Swallow Assessment Guidance For The Mechanically Ventilated Patient With A Tracheostomy Tube

Introduction

Patients with a tracheostomy tube are at high risk of developing swallowing difficulties, although some can swallow normally. The patient's underlying medical condition may compound swallowing difficulties. Assessment of the safety of the swallow is necessary as swallowing difficulties (dysphagia) can result in aspiration and the ensuing complications. A patient with a tracheostomy tube may have difficulty swallowing secretions as well as food and drink.

Exclusions

*Nurse-led assessment is **NOT** suitable in the following groups*

- Patients requiring any mandatory mode of ventilation i.e. SIMV/VC or PC/BIPAP
- Stroke
- Pre-existing or progressive neurological conditions e.g. Multiple Sclerosis, Myasthenia Gravis, Guillain-Barre Syndrome, Motor Neurone Disease
- Spinal injury
- Head and Neck surgery
- Oral surgery
- Paediatrics

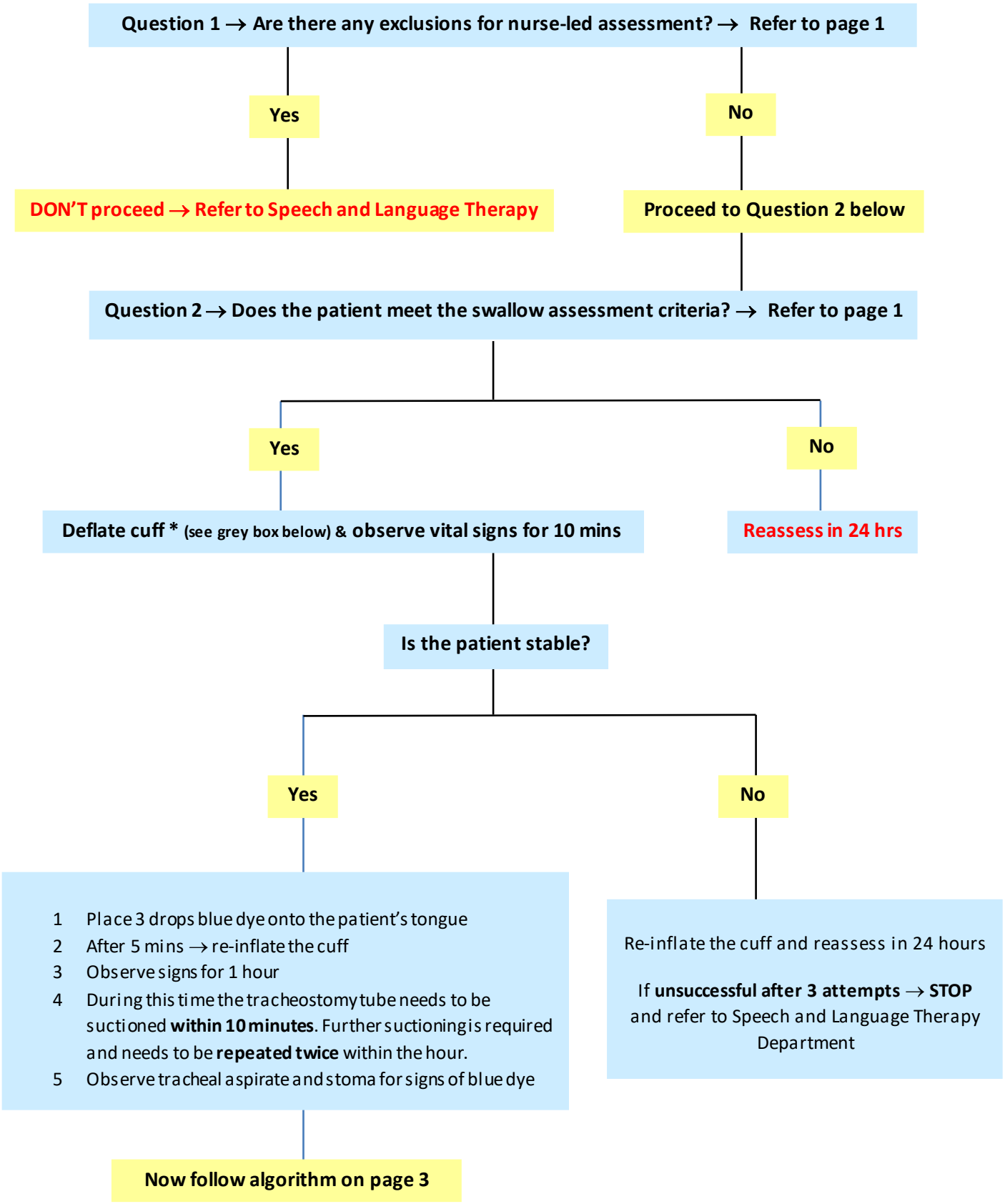
All of the above patient groups require to be referred to the Speech and Language Therapy (SLT) Department

Patients suitable for nurse-led swallow assessment must meet ALL* of the following

- FiO2 < 0.6
- Total airway pressure ≤ 20
- Patient is alert and orientated
- Vital signs have been stable for the previous 24 hours
- Patient is able to cough spontaneously and clear chest secretions
- Oral secretions must not be drooling or pooling

*If the patient does not meet **ALL** of the above criteria → reassess at 24 hour

Swallow Assessment Algorithm for the Mechanically Ventilated Patient with a Tracheostomy Tube



Cuff deflation → slowly deflate the cuff 1ml/second to ensure maximum compliance & patient comfort. Allow the patient a short time to settle following cuff deflation. Suctioning will be needed during cuff deflation

Is there any blue dye present?

No

Yes

STOP

↓

Immediately refer to the
Speech and Language Therapy Department

1. Deflate cuff → administer 3 teaspoons of blue dyed water. If tolerated, let patient have 4 to 5 sips
2. Re-inflate the cuff
3. Observe vital signs for 1 hour. During this time the tracheostomy tube needs to be suctioned within 10 minutes. Further suctioning is needed – and this needs to be repeated twice within the hour
4. Maintain observation of tracheal aspirate for 24 hours using the 24-hr tracheal secretion tracking sheet → refer to page 4
5. The patient must not eat or drink whilst the 24-hr tracking sheet is in progress

Any blue dye observed?

No

Yes

Introduce light diet as tolerated and continue to observe for aspiration of foodstuffs

STOP

↓

Immediately refer to the
Speech and Language Therapy Department

24 our Tracheal Secretion Tracking Sheet for use with Blue Dye Testing

→ Suction patient only when required

→ Monitor secretions for presence of blue dye and record the result below

→ The patient must not eat or drink whilst the 24-hour tracking sheet is in progress

Affix Patient ID Label	Please enter the date & time when blue dye test is commenced Date _____ Time _____

Blue dye present on suctioning

Date	Time	Absent	Present	Signature

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