

TRACHEOSTOMY & LARYNGECTOMY (ADULT) COURSE

**WORKBOOK AND COMPETENCY PACK
2023**

Name.....

Place of Work.....

Version: 11

Effective From: October 2023

Expiry date: October 2026

Ratified By: Dr David Cressey: Trust Lead for Tracheostomy Care and Clinical Policy Group, and Practice and Development group

Date Ratified: September 2023

Reviewed by: Liz Place

Acknowledgements:

The following manual incorporates guidance and competencies from the National Tracheostomy Safety Project (NTSP) 2013

Non-medical Competencies for Tracheostomy & Laryngectomy Care (NTSP) 2018

Contents

Introduction.....	4
Competency and workbook scope	4
Aim	4
Pre-requisites to competency assessment.....	4
Duties, roles and responsibilities.....	5
References	5
WORKBOOK	6
Section 1 Anatomy & Physiology	6
Section 2 Tracheostomy Insertion and Indications	8
Section 3: Tracheostomy Tube Types.....	10
Section 4 Caring for a Tracheostomy.....	11
Section 5 Speech and language	13
Section 6 Cuff Management	15
Section 7 Changing a Tracheostomy Tube	15
Section 8 Weaning and decannulation.....	16
Section 9 Emergencies, Complications & Red Flags	17
Section 10 Patients with a Laryngectomy	19
What is a laryngectomy?	19
Surgical procedure	19
Care of the laryngeal stoma	20
Care guidelines:	20
Communication	21
Valve speech or surgical voice restoration	21
Artificial Larynx (Servox)	22
Oesophageal Speech.....	22
Silent Articulation	22
Laryngectomy questions: Must be completed prior to attendance to the course.	22
Section 11 Learning Contract.....	24
Section 12 Clinical Competency and Assessment Documentation.....	25
Emergency Algorithm	27
Effective and early recognition of tracheostomy “Red Flags” and complications	30
Laryngectomy care: Can demonstrate the skill required to care for a laryngectomy patient.....	33
Suction Technique	35
Humidification	38
Tracheostomy dressing change	40
Caring for inner cannula	43
Cuff Management Deflation and Cuff Pressures.....	46
Types of Communication with Tracheostomy or Laryngectomy.....	49
Can Safely Transfer a Patient with a Tracheostomy or Laryngectomy.....	51
Communication with family	53

Discharge Can demonstrate awareness of safe discharge from hospital of a patient with a tracheostomy or laryngectomy.....	55
Decannulation/removal of tracheostomy tube.....	57
Changing of a Tracheostomy Tube	60
Can Perform Safe Sub-glottic Suction (if applicable to local practice).....	64
Appendix 1. Insertion Check List	66
Appendix 2. Tracheostomy and laryngectomy bed sign.....	68
Appendix 3: Adult basic life support algorithm	73
Appendix 4 Swallow Screening For Tracheostomised Adult Patients.....	74
Pre-Screen Checklist.....	74
Screening Tool	75
Appendix 4 Decannulation checklist.....	76

Introduction

This workbook and competency pack is to facilitate the safe management of patients with tracheostomies and laryngectomies.

The course is in three parts:

- I. Detailed workbook that must be completed prior to attending the course, and brought to the study day.
- II. The study day; a combination of lectures, practical sessions and simulation.
- III. The laryngectomy session is a recommended requirement for completion of the course and can be booked through Human Resources Training Department.

NB: Important:

- I. Completion of the workbook section is mandatory, as some pre-knowledge is essential to your understanding of the taught component of this programme. Perfect answers to the questions within are not expected, and the workbook will not be marked. However, this workbook **MUST** be presented on the day to gain admission to the course.
- II. Non-submission of this document will result in your being denied attendance on the course, and you will be returned to clinical duties.
- III. The answers to the questions within this workbook can be found within National Tracheostomy Safety Project Manual 2013. Refer to [Tracheostomy and Laryngectomy Care \(policies.app\)](#)
- IV. Competency and workbook scope
 - I. Practitioners whilst caring for patients with tracheostomies and laryngectomies are governed by their Code of Professional Conduct, Trust policies and Guidelines: (refer to reference list)
 - II. The following personnel may undertake this training after discussion with their line manager: Registered Nurses, Physiotherapists, Speech and Language Practitioners and Medical Practitioners.
 - III. This guideline does not cover the competency assessment document of learners whose programme of study is managed by an external organisation

Aim

The aim of the education and training package is to:

- I. Facilitate practitioner development and clinical skills acquisition in the management of tracheostomy and laryngectomy care.
- II. Develop theoretical knowledge of the principles of tracheostomy and laryngectomy care.
- III. Acquire new or update existing practical skills to enable practitioners to perform tracheostomy and laryngectomy care competently.
- IV. Demonstrate an awareness of National and Trust Policies and Guidelines related to the procedures.

Pre-requisites to competency assessment

Staff must attend and follow the Trust training programme for Tracheostomies and Laryngectomies. Prior to formal competency assessment it is recommended that individuals perform multiple supervised procedures of each competency as described in each of the clinical competency assessment tools. (See: section 9).

To demonstrate consistency supervised practice should be undertaken on separate occasions. It is recommended that supervised practice is performed on different days and on different patients. However there is no maximum number of times the practitioner should carry out procedures under direct supervision. An action plan must be developed and regularly reviewed if competency assessment is not achieved.

Duties, roles and responsibilities

Trainee:

- Is a registered nurse, physiotherapist and language practitioners, medical practitioner in areas where patients with tracheostomies or laryngectomies are likely to be accommodated
- Must attend and follow the Trust training programme and be able to demonstrate the knowledge and skills to complete the Tracheostomy and Laryngectomy Competencies.
- Once deemed competent, it is the practitioner's responsibility to maintain knowledge, skills and competence. Subsequent assessment maybe required if there has been a change in personal circumstances, e.g. gap in practice, and or, a gap in exposure to patients with tracheostomies or laryngectomies, and or, if concerns are raised regarding competence.

Assessor:

- Must be one of the above registered practitioners who are already deemed competent in the practice of tracheotomy and laryngectomy management.
- Must hold a formal mentor/assessor qualification.

References

GMC (2014) *Good Medical Practice*. GMC, London.

HCP (2016) *Standards for conduct performance and ethics*. HCP, London.

NMC (2018) *Code of Professional Conduct: Standards for conduct, performance and ethics*. NMC, London.

NMC (2010) *Guidelines for records and record keeping*,
[2018 ANTT practice framework for invasive procedures.](#)

Refer to the current policies listed below:

- Asepsis
- Consent to Examination and treatment
- Hand Hygiene Policy
- Health Care Acquired Infection
- Patient Identification Policy
- Personal Protective Equipment
- Sample Acceptance and Rejection
- Standard Precautions Policy
- Waste Management Policy

[NTSP Manual 2013 \(tracheostomy.org.uk\)](http://tracheostomy.org.uk)

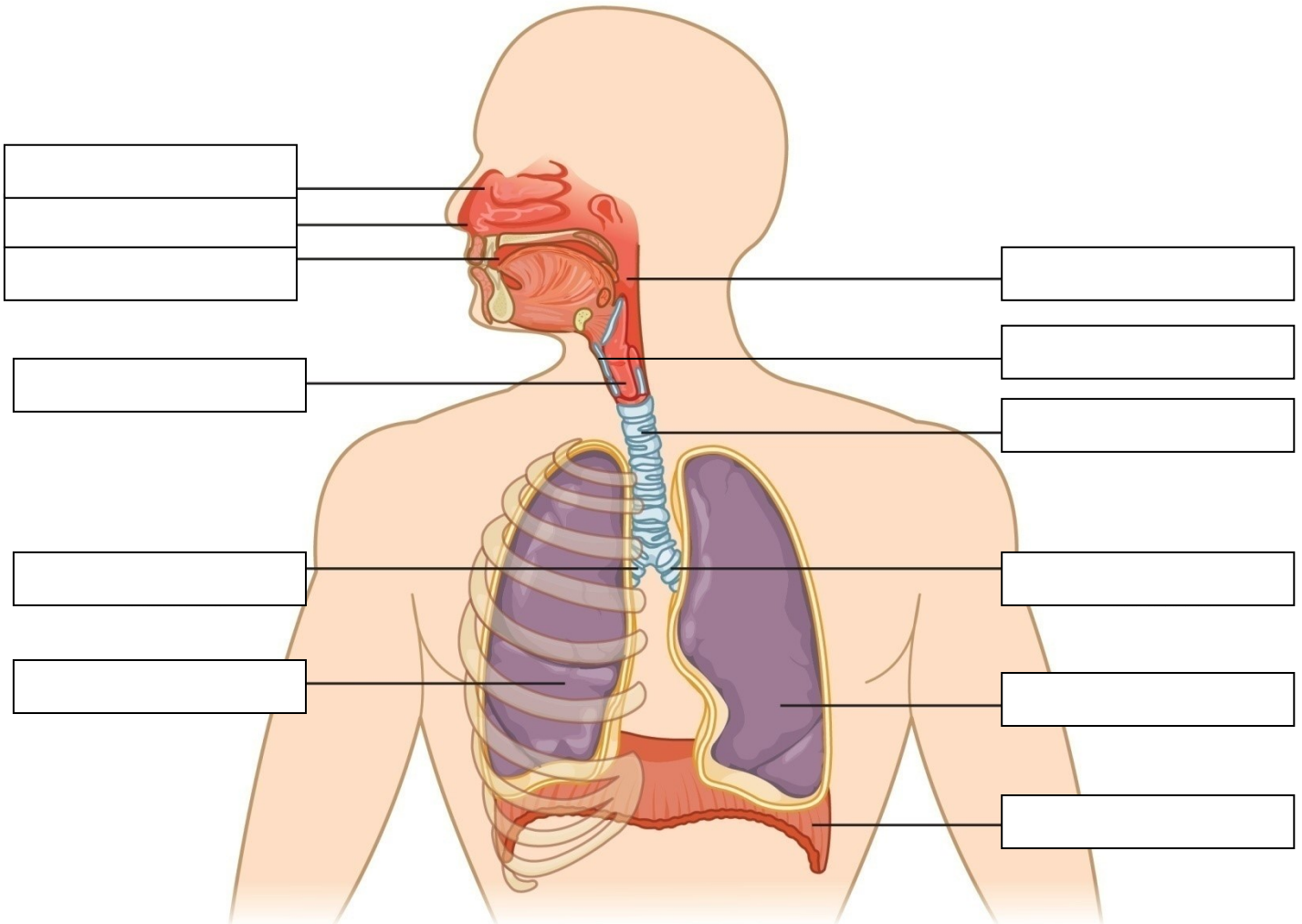
www.laryngectomy.org.uk

WORKBOOK

Section 1 Anatomy & Physiology

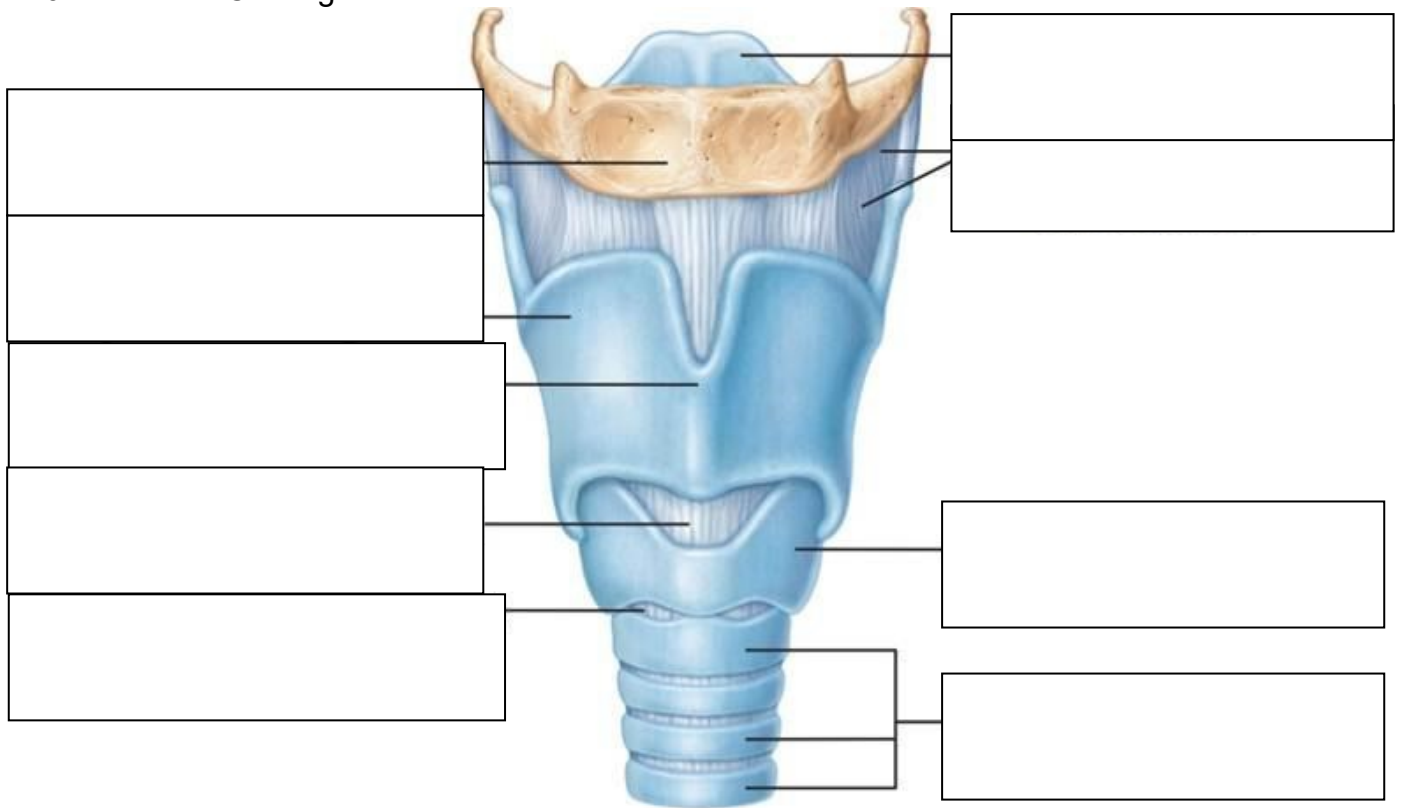
1. Please label the diagram of the respiratory system (below), identifying the following:

- Nasal Cavity
- Nostril
- Oral Cavity
- Pharynx
- Larynx
- Trachea
- Right Main Bronchus
- Left Main Bronchus
- Right Lung
- Left Lung
- Diaphragm
- Vocal Cords



Please label the diagram of the trachea (below), identifying the following:

- Epiglottis
- Hyoid Bone
- Thyroid Cartilage
- Laryngeal Prominence (Adams Apple)
- Cricothyroid Membrane
- Cricothyroid Ligament
- Cricothyroid Cartilage
- Cricotracheal Ligament
- Tracheal Cartilages



Section 2 Tracheostomy Insertion and Indications

1. Describe the process of respiration & breathing
2. What is a tracheostomy?
3. What are the indications for a tracheostomy? (5 reasons)
4. What is a mini tracheostomy and why would it be inserted?
5. What is a surgical tracheostomy and why would this type of trache be chosen?

6. What is a percutaneous tracheostomy and why would it be inserted?

7. What should be documented before and after the procedure?
(see appendix 1.)

8. What are the complications of a percutaneous tracheostomy?

Section 3: Tracheostomy Tube Types

1. What are the differences and benefits of each?

- Cuffed
- Un-cuffed
- Fenestrated
- Unfenestrated
- Single cannula
- Double cannula
- Subglottic suction
- Adjustable flange

2. List the advantages and disadvantages of an air-filled cuff on a tracheostomy tube

5. When should you suction a patient with a tracheostomy tube?

6. How do you accurately 'size' the suction catheter required

7. How far down should the suction catheter go?

8. What are the possible complications of suctioning?

9. How often should the tracheostomy stoma be visually assessed?

10. What type of technique should you employ when redressing a stoma?

11. How many people does it take to safely redress a stoma?

12. How often should the inner cannula (if present) be inspected and/or cleaned?

Section 5 Speech and language

1. Explain why good oral hygiene is essential when caring for a patient with a tracheostomy?

2. Why will a new tracheostomy patient be unable to speak

3. How can verbal communication/phonation be restored for a patient with a tracheostomy?

4. List some non-verbal methods of communication

5. List some effects which can be experienced by the loss of communication

6. List some contra-indications to the use of a speaking valve on a tracheostomy tube?

7. What will happen if a speaking valve is applied to a tracheostomy tube when the cuff is inflated?

8. When should a tracheostomy patient be referred to the Speech & Language Therapist (SLT)?

9. What affects can a tracheostomy have on a patient's ability to swallow?

10. What are the signs and symptoms of an impaired swallow?

11. List some interventions that might be recommended to prevent complications from dysphagia?

12. Why is it preferable to assess a patient for eating and drinking with the cuff deflated?

Section 6 Cuff Management

13. If tracheostomy tube is cuffed, how often should the tracheostomy cuff pressure be measured?

14. What is the recommended cuff pressure?

15. When should the cuff be deflated?

Section 7 Changing a Tracheostomy Tube

1. When planning a tube change, what must you always consider first?

2. Who should change the tube for:

- A patient with a new stoma

- A patient with a well-established stoma

7. What must you do if a blockage occurs in:

a. A single lumen tube

b. A double lumen tube

Now read Laryngectomy Section 10, before answering the questions on page 24.

Section 10 Patients with a Laryngectomy

This workbook section aims to provide a basic understanding of the anatomy, surgical procedure, and types of communication, post op and ongoing care of the laryngectomy patient. There will be a short series of questions to guide your learning at the end of this section

What is a laryngectomy?

A laryngectomy is surgical removal of the larynx (voice box) usually for throat cancer. There is no longer a connection between the patient's nose and mouth (upper airway) and the lungs. The patient can only breathe through their neck/stoma. The procedure is permanent and non-reversible, and completely isolates the mouth from the trachea.

The procedure profoundly alters voice, respiration and to varying degrees, swallowing and defaecating.

Surgical procedure

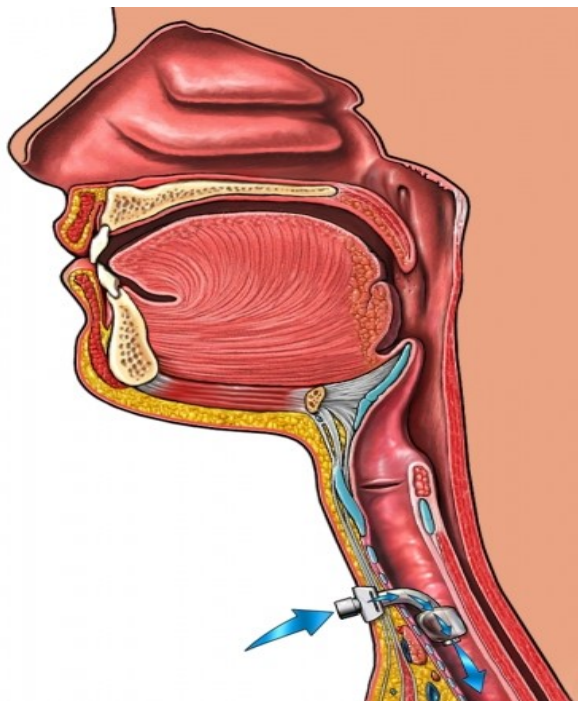
The larynx which produces voice and protects our lungs from aspiration is situated at the entrance to the trachea. It is protected by the epiglottis, a flap of tissue that stops food from entering the trachea, so preventing aspiration.

When the larynx is removed, the oesophagus and trachea become completely separated. The oesophagus still leads directly to the stomach but the severed trachea is now stitched into a new surgically-created opening in the neck which forms a permanent stoma the laryngectomy.

From this point on, all breathing takes place through the stoma. The nose and throat no longer have any part in breathing or coughing. Sputum will be expectorated via the stoma.

Eating and drinking is done in the normal way although the time it takes for successful restoration of this will be different from person to person. Because the larynx is also the front wall of the pharynx, the pharynx has to be repaired to create a new route for swallowing. This usually takes up to 14 days to heal before normal swallowing can recommence.

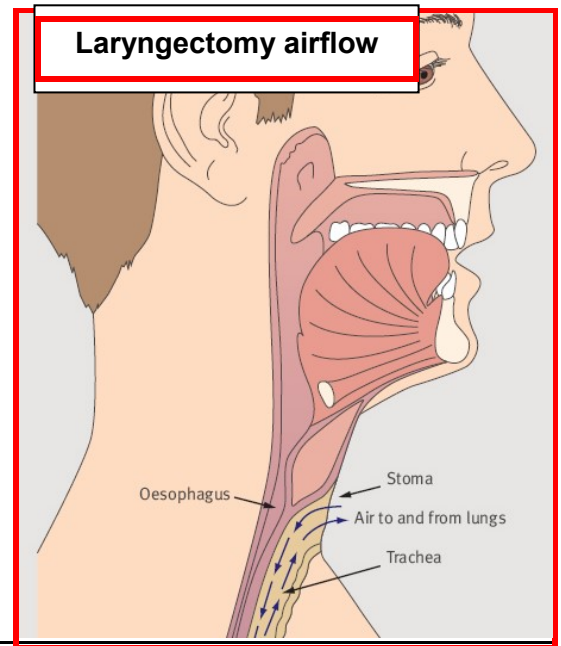
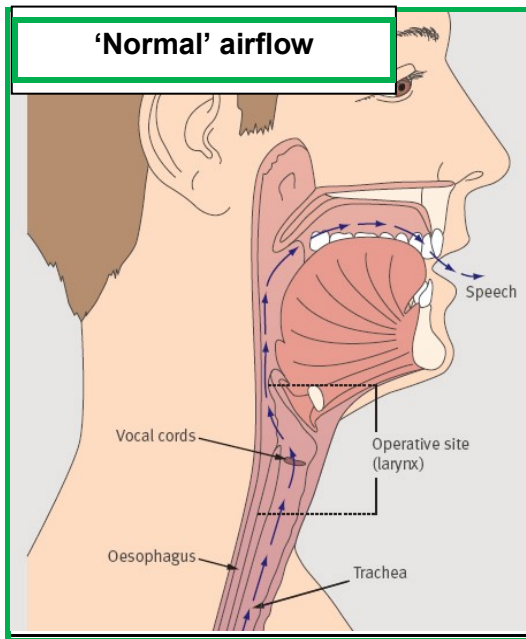
As the larynx is the normal vibratory source for speech, a new method of communication will need to be addressed for the patient.



A laryngeal stoma is always permanent.

- There is no route for air between the nose, mouth and lungs unless there is a specialist speaking prosthesis in situ. It should be noted that no resuscitation can take place via a laryngectomy speaking prosthesis.
- A laryngectomy stoma may not require a tube to keep it open. Some patients with small stomas will require a tube to maintain an adequate sized opening for airway toilet. Other patients may use a tube to house a filter device to maximise humidification.

Tracheostomy Airflow



Both tracheostomy and laryngectomy patients are classed as 'neck-breathers' and all members of the multidisciplinary team need to be aware of this vitally important fact, as these types of patients require **different airway support in an emergency**, than non-neck-breathers.

Always check the stoma for obstruction and if in any doubt as to whether the patient is a tracheostomy or laryngectomy patient, close the nose and mouth when performing resuscitation and resuscitate from the stoma.

The Critical Care Outreach Team must be made aware of any laryngectomy patients within Newcastle's Hospitals. They can offer onsite support and advice and will provide you with a red box, containing airway support equipment for use during an emergency resuscitation of a laryngectomy patient.

If you work in a different trust or organisation, please check to see what provision has been made for emergency airway equipment for laryngectomies in *your* area.

Care of the laryngeal stoma

This is a vital part of care for any laryngectomy patient. Cleaning of the stoma must be done at least twice a day -more frequently if the patient has a particularly productive chest resulting in excessive mucous production.

The stoma must always be kept clear of crusts or obstructions. In general, most laryngectomy patients will be able to conduct their own stoma care but if a patient is unwell they may need full assistance.

