Tracheal Airway Suctioning

Student Name_____ Date_____

Goal: The patient will exhibit improved breath sounds and a clear, patent airway.

	Lewis's Medical-Surgical Nursing (12th ed.) p. 560, 568-574; Edvance360 MSN Video Resources – Tracheal Airway Suctioning & Tracheostomy Care video	S	NI/U
1.	Verify physician order and gather necessary equipment.		
2.	Introduce self & identify patient. Provide privacy.		
3.	Perform hand hygiene and apply gloves.		
4.	Adjust bed to comfortable height with the patient at semi or high-Fowlers position.		
5.	Assess the need for suctioning every 1-2 hours and PRN. Do not suction routinely unless indicated. Indications include: visible coughing, moist cough, course crackles or wheezes over large airways, restlessness or agitation, dyspnea, decreased SpO_2, and increased peak inspiratory pressure (on mechanical ventilator).		
6.	Explain the procedure to the patient, even if the patient does not appear to be alert. Reassure patient you will interrupt procedure if he or she indicates respiratory difficulty or discomfort.		
7.	Apply pulse oximeter, hyper oxygenate patient, and prepare suction (no more than 125 mmHg pressure).		
8.	Remove gloves, perform hand hygiene, and apply mask.		
9.	Open sterile suction kit, apply sterile gloves, open the sterile water bottle and place upright in container.		
10.	With dominant gloved hand, pick up sterile catheter. Pick up the suction tubing with the nondominant hand and connect the tubing and suction catheter. **The dominant hand will manipulate the catheter and must remain sterile. The nondominant hand is considered clean rather than sterile and will control the suction valve (Y-port) on the catheter.**		
11.	Place the tip of the catheter in the sterile water and occlude the Y-port to check suction.		
12.	• If performing nasotracheal suctioning: lubricate the catheter 2-3 inches with a water-soluble solution. • If performing suctioning through an artificial airway: do not lubricate the catheter with a water-soluble solution.		
13.	Remove the oxygen source using your nondominant hand.		
14.	Using your dominant (sterile) hand, *gently* and quickly insert catheter during inspiration until the patient begins to cough. • Nasotracheal- insert tube through the nostril • Artificial Airway- insert into the ETT or tracheostomy tube **Do not occlude Y-port when inserting catheter.**		
15.	As the patient exhales, apply suction by intermittently occluding the Y-port on the catheter with the thumb of your nondominant (clean) hand, and gently rotate the catheter as it is being withdrawn. **Do not suction for more than 10 seconds at a time.** • Continually observe for signs requiring immediate termination of suctioning (bradycardia, hypotension, dysrhythmia, SpO_2 <90%). • Reapply oxygen immediately if this occurs.		
16.	Between suctioning attempts, replace the oxygen delivery device (if applicable) using your nondominant (clean) hand and have the patient cough and take several deep breaths. • Several manual breaths may be needed for ventilated patients.		

17.	Flush catheter with sterile water. Wrap the suction catheter around your dominant (sterile) hand between suction attempts.		
18.	Assess effectiveness of suctioning; repeat as needed according to patient's tolerance. **Allow at least 1 minute between additional suctioning if needed. No more than three suction passes should be made per suctioning episode.**		
19.	Suction the oropharynx after suctioning the trachea. Do not reinsert the catheter in the trachea after suctioning the mouth.		
20.	When suctioning is completed, remove glove from dominant (sterile) hand over the coiled catheter, pulling it off inside out. Pull glove from nondominant (clean) hand over the first glove and dispose of gloves, catheter, and kit with solution in the trash receptacle.		
21.	Perform hand hygiene and apply gloves. Remove mask.		
22.	Return oxygen to previous setting. Turn off suction.		
23.	Assist patient to a comfortable position. Offer oral hygiene after suctioning.		
24.	Place the bed in the lowest position. Call light in reach.		
25.	Remove gloves. Perform hand hygiene.		
26.	Document pre-suctioning assessment, procedure, amount and characteristics of secretions, and post-suctioning assessment of patient.		

