**

• **Sterile Distilled Water (labelled ‘suction’ with opening date) – change every 24 hours.**

• **Oxygen Therapy**
  In order to minimise adverse effects of suction hyper-oxygenation/hyperinflation pre/post suction may be used
  * Care with COPD patients i.e. hypoxic drive

• **0.9% Sodium Chloride Ampoules + Syringes**
  The use of sodium chloride to loosen secretions has no clear scientific basis, yet many health professional remain convinced of its benefit through their own experience. It is now not recommended (ICS, 2011).

  Sodium chloride does not mix with secretions and installations do not disperse beyond the main stem bronchi, however benefit is probably related to the associated coughing. An assisted cough product is now the preferred method, obtainable from the Physiotherapist.

• **+/- Sputum Trap**
  If a sputum specimen is required, a sputum trap may be used in circuit between suction tubing and suction catheter.

• **Standard Infection Prevention & Control Precautions, including eye protection, mask, gloves and apron.**

**SUCTION TECHNIQUE:**
Each patient needs individual assessment and constant re-assessment to ascertain the frequency of suctioning required.

**Tracheobronchial Suction Technique**
1. Decontaminate hands with alcohol hand gel.
2. Position patient appropriately.
3. Explain procedure to patient and reassure.
4. Administer supplementary oxygen to patient (if indicated).
5. Select appropriate vacuum pressure.
6. Attach appropriate sized suction catheter to suction tubing.
7. Place sterile glove on dominant hand.
8. Slide catheter out of packet.
9. Insert catheter via airway, advancing till cough reflex is elicited or resistant felt, then withdraw approximately 1cm before applying suction. The catheter should not touch the carina. Measure the catheter to ensure that only one third of its length is inserted.

**NO SUCTION APPLIED ON INSERTION**

10. Apply suction by placing finger over vent and withdraw catheter smoothly and continuously.
    - Duration must not exceed 10 seconds
    - The longer the duration of suction, the more mucosal damage and hypoxia may occur.
11. Wrap catheter around hand and dispose within glove.
12. Rinse suction tubing with sterile water.
13. Repeat procedure as necessary.
14. A clean catheter should be used for each intervention.
15. Wash hands with soap and water.

**OBSERVATIONS**

Because of the possible adverse effects of suction, the patient’s oxygen saturation, respiratory rate, pattern and heart rate should be monitored closely. In addition sputum yielded on suction should also be assessed for colour, viscosity and amount. A sputum specimen should be sent for culture and sensitivity (C&S) if infection is indicated.

**PRECAUTIONS**

- Pulmonary oedema
- Clotting disorders

**HAZARDS OF SUCTION**

- Cardiac arrhythmias
- Infection
- Hypoxia
- Atelectasis
- Trauma
- Pneumothorax
- Changes in intra-cranial pressure
- Vasovagal stimulation
SECTION 4B - PROTOCOL FOR CHANGING A TRACHEOSTOMY TUBE AND CARE OF TRACHEOSTOMY TUBES

Each tube should have a dual cannula and only be left in place for a maximum of 31 days (EEC Directive 1993).

The first outer tube change may take place 5 days after surgery. This is to allow tract formation

Exceptions include mini-tracheostomies and adjustable flange tubes. Check with CCLT/CNS as single cannula tubes require changing more frequently (weekly).

The frequency from thereon in is dependent on the size and type, also of the individual requirements of the patient. EEC directive (1993) states that the tube should be replaced every 29 days.

In the event there is no inner cannula – the tube should be changed every 7 days. This should be assessed on an individual basis as patients with excessive secretions may require more frequent changes. These patients should remain in the Department of Critical Care or Ward S12 and must not be nursed on general ward. Before transferring to general wards a dual cannula tube should be insitu.

This is a 2 nurse/person procedure. At least one person should be experienced, confident and competent at changing tracheostomy tubes.

EQUIPMENT

The equipment required is:

- A good light source
- 2 tracheostomy tubes, one the same size as is being changed and one size smaller in case of difficulties
- The assistant, in case of emergency, should hold tracheal dilators ready for insertion into the tracheostomy site
- Suction equipment set up ready and turned on – suction may be required pre and post the procedure. The correct pressure should be ensured (100mmHg/120mmHg/13-16 kPa)
- Dependent on medical condition – patient may require pre-oxygenation (i.e. 100% O₂ pre and post procedure) Check O₂ saturations post procedure

Full explanations and the co-operation of the patient are paramount throughout the whole of the procedure.

