Becoming the 1st ITU in the UK to achieve Certification in Humanisation and Good Practices

Lucy Gosnell

- ITU Senior Sister – Tunbridge Wells Hospital, Maidstone and Tunbridge Wells NHS Trust
- Patient Rehabilitation and Follow Up Lead Nurse

Intensive Care is Evolving!

More than just survival.

Patient centred outcomes.

Functional, cognitive and mental health quality of life indicators.

New qualitative studies demonstrate that “patient centred outcomes and long-term quality of life are perceived by patients as more important than survival”

Pollanch, 2022

The Evidence

Of those admitted to critical care-

- 32% will suffer physical impairments.
- 11% will suffer cognitive impairments.
- 36% will suffer mental health impairments.
- At 1 year post discharge only 60% will have returned to work.
- (Tejero-Aranguren, 2022)

Adherence to guidelines

- Reduce mechanical ventilation by 2 days Marra, (2018)
- Reduce length of ITU stay by 3 days Marra, (2018)
- Reduce hospital length of stay by 4 days Marra, (2018)
- Decrease the likelihood of hospital death within 7 days by 68% Marra, (2018)
- Cut ITU readmissions by 46% Marra, (2018)
- 56% improvement in physical limitation Zhang, (2016)

Adherence to guidelines

- 50% reduction in delirium SSCM, (2021)
- 42% reduction in anxiety and depression Neilson, (2019)
- 35% reduction in Post Traumatic Stress Disorders (PTSD) Garrouste-Orgeas, (2016)
- 40% reduction in discharges to nursing homes and rehabilitation facilities Marra, (2018)

TWH Outcomes and Financial Impact

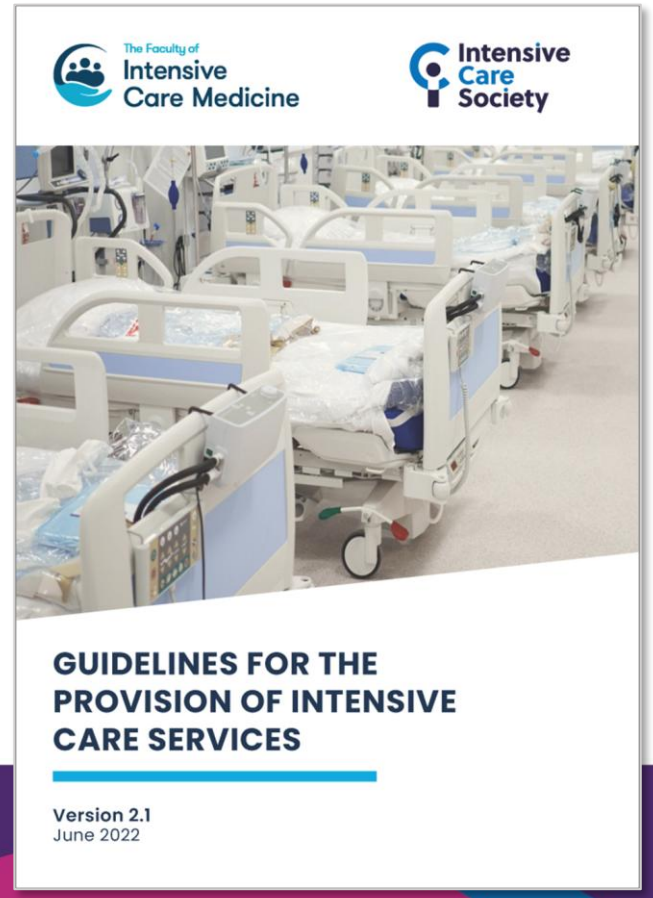
Unit Saved	£ Saved
284 ventilation Days	£76,770 *
426 ITU bed days	£569,136 **
568 hospital bed days	£166,753***
12 less hospital deaths	N/A
10 less readmissions to ITU	N/A

*Based on the cost difference between level 2&3 care. **Based on the cost of level 2 care. ***Based on the cost of level 0 care.

NICE National Institute for Health and Care Excellence

ICU LIBERATION

Clinical Practice Guidelines for the Prevention and Management of Pain, Agitation/Sedation, Delirium, Immobility, and Sleep Disruption in Adult Patients in the ICU- PADIS Guideline 2018



THE HUMANISATION PROJECT

HUCI Humanizando los Cuidados Intensivos

The Humanisation Project

- The Humanisation Project is a multi-disciplinary research group, with the aim of improving care in Intensive Care Units.
- The project has scientific endorsement from several national and international scientific associations.
- Aligns with national Standards and guidelines – NICE, GPICS, SCCM.
- The manual has been downloaded over 15,000 times, from over 20 different countries.
- 18 certificates awarded internationally with more in process
- Tunbridge Wells Hospital is the 1st in the UK.

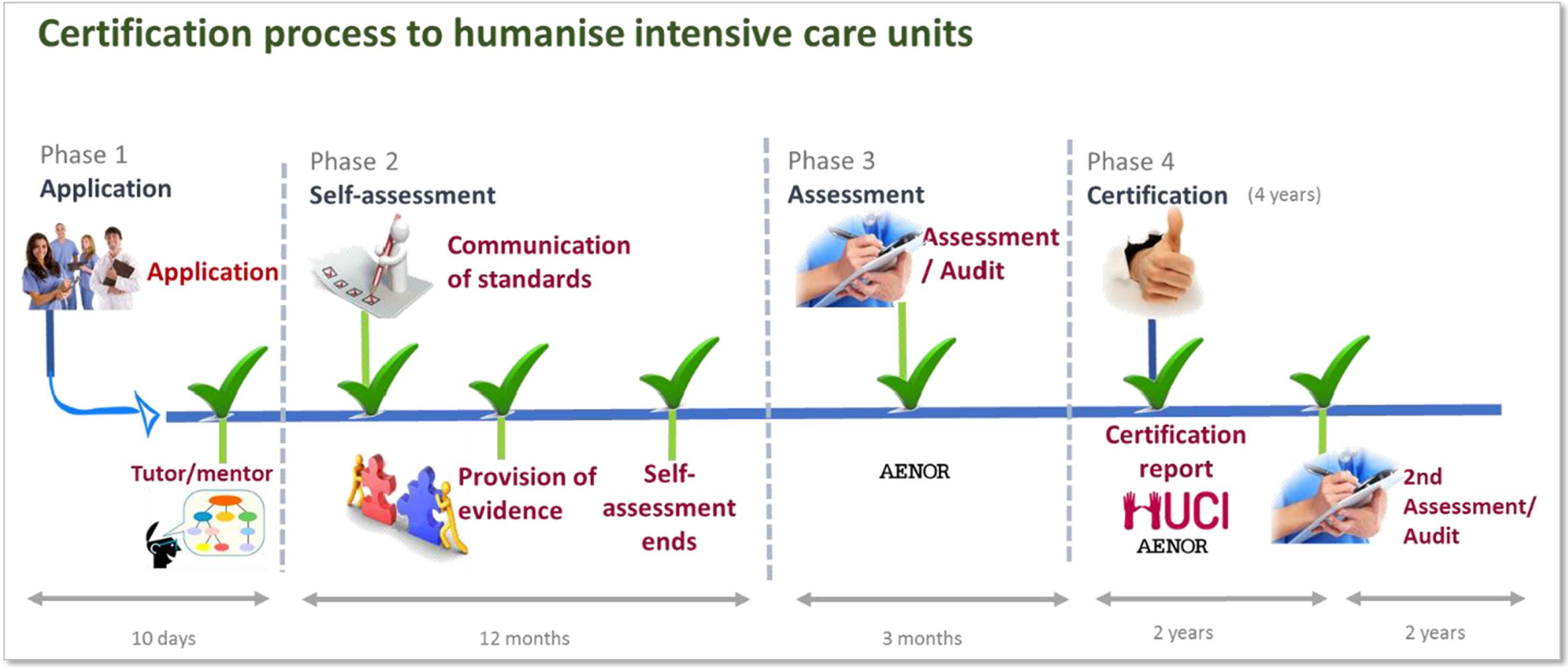
The Humanisation Project

The Manual of Good Practices

- 7 Strategic Lines
- 160 Standards

RETHINKING THE ORGANIZATION TO ADAPT IT TO PEOPLE-CENTERED CARE

Project Process



Application and Funding

Obtained a grant for £7,500 to cover the costs of the project.

Completing the Project

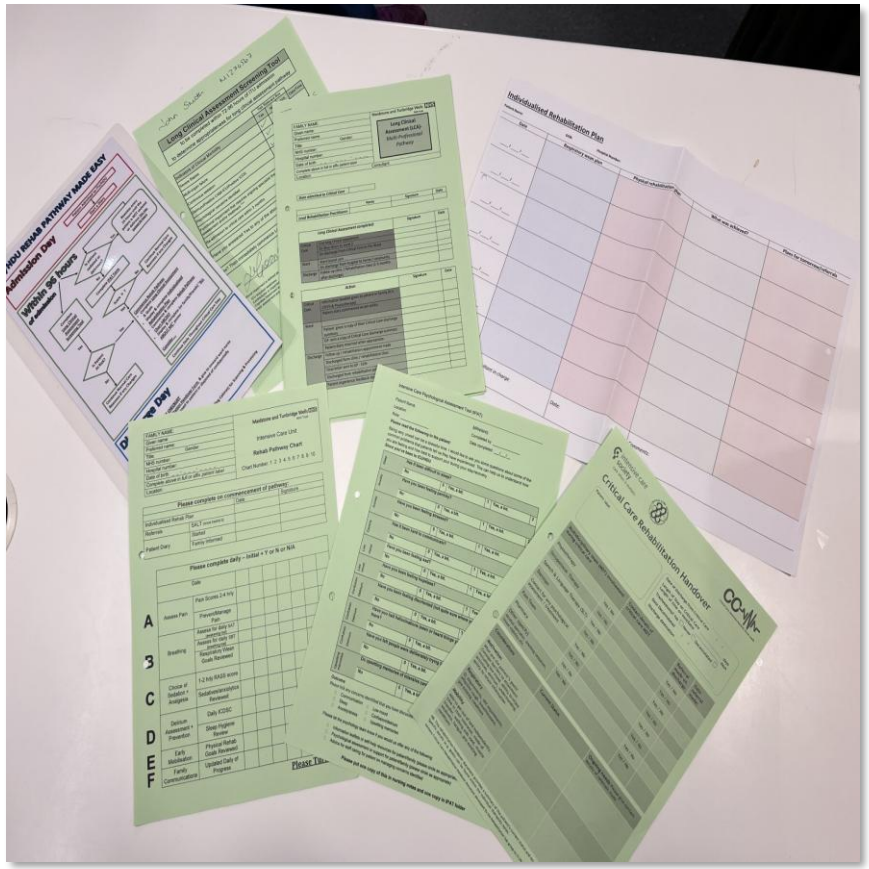
- Presented the vision to senior hospital staff and the MDT
- Formalised our current practices –updating policies, refining models of care
- Identified priority areas (21 out of total 160 Standards)
- Assigned sub working groups
- Regular feedback from project mentors
- Regular contact with MDT for progress reports

Nursing Standards

MTW

NHS
Maidstone and
Tunbridge Wells
NHS Trust

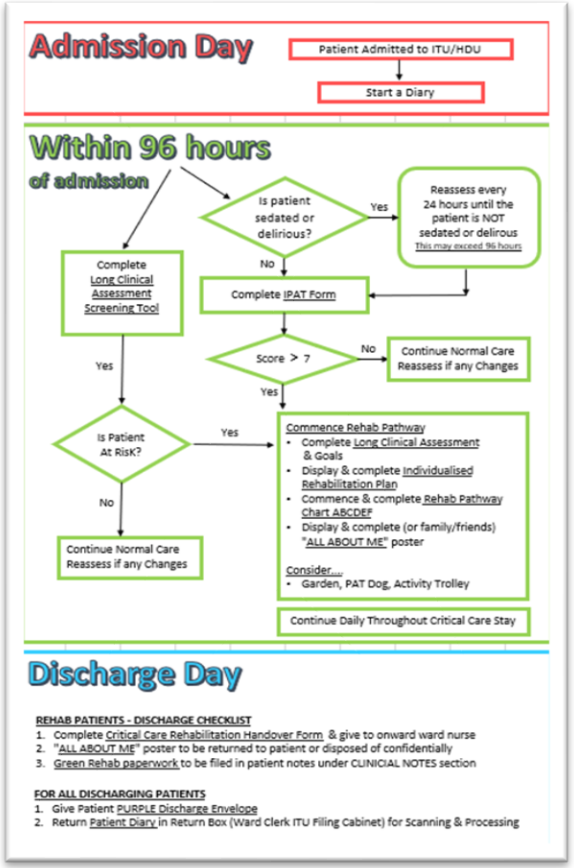
Rehab Pathway Documentation



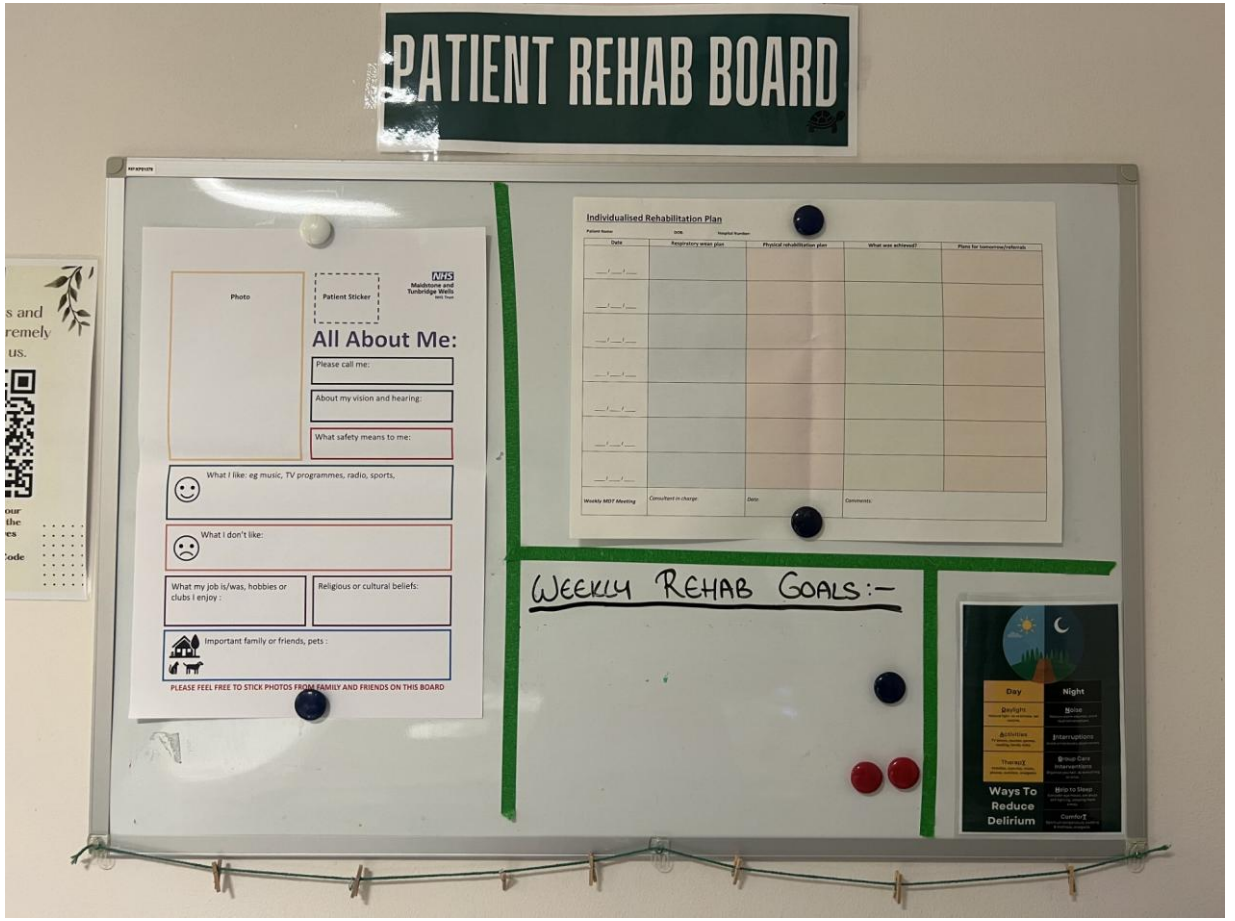
FAMILY NAME:	Maidstone and Tunbridge Wells NHS Trust
Given name:	
Preferred name:	Intensive Care Unit
Title: Gender:	**Rehab Pathway Chart**
NHS number:	
Hospital number:	Chart Number: 1 2 3 4 5 6 7 8 9 10
Date of birth: _ _ - _ _ _ - _ _ _ _	
Complete above in full or affix patient label	
Location:	

Please complete on commencement of pathway:			
		Date	Signature
Individualised Rehab Plan			
Referrals	SALT (once trache'd)		
Patient Diary	Started		
	Family Informed		

	Please complete daily – Initial + Y or N or N/A							
			1	2	3	4	5	6	7
A	Assess Pain	Pain Scores 2-4 hrly							
		Prevent/Manage Pain							
B	Breathing	Assess for daily SAT (awakening trial)							
		Assess for daily SBT (breathing trial)							
		Respiratory Wean Goals Reviewed							
C	Choice of Sedation + Analgesia	1-2 hrly RASS score							
		Sedatives/anxiolytics Reviewed							
D	Delirium Assessment + Prevention	Daily ICDSC							
		Sleep Hygiene Review							
E	Early Mobilisation	Physical Rehab Goals Reviewed							
F	Family Communications	Updated Daily of Progress							

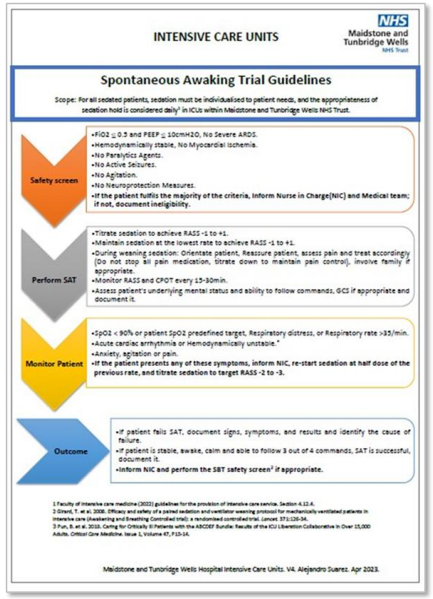


Rehab Board


PATIENT REHAB BOARD
Photo
Patient Sticker
NHS
Maidstone and Tunbridge Wells
All About Me:
Please call me:
About my vision and hearing:
What safety means to me:
What I like: eg music, TV programmes, radio, sports,
What I don't like:
What my job is/was, hobbies or clubs I enjoy :
Religious or cultural beliefs:
Important family or friends, pets :
PLEASE FEEL FREE TO STICK PHOTOS FROM FAMILY AND FRIENDS ON THIS BOARD
Individualised Rehabilitation Plan
Weekly MDT Meeting
Consultant in charge
Date
Comments
WEEKLY REHAB GOALS:-
Day
Night
Ways To Reduce Delirium

Discharge Pack

Local Protocols



INTENSIVE CARE UNITS

Maidstone and Tunbridge Wells NHS Trust

Spontaneous Awaking Trial Guidelines

Scope: For all sedated patients, sedation must be individualised to patient needs, and the appropriateness of sedation hold is considered daily[1] in ICUs within Maidstone and Tunbridge Wells NHS Trust.

Safety screen

- FiO2 ≤ 0.5 and PEEP ≤ 10cmH2O, No Severe ARDS.
- Hemodynamically stable, No Myocardial Ischemia.
- No Paralytics Agents.
- No Active Seizures.
- No Agitation.
- No Neuroprotection Measures.
- If the patient fulfils the majority of the criteria, inform Nurse in Charge(NIC) and Medical team; if not, document ineligibility.

Perform SAT

- Titrate sedation to achieve RASS -1 to +1.
- Maintain sedation at the lowest rate to achieve RASS -1 to +1.
- During weaning sedation: Orientate patient, Reassure patient, assess pain and treat accordingly (Do not stop all pain medication, titrate down to maintain pain control), involve family if appropriate.
- Monitor RASS and CPOT every 15-30min.
- Assess patient's underlying mental status and ability to follow commands, GCS if appropriate and document it.

Monitor Patient

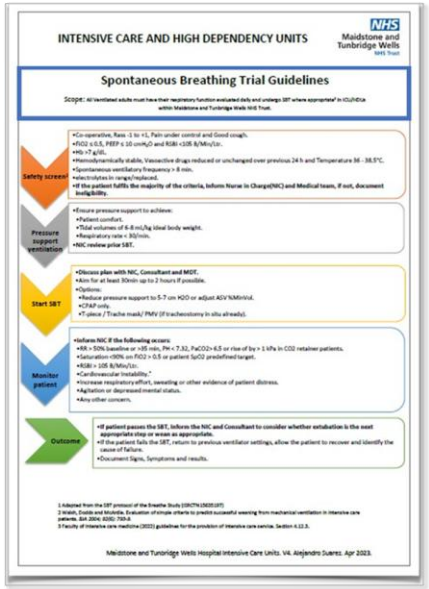
- SpO2 < 90% or patient SpO2 predefined target, Respiratory distress, or Respiratory rate >35/min.
- Acute cardiac arrhythmia or Hemodynamically unstable.*
- Anxiety, agitation or pain.
- If the patient presents any of these symptoms, inform NIC, re-start sedation at half dose of the previous rate, and titrate sedation to target RASS -2 to -3.

Outcome

- If patient fails SAT, document signs, symptoms, and results and identify the cause of failure.
- If patient is stable, awake, calm and able to follow 3 out of 4 commands, SAT is successful, document it.
- Inform NIC and perform the SBT safety screen[2] if appropriate.

1 Faculty of Intensive care medicine (2022) guideline for the provision of intensive care service. Section 4.12.4.
2 Girard, T. et al. 2008. Efficacy and safety of a paired sedation and ventilator weaning protocol for mechanically ventilated patients in intensive care (Awakening and Breathing Controlled trial): a randomised controlled trial. Lancet. 371:126-34.
3 Pun, B. et al. 2018. Caring for Critically Ill Patients with the ABCDEF Bundle: Results of the ICU Liberation Collaborative in Over 15,000 Adults. Critical Care Medicine. Issue 1, Volume 47, P3-14.

Maidstone and Tunbridge Wells Hospital Intensive Care Units. V4. Alejandro Suarez. Apr 2023.



INTENSIVE CARE AND HIGH DEPENDENCY UNITS

Maidstone and Tunbridge Wells NHS Trust

Spontaneous Breathing Trial Guidelines

Scope: All ventilated adults must have their respiratory function evaluated daily and undergo SBT where appropriate[1] in ICU/HDUs within Maidstone and Tunbridge Wells NHS Trust.

Safety screen[2]

- Co-operative, Rass -1 to +1, Pain under control and Good cough.
- FiO2 ≤ 0.5, PEEP ≤ 10 cmH2O and RSBI <105 B/Min/Ltr.
- Hb >7 g/dL.
- Haemodynamically stable. Vasoactive drugs reduced or unchanged over previous 24 h and Temperature 36 - 38.5°C.
- Spontaneous ventilatory frequency > 8 /min.
- electrolytes in range/replaced.
- If the patient fulfils the majority of the criteria, inform Nurse in Charge(NIC) and Medical team, if not, document ineligibility.

Pressure support ventilation

- Ensure pressure support to achieve:
- Patient comfort.
- Tidal volumes of 6-8 ml/kg ideal body weight.
- Respiratory rate < 30/min.
- NIC review prior SBT.

Start SBT

- Discuss plan with NIC, Consultant and MDT.
- Aim for at least 30min up to 2 hours if possible.
- Options:
  - Reduce pressure support to 5-7 cm H2O or adjust ASV %Min Vol.
  - CPAP only.
  - T-piece / Trache mask/ PMV (if tracheostomy in situ already).

Monitor patient

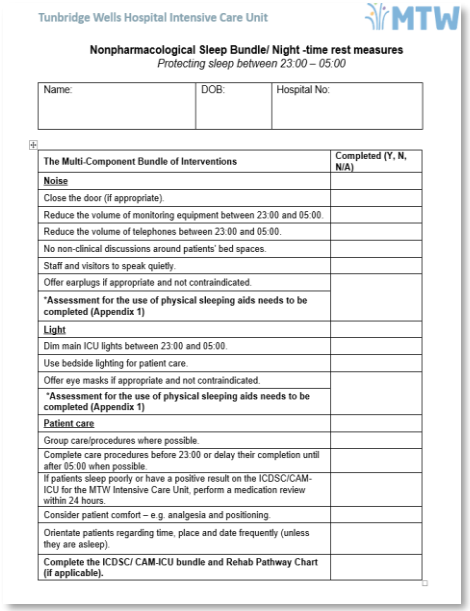
- Inform NIC if the following occurs:
- RR > 50% baseline or >35 min, PH < 7.32, PaCO2> 6.5 or rise of by > 1 kPa in CO2 retainer patients.
- Saturation <90% on FiO2 > 0.5 or patient SpO2 predefined target.
- RSBI > 105 B/Min/Ltr.
- Cardiovascular instability.*
- Increase respiratory effort, sweating or other evidence of patient distress.
- Agitation or depressed mental status.
- Any other concern.

Outcome

- If patient passes the SBT, inform the NIC and Consultant to consider whether extubation is the next appropriate step or wean as appropriate.
- If the patient fails the SBT, return to previous ventilator settings, allow the patient to recover and identify the cause of failure.
- Document Signs, Symptoms and results.

1 Adapted from the SBT protocol of the Breathe Study (ISRCTN 12635107)
2 Walsh, Dodds and Mcbride. Evaluation of simple criteria to predict successful weaning from mechanical ventilation in intensive care patients. BJA 2004: 92(5): 700-8
3 Faculty of Intensive care medicine (2022) guideline for the provision of intensive care service. Section 4.12.3.

Maidstone and Tunbridge Wells Hospital Intensive Care Units. V4. Alejandro Suarez. Apr 2023.



Tunbridge Wells Hospital Intensive Care Unit

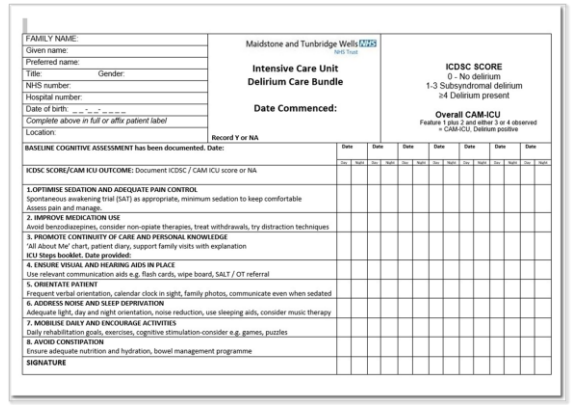
MTW

Nonpharmacological Sleep Bundle/ Night -time rest measures

Protecting sleep between 23:00 – 05:00

Name:	DOB:	Hospital No:

The Multi-Component Bundle of Interventions	Completed (Y, N, N/A)
Noise	
Close the door (if appropriate).	
Reduce the volume of monitoring equipment between 23:00 and 05:00.	
Reduce the volume of telephones between 23:00 and 05:00.	
No non-clinical discussions around patients' bed spaces.	
Staff and visitors to speak quietly.	
Offer earplugs if appropriate and not contraindicated.	
*Assessment for the use of physical sleeping aids needs to be completed (Appendix 1)	
Light	
Dim main ICU lights between 23:00 and 05:00.	
Use bedside lighting for patient care.	
Offer eye masks if appropriate and not contraindicated.	
*Assessment for the use of physical sleeping aids needs to be completed (Appendix 1)	
Patient care	
Group care/procedures where possible.	
Complete care procedures before 23:00 or delay their completion until after 05:00 when possible.	
If patients sleep poorly or have a positive result on the ICDSC/CAM-ICU for the MTW Intensive Care Unit, perform a medication review within 24 hours.	
Consider patient comfort – e.g. analgesia and positioning.	
Orientate patients regarding time, place and date frequently (unless they are asleep).	
Complete the ICDSC/ CAM-ICU bundle and Rehab Pathway Chart (if applicable).	