Care guidelines:

- Wear gloves and an apron when cleaning the stoma and have a light source available
- The patient will need a mirror at their bedside if performing their own stoma care
- Use plastic tweezers or Tilley's forceps to clean and clear crusts
- Use warm water and gauze to gently wipe around the stoma
- Caution should always be applied when using creams or ointments to the area. It may be advisable to check with the ENT surgeon, head and neck specialist nurse or the speech and language therapist first
- Lack of humidification to the stoma will result in a dry and crusty trachea. Saline nebulisers applied to the stoma via a trachy mask at least twice a day will prevent the formation of hard

dry mucous plugs forming in the first place.

- Some patients may be unable to cough up their secretions adequately and will benefit from suction. Remember if the suction catheter is introduced into the trachea it cannot do any damage if used with care and can be lowered as far as the carina.

The patient may or may not wear a stoma button or tube in their stoma. This will vary greatly from patient to patient. Most patients will usually cover their stoma with some type of cover. If in doubt and the patient is capable, ask them what their routine is, remember they are the expert!

If a patient is having radiotherapy to the neck, post-surgery, they will be advised not to apply anything adhesive to the neck such as a base plate for a stoma button, as this can cause further breakdown to the skin.

Communication

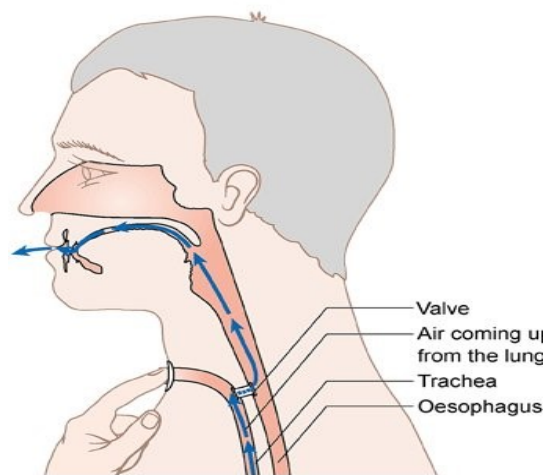
The vocal cords are contained within the larynx itself and are the vibratory source for speech. Therefore, the surgical removal of the larynx will *always* result in the patient being unable to speak. Although the loss of 'normal' speech is permanent, there are a few different methods of communication, post-laryngectomy:

Valve speech or surgical voice restoration

This is the most popular type of communication post –laryngectomy, but it is not suitable for everyone.

The surgeon will create a fistula or TEP (trache-oesophageal puncture) between the back wall of the trachea and front wall of the oesophagus so that air can move from the lungs to the mouth for speech. A speech prosthesis is then inserted into this fistula, enabling the patient to speak when they occlude the stoma. This one-way prosthesis is designed to prevent the backflow of food and saliva into the trachea and it also prevents the TEP itself from closing.

The patient occludes the stoma with a thumb or finger which then pushes the air through the prosthesis and into the oesophagus. As the air travels up the oesophagus to the mouth, it causes a vibration in the upper oesophagus and this sound is carried to the mouth which allows the patient to speak. Accents and mannerisms will remain the same.



Speech Prosthesis can be in-dwelling (requiring placement or change by the head and neck team) or ex-dwelling (the patient is taught to change these independently).

Speech prosthesis will eventually leak for many different reasons. This will cause the patient to cough when taking a drink. Cleaning the prosthesis with the special prosthesis brush may be enough to stop the leakage temporarily, but usually leakage is an indication that the prosthesis is due to be changed.

Daily cleaning of the prosthesis is extremely important for the patient to optimise their speech.

Some patients who wear *ex-dwelling* prosthesis are able to change it themselves but others who wear *in-dwelling* prosthesis will need to have the prosthesis changed by the Speech and Language Therapist.

Artificial Larynx (Servox)

The Servox is an electronic device which produces a mechanical sound. The device is held to the patient's neck or cheek. The vibrations pass through the neck tissues and up to the mouth where words are formed in the usual way. The Servox needs a charged battery to work and will always come with a charging device.

Oesophageal Speech

Oesophageal speech is not used very often, but can be extremely effective. In this case, the patient does not have to occlude the stoma to achieve speech.

The method works by injecting air with the tongue into the oesophagus. This air then travels back up the oesophagus and causes the muscles in the upper oesophagus to vibrate creating a sound source for speech. The words are then formed as usual.

Some patients who use this type of communication will also use a speech prosthesis to communicate with as well.

Silent Articulation

All laryngectomy patients will have had some experience in using silent articulation early in the post-operative phase. This looks like speech, but without the sound.

However for a small percentage of patients this will be their preferred method of communication. A skilled user will communicate extremely effectively but it has its limitations and cannot be used over the telephone as it relies on a face-to-face contact.

It is always worth encouraging the patient to use pen and paper to assist when appropriate, but remember not all patients can write.

Laryngectomy questions: Must be completed prior to attendance to the course.

1. How does the formation of a laryngectomy stoma differ from that of a tracheostomy?

2. When caring for a laryngectomy, how often should the stoma be cleaned?

3. List the essential equipment required for the daily care of a laryngectomy:

4. How can you check that a laryngectomy speech prosthesis is not leaking?

5. If a leak is suspected, what should you do?

6. If a laryngectomy speaking prosthesis is completely dislodged, how long will it take the fistula to close?

7. From whom can you obtain emergency airway support equipment in *your* area?

8. What are the differences when resuscitating a laryngectomy patient, compared to a tracheostomy patient?

Section 11 Learning Contract

The learning contract is to facilitate the practitioner gaining experience in the management of tracheostomy care, specifically: suction, dressing change and tube change or appropriate referral to facilitate tube change.

Following attendance at the study days the practitioner will negotiate with the ward sister/line manager to complete the practical experience necessary to achieve competency in tracheostomy care. These aspects of tracheostomy care will be identified by the ward sister/line manager. Whilst it would be desirable to gain experience in their own clinical area this may not always be possible therefore some nurses may need to negotiate time within either ITU/HDU through Outreach contacts:

- Freeman Hospital Dect phone 48817
- Royal Victoria Infirmary Dect phone; 23956

The assessment can be taken in either the practitioner's own clinical area or ITU/HDU.

I agree to releaseto obtain experience within ITU/HDU in order to gain competency in:

- Tracheostomy suction
- Tracheostomy dressing change
- Tracheostomy tube change or/and appropriate referral for tube change

SignedWard Sister/Manager Date.....

I agree to contact ITU/HDU to obtain access to tracheostomy patients in order to gain competency in:

- Tracheostomy suction
- Tracheostomy dressing change
- Tracheostomy tube change or/and appropriate referral for tube change

SignedNurse Date.....

(Delete any aspects of care which are not to be included in the assessment.)

Section 12 Clinical Competency and Assessment Documentation

Title	Tracheostomy and Laryngectomy Care Competency
Version No	Version 2
Effective From	September 2023
Expiry date	September 2026
Author/Developed by	Critical Care Education Team, Victoria Sample, Liz Place
Ratified By	Practice Development group
Date Ratified	September 2023

1. Introduction

- 1.1 A tracheostomy is a surgical opening in the anterior wall of the trachea to facilitate breathing; the opening is usually maintained by use of a tracheostomy tube. The procedure may be performed either surgically or by a percutaneous method.
- 1.2 Temporary – will be formed when patients require long/short term respiratory support or cannot maintain the patency of their own airway. They can also provide a degree of ‘protection’ of the airways against aspiration if the swallowing or neurological control mechanisms of the larynx or pharynx are damaged (commonly in head injuries or neurological diseases). Certain maxillofacial or ENT surgical procedures require a temporary tracheostomy to facilitate the procedure. These tubes will be removed if and when the patient recovers.
- 1.3 Long term/permanent – are used when the underlying condition is chronic, permanent or progressive. This includes carcinoma of the naso-oropharynx or larynx. Dependent on the stage of the disease either a tracheostomy or a laryngectomy will be performed. Some patients need chronic respiratory support or long-term airway protection and this requires a long term/permanent tracheostomy

2. Competency Scope

This competency applies to adult patients within Newcastle Acute Hospitals Trust and is intended for use for all adult patients with tracheostomies or laryngectomies. Advice may be sought from community leads regarding patients in the community setting, as equipment, staffing and clinical scenario are very different to that reviewed in this document. This competency is an amalgamation of the Newcastle Trust’s Tracheostomy and Laryngectomy Care guideline, the National Tracheostomy Safety Project Manual which includes adaptations to reflect Newcastle Trust’s practice and competencies developed by Newcastle Trust and Improving Tracheostomy Care.

This competency document applies to registered staff working within The Newcastle upon Tyne Hospitals NHS Foundation Trust who are involved in the assessment of competence in tracheostomy and laryngectomy care. This document does not cover the competency assessment of learners whose programme of study is managed by an external organisation (e.g. student nurse, midwife etc)

3. Aim

The aim of this competency document is to ensure a consistent high standard in the assessment of competence in relation to tracheostomy and laryngectomy care within The Newcastle upon Tyne Hospitals NHS Foundation Trust.

4. Prerequisites to competency assessment

- To be employed in an area that takes patients with tracheostomies or laryngectomies.
- Can discuss the anatomy and physiology of the upper airway
- Can discuss the indications for a tracheotomy/laryngectomy
- Can discuss the altered anatomy and physiology of the patient with a tracheostomy
- Can discuss the altered anatomy and physiology of the patient with a laryngectomy
- Can discuss the differences in the management of laryngectomy and tracheostomy patients

Prior to formal competency assessment, it is recommended that individuals perform multiple supervised procedures which may be documented on the supervised practice record (Appendix 1).

To demonstrate consistency, supervised practice should be undertaken on separate occasions. It is recommended that supervised practice is performed on different days and on different patients. However, there is no maximum number of times the practitioner should carry out this skill under direct supervision. An action plan must be developed and regularly reviewed if competence is not achieved.

It is recommended to attend the Newcastle Trust Tracheostomy and Laryngectomy Care training programme.

5. Duties, roles and responsibilities

Trainee:

Once deemed competent, it is the practitioner's responsibility to maintain knowledge, skills and competence. Subsequent assessment may be required if there has been a change in personal circumstances e.g. gap in practice, or if concerns are raised regarding competence.

Assessor:

The assessor must be a registered practitioner who is already deemed competent in the practice of tracheostomy and laryngectomy care

The assessor must hold an up-to-date formal assessor qualification.

6. References

[Tracheostomy and Laryngectomy Care \(policies.app\)](#)

[Tracheostomy.org.uk Comprehensive Tracheostomy Care.pdf](#)

Clinical Competency Assessment Tool

Emergency Algorithm

Staff member: _____ (print) Designation: _____ Payroll Number: _____

Assessor: _____ (print) Designation: _____ Payroll Number: _____

Knowledge	Date achieved	Action Plan
1. Can discuss the importance of the correct use, position and documentation of a bed head sign		
2. Can describe the basic differences of the adult tracheostomy and laryngectomy bed head signs		
3. Has successfully completed an emergency algorithm training session		
4. Can discuss who to call for advanced airway help		

Performance	Date achieved	Action Plan
5. Can demonstrate where to find a colour copy of the correct type of bed head sign with attached emergency algorithm		
6. Can effectively access and use all emergency equipment		
7. Can identify and contact the appropriate expert airway personnel as necessary		
8. Can demonstrate the ability to assess the tracheostomy/laryngectomy patients breathing		
9. Can discuss the ability to assess the tracheostomy/laryngectomy tube patency <ul style="list-style-type: none"> a. Can remove speaking valve cap b. Can pass a suction catheter c. Can deflate the cuff d. Re-assess breathing 		
10. Can discuss the technique to remove the tracheostomy/laryngectomy tube		

<p>11. Can demonstrate or discuss the ability to perform primary emergency oxygenation in patients with patent upper airway and those without a patent upper airway:</p> <ol style="list-style-type: none"> a. Standard airway maneuvers b. Cover the stoma c. Bag-valve-mask d. Oral and nasal airway adjuncts e. Tracheostomy tube f. Tracheostomy stoma ventilation g. Paediatric face mask to stoma h. Laryngeal mask (LMA) applied to stoma <p>12. Can describe in detail the absence of upper airway with laryngectomy patients and its implications for resuscitation</p>		
--	--	--

Professional Approach	Date achieved	Action Plan
13. Maintains patient privacy and dignity at all times		
14. Maintains a professional approach at all times		
15. Works within sphere of competence and escalates anything out with this sphere		

Action Plan - to be used when further actions are required before competence can be achieved.

