PROCEDURE: *M-14*	Title: *Oral-Oralpharyngeal-Nasopharyngeal Suctioning*
	Type: Clinical Procedures **Subsection:** M- Methodology **Authority:** Executive Director with Medical Director **Related Documents:**

Preamble

The purpose of oral suctioning is to maintain a patent airway and improve oxygenation by removing mucous secretions and foreign material (vomit or gastric secretions) from the mouth and throat (oropharynx).

Oral suction is the use of a rigid plastic suction catheter, known as a yankauer, to remove pharyngeal secretions through the mouth. Oral secretions can also be removed using a soft suction catheter.

Oral suctioning is useful to clear secretions from the mouth in the event a resident is unable to do so independently.

Oralpharyngeal suctioning requires the insertion of a suction catheter through the mouth to the to the pharynx.

Nasopharyngeal suctioning the insertion of a suction catheter through the nostrils into the pharynx.

Residents who benefit the most include those with CVA's, drooling, impaired cough reflex related to age or condition, or impaired swallowing.

Policy

This policy applies to Registered Nurses (RN's), Registered Practical Nurses (RPN's) working at Residential Hospice Grey Bruce who provide care to residents who require oral suctioning to remove secretions such as mucous, vomit, gastric secretions.

M-14.01 Equipment

- Suction unit with tubing.
- Sterile suction catheter with Y-port.
- Oral yankauer.
- Tap water.
- Container to hold tap water.
- Non-sterile gloves.

M-14.02 Suctioning

1. Explain procedure to resident/caregiver.

2. Perform hand hygiene.
3. Assemble equipment.
4. Position the conscious resident in a semi-fowler's position. Place the unconscious resident in a lateral position facing you.
5. Auscultate resident's lungs if condition warrants, to serve as baseline data.
6. If possible, encourage the resident to cough and/or breathe slowly and deeply several times prior to suctioning.
7. Fill container with tap water.
8. Don non-sterile gloves.
9. Remove sterile catheter of the appropriate size (usually #6 Fr for infants/children and a #12/14/16 Fr for adults) from its wrapping, keeping it coiled to avoid contamination. Attach catheter to connecting tubing.
10. Turn suction on, set to pressure appropriate for resident (adult 80-120 mmHg for wall suction/portable suction).
11. Dip catheter tip in water and occlude the Y-port to check suction.
12. Discontinue oxygen from the resident, if applicable. If the resident is wearing NP leave oxygen in place.
13. Gently insert catheter with the Y-port open, into the trachea via the resident's mouth or nose. DO NOT apply suction during insertion.
14. Apply suction for 10-15 seconds by placing the thumb of your non-dominant hand over the control valve and gently rotate the catheter as it is being withdrawn.
15. Flush catheter with water and repeat suctioning as needed, allowing at least a 15-20 second interval between suctioning. Encourage the resident to deep breathe between suctioning. If repeated nasal suctioning is required, alternate nares.
16. Continue suctioning until breathing becomes quiet.
17. If applicable, resume oxygen delivery after suctioning.
18. Clear connecting tubing by flushing with the tap water. Turn off the suction and disconnect the catheter from connecting tubing and insert in packaging or discard.
19. Auscultate lungs to assess procedures effectiveness.
20. Perform mouth care as indicated.
21. Doff gloves and perform thorough hand hygiene.
22. Document in Info Anywhere (IA) the following:
    - 22.1. Procedure and resident's response
    - 22.2. Amount, color, and consistency of suctioned secretions
    - 22.3. Auscultation findings pre and post suctioning

M-14.04 Review Cycle

Clinical Policies shall be reviewed in the odd year.

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