PASSY-MUIR SPEAKING VALVE (PMV) ASSESSMENT

I. GENERAL PATIENT INFORMATION

Primary Dx _____ Airway Related Dx _____

Intubation
Date performed _____
Emergency __ yes __ no
Oral Nasal

Extubation
Date performed _____
Length of Intubation _____

Tracheotomy
Date performed _____
__ surgical __ percutaneous

Comments: _____

II. BESIDE ASSESSMENT

Vital Signs Stable
__ Yes __ No
If no, explain
_____
_____

Tracheostomy Tube
Type _____
Size _____
Cuffed vs. Cuffless
Inflated Deflated

Secretions

Oral	Tracheal
Amount _____	Amount _____
Consistency _____	Consistency _____
Color _____	Color _____

Steroids: __ Inhaled __ PO/IV Reason _____

Ventilator Settings

A/C rate	_____	Tidal Vol	_____
SIMV rate	_____	FIO_2	_____
PS	_____	Spont Vol	_____
Pr. Control	_____	PEEP/CPAP	_____
PIP	_____	Compliance	_____
PalvD	_____	Airway Resist	_____

Ventilator Weaning

Trach Collar _____ SIMV/PS _____
Start Date _____ Schedule _____
Progress on Trach Collar Trials: _____
_____
Progress on SIMV/PS: _____
_____

Nutritional Status

NPO _____
Oral (Diet Level) _____
Food Consistency _____
Tube Feeding __ Stomach __ Small Bowel
Comments: _____

Swallowing Status

Clears secretions	__ Yes	__ No
History of aspiration	__Yes	__ No
History of reflux problems	__Yes	__ No
Bedside Swallow	__Passed	__ Failed
3 phase esophagram	__Passed	__ Failed

Cognitive-Communication Status

__Alert __ Oriented __ Disoriented __ Nonresponsive __ Mouthing Words
Comments _____

Air Flow / Cuff Leak

Cuff deflation (vent patient):
_____ #cc air removed from cuff (vent)
__ Oral leak observed (cough, voice, secretions)

Finger Occlusion (non-vent):
Stridor: __Yes __ No
Exhalation: __Passive __ Forced

III. PMV PLACEMENT DATA			
Date	**Time of Day**	**O_2SAT / HR**	**Resp Rate**
Accessory Muscles __ Yes __ No	**Cough** __ Strong __ Guarded __ Weak	**Clears Secretions** __Yes __ No	**Anxiety** __ Yes __ No Explain:
Vocal Intensity __ Strong __ Weak	**Speech** __ Intelligible __ Unintelligible __ Aphasic	**Vocal Quality** __ Whispery __ Clear __ Raspy	**Back Pressure** air release on removal __ Yes __ No

Comments (including limitations to use):

_____

_____

PMV not appropriate, reason

_____

_____

Follow-up Recommendations (mark all that apply and describe reason):

☐ ENT Consult: _____

☐ Trach Downsizing: _____

☐ Reassess in 24-48 hours _____

☐ Other: _____

Goals for PMV Use:

☐ Communciation ☐ Airway Strengthening ☐ Secretion Management

☐ Swallowing ☐ Cognitive Reorientation ☐ End of Life Issues

Reassessment (Attach a Progress Notes sheet for additional comments):

_____

_____

_____

_____

_____

Date		Signature	Date		Signature