Multidisciplinary Collaboration in Ward-Based Care of Patients with Tracheostomies

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Background

- Multidisciplinary team (MDT) working is recognised as central to safe and effective tracheostomy care.[1]
- National enquiries and guidance emphasise its role in reducing complications, supporting timely weaning, and improving outcomes.[2,3]
- Patients on the intensive therapy unit (ITU) at the Royal Glamorgan Hospital (RGH) receive regular, structured MDT input.
- Ward-based MDT input is ad hoc, which may compromise safety and effectiveness of care.

Aim and Objectives

Aim: To examine ward-based tracheostomy care at RGH, focusing on MDT collaboration.

Objectives:

- Benchmark practice against national standards.
- Review patient outcomes where gaps in MDT working may have affected care.
- Highlight good practice and areas for improvement.
- Propose actions to strengthen MDT working.

Methodology

Two approaches were used:

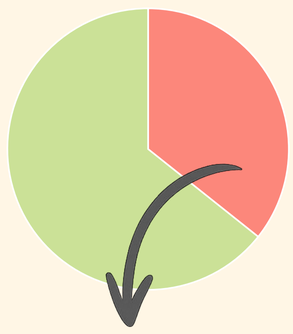
- **Key standards comparison:** Current ward-based tracheostomy practice was compared against key standards pertaining to MDT working set out in national guidance from the Intensive Care Society.[2]
- **Patient outcomes:** A retrospective review of SLT case notes was undertaken for patients stepped down from ITU to the wards with a tracheostomy between January 2024 and June 2025 (n=14) (excluding patients with head and neck cancer, for whom there is a different pathway).
  - ↳ Data extracted: Non-adherence/disruptions to weaning recommendations, adverse events, and MDT agreement regarding decannulation.

Results: Key Standards Comparison

ICS *Guidance for Tracheostomy Care*[2] Standard	Finding
All in-patients with a tracheostomy are seen at least weekly by a tracheostomy MDT	**Not met** ✕
Appointment of an institutional lead for tracheostomy care	**Not met** ✕
Institutional multidisciplinary tracheostomy group with oversight of tracheostomy care	**Met** ✓
Institutional tracheostomy policy in place	**Partially met** ◐

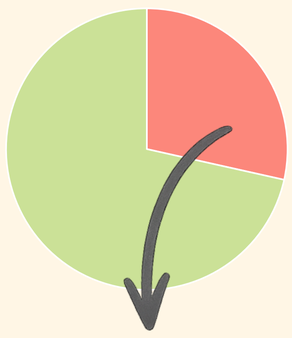
Results: Patient Outcomes

Weaning Plan Adherence



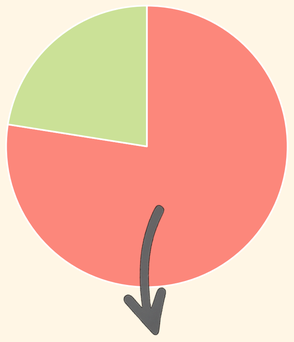
35.7% of patients (n=5) had documented non-adherence to weaning plans

Complications/ Adverse Events



28.5% (n=4) of patients experienced ≥1 adverse event during admission

Decannulation Decision-Making



Broad MDT agreement not present for **77.8%** (n=7) of decannulated patients

In addition to the above, two patients on the respiratory ward (**14.2%** of the total) were referred to ENT for support with weaning despite requiring tracheostomy for purely pulmonary issues. In both cases, subsequent siloed decision making disrupted weaning.

Conclusion

- National key standards pertaining to MDT collaboration in tracheostomy care are only partly met at on the wards at RGH: MDT oversight is broad rather than patient-specific, and there is no structure to ward-level MDT review.
- Case note analysis showed instances of disruption to weaning plans, adverse events, and inconsistent MDT involvement in decannulation decision-making.
- The above may partially stem from the identified gap in structured MDT working (although additional contributing factors are likely, such as suboptimal communication/documentation, variable staff training, and ward pressures).
- This evaluation used only SLT records; any future quality improvement work should aim to obtain more robust baseline data from the full patient record. Other areas for future work include exploring patient and staff perspectives and quantifying the impact of identified issues on outcomes.

Recommendations

In light of these findings, the following areas may warrant consideration to improve MDT collaboration in ward-based tracheostomy care at RGH:

1. Establish structured **weekly MDT reviews** of ward-based tracheostomy patients to facilitate consistent oversight and collaborative decision-making.

2. Appoint a **tracheostomy lead** to provide clear oversight and coordination of care for patients outside ENT pathways.

3. Improve documentation through **standardised proformas/checklists** to capture MDT decision-making and improve communication.

4. Ensure the CTMUHB-wide **tracheostomy policy** is reviewed and updated via the clinical reference group.

References | 1. Ninan, A., Grubb, L.M., Brenner, M.J. and Pandian, V. (2023) 'Effectiveness of interprofessional tracheostomy teams: A systematic review', *Journal of Clinical Nursing*, 32(19–20), pp. 6967–6986. **| 2.** Intensive Care Society (2020) *Guidance for Tracheostomy Care*. London: Intensive Care Society. Available at: https://ics.ac.uk/resource/tracheostomy-care-guidance.html. **| 3.** National Confidential Enquiry into Patient Outcome and Death (NCEPOD). (2014) *On the Right Trach? A review of the care received by patients who underwent a tracheostomy*. London: NCEPOD. Available at: https://www.ncepod.org.uk/2014tc.html.