Tracheostomy Nursing Care Plan

PATIENT INFORMATION

Name: _____ Age: _____

Medical diagnosis:

Date of tracheostomy procedure: _____ dd / mm / yyyy

Tracheostomy type:

- [ ] Surgical
- [ ] Percutaneous
- [ ] Temporary
- [ ] Permanent

ASSESSMENT

Respiratory status

Oxygen saturation: _____ Respiratory rate: _____

Breath sounds: _____

Signs of respiratory distress:

Tracheostomy function

Tracheostomy tube type: _____ Tracheostomy tube size: _____

Inner cannula:

- ○ Clean ○ Dirty

Signs of obstruction:

Tracheostomy site

Stoma appearance: _____

Skin integrity:

- [ ] Intact
- [ ] Redness
- [ ] Inflammation

Presence of secretions:

NURSING DIAGNOSIS

Specify below:

INTERVENTIONS

Specify below:

EVALUATION

Specify below:

CARE PLAN

Specify below: