ICU
MANAGEMENT & PRACTICE

Finding ways to humanise the ICU

In the ICU, clinicians attending to a patient on the brink of death may neglect to carefully consider what the patient is experiencing: to be unable to speak, be stripped naked, have tubes inserted into multiple orifices, have their arms restrained, and to be poked, and prodded – all while family is torn away. Clinicians also may not remember that patients who seem unconscious may feel and remember what they are experiencing.

While ICU clinicians may have expert knowledge of critical care, few have experienced life as an ICU patient or thought carefully about what that experience might feel like. It's important to note that some patients who experience critical illness may experience a loss of their humanity in the process. This loss of humanity may come in many forms, including the loss of personal identity, control, respect, privacy, and support systems, and is referred to as dehumanisation.

Key aspects of patients' illnesses as well as the behaviours and attitudes of healthcare teams contribute to the dehumanisation of ICU patients. Dehumanisation consists of treating someone as an "object" rather than a "person" and is often associated with failures to honour dignity. ICU patients experience a devastating loss of personal identity when, instead of being identified by their names, patients are reduced to their room numbers, their diseases, or the treatments they receive – e.g., "512, resolving sepsis."

ICU patients also lose their ability to control their environment, govern their own actions, and advocate for themselves – often made worse by loss of consciousness. Furthermore, patients often lose their family as they are escorted to the "waiting" room, thus removing from the bedside the world experts on that particular patient, in addition to pulling away the most central support system of most patients – all at the most vulnerable point in their lives.

High workload and burnout may lead healthcare team members to become desensitised to the human aspects of critical illness. Policies and cultures of many ICUs (such as restrictive visitation) promotes dehumanisation by further taking control from patients and families. Fragmented care delivery models (shift work) may also unintentionally prevent ICU physicians from getting to know their patients as people.

To improve the humane and respectful treatment of ICU patients, the following measures should be considered:

• Patient-centred family visitation: Routine restrictions should only be driven by patient request. Open visitation has been associated with less anxiety, less PTSD, less agitation, shorter length of ICU stay, and higher patient/family satisfaction.

• Care providers must speak to all ICU patients – even those who are delirious, comatose, or unable to speak. When entering the patient's ICU room, healthcare team members should introduce themselves, their role, and what is happening.

• Minimise the effects of altered consciousness and impaired mobility, including individualised efforts to minimise sedation, reduce delirium, and promote early physical therapy/mobility.

• Learn something about the patient as a person. Things such as a "get to know me board" or photographs of pre-ICU life may help clinicians better understand the patient as a person.

Efforts to humanise the ICU may have benefits in boosting patients' attitudes and engagement in their own well-being. Understanding and addressing patient-, clinician-, and system-level factors that contribute to dehumanisation of ICU patients represent important areas necessary for investigation and intervention in order to advance the delivery of high-quality critical care.

Source: Critical Care
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Published on : Wed, 6 Feb 2019