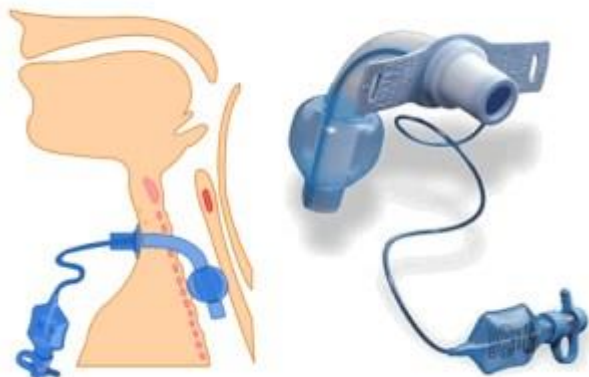


Patient
Information

Tracheostomy on Intensive Care



(www.tracheostomy.org.uk)

This booklet has been put together to increase patient and next of kin understanding about tracheostomies being performed within the Intensive Care Unit.

We know it will not answer all of your questions so please use the blank page at the back of this booklet to write down any concerns or questions you may have. The team caring for you or your family/friend will do their best to answer any questions.



Tracheostomy on Intensive Care

What is a tracheostomy?

A tracheostomy is a small tube which is inserted into an opening at the front of the neck into the trachea (windpipe).

Why do we wish to perform a tracheostomy?

If someone has been on a ventilator (breathing machine) for a week or more, or if we think they will be, we will consider performing a temporary tracheostomy.

This is **not** a tracheostomy that involves removal of the larynx (voice box). An 'Intensive Care' tracheostomy allows us to provide on going ventilator support without the need to be heavily sedated. This usually allows patients the best chance to wake up and begin rehabilitation whilst still receiving breathing support.

A more detailed breakdown of reasons a tracheostomy may be considered is given below.



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Breathing problems: conditions that lead to respiratory failure (not enough oxygen and/or too much carbon dioxide in the blood stream) include:

- Diseases of the lungs for example; pneumonia
- Diseases of the brain such as; severe head injury or stroke causing unconsciousness
- Diseases of the spine or nerves such as; paralysis after a spinal cord injury, Guillain-Barré syndrome, motor neurone disease

Blockages: a tracheostomy can also be used to bypass a blockage as a result of:

- An injury, infection, burn or severe allergic reaction (anaphylaxis) that causes the throat to become swollen and narrowed
- Swelling after head or neck surgery
- A tumour as can sometimes happen with mouth cancer, throat cancer or thyroid gland cancer

Removing secretions: a tracheostomy may be carried out to help remove secretion if the patient is unable to cough properly because of long-term pain, muscle weakness or paralysis.



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Consent for a tracheostomy on Intensive care.

It is possible that the patient can neither agree nor disagree to a planned tracheostomy because they are unconscious. The doctor performing the tracheostomy can consent in the patient's 'best interests'.

However, the intensive care team will make every effort to establish what the patient would wish for **if** they could take part in the decision making process. We will endeavor to discuss care and interventions with the people who know the patient best.

A tracheostomy will only ever be performed if we believe the benefits outweigh the risks.

Within Intensive Care the main benefit of a tracheostomy is to continue to provide breathing support without the need for sedation and anaesthesia. This means the patient will wake if they are able to and can participate in their care, rehabilitation and decision making.

As listed below there are risks associated with the insertion of a tracheostomy;



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Early complications

There are some complications that can happen during or shortly after a tracheostomy.

- Bleeding
- Collapsed lung
- Accidental injury
- Infection

Late complications

Some complications can happen days, weeks, or even months, after a tracheostomy.

- Failure to heal
- Blocked tracheostomy tube
- Collapsed windpipe
- Narrowed windpipe

You can read more about these complications via the NHS website;

www.nhs.uk/conditions/tracheostomy/risks/

These will vary according to each patient. The risks vs. benefits will be discussed individually with you prior to insertion of a tracheostomy.

How is a tracheostomy performed?



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A tracheostomy is usually performed under general anaesthesia so the patient will be unaware and not feel any pain. A senior doctor will make a small opening in the neck and throat and then insert a tracheostomy tube. Tape or stitches will be used to hold the tube in place.

How long will the tracheostomy be in place?

This will depend on the reason it was inserted but for the majority of people on our intensive care a tracheostomy is short term (7-28 days).

What about talking?

Speech is generated when air passes through the larynx and vocal cords - the 'voice box'. Initially, all air goes in and out through the tracheostomy and so the patient will not have a voice. In most tracheostomies performed on intensive care the voice box will remain, over time, adaptations allow some air to pass through the voice box and speech can be attempted. Other ways of communicating include pen and paper, speech board, computer technology or lip reading. This can be a very



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frustrating time for the patient and their family and we will help in any way we can.

What about eating?

Most people will be able to eat with a tracheostomy although swallowing can be difficult at first. A speech and language therapist will not only help the patient to communicate but will also assess their swallow. It is very likely that the majority of nutrition will be given directly into the stomach via a naso (nose) - gastric (stomach) NG tube to make sure the patient receives enough nutrients and calories.

Suctioning.

Suctioning involves passing a small suction tube into the tracheostomy to suck out secretions that would normally be coughed out. It is performed by your nurse or physiotherapist and can prompt a cough but is not painful.

Removal of a Temporary Tracheostomy.

Before tracheostomy decannulation (removal) is considered staff will be looking to see that the patient can:



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- Spend increasing amount of time off breathing support and manage 24-48 hours without the ventilator before decannulation is considered
- Have a strong cough and require minimal suction
- Be as awake and calm as possible

To increase the likelihood of successful tracheostomy removal (decannulation) the tracheostomy tube may be "down-sized" (changed to a smaller size) and/or "capped off" to allow breathing through the nose and mouth again – it is possible to speak when this happens.

It is not painful to have a tracheostomy removed and there is no need for any form of sedation or anaesthetic. Once removed a dressing is applied over the stoma (opening) and the stoma heals in approximately 10 days. A scar, smaller than a ten pence piece, will remain.

Your voice may be weak and/or sound hoarse following the removal of the tracheostomy. If this does not resolve within the first few weeks you may



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require further investigations to identify if there is any damage.

Other ways my tracheostomy may affect me.

Becoming unwell enough to require a tracheostomy can be a traumatic and upsetting time. If you are reading this and require any further support please speak to the team on intensive care. You may find the following resources useful:

- Clinical Psychologist – Leah Callebaut
ICU staff can complete a referral on your behalf
- ICU STEPS
www.icusteps.org
- National Tracheostomy Safety Project
www.tracheostomy.org.uk/
- NHS Website
www.nhs.uk/conditions/tracheostomy



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Questions?

Smoking will not be permitted on any NHS site in England. Smoking will not be permitted within any of our buildings or anywhere outside on our sites. Smoking facilities will not be provided. Please be considerate of others when vaping in hospital grounds.

This information sheet is available to order in other languages and formats. If you would like a copy, please contact us on 01793 604031 or email gwh.pals@nhs.net.

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