# Tracheostomy and Laryngectomy MAIN DOCUMENT

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Who should read this document?

This documented is intended for all staff across the trust (SRFT and Salford Health Care) who are involved in the management of patients with a tracheostomy. It is an amalgamation of all previous documents pertaining to tracheostomy or laryngectomy with the addition of management of patients with a tracheostomy in the community.

Quick Reference Guides contained in this document (Hyperlinked)

QRG Tracheostomy Training and Education
QRG Tracheostomy Types of Tracheostomy Tube
QRG Tracheostomy Care Bundle
QRG Tracheostomy Tracheal Suctioning [Hospital and Community]
QRG Tracheostomy Cuff Deflation
QRG Tracheostomy Standard Speaking Tube
QRG Tracheostomy Speech Following a Laryngectomy
QRG Tracheostomy Tube Change in Hospital
QRG Tracheostomy Tube Change in the Community
QRG Tracheostomy Tube Downsizing
QRG Tracheostomy Decannulation
QRG Tracheostomy Oral Feeding
QRG Tracheostomy Communication
QRG Tracheostomy Bleeding from
Key Practice Points

- New and established stomas are at risk of complications, but good routine care should avoid complications.
- A blocked laryngectomy or tracheostomy is a life-threatening event

It is important to recognise that while there are some similarities between the care of patients with tracheostomies and patients with laryngectomies, there are also vital anatomical differences that will impact the care your patient will receive in both routine and emergency situations.

All staff caring for patients with tracheostomies must comply with the standards for routine and emergency care described within this document.

This document details the tracheostomy care bundle as a tool to ensure best practice. It also sets out requirements for training and education surrounding tracheostomies.

Laryngectomy

- Laryngectomy is a type of tracheostomy stoma. It is the term used to describe the removal of the larynx, (voice box). Patients breathe entirely through the permanent stoma in their neck. They cannot breathe through their mouth or nose.

- As laryngectomies are seen infrequently and present unique problems, training will be required to familiarise staff with a laryngectomy in addition to that expected of all staff caring for patients with tracheostomies. Ideally they should be nursed on H7.
**Background / Scope**

The tracheostomy steering group was set up in response to the formation of the National Tracheostomy Safety project (NTSP) which highlighted that complications with tracheostomies are associated with a high morbidity and mortality and that this can be improved with a series of practice improvements.

Since starting the steering group, we have standardised competency training for all staff managing tracheostomies in the hospital, introduced the NTSP’s emergency algorithms / bedhead signs and instituted mandatory training to ensure all staff are trained in the use of the emergency algorithm. A tracheostomy care bundle has also been implemented to improve basic tracheostomy care.

**Tracheostomy care in the community**

As part of the work of the above steering group a community tracheostomy working party was established by Maria Burney (Transition Facilitator), Ruth Garside (District Nursing Sister) and Rosetta O’Neill (Practice Trainer) to improve tracheostomy care in the community, with a main aim of reducing hospital admission. The community population also deals with child and adolescent patients, aged 12-25 years.

**What is new in this version?**

- The following quick reference guides have been removed and amalgamated into a new quick reference guide: **QRG Tracheostomy Care Bundle**:
  - QRG Tracheostomy Safety Checks and Handover
  - QRG Tracheostomy Essential Equipment for the Patient with a Tracheostomy
  - QRG Tracheostomy Humidification
  - QRG Tracheostomy Inner Cannula Care
  - QRG Stoma Care Dressing and Securing of Tube
  - QRG Tracheostomy Cleaning a Laryngectomy Stoma
  - QRG Tracheostomy Subglottic Suction
  - QRG Tracheostomy Cuff Pressure
- The QRG’s for opening suctioning for hospital and community have been combined into a single document.
- Safety and cohorting QRG is now detailed in the main document.
- Tracheal dilators are now stocked in the emergency tracheostomy box and the emergency transfer bag on wards where tracheostomies are managed.
- A new quick reference guide has been added for the assessment of tracheostomy-related bleeding: **QRG Bleeding from a tracheostomy**.
Guidelines

This document is an amalgamation of all previous policies pertaining to tracheostomy or laryngectomy care and includes a section on community tracheostomy care within Salford Health Care. The previous policies were:

1. Tracheostomy: Standards and management in the care of an adult patient with a tracheostomy.
2. Laryngectomy – Standards for the care of the adult patient with a laryngectomy
3. Tracheostomy: Cuff Deflation, Standard Speaking tubes, Passy-Muir Speaking valves, Oral feeding, Decannulation and Downsizing
4. Changing a tracheostomy tube policy

Whilst all the hospital policies are geared towards adult patients, the population within the community also deals with child and adolescent patients, aged 12-25 years, so details are given where practice in the community deviates from that in the hospital.

The emergency algorithms have had to be adapted to be suitable for different situations, either in a rehab facility, such as the Maples, or for patients at home in the community. (Appendices 3a, 3b and 4a)

It is assumed that all procedures listed follow hospital policies of infection control, consent, documentation and good communication. Use of personal protective equipment is mandatory.

1. Safety – cohorting of patients with a tracheostomy tube

In order to ensure patients are cared for in a safe location by staff who have regular exposure to tracheostomies, the number of wards who can care for these patients has been limited to all critical care areas, H1 (Medical High Care), EAU, H7, B7, B8, H2, C2, B4, B5 (TAU), PACU (levels 1 and 3), A&E and the Maples continuing care unit. Only uncuffed tubes may be used on H2.

It is important to note that this guidance is not intended to exclude patients with tracheostomies from attending outpatients. It is accepted that there may be certain instances when patients with a tracheostomy require care in a hospital setting that is not a cohort ward i.e. day case, SAL or outpatient treatment in MIU. In these cases the risks and benefits to the patient will be considered. It is imperative that the nurse delivering the care is competent to care for tracheostomies and is compliant with Emergency Tracheostomy training. Emergency equipment will be available as per policy.
2. Training and education

Training requirements for staff caring for a patient with a tracheostomy are detailed in the following quick reference guide:

QRG Tracheostomy Training and Education

As detailed in the QRG, this also covers training for the patient with a laryngectomy, but additional training may be required in patients with non-standard tube types or voice prostheses.

3. Types of tracheostomy tube

The different types of tracheostomy and laryngectomy tube are detailed in the following quick reference guide:

QRG Tracheostomy Types of Tracheostomy Tube

4. Tracheostomy Care Bundle

This should be followed for all patients with a tracheostomy, including those patients with a laryngectomy.

The tracheostomy care bundle should be used in all patients with a tracheostomy, but it is accepted that non-standard documentation may be in place on critical care areas as long as all elements are covered.

In patients with a laryngectomy, there are several places where there are specifics to care, which are detailed under the appropriate section headings.

Tracheostomy care is based on these elements:

1. Safety equipment and checks
2. Humidification
3. Inner cannula care
4. Suctioning
5. Tracheostomy dressing
6. Mouth care
7. Cuff pressure
8. Subglottic suction
9. Cuff deflation
10. Standard Speaking valve
11. Passy Muir Speaking valve
12. Speech following laryngectomy
13. Patient position
For patients with a tracheostomy, it is recommended that the care bundle should be completed a minimum of 4 hourly and observations guided by the nEWS system.

The tracheostomy care bundle deals with elements 1-8. Suctioning is detailed below and elements 9-13 have been dealt with separately. Please follow this quick reference guide:

**QRG Tracheostomy Care Bundle**

**Patients who cannot summon help should be on continuous SpO2 monitoring.**

*For patients who are on the end of life care pathway, Oxygen saturation monitoring does not apply. The care bundle should be maintained, however the frequency of suctioning and mouth care may be reduced to avoid unnecessary disturbances for the dying patient.*

**Suctioning**

Standards and process for tracheal suctioning are detailed in the following quick reference guides:

**QRG Tracheostomy Tracheal Suctioning [Hospital and Community]**

**Cuff Deflation**

The standards and process for cuff deflation are detailed in the following quick reference guide:

**QRG Tracheostomy Cuff Deflation**

**Speech and Speaking Valves**

The standards and process of managing speaking tubes (with the considerations for using a Passy-Muir valve) are detailed in the following quick reference guides:

**QRG Tracheostomy Standard Speaking Tube**
**QRG Tracheostomy Speech Following a Laryngectomy**

**Patient Position**

Patients with a cannulated trachea (or laryngectomy patients with a speaking prosthesis) are at increased risk of developing pneumonia due to micro aspiration of oral secretions and gastric contents. To reduce the risk of this, where possible patients should not be cared for lying totally flat. Patient’s neck alignment should always be maintained as able.
Be aware that extreme rotation of the neck may occlude a laryngectomy stoma, so neck alignment must be maintained if there are concerns about the patency of the stoma or if the patient has a reduced conscious level.

5. Tracheostomy tube changes

The criteria and process for changing a tracheostomy tube are detailed in the following quick reference guides:

*QRG Tracheostomy Tube Change in Hospital*
*QRG Tracheostomy Tube Change in the Community*

6. Downsizing

The patient selection and considerations for downsizing are given in the following quick reference guide:

*QRG Tracheostomy Tube Downsizing*

7. Decannulation

The criteria and process for successful removal of a tracheostomy tube are detailed in the following quick reference guide:

*QRG Tracheostomy Decannulation*

8. Oral Feeding in patients with a tracheostomy tube

The considerations for oral feeding with swallow assessment are detailed in the following quick reference guide:

*QRG Tracheostomy Oral Feeding*

9. Patient and relative information

Patients with a tracheostomy or family member, should receive a trust information leaflet.
10. Communication

The considerations for communication between ward staff and that of their patients are detailed in the following quick reference guide:

QRG Tracheostomy Communication

11. Management of emergencies

All nursing staff caring for patients with tracheostomies should have annual training in tracheostomy-related emergency care. The emergency algorithms should be followed (appendices 3&4, or 3a,3b,4a in the community) appropriate to either the green or pink bedhead signs (patent upper airway or laryngectomy respectively, appendices 1&2).

If bleeding is identified from the tracheostomy, either around the stoma site, or on suctioning, please follow the following quick reference guide:

QRG Tracheostomy Bleeding from

12. Patient transfer

Each ward should have an emergency transfer bag, as detailed in the 'In-patient internal/external transfer standards for all adult patients within Salford Royal Foundation Trust' policy. In addition to the standard equipment, wards caring for patients with tracheostomies should have additional equipment within this bag. (See appendix 7.)
12. Standards

- All staff working on wards where tracheostomies are cared for should be trained in the care of tracheostomies, with regular updates as stipulated in the policy. In order to maintain competency, staff should also have regular exposure to managing this group of patients.
- Patients should only be managed on the listed group of cohort wards. Where patients lie outside cohort wards (ie. MIU, SAL) a risk assessment must be undertaken. Exceptions cannot be made for inpatient episodes.
- The tracheostomy care bundle must be adhered to in all cases, accepting non-standard documentation may be used in critical care areas as long as all elements are covered.
- Each patient admitted with a tracheostomy / laryngectomy must have an appropriate bedhead sign in place, ideally with verbal agreement from the patient and/or relatives.
- Patients and relatives should be given written information about the tracheostomy. A trust information booklet is available.
- Each ward has an emergency tracheostomy box and a standard transfer bag, which should be checked regularly and stocked according to policy. This box should be used (along with the crash trolley contents) in the event of an airway emergency.
- Each cohort ward should appoint a tracheostomy link nurse, who will have responsibilities in attending regular link nurse meetings, disseminating important information and ensuring there are adequate resources in place to maintain regular training updates for the staff.

Explanation of terms

1. ADNS – Assistant Director of Nursing Services
2. ADO – Assistant Director of operations
3. SALT – speech and language therapists
4. MDT – Multidisciplinary team
5. AIR – Adverse incident report
6. IPPV – Intermittent Positive Pressure Ventilation
7. MIU – Medical Investigation Unit
8. SAL – Surgical Admissions Lounge
9. EWS – Early Warning Score
10. HME – Heat Moisture Exchanger
11. HMEF – Heat Moisture Exchange Filter
12. CPAP – Continuous positive airway pressure
13. CSS – Closed Suction System
14. HCAI – Healthcare acquired infection
15. ANTT – Aseptic non-touch technique
16. PPE – Personal Protective Equipment
17. FEES – Fibreoptic endoscopic evaluation of swallowing
18. SIARC – Serious incident and review committee
19. PEEP – Postive End Expiratory Pressure
20. PMV – Passy-Muir valve
References and Supporting Documents


