FAUQUIER EAR NOSE & THROAT CONSULTANTS, PLC

Trach Post-Op Care and Decannulation Protocol

POD#0-5:

- Routine Trach Care
  - Obturator at bedside at all times
  - Extra same type (normally Shiley) & size trach tube at bedside at all times along with clean Velcro trach ties.
  - Vent settings to be determined by primary team.
  - Keep cuff inflated. Check cuff daily for appropriate amount of pressure (~20cm water pressure to prevent tracheal necrosis).
  - Suctioning frequency varies per patient. If lots of secretions, suctioning up to q1h along with pulmonary toilet may be necessary.
  - Change and clean inner cannula daily. If lots of secretions and debris, inner cannula may need to be changed to new one or cleaned up to qid if necessary.
  - Bleeding around trach site is common and usual during this period. However, contact ENT if brisk bright red blood bleeding or enough oozing resulting in saturated dressing within minutes requiring multiple dressing replacements.
- During this period, the outer cannula is not to be changed or removed except by ENT who will perform first trach change.

POD#4-6 (approximately):

- First trach change will be performed by ENT.
- After first trach change by ENT, RT/RN may perform all future trach changes of outer cannula unless otherwise instructed by ENT.

Routine After First Trach Change:

- Routine Trach Care as above PLUS:
  - RT/RN may perform q7d total (outer) trach changes. The outer cannula may be re-used if cleaned completely with warm tap water.
  - Clean all debris and crusting around trach stoma daily using 50% hydrogen peroxide.

Once Patient is Weaned Off Ventilator:

- HUMIDIFIED air.
- Trach Care instruction for patient and family including:
  - How to take out and put back in entire trach tube (outer and inner cannulas)
  - Daily cleaning around trach stoma with ½ strength H_2O_2 mixed with water
  - Daily cleaning of inner cannula
  - Q3-7d cleaning of outer cannula
- Deflate cuff if aspiration not a risk factor for patient.
  If aspiration still an issue, keep cuff inflated until time when aspiration no longer an issue.
- ONLY when cuff is deflated, patient may be able to speak by plugging trach opening with finger.
- If patient will not be requiring any further operations and is doing well taking po without difficulty, change trach to metal (Jackson) of same size. Still keep extra same size Shiley at bedside in case of respiratory compromise (one can bag with a Shiley, but not a Jackson)
- If aspiration still an issue, keep Shiley trach in place and do not switch to Jackson trach.

If patient has excellent pulmonary recovery:

• Once patient is ambulating or is of sufficient strength that pulmonary reserve is not a concern and there is no supra-tracheostomy obstruction, a Passy-Muir Valve (PMV) may be placed so patient can speak. It is not unusual that the voice may be breathy or hoarse if intubated for a prolonged period of time. Over a period of weeks, the voice should slowly get stronger. If it does not, notify ENT.

• If patient is tolerating PMV without difficulty, cork the trach opening with pulse oximetry monitoring.

• If patient tolerates continuous trach corking without oxygen desaturations overnight, patient may be decannulated and occlusive dressings applied over trach opening:

Occlusive Dressing application as follows:

- Over trach opening, place Vaseline gauze so that it completely covers stoma by at least 1cm all around.
- Then cover with 4 X 4 gauze
- Then cover with silk tape all around so absolutely no air escape is heard around dressing when patient breathes.
- Of note, it may be easier to create entire occlusive dressing first and place everything all at once on patient (much like when preparing to remove a chest tube).

• Whenever the patient coughs, speaks, or sneezes, the patient should reinforce the occlusive dressing by pressing a hand over the occlusive dressing.

• Over the next 1-2 weeks, the trach opening will close shut.

If patient has weak pulmonary reserve:

• If patient unable to tolerate PMV, finger occlusion should be used to communicate.

• If patient able to tolerate finger occlusion, but not strong enough to tolerate PMV, downsize trach to next smaller trach (ie, if patient using #6, go down to #5).

• Depending on pt's status, one may choose to slowly downsize trach or attempt PMV trial periodically as described above to eventual decannulation.

As always, notify ENT with any questions or concerns. If there is any concern from ENT standpoint regarding trach, ENT will automatically follow along and amend changes to protocol described above.

Definitions:

Shiley trach tube
Rigid white plastic with inflatable cuff
Most often trach tube placed after trach first performed

Jackson trach tube
Rigid metal without a cuff

TTS trach tubes
Trach tube with cuff one uses SALINE to inflate cuff and not air
This trach tube is used when attempting to bypass stenotic areas or for other unusual reasons

Bivona Hyperflex
Flexible plastic with inflatable cuff that one can manually adjust length. Usually used for obese individuals.