Oral Presentations

Adult Content

1. The Critical Illness Recovery Center at UPMC Mercy: The First Year in Review
   Brad Butcher, MD
   Affiliation: UPMC Department of Critical Care

2. Variability in Home Health Rehabilitation Utilization Among Older ICU Survivors
   Jason Falvey, PT, DPT, PhD
   Affiliation: Yale School of Medicine

3. Retrospective Analysis of Mobility in the CICU after Protocol Modification
   Chirag Patel, MS4
   Affiliation: Brody School of Medicine at East Carolina University

4. Development of an ICU Survivorship Program
   Julie Rogan, MSN, CNS, ACCNS-AG
   Affiliation: Penn Presbyterian Medical Center

5. Morale with a Tail: Initiating Animal Assisted Therapy in Critical Care in Plymouth (UK)
   Kate Tantam, MRes, PGCE, BSc (hons), RN
   Affiliation: University Hospital Plymouth NHS Trust, UK

Pediatric Content

6. Increasing Occupational Therapy and Physical Therapy Consultations Through Quality Improvement
   Rebekah Music, OT
   Affiliation: Cincinnati Children’s Hospital

7. Early Mobility in Young Children Supported with Paracorporeal Total Artificial Hearts
   Nathan Thompson, MD, PharmD, MS
   Affiliation: Medical College of Wisconsin
Poster Presentations

Adult Content

1. Addressing Post Intensive Care Syndrome (APICS-01)
   Narges Akhlaghi, MD, MPH
   Johns Hopkins medicine

2. A Unique Approach to Exercise and Mobilization for Individuals Undergoing Venovenous ECMO, a Pilot Study
   *Eric Andersen, PT, DPT*
   Affiliation: University of Minnesota and Fairview Health

3. Support and Compress S.A.C Protocol Scrotal Edema in Trauma Patients
   *Brigit Anderson, OTR/L, CLT*
   Affiliation: HonorHealth Scottsdale Osborn Medical Center

4. Using A Portable Power Source To Ambulate While On Continuous Renal Replacement Therapy
   *Haley Bento, PT, DPT, CCS;*
   Affiliation: University of Utah Health

5. Prevalence and Severity of Laryngeal Injury After Oral Endotracheal Intubation
   *Sai Phani Sree Cherukuri, MBBS*
   Affiliation: Johns Hopkins School of Medicine

   *Arooj Fatima, MD*
   Affiliation: Johns Hopkins Medicine

7. The Safety and Feasibility of the Ramsey Tilt Table Protocol for Mobilizing Critical Care Patients with Femoral IABP
   *Mary G. Fischer, PT, DPT, GCS*
   Affiliation: New York University Langone Health

8. Analgesia using Transcutaneous Electrical Nervous Stimulation in the early Postoperative Period of Cardiac Surgery
   *Giulliano Gardenghi, Ph.D*
   Affiliation: Encore Hospital, Brazil

9. Effects of Tilt Training on Orthostatic Tolerance and Heart rate Variability in Hospitalized HIV+/AIDS Patients
   *Giulliano Gardenghi, Ph.D*
   Affiliation: Encore Hospital, Brazil
10. Optimizing Time to Volume Based Enteral Nutrition and Reaching Goal Within the First Full Day in Critically Ill Patients Reduces Time in ICU, Hospital Length of Stay and Readmit Rate by Half
   *Gerry Howick, MBA, RDN, CDN*
   Affiliation: Legacy Salmon Creek Medical Center

   *Emma Jackson, MBCHB*
   Affiliation: Blackpool Victoria Hospital, England

12. Developing a Culture of Early Identification of Delirium Combined with Reducing Sedation Use in Critical Care Patients
   *Emma Jackson, MBCHB*
   Affiliation: Blackpool Victoria Hospital, England

13. The BEHAB Study: Is a Combined Behavioral Activation and Rehabilitation Intervention in Acute Respiratory Failure Survivors Feasible and Acceptable?
   *Albahi Malik MBBS*
   Affiliation: Johns Hopkins Medicine

   *Pamela Page, PhD, BSc (Hons), PGCert E*
   Affiliation: The Nursing and Midwifery Council (NMC), UK

15. Grupo Ítaca: Returning home after the Odyssey
    *Miguel Rodríguez-Rubio, MD*
    Affiliation: Hospital Universitario La Paz

    *Yunna L. Sinskey, MD*
    Affiliation: Mary Free Bed Rehabilitation Hospital

17. Rehabilitation of a Person with Obesity and Post-Operative Hemiparesis
    *Bonnie B. Swafford, PT, DPT*
    Affiliation: Saint Luke’s Health System

18. The #Rehablegend Campaign – A Motivational Tool to Empower and Promote Excellence
    *Kate Tantum, Mres, PGCE, BSc*
    Affiliation: University Hospital Plymouth NHS Trust, UK
19. Development & Implementation of a Practical Multi-Hospital ICU Rehab and Training Program
   Kari V. Voll, OTR/L
   Affiliation: Sentara Healthcare, Norfolk VA

**Pediatric Content**

20. Quality Improvement Intervention to Promote Early Mobilization in Critically Ill Children
    Sjoukje Hoekstra, RN
    Affiliation: Erasmus Medical Centre Rotterdam

21. Quality Improvement Intervention to Promote Early Mobilization in the PICU: Nurses’ and Physicians’ Opinions and Perceived Barriers
    Sjoukje Hoekstra, RN
    Affiliation: Erasmus Medical Centre Rotterdam

22. The Safety and Feasibility of Sitting an Infant on Extracorporeal Cardiac Life Support: A Case Study
    Holly Hyland, DPT
    Affiliation: Children’s Hospital of Wisconsin

23. “Rady-Set-Go”: Promoting Early Mobilization in the Pediatric Intensive Care Unit
    Elizabeth Kantor BSN, RN, CCRN, C-NPT
    Affiliation: Rady Children’s Hospital Pediatric Intensive Care Unit

24. Barriers for Early Mobilization in a Pediatric Intensive Care Unit in Mexico
    Miguel Angel Martinez, PT
    Affiliation: Universidad Autónoma de Querétaro

25. Grupo Ítaca: Returning home after the Odyssey
    Miguel Rodriguez-Rubio, MD
    Affiliation: Hospital Universitario La Paz

26. Healing Walks: Giving Light to a Pediatric Intensive care Unit
    Miguel Rodriguez-Rubio, MD
    Affiliation: Hospital Universitario La Paz

27. Better Together: Long-Term Behaviors & Perspectives after a Provider-Family Writing Intervention in the ICU
    Madelaine Schaufel, MS
    Affiliation: Hospital Universitario La Paz
28. Optimizing Functional Outcomes After Pott's Shunt Palliative Surgery

*Atara Sheinson, OTR/L*

*Affiliation: Morgan Stanley Children's Hospital*
Oral Presentations: Adult Content
The Critical Illness Recovery Center at UPMC Mercy: The First Year in Review

Brad W. Butcher, MD
Tammy Eaton, MSN, RN, FNP-BC, ACHPN
8th Annual Hopkins ICU Rehab Conference
October 11, 2019
Survivors of critical illness: a growing population

Post-intensive care syndrome (PICS)

Griffith et al., Crit Care Med (2013); R100

Figure 1. Postintensive care syndrome (PICS) conceptual diagram. *ASD*, acute stress disorder; *PTSD*, posttraumatic stress disorder.
Arguments for post-ICU clinics

- Continuity of care
- PICS assessment
- Goal-directed rehab plan
- Therapeutic listening
- Luxury of time
- Benefits to providers
Patient factors

- Refusal
- Distance
- Lost to follow-up
Clinic logistics - operations

Visits occur at 2-4 weeks, 3 months, 6 months, occ 9 months, 12 months after discharge from inpatient care

Clinic occurs every Thursday from 8am to 5pm

Initial visits last 2.5-3 hours, follow-up visits 2 hours

Patients are scheduled at either 9am or 1pm, allowing providers to rotate through the rooms to minimize downtime
Multidisciplinary approach to ICU survivor care
Screening and referral summary

5/22/18 through 9/17/19

- Eligible per LOS criteria (greater than 4 days) (N=795)
  - Excluded (n=403)
    - No PICS risk (n=99)
    - Limited life expectancy < 6mo (n=96)
    - Limited rehab potential (n=93)
    - Active substance abuse (n=44)
    - Insurance (n=29)
    - Hx of non-compliance (n=15)
    - Language barrier (n=10)
    - Incarcerated (n=9)
    - Other (n=8)
- Referred to CIRC (n=392)
  - Patients not seen (n=206)
    - Not interested (n=87)
    - Distance (n=60)
    - LTFU (n=38)
    - Other (n=19)
    - Died before visit (n=2)
- Active CIRC Patients (n=186)
  - Patients seen in clinic (n=131)
    - Awaiting appointment (n=35)
    - Remain in hospital (n=20)
  - 17.5% (n=169) of all patients identified as eligible died before hospital discharge
### Patient demographics

5/22/18 through 4/1/19

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Patients seen (n=82)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, years</td>
<td>59 (51, 67)</td>
</tr>
<tr>
<td>Sex, male</td>
<td>36 (56%)</td>
</tr>
<tr>
<td>Race, white</td>
<td>64 (78%)</td>
</tr>
<tr>
<td>Referral ICU type</td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>42 (51.2%)</td>
</tr>
<tr>
<td>Neurological</td>
<td>19 (23.2%)</td>
</tr>
<tr>
<td>Trauma/Burn</td>
<td>15 (18.3%)</td>
</tr>
<tr>
<td>Surgical</td>
<td>6 (7.3%)</td>
</tr>
<tr>
<td>ICU characteristics</td>
<td></td>
</tr>
<tr>
<td>Acute respiratory failure</td>
<td>71 (86.6%)</td>
</tr>
<tr>
<td>Delirium during ICU stay</td>
<td>62 (75.6%)</td>
</tr>
<tr>
<td>Sepsis/septic shock</td>
<td>55 (67.1%)</td>
</tr>
<tr>
<td>Discharge disposition</td>
<td></td>
</tr>
<tr>
<td>Home</td>
<td>22 (26.8%)</td>
</tr>
<tr>
<td>Skilled nursing facility</td>
<td>27 (32.9%)</td>
</tr>
<tr>
<td>Inpatient rehabilitation</td>
<td>27 (32.9%)</td>
</tr>
<tr>
<td>Long term acute care</td>
<td>6 (7.3%)</td>
</tr>
<tr>
<td>Time to clinic visit (days)</td>
<td></td>
</tr>
<tr>
<td>Home</td>
<td>22 (18, 31)</td>
</tr>
<tr>
<td>Skilled Nursing facility</td>
<td>23 (15, 46)</td>
</tr>
<tr>
<td>Inpatient rehabilitation</td>
<td>52 (38, 70)</td>
</tr>
<tr>
<td>Long term acute care</td>
<td>40 (35, 56)</td>
</tr>
<tr>
<td>Readmitted before visit</td>
<td>30 (36.7%)</td>
</tr>
<tr>
<td>Readmitted after visit, within 90 days of hospital discharge</td>
<td>5 (6.1%)</td>
</tr>
</tbody>
</table>

\(a\) Data presented as a (%) or median (interquartile range)
Visits per month

Critical Illness Recovery Center (CIRC) - Year 1 Visits
6/14/2018 to 6/30/2019

6/1/18 through 6/30/19
Managing No Shows

Initial Visits Completed (n=150)

Total Patients Scheduled (n=220)

Yes

Patient Seen?

No

Initial No-Show Rate (n=70) 31.8%)

Patient Rescheduled?

Yes

Total Visits Completed (n=178)

No

Additional Visits Completed (n=28)

Final No-Show Rate (n=42) 19.1%

No-Show Reasons:
- LTFU (n=16)
- Refused (n=16)
- Died (n=2)
- Hospice (n=2)
- Moved out of Area (n=2)
- Doing Well (n=2)
- Readmitted (n=1)
- Psychiatric Reasons (n=1)

6/1/18 through 6/30/19
## Referrals Generated

<table>
<thead>
<tr>
<th>Specialist</th>
<th># of Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical therapy</td>
<td>112 outpatient, 12 home referrals</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>64 outpatient, 13 home referrals</td>
</tr>
<tr>
<td>Cognitive therapy</td>
<td>81 outpatient, 10 home referrals</td>
</tr>
<tr>
<td>Swallowing therapy</td>
<td>4</td>
</tr>
<tr>
<td>Behavioral health</td>
<td>20</td>
</tr>
<tr>
<td>Pulmonary rehabilitation</td>
<td>15</td>
</tr>
<tr>
<td>Pulmonology</td>
<td>17</td>
</tr>
<tr>
<td>Other sub-specialists</td>
<td>32</td>
</tr>
</tbody>
</table>

5/22/18 through 9/17/19
## Clinic Interventions

<table>
<thead>
<tr>
<th>Specialist</th>
<th># of Interventions (% pts eligible)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunizations</td>
<td>Flu – 15 (23%)</td>
</tr>
<tr>
<td></td>
<td>Pneumovax – 29 (69%)</td>
</tr>
<tr>
<td>Pill boxes provided</td>
<td>33</td>
</tr>
<tr>
<td>Spacers provided</td>
<td>35</td>
</tr>
<tr>
<td>Medication education</td>
<td>217 (100%)</td>
</tr>
<tr>
<td>Medication reconciliation</td>
<td>217 (100%)</td>
</tr>
<tr>
<td></td>
<td>72 visits - unnecessary medications stopped</td>
</tr>
<tr>
<td></td>
<td>56 visits - new medications initiated</td>
</tr>
<tr>
<td></td>
<td>47 visits - dose adjustments</td>
</tr>
<tr>
<td>Inhaler education</td>
<td>55 (100%)</td>
</tr>
<tr>
<td>Smoking cessation counseling</td>
<td>54 (84%)</td>
</tr>
</tbody>
</table>

5/22/18 through 9/17/19
# Goals of Care Conversations and Advance Care Planning

<table>
<thead>
<tr>
<th>Intervention</th>
<th>#s/%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code status determination</td>
<td>96% (only 5 unable to do)</td>
</tr>
<tr>
<td>Surrogate decision maker identification</td>
<td>92% (only 11 unable to do)</td>
</tr>
<tr>
<td>Provision of advance directives</td>
<td>76 (58%)</td>
</tr>
<tr>
<td>Completion of POLST forms</td>
<td>21 (16%)</td>
</tr>
<tr>
<td>Palliative care referral</td>
<td>3 (0.02%)</td>
</tr>
</tbody>
</table>

