

Establishing a Tracheostomy Team: Optimal Outcomes with Coordinated Care

Dawn Krystiniak, RRT, LRT; Bambi Patterson, MCD CCC/SLP

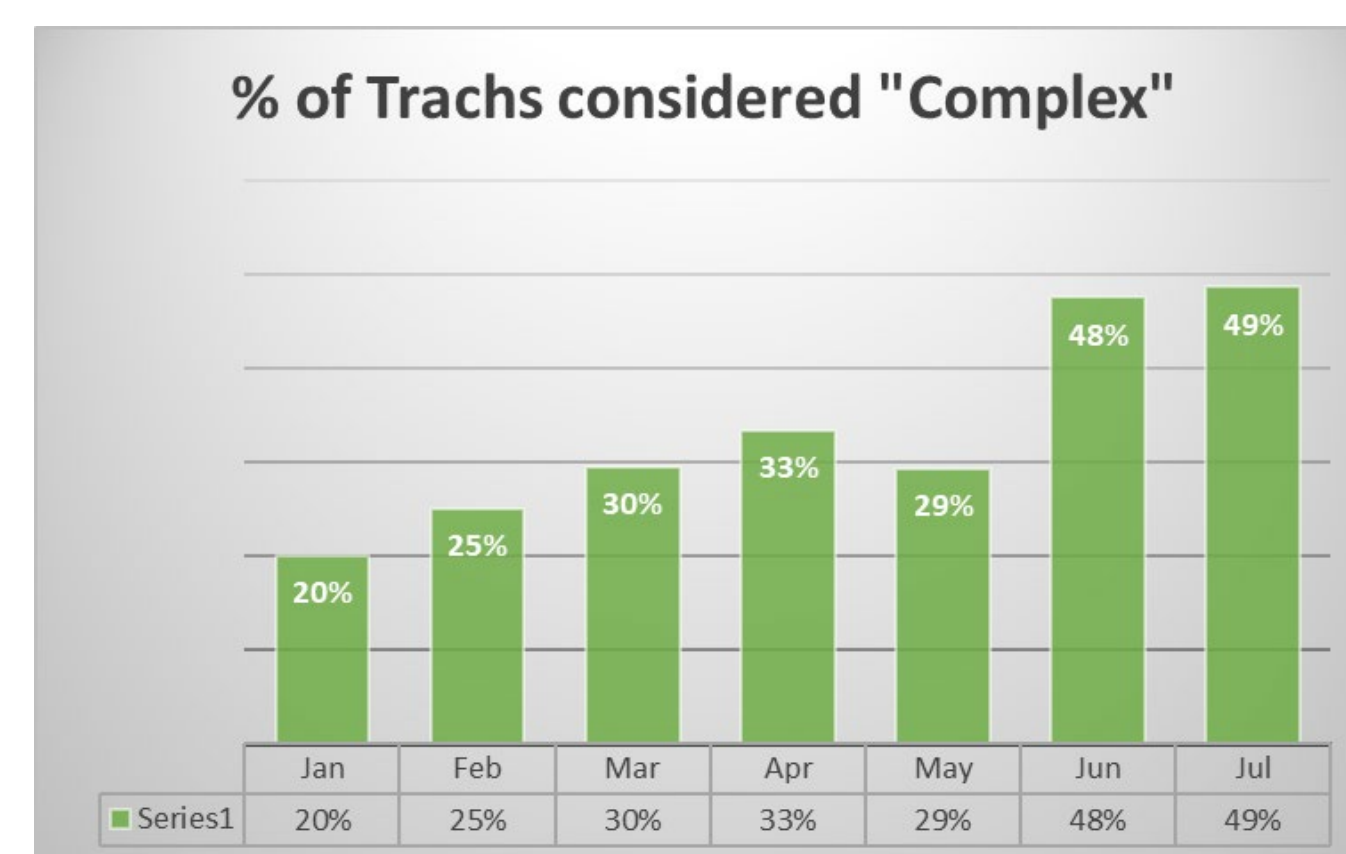
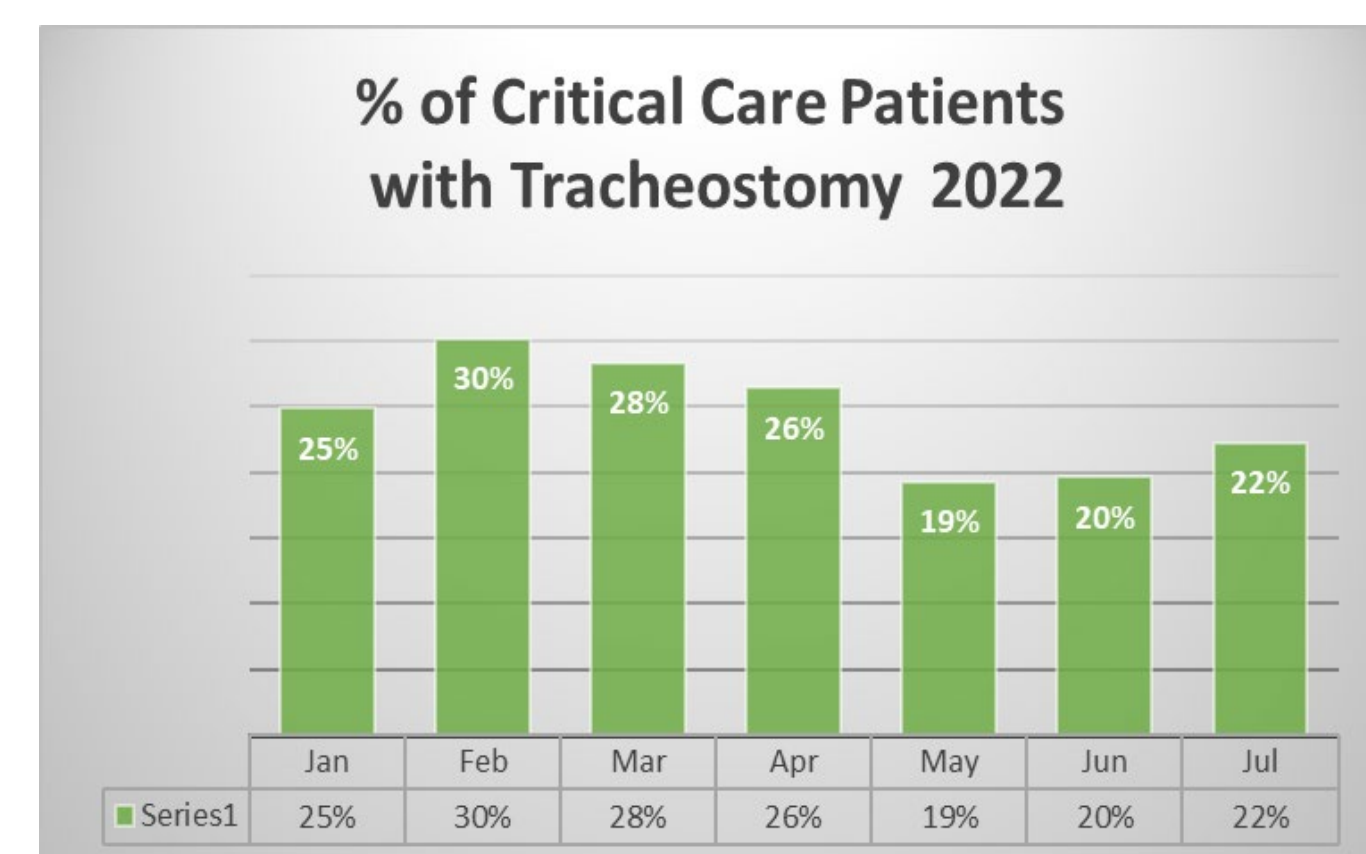


