

PRESIDENT'S MESSAGE



David Roberson
GTC President

The Global Tracheostomy Collaborative lost a special friend, colleague, and member of our family when Alfred E. Smith IV passed away unexpectedly November 20. Al was the consummate cancer survivor and tracheostomy patient, and he and his wife Nan (Moore) Smith threw themselves into the GTC mission with an enthusiasm and sense of mission that was inspiring

to all of us who met them.

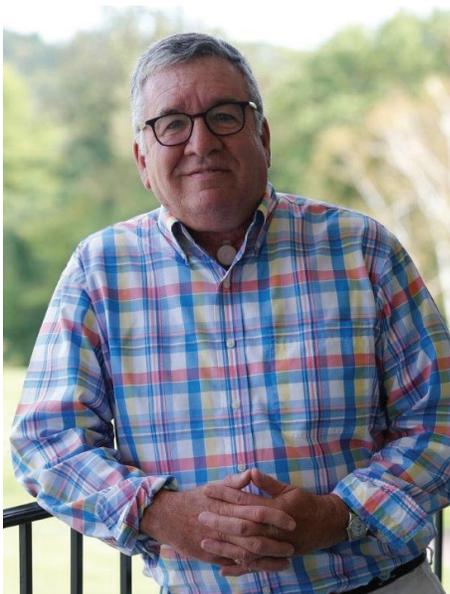
Al became one of the youngest NYSE members in history when, immediately after his father's early passing in 1972, he took over his father's seat. He had a successful 36-year career there, retiring as a managing director at Bear Wagner in 2008. His accomplishments in business are too numerous to mention. But that was only his day job.

Al was diagnosed with laryngeal cancer in his 30s, and although he was cured he lived with a tracheostomy for the rest of his life. He spoke to me privately about some of the many difficulties his tracheostomy created for him, particularly in a career where he lived by shouting out stock orders.

But he shared these issues with me only because he wanted me to understand how important the GTC's work was. Otherwise, he took his tracheostomy in stride, dealt with every problem it imposed without complaint, and could regale for hours with stories

of both humorous and terrifying tracheostomy misadventures – and he never stopped laughing at them. He told me, "I realized right away that I could be the guy who complained all the time, and had no friends, or I could shut up and get on with my life." Al got on with his life in spectacular fashion.

Al founded Hackers for Hope, an annual charity golf tournament that raised more than \$15 million for cancer care and treatment. Al was the great-grandson and name-bearer of Al Smith, governor of New York and Democratic Presidential candidate. In that role he served for 35 years as MC of the Al Smith Dinner, which raised tens of millions of dollars



Alfred E. Smith IV

for Catholic Charities in New York. It was traditional for the presidential candidates to attend each election year; it is one of the few times during the campaign when the candidates are expected to appear together, be positive and polite, and accept some gentle ribbing. Al was a puckish, hysterically funny MC. His tenure was marked by such gems as telling Barack Obama "It's never a good thing when your opponent has produced more sons than you've produced jobs," and following that by complimenting Mitt Romney on his white tie and tails, or "as you call it, governor, business casual." The dinner was a highlight of the presidential campaign for decades under

his stewardship. Behind the scenes, Al and Nan spent thousands of hours organizing and fundraising for this event, which raised millions of dollars annually.

I met Al and Nan in 2017, when Gerry Healy and I drove

to Connecticut to meet with Al and Nan for lunch and tell them about the GTC. None of us had met before, but we took to each other instantly and had one of the most enjoyable meals I recall. Al and Nan were an incredibly well-matched, close couple and it was a joy to be around their relationship. Both of them were thrilled about the GTC's mission and almost immediately were committed to help us succeed. At a time when other couples would be planning to slow down, Al and Nan were overjoyed and enthusiastic at the chance to do more. From that afternoon, the GTC had no better friends and colleagues. Al and Nan joined the board, supported us financially, co-chaired a board committee, attended meetings in Texas and London, gave inspiring keynote speeches, and by their example challenged each of us to give our very best. I worked harder, took our mission more seriously, and found more joy in my work because of the example they set for us.

I'll remember a lot of things about Al. He was an absolute gentleman, a great raconteur, a wonderful friend, a special colleague. I'll never forget watching Al and Elliana Kirsch co-serenade the crowd with "It's a wonderful life," or his stories about launching tracheostomy mucous into unplanned landing spots. But the thing I'll remember most happened the day we met. After an exciting lunch planning for the GTC, as Gerry and I walked out to drive back to Boston, Al called us back. Bubbling over with enthusiasm, he had to share one more story. A young patient who was contemplating tracheostomy had seen him MC the Al Smith Dinner that year, and had reached out to him in fear for what a tracheostomy might mean for her life. Al took this complete stranger under his wing, talked to her at length, and encouraged her to not be limited by her tracheostomy – or anything else. He could not contain his excitement that he'd been able to help a stranger. That was Al.