The patient should be sat upright for the procedure with slight neck extension.
**NB** Observe closely. Monitor the patient’s vital signs. Continuous pulse oximetry should also be carried out (this should be used as a general indicator however, with caution, should the patient be hypothermic or anaemic) (Royal Marsden 2015).

Respiratory assessment should include respiratory rate, depth and regularity. Chest movement should be symmetrical and equal.

<table>
<thead>
<tr>
<th>Care of the Patient with a cuffed tracheostomy tube</th>
<th>Rationale</th>
<th>How to demonstrate statement is being achieved</th>
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<tr>
<td>All cuffed tracheostomy tubes have cuff pressure checked twice daily maintaining pressure between 15 – 20 mmHg using a manometer.</td>
<td>Cuff pressure above 15 – 20 mmHg may cause damage to the tracheal mucosa; if the pressure is below this aspiration may occur.</td>
<td>Local policy/guidelines on recording of cuff pressure are available.</td>
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<tr>
<td>Minimal occlusion volume techniques that do not require the use of a manometer are used as an alternative.</td>
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- While the cuff does not need to be deflated to protect the trachea, it is recommended that the cuff is deflated on a daily basis to check the cuff pressure and allow the removal of secretions that may collect above the cuff.

**KEY POINTS – FENESTRATED TUBES**

1. Fenestrated tubes may be cuffed or uncuffed.
2. Fenestrated tubes are used to encourage weaning from the tracheostomy and also for phonation.
3. Fenestrated tubes are supplied with two inner cannulae; one is fenestrated and one is plain.
4. There is a small risk of granulation if the fenestrated tube does not fit well.
5. The non-fenestrated inner cannula should always be used during suctioning and overnight.

<table>
<thead>
<tr>
<th>Care of the Patient with a Fenestrated Trache Tube</th>
<th>Rationale</th>
<th>How to demonstrate statement is being achieved</th>
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<td>All patients with a fenestrated tracheostomy tube have the fenestrated inner cannula removed prior to tracheal suction and replaced with an unfenestrated inner cannula.</td>
<td>It is possible to insert the suction catheter through the fenestration causing damage to the tracheal wall.</td>
<td>Registered Nurses receive training in the use of fenestrated tracheostomy tubes. Revalidation and the Terri course.</td>
</tr>
<tr>
<td>All patients with a fenestrated tube require an unfenestrated cuffed tube readily accessible for use in an emergency.</td>
<td>To allow ventilation with emergency equipment as air will exit via the fenestration.</td>
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TRAINING AND EDUCATION – TUBE MANAGEMENT/COMPLICATIONS

1. All staff who care for patients with a tracheostomy should have completed their Tracheostomy Skills Packages which have been re-validated and recorded on OLM.

2. All staff caring for patients with tracheostomies must utilise fully the Trust’s Tracheostomy IPOC, complete it and adhere to it - WPR 22881.

3. All staff caring for patients with tracheostomies should have attended a Terri Training Course at Montagu Simulation Centre within the last 3 in order to maintain their skills and competences.
SECTION 4C - TRACHEOSTOMY WOUND CARE PROTOCOL

INTRODUCTION

Patients with a tracheostomy are at risk of infection at the surgical site. Soiled, moist tracheostomy dressings contribute to infection at the tracheal stoma site, by providing a moist environment for bacterial growth. Also secretions that collect above the cuff ooze out of stoma site leading to excoriation.

A key element of tracheostomy management includes the assessment of peri stomal skin integrity. Excessive moisture from secretions, perspiration, pressure and friction from the tracheostomy collar or stabilisation ties may contribute to the breakdown of peri stomal skin.

WOUND CARE PROTOCOL – FOLLOW IPOC DAILY

WOUND ASSESSMENT – assess every day and document accordingly using the IPOC.

Dressings should be changed PRN according to amount of exudate and type of dressing in use (as per manufacturers instructions). A pre-cut dressing e.g. Lyofoam Toppers, Metalline or 3M’s is recommended.

PURPOSE

To promote healing and prevent infection/peri stomal skin breakdown, adhere to infection control policies (local and national).