5/22/18 through 9/17/19
Program Intangibles

- Education
- Discussion
- Expectation management
- Normalization
- Counseling
- Goal setting
- Holistic approach
Critical Illness Recovery CENTER

CIRC Clinic
Multidisciplinary outpatient clinic providing a comprehensive assessment for patients at high risk for PICS

ICU Survivor & Family Peer Support Program
Utilizing clinic specialists, social service, spiritual care, and ICU survivor champions to lead monthly topic-focused sessions

Ward Visits Prior to Hospital Discharge
Inpatient ward visits by APP prior to hospital discharge for risk stratification, exploration of health care goals, and PICS needs assessment

ICU Journal Program
Bringing attention to the ICU experience through written record of the ICU stay

Weekly Family Support
Normalizing feelings and experiences and promoting development of the coping skills needed to face the consequences of their loved one’s critical illness
Variability in Home Health Rehabilitation Utilization Among Older ICU Survivors

Jason Falvey, PT, DPT, PhD
Board Certified Geriatric Clinical Specialist
Post-Doctoral Fellow
Yale School of Medicine
@JRayFalvey
Disclosures

None
Introduction

• Older adults have high vulnerability to functional decline after ICU stays

• Rehabilitation services may improve outcomes after ICU stays

• Yet, the extent of participation in rehabilitation after ICU stays is unclear

Chao, 2014, Brummel, 2015, Major 2016
Post-Acute Care After Critical Illness

- 30% Home Health Care
- 26% Skilled Nursing Facility
- 9% Rehab Hospital
- 9% LTACH

Jones et al, 2015
Home Health Care

Provides nursing, rehabilitation, social support, and health aide services

- Unlimited rehabilitation benefits

No clear rules or guidelines for patients recovering from critical illness
Research Questions

1) Determine the amount and type of home-based rehabilitation that older adults receive after surviving an ICU stay

2) Evaluate factors associated with variability in home-based rehabilitation use
Methods

• Combined data from 2012 5% Medicare hospitalization files, home health files, and beneficiary demographic files
  • Extracted revenue codes for HH physical, occupational, and speech therapy
  • Included granular assessment data from HH admission

• Limited sample to the 3176 Medicare beneficiaries who
  • Stayed in the ICU >1 day
  • Survived at home without readmission or hospice transfer for 30 days
Statistical Methods

• Bivariate and multivariate negative binomial regression to model count of therapy visits received during HH care

• Geographic mapping to visual variability across regions
Results

Median time in home care: 30 days

Median Number of Rehab Visits: 3.5

33% received 0 rehabilitation visits

Falvey, 2019: Slide 9

@JRayFalvey

Yale University
Results

Median time in home care: 30 days

Half of all patients received fewer than 4 rehabilitation visits
Results

Median time in home care: 30 days

65% of rehab patients used PT
23% of rehab patients used OT
5% of rehab patients used SLP
Results

- Age 76-84 vs <=75
- Age 85+ vs <=75
- Race: Other vs White
- Race: Black vs White
- Disability Tertile: Highest Vs Lowest
- Disability Tertile: Middle vs Lowest
- Elixhauser Tertile: Highest vs Lowest
- Elixhauser Tertile: Middle vs Lowest
- Lives Alone
- Moderate/Severe Dyspnea
- Daily/Constant Anxiety
- Daily/Constant Pain
- Hospital LOS<5 days vs >11 days
- Hospital LOS<5 days vs 6-10 days
- Cognitive Impairment
- Mechanically Ventilated
- Rural Residence
- For-Prof HHA

Rate Ratio

<–Favors Fewer Rehabilitation Visits
Favors More Rehabilitation Visits–>
Results

[Map showing rehabilitation visits per week across the United States with color coding from red to yellow indicating varying levels of visits.]
Discussion

• Most patients receive low doses of rehabilitation in HH settings, which may limit functional recovery after critical illness

• Social and geographic factors explain large amount of variability in rehabilitation use, suggesting potential disparities

• Impact of home rehabilitation on recovery after critical illness unclear, but recent research indicates moderate benefit

• Disparities in use likely worsen when patients no longer qualify for home based services
Acknowledgements

Yale Mentors:
• Dr. Thomas Gill, MD
• Dr. Lauren Ferrante, MD, MHS
• Dr. Terry Murphy, PhD

Dissertation Mentor:
• Dr. Jennifer Stevens-Lapsley, PT, PhD

Funding:
• T32 019134 from National Institute on Aging
• Support from Rocky Mountain VA Medical Center and VA VINCI
References


Questions?
RETROSPECTIVE ANALYSIS OF MOBILITY IN THE CICU AFTER PROTOCOL MODIFICATION

By: Chirag Patel, MS4
ECU BSOM, Greenville NC
Leaders in Innovative Care (LINC) Scholar
CICU Population

• 24 beds; one nurse per two patients
• Post-STEMI, decompensated HF, post vascular / thoracic surgery
• Intubations, central lines, IABP, Impella, ECMO
Why is mobility important?

- Decrease ventilator days
- Decrease length of stay
- Reduce delirium and chances of death
- Improves patient outlook / quality of life
Greenville Early Mobility Scale (GEMS)

Mobility Level 1 = In Bed Activity
- Ankle pumps
- Arm raise
- Heel slide
- Straight leg raise
- Rolling
- Bridge

* Turn every 2 hours
* Perform Range of Motion

Mobility Level 2 = Edge of Bed Activity
- Sitting at edge of bed
- Leg kicks
- Seated marching
- Partial stand

Mobility Level 3 = Standing Activity
- Standing
- Walking in place
- Step forward and back
- Walk with assistive device and/or staff member

Mobility Level 4: Independent Activity
- Please encourage patient to walk
- May use assistive device
Concerns with GEMS

- Patient population differences
- Not enough instruction on how long and what type of activities to perform
- Level 1 often assigned with little intervention
- PT consults for mobility difficult to obtain
Protocol Change

- Clarify duration of activities
- Clarify which activities to perform

Increase Patient Mobility
### The ICU Mobility Protocol: VMC Early (IMPROVE) Movement

<table>
<thead>
<tr>
<th>IMPROVE Routine</th>
<th>Exercise Routine</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>GEMS 1A: Bed bound/Non-participatory:</strong> passive range of motion</td>
</tr>
</tbody>
</table>
|                | a. Flexion and extension of elbow and shoulder: 10 min (30-40 reps per joint)  
|                |     And  
|                | b. Flexion and extension of the knee and hip: 10 min (30-40 reps per joint) |
| 2.             | **GEMS 1B: Bed bound/Participatory:** active range of motion |
|                | a. Pedal Exerciser for upper extremities: 10-15 min  
|                |     And  
|                | b. Active leg adduction/abduction and leg raises: 10 min (30-40 reps per)  
|                |     Or  
|                |     Pedal Exerciser for lower extremities: 10-15 min |
| 3.             | **GEMS 2: Able to get in chair but unable to walk:** active range of motion |
|                | a. Pedal Exerciser for upper extremities: 10-15 min  
|                |     And  
|                | b. Sitting to standing exercise with assistance: 10 min (10-20 reps)  
|                |     Or  
|                |     Pedal Exerciser for lower extremities: 10-15 min |
| 4.             | **GEMS 3: Able to walk with support:** active range of motion |
|                | a. Pedal Exerciser for upper extremities: 15 min  
|                |     And  
|                | b. Walk from chair to bed/bathroom 3-5 times with assistance  
|                |     Or  
|                |     Walk the hallway 50-100 feet with cardiac rehab walker |
| 5.             | **GEMS 4: Walking independently** |
|                | a. Walk the hallway 50-100 feet with/without cardiac rehab walker |
Increase Patient Mobility

Protocol Change

- Clarify duration of activities
- Clarify which activities to perform

Education

- Speak to nursing staff to educate
- Place protocol at each nurse station
Feedback

IMPROVE Protocol Survey

Thank you for participating in our survey. This past month the IMPROVE protocol was implemented in the CICU to increase patient mobility and progressive their mobility throughout their stay. This was done by detailing which exercises each patient should perform at a certain level. The current protocol in place is the Greenville Early Mobility Scale (GEMS) and this supplement was added for the CICU. In order to better understand how the IMPROVE protocol has impacted patient care and mobility in the CICU, we invite you to answer these questions honestly to better serve you and our patients!

Instructions: Circle the number that corresponds to your stance on the IMPROVE model:

1) The IMPROVE protocol clearly defined which mobility level each patient falls under.
   1 2 3 4 5

2) The IMPROVE protocol clearly defined which exercises a patient should complete at a specific mobility level.
   1 2 3 4 5

3) I believe that the IMPROVE protocol has helped my patients become progressively more mobile from initial level.
   1 2 3 4 5

4) I believe the IMPROVE protocol has helped me track patient mobility effectively.
   1 2 3 4 5

5) The IMPROVE protocol has exercises that are easy for me to help the patient perform.
   1 2 3 4 5

6) The IMPROVE protocol was a helpful addition to the GEMS.
   1 2 3 4 5

7) I am more aware of the importance of mobility after this protocol was implemented
   1 2 3 4 5
Year vs. Total Number of Documented Activities

Year | Total Documented Activities
--- | ---
2017 | 30
2018 | 60
Roadblocks

- Data collection
  - No flowsheet of GEMS scores
  - Looked at each provider note to determine exercises performed
  - No structured way to track mobility
Increase Patient Mobility

EHR Change

Create drop down menu for level, duration, activity
Auto populate in notes / flowsheet

Rounding

Display GEMS level outside room
Monitor on rounds regardless of provider status
Proposed Rounding Aid

GEMS Score

1   2
A / B

3   4

Images of proposed rounding aids are shown.
Contributors

- Michael Ritchie, MD
- Tim Reeder, MD
- Toni Holden, BSN
- Pamela Moss, RN
- Kimberly Carter, RN, Information Services
- PT representatives
Development of an ICU Survivorship Program

Julie Rogan, MSN, CNS, ACCNS-AG
Philadelphia, Pennsylvania
jrogan@nursing.upenn.edu
@JulieRoganCNS
Support ICU survivors and their families

• Interprofessional implementation team
• ABCDEF bundle
• ICU diary
• Website
• Peer support group
Which survivors are we reaching out to?

- Inclusion criteria ICU Diary:
  - Anticipated intubation for greater than 48 hours
- Inclusion criteria Peer Support:
  - ICU diary recipients
  - Survived ICU stay
When does outreach begin?

• Follow up after ICU
• Before hospital discharge
• Phone call after discharge
• Mailed invitation
• Emailed invitation
What does peer support look like?

- Peer Support Session:
  - In-person
  - Telemedicine option
  - Biweekly
What are the sessions like?

- Rotating themes:
  - ICU survivorship overview
  - ICU diary utilization during recovery
  - Managing challenges with strength and balance
  - Managing challenges with meaning-making
  - Getting back to doing more of what you love
How many people have been reached?

- **160** journals
- **90** invitations/6 cohorts
- **56** phone conversations
- **44** participants
- **6** online participants
- **9** routinely returning participants
Keys to Success

- Organized, consistent process
- Anticipate obstacles
- Interprofessional team
- Frequent reassessment for optimization
- Well-received by ICU survivors and their loved ones
Acknowledgements

• **Penn Presbyterian Medical Center**
  • Megan Zielke, PharmD, BCCCP
  • Kelly Patton, MHA-HMIS
  • Mark Mikkelsen, MD, MSCE, FCCM
  • Abi Sossaman, MOT, OTR/L
  • Kathy Siciliano, PT, DPT
  • John Ehman, MDiv
  • Amy Kaplan, MSW
  • Josh Veith, MD
  • Diane Gorman, MSN, CRNP
  • Kelly Becker, BSN, RN
  • Alicia Ulerick, RRT
  • Abhishek Bardwaj, MD
  • Bridget McQuate, BA

• **Penn Presbyterian Medical Center**
  • PPMC Bach Fund
  • Executive Leadership
  • MICU Healing Journal Team

• **SCCM Thrive Peer Support Collaborative**
  • Adair Andrews

• **ICU Diary Development**
  • UCSD: Miranda Covalesky and Truong-Giang Huynh
  • MAMC: Mary McCarthy
  • Mission Health: Mary Kay Bader and Arianna Barnes

• **Debriefing**
  • Christina Jones
  • Teresa Deffner
  • Anne Nielsen
Thank you!

jrogan@nursing.upenn.edu
@JulieRoganCNS
#MoraleWithATail

Initiating Animal Assisted Therapy in Critical Care in Plymouth (UK)

Kate Tantam  MRes PGCE BSc (hons) RN
Specialist Rehabilitation Sister in Critical Care
Kate.tantam@nhs.net
@tantamkate
#Rehablegend
Animal Assisted Intervention in Critical Care
Our ICU clinical teams wanted to support our patients and their loved ones to engage in rehabilitation in different ways.

They asked if it was possible to bring in dogs..

I wasn’t a “dog person”....
Evaluation of the Quality improvement project has been completed using qualitative and quantitative methodologies in the month of November 2018.

**Staff**
- ICU Staff Survey (n=80)

**Patients were asked to provide a self assessment for**
- Mood (Visual Analogue Scale)
- Pain scores (0-10 Linear Scale)
- Anxiety (0-10 Linear scale)
- Patient feedback – Free Comments
- Patient observations pre and post intervention (Heart Rate, Blood Pressure and Respiratory Rate).

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Choice</td>
<td>Allergy or Asthma</td>
</tr>
<tr>
<td></td>
<td>Phobia of dogs</td>
</tr>
<tr>
<td></td>
<td>Infection control issues</td>
</tr>
<tr>
<td></td>
<td>Immunosuppressed</td>
</tr>
</tbody>
</table>
Staff Survey Findings  (n=80)

- Pet Therapy is incredibly powerful. We see levels of increased awareness when provided with a pet to pat.

- We all love Hovis; he has had such an amazing impact on the whole unit.

- Hovis greatly improves staff morale. He is morale with a tail.

- Hovis’s visits bring some relief and joy on very difficult shifts.

- 100% stated that Hovis visits are a positive experience.
- 99% felt Hovis improves patient experiences of ICU.
- Average staff mood levels lifted by 20%.

**Challenges of service**
- 2.5% of staff reported that some patients found it difficult when Hovis was unable to attend.
Patient Findings \( (n=20) \)

Qualitative feedback from patients and carers has been 100% positive with some of the quotations included below.

- 80% of patients surveyed were unable to fill out outcome measure due to fatigue/limb strength/attention/cognition.
- No changes were observed in physiological parameters, patients reported verbally a change in mood and a reduced pain score.

