

Passport to Successful Outcomes for Patients Admitted to ICU

Meeting Patient Goals of Care

Carole Boulanger
David McWilliams
Editors

Second Edition

 Springer

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Foreword

In the ever-evolving landscape of intensive care medicine, where each single patient's journey through critical illness is as unique as the individual themselves, the significance of comprehensive, multidisciplinary care cannot be overstated. As we navigate the complexities of ICU environments, it becomes increasingly apparent that successful patient outcomes hinge not only on technological advancements but, more crucially, on the collaborative efforts of dedicated healthcare professionals. This human chain is absolutely remarkable.

The second edition of “Passport to Successful ICU Discharge” stands as a testament to this collective commitment to excellence. Under the skilled editorship of Carole Boulanger and David McWilliams, whose unbeatable dedication to research and patient care has set a standard for excellence, this volume delves deeper into the intricacies of ICU management, offering invaluable insights and evidence-based practices for optimising patient recovery.

In the wake of the unprecedented challenges posed by the COVID-19 pandemic, the importance of effective critical care has been thrust into the spotlight. In his foreword to the first edition, Maurizio Cecconi's poignant reflection on the essence of ICU practice resonates profoundly, reminding us that beyond the ventilators and monitors lies the beating heart of intensive care—the compassionate collaboration of nurses, allied healthcare professionals, and clinicians.

“Passport to Successful Outcomes for Patients Admitted to ICU” transcends the traditional confines of medical literature, offering a holistic framework for guiding patients through every stage of their ICU journey. From the meticulous attention to detail during admission to the comprehensive rehabilitation strategies aimed at promoting independence and quality of life, each chapter encapsulates the essence of patient-centred care. The multidisciplinary approach embraced within these pages reflects a fundamental shift in our understanding of critical illness—a recognition that true healing extends beyond the physical realm to encompass the emotional, psychological, and social dimensions of recovery. As we strive to create environments conducive to healing, the significance of effective communication, infection prevention, and psychological support emerges as indispensable pillars of care.

In essence, “Passport to Successful Outcomes for Patients Admitted to ICU” serves as both a beacon of guidance and a testament to the unrestricted dedication of ICU professionals worldwide. Its pages resonate with the collective wisdom of

clinicians, researchers, and caregivers, united in their pursuit of excellence and never-ending commitment to patient well-being.

As we embark on this journey through the corridors of critical care, may this volume serve as a guiding light, illuminating the path towards successful patient outcomes and reaffirming our shared commitment to compassionate, evidence-based practice.

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Preface

In 1892, Dr. William Osler in wrote,

it is much more important to know what sort of a patient has a disease than what sort of a disease a patient has.

This sentiment still very much holds true today. The past few decades has seen increasing numbers of patients admitted to critical care units, with high acuity of illness and an increasingly complex array of comorbidities. Thankfully technological advancements and developments in care delivery mean survival rates have improved. However, with limited resources and stretched healthcare systems, there is a risk that critical care becomes focused on the completion of tasks, losing sight of the individuality of the person receiving that care.

A passport is well recognized as one of the earliest known documents certifying the identity and key details of the bearer, primarily for the purposes of safe passage of travel and return home at the end of a journey. Whilst no patient or their family would choose an intensive care journey, the principles of safe passage do hold true in this context and the goal is always a safe return home. The concept of a “passport” for a critically ill patient therefore comprises the key aspects of care and management to enable safe passage. Avoidance of complications and the early establishment of a relationship between the patient, their family, and the multi-professional team can have a significant impact on how the ICU journey progresses. Person-centred care is at the heart of the intensive care journey and is valued among the intensive care community—how far it reaches into busy intensive care units is less easy to quantify.

