



Collaborative Regional Benchmarking Group Tracheostomy Care in Critical Care



Aim: To provide guidance on nursing care for patients with a tracheostomy in Critical Care
Scope: All adult patients with a tracheostomy

Each shift assess and document:

- Patency of tracheostomy
- Check size of tube
- Cleanliness and health of stoma
- Inner tube: clean and change 4 hourly
- Tapes renewal
- Dressing renewal
- Emergency box present and stocked
- Cuff pressure check 4 hourly
- Closed suction: check change date

SAFETY FIRST!

- Continuous capnography
- Bedhead sign
- Emergency Box present at bedside
- Be familiar with the Emergency Tracheostomy Algorithms (NTSP)

RISK OF DISPLACEMENT

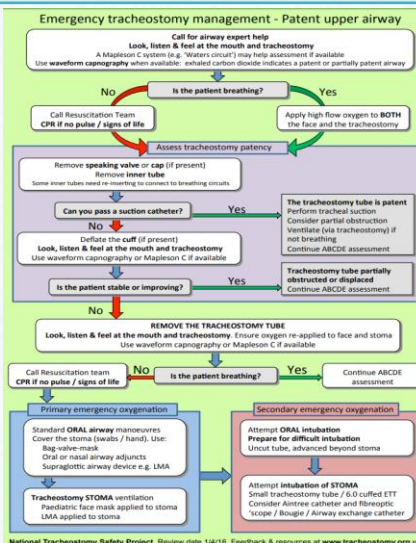
Inform CCOT on discharge

Standard Tracheostomy Care

1	Ensure adequate oxygen and humidification therapy is delivered for both ventilated and non-ventilated patients.
2	Inner cannula should be removed, inspected and cleaned with sterile water 4 hourly or as patient condition dictates. Spare clean inner tube to be kept at bedside.
3	Perform suctioning as often as clinically indicated and aspirate subglottic port, if available, 4 hourly.
4	Stoma site – each shift inspect for infection and pressure damage, clean with sterile gauze & saline, change dressing and ensure tracheostomy is secured with tapes.
5	Maintain cuff pressure between 20 – 30 mmH ₂ O if ventilated. ALWAYS deflate cuff with speaking valve
6	Perform oral care 4 hourly or as required.

Rehabilitation

- Mobilise as able, ensuring tracheostomy is secure
- Regular physiotherapy
- Encourage coughing



Consider

- Swabbing stoma if there are any signs of infection
- Pressure damage from tube
- Weaning plan
- Swallowing assessment
- Speaking Valve
- Communication aids
- Tube change at 29 days

Please see your units full guidelines for more information

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