RISK FACTORS

- Excessive moisture at tracheostomy site (secretions or perspiration)
- Obesity
- Pressure from baseplate of tracheostomy tube
- Poor nutritional status
- Tracheostomy construction resulting in wide stoma
- Immunosuppression (steroid therapy or chemotherapy)
- Over granulation tissue of peri stomal site

EQUIPMENT (CURRENT ROYAL MARSDEN)

- Clean dressing trolley
- Wound care pack/apron
- Normal Sodium chloride
- Appropriate tracheostomy dressing

ALL DRESSINGS MUST BE PRE-CUT.

If secretions are excessive and/or skin maceration is an issue then Cavilon no sting barrier (1ml foam applicator) may be used under dressings.
N.B Only Cavilon cream or 1ml foam applicator to be used NOT SPRAY due to inhalation of external use product.

**PROCEDURE** - This is an Aseptic Technique

1. Wash hands with soap and water;
2. Set up equipment onto pre-cleaned trolley;
3. Put apron on and a pair of sterile gloves;
4. Remove soiled dressing and discard;
5. Remove soiled gloves, wash hands, apply sterile gloves from dressing pack;
6. Clean tracheostomy peri stomal skin with normal Sodium chloride and pat dry. Clean any dried secretions from around the baseplate;
7. Assess the peri stomal skin for any signs of infection/over granulation or pressure ulcer;
8. Apply skin barrier film if required and allow to dry;
9. Apply dressing to tracheostomy site;
10. Remove gloves and wash hands with soap and water;
11. Document dressing change and any observations/problems in patient’s care pathway.

**WOUND CARE FOLLOWING DECANNULATION**

Once the decision to remove the tracheostomy tube has been made it is important that appropriate wound care continues until the site has completely healed.

Wound care continues to be:

1. An aseptic technique
2. PRN (as needed) according to the amount of secretions/or at least daily
3. Clean area with normal Sodium chloride and pat dry
4. Assess wound for any signs of infection/over granulation
5. Apply small dressing to wound (topper) small enough to cover tracheostomy site
6. If skin maceration or redness are present apply 3m skin barrier film to skin around site
7. Apply Allevyn adhesive dressing to site (leaving cot-fil swab dressing in place to cover wound). Ensure a skin-tight seal is made.
8. Ask patient to press onto wound site with fingers when speaking or coughing as this assists the healing process
9. Document each dressing change and any observations/problems in patient’s care pathway.

If you have any problems or concerns regarding any aspect of tracheostomy care do not hesitate to contact the tracheostomy care team. Details on how to contact members of the team can be found at the front of the tracheostomy policy.
COMMUNICATION – POINTS TO CONSIDER

- Where appropriate, the patient/relatives should be informed, before the tracheostomy procedure, that they may be unable to speak while the tracheostomy tube is in place, as air is no longer passing through the vocal cords (see appendix 1). They should be reassured, that it is expected that the voice will return once the tube is removed or changed to a fenestrated one (except when a laryngectomy has been performed). The AHP’s, nursing, medical staff and relatives will provide the patient with an alternative means of communication until then.

- For tracheostomised patients, the initial assessment should include a focus on the patient’s ability to see, hear, touch, write, understand or use facial expressions such as smiling and blinking (ICS 2008).

- Some tracheostomy patients may only be able to communicate by mouthing words or by use of a predetermined coded blink.

- If lip-reading is used, ask the patient to exaggerate their lip movements and to speak in short but complete sentences in order to make the message clearer.

- Watch the patient’s facial expressions and gestures for clues and listen for key words, which may indicate what the patient is saying.

- If a coded eye-blink is the only means of communication available, instruct the patient to blink once for ‘YES’ and twice for ‘NO’ in response to your questions.

- Use alphabet picture boards and phrase books in conjunction with the above methods. Make individualised boards to correspond with the patient’s need.

- Electronic larynx and electronic communication aids may be appropriate. The speech and language therapist will assess the patient for the appropriate equipment and advise the patient and their carers on how to use them. Use paper and pen if patients are able. Wipe boards are also available on Ward S12.

- Communication serves to meet many patient needs, including social interaction, information giving, reassurance, discussion of feelings, advice and counselling.

- The purpose of communication for critically ill patients is to help them maintain their identity as well as psychological, structural, personal and social integrity.

- The psychological status of the patient must be considered as they may be unable to speak and will often be anxious in the hospital environment.
MANIPULATION OF THE TRACHEOSTOMY TUBE FOR COMMUNICATION

Voice production may be achieved in patients with a tracheostomy tube by using one or more of the following:

- Cuff deflation
- The use of fenestrated tracheostomy tubes
- Using a smaller tracheostomy tube
- Intermittent finger occlusion
- One-way speaking valves

The use of one-way speaking valves with tracheostomised and ventilator dependant patients have received increased attention in the literature. For ventilator dependant patients, consider using the ‘Passy Muir’ valve (Mason & Watkins 1992) which assists with communication.