It was so lovely that he came to see me on the ward

.....It always makes a difference when you see a dog like Hovis because he takes my mind off my illness, a good distraction…

.....Hovis helped me to practise throwing the ball with my arm which I needed to recover, from paralysis and build muscle strength …..
Conclusion

• Animal assisted therapy in ICU is seen as a positive and is an active intervention to improve staff and patient experience.

• Patients and their loved ones report that Hovis and Moira are able to help distract and engage patients in a way that clinical staff may not.

• Outreach visits have been positively received by patients and staff outside ICU but the impact of this has not been fully explored.

• Limitations to this project are the challenges with completion of patient feedback due to; fatigue, weakness, memory and impaired communication and availability of our animal team.

• Animal assisted therapy in ICU is feasible and we would encourage other ICU departments to embrace this intervention to support psychological recovery of patients, loved ones and staff.
Future

- ICU specific policy for AAT
- Increase ICU Rehab outreach capacity
- Support staff education in value of AAT for rehabilitation after ICU
- Humanisation of ICU – Secret Garden
- Increase capacity for AAT – Harvey

@hovistherapydog
#Rehablegend
@tantamkate
Oral Presentations: Pediatric Content
Cincinnati Children’s Road to Early Mobility

- **April 2017:** QOM joins
- **July 2017:** Data Analyst joins
- **Nov. 2016:** Early Mobility Taskforce forms
- **Jan. 2018:** OT/PT consult added to admission order set
- **Feb. 2019:** Initiated monthly resident training with OT/PT
- **April 2018:** Implemented PICU Up!™ training
- **June 2018:** EPIC Optimization
- **July 2019:** Installation of one ceiling lift in the PICU
- **Sept. 2019:** QI focused on increased frequency of OOB for PICU Up!™ Level II and III patients
### Evidence

<table>
<thead>
<tr>
<th>Pediatric Early Mobility Programing:</th>
<th>Adult Early Mobility Programing:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Is Safe</td>
<td>• Reduces ICU and hospital LOS</td>
</tr>
<tr>
<td>• Is Feasible</td>
<td>• Decreases number of ventilated days</td>
</tr>
<tr>
<td>• A catalyst to increase OT/PT consults</td>
<td>• Is associated with increased muscle strength</td>
</tr>
<tr>
<td>• Increases early mobility activities</td>
<td>• Improves self perception of functional status</td>
</tr>
<tr>
<td>(Wieczorek et al, 2015; Choong et al, 2017; Wieczorek et al, 2016)</td>
<td>• May decrease sedation utilization and delirium</td>
</tr>
<tr>
<td>(Cameron et al, 2014)</td>
<td></td>
</tr>
</tbody>
</table>
OT/PT referrals were noted to be **perpetually delayed**!

Only 8% of patients received an OT/PT consult within 72 hours of PICU admission in 2016.

**Evidence suggested:**
- Initiation of OT and/or PT within 72 hours of PICU admission should occur for appropriate patients (Wieczorek et al., 2016)
- Patients should be assessed for appropriate level of activity within 24 hours of PICU admission (Choong et al., 2018)
Reasons for no OT/PT consultation within 72 hours of PICU admission were assessed via retrospective chart review and staff interviews.
**Significant delay in therapy consults**

Consult is not placed on admission

Providers skip OT/PT consult, even if they know it is needed

Consult process is too lengthy

Multiple text & check boxes are required to place OT/PT consult

**ROOT CAUSE** Consult isn’t specific to PICU and must meet the needs of multiple units.
PICU OT/PT Consultations Key Driver Diagram

**Global Aim**
Decrease negative effects of immobility and inactivity for critically ill patients in the PICU

**SMART Aim**
Increase OT/PT consults from 8% to 35% of PICU patients by June 2018
- 50% by 12/18
- 60% 6/19

**Population**
Patients who are in the PICU for ≥ 72 hours and excluding those whose already had an existing consult upon admission.

**Key Drivers**
- Collaborative and trusting relationships between OT/PT and staff
- Improved staff understanding & buy in of OT/PT role in critical care patients
- Seamless and accurate identification of patients who need an OT/PT consult
- Real-time feedback and learnings of the OT/PT consult process

**Interventions (LOR #)**
- Communication memo introducing and explaining role of OT and PT posted in common areas of the PICU & sent via weekly line up 9/12/17 (LOR #1)
  - Orienting nurse education 4/19
- Signs/reminder for Fellow/ APRN offices to order OT/PT consults 10/27/17
- Signs on WOWs and in alcoves for providers to order OT/PT consults 1/2/18 (LOR#1)
- Updated RN rounds form w/ need for OT/PT consult 1/23/18 (LOR#2)
  - Level 1 flyer posted in bathrooms to increase awareness 5/19
- EPIC Optimization-OT/PT/Speech Consults added to PICU admission order sets 1/24/18 (LOR #2)
  - Pre-check OT/PT consult in PICU admission order set in EPIC 1/31/18 (LOR #2-3)
- Completion of PICU Up! Education regarding activity level goals for patients May ‘18 (LOR #1)
  - Addition of Early Mobility section to Resident Progress Note March ’18
- Resident education regarding therapy in the PICU and process for “resume referral” 2/19 (LOR#1)
  - K-Card coaching for real time feed back with bedside nurses Summer 2018
Aims

Global Aim
Decrease negative effects of immobility in critically ill children

Smart Aim
Increase OT/PT consults
• From 8% to 35% by 6/18
• To 50% by 12/18
• To 60% 6/19

Inclusions
• Patients in the PICU for ≥ 72 hours

Exclusions
• Patients with existing OT/PT consult
Key Drivers

• Collaborative relationship between OT/PT and PICU staff
• Improved staff understanding PT/OT role in care for critically ill patients
• Seamless and accurate identification of patients needing OT/PT consult
• Real-time feedback of OT/PT consult process
Interventions: Education and Reminders

**Did you know there is a Physical Therapist and an Occupational Therapist in the PICU?**

**OT:**
- Limited participation in daily living skills (ADL)
- Feeding difficulties
- Sensory sensitivities
- Muscle weakness affecting functional participation
- Muscular tightness
- Splinting needs
- Development delays or risk for developmental declines
- Positioning challenges, in or out of bed
- *Prolonged PICU stay lasting more than 72 hours*

**PT:**
- Muscular weakness/weakness deficits
- Muscular tightness
- Bracing needs
- Deficits in ambulation
- Balance deficits
- Positioning needs
- Challenges with endurance
- Challenges with bed mobility
- Developmental delays or risk for developmental declines
- *Prolonged PICU stay lasting more than 72 hours*

An OT/PT consult must be placed by the medical team but can be requested by nursing, family, or other staff members. If you have any questions about OT or PT contact Bekah, OT (42150), Emily, PT (41871), or the Therapy department (803-7396). We are currently working on an early mobility initiative to increase activity in the PICU. More info to come later!

**Stickers placed around the unit**

**Have you consulted OT & PT?**

**Updated RN AM rounds form DO WE NEED A CONSULT?**

**Flyer placed on bathroom doors**
Interventions: EPIC Enhancements

- OT/PT consult was *preselected* in all PICU admission order sets.
- Consult order was *simplified* with auto-filled sections.
- Resident progress note template was updated to include *discussion* of mobility and need for OT/PT consult.
Interventions: PICU Resident Orientation

Please place a therapy consult if your patient has any of these needs:

**OT:**
- Limited participation in daily living skills (ADL)
- Feeding difficulties
- Sensory sensitivities
- Muscle weakness affecting functional participation
- Muscular tightness
- Splinting needs
- Development delays or risk for developmental declines
- Positioning challenges, in or out of bed
  - Prolonged PICU stay lasting more than 72 hours

**PT:**
- Muscular weakness/strength deficits
- Muscular tightness
- Bracing needs
- Deficits in ambulation
- Balance deficits
- Positioning needs
- Challenges with endurance
- Challenges with bed mobility
- Development delays or risk for developmental declines
  - Prolonged PICU stay lasting more than 72 hours

**Exclusions:**
- Bronchiolitics not requiring intubation
- PICU admission less than 72 hours with no acute changes in developmental or functional skills
- DKA with expected return to functional baseline with resolution of illness
- Asthma exacerbation with expected recovery without functional decline

If you are uncertain if a patient needs therapy just ask a therapist!
Interventions: Success Stories

Success stories posted around the unit and sent to staff via email
Run Chart for Tracking Progress

8% to 40% = 400% Improvement!
Learnings:
1. Our OT/PT consult order process was **lengthy and complicated** and progress was not achieved until this was simplified.
2. It is best to narrow in on a **small part** of the process and build over time.
3. Efforts must be **measured** to ensure that change is a real improvement.
4. Without **high reliability interventions**, change is difficult to sustain.

Challenges:
1. Rotating staff adds challenges to maintaining comfort with and understanding of referral process.
2. Can be difficult to define which patients will not need therapy without hands on efforts.
A Special Thank You to:

Dr. Lesley Doughty (Project Co-Leader),
Brandy Seger (Quality Outcomes Manager),
Katie Simon (Data Analytics)
& the CCHMC Early Mobility Taskforce
Early Mobility Taskforce

SPONSORS:
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Dave Mayhaus, PharmD, MS – AVP, Patient Services
Jerry Schwartz, RN - Clinical Director, PICU

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Andrea Chamberlain – Clinical Specialist-Pharmacy
Missy Christen - Nursing Clinical Manager (former member)
Tina Fettig – Nursing Clinical Manager
Lindsay Cipriani – Nursing Education Specialist II
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Amanda Kelly - Respiratory Therapist
Lori Passey – Respiratory Therapist
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Emily Fox – Physical Therapist
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TEAM COACHES:
Brandy Seger, Quality Outcomes Manager
Chris Kremer, Quality Outcomes Manager
Katie Simon, Data Analyst


Early Mobility in Young Children Supported with Paracorporeal Total Artificial Hearts

Nathan Thompson MD, PharmD, MS
Holly Hyland DPT
October 12, 2019
Objectives

- Explain the Paracorporeal Total Artificial Heart
- Describe 2 cases of young children with acute heart failure
- Share their physical therapy achievements

Written consent obtained for all photographs shown
The Paracorporeal Total Artificial Heart

- Novel Ventricular Assist Device (VAD) configuration
- Combines aspects of the Berlin Heart EXCOR and the SynCardia Total Artificial Heart
- Serves as a bridge to transplant
Goals of this VAD Configuration

- Improved three dimensional conformation
  - Small thoracic space
  - Avoids external compression of cannulas

- Improved quality of life while waiting for transplant
  - Reduced length of mechanical ventilation
  - Better nutrition
  - More time out of bed
Mobility Program

- Multidisciplinary approach with buy-in from leadership
- Unit culture
- Team – bedside nurse and therapist
- Tiered approach to therapy
Case #1

- 20 month old with acute heart failure from congenital heart disease
- Placed on ECMO in OR following brief arrest
- TAH placed 14 days later
  - Chest closed following day
- Transplanted 3 months after admission

Mark Johnson, *Milwaukee Journal Sentinel* April 19, 2019
Physical Therapy

- Physical therapy initiated – POD 2
- Sitting in bed – POD 10
- Out of bed playing – POD 14
- Out of room – POD 15
- Off unit to gym – POD 18
- Physical therapy frequency (sessions/wk) - 5
- Total number of therapy encounters - 42
- Average length – 66 mins
Case #2

- 13 month old admitted in cardiogenic shock
- Atypical Kawasaki's disease – giant coronary aneurysm and thrombosis
- V. fib arrest – VA-ECMO
- Converted to TAH 12 days later
  - Chest closed next day
- Transplanted 3 months later
Physical Therapy

- Physical therapy initiated – POD 1
- Sitting in bed – POD 6
- Out of bed playing – POD 12
- Out of room – POD 18
- Off unit to gym – POD 33
- Physical therapy frequency (sessions/wk) - 5
- Total number of therapy encounters - 54
- Average length – 57 mins
Safety

- No significant safety events

- 2 minor events – low battery alarm while in therapy gym
Conclusion

- Aggressive physical therapy can safely be performed in this hemodynamically vulnerable population

- Gross motor skills can be maintained or even increased during the bridge to transplant period with good VAD support
Acknowledgements

- CV surgery
  - Dr. Ron Woods
- Heart failure
  - Dr. Steve Kindel
  - Dr. Ann Punnoose
- CICU
  - Dr. Rob Niebller
  - Kathy Miller
Questions
Poster Presentations: Adult Content
Background

- Acute lung injury (ALI) is a devastating clinical and public health problem across military and civilian populations.
- As ALI mortality has improved in recent decade, focus has shifted to significant long-term morbidities, including impairments in physical, cognitive, and mental health.

Objectives

- Understanding new or worsened disabilities after critical illness, often termed post intensive care syndrome (PICS).
- Evaluating the association between unmet needs in the first few weeks of hospital discharge and adverse outcomes (death or re-hospitalization) and other functional outcomes (physical, mental, cognitive).

Methods

- APICS-01 is a multi-center observational study investigating the implications of unmet medical needs in the first weeks after hospital discharge.

