TRACHEOSTOMY REVIEW AND MANAGEMENT SERVICE

CLINICAL PROCEDURE

PLANNED TRACHEOSTOMY DECANNULATION PROCEDURE

Staff this document applies to:

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

Related Austin Health policies, procedures or guidelines:

Management of patients with a Tracheostomy

Tracheostomy - Mandatory Equipment & Emergency Tracheostomy Management Poster

Suctioning via the Tracheostomy

Tracheostomy Cuff Management

Management of Patients With a Montgomery Long-term Cannula

Escalation Response to Clinical Deterioration - Austin Hospital

Aseptic Technique

Purpose:

To provide a guideline for 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 is required including actions in event of acute deterioration. This should be clearly documented in Cerner.
- If a patient experiences stridor or respiratory distress post decannulation, activate Respond Blue
- A percutaneous dilatational stoma may close quickly after decannulation which may make emergency tracheostomy tube reinsertion more difficult
- ICU MET Registrar should be notified of all high risk decannulations by calling x8409
- The initial 48 hours post decannulation is critical and the patient must be monitored closely by the parent medical team and nursing staff.
- Notify parent medical unit, nurse in charge, bedside nurse, treating physiotherapist and speech pathologists
- 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 or prior to a public holiday, the patient will be reviewed by the Respiratory Registrar or home unit the next day.

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- If decannulation is performed <7 days since initial tracheostomy insertion, the parent medical unit will manage this process and review the following day.

Equipment:

- Routine tracheostomy personal protective equipment (PPE)
    - Clean gloves
    - Safety shield, goggles or glasses
    - Surgical mask
    - Disposable apron (optional)
- Mandatory tracheostomy equipment
- Mouth or nose oxygen delivery system
- Pulse oximeter
- Dressing pack, normal saline and stitch cutter (if sutures in situ)
- Transparent adhesive film dressing

Procedure:

- Prior to decannulation complete a pre-decannulation entry in Cerner, including clear Goals of Care and plan in event of acute deterioration
- Notify relevant staff of planned decannulation. Typically this would include: Treating Medical Unit; ICU MET Registrar (on x8409); Nurse in charge and bedside nurse; Treating physiotherapist and Speech Pathologist;
- Obtain patient consent. If patient is unable to consent, the MTDM/NOK should be notified.
- 2 staff members should be present to perform decannulation
- Identify the patient with 3 x ID checks
- Explain the procedure to the patient and obtain consent
- Check all mandatory equipment is available
- Pause enteral feeding
- Debug and don personal protective equipment
- Set up dressing pack with normal saline and dressings
- Connect pulse oximetry and pre oxygenate if required
- Position the patient comfortably lying in bed, with head of bed slightly elevated and neck in neutral or slight extension
- Remove the tracheostomy dressing
- Remove tracheostomy sutures if present
- Deflate the cuff and suction
- Undo the Velcro tapes or ties
- Ask the patient to take a deep breath, and gently withdraw the tube on exhalation
- Occlude stoma with folded gauze and check that the patient is able to breathe comfortably
    - **If a ward based patient experiences respiratory distress and/or stridor, activate a Respond Blue**
    - **Reinsert new tracheostomy tube if trained to do so, otherwise wait for Respond Blue team to arrive**

- **Check the patient's oxygen saturation. 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.
- Fold gauze into a small square to fit over stoma, then apply transparent adhesive film dressing to prevent air leak. Optional: Steri-strips could be used to bring edges of stoma together.
- Ensure the patient is comfortable and observations are stable
- Ensure the patient can reach the nurse call bell
- Advise patient to apply firm pressure over the stoma dressing during speech or coughing to prevent air leak for the next 24 hours

Post Procedure Care:

- Complete a post decannulation entry in Cerner
- Perform half hourly observations for 2 hours.
- Ensure mandatory tracheostomy equipment remains at the bedside for 48 hours
- If concerned, follow OPPIC guideline: Escalation Response to Clinical Deterioration - Austin Hospital
- For non urgent enquiries, contact the parent medical unit responsible for decannulation or contact TRAMS during business hours.

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Legislation/References/Supporting Documents:

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