



**St. James's Hospital
Tracheostomy Care Working Group.**

**Tracheostomy: Swallowing Assessment and Management Standard Operating Procedure
SJH:N069.11version 5.**

This Standard Operating Procedure (SOP) is effective from September 2020 onwards and is due for renewal in September 2023. It will be reviewed during this time as necessary to reflect any changes in best practice, law, and substantial organisational, professional or academic change. This SOP is supplementary to the [Tracheostomy Care and Management Guideline \(SJH:N069\)](#) and describes standards on swallowing assessment and management for patients with Tracheostomy.

1.0 Swallowing

1.1 All patients with a tracheostomy must be referred to Speech and Language Therapist (SLT) for dysphagia / swallow assessment.

1.2 Impact of Tracheostomy on Swallowing

- Patients with a tracheostomy tube may be at greater risk of swallowing difficulties and aspiration due to variety of reasons including but not limited to the presence of the tracheostomy tube.
- Presence of a tracheostomy tube, cuff status, occlusion status, and mechanical ventilation have been discussed in the literature as potential contributors to dysphagia (IASLT 2017).
- Swallowing difficulties may be due to pre-existing comorbidities and other medical factors surrounding the patient such as severity of illness, exposure to medications, respiratory failure, age and the initial reason for tracheostomy insertion (Carlos et al. 2011).
- Oral intubation is also associated with dysphagia and increased risk of aspiration in the critically ill patient (Scheel et al. 2016) and may patients will have had a period of oral intubation prior to tracheostomy tube placement.

1.3 Dysphagia Assessment

1.3.1 Assessment of swallow is carried out by the SLT and will consist of a bedside/clinical swallow assessment in the first instance.

1.3.2 An objective instrumental assessment of swallow such as videofluoroscopy (modified barium swallow) or FEES (Fibreoptic endoscopic evaluation of swallow) may also be necessary to further assess swallow function and plan appropriate intervention.

1.3.3 In order to undertake a safe effective swallow assessment, the healthcare professional must ensure the following:

1.3.3.1 The patient must be alert.

- 1.3.3.2 Suction facilities are available.
- 1.3.3.3 Patient's tracheostomy tube must usually be uncuffed or have cuff deflated.
- 1.3.3.4 Patients should be able to tolerate speaking valve for short periods.
- 1.3.3.5 Patients who are unable to tolerate cuff deflation/speaking valve placement long-term may be seen for swallow assessment. This will require objective assessment of swallow function.

1.4 Strategies to Minimize Aspiration Risk & Manage Dysphagia

1.4.1 In order to manage dysphagia and minimise the risk of aspiration in patients with a tracheostomy, healthcare professionals must observe the following procedures:

- 1.4.1.1** Follow the instructions and swallowing guidelines provided by SLT in the patient's healthcare record, i.e. EPR or Intellispace Critical Care + Anesthesia (ICCA) and on the patients' swallow chart.
 - 1.4.1.2** Provide modified food and thickened drinks, as recommended.
 - 1.4.1.3** Ensure patient is alert and sitting upright in advance of taking any food or drinks.
 - 1.4.1.4** Facilitate airflow through the vocal tract by using a speaking valve to divert the air through the larynx. This may further assist swallowing by improving cough production and increased pharyngeal sensation.
 - 1.4.1.5** Facilitate the flow of air through the vocal tract by using a fenestrated inner cannula where a fenestrated tracheostomy tube is in-situ.
 - 1.4.1.6** Monitor for food/drink stained secretions when suctioning.
 - 1.4.1.7** Monitor patient for signs of dysphagia (see point 1.4.2) including chest/respiratory function and report to Medical Team, SLT and/or Tracheostomy CNS, as appropriate.
- 1.4.2** If any of the following signs are observed, the patient may have dysphagia and should be placed Nil by Mouth and referred to SLT for review;
- Throat clearing/coughing during or after eating/drinking.
 - Food/fluid stained secretions seen on suctioning.
 - Wet, gurgly voice.
 - Difficulty swallowing.
 - Repeated swallows required to clear a single bolus.
 - Increased respiration rate during eating/drinking.
 - Decreased SpO₂ during eating/drinking.
 - Repeated, unexplained respiratory tract infections (RTIs).

1.4.3 Where there is a safety concern that the patient has dysphagia and is aspirating, the following assessments may be considered:

- **Subglottic port:** If patient has a cuffed suction Aid tube insitu, the subglottic port can be used to determine volume of aspirated secretions over a given time frame.
- **Blue dye test:** Blue dye is administered by the SLT or Tracheostomy CNS. The nurse is required to monitor and report the presence of blue dye in tracheal secretions.
- **Videofluoroscopy (VFU):** Dynamic x-ray of swallow physiology. Carried out by SLT and radiographer.
- **Fibre-optic Endoscopic Evaluation of Swallow (FEES):** a nasendoscope is passed transnasally into the throat to assess voice and swallow function. Carried out by SLT.

Links to related PPPGs:

- [Tracheostomy Care and Management Guideline \(SJH:N069\)](#)
- [Tracheostomy Care and Management Guideline: Associated Documents](#)