Passport to Successful Outcomes for Patients Admitted to ICU-Meeting Goals of Care has been created to highlight key aspects of intensive care from admission through to discharge. Written by an expert multi-professional team of nurses and key therapists from across the world, the ICU patient journey is presented through the lens of individual experts making up the critical care team. The intention is to signpost how focusing the spotlight on the patient as a whole can contribute to a successful return of patients to their previous lives and families or facilitate a peaceful and dignified death. The authors present the latest evidence, emphasising the attention to detail necessary to avoid ICU-related complications, coupled with ensuring that care is person-centred. This edition builds on our first text *Passport to*

Successful Discharge and provides a timely update reflecting the challenges and innovations of the last couple of years. In addition, it is also acknowledged that for some patients admitted to critical care survival is not always possible. A new chapter has now been included to consider how holistic, multidisciplinary care is for the person at the end of their life.

This is by no means an exhaustive text, but one which views the patient journey from the point of admission with the goal of ensuring a successful outcome for people admitted to critical care, whether that is returning the patient and family to their previous lives or supporting them and their family to ensure a good death. It is intended to be practical, informative, and thought provoking to ensure we maximise the expertise of the multi-professional team in the patients' interests.

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The Person Before the Patient: The Importance of a Good History

1

Fiona Howroyd and Andrew Lockwood

1.1 Introduction

The Intensive Care Unit (ICU) is a complex and dynamic environment intended for the care of the critically ill patient [1]. Receiving 24-h care, patients in the ICU are carefully managed for life-threatening illness, through intricate multiorgan support and continuous monitoring [2]. In the initial stages of recovery, treatment goals may be short term, medically focused and interchangeable dependent on the patient's response. Anticipating a patient's post-acute care needs for discharge may be difficult in the ICU due to the uncertainty of recovery and the rapid changing priorities in a patient's condition [3]. However, as medical care advances, the optimisation of recovery as a therapeutic objective has developed increasing prominence rather than mere survival alone [4]. For many survivors of critical illness, their discharge from ICU is the start of an uncertain journey, facing numerous physical and non-physical problems [5]. The overall sequelae of critical illness lead to reduced quality of life amongst ICU survivors [6].

It is essential that the ICU team assesses and manages the physical and non-physical issues experienced by ICU patients as soon as possible, to optimise long-term outcomes. National guidelines in the UK serve as a useful template, recommending the completion of an early and comprehensive assessment of physical and non-physical factors which may influence recovery and long-term outcomes [4]. This assessment requires a detailed understanding of the patient's history, including their pre-admission functional and health status, helping to identify risk

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1

factors for physical and non-physical morbidity [4]. Early assessment of such potential deficits is required to inform holistic care, facilitate early rehabilitation and identify the ongoing specialist needs of survivors of critical illness, beyond their ICU discharge [4]. This chapter will therefore explore the following:

- *When* to attain a patient history in the ICU.
- *How* to attain a patient history in the ICU.
- *What* a good history should include in the ICU.
- *Why* an early, detailed history is important.

Throughout the chapter, the practicalities and challenges of taking a good history in the ICU will be considered, along with practical advice on how to overcome these challenges. The benefits of a good history will also be discussed throughout the chapter, considering how this can inform patient-centred care.

1.2 When to Attain a Patient History in the ICU

Although considered an essential component of patient-centred care, gaining a good history in the ICU can be a challenging concept for healthcare professionals [7]. Every situation is unique, yet it is important for clinicians to gauge the right time to approach patients and their relatives in a sensitive manner [8]. With the constant noise, lights and alarms of machines, the ICU environment alone is considered to be a hostile and stress-inducing place for both patients and their relatives [2]. Furthermore, there is the emotion and grief experienced as patients deal with the uncertainty of critical and life-threatening illness [9]. Gaining a detailed history about the patient in order to inform holistic rehabilitation goals may be misinterpreted at the acute stages; either giving false hope of recovery or being deemed insensitive when prognosis is uncertain [10]. A compassionate judgement is key; considering that ICU patients and their family members experience high levels of anxiety and psychological distress during the ICU admission [11, 12].

