

## GUIDELINE FOR SUCTIONING VIA A TRACHEOSTOMY TUBE

<p><b>AIM;</b> to maintain a patent airway and facilitate optimal respiratory function in patients who are unable to effectively clear their own secretions.</p>	
<p><b>INDICATIONS;</b> presence of secretions in the upper respiratory tract.</p>	
<p><b>PROCEEDURE;</b></p> <ol style="list-style-type: none"> <li>1. Check emergency equipment.</li> <li>2. Ensure all the equipment required for the procedure is present.</li> <li>3. Wash hands, put on an apron and gloves (protective eye wear is also recommended).</li> <li>4. Explain procedure to the patient.</li> <li>5. Screen off the bed area.</li> <li>6. Turn on suction – use minimum pressure required to clear secretions 15 – 20 Kpa (100 – 150 mmHg).</li> <li>7. Select appropriate size suction catheter – not more than half the diameter of the tracheostomy tube (see guidelines for brand of tracheostomy tube).</li> <li>8. <i>IF ADVISED by critical care team, respiratory physiotherapist or doctor, pre-oxygenate the patient prior to suctioning.</i></li> </ol> <p><b>OXYGEN MUST BE PRESCRIBED</b></p> <ol style="list-style-type: none"> <li>9. Put a clean glove on the hand to hold the suction catheter (over the original glove). Touch only the catheter with this clean glove.</li> </ol>	<p><b>RATIONALE;</b></p> <p>In case of emergency.</p> <p>To ensure procedure is carried out without interruption.</p> <p>To minimise cross-infection.</p> <p>To minimise anxiety and obtain consent.</p> <p>To maintain the patients privacy and dignity.</p> <p>To ensure that the equipment is working. Minimal pressure will reduce the risk of the mucosa being damaged. If secretions are tenacious use a larger suction catheter rather than increasing the pressure above 20 Kpa (150mmHg).</p> <p><i>This may be necessary if the suction procedure has been demonstrated to cause the patient compromise, i.e. increased work of breathing, tachypnoea, distress, cyanosis, prolonged reduced oxygen saturations</i></p> <p>To minimise cross infection.</p>

<p>10. Introduce the catheter into the tracheostomy, with the suction port open until the patient vigorously coughs, or a “block” is experienced.</p> <p>11. Withdraw the catheter approx. 1 cm before applying the suction, and slowly and smoothly withdraw the catheter.</p> <p><i>10 &amp; 11 should take no longer than 15 seconds in total.</i></p> <p>12. Wrap the used catheter around your hand and pull off the top glove over the dirty catheter.</p> <p>13. Replace the patients’ oxygen or HME (Swedish nose)</p> <p>14. Flush the suction tubing with water (does not need to be sterile).</p> <p>15. Repeat the procedure until the patient is comfortable and breathing normally, allowing the patient time to recover in-between suction.</p> <p>16. Maintain regular observations as per the tracheostomy pro forma.</p>	<p><i>NB. Fenestrated inner tubes should be changed to non-fenestrated inner tubes for the suction procedure to minimise the risk of damaging the fenestrations.</i></p> <p>To minimise the risk of damage to the mucosa.</p> <p><i>Hypoxia can occur if the suction procedure is prolonged.</i></p> <p>Safe disposal of soiled catheter.</p> <p>To ensure patient safety and comfort.</p> <p>To ensure patency is maintained.</p> <p>To maintain patient comfort and safety.</p> <p>To maintain patient safety and identify any deterioration.</p>
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**Sources:**

St Georges Healthcare Trust (2006) Guidelines for the care of patients with tracheostomy tubes.

The Royal Marsden Manual of Clinical Procedures (on line edition accessed 2005).

Russell, C., Matta, B. (2006) Tracheostomy; A multiprofessional handbook. Cambridge University press. Cambridge.

PEER REVIEW – Ashford & St Peters NHS Trust and Dartford & Gravesham NHS Trust (suction policies).