National Tracheostomy Safety Project www.tracheostomy.org.uk

Nursing and Midwifery Council (2002). Scope of Professional Practice Nursing and Midwifery Council, London


Standards for the care of adult patients with a temporary tracheostomy. Intensive Care Society July 2008

Sense Scotland’s; Women’s and Children Directorate; Meeting the Health Care Needs of People with Multiple Disabilities NHS Glasgow

Sheffield Children’s Hospital NHS Trust Information for Parents – Tracheostomy Care at Home


Roles and responsibilities

Clinical Directors are accountable to the Medical Director for the implementation and adherence to the policy

ADNSs are accountable to the Executive nurse for implementation and adherence to the policy.

ADOs will ensure that correct resources are available to ensure compliance with the policy

Lead Nurses and Matrons are accountable for implementation and adherence to the policy within their clinical areas. Lead nurses will investigate AIRs in collaboration with the ward manager and action subsequent findings. All AIRs will be reported to the tracheostomy steering group via chair or link nurse.

Ward managers and therapy team leads will be responsible for the implementation of this policy and will identify link nurses champions within their area who will attend the tracheostomy steering group meetings.

Each ward that manages tracheostomy patients will have an identified champion, who will be responsible for maintenance of ward resources; competency assessment once they have been competency assessed and have undergone more extensive training.

The ward manager’s role will involve:
- Establishing access to appropriate equipment
- Ensuring the tracheostomy competencies of all staff within their jurisdiction are collated.
- Facilitate education and training to allow staff to develop and maintain appropriate competencies through trust courses
  - Introduction to Tracheostomies (provided in cohort areas by Practice Development Trainers and Link nurses)
  - Emergency tracheostomy training (Mandatory training co-ordinated and provided by resuscitation team and trust trainers) Reported on Snowdrop Reporting Portal.
- Ensure any tracheostomy adverse incidents are reported in a timely manner.
- Participate in investigating adverse incidents and implementing actions as required

All staff caring for the patient with a tracheostomy will ensure they have the knowledge skills and competencies to do so and will comply with this policy. Those caring for patients with a laryngectomy will ensure they have the additional knowledge and skills to do so and comply with this policy
Appendices

Appendix 1. Bedhead sign – Patent Upper Airway

This patient has a **TRACHEOSTOMY**
There is a potentially patent upper airway (Intubation may be difficult)

Percutaneous / Surgical

Performed on (date) ........................................
Trachy Tube size (if present) ............................
Patient Name ............................................

Cuffed [ ] Un-Cuffed [ ]
Fenestrated [ ] Un-Fenestrated [ ]

Indicate tracheostomy type by clicking the relevant figure
Indicate location and function of any sutures inserted
Laryngoscopy Grade & Notes on managing upper airway here.

Call for airway expert help 2222 - ask for 2nd on call anaesthetist & crash team

www.tracheostomy.org.uk

Appendix 2. Bedhead sign – Laryngectomy

This patient has a **LARYNGECTOMY**
and CANNOT be intubated via the mouth

Follow the **LARYNGECTOMY** guideline if breathing difficulties

Performed on (date) ........................................
Trachy Tube size (if present) ............................
Patient Name ............................................

Note: There may not be a tracheostomy tube in place
The trachea (wind pipe) ends at the stoma

Call for airway expert help 2222 - ask for 2nd on call anaesthetist & crash team

www.tracheostomy.org.uk
Appendix 3. Emergency tracheostomy management – patent upper airway

Emergency tracheostomy management - Patent upper airway

Call for airway expert help – 2222 Crash Team and 2nd on call anaesthetist
Look, listen & feel at the mouth and tracheostomy
A Watsers circuit or capnography may help if available

No
Is the patient making efforts to breathe?

Yes
Apply high flow oxygen to BOTH the face and the tracheostomy

Call Resuscitation Team
CPR if no pulse / signs of life

Assess tracheostomy patency

Remove speaking valve or cap (if present)
Change inner tube

Can you pass a suction catheter?

No
Deflate the cuff (if present)
Look, listen & feel at the mouth and tracheostomy

Yes
The tracheostomy tube is patent
Perform tracheal suction
Consider partial obstruction
Ventilate (via tracheostomy) if not breathing
Continue ABCDE assessment

The patient is stable or improving?