Nan, I am sure this is a very difficult time; you were blessed with a wonderful partner and the void in your life is hard for me to imagine. All of our thoughts and prayers are with you. Al, my friend, Godspeed. ■

FROM THE DESK OF DIANE O'TOOLE, GTC EXECUTIVE DIRECTOR



Diane O'Toole
GTC Executive Director

As we enter into the New Year, I want to reflect on some of the GTC developments this past year as well as look to the future for what is on the horizon for this coming year. The manuscript development group and the V3 database working committee have both been hard at work to make the GTC publication and V3 of the database a reality. High quality webinars were produced with hundreds of attendees from across the globe.

Outreach to corporate sponsors is expanding as is our communication to member and potential member hospitals. We had a very successful ITS in Melbourne with expert speakers from around the world and we are seeking to expand our networking and discussion group efforts in between the ITS events. We launched a new website in the Spring of 2019 and also the inaugural GTC wide newsletter in June. The Patient & Family committee is expanding and works diligently on issues important to patients and family members. We have many new hospitals in the pipeline for membership and encourage all hospitals to join in our quality of care and safety efforts. In addition to our many positive achievements this year, we also had the very sad unexpected passing of Al Smith, one of our beloved GTC Board members, a wonderful colleague and friend. The GTC is planning to memorialize Al in a way that would be significant and near and dear to his heart.

Please feel free to contact me at 781-929-6182, or at dotoole@globaltrach.org if I can answer any questions that you may have and/or provide assistance at any time. I look forward to hearing from you! May 2020 be a great year for the GTC and for improving the care, safety and quality of life for all individuals with tracheostomies. ■

WHAT IS THE GTC? The Global Tracheostomy Collaborative (GTC) is a quality improvement collaborative that recruits hospitals to join us, to improve the lives of people living with a tracheostomy through implementing best practices around tracheostomy team care and standardization. Their outcomes are tracked through a world-wide confidential database.

HOSPITALS: Join the GTC Today!
globaltrach.org/member_hospitals

HEALTHCARE PROFESSIONALS: Join Today for Free!
globaltrach.org/healthcare_professionals



IN MEMORIAM

By: Erin Ward, Parent, GTC BOD
& Patient and Family Committee Chair



Gabriel Jason Michot
(9-7-12 - 9-19-19)

It is with sadness we share the passing of Gabriel Jason Michot (9-7-12 - 9-19-19), son of Jessica Michot, member of the GTC Patient and Family Committee. Jessica is also the Co-Founder of Trach Mommas of Louisiana and presented at our 4th International Trach Symposium in Dallas, TX. Jessica co-founded Trach Mommas of Louisiana in order to help serve the tracheostomy community in honor of her two

twin boys, Gabriel and Michael, both who lived with tracheostomies.

You can learn more about Jessica's efforts for those with medical complexities through service, support, advocacy, and supplies with Trach Mommas of Louisiana at www.trachmommas.org. Thank you Jessica for your tracheostomy service and volunteerism in loving memory of both Gabriel and Michael, as their loving legacies will live on. ■

GTC MENTORSHIP PROGRAM SEEKING INTERESTED PATIENTS, PARENTS, AND CAREGIVERS:

The GTC is exploring the creation of a mentorship program with an aim to connect patient, parents, and caregivers. We are reaching out to see if there would be individuals interested in having a mentor to help navigate the tracheostomy experience and share knowledge and resources. We are also interested in hearing from members of the community that might like to serve as a patient, parent or caregiver mentor. The mentorship program is still in development, but if you have an interest in being matched with a mentor, or volunteering as a mentor, please email us at patientandfamilies@globaltrach.org. Please also include your CV or biography if you are interested in participating as a potential mentor. ■

UPDATES

By: Melissa Webb



Melissa Webb

Following is an update to Melissa Webb's article in our last newsletter (Sept. 2019)

I have recently found a school where I can pursue an Associate's degree in Business Administration for nonprofit online. If my financial needs work the way they should, I will be starting classes in early 2020.

I have been looking to pursue a degree for nonprofit businesses for a while.

I still hope one day to help run the Ronald McDonald House in Rochester, Minnesota. Until then I am going to keep supporting nonprofits, especially those in the medical field. I believe that everyone should have the best care for themselves or a loved one as is possible.

Until I start my journey of the Associate's degree in Business Administration, I am continuing to use my own story of going through a tracheotomy at the age of six years old to inspire others. My message is one of not giving up on who you are and on others that need someone to be there to lift them back up again.

