

**PARKLAND HEALTH & HOSPITAL SYSTEM**  
**Nursing Services**

Section: Respiratory  
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**CARE OF TRACHEOSTOMY and DISCHARGE TEACHING**

**PRACTICE**

**STATEMENT:** Qualified personnel shall perform tracheostomy care and suctioning, using sterile technique.

**PURPOSE:** To maintain adequate ventilation and a patent airway.  
To remove secretions in the tracheobronchial tree  
To maintain cleanliness of the tracheostomy area  
To prepare patient and family for discharge

**EQUIPMENT:** Wall suction apparatus and tubing *or* suction machine at bedside at all times  
Sterile suction kit with gloves at bedside at all times  
Yankauer suction at bedside at all times  
Tracheostomy care kits  
Normal saline  
Gloves, mask and goggles  
Normal Saline for instillation  
Paper cup of tap water  
Disposable Inner cannula — size appropriate  
Syringe 10 ml for cuff  
Cuffed tracheostomy tube with inner cannula (same size of the existing trach tube) in plastic bag taped to head of bed at all times  
Correct size obturator in plastic bag taped to head of bed at all times

**NOTE:** The patient should be provided with a means of communication; e.g., paper and pencil.

The extra cuffed tracheostomy tube and inner cannula (same size of existing trach) should be placed in a clean bag, sealed with patient's label and secured at the head of the bed.

Obturator should be placed in a separate bag and secured at the head of the bed.

The presence of functional safety equipment (extra trach, obturator, suction catheters, functional suction setup) should be documented at the beginning of the shift on the Multidisciplinary Tracheostomy Flowsheet.

PROCEDURE:

A. Suctioning the Tracheostomy

Identify patient using two unique identifiers, name and medical record number or name and date of birth.

Suctioning shall be performed as necessary, to keep airway clear and free of secretions. See procedure NSG-34-06, Suctioning of Adult Patient, for suctioning details. <http://intranet.pmh.org/home/home/PP-Index/Nursing/34-06.pdf>

B. Tracheostomy Care

Identify patient using two unique identifiers, name and medical record number or name and date of birth.

1. Change tracheostomy dressing at least every 24 hours or as often as necessary to keep dry and clean.
2. After suctioning, remove the old dressing, using non-sterile gloves.
3. Open tracheostomy care kit.
4. Put on sterile gloves.
5. Cleanse the wound with sterile cotton-tipped applicators moistened with 1:1 NS-Hydrogen Peroxide and then clean with Normal Saline.
6. Apply sterile dressing. Trach sponges or 4X4's may be utilized.
7. The trach ties shall be changed every 24 hours or if they become soiled or wet with secretions. Insert the new trach ties through one flange and pull it through to form a double strand at the back of the neck. Insert one end through the second flange and tie both ends with a square knot. Remove the old ties.
8. Remove gloves and wash hands.
9. Document in the Multidisciplinary Tracheostomy Flowsheet.

C. Disposable Inner Cannula:

1. Assess the need for inner cannula change every eight hours. Change inner cannula at least every 24 hours and prn according to patient's need.
2. Remove inner cannula and discard.

3. Open disposable inner cannula package keeping the clear tube sterile for insertion. Lift only by hub. Reinsert inner cannula and secure in place.
4. Remove gloves and wash hands.
5. Document in Multidisciplinary Tracheostomy Flowsheet.

D. Clean the inner cannula (non-disposable):

1. Clean the inner cannula at least once every eight hours and more frequently, if needed.
2. Remove inner cannula and place in basin of 1:1 Hydrogen Peroxide/ Sterile Saline.
3. Don sterile gloves.
4. Thoroughly cleanse the inner cannula, using sterile cotton-tipped applicators.
5. Transfer inner cannula to basin of sterile Normal Saline and rinse. Shake dry.
6. Reinsert inner cannula and secure in place.
7. Remove gloves and wash hands.
8. Document in Multidisciplinary Tracheostomy Flowsheet.

E. Care of the Tracheostomy Cuff

1. The cuff is always deflated unless the patient is on a ventilator or is receiving intermittent positive pressure therapy.
2. If a patient becomes nauseated or vomits while the cuff is deflated, immediately inflate the cuff and notify the provider.
3. Always suction the mouth and oral pharynx prior to deflating the cuff.
4. When the patient is mechanically ventilated, the cuff is inflated utilizing the minimal occlusive volume technique.

F. Preparation for Discharge:

1. Ensure provider has changed to non-disposable tracheostomy.
2. Teach patient and caregiver all aspects of trach care.
3. Initiate teaching early enough to allow the patient and/or caregiver adequate time to practice with the suction machine and to give return demonstrations on all aspects of care.
4. Notify the social worker to order a suction machine to be delivered to the patient's home prior to discharge.
5. Notify patient care coordinator to evaluate the patient for follow-up teaching visits after discharge.
6. Parent/guardian will be taught CPR prior to discharge of pediatric patients. CPR is taught by a staff member with CPR instructor credentialing. Documentation of CPR instruction is recorded in the progress notes of the patient's chart and on the discharge instruction sheet.

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