However, delays need to be avoided whilst selecting the optimal time to obtain this detailed information. As recommended by the NICE guidelines, rehabilitation needs to commence early in the ICU in order to prevent the physical and non-physical complications of critical illness. Specifically, the associated Quality Standards advise that rehabilitation goals should be set and agreed by day 4 of ICU admission [13]. At this time, patients may still be acutely unwell requiring multi-organ support. Although this may seem early, it is important to recognise patients who are critically ill for more than 4 days are at greater risk of physical and non-physical symptoms. A delay in goal setting may subsequently delay the care and rehabilitation required to overcome such negative effects. Early goal setting is therefore essential, even if preventative in nature, ensuring a well-structured holistic rehabilitation plan that is documented, communicated and executed [14].

On balance, although this would seem to be at a stressful and uncertain time for patients and their families, comprehensive assessment and detailed history taking

are required in the first few days of admission, in order to inform individualised rehabilitation goals by day 4 [13]. Information gathering at such an early stage therefore requires a systematic, professional and sensitive manner [8].

1.3 How to Obtain an Effective Patient History in the ICU

As well as gauging when it is an appropriate and sensitive time to gain a good patient history, it is also important to consider the practicalities of *how*.

1.3.1 Taking a History from the Patient

The first line of approach to history taking should be from the patient themselves. This will allow the clinician to hear the patients thoughts, beliefs and priorities in their own words. Although challenging to approach in the ICU, when handled correctly, the interview process can concurrently support clinicians in developing a therapeutic relationship. Through open communication, empathy and listening skills, the clinical team is able to evoke a relationship of trust and understanding. This may be reassuring for both patients and their relatives, whilst also helping to initiate conversations regarding goals, expectations and discharge planning.

However, for the ICU patient, their ability to verbally communicate may often be compromised due to the presence of artificial airway devices and respiratory system support [15]. Furthermore, non-verbal communication methods such as gestures or lip-reading are often ineffective and unsuccessful in the ICU due to factors such as weakness or injury [16]. Attempting to communicate via non-verbal methods with ICU patients can subsequently cause frustration, stress and anxiety, for patients, relatives and staff [16].

As well as challenges with communication, history taking from the ICU patient may also be limited by other common factors such as sedation or cognitive impairment [17]. Delirium in the ICU is common and may also be associated with memory impairments, reduced concentration, inattention and poor sleep [18]. Obtaining a detailed and accurate history from the patient in the acute stages of critical illness may therefore be challenging or even impossible, therefore other means may need to be considered.

1.3.2 Taking a History from the Patient's Relatives

Due to the implications of critical illness and ICU therapies, clinicians are often required to collate information from patient relatives. Ideally the clinical team are able to speak with the patients family on a face-to-face consultation, such as during patient visiting hours. This allows the clinician to gauge a sensitive and appropriate time to collate the patient history as part of a natural conversation. Family-centred

care and family visitation is advocated by ICU guidelines, with known benefits upon patient outcomes [19–21].

However, coordination of timings between clinicians and visiting times may not always be possible, therefore reliant instead upon telephone communication. Although convenient, it is important to recognise that relatives can experience stress and panic when receiving telephone calls from the hospital when a loved-one is in ICU [22]. It is important to start the telephone call with reassurance and maintain calm and empathetic communication throughout.

There has been significant learning and reflection following the COVID-19 pandemic regarding relative communication. In the height of the pandemic, hospital visiting restrictions were implemented to maintain public safety [23–25]. In addition to the visitation restrictions, telephone communication was also challenging due to face masks and personal protective equipment hampering the ability to hear and speak clearly [23, 26]. This breakdown in family-centred ICU care had profound effects, with moral distress, emotional exhaustion and reduced job satisfaction reported amongst healthcare workers during the COVID-19 pandemic [21, 23, 25, 27].

1.3.3 Video Consultations

To lessen the effect of the COVID-19 quarantine restrictions, guidelines were published to support alternative modes of communications and enable creative and flexible family-centred ICU care [23, 28]. Although unable to replace the value of physical presence at the bedside, video calls offered one alternative [22, 29]. ‘Virtual visiting’ enabled family members in any geographical locations to connect with the patient. It also allowed the patient to be immersed back into their everyday life and virtually take them to their own home, or to wider members of their support network, including pets [30]. Although there are conflicting perspectives regarding virtual interactions, with care to be taken to adhere to patient consent and privacy, it can continue to offer an alternative method of family communication when in-person visitation is limited [31].

