

Trach care and suction

Purpose: Routine trach care is provided to aid in the healing process of the stoma and prevent skin breakdown. Frequent suction aids in clearing the clients secretions and decreases the risk of infection and oxygen deprivation.

Assessment

- Assess odor.
- Assess cannula type.
- Assess respiratory sounds before and after procedure.
- Assess for secretions.
- Assess skin integrity and for signs of infection.
- Assess type of tracheostomy and dressing.

Risks

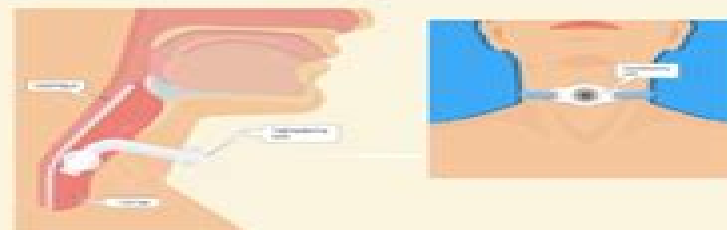
- Risk for infection.
- Risk for decreased oxygenation.
- Risk for injury from insertion or removal.
- When performing tracheostomy care, emergency supplies should be available at all times in case the tube is inadvertently dislodged, and an ambu bag to administer breaths as needed for the client on a vent.

Patient Teaching

- Explain procedure and indications.
- Patients should verbalize understanding of proper care.
- Explain feelings the client will feel (they may gag).
- Explain you will maintain privacy.
- Be supportive.

Procedure

1. Confirm the patient's ID using two identifiers.
2. Explain procedure to patient.
3. Open trach tray and put on one sterile glove in order to set up two basins.
4. With an ungloved (non-sterile) hand, pour saline into each basin.
5. Don the second sterile glove - both hands are now sterile.
6. Remove inner cannula, if applicable: Secure outer cannula neck plate with index finger and thumb. Unlock inner cannula - usually by turning LEFT 90 degrees. Gently pull cannula up and out - it should withdraw easily.
7. Soak and clean the inner cannula in sterile normal saline or discard if disposable. Remove any secretions by cleansing and wiping the lumen with moistened brush.
8. Place cleaned inner cannula on sterile gauze and dry thoroughly.
9. Replace inner cannula with care, stabilizing outer flange with opposite hand. Lock into place (turn RIGHT).
10. Cleanse skin around stoma with gauze or applicator soaked in sterile saline from the clean basin (the basin that was not used to clean inner cannula). Use a separate gauze/applicator to clean the outer cannula.
11. Apply new dressing: Apply presplit non-fraying gauze/split drain sponge around ostomy/trach tube with flaps pointing up. (See picture of how to make folded 4x4 dressing if a presplit is not available.)
12. Change trach ties/tube holder if needed. (See: Changing tracheostomy tube ties)
13. Ask the pt if they need anything. Lock bed, put it in lowest position with call bell in reach.



Supplies for trach care

- Trach cleaning tray (includes sterile gloves, sterile basins, pipe cleaners, brush, cotton-tipped applicators, gauze).
- Presplit non-fraying 4x4 or split drain sponge.
- Replacement inner cannula, if applicable.
- Sterile normal saline.
- Clean cotton trach ties or Velcro tube holder.
- Two sterile containers for cleaning solution and extra sterile gloves.



Documentation

- Date and Time of procedure.
- Any drainage, color, odor and amount on dressing.
- Client's response and tolerance.
- Position of the client post procedure.
- If suctioned, color, type and amount of secretions.



Sample Documentation After Trach Suctioning

**Anne G. Perry, Patricia A.
Potter, Wendy R. Ostendorf**



Sample Documentation After Trach Suctioning:

Unveiling the Magic of Words: A Report on "**Sample Documentation After Trach Suctioning**"

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