Notice to staff using a paper copy of this guidance

The policies and procedures page of Intranet holds the most recent version of this guidance. Staff must ensure they are using the most recent guidance.

Author: Consultant Therapist in Neurosurgery

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<tr>
<td><strong>Author</strong></td>
<td>The Acute to Community Discharge Working Party for Patients with a Tracheostomy. Chair: Jude Fewings, Consultant Therapist</td>
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<td><strong>Ratification Date and Group</strong></td>
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<td>Consultant Therapist in Neurosurgery.</td>
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<td><strong>Impact Assessment</strong></td>
<td>References/Source See Reference Section at end of document</td>
</tr>
<tr>
<td><strong>Author Contact Details</strong></td>
<td>By E-mail: <a href="mailto:jude.fewings@nhs.net">jude.fewings@nhs.net</a></td>
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## Document Review History

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Tracheostomy Care Guidelines Discharge Process

1. Introduction

2. Purpose

These guidelines are intended to support practitioners and ensure a safe, timely and effective discharge from acute care to the community for adult patients with a tracheostomy, +/- ventilatory support, +/- nutritional support.

3. Mission Statement

The medically stable patient with a long term artificial airway / tracheostomy with or without the need for ventilation and nutritional support can expect a better quality of life outside the environment of the acute hospital setting.

The option of out of hospital care may be raised by either the medical team or the family. The discussions often evolve in informal meetings.

The purpose of these guidelines is to create a proactive process for discharging the patient with a tracheostomy in a timely and efficient manner.

The transition from acute care to the community setting can produce stress for the family and the patient. This makes adequate planning for support after discharge all the more important.

Self-care and independence should be encouraged wherever possible.

This is a multi-professional document and should be used by all health care professionals involved in tracheostomy care.

4. Description

The discharge plan is the mechanism that guides a multidisciplinary effort to achieve the successful transfer of the patient with an artificial airway / tracheostomy from acute health care to an alternative site of care.

The discharge plan includes:

- Evaluation of the patient for the appropriateness of the discharge
- Determination of the optimal site of care and of patient–care resources
- Determination that financial resources are adequate, applied for and in place prior to discharge
5. **Indications**

**Background**

Discharge planning is indicated for **all** patients with an artificial airway / tracheostomy who are being considered for discharge or transfer to alternative sites including home. The alternative site may provide a higher or lesser level of care (depending on the patient’s condition). Before the discharge process can begin the destination needs to be established and any funding needs identified.

A home discharge is usually the patients preferred location, However there may be factors which delay or prevent this.

The discharge location must be considered to be safe and appropriate to accommodate care and future management of the tracheostomy and / or the respiratory care (with regard to medical condition and prognosis).

Examples of discharge locations are:

- Home
- Continuing Care
- Residential home
- Nursing home
- Hospice

The patient, their carer and/or family, a nurse or therapist known to the patient as well as a representative from the medical and discharge teams need to sit down and make a realistic evaluation of the most appropriate location.

Factors that will influence the care location include:

- Medical condition, prognosis and clinical need
- Ability to self care
- Carer preparation/education

6. **Structured Method of Discharge Planning**

**Background**

Discharge planning and implementation should begin as early as possible. The complexity of the plan is determined by the patient’s medical condition as well as consideration of their needs and goals. Members of the discharge planning team and their responsibilities should be identified and a co-ordinator specified. This will usually be the ward manager or nominated deputy in the acute trust setting.
7. Medical Condition, prognosis and clinical need

Background

The clinical stability of the tracheostomy will be the primary consideration in determining a discharge destination and plan. The level of health care and the environment required to deliver this care will need careful consideration. Availability of equipment and supplies necessary for the future management of the patient's clinical needs will also be a factor in preparing for discharge.

Discharge planning firstly requires the following tracheostomy needs to be answered:

- Respiratory function/stability and/or ventilatory support required
- Suctioning requirements
- Stoma and general tracheostomy care
- Frequency and associated risks of tube changes
- Agitation/ Risk to self

8. Ability to Self Care

Background

The patient's capability to maintain and manage their continuing tracheostomy care needs to be established. Consistent and reliable abilities need to be shown in coping with day to day routine care and assessment. The following questions are essential to answer:

- What is the patient’s physical ability e.g. is there an impairment of manual dexterity that may prevent them caring for the tracheostomy?
- Is their condition progressive and is a decline in their abilities expected?
- Are there any cognitive impairments that may limit problem solving and cause difficulties in planning tasks or making decisions?
- What is the patient’s level of motivation?
- Are there any social or behavioural issues and concerns?

