Temple Street
CHILDREN'S UNIVERSITY HOSPITAL

Ward: _____ Date: _____

Ward: _____ Date: _____

Addressograph

Tracheostomy Nursing Care Plan

Problem: : _____ **has a tracheostomy due to** _____ **(use in conjunction with the Tracheostomy guidelines and teaching plans – please refer to these for further information)**	**S/N Sig:**_____ **NMBI:**_____	**Date:** _____ **Planned by:** _____ **Grade:**_____	**Problem no: 74**

Goals:

a) **To ensure patent airway and prevent infection**
b) **To educate the child & family and promote optimal lifestyle.**

1 Tube Type and Size:……. **2 Catheter Size:…… Depth:……..cms** **Nursing care:**	**Self / family care**	**Date/signature/grade/NMBI for any changes made to care**
a) Nurse patient in a high visibility area on the ward with immediate access to suction and O_2.	Parents will be educated regarding_____'s condition	
b) Ensure bedspace is equipped with UNOPENED tracheostomy tubes x 2, one of which is the same make and size as patient's present tracheostomy tube and one shiley a half size smaller and a PREPARED emergency shiley tube with Velcro ties attached which is changed every 12 weeks and date should be highlighted on bag.		
c) Ensure *tracheostomy pack, *tracheal dilator only if patient >10yrs, disposable sterile tracheal scissors packs (x 4), appropriately sized suction catheters, velcro ties (for emergency use only) and suction machine are in the room at all times.		
***(Tracheostomy pack required for all patients < 4 weeks from time of insertion unless otherwise indicated).**		
***(Tracheal dilator only needed 1st week post insertion of tube and >10yrs of age)**		
d) Be familiar with patient's past and present respiratory status e.g. Broncho Pulmonary Dysplasia (BPD).		
Suctioning		
a) Use clean technique (latex **free** gloves) during suctioning whilst the child is in hospital **(AARC, 2010)**		
b) Suction as condition indicates (i.e. patient unable to clear own secretions; oxygen saturations decreasing less than 92% and change of colour e.g. cyanosis, pallor; increased work of breathing, intercostal recession		
c) Use appropriately sized catheter when suctioning (½ the internal diameter of the tracheostomy tube**. (Dougherty and Lister 2011, Wilson 2011)**). **Use gradient suction catheters.**	Parents will be educated in suctioning and tracheostomy care	
d) Ensure suction pressure is no greater ***60-80mmHg <4 weeks, 80-100mmHg 4 weeks up to 3 years,100-120mmHg >3 years*** when suctioning.(Hockenberry & Wilson 2011, Barron and Hollywood 2010)		
e) Remove visible secretions from the tube and around area i.e. coated tube. Suction for no longer than 5 seconds and apply suction on withdrawal of suction catheter only. (AARC Guidelines 2010*)*		

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Tracheostomy Nursing Care Plan Continued

Nursing care:	Self / family care	Date/signature/grade/NMBI for any changes made to care
f) Do not advance the suction catheter any further than the length of the tracheostomy tube, to avoid irritation / trauma to tissues beyond this point. Place an example of the distance the suction tube should be inserted at the bedside. This can be used as a guide when suctioning as well as your gradient markings g) **Length is achieved by measuring the obturator from the 2nd semi-circle to the tip. (Refer to suction depth guide). Suctioning depth should also be documented.** h) **The same suction catheter may be used if secretions are loose and clear. Do not suction more than 3 times on any occasion. If secretions are thick and purulent, change suction catheter and gloves after each use (Wood 1998, AARC 2010).** i) Allow patient time to recover adequately post suctioning and prior to next suction. j) Administer Sodium Chloride (NaCl 0.9%) nebulisers as prescribed prior to suctioning to help loosen the secretions as prescribed. k) Observe patient pre, during and post suctioning (oxygen desaturations, colour changes, increased effort & respiratory rate). l) Note & record colour, consistency and volume of secretions during suctioning. m) Obtain sputum sample for culture and sensitivity if indicated - pyrexia, increased cough, discoloured secretions, increased frequency of tube changes e.g emergency tube changes due to purulent secretions. n) Instilling saline is controversial we **do not recommend it.** **Humidification** o) Attach heat moisture exchange (HME) e.g. thermovent to tracheostomy tube at all times to maintain humidity. Change daily or if visible secretions present. ***If the child is <10kgs use the GIBECK and > 10kgs Thermovent T.*** p) Administer Sodium Chloride (NaCl 0.9% 2.5mls) nebulisers as prescribed to help loosen secretions. q) Warmed humidified air may be given overnight to keep secretions loose using the ***Airvo machine*** if available. r) Ensure child is adequately hydrated as secretions become thicker when patient is dehydrated. s) BVM/anaesthetic circuit with appropriate connection. **Stoma Hygiene** a) Leave stoma area exposed and keep clean and dry. Where a dressing is recommended by ENT team, adhere to written guidance given. b) Clean stoma area daily with NaCl 0.9% using gauze **not cotton wool. Use soap and water e.g Elave or Johnson's baby bath to neck area only when cleaning.** c) Change neck ties daily or more frequently if required e.g soft collar cotton twill (Marpac). Assess neck and stoma area at this time for any signs of discharge, reddened areas, infection or neck excoriation. Inform team of any changes.	Parents will report observations on sputum/tolerance of suctioning Parents will be educated on cleaning and observation of stoma site	

