Licensed Health Provider's Tracheostomy Orders and Procedure Request at School

Student Name	DOB	School	FAX	School Year

To Be Completed by a Licensed Health Provider with Prescriptive Authority

Airway Diagnoses/Reason for Tracheostomy	_____ _____
Type of Tracheostomy Tube	**Routine trach:** Brand: _____ Size: ____ ☐ Pediatric ☐ Adult Length: _____mm Cuff: ☐ yes ☐ no ____Fill cuff with water (Bivona) _____mL, always maintain minimal leak ____Fill cuff with air (Shiley) _____ mL, always maintain minimal leak ____Do not fill the cuff Inner Cannula: ☐ yes ☐ no Change as needed: ☐ yes ☐ no **Emergency backup trach:** Brand:_____Size: _____ ☐ Pediatric ☐ Adult Length: _____mm Cuff: ☐ yes ☐ no ____Fill cuff with water (Bivona) _____mL, always maintain minimal leak ____Fill cuff with air (Shiley) _____ mL, always maintain minimal leak ____Do not fill the cuff Inner Cannula: ☐ yes ☐ no Change as needed: ☐ yes ☐ no ☐ Nurse must verify the correct trach tube is in the stoma at pick up from the home/on arrival at school. Nurse must assess breath sounds, condition of the stoma and neck on arrival to school. ☐ Student must go to the ED if smaller backup trach is in place, notify parent/guardian if the smaller trach has been placed. ☐ Same size trach tube and one size smaller trach tube to be available at all times for urgent/emergent changes. ☐ Change trach tube emergently with any signs of distress that do not resolve with suctioning. Call 911 if the trach tube cannot be replaced into the stoma or if distress cannot be relieved. ☐ 1:1 supervision and care at all times by a sufficiently trained caregiver who can perform and provide both routine and emergency care. ☐ Trach ties to be clean, dry, and tight enough so that one finger can fit snuggly on each side. Trach is to be midline and resting on the neck. Nurses can change trach ties at school when properly trained. ☐ yes ☐ no
Resuscitator/Ambu Bag	☐ Resuscitator bag must be present at school and near student at all times. Appropriate size related to the size/weight of the student. Check use and function daily at pickup from home/on arrival to school. Use via tracheostomy if in the stoma with pop-off valve activated. Can use the override for up to 2 power breaths if needed with a suspected trach obstruction. ☐ Stoma mask and face mask must be available for use at all times for when trach cannot be replaced into the stoma. _____ Use via Nose/Mouth if the trach is out of the stoma and upper airway is patent. _____ Use via trach stoma if the trach is out of the stoma and upper airway is NOT patent. PEEP valve present: ☐ yes ☐ no PEEP valve setting: _____ (should match PEEP setting on ventilator, if applicable)

