



- This Tracheostomy Support Plan must be developed with the person we support and their Health Practitioner.
- The Tracheostomy Support Plan must be overseen by the Health Practitioner.
- **Staff members must be appropriately trained to administer or dispense medication and undertake any Tracheostomy Support Procedures.**
- This Tracheostomy Support Plan should be read in conjunction with the relevant policies and procedures.

Personal Details <i>(to be completed by staff &amp; person we support)</i>				
Name:		CIRTS ID:		
Date of Plan:		Review Date:		
Risks and Emergency Response				
Risks				
When to call an ambulance				
When to seek medical assistance				
My Support includes (tick all that apply) and who undertakes this:				
Procedure	Me	LWB DSW	Health Professional	Other
<input type="checkbox"/> Changing HME	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Stoma Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Changing ties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Ventilator (see separate procedure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Oral suctioning (see separate procedure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Tracheostomy suctioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

<input type="checkbox"/> Changing inner cannula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Changing tracheostomy tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Checking cuff pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Oxygen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

My Preferences <i>(Completed by the person we support or their Support Network)</i>				
I like my tracheostomy tube to be changed every .				
I like the HME to be changed every .				
I need to have my tracheostomy suctioned every .				
I like the inner cannula to be changed .				
My communication needs are captured in my:				
<input type="checkbox"/> NDIS LWB 5001 Client Profile <input type="checkbox"/> Communication Profile <input type="checkbox"/> Other:				
My Equipment <i>(Completed by the person we support or their Support Network)</i>				
<ul style="list-style-type: none"> <li>Refer to Tracheostomy Procedure for tracheostomy and suctioning equipment</li> <li>Refer to Ventilator Procedure for ventilator equipment (where applicable)</li> </ul>				
Item	Description	Who orders this	How often	Where
Tracheostomy tube	Make:			
	Size:			
	<input type="checkbox"/> Cuffed <input type="checkbox"/> Non-cuffed <input type="checkbox"/> Inner cannula <input type="checkbox"/> Fenestrated			
HME	Make:			

<b>Suction Management</b>	<input type="checkbox"/> *Oral suction			
	<input type="checkbox"/> Tracheostomy suction			
	<input type="checkbox"/> Yankeaur Sucker			
	<input type="checkbox"/> Open Y catheter			
	<input type="checkbox"/> Closed unit			
<b>Other</b>				

**Person specific support requirements** *(To be completed prior to completion/approval by the AQHP)*

*Record any information specific to the person's support needs in relation to this plan.*

**Details about any specific changes or preferences staff must know in order to support the person with this plan:** *(This section must be completed by the Health Professional )*

- ☐ Not Applicable, the person's supports do not require any modification.
- ☐ Modifications are required as follows:

**In the event of an emergency, please contact 000 plus** *(Completed by Person):*

<b>Name:</b>		<b>Contact Number:</b>	
<b>Relationship:</b>			
<b>Name:</b>		<b>Contact Number:</b>	
<b>Relationship:</b>			

- ☐ **Set review:** **Date:**
- ☐ **As needed review:** This plan will be reviewed following
- a problem being identified while following this plan
  - a new risk being identified
  - advice from the person's GP/ Allied Health Professional

<b>Review of plan</b> <i>(completed by Health Professional)</i>			
<b>Name:</b>		<b>Profession:</b>	
<b>Signature</b>		<b>Date:</b>	
<b>Name:</b>		<b>Profession:</b>	
<b>Contact details:</b>		<b>Date:</b>	

## Consent and Authorisation

I consent to the support requirements as detailed in this Plan to be implemented in order to assist in the management of my health supports or receive general emergency response as required. If I am unable to give consent, LWB will seek consent from my guardian/person responsible.			
<b>Name</b>	<b>Relationship</b>	<b>Signature</b>	<b>Date</b>
	<b>Self</b>		
	<b>Guardian / Person Responsible</b>		
	<b>LWB Line Manager</b>		

### Upload to CIRTS as follows:

Plans & Assessments > New Plan > Service Type = the service providing the HIDPA > Plan name – [select from drop down] Tracheostomy Management Plan > relevant dates > Add New Attachment > SURNAME, First Name. YYYY.MM.DD