CLINICAL PROCEDURE

PLANNED TRACHEOSTOMY DECANNULATION PROCEDURE

Staff this document applies to:

- Medical Staff, Nurses, Speech Pathologists, Physiotherapists on all campuses

Who is authorised to perform this procedure?:

Medical Staff, Nurses and Physiotherapists trained in decannulation

State any related policies, procedures or guidelines:

- Tracheostomy policy – Management of patients with a Tracheostomy
- Tracheostomy procedure - Mandatory Tracheostomy Equipment
- Tracheostomy procedure - Suctioning via the Tracheostomy
- Tracheostomy procedure - Cuff Release, Deflation and Reinfation
- Tracheostomy documentation – Decannulation Documentation (SMR Form No M79.30)
- Tracheostomy e learning package – Tracheostomy decannulation
- Escalation Response to Clinical Deterioration

Definition:

The safe and timely removal of a tracheostomy tube when it is no longer medically indicated

Clinical Alert:

- Prior to decannulation, a clearly documented plan (Decannulation documentation M79.30) is required including actions in event of acute deterioration.
- Ideally, tracheostomy tubes should be removed Monday-Thursday, during daytime working hours, and preferably in the morning to enable increased observation.
- If decannulation is to occur on a Friday, the patient will be reviewed by the Respiratory Registrar (or unit responsible for decision to decannulate) on Saturday for their 24hr review.
- Patients identified on the ICU tracheostomy discharge summary M79.3 require ICU to be notified prior to decannulation. TRAMS or the parent unit should contact the ICU Registrar or Consultant.
- If a patient experiences stridor or respiratory distress post decannulation, a Code Blue response should be activated.
- The initial 48 hours post decannulation is critical and the patient must be monitored closely by the parent medical team and nursing staff. The TRAMS team will review the patient after 24 hours.
- A percutaneous dilatational stoma closes quickly after decannulation which may make tracheostomy tube reinsertion more difficult if required.
**Expected Outcome:**

- Pre and post decannulation entry is completed. (Decannulation documentation M79.30). This entry includes the action plan in the event of failed decannulation as per direction by the parent unit.
- The patient is decannulated and monitored.

**Equipment:**

- **Mandatory tracheostomy equipment**
- Mouth or nose -Oxygen delivery system
- Pulse oximeter
- Dressing pack, normal saline sachet and stitch cutter (if sutures insitu)
- 2 x gauze and occlusive dressing

**Procedure:**

- Prior to decannulation complete the pre-decannulation entry Decannulation documentation M79.30)
- Formally identify the patient
- Explain the procedure to the patient and obtain consent
- Check all mandatory equipment is at hand
- This is a 2 person procedure. Ideally, the bedside nurse should be present during the decannulation.
- Pause enteral feeding
- Debug and don personal protective equipment
- Set up dressing pack with n/saline, 2 x gauze and occlusive dressing
- Connect pulse oximeter and pre oxygenate the patient if required
- Position the patient comfortably lying in bed with neck in neutral or slight extension
- Deflate the cuff and suction if indicated
- Remove the tracheostomy dressing
- Remove tracheostomy sutures if present
- Undo the Velcro tapes or ties
- Ask the patient to take a deep breath, and gently withdraw the tube on exhalation
- Occlude stoma with gauze and check that the patient is able to breathe comfortably
- **If a ward based patient experiences respiratory distress and/or stridor call a Code Blue**
- **Reinsert new tracheostomy tube if trained to do so**
• Check the patient’s oxygen saturation and apply oxygen to the mouth/nose (or the tracheostomy stoma if the upper airway appears to be obstructed)
  • Clean the stoma with saline
  • Inspect the stoma for bleeding, infection or granulation tissue.
  • Apply gauze and occlusive dressing
  • Ensure the patient is comfortable and observations stable
  • Leave the patient with a nurse call bell within reach
  • Advise patient to apply firm pressure over the stoma dressing during speech or coughing to prevent leak

**Post Procedure Care:**

• Ensure tracheostomy decannulation - documentation ‘Post decannulation entry’ is complete
• Perform half hourly observations for 2 hours.
• Monitor the patient over the next 24 hours for any signs of respiratory distress or compromise, such as increased respiratory rate, increased work of breathing, decreased oxygen saturations or difficulties with sputum clearance.
• If concerned follow [Deteriorating Patient Guidelines](#) via ePPIC
• For non urgent enquiries contact treating unit responsible for decannulation /TRAMS with any concerns 8:30-17:00 Monday to Friday.

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**References:**

- O’Connor H H, White A C. Tracheostomy Decannulation. Respiratory Care 55 (8) 2010: 10761-081

**Department Responsible for Document:**

Tracheostomy Review and Management Service (TRAMS)