PEDIATRIC COMPLEX CARE PLATFORM | منصة رعاية الأطفال ذوي الحالات الطبية المعقدة

CLINICAL TOOL · PEDIATRIC COMPLEX CARE PLATFORM

Trach / Ventilation Review Sheet

Focused clinic review for children with a tracheostomy and/or home ventilation

Version 1 | Published October 2026 | Review due October 2028

DOCUMENT TYPE	PUBLISHED	NEXT REVIEW DUE
Clinical Review Tool	October 2026	October 2028
OWNER	**VERSION**	**APPLIES TO**
Pediatric Complex Care Platform	1	Pediatric patients

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Patient: _____ **ID:** _____ **Date:** _____

1 Tracheostomy

INDICATION

☐ Long-term ventilation ☐ Upper airway obstruction ☐ Airway protection / secretion management

Brand: _____ **ID:** _____ mm **OD:** _____ mm **Length:** _____ mm

Cuff: ☐ No ☐ Yes If yes — content: ☐ Water ☐ Air volume: _____ mL

Last change / frequency: _____ **Change complications:** _____

Stoma: _____ **ENT: last / next review:** _____

Spare trach at home: ☐ No ☐ Yes How many: _____ **Trach go-kit available:** ☐ No ☐ Yes

Decannulation readiness: ☐ Not a candidate ☐ Under evaluation ☐ Ready

Decannulation plan (e.g., speaking valve, capping trial, airway endoscopy, PSG)**:** _____

2 Suctioning & Secretions

Catheter size / depth: _____ **Suction frequency (per day):** _____

Secretions (amount, consistency, colour): _____ **Complications:** _____

3 Airway Clearance

Cough assist: ☐ No ☐ Yes _____ **Insp / exp pressure (cmH_2O):** _____

Cycles: _____ **Sets:** _____ **Treatments/day:** _____ **Tolerance:** _____

Chest physiotherapy: _____

4 Humidification, Oxygen & Monitoring

HUMIDIFICATION

☐ **Heated humidification**

Device / interface: _____

Settings (temp / flow / O_2): _____

Duration (hrs/day; when): _____

☐ **HME**

Type: _____

Use (hrs/day; when): _____

Tolerance (secretions, plugging): _____

OXYGEN & OXIMETRY

O_2 requirement (day / night): _____

Target SpO_2: _____

Oximetry use (day / night): _____

Average SpO_2 / HR: _____

Alarm limits (SpO_2 / HR): _____

Real alarms / actions: _____

5 Ventilation

Indication: _____

Type: ☐ Invasive ☐ Noninvasive

Ventilator model: _____

Airway / interface: _____

USAGE (select all that apply)

☐ Continuous (24 hours/day) ☐ During sleep (including naps) ☐ Intermittent while awake

Schedule (timing and duration): _____

Total hours/day: _____

Mode: _____

Ventilator settings					
IPAP / PIP (cmH_2O)		EPAP / PEEP (cmH_2O)		PS (cmH_2O)	
Backup RR (/min)		Target VT (mL)		Ti (sec)	
Rise time (ms / setting)		FiO_2 (%) / O_2 flow (L/min)			
Monitored parameters					
VTi (mL)		VTe (mL)		MV (L/min)	
Total RR (/min)		Leak (L/min or %)		Patient-triggered breaths (%)	
pCO_2 (mmHg)		Date of pCO_2 assessment			

ALARMS REVIEWED (as applicable)

☐ VTe ☐ MV ☐ RR ☐ Disconnect ☐ Pressure ☐ Apnea ☐ Other: _____

Alarm settings, events & actions: _____

Last / next PSG: _____

Data downloaded (date): _____

Weaning plan / goals: _____

6 Medications & Vaccinations

Respiratory medication	Dose	Route	Frequency	Adherence

Vaccinations up to date: ☐ Influenza ☐ Pneumococcal ☐ RSV prophylaxis (if eligible)

7 Assessment & Plan

Clinical assessment:

Impression:

Plan: