

Improving intensive care

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Researchers from a team at the Cicely Saunders Institute, King's College London, and Intensive Care Specialists and Palliative Care Specialists at King's College Hospital have discovered and tested a new way to improve care and communication for patients and their families in the Intensive Care Unit (ICU). The research published today in open access journal *BMC Medicine* is the result of a three year study to develop and test ways to improve communication and support in Intensive Care.

Communication and support for patients and their families are of central concern in healthcare, and yet too often are poorly met – as is evidenced by recent public inquiries, such as those chaired by Robert Francis and Julia Neuberger.

'The Intensive Care Unit is a highly challenging environment for patients and families. Patients are normally profoundly ill, making communication very difficult. It is an unfamiliar place for families.

Things can change quickly, and there is a lot of information for families to take in. For this reason it is a place where communication and support can be very difficult and can often go wrong' explained Professor Irene Higginson, lead author of the study.

The study, which was funded by the National Institute for Health Research (NIHR) Research for Patient Benefit Programme, has developed a simple tool called PACE – which stands for Psychosocial Assessment and Communication Evaluation. The goal of developing this tool was to improve assessment and communication for all patients in the ICU, both those who may deteriorate and equally those who may recover. PACE comprises the [training programme](#) and an assessment, which is recorded in the person's clinical record. The training programme involves collaborative work between the ICU and hospital palliative care team staff to look at ways to improve the communication and how the PACE questions might serve as a prompt to improve social assessment and continue dialogue.

'This collaborative approach, both in research and training, has also improved day to day communication between the ICU and palliative care teams, facilitating improved patient and family care' said Dr Wendy Prentice, Consultant and Honorary Senior Lecturer in Palliative Medicine and Clinical Lead for the Palliative Care Team at King's College Hospital.

The clinical record within PACE asks for assessment of five aspects of care. PACE is completed by the key worker for the patient, usually a nurse, within 24 hours of admission.

PACE components:

1. Training programme for all staff with [intensive care](#) and [palliative care](#) staff working together

2. Short clinical record of:

- Family Details - key details of the family
- Social Details - social details of the individual's needs – these can include language, culture, but also financial concerns or even need for transport and parking for the family
- Preferences - the individual's preferences and any previous wishes about who they would want informed about their treatment
- Communication and information - how much the patient and the families are aware of the situation and who is key in a family to be involved in communication. It also involves explaining what happens in the ICU
- Any other issues that the patient and/or family would like staff to know about them which they feel is important.

The record then gives space for a continuing log of any communication updates. This is so that when the clinical team changes during the 24 hour period, everyone is kept up to date.

Dr Phil Hopkins, Consultant & Hon Senior Lecturer in Intensive Care Medicine, Anaesthesia & Trauma at Kings College Hospital, and senior intensivist on the study explained how PACE might work: 'The background chronic health status, health care preferences, social history and psychology of patients with critical illness has historically received less attention than acute resuscitation or physical supportive care. Further, family relationships and communication between critical care and next of kin has also been a neglected area. PACE provides a platform to better explore these issues in the hope that improved short and long term outcomes and quality of care will result.'

The preliminary evaluation of PACE surveyed the views of family members on the ICU. Of the 213 family members, 165 (78 per cent)

responded to their survey. Two-thirds had PACE completed. Those for whom PACE was completed reported significantly higher (better) satisfaction with the honesty and consistency of information from staff and with the symptom control that [patients](#) received compared with those where it was not (Mann-Whitney U-test ranged from 616 to 1247, P-values ranged from 0.041 to 0.010). Staff also found PACE useful, of 95 ICU staff surveyed, 89 per cent rated PACE as very or generally useful. Reports from the families when interviewed suggested that PACE helps the staff to get to know the patient and [family](#) better, helps them feel that someone listens to them and is interested in them and their wishes, as well as in the purely biomedical aspects of the disease.

'PACE now needs to be evaluated more widely and in a comparative, ideally randomised, trial and across other centres" said Professor Higginson. "There are similar needs for good [communication](#) and psychosocial care, and uncertainty, across health care. So PACE might be helpful in other settings especially hospitals. But this would need to be assessed.'

Provided by King's College London

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