A speech and language therapist will be able to contribute to MDT advice on integrating ventilation and communication systems for individual patients as required.

This type of speaking valve has a one-way mechanism that allows air to be entered via the tube opening on inhalation but not exhaled through this route. Airflow is then redirected, either through the fenestrations or back down to the tube tip and up into the larynx on exhalation permitting vocalisations.

**NB** A speaking valve must never be placed on the 15mm connector of a non-fenestrated tube when the cuff is inflated as the patient will not be able to exhale.

CONTRA-INDICATIONS FOR SPEAKING VALVE USE

- Inability to tolerate cuff deflation
- Airway obstruction
- Unstable medical/pulmonary status
- Laryngectomy
- Sever anxiety/cognitive dysfunction
- Anarthria
- Severe tracheal/laryngeal stenosis
- End stage pulmonary disease
- Excessive secretions

Remove the speaking valve, clean, dry (refer to manufacturer’s guidelines) to prevent fatigue and deterioration in status and store in a sealed container if:

- The patient is having difficulty in breathing or appears in distress
- O2 saturation levels drop
- The patient requests it

If communication is particularly difficult, please contact the Speech & Language therapy department at Doncaster Royal Infirmary on Ext 3178 or at Bassetlaw District General Hospital on Ext 2343.
SWALLOWING

Patients with tracheostomies may experience problems with swallowing. Whilst oral intake may be permitted with an inflated or partially deflated cuff for psychological well-being and to help establish enteral feeding early, the presence of an inflated cuff compresses the oesophagus, and makes swallowing difficult for some patients, increasing the risk of aspiration. The risk is greatest in those patients with associated neurological or mechanical causes of dysphagia, or those with significant on-going respiratory failure. The decisions to allow feeding with an inflated cuff should be made on an individual patient basis after a swallowing assessment, and the patient should be regularly reviewed for evidence of aspiration. Sips of sterile water are initially given and if tolerated without cough, desaturation, fatigue or signs of aspiration on tracheal suctioning then their normal diet and fluids should be introduced with care and supervision. Guidance for initiating oral intake, along with risk factors for likely problematic patients, is shown in the boxes below.

Guidelines for the initiation of oral intake in patients with a tracheostomy

- Confirm that patient can tolerate cuff deflation (see above for exceptions)
- Sit patient up with head slightly flexed and deflate cuff
- Start with sips of water, moving onto their normal diet providing patient shows no signs of respiratory distress (coughing, desaturation, increased tracheal secretions, increased respiratory rate etc)
- In problematic cases consider referral to Speech and Language Therapy.

Risk factors for swallowing problems in patients with a tracheostomy

- Neurological injury e.g. bulbar palsy
- Disuse atrophy
- Head & Neck Surgery
- Evidence of aspiration of enteral feed or oral secretions on tracheal suctioning
- Increased secretion load, or persistent wet/weak voice, when cuff is deflated
- Coughing and/or desaturation following oral intake
- Patient anxiety or distress during oral intake

No one should be prescribed thickened fluids without full assessment by Speech & Language Therapy.
5. TRAINING/ SUPPORT

Training/Support – NMC 2011 states ‘staff should have skills and knowledge and fitness to practice in relevant clinical procedures’. Specialist training takes place at regular intervals throughout the year. These include the Annual Tracheostomy Masterclass and the TERRI course (Tracheostomy Emergency Respiratory Resuscitation Issues) which can be accessed by contacting the Clinical Simulation Centre at Montagu Hospital. It is recommended that all relevant Band 5 staff and above should attend these courses and also attend regular updates.

The new Clinical Skills Packages for Tracheostomy Care can now be requested by contacting the Clinical Skills Department. There is also a Modified Clinical Skills Training package which can be accessed by Healthcare Assistants who work in specialist areas with relevant experience and who have attended the above courses. This must be agreed by their manager and the Head and Neck Nurse Specialist or Tracheostomy Nurse before the package is requested. This training will be monitored and recorded on OLM.

6. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

<table>
<thead>
<tr>
<th>What is being Monitored</th>
<th>Who will carry out the Monitoring</th>
<th>How often</th>
<th>How Reviewed/ Where Reported to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective and Safe Care of Patient</td>
<td>Matrons/Ward Managers</td>
<td>Minimum weekly</td>
<td>Walk around wards and any shortfalls reported via the Ward Quality Assurance Tool.</td>
</tr>
<tr>
<td>Compliance with Policy to ensure best practice</td>
<td>Lead Tracheostomy Nurse</td>
<td>Annually</td>
<td>Audit of Tracheostomy IPOC</td>
</tr>
<tr>
<td></td>
<td>All staff involved in caring for Tracheostomy patients</td>
<td>As required</td>
<td>Any adverse incidents reported on DATIX</td>
</tr>
<tr>
<td>Training Needs for Tracheostomy Care</td>
<td>Ward managers/ matrons, individual staff/</td>
<td>Annually or as identified</td>
<td>Staff Professional Development Appraisal Adverse Incident Reporting</td>
</tr>
<tr>
<td>Compliance with policy</td>
<td>All staff involved in caring for Tracheostomy patients</td>
<td>As required</td>
<td>Adverse incidents reported on DATIX</td>
</tr>
</tbody>
</table>
7. DEFINITIONS

**BIPAP** – Intermittent Positive Airway Pressure  
**CCG** – Clinical Commissioning Group  
**CNS** – Clinical Nurse Specialist  
**CPAP** – Continuous Positive Airway Pressure  
**DCC** – Department of Critical Care  
**ENT** – Ear, Nose and Throat  
**ICU** – Intensive Care Unit  
**NMC** - Nursing and Midwifery Council

8. EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 6)

9. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

- Aseptic Non Touch Technique Policy - PAT/T 32  
- Standard Infection Prevention & Control Precautions Policy – PAT/IC 19  
- Cleaning and Disinfection of Ward Based Equipment – PAT/IC 24 (previously called Decontamination Policy  
- Glove Use Policy - HSFS 13  
- Hand Hygiene - PAT/IC 5  
- Mental Capacity Act 2005 - PAT/PA 19  
- Privacy and Dignity Policy - PA 28  
- Pathology Specimens- Collection and Handling of Pathology Specimens - PAT/IC 11  
- Waste Disposal Policy and Manual - CORP/HSFS 17 A & B  
- Sharps Injuries Management and Other Blood or Body Fluid Exposure Incidents - PAT/IC 14  
- Management of Respiratory Influenza Type Viruses- PAT/IC 10

10. REFERENCES


http://www.healthcareimprovementscotland.org/idoc.ashx?docid=e1af5a07-8c57-4927-b99a-210f3e0a6912&version=-1

http://www.ics.ac.uk/EasysiteWeb/getresource.axd?AssetID=481&type=full&servicetype=Attachment


National Tracheostomy Safety Project [online]( Accessed 21 February 2014)
http://www.tracheostomy.org.uk/

NPSA (2005) Protecting patients who are neck breathers [online]( Accessed 21 February 2014)
http://www.nrls.npsa.nhs.uk/resources/?entryid45=59793


St Georges Healthcare NHS Trust. Tracheostomy guidelines [online]( Accessed 21 February 2014)
https://www.stgeorges.nhs.uk/gps-and-clinicians/clinical-resources/tracheostomy-guidelines/
## APPENDIX 1 - TRANSFER INFORMATION SHEET
(MUST BE FILED IN PATIENTS MEDICAL NOTES)

### Doncaster and Bassetlaw Hospitals

**TRANSFER INFORMATION FOR A PATIENT WITH A TRACHEOSTOMY**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Doncaster</th>
<th>Montagu</th>
<th>Bassetlaw</th>
<th>Tickhill Road</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of discharge</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date tracheostomy inserted</td>
<td>/ /</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of tracheostomy:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percutaneous</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mini</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reason for tracheostomy:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Airway maintenance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secretion clearance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk of aspiration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of tube in situ at ICU/HDU discharge:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard single-lumen perox with cuff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NB: Single lumen tubes only accepted on</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT ward: General wards should only</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shiley fenestrated</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shiley uncuffed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjustable Flange</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management at discharge:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxygen concentration:</td>
<td></td>
<td>Delivery system</td>
<td>Humidification</td>
<td></td>
</tr>
<tr>
<td>........................</td>
<td></td>
<td>Thermovent</td>
<td>HME</td>
<td></td>
</tr>
<tr>
<td>........................</td>
<td></td>
<td>Trache mask</td>
<td>Sodium Chloride 0.9% nebuliser</td>
<td></td>
</tr>
<tr>
<td>........................</td>
<td></td>
<td>T-piece</td>
<td>Cold water</td>
<td></td>
</tr>
<tr>
<td>........................</td>
<td></td>
<td>CPAP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>........................</td>
<td></td>
<td>BPAP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cuff inflated?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speaking valve with fenestrated cannula?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient's swallowing ability</td>
<td>No problems; may eat and drink</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nil by mouth; awaiting Speech Therapy assessment</td>
<td></td>
<td>Speech Therapy advice recorded in notes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuing care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of review:</td>
<td></td>
<td>Name of Reviewer:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Date tube changed

<table>
<thead>
<tr>
<th>Date tube changed</th>
<th>Type and size of tracheostomy tube</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Designation & Name: ........................................ Signature: ........................................ Date & Time: ........................................

Send this form to: Lead Tracheostomy Nurses, Ward 512, Doncaster Royal Infirmary  Fax: 01302 647081
For each patient with a tracheostomy, the following must be available at the bedside:

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Tick</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suction apparatus/ Wall Suction</td>
<td></td>
<td>For aspiration of secretions</td>
</tr>
<tr>
<td>Suction catheters</td>
<td></td>
<td>Size of tracheostomy tube x 3 then divide by 2 – or add 4 to the size of tube i.e. Size 8 tube = size 12 catheter</td>
</tr>
<tr>
<td>Sterile disposable gloves</td>
<td></td>
<td>Suction is a sterile technique as per Royal Marsden</td>
</tr>
<tr>
<td>Sterile distilled water</td>
<td></td>
<td>To clean suction tubing</td>
</tr>
<tr>
<td>Oral suction catheter</td>
<td></td>
<td>For mouth care/clearing oral secretions/ oral suction</td>
</tr>
<tr>
<td>3 tracheostomy tubes – one same size as tube in situ – plus type one that is a size smaller plus a cuffed one for resuscitation purposes.</td>
<td></td>
<td>In the event of an emergency tube change e.g. occlusion or dislodgement/ in the event of cardiac arrest.</td>
</tr>
<tr>
<td>Tracheal dilators</td>
<td></td>
<td>For maintaining stoma open in an emergency situation</td>
</tr>
<tr>
<td>Tracheostomy tube holder</td>
<td></td>
<td>To maintain tracheostomy tube in place</td>
</tr>
<tr>
<td>1 plastic sterile bowl for sterile water for flushing connections</td>
<td></td>
<td>NB Do not store spare tubes in open containers with fluid (must be stored in a separate dry container) as there is a risk of bacterial culture.</td>
</tr>
<tr>
<td>1 covered plastic sterile bowl for spare tubes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10ml syringe</td>
<td></td>
<td>For deflation of cuff (only if cuffed tube in situ) use manometer for inflation purposes and monitoring</td>
</tr>
<tr>
<td>Orange waste disposal sack</td>
<td></td>
<td>For clinical waste</td>
</tr>
<tr>
<td>Topper drain swabs 10cm x 10cm (pre-cut)/Lyofoam T dressings/3M 3½“ x 3½”</td>
<td></td>
<td>To protect tissue around stoma</td>
</tr>
<tr>
<td>Swedish nose (Thermovent) and O2 attachment/or Provox trache phone/or Mallincrodt phonation valve, if tolerated</td>
<td></td>
<td>Acts as humidifying filter – an adequate supply is needed as trapped secretions negate the effect/valve for speaking</td>
</tr>
<tr>
<td>Tracheostomy mask with:</td>
<td></td>
<td>For patients requiring nebuliser therapy</td>
</tr>
<tr>
<td>a) nebuliser acorn</td>
<td></td>
<td>For delivery of humidified O2 obtained from physiotherapy</td>
</tr>
<tr>
<td>b) Humidification kit</td>
<td></td>
<td>- Usually used on ENT ward</td>
</tr>
<tr>
<td>c) RespFlo closed circuit aerodyne cervsol heater/ultrasonic nebuliser</td>
<td></td>
<td>- Check with physiotherapist re correct type</td>
</tr>
<tr>
<td>Sodium chloride 0.9% ampoules</td>
<td></td>
<td>For additional humidification via nebulisers</td>
</tr>
<tr>
<td>Catheter mount</td>
<td></td>
<td>For emergency resuscitation or ventilated patients</td>
</tr>
<tr>
<td>Sputum trap</td>
<td></td>
<td>For obtaining sputum sample via suction</td>
</tr>
<tr>
<td>Hand held Pressure Gauge</td>
<td></td>
<td>(Only if cuffed tube in situ) For checking pressure of cuffed tube</td>
</tr>
<tr>
<td>Tracheostomy Swabs/Brushes</td>
<td></td>
<td>For cleaning inner cannulae</td>
</tr>
</tbody>
</table>
Advice on where to obtain equipment is available from Ward S12. However, under no circumstances whatsoever are the tracheostomy trolleys to be removed from Ward S12. Contact physiotherapy in first instance.
### APPENDIX 3 - TRACHEOSTOMY DISCHARGE EQUIPMENT

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Tick</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tracheostomy tube – same type and size plus cuffed tube + 1 tube size smaller</td>
<td>✓</td>
</tr>
<tr>
<td>Trache-hold x 2</td>
<td></td>
</tr>
<tr>
<td>Trache-masks x 2</td>
<td></td>
</tr>
<tr>
<td>O2 Tubing x 2</td>
<td></td>
</tr>
<tr>
<td>Nebuliser chambers x 2</td>
<td></td>
</tr>
<tr>
<td>Connection tubing for suctioning x 2</td>
<td></td>
</tr>
<tr>
<td>Sodium chloride for nebuliser (5mls)</td>
<td></td>
</tr>
<tr>
<td>Suction catheters, correct size for tube</td>
<td></td>
</tr>
<tr>
<td>Provox trachephone x 2</td>
<td></td>
</tr>
<tr>
<td>Shileys phonation valve x 1 – if patient able to tolerate otherwise Swedish nose</td>
<td></td>
</tr>
<tr>
<td>Disposable gloves x 1 box</td>
<td></td>
</tr>
<tr>
<td>Disposable wipes x 1 packet</td>
<td></td>
</tr>
<tr>
<td>Disposable aprons x 6</td>
<td></td>
</tr>
<tr>
<td>Tracheostomy dressings x 7</td>
<td></td>
</tr>
<tr>
<td>Buchanan bib x 1</td>
<td></td>
</tr>
<tr>
<td>Tracheal Dilators x 1 pair</td>
<td></td>
</tr>
</tbody>
</table>

Suction machine from CCG or district nurses/GP – must have been delivered 7 days prior to discharge.

Nebuliser machine either from GP surgery or District Nursing Services, or on loan from S12 or Chest clinic, or if Oncology patient – a Macmillan grant may be available.

Ensure visit from Community nurses takes place to meet the patient and address any educational needs prior to discharge. Case conference must take place.

See IPOC for procedure to follow and accurate record keeping.
APPENDIX 4 – EMERGENCY TRACHEOSTOMY MANAGEMENT

This patient has a

TRACHEOSTOMY

There is a potentially patent upper airway (Intubation may be difficult)

Surgical / Percutaneous

Performed on (date) .................................
Tracheostomy tube size (if present) ..............
Hospital / NHS number .............................

Notes: indicate tracheostomy type by circling the relevant figure.
Indicate location and function of any sutures.
Laryngoscopy grade and notes on upper airway management.
Any problems with this tracheostomy.

Emergency Call:  Anaesthesia  ICU  ENT  MaxFox  Emergency Team

www.tracheostomy.org.uk
Emergency tracheostomy management - Patent upper airway

Call for Airway Expert help
Look, listen & feel at the mouth and tracheostomy
A Waters circuit may help assessment if available
Use Capnography whenever available: exhaled carbon dioxide indicates a patent or partially patent airway

No

Is the patient breathing?

Yes

Apply high flow oxygen to BOTH the face and the tracheostomy

No

Call Resuscitation team
CPR if no pulse

Assess tracheostomy patency

Yes

Remove speaking valve or cap (if present)
Remove inner tube
Some inner tubes need re-inserting to connect to breathing circuits

Can you pass a suction catheter?

The tracheostomy is patent
Perform tracheal suction
Consider partial obstruction
Ventilate if not breathing
Continue ABCDE assessment

No

Deflate the cuff (if present)
Look, listen & feel at the mouth and tracheostomy
Use Waters circuit or capnography if available

Is the patient stable or improving?

Yes

Partially obstructed or displaced
Continue ABCDE assessment

No

REMOVE THE TRACHEOSTOMY TUBE
Look, listen & feel at the mouth and tracheostomy. Ensure oxygen re-applied to face and stoma
Use Waters circuit or capnography if available

Call Resuscitation team
CPR if no pulse

Is the patient breathing?

Yes

Continue ABCDE assessment

No

Primary emergency oxygenation

Standard ORAL airway manoeuvres
Cover the stoma (swabs / hand)
Bag-Valve-Mask
Oral or nasal airway adjuncts
LMA

Secondary emergency oxygenation

Attempt ORAL intubation
Prepare for difficult intubation
Uncut tube. Advance beyond stoma

Tracheostomy STOMA ventilation
Paediatric face mask applied to neck
LMA applied to neck

Attempt intubation of stoma
Small tracheostomy tube / 6.0 cuffed ETT
Consider Bougie / Aintree catheter / Fibreoptic `scope

National Tracheostomy Safety Project  www.tracheostomy.org.uk
This patient has a **LARYNGECTOMY** and CANNOT be intubated or oxygenated via the mouth

Follow the LARYNGECTOMY algorithm of breathing difficulties

**Performed on (date)** ...........................................

**Tracheostomy tube size (if present)** ..................

**Hospital / NHS number** .................................

**Notes:**

There may not be a tube in the stoma.
The trachea (wind pipe) ends at the neck stoma

**Emergency Call:**  Anaesthesia  ICU  ENT  Max-Fax  Emergency Team

[www.tracheostomy.org.uk](http://www.tracheostomy.org.uk)
Emergency laryngectomy management

**Call for Airway Expert help**

*Look, listen & feel at the mouth and tracheostomy*

A Waters circuit may help assessment if available

*Use Capnography whenever available: exhaled carbon dioxide indicates a patent or partially patent airway*

---

**Is the patient breathing?**

**No**

Call Resuscitation team

CPR if no pulse

---

**Yes**

Apply high flow oxygen to laryngectomy

If any doubt whether patient has a laryngectomy, apply oxygen to face also*

---

**Assess laryngectomy patency**

**Not all laryngectomy stomas will have a tube in situ**

---

**Remove humidification cover or button (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 if not breathing

Continue ABCDE assessment

---

**No**

Deflate the cuff (if present)

*Look, listen & feel at the laryngectomy stoma or tube*

Use Waters circuit or capnography 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 Waters circuit or capnography if available

---

**Call Resuscitation team**

**CPR if no pulse**

---

**Primary emergency oxygenation**

**Laryngectomy STOMA ventilation**

Paediatric face mask applied to neck

LMA applied to neck

---

**Secondary emergency oxygenation**

**Attempt intubation of stoma**

Small tracheostomy tube / 6.0 cuffed ETT

Consider Bougie / Aintree catheter / Fibreoptic ‘scope

---

*Laryngectomy patients have an end stoma and cannot be oxygenated via the mouth or nose*

Applying oxygen to the face and neck is the default emergency action for all patients with a tracheostomy

---

National Tracheostomy Safety Project  www.tracheostomy.org.uk
### APPENDIX 6 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

<table>
<thead>
<tr>
<th>Service/Function/Policy/Project/Strategy</th>
<th>Care Group/Executive Directorate and Department</th>
<th>Assessor(s)</th>
<th>New or Existing Service or Policy?</th>
<th>Date of Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAT/T 20 v.5 – Tracheostomy Adult Care Policy</td>
<td>Surgical Care Group</td>
<td>Janet Ryles/Lucy Brooks</td>
<td>Existing Policy</td>
<td>November 2015</td>
</tr>
</tbody>
</table>

1) **Who is responsible for this policy?** Surgical Care Group

2) **Describe the purpose of the service / function / policy / project/ strategy?** Who is it intended to benefit? What are the intended outcomes? Safe and effective care for patients

3) **Are there any associated objectives?** Legislation, targets national expectation, standards - No

4) **What factors contribute or detract from achieving intended outcomes?** – Non-compliance of policy

5) **Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief?** Details: [see Equality Impact Assessment Guidance] - No

6) **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –

7) **Is there any scope for new measures which would promote equality?** [any actions to be taken] No

8) **Provide the Equality Rating of the service / function /policy / project / strategy** – tick (√) outcome box

<table>
<thead>
<tr>
<th>Outcome 1</th>
<th>Outcome 2</th>
<th>Outcome 3</th>
<th>Outcome 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a Detailed Equality Analysis form in Appendix 4

Date for next review: November 2018

Checked by: Janet Ryles Date: November 2015