1.3.4 Family Liaison Teams

Another useful communication tool adopted at the height of the COVID-19 pandemic was the use of Family Liaison Teams (FLT). FLT were specialist teams dedicated to relative communication, information and support and were associated with high levels of satisfaction by patient families [24, 32]. In some cases, they also facilitated the ‘virtual visiting’, bedside photographs, voice recordings or music playlists sent in by relatives [26].

Although visitation is now possible again, the COVID-19 pandemic has reinforced the importance of family members being informed and connected in ICU patient care [29]. Whether in person, by telephone or a virtual platform, attaining a

patient history requires a sensitive approach due to the grief, stress and emotion experienced by relatives of ICU patients [9].

It is important that appropriate time is given for retrieving a good history. It may require time and perseverance to gain a detailed understanding of the patient, and clinicians should consider that it is not always possible to gather all information in a single meeting or from one individual. In order to help initiate and structure these conversations, there are tools which may be used to help.

1.3.5 The Clinical Frailty Scale

Frailty, distinct from co-morbidity and age, is a state of vulnerability predisposing certain individuals to increased risk of falls, delirium, disability, and mortality during hospitalization, which consequently increases length of hospitalization stay [33].

Baseline functional status in addition to the burden of pre-existing illness is considered to have prognostic value in the ICU [34]. The development of critical illness may lead to frailty in vulnerable patients; furthermore, critical illness may impede recovery in those already considered frail [35]. Frailty is therefore an important short-term prognostic tool, with frail patients more likely to experience adverse events and have longer lengths of stay in ICU and hospital [36]. Furthermore, in the longer term, frail patients are more likely to leave hospital with impaired functional dependence and quality of life and have greater mortality [36].

The Clinical Frailty Scale (CFS) provides clinicians with an easily applicable tool to stratify according to the level of vulnerability [33]. Although the components of frailty are well known to be complex and diverse, time constraints necessitate a simple assessment tool that is easy to complete on ICU admission, by patients or their relatives [34] (Fig. 1.1). Although the CFS does not provide a detailed history, in the early and acute stages, this may help ICU clinicians to understand the dependency, or independency of their patients, considering health status, physical activity levels and functional participation in activities of daily life. The CFS therefore helps to develop a picture of physical and non-physical risk factors of ICU recovery and may help clinicians to identify their patient's potential rehabilitation and care needs.

1.3.6 Patient Questionnaires: Key Relative Involvement

Documents such as the 'All About Me' or 'This is Me' are commonly used in dementia care and have been adapted for use in the ICU, where patients may not be able to communicate key facts about themselves. These are useful tools when collecting a patient history in the ICU (Fig. 1.2). The questionnaires aim to capture detailed personal information about the patient, including their family and significant others, hobbies, work and independence with activities of daily living. This information is then recorded in a single document accessible for all staff involved in the patient's care. The use of this document, displayed with a photograph, serves as

Clinical Frailty Scale*



1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.



2 Well – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.



3 Managing Well – People whose **medical problems are well controlled**, but are **not regularly active** beyond routine walking.



4 Vulnerable – While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being “slowed up”, and/or being tired during the day.



5 Mildly Frail – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.



6 Moderately Frail – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.



7 Severely Frail – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).



8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.



9. Terminally Ill - Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise evidently frail**.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. *CMAJ* 2005;173:489-495.

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Fig. 1.1 Clinical frailty scale. (Reproduced with permission from Dalhousie University)

a reminder of the person who is the patient. The frequent use of prone positioning during the COVID-19 pandemic led to feelings of dehumanised, depersonalised and ‘faceless’ patient care [25]. A patient photograph can be a valuable way of allowing staff to connect with their patients and knowing the ‘person’ before they became a patient.

By providing a questionnaire to the family member, it allows them to write down this information in their own time. Considering their stress, emotion and grief, this can often be a more appropriate and sensitive way to collect a good history and can subsequently be a more comfortable approach for healthcare professionals. Relatives commonly report that completing the questionnaire is a therapeutic task, particularly at a time when they feel helpless, valuing the importance of their input in describing the person who has become our patient. It also prevents repetitive conversations for relatives who may come across many different professionals during the course of the patient’s ICU admission.

