NDIS LWB 5651 HIDPA Tracheostomy Support - Plan

- 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 *(to be completed by staff & person we support)*			
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**
☐ Changing HME	☐	☐	☐	
☐ Stoma Care	☐	☐	☐	
☐ Changing ties	☐	☐	☐	
☐ Ventilator (see separate procedure)	☐	☐	☐	
☐ Oral suctioning (see separate procedure)	☐	☐	☐	
☐ Tracheostomy suctioning	☐	☐	☐	

☐ Changing inner cannula	☐	☐	☐	
☐ Changing tracheostomy tube	☐	☐	☐	
☐ Checking cuff pressure	☐	☐	☐	
☐ Oxygen	☐	☐	☐	

My Preferences *(Completed by the person we support or their Support Network)*
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: ☐ NDIS LWB 5001 Client Profile ☐ Communication Profile ☐ Other:

My Equipment *(Completed by the person we support or their Support Network)*

- Refer to Tracheostomy Procedure for tracheostomy and suctioning equipment
- Refer to Ventilator Procedure for ventilator equipment (where applicable)

Item	Description	Who orders this	How often	Where
Tracheostomy tube	Make: Size: ☐ Cuffed ☐ Non-cuffed ☐ Inner cannula ☐ Fenestrated			
HME	Make:			

Suction Management	☐ *Oral suction ☐ Tracheostomy suction			
	☐ Yankeaur Sucker ☐ Open Y catheter ☐ Closed unit			
Other				

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 <u>000</u> plus *(Completed by Person)*:			
Name:		**Contact Number:**	
Relationship:			
Name:		**Contact Number:**	
Relationship:			

☐ **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

Review of plan *(completed by Health Professional)*			
Name:		**Profession:**	
Signature		**Date:**	
Name:		**Profession:**	
Contact details:		**Date:**	

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.			
Name	**Relationship**	**Signature**	**Date**
	Self		
	Guardian / Person Responsible		
	LWB Line Manager		

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