TRACH CARE TEAM ROUNDS

Initial date of trach ___________ Trach Size______ Trach Type __________________________
☐ Non-fenestrated ☐ fenestrated

Date of trach change __________ Trach Size _____ Trach Type _________________________
☐ Non-fenestrated ☐ fenestrated

Sutures present ☐yes ☐no Planned removal date for sutures on or around _______________

Cuff ☐ Inflated ☐ Deflated Cuff Pressure _________________________________

Condition of stoma/tube __________________________mouth/lips____________________________

Ventilator/O2 status ____

Nutritional status ____

Method of Communication ____

Cough/secretions management ____

Emergency equipment at bedside ☐ yes ☐ no

Capping trials ☐ yes-date __________ ☐ no PMV Trials ☐ yes - date _________ ☐ no

Decannulation ☐ yes – date _________ ☐ no

Swallow Evaluation performed ☐ yes- date___________ ☐ no

Swallow Evaluation Passed ☐ yes - date _________ ☐ no ☐ na

Therapy status ____

Referrals needed ☐PT ☐OT other____

Findings ____

Recommendations ____

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Goals and Plan ____

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__________________________________ ____________________________

Signature Date