Tracheostomy Clinical Pathway

Site Applicability

Vancouver General Hospital (VGH)

UBC Hospital

Pathway Patient Goals

Inclusion Criteria

Home Discharge Criteria

Instructions

1. Review pathway once per shift for patient care goals and expected outcomes
2. Do not document on this pathway, complete documentation in the Electronic Health Record (Cerner) or paper chart as per policy

POST – OR Day	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Orient to unit & hospital routine • Reinforce pre-op teaching (deep breathing, coughing and leg exercises) • **Review purpose of tracheostomy** • Review pain scale/management • Patient and family understand outcome of surgery
Tests	• Standing orders for blood work
Consults	
Assessments, Treatments	• Level of consciousness (alert & oriented x 3) • Vital signs and temp as per post-op protocol (R12-20 min, P60-100, BP 90-150) • Chest auscultation Q4hrs prn (breath sounds clear, resps easy & regular, Ø SOB, Ø resp distress) • Pulse oximeter Q4hrs prn (>93%) - maintain oxygen saturation levels with oxygen therapy • Assess for minimal neck swelling (**no airway obstruction/hematoma**) • Assess abdominal status Q4hrs prn (soft, non distended, bowel sounds audible x 4) • Assess IV site (free of redness, swelling & pain) • Capillary blood glucose monitoring QID x 72 hours • **Staple remover, suture scissors and suction at bedside at all times (Tape to HOB)** • **Emergency trach equipment at bedside/accompany patient at all times**
Adequate Airway	• **RT following patient (re: trach)** • Airway patent, can clear own secretions • Trach in situ & secure • Note trach size and type • Note if trach cuff inflated or deflated • Document frequency of suction required • Measure cuff pressure Q shift • **Trach care Q shift and PRN** • Instill with NS prn (to liquefy secretions) • **Trach sign at HOB**
Activity, Rest	• Elevate HOB 30° • Encourage deep breathing, coughing and leg exercises Q1hr while awake • ICOUGH protocol followed • Plantar dorsi-flexion exercises Q1hr while awake • Dangle at edge of bed
Medications	• Analgesics prn • Antiemetic prn
Pain	• Pain assessment Q1hr until pain is controlled then Q4hrs prn (pain adequately controlled) • Sedation level within norm
Nutrition	• **NPO** • Nausea controlled

Elimination	• Foley catheter to straight drainage (urine output > 30 mls/hr) • Voiding adequately (urine output > 30 mls/hr) • Passing flatus
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes **WNL -** **within normal limits**	• Airway patent; trach in situ- secretions clear • Vital signs and temp stable - within normal range/satisfactory • Patient states pain is at an acceptable level • Nausea controlled • Fluids & electrolytes balanced • IV patent (site free from pain, swelling or redness) • Patient describes anxiety as acceptable

Post-op Day 1	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Patient and family understand outcome of surgery • Reinforce deep breathing, coughing and leg exercises • **Review importance of tracheostomy** • Review pain scale/management • Review feeding schedule • **Explain purpose and process of cuff deflation trials** • Patient and family understand emergency protocol for airway obstruction; importance of tracheostomy care • **Provide & review "Going Home after Tracheostomy" pamphlet with patient/family** • Teaching of self trach care initiated (if applicable)
Tests	• Standing orders for blood work
Consults	
Assessments, Treatments	• Level of consciousness (alert & oriented x 3) • Vital signs and temp as per post-op protocol (R12-20 min, P60-100, BP 90-150) • Chest auscultation Q4hrs prn (breath sounds clear, resps easy & regular, Ø SOB, Ø resp distress) • Pulse oximeter Q4hrs prn (>93%) - maintain oxygen saturation levels with oxygen therapy • Assess for minimal neck swelling (**no airway obstruction/hematoma)** • Assess abdominal status Q4hrs prn (soft, non distended, bowel sounds audible x 4) • Assess IV site (free of redness, swelling & pain) • Capillary blood glucose monitoring QID x 72 hours • **Staple remover, suture scissors and suction at bedside at all times (Tape to HOB)** • **Emergency trach equipment at bedside/accompany patient at all times**
Adequate Airway	• **RT following patient (re: trach)** • Airway patent, can clear own secretions • Trach in situ & secure • Note trach size and type • Note if trach cuff inflated or deflated • Document frequency of suction required • Measure cuff pressure Q shift • **Trach care Q shift and PRN** • Instill with NS prn (to liquefy secretions) • **Trach sign at HOB**
Activity, Rest	• Elevate HOB 30° • Encourage deep breathing, coughing and leg exercises Q1hr while awake • ICOUGH protocol followed • Dangle to edge of bed • Mobilize to chair (~2 hours) • Assisting with am care
Medications	• Analgesics prn