9. Carer preparation and education

Background

In addition to the above, assessment of the patient the level of support required and available will need to be established and is fundamental to determining whether an individual can return home. If discharge home is to be pursued as an option for a patient who does not have self caring abilities then an individual or key care provider should be agreed.

If the patient is to have support at home additional to any family members who agree to help then the process of applying and having funding agreed must
begin as early as possible in the in-patient stay. It is prudent to ensure that even if a care agency is responsible for the day to day care of the patient’s tracheostomy that at least one family member or other nominated person be made aware of basic life saving procedures as a back up in case of emergency.

10. **Hazards/Complications/Contraindications**

   **Background**

   There are no contraindications to developing a discharge plan for an individual patient. However, undesirable and/or unexpected outcomes may occur if the patient is discharged prior to the full implementation of the discharge process. It is often the case that undesirable outcomes occur prior to the discharge process being completed and these may be as a result of the disease process or other factors beyond the control of the discharging Multidisciplinary team.

11. **Preparation of the Community Teams**

   **Background**

   Although patients with tracheostomy are becoming increasingly common in community settings they are still in the minority. Consequently the community health care teams are likely to require support and education in meeting the needs of that patient. Early contact and interaction with the community teams will promote continuity of care. The use of the Plymouth Health Care Community Tracheostomy guidelines that follow the patient from the acute care setting into the community encourages standardisation of the basic daily care tasks and further reduces risk.

12. **Information the community team may require**

   - Indication for the tracheostomy
   - Prognosis and management plan
   - Ongoing care requirements
   - Equipment /supplies required
   - Identification and first line management of potential complications
   - Management of emergency situations
   - Basic Life Support training for patients with Tracheostomies

13. **Contacts for Advice**

   General advice concerning patients with Tracheostomies can be sought from the following sources:

   24 Hours a day
   - The Acute Care Team – Bleep 89048 or 0195
Alternatively: Between the hours of 9 – 5pm Monday to Friday:

- Senior Physiotherapist for Respiratory – Bleep 0179 via switchboard
- Specialist Nurse for head and neck – Bleep via switchboard
- Speech and Language Therapist for non-emergency information – Bleep 0960 via switchboard

Outside of these hours:

- Nurse in Charge Penrose/Pencarrow Critical Care wards (ex 31419/31440)
- Nurse in Charge Lynher Ward (ex 52274)
- On-call physiotherapist can be contacted via switchboard

14. Tracheostomy Tube Occlusion

**Background:** Tracheostomy tube occlusion is a serious complication which is life threatening, therefore, it is important to first of all avoid this situation with good patient hydration and stoma humidification. However, should this situation arise it is vital to recognise tube occlusion and act promptly to change the tube or inner tube.

**Early signs of increased potential for tube occlusion**

- Increased respirations
- Thick secretions
- Large amount of secretions
- Difficulty in passing suction catheter down tube
- Increasing difficulty in breathing
- Noisy breathing
- Patient agitation

**Flow chart follows**
Emergency procedure for suspected occlusion of a tracheostomy tube in the community setting

1. Does the patient have any of the following?
   - Difficult or laboured breathing, abnormal chest movement
   - None or limited expired air from the Tracheostomy tube
   - Pale/cyanosed skin colour
   - Anxiety/agitation
   - Increased pulse and respiratory rate
   - clamminess

   YES →
   - Call for help immediately or if alone call 999
   - Reassure the patient
   - Check inner tube if present and change if appropriate
   - Ask the patient to cough or attempt to clear secretions using suction if available
   - Gently extend head and neck to ensure correct alignment and eliminate kinking and to ensure the tube is in the correct position
   - Administer oxygen if available

   N.B.1. For patients that are neck breathers (e.g. there is a disruption between the upper and lower airways, an example is following a laryngectomy) oxygen if available must be delivered via the stoma.