I hope everyone will remember to support a person that is going through or has gone through a tracheotomy to allow them to succeed at anything they dream of doing. Often, their confidence will be down, so it is important to support them in whatever their dreams are. ■



BE A PART OF SAVING LIVES AND IMPROVING THE QUALITY OF CARE FOR TRACHEOSTOMY PATIENTS - DONATE TO THE GTC TODAY!

GLOBALTRACH.ORG/DONATE

THE 5TH INTERNATIONAL TRACHEOSTOMY SYMPOSIUM; SAFER TRACHEOSTOMY CARE EVERYWHERE HAILED A RESOUNDING SUCCESS

By: Tanis Cameron | Manager TRAMS Austin Health | Co Convenor 5th ITS | Vice Chair GTC

Since the inaugural ITS in 2011 in Melbourne the ITS has grown to become the premier event in tracheostomy care world wide

Austin Health, The Global Tracheostomy Collaborative (GTC) and the Royal Children's Hospital hosted the 5th ITS in Melbourne Australia. Attendees rated this event as super successful with all present enjoying the buzz of new energy surrounding a shared vision.

Zealand, the USA, Germany, the UK and Ireland, Singapore, Japan, South Korea and Qatar. There was a tremendous line up on international speakers, scientific presentations, patient and family sessions and corporate sponsors. Unequivocally the richness and most inspiring aspects of the of the meeting were created during sessions where patients and families shared their stories. Visit www.tracheostomyteam.org to listen to the remarkable patient videos.



Left to Right: Sue and Gerard Stevenson, Brendan McGrath



Left to Right: Jenny and Sally Messer, Erin Ward, Tanis Cameron



Left to Right: Brendan McGrath and Peter Stickney

The themes of this year's meeting were **INNOVATE – IMPROVE – INSPIRE** ... these aims were truly achieved. The ITS became a collective conversation between delegates, presenters, patients and families and sponsors. We all came away richer for having participated. The conversations sparked many new and exciting ideas around best practices in tracheostomy care world wide.

Huge thanks and congratulations to all who participated on the Organising Committees of the 5th ITS. There were over 75 folks involved in creating this event. Numerous hours, international meetings and creative brainstorming over the past two years ensured that the meeting was unique, fast paced and great fun. The Suspects Jazz Band rounded out a fantastic day at the closing cocktail reception.

More than 350 patients, family and health professionals attended, with delegates from around the world including across Australia, New

Keynote speaker, Professor Rinaldo Bellomo, Austin Health Director of ICU Research, provided an inspiring overview of the world literature on tracheostomy care. He stressed the importance of teamwork in tracheostomy care and concluded that all medical centres should join the GTC. Dr Brendan McGrath, Anesthetist and Lead of the National Tracheostomy Safety Professor presented remarkable outcomes of implementing 20 tracheostomy teams in the UK. Drs David Roberson and Dionne Graham presented the encouraging GTC outcomes on over 6,000 patients entered into the GTC Database.

The Awards ceremony at the conclusion of the day included scientific sessions awards, patient and family awards and Global Tracheostomy Collaborative Awards. Congratulations to all participants and to those who were awarded during the 5th ITS.

Austin Health patients Gerard Stevenson and his wife Sue, Daisy Xu and her father Geoff, Sally Messer and



5th ITS Organising Committee, patients and family attendees

her mother Jenny, Colin Gray and his wife Jenny, Peter Stickney and his wife Sue all shared their personal stories with attendees. Gerard and Sue introduced keynote speaker Dr. Brendan McGrath whom they had met in Melbourne in 2014. Gerard and Dr. McGrath discussed how their meeting went on to improve the care of patients in the UK to speak earlier. What a great example of international collaboration improving patient care.

2017 and broke her spine, becoming quadriplegic. Within a month of her arrival at Austin Health after her accident, she was able to speak again and was out of ICU and in the Austin Spinal Unit. With the assistance of music therapist, Dr. Jeanette Tamplin, she has learnt to sing and performed live at Friday's symposium. Daisy truly shone on stage while as she sang, treating the audience to a powerful performance.



Chair of the GTC, Tony Narula presenting GTC findings



Will de Oliveira with clinician Elena Sunderland

Be sure to check out Daisy's blog called Mad Grit <https://daizy4life.tumblr.com/>.

Thanks to all who attended and participated in the 5th ITS. Keep up the great work and keep sharing your insights and research. Together we are meeting our shared goal of Improving Tracheostomy Care Around the World.

Gerard is a businessman and author and is fully ventilated via tracheostomy since suffering a high level spinal cord injury in 2014. He discussed the importance of finding community, purpose and striving to stay positive in the face of adversity, themes which he uses to write in his blog: <http://www.standontheshouldersofgiants.com.au/>.

Be certain to plan attending and contributing to the 6th ITS which will be held in Manchester, UK on September 29 and 30, 2021. ■

Visit www.its2019.org for more information on the meeting.