Results

- **1930 (87%) Patients Excluded (can have >1 exclusion)**
  - 548 (28%) Not expected to go home (e.g., transfer SNF, Rehab)
  - 439 (23%) Died in hospital
  - 357 (18%) Mechanical ventilation solely for airway protection
  - 189 (10%) Residing in a medical institution before admission
  - 171 (9%) Unable to communicate by telephone in English
  - 92 (5%) Not expected to survive 6 mo or transferred to hospice
  - 63 (3%) Neurological injury
  - 53 (3%) Patient on hospice at or before time of enrollment
  - 43 (2%) Mechanical ventilation at baseline
  - 36 (2%) Homeless
  - 9 (1%) Primary residence not in USA
  - 8 (0%) Prisoner
  - 5 (0%) Pregnancy
  - 4 (0%) Age < 18 years old

Discussion

The recovery of the wounded Service Member with ALI (and civilians who are similarly ill or injured) is an urgent clinical and research priority. Having survived life-threatening illness, many individuals struggle to reintegrate into their former lives and may experience new morbidities. Interventions that can limit such burden and thereby improve recovery is a high priority. It is possible that focused interventions in the first days and weeks after hospital discharge may improve patient-centered outcomes, and the first steps to evaluating this hypothesis are being explored in the APICS-01 study.
A Unique Approach to Exercise and Mobilization for Individuals Undergoing Venovenous ECMO, a Pilot Study

OBJECTIVES
- Determine the safety and feasibility of lower extremity weight-bearing exercise in subjects undergoing ECMO
- Identify barriers to physical therapy intervention
- Assess function and hospital outcomes

METHODS
- Three subjects met inclusion criteria
  - Adults undergoing venovenous ECMO
  - Follow 3/3 commands
  - Able to weight-bear on legs
- Functional outcomes measured
  - Days to standing/ambulation
  - Medical Research Council (MRC) sum score
- Hospital outcomes measured
  - Length of stay
  - Discharge destination

RESULTS

<table>
<thead>
<tr>
<th>Pt 1</th>
<th>Pt 2</th>
<th>Pt 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>27 y.o. male</td>
<td>49 y.o. male</td>
<td>48 y.o. male</td>
</tr>
<tr>
<td>32 → 55</td>
<td>14 → 53</td>
<td>19 → 53</td>
</tr>
<tr>
<td>35 days</td>
<td>49 days</td>
<td>69 days</td>
</tr>
<tr>
<td>Long term acute care hospital</td>
<td>Long term acute care hospital</td>
<td>Home with outpatient PT</td>
</tr>
</tbody>
</table>

Table 1. Hospital Outcomes. MRC; Medical Research Council

DISCUSSION
- MOVEO™ (DJO, LLC, Dallas, TX) was utilized safely with one individual undergoing venovenous ECMO
- Patient 1 had a shorter hospital length of stay
- Strength and functional measures were not greater when compared to those who did not use the MOVEO
- All three subjects ambulated before leaving the hospital
- Limitations include: interdisciplinary coordination and a small sample

CONCLUSION
- Due to a small sample size, we were unable to determine if this specified training improves functional capacity compared with standard care
- We propose this to be a safe and potentially effective tool to utilize with patients on ECMO
Background

Clinical intervention of scrotal edema in the trauma patient has essentially been ignored. Literature on scrotal edema in an acute care setting with traumatic injuries is limited and there are no standard of care models. Recognizing the need for intervention, we adapted the lymphedema principle of complete decongestive therapy (CDT) components: compression, elevation, isometric exercise, deep breathing and manual lymph drainage to treat scrotal edema patients focusing on traumatic injuries in the acute care setting. Therapy was initiated with the aim of improving patient outcomes by increasing functional mobility, decreasing ICU stay, ventilator and urinary-catheter days, decreasing pain levels and scrotum size.

Inclusion: Male trauma patients; ≥18 years old; physician order for interventional treatment; swollen scrotum; following commands with spontaneous movements

Exclusion: ICU admission <72hr (earlier if patient is stable) GCS <8; unstable ICP; unstable hemodynamics significant hematuria or urethral trauma; wound present; enrolled in Donor Network

Materials:
- Paper measuring tape, stockinette, tubular netting, pillow cases

This is an observational study of 50 patients, 25 interventional and 25 standard of care. The primary objective of this study is to compare the current standard of care to our modified CDT intervention on functional mobility, pain level, scrotal size, UTI and urinary catheter days in trauma patients with scrotal edema

Process

**Process Steps:**
1. Visual assessment  
2. Measurements  
3. Application of compression  
4. Elevation  
5. Deep breathing as appropriate  
6. Therapeutic exercise

**Visual Assessment and Measurements (in centimeters)**
- Scrotum measurements to be taken pre-intervention and at 24 hour intervals.
- Position for measuring: Patient is supine with head of bed elevated no greater than 20 degrees or specify degree.
- Support and elevate scrotum so the posterior surface is flush with top of thigh (as tolerated).

**Circumferential:** Measure in centimeters to the nearest millimeter of scrotum at widest visual point of scrotum using disposable tape measure.

U/SMILE: Most medial point of inguinal ligament within the inguinal crease to same point on the opposing inguinal ligament within inguinal crease. Record measurements in data table.

**Application of Compression**
- Stockinette and tubular netting size appropriate with multiple layering

**Elevation**
- Support and elevate scrotum so the posterior surface is flush with top of thigh (as tolerated). Keep scrotum elevated as often as possible.

**Deep breathing:**
- Hourly or as often as possible, complete 2 sets of 10 repetitions each
- Instruct patient to inhale through the nose and out the mouth using abdominal muscle to expand (inhale), to contract (exhale).

**Isometric/concentric exercise:**
- Hourly or as often as possible complete, 2 sets of 10 repetitions each
- Isometric: tighten/release of muscles i.e. gluteal, quadriceps, stomach
- Concentric: AROM for hip flexion/extension, knee flexion/extension, and ankle dorsiflexion as able

Discussion

**Results:**
This is an ongoing study, 25 interventional patients completed therapy and the data is in analysis. The control arm standard of care patient data is currently being collected. Preliminary data shows statistical significance in edema and pain reduction with modified complete decongestive therapy.

**Conclusion:**
During the study modifications of inclusion/exclusion criteria along with improved measurement technique were implemented. This was done to create a more objective parameter in patient selection and data collection. We plan to initiate procedural change in the treatment of scrotal edema by implementing a standard of care practice model for all patients with scrotal edema. Future studies are under development

**References**

**Acknowledgments**
HonorHealth Scottsdale Osborn MC  
HonorHealth John C. Lincoln MC  
HonorHealth Research Institute  
©Brigit Anderson
Using A Portable Power Source To Ambulate While On Continuous Renal Replacement Therapy

Haley Bento, PT, DPT, CCS; Ross Imburgia, BSME; Christopher Noren, OTR/L; Joseph Tonna, MD

BACKGROUND

Early Mobility is largely regarded as a safe and feasible way to help mitigate the immobility harm in critically ill patients. Barriers to mobility for patients on continuous renal replacement therapy (CRRT) include catheter type and location, sensitivity of the scales, risk of catheter dislodgement, and lack of internal battery power on the machine itself. Previous studies have looked at safety of bed exercises, edge of bed activity, standing and marching at edge of bed or transferring to a chair while still receiving CRRT and have so far supported the notion that mobility while on CRRT is safe. The lack of battery power, however, has kept patients from being able to mobilize out of their rooms while on these devices.

FIRST PATIENT TRIAL

A patient requiring CRRT and deemed appropriate for ambulation by the physical therapy team was chosen. The patient consented, and was excited about being able to mobilize. The portable battery was placed on a dolly which was able to rest on the IV pole. As this was the patient’s first time out of bed in 6 days, he was assisted by 2 staff members. A third and fourth person were used to follow with a chair and help manage both the equipment and the patient.

The patient successfully ambulated 170 ft, and including rest breaks was out of his room for 19 minutes. There were no alarms on the CRRT machine or interruption to the renal therapies. The patient and his family were excited to see the degree of mobility he achieved and to have the opportunity to participate in activity outside of the patient’s hospital room.

CONCLUSIONS

Use of a portable battery source is a feasible way to overcome the barriers limiting mobility for patients requiring CRRT. The process required multidisciplinary support and approval from various hospital committees for purchase of a device. Careful testing should be performed to determine run-time and learn how to use the battery. Patients enjoy not being confined to their rooms while on CRRT and it allows for increased participation in mobility.

THE BATTERY

Requirements:
- Adequate for max power draw of CRRT machine (600W) +10%
- Certified medical grade
- Small enough to fit on IV pole and be portable
- Mechanical engineer gave choices, approved by biomedical engineers

Chosen Equipment:
- Brand: Cyberpower*  
  Model: M1100XL*  
  Capacity: 1100VA / 880W  
  Output: 120 VAC  
  Plug type: NEMA 5-15P-HG, 6 ft. cord  
  Outlet types: 6 x NEMA 5-15R-HG  
  Warranty: 3 year

Connected Equipment Guarantee: $400,000  
*Note, equivalent models exist from other brands

TESTING AND PERFECTING

- Testing on CRRT machines while not in use  
- Testing while machine was providing CRRT for a patient in bed  
- Testing while machine was providing CRRT for a patient while ambulating in hallway  
- Perfected ease of use including testing a dolly for transport, securement to IV pole  
- Worked on written instructions for use, educating staff  
- Will continue tracking data each time the battery is used for several months to gather as much data as possible to understand battery properties and usage

Testing determined the CRRT machine could run while using the portable battery safely for 90 minutes with no interruption to the renal therapies or equipment

REFERENCES:
Post-extubation laryngeal injury was present in ALL patients; moderate-to-severe injuries are more common than mild injuries after endotracheal intubation.

**OBJECTIVE**

To identify the presence and severity of laryngotracheal injuries found in critically ill patients post-extubation from mechanical ventilation in the intensive care unit (ICU).

**METHODS**

- Prospective, single site, academic hospital, non-randomized cohort study
- Subjects recruited from 5 ICUs (i.e., medical, surgical, neurologic)
  - Inclusion criteria
    - Adult patients (≥18 years old)
    - Intubated with mechanical ventilation >48 hours
  - Relevant exclusion criteria
    - Pre-existing dysphagia, aspiration, voice disorder
    - Head and neck disease/surgeries
    - Pre-existing CNS, neuromuscular, or connective tissue disease
    - Prior intubation/tracheostomy
    - Expected death
    - Flexible nasolaryngoscopy completed ≤48 hours following extubation
    - Laryngeal injury grading: 4-point categorical scale (Table 1)
  - Statistical analysis
    - Non-parametric descriptive statistics
    - MS Excel 2016

**RESULTS**

**Table 1. Laryngeal Injury Grading Schema**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No injury</td>
</tr>
<tr>
<td>1</td>
<td>Self-limited, soft tissue injury</td>
</tr>
<tr>
<td>2</td>
<td>Hematoma, ulceration, fibrin without glottis narrowing, mass lesion, granulation</td>
</tr>
<tr>
<td>3</td>
<td>Stenosis, stenosis with glottis narrowing, hypomobility/immobility of the vocal folds and/or the arytenoid complex</td>
</tr>
</tbody>
</table>

**Table 2. Demographics (N = 33)**

| Age in years, median (IQR) | 63 (52, 68) |
| Sex, Males (%)            | 17 (51%)    |
| Endotracheal tube size in Males, median (IQR) | 7.5 (7.5) |
| Endotracheal tube size in Females, median (IQR) | 8 (7, 8) |

**DISCUSSION**

- All 33 (100%) patients presented with laryngeal injury, most were moderate-to-severe.
  - Grade 1: 3/33 (9%)
  - Grade 2 injury: 17/33 (52%)
  - Grade 3 injury: 13/33 (39%)
- Recommendations:
  - Grade 1 injuries: recommended observation
  - Grade 2 injuries: recommended for follow-up
  - Grade 3 injuries were recommended for acute intervention by a laryngologist.

Figure 1. Prevalence of laryngeal injury by grade

- Grade 0: 0%
- Grade 1: 9%
- Grade 2: 39%
- Grade 3: 52%
Background

- Mechanically ventilated patients frequently experience long-term post-ICU morbidities, including muscle weakness and impaired physical functioning
- Exercise and protein supplementation, delivered early during critical illness, is hypothesized to mitigate muscle weakness and impaired physical functioning, and is being evaluated in the ongoing NIH-funded NEXIS randomized trial (NCT03021902)
- This case series reports on the intensity and duration of in-bed cycle ergometry-based exercise completed by mechanically ventilated patients enrolled in the NEXIS trial.

Case Description

- NEXIS is a multi-centered Phase II randomized trial, with blinded outcomes assessment, evaluating a combination of intravenous (IV) amino acid supplementation and early in-bed cycle ergometer exercise versus usual care in ICU patients requiring mechanical ventilation.
- As part of this trial, we report on 3 enrolled patients receiving in-bed cycle ergometry:
  - Case 1: 18 year old male with septic shock
  - Case 2: 35 year old male with hypothermia
  - Case 3: 52 year old male with traumatic injury and shock

  This case description includes:
  - (1) total cycling time (active + passive) for all sessions (NEXIS goal: 45 min/session)
  - (2) average percent of active cycling/session
  - (3) average active cycling watts (W).

Outcomes

- Case 1: completed 5 cycling sessions, actively cycling a maximum of 41 min/session at mean of 4 Watt. This participant reached 87% of the goal total cycling time and actively cycled for a mean of 83% of sessions.
- Case 2: completed 5 cycling sessions, actively cycling a maximum of 45 min/session at mean of 3.6 W. This participant reached 98% of the goal total cycling time and actively cycled for a mean of 80% of sessions, but 99% for 4 of 5 sessions.
- Case 3: completed 4 cycling sessions, actively cycling a maximum of 33 min/session at mean of 1.9 W. This participant reached 41% of the goal total cycling time and actively cycled for a mean of 78% of sessions.

  All participants received physical therapy sessions, as part of routine care, in addition to the research cycling intervention. Case 1 reported pain due to a posterior chest tube, contributing to reduced cycling time, but there were no serious adverse events related to cycling.

Discussion

- The case series reports how 3 critically ill participants engaged in early in-bed cycle ergometry as part of the NEXIS clinical trial.

Reference

The safety and feasibility of the Ramsey tilt table protocol for mobilizing critical care patients with femoral IABP

Mary G. Fischer, PT, DPT, GCS, Wendy Chan, PT, DPT, L. Ac. Dipl. OM, Mary Saputo, APRN, MSN, AGCNS-BC, CCRN, CSC, Mary Maloney, MS, RN, CCRN, Greta Piper, MD

INTRODUCTION
The IABP is a temporary mechanical circulatory assist device which provides hemodynamic support by augmenting cardiac output and coronary blood flow. Used for patients in cardiogenic shock, the IABP can be inserted via the femoral or axillary artery. The tip of the flexible catheter is a helium filled balloon which rests in the thoracic aorta. The IABP inflates during cardiac diastole, thereby increasing coronary perfusion, and deflates during systole, thereby reducing left ventricular afterload. Patients with femoral IABPs must not flex the hip housing the IABP greater than 30 degrees relegating them to bedrest while awaiting a procedure such as VAD, Heart Transplant or CABG.

Stephen Ramsey, a critical care PT developed a protocol to allow patients with femoral IABPs to safely transfer out of bed to a standing position through the use of a tilt table. This protocol includes assessment of the patient's pre-morbid function, current strength and medical stability. Candidates for this protocol include those who were ambulatory prior to femoral IABP insertion, demonstrated against gravity muscle strength, followed multi-step instructions and had stable vitals. The NYULH protocol added: IABP augmentation parameters, print-out of the IABP waveform before and after mobilization, and tilt table follow during ambulation

PURPOSE
To determine the safety and feasibility of ambulating patients with femoral Intra-aortic Balloon Pumps (IABP) using a tilt table protocol.

