INVASIVE PROCEDURE SAFETY CHECKLIST: Tracheostomy

The Pennine Acute Hospitals NHS
NHS Trust

BEFORE THE PROCEDURE *Before withdrawal of ETT*		
Have all members of the team introduced themselves and roles allocated?	Yes	No
Patient identity checked as correct?	Yes	No
Appropriate consent completed?	Yes	No
Risk assessment completed? (see appendix 2 of tracheostomy policy)	Yes	No
Is suitable tracheostomy and airway equipment available? (difficult airway trolley/bronchoscope)	Yes	No
Is appropriate monitoring available? (including $EtCO_2$)	Yes	No
Sandbag/pillow under shoulders?	Yes	No
Ultrasound of neck considered?	Yes	No
Are there any Contraindications to performing the procedure? (High FiO2, PEEP, anatomical, vascular, coagulopathy/anticoagulants)	Yes	No
Any Known drug allergies?	Yes	No
Is feed stopped and NG aspirated?	Yes	No
Is adjustable flange required?	Yes	No
Are there any concerns about this procedure for the patient?	Yes	No

Level of difficulty anticipated prior to the start of the procedure:

None anticipated	Possibly difficult	Considerable difficulty anticipated

If considerable difficulty required, consider involvement of ENT surgeon.

TIME OUT *Verbal confirmation between team members before incision*		
Is patient on adequate ventilator settings and 100% O2?	Yes	No
Is patient adequately sedated and paralysed?	Yes	No
Is position optimal?	Yes	No
Cuff tested as intact?	Yes	No
Capnography waveform displayed?	Yes	No
Local anaesthetic with adrenaline instilled?	Yes	No

If you had any concerns about the procedure, how were these mitigated?

Procedure date:		
Time:		
Operator:		
Bronchoscopist:		
Assistant:		
Supervision:	SpR	Consultant

SIGN OUT *After completion of procedure*		
Tracheostomy position confirmed with capnography?	Yes	No
Tracheostomy position confirmed with bronchoscope?	Yes	No
Ventilator settings reviewed post procedure + weaning plan?	Yes	No
Sedation reviewed + weaning plan?	Yes	No
Inner tube in place?	Yes	No
NG feed restarted?	Yes	No
Sharps accounted for?	Yes	No
Post procedure hand over given to nursing staff?	Yes	No
Bed head sign completed + displayed?	Yes	No
CXR considered	Yes	No

Signature of responsible clinician completing the form	

Patient Name:

Hospital Number:

Date of Birth:

Patient Name:	**Hospital Number:**
Date of Birth:	

The Procedure

Bronchoscopist: Name: GMC: Grade:	Insertion of tracheostomy by: Name: GMC: Grade:

Sterile Scrub + Gown/Gloves/Hat/Mask?	Yes ☐
Chlorhexidine gluconate 2% / 70% isopropyl alcohol formulation to skin?	Yes ☐
Large fenestrated drape used?	Yes ☐

Sedation + Muscle Relaxant:	Local Anaesthetic:

Level of Entry	1st-2nd Ring		Size/type Tracheostomy: Additional Procedure notes:
	2nd-3rd Ring		
	Other(Specify)		

Tracheostomy tip position: cm from carina as confirmed by endoscope
Tracheostomy Kit/ Batch No:

Complications

None ☐	Vascular puncture ☐	Malposition ☐
2nd person required ☐	Unable to place ☐	Other ☐

Additional Comments:

Chest X-Ray Ordered Post Procedure?	Yes ☐	No ☐
Chest X-Ray Comments:		

Signature: **Name:**