No
Tracheostomy tube partially obstructed or displaced
Continue ABCDE assessment

Yes
Tracheostomy tube partially obstructed or displaced
Continue ABCDE assessment

REMOVE THE TRACHEOSTOMY TUBE
Look, listen & feel at the mouth and tracheostomy. Ensure oxygen reapplied to face and stoma

Call crash team and anaesthetist
CPR if no pulse / signs of life

Is the breathing adequate?

No
Continue ABCDE assessment
Support ventilation if hypoxic

Yes
Primary emergency oxygenation

Standard ORAL airway manoeuvres
Cover the stoma (hands / hands)
Use oral or nasal airway adjuncts / LMA / LMA / Intermittent

OR

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

Expert emergency oxygenation

Attempt ORAL intubation
Prepare for difficult intubation
Unblock tube, advanced beyond stoma

OR

Attempt intubation of STOMA
Small tracheostomy tube / 6.0uffed ETT
Consider Airway catheter and then look / scope / Bougie / Airway exchange catheter

Appendix 4. Emergency tracheostomy management – laryngectomy

**Emergency laryngectomy management**

Call for airway expert help - 2222 and 2nd on call anaesthetist
Look, listen & feel at laryngectomy stoma
A Waters circuit or capnography may help if available

**Is the patient making efforts to breathe?**

- **No**
  - Call crash team and anaesthetist
  - CPR if no pulse / signs of life

- **Yes**
  - Apply high flow oxygen to laryngectomy stoma
  - If any doubt whether patient has a laryngectomy, apply oxygen to face

**Assess laryngectomy stoma patency**

- Most laryngectomy stomas will NOT have a tube in situ
- Remove stoma cover (if present)
- Change inner tube (if present)
- Do not remove a tracheopharyngeal puncture (TTP) prosthesis

**Can you pass a suction catheter?**

- **No**
  - Deflate the cuff (if present)
  - Look, listen & feel at the laryngectomy stoma or tube

- **Yes**
  - The laryngectomy stoma is patent
  - Perform tracheal suction
  - Consider partial obstruction
  - Ventilate via stoma if not breathing
  - Continue ABCDE assessment

**Is the patient stable or improving?**

- **No**
  - REMOVE THE TUBE FROM THE LARYNGECTOMY STOMA if present
  - Look, listen & feel at the laryngectomy stoma. Ensure oxygen is re-applied to stoma

- **Yes**
  - Continue ABCDE assessment

**Continue ABCDE assessment**

**Primary emergency oxygenation**

- Laryngectomy stoma ventilation via paediatric face mask applied to stoma

**Secondary emergency oxygenation**

- Attempt intubation of laryngectomy stoma: Small tracheostomy tube / 6.0 cuffed ETT
  - Consider Airtree 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

Appendix 3a. Emergency Algorithm – Distant site rehabilitation unit

Management of the tracheostomy patient with breathing difficulties (Distant site) – Patent upper airway

**Apply oxygen to BOTH the face and tracheostomy stoma**

**CALL FOR HELP**

**Is the patient making efforts to breathe?**

- **Yes**
  - **Apply oxygen to BOTH face and tracheostomy stoma**
  - **Ensure 999 has been called**

- **No**
  - **Call Resuscitation Team**
  - **CPR if no pulse / signs of life**

**Assess tracheostomy patency**

**Remove speaking valve or cap (if present)**
- **Change inner tube**
- **Attempt tracheal suction**

**Can you pass a suction catheter?**

- **Yes**
  - **The tracheostomy tube is patent**
  - **Perform tracheal suction**
  - **Continue ABCDE assessment**
  - **Ensure 999 has been called**

- **No**
  - **Deflate the cuff (if present)**
  - **Look, listen & feel at the mouth and tracheostomy**

**Is the patient stable or improving?**

- **Yes**
  - **Tracheostomy tube partially obstructed or displaced**
  - **Continue ABCDE assessment**

- **No**
  - **Ensure 999 has been called**
  - **REMOVE THE TRACHEOSTOMY TUBE**
  - **Look, listen & feel at the mouth and tracheostomy. Ensure oxygen re-applied**

**Is the breathing adequate?**

- **No**
  - **If no pulse, start CPR**
  - **Follow BLS algorithm with airway maintenance**

- **Yes**
  - **Continue ABCDE assessment**
  - **Support ventilation if needed**

**Emergency Oxygenation**

**OR**

**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**

Adapted from algorithms written by the National Tracheostomy Safety Project
Appendix 3b. Emergency Algorithm – Community Patient Upper Airway

Management of the community tracheostomy patient with breathing difficulties – Patent upper airway

Apply oxygen if available (face and/or tracheostomy stoma)
CALL FOR HELP

Is the patient making efforts to breathe?

