Integrated Care Pathway
for
Patients with a Tracheostomy

Name…… **Hospital number**……..……...

Date of birth …….. **Consultant** ……..….

First Tracheostomy			
Type & Size:	Date inserted:	Fenestrated yes/no	Cuff yes/no

Reason for tracheostomy / type of tube

Percutaneous / surgical

Any complications on insertion?

Date sutures removed……

Tracheostomy tube changes			
Type & Size:	Date inserted:	Fenestrated yes/no	Cuff yes/no
Type & Size:	Date inserted:	Fenestrated yes/no	Cuff yes/no
Type & Size:	Date inserted:	Fenestrated yes/no	Cuff yes/no
Type & Size:	Date inserted:	Fenestrated yes/no	Cuff yes/no
Type & Size:	Date inserted:	Fenestrated yes/no	Cuff yes/no

Date of decannulation ……

(please print out on yellow paper)

Integrated Care Pathway

for

Patients with a Tracheostomy

This document should include:

- A front sheet (overleaf)
- Tracheostomy equipment check / tracheostomy shift care record sheets
- Tracheostomy weaning charts
- Multi-disciplinary team record sheets

Additional sheets should be added as appropriate.

On the patient's discharge from the hospital, this document should be filed in the medical notes.

If the patient is to be transferred to another hospital with the tracheostomy in place, please send with the patient –

- A photocopy of the front sheet
- Photocopies of the MDT record sheets
- A photocopy of the most recent equipment check / shift care record sheets.

Name …….. **Hospital Number ……..**

Tracheostomy equipment check: to be completed on EVERY shift

	Date								**You must also complete the Tracheostomy Care Record (see over)**
	Time								
	Non-re-breathe circuit (green bag)								
	Adult BVM (Bag Valve Mask) with reservoir and tubing								
	Oxygen flow meter (check function)								
	Suction unit (set to – 20kPa on open suction)								
	Suction catheters (Size of trache -2) x2								
	Yankauer sucker								
	Flush for tubing								
Emergency bag	Spare trache tubes *(Same type. 1 same size & 1 one size smaller)*								
	Tracheal dilators								
	Tracheostomy disconnection wedge								
	10ml syringe								
	Stitch cutter								
	Aquagel								
	Gloves								
	Aprons								
	Protective eye wear								
	Signature								

Name …….. Number ……..

Tracheostomy Care Record -To be completed ON EVERY SHIFT

Date and time								
Start of shift	**Start of shift**	**Start of shift**	**Start of shift**	**Start of shift**	**Start of shift**	**Start of shift**	**Start of shift**	**Start of shift**
Tracheostomy equipment checklist completed **(see over)** *(Yes / No)*								
Cuff pressure = (*Should be* 15-25 cm H_2O. *If not, alert MDT to query cuff leak)*								
FiO2 required *(state percentage)*								
Humidification device in use? *(state which)*								
How often should respiratory obs be done?								
Is regular suction required? *(frequency or 'as required')*								

End of shift	**End of shift**	**End of shift**	**End of shift**	**End of shift**	**End of shift**	**End of shift**	**End of shift**	**End of shift**
Inner cannula inspected & cleaned at least four hourly? *(Yes / No)*								
How often was suction performed? *(e.g. 1-2 hourly, etc)*								
Quantity of secretions *(e.g. minimal, moderate or copious)*								
Colour (*describe e.g. clear, purulent, blood stained)*								
Specimen sent? *(Yes / No)*								
Stoma condition *(describe e.g healthy, inflamed, oozing, sputum leak)*								
Wound swab sent? *(Yes / No)*								
Dressing changed? *(If more than once, state how often)*								
Variances *(If routine care is not carried out, please state the reason clearly)*								
Signature								

ST. GEORGE'S HEALTHCARE -**OBSERVATION CHART FOR TRACHEOSTOMY-WEANING** **SHEET No.** _____

Surname _____ D.O.B/ or Hospital No. _____ Physio Name + Bleep No. _____

Forename _____ Ward _____

Please ensure patient is in an upright position and before commencing weaning suction trachea and oropharynx.

Please circle/tick as appropriate	Date Time Initials	Date Time Initials	Date Time Initials
1. Cuff Deflated +/- synchronous suction (ss)	Yes/No If 'Yes' - go to step 2 **If 'No' –stop. Do not proceed further**	Yes/No If 'Yes' - go to step 2 **If 'No' –stop. Do not proceed further**	Yes/No If 'Yes' - go to step 2 **If 'No' –stop. Do not proceed further**
2. With finger occlusion – is there air flow through the mouth?	Yes / No If 'Yes' go to step 3 If 'No' there may be an obstruction – do not proceed further. Discuss with Trache team/ENT/ Anaesthetist to consider downsizing trache tube	Yes / No If 'Yes' go to step 3 If 'No' there may be an obstruction – do not proceed further. Discuss with Trache team/ENT/ Anaesthetist to consider downsizing trache tube	Yes / No If 'Yes' go to step 3 If 'No' there may be an obstruction – do not proceed further. Discuss with Trache team/ENT/ Anaesthetist to consider downsizing trache tube
3. Is fenestrated trache in situ ?	Yes/No If 'Yes' place fenestrated inner cannulae in (unless suctioning)	Yes/No If 'Yes' place fenestrated inner cannulae in (unless suctioning)	Yes/No If 'Yes' place fenestrated inner cannulae in (unless suctioning)
4. Put on speaking valve or cap	speaking valve / cap / neither	speaking valve / cap / neither	speaking valve / cap / neither
5**. Planned** length of time for:	Cuff down _____ Speaking valve _____ Cap _____	Cuff down _____ Speaking valve _____ Cap _____	Cuff down _____ Speaking valve _____ Cap _____
6. **Actual** length of time managed for point 5.	Hours _____ Minutes _____	Hours _____ Minutes _____	Hours _____ Minutes _____
7. If planned time not equal to actual time – Why not? (e.g.increased work of breathing excessive secretions, fatigue)	Comments:	Comments:	Comments:
8. Suggested progression			

Tracheostomy ICP – Multi-Disciplinary Team notes

Date and time		Signature / print Discipline / grade
	…… ……	