Oxygen via Tracheostomy	☐ Oxygen as needed at _____ lpm to keep sats >/ = to: _____% via _____(trach tube/HME, vent circuit) ☐ Continuous oxygen at _____ lpm via _____ (trach tube/HME, vent circuit). ☐ Call parent/guardian if additional oxygen is used for more than _____ minutes for persistent desaturation not responsive to other interventions. Other Oxygen instructions: _____ ☐ Oxygen must be nearby student at all times with regulator in place or available and quantity verified by nurse on arrival as sufficient for the time at school. Tubing must be present and attach to the source of oxygen and to the student if needed. If on a ventilator, device to add oxygen to the ventilator must be present while at school. Oxygen secured safely with the appropriate device to either secure upright or laying down. Oxygen must not be stored upright if not secured. No open flames near the source of oxygen. Post appropriate signs of "oxygen in use" for location of student as needed during the school day. Oximeter use, check all that apply: ☐ Oximeter and power cord (if applicable) to accompany student to school. Alarm settings verified at the start of the school day by 1:1 caregiver. ☐ Continuous, rotate site every 2-4 hours ☐Before activity ☐After activity ☐ Start of school day ☐ Before dismissal ☐ Before breathing treatment ☐ After breathing treatment ☐PRN spot check (specify frequency): _____
Tracheostomy Suctioning	☐ Suction Machine Pressure: _____mmHg. (300 mmHg routine, up to 400 mmHg for thick secretions.) Suction machine and power cord must always be present and operational while at school. ☐Notify parent/guardian for any change in baseline secretions for amount, color or smell. Call 911 for excessive blood in secretions. ☐ Limit time of suction to not more than 10 seconds per suction attempt. Give oxygen as ordered if desaturation occurs with suctioning. Trach Suction Depth: Inline: _____ Open suction: _____ Suction Frequency (check all that apply): ____Suction trach to the prescribed depth every _____ minutes ____Suction trach to the prescribed depth every _____hours ____Suction trach as needed for following signs/symptoms—check all that apply: ☐Noisy, rattling breathing ☐Visible secretions ☐Choking ☐Coughing ☐Color Changes ☐Wheezing ☐Agitation ☐Retractions ☐Nasal flaring ☐ Upon student request ☐Before eating or drinking ☐Aspiration of foreign materials ☐After eating or drinking ☐Other:_____ Other suction instructions: _____
Emergency Plan	☐ Call 911 for distress that cannot be resolved and/or the trach tube cannot be replaced. ☐ Licensed nurses may reinsert trach (per training). Assess patency and student condition after any trach change. ☐ Notify parent/guardian if trach tube becomes dislodged/replaced during the school day. ☐ "Go Bag" must be fully stocked with all routine and emergent supplies and present for the student to attend school. "Go Bag" supplies also include oxygen, oximeter, suction machine and catheters, backup trach, obturator, trach ties, scissors and cough assist/CPT devices if ordered. Supplies also include power cords. Other instructions: _____
Activity Restrictions	☐ No activity restrictions. ☐ May participate in PE class if oxygen saturation >/= _____% ☐ May participate in outdoor physical activity if oxygen saturation >/= _____% and outdoor temperature above _____ and below _____degrees Other instructions: _____

Tracheostomy Humidity	☐ HME on trach at all times and/or when not on a ventilator. Remove and replace as needed if soiled, wet or drops to the floor. Muir Valve use: ☐ yes ☐ no ☐Deflate cuff when using PMV Trach cap: ☐ Capped at all times ☐ Do not use a trach cap ☐ Capped as tolerated, instructions:_____ ☐ Remove cap or PMV for any signs of distress or if not tolerated, 1:1 supervision at all times while using a cap or PMV.
Saline via Tracheostomy	☐ No saline drops via trach tube. ☐ No routine saline drops via tracheostomy tube for extra moisture, can use 1-4 drops PRN with suctioning to dislodge thick secretions. ☐ Instill 1-4 drops of normal saline every 1-4 hours as needed to trach tube for thick/dry secretions Other instructions: _____
Tracheostomy Stoma Care	☐ No trach stoma care at school. ☐ Trach stoma care instructions per parents/guardian, supplies must be present at school to perform stoma care. Other instructions: _____
Parent/Guardian Contact	☐ Contact parent/guardian if any of the following occur at school: fever, persistent change in tracheal secretions, change in activity level or mental status, unexpected oxygen use, equipment malfunction Other instructions: _____
Additional Considerations in 72-Hour Emergency	☐ Student should have sufficient supplies, medications (routine, emergent), formula/food/pump, power cords, diapers/catheters/wipes/etc. for all equipment for emergency use lasting up to 72 hours. Other instructions: _____
Additional Medical Provider Instructions	_____ _____
Parent/Guardian Comments	_____ _____

Duration of order(s): School Year (mm/dd/yr) _____ to _____.

Health Care Provider's Signature: _____ Date: _____

Print Health Care Provider Name: _____ Phone: _____Fax: _____

THIS AUTHORIZATION IS GOOD FOR THE CURRENT SCHOOL YEAR ONLY.

To Be Completed by the Parent or Legal Guardian

I request that the school nurse or designated staff member be permitted to discuss my child's medical issues with health care providers, and administer to my child, *(name of child)* _____ , the treatment prescribed by *(name of health care provider)* _____for the _____ school year. I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the treatment is administered in accordance with the health care provider's directions. **I will collect any necessary supplies and equipment from the school at the end of the year or understand that it will be discarded.** I am the parent or the legal guardian of the child named.

- I will notify the school immediately with any changes or cancellations.
- I understand that a procedure will not begin until adequate training of qualified staff is completed.
- I understand that I must provide all necessary supplies and equipment to perform this service.

Parent/Guardian Signature: _____ Date: _____

Phone Contacts: Home/Cell: _____ Work: _____ Other: _____