	• Antiemetic prn
Pain	• Pain assessment Q1hr until pain is controlled then Q4hrs prn (pain adequately controlled) • Sedation level within norm
Nutrition	• **NPO** • Nausea controlled
Elimination	• Foley catheter to straight drainage (urine output > 30 mls/hr) • Voiding adequately (urine output > 30 mls/hr) • **Foley Removed** • Passing flatus
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes **WNL - within normal limits**	• Airway patent; trach in situ- secretions clear • Vital signs and temp stable - within normal range/satisfactory • Patient states pain is at an acceptable level • Nausea controlled • Fluids & electrolytes balanced • IV patent (site free from pain, swelling or redness) • Patient describes anxiety as acceptable • Ambulating with assistance • Participating in self trach care (if applicable)

Post-op Day 2	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Reinforce deep breathing, coughing and leg exercises • Review pain scale/management • Review feeding schedule • Patient and family understand emergency protocol for airway obstruction; importance of tracheostomy care • **Reinforce process of cuff deflation trials** • Explain purpose and process of downsizing tracheostomy tube • **Trach teaching in progress (if applicable)** • **Provide & review "Going Home after Tracheostomy" pamphlet with patient/family**
Tests	• Standing orders for blood work
Consults	
Assessments, Treatments	• Level of consciousness (alert & oriented x 3) • Vital signs and temp as per post-op protocol (R12-20 min, P60-100, BP 90-150) • Chest auscultation Q4hrs prn (breath sounds clear, resps easy & regular, Ø SOB, Ø resp distress) • Pulse oximeter Q4hrs prn (>93%) - maintain oxygen saturation levels with oxygen therapy • Assess for minimal neck swelling (**no airway obstruction/hematoma**) • Assess abdominal status Q4hrs prn (soft, non distended, bowel sounds audible x 4) • Assess IV site (free of redness, swelling & pain) • Capillary blood glucose monitoring QID x 72 hours • **Staple remover, suture scissors and suction at bedside at all times (Tape to HOB)** • **Emergency trach equipment at bedside/accompany patient at all times**
Adequate Airway	• Airway patent, can clear own secretions • Trach in situ & secure • Note trach size and type • Note if trach cuff inflated or deflated • Document frequency of suction required • Measure cuff pressure Q shift • **Trach care Q shift and PRN** • Instill with NS prn (to liquefy secretions) • **Trach sign at HOB**
Activity, Rest	• Elevate HOB 30° • Encourage deep breathing, coughing and leg exercises Q1hr while awake • ICOUGH protocol followed • Dangle, sit in chair (2-3 times/day) • Assisting with am care • Ambulating with assistance
Medications	• Analgesics prn • Antiemetic prn

Pain	• Pain assessment Q1hr until pain is controlled then Q4hrs prn (pain adequately controlled) • Sedation level within norm
Nutrition	• **NPO** • Sips of clear fluids • Nausea controlled
Elimination	• Voiding adequately (urine output > 30 mls/hr) • Passing flatus
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes **WNL -** **within normal limits**	• Airway patent; trach insitu- secretions clear • Vital signs and temp stable - within normal range/satisfactory • Tolerates cuff deflation of trach • Patient states pain is at an acceptable level • Nausea controlled • Tolerates oral intake • Fluids & electrolytes balanced • IV patent (site free from pain, swelling or redness) • Patient describes anxiety as acceptable • Ambulating with assistance (returning to baseline level of function) • Participating in self trach care (if applicable)