Yes
Apply oxygen to face and/or tracheostomy stoma(if available)

No
Call Resuscitation Team
CPR if no pulse / signs of life

Assess tracheostomy patency

The tracheostomy tube is patent
Perform tracheal suction
Continue ABCDE assessment
Ensure 999 has been called

The tracheostomy tube is obstructed or displaced
Continue ABCDE assessment

Can you pass a suction catheter?

Yes

No
Deflate the cuff (if present)
Look, listen & feel at the mouth and tracheostomy

Is the tracheostomy tube partially obstructed or displaced?

Yes

No
Remove speaking valve or cap (if present)
Change inner tube
Attempt tracheal suction

Is the patient stable or improving?

Yes

No
Ensure 999 has been called

REMOVE THE TRACHEOSTOMY TUBE
Look, listen & feel at the mouth and tracheostomy. Re-apply O₂ if available

Is the breathing adequate?

Yes

Continue ABCDE assessment
Support ventilation if needed

No
Is the patient making efforts to breathe?

Yes
Apply oxygen to face and/or tracheostomy stoma(if available)

No
Call Resuscitation Team
CPR if no pulse / signs of life

Evaluate for airway maintenance

Standard ORAL airway manoeuvres
Cover the stoma (swabs / hand)
Consider use of pocket mask

OR

Tracheostomy STOMA ventilation
Cover nose and mouth and consider use of pocket mask over stoma

Adapted from algorithms written by the National Tracheostomy Safety Project
Management of the community laryngectomy patient with breathing difficulties

Apply oxygen to laryngectomy stoma (if available) 
CALL FOR HELP

No

Is the patient making efforts to breathe?

Call 999  
Follow BLS algorithm

Yes

Apply high flow oxygen to laryngectomy stoma

Assess laryngectomy stoma patency

Most laryngectomy stomas will NOT have a tube in situ

The laryngectomy stoma is patent  
Perform tracheal suction  
Continue ABCDE assessment

Yes

Can you pass a suction catheter?

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

Partially obstructed or displaced  
Continue ABCDE assessment  
Ensure 999 has been called

No

If no pulse, start CPR  
Follow BLS algorithm with airway maintenance

Yes

Is breathing adequate?

Primary emergency oxygenation

Laryngectomy stoma ventilation via paediatric face mask applied to stoma

Ensure 999 has been called

REMOVE THE TUBE FROM THE LARYNGECTOMY STOMA if present

Look, listen & feel at the laryngectomy stoma. Re-apply oxygen if available

Airway maintenance  
Continue ABCDE assessment  
Support ventilation if hypoxic  
Wait for help

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

* Adapted from algorithms written by the National Tracheostomy Safety Project
### Appendix 6. Emergency Tracheostomy Box

<table>
<thead>
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<th>Equipment</th>
<th>Stock Level</th>
<th>Stock Inventory</th>
<th>Equipment</th>
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<td>15L Non-Rebreathe Mask</td>
<td>1</td>
<td>Ward Stock</td>
<td>15L Non-Rebreathe</td>
</tr>
<tr>
<td>15L Non-Rebreathe Paediatric mask</td>
<td>1</td>
<td>FDD113</td>
<td>1+ 98p</td>
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<tr>
<td>Suction Catheter Size10</td>
<td>3</td>
<td>Ward Stock</td>
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</tr>
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<td>Suction Catheter Size12</td>
<td>3</td>
<td>Ward Stock</td>
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<tr>
<td>Yankeur Suction</td>
<td>1</td>
<td>Ward Stock</td>
<td>Ward Stock</td>
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<tr>
<td>10ml Syringe</td>
<td>1</td>
<td>Ward Stock</td>
<td>Ward Stock</td>
</tr>
<tr>
<td>Size 0 paediatric mask</td>
<td>1</td>
<td>FDE381</td>
<td>1 + £5.71</td>
</tr>
<tr>
<td>Water circuit</td>
<td>1</td>
<td>FDC101</td>
<td>£118.20 pack of 15</td>
</tr>
<tr>
<td>Gauze Swabs</td>
<td>2</td>
<td>Ward Stock</td>
<td>Ward Stock</td>
</tr>
<tr>
<td>Catheter mount</td>
<td>1</td>
<td>FDE443</td>
<td>1 + 48p</td>
</tr>
<tr>
<td>Tracheal Dilator</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Tracheostomy and Shiley tubes are used in ward environments, please order what is currently in use on your ward

