TRACHEOSTOMY CARE

Definitions:

Trachea-Windpipe

Tracheostomy- Surgically created hole that extends from the neck skin into the windpipe or trachea.

Outer Cannula- The outer part of a trach tube. Usually stays in place as long as you have a tracheostomy.

Inner Cannula- The inner part of a trach tube. It can be removed for cleaning without removing the entire tracheostomy tube.

Stoma- The connection from the skin to the trachea. It may be used to refer to the neck hole of a tracheostomy.

Obturator- Enables the tracheostomy tube to be precisely guided through the stoma into the windpipe. It is removed after insertion and typically replaced with an inner cannula.

Reasons for having a Trache:

1. A large object blocking the airway
2. An inherited abnormality of the larynx or trachea
3. Breathed in harmful material such as smoke, toxic gases, etc.
4. Sleep apnea
5. Cancer
6. Paralysis
7. Neck/mouth injuries
8. Inability to breath on your own

Some risks of having a Trache:

1. Erosion of the trachea
2. Nerve damage
3. Scar tissue
4. Bleeding
5. Infection

Other Possible Complications of Tracheostomy:

1. Inability to communicate/ Ineffective communication
2. Drying out of secretions
3. Reduced ability to heat, moisten and filter incoming gases and to cough.
4. Displacement of trache tube
5. Constipation due to inability to increase intrathoracic pressure used to defecate
Caring for a patient with a trache in the home is a multi-disciplinary approach. Nurses, physical therapists, occupational therapists, speech therapists and social workers may all be involved in coordination of care. Patients will travel through various stages of acceptance of their trache. Teaching of trache care, infection control, possible complications and discharge planning should be an ongoing process. Whether or not trache care is completed at a visit, the trache site should be assessed and documented accordingly at each visit.

There are many designs of trache tubes. Most patients have a plastic device made up of a small inner tube inserted into a larger outer tube. This smaller tube (inner cannula) can be removed for cleaning while the outer tube (outer cannula) remains in place to maintain the patency of the airway. Tubes may or may not have an inflatable cuff, which prevents aspiration of secretions. Cuffs are also used to maintain a seal where patients require mechanical ventilation. Some tubes have a small hole “fenestration” to allow air to pass through the vocal cords. The enables the patient to speak and re-establish upper airway breathing when the trache tube is occluded with a one way valve. Traches with an inner tube is safer than one without. If there is an obstruction the inner tube can be removed quickly and a clean patent tube inserted.
Frequency of changes depends on the type and amount of secretions produced. Refer to the physicians orders.

Safety Measures:

1. It is important to assess respiratory function and the type of secretions removed through suctioning or coughing.
2. A replacement inner tube should be specifically designed for the size and type of trache tube.
3. If a fenestrated inner tube is used, then a non-fenestrated inner tube should be used to avoid trachea-bronchial trauma.
4. Instruct the patient/caregiver on what to do in an emergency and how to access emergency aide.
5. Instruct patient/caregiver prior to any trache cleaning, changing, manipulation.
6. Wash hands per policy and maintain proper universal precautions, wearing personal protective equipment at all times.
7. Document thoroughly any care provided in the patients medical record.
8. Obtain physician orders for trache care/maintenance.

For cleaning of Trache, refer to “Trach Button Cleaning Policy”. See below.

- Prior to cleaning, explain procedure to patient, assess patients ability to tolerate procedure, implement infection control procedures, handwashing, and apply personal protective equipment.
- Ensure you are familiar with how the inner tube is locked in place to the outer tube.
- Alert patient to the fact that the procedure may make the patient cough.
- Temporarily disconnect oxygen supply if one is attached.
- Unlock trache inner tube. Remove the “inner cannula” tube following the line of the tube.
• Insert the replacement inner cannula into the outer cannula following the line of the tracheostomy. Lock the inner tube in place according to manufacturer’s guidelines.
• Reapply oxygen therapy as ordered.
• Clean “dirty” tube according to policy. Never blow on or fan tube to dry. Allow to air dry.

Company Policy: From “HomeCareForYou.com > Intranet>Policies

PURPOSE: Is to maintain a clean environment surrounding the stoma as well as the cannula/closure button.

EQUIPMENT/SUPPLIES NEEDED: Hydrogen peroxide solution, sterile water, normal saline solution, small container for liquids utilized, sterile cotton swabs

PROCEDURE KEY POINTS

1. The trach button (cannula) is to be removed for cleaning at least weekly and more often as necessary If stoma care is needed more often, then clean the button at the same time

2. Remove the cannula and inspect the area surrounding the stoma for dried secretions and/or redness.

3. Clean the stoma area with normal saline solution This will loosen the dried secretions
Keep stoma area under the trach button clean and dry to minimize possible irritation

4. Clean cannula/button by applying Use sterile technique while
hydrogen peroxide solution and wiping performing this procedure
clean and then rinsing with sterile water

5. After cleaning reinsert cannula (button) To minimize irritation, a flange (spacer) may be placed next to Patient’s skin

After, the procedure, remove and discard personnel protective equipment and wash hands according to policy. Reassess patient for airway patency, tolerance of procedures and knowledge of emergency airway management. Document thoroughly in the patients’ medical record.

Suctioning:

Suctioning is at best an uncomfortable procedure and may be frightening for the patient. Physiological and psychological defensive reflexes may come into play for the protection of the airway. A few reminders when suctioning a patient:

1. Strict asepsis and universal precautions should be observed.
2. The patient deserves a clear explanation of the procedure with reassurances. Explanations help to alleviate patient’s anxiety and fears.
3. Partial occlusion of the airway by the suction catheter, combined with aspiration of air from the lung while using an open suction system, can result in hypoxia, cardiac arrhythmia and even cardiac arrest. Suctioning procedures should NEVER exceed 15 seconds even if no visible signs of stress are noted. Preoxygenate the patient if possible prior to suctioning and take caution to continually observe patient for signs of hypoxia during suctioning.
4. The upper airway of the trachea is lined with delicate tissue and care must be taken to avoid damage. Suction is applied only intermittently and with catheter rotation while withdrawing catheter. This will reduce possible trauma to the trachea walls.