   N.B.2. For patients with intact anatomy it is appropriate to deliver oxygen if available via the face mask if the tracheostomy is not patent

2. Is the occlusion risk still present? NO →
   - No further action required

   YES →
   - Attempt to remove the inner cannula
   - Proceed as step one

3. Has the inner cannula been removed?

   YES →
   - Clear any secretions with suctioning if available
   - Check patients chest movement, respiratory rate, saturations
   - Replace a new inner cannula if double lumen
   - Check, if patient is still in distress. The whole tube may need changing

   NO →
   - If inner cannula cannot be removed or is not present ie. single lumen deflate cuff (if present) and prepare to change for a new tube
   - Continually explain procedure to patient

4. Has the patient stopped breathing?

   YES →
   - Call 999 immediately.
   - Lie patient flat
   - Commence Basic Life Support as possible within environment
   - If tracheostomy tube has been removed and the stoma appears blocked, ventilate patient using BLS measures

   N.B.1. For patients that are neck breathers (e.g. there is a disruption between the upper and lower airways, an example is following a laryngectomy) ventilation must be delivered via the stoma

   N.B.2. For patients with intact anatomy ventilate over mouth/nose and occlude stoma site with gauze and gentle hand pressure to provide occlusion

   NO →
   - No further action required

Plymouth Hospitals
NHS

Issue 10/10
Emergency procedure following accidental decannulation or tracheostomy tube change failure in the community setting

Accidental Decannulation or tube change failure
Call for urgent assistance

- Patient is breathing
  - Not in distress
  - Stoma is patent

- Patient is breathing
  - In distress
  - Stoma is occluded

- Patient is not breathing
  Call 999

• Call for help and 999 immediately
• Reassure the patient
• Administer oxygen if available
• Monitor patient's
  • chest movement
  • respiratory rate
  • saturations

N.B.1. For patients that are neck breathers (e.g. there is a disruption between the upper and lower airways, an example is following a laryngectomy) oxygen if available must be delivered via the stoma

N.B.2. For patients with intact anatomy it is appropriate to deliver oxygen if available via the face mask, occlude stoma site with gauze and gentle hand pressure to provide occlusion
• Perform tracheal/oral suction if available
• Reinsert/re-attempt tube change initially with same size then try smaller size

• Reinsert/re-attempt tube change initially with same size then try smaller size

Success

• Emergency call for GP or other competent practitioner to assess position of tracheostomy tube

Fail

• Lie patient flat
• Commence basic life support

N.B.1. For patients that are neck breathers (e.g. there is a disruption between the upper and lower airways, an example is following a laryngectomy) ventilation must be delivered via the stoma.

N.B.2. For patients with intact anatomy ventilate via mouth/nose and occlude stoma site with gauze and gentle hand pressure to provide occlusion

Plymouth Hospitals
NHS

Issue 10/10

NHS Trust
15. References


Other Sources used:

Standards for the care of adult patients with a temporary tracheostomy ; Intensive care society, 2008

Tracheostomy care bundle for ward patients procedures; Dartford and Gravesham NHS Trust, 2008

Guidelines for the care of patients with tracheostomy tubes; St Georges Heathcare NHS Trust, 2006

Guidelines for the care of the adult patient following tracheostomy formation; Norfolk and Norwich University Hospital NHS Trust, 2003

AARC Clinical Practice Guideline; Discharge Planning for the Respiratory Care Patient Respiratory Care 1995;40(12): 1308-1312

Tracheostomy Care Policy and Procedure; Birmingham East and North NHS Trust, 2009
16. Monitoring compliance and effectiveness

Associated documentation **to be used** when Discharging a patient to the community setting.

(Appendix 1)

**Discharge transfer document for patient with a Tracheostomy:** To be used in conjunction with the guidelines to ensure a seamless record is established between acute and community teams on discharge of the patient. This records the up to date care of the patient and includes the names and contact details of those members of the MDT that are known and have been working with the patient prior to discharge. These staff members will be available to contact for advice following the patients discharge.

**Discharge Checklist:** To be used in conjunction with the guidelines to ensure a seamless record is established between acute and community teams on discharge of the patient. This is a record of the specific equipment needs of the patient to be discharged and assists both the hospital team and the community team to procure the appropriate items in a timely and efficient manner.
# DISCHARGE TRANSFER DOCUMENT FOR PATIENT WITH A TRACHEOSTOMY

<table>
<thead>
<tr>
<th>Patient’s Full Name: (or patient label)</th>
<th>Discharge address:</th>
<th>Usual address □ Temporary □</th>
</tr>
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<tbody>
<tr>
<td>NHS Number:</td>
<td></td>
<td>Care Home □</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td></td>
<td>GP:</td>
</tr>
<tr>
<td>Date of discharge:</td>
<td></td>
<td>Contact no:</td>
</tr>
<tr>
<td>Ward: Consultant:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reason for hospital admission:</td>
<td>Relevant Past medical conditions/history/allergies:</td>
<td></td>
</tr>
<tr>
<td>Diagnosis and brief summary of treatment received in hospital:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of initial tracheostomy:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of last tracheostomy tube set change:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any complications Y / N. If yes please explain below:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of next planned tracheostomy tube set change:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identified person to do change, please state: NAME:</td>
<td>Contact Details:</td>
<td></td>
</tr>
<tr>
<td>Overall PLAN for tracheostomy Management (Please circle) Permanent / Temporary</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DAILY CARE OF THE PATIENT WITH A TRACHEOSTOMY</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>TYPE OF TUBE INSERTED (Please tick)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Lumen □ Double Lumen □ Cuffed □ Uncuffed □ Fenestrated □ Unfenestrated □</td>
<td></td>
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<tr>
<td><strong>SIZE OF TUBE AND MAKE:</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>CHEST SECRETIONS</strong> (Please tick)</td>
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<td></td>
</tr>
<tr>
<td>Clear □ Creamy □ Yellow □ Green □</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thick □ Thin □</td>
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<td></td>
</tr>
<tr>
<td><strong>AMOUNT ON DISCHARGE</strong> (Please tick)</td>
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<td></td>
</tr>
<tr>
<td>Minimal □ Moderate □ Copious □</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>METHOD OF REMOVAL OF SECRETIONS</strong> (Please tick)</td>
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<td></td>
</tr>
<tr>
<td>SUCTION □ INNER TUBE CHANGE □ INDEPENDENT CLEARANCE □</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If requiring SUCTION / INNER TUBE CHANGE please indicate <strong>WHO is responsible in undertaking this</strong> (Self, Carer, Care agency):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUCTION EQUIPMENT (machine and catheters) IN PLACE AND WORKING IF SUCTION REQUIRED □</td>
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Discharge Transfer Document for
Patient with a Tracheostomy

HRO: 0412/1
### Humidification / Oxygen (Please tick)
- Heated circuit system (e.g. F+P) □
- Bib + Spray □
- Dry (Heat and moisture exchanger: HME) □
- Other (Please state): .................................................................
  Oxygen (Please circle): N / Y
  Percentage (Please state): ..........................................................
  Oxygen Prescription complete □

### How is Tracheostomy Secured (Please tick)
- Velcro Tapes □
- Ribbon gauze tapes □
- Other (please state): ........................................................................
  Please indicate WHO is responsible for tape changes (Self, Carer, Care agency):

### Stoma Care
- Cleaned with saline (where available or cooled boiled water) and gauze □
- Barrier cream required □
  Please state what ............................................................................
- Tracheostomy dressing required □
  Please state what ............................................................................

### Nutrition and Hydration
- Patient taking normal diet and fluids □
- Patient needs help to eat/drink □
- Patient needs feeding □
- Patient needs purée diet □
- Patient needs thickened fluids □
- Has PEG □
- Has NG tube □
  with additional oral intake □
- Has IVI / S/C FLUIDS □
  with additional oral intake □

Please indicate WHO is responsible for providing management of these needs:
Contact Details .................................................................

### Communication Needs
- Indicates Yes/No by .................................................................
- Difficulty with understanding □
- Is patient able to read □
  Is patient able to write (needs pen & paper) □
- Is patient able to speak with speaking valve in place □
- Is patient able to silently mouth word shapes □
- Can patient point to symbols □
- Uses servox / light writer / alphabet chart / e-trans frame (please circle) □

### Community Care/package of care arranged (tick all arranged):
- Community Nursing □
- Palliative care team □
- Mental health services □
- Rehabilitation/Therapists □
- Personal care □
- Meals on wheels □
- Social support □
- Day-care services □
- Equipment □
- Voluntary sector support □
- Informal carers (family, neighbours etc) □
  On the end of life register □
- Other □ (Please state): .................................................................
- Ventilator Prescription □
- Care package provider □
  (Please state): .................................................................

