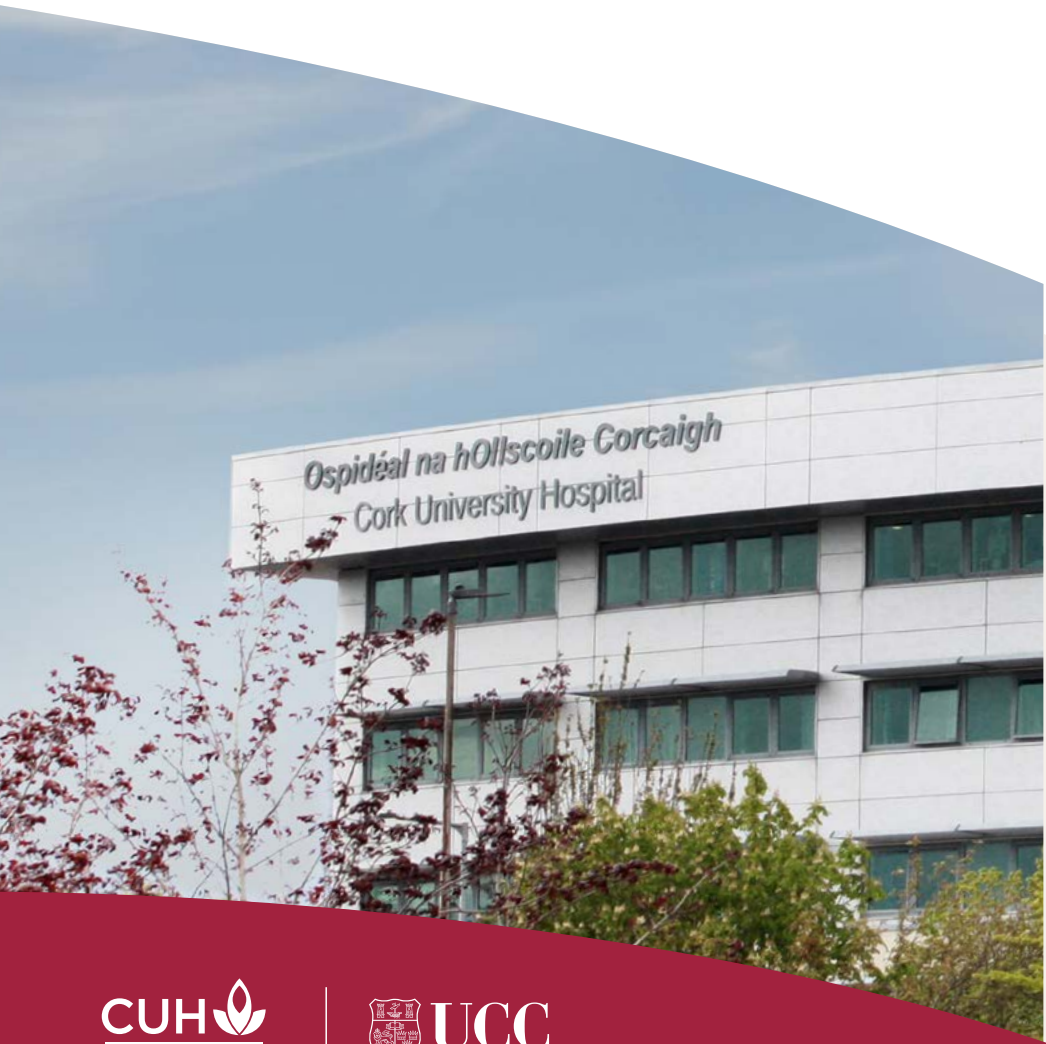
Intensive Care Unit **Information**

CORK UNIVERSITY HOSPITAL



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Ospidéil Ollscoile Chorcaí
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Introduction

Welcome to the Intensive Care Unit (ICU). Admission to the unit may be planned or unplanned. We understand that having a loved one in ICU can be very stressful for you and your family. We hope this leaflet helps you understand the care they are receiving.

We have two intensive care units: General Intensive Care (GICU) and Level5 Intensive Care (L5 ICU). There is no difference in the care provided, the same healthcare professionals rotate between the units.

On admission to the unit it will take some time for the ICU team to assess your relative. During this time you will be asked to wait in the relatives room. We appreciate that this wait can add to your worry but we will update you and bring you into the unit as soon as possible. There is an intercom outside the doors of each unit. Please use this to let us know you are here.

Visiting:

Visiting is an important part of each day for you and your relative. Visiting times to the unit are 14:00-16:00 and 17:30-20:00. 2 visitors are permitted at the bedside at any one time. Children under 14 years of age are not permitted to visit unless discussed with the Clinical Nurse Manager (CNM)/Nurse in Charge. If there are special circumstances please discuss this issue with the CNM- we are happy to help.

We will do our best to keep disruptions to a minimum during visiting hours but this will depend on the activity in the unit and your relative's condition.
We advise that you nominate one family member as the source of contact for updates on your relative's condition. This person can relay information to the rest of the family. Family meetings with the consultant or member of the team can be arranged by speaking with the bedside nurse.

Contact Numbers:

GICU:	021-4922230	L5ICU:	021-4920848
	021-4922772		021-4234349

Limited accommodation may be available for families of patients who are critically unwell. Accommodation is prioritised for those visiting outside of the greater Cork area. Please speak to your relative's nurse or the CNM to discuss further.

Care is provided by a multidisciplinary team of healthcare professionals. We have included an overview of each disciplines' role with the critically ill patient. For further information, don't hesitate to ask a member of staff.

Medical and Nursing team

On admission to the intensive care unit (ICU), your loved one will require constant monitoring and support. Care is delivered by the ICU team who work in tandem with the primary medical/surgical teams. In ICU, our team consists of specialist ICU trained doctors, nurses and health and social care professionals who work exclusively in the ICU caring for critically unwell patients. Jointly, we provide specialist, holistic care to your loved one throughout their stay in ICU.

The care of the patient is led by the primary ICU nurse at the bedspace. The medical team, led by an ICU consultant, reviews patients routinely at least twice per day and more frequently if needed. All decisions regarding the management of our patients are coordinated and managed by the ICU team in conjunction with the primary medical/surgical team. We understand the importance of communication and your need for information and are available 24 hours a day, 7 days a week.

Each patient in ICU is assigned a designated nurse on a daily/nightly basis. As the hospital is a teaching hospital, student nurses, new staff on orientation and students from other disciplines may also be assigned to work with the primary nurse caring for your relative. We also have Clinical Facilitators in the Unit and their role is to educate/orientate new staff, oftentimes working between 2 staff members.

There is a Clinical Nurse Manger 2 (CNM 2) or a Senior Nurse in charge on each shift, his/her role is to coordinate the unit for the day/night with responsibility for the patients in the unit and the staff. If the nurse assigned to care for your relative is unable to answer your queries he/she will speak to the CNM 2 or Senior Nurse in Charge.

The overall management of the Unit comes under the remit of Clinical Nurse Manager 3 – available Monday to Friday (07.45- 16.30 Mon – Thurs and 07.45 – 13.30 Friday) Contact Number 0214922780 email – bridget.doyle@hse.ie

Staff of all disciplines in ICU wear scrub uniforms, utilising names badges to help be readily identifiable. We acknowledge that the ICU is a high-tech, fast paced environment. In an effort to demystify the daunting nature of the ICU, we have created a visual representation of the bedspace which is on display in the waiting areas of each of the units. The aim of this resource is to humanise the experience of the ICU for our relatives while also meeting some of your informational needs.

Physiotherapy

Physiotherapists play a vital role in the care of patients in Intensive Care Units (ICU), providing a 24/7 service and contributing significantly to the multidisciplinary team that manages critically ill patients. The role of physiotherapists in the ICU encompasses several key functions aimed at improving patient outcomes, facilitating recovery and preventing complications associated with prolonged immobility and critical illness.
The primary roles comprise:

1. Respiratory management

Breathing exercises, physiotherapy respiratory devices and airway clearance techniques are used to help clear mucus from the airways, re-expand areas of the lungs that have collapsed, improve lung function and oxygenation as well as helping patients to wean from mechanical ventilation and tracheostomy tubes.

2. Rehabilitation

a. Early mobilisation:

Physiotherapists initiate mobilisation as early as possible to help prevent/ minimise the adverse effects of bed rest such as muscle weakness and joint contractures. This can include positioning, passive range of movement exercises, active exercises as patients are more awake, sitting, stand and gait re-education as indicated.

b. Strength and functional training:

Individualised progressive exercise programmes are designed by the Physiotherapist, taking consideration of the patients diagnosis and clinical status, to restore muscle strength, endurance and functional mobility, aiming to enhance the patients overall physical capacity and recovery. Equipment such as therabands, theraputty, pedals, tilt table etc. may be utilised.

3. Education and Support

Physiotherapists discuss patient progress on a daily basis with other members of the multidisciplinary team, to ensure a co-ordinated comprehensive approach to care.
They are available every day to talk to patients and their families about techniques to assist with mobility and recovery.

4. Tracheostomy care

Physiotherapists work closely with Speech & Language therapists, nurses and doctors in caring for patients with tracheostomy tubes to co-ordinate tracheostomy weaning and progressing respiratory function. A tracheostomy information leaflet is available for patients and families.

Occupational Therapy

Occupational Therapists (OTs) help facilitate patients' recovery in ICU by focusing on holistic evaluation and treatment. Occupational Therapy in the ICU focuses on improving patients' strength, mobility, cognition, and functional independence in activities of daily living and decreases the duration and incidence of delirium. Our aim is to support patients' in doing the things they want, need or are expected to do in their daily lives. Some areas the OT will focus on are listed below;

Seating

There are many benefits to early mobilisation and sitting out of bed for patients in the ICU. These include improving respiratory function, managing delirium and helping reduce long-term mobility issues. Appropriate seating in the ICU is critical for a patient's recovery and overall well-being. Improper seating can lead to pressure ulcers, contractures, pain, falls and reduced engagement in a person's environment. The OT assessment will focus on the person's postural alignment, range of motion, skin integrity, muscle strength, head control, level of function and cognitive abilities when carrying out a seating assessment and will make recommendations regarding appropriate seating systems.

Splinting

Prolonged immobility in the ICU can lead to contractures, where muscles and tendons shorten and harden reducing joint mobility. The OT may provide a splint to help maintain joints in a certain position to prevent this.

Cognition

For many different reasons, some patients on ICU may be experiencing cognitive issues. This may include difficulties paying attention to a task, remembering day-to-day events, processing information or problems with planning, sequencing and self-regulation. The OT will screen the patient for cognitive impairments during their assessment, and may carry out further assessments and interventions where appropriate.

Delirium management

ICU delirium can result from acute cognitive disruption from altering states of alertness, medications, sleep disturbances and loss of natural light. The occurrence of delirium in ICU is 30-60%. Delirium can increase length of stay, readmissions and mortality. OT interventions such as early mobilisation, engagement in activities of daily living, environmental modifications and cognitive stimulation, can help prevent or manage ICU delirium.

Equipment

The OT may utilise a range of different adaptive aids to facilitate patients' rehab and engagement. This may include adapted feeding utensils, communication switches, specialised shower chairs, bariatric seating, personal care aids as well as a range of other adaptive equipment to support engagement in activities of daily living.

Speech and Language Therapy

Speech and Language Therapists (SLT) in Critical Care ICU have a variety of roles, both individually and as part of the multidisciplinary team (MDT).

The main roles of SLT, with the critically ill patient, are the diagnosis, assessment and management of:

- *Dysphagia (eating, drinking and swallowing difficulties)*
- *Communication*
- *Tracheostomy*

Dysphagia

Patient's can be admitted to critical care for a variety of reasons such as traumatic brain injury, stroke, spinal injury, progressive neurological and following surgery. These patients are at higher risk of dysphagia due to being critically unwell and ventilated as a result of They often find it difficult to manage saliva, chew or swallow food, and/ or experience food or fluids going "the wrong way" into their lungs. The assessment and management of dysphagia is important to minimise preventable respiratory and/or nutritional complications of swallowing difficulties. Assessment and management of dysphagia may include the use of diet or fluid modifications, swallowing exercises, and objective assessments such as videofluoroscopy (video swallow) or FEES (fibreoptic endoscopic examination of swallow) when necessary.

Communication

Speech and Language Therapist assess a patient's communication by identifying the type of difficulties they are experiencing and provide a subsequent management. This management can be in the form of alternative and augmentative communication (picture boards, whiteboards etc), and/or speech and language exercises or startegies. Providing a patient with a means of communication can help reduce negative emotional responses and improve the psychological well-being of the patient, family and staff
Restoring or facilitating communication enables the patient to consent to treatment and participate in their rehabilitation journey. Increased participation enables improved outcomes and may shorten length of stay

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Tracheostomy

The SLT and the MDT work together with the patient following the insertion and removal of a tracheostomy. The SLT works on establishing communication through the use of a one way valve and by using alternative and augmentation communication. The SLT also manages swallowing difficulties during the presence of a tracheostomy.

Nutrition and Dietetics

If patients are admitted ICU with an illness or injury, their nutritional needs will change. The ICU Dietitian will make sure they get the right amount of nutrition, at the right time and in the right way to support their recovery. The ICU Dietitian is a vital member of the ICU MDT and their role includes assessing nutritional requirements and how well patients are fed, preventing malnutrition and monitoring complications. Critically ill patients that that receive the correct nutrition for their need have better outcomes.

Indirect Calorimetry (Gold Standard for determining Energy Requirements)

To accurately determine how much energy a patient needs, the ICU Dietitians perform indirect calorimetry in our ICU. This is carried out on multiple occasions for each patient and this allows the Dietitian to prescribe an individualised nutrition plan. Nutrition prescriptions that are guided by indirect calorimetry have been shown to improve outcomes in critically ill patients.

Feeding

If your relative is unable to eat and drink, the ICU Dietitian will help them get the nutrition they need through a tube, usually placed in the nose or mouth or straight into the blood supply through an IV line in the neck. Once able to eat and drink again, they may have ongoing problems with reduced appetite, taste changes or swallowing difficulties. The ICU Dietitian will advise on how to get the nutrition they need. The ICU dietitian will regularly measure their nutritional requirements, assess their nutritional adequacy and nutritional status during their admission.

Role of pharmacist in ICU

Pharmacists play a crucial role in the ICU, where patients often require complex medication regimens, including multiple medications and intravenous therapies. They ensure patients receive safe, effective, and appropriate medication therapy.

Their main roles include:

- *Working with the critical care team to select the most appropriate medications for patients, considering diagnosis, comorbidities, allergies, and potential drug interactions.*
- *Medication dosage optimisation to ensure therapeutic effectiveness while minimising adverse effects.*
- *Monitoring patient response to medications and collaborating with the ICU team to adjust medication regimens as needed.*
- *Participation in antimicrobial stewardship programmes within the ICU, ensuring that antibiotics are prescribed appropriately and with minimal risk.*
- *Reconciliation of medications when patients are admitted to or discharged from the ICU, ensuring continuity of care and minimising the risk of medication errors.*
- *Pharmacists educate ICU staff on medication use, safety, and best practices. They serve as drug information resources. At the same time, they can educate patients and their families about their medications, including administration, side effects, and medication adherence.*

Advanced Nurse Practitioner (ANP)

The Critical Care ANP service will come to the ward after your leave the ICU. This is a nurse-led service, and you/your relative will be visited by this service within a couple of days. The aim of this visit is to support you getting better and review the progress of patients who have been critically ill. We will be able to give you advice, or if needed refer you for further specialist advice. It will also give you the opportunity to discuss any problems that you may have or questions you may have about your time in ICU.

Research Nurse Coordinators

There are two Research Nurse Coordinators who work in the Critical Care unit. Our role is to screen and recruit patients within the ICU setting onto Research studies appropriate to their injury/condition.

If your relative is suitable to take part in a research study while they are in the ICU, you may be approached by one of the Research Team who will go through the research study that is appropriate for your relative and gain consent from you for your relative to be recruited onto the study.

Participation in any study is entirely voluntary.

Medical Social Work

Many admissions to the intensive care unit are unexpected and can be a challenging and overwhelming time for both patients and their loved ones. Access to supportive counselling during hospitalisation can promote recovery and improve longer term outcomes. The provision of psychosocial care and support is an integral part of patient and family care in the Unit. Medical Social Workers are uniquely qualified to provide such counselling and support and form part of the multidisciplinary team caring for patients and their families during admission.

The intervention provided by social workers will be different for each patient/family member depending on individual circumstances. When a Social Worker meets with you they will often ask you questions about home, social and family circumstances. This allows the social worker to understand how they can best support you. The primary role of the social worker is to safeguard patients and provide psychosocial assessment and counselling. Social Workers also support patients and family members during meetings or when difficult conversations need to take place.

Medical social workers support the multidisciplinary team in providing end of life care and deliver a bereavement counselling service.

Direct work with children:

Social Workers are trained to work directly with children or can support adults when talking to children. Providing children with an opportunity to express their feelings about significant life events is important in helping them to gain an understanding and process new information. Direct work is an outlet for difficult emotions, thoughts and feelings and helps children make meaning of what is happening.

A member of the team can make a referral to social work on your behalf or you can contact the Medical Social Work Department directly on 021-4922488.

Delirium in Critical Care

ICU delirium is a common and often temporary condition that affects many patients in ICUs. It is characterized by sudden confusion, difficulty focusing, and changes in perception or hallucinations, which can be distressing for both patients and their families.

This condition can arise from various factors, including the illness itself, medications like sedatives, disturbed sleep, and the unfamiliar ICU environment. It's important to know that delirium is usually reversible and the ICU teams are trained to manage and treat it.

If you notice any signs of delirium, such as disorientation or unusual behaviour, inform the medical staff immediately, as early intervention can help in the recovery process. Support from family members, like speaking calmly to the patient and providing a familiar presence, can also be beneficial in easing the symptoms.

You may be asked to be present at the patient's bedside more than usual, in order to have a familiar face or voice. It would also be helpful if you bring any eyeglasses or hearing aids, some family pictures for the bedside and tell us what music or TV shows/activities they enjoy at home. This will help us create an environment that is as familiar to them as possible.

Factors That May Affect The Condition

The Illness Itself

Medications Like Sedatives

Disturbed Sleep

Infection Prevention And Control For Intensive Care Visitors

Intensive Care patients are the most vulnerable so when visiting your loved one please adhere to the following guidelines to help protect them from infection.

Anyone who has a cold or any sign of an illness should not visit the Intensive Care Unit (ICU). If passed on to patients, this can cause serious infections

To prevent exposing patients to contagious viruses and infections, ICU visitors should not bring in young children or infants if they can not follow infection control advice.

Germs are often found in your hands or on things you touch. When germs get on or in the body, they can cause an infection.

Sanitise your hands before and after visiting your relative with either the provided alcohol- based sanitiser or soap and water. If you're using an alcohol-based sanitiser, be sure to cover every part of your hands. Rub them together until they are dry. If you're washing your hands with soap and water, wet your hands, then apply the soap and rub your hands thoroughly for 20 seconds. Dry your hands with a paper towel.

Sometimes you may need to take additional precautions and asked to wear a gown, gloves or a mask which must be 'put on' prior to entering the room and 'taken off' prior to leaving the room and placed in the yellow bin alongside hand hygiene. The nurse assigned to your loved one will guide you with this.

The patient may have a series of invasive devices e.g. breathing tube, Intravenous lines, feeding tubes, drains or catheters. Please do not touch any of these lines as they need to be kept clean and touched minimally to avoid an infection entering their body. You may hold your loved one's hands if they are clean and providing your hands are clean.

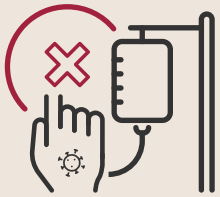
No flowers are allowed in hospital due to the infection risk as some flowers carry germs.

Food and drink should not be consumed at the bedside due to the infection risk.

Wash and sanitise hands thoroughly and often.

Children/infants who cannot follow infection control rules.

Visitors with cold/flu or illness symptoms.



Touching of any medical devices is not permitted.

Consuming Food and/or Drink at bedside is not permitted.

Bouquets of flowers are not permitted in ICU.

Simulation Training in Critical Care

Simulation based education is a teaching method used in healthcare education. The primary advantage of simulation based education is the ability to train for emergency secenarios and/or procedures without any risk to patients. In-situ simulation is a form of simulation based education that takes place in the actual working environment involving those who work there. It has been been shown to have a positive impact on patient outcomes and is widely used internationally in critical care training.