No.	Action agreed:	Review date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referral to manager - to be used when an action plan has not resulted in competence being achieved and further action is necessary.

Reason for referral:

Signatures to confirm that full competence is achieved:

Staff member: _____ Date: _____

Printed Name and Signature of Assessor: _____ Date: _____

Supervised Practice Record

There is no maximum or minimum requirement for supervised practices, competency assessment should be undertaken when the practitioner and assessor feel confident in the practitioner's ability.

No. of Practices	Date	Supervisors Name Print/Signature & Designation	Trainee Name Print/Signature & Designation	Comments
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Clinical Competency Assessment Tool

Effective and early recognition of tracheostomy “Red Flags” and complications

Staff member: _____(print) Designation: _____ Payroll Number: _____

Assessor: _____(print) Designation: _____ Payroll Number: _____

Knowledge	Date achieved	Action Plan
1. Can identify all emergency equipment. <ul style="list-style-type: none"> a. Suction device and correct size suction catheters b. Oxygen with correct delivery system (tracheostomy mask, paediatric mask, Bag-Valve-Mask. T-piece or Waters circuit as applicable) c. Tracheostomy box and laryngectomy box standard d. Resuscitation/advanced airway trolley 		
2. Explains when and how to call for expert airway help		
3. Can discuss the tracheostomy “Red Flags” <ul style="list-style-type: none"> a. Airway b. Breathing c. Tracheostomy-specific d. General 		
4. Can identify the general complications of a tracheostomy/laryngectomy and discuss the effective and early treatment of <ul style="list-style-type: none"> a. Tube blockage b. Tube displacement c. Increased viscosity/dry secretions d. Increased chest infections e. Bleeding 		

Performance	Date achieved	Action Plan
5. Can identify the general complications of a tracheostomy/laryngectomy and discuss the effective and early treatment of <ul style="list-style-type: none"> a. Tube blockage b. Tube displacement c. Increased viscosity/dry secretions d. Increased chest infections e. Bleeding 		

Professional Approach	Date achieved	Action Plan
6. Maintains patient privacy and dignity at all times		
7. Maintains a professional approach at all times		
8. Works within sphere of competence and escalates anything out with this sphere		

Action Plan - to be used when further actions are required before competence can be achieved.

No.	Action agreed:	Review date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referral to manager - to be used when an action plan has not resulted in competence being achieved and further action is necessary.

Reason for referral:

Signatures to confirm that full competence is achieved:

Staff member: _____ Date: _____

Printed Name and Signature of Assessor: _____ Date: _____

Supervised Practice Record

There is no maximum or minimum requirement for supervised practices, competency assessment should be undertaken when the practitioner and assessor feel confident in the practitioner's ability.

No. of Practices	Date	Supervisors Name Print/Signature & Designation	Trainee Name Print/Signature & Designation	Comments
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Clinical Competency Assessment Tool

Laryngectomy care: Can demonstrate the skill required to care for a laryngectomy patient

Staff member: _____ (print) Designation: _____ Payroll Number: _____

Assessor: _____ (print) Designation: _____ Payroll Number: _____

Knowledge	Date achieved	Action Plan
1. Discusses the anatomical changes to the airway following a laryngectomy		
2. Discusses the different types of laryngectomy stoma equipment: <ul style="list-style-type: none"> a. Stoma button b. Laryngectomy tube c. Baseplates and HME cassettes 		
3. Demonstrate how to clean a voice prosthesis (as per manufactures guidance)		
4. Explains how to identify when voice prosthesis may need changing.		
5. Identifies who to contact to change the prosthesis in hours and out of hours		
6. Discusses other methods of communication i.e. electrolarynx		
7. Discusses the method for emergency airway management		

Professional Approach	Date achieved	Action Plan
8. Demonstrates an awareness of the legal and professional issues.		
9. Communicates effectively with patient; alleviating any anxiety or concerns		
10. Keeps the patient informed of actions throughout the procedure + scope of practice		

Action Plan - to be used when further actions are required before competence can be achieved.

No.	Action agreed:	Review date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referral to manager - to be used when an action plan has not resulted in competence being achieved and further action is necessary.

Reason for referral:

Signatures to confirm that full competence is achieved:

Staff member: _____ Date: _____

Printed Name and Signature of Assessor: _____ Date: _____

Supervised Practice Record

There is no maximum or minimum requirement for supervised practices, competency assessment should be undertaken when the practitioner and assessor feel confident in the practitioner's ability.

No. of Practices	Date	Supervisors Name Print/Signature & Designation	Trainee Name Print/Signature & Designation	Comments
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Clinical Competency Assessment Tool

Suction Technique

Staff member: _____ (print) Designation: _____ Payroll Number: _____

Assessor: _____ (print) Designation: _____ Payroll Number: _____

Knowledge	Date achieved	Action Plan
1. Can discuss the main complication tracheostomy/laryngectomy suctioning a. Trauma/Bleeding b. Hypoxia c. Bradycardia d. Bronchospasm e. Pain/anxiety		
2. Can highlight potential areas where infection may be introduced if ANTT is not maintained		
3. Can discuss the risks associated with patients with fenestrated tubes.		
4. Can discuss knowledge of the anatomy and physiology of the trachea		
5. Can identify BLS requirements in the event of CPR being required		
6. Demonstrates an understanding of the patient's history and the rationale for tracheostomy with this patient group.		
7. Identifies when suctioning should be performed and the maximum number of episodes to be carried out in succession		

Performance	Date achieved	Action Plan
8. Correct identification of patient.		
9. Correct explanation of procedure to patient		
10. Checks and prepares all necessary equipment		
11. Switches suction unit on and checks suction pressure on circuit occlusion does not exceed-150 mm Hg or 20kPa pressure		
12. Ensures an appropriate non-fenestrated inner tube is in place		

13. Pre-oxygenation if appropriate		
14. Performs hand hygiene and dons appropriate PPE		
15. Removes tracheostomy devices prior to open suctioning		
16. Connects suction catheter keeping catheter tip covered (sterile)		
17. Dons sterile suction glove		
18. Suctions as per Trust guideline		
19. Assess the patient's condition post suction, identifies the need for further suctioning if appropriate		
20. If O ₂ delivery was increased, reviews for return to previous level.		
21. Flushes through the connection tubing with the clean water, as per manufacturers guidance.		
22. Decontaminate hands as per trust policy		
23. Disposes of waste in accordance with Trust policy		
24. Appropriate documentation completed including post-suction observations		

Professional Approach	Date achieved	Action Plan
25. Demonstrates an awareness of the legal and professional issues		
26. Maintains patient privacy and dignity at all times		
27. Maintains a professional approach at all times		
28. Works within sphere of competence and escalates anything out with this sphere		

Action Plan - to be used when further actions are required before competence can be achieved.

No.	Action agreed:	Review date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referral to manager - to be used when an action plan has not resulted in competence being achieved and further action is necessary.

Reason for referral:

Signatures to confirm that full competence is achieved:

Staff member: _____ Date: _____

Printed Name and Signature of Assessor: _____ Date: _____

Supervised Practice Record

There is no maximum or minimum requirement for supervised practices, competency assessment should be undertaken when the practitioner and assessor feel confident in the practitioner's ability.

No. of Practices	Date	Supervisors Name Print/Signature & Designation	Trainee Name Print/Signature & Designation	Comments
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Clinical Competency Assessment Tool

Humidification

Staff member: _____ (print) Designation: _____ Payroll Number: _____

Assessor: _____ (print) Designation: _____ Payroll Number: _____

Knowledge	Date achieved	Action Plan
1. Can describe the normal anatomical humidification processes		
2. Discuss the importance of humidification in the patient with a tracheostomy or laryngectomy and describe appropriate methods of humidification		

Performance	Date achieved	Action Plan
3. Can describe and apply (set up) the different methods of humidification <ul style="list-style-type: none"> a. Warm humidification b. Cold bath humidification c. Humidification and Moisture Exchange (HME's) e.g. Swedish Nose d. Laryngectomy bib e. Nebulisers 		
4. Can assess and document the effectiveness of the applied humidification		

Professional Approach	Date achieved	Action Plan
5. Maintains patient privacy and dignity at all times		
6. Maintains a professional approach at all times		
7. Works within sphere of competence and escalates anything out with this sphere		

Action Plan - to be used when further actions are required before competence can be achieved.

No.	Action agreed:	Review date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referral to manager - to be used when an action plan has not resulted in competence being achieved and further action is necessary.

Reason for referral:

Signatures to confirm that full competence is achieved:

Staff member: _____ Date: _____

Printed Name and Signature of Assessor: _____ Date: _____

Supervised Practice Record

There is no maximum or minimum requirement for supervised practices, competency assessment should be undertaken when the practitioner and assessor feel confident in the practitioner's ability.

No. of Practices	Date	Supervisors Name Print/Signature & Designation	Trainee Name Print/Signature & Designation	Comments
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Clinical Competency Assessment Tool

Tracheostomy dressing change

Staff member: _____ (print) Designation: _____ Payroll Number: _____

Assessor: _____ (print) Designation: _____ Payroll Number: _____

Knowledge	Date achieved	Action Plan
1. Discusses infection prevention and control principles as per Trust policy.		
2. Explains anatomy and physiology of the trachea		
3. Discusses patient's history and the rationale for tracheostomy with this patient		
4. Explains the following when assessing stoma: <ul style="list-style-type: none"> a. Sign of infection b. Purulent discharge c. Pain d. Odour e. Abscess formation f. Cellulitis and discolouration g. Hypergranulation granulomas 		

Performance	Date achieved	Action Plan
5. Performs routine safety checks to ensure equipment is working correctly.		
6. Correctly identifies patient		
7. Discusses procedure with the patient and gains consent if appropriate		
8. Ensures competent colleague is available to assist in securing tracheostomy		
9. Prepares dressing trolley and gathers equipment		
10. Performs hand hygiene and dons appropriate PPE		
11. Positions the patient appropriately, removing any clothing that will impede procedure		
12. Ensures tracheostomy is secure prior to commencing procedure		

13. Assess the stoma for signs of infection, inflammation, or trauma		
14. Takes a swab if there are any signs of infection		
15. Performs dressing change safely and effectively as per local guideline ensuring minimal movement of tube		
16. Keeps the patient informed of actions throughout the procedure		
17. Communicates effectively with colleague; ensuring the tube is securely held in place throughout the procedure.		
18. Re-secure the tube using an appropriate tie		
19. Disposal of waste in accordance with Trust policy		
20. Appropriate documentation completed including post-dressing change observations.		

Professional Approach	Date achieved	Action Plan
21. Demonstrates an awareness of the legal and professional issues.		
22. Communicates effectively with patient; alleviating any anxiety or concerns		

Action Plan - to be used when further actions are required before competence can be achieved.

No.	Action agreed:	Review date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referral to manager - to be used when an action plan has not resulted in competence being achieved and further action is necessary.

Reason for referral:

Signatures to confirm that full competence is achieved:

Staff member: _____ Date: _____

Printed Name and Signature of Assessor: _____ Date: _____

Supervised Practice Record

There is no maximum or minimum requirement for supervised practices, competency assessment should be undertaken when the practitioner and assessor feel confident in the practitioner's ability.

