ChildrenFirst
Health Care System
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TRACH INFORMATION SHEET

TWO TYPES: Shiley & Bivona

CHARACTERISTICS:

Shiley trachs tend to be a little more rigid compared to Bivona trachs. Either trach may or may not have a cuff. The trach has the same sized obturator (i.e. 3.0 trach has a 3.0 obturator).

TRACH CUFFS:

Shiley trach cuffs are filled with air. Bivona trach cuffs are filled with sterile water.

SITE CARE:

Once a shift or more frequently as needed. Clean technique is used unless otherwise ordered by the Physician.

CLEANING THE TRACH ITSELF:

Shiley trachs are cleaned in the following way:

- Using ½ strength hydrogen peroxide solution, rinse with sterile water and air dry. Package in a clean container.

Bivona trachs are cleaned in the following way:

- Bring water to a boil and remove from the heat source. Place the trach and the obturator in the water for 10 minutes. Remove the items after 10 minutes, allow to air dry, and package in a clean container.

These are the manufacturer's recommendations. Both Shiley and Bivona trachs can be cleaned using ½ strength hydrogen peroxide.

TRACH TIES:

Changed once a shift or more frequently as needed.

SUCTIONING:

- ChildrenFirst Policy states suctioning should be performed at a minimum of every 4 hours. More frequent suctioning will be needed for increased amounts of secretions or for smaller sized trachs.
- Apply suction only when pulling back on suction catheter.
- Suctioning is performed using clean technique unless otherwise ordered by the Physician.

FREQUENCY OF TRACH CHANGE: As ordered by the Physician.

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SUCTIONING THE TRACHEOSTOMY

POLICY:
Tracheostomy suctioning is performed every shift and PRN

PURPOSE:
To maintain a clear airway.

RESPONSIBILITY:
Qualified RN, LPN, Parent or Caregiver

EQUIPMENT:

- Sterile Suction Catheter
- Sterile gloves
- Sterile H2O
- Sterile normal saline
- Suction machine and tubing
- Ambu bag available in case of emergency

PROCEDURE:

- Gather all supplies
- Wash hands well
- Explain procedure to client
- Open sterile suction catheter kit
- Put sterile water in container provided
- Don sterile gloves
- Attach catheter to suction tubing, maintaining sterility of suction catheter
- Turn on suction machine
- Remove client from ventilator
- Suction just past tip of trach tube – usually this elicits a cough
- Clear suction tubing with sterile water after pass
- Provide supplemental oxygen, as needed and/or place client back on ventilator between suction passes.
- Note amount, character and odor of secretions.

DOCUMENTATION:

1. Document on client flow sheet and nurse's notes, including type of secretions and tolerance of procedure.
2. Report signs of infection or intolerance of procedure to nursing supervisor.

SUCTIONING THE TRACHEOSTOMY (STERILE)

POLICY:
Tracheostomy suctioning is performed every shift and PRN. Sterile suctioning is performed only when specifically ordered by the Physician.

PURPOSE:
To maintain a clear airway.

RESPONSIBILITY:
Qualified RN, LPN, Parent or Caregiver

EQUIPMENT:
- Sterile suction catheter
- Sterile gloves
- Sterile H2O
- Sterile normal saline
- Suction machine and tubing
- Ambu bag available in case of emergency

PROCEDURE:
1. Gather all supplies
2. Wash hands well
3. Explain procedure to client
4. Open sterile suction catheter kit
5. Put sterile water in container provided
6. Don sterile gloves
7. Attach catheter to suction tubing, maintaining sterility of suction catheter
8. Turn on suction machine
9. Remove client from ventilator
10. Suction just past tip of trach tube – usually this elicits a cough
11. Clear suction tubing with sterile water after pass
12. Provide supplemental oxygen, as needed and/or place client back on ventilator between suction passes
13. Note amount, character and odor of secretions

DOCUMENTATION:
1. Document on client flow sheet and nurse's notes, including type of secretions and tolerance of procedure.
2. Report signs of infection or intolerance of procedure to nursing supervisor.

CHANGING TRACHEOSTOMY TIES

POLICY:

Tracheostomy ties will be routinely changed, and skin area affected, inspected every shift and PRN per Physicians order.

PURPOSE:

To maintain skin integrity.

RESPONSIBILITY:

Qualified RN, LPN, Parent or Caregiver

EQUIPMENT:

- Non-sterile exam gloves
- Clean tracheostomy ties (Supplies may vary: Dale holders, etc.)
- Two (2) wash cloths, one cloth for rinsing and one cloth for drying
- Warm water in basin
- Soap, cleanser, and water

PROCEDURE:

1. Wash hands thoroughly with antimicrobial cleanser
2. Assemble equipment at client's side
3. If using twill tape, measure and cut twill tape long enough to circle child's neck and to tie a square knot
4. Explain to client what you are doing
5. Don non-sterile exam gloves
6. Securely holding trach flanges remove one side of the tracheostomy tie, and inspect neck for redness, drainage, or loss of skin integrity
7. Wash and dry neck thoroughly - use soap and water unless otherwise ordered
8. Loop one side of new tracheostomy tie through flange
9. Remove old tie from second side of trach
10. Wash and dry neck thoroughly
11. Loop second side of new tie through flange and secure
12. Adjust ties as needed to assure snugness (2 fingers can fit)
13. If using twill tape, tie to one side with square knot
14. Alternate the square knot site each day from one side to the other
15. Apply ointments or cream as directed by the Physicians order

DOCUMENTATION:

1. Document on client flow sheet, visit repost summary, or individual nurses' notes.
2. Repost signs of infection or skin breakdown to nursing supervisor.

COMPLIANCE:

100% Compliance with Physician's order.

CHANGING TRACHEOSTOMY TUBE

POLICY:

Change tracheostomy tube as directed by the Physician.

PURPOSE:

1. To maintain patency of airway.
2. To maintain integrity of tracheostomy stoma.

RESPONSIBILITY:

Qualified RN, LPN, Parent or Caregiver

EQUIPMENT:

- Assure proper size for client
- Clean tracheostomy tube
- Clean tracheostomy ties
- Two (2) wash cloths, one for cleaning and one for drying the neck area
- Suction catheter and suction machine set up and ready for use
- One pair of non-sterile gloves
- Ambu bag or O2 as necessary
- 2x2 or 4x4 drain sponges
- K-Y jelly or other lubricant

PROCEDURE:

1. Wash hands with antimicrobial soap
2. Collect all materials needed for procedure at client's bedside
3. Asses respiratory status
4. Don non-sterile gloves
5. Place lubricant on 4x4 and place tip of tracheostomy tube, with obturator in place, in lubricant
6. If tube cuffed, test cuff prior to trach insertion
7. Explain to client what you are going to perform
8. Position client for replacement of tracheostomy tube: Gentle hyperextension of neck in sitting or supine position
9. If 2 people are involved, determine roles prior to beginning procedure
10. Suction dirty tracheostomy tube prior to replacement - assure tracheostomy tube, oral, and nasal passages are clear of secretions prior to removal
11. Deflate cuff
12. Remove dirty tube with one hand and insert clean tube with the other, then remove obturator
13. Secure tracheostomy tube position by holding the flanges of tracheostomy tube while attaching clean trach ties
14. Inflate cuff
15. Assure tracheostomy tube is securely in place
16. Repeat suctioning as necessary

CHANGING TRACHEOSTOMY TUBE (CONT.)

17. If client is ventilator dependent, either use Ambu bag or continue with mechanical ventilation after tube is placed
18. Assess respiratory status

19. Inspect neck area and stoma site for any redness or swelling

DOCUMENTATION:

1. Document procedure, respiratory assessment and patient tolerance on client flow sheet, visit report summary, or individual nurses' notes.
2. Report any untoward effect to nursing supervisor.

COMPLIANCE:

100% compliance with Physician's order.