<table>
<thead>
<tr>
<th>Tracheostomy Cuffed, Non fenestrated Tube Size 6</th>
<th>1</th>
<th>FDH340</th>
<th>1 + £60.16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tracheostomy Cuffed, Non fenestrated Tube Size 7</td>
<td>1</td>
<td>FDH341</td>
<td>1 + £60.16</td>
</tr>
<tr>
<td>Tracheostomy Cuffed, Non fenestrated Tube Size 8</td>
<td>1</td>
<td>FDH342</td>
<td>1 + £60.16</td>
</tr>
</tbody>
</table>

Portex tubes generally used in critical care environments

<table>
<thead>
<tr>
<th>Portex Blue line ultra size 7mmID</th>
<th>1</th>
<th>FDG192</th>
<th>1x £35.45</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portex Blue line ultra size 7.5mmID</td>
<td>1</td>
<td>FDG193</td>
<td>1x £35.45</td>
</tr>
<tr>
<td>Portex Blue line ultra size 8mmID</td>
<td>1</td>
<td>FDG14</td>
<td>1x £35.45</td>
</tr>
</tbody>
</table>
TRACHEOSTOMY WARDS ONLY

1. Every ward and department must have a transfer grab bag.

The Bag Should be Packed in the Following Way
2. The bag must be kept close to the resus trolley, if this is not possible then a laminated sign must be placed above the resus trolley giving the exact location of the bag.

3. The transfer bag content’s must be checked on the 1st of the month, ensuring all equipment is in date and packaging and equipment is intact.

4. Once the contents have been checked, a red security seal must be attached to the zip to seal the bag. Security seals available form the resuscitation team.

5. The security seal number must be written on the record below along with the date of check and the signature of the person completing the check.

6. If the seal is broken on transfer, it is the responsibility of the nurse completing the transfer to replenish, recheck and reseal the bag and complete this document.

7. This document should be kept with the resuscitation trolley check list.

### Minimum Bag Contents

**Tracheostomy Wards and Departments only**

Extra stock may be required by some areas, but staff are advised not to overstock.

<table>
<thead>
<tr>
<th>Item</th>
<th>Number</th>
<th>Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tourniquet</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Blood giving sets</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>IV Cannulae</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>3-way taps</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Tape</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV line dressings</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>2% chlorhex wipes</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>0.9% saline</td>
<td>1</td>
<td>1000mls</td>
</tr>
<tr>
<td>Gelofusine</td>
<td>1</td>
<td>500mls</td>
</tr>
<tr>
<td>IV caps</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Ambu bag/self-inflating bag and mask</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Non rebreathe mask</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Guedel airway</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Nasal airway</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Item</td>
<td>Quantity</td>
<td>Notes</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Non sterile gloves</td>
<td>2 pairs</td>
<td>medium</td>
</tr>
<tr>
<td>Water circuit</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Catheter mount</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Tracheal suction catheters</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Tracheal suction catheters</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Yankeur suction</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>10 ml syringe</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Paediatric anaesthetic mask</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Gauze swabs</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Cuffed non fenestrated tracheostomy tubes</td>
<td>2</td>
<td>Dependant on type of tube used locally, 1x most common size + 1x smaller size i.e.; trachoetwist size 7 + 6, Portex size 8 + 7</td>
</tr>
<tr>
<td>Sachet of water based lubricant</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Security seal number</th>
<th>Signature</th>
</tr>
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<tbody>
<tr>
<td></td>
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