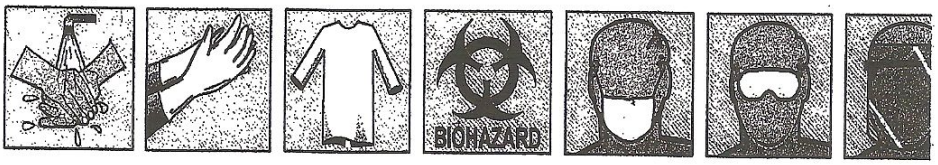
Suctioning the Upper Airway (Nasal Pharyngeal Suctioning)

Protective Barriers
(as necessary to prevent exposure to blood or body fluids)



Handwashing | Gloves | Gown | Designated Waste Disposal | Mask | Goggles | Face Shield

Purpose

The purpose of this procedure is to clear the upper airway of mucous secretions and prevent the development of respiratory distress.

Preparation

1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for suctioning.
2. Review the resident's care plan to assess for any special needs of the resident.
3. Obtain baseline vital signs and oxygen saturation from the resident's medical record.
4. Assemble the equipment and supplies as needed.
5. Test equipment before use. Determine if suction equipment is generating appropriate negative pressure. **Use lower negative pressure with older residents whose oral mucosa is fragile.**
   a. **Wall** suction units should be set between **100-120 mm Hg.**
   b. **Portable** suction devices should have negative pressure set at **10-15 mmHg.**

General Guidelines

1. Use the nasal route to suction the pharynx whenever practical. Suctioning from the mouth increases the introduction of bacteria into the airway.
2. Older clients are more susceptible to aspiration of secretions because of weakened cough and gag reflexes.
3. Do not routinely suction. Suctioning irritates the mucous membranes and can increase secretions if performed too frequently. Type and frequency of suctioning is based on assessment of resident's respiratory distress.
4. **Nasopharyngeal** suctioning is performed using **clean** technique. Catheters may be reused for a 24 hour period.
5. Monitor the resident's pulse and oxygen saturation (see procedure entitled *Pulse Oximetry*) during suctioning. If pulse decreases more than 20 beats per minute (BPM) or increases more than 40 BPM, or oxygen saturation drops below 90 percent (or 5 percent from baseline) discontinue suctioning and re-ventilate and re-oxygenate the resident.

Equipment and Supplies

The following equipment and supplies will be necessary when performing this procedure.

1. Clean suctioning kit; *
2. 100 cc sterile saline or sterile water;
3. Clean drape;
4. Clean cup;
5. Gloves;
6. Curve-tipped #10 to #16 French catheter; with suction control port or adapter;
7. Water-soluble lubricant;
8. Sterile gauze;
9. Tubing (approximately 6 feet); and
10. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed).

* Most of the equipment/supplies listed above are contained in the suctioning kit. However, they are listed individually because there may be times when you will need to obtain and assemble such supplies without the benefit of a kit.

Assessment

1. Identify the following risk factors for impaired airway clearance or aspiration:
   a. Impaired cough or gag reflex;
   b. Dysphagia;
   c. Weak respiratory muscles (from injury, abdominal surgery, etc.);
   d. COPD;
   e. Smoking; and/or
   f. Decreased level of consciousness.
2. Assess for the following signs and symptoms of respiratory distress:
   a. Dyspnea;
   b. Gurgling or rattling breath sounds;
   c. Cyanosis;
   d. Decreased oxygen saturation (SpO2);

e. Restlessness; and/or
f. Obvious secretions or vomitus in mouth.

Steps in the Procedure

1. Provide for resident privacy.
2. Explain the procedure to the resident.
3. Perform hand antisepsis.
4. Put on gloves.
5. Put on mask and protective eyewear (goggles or face shield), as indicated.
6. Assist the resident to semi-Fowler's position with head turned toward you. If the resident is unconscious, place in lateral position facing you.
7. Place towel or Chux pad under the chin.
8. Turn on suction unit and adjust to appropriate negative pressure (100-120 mmHg for wall unit or 10-15 mmHg for portable unit).
9. Verify that suction tubing is attached to wall or portable unit.
10. Open the suction kit.
11. Place drape across the resident's chest.
12. With (clean) gloved hand, remove the cup touching only the outside edge.
13. Fill cup with 100 cc sterile saline or sterile water.
14. Open the water-soluble lubricant. Squeeze contents onto clean place in suction kit.
15. Put on sterile gloves. **The dominant hand will remain clean.**
16. Pick up the catheter with clean hand and attach to the suction tubing (held in non-sterile hand).
17. Test equipment by suctioning a small amount of sterile saline or water from the cup.
18. Measure the depth of catheter insertion by estimating the distance between the tip of the nose and the earlobe. Mark the position on the catheter with the clean hand.
19. Lubricate 2-3 inches of the distal end of the catheter.
20. Instruct the resident to inhale.
21. Upon inhalation, insert the catheter into either nostril **without applying suction.** Advance the catheter the estimated distance to the pharynx, staying on the floor of the nasal cavity. Pull back 1-2 cm if resistance is met.
22. Apply intermittent suction and slowly withdraw catheter while rotating between thumb and forefinger. Limit suction time to no more than 10 seconds.
23. Wipe the outside of the catheter with clean gauze.
24. Suction sterile water to flush the catheter and tubing.
25. Assess the respiratory status of the resident and effectiveness of procedure.
26. Lubricate the catheter and repeat procedure in opposite nostril, if necessary. (Note: Suction at 20-30 second intervals and for no longer than 5 minutes total.)
27. Encourage the resident to cough and deep breathe between suctions.
28. If the resident's physical or medical condition permits, assist the resident to a position that promotes deep breathing and coughing.
29. Turn off suction.
30. Disconnect catheter from tubing. Wrap catheter around gloved hand. Pull the glove off and over the catheter. Discard in designated receptacle.
31. Remove drape and discard in designated receptacle.
32. Discard water or saline in commode. Dispose of cup in designated receptacle.
33. Empty and rinse collection container if necessary or as indicated by facility protocol.
34. Discard personal protective equipment in designated receptacles. Wash and dry your hands thoroughly.
35. Apply clean gloves and provide oral hygiene for the comfort of the resident, if indicated.
36. Perform hand antisepsis.
37. Reposition the bed covers. Make the resident comfortable.
38. Place the call light within easy reach of the resident.
39. If the resident desires, return the door and curtains to the open position.

Documentation

The following information should be recorded in the resident's medical record:

1. The date and time that the procedure was performed.
2. The type and size of catheter used.
3. Amount of negative pressure (mmHg) used to suction.
4. Amount, color and characteristics of secretions (color, odor, thickness, etc.).
5. The resident's response to the procedure.
6. Cardio-pulmonary status, including lung sounds, during the procedure.
7. Assessment data before and after the procedure.
8. If the resident refused the treatment, the reason(s) why and the intervention taken.
9. The signature and title of the person performing the procedure.

Reporting

1. Notify the supervisor if the resident refuses the procedure.
2. Report other information in accordance with facility policy and professional standards of practice.