**INVASIVE PROCEDURE SAFETY CHECKLIST: Tracheostomy**

|  |
| --- |
| **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.  |



|  |
| --- |
| **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? |
|  |

|  |  |
| --- | --- |
| **Procedure date:** |  |
| **Time:** |  |
| **Operator:** |  |
| **Observer:** |  |
| **Assistant:** |  |
| **Level of supervision:**  | SpR | Consultant |
| **Equipment & trolley prepared:** |  |

|  |
| --- |
| **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 |

|  |  |
| --- | --- |
| Signature of responsible clinician completing the form |  |

**Patient Identity Sticker:**



|  |
| --- |
| **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: |
|  |

|  |
| --- |
| **Complications** |
| Correct ventilator settings set post procedure | Yes |  |
| None [ ]  | Vascular puncture [ ]  | Malposition [ ]  |  |
| 2nd person required [ ]  | Unable to place [ ]  | Other [ ]  |  |