From a clinician’s perspective, it is very useful to understand the patient’s history from the relatives’ perspective, not only knowing their medical and social history but also their likes, dislikes and aspects of their personality. This can help to personalise care and ensure that rehabilitation is patient centred. This can be comforting and reassuring not only for the patient but also their relatives, knowing that their nurse or therapist has taken the time to understand the patient and utilise the ‘All About Me’ or ‘This is Me’ to inform *person-centred* care.

THIS IS ME	
<p>This information is designed to provide the staff caring for your relative with an insight into who they are – it is hoped that by having a better understanding of a patient’s normal environment and lifestyle we can aim to provide aspects of care that are tailored to their individual needs. Please help us by completing the information below and providing a photo of your relative.</p>	
<p>Name – Likes to be known as: _____</p>	
<p>Insert photo here</p>	
Spiritual/Religious/Cultural beliefs	Occupation:
Disability (hearing aid/glasses/walking stick etc.):	Preferred TV/radio station:
Interests/hobbies:	Social – family/friends/pets:
<p>Any other information (i.e. Right/Left handed, things which may worry or upset me :</p> 	
<p><small>Adapted from www.dignityincare.org.uk/</small></p>	

Fig. 1.2 Example of a ‘This is Me’ document

1.4 What a Good History Should Include in the ICU

The overall aim of the history is to inform patient-centred care that is respectful of and responsive to the individual patient's preferences, needs and values. A good history should therefore consider a holistic overview of the patient's physical, psychological and social needs, as listed in Table 1.1.

Table 1.1 Suggested topics and questions included in a detailed patient history

Topic	Questions to consider
Family	<ul style="list-style-type: none"> • Who does the patient live with? • Who is their next of kin? • Who is important to the patient? This may include direct family, close friends, neighbours or pets • Do family live locally? If not, will relatives be able to visit? • When are family usually able visit the patient?
Mobility	<ul style="list-style-type: none"> • Prior to admission could the patient mobilise independently? • Did they require any mobility aids? • Could they manage the stairs? • Were they able to leave the house? • What was their outdoor mobility like? • What was their exercise tolerance like? If limited, why? • Is there any history of falls?
Functional independence and housing	<ul style="list-style-type: none"> • Can the patient complete all activities of daily living independently? Including washing, dressing, cooking, shopping, cleaning and house-work • Did the patient have any support with any functional activities? • If so, who from? • Did the patient require a package of care or assistance from any carers; do they require social services support? • Are they normally continent? • Where does the patient live? Are they local? • What type of accommodation do they live in? • Are there stairs or steps to access the property? • Is the bedroom and bathroom up or downstairs?
Hobbies, interests and employment	<ul style="list-style-type: none"> • Did the patient work prior to admission? • If not, when did they stop working and why? • What do/did they do for a living? • What do they like to do in their spare time? • Do they have any hobbies? • Do they follow any sports or teams? • What TV and radio stations do they like? • Do they like to listen to certain music?
Medical issues	<ul style="list-style-type: none"> • Did the patient have any health problems prior to admission? • How do their health problems affect them? Physically and non-physically including fatigue, mood or pain • How are their health problems managed? • Are they under any specialist medical or support teams? • Have they required ICU or hospital care before? • Were they deconditioned or malnourished pre-admission? • Do they have any mental health issues? • Any history of alcohol, drugs or smoking? • Vaccination status? • Any issues with their vision? Do they wear glasses? • Any issues with their hearing? Do they wear hearing aids?

(continued)

Table 1.1 (continued)

Topic	Questions to consider
Lifestyle	<ul style="list-style-type: none"> • What is the patient's normal, daily routine? • Do they normally have any issues with sleep? • Do they normally have any issues with pain? • How do they like their appearance? E.g., are they clean shaven? • What is their favourite food or drink?
Understanding and expectations	<ul style="list-style-type: none"> • What is the patient's perception of their own problems? • What are their main concerns? • Do they understand why these problems have occurred? • What is their expectation of recovery? • What is their understanding of what has happened? • Do they have memory loss? • Do they have insight and understanding?

