

PAEDIATRIC NURSING PRACTICE MANUAL
SECTION 7

CARE OF THE CHILD WITH A RESPIRATORY CONDITION

7.4 CARE OF THE CHILD WITH A TRACHEOSTOMY

7.4.12 STAFFING AND WARD LOCATION GUIDELINES

The following guideline has been developed to assist in decision-making as it relates to key considerations for nursing care. Considerations include the safest position on the ward for tracheostomised children, isolation room use and nurse to patient ratios.

Due to the morbidity and mortality risks associated with having a tracheostomy tube, children who are tracheostomised should not be left unattended. A child with a tracheostomy should always be within the sight and hearing of a nurse, other approved trained staff member or suitably trained parent/carer in order to either respond directly to the patient care or alert other staff as required.

1. Isolation requirements for tracheostomised children

Children with a tracheostomy do not automatically require protective isolation unless for reasons as per CAHS Infection Control Manual

http://cahs.hdwa.health.wa.gov.au/_data/assets/pdf_file/0018/43407/Inf_Cont_2.2_Add_prec.pdf.

1.1 Tracheostomised child not requiring isolation

Children with a tracheostomy, who do not require isolation, should be cared for in a multiple bed room. Whilst a tracheostomised child is being cared for in this room, a nurse should be within the room at all times, so the child can be visualised and heard at any time. The nurse may be caring for all of the patients in the room or only the tracheostomised child, but one nurse must be in the room at all times.

If a child has a suitably trained person (ie. parent, CATCH program support worker or Lady Lawley Cottage RN, EN or Residential Care Worker) in the room to specifically supervise the child with a tracheostomy, a PMH Nurse is **NOT** required to be in the room supervising the child at all times.

1.2 Tracheostomised child requiring isolation

In the event that a tracheostomised child requires isolation they should be isolated as per hospital policy. A child with a tracheostomy, who requires isolating, must have a nurse or another suitably trained person within sight and hearing at all times.

2. Staff to patient ratios for children with a tracheostomy

Considering the above information, the specific staff to patient ratio when caring for children with a tracheostomy varies depending on the age and acuity of the patient.

Considerations to be made when determining staff to patient ratios include:

- **The age of the child.** Infants and children <2years of age usually require a lower staff to patient ratio than older children/adolescents.
- **The safety of the child's upper airway.** Is the child completely dependent on this tracheostomy tube? Or would they be safe for a short period if the tube became blocked or decannulated?
This information is available on the child's airway profile
http://cahs.hdwa.health.wa.gov.au/wards_and_depts/paediatric_medicine_ccu/ambulatory_care/air_profiles
- **Dependence on other respiratory technology.** Is the child completely dependent on positive pressure ventilation or are they self ventilating in air?
- **Amount of suctioning required by the child.**
- **Acuity of illness, current clinical condition of the child and reason for admission.**
- **Presence of parents/carers.**

The decision about the staff to patient ratio should be made by the patient's admitting Consultant in consultation with ward nursing staff. This should be reviewed on a continuing basis. The admitting medical team should document in the patient record whether the child requires a higher level of supervision than usual ward staff to patient ratios.

3. Essential vs. Non essential power requirements

It is important for ward staff to be familiar with the location of which bed spaces in the ward that has essential power. Essential power should have red toggle switches.

Children who **do** require essential power:

- **Ventilator dependent children** should always be located in a room that has essential power. Ventilator dependence refers to a patient who requires their ventilator 24 hours per day. This dependence may be current (i.e. because they are unwell) or indefinitely (ie. high spinal cord injury).

Children who **do not** require essential power:

- **Children requiring intermittent ventilation:** Children who require positive pressure ventilation for certain periods of each day, but are not currently considered ventilator dependent are not required to be located in a room that has essential power. **It is imperative that nursing staff are aware that the majority of BiPap machines DO NOT have an internal battery. Therefore, if power is lost, the child should be removed from the BiPap machine immediately to prevent them from rebreathing air within the BiPap circuit.**
- **Tracheostomised without positive pressure ventilation:** children who have a tracheostomy and do not require any positive pressure ventilation are not required to be located in a room that has essential power

Consideration should be given to other clinical contingency planning strategies including the use of portable battery back-up systems.

As suction may be interrupted when the hospital power supply is disrupted, tracheostomised children should always have a portable suction source available. If the child has their own allocated Devilbis (or equivalent) portable suction unit, this should be available and checked at the commencement of each shift. If the child does not have their own portable suction unit available, they should have a portable oxygen cylinder with functioning Twin-o-vac suction at all times. Again, this should be checked at the commencement of each shift.


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