BACKGROUND

Historically, clinicians perform specialized interventions independently. While interdisciplinary in approach, this may result in added risk of delays or complications for the person with a tracheostomy.

After a careful review of current trends and care models, the development of a dedicated Tracheostomy Team was identified as a potential solution.

Our current audit results (January 2022-July 2022) indicate a range of **19-30%** of patients in the critical care units meet criteria for benefit of coordinated care by a "Trach Team" (up to **32%** of those considered "complex" i.e either difficult airway or with anatomical challenges)



PURPOSE

Recent research reveals that "the coordinated effort of a multidisciplinary team may positively affect patient outcomes." (Bartow C., 2022)

"Our findings indicate that the use of specialized tracheostomy care teams is associated with decreased time to decannulation, less tracheostomy-related adverse events, and increased use of speaking valves." (Mussa et al 2021)

The preliminary review of our current practice, policy review and assessment of staff awareness has identified opportunities for improvement consistent with the research.

It is our hope to demonstrate validity of a dedicated "Trach Team" for improved patient outcomes.

REFERENCES

Bartow C., Establishing a Trach Team; Tips to getting started (2022)

Mussa, C., Gooma, D., Rowley, D., Schmidt, U., Ginier, E., & Strickland, S. (2021). AARC Clinical Practice Guideline: Management of Adult Patients with Tracheostomy in the Acute Care Setting. *Respiratory Care*, 66(1), 156-169.