No. of Practices	Date	Supervisors Name Print/Signature & Designation	Trainee Name Print/Signature & Designation	Comments
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Clinical Competency Assessment Tool

Caring for inner cannula

Staff member: _____ (print) Designation: _____ Payroll Number: _____

Assessor: _____ (print) Designation: _____ Payroll Number: _____

Knowledge	Date achieved	Action Plan
1. Demonstrates knowledge of the anatomy and physiology of the trachea		
2. Explains the patient's history and the rationale for tracheostomy with this patient group.		
3. Can explain the differences in tracheostomy tubes and implications for inner cannula care		
4. Describes equipment to be maintained at bedside.		
5. Can describe the minimum frequency that the inner tube needs to be replaced as per recommendations.		
6. Can describe the action to be taken if the inner cannula is fully or partially blocked with secretions		
7. Explains the action to be taken if there is difficulty in removing the inner tube and how to escalate appropriately		

Performance	Date achieved	Action Plan
8. Performs routine safety checks to ensure equipment is working correctly		
9. Explains procedure with the patient and gains consent as appropriate,		
10. Decontaminates hands and dons appropriate PPE as per Trust policy		
11. Ensures airway is clear prior to procedure commencing, performs tracheal suction if necessary		
12. Stabilises the outside of the tracheostomy tube and removes inner tube with minimal movement.		
13. If the inner tube is clean and clear of secretions, simply reinsert and no further cleaning is required		
14. If inner tube requires cleaning, replace with clean/spare inner cannula whilst cleaning is taking place		
15. Shake excess water off inner cannula and place in covered clean container to dry prior to re-use		
16. Ensures the cannula is locked into place as per the manufacturer's instructions		

17. Monitors amount and consistency of secretions for adequacy of humidification and infection.		
18. Disposes of waste in accordance with Trust policy		
19. Appropriate documentation completed including post-inner cannula change observations		
20. Ensures the patient is observed post procedure for any signs of complications		
21. Adheres to Trust Infection Prevention and Control policy throughout procedure		

Professional Approach	Date achieved	Action Plan
22. Demonstrates an awareness of the legal and professional issues.		
23. Communicates effectively with patient; alleviating any anxiety or concerns		
24. Keeps the patient informed of actions throughout the procedure		
25. Works within scope of practice		

Action Plan - to be used when further actions are required before competence can be achieved.

No.	Action agreed:	Review date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referral to manager - to be used when an action plan has not resulted in competence being achieved and further action is necessary.

Reason for referral:

Signatures to confirm that full competence is achieved:

Staff member: _____ Date: _____

Printed Name and Signature of Assessor: _____ Date: _____

Supervised Practice Record

There is no maximum or minimum requirement for supervised practices, competency assessment should be undertaken when the practitioner and assessor feel confident in the practitioner's ability.

No. of Practices	Date	Supervisors Name Print/Signature & Designation	Trainee Name Print/Signature & Designation	Comments
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Clinical Competency Assessment Tool

Cuff Management Deflation and Cuff Pressures

Staff member: _____ (print) Designation: _____ Payroll Number: _____

Assessor: _____ (print) Designation: _____ Payroll Number: _____

Knowledge	Date achieved	Action Plan
1. Demonstrates knowledge of the anatomy and physiology of the trachea		
2. Demonstrates an understanding of the patient's history and the rationale for tracheostomy with this patient group.		
3. Describes optimal tracheostomy tube cuff pressure reading as per Trust policy		
4. Identifies and safely uses a cuff pressure manometer where available.		
5. Accurately documents routine tracheostomy cuff pressure observations.		
6. Describe the signs of a tracheostomy cuff leak and discuss the reporting and correct remedial action.		
7. Accurately documents tracheostomy cuff leak issues and the action taken.		
8. Describes equipment to be maintained at bedside.		

Performance	Date achieved	Action Plan
Cuff Management:		
9. Decontaminates hands and dons appropriate PPE		
10. Performs routine safety checks to ensure equipment is working correctly		
11. Explains procedure with the patient and gains consent as appropriate.		
12. Suctions secretions via tracheostomy and/or mouth (where necessary); to remove secretions prior to cuff deflation and minimise the risk of aspiration.		
13. Uses manometer to connect pilot balloon to gauge the cuff pressure is between 20-30 cm H ² O		
14. Takes appropriate action if the cuff pressure is above or below this.		

15. Reconnects cuff manometer to ensure that cuff pressure is no higher than 30 cm H ² O		
16. Listens for upper airway sounds, if ventilated; checks ventilator parameters are appropriate and no audible or detected air leaks are present.		
17. Adheres to Trust Infection Prevention and Control policy throughout procedure		
Cuff Deflation		
18. Suctions secretions via tracheostomy and/or mouth (where necessary); to remove secretions prior to cuff deflation and minimise the risk of aspiration.		
19. Deflates the cuff slowly using a clean syringe to aspirate air from the cuff		
20. Assesses patient comfort, respiratory rate and oxygen saturation throughout the procedure.		
21. Provides continuous assessment for the need for re-inflation and re-inflates cuff if required		
22. Adheres to Trust Infection Prevention and Control policy throughout procedure		
23. Appropriate documentation completed including post-deflation observations		
24. Disposal of waste in accordance with Trust policy		

Professional Approach	Date achieved	Action Plan
25. Demonstrates an awareness of the legal and professional issues.		
26. Communicates effectively with patient, alleviating any anxiety or concerns		
27. Keeps the patient informed of actions throughout the procedure		
28. Works within sphere of competence and escalates anything out with this sphere		

Action Plan - to be used when further actions are required before competence can be achieved.

No.	Action agreed:	Review date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referral to manager - to be used when an action plan has not resulted in competence being achieved and further action is necessary.

Reason for referral:

Signatures to confirm that full competence is achieved:

Staff member: _____ Date: _____

Printed Name and Signature of Assessor: _____ Date: _____

Supervised Practice Record

There is no maximum or minimum requirement for supervised practices, competency assessment should be undertaken when the practitioner and assessor feel confident in the practitioner's ability.

No. of Practices	Date	Supervisors Name Print/Signature & Designation	Trainee Name Print/Signature & Designation	Comments
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Clinical Competency Assessment Tool

Types of Communication with Tracheostomy or Laryngectomy

Staff member: _____ (print) Designation: _____ Payroll Number: _____

Assessor: _____ (print) Designation: _____ Payroll Number: _____

Knowledge	Date achieved	Action Plan
1. Discuss the different types of speaking valves available in the area.		
2. Explains how a speaking valve works		
3. Discuss appropriate use of a speaking valve, including local policies for head/neck surgery		
4. Discusses different communication methods i.e., pen and paper, tablet, picture charts or alphabet charts.		
5. Explains when and how to refer to SALT for specialist assessment or advice on communication difficulties		

Performance	Date achieved	Action Plan
6. Demonstrate how to safely attach and detach speaking valve in relation to tube in place		
7. Demonstrates how to clean and store the valve (as per manufacturers guidance)		

Professional Approach	Date achieved	Action Plan
8. Demonstrates an awareness of the legal and professional issues.		
9. Communicates effectively with patient; alleviating any anxiety or concerns		
10. Keeps the patient informed of actions throughout the procedure		

Action Plan - to be used when further actions are required before competence can be achieved.

No.	Action agreed:	Review date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referral to manager - to be used when an action plan has not resulted in competence being achieved and further action is necessary.

Reason for referral:

Signatures to confirm that full competence is achieved:

Staff member: _____ Date: _____

Printed Name and Signature of Assessor: _____ Date: _____

Supervised Practice Record

There is no maximum or minimum requirement for supervised practices, competency assessment should be undertaken when the practitioner and assessor feel confident in the practitioner's ability.

No. of Practices	Date	Supervisors Name Print/Signature & Designation	Trainee Name Print/Signature & Designation	Comments
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Clinical Competency Assessment Tool

Can Safely Transfer a Patient with a Tracheostomy or Laryngectomy

Staff member: _____ (print) Designation: _____ Payroll Number: _____

Assessor: _____ (print) Designation: _____ Payroll Number: _____

Knowledge	Date achieved	Action Plan
1. Discusses the safety implications of transferring a patient with tracheostomy or laryngectomy		
2. Has existing knowledge of equipment required and understand how to use it.		
3. Can identify all emergency equipment. <ul style="list-style-type: none"> e. Suction device and correct size suction catheters f. Oxygen with correct delivery system (tracheostomy mask, paediatric mask, Bag-Valve-Mask. T-piece or Waters circuit as applicable) g. Tracheostomy box and laryngectomy box standard 		
4. Explains when and how to call for expert airway help		

Performance	Date achieved	Action Plan
5. Can effectively identify and assemble the correct equipment required to safely transfer a patient with a tracheostomy or laryngectomy.		
6. Ensures all equipment has had pre use safety checks performed.		
7. Can identify and ensure that all the personnel required for a safe transfer are present (where applicable).		
8. Ensure that the receiving department/ward/unit is aware of the patient and are in agreement prior to transfer.		
9. Uses Tracheostomy or Laryngectomy Passport to handover the patient.		
10. Ensures that any ongoing issues with patient's tracheostomy or laryngectomy are identified and understood		

Professional Approach	Date achieved	Action Plan
11. Demonstrates an awareness of the legal and professional issues.		
12. Communicates effectively with patient; alleviating any anxiety or concerns		

13. Keeps the patient informed of actions throughout the procedure		
--	--	--

Action Plan - to be used when further actions are required before competence can be achieved.

No.	Action agreed:	Review date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referral to manager - to be used when an action plan has not resulted in competence being achieved and further action is necessary.
Reason for referral:

Signatures to confirm that full competence is achieved:

Staff member: _____ Date: _____

Printed Name and Signature of Assessor: _____ Date: _____

Supervised Practice Record

There is no maximum or minimum requirement for supervised practices, competency assessment should be undertaken when the practitioner and assessor feel confident in the practitioner's ability.

No. of Practices	Date	Supervisors Name Print/Signature & Designation	Trainee Name Print/Signature & Designation	Comments
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Clinical Competency Assessment Tool

Communication with family

Staff member: _____ (print) Designation: _____ Payroll Number: _____

Assessor: _____ (print) Designation: _____ Payroll Number: _____

Knowledge	Date achieved	Action Plan
1. Can discuss the psychosocial impact on the family		
2. Demonstrates awareness of local family education policy for those that wbe discharged with a tracheostomy or laryngectomy		
3. Can discuss available family support after discharge from hospital.		

Action Plan - to be used when further actions are required before competence can be achieved.

No.	Action agreed:	Review date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referral to manager - to be used when an action plan has not resulted in competence being achieved and further action is necessary.

Reason for referral:

Signatures to confirm that full competence is achieved:

Staff member: _____ Date: _____

Printed Name and Signature of Assessor: _____ Date: _____

Supervised Practice Record

There is no maximum or minimum requirement for supervised practices, competency assessment

should be undertaken when the practitioner and assessor feel confident in the practitioner's ability.

No. of Practices	Date	Supervisors Name Print/Signature & Designation	Trainee Name Print/Signature & Designation	Comments
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Clinical Competency Assessment Tool

Discharge Can demonstrate awareness of safe discharge from hospital of a patient with a tracheostomy or laryngectomy

Staff member: _____ (print) Designation: _____ Payroll Number: _____

Assessor: _____ (print) Designation: _____ Payroll Number: _____

Knowledge	Date achieved	Action Plan
1. Discusses the discharge process including: <ul style="list-style-type: none"> a. Register with ambulance service b. Set up an account with consumables supplier c. Follow-up appointment for tube change d. GP and district nurse referral e. Tracheostomy/laryngectomy equipment bag 		
2. Explains how to obtain a portable suction machine/nebuliser/other essential equipment if required.		
3. Explains the process of obtaining the necessary consumables		
4. Discusses which consumables should be sent with the patient on discharge		
5. Identifies the contact details to be given should issues arise on discharge (for example ward, nurse specialist, physiotherapist)		

Professional Approach	Date achieved	Action Plan
6. Demonstrates an awareness of the legal and professional issues		
7. Communicates effectively with patient; alleviating any anxiety or concerns		
8. Keeps the patient informed of actions throughout the procedure + scope of practice		

Action Plan - to be used when further actions are required before competence can be achieved.

No.	Action agreed:	Review date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referral to manager - to be used when an action plan has not resulted in competence being achieved and further action is necessary.

Reason for referral:

Signatures to confirm that full competence is achieved:

Staff member: _____ Date: _____

Printed Name and Signature of Assessor: _____ Date: _____

Supervised Practice Record

There is no maximum or minimum requirement for supervised practices, competency assessment should be undertaken when the practitioner and assessor feel confident in the practitioner's ability.

No. of Practices	Date	Supervisors Name Print/Signature & Designation	Trainee Name Print/Signature & Designation	Comments
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Clinical Competency Assessment Tool

Decannulation/removal of tracheostomy tube

Staff member: _____ (print) Designation: _____ Payroll Number: _____

Assessor: _____ (print) Designation: _____ Payroll Number: _____

Staff member must perform the decannulation checklist above before proceeding

Knowledge	Date achieved	Action Plan
1. Discusses the importance of a stage weaning approach and how this may typically unfold		
2. Is able to outline emergency airway management being required, identifying potential complications and appropriate action to be taken if necessary.		
3. Demonstrates knowledge of infection control issues as per Trust policy.		
4. Demonstrates knowledge of the anatomy and physiology of the trachea		
5. Demonstrates an understanding of the patient's history and the rationale for tracheostomy with this patient group.		
6. Discusses the importance of monitoring the successful closure of the tracheostomy stoma/fistula		
7. Discusses the complications of an open stoma regarding washing, bathing and entry of foreign bodies.		

Performance	Date achieved	Action Plan
8. Explains the procedure with the patient. Have communication aids available.		
9. Correct selection of equipment to be maintained at bedside.		
10. Washes hands and apply appropriate PPE to reduce the risk of crossinfection		
11. Initiates continuous oxygen saturation monitoring for procedure		
12. Ensures patient is sitting in an upright position.		
13. Stops any naso-gastric feed or oral intake for 4 hours pre-procedure.		
14. Aspirates NG tube		
15. Secures tracheostomy tube whilst undoing ties and removing all dressings in preparation for removal.		

16. Ensures cuff is deflated if present.		
17. Removes the tracheostomy on maximal inspiration.		
18. Prior to dressing application: checks for signs of respiratory distress and confirms patient can voice/cough whilst stoma occluded		
19. Using ANTT cleans the stoma site with saline and dresses site with a semi-permeable occlusive dressing.		
20. Ensures close observation of patient's respiratory status post-procedure as per local guidelines.		
21. Updates MDT post-procedure and clarifies further monitoring requirements, dressing needs and alert to possible complications		
22. Discusses the frequency of dressing changes.		

Professional Approach	Date achieved	Action Plan
23. Demonstrates an awareness of the legal and professional issues.		
24. Communicates effectively with patient; alleviating any anxiety or concerns		
25. Keeps the patient informed of actions throughout the procedure.		

Action Plan - to be used when further actions are required before competence can be achieved.

No.	Action agreed:	Review date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referral to manager - to be used when an action plan has not resulted in competence being achieved and further action is necessary.

Reason for referral:

Signatures to confirm that full competence is achieved:

Staff member: _____ Date: _____

Printed Name and Signature of Assessor: _____ Date: _____

Supervised Practice Record

There is no maximum or minimum requirement for supervised practices, competency assessment should be undertaken when the practitioner and assessor feel confident in the practitioner's ability.

No. of Practices	Date	Supervisors Name Print/Signature & Designation	Trainee Name Print/Signature & Designation	Comments
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Clinical Competency Assessment Tool

Changing of a Tracheostomy Tube

Changing the tracheostomy tube should be a multidisciplinary decision. The first change should always be performed or supervised by a suitably trained member of the medical staff.

Staff member: _____(print) Designation: _____ Payroll Number: _____

Assessor: _____(print) Designation: _____ Payroll Number: _____

In order to change a tracheostomy tube safely and appropriately, the practitioner must appreciate the specific clinical indications for the original formation of the individual patient's tracheostomy. In addition, they will need to know when and how the tracheostomy was formed. It is considered that a newly formed tracheostomy will close more quickly than an established tracheostomy tract, and indeed, within the first 48 hours of a surgical tracheostomy or 3-7 days for a percutaneous tracheostomy, extreme caution must be taken, as a tube change may be difficult or even impossible.

NB: If a difficult tube change is anticipated then a clinician experienced in upper airway management (including endotracheal intubation) and a clinician or practitioner proficient and experienced in managing tracheostomy tubes should be present. All relevant equipment and emergency anaesthetic drugs should be available. Plan for loss of airway and failure to cannulate the tracheostomy.

Knowledge	Date achieved	Action Plan
1. Discusses the following contra-indications to the tracheostomy tube change. a) Insitu for 7-10 days b) Unstable clinical condition c) Risk of losing the airway is high d) Patient is undergoing radiotherapy to the neck region; or has completed in the last two weeks e) In palliative care patients where quality of life will not be improved by tube change f) Patient refuses.		
2. Describes equipment to be maintained at bedside.		
3. Describes emergency airway management, identifying potential complications and appropriate action to be taken if necessary.		
4. Demonstrates knowledge of infection control issues as per Trust policy.		
5. Demonstrates knowledge of the anatomy and physiology of the trachea		
6. Demonstrates an understanding of the patient's history and the rationale for tracheostomy with this patient group.		

7. Explains when to keep patient nil by mouth and the reasons for this.		
---	--	--

Performance	Date achieved	Action Plan
1. Decontaminates hands and dons appropriate PPE		
2. Explains procedure the patient ensuring understanding and obtains verbal consent if appropriate		
3. Assembles appropriate equipment for method of change		
4. Prepares, checks and lubricates new tube, including removing any inner cannula from both old and new tubes.		
5. Performs routine safety checks to ensure equipment is working correctly. Sets up bedside suction and oxygen equipment		
6. Ensures appropriate staff and equipment are available.		
7. Ensures patient's neck area is accessible for tube change, removes any obstructing clothing or equipment		
8. Positions patient for procedure by placing a roll under the patient's shoulders, extending the neck. Patient may be placed lying down or sitting upright depending on individual patient assessment.		
9. Identifies the role of any stay sutures		
10. If the tracheostomy tube is sutured insitu, remove all sutures.		
11. Suctions via pharyngeal sub-glottic and oral route or via dedicated port on tube		
12. Deflates cuff (if present) simultaneously suctioning.		
13. Unties tapes and removes dressing whilst tube is held firmly in place		
14. Inserts guide via old tube (if using)		
15. Removes existing tube with a firm out-and-downwards movement as patient breathes out		
16. Holds the introducer (obturator) in place inserts new tube directly into stoma OR using the guide, railroad the new tube		
17. Removes introducer guide; to allow patient to breathe and to allow confirmation of correct tube position <ul style="list-style-type: none"> a. Checks correct positioning b. Ask patient to breathe out, air should be felt through end of tracheostomy c. Auscultate d. Bilateral chest movement e. Suction below the end of the tracheostomy to confirm placement within trachea 		

f. Capnography* g. Fibre optic endoscopy <i>*Capnography and endoscopy should be immediately available for difficult cases</i>		
Following successful exchange		
18. Re-attaches any oxygen or ventilation		
19. Inflates cuff and check cuff pressure (as per guidelines)		
20. Applies tapes and dressing (as per guidelines)		
21. Re-positions patient as to patient requirements and comfort		
22. Adheres to trust infection prevention and control policies during procedure		
23. Disposes of waste in accordance with Trust policy		
24. Appropriate documentation completed including post-tube change observations		

Professional Approach	Date achieved	Action Plan
25. Demonstrates an awareness of the legal and professional issues.		
26. Communicates effectively with patient; alleviating any anxiety or concerns		
27. Keeps the patient informed of actions throughout the procedure		

Action Plan - to be used when further actions are required before competence can be achieved.		
No.	Action agreed:	Review date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referral to manager - to be used when an action plan has not resulted in competence being achieved and further action is necessary. Reason for referral:

Signatures to confirm that full competence is achieved:

Staff member: _____ Date: _____

Printed Name and Signature of Assessor: _____ Date: _____

Supervised Practice Record

There is no maximum or minimum requirement for supervised practices, competency assessment should be undertaken when the practitioner and assessor feel confident in the practitioner’s ability.

No. of Practices	Date	Supervisors Name Print/Signature & Designation	Trainee Name Print/Signature & Designation	Comments
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Clinical Competency Assessment Tool

Can Perform Safe Sub-glottic Suction (if applicable to local practice)

Staff member: _____ (print) Designation: _____ Payroll Number: _____

Assessor: _____ (print) Designation: _____ Payroll Number: _____

Performance	Date achieved	Action Plan
1. Identifies the sub-glottic port.		
2. Demonstrate the ability to safely suction the sub-glottic as per local policy		
3. Accurately document the sub-glottic port aspirates		

Action Plan - to be used when further actions are required before competence can be achieved.

No.	Action agreed:	Review date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referral to manager - to be used when an action plan has not resulted in competence being achieved and further action is necessary.

Reason for referral:

Signatures to confirm that full competence is achieved:

Staff member: _____ Date: _____

Printed Name and Signature of Assessor: _____ Date: _____

Supervised Practice Record

There is no maximum or minimum requirement for supervised practices, competency assessment should be undertaken when the practitioner and assessor feel confident in the practitioner's ability.

No. of Practices	Date	Supervisors Name Print/Signature & Designation	Trainee Name Print/Signature & Designation	Comments
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Appendix 1. Insertion Check List

<h3 style="text-align: center;">Percutaneous Tracheostomy Insertion (OPCS code: E42.3)</h3>	
Date	Time
Pre-requisites	Neck anatomy, CVS stability, Oxygenation & Ventilation acceptable? Yes No
	Coagulation status acceptable/anticoagulants suspended? Yes No
	Date of failed trial of extubation : _ _ / _ _ / _ _ If not done record reason overleaf
WHO Checklist	Consent (Form 1) / Assent (Form 4) signed (delete as appropriate) Yes No
	Crossmatch/blood products required and completed/given? Yes N/A
	Sedation/analgesia/muscle relaxant available? Yes
	Rescue drugs (e.g. vasoconstrictors) available? Yes
	Appropriate airway equipment available and checked? Yes
	Any Known Allergies? Yes / No
Operator:	Bronchoscopy:
Grade:	Grade:
Supervisor:	
	Procedure
Elective re-intubation pre-insertion?	Yes No Uneventful? Yes No (detail overleaf)
Throat pack inserted?	Yes No Removed at end of procedure? Yes / NA
Local Anaesthetic to skin? <small>*(lignocaine 1% or Bupivacaine with/without adrenaline)</small>	Yes No <small>* delete as appropriate</small>
Blunt dissection to tracheal rings	Yes No
Trachea cannulated under direct vision	Yes No
SpO2 > 92% throughout	Yes No – detail overleaf
Position confirmed with EtCO2	Yes No
Insertion	Easy Average (If difficult detail overleaf) Difficult
Immediate complications	No Yes - detail overleaf
Trache tip distance above carina	cm
CXR required	Yes No
CXR requested	Yes No N/A
CXR reviewed	Yes No N/A

Percutaneous Tracheostomy Insertion

Appendix 2. Tracheostomy and laryngectomy bed sign

This patient has a
TRACHEOSTOMY

There is a potentially patent upper airway (Intubation may be difficult)

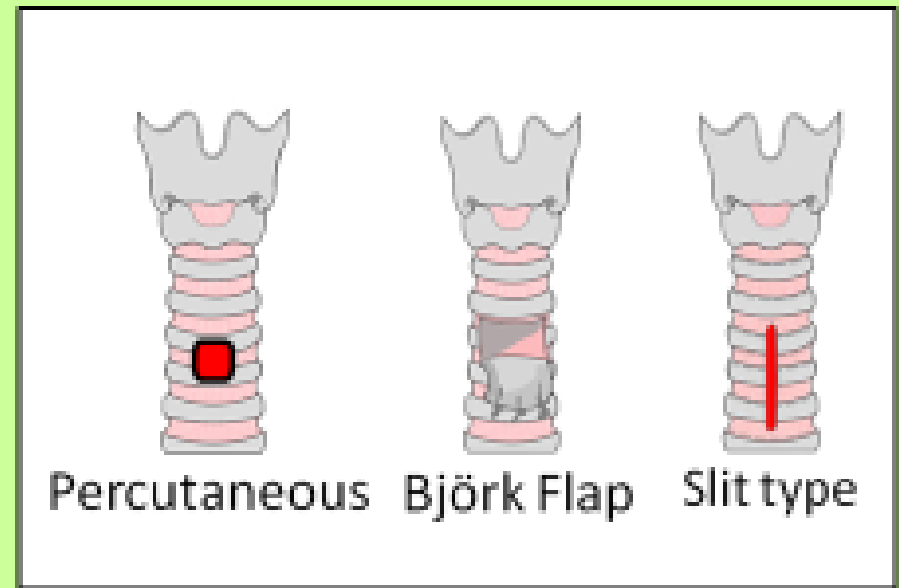
Surgical / Percutaneous

Performed on (date)

Tracheostomy tube size (if present)

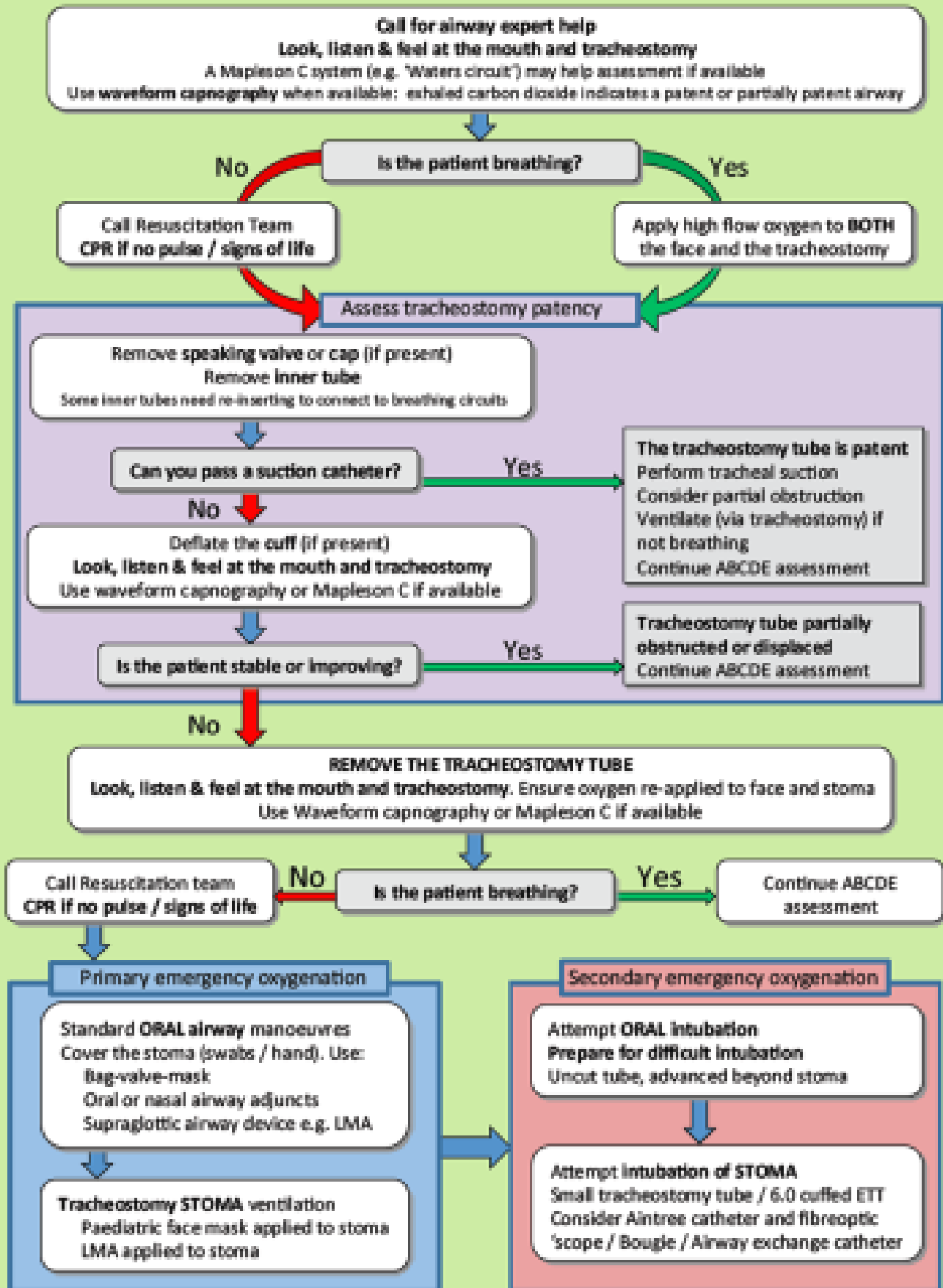
Hospital / NHS number

Notes: Indicate tracheostomy type by circling the relevant figure.
Indicate location and function of any sutures.
Laryngoscopy grade and notes on upper airway management.
Any problems with this tracheostomy.



Emergency Call: Anaesthesia ICU ENT MaxFax Emergency Team

Emergency tracheostomy management - Patent upper airway



National Tracheostomy Safety Project. Review date 1/1/24. Feedback & resources at www.tracheostomy.org.uk

This patient has a
LARYNGECTOMY
and CANNOT be intubated or oxygenated via the mouth

Follow the LARYNGECTOMY algorithm of breathing difficulties

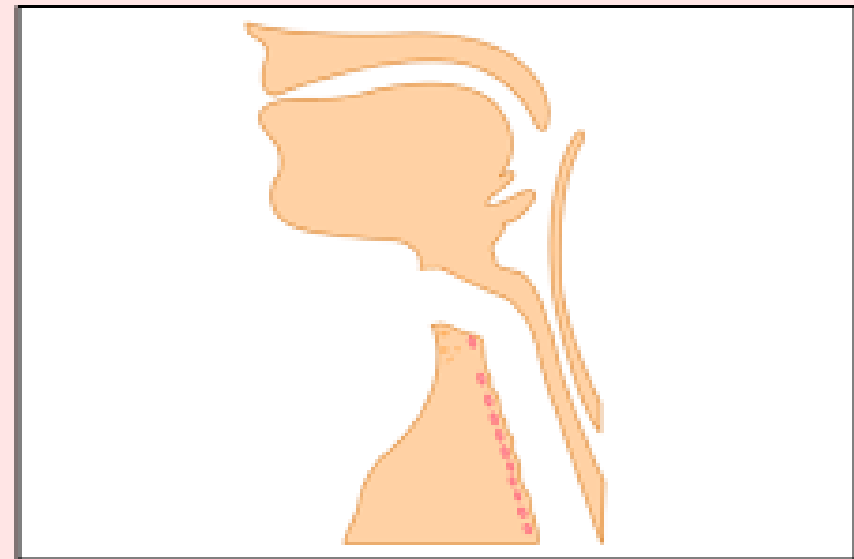
Performed on (date)

Tracheostomy tube size (if present)

Hospital / NHS number

Notes:

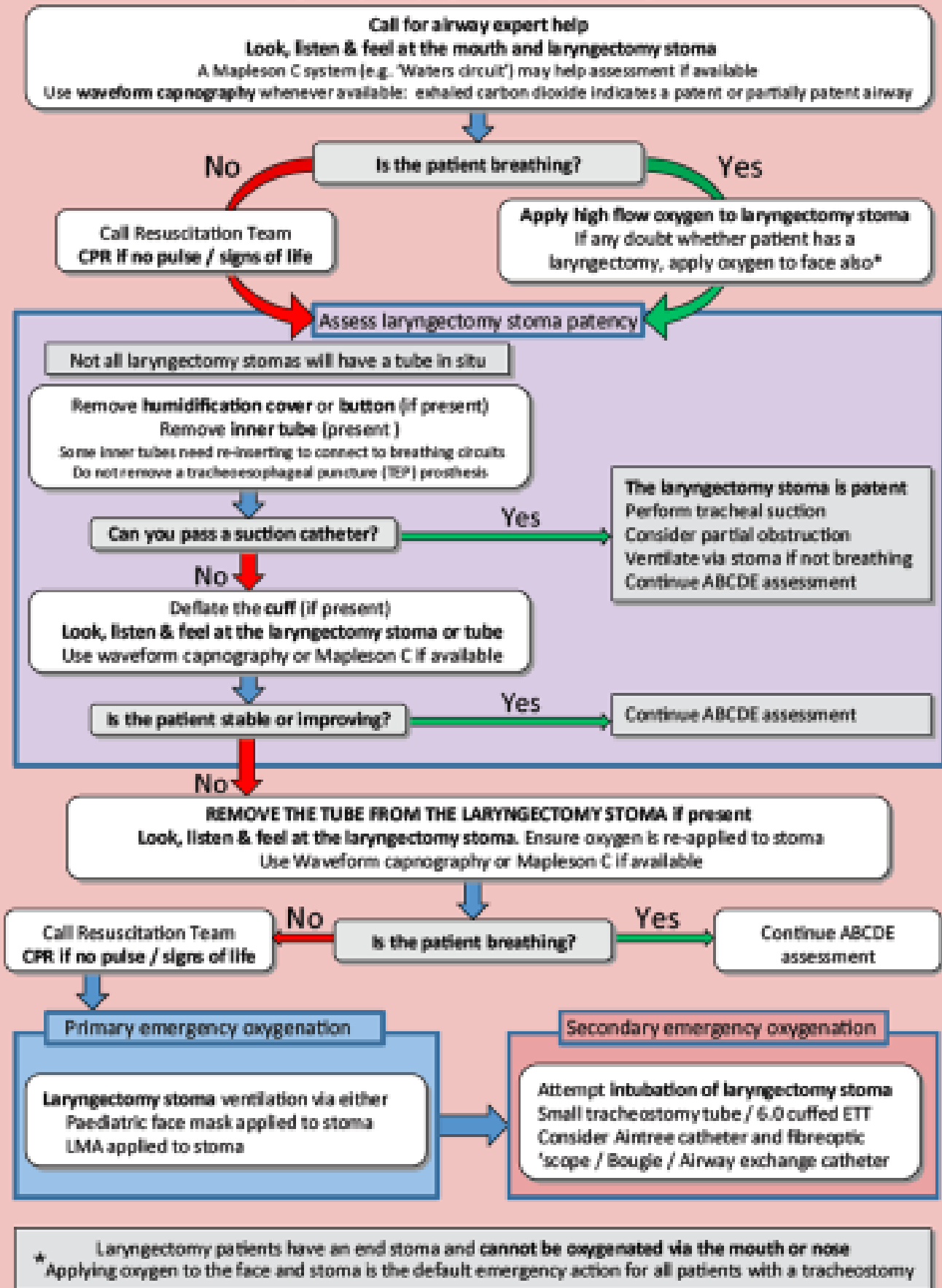
There may not be a tube in the stoma.
The trachea (wind pipe) ends at the neck stoma



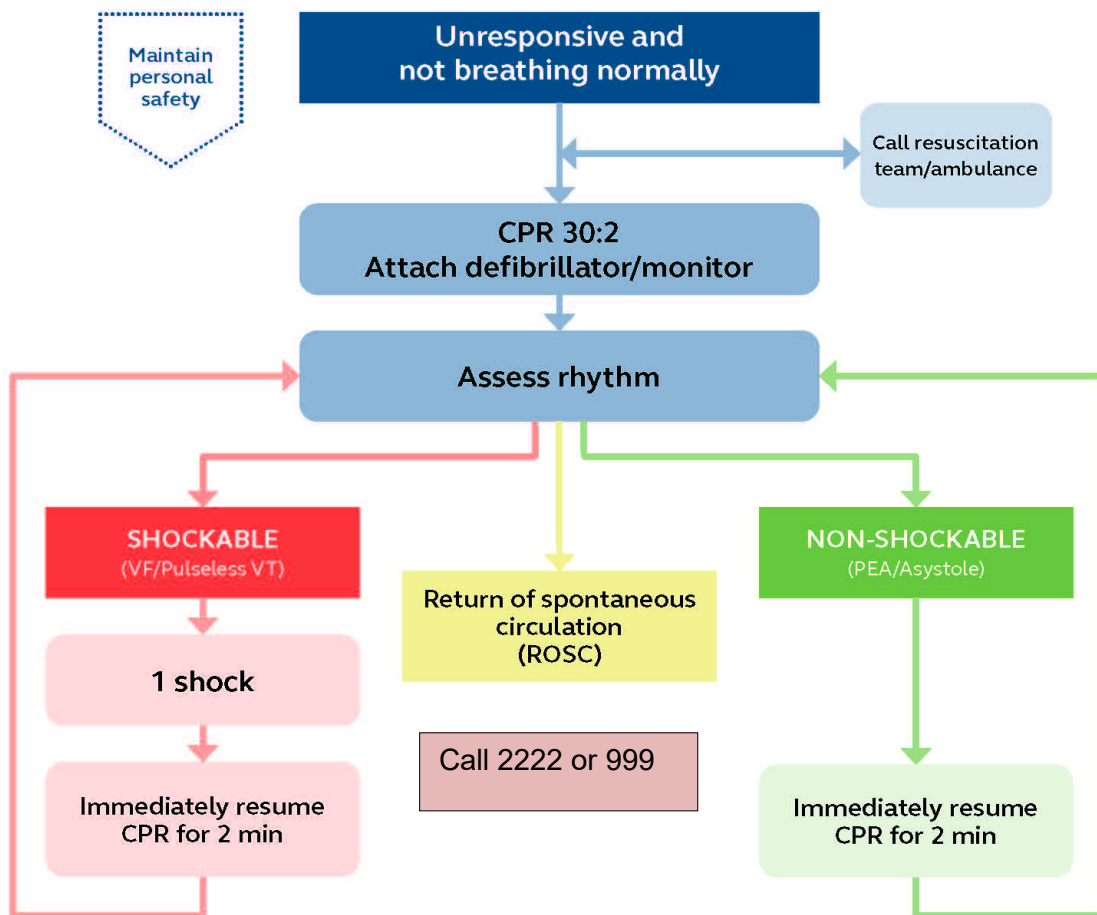
Emergency Call: Anaesthesia ICU ENT MaxFax Emergency Team

www.tracheostomy.org.uk

Emergency laryngectomy management



Adult advanced life support



Give high-quality chest compressions, and:

