SUCTIONING

Los Angeles County College of Nursing and Allied Health
N233L - 3rd Semester
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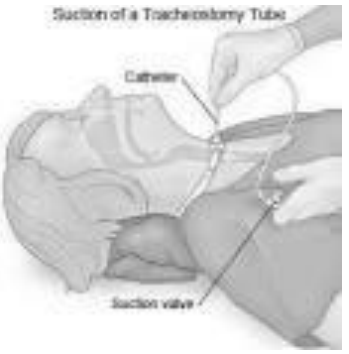
Skills Competency (at end of semester)

- **You must be able to answer:**
  - Three interventions to perform on patient prior to suctioning
    - 1. ID patient
    - 2. Respiratory Assessment
    - 3. Establish communication via hand signals
  - Five objects that must be in the room prior to suctioning
    - 1. Obturator
    - 2. O2 wall/tank set up (with tubing)
    - 3. Ambubag
    - 4. Suction setup (including suction canister and tubing)
    - 5. O2 Sat machine (only if patient tends to desat on suctioning)

Suctioning

- When pts cannot handle their secretions or an artificial airway is applied, suctioning may be needed to clear airway
- Suctioning is the aspiration of secretions through a catheter connected to a suction machine or wall suction outlet
- Use sterile technique

Suctioning a Patient



Prior to Suctioning

- Introduce self and ID your pt
- Explain what you are goin to do, why necessary, and how pt can participate
- Inform pt that suctioning will relieve breathing difficulty and is painless but uncomfortable as may stimulate cough, gag, or sneeze reflex.
- Perform hand hygiene
- Provide privacy
- Position pt in semi-fowlers to promote deep breathing, lung expansion, and productive coughing

Nursing Clinical Protocol 638-5

1. Encourage pt to expectorate secretions via tracheostomy if possible as needed
2. Pre-oxygenate prior to suctioning if pt has been using 02 a minimum of 1 minute prior to suctioning
3. Suction artificial airway and mouth as indicated by the following:
   a) Pt indicates need for suctioning
   b) Secretions present from and around trach tube
   c) Coarse breath sounds/rhonci present
   d) Unexplained resp distress
   e) Noisy breathing
   f) Audilbe secretions/gurgling
   g) Increased RR, HR & BP
   h) Decreased 02 Sat on pulse ox

Nursing Clinical Protocol 638-5 (cont'd)

4. Monitor for s/s of hypoxia during suctioning, including:
   a) Change in LOC
   b) Pallor, diaphoresis, cyanosis
   c) Sustained SOB
   d) Sustained anxiety
5. Suction nose then mouth after tracheal suctioning

Suction Catheter Kit

Thumb suction control valve

Select a kit by the appropriate size catheter.

Suction Catheter

- Kits can come with a tray or be flat
- Each kit has:
  - 1 Suction catheter
  - 1 Pop-up cup
  - 2 Sterile gloves
- You'll need Normal Saline to fill the pop up cup

Steps in Suctioning

- After steps in prior suctioning done
  - Make sure your wall suction is on with tubing connected
  - Be sure Ambu bag nearby
  - Place a towel below trach
  - Apply goggles & mask if needed
  - Open sterile suction kit
  - Pour NS in cup
  - Apply sterile gloves

SEE NEXT SLIDE……..

Once Sterile Gloves Applied

- Hold catheter in dominant hand and the connector tubing in nondominant hand, attach suction cath to suction tubing {See pg 1273-1275 Berman}
- Flush and lubricate the catheter
  - Using dominant hand, place cath tip in sterile NS
  - Using thumb of nondominant hand, occlude the thumb control and suction a small amount of NS with cath (this assures suction and lubricates cath)

Inserting Catheter

- Quickly but gently insert the catheter WITHOUT applying any suction
  - With nondominant thumb off the suction port, quickly but gently insert the cath into trachea through the trach tube (this prevents trauma and 02 loss)
  - Insert cath 0.5-1cm past the distal end of the tube OR until the pt coughs
  - If you feel resistance, withdraw cath 1cm before applying suction

Apply Suction

- Apply suction for 5-10 seconds by placing nondominant thumb over the thumb port
- Rotate the cath by rolling it between thumb and forefinger while slowly withdrawing it while
- Withdraw cath completely and release suction (per your book)
  - Our protocol is to apply intermittent suction (controlled by thumb) as catheter is withdrawn.
- Reassess pt 02 status and repeat suctioning if needed

Reassess Before Suctioning Again

- Reassess pts 02 status before suction again:
  - Observe resps, skin color, pulse if needed using nondominant hand
  - Encourage pt to breath deeply and cough between suctions
  - Allow 2-3 minutes with 02 on between suctions if needed
  - Flush cath and repeat if needed
- When done suctioning trach, suction nose then mouth
  - Clear the catheter with NS if secretions thick

Very Thick Secretions

- If secretions are very thick, we can "lavage with 10 mL of NS ONLY if tenacious secretion are noted" per Respiratory Care Services Policy/Procedure #7.122
- Use caution when lavaging as this may stimulate patient's cough reflex and may spew the NS and secretions out of trach
  - Use goggles if lavaging to avoid pt spewing in your eyes

After Suctioning

- Provide comfort and safety for patient
- Assist to a comfortable position that aids in breathing

Documentation

- Record the suctioning, including
  - Amount and description of secretions
  - How patient tolerated it
  - If patient desaturated or any other relevant assessments
- Evaluation
  - Perform a follow-up assessment in 20-30 minutes to determine effectiveness of suctioning

The End

- Information for this handout from:
  - Berman, A., Snyder, S. Kozier, B. (2016). *Kozier & Erb's Fundamentals of nursing: Concepts, process and practice (10th Ed.)* New Jersey: Prentice-Hall, Inc.
  - LAC-USC Medical Center Dept. of Health Services (2015). *Nursing Clinical Protocol (NCP) 638-5.*
  - LAC-USC Respiratory Care Services (2010). *Artificial Airway Suctioning Policy/Procedure #7.122.*

Thank You – Good Luck on Skills Comps!!!