Daisy was in a motorbike accident in Vietnam in



Daisy Xu



Left to Right: Dionne Graham and David Roberson



Professor Rinaldo Bellomo

5TH INTERNATIONAL TRACHEOSTOMY SYMPOSIUM AWARDS

SCIENTIFIC AWARDS

ORAL/PODIUM PRESENTATIONS

FIRST PLACE:

Improving the Quality and Safety of Paediatric Tracheostomy Care: Implementation of a Weekly Multidisciplinary Ward Round

CO-AUTHORS: M. Higson, C. English, J. Marks, R. Howarth, K. Constardine, R. Beggs, B. A. McGrath

SECOND PLACE:

Factors Associated with Successful Early and Late Tracheostomy Decannulation

CO-AUTHORS: Ms. Joanne M. Sweeney, Ms. Tanis Cameron, Dr Stephen Warrillow & A./Prof Mark E. Howard.

THIRD PLACE:

Raising the Bar in Safety and Quality of Children at Home with Tracheostomy: Knowledge and Challenges of AHC Nurses

AUTHOR: Miss Cora O. Leary, Resilience Care, Cork, Ireland

POSTER PRESENTATIONS

FIRST PLACE:

Christine Knee Chong, Ross, J., Chao, C., Zaga, C., Graham, J., Cameron, T.

Evaluation of a multimodal interdisciplinary tracheostomy educational model

SECOND PLACE:

Jack Ross, McMurray, K., Lanterni, C. Cameron, T.
Use of a Silicon Stoma Stent as an Interim Step in High-Risk Tracheostomy Decannulation

THIRD PLACE:

Vinciya Pandian, Cherney, R., Ninan, A., Barnes, B., Berkey, S., Creutz, E., Judkins, S., Voris, K., Sterling, B. Eastman, D., Hanley, J., Schneider, K. J., Casper, K., Davidson, P., Brenner, M.
Trach Trail as a model system for Interdisciplinary Learning: Implementation of a Systems-based approach to Tracheostomy care

PATIENT & FAMILY AWARDS

Outstanding participation in the production of the 5th ITS Patient and Family videos Award Poster
Scientific Presentation Awards

ADULT: Peter & Sue Stickney, Andrew Follows and Leo, & Daisy Xu

PAEDIATRIC: Amalia & Kate Corbalan, Lottie, Paul & Haley Abbey, William De Oliveira & Kathleen Bodycoat and Jude & Alison McCallum

Outstanding involvement in Patient and Family Forums, attending meetings, webinars and assistance with safety and quality initiatives

Jenny and Sally Messer
Colin and Jenny Gray

Outstanding innovations in tracheostomy related awareness via through social media, newsletters and event organization

ADULT: Gerald and Sue Stevenson
PAEDIATRIC: Tyler Luedi, Emma Mercer & Heather Luedi

GTC PATHFINDER AWARDS

AUSTRALIA

Royal Adelaide Hospital

Royal Brisbane and Women's Hospital

Monash Health (Monash Children's Hospital and Monash Medical Centre)

UNITED KINGDOM

Royal Liverpool & Broadgreen University Hospitals

Norfolk & Norwich University Hospitals

Cardiff & Vale University Health Board

UNITED STATES

Joe DiMaggio Children's Hospital
Texas Children's Hospital

GTC TRAILBLAZER AWARD

Brendan McGrath

WE'RE MAKING IT WORK

By: Kimberley Mincie

First off I was born with severe scoliosis and a hole in my heart... awesome right!??

Fast track many, many years, my scoliosis is curving more and pushing up against my lungs trapping liquid which was preventing me to breathe properly. Without health insurance and improper diagnosis (just take more water pills was what one of my former drs suggested) I was getting sicker. During that time I was doing DoorDash, Uber Eats, Lyft and barely getting enough sleep... again... running around with my head cut off!!

One night in April, this year, I could barely breathe. Weeks prior it was getting worse... walking slower, less energy, shortness of breath, I didn't know about the liquid in my lungs until I was hospitalized. I called 911 and woke up 2 days later with a tube down my throat!!! 😞 I couldn't talk, I didn't know what happened, scariest time in my adult life. I was there for 2 months. Had to be shocked twice because of my heart. So many medication changes and x-rays and pokes and prodding. If it wasn't for the great nursing staff to keep me going... and my mom driving back and forth from Atlanta, I don't know what I would have done! I also have amazing friends that came to see me. I don't know how I was able to put a smile on my face most days!!

I am in Atlanta now with my mom until my disability hopefully gets approved. My back is hurting more but it is pain I have lived with all of my life. I have discovered some hidden talents while recovering... cooking, gardening, now knitting and crocheting. Before my tracheostomy, I was all about hanging with friends and trying to make money. Maybe this was mother earth's way of saying... focus on something and slow down.