Post-op Day 3	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Reinforce importance of deep breathing, coughing and leg exercises • Review pain scale/management • **Review importance of tracheostomy care, process of downsizing tracheostomy** • **Self trach care teaching in progress (if applicable)** • Organize home trach suction equipment upon discharge (if applicable) • **Review "Going Home after Tracheostomy" pamphlet with patient /family**
Tests	
Consults	Speech language pathologist (re: swallow assessment)
Assessments, Treatments	• Level of consciousness (alert & oriented x 3) • Vital signs and temp (R12-20 min, P60-100, BP 90-150) • Chest auscultation Q4hrs prn (breath sounds clear, resps easy & regular, Ø SOB, Ø resp distress) • Pulse oximeter Q6hrs prn (>93%) Titrate oxygen requirements to saturation level - **wean to humidified air** • Assess for minimal neck swelling (**Ø airway obstruction/hematoma**) • Assess abdominal status Q4hrs prn (soft, non distended, bowel sounds audible x 4) • Assess IV site (free of redness, swelling & pain) • **Staple remover, suture scissors and suction at bedside at all times (Tape to HOB)** • **Emergency trach equipment at bedside/accompany patient at all times**
Adequate Airway	• Airway patent, can clear own secretions • Trach in situ & secure • Note trach size and type • **Cuff deflated** • Document frequency of suction required • Measure cuff pressure Q shift • **Cuff deflation trials** • Trach downsized, note new size • **Trach care Q shift and PRN** • Instill with NS prn (to liquefy secretions) • **Update trach sign at HOB**
Activity, Rest	• Elevate HOB 30° • Encourage deep breathing, coughing and leg exercises Q4hr while awake • ICOUGH protocol followed • Up to chair (2-3 times/day) • Independent with self care • Mobilizing independently
Medications	• Analgesics prn • Antiemetic prn
Pain	• Pain assessment Q1hr until pain is controlled then Q4hrs prn (pain adequately controlled) • Sedation level within norm

Nutrition	• NPO • Sips of clear fluids • Clear fluids • Nausea controlled
Elimination	• Voiding adequately (urine output > 30 mls/hr) • Passing flatus • Note any normal BM • Note any diarrhea
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes **WNL -** **within normal limits**	• Airway patent; trach in situ - secretions clear • Vital signs and temp stable - within normal range/satisfactory • Tolerating cuff deflation of trach • Tolerates downsizing of trach • Patient states pain is at an acceptable level • Nausea controlled • Tolerates oral intake • Fluids & electrolytes balanced • IV patent (site free from pain, swelling or redness) • Patient describes anxiety as acceptable • Participating and becoming independent with trach care (if applicable) • Mobilizing independently (at baseline level of function)

Post-op Day 4	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Reinforce importance of deep breathing, coughing and leg exercises • Review pain scale/management • **Review importance of tracheostomy care, process of downsizing tracheostomy** • **Self trach care teaching in progress (if applicable)** • Organize home trach suction equipment upon discharge (if applicable) • **Review "Going Home after Tracheostomy" pamphlet with patient /family**
Tests	
Consults	• Speech language pathologist (re: swallow assessment)
Assessments, Treatments	• Level of consciousness (alert & oriented x 3) • Vital signs and temp (R12-20 min, P60-100, BP 90-150) • Chest auscultation Q4hrs prn (breath sounds clear, resps easy & regular, Ø SOB, Ø resp distress) • Pulse oximeter Q6hrs prn (>93%) Titrate oxygen requirements to saturation level - **wean to humidified air** • Assess for minimal neck swelling (**Ø airway obstruction/hematoma**) • Assess abdominal status Q4hrs prn (soft, non distended, bowel sounds audible x 4) • Assess IV site (free of redness, swelling & pain) • **Staple remover, suture scissors and suction at bedside at all times (Tape to HOB)** • **Emergency trach equipment at bedside/accompany patient at all times**
Adequate Airway	• Airway patent, can clear own secretions • Trach in situ & secure • Note trach size and type • **Cuff deflated** • Document frequency of suction required • Measure cuff pressure Q shift • **Cuff deflation trials** • Trach downsized, note new size • **Trach care Q shift and PRN** • Instill with NS prn (to liquefy secretions) • **Update trach sign at HOB**
Activity, Rest	• Elevate HOB 30° • Encourage deep breathing, coughing and leg exercises Q4hr while awake • ICOUGH protocol followed • Up to chair (2-3 times/day) • Independent with self care • Mobilizing independently
Medications	• Analgesics prn • Antiemetic prn
Pain	• Pain assessment Q1hr until pain is controlled then Q4hrs prn (pain adequately controlled) • Sedation level within norm

Nutrition	• NPO • Sips of clear fluids • Clear fluids • Nausea controlled
Elimination	• Voiding adequately (urine output > 30 mls/hr) • Passing flatus • Note any normal BM • Note any diarrhea
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes **WNL -** **within normal limits**	• Airway patent; trach in situ - secretions clear • Vital signs and temp stable - within normal range/satisfactory • Tolerating cuff deflation of trach • Tolerates downsizing of trach • Patient states pain is at an acceptable level • Nausea controlled • Tolerates oral intake • Fluids & electrolytes balanced • IV patent (site free from pain, swelling or redness) • Patient describes anxiety as acceptable • Participating and becoming independent with trach care (if applicable) • Mobilizing independently (at baseline level of function)

Post-op Day 5	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Reinforce importance of deep breathing, coughing and leg exercises • Review pain scale/management • **Review feeding schedule** • **Explain purpose and rationale for corking tracheostomy** • Patient and family understand emergency protocol for airway obstruction - **Patient able to uncork tracheostomy** • Discuss potential needs upon discharge (home support / home care nursing**) plan home in 2-3 days** • **Review "Going Home after Tracheostomy" pamphlet with patient/family** • **Self trach care teaching nearly established (if applicable)** • Organize home trach suction equipment upon discharge (if applicable)
Tests	
Consults	• Home Care Nursing (re: tracheostomy care & management)
Assessments, Treatments	• Level of consciousness (alert & oriented x 3) • Vital signs and temp (R12-20 min, P60-100, BP 90-150) • Chest auscultation Q4hrs prn (breath sounds clear, resps easy & regular, Ø SOB, Ø resp distress) • Pulse oximeter Q6hrs prn (>93%) Titrate oxygen requirements to saturation level - **wean to humidified air/room air** • Assess for minimal neck swelling (**Ø airway obstruction/hematoma**) • Assess abdominal status Q4hrs prn (soft, non distended, bowel sounds audible x 4) • Assess IV site (free of redness, swelling & pain) • **Saline lock IV** • **Staple remover, suture scissors and suction at bedside at all times (Tape to HOB)** • **Emergency trach equipment at bedside/accompany patient at all times**
Adequate Airway	• Airway patent, can clear own secretions • Trach in situ & secure • Note trach size and type • Document frequency of suction required • **Trach corked** • **Trach care Q shift and PRN (only if trach uncorked)** • Instill with NS prn (to liquefy secretions) • **Update trach sign at HOB**
Activity, Rest	• Elevate HOB 30° • Encourage deep breathing, coughing and leg exercises Q4hr while awake • ICOUGH protocol followed • Up to chair (2-3 times/day) • Independent with self care • Mobilizing independently
Medications	• Analgesics prn • Antiemetic prn

Pain	• Pain assessment Q1hr until pain is controlled then Q4hrs prn (pain adequately controlled) • Sedation level within norm
Nutrition	• NPO • Sips of clear fluids • Clear fluids • Nausea controlled
Elimination	• Voiding adequately (urine output > 30 mls/hr) • Passing flatus • Note any normal BM • Note any diarrhea
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes **WNL - within normal limits**	• Airway patent; trach in situ - secretions clear • Vital signs and temp stable - within normal range/satisfactory • Tolerating trach corking • Patient states pain is at an acceptable level • Nausea controlled • Tolerates oral intake • Fluids & electrolytes balanced • Patient describes anxiety as acceptable • Independent with self trach care (if applicable) • Mobilizing independently (at baseline level of function)

Post-op Day 6	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Reinforce importance of deep breathing, coughing and leg exercises • Review pain scale/management • Review feeding schedule • **Explain purpose of corking tracheostomy if applicable** • Patient and family understand emergency protocol for airway obstruction - **Patient able to uncork tracheostomy** • Explain process of tracheostomy removal and importance of tracheostomy site closure • **Self trach care teaching accomplished (if applicable)** • Discuss potential needs upon discharge if applicable (home support / home care nursing) **plan home in 2-3 days** • **Review "Going Home after Tracheostomy" pamphlet with patient/family** • **Inform patient/family of all resources arranged upon discharge** • **Plan home possibly tomorrow**
Tests	
Consults	• Home Care Nursing (re: tracheostomy care & management)
Assessments, Treatments	• Level of consciousness (alert & oriented x 3) • Vital signs and temp (R12-20 min, P60-100, BP 90-150) • Chest auscultation Q4hrs prn (breath sounds clear, resps easy & regular, Ø SOB, Ø resp distress) • Pulse oximeter Q6hrs prn (>93%) Titrate oxygen requirements to saturation level - **wean to humidified air/room air** • Assess for minimal neck swelling (**Ø airway obstruction/hematoma**) • Assess abdominal status Q4hrs prn (soft, non distended, bowel sounds audible x 4) • Assess IV site (free of redness, swelling & pain) • **Saline lock IV** • **Staple remover, suture scissors and suction at bedside at all times (Tape to HOB)** • **Emergency trach equipment at bedside/accompany patient at all times**
Adequate Airway	• Airway patent, can clear own secretions • Trach in situ & secure • Note trach size and type • Document frequency of suction required • **Trach care Q shift and PRN (only if trach uncorked)** • **Trach corked x 24 hours** • **Trach removed** • Instill with NS prn (to liquefy secretions) • **Update trach sign at HOB**
Activity, Rest	• Elevate HOB 30° • Encourage deep breathing, coughing and leg exercises Q4hr while awake • ICOUGH protocol followed • Up to chair (2-3 times/day) • Independent with self care • Mobilizing independently

