SUCTIONING

- Suction vacuum pressure < 20kpa or 150mmHg
- Sterile technique
- Observation sheet
- Suction catheter : pens length,
- Only apply suction and withdraw in 15 Seconds
- Always use a non fenestrated inner cannula when suctioning
- Ensure suction container changed when ¾ full
- Suction catheter size; *Or size of tube add 4*

$$\frac{\text{Size of tracheostomy tube} \times 3}{2}$$

HUMIDIFICATION/PROTECTION

Patients who have a tracheostomy or laryngectomy their humidifying functions are lost or bypassed.

- AIRVO will humidify and filter the airways. *All new tracheostomy/ laryngectomy patients require an AIRVO for the first 24hrs*
- Must use an AIRVO on all patients with an oxygen requirement
- Use the sofshield bib, or HME device. *disposed of when soiled*
- Regular saline nebulisers
- Ensure adequate hydration.
- The bib is placed over the top of the tube/ stoma and tied around neck.

EMERGENCY BEDSIDE EQUIPMENT.

- Tracheostomy tray / Laryngectomy tray
- Tracheal dilator or tilleys forceps
- Functioning suction
- Functioning oxygen
- Spare inner cannulas.
- Sterile gloves

Tracheostomy tray

- Portex suction aid cuffed tube size 8 and 7 and shiley size 4 non cuffed (4DCFS)
- Tracheal dilators
- Stitch cutter
- Scissors
- Pen torch
- Tube ties, Velcro and cotton
- 10ml syringe
- Sleek tape
- Surgilube.

Emergency situations

This patient has a

TRACHEOSTOMY

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

Percutaneous / Surgical

Indication: **Difficult Airway** ☐ **Prolonged Ventilation** ☐

Prophylactic Airway Management ☐

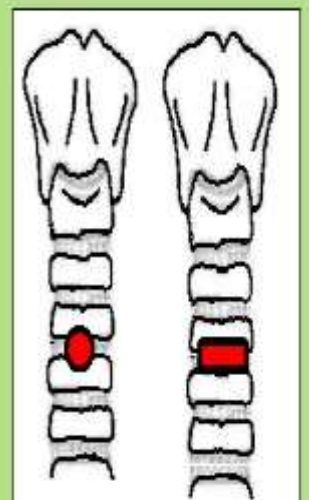
Performed on (date).....

Trachy Tube type and size .....

Patient Hospital No. .....

Laryngoscopy Grade & Notes on managing upper airway:

Special Instructions:



Percutaneous Surgical

Indicate tracheostomy type by circling the relevant figure
Indicate location and function of any sutures inserted

Emergency: ICU Reg: #889 or #666 ENT Reg/ Max fax Reg/ Anaesthetic Senior Reg: call switch
Mon-Fri: Tracheostomy Nurse: #538 Staff St Johns Ward for support/advice: ext 2181

Management of the tracheostomy patient with breathing difficulties - Patent upper airway

Apply high flow oxygen to **BOTH** the face and the tracheostomy stoma
Call for Airway Expert help – Anaesthetics/ITU **AND** ENT/Max Fax

Look, listen & feel at the mouth and tracheostomy
A Waters circuit or capnography may help if available

Is the patient breathing?

Yes

No

Assess patency

Remove **speaking valve** or **cap** (if present)
Remove **inner tube**[1] (if present)
Attempt **tracheal suction**

Call Resuscitation team
Follow ALS algorithm
Assess tracheostomy patency

Can you pass a **suction catheter**?

Yes

The tracheostomy is patent
Consider partial obstruction
Continue ABCDE assessment

No

Deflate the **cuff** (if present)[2]
Look, listen & feel at the mouth and tracheostomy

Is the **patient improving?**
Eg. SpO_2 >90%,

Yes

Partially obstructed or displaced
Continue ABCDE assessment
Await Airway Expert

1. Some inner tubes need re-inserting to connect to breathing circuits
2. If bleeding from tracheostomy, await expert before deflating cuff

No

REMOVE THE TRACHEOSTOMY TUBE
Look, listen & feel at the mouth and tracheostomy. Ensure oxygen re-applied

Is the patient breathing?