I have also become vegan... it started with all the excess secretions (mucus) and so I cut dairy from my diet. Since I am homebound for the most part I had to figure out... no going out to eat... I started researching recipes with no dairy. Then went to meatless Monday's then by August I decided to go vegan. It has helped but I'm still dealing with suctioning... not



Super Star Kimberley Mincie

as often as before and sometimes I only do it every couple of days.

This trach has changed my life drastically. I am very much dependent on my mother still. She's retired and on limited income. We're making it work. My bad days aren't as frequent. I try to stay positive and keep myself busy. I've never been much of a home body.

I would like to help with the awareness of the trach community. Everyone I have encountered thinks it's from smoking because of the commercials they see. I am part of 2 Facebook trach groups with some amazing people doing amazing things. They help keep me motivated.

If you would like to reach out to me, I am [ryydethis](#) on Instagram and [Rifqah Kimberley Mincie](#) on Facebook. ■

IMPROVING RN COMPETENCY WITH TRACH CARE & TRACH EMERGENCIES

By: Joan Cavanaugh MHA RN CNRN SCRNP, Clinical Educator;
Doreen Kane, MSN, RN, Clinical Educator; and
Angela Sesin MSN, RN, Clinical Educator; Lahey Hospital & Medical Center

For those nurses working on medical surgical and progressive care units, care of the tracheostomy patient is considered a low-volume high-risk occurrence. At Lahey Hospital and Medical Center these areas see an average 3 to 5 patients per week with tracheostomy. This poses a problem as nurses can go months without caring for one of these patients. Because of this, tracheostomy care and handling of tracheostomy emergencies are identified by the nursing staff as having the greatest need for education. Nursing questions revolved around, frequency of care, supplies needed for routine care and supplies needed for emergencies and handling of tracheostomy emergency such as abnormal bleeding, blocked tracheostomy and accidental decannulation.

To address the first need regarding supplies, nursing education provided to each unit a laminated tracheostomy supply card. On one side is listed all the emergency supplies that should be with the patient at all times. The other side lists general tracheostomy care supplies. While nurses felt this was helpful, they found it burdensome to call Central Supply and request the multiple items that were needed.

The creation of an "Emergency Tracheostomy Box" solved this problem. Small plastic see through boxes are stocked and distributed by Central Supply. They contain a suction catheter, suture removal kit, curved Kelly clamps, 12cc syringe. A tag attached to the outside of the box reminds the nurse to add to the box 2 extra sterile cuffed trach tubes (the same size

and one size smaller) and that an oxygen and suction source should be available at all times.

The box is returned to Central Supply for cleaning and restocking when patient is discharged. The box neatly holds all supplies and is nicely contained to travel with the patient.

The issue of education needs regarding routine care and handling of emergencies is being addressed in a multidisciplinary manner. Tracheostomy education was routinely taught during new hire orientation. Since it is known that skills taught are forgotten if

not used within the first 3 months, and tracheostomy care is a low-volume occurrence, tracheostomy education was removed from orientation. In its place nursing education has developed a tracheostomy education program which includes online education covering routine tracheostomy care, suctioning

and tracheostomy emergencies and attendance at a skills simulation workshop. The online portion will be available on a learning platform for all nurses. Completion of the online portion and attendance at the workshop will be mandatory for all Tertiary Nurse Leaders (charge nurses) and preceptors. By targeting the unit leadership this assures that there will always be a resource for the nurse caring for the rare tracheostomy patients.

The program and simulation was presented to our Nursing Engagement and Professional Development Council with rave reviews and will go live in January 2020. ■



TRAC.

TRACHEOSTOMY REVIEW AND CARE

By: Leeanne Graham and Megan Kepreotis

In 2018 Megan Kepreotis and I were given our first opportunity to attend the Global Tracheostomy Collaborative International Tracheostomy Symposium in Dallas, Texas, USA, to present our poster presentation.

CARING FOR ONCOLOGY PATIENTS WITH A TRACHEOSTOMY IN THE ABSENCE OF A SPECIALIZED ENT UNIT

This opportunity to network with leaders in the field was invaluable. Giving us the education and knowledge we needed to implement changes that were needed to assist us to create the now successful team we now lead.

Megan Kepreotis and I are co-clinical lead of the CMN Tracheostomy MDT. We took over this role in 2016 having been members of the Tracheostomy MDT since 2013. Since taking over the role of clinical lead we have increased staff education, updated policies and guidelines and developed the Tracheostomy Review and Care (TRAC) program.

This article outlines the problems we were facing with the implementation and introduction of the TRAC program.

