

## SUPPORTING FAMILIES OF ICU PATIENTS - INFORMATION MAKES A DIFFERENCE

by Lisa Rapple M.Ed RRT



The Intensive Care Unit is a strange and confusing environment. It is like no other place in the hospital or the world. A layperson walking into this critical-care-world has no experience to help understand what is happening or what to do.

We are a society of etiquette and prediction. Just watch us on an elevator. We scatter appropriately to fill the space and always face the front....eyes on the lighted buttons or on our feet. But in the ICU, there are no social cues as to where to walk, who you can talk to, where you can look, what you are hearing and seeing, when you can enter and when you must leave. It has to be like entering a party uninvited. Everyone dresses similarly so there is no way of knowing who is who, or what role each person plays. Add to this the physician's varying abilities to communicate with patient's families. And the busy nurses carrying heavy assignments with high patient acuity. It is very difficult for families and friends of the critically ill to find the support that they need to successfully deal with their predicament.

After decades of working in the critical care environment, two top clinicians in the field decided to address this compromised condition. They observed: "Physicians and nurses spend inadequate time communicating with patients and their families. Unanswered questions lead to a lack of understanding about the patient's condition and treatments. The results are reduced patient and family satisfaction with medical care and, often, increased costs."

Finding commonality in the questions and needs expressed by ICU families and friends, they used their experience and professional expertise in critical care medicine to develop an informational and educational website known as ICU-USA, Inc.

The goal of the website is to assist in explaining critical medical conditions, medications, procedures, equipment and professional staff roles. It is the official patient and family web site of the Society of Critical Care Medicine, and is endorsed by the American

Association of Critical-care Nurses. It is written and presented in layman's terms to best support families of patients in the ICU.

ICU-USA, Inc. was co-founded in 1999 by Dr. Robert W. Taylor, MD, FCCM, FCCP and Dr. Thomas Ahrens, DNS, RN, CS, FAAN, both with extensive credentials in critical care medicine and education, and leaders in their prospective fields. (read more about the founders at: <http://www.icu-usa.com/about/founders.html>)

"Robert Taylor brings more than 25 years of experience and provides the medical leadership for the program. Dr. Taylor is author of several prestigious textbooks about critical care and is past President of the Society of Critical Care Medicine. Thomas Ahrens, DNS RN CCRN CS brings 25 years of critical care experience and the nursing vision to the program. Dr. Ahrens is an award-winning author and is nationally known in acute and critical care nursing."

The company is located in St. Louis, Missouri. The main goal of the founders was to develop and operate a consumer-oriented medical information and education program based on computerized, Internet-based kiosks located in hospitals combined with educational services for hospital staff. These programs are now licensed to medical facilities. To explore the staff education and customized kiosk programs go to "About ICU-USA" for the online brochure and more details. In the future they plan to offer slightly varying versions of the program for specialized ICUs, such as post-anesthesia care unit (PACU), pediatric ICU, and cardiac ICU. MedCenter-USA, has already been customized for other specialized areas of medical care, such as the emergency room, neurology, obstetrics, pediatrics, etc.

From the homepage there is a left-vertical bar with the following links: Home, About ICU-USA, Table of Contents, MedCenter-USA, After the ICU, Patient Bill of Rights, Related Links, Sponsors, Feedback. All the information on the website is available to the general public. The materials I found valuable are located under Table of Contents and Related Links. By clicking on the Table of Contents from the homepage you will be taken to a list of key categories to answer questions and counsel families. Topics that can be explored include; predicting outcomes, specialized ICUs, medications, children and the ICU, CPR, questions families should always ask, medical conditions, and the ICU waiting room. "The ICU Waiting Room" discusses communication. It promotes the idea of a family spokesperson to develop a communication relationship with the doctors and all family members. It also answers questions about visiting, touching, and talking with critically ill patients.

You can also find a picture of an ICU patient room displayed at the Table of contents. If you click on items in the picture you will be given an explanation about that item (such as ventilator, IV pump, personnel, etc). By clicking near the face of the patient you can get a second picture close-up of the face for explanations of E-T tubes, feeding tubes, catheter ports, etc.

Under "Related Links" the topics include; The ICU Team, Legal Issues, Loss of a Loved One, Medical Conditions, Medical

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*Pulmonary Lab Quality Control... Continued from page 22*

Here are some guidelines for reasonable targets. In research settings, spirometry acceptability criteria are met 95-98% of the time and repeatability criteria are met 85-97% of the time. We know the clinical setting is not likely to meet the research setting levels partly because sick patients are less likely to meet standards. A retrospective analysis of 500 patients tested in our laboratory (relatively high acuity setting) in 1995 showed repeatability criteria for FVC and FEV1 were met about 88%, breath hold times on the DLCO were met 95% of the time. In general, we met quality criteria between 80 and 90% of the time. That's the baseline from which we can set goals to try and improve. The fact that they are high does not allow us to relax or to attribute the failure to the patients (out of our control). At the very least, it is a level below which we do not wish to fall.

In our laboratory, we do a few things to help the technicians meet quality control elements. We started by creating a table of the essential quality elements for spirometry and DLCO. The technicians checked appropriate Q.C. boxes for each trial. This has been a good tool; just having to mark the box focused the technicians on quality issues. It's now incorporated into their thinking and the check boxes are no longer needed. Implausible values (e.g., a vital capacity >140% predicted) launches a check to make sure the instrument is working correctly. In the patient test mode, we slowly inject a 3 liter of air with a calibrated syringe looking for zeroing or sensor contamination errors. We'll probably keep doing it because we have found - and fixed - a couple even after the machine met its morning calibration check.

If you are interested, Mary Townsend has written an excellent paper (Is my lung function really that good? Chest 2004, 125:1902-1909).

Finally, an important step is to evaluate test quality in the interpretation. This step must be taken by the person interpreting the test. The ATS standard is that the first comment in all interpretations of lung function is to comment on test quality. An interpretation without this assurance is, in my opinion, suspect. All tests will not meet the quality standards because some patients will be unable to perform adequate tests so the interpreter has to state a judgment on the reliability of the test data. When the medical director is engaged in this process and making comments on the test quality, you can expect things to change. In our laboratory, the technicians read the reports after interpretation and that engages the whole laboratory in the quality control process. I can think of no more important step in moving to a new level.

In summary, tests should be reviewed for test quality and technicians should be aware of the physician assessment of test quality. Pulmonary labs should track several quality elements and technicians should learn to recognize patterns of abnormality, and sub maximal efforts. Invalid results should be removed from the patient record or at least commented on and the staff should meet to discuss quality issues. This is a human system that can be lubricated with compliments when performance is good and the whole process should be approached with a positive teaching attitude avoiding a punitive or critical tone. It is important to remember that not all patients can perform the test to the standards. We're looking for control of the things within our control.

*Supporting Families of ICU Patients... Continued from page 56*

Procedures, Laboratory Tests, X-rays and Scans. The ICU Team explains the role of each clinician found in the ICU including a respiratory therapist and it links over to the AARC website.

Though there is no federal patient bill of rights at "Patient Bill of Rights" a Bill of Rights is presented that represents what most hospitals and medical facilities might use with slight variations.

To visit the website or make comments log on to:  
<http://www.icu-usa.com/about/index.htm>

*For more information regarding this program contact:*

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