secretions around the stoma may be gently removed with half-strength hydrogen peroxide. Hydrogen peroxide should not be used with sterling silver tracheostomy tubes, because it tends to pit and stain the silver surface. The nurse should be aware of wet tracheostomy dressings, which can predispose the peristomal area to skin breakdown. Several products are available to prevent or treat excoriation. The Allevyn tracheostomy dressing is a hydrophilic sponge with a polyurethane back that is highly absorptive. Other possible barriers to help maintain skin integrity include the use of hydrocolloid wafers (e.g., DuoDERM CGF, Hollister Restore, Mepilex Lite) under the tracheostomy flanges, as well as extra-thin hydrocolloid wafers under the chin.

The tracheostomy tube is held in place with tracheostomy ties made of a durable, nonfraying material. The ties are changed daily and when soiled. A self-adhering Velcro collar is commonly used. The collar or ties should be tight enough to allow just a fingertip to be inserted between the ties and the neck (Fig. 20-27). It is easier to ensure a snug fit if the child's head is flexed rather than extended while the ties are being secured.

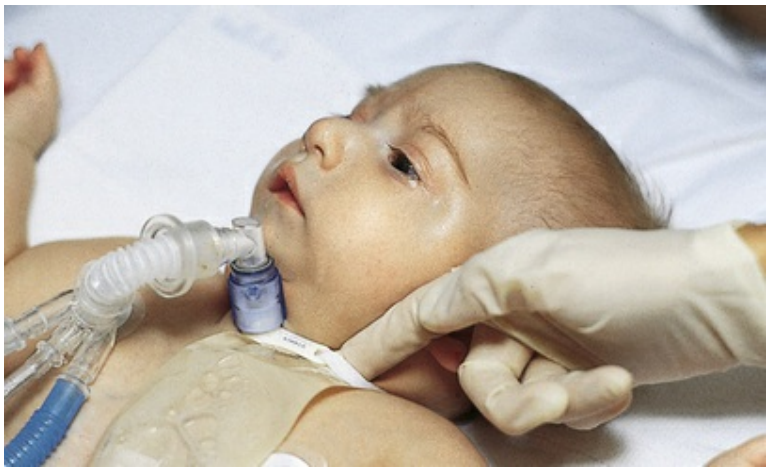

**FIG 20-27** Tracheostomy ties are snug but allow one finger to be inserted.

Routine tracheostomy tube changes are usually carried out weekly after a tract has been formed to minimize the formation of granulation tissue. The first change is usually performed by the surgeon; subsequent changes are performed by the nurse and, if the child is discharged home with the tracheostomy, by either a parent