

Full Clinical Guideline & Risk Assessment

Taking Recovering Intensive Care Level 2/3 Patients Outside into Courtyard 13 for Rehabilitation Purposes.

Introduction

The development of generalised neuromuscular weakness in the critically ill is referred to as critical illness polyneuropathy and critical illness myopathy (Pattanshetty and Gaude 2011), it is a major complication in patients admitted to intensive care units (Johnson 2007). It leads to muscle weakness and significantly contributes to difficulty in weaning from mechanical ventilation. It is a causative factor for prolonged rehabilitation and people may experience a poor quality of life after discharge (Rattray 2014). A review by Griffiths and Hall (2010) suggested that when early physical and occupational therapy, can be safely performed, it will likely improve patient outcomes with regard to functional status. The National Institute for Health and Care Excellence (NICE 2009) Clinical guideline (CG83) support this theory, emphasising the importance of early rehabilitation following critical illness and Needham (2008) describes potential benefits for patients participating in early rehabilitation in the ICU include improved muscle strength, physical function and quality of life. NICE (2009) advise that care should be patient centred, with good communication that takes into account patients' preferences and with consent and that relatives are given the opportunity to be involved in the decision making process. In all cases, a multidisciplinary team-based approach is essential to ensure a successful philosophy of early rehabilitation becomes embedded into routine practices within ICU (Parker 2013). Therefore, a shift in ICU "culture" with a focus on interventions to reduce subsequent physical and mental health impairment is essential to reduce duration of mechanical ventilation and length of stay in both ICU and hospital which will ultimately reduce hospital cost (NICE CG83 2009).

There is a paucity of literature that illustrates research involving patients actually leaving ICU for short periods of time for rehabilitation purposes. Historically patients have always been taken out into hospital grounds and it does appear to be that after a period of absence, hospital gardens are making a comeback because of an increasing recognition for improving wellbeing (Burton 2014). Doyle, Nikiel, Hickman and Hurtado (2015) refer to it as 'sunshine therapy' and are including a bespoke sunshine therapy zone within the 6 bedded extension that is to be added to the intensive care unit at the Royal Brompton. This type of intervention is supported by their qualitative study in which a questionnaire survey sent to patients, relatives and nursing staff revealed perceived benefits for both physical and psychological recovery following critical illness. Additionally the Chelsea and Westminster Hospital having recognised the importance of garden space and its' positive effects have set themselves the task of constructing an indoor garden within their expanding intensive care

unit to enable a change of environment for patients and their relatives to enjoy and with an aim to facilitate engagement to enhance recovery after critical illness (Vizcaychipi 2017).

There are various anecdotal stories online from people who having suffered critical illness on how they felt when they were well enough to be taken outside again for the first time. One woman stated that she had insisted on being taken outside as it was so long since she'd seen natural daylight and felt fresh air (Dobson 2017) and others didn't go outdoors until they left hospital. Beresford (2016) explains that when patients are well enough, they can be taken off their monitors and taken outside with smaller portable monitors and this has an immeasurable effect on a persons' psychological wellbeing. Believing, makes a world of difference and changes attitudes with an effect that is hard to quantify, but anybody who works on intensive care can see the beneficial effect it has on patients. Patients can see themselves getting better.

Courtyard 13 is a small courtyard garden that is situated adjacently to the rear of intensive care. Permission has been granted to adapt this area in order to take recovering level 2/3 high dependency patients outside to experience fresh air for a while.

It is believed that patients recovering from critical illness would benefit greatly from use of this area as they may be taken into a place that is away from the hustle and bustle of intensive care and into a peaceful environment but still remain in close proximity to the unit. It would, perhaps be a good incentive for them to want to go outside where they could maybe be re-acquainted with younger members of their family, with pets or just take a moment. Having access out would be part of their rehabilitation plan.

From a staff point of view, this area is a much safer environment to use, as should it be needed, assistance is available from close by. Currently patients have to be wheeled through the hospital to the front entrance to gain outside access.

Aim and purpose:

This document forms a clinical guideline that applies to all adult patients who, following admission and treatment on Intensive Care (ICU) at the Royal Derby Hospital are recovering from critical illness. As part of their recovery plan it is deemed appropriate for both their physical and psychological wellbeing to be taken outside. Courtyard 13 has been adapted and made safe for patients to be taken out into this area.

A risk assessment has been designed to identify and reduce any foreseeable risks associated with taking this group of patients outside. This full multidisciplinary supported risk assessment document must be completed prior to any patient leaving the unit to visit this area. The safety of the patient is paramount.

Keywords & Explanations:

- Risk assessment : *to identify hazards or risks*
- Clinical Guideline : *advises best practice for practitioners*
- Intensive Care / ICU : *a hospital ward where critically ill patients are managed*
- High Dependency / HDU : *a ward where patients need more intensive observation, treatment and nursing care than is possible in a general ward but slightly less than that given in intensive care*
- Level 2 / HDU Patients : *patients requiring detailed observation or intervention including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care.*
- Level 3 / ICU Patients : *patients requiring two or more organ support, or needing mechanical ventilation alone*
- Rehabilitation / Rehab : *intensive physical therapy that aims to improve a patients physical function*
- Multidisciplinary team / MDT : *a care model which includes ICU doctors, critical care nurses, physiotherapists, occupational therapists, dieticians, pharmacists, and other staff members work together to provide patient centred care*
- Courtyard 13 : *a small garden area that is situated alongside ICU and is used for patient rehab.*

Process:

Once a week, ICU level 2 patients are discussed during the Multi-Disciplinary Team rehabilitation meeting. A plan for rehab is formulated and communicated to the patient, their relatives (if appropriate) and relevant clinical staff made aware during handovers.

For those who are sitting out of bed and in need of further stimulation to progress, discussion takes place on whether it would be appropriate to be taken outside with full ICU support of staff and equipment.

The nurse allocated to the provide care to the patient completes a risk assessment and the ICU Consultant or Senior ICU Doctor and the Nurse Shift Co-ordinator for the day signs this form to consent to the plan.

Sections for completion:

1. Patient details
2. Assessor Details

3. Indication and goals
4. Patient condition - *Plan to address practicalities in mobilising patient*
5. Patient Specifics
 - Timing
 - Staff required + grades
 - Patient consent.
 - Family involvement
 - Equipment required
6. Emergency procedure
7. Approval - *Consultant + Shift Co-ordinator sign off of the risk assessment*
8. Review - *A short evaluation valuation to review the actioned plan follows.*

When the assessment has been completed and the patient is deemed fit to go outside, staff must follow the assessment. In the event of the patients' condition deteriorating; a panic alarm situated within the courtyard to alert unit staff of a problem must be deployed. Should this alarm be activated, each risk assessment will identify staff members to respond and attend urgently.

These guidelines to be used in conjunction with

- Resuscitation – Trust Policy and Procedure. Reference Number: POL-CL/1185/08
- Trust tracheostomy policy
- Manual Handling: Trust Policy and Procedure. Reference Number: POL-RKM/1089/2004
- Inter-hospital ICU Transfer – ICU Clinical Guideline. Reference Number: CG-T/2014/180

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