the patient’s resuscitator bag to temporarily supply oxygen while you drain the tubing.

Perform suctioning as indicated: Audible, noisy secretions; coughing; decreased pulse oximeter saturation; and rhonchi heard on auscultation all point to the need to suction. Use sterile technique and follow the standard steps for suctioning.

Oral care helps reduce the risk of infection by removing oral secretions and by controlling bacterial growth in the mouth. It also adds to the patient’s comfort and well-being. Avoid using products that contain alcohol; they tend to dry out the oral mucosa, change the pH, and promote bacterial growth. Clean the patient’s teeth with a soft toothbrush and water, and apply balm to his lips to prevent cracking. Carefully suction the oropharynx with a tonsillar (Yankauer) suction catheter to clear esophageal and oral secretions. Never use oral suction equipment to suction the tracheostomy; you’ll bring in oral bacteria to the lower airway and greatly increase the risk of infection.

Avoiding obstacles
Your patient with a tracheostomy may be frustrated by the difficulty he has in speaking. Even with a fenestrated tracheostomy, his voice may be very weak; trying to make himself heard can be exhausting. Provide writing supplies or a communication board with letters and pictures. Everyone wins! Your patient can get his message across, and you can stop trying to read his lips.

Nutrition may be compromised due to difficulty swallowing or aspiration of mouth contents while trying to eat. Most long-term tracheostomy patients will be given tube feedings; some may be given oral feedings. No matter how patients are fed, keep the head of the bed elevated at least 45 degrees during meals to lower the risk of aspiration. The head of the bed is also elevated at least 30 degrees when patients are receiving tube feedings. Ask the dietary department to provide smaller, more frequent meals. Counsel the patient to take his time eating. “Don’t inhale your food!” isn’t just a figure of speech.

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Assess the tissue around the stoma for signs of infection (redness, swelling, drainage) or bleeding. Report any concerns promptly to the surgeon or other appropriate health care provider. If the patient is clearing a lot of secretions or if the incision is bleeding, you may need to change the dressing between stoma cleanings.

If the patient has a reusable inner cannula and is getting mechanical ventilation, keep two inner cannulas at his bedside, if required by facility policy. That way, you can minimize the time the patient’s disconnected from the ventilator by cleaning the used one as you insert a clean one, leaving it at his bedside in a sterile container to use next time. Some patients will require bagging or other manual assistance with their breathing while they’re disconnected from the ventilator.

Breathe easy
Because a tracheostomy bypasses the patient’s upper airway, the air must be warmed and humidified to avoid hypothermia and thickening of secretions. For patients who are breathing spontaneously, a large-volume jet nebulizer with a heater attachment can do the job. These devices supply fraction of inspired oxygen (FIO2) in the range of 0.28 to 1.00 and 100% humidity at or around body temperature.

The oxygen humidifier-heater setup should provide a visible mist through the oxygen delivery system (either a T-piece or a trach collar setup). Never let water collect in the tubing that runs from the nebulizer to the patient: It can increase the risk of infection, decrease the delivered FIO2, and possibly drown the patient.

Some institutions use a drainage bag at the midway point of the tubing. Otherwise, if you see water starting to collect, disconnect the T-piece or trach collar from the trach, drain the water out of the distal end of the tubing, then reconnect the oxygen delivery system to the trach. If your patient’s sensitive to being off supplemental oxygen, use a secondary source for oxygen. For example, use

Some assembly required
Prepackaged tracheostomy kits are available to replace the tracheostomy. Many facilities require that a duplicate tracheostomy kit be kept at the patient’s bedside in case the trach tube needs to be replaced. Once a tracheostomy’s in place, monitor the site frequently until the tissue surrounding the stoma is stabilized. Expect a new stoma to bleed at first and to stop bleeding during the stabilization period, about 48 to 72 hours postprocedure. Follow your facility’s policies and procedures for postoperative care. Usually, the dressing and trach ties (or neck strap) should remain undisturbed for 48 hours to let the stoma heal and the bleeding stop. Report any excessive bleeding promptly to the surgeon.

Maintenance schedule
Once the stoma is healed, follow your facility’s policy regarding the frequency of trach care. The tasks involved in routine care include:
- checking the trach ties (or neck strap) and replacing or adjusting them as needed if they’re soiled, too loose, or too tight
- assessing and cleaning the stoma and changing the dressing
- replacing or cleaning and reinserting the inner cannula
- checking the oxygen humidifier-heater setup
- assessing the patient for the need for suctioning
- performing oral care.

Change the trach ties or neck strap whenever it gets soiled or once a day if your facility’s policy recommends that. Make sure it doesn’t bind: You should be able to get one or two fingers between it and your patient’s neck.

**MOVe it!**
The minimal occluding volume (MOV) technique can verify that the tube cuff is at its lowest inflation point for patients receiving positive pressure ventilation; pressures can also be measured with a cuff pressure-measuring device. The MOV technique is as follows:
1. Position your stethoscope on the patient’s neck at the area of the carotid pulse.
2. Attach a 10-mL syringe to the pilot balloon of the inflated cuff.
3. Slowly remove air from the cuff (1 mL at a time) until you hear a very slight leak at the peak of inspiration. Once you hear the leak, add 1 mL of air back into the cuff.

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