

TRACHEOSTOMY REVIEW AND MANAGEMENT SERVICE CLINICAL PROCEDURE

RECOGNISING AND MANAGING A BLOCKED TRACHEOSTOMY TUBE

Staff this document applies to:

Medical Staff, Nurses, Physiotherapists and Speech Pathologists on all campuses

Related Austin Health policies, procedures or guidelines:

- [Mandatory Equipment & Emergency Tracheostomy Management Poster](#)
- [Humidification of Inspired Gases in Patients with Tracheostomy](#)
- [Changing a Tracheostomy Tube](#)
- [Suctioning via the Tracheostomy](#)
- [Tracheostomy Cuff Management](#)
- [Escalation Response to Clinical Deterioration - Austin Hospital](#)

Purpose:

To describe the procedure of recognising and managing a blocked tracheostomy tube.

Definition:

- A blocked tracheostomy tube is one in which airway patency is compromised by:
 - dried secretions
 - blood clots
 - a displaced over-inflated cuff
 - the tracheal wall (if the tracheostomy tube is malpositioned)
- Indicators that a tracheostomy tube is blocked:
 - The tracheostomy tube feels roughened when passing a suction catheter
 - There is resistance felt when passing a suction catheter
 - Inability to pass a suction catheter through the tracheostomy tube

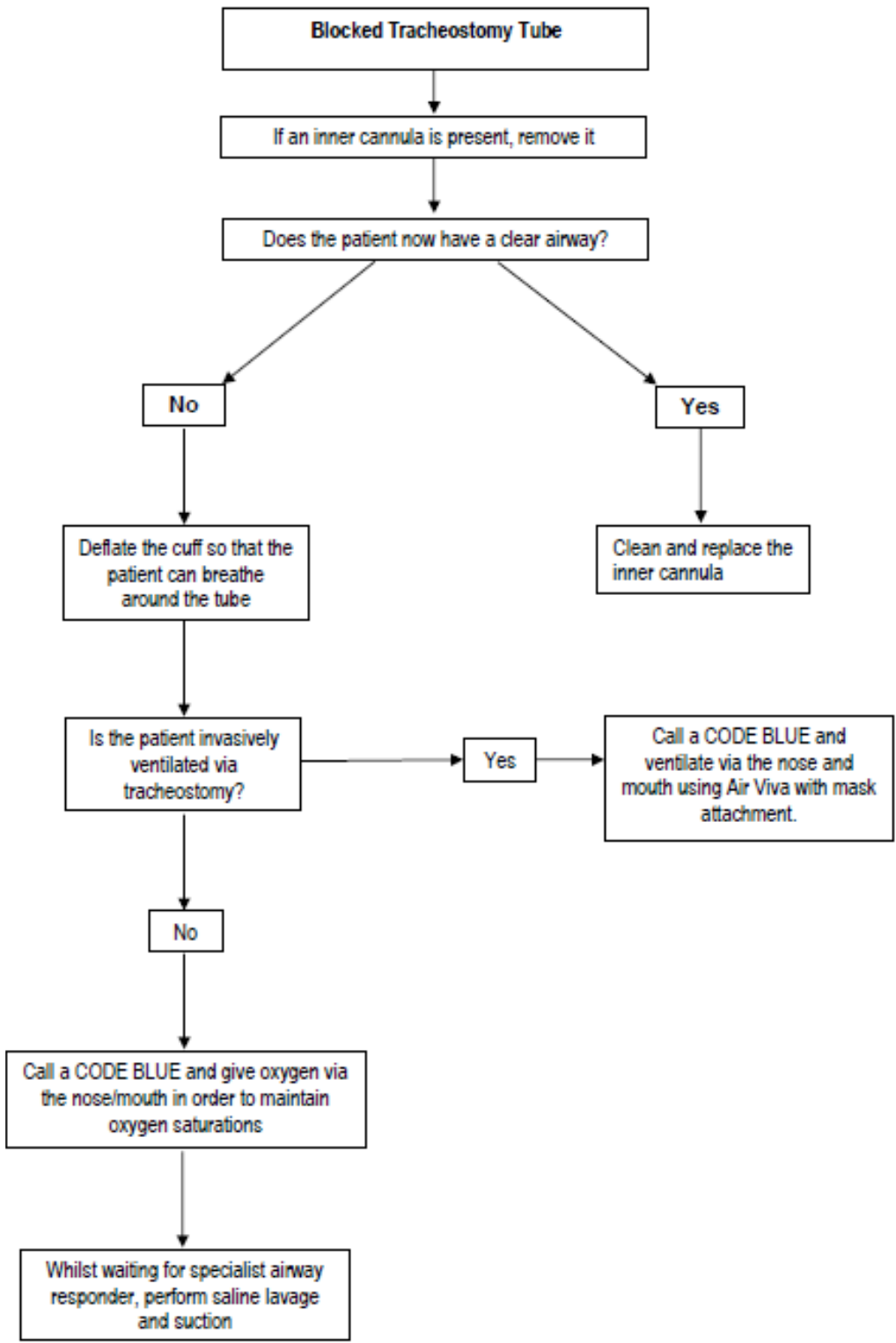
Clinical Alert:

- Maintaining a patent tracheostomy tube is vital to the safety of the patient
- A blocked tracheostomy tube is an emergency, and can result in respiratory arrest or death. Call a Respond Blue.
- A partially blocked tracheostomy tube can quickly progress to becoming completely blocked, and should be regarded as an impending emergency. If unable to restore complete patency, the tracheostomy tube should be changed
- Respiratory distress, increased work of breathing, or increased airway pressures in mechanically ventilated patients, should be assumed to be due to tracheostomy tube blockage until proven otherwise.

Equipment:

- Routine tracheostomy personal protective equipment (PPE)
 - Clean gloves
 - Safety shield, goggles or glasses
 - Disposable apron
 - Surgical mask
- Working suctioning equipment
- Suction catheters: standard size FG12
- Tracheostomy tube of the same size and 1 size smaller.
- Sterile normal saline ampoules
- 10ml syringes
- Cuff manometer (if tracheostomy has an air filled cuff)
- Bag-Valve-Mask (e.g. Air Viva) with face mask and tracheostomy connector
- Pulse oximeter
- Refer also to: [Mandatory Equipment & Emergency Tracheostomy Management Poster](#)

Procedure: If Tracheostomy Tube is Blocked or Apparently Blocked:



- If the tracheostomy remains blocked, the tracheostomy should be changed:
 - If it is > 7 days post initial insertion of the tracheostomy, trained clinical staff may change the tracheostomy
 - If it is < 7 days post initial insertion of the tracheostomy, the tracheostomy must be changed by an airway specialist
- Advanced airway responders (ICU Consultant, Anaesthetist, ENT, Thoracic or Maxillofacial surgeon): refer also to the reverse side of [Emergency Tracheostomy Management Poster](#)

Post Procedure:

- Recheck all oxygen and humidification equipment.
- The treating medical team and ward physiotherapist should be notified.
- The patient must remain on a humidifier that heats to a guaranteed 37°C. The use of a Heat Moisture Exchanger (HME) is not acceptable until reviewed by the TRAMS team, a senior physiotherapist or medical staff.
- Monitor oxygen saturations continuously with 30 minute vital observations for 2 hours
- Contact TRAMS on pager 1291 during business hours to review the patient and assist with strategies to prevent further episodes of tube obstruction.
- Document in medical history (including Riskman number)
- Complete Riskman

Document Author/Contributors:

TRAMS Policy and Procedure Committee (Updated May 2021)

Legislation/References/Supporting Documents:

Agency for Clinical Innovation (2013), Care of Adult Patients in Acute Care Facilities with a Tracheostomy: Clinical Practice Guideline

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Endorsed by:

- Deteriorating Patient Committee
- Austin Airway Group
- Clinical Nursing Standards Committee

Document Owner /Person Responsible for Document:

- Tanis Cameron, Tracheostomy Review and Management Service