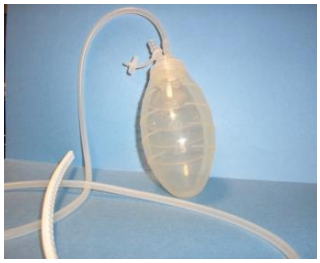
Education for Pandemic Staff (March, 2020)

Drains

	Drain Type	Purpose	Key Point
	**Bulb Drain** (i.e. Jackson-Pratt or JP drain)	Removes drainage from a surgical site • Patients may go home with the drain	• Suction occurs when bulb is compressed • Record accurate I & O • Attach to gown or secure so doesn't become dislodged • When opening the valve, hold and control the decompression of the bulb as blood spatter can occur – wearing gloves and protective eye wear is advised • When recompressing gently squeeze bulb to reduce spraying. Compress till all the air is out of the drain, roll it up, for the correct amount of suction. • Clean plug and opening with alcohol wipe and replace plug keeping bulb compressed
	**Hemovac Drain**	Removes drainage from a surgical site • Usually used in orthopedic surgeries to remove a large amt of drainage for a short time period	Suction occurs when container is compressed • Record accurate I & O • Attach to gown or secure so doesn't become dislodged • When opening the valve, hold and control the decompression of the collection chamber as blood spatter can occur – wearing gloves and protective eye wear is advised • Clean plug and opening with alcohol wipe • The spring must be compressed and flattened before recapping to maintain suction – taking caution to cover opening because blood spatter may occur
	**Urinary Catheter** (i.e. Foley)	Drains urine from the bladder • Usually short term • High risk for infection	• Record accurate I & O • Document catheter care minimum of every shift

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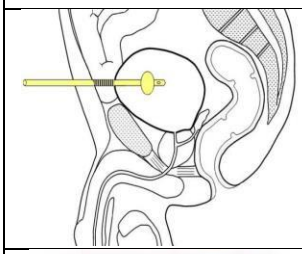
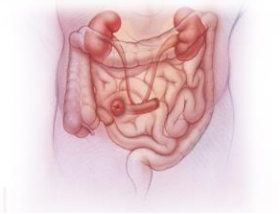
	**Purewick (Female External Catheter)**	Non-invasive urine incontinence system	• Nurse must place initial and replace new catheters every 8-12 hours or if soiled with blood or stool. Let nurse know if patient has frequent stools (they may not be candidate) or if leaking • Suction should be 40 mmHg or more via canister or more depending on height of system. Suction must be continuous. Consult nurse for suction setting. • Skin checks under catheter must be done every 2 hours by Care Tech or nurse. Remove catheter, check skin, and replace. Let nurse know if there are skin issues. • Catheter must be removed with repositioning or bowel movement. Be sure to clean and replace. • Normal I&O. Canister can be emptied and reused (use spout at top and not remove top)
	**Suprapubic Catheter**	Drains urine from bladder out of abdomen bypassing the urethra.	• Record accurate I & O • Document catheter care minimum of every shift
	**Urostomy**	Drains urine from the ureters bypassing the bladder and urethra.	• An ostomy appliance may be present over the stoma and emptied regularly. Also may be connected to a catheter bag while the patient is in the hospital.
 	**Nasogastric Tube** (i.e. NG or OG to Suction Canister)	Removes gastric contents from the stomach	• Mark the drainage level on the canister with the date and time, then calculate the difference in the drainage amount from the previous marking and document the output. Then replace the canister when it is ¾ full. OR • Empty the canister into the toilet and document the output. • If any suspicion of the NG moving or dislodging notify the RN. • DO NOT turn off suction. Consult your nurse.

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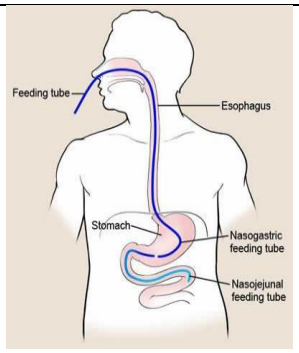
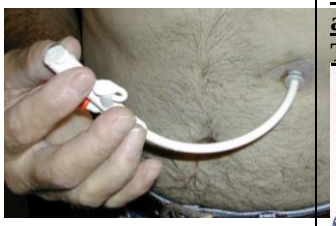
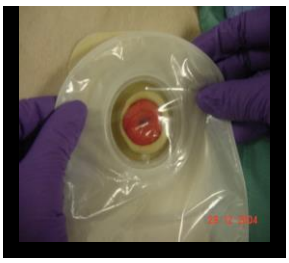
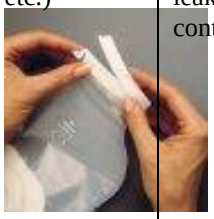
	**Dobhoff**	Tube feeding administered via this tube inserted thru the patient's nose into the stomach or small intestine. Specific placement is confirmed via Xray. • Short term feeding option	• If any suspicion of the NG moving or dislodging notify the RN.
	**G-Tubes and J-Tubes** 	Tube feeding administered via tube inserted by physician directly into stomach (Gastric) or Jejumum (Small intestine). • Long term feeding option	• Contact nurse for necessary aspiration precautions when positioning patient flat for cares. • Site care with soap and water with the patient's bath daily.
	**Ostomy** (i.e. colostomy, ileostomy urosotomy, , etc.) 	Contains drainage (urine or stool), prevents leakage, and controls odor	✓ Only a nurse can change the ostomy bag, but a care tech can empty it • Empty drainage device & record amt of output • Drainage consistency may vary • Notify RN immediately of any leakage out of device. This will cause skin breakdown. ***colostomy*** = liquid to formed ***ileostomy*** = liquid to pasty ***urostomy*** = urine
	**Rectal Tube** (i.e. FlexiSeal)	Draining liquid or semi-liquid stool to protect the skin from breakdown	• Change collection bag as needed by removing & replacing with new bag • Record output amount • On the removed bag-- snap the cap in place and discard it in a red biohazard container