- Give oxygen
- Use waveform capnography
- Continuous compressions if advanced airway
- Minimise interruptions to compressions
- Intravenous or intraosseous access
- Give adrenaline every 3-5 min
- Give amiodarone after 3 shocks
- Identify and treat reversible causes

Identify and treat reversible causes

- Hypoxia
 - Hypovolaemia
 - Hypo-/hyperkalaemia/metabolic
 - Hypo/hyperthermia
 - Thrombosis – coronary or pulmonary
 - Tension pneumothorax
 - Tamponade – cardiac
 - Toxins
- Consider ultrasound imaging to identify reversible causes

Consider

- Coronary angiography/percutaneous coronary intervention
- Mechanical chest compressions to facilitate transfer/treatment
- Extracorporeal CPR

After ROSC

- Use an ABCDE approach
- Aim for SpO₂ of 94-98% and normal PaCO₂
- 12-lead ECG
- Identify and treat cause
- Targeted temperature management

Appendix 4 Swallow Screening For Tracheostomised Adult Patients

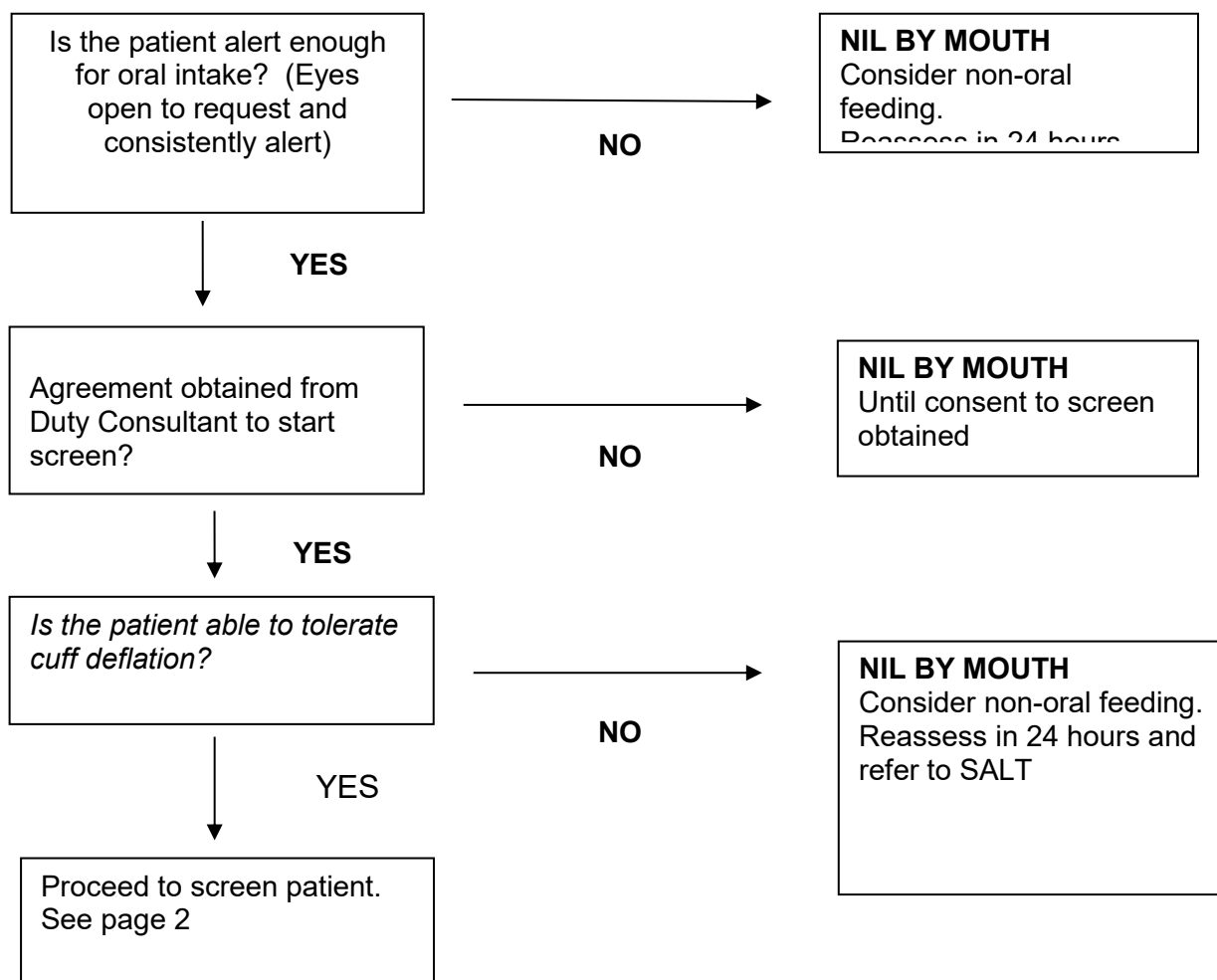
For initial assessment of tracheostomised patients who have been nil by mouth before starting oral intake

PLEASE AFFIX PATIENT LABEL

Pre-Screen Checklist

Does the patient have neurological impairment?	Y	N
Has the patient undergone head or neck surgery or have suspected head or neck cancer? (including any vocal fold pathology).	Y	N
Has the patient previous known dysphagia, e.g. modified diet or fluids	Y	N

If answer yes to any of the above DO NOT proceed with screen and refer to Speech and Language Therapy (SALT)



Screening Tool

IF AT ANY STAGE YOU ARE CONCERNED OR NEED ADVICE, PLEASE REFER TO SPEECH AND LANGUAGE THERAPY ON EXTENSION 24324 (RVI), 38270 (FRH Neuro) or 37646 (FRH ENT).

FLUIDS (using water)			
1 st tsp	Pass <input type="checkbox"/>	Continue <input type="checkbox"/>	Fail <input type="checkbox"/> → <u>STOP</u>
2 nd tsp	Pass <input type="checkbox"/>	Continue <input type="checkbox"/>	Fail <input type="checkbox"/> → <u>STOP</u>
Sips up to 50ml (hand over hand assistance from cup)	Pass <input type="checkbox"/>	Continue <input type="checkbox"/>	Fail <input type="checkbox"/>
→ <u>STOP</u>			
Give patient glass of water	Pass <input type="checkbox"/>	Continue <input type="checkbox"/>	Fail <input type="checkbox"/> → <u>STOP</u>
Please indicate any difficulties (can be more than one)			
Coughing <input type="checkbox"/>	Choking <input type="checkbox"/>	No attempts to swallow <input type="checkbox"/>	Wet/gurgly voice after drinking <input type="checkbox"/>
Breathlessness/respiratory difficulty <input type="checkbox"/>	Droling <input type="checkbox"/>	Drinks come back out of nose <input type="checkbox"/>	
Evidence of fluids on tracheal suctioning <input type="checkbox"/>	Other (please specify) <input type="checkbox"/>		
PASS <input type="checkbox"/> Continue to diet section of screen - see below			
FAIL <input type="checkbox"/> Stop screening if ticked at least one of the boxes above. Place NBM and refer to SALT and Dietitian			

DIET		
Yoghurt (at least ½ pot) - puree	PASS <input type="checkbox"/> Continue screen	FAIL <input type="checkbox"/> Stop, NBM; refer to SALT
Bread (at least ¼ slice) - soft	PASS <input type="checkbox"/> Continue screen	FAIL <input type="checkbox"/> Puree diet; refer to SALT
Biscuit (at least 1 biscuit) - normal	PASS <input type="checkbox"/> Continue screen	FAIL <input type="checkbox"/> Soft diet; refer to SALT
Please indicate any difficulties (can be more than one)		
Excessive chewing <input type="checkbox"/>	Inadequate chewing <input type="checkbox"/>	Food left in the mouth <input type="checkbox"/>
Food spat out <input type="checkbox"/>	Eating at inappropriate speed <input type="checkbox"/>	No attempts to swallow <input type="checkbox"/>
Coughing <input type="checkbox"/>	Wet/gurgly voice after swallowing <input type="checkbox"/>	Choking <input type="checkbox"/>
Feeling of food sticking in the throat <input type="checkbox"/>	Breathlessness/respiratory difficulty <input type="checkbox"/>	
Evidence of food on tracheal suctioning <input type="checkbox"/>	Other (please specify) <input type="checkbox"/>	
<input type="checkbox"/>		

Outcome of screen: NBM Oral Intake

Diet texture (please circle) Puree Soft Normal

If there is any deterioration in the patient's condition, please refer to Speech and Language Therapy

Nurse completing screen (print name):

Signature: _____ Designation: _____

Ward: _____ Date and time screen completed: _____

Please file in medical notes
PLEASE REFER ANY COMMUNICATION PROBLEMS IMMEDIATELY TO SPEECH AND LANGUAGE THERAPY

Appendix 4 Decannulation checklist

Prior to Decannulation the inter-professional team will confirm that the following points are considered prior to proceeding with decannulation

- The timing of the decannulation procedure needs consideration; to minimise the risks to the patient.
- The clinical environment should have sufficient competent staff and equipment available.
- The position of the patient within their clinical setting should allow staff to visualise the patient easily and the patient should have constant access to an appropriate call system.
- It may be necessary to transfer the patient undergoing decannulation to an area where 1:1 nursing care can be offered and ready access to specialist staff who could appropriately deal with a failed decannulation or other complications.
- Extra caution is essential if the patient is known to have a complex airway (E.g. requiring an adjustable flange tracheostomy) or has a previously documented difficult intubation.
- This document may not be appropriate for patients requiring palliation. Please refer to medical team for guidance.

1	They are considered clinically stable	YES/NO
2	The patient can maintain and protect their airway spontaneously	YES/NO
3	They are requiring less than 40% supplemental oxygen to maintain adequate oxygen saturation and with respiratory rate less than 20 bpm, or as otherwise specified by a respiratory physician or intensivist	YES/NO
4	They are free from ventilatory support with adequate respiratory function	YES/NO
5	They are haemodynamically stable	YES/NO
6	They are absent of fever or active infection	YES/NO
7	The patient is consistently alert	YES/NO
8	They have a strong consistent cough (able to cough into mouth)	YES/NO
9	Patient not dependant on deep suctioning to maintain respiratory clearance.	YES/NO
10	They have control of saliva +/- a competent swallow	YES/NO
11	They are not planned for procedures requiring anaesthesia within next 24-48 hours	YES/NO

Decannulation checklist continued

If all the criteria above not met and decannulation to proceed, provide additional information below:

Decannulating nurse/doctor to complete date and sign: