PHYSIOTHERAPY LED INTENSIVE PRONING (PHLIP) TEAM – A PRACTICAL IMPLEMENTATION OF THE ANZICS COVID-19 GUIDELINE IN A VICTORIAN ICU

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Introduction: The COVID-19 pandemic has resulted in a surge of patients with refractory hypoxaemic respiratory failure presenting to the intensive care unit (ICU). Prone positioning can improve oxygenation and requires a team of skilled personnel to complete safely. Critical care physiotherapists are ideally suited to lead prone teams, due to their expertise in moving critically unwell, invasively ventilated patients.

Objectives: To implement a physiotherapy led intensive proneing (PhLIP) team to support the critical care team in accordance with the ANZICS COVID-19 Guidelines.

Methods: Additional critical care trained physiotherapists competent in prone positioning were rostered at the COVID ICU for 8-hour shifts between 08:00 and 22:00. The PhLIP physiotherapist led a team of medical, nursing, and allied health staff. Decisions to prone were made by the intensivist in consultation with the PhLIP physiotherapist, who then coordinated and led the intervention. Data on the number of patients, prone episodes, and complications associated with the manoeuvre were collected.

Results: Between 17 September and 19 November 2021, 93 patients with COVID-19 were admitted to the ICU. Fifty-one (55%) were positioned prone a median 2 [IQR 2, 5] times, mean duration 16±2 hours, across 161 episodes. Ninety-four percent (154) were led by the PhLIP physiotherapists with a median 2 [IQR 1.4] prone manoeuvres per day. Potential airway adverse events occurred on three occasions (1.8%) and included an endotracheal tube leak, displacement, and obstruction. Each incident was promptly managed without adverse impact on the patient. No manual handling injuries were reported.

Conclusion(s): The implementation of a physiotherapy led proneing team was safe and feasible and can release critical care trained medical and nursing staff to other duties in the ICU.

OBSERVATION OF NICOTINE DEPENDENCE INTERVENTIONS IN ICU AND WILLINGNESS OF PATIENT PARTICIPATION IN FOLLOW UP

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Introduction:
Tobacco smoking is a significant issue for many patients admitted to the ICU, affecting both their short- and long-term morbidity and mortality. Evidence for nicotine replacement therapy (NRT) in the ICU remains inconclusive and consists of predominantly low-quality evidence and little guidance on the prescription of NRT. However, NRT prescription is common in Australian and New Zealand ICUs, with two-thirds of ICUs reporting standardised prescribing of NRT. NRT may reduce/treat nicotine withdrawal, which contributes to agitation and delirium in the ICU, and may promote longer term smoking cessation.

Objectives: In current smokers admitted to ICU, to review i) nicotine dependence level; ii) NRT used; iii) nicotine withdrawal symptoms; iv) willingness to cut down or quit smoking; and v) zillleness to follow up on discharge regarding smoking cessation

Methods: Survey of 30 smokers admitted to ICU.

Results: Thirteen patients (43.3%) received NRT. According to Western Australia health clinical guidelines for nicotine dependent inpatients, 22 patients (73.3%) met the criteria for NRT based on their dependence scores (3 and above). Six patients (46.2%) receiving NRT were given the recommended dose for their dependence score. There was 41% of patients not receiving NRT who reported higher severities of withdrawal symptoms, compared with 23% of those receiving NRT. Twenty-eight patients (93.3%) were willing to be followed up on discharge with all expressing their interest in cutting down or quitting smoking. This is a positive indicator that interventions during or following an ICU admission can promote patients to act on smoking cessation.

Conclusion: There is little guidance into application and dosing of NRT in ICU patients. Given there is a high level of willingness to cease smoking and participate in follow up, a larger study considering the efficacy of NRT in the ICU appears feasible and warranted.

FAMILY SUPPORT NEEDS AT THE END OF LIFE IN CRITICAL CARE: A RETROSPECTIVE DESCRIPTIVE STUDY

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Introduction: Despite clear evidence that family care and support are essential in critical care, little is known about how family support needs are assessed and facilitated at the end of life.

Objective: To explore how next-of-kin support needs at the end of life are assessed and/or facilitated.

Methods: A retrospective medical record audit of 50 adult patients who died in a Melbourne metropolitan intensive care unit in 2019.

Results: Next-of-kin were documented in 96% (n=48) of cases, with the majority being the decedent’s spouse (46.0%, n=23) followed by another relative (44.0%, n=22). A Goals of Care Summary was completed in 74.0% (n=37) of cases, with evidence of next-of-kin consultation in 75.5% (n=28) of these cases. Where a Goals of Care Summary was completed, 32.4% (n=12) of patients were for palliative/terminal care. Formal family meetings were held in 90.0% (n=45) of cases to communicate prognosis, plan care and facilitate decision-making, and in some cases to resolve family disagreement. There was evidence of nurse assessment of family needs and preferences in 60.0% (n=30) of cases, with social and pastoral care workers involved in 68.0% (n=34) and 10% (n=5) of cases respectively, and specialist palliative care involved in only 6.0% (n=3) cases. In addition to immediate support offered by bedside nurses, family requests for cultural/ religious practices were supported after patient death in 34.0% (n=17) of cases. Eleven (22.0%) next-of-kin received bereavement support.

Conclusion: Assessing family support needs at the end of life, including their cultural and religious needs is essential to providing optimal end-of-life care. Whilst these data demonstrate a high rate of family meetings, nurse assessment of family needs including a cultural assessment, and routine referral to multidisciplinary supports including palliative care, social work and pastoral care should be considered as part of routine care when patients are deemed for palliative or terminal care.