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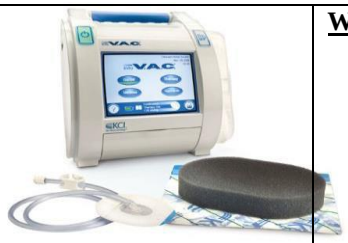
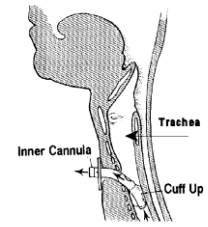
	**Wound Vac**	Helps promote wound healing by removing infectious material and fluid from wounds	• Mark the drainage level on the canister with the date and time, then calculate the difference in the drainage amount from the previous marking • Notify the nurse immediately if bright red blood is in the canister • Remove the canister to discard – do **NOT PUT THE WOUND VAC IN A BIOHAZARD BAG OR IN THE TRASH!**
	**Chest Tube** (i.e. Pleurevac or CT drain)	Removes air and fluid surrounding lungs or heart	• NOTE that the increments increase from the first chamber to the second drainage chamber • Mark the drainage level with the date and time, then calculate the difference in the drainage amount from the previous marking • The drainage system should always be upright and below the level of the patient's heart • Contact nurse if container is not upright (falls over)
	Tracheostomy	Opening in the skin into the trachea for a protected airway.	• Communication is going to be different for every patient. Make sure it is reported to you how the patient communicates. • For your information only: Emergency equipment to be keep at bedside at all times includes: ambu bag, oxygen, suction supplies, extra trach of same or smaller size with obturator. • Cares for tracheostomy will be performed by Respiratory Therapist or nurse.

ALWAYS:

- Wear gloves and goggles when emptying drains. Utilize other PPE (masks and gowns for isolation) as needed.
- Report anything that seems abnormal to you; *report it to your nurse*!
- Use permanent markers to mark drainage amounts.
- Check for kinks or patients lying on tubing to ensure tubes are secure and skin integrity is intact.
- Notify the nurse when the chest tube collection system is nearly full – the nurse will need to replace the chamber.
- Notify the nurse when a chest tube has been knocked over – the system may be damaged and the nurse will need to record the drainage amount and replace the chamber.
- Cuff the ostomy bag before emptying, and wipe clean before uncuffing and replacing clamp.

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NEVER:

- Use dry erase markers to mark your drain outputs – they may fade or be wiped away accidentally.
- Clamp or disconnect any drainage tubing, especially chest tubes and urinary catheters.
- Strip tubing to generate more output – this is only to be done by the nurse as ordered by the MD.
- Empty a drainage system if you do not know what it is and have not been trained to do it! There are some drainage systems that should only be checked and changed by a nurse. Discuss any and all drains with the nurse and your comfort level with them.
- Turn off or adjust suction level on suction head when marking, emptying, or changing canisters.
- Silence any patient care equipment that is beeping. Seek direction from your nurse

Intake and Out is done usually every 8 hours

- Be sure to refill mugs and empty drains and rec
- Record food tray liquid items and consumption with each meal
- Content Items (found on Intranet):

Fluid Content of Room Service Items

Food Item	Serving Size	Fluid Content/ Serving
Soup		
Soup, broth based	4 oz (cup)	115 mL
Soup, broth based	8 oz (bowl)	230 mL
Soup, cream based	4 oz (cup)	108 mL
Soup, cream based	8 oz (bowl)	215 mL
Juice		
Apple, Orange, Grape, Cranberry	4 fl oz	120 mL
Apple, Orange, Grape, Cranberry	8 fl oz	240 mL
Thickened Juices	4 fl oz	120 mL
Milk/Dairy		
Skim, 2%, or Whole	4 fl oz	120 mL
Skim, 2%, or Whole	8 fl oz	240 mL
Thickened Milk	8 fl oz	240 mL
Yogurt	6 oz	130 mL
Other Beverages		
Soda	8 fl oz	240 mL
Soda (can)	12 fl oz	360 mL
Coffee or Hot Tea	6 fl oz	180 mL
Hot Chocolate	6 fl oz	180 mL
V8 Juice / Tomato Juice	5.5 oz	165 mL
Cup of Ice	8 oz glass	120 mL
Desserts		
Ice cream	4 oz	50 mL
Sherbet	4 oz	60 mL
Gelatin	4 oz	120 mL
Pudding	4 oz	100 mL
Popsicle	Twin pop	75 mL
SF Popsicle	Single pop	50 mL
Supplements		
CBE (Prepared with 8oz Milk)	8 fl oz	240 mL
Ensure Plus / Glucerna	8 fl oz	240 mL
Ensure Pudding	4 fl oz	90 mL
Ensure Clear	6.8 fl oz	200 mL
Milkshake or Ice Cream shake	10 oz	240 mL

Note: 30 mL=1 fl oz