Sputum Specimen

Purpose

The purpose of this procedure is to collect a sputum specimen for laboratory testing.

Preparation

1. Verify that there is a physician's order for this procedure.
2. Review the resident's care plan to assess for any special needs of the resident.
3. Assemble the equipment and supplies as needed.

Equipment and Supplies

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

1. Sputum container (with lid);
2. Label;
3. Pen or pencil;
4. Paper towels; and
5. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed).

Steps in the Procedure

1. Explain procedure to the resident and/or family.
2. Wash your hands thoroughly before beginning the procedure.
3. Place the equipment on the bedside stand or overbed table. Arrange the supplies so that they can be easily reached.
4. If the resident has recently eaten, instruct the resident to rinse his or her mouth. Provide assistance as necessary.
5. If the resident can hold the sputum container, ask him or her to take three (3) deep breaths and on the third exhalation, to cough deep from the lungs to bring up the sputum.
6. Instruct the resident to spit into the container. (**Note**: If the resident cannot hold the container, hold the container up to the resident's mouth.)
7. Once the resident has produced the sputum, cover the container immediately. (**Note**: The resident may need to cough several times to bring up enough sputum for the specimen.)
8. Do not touch the inside of the container or the lid.
9. Label the container. Record the resident's name, room number, and the date and time you collected the specimen.
10. Remove gloves. Discard into the designated container. Wash and dry your hands thoroughly.
11. Reposition the bed covers. Make the resident comfortable.
12. Place the call light within easy reach of the resident.
13. If the resident desires, return the door and curtains to the open position and if visitors are waiting, tell them that they may now enter the room.
14. Send the specimen to the laboratory for testing as ordered.
15. Wash and dry your hands thoroughly.

Equipment: Aspiration Method

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

1. Sterile Suction Kit;
2. Sterile Saline;
3. Sputum container (with lid);
4. Label;
5. Pen or pencil;
6. Paper towels; and
7. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed).

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Steps in the Procedure - Aspiration Method

1. Explain procedure to the resident and/or family.
2. Wash your hands thoroughly before beginning the procedure.
3. Place the equipment on the bedside stand or overbed table. Arrange the supplies so that they can be easily reached.
4. Position the resident in a semi-to high Fowler's position.
5. Open sterile suction kit, using aseptic technique.
6. Open the sterile aspirating collection tube and place it on the sterile field.
7. Pour 30-50 cc of sterile saline into the suction container.
8. Turn on suction unit.
9. Put on sterile gloves.
10. Attach aspirating collection tube to suction unit connecting tubing, maintaining asepsis of dominant hand.
11. Attach sterile suction catheter to aspirating tip of collection tube, maintaining asepsis of the dominant hand.
12. Assure that the top of the aspirating tube is firmly in place and right.
13. Suction the resident.
14. Clear the mucus from the catheter by placing it in the saline and applying the suction.
15. Disconnect the aspirating collection tube from the suction catheter and connecting tube. Seal according to manufacturer's instructions.
16. Remove the gloves.
17. Turn off suction unit.
18. Label specimen and place in plastic bag. Include lab request form.
19. Send to the lab immediately.
20. Assist the resident to a comfortable position.
21. Discard supplies and return equipment to appropriate location for cleaning.

Documentation

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

1. The date and time that the specimen was collected.
2. The name and title of the individual(s) who performed the procedure.
3. All assessment data obtained during the procedure.
4. How the resident tolerated the procedure.
5. If the resident refused the procedure, the reason(s) why and the intervention taken.
6. The signature and title of the person recording the data.

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.