Creating an integrated tracheostomy care pathway for patients in an Irish regional hospital setting - the feasibility and effectiveness of a dedicated tracheostomy team

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Anne Claffey, Chloe Heslin, Grace Donnelly, Ron Charles, Sharon Gorman

Regional Hospital Mullingar, Ireland

Introduction: Temporary tracheostomy is increasingly used earlier in the management of the general critical care population. With rising numbers of temporary tracheostomies, more patient are being transferred from the Intensive Care Unit (ICU) to general wards, so the care pathway for inpatients has to be considered in both ICU and ward environments (Paul, 2010). International guidelines emphasise that the timely involvement of the multidisciplinary team (MDT) is essential for the good aftercare of patients with a tracheostomy (Global Tracheostomy Collaborative). A number of studies have documented the benefits of a dedicated or outreach tracheostomy MDT to support patient care and weaning from tracheostomy. Reduction in length of stay, time to decannulation, and incidence of adverse events have been reported. Impacts on quality of patient care have not been well documented (Garruba, Turner & Grieveson, 2009).

In the Irish context, dedicated tracheostomy teams are less common in regional hospital settings. Little is known about their potential to improve patient outcomes.

Objectives: The aim of this project was to:

1. Explore the feasibility of creating a dedicated tracheostomy team in an Irish regional hospital setting
2. Examine the potential for this team to improve outcomes and experience for patients with temporary tracheostomy in a regional hospital setting

Method: With the support of a local quality improvement forum, a process mapping exercise was completed examining the journey for the patient with a temporary tracheostomy in a regional hospital setting. An audit of patient charts was completed, and outcomes at various stages of the patient journey were documented. Potential points for co-ordination of MDT care along the patient journey were identified, based on a comparison with international guidelines. A dedicated tracheostomy team was convened, based on need identified from audit findings, and staff resources available. The team consisted of Consultant Intensivist, Physiotherapy, Speech & Language Therapy, Intensive Care Nursing, and Respiratory Nursing.
A once weekly MDT tracheostomy ward round was established. Repeat audit of patient charts was completed to evaluate the impact of above.

**Results:** It is feasible to create and maintain a dedicated tracheostomy team in this regional hospital setting. Challenges were encountered, particularly in relation to availability of staff, but these can be addressed through planning and flexibility. The implementation of the team and ward rounds led to improvements in:

- clarity of plan for weaning and decannulation
- cuff management
- time to assessment for basic communication support
- time to assessment for speaking valve
- time to swallow assessment

**Conclusion:** A dedicated tracheostomy team can contribute to improvements in quality of care for the patient with temporary tracheostomy in a regional hospital setting. Due to the heterogeneity of this clinical population, a larger sample size is required to explore its effectiveness, with regards to reducing length of hospital and ICU stay.

Process mapping is a useful form of clinical audit. In this instance, multiple potential points for co-ordination of MDT care along the patient journey were identified, which could be addressed with further quality measures going forward.

**Keywords:** tracheostomy; care pathway; regional hospital