No

Call Resuscitation team
Follow ALS algorithm
Emergency oxygenation

Yes

Continue ABCDE assessment
Support ventilation if hypoxic
Await Airway Expert

Basic emergency oxygenation

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

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

Expert emergency oxygenation

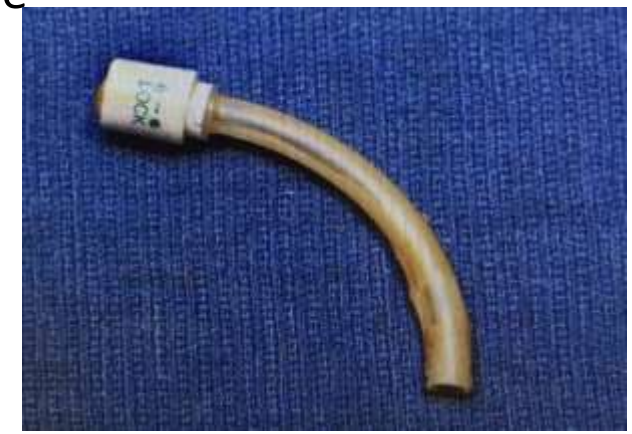
Attempt **ORAL intubation**
DIFFICULT INTUBATION
Uncut tube. Advance beyond stoma

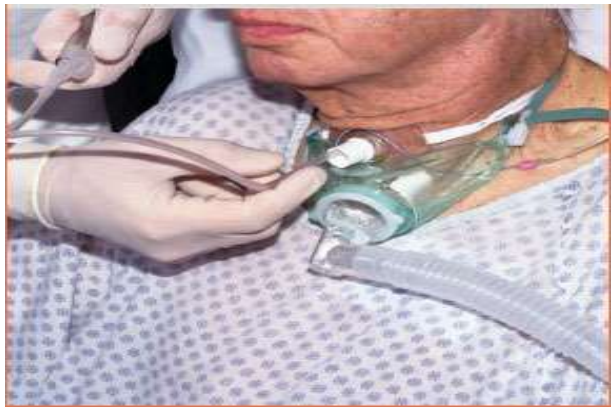
Attempt **intubation of stoma**
Small trachy tube / 6.0 cuffed ETT
Consider Bougie / Aintree catheter / Fibre-optic 'scope

Hypoxia/ acute dyspnoea

Patient has difficulty breathing, partially blocked or fully occluded tube

- Assess the patient, Remove speaking valve if has one
- Check and change the inner cannula.



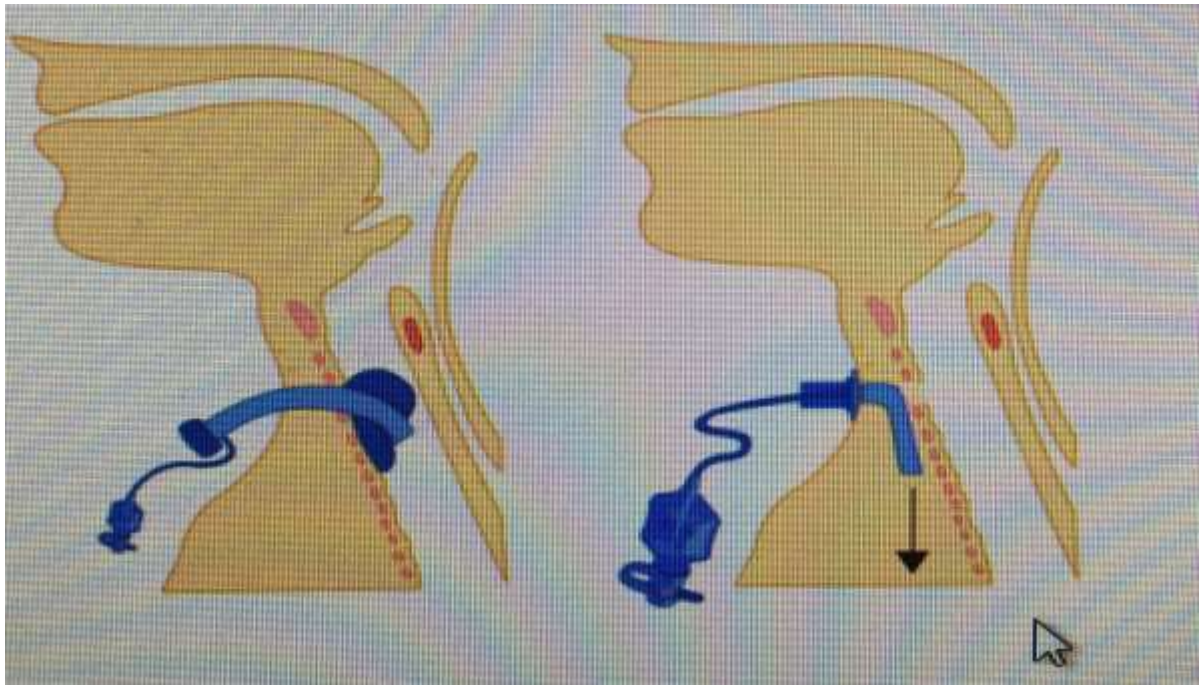


- Administer oxygen and monitor SpO2.
- uction patient
- ssess for resistance, if resistance noted, Red flag

- Deflate cuff (if has cuffed tube) and see if SpO2 improve.

