Manual of good practices to humanise intensive care units

2019 revision

HUCI Humanizando los Cuidados Intensivos

Manual of good practices

2019

Revision

How to cite this document:

Certification work group HU-CI Project. Manual of good practices to humanise intensive care units. Madrid: HU-CI Project; 2019 [access 25 Jan 2022]. Available at: https://proyectohuci.com/en/good-practices/

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1st edition. November 2017 **ISBN:** 978-84-697-7456-4
2nd revised edition. May 2019 **ISBN:** 978-84-09-11618-8

HUCI Humanizando los Cuidados Intensivos

Certification programme to humanise intensive care units

Who are we:

The **HU-CI Project** is a multidisciplinary research group including doctors and nurses who work in intensive care units, as well as patients, family members and other professionals, such as psychologists, designers, interior designers, architects, etc. The project is based on a comprehensive vision of the current situation including patients, families and professionals with the aim of jointly improving care in intensive care units.

The **HU-CI Project** has the following goals:

1. Humanise intensive care.
2. Be a forum and meeting point for patients, families and professionals.
3. Communicate intensive care and bring it to the general population, emphasising activities related to humanising it.
4. Promote training in humanisation skills: communication, providing help, etc.
5. Be a guide towards a humanised service by establishing standards and validating compliance in units that request so.

The **HU-CI Project** has scientific endorsement from several national and international scientific associations.

HUCI Humanizando los Cuidados Intensivos

Purpose:

The **HU-CI Project** proposes, among its lines of actions, to certify compliance with humanisation standards of healthcare organisations, as well as of their professionals and the training they receive. Therefore, the **HU-CI Project** guides healthcare organisations and professionals in order to improve quality of work through certification and other projects that enhance humanisation in **intensive care**.

Certification requires express and public **recognition** for complying with the requirements that are deemed necessary to provide humanised and quality healthcare by the units that have embarked on a path of continuous improvement.

This certification programme includes a total of **160 good practices** divided into 7 strategic lines.

Scope:

The certification programme to humanise intensive care units is aimed at intensive care units, resuscitation and any other units/departments that offer continuous healthcare to critical patients, belonging to hospitals that request it (public or private, national or international).

Methodology:

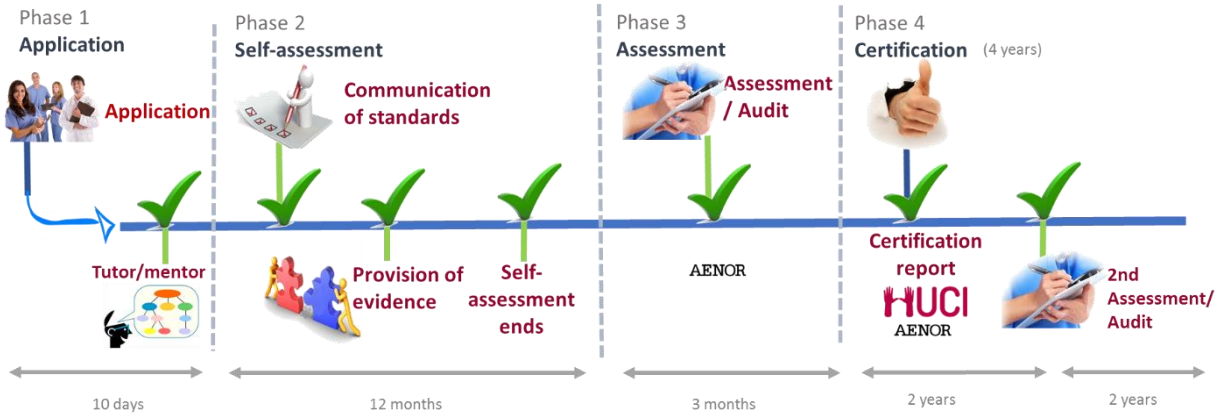
The certification process begins by filing a voluntary application for the unit to be part of the review process that will conclude with certification by the **HU-CI Project**.

Said certification will be valid for four years once granted. Once this period of time has passed, the good practices must be re-certified to maintain the level of certification.

The process involves the following steps:

- Application.
- Self-assessment.
- Assessment.
- Certification.

Certification process to humanise intensive care units



Phase 1: Application.

The applications begins with a formal request indicating all the relevant information of the requesting unit, as well as the people responsible for the process.

Once the application has been received, two tutors from the **HU-CI Project** team will be assigned and will be in charge of accompanying and advising the requesting unit throughout the certification process.

The local leaders will receive access codes to the certification programme through which they will remain in contact with the team throughout the whole process. They will be provided the necessary tools to send the requested documents to verify the required good practices.

Phase 2: Self-assessment.

