NSW HEALTH

Safety Notice 018/09

Reducing Incidents Involving Tracheostomy Tube Care

16 September 2009

Distributed to:

- Chief Executives
- Directors of Clinical Governance
- Directors of Clinical Operations

Action required by:

- Directors of Clinical Governance

We recommend you also inform:

- Directors of Surgery
- Directors of Anaesthetics
- Directors of Intensive Care/Critical Care
- Area Directors of Nursing and Midwifery
- Intensive Care Nurses
- Emergency Department Clinicians and Nurses
- Nurse Unit Managers

Expert Reference Group

Content reviewed by:

- Intensive Care Taskforce
- ICCMU
- Emergency Care Taskforce
- GMCT Respiratory Network
- GMCT Spinal Injury Network
- GMCT Brain Injury Network
- Critical Care Health Priority Taskforce
- Rural Critical Care Taskforce
- Paediatric Intensive Care Advisory Group
- Nursing and Midwifery Office
- Statewide Services Development Branch
- Clinical Excellence Commission

Clinical Safety, Quality and Governance Branch
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http://www.health.nsw.gov.au/quality/sabs

Background

A Statewide review of reported incidents involving patients with insitu tracheostomy tubes, has identified a catastrophic event occurs approximately every six weeks.

Contributing Factors

Contributing factors relate to poor recognition and communication by staff of specific risks associated with tracheostomy management, securing of the tracheostomy tube, poor clinical handover and acceptance of care when transferring patients, and workforce/skill mix issues.

Incidents included tube dislodgement, patient self removal, tube blockage, ineffective airway management, and lack of appropriate care of the tube when a patient is being repositioned.

Suggested strategies for reducing tracheostomy incidents

➢ Recognition of Tracheostomy Care Risks

Dislodgement of tubes following repositioning is a frequently reported incident. It is recommended that local protocols be reviewed using the attached references as a guide, to ensure guidelines and minimum standards are developed.

Proper maintenance should include but not be limited to regular suctioning, cleaning of inner tubes and the use of humidification and nebulisers to assist the airway to remain patent.

The NSW Health Policy *PD2006_098: Tracheostomy - Unavoidable early (<72 hours) Tracheostomy Tube Change* outlines the risks associated with changing a tracheotomy tube within 72 hours of first being inserted and it provides a protocol for early tracheotomy tube change. These protocols may assist staff in addition to supporting unit guidelines when providing tracheostomy tube care for patients.

Clear guidelines should include, but not be limited to the minimum number of staff required when repositioning a patient, the use of a standard check X-ray to ensure correct and secure tube placement, and effective management of the tracheostomy tube. It is important protocols address tracheostomy care for adult, paediatrics and neonates.

Whilst the principles of safe tracheostomy management are the same for adults, paediatric and neonatal patients, staff should refer to local management guidelines for specific paediatric and neonatal tracheostomy management guidelines.

Suggested strategies (cont page 2)

Suggested Actions by Area Health Services:

1. Distribute this Safety Notice to all relevant clinical staff.
2. Develop and/or review local protocols to ensure all aspects of tracheostomy tube management are addressed for adults, paediatrics and neonates as relevant. (See attached references)
3. Develop unit guidelines to include but not be limited to indicate the minimum number of staff required to safely reposition patients with a tracheostomy tube insitu.
4. That staff ensure when transferring patients that they identify all specific tracheostomy tube management issues, discuss these with the receiving ward acknowledging acceptance of patient care and document handover using the nursing handover sheet or equivalent.
5. Provide staff with readily available education to develop and maintain skills/competency levels to effectively manage tracheostomy tubes.
6. Ensure patient care plans clearly document the level of intervention and Advanced Care Directives where relevant, in the event of a medical emergency involving the tracheostomy tube.
7. Ensure staff are aware that further information is available via the CIAP website at http://www.ciap.health.nsw.gov.au or http://internal.health.nsw.gov.au

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Suggested strategies for reducing tracheostomy incidents (cont)

- Education and Training for Tracheostomy Tube Management
  Appropriate education for any clinical staff caring for patients with tracheostomies should be provided to ensure minimum standards and competency assessments for staff are completed to safely manage patients with tracheostomy tubes insitu. Continuing education should be available to ensure skill levels and competencies are maintained to effectively manage tracheostomy tubes. E- learning competency assessment tools may assist maintaining staff awareness of key tracheostomy care components.
- Clinical Handover of Patients with Tracheostomy Tubes Insitu
  Poor handover of information during transfer of care was identified in the review. To improve communication at handover it is suggested staff ensure when transferring patients that they identify all specific tracheostomy tube management issues, discuss these with the receiving ward acknowledging acceptance of patient care and document handover using the nursing handover sheet or equivalent.
- Minimum Equipment
  Develop standardised minimum sets of equipment and ensure that the minimum equipment set is available for the proper provision of tracheostomy management and patient care.

Other useful information can be found at:

- Tracheostomy Care Resources: Austin Health Tracheostomy Review and Management Service
  http://www.tracheostomyteam.org/tracheostomycare.asp
- NSW Health Policy PD2006_098: Tracheostomy - Unavoidable early (<72 hours) Tracheostomy Tube Change 13-Nov-2006
  http://www.health.nsw.gov.au/policies/pd/2006/pdf/PD2006_098.pdf

  The document outlines the risks associated with changing a tracheostomy tube within 72 hours of first being inserted and provides a protocol for early tracheostomy tube change.
- NSW Health Guideline GL2005_056: Using Advance Care Directives 22 March 2005
  http://www.health.nsw.gov.au/policies/gl/2005/pdf/GL2005_056.pdf
- Clinical Excellence Commission November 2008. Between the Flags Project - Interim Report: A statewide initiative of the CEC / GMCT / NSW Department of Health to enhance the recognition and management of the deteriorating patient.
  http://www.cec.health.nsw.gov.au/resources/betweentheflags/InterimReport.pdf