

Hospital in-patients with a Tracheostomy

Introduction

- Patients with a tracheostomy or laryngectomy are at increased risk of death or harm if inappropriate or inadequate care is provided.
- Patients with a tracheostomy or laryngectomy should be cared for in an environment that has trained staff, appropriate equipment and can manage tracheostomy daily care and emergencies.

On admission to hospital of a patient with a tracheostomy/laryngectomy or formation of a tracheostomy/laryngectomy whilst an in-patient

1. Check patient has **'Alert'** on TRAK
2. If not, insert **'Alert'** for patient
 - a. Under EPR, Allergies/Alerts/Risks, Alerts, Permanent Alert, Select New. A text box will appear, select 'Alert Category' – 'Clinical' from dropdown list, select 'Alert' either 'Airway alert – Tracheostomy' or 'Airway alert – Laryngectomy' from dropdown list.
 - b. In the Extra Information Box, type \liptrach then press SPACEBAR
3. Inform Critical Care
 - a. **RIE** – Bleep 2306
 - i. Advise of admission
 - ii. The patient will be cared for on Critical Care or Ward 204 only
 - iii. Bedside equipment will be provided by Critical Care
 - b. **WGH** – Call 31664
 - i. Advise of admission
 - ii. The patient will be cared for on a ward agreed by the Critical Care Team.
 - iii. Bedside equipment will be provided by Critical Care
 - c. **SJH** – Call 54056 or 54063 for ITU Charge Nurse.
 - i. Advise of admission and request Emergency Tracheostomy Box and Bedside Poster Signs.
 - ii. Patients will be cared for on a ward agreed by ITU and Bed Manager +/- HAN. If this is outwith Ward 18/19a or ITU, the ITU Charge Nurse will identify a staff member to attend the ward and ensure staff have appropriate equipment in situ. (Staff member will attend from either ITU, HAN, HAW OR Ward 19a).
 - iii. Support for these patients will be co-ordinated by ITU and if they are not in ITU they will be noted at all ITU medical and nursing handovers and hospital bed meetings whilst still in-patients.
4. If the tracheostomy is permanently removed please remove the **'Alert'** on TRAK
5. On patient discharge from hospital please return the Emergency Tracheostomy Box and Head of Bed Signs to Critical Care

Bedside equipment for all tracheostomised patients

- **Emergency tracheostomy box** containing:
 - Spare tracheostomies, one same size as in patient and one size smaller than that in patient
 - Stitch cutters / 1 x 10ml syringe / head torch (RIE) / 2 x sachets of KY jelly
 - 2 x 14G suction catheters / tracheal dilator forceps
 - Paediatric face mask
 - Miniature bed sign
- **Spare non-fenestrated inner tube**
- **Head of bed sign** (date and type of tracheostomy and what to do in emergency)
- **Laminated Emergency tracheostomy management algorithm**

Tracheostomy occlusion/blockage

CALL FOR HELP, FOLLOW GUIDELINES ON HEAD OF BED SIGN

- Oxygen to face & stoma
- Remove cap/inner tube
- Pass a suction catheter
- Deflate cuff/remove tube
- Consider ventilation via upper airway or stoma using a mask or tube (If ventilating via mouth occlude stoma site)

A Mapleson C circuit with capnography may help assessment of airway patency

Emergency decannulation

If patient accidentally decannulates, **CALL FOR MEDICAL HELP**.

Ensure patient is oxygenated via bag-valve-mask or Mapleson C circuit with capnography over mouth (occlude stoma site) until medical help arrives.

