Daily checks

There should be a detailed plan of care for all patients with a tracheostomy. A suggested care plan is provided in this manual, but local policies may already be in place. The care plan should be reviewed on a daily basis and updated if there is any change.

The patient with a tracheostomy needs diligent observation and assessment. The nurse caring for the patient is responsible for this, seeking advice from other professionals as appropriate.

Patient assessment
At the start of each shift the Staff Nurse caring for the patient with a tracheostomy should carry out a full assessment of the patient, which should include:

- Why does the patient have a tracheostomy?
- When was the tracheostomy performed? Was it surgical or percutaneous (may have implications for ease of re-insertion) and does the patient have a larynx? (i.e do they have a communication between the oral airway and the lungs?) Bed-head signs should be available at the patients' bed space to quickly and easily communicate this information.
- Type and size of tracheostomy tube & availability of spare & emergency equipment
- Cough effort
- Ability to swallow, including any SALT assessments
- Sputum characteristics (Colour, Volume, Consistency, Odour)
- Check and change inner cannula for any build up of secretions (see later)
- Check tracheostomy holder is secure and clean
- Check stoma dressing is clean
- Routine observations

This assessment should be documented on the care plan at the start of every shift.