Medications	• Analgesics prn • Antiemetic prn
Pain	• Pain assessment Q1hr until pain is controlled then Q4hrs prn (pain adequately controlled) • Sedation level within norm
Nutrition	• NPO • DAT • Nausea controlled
Elimination	• Voiding adequately (urine output > 30 mls/hr) • Passing flatus • Note any normal BM • Note any diarrhea
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes **WNL -** **within normal limits**	• Airway patent; trach in situ - secretions clear • Vital signs and temp stable - within normal range/satisfactory • Trach removed • Patient states pain is at an acceptable level • Nausea controlled • Tolerates oral intake • Fluids & electrolytes balanced • Patient describes anxiety as acceptable • Independent with self trach care (if applicable) • Mobilizing independently (at baseline level of function)

Post-op Day 7	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Patient and family understand emergency protocol for airway obstruction - Patient able to uncork tracheostomy • Explain process of tracheostomy removal • **Reinforce importance of tracheostomy site closure** • **Self trach care teaching accomplished (if applicable)** • **Review "Going Home after Tracheostomy" pamphlet with patient/family** • **Plan home today**
Tests	
Consults	• Home Care Nursing (re: tracheostomy care & management)
Assessments, Treatments	• Level of consciousness (alert & oriented x 3) • Vital signs and temp Q6hrs prn (R12-20 min, P60-100, BP 90-150) • Chest auscultation Q6hrs prn (breath sounds clear, resps easy & regular, Ø SOB, Ø resp distress) • Pulse oximeter Q6hrs prn (>93%) **on room air** • Assess for minimal neck swelling (**Ø airway obstruction/hematoma**) • Assess abdominal status Q4hrs prn (soft, non distended, bowel sounds audible x 4) • **Staple remover, suture scissors and suction at bedside at all times (Tape to HOB)** • **Emergency trach equipment at bedside/accompany patient at all times**
Adequate Airway	• Airway patent, can clear own secretions • Trach in situ & secure • Note trach size and type • **Trach removed** • Trach care Q shift and PRN • Instruct patient to apply firm pressure to trach site (when coughing/speaking) - **helps to seal/close trach site**
Activity, Rest	• Elevate HOB 30° • ICOUGH protocol followed • Up to chair (2-3 times/day) • Independent with self care • Mobilizing independently
Medications	• Analgesics prn • Antiemetic prn
Pain	• Pain assessment Q1hr until pain is controlled then Q4hrs prn (pain adequately controlled) • Sedation level within norm
Nutrition	• DAT • Nausea controlled
Elimination	• Voiding adequately (urine output > 30 mls/hr) • Passing flatus • Note any normal BM • Note any diarrhea

Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes **WNL - within normal limits**	• Airway patent • Vital signs and temp stable - within normal range/satisfactory • Patient states pain is at an acceptable level • Nausea controlled • Tolerates oral intake • Fluids & electrolytes balanced • Patient describes anxiety as acceptable • Independent with self trach care (if applicable) • Mobilizing independently (at baseline level of function)

Developed By

Effective Date:	
Posted Date:	
Last Revised:	
Last Reviewed:	
Approved By:	
	Endorsed By: **Final Sign Off:**
Owners:	VCH
	Developer Lead(s): • Clinical Nurse Educator, General/Vascular Surgery, OTL-HNS & GI Medicine, VGH