Improving communication using a daily goals sheet

I am writing in regards to the article by Peggy Siegele (“Enhancing Outcomes in a Surgical Intensive Care Unit by Implementing Daily Goals Tools,” December 2009:58-69) on improving outcomes in a surgical intensive care unit (SICU) after initiating a daily goals tool. I must say the timing of this article was perfect. The Shared Governance Council for our SICU began work on a daily goals sheet a few months ago. Our aim was to improve communication among the physicians, nurses, patients, and families. Our sheet was basic and included the resident completing the form on rounds and writing down the plan for the day, including diet, change of central catheter, and transfer to the step-down unit.

As this daily goals sheet was discussed among the council, physicians, and management, we found that, as described in the article by Siegele, this tool could be used to improve communication and teamwork but also to improve Institute for Healthcare Improvement and Surgical Care Improvement Project (SCIP) bundle adherence.

Another strength of the daily goals sheet is to help educate the staff and resident physicians about the concept of “bundles,” which facilitate best practices based on the literature. Use of this tool also coordinates and streamlines patient care, which improves patient outcomes. The daily assessment of the 12 major aspects of care also progress the patient toward recovery and transfer out of the SICU.

We discovered that the final outcome, or improvement, was not mentioned in the article and involves development of the staff through role modeling. Our unit has a relatively young staff with newly acquired critical care skills. Consequently, they are uncomfortable participating in physician rounds and communicating with the physicians. Educating the nurses about the common patient-centered goals, the bundles, and SCIP elements as the standard of care empowers the nurses. It allows them to go through the daily goals list, to see which aspects of care need to be addressed for that day, to make a “wish list” for the team, and to discuss their desired plan of care with the physicians. During daily rounds with the team, the clinical nurse educator (CNE) observes staff for further educational needs, in-servicing, and processes that may need further improvement.

Our plan includes the CNE, who is an acute care ARNP, rounding daily with the critical care team. She is a role model for communication between physicians and nurses. The bedside nurse is brought to the bedside for each of his/her patients. The nurse is then encouraged to go through the 12 aspects of care, bundles, and SCIP elements with the physician team. The CNE facilitates this discussion and models the interdependence among team members to promote better patient outcomes.

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Understanding patients with VADs

I recently had the chance to read “Edgar Allan Poe, ‘The Pit and the Pendulum,’” and Ventricular
the days before the VAD existed and how many patients probably lived those last days at home, with no expectation for tomorrow. To know that this device provides increased functionality and quality of life helps to make it easier to accept. Many of these patients get a second chance with the VAD, saving them from the monotonous hospital admissions and continuous medications.

In another article, the incidence of home discharge was shown to increase due to better perfusion and activity tolerance. Early mobilization and increasing physical exercise seemed to be the key to these patients’ recovery and optimal living with the VAD. I found that the “The Pit and the Pendulum” theory would still apply to the patients who had better outcomes with a smaller VAD-style device such as the axial pump. These patients had better recovery periods and less time in the hospital.

I think that education about how to help patients with VAD implantation will improve nursing care and empathy for these patients. Nurses need to know the different types of VADs available so they can help patients make a more informed decision about what is best for them and how they want to live their lives. Giving the patient control over their health can decrease the emotional weight on their lives. It definitely helps patients make a more informed decision about what is best for them and how they want to live their lives.

Reading about how often the patients are not able to use the VADs as bridge to transplant is very disheartening. In another article, Granfeldt et al[1] discussed implantation of VADs and the problems that these patients faced. Interestingly, this article also related to “The Pit and the Pendulum” because the patients felt they were “stuck” living with their devices; of 11 patients, only 1 needed the VAD for destination therapy. What a burden to know that there is no way out and that this is “it” for therapy. These patients must be both physically and mentally troubled to have this weight on their lives. It definitely would make for a great Edgar Allan Poe story!

Slaughter et al[2] performed a study of 134 patients undergoing implantation of a left VAD. This article discussed the differences between the pulsatile and continuous flow devices and how the continuous flow devices had the overall better outcomes. Definitely what I would want to know to recommend this device to my patients. All of the patients in the study were ineligible for transplantation and had this one chance to continue with life. I think about the days before the VAD existed and how many patients probably lived those last days at home, with no expectation for tomorrow. To know that this device provides increased functionality and quality of life helps to make it easier to accept. Many of these patients get a second chance with the VAD, saving them from the monotonous hospital admissions and continuous medications.

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The Critical Care Nurse article, as well as the additional information I was able to find, will definitely help me better prepare for the day when I get the opportunity to care for a patient with a VAD. Thank you for this article; I hope to keep reading such informative material in the future.

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Intensivists in our ICU

It is always a challenge for critical care nurses to manage critically ill patients. Even with the availability of more diagnostic and treatment options, the care of these patients has become increasingly complex and require the assistance of intensivist physicians.

Intensivists are physicians who have received board certification in a medical specialty. An additional fellowship allows a subspecialty certification specifically in critical care medicine. The intensivists collaborate with other health care providers to deliver optimized patient care in the intensive care unit (ICU). Intensivists look at all organ systems and treat the patients accordingly. Their other important contributions include setting up policies, developing protocols, and facilitating communication within the ICU.

In 2004, a group of intensive care physicians implemented the intensivist program in our 24-bed coronary care unit/medical ICU at Memorial Regional Hospital, Hollywood, Florida. The intensivists are present in our unit 24 hours a day, 7 days a week. They directly care

References
for the patients and are readily available when called upon to institute immediate treatment. Knowing we can rely on the intensivists to take better care of our critically ill patients makes us feel secure. Nothing is more frustrating than not reaching a physician to let him/her know of the changes in a patient’s condition—and time is critical when you are taking care of these patients.

When patients are admitted to our unit, their care is transferred to the intensivists, who handle consults with cardiologists, nephrologists, neurologists, surgeons, and other specialists. Any orders written by the other physicians have to be approved by the intensivists before they are carried out. Bedside procedures such as bronchoscopy, thoracentesis, paracentesis, and lumbar puncture are performed immediately, as needed. The intensivists also perform bedside tracheostomies, insert gastrostomy tubes, and insert central catheters in patients with poor peripheral venous access or who need multiple intravenous medications. A portable ultrasound machine is available in the unit for central catheter insertions and for other immediate diagnostic procedures.

Hemodialysis catheters are used in patients needing immediate dialysis, either by continuous venous-venous hemodialysis filtration, which is done by trained critical care nurses, or by hemodialysis, which is performed by the dialysis nurse. Patients receiving mechanical ventilation are extubated according to a weaning protocol. Daily sedation vacation and weaning trials are done, as needed. If the patient fails extubation, the intensivists are there, ready to reintubate them and attend to their needs.

The intensivists also introduced us to the induced hypothermia protocol. Cardiac arrest patients, meeting the criteria as outlined in the hypothermia protocol orders, are cooled to 33°C for 24 hours, then gradually warmed to 37°C for another 24 hours.

There is no dull moment in our unit. Yes, we work hard but it is rewarding to see our patients benefit from our hard work. The intensivists provide us with knowledge to better understand the patient’s disease process and why we do what we do. We cannot imagine working in the ICU without the presence of the intensivists.

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