The critical care in-situ simulation programme commenced in CUH in November 2023. We aim to hold sessions approximately fortnightly with all members of the critical care team. You may be visiting during one of these sessions taking place and witness the simulation in another bedspace. Please rest assured that this will not impact on the care of your loved one or any other patients in the unit. If you have any questions or concerns regarding the simulation programme please do not hesitate to ask a member of staff.

End of Life Care

Placed on door/surrounding bed space when a patient is recognized as dying or has died, to bring dignity to the surrounding environment. Explaining to family the importance and reason behind using the symbol before placing it on the door is important. The use of this symbol does not mean that care has stopped. It means we have just changed the focus of care from curative to comfort and symptom management.

Explanation of the End-of-Life Care symbol:

- *Celtic in origin*
- *The three stranded interconnected spirals represent birth, life and death*
- *White circle represents continuity of care and infinity*
- *Colour purple represents* solemnity *and dignity*

What does it mean if I see this symbol on a ward?

If you see the End of Life symbol displayed in a ward or unit, please:

- *Be respectful*
- *Avoid loud conversations in the corridor areas of the ward or unit*
- *Avoid loud mobile phone use in the corridor areas of the ward or unit*
- *Keep the environment quiet and appropriate*
- *Check with a staff member before entering a room with the End of Life Care Symbol*

Ask a staff member on the ward or unit if you are unsure about what to do.

End-of-Life Care Co-ordinator

My name is Máiréad Lyons and I am your End-of-Life Care Co-ordinator here at Cork University Hospital. I began in my role in 2023. My key priority being to lead, support and co-ordinate activities in relation to End-of-Life care.

Cork University Hospital is part of the Hospice Friendly Hospital (HfH) Programme. A programme, which endeavours to ensure that in the midst of an acute care setting, patients who are dying are cared for not just physically but holistically by compassionate and well-informed staff. We recognize that the psychological, social, spiritual and emotional domains of care are paramount to how we look after our patients in conjunction with their physical needs.

In the ICU setting, the provision of high quality and compassionate care to patients who are recognized as dying, and their families is a priority to us.

Firstly may I acknowledge how difficult a time this must be for you and your family. When a loved one is dying there are many emotions which can overwhelm us. To help you on this difficult journey of grief and loss there are many supports in the hospital available not only to your loved one but to you and your family also. These especially include our pastoral care team and our social work team. If you would like to meet a member of one of these team(s) please just ask the nurse on shift to arrange this for you.

The provision of consistently high quality End-of-Life Care remains the priority of all health care professionals. When difficult medical decisions result in the withdrawal of active treatment for your loved one, and we must allow for a natural death, please know that the care for your loved one will not stop. Your loved one remains our priority. Our focus of care now will be on their comfort, dignity and management of symptoms.

Organ Donation

Cork University Hospital facilitates organ donation with the support of a specialist nurse, an Organ Donation Nurse Manager (ODNM) who works within the hospital, with the critical care team, in offering organ donation to families where it is possible. The role of the ODNM is to identify patients that may have the option to donate their organs and offer their families this choice, in end of life care for their loved one, together with the intensive care team. This nurse supports the family and healthcare team through the donation pathway.

Organ Donation is a relatively rare event. Patients can donate in specific circumstances where they are admitted to an Intensive Care Unit and are placed on a ventilator to support organ function. Organ Donation is only offered where all medical treatment options have been provided to the patient and the patients' medical condition has continued to deteriorate despite maximum care. Organ Donation occurs after a patient's death.

One person can save up to seven lives through the donation of their heart, both lungs, liver, their kidneys and pancreas. Heart valves, heart tissue and blood vessels are also possible to donate.

A person can become an organ donor by discussing their wishes regarding organ donation with family members and their next of kin. You can also indicate your support for organ donation by carrying an organ donor card offered by the Irish Kidney Association or on your driver's licence by ticking code 115 your intention to donate your organs after death.

Organ Donation is a lifesaving gift. Without organ donor patients with the support of their families many patients would not be given the opportunity of an organ transplant to restore them to health and enable them to lives their lives with family and friends. We are honoured to support these truly amazing people.

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