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### CRITICAL REFLECTION ON PRACTICE DEVELOPMENT

#### Holistic rehabilitation from intensive care: lessons from America

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#### Abstract

The Winston Churchill Memorial Trust offers travelling fellowships to individuals each year to travel overseas. This paper will critically reflect on a recent travelling fellowship to the USA. Hospitals and intensive care units were visited in Texas, Utah, Tennessee and Massachusetts, with the aim of exploring strategies for implementing patient-centred, individualised care within and after discharge from the intensive care unit.

**Keywords:** Nursing, critical care, rehabilitation, mobilisation, delirium, patient-centred care

#### Background to fellowship

After working in the critical care environment for many years, I have witnessed patients experiencing ongoing physical and psychological issues that affect their lives for many months after discharge from intensive care. North American researchers and practitioners have made incredible steps in improving rehabilitation from intensive care and preventing long term consequences of critical illness. Reading about these techniques in care motivated me to apply for a Winston Churchill Memorial Trust travelling fellowship.

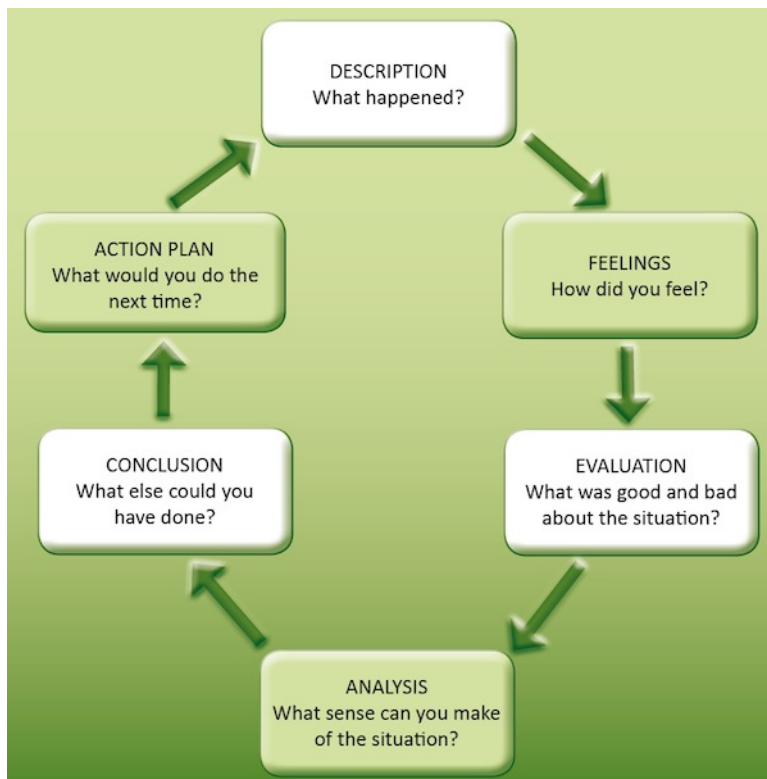
The trust is a grant making trust established in 1965 as a living memorial to Sir Winston Churchill. Each year it offers fellowships to British citizens to travel overseas and study areas of topical and personal interest. For full details of how to apply visit: [www.wcmt.org.uk](http://www.wcmt.org.uk).

#### Reflective practice

Reflective practice means creating a learning situation and ensuring that the learning outcome is a combination of previous experience, specific context and theory (Peden-McAlpine et al., 2005). Heath (1998) suggests that it is through the reflective process that new understandings and appreciations of nursing may be required. Others have suggested that reflective practice helps with the development of 'knowledge creation capacities' (Eraut, 1994, p21) and that reflection may be a vehicle through which values or beliefs can be challenged or changed, and new perspectives achieved (Burton, 2000).

A number of reflective models and structures exist (Gibbs, 1988; Johns, 1995; De Bono, 1999). Gibbs' (1988) reflective cycle will be used to structure a critical reflection on this travelling fellowship (Figure 1), with the aim of creating new understandings and perspectives of the experience.

**Figure 1:** Gibbs' reflective cycle (1988)



### **Description: the fellowship structure**

#### ***Houston, Texas***

Memorial Hermann is one of the busiest trauma centres in the USA. The surgical and trauma intensive care unit within Memorial Hermann has a permanent social worker assigned specifically to the unit. The aim of the visit to Houston was to analyse critically the role of the social worker within the critical care environment.

#### ***Salt Lake City, Utah***

Recent work on outcomes for intensive care unit survivors has recognised that these patients suffer profound and persistent impairments in physical function (Herridge et al., 2003; Kress, 2009). Although there is limited evidence regarding the risks of immobilisation in critical illness and the correlation between early mobility and improved functional outcome (Bailey et al., 2009), it does make intuitive sense to implement some level of physical activity (Morris and Herridge, 2007).

Intermountain Medical Center and LDS Hospital, both based in Salt Lake City, have been leaders in the development of early mobility for ICU patients (Bailey et al., 2009). The aim of the visit to Intermountain and LDS was to explore how these units had successfully implemented a mobility protocol for critically ill patients.

#### ***Nashville, Tennessee***

The American Psychiatric Association (1994) defines delirium as a manifestation of acute brain dysfunction, characterised by an acute disturbance of consciousness, accompanied by inattention, disorganised thinking and perceptual disturbance that fluctuate over a short period of time (hours to days). This form of acute brain dysfunction affects up to 80% of intensive care patients, depending on the severity of illness and the need for mechanical ventilation (Pandharipande et al., 2008; Girard et al., 2008).

Vanderbilt University Hospital is located in the heart of Nashville and is the home of the Confusion Assessment Methods for ICU (CAM-ICU). The CAM-ICU is a reliable and validated instrument for diagnosing delirium; it is highly specific and sensitive and takes only 60-90 seconds to administer (Banerjee et al., 2011).

The primary purpose of the visit to Nashville was to spend time with the delirium and cognitive impairment study group and critically evaluate how delirium and sedation are managed within their patient group. The study group has completed large amounts of work analysing delirium, sedation management and rehabilitation from critical care in the past decade (Pandharipande et al., 2006; Morandi et al., 2010).

### ***Boston, Massachusetts***

The delivery of patient-centred care is central to current policy, nationally and internationally (Healthcare Improvement Scotland, 2011). Many definitions of patient-centred care exist; however, in essence it is the delivery of healthcare that is responsive to individual preferences, needs and values (Stewart, 2001; Timmins and Astin, 2009; Healthcare Improvement Scotland, 2011). This can be achieved in part by ensuring that patients and carers are involved in clinical decision making (Kelleher, 2006).

Beth Israel Deaconess Medical Centre is a major teaching hospital of Harvard Medical School. The intensive care Patient and Family Advisory Council was set up in 2008, with the purpose of providing a forum for patients and families to suggest improvements in quality, safety and hospital processes. The group, which is run primarily by a social worker and a consultant intensivist, looks at various topics and issues within the intensive care unit and the information generated directly feeds into practice within the unit. The group has helped shaped decisions on, for example: relative visiting times; patient and relative information forms; the design of relative waiting areas; and the role of family members during multidisciplinary ward rounds in the unit.

### **Feelings: how did I feel about the difference in practice?**

My interest in rehabilitation from critical care has evolved from seeing many patients struggle physically and psychologically after they have overcome a period of critical illness. Consequently, analysing strategies to help reduce these long term problems was fascinating. Additionally, the area where I work is infamous for social inequalities, so it was incredibly exciting for me to see how the social worker and the Patient and Family Advisory Council influenced practice.

### **Evaluation: what was good and bad about the experience?**

There were many areas of practice within the intensive care unit setting in the USA that could be used within the UK. For example, the Patient and Family Advisory Council is a practical structure that could be easily duplicated within the UK. Having a social worker directly attached to the unit is a further model of integrated care that could be transferred to the UK setting, especially within well-known areas of deprivation.

However, many of the patients admitted to the units I visited were quite different to those I see in my own clinical practice, especially with regard to mental health issues and drug and alcohol use. This clearly impacts on the transferability of many of the techniques and management tools I practised during my fellowship.

### **Analysis: how does UK practice compare with international practice?**

#### ***The role of the social worker***

The social worker in the intensive care unit had diverse roles that would not necessarily fit with the traditional UK social work model. These included the following:

- Stress reduction for family members and also the multidisciplinary team
- Discharge planning, including referrals to other agencies such as alcohol and drug professionals and enhanced rehabilitation centres
- Practical assistance with applying for benefits and managing healthcare insurance
- Facilitation of communication between family members, patients and the multidisciplinary team
- Psycho-social support

The role of the social worker was pivotal for holistic patient and family care. However, the most surprising element of the role was the support that was given to staff within the unit. Staff in critical care deal with stressful activities on a daily basis and stress levels are known to be high in this group of healthcare professionals (Embriaco et al., 2007). Social workers can provide interventions in the unit to enable patients, families and staff to cope with the disequilibrium that accompanies the stress of critical illness (Hartman et al., 2011). The social worker role in the UK's intensive care environment is limited; however, expansion of this role clearly merits further consideration and research in the future.

### ***Early mobilisation***

By experiencing firsthand the mobility programme in Salt Lake City, it is apparent that mobilising critically ill patients is not only feasible, it is necessary and hugely important. There were a number of factors that made the mobility programme feasible and safe. Firstly, family members were involved in the mobilisation process, which was essential to motivate the patient. Secondly, there was involvement from all members of the multidisciplinary team: physical therapists; respiratory therapists; nurses; nursing assistants; and medical staff were all involved in the decision making process and the actual mobilisation of patients. Finally, having mobilisation of patients as part of the daily routine and embedded within the culture of the unit was crucial to the success of the mobilisation programme.

However, the everyday implementation of early mobility programmes within UK intensive care units possibly requires a paradigm shift in culture, as traditionally it is seen as 'best' to ensure bed rest for patients, with minimal exertion until discharge (Bailey et al., 2007). If this change in practice is to be successful and sustained within the UK, individuals and teams must be supported not only with skill development but also with continuing education regarding the impact of this change in practice and its benefits for patient outcomes.

### ***Sedation in critical care***

Delirium should be recognised as organ failure similar to renal or respiratory failure, which, if not managed appropriately, can increase morbidity, mortality and impact on quality of life (Girard et al., 2008). It was interesting to experience the emphasis placed on sedation, analgesia and delirium during the ward round discussion. Information regarding CAM-ICU scoring and delirium was not seen as an afterthought – it was part of the fabric of the workload and documented and discussed in a similar fashion to other vital signs within the unit. Despite the challenges of time and workload faced by multidisciplinary teams in the NHS, delirium screening takes seconds to complete and can have huge implications for patient treatment and care.

### ***Patient and family involvement***

Learning more about the Patient and Family Advisory Council and the impact that this has made on clinical practice has highlighted the necessity of public involvement in the management of the NHS. Despite the simplicity of this advisory council, the impact of its decisions was clearly significant. The waiting rooms, for example, were bright and spacious, and had communal areas as well as small, private areas and individual interview rooms.

The local, non-technical feel of this group made it particularly powerful. Patients and families who had actually used the unit and knew firsthand the needs of the public in relation to the intensive care unit were involved in decision making. In future practice, this cost effective and easily replicable tool could be used to influence local population needs and demands. After visiting Beth Israel Deaconess Medical Centre, it was evident that including patients and family members in decisions must be central to healthcare decision making and not seen as an optional extra.

### **Conclusion: how has my practice been influenced since my return?**

Since my return to the UK, my practice has been influenced in a variety of ways. There is still apprehension from many members of the multidisciplinary team regarding mobility in the intensive care unit; however, by using Plan-Do-Study-Act (PDSA) cycles, we are engaging all members of the team to promote and become involved with early mobility. This has allowed the concept of mobilisation to be introduced gradually and has allowed staff to become more familiar with the logistics of this change in practice.

Implementing my learning from Vanderbilt has been much more challenging. The critical care unit where I am based, similarly to many units in the UK, has a large proportion of patients who are admitted either directly or indirectly as a result of drug and/or alcohol abuse (O'Brien et al., 2011), which is quite different to some of the units I visited during the fellowship. Alcohol withdrawal syndrome particularly, may require a different management strategy than 'garden variety' delirium, with early administration of sedative drugs improving outcomes for this subgroup of patients (Skrobik, 2007; Gold et al., 2007). Currently we are reviewing optimal assessment and management practices for alcohol related admissions to the unit, with the aim of improving delirium management and treatment for all patients.

I have used my learning from Beth Israel in the development of a stakeholder group in an ongoing research project. This group, which has been formed to help with decision making includes: a previous patient; a previous family member; a local member of an alcoholics anonymous group; a senior charge nurse from intensive care; an addiction liaison nurse; and a member of a local ethics committee. This group has been pivotal in helping guide the evolving research project.

Finally, before visiting the USA, I was, in some respects, slightly sceptical about mobility programmes and delirium management. There are extensive differences between how healthcare is offered in the two countries, which I believed would make some of the evidence difficult to transfer. The UK and the USA do have different ways of delivering healthcare but UK critical care units can deliver these elements of care. Creativity in our use of resources, breaking down professional barriers to ensure effective teamwork and clear leadership will help deliver these challenging programmes. Further, appreciating differences in patient groups will help ensure appropriate and effective healthcare delivery.

### **Action plan – implications for clinical practice with the UK**

- Early mobility within the intensive care unit appears to be feasible and safe and should be a part of routine care
- Delirium screening and appropriate management is key to reducing morbidity and mortality from intensive care
- The multidisciplinary team, patients and family members must share decision making within the NHS to ensure delivery of appropriate, patient-centred care

## Summary

This Winston Churchill Memorial Trust travelling fellowship offered an excellent opportunity to explore strategies to help reduce morbidity and mortality during and after a stay in intensive care. Simple interventions such as early mobility and appropriate screening for delirium can have a positive impact on short and long term patient outcomes. However, the key to the successful implementation of these strategies is ensuring that members of the multidisciplinary team work closely together. Furthermore, healthcare practitioners in the NHS must guarantee that the views and experiences of patients and the public are used to improve the quality of healthcare services

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