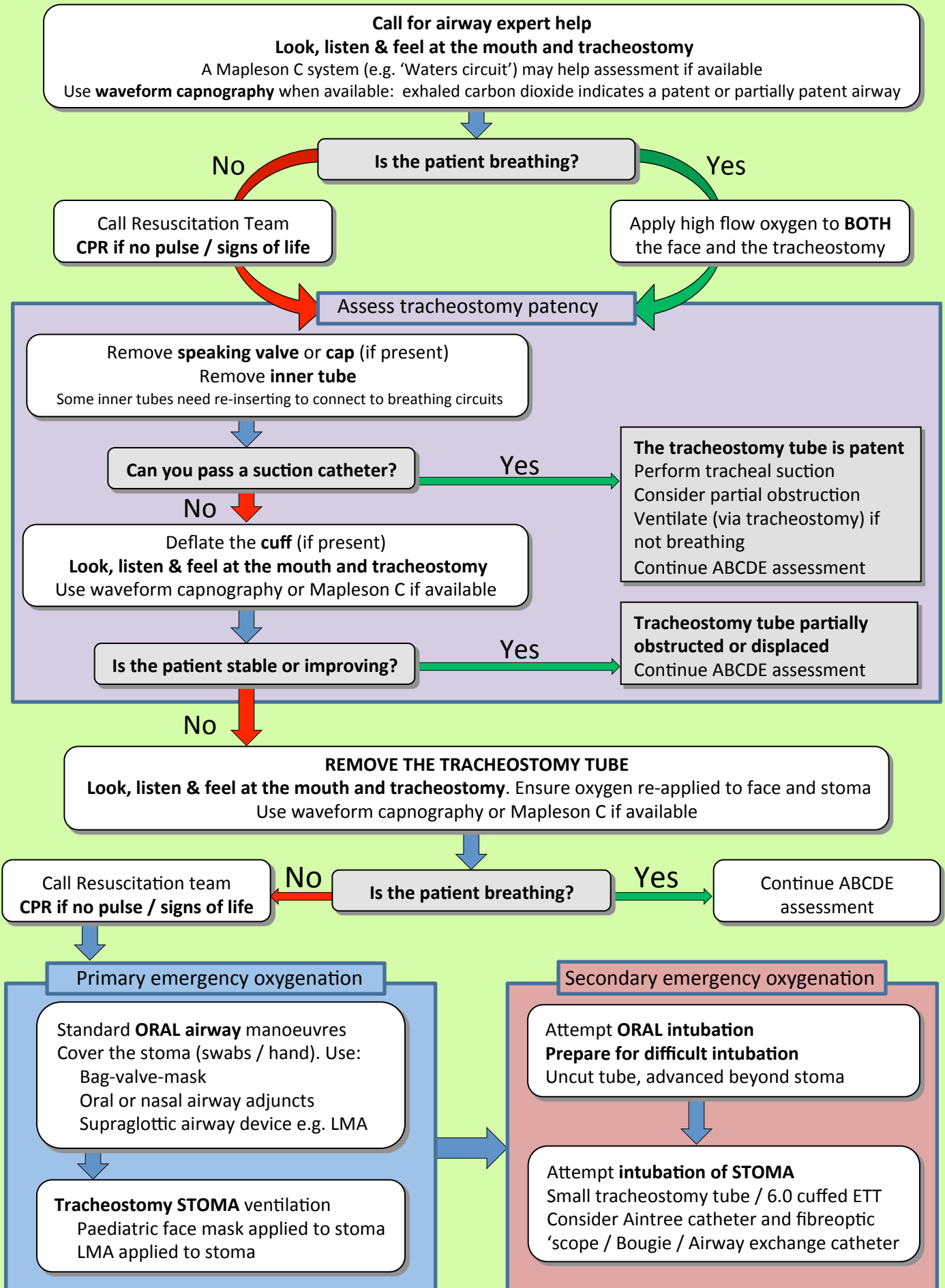
Once a senior medic is present the default would usually be to

1. Oxygenate the patient either via
 - a. The mouth using BVM or Mapleson C circuit with airway adjuncts OR
 - b. The stoma using a paediatric face mask applied to the stoma
2. Secure an airway using an uncut ETT (with cuff beyond stoma) in the emergency. Then refashion a tracheostomy as required or appropriate, usually in daylight hours as a planned procedure.
3. However depending on the reason for tracheostomy and how well formed the stoma is, the stoma may be re-cannulated immediately, often using fiberoptic scope and an airway exchange catheter.

NB. An expert may choose to use the tracheal dilators – these should not be used by non-experts.

Title: Hospital in-patients with a Tracheostomy	
ID: HIPWATv2.20151119	Authors: S Moultrie, K Watson, R MacFadyen, M Dunn, C Barker
Category:	Document Version: 2
Status Draft/Final: Final	Review Date: Nov 2017
Authoriser: QIT, LATE	Date Authorisation: Nov 2015
Date added to Intranet:	
Key words: Airway, Tracheostomy	

Emergency tracheostomy management - Patent upper airway



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

No

Is the patient breathing?

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

No

Is the patient breathing?