It is important to ensure that history taking is a caring, empathetic conversation, rather than a checklist, paying due attention to the primary language of the patient and their relatives. History taking requires good communication and active listening skills. The information is personal and important to the patient and their families, as it is these finer details which make the patient a person. It is therefore important to give the patient and their families time to convey this information, showing respect and understanding during the stressful experience of ICU.

1.5 Why an Early, Detailed History Is Important

The rationale for why an early, detailed patient history is necessary and valuable to patient care is detailed below, considering each of the topics outlined in Table 1.1. To appreciate the importance of a history in the ICU, it may be beneficial to consider patient examples.

Patient 1:

A 68-year-old patient has had three failed sedation holds and is now 6 days into her ICU stay following emergency surgery. Staff have recorded that her waking response is neurologically inappropriate and that she is agitated and confused. She is listed for a tracheostomy today and potentially a head CT. A later detailed history from the family reveals the patient normally wears glasses, has bilateral hearing aids and her first language is Urdu. Her glasses and hearing aids were left at home, and the sedation holds were completed without the family present, by English-speaking staff. She is normally very active and independent; she walks to the local library every week and is a member of a book-club.

Patient 2:

An elderly patient is distressed and has pulled out her NG tube. She has remained in bed for the last 5 days as she is restless and considered unsafe to get out of bed. She has required low-dose sedation at night-time and therefore unable to transfer to the ward. Following a detailed history, it is revealed that she has a background of severe arthritis of the hip and requires daily analgesia. Despite her pain, she remains fully independent, living at home alone. She is mobile with a walking-stick and is able to drive, going to the shops and church on a weekly basis. Unfortunately,

her usual medication has not been prescribed. She was initially given morphine, yet this was ceased as it caused constipation and nil further analgesia was prescribed. She has not opened her bowels for 2 days.

1.5.1 Family: Key Relationships

Post-traumatic stress after ICU is common amongst patients and their relatives. Involvement of family in the ICU can improve patient care as well as offer support and reassurance to the family themselves [37]. Furthermore, rehabilitation goal setting requires family support and engagement, as recommended by NICE guidelines [4]. In the example of Patient 1, family members could offer support with language interpretation as well as offer reassurance to the patient at a time of fear, disorientation and distress. Knowing who is important to the patient and including them in care can be reassuring and comforting for the patient as well as their relatives. Once Patient 1 had been successfully weaned from sedation, family could also help to support with rehabilitation sessions by offering interpretation or provide incentive to rehabilitation goals. For example, a short-term goal could be for the patient to transfer to the chair for 1 hour periods during relative visiting hours or during a relative video call, to enable social interaction. Photographs and cards from family members could be brought in to the patient's bed-space to make the environment feel less clinical and disorientating. Relatives often feel disempowered and separated from their loved ones and simple involvement in aspects of care reinforces their unique position in progression towards recovery, giving them a valued sense of purpose. Another useful tool to help empower family members in their relatives care is to encourage them to contribute to an ICU patient diary [38, 39]. The ICU diary is a document that the ICU team and families can contribute to on a daily basis. The diary can help patients understand what has happened to them during their admission and fills in the potential gaps in time.

1.5.2 Mobility

Having a good understanding of the patient's baseline level of mobility is important to help set expectations of recovery. This also helps to inform rehabilitation goals, which should be communicated and implemented by all members of the ICU team. For example, Patient 2 may require more intensive rehabilitation due to potential pain, stiffness and weakness associated with arthritis in addition to bed rest and critical illness. In this instance, the nurses could help Patient 2 into the chair for her breakfast and encourage her to participate in her own wash, then later the physiotherapy team could review to practice mobilisation with a frame and complete a strengthening exercise programme. Involving all members of the team helps to promote a normal daily routine for the patient and also provides consistency to care and rehabilitation. Understanding the patient's history and baseline mobility at an early stage may also help to inform the care and rehabilitation needs of the patient beyond ICU discharge.