Stronger Together

London North West Healthcare NHS Trust

Tracheostomy MDT W/R Proforma

Ward: ___________

Consultant:___________

Size: ______ **Brand/Make:** ___________

Patient Sticker
Or
Details

Name:
Hospital Number:
D.O.B.

Tracheostomy details

Current Type of trache-tube: Fenestrated ☐ Non-fenestrated ☐ Armored ☐ Adjustable flange ☐

Mini tracheostomy ☐ Single lumen ☐ Double lumen ☐ Cuffed ☐ Uncuffed ☐ Use of Voice valve ☐

Primary reason for tracheostomy: emergency due to airway obstruction ☐ long term intubation ☐ improve respiratory function ☐ Neurological compromise ☐ Secretion management ☐

Procedure : Surgical ☐ Percutaneous ☐

Hospital tracheostomy was performed/Team that performed/Date: / /

Reported complications during tracheostomy:

Initial type of trache-tube: Size_____ Make:_______

FNE: secretions above tube ☐ granulations above tube ☐ mass above tube ☐ foreign body above tube ☐ signs of aspiration ☐ vocal cords seen ☐ clear airway above tube ☐ Other___________________________

FE through tube : granulations in trachea ☐ secretions in the airway ☐ signs of aspiration ☐ blocked tube ☐

Infection of trachea ☐ collapse of trachea ☐ tube off trachea ☐ clear FE ☐ Other _______________________

Inspection of tracheosotmy site including skin: granulations around tube ☐ skin infection ☐ tract infection ☐ Other ____

Tracheostomy-Round MDT

Previously reported problems/complications:

Decision of tracheostomy round MDT on / / (date):Start Weaning ☐ Test to Decannulate ☐ change tube same size ☐ change tube smaller size/bigger size (please state new size) ☐_________
inform team for need of enhanced trache-care ☐ surgery ☐ continue same care/size/type of trache ☐
Other____

____

____

Names and Signatures of MDT:

Nurse Specialist: Physiotherapist:

Medical Practitioner: SALT :

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Dietitian :	Other:

Decision of tracheostomy round MDT on / / (date): Start Weaning ☐ Test to Decannulate ☐ change tube same size ☐ change tube smaller size/bigger size (please state new size) ☐________
inform team for need of enhanced trache-care ☐ surgery ☐ continue same care/size/type of trache ☐
Other____
____
____

Names and Signatures of MDT:

Nurse Specialist:	Physiotherapist:
Medical Practitioner:	SALT :
Dietitian :	Other:

Decision of tracheostomy round MDT on / / (date): Start Weaning ☐ Test to Decannulate ☐ change tube same size ☐ change tube smaller size/bigger size (please state new size) ☐________
inform team for need of enhanced trache-care ☐ surgery ☐ continue same care/size/type of trache ☐
Other____
____
____

Names and Signatures of MDT:

Nurse Specialist:	Physiotherapist:
Medical Practitioner:	SALT :
Dietitian :	Other:

Decision of tracheostomy round MDT on / / (date): Start Weaning ☐ Test to Decannulate ☐ change tube same size ☐ change tube smaller size/bigger size (please state new size) ☐________
inform team for need of enhanced trache-care ☐ surgery ☐ continue same care/size/type of trache ☐
Other____
____
____

Names and Signatures of MDT:

Nurse Specialist:	Physiotherapist:
Medical Practitioner:	SALT :
Dietitian :	Other:

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Weaning details

Cuff Deflation

Criteria met:

	Trial: 1	2	3
No ventilatory requirements	☐	☐	☐
$FiO_2 \leq 0.35$	☐	☐	☐
Effective cough	☐	☐	☐
CVS and CNS stable	☐	☐	☐
No bronchopulmonary infection	☐	☐	☐
Manages oral secretions (by expectoration / Yankauer suction / swallow)	☐	☐	☐

Activity seen:

Trial	Date	Requested by: (Profession and grade)	Location	Professional performing task	Duration	No. times suction required in this period
1						
2						
3						

Reason for reinflation if required:

	Trial: 1	2	3
Deflation was for set period	☐	☐	☐
Desaturation ≥ 5 %	☐	☐	☐
Respiratory distress	☐	☐	☐
Cardiovascular distress	☐	☐	☐
Failure to protect airway	☐	☐	☐
Fatigue evident (e.g. ↑ RR >25, ↑ effort, sweating etc.)	☐	☐	☐
Other	☐	☐	☐

Please specify...

....

Finger Occlusion

Activity seen:

Trial	Date	Requested by: (Profession and grade)	Location	Professional performing task	Duration
1					
2					
3					

Problems:

	Trial: 1	2	3
None	☐	☐	☐
Desaturation ≥ 5 %	☐	☐	☐
Respiratory distress	☐	☐	☐
Cardiovascular distress	☐	☐	☐
Stridor	☐	☐	☐

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Increased WOB ☐ ☐ ☐ *Please specify*..
Other ☐ ☐ ☐ ....

Capping / Speaking Valve Trial

Activity seen:

Trial	Date	Requested by: (Profession and grade)	Reason for trial given	Location	Professional performing task	Duration
1						
2						
3						

Comments:

Decannulation

Criteria met:

Initial reason for tracheostomy has resolved ☐
Able to maintain airway when cuff is deflated +/- tracheostomy occluded ☐
Able to maintain airway when tracheostomy is occluded ☐
Strong cough to clear secretions out of the tracheostomy or into the mouth ☐

Activity Seen:

Date	Requested by (Profession and grade)	Location	Professional performing task	Immediate problems up to 60 mins?

Comments:

Time	Success/Fail?	Comments
60 mins		
24 hours		
48 hours		
1 week		

Fail = Any reason for re-cannulation/intubation or **unexpected** death due to **RESPIRATORY** failure

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