Farrell MS, Gillin TM, Emberger JS, Getchell J, Caplan RJ, Cipolle MD, Bradley KM. Improving Tracheostomy Decannulation Rate In Trauma Patients. *Crit Care Explor*. 2019 Jul;1(7)

RESULTS

Current state: (January 2022-July 2022)

Out of **108** tracheostomy placements reviewed :

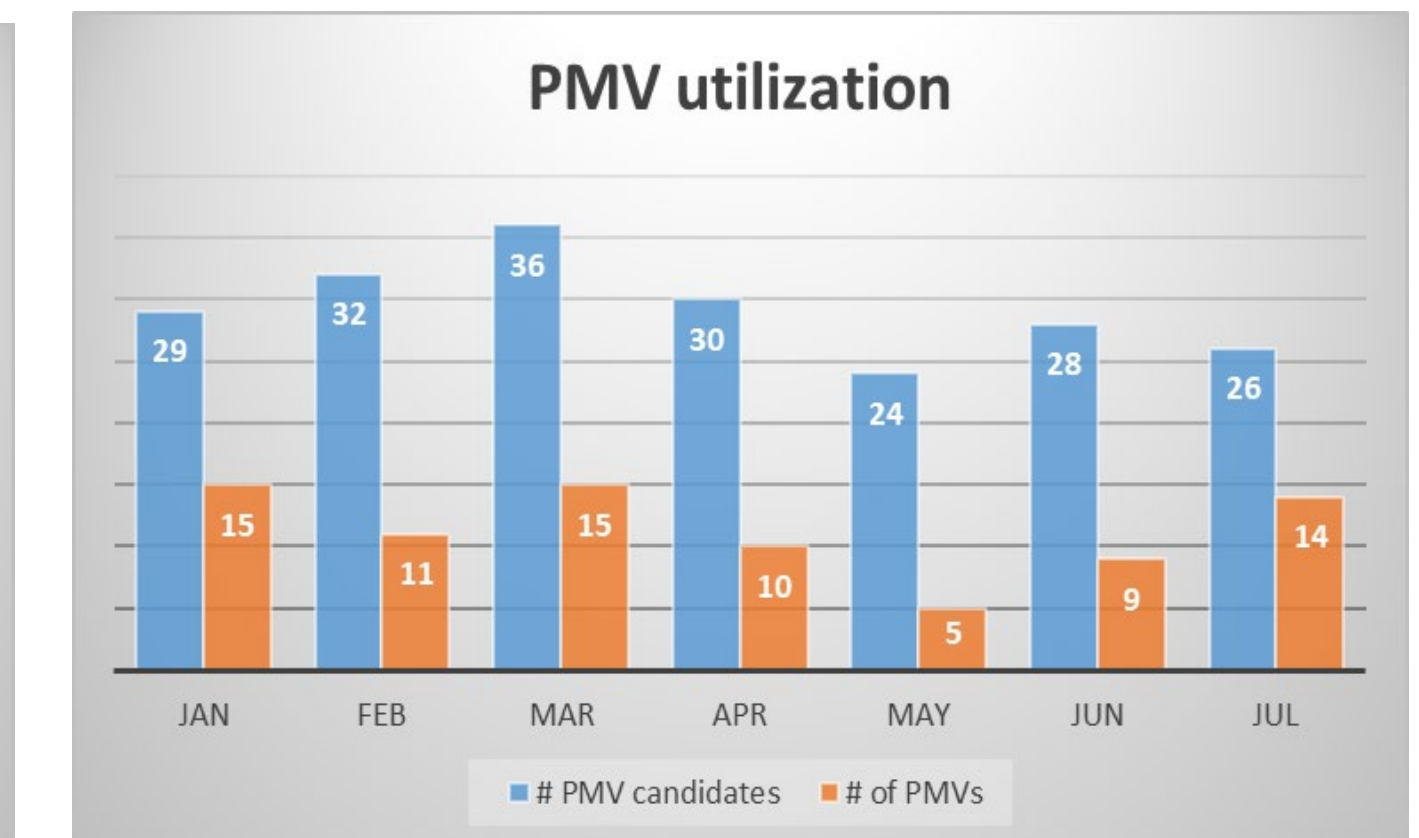
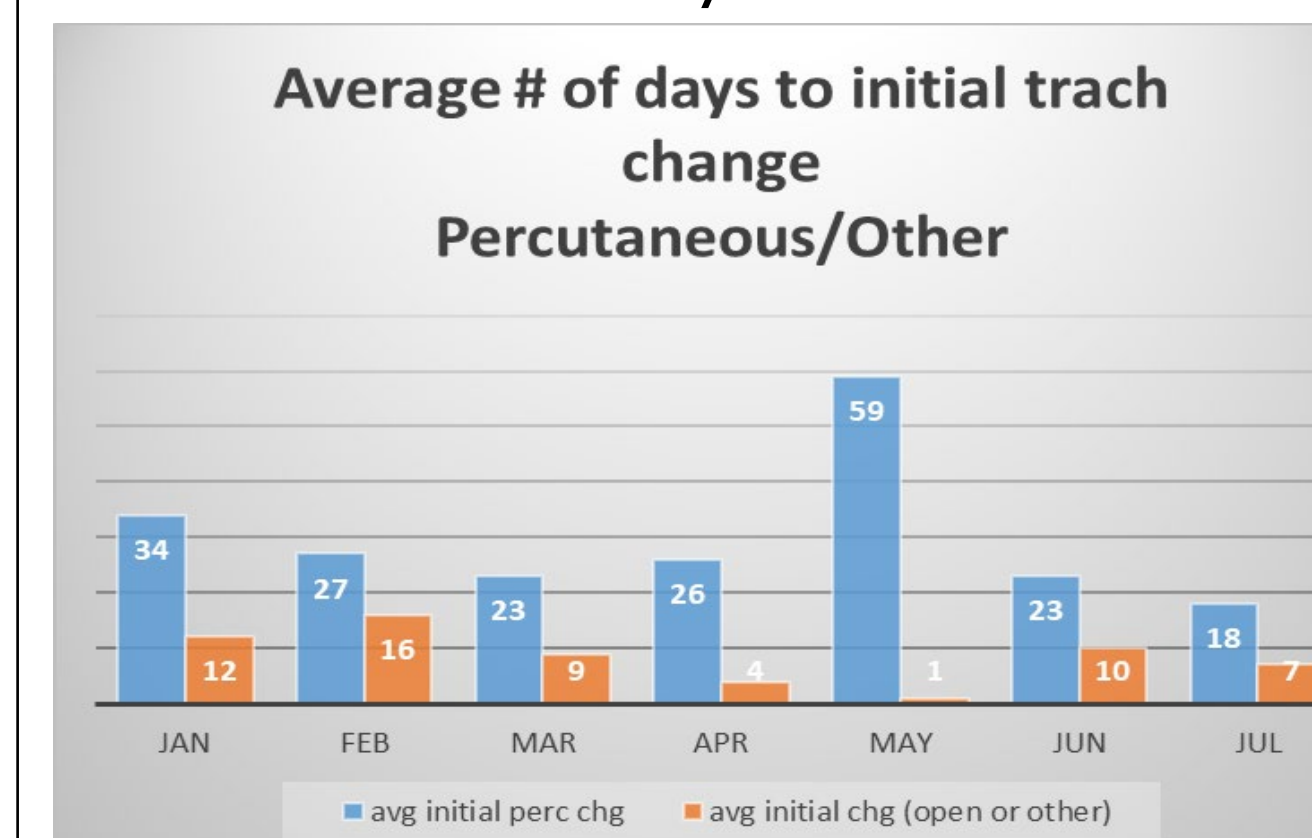
There was an average of **30** days to initial percutaneous trach change (with a range of **7** to **59** days). Average to initial change for "other/open" trachs **10** days (with a range of **1** to **71** days).

Additional patients reviewed, discharged without an initial trach change = **41** (with a range of **3** to **102** days post-placement).

Of those patients meeting criteria, an average of **38%** received evaluations for Passy Muir Valves (PMV).

Mean number of days to decannulation = **36.5 days** (with a range of **7** to **147** days).

Inconsistent reporting of adverse events directly related to tracheostomy care.



METHODS

- Literature review and comparison of models of care in similar acute care settings (Level 1 Trauma).
- Evaluation of current state
- Identification of key indicators for improvement
- Identify key stakeholders
- Implementation of process including standards of care from trach placement through decannulation.

CONCLUSIONS

4 KEY Areas for improvement based on review:

	Development of standards of care/protocols to guide weaning and potential decannulation
	Increase consistency of timely tracheostomy changes (initial and routine)
	Decrease delay in implementation of speaking valve use (PMV) to optimize potential for oral intake and decannulation
	Improved identification of adverse events (tracheostomy-related emergencies) for timely review and follow through