### Inpatient Multidisciplinary Team Involved
- (Print name and Bleep/Contact No.)
- Physiotherapy □
- SLT □
- OT □
- Dietician □
- Psychology □
- Clinical Nurse Specialist □
- Home Ventilation □
- Specialist Palliative Care Team □

### Please Photocopy, Send Copy with the Patient. Retain Original in Medical Notes

### Discharging Nurse: (print name) | Signature: | Date:

### Ward Discharged From: | Telephone No. of Ward:

---

Discharge Transfer Document for Patient with a Tracheostomy

HRSG: 0412/1
Plymouth Hospitals NHS Trust

Surname: 
First Name: 
Hospital Number: 
NHS Number: 

Ward ...........................................Consultant...........................................

**Discharge Checklist for Patient with a Tracheostomy**

This checklist must be completed as part of the process of discharge and be sent home with the patient. A copy should be filed and retained in the patients medical notes.

Planned date of discharge..............................

Planned place of discharge..............................

Organise MDT and invite community nurse to visit    ☐

Organise training and transfer of specific patient care needs to accepting MDT    ☐

**Clinical components on discharge for the care of the Tracheostomy:**

Has a competent person been identified and educated in complete care of tracheostomy in discharge setting    ☐

Please document who has been identified and contact details (ensure the transfer date has been agreed)    ☐

Name ..............................................................................................................................

Contact Details..............................................................................................................

Ensure Tracheostomy Discharge Transfer Document is completed and sent with patient on discharge.    ☐

(This has all the up to date clinical detail on the care of the patient and their tracheostomy, a copy should be filed in the medical notes on discharge)

**Home Oxygen and Suction Requirements**

**Clinical components on discharge for the care of the Peg/Rig**

Is there a Peg/Rig insitu? (Please Circle)    Yes / No

If Yes, please state type and date of insertion:
.................................................................................................................................

Current, in-patient Dietician name and contact details:
.................................................................................................................................
.................................................................................................................................

Type of feed patient currently having
.................................................................................................................................

File in the Nursing Notes
HRSG: 0411/1

Tracheostomy Care is variable, do not underestimate the importance of looking and listening to the patient to decide care delivery and frequency of intervention.
Regime patient on

Has a competent person been identified and educated in complete care of the Peg/Rig in discharge setting  □

Please document who in the discharge setting has been identified and contact details (ensure the transfer date has been agreed)  Name ...........................................................................................................

Contact Details .................................................................................................

PEG/RIG Stoma

- Stoma clean on discharge  □
- Any additional care for stoma detail here .............................................................................................................................

TTA’s (Ensure SOLUBLE medication if PEG/RIG insitu. Ensure the medication is licensed for Peg/Rig use as per policy.

- Five Day supply ordered  □
- Currently in pharmacy  □
- Given to patient  □
- In patient property  □
- TTA’s explained to patient  □
- Written information with patient  □
- Oral enteral syringes (purple) as TTA’s  □
- Type of feed, regime, pump and giving sets all organised  □

Home arrangements

- Patient lives alone  □
- House key is with patient  □
- House key with other State ............
- Next of kin/carer informed of discharge: state who .......... state when informed ..........
- Key safe  □

Tracheostomy Care is variable, do not underestimate the importance of looking and listening to the patient to decide care delivery and frequency of intervention.
Transport

- Patient has made own transport arrangements
- Hospital transport booked: Estimated time.................. Booking code..................................

Patient property

- Patient packed own property
- Patient belongings packed by hospital staff
- Property list completed
- Patient has walking aid/personal items e.g. glasses/hearing aid/speaking aid/dentures
  - Please state:...............................................................................................□

Follow up care

- G/P aware of discharge. Date....................
- District nurse aware. Date made aware.................. Date of planned first visit...................
- Patient aware of District Nurse visit □
- Care home aware. Date.......................□
- Tracheostomy Tube set change arranged: □
  - Please state name and contact details .................................................................□
  - Date arranged........................................□
- Formal consultant follow-up in hospital: Date...................
- Tracheostomy Transfer letter completed □
- Complex discharge letter completed □
- Further referrals made to:
  - □ Community physio: date ref. made...........
  - □ Community Dietician: date ref. made...........
  - □ Community Occupational therapist: date ref. made...........
  - □ Community Speech and language: date ref. made...........
  - □ Other (e.g. Macmillan )specify...........................................................

Tracheostomy Care is variable, do not underestimate the importance of looking and listening to the patient to decide care delivery and frequency of intervention.
Supplies

- □ Spare tracheostomy set of same size, make and type as patient currently using
  ➢ Current Eproc number

- □ Saline for spray and cleaning stoma
  ➢ Current Eproc number

- □ Gauze (non fluffy)
  ➢ Current Eproc number

- □ Spray bottle
  ➢ Current Eproc number

- □ Spare tracheostomy tapes
  ➢ Current Eproc number

- □ Spare inner tubes
  ➢ Current Eproc number

- □ Inner tube cleaning swabs
  ➢ Current Eproc number

- □ Speaking valve
  ➢ Current Eproc number

- □ Sterile suction catheters, same size, make and type
  ➢ Current Eproc number

- □ Sterile water for irrigation for Fisher Paykell Humidifier
  ➢ Current Eproc number

- □ Tracheostomy Bibs
  ➢ Current Eproc number

- □ Heat and moisture Exchanger
  ➢ Current Eproc number

- □ Nebuliser sets and Tubing
  ➢ Current Eproc number

Tracheostomy Care is variable, do not underestimate the importance of looking and listening to the patient to decide care delivery and frequency of intervention.
• □ Suction Tubing
  ➢ Current Eproc number.................................................

• □ Enteral feeding pump
  ➢ Current Eproc number.................................................

• □ Enteral feeding giving sets
  ➢ Current Eproc number................................................

• □ Enteral feed
  ➢ Current Eproc number................................................

Please add any other specific equipment not mentioned above

• □ ..................................................................................
  ➢ Current Eproc number.................................................

• □ ..................................................................................
  ➢ Current Eproc number.................................................

• □ ..................................................................................
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• □ ..................................................................................
  ➢ Current Eproc number.................................................

Tracheostomy Care is variable. Do not underestimate the importance of looking and listening to the patient to decide care delivery and frequency of intervention.
Other documentation that is strongly recommended for use when caring for a patient with a tracheostomy.

(Appendix 2)

Each care setting or Primary Care Trust that the patient is returning to should have their own similar documentation for use with this patient group.

Included here are current examples of each document used within Plymouth Teaching Hospitals Trust.

Care Plan: A tracheostomy care plan should be used for all adult patients with a tracheostomy. The care plan should be updated as the patient’s condition changes or at least every 7 days. An example which is used currently in Plymouth Teaching hospitals NHS Trust can be provided on discussion with the discharging ward.

Daily management plan: All interventions relating to the tracheostomy must be documented on the daily tracheostomy management plan. An example is provided here which is used currently in Plymouth Teaching hospitals NHS Trust.

Patient Information Leaflet: To be provided to the patients and family in order that they fully understand the procedure that has been performed. An example is provided here which is used currently in Plymouth Teaching hospitals NHS Trust.
Daily Tracheostomy Management Plan

O₂ amount: ....................
Humidification type & Temperature: .................................................................
Cuff inflation/deflation regime: .................................................................
Speaking valve regime: .................................................................

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Targets:  Resp rate  8 – 30.
SaO₂ > 92 %.
Inner tube cleaned at least T.D.S.

Signature: ____________________________
File in Nursing Record
Outreach bleep 89048.

Surname: ____________________________
First Name: _________________________
Hospital Number: ____________________
NHS Number: ________________________
DOB: ________________________________

Affix patient label here
Information for patients, relatives and carers

Having a tracheostomy

Derriford Hospital
Derriford Road
Plymouth
PL6 8DH

Tel: 0845 155 8155
www.plymouthhospitals.nhs.uk
Introduction

This leaflet has been written for patients and their relatives to explain a tracheostomy and how the procedure is performed.

What is a tracheostomy?

A tracheostomy is a small tube, which fits into the windpipe to help patients breathe. A tracheostomy is done under general anesthetic, when a doctor makes a small incision in the patient’s neck, and then inserts the tube through this incision. The tube is held in place externally by securing tapes around the neck and internally by a small inflatable balloon.

The nurse caring for you or your relative will make sure that the tube is kept secure and the area where it is inserted is kept clean.
Why is a tracheostomy tube needed?

Most patients who need a tracheostomy have difficulty breathing for themselves through their nose or mouth or they have problems with their swallow or cough mechanisms. Some patients also need help from an artificial breathing machine (a ventilator). On intensive care or in the operating theatre the ventilator is usually connected to a patient’s windpipe via a tube through their mouth (or occasionally through their nose). For those patients needing support with breathing for several days or more, or who have difficulty with their swallow or coughing up their chest secretions, a tracheostomy is sometimes advised. A tracheostomy is usually more comfortable and for patients on a ventilator it can make the process of becoming independent of the ventilator easier and more gradual.

The tracheostomy tube helps patients to breathe by providing a direct and clear route for air into the lungs. It also provides nurses/physiotherapists with access to the lungs for ‘suctioning’, when secretions like phlegm need to be removed.

What are the risks?
The formation of a tracheostomy is done under a general anesthetic and is usually free of complications but as with any surgical procedure, there are risks associated with having a tracheostomy.
There is a risk of developing an infection at the site of the tracheostomy, as the tracheostomy tube bypasses the body’s upper airway natural defences (nasal hair and mucus membranes) that filter out dust and bacteria. An infection may require the use of antibiotics. Pressure from the tracheostomy may lead to some bleeding in the surrounding tissues and, in a small percentage of cases; this can result in excessive bleeding which requires the patient to have an operation to seal off the blood vessel. There is also a very small risk of death; however, the team will have carefully assessed the balance of risks and benefits for a patient before the tracheostomy is recommended. Wherever possible these risks and the implications of not having a tracheostomy will be discussed with you and your relatives prior to the procedure being carried out.

The alternative treatment to tracheostomy is to continue with a tube in the patient’s mouth, which is more uncomfortable and makes communication more difficult. It also means that the patient will remain sedated for longer and it may take longer to become independent of the ventilator.

**Why is it necessary to remove phlegm by suctioning?**

A patient’s ability to cough and clear the lungs naturally is often reduced because of general muscle weakness and the length of time they have to spend in bed in hospital. Suctioning helps to treat and prevent patients getting chest infections, by clearing the phlegm from the lungs.
This process can be a little unpleasant, but it is important for the lungs to work efficiently and patients to breathe comfortably. Please be assured it will only be carried out if the staff caring for you or your relative think it necessary.

**What about speaking?**

When the cuff of the tracheostomy tube is inflated air cannot pass through the voice box. During this time the staff will help with communication. This may be by using writing, mouthing words or aids such as picture and letter boards.

As care progresses the nurses, physiotherapists or speech & language therapists may assess speech by deflating the cuff and using a speaking valve. The voice should return to full strength once the tracheostomy tube is removed.

**What about swallowing?**

A patient will be unable to eat and drink if they are attached to the ventilator. During this time they will receive all the nutrients that they need by a feeding tube, usually inserted through the nose.

If a patient is not on a ventilator it may be possible to eat and drink with the tracheostomy tube in place. However, sometimes the tube can make swallowing difficult. If the nurses think that there is a swallowing problem they will make a referral to a speech and language therapist who will assess swallowing and make appropriate recommendations.
When will the tracheostomy be removed?

The team responsible for you or your relative’s care will decide on the best time to remove the tracheostomy tube. The assistance received with breathing from the tracheostomy tube needs to be reduced gradually. This is called weaning. The usual process for weaning is shown in the following diagram:

**Tracheostomy balloon is deflated**

The amount of time that the balloon is deflated will be gradually increased

**A speaking valve is placed over the opening**

This will allow you to use your voice

*The size of the tracheostomy tube may be reduced and further assessment will take place*

**The tracheostomy is removed.**

This process can take several days or weeks, depending on your or your relative’s condition.
How is the tracheostomy tube removed?

When the tracheostomy tube is no longer needed it will be simply removed and covered with an airtight dressing. Within a short time (usually one to two weeks) the hole closes and heals over leaving a tiny scar.

For more information

If you have any questions or would like more information about the tracheostomy, please speak to one of the team who are caring for you or your relative.
This leaflet is available in large print and other formats and languages.
Contact: Patient Services
Tel. 01752 763031

Date issued: Nov 2010
For review: 2012
Ref: B-181/JF/OT/Having a Tracheostomy

All policies are required to be electronically signed by the Lead Director.