STARTING POINTS FOR PERSUADING AN ORGANISATION THAT THEY SHOULD IMPROVE TRACHEOSTOMY CARE

Healthcare organisations don't set out to provide poor care. Leaders in our hospitals have many competing priorities, dictated by internal and external pressures. Often however, frontline healthcare staff who are working with tracheostomy patients are aware of problems with care and want to try to influence their hospital leadership to do something about it.

There is increasing evidence that tracheostomy care is a field in which quality improvement initiatives can have a big impact. Over the last 8 years, a number of individuals, hospitals and groups from around the world have shown that it is possible to make meaningful changes in the way we care for patients and have significant impact on the quality, safety and efficiency of care.

The purpose of this short document is to highlight strategies for staff who want to encourage their organisation to take the first steps.

MAKING THE CASE:

These are national data that show care isn't very good currently. The usual defence against this from groups resistant to change is that "these aren't *our* data" or "*we* don't have a problem." In this case, ask to see the data, or ask the governance department to report into incidents involving tracheostomies or laryngectomies in the last 2 years. These reports usually only capture 'patient safety incidents' and will not usually capture the things that are important to patents, such as eating, drinking and talking. High performing organisations capture, review and act on patient safety and incident data.

Some examples of useful resources are linked below:

NCEPOD 2014: https://www.ncepod.org.uk/2014tc.html

NPSA 2010: https://www.ncbi.nlm.nih.gov/pubmed/20709764

Eibling DE, Roberson DW. Managing tracheotomy risk: time to look beyond hospital discharge. *Laryngoscope*. 2012 Jan;122(1):23–4.

LEARNING FROM OTHERS

To improve tracheostomy care, you don't have to reinvent the wheel – plenty of others have shown that this can be done. The Global Tracheostomy Collaborative (GTC) was formed by a group of hospitals from around the world (www.globaltrach.org) and brings together expertise and experience not only in tracheostomy care, but in getting things done and making changes in our complex healthcare systems.

The advantage here is that many of the problems experienced by staff trying to take those first steps to improve care will have been experienced by others. Some strategies work in certain settings, whilst others

are more difficult to implement or are less effective. The power of the Collaborative is that there are people to ask.

The GTC also provides a patient-level database so you can track care and see the impact of the changes that you make. They provide comprehensive reports and allow you to compare and benchmark your care with others. There are examples of these reports on the GTC website and an article explaining the work of the Collaborative is detailed below:

https://members.globaltrach.org/2017/09/02/article-by-dr-david-roberson-and-dr-gerry-healy-posted-in-the-american-college-of-surgeons-bulletin

REAL WORLD EXAMPLES OF IMPROVING CARE

Building on these ideas, a group of 4 hospitals in the North West of England joined the GTC together. Over a 12-month period, they saw significant improvements in the safety of care provided and also significant reductions in length of stay, both in the hospital and in the ICU. The improvements were rapid and significant impact was seen within 6 months. Whilst other hospitals around the world have seem similar impacts, these 4 sites measured lots of key outcomes and tracked what they did, to make the links stronger. The full report was published in BMJ Quality.

https://bmjopenquality.bmj.com/content/6/1/bmjqir.u220636.w7996

Following on from this, the Health Foundation funded a scaled-up version of implementing the GTC into 20 diverse UK sites. This project will report formally over the Autumn of 2019, but it has shown a significant impact on improving the quality and safety of care. Importantly, we saw improvements in the things that patients told us they cared about, such as reduced time to eating and drinking, faster mobilisation, earlier talking and quicker times to decannulation. Independent economic analysis demonstrated that through organisational efficiencies (proving better coordinated care) a £15,000 saving per patient admission was seen when comparing care at the start and the end of the project.

PATIENT POWER

Initiatives such as the National Tracheostomy Safety Project and the Global Tracheostomy Collaborative have re-emphasised the importance of having patients and their families at the heart of our improvement efforts. A patient champion in your hospital will have experienced *your* care and know what needs to change locally. Patients also keep us focussed on the things that matter and can help diffuse arguments over which wards should accept patients with tracheostomies, for example, because to the patient (the most important person) it really doesn't matter.

THE FIRST STEPS

If you are struggling to get tracheostomy improvements on the table in your organisation, we suggest the following approaches:

- Do your homework – look at the NTSP and GTC websites to know what can be done
- Understand your local problems in the national context
- Have some local examples of when care didn't go well. This may have resulted in harm to a patient, delays, frustration, unnecessary cost or a complaint that could have been avoided.
- Make a plan. Leaders often respond better to a plan of what to do rather than a list of problems for them to solve. Start with small steps that could improve:
    - **Safety** – for example universal use of bedhead signs, emergency training for staff
    - **Quality** – all new tracheostomy patients being seen by dedicated speech and language therapists or respiratory physiotherapists for example
    - **Efficiency** – simply highlighting delays in discharging patients from an ICU or from a ward to the bed management team or discharge team

- Aim high – go and see the chief executive, medical director or chief nurse. Ideas can take ages going up and down managerial hierarchies, so go straight to the top if you can. Involve your immediate bosses if they are supportive, or just tell them what you are doing – this may help with any 'politics' afterwards.
- Take a patient or family with you to a hospital executive meeting – they are much more likely to listen, and from experience, to say 'yes.'
- Arrange a grand round or presentation at a mandatory training or departmental study day. Invite all the key players you will need on side to get things moving. Follow this up with fixed meetings and deadlines (e.g. monthly meetings for 6 months to kick things off) which will stop any loss of initial momentum
- Join the Collaborative – get access to help, support and the data to drive change

Membership of the GTC costs money, currently £5,000 GBP per year. This is to pay for the database, analytics and functions of the Collaborative. This is the equivalent of 2 days in ICU, which you are virtually guaranteed to save within one year if you start improving care.

You can do it alone for sure, but it's much harder to work out what to do, how to do it and demonstrate the impact without the Collaborative.

Good luck!