	# Tracheostomy Adult Airway Emergency Management Protocol
Scope	• BHCG Inpatient Units • Medical Officer • Registered Nurse • Speech Pathologist • Physiotherapist
Policy	• Emergency equipment to manage tracheostomy complications must be kept at the bedside as per the BHCG Tracheostomy: Mandatory Equipment For Non-Ventilated Patients Policy • Blocked tracheostomy tubes and accidental decannulation are medical emergencies. Code Blue must be called for blocked tracheostomy and or for accidental decannulation.
Definitions	• Decannulate: removal of the tracheostomy tube
Considerations	• A difficult airway trolley is located in the Operating Theatre and the Emergency Department • ICU has a limited stock of airway management equipment which can be accessed in an emergency
COMPLICATIONS	
Accidental decannulation	• Is a potential clinical emergency • Call immediately for assistance. Depending on the patient's clinical status MET or Code Blue must be called. • If the patient does **not** have a patent upper airway (eg laryngectomy) they will be dependent on the stoma to breathe. • CAUTION: Reinsertion of a tracheostomy less than 7 days after formation is a relative contraindication due to the increased risk of misplacement.
Procedure for emergency recannulation	• Initiate Code Blue • Administer oxygen to both mouth/nose and stoma. • If the patient has a non-patent upper airway and the tracheal stoma is not well formed (eg recent stoma formation), consider applying tracheal dilators to a collapsed stoma to dilate and improve airflow • If the patient has long blue sutures in situ (as in the case of a surgically inserted tracheostomy) these may be manipulated to keep stoma open. • Attempt tracheostomy tube reinsertion if suitably qualified to do so. • Use spare tube of same size, lubricate and insert. Inflate cuff as required. • Check tube position by auscultating chest and passing a y-suction catheter freely into the patent airway • If the same size tube is unable to be inserted, downsize to a tube half a size smaller • Reapply humidified oxygen or reattach ventilator. • If a new tracheostomy cannot be inserted and the stoma airway

	is inadequate for ventilation, endotracheal intubation should be performed by an expert in airway management.
Monitoring Post Accidental decannulation	• Monitor oxygen saturation continuously for a minimum of 2 hours. • Monitor respiratory rate, heart rate and blood pressure every 30 minutes for a minimum of 2 hours. • Document events in medical record and notify the consultant of the parent unit. • Complete VHIMS incident report.
Blocked Tracheostomy tube	• This is a clinical emergency immediately call for assistance. Code Blue must be called.
Considerations	• Causes of a blocked tracheostomy tube include sputum impaction, blood, a foreign body lodged in the inner lumen, a malposition of tube or a tissue flap within the airway. • Adequate humidification will lessen the risk of tube blockage due to secretions
Procedure for blocked tracheostomy tube	• Remove the inner cannula and Passy Muir Speaking Valve if in situ. • Deflate cuff to allow the patient to breath around the cuff. • Administer oxygen via the mouth/nose and tracheostomy • Gently pass a y-suction catheter into the tracheostomy tube and apply suction on withdrawal. Note if the catheter passes freely into the airway or meets resistance. If resistance is evident beyond the tip of the tracheostomy tube, a malpositioned tube or mucosal injury should be considered. Seek specialist (ENT/ICU/Anaesthetics) advice. Consider inspection of the airway via bronchoscopy. • If there is ongoing respiratory compromise due to obstruction, remove the tracheostomy tube and reinsert a new tracheostomy tube if suitably qualified to do so. • If a new tracheostomy cannot be inserted call Code Blue, if not already called. The airway should be secured by an endotracheal tube by an expert in airway management.
Observations post blocked Tracheostomy and tube replacement.	• Monitor oxygen saturation continuously for a minimum of 2 hours. • Monitor respiratory rate, heart rate and blood pressure every 30 minutes for a minimum of 2 hours. • Document events in medical record and notify the consultant of the parent unit • Review humidification settings and equipment • Complete VHIMS as per: Patient/Client Incident and Adverse Event Protocol.
Related Bendigo Health Documents	– Tracheostomy: Adult Decannulation Management Protocol – Tracheostomy Adult Dressing And Tape Change Management Protocol – Tracheostomy: Adult, Humidification HME and Heated Water Humidifiers Protocol – Tracheostomy: Adult Inner Cannula Management Protocol – Tracheostomy: Mandatory Equipment For Non-Ventilated

<table>
<tr><td></td><td>Patients Policy
– Tracheostomy: Adult Suctioning Protocol
– Tracheostomy: Team Roles Policy
– Tracheostomy: Adult Tube Changing Protocol
– Tracheostomy: Adult Cuff Management Protocol
– Code Blue Initiation, Response & Documentation - Acute Campus
– Code Blue- Initiation, Response & Documentation -Anne Caudle Campus
– Medical Emergency Team- Anne Caudle Centre. MET- ACC
– Medical Emergency Team (MET) - Acute Campus
– Patient/Client Incident and Adverse Event Protocol.
– Hand Hygiene (Includes Glove Use & Staff Attire)</td><td></td></tr>
<tr><td>References and Associated Documents</td><td colspan="2">State and Commonwealth Legislation, Standards / Codes of Practice / Industry Guidelines</td></tr>
<tr><td colspan="3">MANDATORY INCLUSION
Personal information and health information as defined in the relevant Victorian law, which is required to be collected, used, disclosed and stored by BHCG in order to achieve the Purpose of this policy, will be handled by the Group and its employees in accordance with their legal obligations.
When developing this policy, BHCG has taken all reasonable steps to make its content consistent with the proper discharge of its obligations under the Charter of Human Rights and Responsibilities Act 2006</td></tr>
<tr><td>Responsible Department & Position</td><td colspan="2">Intensive Care Unit: Business Unit Manager</td></tr>
<tr><td>Approved by</td><td>Medical Surgical Clinical Standards Committee</td><td>29/09/2015</td></tr>
<tr><td>Authorised By</td><td>Group Clinical Standards Committee</td><td>19/10/2015</td></tr>
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