FAMILY NAME:	Maidstone and Tunbridge Wells NHS Trust **Intensive Care Unit** **Delirium Care Bundle**	**ICDSC SCORE** 0 - No delirium 1-3 Subsyndromal delirium ≥4 Delirium present
Given name:		
Preferred name:		
Title: Gender:		
NHS number:		
Hospital number:		
Date of birth: __-__-____	**Date Commenced:**	**Overall CAM-ICU** Feature 1 plus 2 and either 3 or 4 observed = CAM-ICU. Delirium positive
Complete above in full or affix patient label		
Location:		
	Record Y or NA	

BASELINE COGNITIVE ASSESSMENT has been documented. Date:	Date	Date	Date	Date	Date	Date
	Day / Night	Day / Night	Day / Night	Day / Night	Day / Night	Day / Night
ICDSC SCORE/CAM ICU OUTCOME: Document ICDSC / CAM ICU score or NA						
1.OPTIMISE SEDATION AND ADEQUATE PAIN CONTROL Spontaneous awakening trial (SAT) as appropriate, minimum sedation to keep comfortable Assess pain and manage.						
2. IMPROVE MEDICATION USE Avoid benzodiazepines, consider non-opiate therapies, treat withdrawals, try distraction techniques						
3. PROMOTE CONTINUITY OF CARE AND PERSONAL KNOWLEDGE 'All About Me' chart, patient diary, support family visits with explanation **ICU Steps booklet. Date provided:**						
4. ENSURE VISUAL AND HEARING AIDS IN PLACE Use relevant communication aids e.g. flash cards, wipe board, SALT / OT referral						
5. ORIENTATE PATIENT Frequent verbal orientation, calendar clock in sight, family photos, communicate even when sedated						
6. ADDRESS NOISE AND SLEEP DEPRIVATION Adequate light, day and night orientation, noise reduction, use sleeping aids, consider music therapy						
7. MOBILISE DAILY AND ENCOURAGE ACTIVITIES Daily rehabilitation goals, exercises, cognitive stimulation-consider e.g. games, puzzles						
8. AVOID CONSTIPATION Ensure adequate nutrition and hydration, bowel management programme						
SIGNATURE						

Visiting Guideline

Visiting Guideline

Visiting time 11:00-19:00

Continuous visiting access for one nominated visitor

- Only 2 visitors at the time per patient;
- Reasonable adjustments can be made and number of visitors at one time can be discussed in special circumstances (e.g. End of Life Care);
- All visitors must wash their hands or use the hand gel on entering and leaving the room and the Intensive Care Unit (hand gel is available);
- All the visitors must use appropriate personal protective equipment according to local infection prevention and control policies and produces;
- When appropriate, patient's children are allowed to visit when accompanied by adults – this should be previously discussed and agreed by the nurse in charge of ICU;
- Visitors who are unwell will be discouraged from visiting, due to the risk of transmission and infection to vulnerable patients on ICU;
- Information on visiting times and any restrictions that may be relevant are clearly displayed in the waiting area.

Nominated Next of Kin (NOK)

- Nominated by the patient if patient has capacity, otherwise it should be the Next of Kin indicated on the admission sheet.
- The NOK can nominate another person instead of themselves (please discuss this with the NIC);
- The NOK can stay in the patient's room (reclining chair will be provided when possible) or in the relatives waiting room. Please ensure that visitors are aware they will not be authorised to circulate freely around the unit, in order to maintain the privacy and confidentiality of the remaining patients. Relatives / Visitors should be escorted from the waiting area to the patient's room and vice versa;
- Visitors may still be asked to leave the room at times, for procedures, patient's personal care and ward round;
- **The nominated NOK should not be changed or rotated**, except in some special circumstances (eg: patient < 18) then the nominated relative can be alternated between the parents.
- A communication **Password** for telephone updates should be discussed with the NOK on admission or at the earliest opportunity.
- The NOK is responsible for liaising with the remaining relatives / friends and provide regular updates.

Staff Wellbeing

Physiotherapy Standards

MTW

NHS
Maidstone and Tunbridge Wells
NHS Trust

Early Mobilisation in ICU Protocol

Guidance for early mobility intervention on the ICU at Maidstone and Tunbridge Wells Hospitals

Prolonged ICU stay.

Advances in critical care have led to increased survival but also the recognition of prolonged physical and psychological morbidity on discharge. Long periods of induced bed rest by sedation, prolonged mechanical ventilation and sepsis all contribute to reduced activity and therefore the additional complications of prolonged inactivity are becoming increasingly common and many patients will experience a decreased quality of life for many months post ICU discharge.

Improving survival rates of the critically ill population has presented us with a new problem of how to optimise physical and psychological function for an increasing number of patients post discharge from Intensive care and the key is to start rehab early.

Complications of bed rest.

When lying flat the volume of blood plasma is reduced as fluid moves from the blood vessels into tissues which results in hypovolaemia and increased blood viscosity. Cardiac output and stroke volume are subsequently reduced and the heart then has to work harder and tachycardia is common.

Venous pooling exacerbates the problem because the normal skeletal muscle pump which assists with returning blood to the heart does not function and therefore blood pools in the veins and there is a reduction in venous return to the heart. As a result of blood pooling, reduced venous return and reduced cardiac output you then see postural/ orthostatic hypotension, as the patient moves from lying to standing there can be up to 700mls of blood lost from the thorax into the lower limbs resulting in insufficient perfusion of the upper body and head.

From a respiratory point of view immobility results in reduced diaphragmatic excursion and rib movement which reduces lung volumes, impairing cough and increasing the risk of atelectasis and sputum retention. Ventilation and perfusion are optimally matched in an upright posture and without this the combination of dead space (where there is ventilation but no perfusion) and shunt (where there's blood but no ventilated tissue) gas exchange becomes impaired.

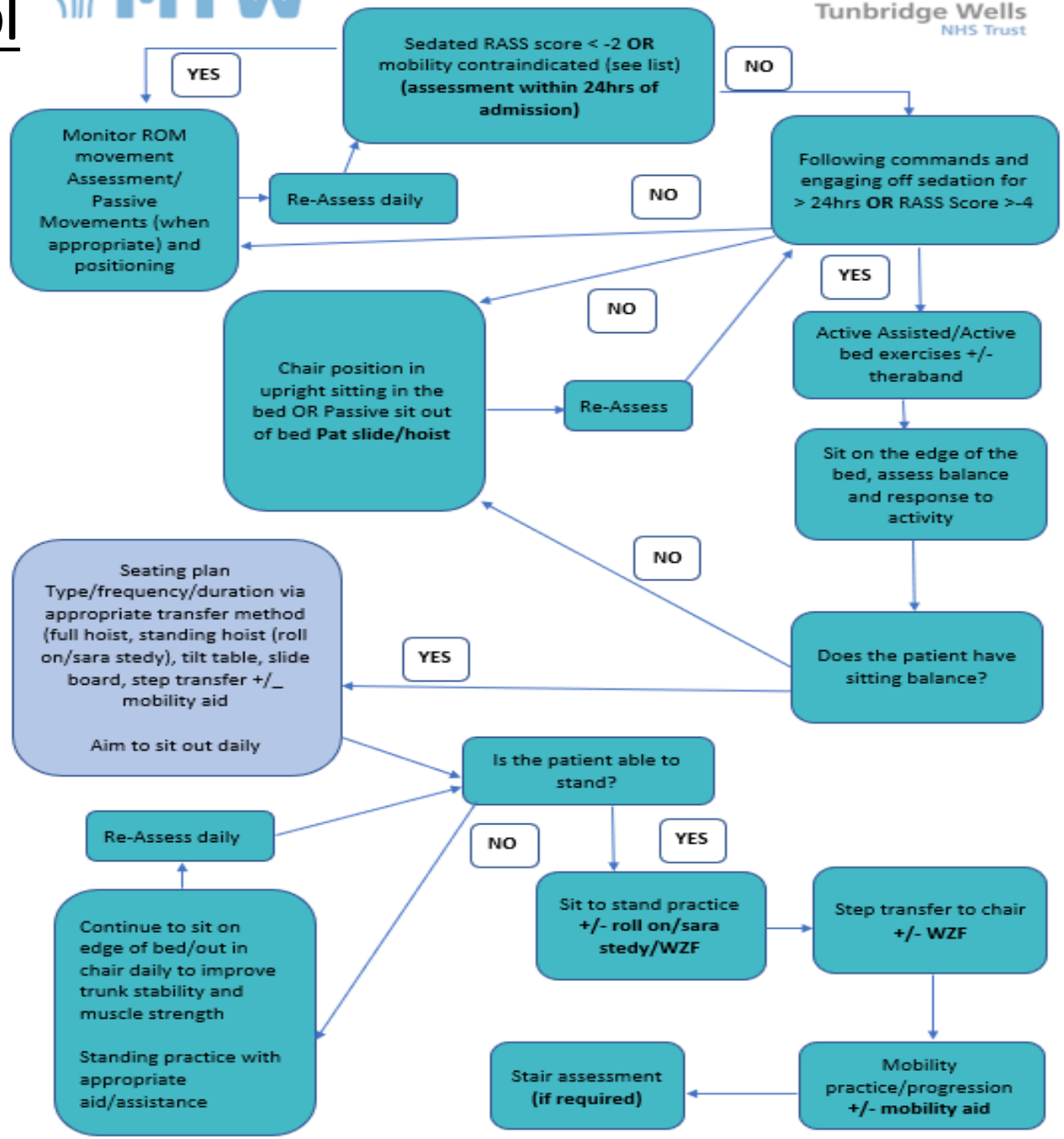
Also, if there is no gravitational or muscle pull on the bones then calcium begins to be excreted and there is an increased risk of osteoporosis and alarming, disuse atrophy occurs in skeletal muscle with a 1-1.5% loss of strength per day and up to 50% loss in strength in 5 weeks. Through loss of muscle fibre length, you get contractures and the skin, like any other organ with reduced blood supply will lose its elasticity, atrophy and become prone to pressure sores.

Early mobility

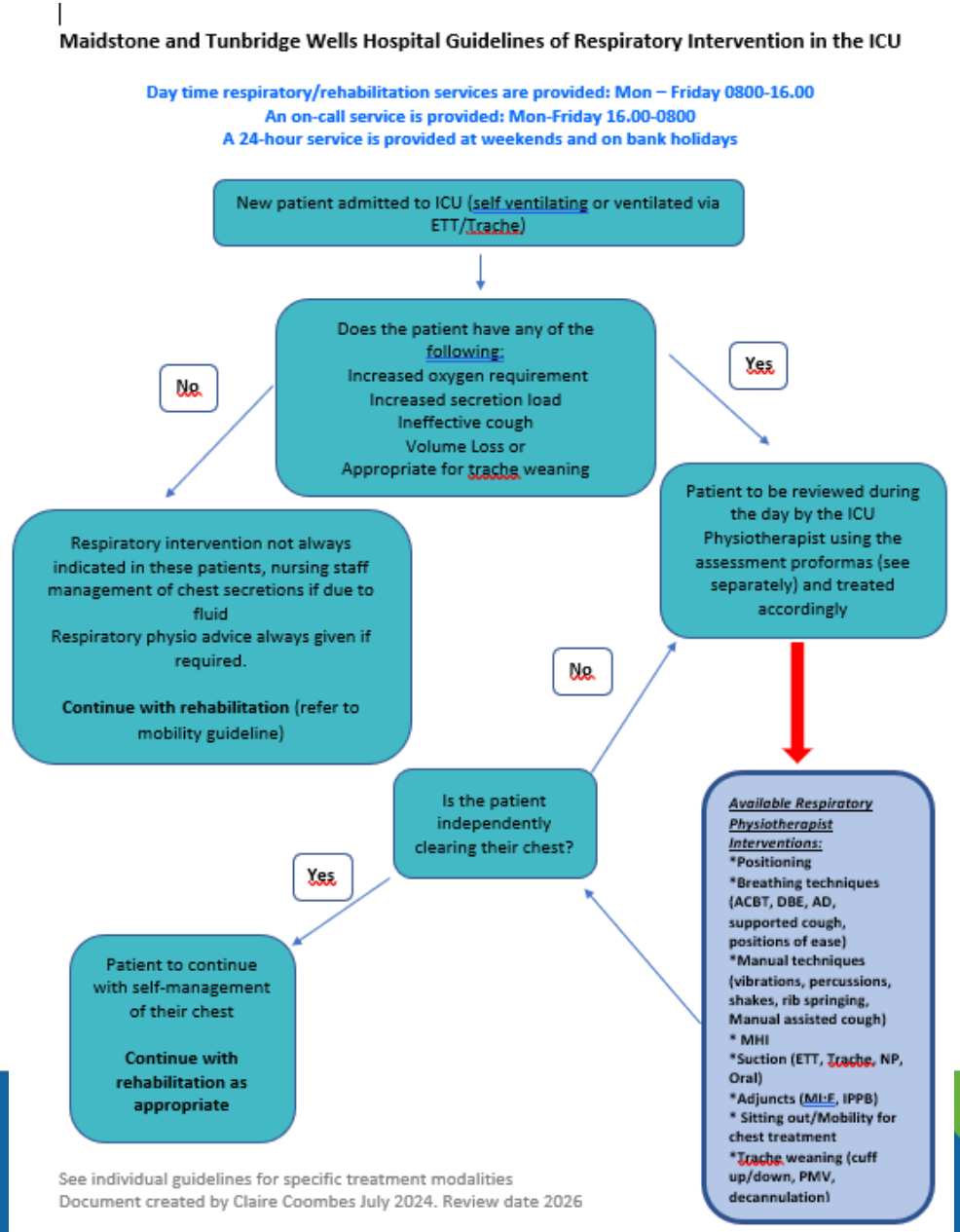
ICU patients are susceptible to a range of complications and wherever possible we should be trying to avoid prolonged periods of bed rest and start rehab as early as possible. A number of feasibility studies have shown early rehabilitation to be safe in the ICU population and NICE guidance CG83 (2009) for the rehabilitation after critical illness provide a guideline for rehabilitation from admission through to ICU discharge and 2-3 month follow up.

