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| Suctioning | | | | NO. | |
| Purpose: To provide safe suctioning to residents.  Statement: It is the policy of this facility that there must be a physician’s order for suctioning stating the frequency and only licensed nurses are authorized to suction residents.  Procedure:   1. When taking a suction machine from the supply room, the nurse must enter on the supply room log: 2. Date 3. Signature 4. Resident’s name and room number 5. Suctioning Technique 6. Put on goggles and mask or face shield. 7. Turn on the suction machine. 8. Set the vacuum regulator to the appropriate negative pressure. A negative pressure of 80-100 mmHg is recommended. 9. Secure one end of the connection tubing to the suction machine. 10. Open the sterile package containing the suctioning kit. 11. Open the container of sterile normal saline, and pour into the well of the kit to fill it halfway. 12. Put on sterile gloves. 13. The dominant hand must remain sterile throughout the procedure. 14. Pick up suction catheter with the dominant hand. 15. Pick up the connection tubing with the non-dominant hand. 16. Attach the suction catheter to connection tubing. 17. Suction a small amount of sterile saline from the well in the suction kit. 18. With the dominant hand insert the catheter without suction pressure into the tracheostomy until resistance is met; then pull back 1-2 cm. 19. Never apply suction pressure when inserting. This could cause hypoxia and damage to the tracheal mucosa. 20. Apply intermittent suction by moving the dominant thumb up and down over the control vent of the suction catheter. 21. Rotate the catheter gently, and withdraw the catheter. 22. Suction sterile saline from the suction kit well until the suction catheter and connection tubing are clear of secretions. 23. Monitor the resident’s respiratory status during and between suctioning. 24. Observe for signs of hypoxemia, cyanosis, and bronchial spasms. 25. After tracheal suctioning is completed, perform oral and nasal suctioning if needed, to remove upper airway secretions. The catheter is contaminated after oral and nasal suctioning, and should not be reinserted into the tracheostomy. 26. After all suctioning is completed, wrap the catheter around the dominant hand, and pull it glove off inside out so the catheter stays inside the glove. | | | | | |
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| Suctioning | | | | NO. | |
| 1. Pull off the other glove, and discard both. 2. Turn off the suction machine. 3. Replace the suction container, connection tubing, and sterile saline solution every 24 hours. Date and initial the replacement equipment. 4. Keep the resident well hydrated to thin secretions. 5. Monitor the resident every four hours for: 6. Respiration rate and depth 7. Cough 8. Abnormal lung sounds 9. Tachypnea or dyspnea 10. Excessive or thick secretions 11. Cyanosis 12. Choking 13. Chest pain 14. Wheezing 15. Encourage the resident to turn every two hours. 16. Teach the resident to cough and deep breathe. 17. Keep the head of the resident’s bed up 45 degrees at all times. 18. The Unit Nurse must document each shift: 19. Times suctioned 20. Results: amount, color, consistency 21. Respiratory rate, depth, effort 22. Lung sounds 23. Cough, character of sputum 24. Temperature 25. Treatments and medications given 26. Oxygen rate, flow, and route 27. Activity tolerance 28. Laboratory results and pulse oximeter readings 29. When the physician orders suctioning to be discontinued, the suction machine must be: 30. Bagged and sealed in a plastic hazardous waste bag 31. Removed from the resident’s room 32. Placed in the dirty utility room | | | | | |
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