**Tracheostomy/Suctioning Policies**

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SUBJECT: SUCTIONING/TRACHEOSTOMY, ENDOTRACHEAL, NASOTRACHEAL

POLICY STATEMENT: Suctioning is the mechanical removal of secretions from the airway to maintain an unobstructed airway, allow for adequate air exchange, and prevent airway infection.

SCOPE OF RESPONSIBILITY: Can be performed by an RN, LPN/LPTN/Licensed Care Associate, or Licensed Respiratory Care Practitioner.

GENERAL INFORMATION:

1. Personal Protective Equipment (PPE) should be worn if there is potential for splatter of body substances.

2. Suction catheters should be of adequate size to remove secretions but not so large (no greater than ½ internal diameter of tube/airway) that it obstructs the airway.

3. Suctioning removes air as well as secretions. To avoid hypoxemia, restrict the time to <10 seconds and always hyperoxygenate prior to, during, and after suctioning. Prolonged suctioning or repeated insertion of catheter may produce vagal stimulation, which can cause bradycardia, decreased perfusion, and hypotension.

4. Supply changes:
   a. Replace irrigation Normal Saline, yankauer tubing and nasal trumpet every 24 hours or as needed. Label with date when opened.
   b. Sterile suction catheter kit is required for each suctioning treatment.
   c. On same patient change suction liner when filled to the line or every 24 hours.
   d. Change tubing and liner between patients except in short term areas i.e. day surgery, change liner when filled to line but change tubing between patients.
   e. In-line closed suction catheters will be changed when it is visibly soiled, grossly contaminated, or if the ventilator is malfunctioning.
5. Upon performing nasotracheal suctioning, exercise caution to avoid unnecessary discomfort secondary to deviated septum, nasal trauma, or nasal obstruction.

6. The frequency of suctioning is determined by unit specific standards, presence of secretions observed or auscultated in the airways or after inhalation therapy.

EQUIPMENT:

- Suction catheter kit or in-line dosed suction kit
- Normal Saline for irrigation (1000ml)
- Wall suction unit
- Connecting tubing
- Suction liner
- Oxygen source
- 5cc sterile saline for irrigational/lavage
- Sterile lubricating gel (for NT suction)
- PPE (if indicated)
- Ambu bag (if indicated)
- Yankauer (if needed)
- Nasal trumpet (if indicated)
- Trach kit (if patient has trach)

PROCEDURE:

I. Preparation
   A. Wash hands.
   B. Explain procedure to the patient.
   C. Assemble equipment at bedside. Assure suction apparatus is working at proper settings.
   D. Open suction kit, maintaining sterility.
   E. Pour approximately 30cc normal saline in disposable pop-up basin.

II. Hyperoxygentation

   Hyperoxygenate patient prior to suctioning, between catheter passes, and following completion of procedure.

   A. The method selected should be determined by the patient’s status, type of airway and response to suctioning.
1. **Deep Breathing**
   
   a. Ask the patient to take 3-6 breaths initially.
   
   b. Allow patient to rest and reoxygenate between suction passes.
   
   c. Continue oxygen (if ordered) as much as possible during the procedure.

2. **Manual Resuscitation Bag**

   Provide 3-6 large breaths with 100% oxygen via bag.

3. **Ventilator Oxygenation** - to be used with Ventilator with option of 100% automatic cutoff otherwise use manual resuscitation bag.

   a. Increase ventilator FiO₂ to 1.0 (100%).
   
   b. Allow 1-2 minutes.
   
   c. Allow patient 3-6 breaths by ventilator.
   
   d. Be sure FiO₂ is decreased to ordered level after suctioning.
   
   e. Use swivel adaptor port closed system for patients ventilated with PEEP > 5cm so patient is not disconnected from the ventilator. If port closed system not available, use a manual resuscitation bag with a PEEP adaptor.

III. **Suctioning**

   A. **Tracheostomy or Ventilated Patient**

      1. Choose appropriate sized suction catheter. Diameter should be no larger than half the inside of any tracheal or endotracheal tube.
      
         Turn wall suction to medium pressure prior to procedure:
         
         | Wall             | Portable |
         |------------------|----------|
         | 80-120 mmHg      | F-15cmH₂O |
      
      2. Put on PPE (if indicated). Wash hands, put on gloves using sterile technique and keep one hand sterile for suctioning.

      3. Connect suction catheter to connecting tube maintaining sterility.

      4. Unless contraindicated, place the conscious patient in semi fowler’s position to promote lung expansion and promote coughing.

      5. Hyperoxygenate patient by one of the methods described above. Allow for reoxygenation between attempts.

      6. Instill 5-10cc normal saline into E.T.T. or trach if needed to loosen secretions, stimulate cough or facilitate removal of secretions.
7. Using sterile hand with suction port open, insert catheter until area to be suctioned is reached or resistance is felt. (If resistance felt, withdraw catheter ½ inch as catheter could be touching carina.) Suction intermittently by opening and closing suction port, rotating catheter 360 degrees as you quickly withdraw. This action captures more secretions and decreases trauma to tissues.

8. Apply suction for 5-10 seconds, if no signs of hypoxia. NEVER suction for more than 10 seconds. Observe for signs of hypoxia, such as arrhythmia, bradycardia or decrease in peripheral tissue perfusion. Stop immediately, oxygenate patient and document intolerance upon completion of procedure.

9. Flush catheter and tubing with normal saline.

B. Naso Tracheal Suctioning:

1. Lubricate catheter with water soluble jelly.
2. Consider use of a nasal (trumpet) airway for repeated suctioning.
3. Advance catheter through the nose anteriorly and medially to the back of nasopharynx.
4. Instruct patient to take a deep breath or cough as the suction catheter is advanced into the trachea.
5. Suction as described in A, 1-6.

C. Oral Suctioning:

1. Wash hands and wear gloves.
2. Performed using clean technique.
3. Insert yankauer or suction catheter into mouth using sweeping motion to clear sides of mouth and back of throat.
4. Flush catheter, yankauer or tubing with normal saline.

DOCUMENTATION:

Document on the appropriate form/screen the following:

1. Number of times suctioned each shift.
2. Estimated amount suctioned.
3. Characteristics of secretions
4. Patient tolerance to procedure
5. Auscultation of breath sounds heard prior and post suctioning.
RESOURCES:

SUBJECT: TRACHEOSTOMY TUBE CARE

POLICY STATEMENT: Stoma care, dressing of tracheostomy, insertion of trach tube into patient’s stoma and related care will be performed according to this policy/procedure.

SCOPE OF RESPONSIBILITIES: May be performed by Registered Nurse, LPN/LPTN/Licensed Care Associate, Licensed Respiratory Care Practitioner II, III or IV.

GENERAL INSTRUCTION:

1. Routine tracheostomy care should be performed a minimum of every eight (8) hours and as necessary (PRN).

2. Personal protective equipment should be used in the event of potential splash/exposure to body substance.

3. The stoma can close very quickly during the first twenty-four (24) to seventy-two (72) hours after surgery if the tube becomes dislodged. For this reason, ties should not be changed for a minimum of seventy-two (72) hours or as specified by the physician. Immediate post-op tracheostomy care may be performed as needed, per physicians order, in the first twenty-four (24) hours after procedure. Sutures are only to be removed by physicians order.

4. An obturator should be at the bedside in the event the entire tracheostomy is dislodged and needs to be replaced. A spare tracheostomy the same size or smaller than the patients tube should also be kept at the bedside.

5. The nurse should determine on admission if patient has had a complete laryngectomy. Patients with complete laryngectomies utilize their stoma as the ONLY opening into the lower airway. This should be posted above the bed to assure correct artificial ventilation into the stoma instead of the mouth during CPR.

6. The nurse should determine if the tracheostomy tube has an inner cannula. Inner cannula care may be deleted in patient requiring continuous mechanical ventilation. If disposable inner cannulas are available, they may be replaced as necessary (PRN).
7. Use commercial drain sponges only. 4X4 gauze should never be cut to fit around the stoma as small threads may ravel and enter the trachea.

8. The physician will order if a cuffed tracheostomy is to be inflated or deflated. If a Passey-Meuir Valve is used, the tracheostomy must be deflated.

9. A method of communication should be determined for all patients with tracheostomies.

PROCEDURE:

1. TO CLEAN INNER CANNULA (IF PRESENT), TO CHANGE TIES, TO INFLATE CUFF OR TO PLUG TRACH.

   See Nursing Procedures, 4th Edition, p 455-459

DOCUMENTATION:

Document on the appropriate form/screen the following:

1. Date and time of tracheostomy care/suctioning.

2. Appearance/amount of secretions, ability to remove secretions by coughing, breath sounds and any signs of wound infection.

RESOURCES: