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

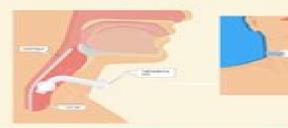
- Risk for infection.
- Risk for decreased oxygenation.
- Risk for injury from insertion or removal.
- When performing tracheostomy care, emergency supplies should be available at all times in case the tube is inadvertently dislodged, and an ambu bag to administer breaths as needed for the client on 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.
- Explain procedure to patient.
- Open trach tray and put on one sterile glove in order to set up two basins.
- With an ungloved (non-sterile) hand, pour saline into each basin.
- Don the second sterile glove both hands are now sterile.
- 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.
- 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.
- Place cleaned inner cannula on sterile gauze and dry thoroughly.
- Replace inner cannula with care, stabilizing outer flange with opposite hand. Lock into place (turn RIGHT).
- 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.
- 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.)
- Change trach ties/tube holder if needed. (See: Changing tracheostomy tube ties)
- 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.



Trach Care Documentation

JE Gale

Trach Care Documentation:

Nursing Know-how, 2009 Provides information on documentation issues including electronic medical records legal and ethical implications and documentation in acute cases along with a variety of charting examples Documentation ,2007 This full color handbook is a guick reference guide to all aspects of documentation for every nursing care situation It covers current documentation systems and formats including computerized documentation and features scores of sample filled in forms and in text narrative notes illustrating everything from everyday occurrences to emergency situations Coverage includes timesaving strategies for admission to discharge documentation in acute outpatient rehabilitation long term and home care environments and special documentation practices for selected clinical specialties critical care emergency perioperative maternal neonatal and psychiatric The book includes advice on legal safeguards dangerous abbreviations and compliance with HIPAA guidelines and JCAHO requirements <u>Documentation in Action</u> Lippincott Williams & Wilkins, 2006 Designed for rapid on the job reference Documentation in Action offers comprehensive authoritative practice oriented up to the minute guidelines for documenting every situation in every nursing practice setting and important nursing specialties Need to know information is presented in bulleted lists charts flow sheets sidebars and boxes with icons and illustrative filled in samples Coverage includes documentation for care of patients with various diseases complications emergencies complex procedures and difficulties involving patients families and other health care professionals Suggestions are given for avoiding legal pitfalls involving telephone orders medication reactions patients who refuse care and much more A section addresses computerized documentation HIPAA confidentiality rules use of PDAs nursing informatics and electronic innovations that will soon be universal Taylor's Clinical Nursing Skills Pamela Lynn, 2022-08-03 Extensively updated with the latest evidence based approaches engaging learning features and detailed high quality photographs Taylor's Clinical Nursing Skills 6th Edition gives students the confidence and clinical judgment to effectively incorporate cognitive technical interpersonal and ethical legal skills for exceptional patient care This robust text guides students step by step through the full continuum of clinical nursing skills and complements Fundamentals of Nursing The Art and Science of Person Centered Care 10th Edition to create a seamless superior learning experience throughout the nursing curriculum and equip students for successful nursing practice Long Term Care Survey ,1986 The Code of Federal Regulations of the United States of America, 1995 The Code of Federal Regulations is the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal Government Federal Register ,1988-06-17 Code of Federal Regulations, Title 42, Public Health, Pt. 482-End, Revised Code of Federal Regulations ,1994 **As of October 1 2012** U S Office of the Federal Register, 2012-12-20 Code of Federal Regulations United States. Department of the Interior, 2000 Special edition of the Federal register containing a codification of documents of general applicability and future effect as of with ancillaries Documentation and Reimbursement for Speech-Language

Pathologists Nancy Swigert, 2024-06-01 Although it is the least noticed by patients effective documentation is one of the most critical skills that speech language pathologists must learn With that in mind Documentation and Reimbursement for Speech Language Pathologists Principles and Practice provides a comprehensive guide to documentation coding and reimbursement across all work settings The text begins with section 1 covering the importance of documentation and the basic rules both ethical and legal followed by an exploration of the various documentation forms and formats Also included are tips on how to use electronic health records as well as different coding systems for diagnosis and for procedures with an emphasis on the link between coding reimbursement and the documentation to support reimbursement Section 2 explains the importance of focusing on function in patient centered care with the ICF as the conceptual model then goes on to cover each of the types of services speech language pathologists provide evaluation treatment planning therapy and discharge planning Multiple examples of forms and formats are given for each In section 3 Nancy Swigert and her expert team of contributors dedicate each chapter to a work setting in which speech language pathologists might work whether adult or pediatric because each setting has its own set of documentation and reimbursement challenges And since client documentation is not the only kind of writing done by speech language pathologists a separate chapter on other professional writing includes information on how to write correspondence avoid common mistakes and even prepare effective PowerPoint presentations Each chapter in Documentation and Reimbursement for Speech Language Pathologists contains activities to apply information learned in that chapter as well as review questions for students to test their knowledge Customizable samples of many types of forms and reports are also available Included with the text are online supplemental materials for faculty use in the classroom Documentation and Reimbursement for Speech Language Pathologists Principles and Practice is the perfect text for speech language pathology students to learn these vital skills but it will also provide clinical supervisors new clinicians and speech language pathologists starting a private practice or managing a department with essential information about documentation coding and reimbursement **Journal** ,1988 Canadian Clinical Nursing Skills and Techniques E-Book Shelley Cobbett, Anne G. Perry, Patricia A. Potter, Wendy R. Ostendorf, 2019-05-21 NEW Fully revised for a Canadian classroom includes Canadian statistics references and resources protocols documentation standards delegation rules Canadian nursing best practice guidelines metric measurements and more NEW All topics skills and sample documentation conform to Canadian provincial and territorial scopes of practice and Canadian standards in nursing practice NEW Inclusion of Canadian concepts Person Centred Care Evidence Informed Practice Interprofessional Collaboration and Delegation and Care in the Community NEW Greater emphasis on cultural assessment considerations and caring for Indigenous and vulnerable populations NEW Thoroughly revised chapters reflect Canadian practice and guidelines including Emergency Preparedness and Disaster Management Palliative Care Cardiac Care Vascular Access and Infusion Therapy Oral Nutrition and Prevention of Skin Breakdown and Wound Care NEW Enhanced and updated art program includes 70 new figures **Document**

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Table of Contents Trach Care Documentation

- 1. Understanding the eBook Trach Care Documentation
 - The Rise of Digital Reading Trach Care Documentation
 - Advantages of eBooks Over Traditional Books
- 2. Identifying Trach Care Documentation
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
- 3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Trach Care Documentation
 - User-Friendly Interface
- 4. Exploring eBook Recommendations from Trach Care Documentation
 - Personalized Recommendations
 - Trach Care Documentation User Reviews and Ratings
 - Trach Care Documentation and Bestseller Lists
- 5. Accessing Trach Care Documentation Free and Paid eBooks
 - Trach Care Documentation Public Domain eBooks
 - Trach Care Documentation eBook Subscription Services
 - Trach Care Documentation Budget-Friendly Options
- 6. Navigating Trach Care Documentation eBook Formats

- o ePub, PDF, MOBI, and More
- Trach Care Documentation Compatibility with Devices
- Trach Care Documentation Enhanced eBook Features
- 7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Trach Care Documentation
 - Highlighting and Note-Taking Trach Care Documentation
 - Interactive Elements Trach Care Documentation
- 8. Staying Engaged with Trach Care Documentation
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Trach Care Documentation
- 9. Balancing eBooks and Physical Books Trach Care Documentation
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Trach Care Documentation
- 10. Overcoming Reading Challenges
 - $\circ\,$ Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
- 11. Cultivating a Reading Routine Trach Care Documentation
 - Setting Reading Goals Trach Care Documentation
 - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Trach Care Documentation
 - Fact-Checking eBook Content of Trach Care Documentation
 - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
- 14. Embracing eBook Trends
 - Integration of Multimedia Elements
 - Interactive and Gamified eBooks

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