

Critical care

Person Centred Care in the ICU

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The importance of person-centred care is widely acknowledged within healthcare, forming part of core standards of care as well as becoming integrated into organisations' strategic plans and healthcare policies.¹⁻³ Person-centredness refers to a philosophy of healthcare practice which reflects the needs, values, and preferences of the individual to optimise their experience of care.⁴ Research has demonstrated benefits including improved patient experience, reduced length of hospital stay and improved physical and social wellbeing.^{5,6} Within critical care, deliberate attention to promote active involvement of both patients and their families is recognised as an integral part of their care and rehabilitation.⁷

A huge range of skills and approaches are required for healthcare professionals to successfully integrate patient and family values into healthcare.⁸ Physiotherapists are well placed within the critical care team to offer continuity of care in an environment with frequent changes of staff throughout a patient's admission and build therapeutic relationships with patients, providing a foundation for person centred care to be outworked.⁹ Consistency and an individualised approach are recognised as important factors in the weaning of ventilation¹⁰ and rehabilitation of patients within critical care¹¹ and were key components of success for this case study. Permission has kindly been given by the patient's parents for this case report to be shared.

An 18-year-old male was admitted to critical care with acute on chronic type two respiratory failure and a community acquired pneumonia. He had a background of restrictive lung disease due to a significant scoliosis. He also had complex behavioural and learning needs with a comprehensive community care plan and risk assessment in place. His respiratory team had previously attempted to initiate nocturnal non-invasive ventilation (NIV) but this had been unsuccessful due to issues with tolerance of the NIV mask. Initially he was intubated, ventilated and sedated with physiotherapy intervention for airway clearance. Weaning from mechanical ventilation and sedation were started with time taken to achieve an optimal balance between management of agitation and requirement to wean high levels of pressure support. Active rehab commenced while the patient remained intubated and sitting out in a chair occurred regularly as this was particularly enjoyable for him. Repeated failure of spontaneous breathing trials (SBTs) and frequent adjustments to the weaning plan with regular changes of medical staff lead to some autonomy be-



Image 1. Standing to transfer into chair

ing given to physiotherapy staff to co-ordinate and guide weaning. The combination of significant weakness, repeated inability to tolerate SBTs and concerns around secretion clearance, as evident in this patient, often result in the need for a tracheostomy. However, concerns around his behavioural difficulties and discharge destinations able to meet these needs, meant that the focus was placed on 'tracheostomy avoidance', with a plan for early extubation to NIV.

Consistent and dependable therapeutic support for the patient during this process was instrumental to achieving liberation from mechanical ventilation and use of NIV as well as adjusting communication and goal setting to match the patient's needs. The ability to lead the patient's weaning allowed physio staff the freedom to balance his respiratory needs, rehabilitation and functional goals. His family were essential to his care and provided activities, enrichment and support to optimise the environment as well as advocate for him during an undoubtedly stressful time. To help prepare for using a NIV mask he responded well to a personalised video from a local fire station of firefighters

wearing masks and explaining their importance. Time spent reassuring the patient and engaging in his chosen activities was rewarded with development of trust and respect, and ability of staff to encourage the use of NIV after extubation which occurred 40 days after admission. Re-intubation was required two days later with subsequent treatment for a chest infection. A week later a second attempt at extubation was made with the risks of 'failure' acknowledged.

Initially, after changing the type of mask to reduce discomfort it was tolerated well and he was able to make trips off unit wearing the NIV mask. This ability to leave critical care, spend time with his family and experience a change of environment was hugely important for him. To help with weaning NIV support during the day a picture timetable was used to establish NIV periods and time off using high flow nasal oxygen to support weaning. With significant time spent reassuring, encouraging and facilitating the patient's desired activities in and out of normal working hours, he was established to nocturnal NIV and was self-ventilating on room air during the day. He was able to mobilise short distances and have regular trips off the unit in a wheelchair. Co-ordinating his care with nursing staff, therapists and input from the home ventilation team gradually allowed his parents to carry out much of his care and input from physiotherapists was stepped back. Fifty-nine days after admission he was discharged home with follow up from the home ventilation team and learning disabilities therapy team for ongoing rehabilitation.

Patient and family centred care is of vital significance yet often challenging to implement in practice.⁷ This experience of caring for a young man with complex needs has reminded us of the importance of adopting and promoting an environment in which the patient and their family can be actively involved and participate in the patient's care and rehabilitation. We learned that being consistent as well as flexible and willing to adapt our approach leads to a respectful therapeutic alliance that is mutually beneficial. This alliance allowed us to more confidently advocate for him to achieve the best outcome. We are grateful to have a supportive wider critical care team to allow us some autonomy to lead and co-ordinate weaning as well as other allied health professionals to provide joined up care with patient and family focussed goals.



Image 2. Wearing the NIV mask

Key Points

- Using a person-centred approach to physiotherapy interventions is imperative in supporting the needs of patients with long-term complex physical and behavioural needs
- Having a consistent and joined up approach to mechanical ventilation weaning and transitioning to NIV in this case study helped reduce chances of weaning failure

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