Small addressograph

Tracheostomy Nursing Care Plan Continued

Nursing care:	Self / family care	Date/signature/grade/NMBI for any changes made to care
d) Record change of ties and any changes to stoma site on *Tracheostomy Tube Change Record Sheet.*		
Tracheostomy Tube Changing - Elective a) Change tracheostomy tube **weekly if a Shiley tube** or more frequently if clinically indicated – refer to tube change flow sheet. A **Bivona tube may be changed every 28-30 days Shiley and bivona tubes are single use.** b) **NB Bivona tubes cannot be used for any child who requires an MRI – a Shiley tube should be inserted specifically for that investigation.** c) Ensure oxygen and suction are close at hand and are switched on at time of tube change. d) Use the same tube size. e) Ensure that there are two staff members (one must be a staff nurse) present during the tube change. f) Carry out tube change prior to feeding (reduces the risk of vomiting). g) Prepare equipment i.e. Tube, ties, oxygen, suction, rolled towel for behind the neck. h) **Responsibilities** **Changer –** stands beside oxygen and suction **Assistant** – holds tube in position using a **C shape** with thumb and index finger **Changer** – cuts ties with sterile scissors and **assistant** removes old tube on the count of 3. **Changer** - inserts the new tube in a C shape manoeuvre and removes the introducer as soon as new tube is in place. **Changer** – holds new tube in position **Assistant** – cleanses the neck and stoma, ties the tie using 3 knots (refer to template at bedside) the ties and **ensuring one finger breadth between the ties and the patient's neck at the back.** During tube change, observe stoma for signs of infection, record and report findings. i) Be aware of indications for emergency tube change –increased work of breathing, stridor, audible sounds, cyanosis, inability to pass suction catheter. j) **Emergency Tube change**: (REFER TO EMEREGENCY PAEDIATRIC MANAGEMENT ALGORITHYM (SEPT. 2014)) k) Remove fresh tracheostomy tube from package/prepared emergency tube in emergency bag. l) Insert tracheostomy tube. m) Secure with velcro ties n) When patient's condition has stabilised change **velcro** ties to Marpac **cotton** ties unless otherwise indicated.	Parents will report observations on sputum/tolerance of suctioning Parents will be educated on tube changes	
Feeding		

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Tracheostomy Nursing Care Plan Continued

Nursing care:	Self / family care	Date/signature/grade/NMBI for any changes made to care
a) **Involve the speech and language team.** b) Protect the tracheostomy tube with humidified moisture exchanger to minimise risk of food entry. c) Allow time for feeding, giving small amounts and wind an infant regularly. Do not use plastic backed feeding bibs as these may occlude the tube. d) Stay with and monitor the child during feeding. e) Assist and supervise the parents until they are confident with feeding. **Communication** a) Involve the speech and language team. Use speaking valve if appropriate. b) Refer to Passy Muir Valve care plan. **Education** a) Continue on-going education and support for parents. b) Begin discharge planning in conjunction with the parents and the ENT team**(refer to the Discharge process for a child with a tracheostomy)** c) **USE THE RELEVANT TRACHEOSTOMY TEACHING PLANS TO ENSURE ALL EDUCATION IS COMPLETED** d) **NB:** Arrange C.P.R education for parents.: Date provided:_____ e) When parents are deemed competent (date _____) commence gradual discharge process if circumstances allow in conjunction with the ENT team.	Parents will assist with feeding Parents are aware of entitlements Parents have written, verbal and practical information available to them Parents will be educated on cleaning and observation of stoma site	

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