- Check for air flow from tracheostomy using your arm.

- If there is no airflow from tracheostomy tube it is likely the tube has become displaced into false tract and *should be removed and recited into airway*. **Except in ICU**
- Call for help ENT/TRACHY CNS/ ANAESTHETICS bleep 666/ or arrest 2222



- Remove tube, Insert new tube if competent to do so. Once resited get ENT to review and confirm position with flexiscope.

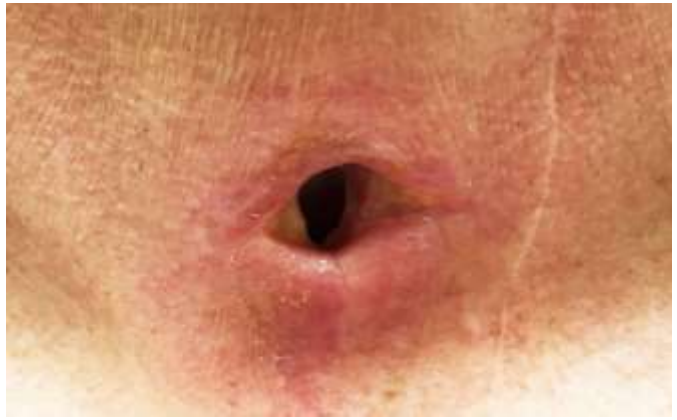
- If unable to resite new tube – keep stoma open using tracheal dilator(north south position)

- Ensure help is on the way.

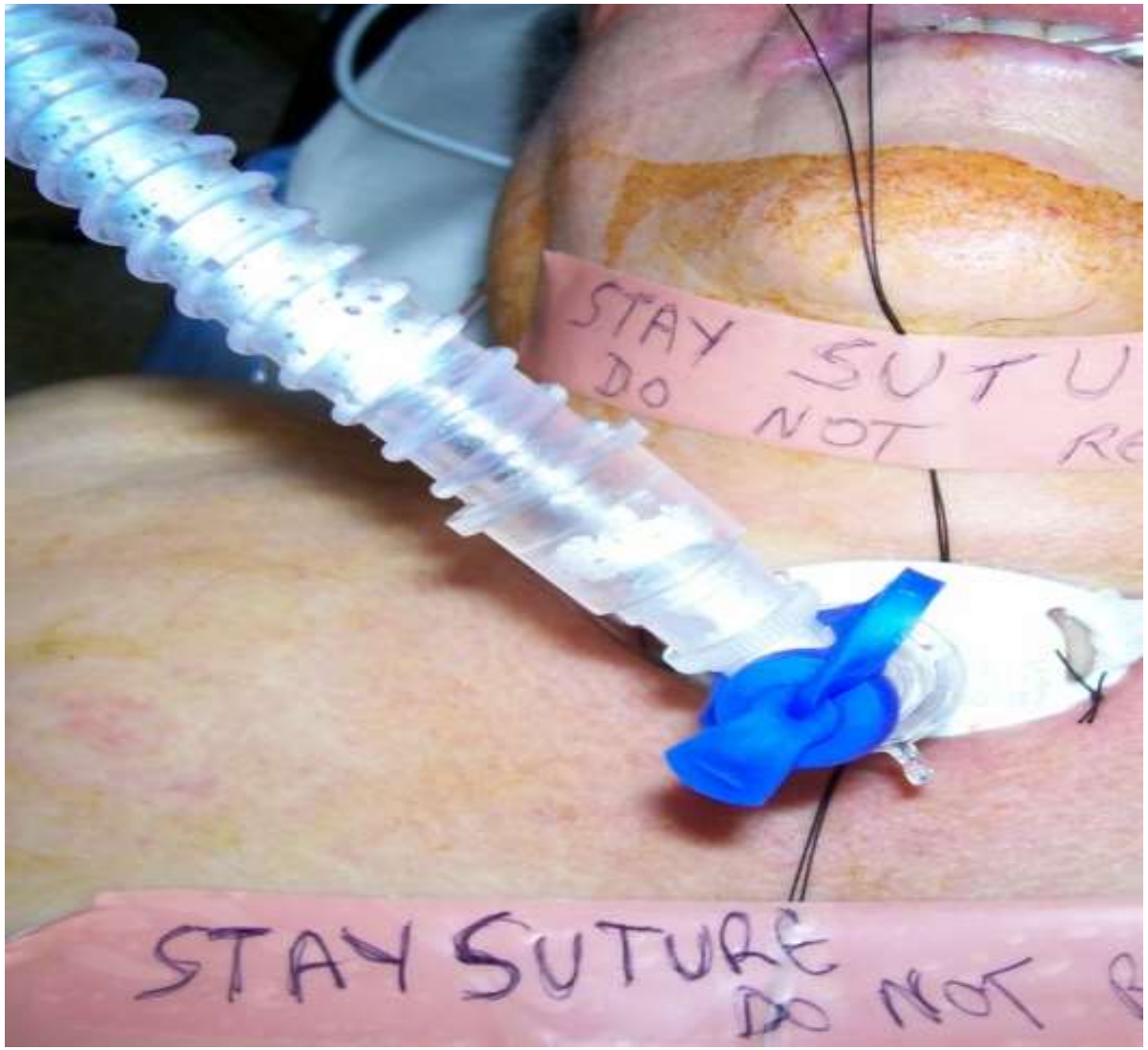
Tracheal Dilator

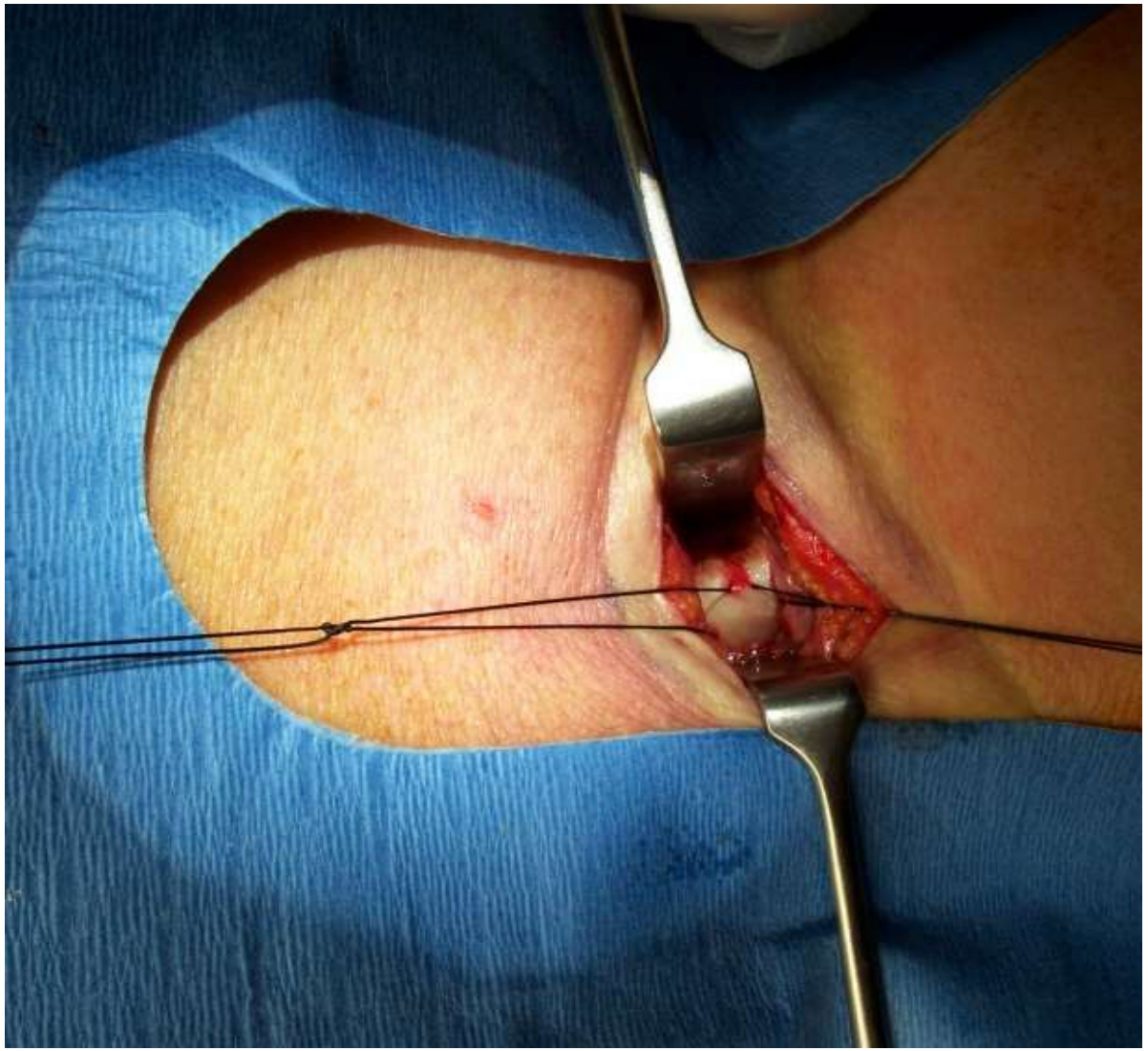
Accidental decannulation

- Don’t panic.
- Once tube in place for more than one week the tract is usually well formed and will not close over straight away.
- Surgical tracheostomy should have a stay suture By pulling on this suture the trachea can be brought forward and the airway opened to facilitate tube replacement
- Reassure patient.
- Call for help.
- Reinsert new tracheostomy tube if competent to do so.
- keep stoma open with tracheal dilator from emergency tray, north south direction
- Administer O2 via stoma and mouth until help arrives.



All surgical tracheostomies will have a stay suture and can be used if tracheostomy tube becomes dislodged





- Administer oxygen and reassure patient. If has patent upper airway can oxygenate both via stoma and face(nose/mouth)

RESUSCITATION

- Know your patient know your tube.
- Follow the algorithm on the back of the bed head sign.
- Has the patient a cuffed tube insitu?
    - Yes – ensure cuff is inflated (5-7mls air)
    - No – change to cuffed tube it competent to do so.

Maximum ventilation and oxygenation occurs when there is a cuffed, non fenestrated tracheostomy tube insitu with the cuff inflated.

RESUSCITATION

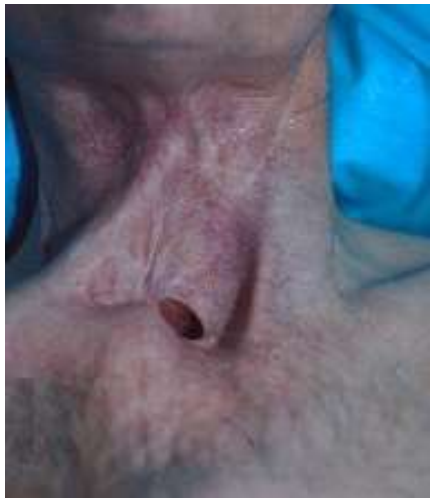
- Check patient for response
- If unresponsive call cardiac arrest 2222