This phase involves the local leaders meeting and providing evidence that verifies compliance with the required good practices. Said requirements are covered in this certification manual, which is a guide to prepare evidence on compliance.

Once the process has started, a maximum time frame of two months is set to finalise this phase. The evidence provided is valid throughout this period and should be renewed if the established timeframe is exceeded.

Self-assessment allows the requesting unit to identify their current position, determine where they want to reach and plan actions to achieve so.

This phase comes to an end at the request of the requesting unit once they consider all the necessary requirements are met and, therefore, the evaluation phase can commence.

Phase 3: Assessment.

Once the self-assessment phase finishes at the request of the requesting unit, an external audit will be carried out. The assessment teams will review the evidence provided throughout the certification process. This phase includes assessing the provided documents and on-site verification of the required good practices.

Phase 4: Certification.

Based on the results obtained in the assessment phase, a report will be drafted to certify compliance with the proposed good practices. This report will include any details detected that could be improved.

The report will certify a **basic, advanced or excellent compliance level** in accordance with the level of achievement of the proposed standards.

Good practices are divided into three groups:

- On the one hand, those that are considered **basics** in order for the unit to have a basic level of humanisation (marked with the letter B).
- On the other hand, good practices classed as **advanced**, but which are not obligatory to reach a basic level. Compliance with these good practices reaches a more advanced level of recognition (marked with the letter A).
- Furthermore, although not considered obligatory or essential, there are **excellent** good practices that provide an excellent level of recognition and certification (marked with the letter E in the text).

This manual has been prepared by healthcare professionals with the participation and guidance from other professionals in fields related to the certification standards, as well as patients and family members.

STRATEGIC LINES

Strategic line 1	OPEN-DOOR ICU: PRESENCE AND INVOLVEMENT OF FAMILIES IN CARE	AWARENESS BY PROFESSIONALS
		ACCESSIBILITY
		CONTACT
		PRESENCE AND INVOLVEMENT IN PROCEDURES AND CARE
		EMOTIONAL AND PSYCHOLOGICAL SUPPORT FOR THE FAMILY
Strategic line 2	COMMUNICATION	COMMUNICATION IN THE TEAM
		COMMUNICATION AND INFORMATION FOR THE FAMILY
		COMMUNICATION WITH THE PATIENT
Strategic line 3	PATIENT WELL-BEING	PHYSICAL WELL-BEING
		PSYCHOLOGICAL WELL-BEING
		PROMOTING PATIENT AUTONOMY
		ENVIRONMENTAL WELL-BEING AND NIGHT-TIME REST
Strategic line 4	CARING FOR PROFESSIONALS	AWARENESS OF OCCUPATIONAL BURNOUT AND ASSOCIATED FACTORS
		PREVENTING OCCUPATIONAL BURNOUT AND PROMOTING WELL-BEING
Strategic line 5	POST-INTENSIVE CARE SYNDROME (PICS)	PREVENTION AND MANAGEMENT
		FOLLOW-UP

Strategic line 6	**END-OF-LIFE CARE**	PROTOCOL FOR END-OF-LIFE CARE
		CONTROLLING PHYSICAL SYMPTOMS
		END-OF-LIFE ACCOMPANIMENT
		COVERING EMOTIONAL AND SPIRITUAL PREFERENCES AND NEEDS
		LIMITATION OF LIFE-SUSTAINING TREATMENT PROTOCOL
		MULTIDISCIPLINARY IMPLICATION IN DECISION AND DEVELOPMENT OF MEASURES OF LIMITATION OF LIFE-SUSTAINING TREATMENT

Strategic line 7	**HUMANISED INFRASTRUCTURE**	PATIENT PRIVACY
		COMFORTABLE SURROUNDINGS FOR PATIENTS
		PATIENT ORIENTATION
		COMFORTABLE FAMILY AREAS
		COMFORTABLE AND FUNCTIONAL CARE AREA
		COMFORTABLE ADMINISTRATION AND STAFF AREA
		PATIENT DISTRACTION
		CREATING SPACES IN GARDENS OR PATIOS
		SIGNS AND ACCESSIBILITY

GOOD PRACTICES

STRATEGIC LINE 1:

OPEN-DOOR ICU: PRESENCE AND INVOLVEMENT OF FAMILIES IN CARE

Historically, the policy for families to visit patients in the ICU and participate in their care has followed a restrictive model in Spain and many places in Latin America and Europe. Patients are limited to between one and three visits a day from their loved ones, with each visit lasting less than an hour.

Nonetheless, in recent decades there have been consolidated experiences in terms of opening ICUs, led by paediatric and neonatal units. This has included the family in caring for small patients, following the line of care focused on development and maternal bonding. However, the restrictive model (although there are exceptions) is still in force in adult ICUs, despite the increasing amount of scientific literature that supports flexible visiting hours according to the needs and preferences of patients and families.

