

Communication interaction in ICU-Patient and staff experiences and perceptions.

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Abstract:

Patients on intensive care units (ICU) have difficulty with communication [Menzel LK. Factors related to the emotional responses of intubated patients to being unable to speak. *Heart Lung* 1998; 27(4):245-52]. Feelings of anger and low mood have been reported, which can lead to reduced participation in rehabilitation. For members of the multidisciplinary team breakdown in communication with patients may be frustrating and related to a limited knowledge of strategies and resources to facilitate communication. The NHS Modernisation Agency Critical Care Programme (2002) identified speech and language therapists (SLTs) as having a role in the assessment and management of patients with communication difficulties on ICU. This multi-centre pilot study aimed to investigate staff and patient perceptions and experiences of communication within ICUs. A short questionnaire was devised using semi-structured interviews to collect quantitative and qualitative information. Patterns were identified including insights into SLT service delivery and possible directions for future research and development.

Communication, swallowing and feeding in the intensive care unit patient.

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Background:

It is not uncommon for patients requiring a period of time in the intensive care unit (ICU) to experience difficulties with communication and/or swallowing, either as a result of their illness or as a result of the treatments they receive. These difficulties can be both short term and long term and require timely and appropriate intervention in order to improve the patient's experience and expedite recovery/rehabilitation.

Aims:

The purpose of this article is to provide critical care nurses with an update on aspects of communication, swallowing and feeding in the ICU. The paper will focus on each area in relation to the current evidence base and factors of 'best practice' (as determined by expert opinion).

Implications for Critical Care Nursing Practice:

Enabling communication can improve well-being, increase compliance and reduce length of stay; Simple modes of communication, e.g. writing/gesture/pictures can be very effective; Coded eye blinking may be unreliable because of confusion with reflexive blinking; Non-oral nutrition will generally not meet the psychological and physical needs and benefits of oral intake; Not all patients with a tracheostomy in situ will experience dysphagia; however, those considered 'at risk' should have their swallow assessed by an appropriately trained professional, e.g. speech and language therapist/dysphagia trained professional; An inflated tracheostomy cuff will not prevent aspiration. The decision to commence oral intake in the presence of an inflated cuff should be made as a team and take into consideration the patient's medical and psychological status; The use of blue dye to assess the swallow carries a high false-negative rate and cannot be relied on alone to predict either the presence or the absence of aspiration.

Conclusion:

There is still much more research to be performed and evidence to be gained regarding the input into communication, swallowing and feeding in the ICU; however, a full-team approach to these areas can have very positive effects on the patient's experience.

Effects of tracheostomy on well-being and body-image perceptions

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Objective:

Quality of life after tracheostomy was addressed by measuring its impact on well being and body image perceptions.

Study Design and Setting:

A controlled study in a laryngotracheal clinic of a tertiary referral center. Three groups were studied: 24 cannulated, 19 decannulated, and 20 noncannulated patients. They filled up 3 conventional questionnaires.

Results:

- (1) Satisfaction-with-life scale: reduced scores were detected between cannulated and noncannulated patients.
- (2) Personality traits: neuroticism and extroversion: no differences were noted.
- (3) Body cathexis scale: both cannulated and decannulated patients scored less than noncannulated. In tracheostomy-specific issues, decannulated patients scored better than cannulated patients.

Conclusions:

Reduced scores after tracheostomy indicate an overall diminished quality of life. These changes correlate with personality traits. Decannulated patients exhibited only slight improvement indicating an incomplete psychosocial recovery.

Significance:

This is the first report on tracheostomy related quality of life in noncancer patients conducted with specific psychological questionnaires.

More than nothing: the lived experience of tracheostomy while acutely ill

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Abstract:

While the physical sensations surrounding tracheostomy tube insertion have been reported within nursing and allied healthcare literature, the lived experience of these sensations is poorly described. This appears relevant given the imminent results of the Tracman study (2008). A purposive sample of three participants who had tracheostomy tubes previously within a critical care area or still in situ were recruited. They described their experiences in a face-to-face semi-structured interview that were audio taped. The interviews were transcribed verbatim and analysed using Giorgi's 5 concrete steps of the human scientific phenomenological method (1997). Findings revealed themes that drew attention to the fundamental aspects of the experience. These were: Practical recommendations draw attention to the organisational support required for staff expected to care for these patients in the ward environment. This involves the introduction of evidence based guidelines and competency based care to promote the acquisition of skills required to perform those essential tasks such as suction and stoma care to a high standard. Protected, formalised skills based teaching is seen as fundamental in this process. Patients' felt confident in nursing staff that were able to demonstrate proficiency with such tasks and this is seen as crucial when one considers that the tracheostomy tube is a new experience for patients.

The Chronically Critically Ill: Opportunities for the Palliative Care Team

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Abstract:

The chronically critically ill population is growing rapidly in this country with continued improvement of life-prolonging treatments. This population is characterized by multiple advanced medical problems, which frequently include prolonged mechanical ventilation. Because of the complexity surrounding chronically critically ill patients, the morbidity and mortality rates are high at discharge and after one year. Psychological and physical symptom burden also has been more recently examined and found to be significant. Impaired communication has been reported as most distressing during this difficult time of prolonged critical illness. Because communication and symptom management is a focus for the hospice and palliative care provider, it is becoming more vital for this role to be incorporated into the care of the chronically critically ill. Specifically, the role of the advanced practice nurse in palliative care has been found to be increasingly beneficial in such medically complex patients. The opportunities for enhanced palliative care are abundant in the management of this patient population to ensure ongoing clarification of goals and communication surrounding the patient's wishes and needs. A case study is used to present the effects of effective communication, including use of the Passy-Muir Valve, and aggressive symptom management by a palliative care advanced practice nurse that allowed comfort and positive outcomes for a patient's goal of returning home in the setting of chronic critical illness.