IMPROVING MULTI-DISCIPLINARY STANDARDS OF CARE POST PARTICIPATION IN THE GLOBAL TRACHEOSTOMY COLLABORATIVE

Samuel T. Ostrower MD, Linda Reesor PhD PNP-BC, Diane Randall RRT-NPS
Joe DiMaggio Children’s Hospital

STRATEGIES FOR MULTI-DISCIPLINARY EDUCATION FOLLOWING PARTICIPATION IN THE GTC

In September of 2014, following organizational review of current literature on tracheostomy care produced by the steering committee members of the GTC, changes to standards of tracheostomy care at JDCH were discussed by administration, physicians, nurses, and respiratory care representatives. A two-step process was discussed to implement the changes: changes to the policy and procedure to reflect the evidence provided as well as an educational platform to present the changes to all staff.

A mandatory 1 hour class with accompanying CEU was required of all respiratory therapy and nursing staff. From September 2014 to April 2015, 55 classes were given to a total of 704 RT and nursing staff. In addition, approximately 50 physicians, nurse practitioners and physician assistants representing neonatologists, pediatric intensivists, pediatric emergency physicians, inpatient pediatricians and pediatric surgeons received training in the updated standards of care. Included in the class was the introduction of the EMR based tracheostomy bundle; emergency equipment required to accompany any tracheostomy patient at all times; safety considerations of patient with new surgical tracheostomies; the emergency algorithms created by the NTSF of the UK, and a customized postoperative order set in the EMR for “fresh” tracheostomies.

An important part of the education program was staff participation in a non-emergent tracheostomy change on either an adult or infant manikin. A pre-tracheostomy change “time out” was also implemented in which 5 people were required to verify patient, tracheostomy (ID, OD, and length), and delegation of responsibilities (who takes trach out, who puts trach in, who assess placement, who secures trach). Each subsequent year, all staff are required to demonstrate proficiency during a “blitz” of other proficiencies.

An improvement to patient safety was the “bedhead sign” or Head of Bed (figure 2). In 2013, McGrath, B.A. et al reported there was a reduction in hard suctioning to prevent trauma to tracheal mucosa.

The updated standards of care had an immediate financial cost in that individual patient’s bedside emergency equipment was increased from only 1 spare trach at the bedside to the following: 1 spare trach same size, 1 spare trach size smaller, 1 Suction catheter, 10 ml spring, 1 Suction mask.

In addition, all patients are required to travel throughout the hospital with portable oxygen and suction at all times.

CONCLUSIONS

Quality improvement collaboratives seem to play a part in encouraging safety and improving care by sharing evidence-based best practices. Participating institutions can generate objective data to improve the standards of care and increase safety. The GTC has led the way for JDCH to develop, educate and implement such standards.

REFERENCES