- Assess carotid pulse, 5 seconds if no pulse start compressions
- Open airway remove any clothing from neck. know if your patient is a neck breather.
- Apply high flow O2 to **BOTH** face and tracheostomy
- Check inner cannula
- Assess breathing for 5 seconds
- If cuffed tube in place- inflate cuff with 5-7mls of air, if not a cuffed tube then work with what you have and when possible change to cuffed tube.
- Give 2 breaths via tracheostomy with BVM
- **Ensure you see patient's chest rising**
- Attach catheter mount to top of *ideally a cuffed* tracheostomy tube
- Attach BVM to catheter mount
- Attach BVM to 15L O2
- Continue basic life support **30 compressions to 2 breaths**

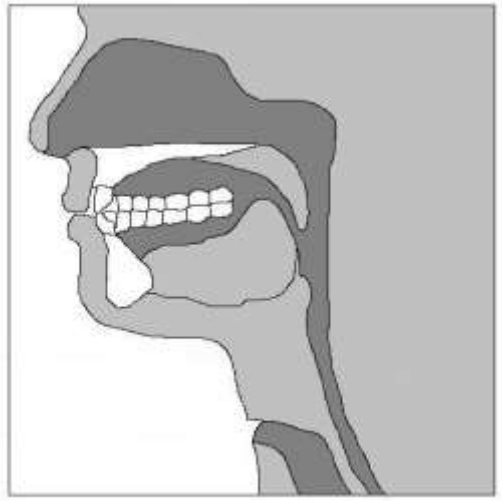

CATHETER MOUNT


CATHETER MOUNT WITH AMBU BAG ATTACHED

LARYNGECTOMY PATIENT

Laryngectomy patients are neck breathers they can not be intubated orally or nasally





- Same steps as before – Basic Life Support
- Use a paediatric face mask or Laryngeal mask over stoma
- Insert cuffed, non fenestrated tracheostomy tube.

All staff are permitted to insert trachy tube into laryngectomy stoma

Conclusion

- Ensure emergency equipment at bedside
- Early referrals on EPR
- Tracheostomy guidelines and SOP's available on hospital intranet
- NSV codes for ordering items available

OUR CONTACT DETAILS:

Tracheostomy CNS team
Bleep: 538/ 4430
Tracheostomy@stjames.ie

Study day bookings 2022

22nd Feb
18th May
14th Sept
23rd Nov