METHOD
Patients are dependently transferred from bed to the tilt table which is then gradually tilted (20° increments) from supine to 90 degrees with continual monitoring of vital signs, IABP augmentation, patient status. If all factors are stable, the patient steps off the tilt table with the non-IABP lower extremity. The patient then ambulates with assistance making sure they do not flex their hip past 30°. The patient then returns to the tilt table, stepping up with the non-IABP lower extremity. Patient is lowered to supine and returned to bed.

RESULT
NYULH has safely mobilized 9 patients for 23 sessions of ambulation without major or minor complication. No changes in augmentation, waveform, or balloon position were noted. 9 of the 9 patients received heart transplants and progressed well post-procedure.

CONCLUSION
Select patients with femoral IABPs who meet criteria for the Ramsey tilt table protocol can be safely mobilized and ambulated, avoiding the deleterious effects of bedrest (deconditioning, delirium, impaired ventilation) often seen in this population. We plan to continue to use and refine our protocol to safely mobilize patients with femoral IABP and potentially other populations with restrictions in hip flexion due to invasive equipment or post-operative precautions.

REFERENCE
Ramsey, S., Lucas, J., Ratliff, K., Barrett, P., Krishnasoorthy, A., Hrobowski, T., ... & Yehya, A. Ambulation with Femoral IABP, Pumped and Moving! Journal of Cardiac Failure. 2017; 23(8), S111.
Estep, J.D., Cordero-Reyes, A.M., Bhimaraj, A., Trachtenberg, B. Percutaneous placement of an intra-aortic balloon pump in the left axillary/subclavian position provides safe, ambulatory long-term support as bridge to heart transplantation. JACC 2013;5:382-388.
INTRODUCTION

Patients undergoing cardiac surgery and median sternotomy present significant pain during hospitalization. Transcutaneous electrical nerve stimulation (TENS) is a noninvasive method capable of promoting analgesia and may be an alternative in the management of postoperative pain in this population.

OBJECTIVE

To verify the effects of the use of TENS on sternum pain sensation and on the cardiovascular and respiratory parameters in patients undergoing cardiac surgery by median sternotomy.

METHODS

⇒ Case series including 15 patients, age: 54 ± 13 years old, 11 male;
⇒ Submitted to cardiac surgery (myocardial revascularization or valve replacement) and median sternotomy.
⇒ Pain evaluation

⇒ Patients underwent TENS (frequency of 80 to 110 Hz and pulse width between 50 and 80 µs) for a period of 20 minutes and were reevaluated;
⇒ None of the individuals used analgesics for eight hours prior to the application of TENS.

RESULTS

Table 1. Values of the various variables studied before and after the application of TENS.

<table>
<thead>
<tr>
<th>Protocol Assessed Items</th>
<th>Pre (n = 15)</th>
<th>Post (n = 15)</th>
<th>*p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain – VAS (points)</td>
<td>4 ± 2</td>
<td>1 ± 1</td>
<td>0.00</td>
</tr>
<tr>
<td>HR (bpm)</td>
<td>104 ± 20</td>
<td>97 ± 16</td>
<td>0.02</td>
</tr>
<tr>
<td>RR (rpm)</td>
<td>26 ± 5</td>
<td>29 ± 2</td>
<td>0.00</td>
</tr>
<tr>
<td>SpO2 (%)</td>
<td>93 ± 2</td>
<td>96 ± 1</td>
<td>0.00</td>
</tr>
</tbody>
</table>

VAS - visual analogue pain scale; HR - heart rate; RR - respiratory rate; SpO2 - arterial oxygen saturation. Student’s t-test “p” value (5%)

None of the patients had EKG changes during TENS application.

CONCLUSION

The use of TENS was able to minimize the pain sensation in patients undergoing cardiac surgery. There was a significant improvement in all measured variables. No EKG changes were observed using this technique, which should be considered as an alternative for pain control after cardiac surgery.
EFFECTS OF TILT TRAINING ON ORTHOSTATIC TOLERANCE AND HEART RATE VARIABILITY IN HOSPITALIZED HIV+/AIDS PATIENTS

INTRODUCTION

Hospitalized HIV+/AIDS patients may have autonomic dysfunction associated with regular use of antiretroviral therapy. Bed immobilization may potentiate orthostatic intolerance (OI) and dysautonomia with sympathetic hyperactivation, which in turn is related to the higher frequency of OI. Exposure of the cardiovascular system to orthostatic stress may have a therapeutic effect, causing the reconditioning of the arterial baroreceptor system, preventing exacerbated increases in sympathetic activity.

OBJECTIVE

To verify if tilt training (TT) during hospitalization improves the autonomic balance and orthostatic tolerance of hospitalized HIV+/AIDS patients who remain bedridden.

METHODS

⇒ Controlled clinical trial; 31 patients (age: 36±15 years old, 14 males) diagnosed with HIV+/AIDS who remained in the ward for a minimum of seven days prior to inclusion in the protocol;

⇒ Before discharge, patients underwent a new TTT. During TTT, HRV data were collected and analyzed in the frequency domain (Polar S810i®).

⇒ Statistical analysis used Chi-square test or two-way ANOVA with Scheffé Post hoc when necessary (5% significance). Data presented as mean ± standard deviation.

RESULTS

Table 1. Variables studied, comparing the CO and TT groups.

<table>
<thead>
<tr>
<th>Protocol Assessed Items</th>
<th>CO (n=9)</th>
<th>TT (n=10)</th>
<th>p between groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of stay in hospital (days)</td>
<td>9±11</td>
<td>8±4</td>
<td>0.58</td>
</tr>
<tr>
<td>Positive TTT before hospital discharge</td>
<td>6 (66%)</td>
<td>1 (10%)</td>
<td>0.00</td>
</tr>
<tr>
<td>Time for pre-discharge positivity (minutes)</td>
<td>17±12</td>
<td>30</td>
<td>---</td>
</tr>
<tr>
<td>HRV in 1st TTT (LF / HF index)</td>
<td>2.2</td>
<td>4.4</td>
<td>0.32</td>
</tr>
</tbody>
</table>

CO - control group; TT - tilt training; TTT - tilt table test; HRV - heart rate variability; LF - low frequency; HF - high frequency.

CONCLUSION

TT during hospitalization minimized the incidence of OI in patients with HIV+/AIDS, and a higher sympathetic predominance was observed in the CO group during the pre-discharge period, which could be related with triggering OI.

References:
“Optimizing Time to Volume Based Enteral Nutrition and Reaching Goal Within the First Full Day in Critically Ill Patients Reduces Time in ICU, Hospital Length of Stay and Readmit Rate by Half”

Presented by: Gerry Howick, MBA, RDN, CDN, Krysta Pilot, MSN, RN, CCRN, Racquel Regala, MBA, RDN, CDN, CNSC

Abstract:
Reduce time to initiate nutrition and decrease time to goal nutrition by 25% in critically ill patients using an early volume based enteral nutrition protocol. Therefore improving patient outcomes.

A retrospective analysis was used to review the adequacy of protein and calorie provision and outcomes of an ICU early volume based enteral nutrition protocol (EVBEN). The protocol transpired in three phases. Phase one initiated Enhanced Protein Energy Provision via the Enteral Route (PEP-uP) which followed a standard early volume-based feeding program utilizing any gastric tube for nutrition to start on the first day of admit, with the intention to reach goal calorie and protein needs in first full day in ICU. Phase two, EVBEN, incorporated PEP-uP and specified using a small-bore feeding tube to aid in post-pyloric placement within four hours of intubation. Using plan-do-study-act (PDSA), it was clear time to feed was prolonged and phase three, EVBEN QII, was created which successfully focused on reducing time to start nutrition and time to goal nutrition.

Methods / Strategies:
The clinical nutrition and ICU team at LSCMC utilized lean management tools including root cause analysis and PDSA to analyze the workflow around the existing protocol. This process enabled us to differentiate between what is successful and what needs improvement through the collaboration of the Interdisciplinary team in order to start and advance nutrition early, accordingly and appropriately.

<table>
<thead>
<tr>
<th>Process</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEP-uP (Enhanced Protein Energy Provision via the Enteral Route - Prior to October 2017)</td>
<td>First early feeding protocol using gastric tube and feeding started on day 1 of ICU admit.</td>
</tr>
<tr>
<td>EVBEN (Early Volume Based Enteral Nutrition - October 2017)</td>
<td>Continue PEP-uP goals and initiating TF within 4 hours of intubation using small bore feeding tube.</td>
</tr>
<tr>
<td>EVBEN QII (Quality Improvement initiative - July 2018)</td>
<td>Continue EVBEN with clinical nutrition and ICU team collaboration, updating bedside RN’s, weekly to monthly meetings, education, daily huddles, flyers, and daily Interdisciplinary rounds which includes nutrition adequacy assessments (pt needs to meet &gt;80% of estimated nutrition needs).</td>
</tr>
</tbody>
</table>

Background:
The clinical nutrition and ICU team created an early feeding volume-based protocol in 2015. In 2017, this protocol was updated to specify a small-bore weighted tip feeding tube to meet best practice standards.

In July 2018, the updated protocol was deemed successful in shortening time to goal nutrition but had an increase in time to start nutrition.

Research suggests starting nutrition sooner and reaching goal volume by day one in stable ICU patients reduces ICU length of stay (LOS) and hospital LOS. Observing the practice prompted a “deep dive” and collaboration with the ICU team to review the protocol and modify practice to start nutrition within four hours of intubation.

Measurement / Results:
A 2-year retrospective review of ICU patients found that patients who received nutrition earlier and transitioned to volume goal had:
- Decreased ICU LOS by 5 days.
- Decreased Hospital LOS by 7-11 days
- Reduced readmission rate to 9%.

Conclusions:
Early nutrition and providing goal calories and protein significantly reduced ICU LOS, hospital LOS and readmission rates. The use of a small-bore feeding tube allows patients to continue nutrition support post extubating, which ensures to bridge the gap as they transition to oral diet. This time is typically found to be low in nutrition intake and may have impacted these results.

Recommendations:
Evidence supports the standardization of an early feeding protocol as it is associated with improved patient outcomes.

This is a small retrospective study, and recommendation for a large-scale study is warranted.
Current use of Animal Assisted Therapy in Critical Care throughout the United Kingdom and the development of a set of National Guidelines.

Dr Emma Jackson†, Sarah Anderson ‡, James Evans §, Kate Tantam ¶, Lyndsey Uglow ‡, Simon Riley-Fuller ‡


Objectives
There is limited evidence and guidelines on how to make Animal Assisted Therapy (AAT) accessible in a safe and controlled manner following its increasing use in the Critical Care environment.

Methods
A National meeting was coordinated by the Leeds Teaching Hospitals inviting 21 Critical Care Units using AAT. We had a variety of representatives from 14 different hospitals.

Results:
- Varying use of AAT in current practice.
- Local policies had already been developed; others used the Royal College of Nursing ‘Working with Dogs in Healthcare settings.’ This provided robust internal measures and was reflected in positive reference to AAT in CQC reports.
- Wide discussion on the varying views held by infection control teams on the use of AAT and the importance of adhering to the strict infection prevention on visits.
- Consensus about the importance of accountability and development of a set of standards which AAT can be held up to, in particular logging patients who experience AAT.
- Each hospital had its own inclusion and exclusion criteria for the use of AAT in Critical Care.
  - Common exclusion criteria included patients that are: in isolation, barrier-nursed, immunosuppressed, allergic, phobic, affected by hyperactive delirium, and patients who declined a visit from AAT.

Conclusions:
- Great enthusiasm for the use of AAT in Critical Care but this needs to be balanced with protecting patients, staff, handlers and the animals.
- Need to collect data to show that AAT is beneficial for our patients.
- We are currently working towards creating a set of National Guidelines with the target of launching them by the end of 2020 with the support of Intensive Care Society and long-term aim of inclusion into Guideline for the Provision of Intensive Care Services.

Conclusions:
- Great enthusiasm for the use of AAT in Critical Care but this needs to be balanced with protecting patients, staff, handlers and the animals.
- Need to collect data to show that AAT is beneficial for our patients.
- We are currently working towards creating a set of National Guidelines with the target of launching them by the end of 2020 with the support of Intensive Care Society and long-term aim of inclusion into Guideline for the Provision of Intensive Care Services.
Developing a culture of early identification of delirium combined with reducing sedation use in Critical Care Patients

Dr Emma Jackson, SN Rebecca Bell, Dr Jason Cupitt
Blackpool Victoria Hospital

OBJECTIVES

Identification and treatment of delirium in Critical Care (CC) patients is notoriously poor. This Quality Improvement (QI) project aimed to facilitate earlier rehabilitation of patients through:

1. Improving CC staff knowledge of delirium
2. Improving detection of delirium
3. Reducing patient sedation levels

METHODS

Stage One: Nursing staff survey revealed identifying delirium was a key barrier to treatment.

Stage Two: In response, we introduced a novel delirium scoring system (TUFT)\(^2\). This system tracks a patient over a whole shift, producing an overall delirium score on which to base treatment.

We supported this with Raspberry Pi technology and the introduction of nurse champions in 4 key fields; Delirium, Sleep, Mobility and Sedation.

Alongside this system, we enforced prescribing of target RASS levels for each patient.

RESULTS

Stage One: Survey

- Staff felt the greatest barriers to reducing sedation were:
  - Poor staffing
  - Fear of self-extubation.

- Increased sedation and/or analgesia was the most common response to patient agitation

Stage Two: TUFT and RASS interventions

- Introduction of TUFT resulted in a 12-27% reduction in delirium score over 4 months

- Enforcement of RASS target prescription standards resulted in 74% compliance

- RASS compliance led to average RASS reduction of 3 points

- Nurses felt both systems were easy to implement and follow

CONCLUSIONS

A short and dedicated teaching period, in combination with the introduction of minimally effortful technologies:

- Significantly improved delirium detection
- Significantly reduced unnecessary deep sedation of CC patients

REFERENCES

The BEHAB Study:
Is a combined Behavioral Activation and Rehabilitation intervention in acute respiratory failure survivors feasible and acceptable?

