**INVASIVE PROCEDURE SAFETY CHECKLIST: Tracheostomy**

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| **BEFORE THE PROCEDURE** | | | | |
| Have all members of the team introduced themselves? | | | Yes | No |
| Patient identity checked as correct? | | | Yes | No |
| Appropriate consent completed? | | | Yes | No |
| Is suitable tracheostomy and equipment  available? (difficult airway trolley/bronchoscope) | | | Yes | No |
| Is appropriate monitoring available? (including EtCO2) | | | Yes | No |
| Are there any Contraindications to performing the procedure? (High FiO2, PEEP, anatomical, vascular, coagulopathy) | | | Yes | No |
| Medicines and coagulation checked? | | | Yes | No |
| Any Known drug allergies? | | | Yes | No |
| Is feed stopped and NG aspirated? | | | Yes | No |
| Are spinal precautions 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 | Difficulty anticipated | | |
| Names and registering body numbers of clinicians responsible for the procedure | | | | |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |



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| --- | --- | --- |
| **TIME OUT**  Verbal confirmation between team members before start of procedure | | |
| Is patient on adequate ventilator settings and 100% FiO2? | Yes | No |
| Is patient adequately sedated and paralysed? | Yes | No |
| Is position optimal? | Yes | No |
| Cuff tested as intact? |  |  |
| All team members identified and roles assigned? | Yes | No |
| Any concerns about procedure? | Yes | No |
| If you had any concerns about the procedure, how were these mitigated? | | |
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| **Procedure date:** |  | |
| **Time:** |  | |
| **Operator:** |  | |
| **Observer:** |  | |
| **Assistant:** |  | |
| **Level of supervision:** | SpR | Consultant |
| **Equipment & trolley prepared:** |  | |

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| **SIGN OUT** | | |
| Tracheostomy position confirmed  with Bronchoscope? | Yes | No |
| Capnography in situ? | Yes | No |
| Ventilator settings reviewed post  procedure? | Yes | No |
| Sedation reviewed? | Yes | No |
| Post procedure hand over given to nursing staff? | Yes | No |

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| Signature of responsible clinician completing the form |  |

**Patient Identity Sticker:**



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| **The Procedure** | | | | | | |
| **Personnel** | | | | | | |
| Bronchoscopy:  Grade: | | | Tracheostomy:  Grade: | | | |
| Supervising consultant: | | | | | | |
| Sterile Scrub/Gown and Gloves? | | | | | | Yes |
| 2X Chloraprep sticks to skin? | | | | | | Yes |
| Large fenestrated drape Used? | | | | | | Yes |
| Sedation: | | | Local Anaesthetic: | | | |
| Level of Entry | 1-2 Ring |  | AP Entry Point: | | | |
| 2-3 Ring |  |
| Other(Specify) |  |
| Tracheostomy tip is: Cms from carina as confirmed by endoscope | | | | | | |
| Tracheostomy Kit/ Batch No: | | | | | | |
| Size/Type Tracheostomy: | | | | | | |
| Additional Comments: | | | | | | |
| Chest X-Ray Ordered Post Procedure? | | | | Yes | No | |
| Signature: | | | | | | |
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| **Complications** | | | | | |
| Correct ventilator settings set post procedure | | | | Yes |  |
| None | Vascular puncture | Malposition |  | | |
| 2nd person required | Unable to place | Other |  | | |