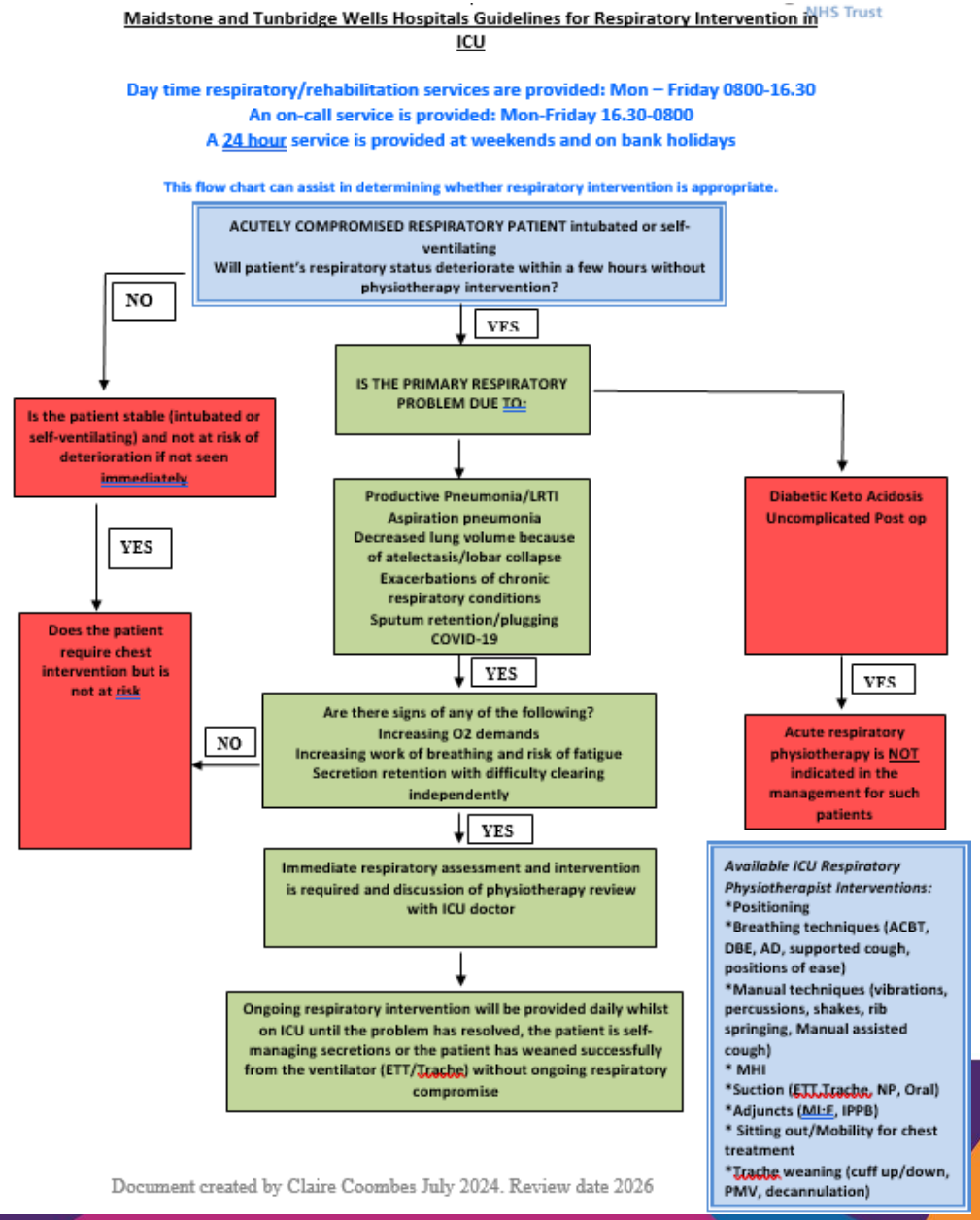
Who can perform early mobility?

ICU physiotherapists, neuro physiotherapists, orthopaedic physiotherapists, therapy assistants, occupational therapists and nurses can all mobilise patients on ICU. Nurses can routinely assist patients out of bed but if patients are significantly off their base line level of mobility or waking up from sedation and therapeutic interventions are required, therapists will review mobility and guide the appropriate transfer/mobility techniques.

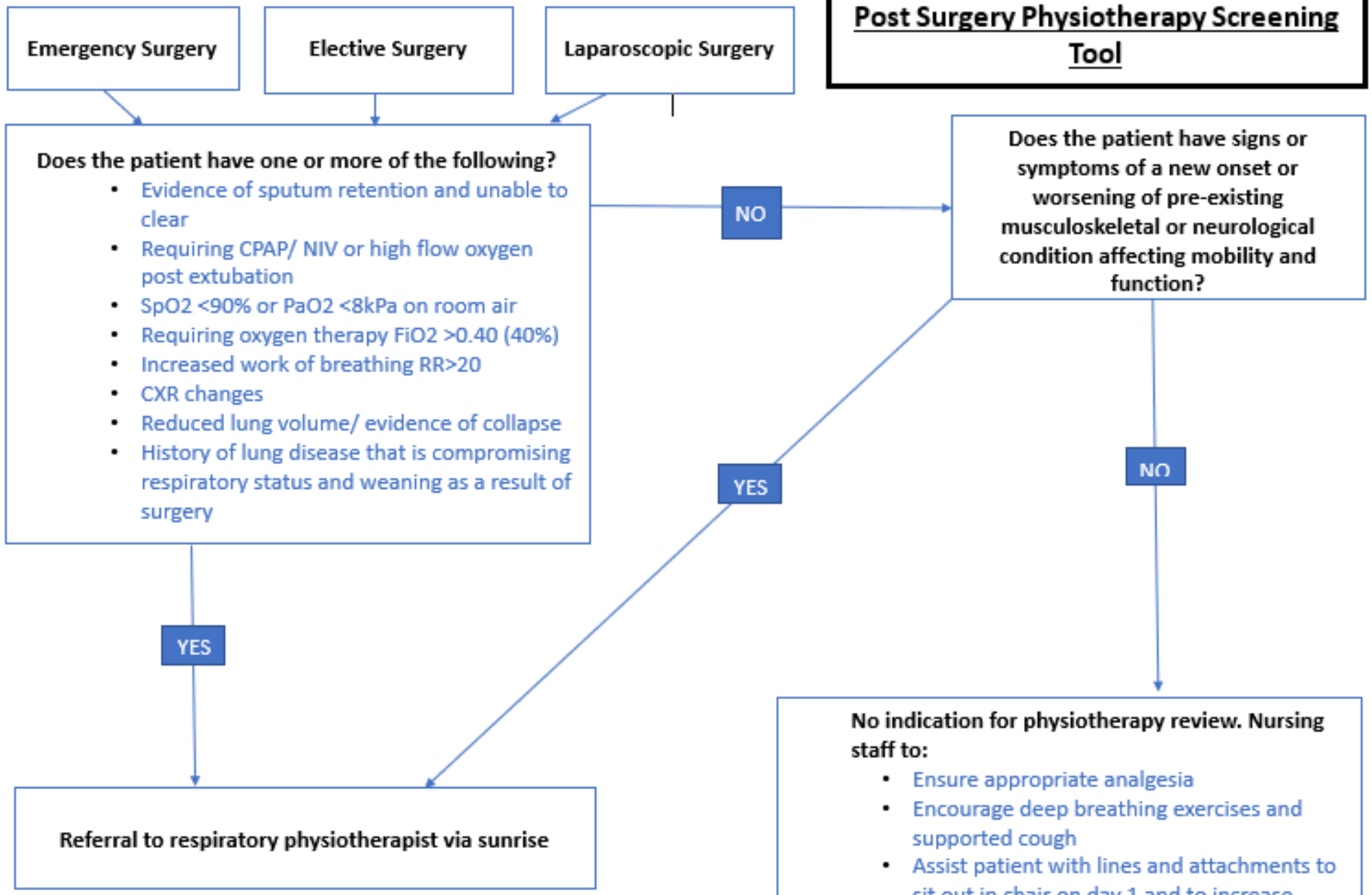


Respiratory intervention to ICU





Post Surgery Physiotherapy Screening Tool



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Speech and LanguageTherapy Standards

MTW

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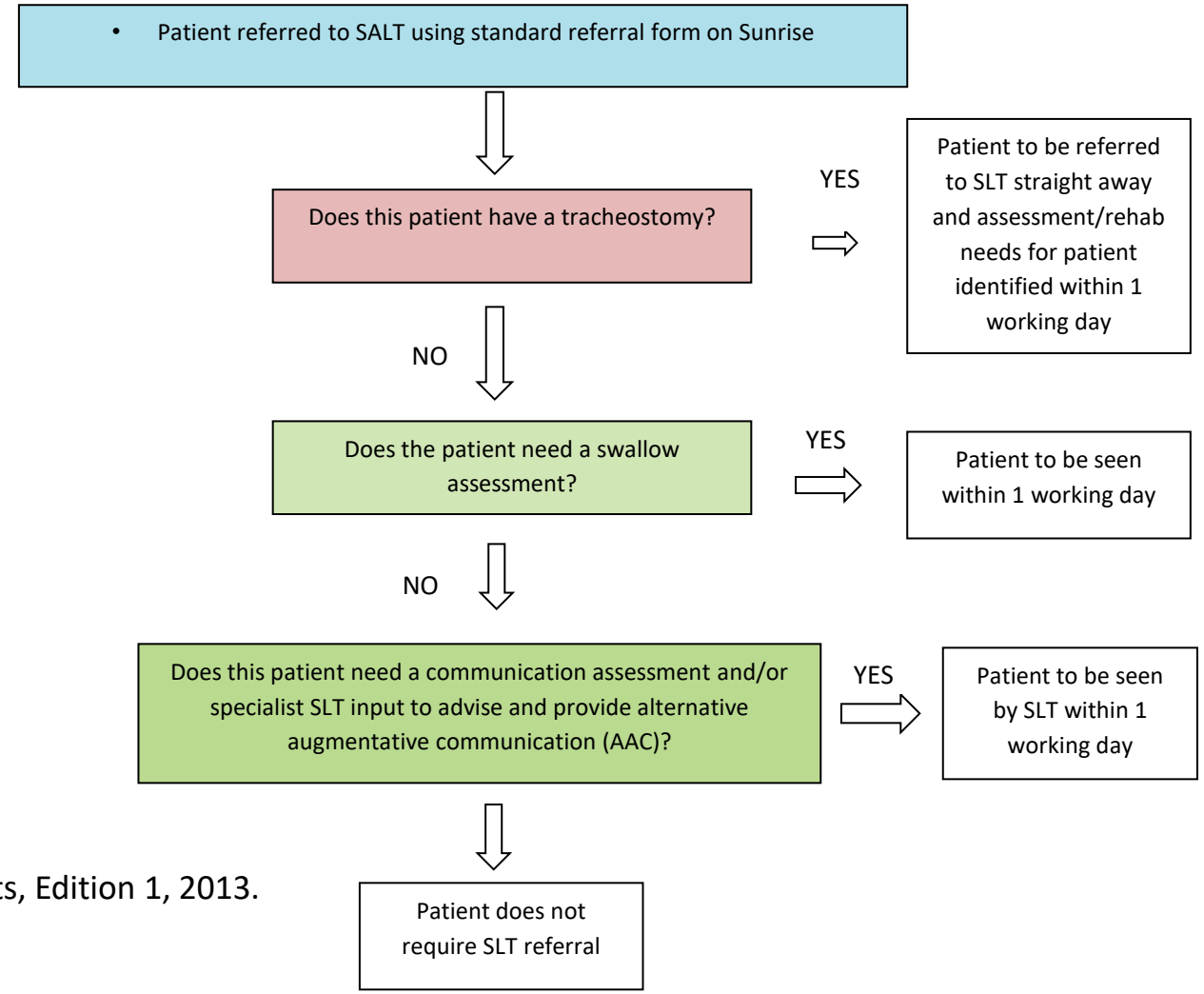
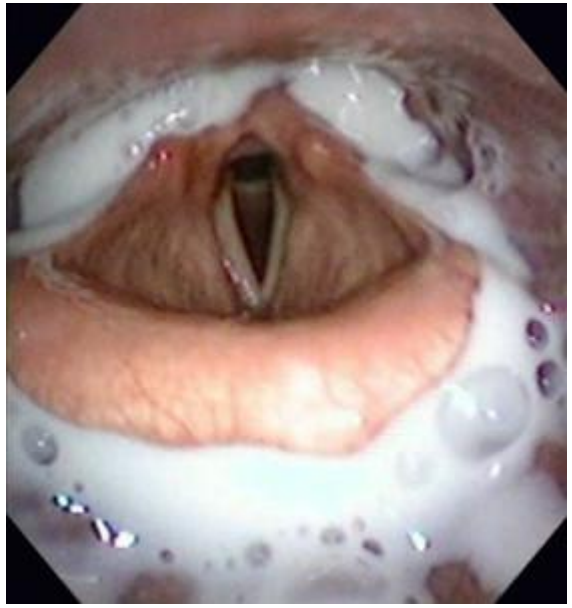
NHS Trust

