TRACHEOSTOMY SUPPORT PLAN

Goals

- ☐ Maintain clear airway with routine suctioning
- ☐ To ensure effective delivery of oxygen as prescribed
- ☐ Maintain skin integrity/keep stoma clean
- ☐ Prevent infection
- ☐ Promote comfort
- ☐ Ensure equipment safety and effectiveness
- ☐ Other: _____

Identified need for support

Tracheostomy required secondary to:

- ☐ Respiratory Failure
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Obstructive Sleep Apnoea
- ☐ BPD (Broncho Pulmonary Dysplasia)
- ☐ Chest wall injury/cervical spinal cord injury
- ☐ Neuromuscular disease
- ☐ Positive Airways Pressure (CPAP)
- ☐ Tumours (e.g. Cystic Hygroma)
- ☐ Infections (epiglottitis/croup)
- ☐ Vocal cord paralysis
- ☐ Tracheal Damage/Stenosis
- ☐ Neck or mouth difficulties or structural difficulties
- ☐ Participant unable to self- manage and requires full assistance of staff
- ☐ Other: _____

Evidenced by

- ☐ Medical Notes
- ☐ Progress Notes
- ☐ Health Care Directive Date: _____
- ☐ Other: _____

Note: Support workers deployed to undertake tracheostomy support. Must have current First Aid and CPR skills.

Interventions

Tracheostomy Care

- ☐ Follow personal hygiene and infection control procedures

Stoma Care

- ☐ Check and clean skin around tracheostomy tube and stoma with saline daily
- ☐ Apply dry gauze dressing to prevent irritation
- ☐ Do not apply powders or cream unless prescribed
- ☐ Observe and report any abnormal changes, infection, inflammation to a relevant health practitioner

☐ Undertake routine suctioning as per procedure and plan. (Each suction of tracheostomy tube should not be any longer than 5-10 seconds)

☐ Monitor and maintain equipment

Undertake recording requirements

☐ Monitor for, and report respiratory distress; reduced oxygen saturations; spontaneous coughing; audible or visible secretions from the tracheostomy, chest auscultation suggesting secretion build-up

☐ Change tube ties (Note: a health professional and another worker (2 people to always be present) to attend due to accidental risks of decannulation). Old ties to remain in situ until new ties are secured

	☐ Ensure that tube ties or collars are fastened securely but not too tight - allow a finger width space between the tie and the neck ☐ Monitor and report tube obstruction, dislodgement or aspiration to help participant immediately ☐ If blocked or partially blocked tube is suspected, report immediately for tracheotomy tube change ☐ Tracheostomy tube change as per health practitioner's directive ☐ Maintain oral hygiene

Other participants specific interventions:

Risk / Response:

☐ Signs of infection (e.g., fever, shortness of breath, sweating)

☐ Respiratory distress (e.g., laboured breathing, gurgling, breath sounds or no breath sounds, oxygen desaturation unable to suction)

☐ Tube obstruction/dislodgement (tube falling out)

☐ Aspiration (shortness of breath, coughing, chest/throat discomfort)

☐ Not knowing when to inflate/deflate cuff

Refer to Health Practitioner or transfer to hospital if any of the above risks occur to ensure participants well-being.

Prepared by:		
Position Title:		
Signature:		Date:
Reviewed and Approved by:		
General Practitioner Name:		
General Practitioner Signature:		Date:
Health Professional Name:		
Health Professional Signature:		Date:

Agreement

By signing this Support Plan, I agree that I have been involved in the development of my plan. I agree and consent to the care and interventions of this Tracheostomy Support Plan.

Participant/Representative Name:		
Participant/Representative Signature:		Date:
Company Representative Name:		
Company Representative Signature:		Date:

Communication / Copy of Support Plan	
Copy of Support Plan given to:	☐ Participant ☐ Health Professional ☐ Health Practitioner ☐ Other:

Progress Chart

Date	Change to Identified Need / New Problem	Intervention	Name / Signature / Delegation

Evaluation Chart

Date	Evaluation	Name / Signature / Delegation

Tracheostomy Support Medical Practitioner Directive

Medical Practitioner / Respiratory Specialist / Consultant

Date:	

Diagnosis/Medical History
Specific Care Orders/Treatment Plan
Risks and Complications

Plan Review Frequency	

Informed Consent Obtained	☐ Yes ☐ No
If NO, state details:	

Authorisations

Medical Practitioner Name			
Medical Practitioner Signature		**Date**	
Client Name			
Client Signature		**Date**	

Tracheostomy Support Directive
Physiotherapist / Occupational Therapist

	Date:	

Diagnosis/Medical History
Specific Care Orders/Treatment Plan
Risks and Complications

Plan Review Frequency	

Informed Consent Obtained	☐ Yes ☐ No
If NO, state details:	

Authorisations

Medical Practitioner Name			
Medical Practitioner Signature		**Date**	
Client Name			
Client Signature		**Date**	

Document Control

Version No.	Issue Date	Document Owner
1	08/01/2025	Elizabeth Bradshaw
Version History		
Version No.	**Review Date**	**Revision Description**