INTRO
- Decreasing mortality from acute respiratory failure → growing number of survivors
- Survivors have long-lasting impairments in physical function, mental health & cognition (Post-intensive care syndrome (PICS))
- Depressive symptoms are risk factor for new impairments in physical function post-ICU

Objectives
- A 12-week BA-R intervention will be feasible by 1.5 patient/month accrual rate and 80% completion of intervention calls
- Decreased depressive symptoms, less impairments in physical function and quality of life, and reduced healthcare utilization.
- The HADS and PHQ-8 will adequately discriminate depressive symptom severity vs. the SCID-5 “gold standard” using the combined patient cohort from the BA-R and control groups

METHODS
To conduct a single-site, pilot RCT (N=54) evaluating the feasibility (primary objective) and efficacy (secondary objective) of a 12-week behavioral activation-rehabilitation (BA-R) intervention versus “usual care”, in acute respiratory failure (ARF) survivors.
- Primary outcome – feasibility
- Secondary outcome – HADS and PHQ-8
Constructing a Grounded Theory of Critical Illness Survivorship: The dualistic worlds of survivors and family members

Background, Study Aims and Research Question:
In the context of increasing survivorship from critical illness it is important to enhance our understanding of the subjective experience of survivors and their families. The critical illness experience is extremely complex, varied and multifaceted. The need to consider the legacy of critical care beyond physiological survival is imperative.

Research question:
How do patients and family members experience their critical illness trajectory?

Methods:
- Working within a relational ontology and a constructivist grounded theory methodology (Charmaz 2014), a series of in-depth interviews were undertaken with survivors of critical illness (n=16), family members (n=15). Interviews were undertaken in a district general hospital setting in England, UK. All interviews were transcribed verbatim. Cross-case analysis and data collection occurring concurrently with theoretical sampling commencing from the outset.

Drivers for Study:
A 55-year-old professional woman involved in a road traffic collision survived a prolonged stay in Critical Care. She describes the experience of surviving critical illness:

"I was having sleep in the deep sleep. You know, and that was weird, and I was shivering so much, you know. And then I thought I can't do this. I can't do this. I just want to die. So I said, 'Am I alive? Am I alive?' at 12:30. And 1:00, 4:00, 7:00. And then I fell asleep, I fell asleep."

Data Analysis
- Data analysis techniques included concept analysis and development, exploration and formulation of the conceptual name. And is exemplified by the concept of “dualistic worlds”. A useful lens as it captured the betwixt and between worlds that survivors experience.

Ethical approval and sample size
- IRAS ethical approval gained via proportionate review (13/LO/0798)
- R&D approval gained at UK NHS Trust (R&D 936)
- 32 patient interviewees, open to 5 semi-structured interviews

Purposeful Sampling
- Survivors of critical illness are followed up post discharge from critical care between 3-6 months in an ambulatory setting

Discussion
- "You must decide what you will be like. You will be different from before the ICU, because you are different." The people who care about you may not understand, but that’s OK. The only way to really understand it is to have lived through it..." 

Critical Junctures of Care
- Ambiguous loss
- Experiencing Delirium
- Physical Debilitation
- Psychological Sequelae

Abstract Inclusion and Exclusion criteria
- Survivors of critical illness and their family members interviewed post discharge from critical care
- Critical illness survival of greater than 72 hours e.g. medical & surgical emergencies
- Survivors interviewed before 6 months post discharge

Cultural and Social Context
- In the middle of our society today, there is a fundamental lack of understanding of the critical illness experience.

Supporting theoretical lens – anthropological theory of liminality.
- Critical illness causes relational disruption
- Leading to dualistic worlds

Scaling up Mid-Range Theory.
- I sought to and assessed my constructed mid-range theory through the theoretical lens of liminality. This was a useful lens as it captured the between and between worlds that survivors experience. Survivors experience a desynchrony with real time and critical illness which can and does cause relational disruption. This may be theorised as the concept of moving from surviving to thriving is considered the greatest challenge for C21st critical care survivors.
A Predictive Validity Comparison Between Domestic and International Students
Non-Cognitive Predictors of Student Success:

RESULTS

• Post intensive care syndrome (PICS) was defined by Needham et al. in 2012 and pediatric PICS (PICSp) was conceptualized by Manning et al. in 2018.
• Collaborative groups have gained interest in the field since the SCCM launched THRIVE.
• We present the first collaborative group for the prevention, detection, treatment and follow-up of PICS and PICSp in Spanish and Portuguese speaking countries.

METHODS

• Support from the International Research Project for the Humanization of Intensive Care Units (Proyecto HU-Cl).
• Founders: 4 adult Critical Care Physicians, 2 Pediatric Critical Care Physicians and 1 adult Critical Care Registered Nurse.
• The founders elaborated:
  • Minimum requirements for acceptance
  • Obligations of the members
  • Design of a shared database
  • Social media presence
  • Program for the 2nd edition of the Spanish National Post Intensive Care Syndrome Meeting.

INTRODUCTION

Returning home after the presented in: Spain, Brazil and Portugal.

The project has been gained since 2018.

The founders elaborated:
  • Minimum requirements for acceptance
  • Obligations of the members
  • Design of a shared database
  • Social media presence
  • Program for the 2nd edition of the Spanish National Post Intensive Care Syndrome Meeting.

RESULTS

• Expression of interest:
  • 6 adult teams from Spain
  • 3 pediatric teams from Spain and Mexico
  • The project has been presented in: Spain, Brazil and Argentina.
  • Endorsement from:
    • FEPIMICTI: Pan American and Iberian Federation of Societies of Intensive Care
    • SEMICYUC: Spanish Society of Intensive, Critical and Coronary Unit Medical Care
    • SECIP: Spanish Society Of Pediatric Intensive Care.

Scan the code with your phone to visit our website (in Spanish) and join us!

Feel free to share on Twitter. Don’t forget to add #ICUREhab
Abdominal Functional Electrical Stimulation in Spinal Cord Injury Patients May Decrease ICU Cost and Length of Stay

Yunna L. Sinskey, MD; Nickolas L. Meyerkord, DO; Paul Lange, MD

Introduction

Respiratory failure is a common cause of ICU admission and the primary cause of morbidity and mortality in spinal cord injury (SCI) patients. SCI patients have impaired respiratory muscle functions making it difficult to clear airways often resulting in respiratory complications. This is most frequent in patients with injuries higher than T7 due to weakened expiratory muscle force resulting in impaired cough. In high tetraplegic patients, the peak expiratory flow rate was less than 50% of predicted normal values. Artificial cough generation are commonly assisted by physiotherapists or through the use of mechanical devices that passively inflate and deflate the lung. However, these techniques are both expensive and cumbersome.

Functional electrical stimulation (FES) is a non-invasive application of electrical pulses to a motor nerve, causing muscles to contract. For patients with impaired ventilatory respiration, FES can be applied to the abdominal muscles (Abdominal-FES) to activate paralyzed respiratory muscles. Furthermore, FES applied repeatedly to paralyzed muscles can improve muscle strength and endurance overtime.

Method

Literature search was performed on PubMed for peer-reviewed articles that investigated the effect of functional electrical stimulation on respiratory function in human subjects. Keywords used were electrical stimulation or functional electrical stimulation or muscle stimulation, and respiratory function or respiration or cough or tidal volume.

Results

Results of A-FES can be largely divided into two categories: acute and chronic effects. Acutely, the use of Abdominal-FES has shown to improve cough peak flow in SCI patients causing immediate effective cough in tetraplegic patients. FES applied repeatedly overtime to paralyzed abdominal muscle also improves muscles strength and endurance, further improving respiratory functions in SCIs. Chronically, Abdominal-FES has also resulted in decreased duration of ventilatory support, decreased duration to achieve tracheostomy decannulation, and reduction of respiratory complications including pneumonia, atelectasis, ventilatory failure.

Conclusion

Ventilatory patterns significantly alters during the first year of SCI due to flaccid paralysis of intercostal and abdominal muscles. The increase in muscle tone overtime assists in improvement of ventilation capacity. However, the ventilation capacity still remains at 60% prior to injury resulting in atelectasis and basal pulmonary fibrosis. Abdominal-FES is effective in significantly decreasing pulmonary complications in SCI patients both in acute and chronic settings. Acutely, the use of abdominal-FES resulted in significant increase in cough peak flow and increase in forced vital capacity. These combined results may overall improve quality of life, morbidity, and mortality. Furthermore, given the noninvasive nature of FES, cheap utilization cost, and decreased ventilatory duration, A-FES has high potential to result in significant cost savings especially in ICU patients. This effect suggests a possible expanded use of A-FES to all ventilated patients regardless of underlying cause of respiratory failure or even patients who were recently weaned off ventilatory support.

Future Directions

Current studies have low participant numbers. A large scale study using abdominal-FES in SCI patients is necessary to further analyze its efficacy. An outcome measure study is planned to expand the use of Abdominal-FES to all ventilated patients within the critical care setting. This existing research has potential to decrease length of ICU stay with cheap non-invasive technology. Limitations of Abdominal-FES include decreased penetration through fat layers limiting patient populations. Potential alternative treatments include magnetic stimulation over thoracic nerve roots or implanted spinal cord stimulation at T9-L1, which is more invasive.

References


Rehabilitation of a Person with Obesity and Post-Operative Hemiparesis

Bonnie B. Swafford, PT, DPT, Saint Luke’s Health System, Kansas City, Mo.

Objective
Healthcare workers have among the highest on-the-job injury rates, according to the U.S. Centers for Disease Control and Prevention. Accreditation and reimbursement pressures are encouraging healthcare facilities to focus on safe, effective care of the highest quality. This report outlines an inpatient rehabilitation program for a person with obesity and post-operative hemiparesis—while maintaining the highest levels of safe patient handling.

Methods
A 42-year-old male with BMI of 65.2 presented with flaccid left upper and lower extremities following a surgical resection of a glioma that was causing complex partial seizures. This summary outlines the interprofessional collaboration of hospital staff and equipment vendors for his care from intensive care to inpatient rehabilitation to discharge home. Patient evaluation and interventions included safe patient handling techniques and appropriate equipment.

Interventions

**Neuro ICU (4 days)**
- Active right-sided exercise, passive and assisted left-sided exercises
- Assisted rolling and sitting edge of bed
- Dependent transfers out of bed to chair using mechanical lifts

**Step-Down Unit (9 days)**
- Progression of ICU interventions to facilitate more patient participation in movements and activities

**Inpatient Rehab Unit (26 days)**
- Supine and seated assist, progressing to active then resistive left-sided exercises
- Sit to and from supine, lateral scooting, sliding board transfers
- Sit to stand from elevated mat with bariatric walker
- Static and dynamic standing balance activities
- Gait with roller walker and wheelchair follow
- Progression of walking to cane
- Step up on 4” curb in parallel bars progressing to 6” steps with rail

Results/Outcomes
Patient’s level prior to surgery was independent in all mobility and working full time. After surgery he was dependent in functional mobility. Patient was in Neuro ICU for four days, Step-Down Unit for nine days, and Inpatient Rehab Unit for 26 days. Mechanical lifts and bariatric seating systems were utilized as out-of-bed mobility started in the ICU. Specialized equipment was used for supine lateral transfers, upright standing transfers, seated mobility, and ambulation training.

Initial and discharge function was documented with outcome measures. Functional Index Measure mobility score improved 17 points. KUH sitting and standing balance improved 8 points. KUH Physical Therapy Acute Care Functional Outcomes improved 22 points.

Conclusions
Patient progressed from dependent, using mechanical lifts and specialized bariatric equipment with assistance of 2-4 staff members to independent and safe walking with a cane on level surfaces and stairs. Extensive planning and procurement of appropriate equipment helped the patient progress in a safe and effective manner and no employees were injured providing care for this complex patient.

KUH Physical Therapy Acute Care Functional Outcomes Tool

<table>
<thead>
<tr>
<th></th>
<th>Eval</th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Mobility</td>
<td>2</td>
<td>3</td>
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</tr>
<tr>
<td>Transfer</td>
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<tr>
<td>Gait Assist</td>
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<tr>
<td>Gait Distance</td>
<td>0</td>
<td>2</td>
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<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

References

About the Author
Bonnie B. Swafford, PT, DPT
Bonnie is a front-line clinician at Saint Luke’s Health System in Kansas City, Mo. She has specialty experience in the rehab of bariatric patients. She is a clinical instructor, a frequent presenter, and a manuscript reviewer. bbswafford@gmail.com

Special Thanks:
Mark Dwyer, PT, MHA, FACHE; Lorra Embers, PT, MSHA, FACHE; Jackie Dwyer, PT, DPT; Sue Worden, PT, MS; Sizewise.

Poster Presentation at the Johns Hopkins Critical Care Rehabilitation Conference, Baltimore, Md., 2019

The author and her rock star patient, RB.
(Photo used with permission.)
Introduction

We were a new rehabilitation team working in Critical Care. We wanted to support our colleagues and our patients to showcase the everyday excellence that takes place in practice, promoting rehabilitation and recovery during and after critical illness.

We launched our twitter campaign in June 2018. We have now shared over 2000 badges, 30 lightboxes, 200 cards and we have shared the idea online with 50 different healthcare teams from across the world. We have had an online reach of over 1 million.

We share patient, loved ones and staff stories to promote the "little things" that happen everyday. Promoting rehabilitation and recovery after Critical Care.

Follow us @tantamkate, @PlymouthICUReh1 using the #Rehablegend to be inspired and to share the success of your patients and colleagues.

We wanted to improve the culture of rehabilitation
We wanted to promote holistic recovery
We wanted to improve teamwork
We wanted to share patient stories
We wanted to celebrate success
We wanted to empower staff, patients and loved ones

Sharing Stories – A catalyst for change

We found that by sharing recovery stories from patients, staff and loved ones we were able to motivate, inspire and innovate clinical practice.

Stories of Recovery - shared across professional teams and locations

We needed a way to share these stories in teams, across hospitals - promoting clinical excellence

We created the #Rehablegend campaign

A #Rehablegend - Anyone who has done anything to enhance, support or facilitate rehabilitation

Feedback

We launched our twitter campaign in June 2018

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Conclusions

• Sharing stories online to promote and foster a supportive rehabilitation culture is positively received by patients, loved ones and inter professional teams.

• Patients, loved ones and staff have been happy to share stories and have enjoyed receiving #Rehablegend badges, boxes and cards.

• This may be a useful tool to motivate staff and initiate a culture shift in Rehabilitation practice in Critical Care.

For more details please see @tantamkate Kate.tantam@nhs.net
Development & Implementation of a Practical Multi-Hospital ICU Rehab and Training Program

Kari V. Voll, OTR/L, MBA, PMP & Shereen M. Davis, MS OTR/L

Background

Hospital physicians and administrators requested a review of resources needed to have patients in Intensive Care Unit(s) treated by therapy more frequently. Therapy leadership responded to this request by using a structured approach to define the request and response.