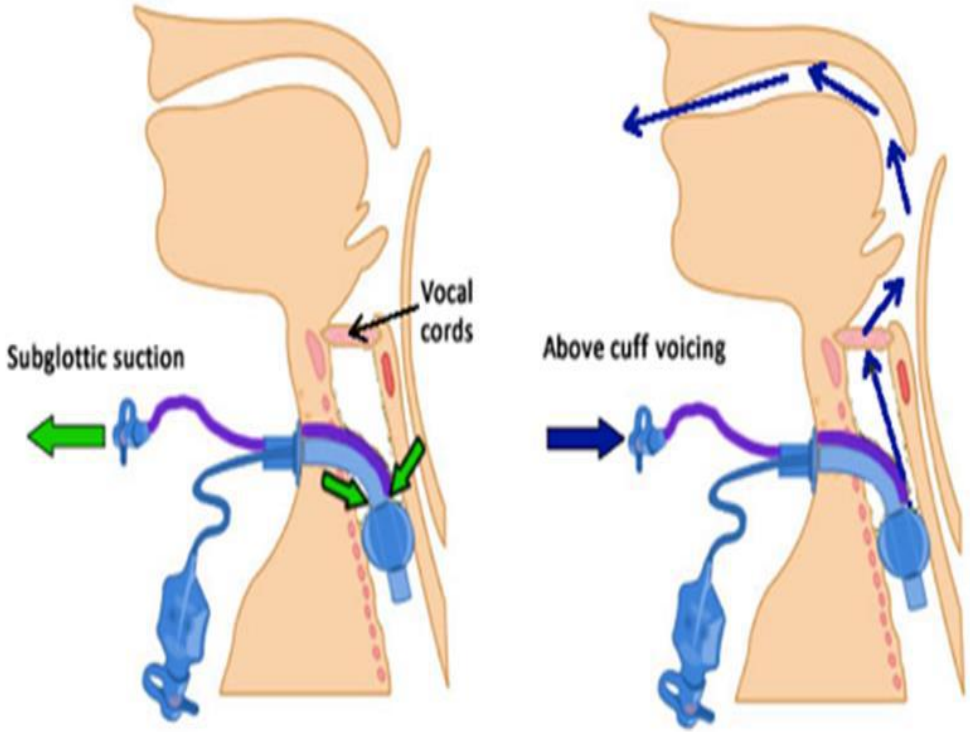
Pathway for Critical Care Referrals for Speech and Language Therapy (SLT)



References:
Core Standards for Intensive Care Units, Edition 1, 2013.
RCSLT – Critical Care Guidance
GPICS 2022

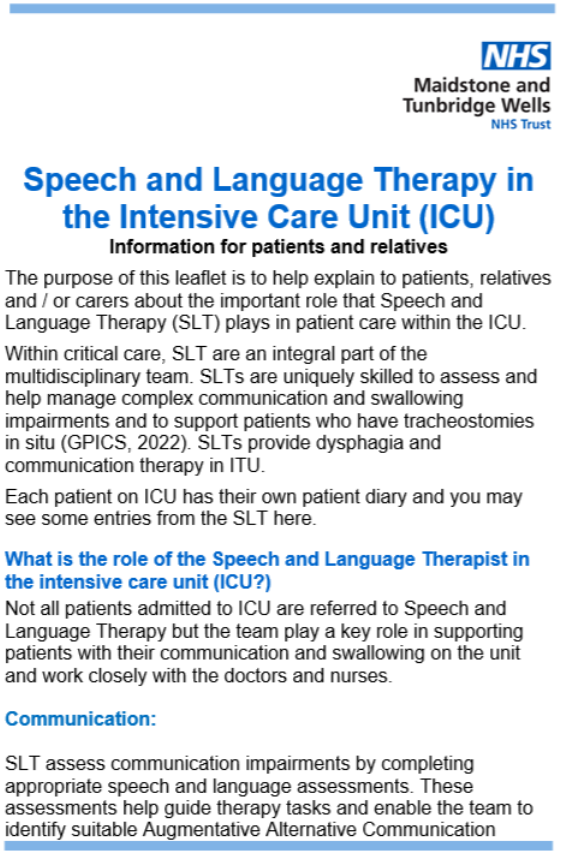
FEES, One-Way Valves, ACV





SLT Leaflets and Training

- Communication support for patients and relatives
- SLT in the Intensive Care Unit



NHS
Maidstone and Tunbridge Wells NHS Trust

Speech and Language Therapy in the Intensive Care Unit (ICU)

Information for patients and relatives

The purpose of this leaflet is to help explain to patients, relatives and / or carers about the important role that Speech and Language Therapy (SLT) plays in patient care within the ICU.

Within critical care, SLT are an integral part of the multidisciplinary team. SLTs are uniquely skilled to assess and help manage complex communication and swallowing impairments and to support patients who have tracheostomies in situ (GPICS, 2022). SLTs provide dysphagia and communication therapy in ITU.

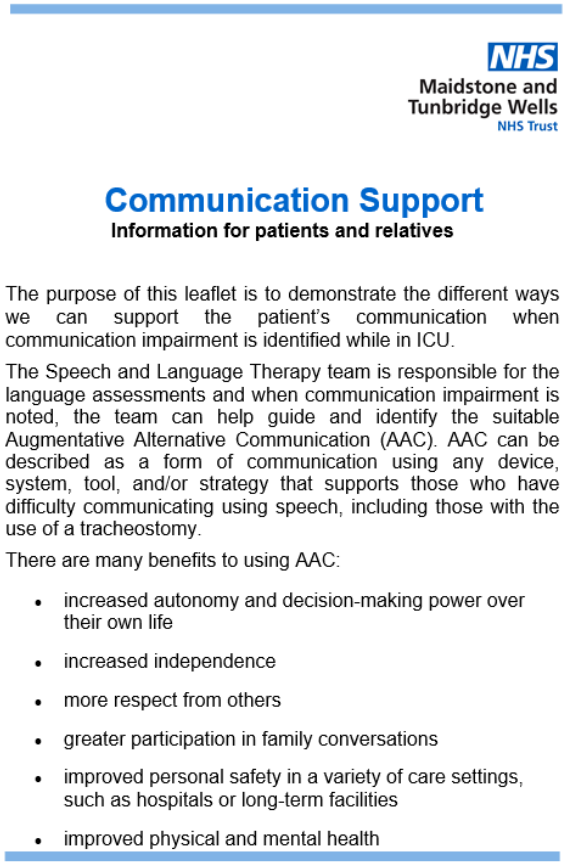
Each patient on ICU has their own patient diary and you may see some entries from the SLT here.

What is the role of the Speech and Language Therapist in the intensive care unit (ICU?)

Not all patients admitted to ICU are referred to Speech and Language Therapy but the team play a key role in supporting patients with their communication and swallowing on the unit and work closely with the doctors and nurses.

Communication:

SLT assess communication impairments by completing appropriate speech and language assessments. These assessments help guide therapy tasks and enable the team to identify suitable Augmentative Alternative Communication



NHS
Maidstone and Tunbridge Wells NHS Trust

Communication Support

Information for patients and relatives

The purpose of this leaflet is to demonstrate the different ways we can support the patient's communication when communication impairment is identified while in ICU.

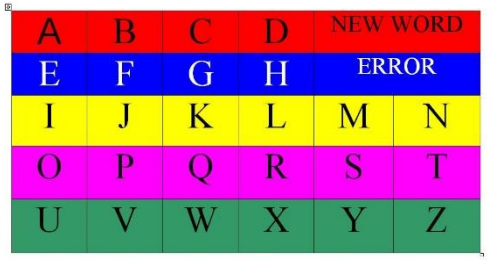
The Speech and Language Therapy team is responsible for the language assessments and when communication impairment is noted, the team can help guide and identify the suitable Augmentative Alternative Communication (AAC). AAC can be described as a form of communication using any device, system, tool, and/or strategy that supports those who have difficulty communicating using speech, including those with the use of a tracheostomy.

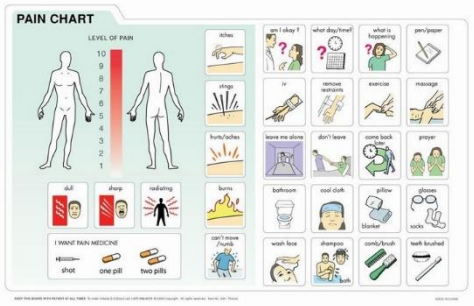
There are many benefits to using AAC:

- increased autonomy and decision-making power over their own life
- increased independence
- more respect from others
- greater participation in family conversations
- improved personal safety in a variety of care settings, such as hospitals or long-term facilities
- improved physical and mental health

A.A.C Resources

- Mouthing
- Gesture/body language
- Writing
- Eye blinking
- Alphabet boards
- Picture charts
- Voice output aids
- High tech eye gaze
- E-tran frame
- Artificial larynx





Occupational Therapy Standards

MTW

NHS
Maidstone and Tunbridge Wells
NHS Trust

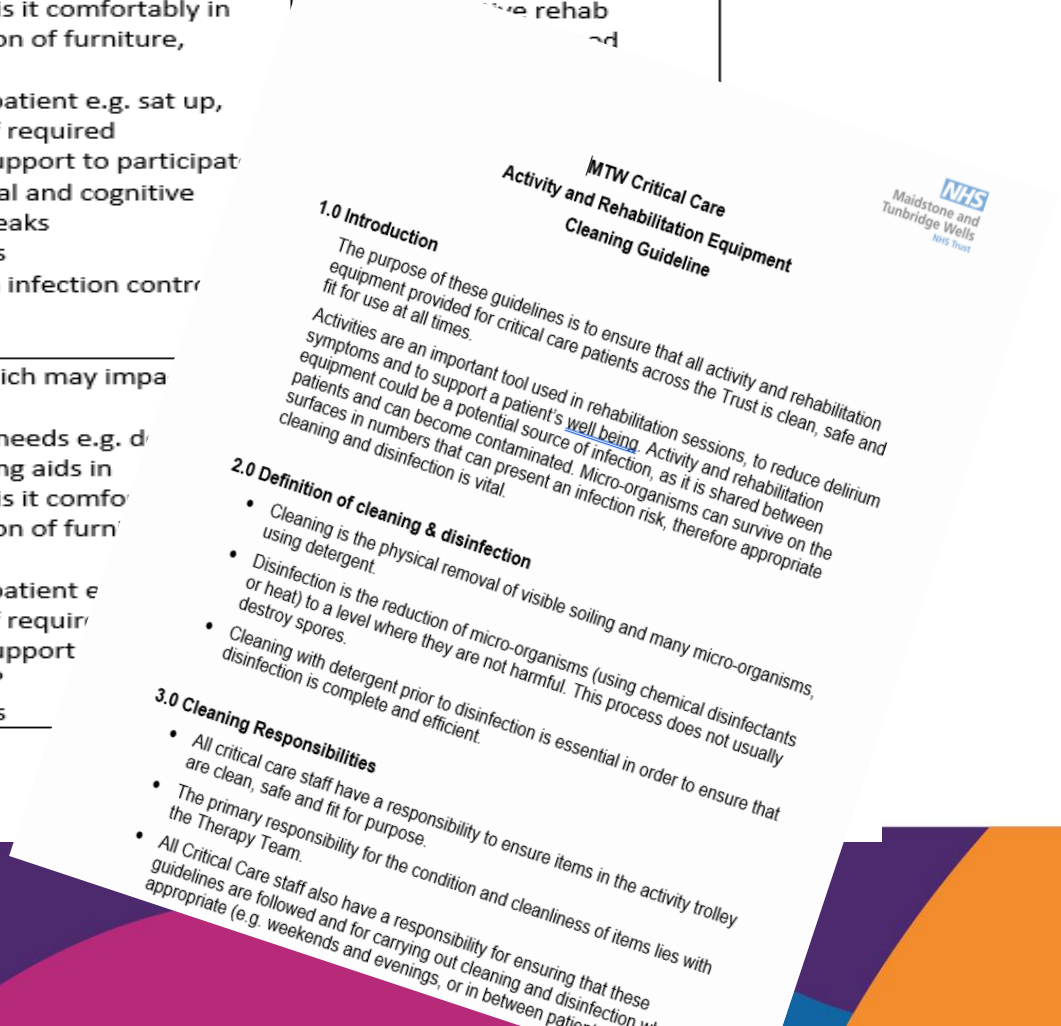
Rehab Activity Trolley

- Communication aids
- iPads and clamps
- Paper puzzles and colouring
- Games
- Books and magazines
- Physical activities

ICU Entertainment, Media and Activity Guidelines

Activity Type	Activity	Resources	Considerations	Benefits
Entertainment media	Watching programmes/ films	TV DVD player iPad	• Check electrical equipment is Pat tested • Check patient's sensory needs i.e. do they need glasses on or hearing aids in? • Environmental checks – is it comfortably in the patients view, position of furniture, lighting • Consider positioning of patient e.g. sat up, upper limbs supported if required • Does the patient need support to participat • Consider patients physical and cognitive fatigue – take regular breaks • Use of volunteer services • Follow trust guidance on infection contr cleaning procedures	• Fun and entertaining • Distraction Cognitive stimulation e rehab ad
	Listening to music/radio/audio books	Radio iPad TV Computer		
	Using the internet	iPad apps i.e. games, mindfulness, web browser Patients phone		
Paper based activities	Reading	Books Magazines Newspaper	• Consider distractions which may impa ability to participate • Check patient's sensory needs e.g. d need glasses on or hearing aids in • Environmental checks – is it comfo the patients view, position of furn lighting • Consider positioning of patient e upper limbs supported if requir • Does the patient need support e.g. can they hold a pen? • Use of volunteer services	
	Puzzles	Crosswords Word searches Word fit Sudoku Mazes		

Guidelines for review in July 2026



MTW Critical Care
Activity and Rehabilitation Equipment
Cleaning Guideline

NHS Maidstone and Tunbridge Wells NHS Trust

1.0 Introduction

The purpose of these guidelines is to ensure that all activity and rehabilitation equipment provided for critical care patients across the Trust is clean, safe and fit for use at all times.

Activities are an important tool used in rehabilitation sessions, to reduce delirium symptoms and to support a patient's well being. Activity and rehabilitation equipment could be a potential source of infection, as it is shared between patients and can become contaminated. Micro-organisms can survive on the surfaces in numbers that can present an infection risk, therefore appropriate cleaning and disinfection is vital.

2.0 Definition of cleaning & disinfection

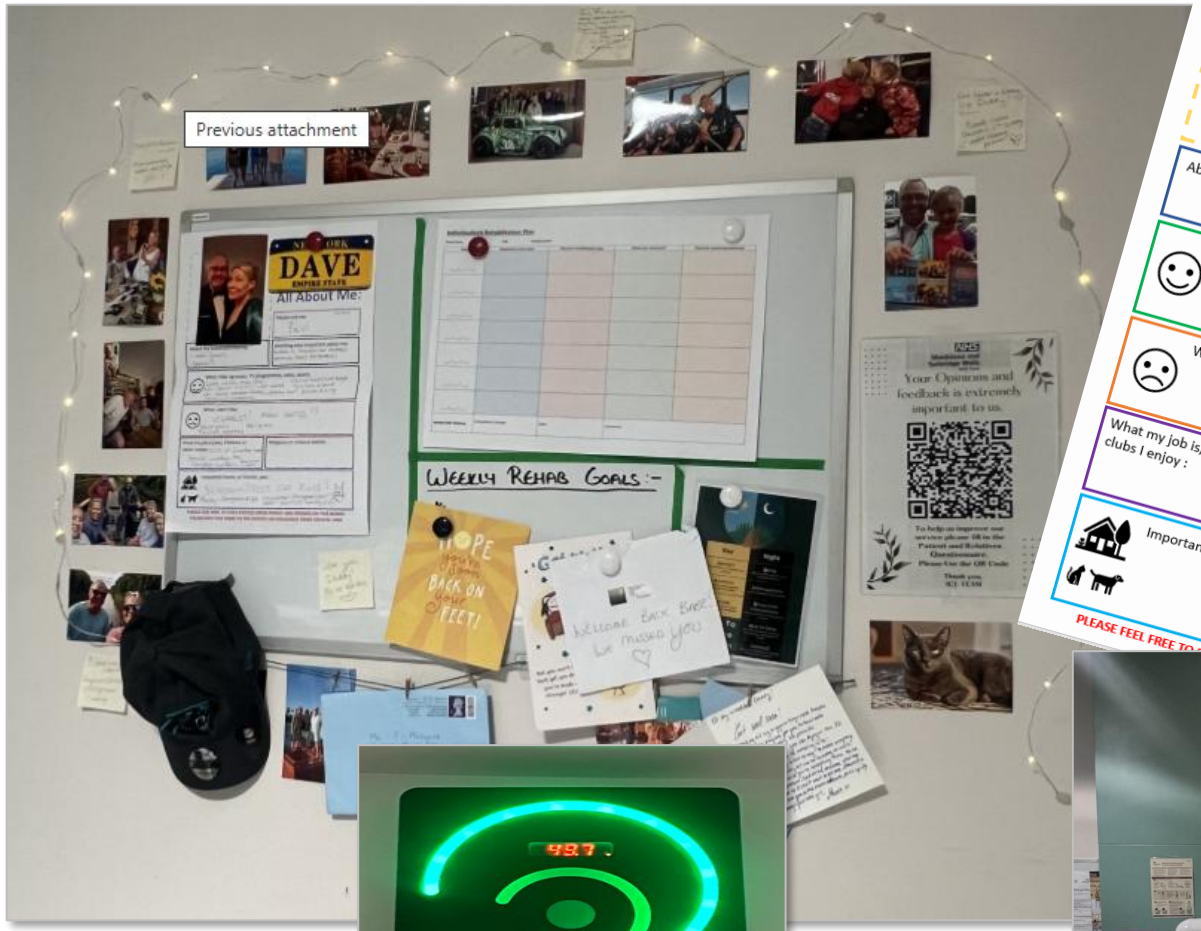
- Cleaning is the physical removal of visible soiling and many micro-organisms, using detergent.
- Disinfection is the reduction of micro-organisms (using chemical disinfectants or heat) to a level where they are not harmful. This process does not usually destroy spores.
- Cleaning with detergent prior to disinfection is essential in order to ensure that disinfection is complete and efficient.

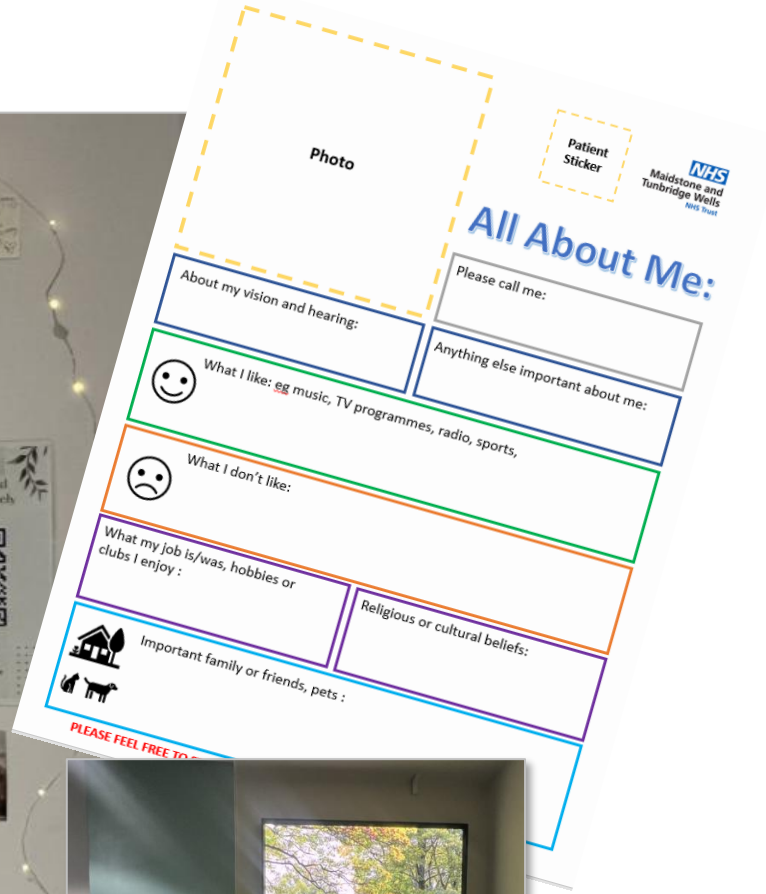
3.0 Cleaning Responsibilities

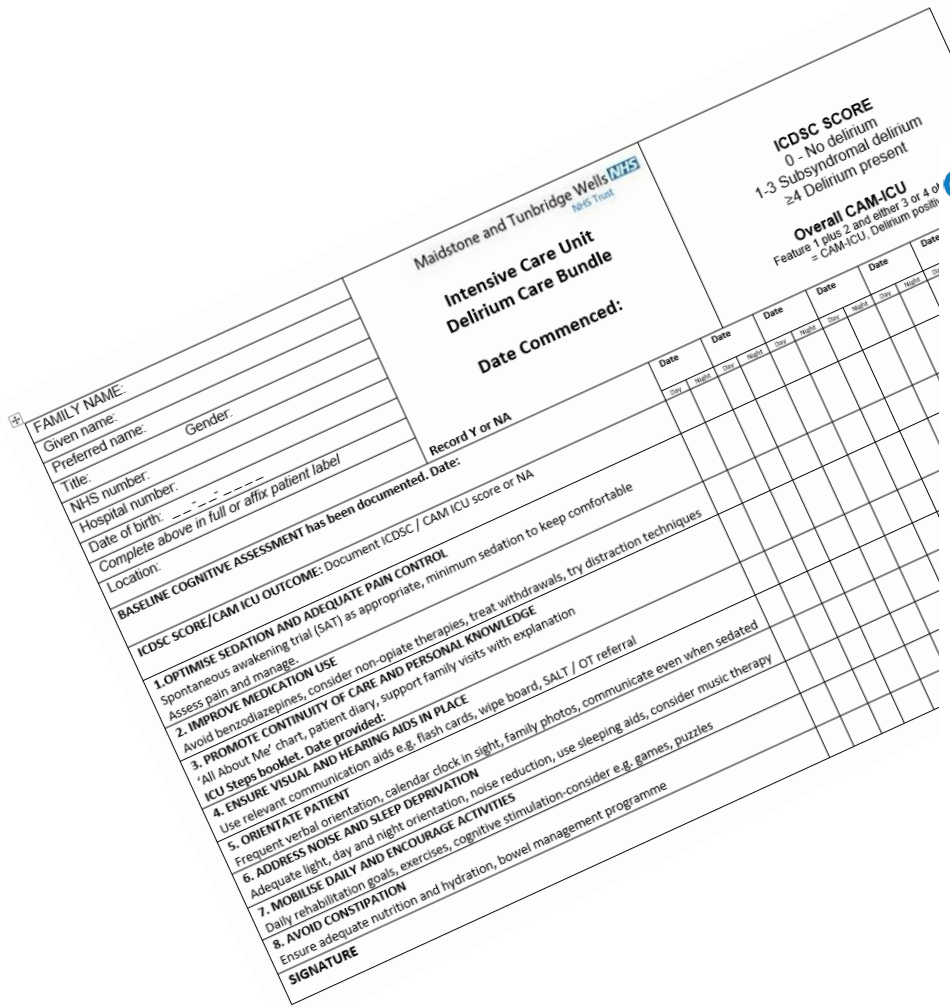
- All critical care staff have a responsibility to ensure items in the activity trolley are clean, safe and fit for purpose.
- The primary responsibility for the condition and cleanliness of items lies with the Therapy Team.
- All Critical Care staff also have a responsibility for ensuring that these guidelines are followed and for carrying out cleaning and disinfection appropriate (e.g. weekends and evenings, or in between

Cognition and Delirium

- Orientation clocks
- Use of natural light
- Monitoring of noise
- Routines
- Timing of interventions
- Sleep quality
- Use of personal items
- All about me boards
- Management of delirium protocol






Maidstone and Tunbridge Wells NHS Trust

Intensive Care Unit
Delirium Care Bundle

Date Commenced:

ICDSC SCORE
0 - No delirium
1-3 Subsyndromal delirium
≥4 Delirium present

Overall CAM-ICU
Feature 1 plus 2 and either 3 or 4 of
= CAM-ICU, Delirium positi

FAMILY NAME:
Given name:
Preferred name: Gender:
Title:
NHS number:
Hospital number:
Date of birth: _ _ - _ _ - _ _ _ _
Complete above in full or affix patient label
Location:

Record Y or NA

Date / Day / Night

BASELINE COGNITIVE ASSESSMENT has been documented. Date:

ICDSC SCORE/CAM ICU OUTCOME: Document ICDSC / CAM ICU score or NA

1. OPTIMISE SEDATION AND ADEQUATE PAIN CONTROL
Spontaneous awakening trial (SAT) as appropriate, minimum sedation to keep comfortable
Assess pain and manage.

2. IMPROVE MEDICATION USE
Avoid benzodiazepines, consider non-opiate therapies, treat withdrawals, try distraction techniques

3. PROMOTE CONTINUITY OF CARE AND PERSONAL KNOWLEDGE
'All About Me' chart, patient diary, support family visits with explanation
ICU Steps booklet. Date provided:

4. ENSURE VISUAL AND HEARING AIDS IN PLACE
Use relevant communication aids e.g. flash cards, wipe board, SALT / OT referral

5. ORIENTATE PATIENT
Frequent verbal orientation, calendar clock in sight, family photos, communicate even when sedated

6. ADDRESS NOISE AND SLEEP DEPRIVATION
Adequate light, day and night orientation, noise reduction, use sleeping aids, consider music therapy

7. MOBILISE DAILY AND ENCOURAGE ACTIVITIES
Daily rehabilitation goals, exercises, cognitive stimulation-consider e.g. games, puzzles

8. AVOID CONSTIPATION
Ensure adequate nutrition and hydration, bowel management programme

SIGNATURE

intensive care society
care when it matters

CC-NN
Critical Care Networks-National Nurse Leads

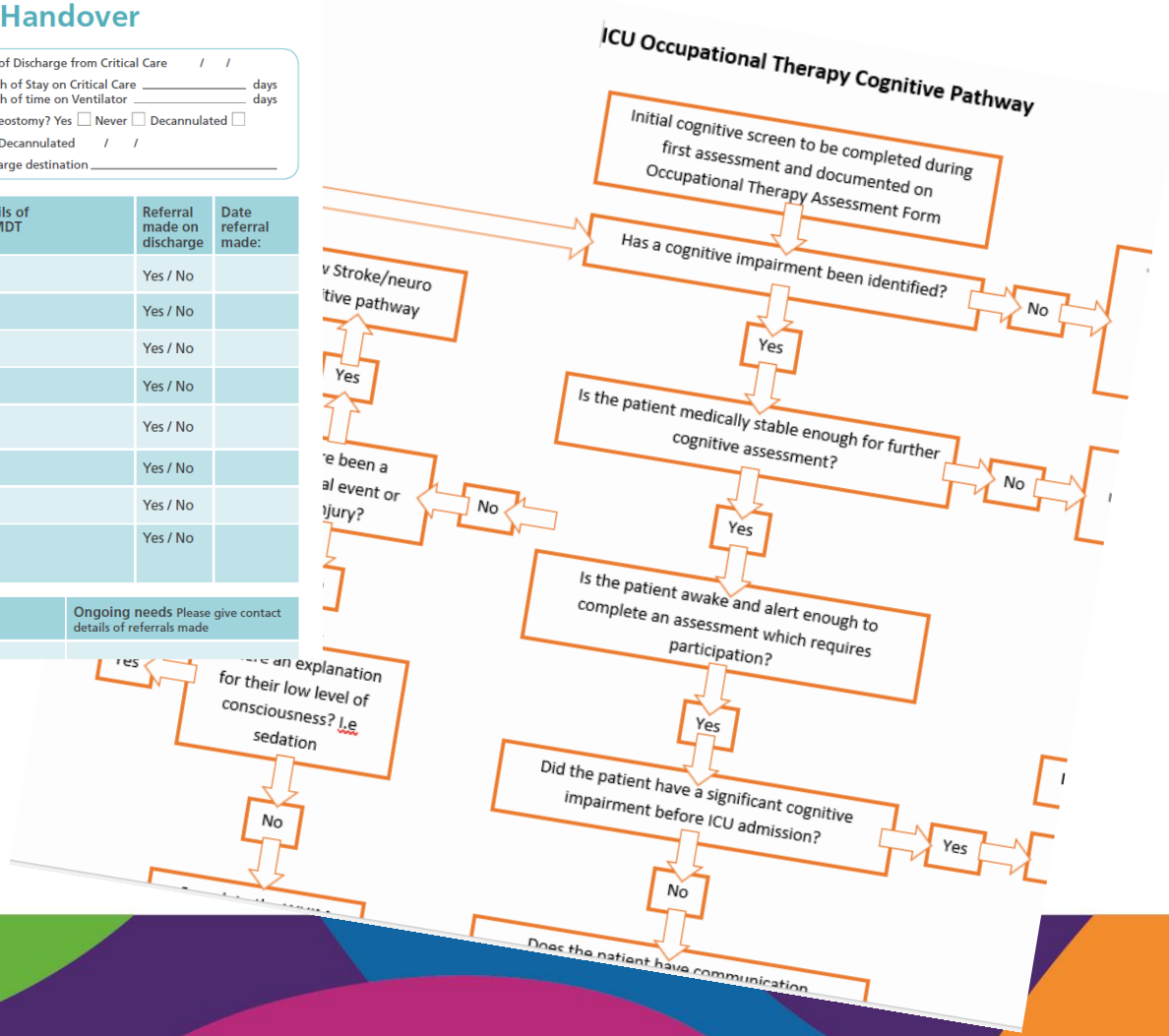
Critical Care Rehabilitation Handover

Patient label

Date of Discharge from Critical Care / /
Length of Stay on Critical Care _____ days
Length of time on Ventilator _____ days
Tracheostomy? Yes ☐ Never ☐ Decannulated ☐
Date Decannulated / /
Discharge destination _____

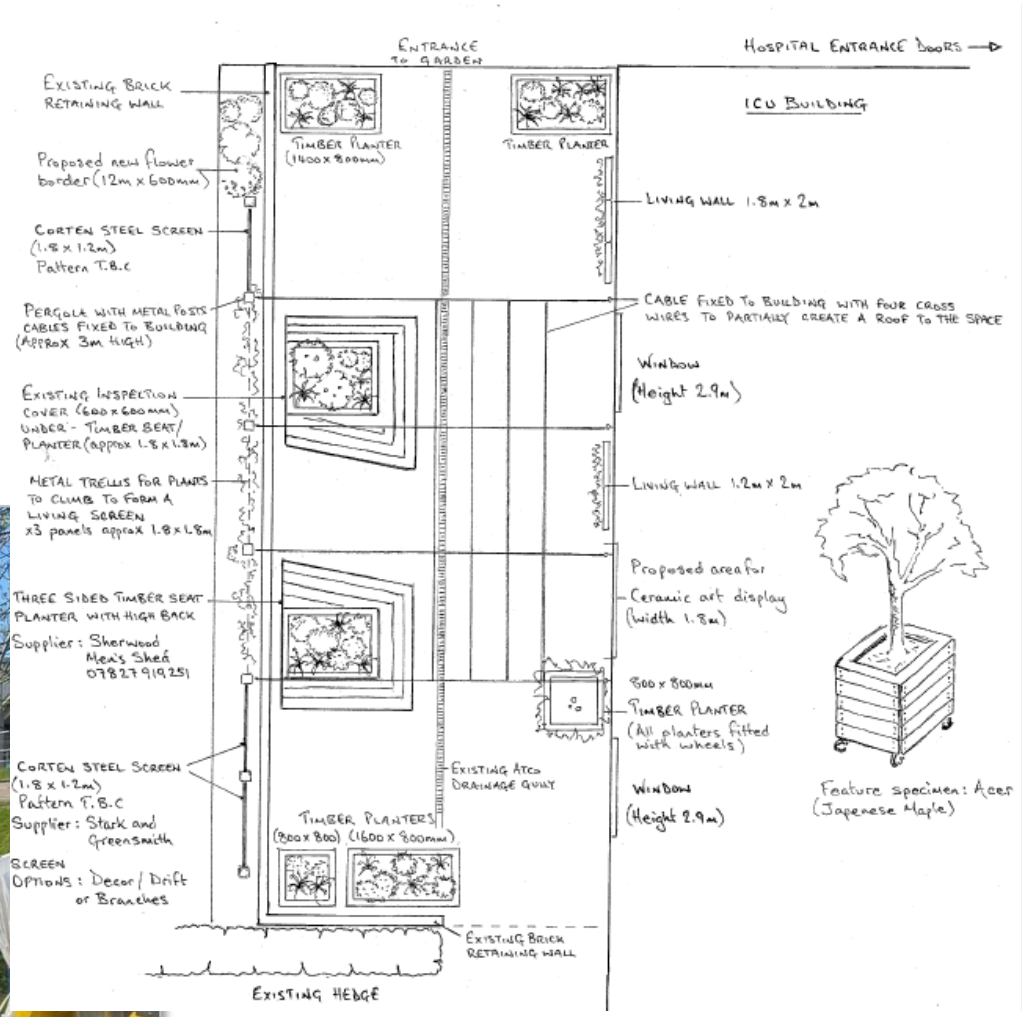
Multidisciplinary team (MDT) involvement during critical care		Contact details of critical care MDT	Referral made on discharge	Date referral made:
Physiotherapy	Yes / No		Yes / No	
Occupational Therapy	Yes / No		Yes / No	
Speech & Language Therapy (SLT)	Yes / No		Yes / No	
Dietitian	Yes / No		Yes / No	
Contact for any psychological assessment / treatment	Yes / No		Yes / No	
Pain Team	Yes / No		Yes / No	
Pharmacy	Yes / No		Yes / No	
Other (specify) Alcohol specialist, smoking cessation, tissue viability etc.	Yes / No		Yes / No	

Considerations	Current Status	Ongoing needs Please give contact details of referrals made
Motivation		



Exceptional people,
outstanding care

ICU Garden


ENTRANCE TO GARDEN
HOSPITAL ENTRANCE DOORS
ICU BUILDING
EXISTING BRICK RETAINING WALL
TIMBER PLANTER (1600 x 800mm)
TIMBER PLANTER
Proposed new flower border (12m x 600mm)
LIVING WALL 1.8m x 2m
CORTEN STEEL SCREEN (1.8 x 1.2m) Pattern T.B.C
PERGOLA WITH METAL POSTS CABLES FIXED TO BUILDING (APPROX 3m HIGH)
CABLE FIXED TO BUILDING WITH FOUR CROSS WIRES TO PARTIALLY CREATE A ROOF TO THE SPACE
WINDOW (Height 2.9m)
EXISTING INSPECTION COVER (600 x 600mm) UNDER - TIMBER SEAT/ PLANTER (approx 1.8 x 1.8m)
METAL TRELLIS FOR PLANTS TO CLIMB TO FORM A LIVING SCREEN x3 panels approx 1.8 x 1.8m
LIVING WALL 1.2m x 2m
Proposed area for Ceramic art display (width 1.8m)
THREE SIDED TIMBER SEAT PLANTER WITH HIGH BACK
Supplier: Sherwood Men's Shed 07827 919251
800 x 800mm TIMBER PLANTER (All planters fitted with wheels)
CORTEN STEEL SCREEN (1.8 x 1.2m) Pattern T.B.C
Supplier: Stark and Greensmith
EXISTING ACO DRAINAGE GULLY
WINDOW (Height 2.9m)
TIMBER PLANTERS (800 x 800) (1600 x 800mm)
SCREEN OPTIONS: Decor / Drift or Branches
EXISTING BRICK RETAINING WALL
EXISTING HEDGE
Feature specimen: Acer (Japanese Maple)

PETS AS THERAPY

Psychology Standards

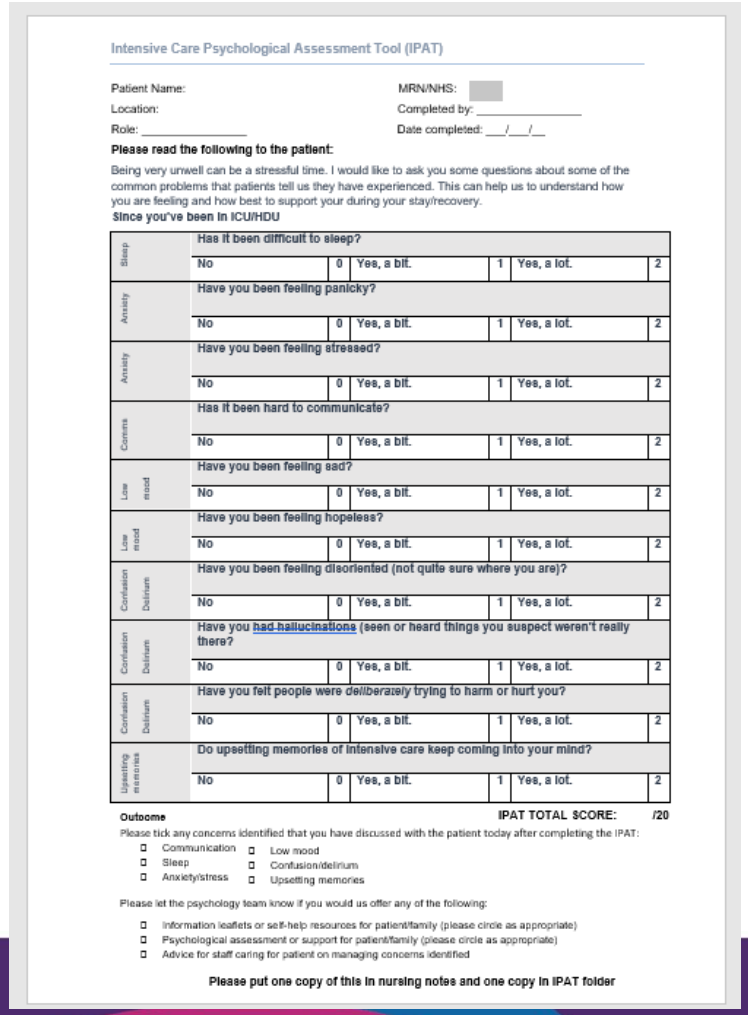
MTW

NHS
Maidstone and
Tunbridge Wells
NHS Trust

Routine Screening Quality Improvement Project

2 x Assistant Psychologists (1.6 WTE) Recruited on fixed term contract for Screening Project

- All patients admitted 72 hours+ routinely screened
- IPAT measure completed – training given to nursing staff supported by Aps
- Demonstrated high level of psychological needs not previously identified and high level of family support need



Intensive Care Psychological Assessment Tool (IPAT)

Patient Name: MRN/NHS:
Location: Completed by: _____
Role: _____ Date completed: ___/___/__

Please read the following to the patient:

Being very unwell can be a stressful time. I would like to ask you some questions about some of the common problems that patients tell us they have experienced. This can help us to understand how you are feeling and how best to support your during your stay/recovery.

Since you've been in ICU/HDU

Sleep	Has it been difficult to sleep?	No	0	Yes, a bit.	1	Yes, a lot. 2
Anxiety	Have you been feeling panicky?	No	0	Yes, a bit.	1	Yes, a lot. 2
Anxiety	Have you been feeling stressed?	No	0	Yes, a bit.	1	Yes, a lot. 2
Comms	Has it been hard to communicate?	No	0	Yes, a bit.	1	Yes, a lot. 2
Low mood	Have you been feeling sad?	No	0	Yes, a bit.	1	Yes, a lot. 2
Low mood	Have you been feeling hopeless?	No	0	Yes, a bit.	1	Yes, a lot. 2
Confusion Delirium	Have you been feeling disoriented (not quite sure where you are)?	No	0	Yes, a bit.	1	Yes, a lot. 2
Confusion Delirium	Have you had hallucinations (seen or heard things you suspect weren't really there?	No	0	Yes, a bit.	1	Yes, a lot. 2
Confusion Delirium	Have you felt people were deliberately trying to harm or hurt you?	No	0	Yes, a bit.	1	Yes, a lot. 2
Upsetting memories	Do upsetting memories of intensive care keep coming into your mind?	No	0	Yes, a bit.	1	Yes, a lot. 2

Outcome **IPAT TOTAL SCORE:** /20

Please tick any concerns identified that you have discussed with the patient today after completing the IPAT:

- ☐ Communication
- ☐ Sleep
- ☐ Anxiety/stress
- ☐ Low mood
- ☐ Confusion/delirium
- ☐ Upsetting memories

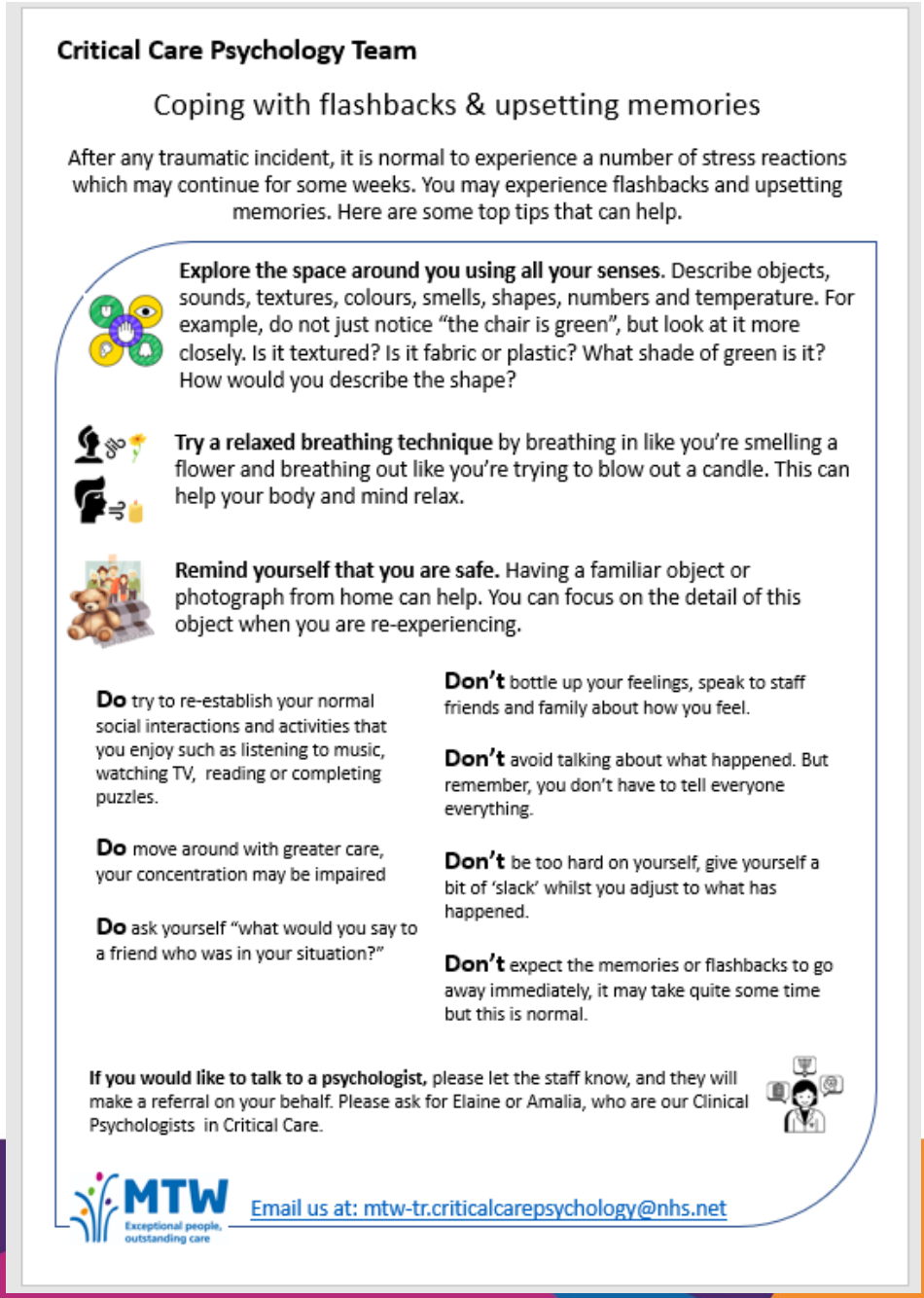
Please let the psychology team know if you would us offer any of the following:

- ☐ Information leaflets or self-help resources for patient/family (please circle as appropriate)
- ☐ Psychological assessment or support for patient/family (please circle as appropriate)
- ☐ Advice for staff caring for patient on managing concerns identified

Please put one copy of this in nursing notes and one copy in IPAT folder

Resource Pack Development

- **Resource pack of psycho-education material created for nursing staff to use based on outcome of screening**
  - Coping with low mood
  - Coping with delirium
  - Coping with flashbacks and upsetting memories
  - Coping with low mood and sadness
  - Coping with poor sleep
  - Coping with stress and anxiety
  - Communication support checklist for staff



Critical Care Psychology Team

Coping with flashbacks & upsetting memories

After any traumatic incident, it is normal to experience a number of stress reactions which may continue for some weeks. You may experience flashbacks and upsetting memories. Here are some top tips that can help.

Explore the space around you using all your senses. Describe objects, sounds, textures, colours, smells, shapes, numbers and temperature. For example, do not just notice "the chair is green", but look at it more closely. Is it textured? Is it fabric or plastic? What shade of green is it? How would you describe the shape?

Try a relaxed breathing technique by breathing in like you're smelling a flower and breathing out like you're trying to blow out a candle. This can help your body and mind relax.

Remind yourself that you are safe. Having a familiar object or photograph from home can help. You can focus on the detail of this object when you are re-experiencing.

Do try to re-establish your normal social interactions and activities that you enjoy such as listening to music, watching TV, reading or completing puzzles.

Do move around with greater care, your concentration may be impaired

Do ask yourself "what would you say to a friend who was in your situation?"

Don't bottle up your feelings, speak to staff friends and family about how you feel.

Don't avoid talking about what happened. But remember, you don't have to tell everyone everything.

Don't be too hard on yourself, give yourself a bit of 'slack' whilst you adjust to what has happened.

Don't expect the memories or flashbacks to go away immediately, it may take quite some time but this is normal.

If you would like to talk to a psychologist, please let the staff know, and they will make a referral on your behalf. Please ask for Elaine or Amalia, who are our Clinical Psychologists in Critical Care.

MTW Exceptional people, outstanding care

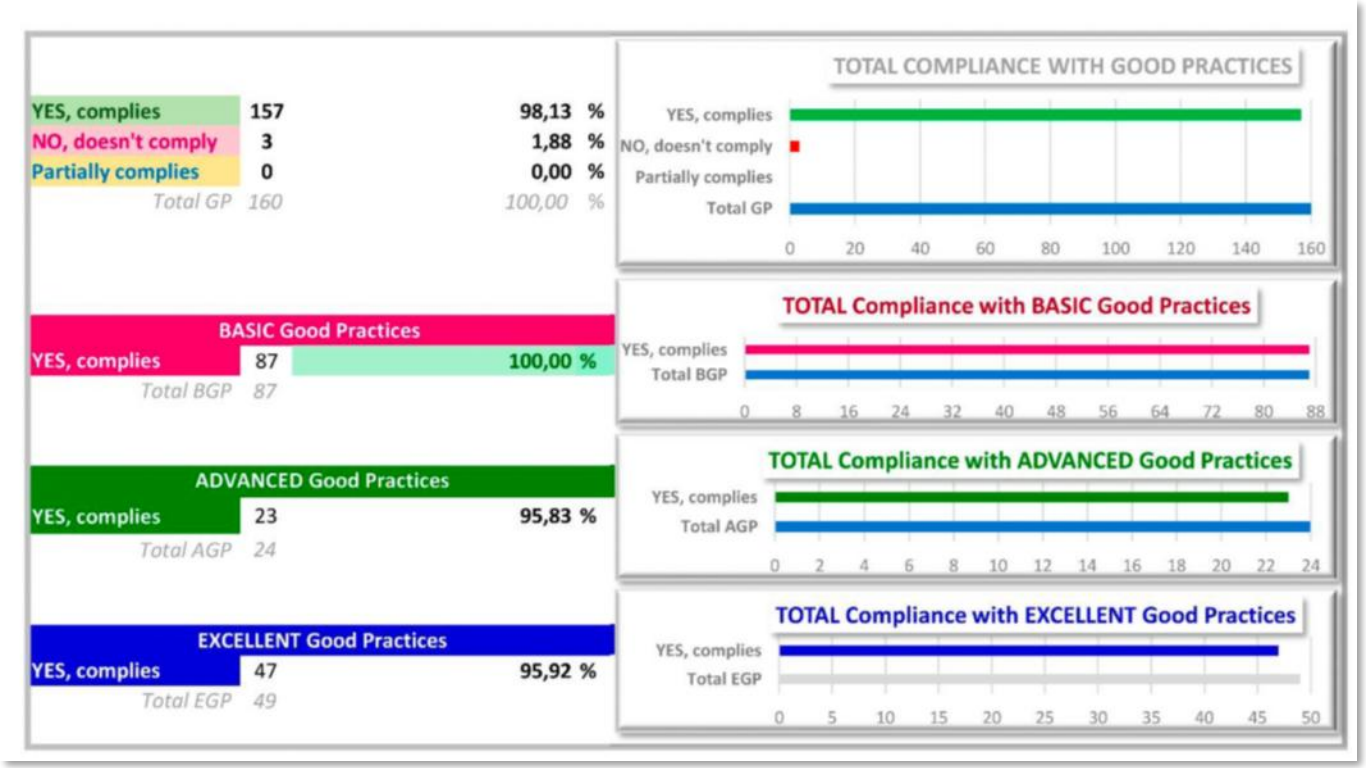
Email us at: mtw-tr.criticalcarepsychology@nhs.net

Post ICU Patient Support Group QIP

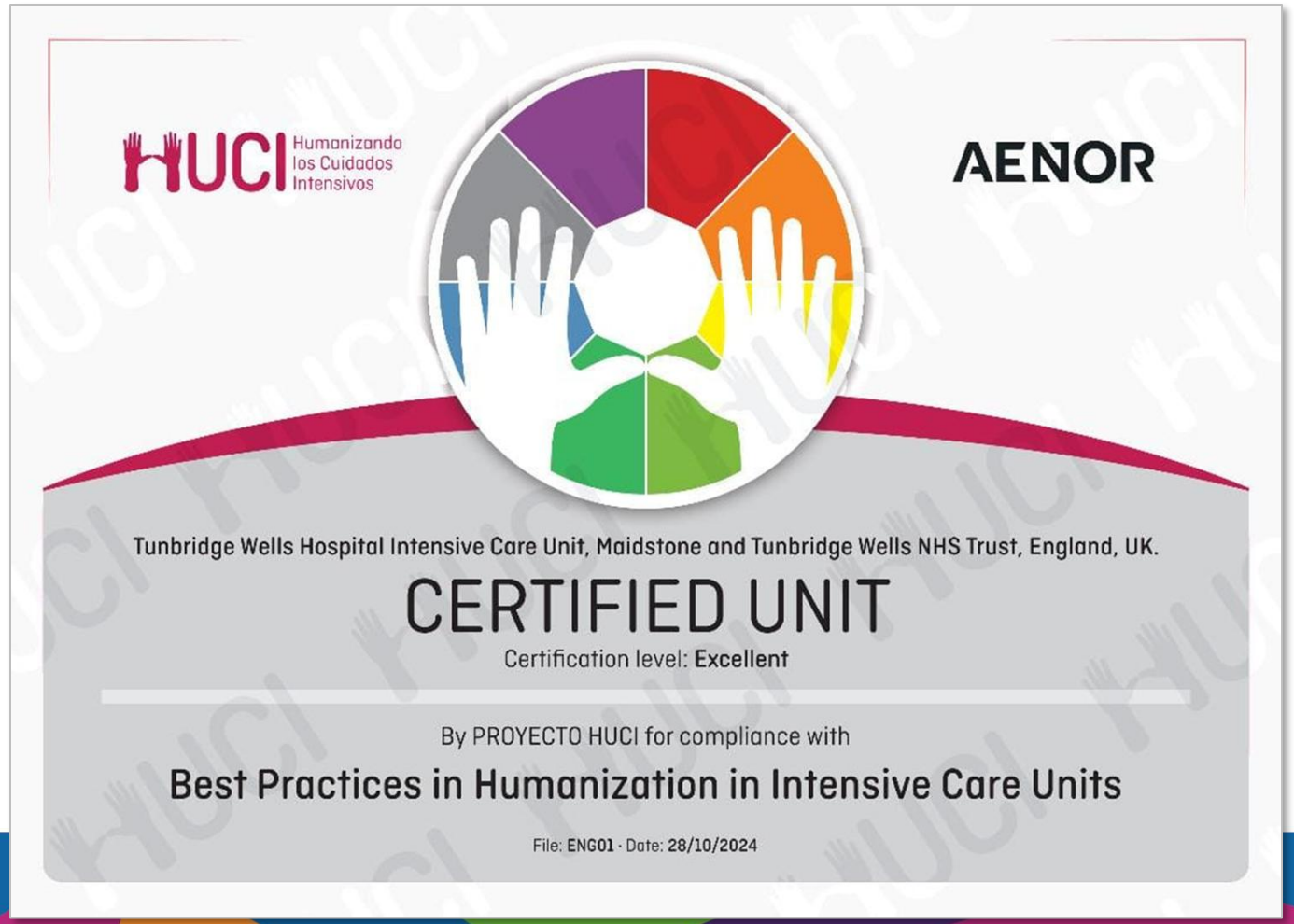
- Allowed additional resource from nursing team to support a post ICU patient support group pilot
- Designed and developed with former patients
- Successful 6 month pilot-group now runs monthly online

Assessment

- Collated the evidence and submitted it to the digital platform.
- External Audit.



Outcomes


HUCI
Humanizando los Cuidados Intensivos
AENOR
Tunbridge Wells Hospital Intensive Care Unit, Maidstone and Tunbridge Wells NHS Trust, England, UK.
CERTIFIED UNIT
Certification level: Excellent
By PROYECTO HUCI for compliance with
Best Practices in Humanization in Intensive Care Units
File: ENG01 · Date: 28/10/2024

Implications for Practice

- Provided a blueprint for the provision of excellent rehabilitation in our ITU.
- Put all the standards and guidelines in 1 place, under 1 umbrella.
- Formalised our practices and ensures consistency in delivery.
- Opened doors.
- The whole team listened and engaged.
- MDT is now more efficient and cohesive
- A rehab approach is now firmly embedded in our ITU.
- Service provision now TARGETS the best possible patient recovery.

Lucy Gosnell – lucygammon@nhs.net

HUCI - https://proyectohuci.com/en/certification/

Gabriel Heras La Calle - gabi@proyectohuci.com