WRITE OR ATTACH ADDRESSOGRAPH

Surname.....

Forenames.....

DOB dd / mm / yyyy Age.....

Hospital number.....

South Tees Hospitals NHS
NHS Foundation Trust

PERSON COMPLETING CHECKLIST

DECANNULATION CHECKLIST	Enter Yes/No
Resolution of original need for tracheostomy insertion	
No planned intervention that will need artificial airway within 2 weeks	
Appropriate conscious level and able to maintain open airway. Patient will need to be observed for signs of airway obstruction post-decannulation	
Minimal oxygenation requirements last 24 hours, i.e., FiO_2<40%	
Able to clear secretions independently to mouth. if cough effort insufficient (PCF < 180 L/min) the patient should be well established and tolerating cough assist device via mouth piece/mask	
Minimal secretions, patient not needing regular suctioning via tracheostomy last 48 hours	
Patient tolerating cuff deflation for 24 hours	
If occlusion cap or speaking valve used, it should be tolerated for up to 4 hours	
CVS stability	
MDT (physiotherapist , SLT, specialist consultant, ward nurse, CCOT) informed and agreed	
Staff trained in advanced airway management (critical care or anaesthetist) available nearby or by the bedside if known previous problems with patient's airway	
If all of the above YES then proceed to decannulation	

Equipment	**Procedure**
Dressing pack and gauze Appropriate dressing Sterile water Gloves, apron and protective eye wear Appropriately sized tracheostomy tube and one a size smaller (available not opened) Oxygen, facemask or nasal specs Functioning suction unit and appropriate sized suction catheters Stethoscope Microbiological swab Resuscitation equipment available on the ward	Two-person technique, clear understanding of roles Check emergency equipment availability Explain procedure to patient and gain patient consent where possible Position patient in semi-recumbent position When required place supplemental oxygen over nose/ mouth Remove old dressing and tapes and support the tube Suction patient Remove tube on expiration Observe stoma site, swab if required and clean stoma Check patient is comfortable Apply an appropriate dressing over the stoma site Advise patient to provide pressure to the stoma site when coughing and talking in the initial stages Document the procedure in the case notes and make a final check of the patient

DECANNULATION

DATE_____TIME_____LOCATION_____

OPERATOR (Name and GMC/RCN/HCPC no.) _____

COMMENTS_____

_____

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_____

_____

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_____

Monitoring of the patient post decannulation

Assess for possible deterioration post decannulation.

End of bed assessment by experience nurse. On ward areas document NEWS initially at least every 15 minutes for first hour, then hourly for next 2 hours and increase to 4 hourly as stability allows.

Signs and symptoms that could indicate deterioration are:

- Breathlessness
- Laboured breathing
- Noisy respiration
- Stridor
- Increased respiratory rate
- Increased heart rate
- Excess use of accessory muscles
- Change in respiration pattern
- Change in respiration depth
- Agitation
- Oxygen desaturation

PLEASE INFORM WARD DOCTOR IF CONCERN.

IF AIRWAY PROBLEM OR RAPID DETERIORATION OF BREATHING PLEASE INFORM CRITICAL CARE OUTREACH (BLEEP 7000 JCUH AND 784 AT FHN) AND SENIOR CRITICAL CARE DOCTOR / ANAESTHETIST (BLEEP 1005 JCUH, BLEEP 161 FHN)

CONSIDER CARDIAC ARREST CALL 2222 IF VERY URGENT