Objectives:
- Standardize and enhance the frequency and quality of therapy services provided to patients admitted to the ICU
- Supplement the current nurse-driven mobility practices

Actions Taken:
- Extensive literature review to explore best practice and model programs
- Examined current practice versus best practice
- Provided ICU Rehab course by international expert for key therapy staff and leaders
- Developed and provided 4-hour training class for therapy staff
- Therapy leadership attendance at Johns Hopkins Critical Care Rehab Conference
- Reviewed financial models that project savings based on volume and program implementation
- Utilized a project management approach to define and manage program requirements including: expenses, risks, human resources, stakeholder analysis, outcomes measures, and data collection
- Developed a strategic communication plan
- Obtained stakeholder support, including hospital Presidents, VPMAs, Nurse Executives, Intensivists, and ancillary department leaders

Pilot Program

Using the above process, a pilot program was developed. The pilot was implemented at 3 demographically diverse hospitals in the Hampton Roads region of Virginia.

Pilot Program Parameters:
- Patients admitted to General/Medical ICU for >= 48 hours who met criteria for therapy
- Physical Therapy 5 times per week
- Staffed PT at 1.9 patient ratio
- Occupational and Speech Therapy as indicated
- Attendance at Multi-Disciplinary Rounds
- Collaboration with ICU clinical leaders and staff

Pilot Program Results

During the 3-month pilot program:
- 412 patients received 951 therapy interventions
- Average visits per patient while in ICU = 2.3
- 64.7% of interventions involved getting out of bed
- 33.8% of interventions involved ambulating > 10 feet
- 20.6% of interventions involved ambulating > 50 feet
- 10.3% of interventions were with a ventilated patient
- 75.3% of out of bed interventions were performed by a therapist without additional staff
- No significant adverse events

The limited data available did not indicate a significant improvement for the cumulative ICU population (those receiving and not receiving therapy) for the following:
- ICU LOS
- Hospital LOS
- VAE, HAPI, CLABSI, CAUTI, Fall rates
- Ventilator days

Positive Impact

While data was not available to demonstrate an impact on hospital metrics, other areas of impact were noted:
- Higher levels of mobility interventions occurred
- Substantially more therapy was provided
- Pilot was completed FTE neutral and without added expenses
- Significant impact on staff knowledge, engagement, interdisciplinary collaboration
- Overwhelming support from hospital leadership
- Requests to implement system-wide

Lessons Learned

The program was unanimously supported by executive leaders, clinical leaders, and front-line staff. Keys to success included:
- Gap analysis between current and best practices
- Stakeholder support
- Strategic communication plan
- Interdisciplinary collaboration
- Therapy staff education

Multi-Hospital Training Program

Classroom Training – 4 Hours:
- Program overview
- Video demonstrations
- Therapy presentation
- Respiratory presentation
- Panel Q&A

ICU Therapy Standardization Toolkit:
- Importance of therapy in the ICU
- Benefits of early ICU therapy
- Cautions with therapy in the ICU
- Medical, respiratory, and safety considerations
- Delirium in the ICU
- ICU-acquired Weakness
- Barriers to implementation
- Outcomes – evidence-based intervention
- The ICU Rehab Program expectations
- ICU monitoring
- Lab values
- Treatment ideas
- Education resources, websites
- Literature list

Expansion

Project initiation and program development: 10 months
Pilot program: 3 months
Data analysis and program refinement: 6 months
Training and implementation at 8 additional hospitals: 7 months

Literature List


Kari V. Voll, OTR/L, MBA, PMP & Shereen M. Davis, MS OTR/L
Poster Presentations: Pediatric Content
Quality improvement intervention to promote early mobilization in critically ill children

Sjoukje Hoekstra RN1, Tabitha van den Adel MSc2, Judith Steenhorst RN1, Mariska de Heer RN1, Petra Floor RN1, Sascha Verbruggen MD PhD1, Erwin Ista RN PhD1

1 Pediatric Intensive Care Unit, Department of Pediatric Surgery, Erasmus MC-Sophia Children’s Hospital, Rotterdam, The Netherlands; 2 Department of Orthopedics, Physical therapy, Erasmus MC-Sophia Children’s Hospital, Rotterdam, The Netherlands

Contact: w.ista@erasmusmc.nl

Aim

We determined the feasibility and safety of the implementation of an early mobilisation program in a PICU.

Setting

The PICU of the Erasmus MC-Sophia children’s Hospital has 28 beds. Specialties are: ECMO center, (neuro) trauma center, neonatal surgery (e.g. gastro-abdominal birth defects) and cardiac(surgical) care.

Methods

Design

A prospective pre-posttest implementation study was conducted in patients on a PICU for at least 3 days with a maximum of 28 days.

Before EM (usual care)

- During this phase we assembled a mobilization team, consisting of PICU nurses, intensivist and pediatric physical therapist

Quality improvement (QI) phase

- Set up a multicomponent, multidisciplinary protocol for EM with safety levels
- Education among PICU staff about the protocol
- Use of new equipment.
- More consultation between PT and nurse

After implementation EM

- The last phase was after QI all included patients were treated according to early mobilization program
- Challenge: To keep EM embedded in daily regular care

Outcomes

Primary outcome was the number of mobilization activities. Secondary outcomes were prevalence of delirium, consumption in sedatives, and mobilization related adverse events.

Results

Demographics

In total, 55 children (pretest) and 58 children (posttest) were included, with a median age of 31 months (IQR 7-106) and 35 months (IQR 8-147), respectively. More 60% of the patients were ventilated, with a median duration of 6 days (IQR 3-11) and 5 days (IQR 2-12), respectively.

Mobilization activities

The median number of mobilization activities increased from 4 (IQR 3-5) to 5 (IQR 4-7) (p<0.0001) (Table 1). Among children who were ventilated, there was an increase in the proportion who participated in sitting in a chair: 27% vs. 54% (p<0.029) (Figure 1).

The physical therapist was significantly more involved in mobilization after implementation of EM, 46% vs. 24% before (p=0.049).

Table 1 Mobilization activities (per patient per day)

<table>
<thead>
<tr>
<th></th>
<th>Before QI (n= 55)</th>
<th>After QI (n= 58)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-bed activities*</td>
<td>3 (3-5)</td>
<td>5 (3-6)</td>
<td>0.01</td>
</tr>
<tr>
<td>Out-of-bed activities*</td>
<td>0 (0-1)</td>
<td>1 (0-1)</td>
<td>0.12</td>
</tr>
<tr>
<td>Total mobilization activities*</td>
<td>4 (3-5)</td>
<td>5 (4-7)</td>
<td>0.006</td>
</tr>
</tbody>
</table>

Table 2 Clinical outcomes

<table>
<thead>
<tr>
<th></th>
<th>Before QI (n= 55)</th>
<th>After QI (n= 58)</th>
<th>p-value</th>
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</thead>
<tbody>
<tr>
<td>Safety, adverse events (n)</td>
<td>0</td>
<td>0</td>
<td>NA</td>
</tr>
<tr>
<td>Sedatives / opioids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Midazolam, cumulative dose (mg/kg)*</td>
<td>2.8</td>
<td>2.9</td>
<td>0.79</td>
</tr>
<tr>
<td>- Morphine, cumulative dose (mg/kg)*</td>
<td>0.18</td>
<td>0.22</td>
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<tr>
<td>Prevalence delirium (%)</td>
<td>15.3</td>
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</tbody>
</table>

Table 2 Clinical outcomes

SOS-PD score, at least one score ≥4

Conclusions

Implementation of a structured EM program in PICU patients is feasible and resulted in no adverse events.
Quality Improvement Intervention to promote Early Mobilization in the PICU: nurses’ and physicians’ opinions and perceived barriers

Sjoukje Hoekstra RN1, Tabitha van den Adel MSc2, Judith Steenhorst RN1, Mariska de Heer RN1, Petra Floor RN1, Sascha Verbruggen MD PhD1, Erwin Ista RN PhD1

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Introduction

Early mobilization (EM) of critically ill adults has been found safe and effective, resulting in improved muscle strength and functional abilities to reduction in ICU and hospital length of stay.1 Early mobilization of pediatric ICU patients seems feasible and safe.2,3 However implementation of physiotherapy and mobilization is often withheld in critically ill children because of perceived problems to implement this strategy. To characterize these perceived barriers we evaluated the opinions of our PICU staff, including PICU nurses and physicians, before and after implementation of an EM program.

Aim

In the current study we evaluated the opinions and perceived barriers of nurses and physicians to EM before and after implementation of an EM program.

Methods

Design A 15-questions survey was disseminated before and after the implementation of an EM program to nurses, nurse practitioners and physicians of a level 3, 28-beds medical/surgical PICU in the Netherlands.

Survey A multidisciplinary team developed the questionnaire, using previously published data on provider concerns and barriers to implementation from adult and pediatric quality improvement studies. The questionnaire was sent out electronically to the PICU staff, 4 months before (December 2017) and 4 months after (October 2018) implementation of the EM program.

Results

Demographics Ninety-four (59.1%) and seventy-one (48.6%) members of the PICU staff completed the survey respectively before and after implementation. Figure one shows the demographics of the respondents. The majority (83%) of the respondents were nurses.

Questionnaire results Support of physical therapists for EM was perceived as significantly higher after implementation: 33% vs. 76% (p<0.001). 17% of all participants before and 32% after implementation thought that patients’ family satisfaction would increase with EM.

Conclusions All nurses and physicians considered EM as important for critically ill children. Further, our research demonstrates that most of the perceived barriers had been resolved after implementation of EM.

References

The safety and feasibility of sitting an infant on Extracorporeal Cardiac Life Support: a case study

Holly Hyland, DPT
Children’s Hospital of Wisconsin
Milwaukee, WI

Introduction

- Extracorporeal life support provides mechanical support to the heart, lungs, or both.
  - A rotary or centrifugal pump, such as Rotaflow, can be used for short-term ventricular assist device (VAD) support.
  - The circuit set-up of Rotaflow VAD support and extracorporeal membrane oxygenation (ECMO) are similar; however, an oxygenator is not utilized in VAD support.
  - Extracorporeal VAD systems can be used for bridge-to-transplant.

- Deconditioning and immobilization are correlated with worse outcomes post heart transplant.
- Mobilizing infants on extracorporeal short-term VAD support has not been studied.

Case

- Former 35 week male twin born with decompensated heart failure likely due to intrauterine myocardial infarction.
- Required inotropic support and intubation at birth.
- 12 weeks of life:
  - Septic shock and necrotizing enterocolitis.
  - Cannulated onto VA-ECMO via the neck.
  - Left ventricular vent placed the next day.
- On ECMO for 11 days prior to transition to left ventricular assist device (LVAD) via Rotaflow pump.
- Extubated 30 days after cannulation.
- Remained on extracorporeal cardiac life support for a total of 76 days prior to heart transplant.

Intervention

- Critical care attending physician approved transition to sitting.
- Bedside RNs and PT or OT evaluated patient for appropriateness of sitting prior to each therapy session.
- Caregivers involved:
  - One RN supported cannulas.
  - Second RN supported endotracheal tube, chest tubes, and other lines.
  - PT or OT.
  - Child life specialist.
- PT or OT actively transitioned patient to sitting position and provided patient with trunk and neck support while sitting.
- Duration of sitting progressed with each session.
- Therapist facilitated activation of neck flexors and extensors to work towards head control.
- Activities while sitting included: reaching, sensory play, visual skills, and social interaction.

Results

- Patient sat for a total of 399 minutes:
  - Reclined sitting: 57 minutes.
  - Full upright sitting: 342 minutes.
- Patient had 52 PT or OT sessions while cannulated with 22 of these sessions focused on sitting.
- Patient started sitting 24 days after cannulation onto ECMO.
- Sitting duration per therapy sessions:
  - Average: 18.13 minutes.
  - Longest: 45 minutes.
- Sitting terminated in each session due to patient fatigue with no sessions being terminated due to safety concerns.
- Sitting therapy sessions cancelled 14 times prior to initiation of session due to: newly repositioned cannula, acute hemodynamic instability, procedures, and decreased comfort level of nursing.
- Patient progressed from no head control at initiation of sitting to bobbing head control by the last pre-transplant therapy session.

Conclusions

- Sitting/mobilizing an infant on extracorporeal cardiac life support via Rotaflow LVAD can be safe and feasible.
- A multidisciplinary team approach is crucial.
- Continued evaluation of a patient’s appropriateness for sitting prior to each session is essential.

References


Acknowledgments

Special thanks to Sonya Baillie, OTD, CTR/L and Nate Thompson, MD, PharmD for guidance on this poster presentation, to the cardiac ICU nurses who assisted diligently with every therapy session, and to the cardiac ICU physical and occupational therapists, the cardiac intensive care physicians, and the heart transplant team.

Photographs used with permission.

Figure 1: Patient participating in sensory play

Figure 2: Patient in supported upright sitting
“Rady-Set-Go”: Promoting Early Mobilization in the Pediatric Intensive Care Unit
Elizabeth Kantor BSN, RN, CCRN, C-NPT

PICO Question
In pediatric intensive care unit patients, does an early mobilization protocol compared to current practice increase the number of early mobilization orders and nursing compliance?

Methods
• Evidence Based Practice Implementation
• Met with stakeholders to cultivate early mobilization champions
• Created nomenclature: “Rady-Set-Go”
• Presented didactic education at team meetings and symposiums
• Executed scenario simulations at skills fairs
• Each identified champion spent 1:1 time on-shift with staff to role model and assist with compliance of activity orders

Summary
This project demonstrated a multidisciplinary, collaborative approach and proper equipment for staff and patient protection as essential components to successful and safe mobilization of a PICU patient.
• Engage champions from each discipline: Physicians, NP, RN, RT, OT, PT, and nutrition
• Create and market a catchy name
• Write early mobilization maneuvers into order sets and standards of care
• Include parents and caregivers in early mobilization plans

Results
To date, efforts to promote early mobilization have resulted in an increased number of patients getting out of bed for the first time while in the PICU.

Graph: First Time Out of Bed

This intubated PICU patient transferred out of bed to a wheelchair with the help of one nurse, one respiratory therapist, two physicians, and one parent!
“RADY-SET-GO!”

Rady Childrens Hospital, San Diego, CA
Elizabeth Kantor: ekantor@rchsd.org
Introduction:
Early mobilization (EM) is defined as the application of physical activity within the first two to five days of critical illness or injury in an intensive Care Unit (ICU). EM is proven to be a safe practice. It is also been described as feasible and with great short to long term benefits. In order to implement EM in the ICU the multidisciplinary team must identify and overcome perception barriers. In Mexico EM is not a standardized practice in the ICU.

Objetives:
• Describe the barriers for EM in a Pediatric intensive Care Unit (PICU) in a specialized children's hospital in Central Mexico.
• Identify the knowledge and beliefs about the benefits of EM in among the pediatric intensive care professionals.

Method:
• Apply a survey that determines the perceptions of PICU professionals concerning the most important barriers for EM in the Hospital of Children and Women Specialties in Querétaro.
• The survey instrument was based on Hoyer (2015), translated and validated by experts. Data was analyzed using Cronbach’s Alpha (0.70).
• Twenty three professionals completed the survey. Of these, 63% were female and 37% male with a mean age of 32.0 ± 7.6 years and 2.6 ± 3.1 years of experience treating critically ill children.

Results:
Health providers at the hospital knew the benefits and the security of EM. A total of 67.8% agreed or totally agreed that the hospital does not have the equipment and/or furnishing to apply EM. Survey results found that basic EM procedures were conducted by at least once a day. The most limiting barrier to greater implementation of EM identified by the survey was the lack of proper equipment.

Conclusion:
EM is accepted as an important part of the treatments involved in this PICU. If we want to completely describe Mexican’s barriers for EM in pediatrics further multicenter study will be needed.
"A new collaborative PICS and PICSp group is being launched in Spanish and Portuguese speaking countries"

INTRODUCTION
• Post intensive care syndrome (PICS) was defined by Needham et al. in 2012 and pediatric PICS (PICSp) was conceptualized by Manning et al. in 2018.
• Collaborative groups have gained interest in the field since the SCCM launched THRIVE.
• We present the first collaborative group for the prevention, detection, treatment and follow-up of PICS and PICSp in Spanish and Portuguese speaking countries.

METHODS
• Support from the International Research Project for the Humanization of Intensive Care Units (Proyecto HU-CI).
• Founders: 4 adult Critical Care Physicians, 2 Pediatric Critical Care Physicians and 1 adult Critical Care Registered Nurse.
• The founders elaborated:
  - Minimum requirements for acceptance
  - Obligations of the members
  - Design of a shared database
  - Social media presence
  - Program for the 2nd edition of the Spanish National Post Intensive Care Syndrome Meeting.

RESULTS
• Expression of interest:
  6 adult teams from Spain
  3 pediatric teams from Spain and Mexico
• The project has been presented in: Spain, Brazil and Argentina.
• Endorsement from:
  - FEPIMCTI: Pan American and Iberian Federation of Societies of Intensive Care
  - SEMICYUC: Spanish Society of Intensive, Critical and Coronary Unit Medical Care

Scan the code with your phone to visit our website (in Spanish) and join us!

Feel free to share on Twitter. Don’t forget to add #ICUREhab

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@itaca_grupo
@grupo_itaca

Miguel Rodriguez-Rubio1,10, MD; Elena Álvarez-Rojas, MD1; M Ángeles De La Torre Ramos, MD2; Ángela Alonso-Ovies, MD2,3; Gabriel Heras La Calle, MD3,4,5, Carlos Velayos Amo, MD2, Jose Antonio Ángel Sesmero, RN, MSc3,4,5, Jose M. Arón MD, PhD7,8,9

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8 Instituto de Investigación del Hospital Universitario La Paz (IdiPAZ), Madrid, Spain.
9 Centro de Investigación Biomédica en Red Enfermedades Respiratorias (CIBERES), Spain.
10 Department of Pediatrics, Universidad Autónoma de Madrid, Madrid, Spain.
**Healing walks** expose critically ill children to natural light and natural views and they could decrease the incidence of delirium, Pediatric Post Intensive Care Syndrome (PICSp) and contribute to illness recovery.

**CONCLUSIONS**

- Protocolized HEALING WALKS outside of PICU are a safe and effective way of exposing patients to natural light.
- They provide an opportunity for the family to gather around the critically ill child outside the PICU environment and help establish a positive work climate with families and healthcare practitioners.

**METHODS**

- With support from the Spanish Fundación para el Progreso en el Tratamiento del Niño grave (Foundation for the Improvement in the Treatment of the Critically Ill Child) we developed a project called 'Healing Walks' consisting of protocolized walks outside of the Unit.
- Patients with risk factors or previously diagnosed with delirium are selected for 'Healing Walks' hypothesizing that exposure to natural light and natural views can decrease the incidence of delirium, contribute to illness recovery and help prevent pediatric Post Intensive Care Syndrome (PICSp).
- Individual risk assessment for patients is mandatory before planning the walk in an open space within the hospital facilities but outside of the PICU. Family involvement in the planning process is ensured.
- An informational video in Spanish was produced to promote this project and help families and institutions. In it, parents and siblings reflect on the impact of the admission to PICU and of the environment, specially the absence of natural light.
- The video was uploaded to YouTube® in Spanish with great impact on Social Media, specifically more than 8000 impressions on Twitter® and close to 3000 views on YouTube®.
- We hereby present the Spanish version with English subtitles.
Introduction

Expressive Writing Background

- Expressive writing (EW): therapeutically-focused writing that involves disclosure of personal information, thoughts, or feelings (1).
- The ICU and other medical settings feature many stressors for patients, their families, and clinicians.
- Stress has been shown to be detrimental to human health in many ways (2).
- EW has been shown to reduce stress, improve disease-related quality of life, and reduce physical symptoms in numerous populations (3-15).
- EW interventions also have the potential to be cost-effective, low-risk, and generally well-accepted by patients.
- Many questions still exist related to optimal EW intervention design, delivery, and mode of benefit.

History of The 3 Minute Mental Makeover (3MMM)

- The 3MMM is a brief, clinically-focused EW intervention designed for use in routine clinical practice (16).
- Practitioner and patient/family members both complete a short writing exercise and share what they have written with one another.
- The 3MMM has been shown to be associated with reduced stress for patient/family members and practitioners immediately post-intervention.

 Aim of this Study:

To examine long term practitioner and patient/family member perspectives regarding the 3MMM, as well as long term use of writing to cope with stress.

Methods

Sample: Patients and families in the NICU, PICU, general inpatient units and outpatient clinics of a suburban children’s hospital (n=61).

- Practitioners who facilitated 3MMM intervention in the original study (n=8): 2 pediatric residents, 3 pediatric nurses, a developmental psychologist, a developmental educator, and a pediatric cardiologist.

Patient/Family Contact: A follow-up phone survey was attempted for all original patient/family participants (n=96) 12-18 months after participation in original 3MMM study.

Practitioner Contact: A follow-up survey was emailed to the practitioners (n=8) approximately 24 months after participation in original 3MMM study.

Survey Contents:

- Perceived usefulness of 3MMM.
- Important/Unimportant aspects of the 3MMM.
- Continued use of the 3MMM/ other forms of writing to cope with stress.
- Barriers and benefits to using the 3MMM in clinical practice.

Analysis: Responses from the original study and follow-up survey were compared using the Wilcoxon signed rank test.

Results

- Of the 61 original patient/family participants, 96 (64%) were reached for follow-up.

- 52 (85%) agreed that the 3MMM had been helpful.
- 54 (89%) of patient/family participants agreed it was important that providers and participants wrote together.
- 56 (92%) indicated that it was important that both provider and patient shared what they wrote.

Writing Behavior Changes

Figure 1. At follow-up, 36 (59%) of patient/family participants reported using writing to help cope with stress, compared to only 23 (38%) at baseline (p = 0.005).

Clinician Perspectives

Figure 2. There was also a trend towards more clinicians using EW (the 3MMM) with their patients, comparing pre and post-original study.

Figure 3. The majority of clinicians (87%) also continued to use the 3MMM in clinical practice following the 3MMM study and ranked it as both feasible (6/8) and worth the time investment (6/8).

Discussion

Comparing to current literature: Compared to other EW interventions, the 3MMM is brief, used in clinical practice, and does not require advanced training. No other EW interventions in the literature have patient/family and practitioner write and share together, which may be an important factor. Also, no other EW studies have examined long-term clinician perspectives and use of an EW intervention.

Limitations: Possible volunteer bias, non-controlled, small practitioner sample size, non-validated survey instruments.

Future Research: Examine short and long-term effects on a larger group of practitioners, evaluate the impact of 3MMM on patient satisfaction, physical markers of stress (BP, cortisol, etc.), and practitioner burnout and job satisfaction.

Conclusion

- 3MMM intervention demonstrated long-term perceived benefit and may be associated with lasting behavior change in both patients/family and practitioners.
- These findings provide preliminary support for the acceptability, feasibility, and helpfulness of 3MMM for practitioner use with patients and families in the ICU and other clinical settings.
8th Annual Johns Hopkins Critical Care Rehabilitation Conference
Poster Session

TITLE
Better Together: Long-Term Behaviors and Perspectives after a Provider-Family Writing Intervention in the ICU

ABSTRACT

Objective: An expressive writing intervention, the Three-Minute Mental Makeover (3MMM), was previously associated with reduced stress for providers, patients, and families in ICUs and other clinical settings. The goal of this follow-up study was to evaluate long-term use of writing and perspectives after participation in the 3MMM.

Methods: The original study involved patients and families in the neonatal and pediatric intensive care, inpatient units and outpatient clinics of a children's hospital. Healthcare providers led the writing intervention, writing concurrently with patients and families using the 3MMM format. Follow-up contact by phone was attempted for all original patient/family participants 12 to 18 months after completing the exercise, and for providers, approximately 24 months. Participants were surveyed about perceived usefulness, what aspects of the 3MMM were important, and continued use of the 3MMM and other writing to cope with stressful situations. Original and follow-up survey responses were compared using the Wilcoxon signed rank test.

Results: Of the 96 original patient/family members, 61 individuals were reached, remembered the 3MMM, and agreed to participate in the follow-up study. Of the 61 participants, 52 (85%) agreed that the 3MMM had been helpful, 54 (89%) agreed it was important that providers and participants wrote together and 56 (92%) indicated that it was important that both provider and patient shared what they wrote. At follow-up, 36 (59%) reported using writing to help cope with stress, compared to only 23 (38%) at baseline (p = 0.005). The majority of clinicians (87%) also continued to use the 3MMM in clinical practice following the 3MMM and ranked it as both feasible (6/8) and worth the time investment (6/8).

Conclusion: The 3MMM intervention demonstrated long-term perceived benefit and may be associated with lasting behavior change. Over one year after participating in this short writing exercise, families and patients continued to report that the 3MMM had been helpful. Respondents also reported that it was important to write and share together with their provider, and participation in the 3MMM was associated with increased writing use as a coping technique. Additionally, findings among practitioners surveyed provide preliminary support for the feasibility of 3MMM use as part of routine clinical practice.

Abbreviations: EW: expressive writing; 3MMM: Three-Minute Mental Makeover; NICU: neonatal intensive care unit; PICU: pediatric intensive care unit.

Keywords: communication, expressive writing, mindfulness, narrative medicine, stress reduction, writing together

3MMM PROMPT
1. Three things you are grateful for (be specific; for clinicians- make one of them about the patient).

2. The story of your life in 6 words (example: Born, school, work, work, work, work).

3. Three wishes -pretend you rub a magic lamp (for clinicians- make one of them about the patient).
3MMM Poster References


Want to learn more? Read about the 3MMM Project:

http://almanac.acehp.org/p/bl/et/blogid=2&blogaid=468


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Case Series Description

• Four case series discussion performed at NY Presbyterian Children’s Hospital over the past two years.

• Post operatively patients received ECMO, and participated with pediatric rehabilitation therapies during their ICU course.

• Therapists attended ECMO rounds, bedside rounds and closely communicated with ICU and ECMO teams, Perfusion and Nursing with regards to treatment progression and positioning.

• Clinical decisions guided by activity levels on daily basis.

• 2 of 4 patients were successfully mobilized while cannulated.

Results

• Early therapy consult and collaborative team approach are vastly beneficial.

• Pain, anxiety and skin care optimization.

• Individualized SpO2 parameters adapted to post-operative anatomy.

• Importance of patient and caregiver education regarding activity pacing and energy conservation methods.

• Beneficial use of the Livengood walker for this patient population.

• Initiating PICU levels of care for the Pott’s Shunt patients.

<table>
<thead>
<tr>
<th>Case</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<tr>
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<td>16</td>
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<tr>
<td>Duration Cannulation</td>
<td>4 days</td>
<td>3 days</td>
<td>13 days</td>
<td>6 days</td>
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<tr>
<td>Timing for therapy orders</td>
<td>POD 5</td>
<td>POD 2</td>
<td>POD 2</td>
<td>POD 1</td>
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<td>Therapy Sessions</td>
<td>10 OT 14 PT</td>
<td>13 OT 15 PT</td>
<td>17 OT 16 PT</td>
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<td>32 days</td>
<td>27 days</td>
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<td>Pressure ulcers</td>
<td>Stage 1 sacral</td>
<td>Stage 2 coccyx</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Rehabilitation Limitations

• Complicated discharge issues with this special population due to limited outpatient pediatric pulmonary rehab programs.

• Travel considerations and equipment needs.

Conclusion

• This complex management of patients with pulmonary hypertension management is evolving and initiation of therapeutic interventions during the ICU course is substantially beneficial.

• Pain, skin care management, ADL and mobility performance improved with therapy interventions.

• Pulse oximetry monitoring parameters from several anatomical sites are important to monitor for appropriate shunting.

• Clear communication and parameter determination with the medical team is essential.

References


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The authors would like to acknowledge the staff of Morgan Stanley Children’s Hospital for their collaboration and teamwork.

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Optimizing Functional Outcomes After Pott's Shunt Palliative Surgery

Atara Sheinson, OTR/L
Kathleen Riley, DPT
Denise Gibbs, DPT

Objectives

• Discuss rehabilitation considerations with the pediatric population recovering from Pott’s Shunt procedure.

• Explore rehabilitation potential during and post hospital course.

• Reinforce the importance of an interdisciplinary approach and culture of care.

Medical Background

• Recent treatment strategies have improved the life expectancy of pediatric pulmonary hypertension patients via medical management and a novel surgical approach called the Pott’s Shunt.

• The shunt relieves pressure on the right ventricle and increases oxygen blood flow to upper body, preserving right ventricular function prior to lung transplantation. Team expects to see a decrease in lower extremity SpO2 with activity to ensure proper shunting of deoxygenated blood.

• Post operatively patients are on ECMO as a bridge to recovery, and rehabilitation consultations were conducted with each case.

Palliative Surgery

• Pain, anxiety and skin care optimization.

• Individualized SpO2 parameters adapted to post-operative anatomy.

• Importance of patient and caregiver education regarding activity pacing and energy conservation methods.

• Beneficial use of the Livengood walker for this patient population.

• Initiating PICU levels of care for the Pott’s Shunt patients.

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