Yes

Continue ABCDE assessment

Call Resuscitation Team
CPR if no pulse / signs of life

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 fiberoptic '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

This patient has had a TRACHEOSTOMY

In Emergency:

CALL FOR HELP

Call 2222 or bleep ITU Reg/Con

Surgical / Percutaneous:

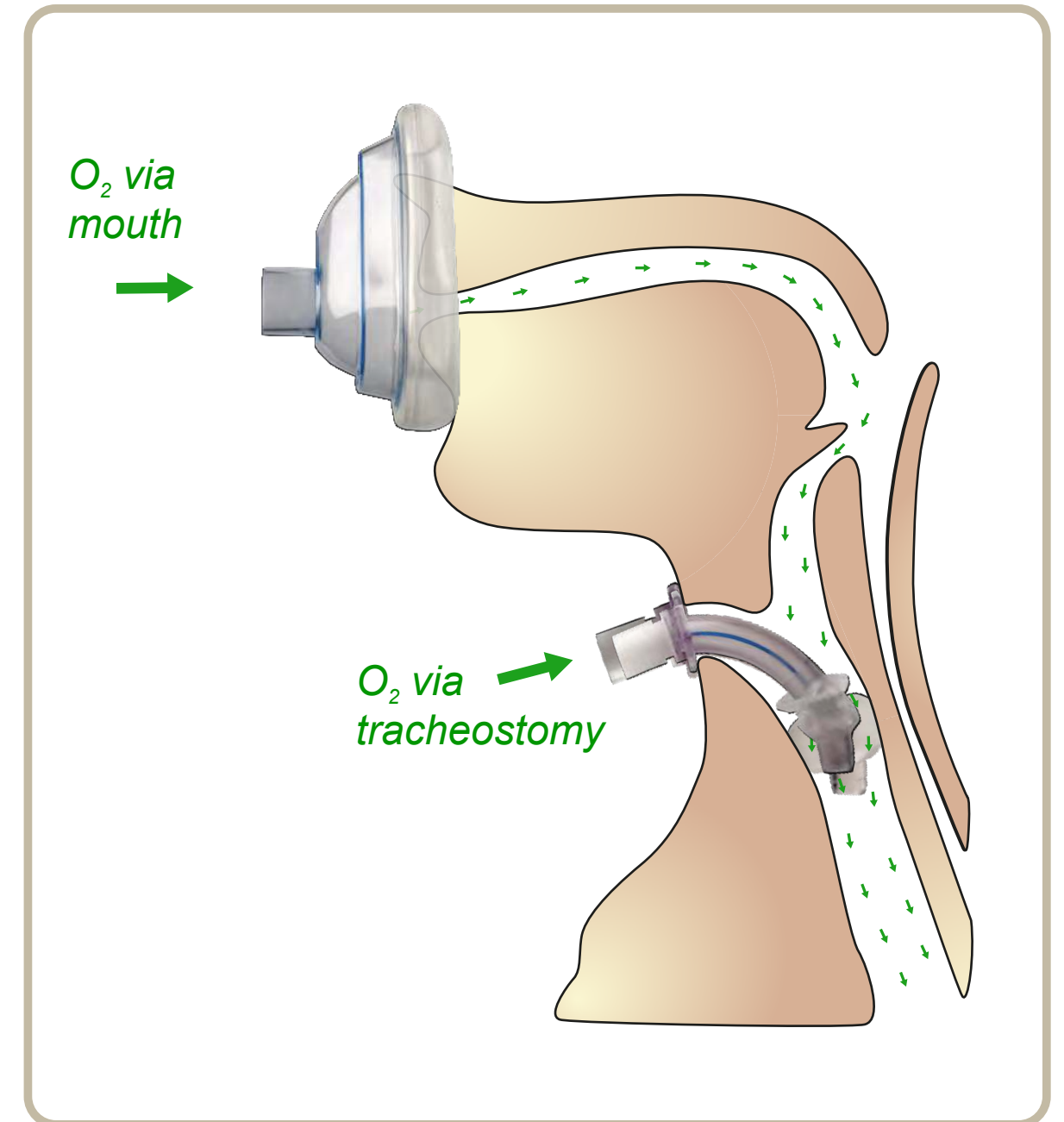
Performed on:

Tracheostomy tube size:

(Note: The upper airway may provide an intact airway)

Give oxygen via BOTH stoma & mouth

- Oxygen to face & stoma
- Remove cap/inner tube
- Pass a suction catheter
- Deflate cuff/remove tube
- Consider ventilation via upper airway or stoma using a mask or tube
(If ventilating via mouth occlude stoma site)



This patient has had a LARYNGECTOMY

In Emergency:

CALL FOR HELP

Call 2222 or bleep ITU Reg/Con

Performed on:

Tracheostomy tube size:

(Note: there is NO connection between the trachea and the mouth/nose)

DO NOT give oxygen via mouth!

- Apply Oxygen to stoma
- Remove cap/inner tube
- Pass a suction catheter
- Deflate cuff/remove tube
- Consider ventilation via stoma using a mask or tube