NURSE LED INITIATIVES IN TRACHEOSTOMIES PATIENTS IN THE ONCOLOGY SETTING TRACHEOSTOMY REVIEW AND CARE TRAC

Calvary Mater Newcastle (CMN) is the Hunter region's major centre for cancer services. Numerous complex head and neck patients are transferred to CMN for cancer therapies post insertion of a tracheostomy performed at another facility. Currently there is no Ear, Nose and Throat (ENT) specialty at CMN. In the absence of a specialised ENT unit at CMN there have been many challenges in the management and care of this complex and vulnerable group.

Without ENT specialty this nurse led program, TRAC (Tracheostomy Review and Care), was developed to improve patient outcomes enabling staff to provide ongoing support to oncology patients and their careers with a tracheostomy/ Laryngectomy This program was developed in response to identified gaps in care and education for tracheostomy /

Laryngectomy undergoing treatment for cancer. A service provided to Tracheostomy and Laryngectomy patients receiving treatment as an out patient.

ABSTRACT

TRAC is a service that we felt we could provide to tracheostomy and Laryngectomy patients receiving treatment in the outpatient setting. The development of TRAC was to assist in closing the gap that is created from time of surgery till when the patient starts their oncology treatment. We implemented this team so patients that will receive chemotherapy or radiation treatment after they have had surgery to create a tracheostomy or laryngectomy will be reviewed prior to these patients starting their treatment. We aim to collect data, form a baseline of the patient's current health and educate the patient on the care needed to maintain their tracheostomy or Laryngectomy. We will also explain to the patient and family what to expect as a result of the treatment in relation to their Tracheostomy or Laryngectomy. We also offer the patients a contact for advice and support that is available to them 24/7.

While the risk of the patient becoming anxious stressed or unwell cannot be totally removed providing the patient with education and support can assist with minimising these issues.

INTRODUCTION

Our goal is to reduce patient stress and any anxiety they may be experiencing by providing support to head and neck cancer patients and their families in what is a very stressful time. The nature of most head and neck cancers is that it has a huge impact on lifestyle. It often affects speech and eating making basic social interaction difficult. The patients often feel extremely socially isolated. Having a tracheostomy or laryngectomy adds to that stress. TRAC was created to promote patient comfort and satisfaction and help to reduce adverse events.

Within the hospital setting there a number of factors that can affect a patient's anxiety and stress levels. These factors can range from lack of privacy, change in environment, dietary modifications, poor or

decreased mobility and recent surgery. These factors are known to place the patient at an increased risk of complications and the need for hospital admission. This can then result in the patient requiring medical investigations that leads to significant cost to the health care system and the patient. With our ongoing support patients are able to be treated in an outpatient setting and able to return to their own home. The effect of patient requiring hospital admission impacts on the health care system, placing an increased burden on hospital resources. Patients that have been poorly managed in the outpatient setting can lead increased length of stay, bed occupancy and increasing the cumulative cost of the patient's treatment.

THE PROBLEMS

Through collecting data from patients we found that Tracheostomy/Laryngectomy patients that were receiving or about to receive treatment in the outpatient setting had not received sufficient information education or support. We found this information education and support could assist them with completing their treatment with minimal side effects, these side effects if not treated early and correctly could result in the patient being hospitalised and treatment begin delayed.

Ideally patients would be referred to the TRAC team as early as possible and introduce to our service so a review of the patient can be attended before treatment starts. The Original process for these patients was they were discharged from the surgical ward at one hospital and advised to present them self to a different hospital where they commence their oncology treatment. There was no formal referral to nursing staff. These approaches ultimately resulted in high levels of stress, anxiety and increase length of stay, delay the patient's treatment and recovery.

IMPLEMENTATION

By using a proactive approach on admission through assessment and education it was anticipated that a comprehensive review of the patient prior to starting treatment and throughout their treatment could assist the patient to complete their treatment.

This review prior to the patient starting treatment will provide education for ongoing cares, offer assistance with any tracheostomy related issues, ensure equipment is provided, obtain a history and conduct a head to toe examination of the patient. This review will be documented in the patient health care record and any recommendations are forwarded to the treating team.

The role of the TRAC nurse is to review the patient, identify potential issues, troubleshoot existing issues and ensure the patient is feeling well supported and able to attend to all cares. The TRAC nurse liaises with the treating team and allied health to ensure the patient is kept at optimal health and able to continue with their treatment. We aim to keep our patients healthy, well and out of hospital as much as possible.

Since implementing the program a specialised team of TRAC nurses have attended 77 reviews throughout all areas of the hospital. Of these reviews there have been 68 instances where the TRAC team provided interventions that prevented a potential hospital admission. 9 TRAC reviews have resulted in patient admission to hospital.

INTRODUCTION OF TRAC

TRAC was launched at Calvary Mater Newcastle, a public hospital in Newcastle, NSW; it is the major cancer care centre for the Hunter New England Local Health District, delivering more than 340,000 occasions of outpatient services and in excess of 17,000 inpatient treatments per year with a 30 bed oncology ward.

Initially the trial was conducted in the outpatient radiation ward, followed by the emergency department and day treatment centre. The trial included all tracheostomy patients receiving treatment in these areas. Before implementation, a range of education sessions and discussions were carried out with nursing and medical staff on TRAC. Most of the nursing staff received education; however, incorporating medical officers into education was more difficult due to education times and medical officers' lack of willingness to attend and participate.

Despite a trending increase in the treatment of HNC patients with tracheostomy or laryngectomy at CMN there has been a significant decline in the length of stay of these patients since implementation of TRAC. Patient satisfaction surveys have indicated a higher level of confidence and improved health outcomes for these patients. ■

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PAEDIATRIC TRACHEOSTOMY SERVICES AT A CENTRAL LEVEL HOSPITAL IN SOUTH AFRICA

By: Elizca Spies and Annika Lynn Vallabhjee

The Paediatric Multidisciplinary (MDT) Tracheostomy Service at Chris Hani Baragwanath Academic Hospital (CHBAH) was established in 2013 by the Speech Therapy Department, with involvement from major stakeholders including otolaryngologists, paediatric pulmonologists and physiotherapy. The extended team includes nurses, paediatricians, social work, occupational therapy, dietitians and the paediatric palliative care team.

Prior to the initiation of the multidisciplinary service, paediatric patients requiring long-term tracheostomies remained in the wards for months, this had a significant impact on early childhood development, education as well as psycho-social development. Prolonged hospitalizations were a result of families not being equipped with the skills or resources to conduct home based tracheostomy care. These prolonged hospitalizations also result in substantial financial consequences for the hospital and state.

A service that provides education and training to caregivers on the implementation of successful, cost effective, home-based tracheostomy care was

therefore established by members of the paediatric speech team who adapted the Breatheasy Programme (Booth, 1989) used at the Red Cross War Memorial Children's Hospital to ensure best practice within a locally relevant context.



All components of the Paediatric MDT Tracheostomy Service are provided within a multi-disciplinary approach to ensure holistic management that is both patient and family centered. Patients and their families are consulted about every aspect of their management.

This model of family centred care improves

health outcomes and satisfaction for patients and their families by reducing the socio-economic and financial impact that prolonged hospitalization and multiple appointments have on our families. The service takes into consideration the socio-economic status of our patients – donations are sought to purchase all required equipment for patients who are unable to contribute to their equipment. The programme further considers infrastructural restrictions of patient's home settings by ensuring that all equipment is compatible and functional within their specific setting (e.g. battery-operated and rechargeable nebulizers, foot-pump suction units where electricity is not available, portable hand-held suction units for use during travelling or use at schools). It further encourages effective communication and accountability of all stake holders involved and more efficient use of hospital resources.

The service comprises of a weekly MDT ward round (involving all major stakeholders), as well as a bi-monthly outpatient service post discharge.



COMPONENTS OF THE SERVICE

- + **Pre-surgery counselling:** Indication for tracheostomy and function thereof (informed decision and consent process).
- + **MDT ward round:** Initial cleaning and changing of tracheostomy, medical management, assessment of decannulation candidacy, caregiver education and training, equipment procurement through donations and issuing, discharge planning and follow-up.
- + **Caregiver education and training:** Components of tracheostomy, cleaning and changing of tracheostomy, training on suctioning and humidification, home-based care considerations, emergency procedures, contact information and follow-up.
- + **Tracheostomy clinic follow-up:** Review tracheostomy, caregiver feedback on home-based care, medical management, assessment of decannulation candidacy, issuing of resources, follow-up on rehab requirements and support.

CONCLUSION

Previously, prolonged hospitalization resulted in the isolation of patients and their caregivers from the rest of their families and communities. By promoting home based tracheostomy care, traveling costs as well as the primary caregiver's absence from home

and other caregiving responsibilities is reduced. The service provides the opportunity for children to be nurtured and cared for by their families and



enables access to developmental and educational opportunities within the community. The service has also built caregivers and families' confidence and competence by building on their knowledge, skills and understanding of how to care of their child with a tracheostomy.

Caregiver confidence and independence in home-based tracheostomy care, has resulted in earlier discharge from hospital and integration into the community, with improved quality of life for both the child and their family. As a result of the service, more children have been discharged home sooner with a tracheostomy where home-based care is being successfully implemented. ■

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AWARD PRESENTATION

The National Institute of Academic Anaesthesia (NIAA) was established in 2008 with a vision to improve patient care by promoting the translation of research findings into clinical practice; to facilitate high profile, influential research; and to facilitate and support training and continuing professional education in academia. The NIAA is the umbrella organisation for the Health Services Research Centre (HSRC), National Audit Projects, and Perioperative Quality Improvement Programme (PQIP), amongst others.

The NIAA held its first combined meeting with the Anaesthesia Research Society, BJA Research Forum, and UK Perioperative Medicine Clinical Trials Network (POMCTN) in York in December 2019, featuring a wide variety of presentations and topics from active researchers. The meeting incorporated the Annual NIAA Research Award, awarded to an individual who has demonstrated excellence



Brendan McGrath, GTC European Lead receiving the NIAA/HSRC Research Award for 2019 from Professor Mike Grocott, Vice President of the Royal College of Anaesthetists and NIAA Lead.
CONGRATULATIONS BRENDAN!

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in scientific research relevant to anaesthesia, perioperative care or pain. Applicants were invited to present a body of work typically the equivalent of two or more research papers on a subject area or from a higher degree or thesis (MD/PhD).

Dr. Brendan McGrath from Wythenshawe AICU presented his themed body of work (that comprised his PhD by publication) comprising several papers relating to understanding problems with tracheostomy care in the NHS, developing and testing strategies to address educational and infrastructure shortfalls, and then large scale evaluations of quality improvement interventions to change practice. Brendan's work is typical of a clinical academic who has increasingly engaged in research alongside his NHS consultant role. You can read about Brendan's experiences undertaking a PhD by publication in the October 2018 Difficult Airway Society newsletter [https://das.uk.com/files/2018/page/DAS Newsletter-October18-updated.pdf](https://das.uk.com/files/2018/page/DAS%20Newsletter-October18-updated.pdf).

Brendan's work was shortlisted for presentation at the NIAA Research Awards 2019. Brendan won the award with his presentation entitled Improving Tracheotomy Care: an evidence-based approach. Brendan was keen to point out the collaborative and multi-disciplinary nature of the National Tracheostomy Safety Project and the Manchester team's contribution to this award. The award is in recognition of the work that we have done in the UK in implementing, testing and evaluating the GTC in 20 UK sites. The award was accepted by Brendan on behalf of his multidisciplinary colleagues, patients and families who have helped lead and implement this in the UK.

If this article has peaked your interest in what you could achieve by formalising your academic achievements into research proposal, or you want to find out more about what we do, please get in touch: macc@manchester.ac.uk. ■



HOW HAS IMPLEMENTING THE GTC HELPED YOUR ORGANIZATION?

DO YOU HAVE A POSITIVE STORY TO TELL?

Please send us an article or infographic to info@globaltrach.org and we will showcase you in our next GTC newsletter. ■

NEW BOARD MEMBER



New Board Member
Patrick James Bradley

At the June Board meeting, the GTC Board appointed Professor Patrick James Bradley, MBA, MB, BCh, FRCSIr, FRCSEd, FACS, FRCS (Hon), FRACS (Hon), FRCSLT (Hon) as a member of the GTC Board of Directors.

Professor Bradley is a Consultant Otorhinolaryngologist, in Nottingham, UK, Head and Neck Oncologic Surgeon, Nottingham, UK, Lead

Clinician Head and Neck Cancer, NHS (England & Wales), Clinical Director of Audit, Risk and Governance, Nottingham University Hospital, Formerly Honorary Professor, Middlesex University, London and Honorary Professor of Head and Neck Oncologic Surgery, The University of Nottingham, UK.

He has also been President of the British Association of Head and Neck Oncologists (2003 – 2005); President of the European Laryngological Society (2004 – 2006); President of the European Salivary Gland Society (2007 – 2009). He has been the National Lead Clinician – Head and Neck Cancer for the English & Wales National Health Service (2003 – 2008). He has been a Founder Board Member of the European Head and Neck Society, and The European Academy of Otorhinolaryngology, Head and Neck Surgery. He has been Hunterian Professor, 2007/08 Royal College of Surgeons, England. He was the 5th Eugene Myers International Lecturer in Head and Neck Surgery at the American Academy of ORL-HNS in 2000.

He has published >300 peer-reviewed articles, >70 book chapters and Edited or Co-Edited 9 books. Is currently Joint-Editor of Current Opinions ORL-HNS and Editor of "Advances in Oto-Rhino-Laryngology", and is/or has been a member of several editorial boards: Head and Neck, Laryngoscope, Oral Oncology, Journal Laryngology & Otology, European Archives ORL-HNS, Clinical Otolaryngology etc. He has travelled most parts of the World as visiting Professor partaking of eponymous lectures, grand-rounds as well as partaking of National and International lecturer. He has been awarded 17 Honorary Memberships of ORL-HNS Societies, as well as 3 Honorary Fellowships of Royal Colleges.

We are honored to have a Professor Bradley on the GTC Board of Directors! ■