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Message from Guest Editor

Safety in tracheostomy care: An individual and system-wide responsibility

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Safety is a core pillar in healthcare. As a fundamental right, safety is central in all healthcare practices, and its optimization is integral to hospital facility accrediting bodies.[1]

But what is safety? The World Health Organization defines patient safety as "the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum. Within the broader health system context, it is a framework of organized activities that creates cultures, processes, procedures, behaviors, technologies and environments in health care that consistently and sustainably lower risks, reduce the occurrence of avoidable harm, make error less likely and reduce impact of harm when it does occur".[2] Over the past two decades, there has been an increased focus on improving safety in tracheostomy care.[3,4] Safety initiatives to improve the care and outcomes for people with tracheostomy have spanned the age continuum, included acute and community settings, and are now being explored in new virtual learning technologies.[5-7] Since its inception in 2012, The Global Tracheostomy Collaborative has championed safety efforts via an interprofessional team, inclusive of patients and families, through data collection and education efforts.[8]

This edition of the *Tracheostomy Journal* focuses on safety in tracheostomy, with insights across clinical practices and the broader systems approach.

In our first feature article, Sherlock et al. consider and report on system contributors to safety outcomes.[9] They report on safety outcomes following a multifaceted system approach to tracheostomy care within a large UK hospital. The multipronged intervention was developed, implemented, and evaluated by a multiprofessional stakeholder group. The 12-month intervention included streamlining and aligning tracheostomy equipment across all ward areas, a structured tracheostomy training program (including emergency and standard care), and implementation of tracheostomy guidelines. This was supported by a governance framework that included monitoring and evaluation. Following the intervention, there was evidence of reduced frequency and severity of clinical incidents, improved staff confidence in the provision of care, and reduced costs with centralized tracheostomy supply lists.

As patients progress through the tracheostomy pathway, decannulation or removal of the tracheostomy is a common goal. To optimize safety and enhance outcomes, different variables must be considered in the decannulation process,[10] which can be enhanced through use of clinical guidelines, algorithms and standardized care processes.[11,12] In our second feature article, Hill et al. report patient safety outcomes following implementation of a locally developed decannulation protocol.[13] In their observational study, they report on decannulation outcomes involving tracheostomy capping. Whilst they report on the benefit of standardized approaches, their results highlight the ongoing need for an interprofessional approach to consider individual patient factors for safe decannulation.

In our third feature article, Erhieyovwe et al. report on the impacts of tracheostomy surgical delay and subsequent safety impacts.[14] In their case report, they highlight key contributors to the delay from decision to tracheostomy placement, including availability of staff and operating room access. Whilst the tracheostomy was successfully placed, during the tracheostomy placement wait time, the patient continued to receive ongoing high levels of sedation, experience periods of fasting in anticipation of surgery, and experience prolonged endotracheal intubation. Exposure to ongoing risks have known patient and system consequences.[15,16]

To advance our understanding of effective tracheostomy care, we can use knowledge from research studies, quality improvement initiatives and evaluation of data reported in clinical incident events. In our first commentary *Just Culture in a Fragmented System: Ethical and Quality Imperatives in Cross-Institutional Tracheostomy Care*, the concept of examining care through a safety lens is considered.[17] Concepts of investigation, root-cause analysis and reporting clinical incidents are discussed in a learning framework.

Rounding out our issue, the commentary *Tracheostomy Care in the Crosshairs: Supporting Science and Safety Nets in Tumultuous Times* discusses current contemporary issues regarding system decisions on healthcare and research funding.[18] In this commentary paper, Brenner and Pandian highlight the downward stream impacts on patient outcomes with cessation and changes to national funding. Whilst fiscal decisions are required by governments to manage resources, broader decisions can impact and create unintended consequences for individuals. Effective and safety tracheostomy is reliant on well-resourced interprofessional teams, access to equipment and support across settings.[19] Ongoing research into care practices are essential to establish clinical and economic benefits given the known clinical and financial cost associated with tracheostomy care.[20]

Safety is essential for effective care for individuals with a tracheostomy. Safety should be a primary driving outcome with

the design, delivery, evaluation and funding of tracheostomy care practices. From individuals in a clinical setting to policymakers, we all have a responsibility to provide and advocate for safe and better care.

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