Each item must be completed at a Satisfactory level in order to obtain an overall Satisfactory on this skill. You may receive up to two general prompts from the faculty following completion of the skill. Any items that were omitted or performed incorrectly and not addressed to a satisfactory level during prompting will be evaluated as unsatisfactory and your overall evaluation will result in an Unsatisfactory. Unsatisfactory evaluation will require remediation and satisfactory re-demonstration of the skill.

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Faculty Signature_____ Overall Evaluation_____

Tracheostomy Care

Student Name_____ Date_____

Goal: The patient's tracheostomy tube and site will be free from drainage, secretions, and skin irritation/breakdown.

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1.	Verify physician order and gather necessary equipment.		
2.	Introduce self & identify patient. Provide privacy.		
3.	Perform hand hygiene.		
4.	Explain the procedure to the patient, even if the patient does not appear to be alert.		
5.	Adjust bed to comfortable height. Lower side rail closer to you. If patient is conscious, place him or her in a semi-Fowler's position.		
6.	Move the overbed table close to your work area and raise to waist height. Place a trash receptacle within easy reach of work area.		
7.	Suction tracheostomy if necessary.		
8.	Apply mask and prepare supplies: • Open tracheostomy care kit and separate basins, touching only the enlarged edges of inner tray. • Without contaminating it, place the sterile drape on an appropriate working surface. This will be used as a sterile field. • Fill both sides of the empty basin 0.5″ deep with saline.		
9.	Perform hand hygiene. Apply clean gloves.		
10.	Remove the oxygen source if one is present. Stabilize the outer cannula and faceplate of the tracheostomy with one hand. Rotate the lock on the inner cannula in a counterclockwise motion with your other hand to release it. Continue to hold the faceplate. Gently remove the inner cannula and carefully place it in the larger section of the basin filled with saline.		
11.	Remove soiled dressing from around the tube and dispose of it in the trash. Replace the oxygen source over the outer cannula if applicable. Remove gloves and perform hand hygiene.		
12.	Clean the inner cannula as follows: a. Put on sterile gloves. b. Organize sterile supplies on sterile drape. c. Remove inner cannula from soaking solution. Moisten brush or pipe cleaner in saline and insert into tube, using back-and-forth motion to clean. d. Agitate cannula in second saline filled basin. Remove and dry inner cannula with a 4x4 sterile gauze pad.		
13.	Remove oxygen source with nondominant hand if applicable. Stabilize the outer cannula and faceplate with nondominant hand. Replace inner cannula into outer cannula using your dominant hand. Turn to lock in a clockwise manner and check that the inner cannula is secure. Reapply oxygen source with nondominant hand if applicable.		
14.	Dip cotton-tipped applicator in second basin of sterile saline. Remove oxygen source with nondominant hand. Clean the stoma under the faceplate. **Use each applicator only once, moving from stoma site outward.** Dip the gauze pad in the same sterile saline and clean the faceplate.		

15.	Slide commercially prepared tracheostomy dressing under faceplate. Reapply the oxygen source if applicable.		
16.	If soiled, change the tracheostomy tube holder/ties: a. **Leave soiled holder/tie in place until new one is applied.** b. Insert one end of the tie through faceplate opening alongside old tie. Pull through until both ends are even length. c. Slide both ends of the tie under patient's neck and insert one end through remaining opening on other side of faceplate. Pull snuggly and tie ends. You should be able to fit two fingers between the neck and the ties. Check to make sure that the patient can flex neck comfortably. d. Carefully remove old holder/tie.		
17.	Discard supplies. Remove gloves and mask.		
18.	Perform hand hygiene and apply clean gloves.		
19.	Assist the patient to a comfortable position. Reassess patient's respiratory status.		
20.	Place the bed in the lowest position. Call light in reach.		
21.	Remove gloves. Perform hand hygiene.		
22.	Repeat tracheostomy care every 8 hours and PRN.		
23.	Document procedure, assessment of patient's respiratory status and response to procedure.		

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Faculty Signature_____ Overall Evaluation_____