Critical reflection is one of the keys to promoting a change in this way of conceiving the presence and involvement of families. There are indications that the barriers to opening the ICU doors are based on habits and assumptions that have taken form over time by professionals and managers and the physical structure of the units. For instance, professionals and managers have internalised assumptions that the presence of families interferes with their work and distracts them, or that relatives can cause complications in the development of the pathological process of the patient. Furthermore, there are beliefs that going into the ICU can cause families psychological trauma and anxiety. The physical structure of the units does not help to change these habits, as there is a strong physical separation between the patient and the outside world.

There are many and several alternatives to the closed-door model. Therefore, each ICU has the option of establishing the most feasible ones according to its idiosyncrasy. Open and/or flexible visits are shown to be beneficial for patients, families and professionals. Thus, a higher presence from families does not increase infections, but it improves stress hormones and can improve delirium and weaning processes, among others.

A higher presence also favours higher family involvement in the patient's process. Again, there are different options for families to be involved. For instance, if clinical conditions allow so, families can collaborate with looking after the patient (hygiene, eating, moving ...), under the supervision and guidelines of healthcare professionals. Giving the family the chance to be involved in the decision-making process and help towards patient recovery can have positive effects for the patient, family and healthcare professionals, as emotional stress is reduced and communication and proximity by all involved parties is enabled.

Being present throughout certain procedures has not been associated with negative consequences and generates synergies between the healthcare professionals and family members in order to keep privacy, dignity and manage pain during procedures, as well as achieving higher satisfaction from families and better acceptance of the situation, which can help the grieving process if the worst should happen.

Families can be more involved during the day and this also contributes to improving communication and gives them the chance to ask questions and clarify any doubts, therefore increasing family satisfaction.

Finally, it seems that the figure of the "main carer" makes it easier for other relatives to adapt to the individual needs of each patient and their surroundings.

Without a doubt, depending on the culture of each ICU, a process of reflection, learning and consensus will be necessary to move towards an open-door model. Professionals will need to participate and plan strategies and assessment systems that are more feasible for each context. Below we propose a set of strategies among which it is undoubtedly possible to adapt some in each of your units.

Strategic line 1	**OPEN-DOOR ICU: PRESENCE AND INVOLVEMENT OF FAMILIES IN CARE**	AWARENESS AND TRAINING OF HEALTHCARE PROFESSIONALS
		ACCESSIBILITY
		CONTACT
		PRESENCE AND INVOLVEMENT IN PROCEDURES AND CARE
		EMOTIONAL AND PYCHOLOGICAL SUPPORT FOR THE FAMILY

Strategic line 1	OPEN-DOOR ICU	AWARENESS AND TRAINING OF HEALTHCARE PROFESSIONALS

Carry out awareness-raising and training activities for the healthcare team on the benefits of applying the open-door ICU model.

Good practice 1.1	There is an interprofessional work group in charge of coordinating and monitoring compliance with the model of making family accompaniment hours flexible.	B A E
Good practice 1.2	Reflexive activities and multidisciplinary sessions are carried out related to making visits flexible.	B A E
Good practice 1.3	Continuous training in non-technical skills for the healthcare team is carried out to enable family presence and involvement.	B A E

Strategic line 1	OPEN-DOOR ICU	ACCESSIBILITY

Carry out activities that enable the patient's family to access the ICU.

Good practice 1.4	There is a protocol for family care that reflects a flexible access schedule.	B A E
Good practice 1.5	The figure of the main carer/companion is recognised and respected and granted continuous access, regardless of the relatives who wish to visit the patient at other scheduled times.	B A E
Good practice 1.6	Minors are allowed to visit the unit after having received instructions.	B A E
Good practice 1.7	A procedure is available to prepare minors when accessing the unit.	B A E
Good practice 1.8	The possibility of allowing pets to enter the unit is considered.	B A E
Good practice 1.9	There is a guide, leaflet and/or poster to welcome families and patients admitted to the ICU that includes instructions on accessing the unit.	B A E

Strategic line 1	OPEN-DOOR ICU	CONTACT
Establish measures to favour family contact and relation with the patient while in the ICU.		
Good practice 1.10	Unnecessary barriers are not applied (shoe covers, gowns, gloves, masks), except for special cases when they are required.	B A E
Good practice 1.11	Breastfeeding is facilitated when the conditions of the mother and infant allow so.	B A E

Strategic line 1	PRESENCE AND INVOLVEMENT OF FAMILIES IN CARE	PRESENCE AND INVOLVEMENT IN PROCEDURES AND CARE
Offer families the possibility of being involved in looking after the patient and being present for certain procedures.		
Good practice 1.12	There is a healthcare protocol available regarding family involvement in basic care (food, hygiene and moving) for critical patients.	B A E
Good practice 1.13	The structure and function of the family is assessed to identify the person who possibly wishes to take on the role of main carer.	B A E
Good practice 1.14	Family training activities are programmed (ICU family school).	B A E
Good practice 1.15	Families are considered and facilitated to accompany the patient for certain procedures when requested.	B A E
Good practice 1.16	In the case of programmed hospitalisation, the possibility of visiting the ICU prior to admission is considered (in order to minimise the stress generated by being admitted to a critical care unit).	B A E
Good practice 1.17	The healthcare protocol regarding family involvement in critical patient care includes making decisions about treatment and care in a shared manner in the case of patients who are unable to make such decisions.	B A E

Good practice 1.18	The healthcare protocol related to family involvement in critical patient care includes on-site customised training.	B A E
Good practice 1.19	Patient consent on family involvement is recorded, if applicable.	B A E
Good practice 1.20	The organisational system promotes care continuity, assigning healthcare professionals of reference for each specific patient.	B A E
Good practice 1.21	There is a guide, leaflet and/or poster to welcome families and patients including information on the possibility to participate in patient care.	B A E
Good practice 1.22	There is a welcome guide for families indicating the possibility of participating in the day shift with professionals.	B A E

Strategic line 1	PRESENCE AND INVOLVEMENT OF FAMILIES IN CARE	EMOTIONAL AND PSYCHOLOGICAL SUPPORT FOR THE FAMILY
Detect and provide support according to the family's emotional, spiritual and psychological needs.		
Good practice 1.23	The possible emotional, psychological, religious and/or spiritual needs of the family are enquired and detected.	B A E
Good practice 1.24	Regulated use of a mobile phone and other devices is facilitated (to favour keeping in touch with relatives).	B A E
Good practice 1.25	There is a guide, leaflet and/or poster to welcome families and patients including information on the different ways they can communicate with the patient.	B A E
Good practice 1.26	Psychological assistance is available for families who need it.	B A E

Recommended bibliography:

- Au S, Ordons AR, Soo A, Stelfox H. Determining best practices for family participation in ICU rounds. Crit Care Med. 2015;43(12 Suppl 1):15.
- Azoulay E, Chaize M, Kentish-Barnes N. Involvement of ICU families in decisions: fine-tuning the partnership. Ann Intensive Care. 2014;4:37.
- Azoulay E, Pochard F, Chevret S et al. Meeting the needs of intensive care unit patient families: a multicenter study. Am J Respir Crit Care Med. 2001;163:135-9.
- Cappellini E, Bambi S, Lucchini A, Milanesio E. Open intensive care units: a global challenge for patients, relatives, and critical care teams. Dimens Crit Care Nurs. 2014;33:181-93.
- Curtis JR, Sprung CL, Azoulay E. The importance of word choice in the care of critically ill patients and their families. Intensive Care Med. 2014;40:606-8.
- Davidson JE, Aslakson RA, Long AC, Puntillo KA, Kross EK, Hart J et al. Guidelines form Family-Centered Care in the Neonatal, Pediatric, and Adult ICU. Crit Care Med. 2017; 45:103-128.
- Escudero D, Martín L, Viña L, Quindós B, Espina MJ, Forcelledo L, et al. [Visitation policy, design and comfort in Spanish intensive care units]. Rev Calid Asist. 2015;30:243-50.
- Gélinas C et al. Patients and ICU nurses' perspectives of non-pharmacological interventions for pain management. Nur- sing in Critical Care. 2013;18:307-18.
- Gerritsen RT, Hartog CS, Curtis JR. New developments in the provision of family-centered care in the intensive care unit. Intensive Care Med. 2017;43:550-553
- Giannini A. The "open" ICU: not just a question of time. Minerva Anestesiol. 2010;76:89-90.
- Hetland B, Hickman R, McAndrew N, Daly B. Factors Influencing Active Family Engagement in Care Among Critical Care Nurses. AACN Adv Crit Care. 2017;28:160-170.
- Hetland B, McAndrew N, Perazzo J, Hickman R. A qualitative study of factors that influence active family involvement with patient care in the ICU: Survey of critical care nurses. Intensive Crit Care Nurs. 2018;44:67-75.
- Holanda Peña MS, Ots Ruiz E, Domínguez Artiga MJ, García Miguélez A, Ruiz A, Castellanos Ortega A, et al. Measuring the satisfaction of patients admitted to the intensive care unit and of their families. Med Intensiva. 2015;39:4-12.
- Hopkins RO. Family Satisfaction in the ICU: Elusive Goal or Essential Component of Quality Care. Crit Care Med. 2015;43:1783-4.
- Jabre P, Belpomme V, Azoulay E, Jacob L, Bertrand L, Lapostolle F, et al. Family presence during cardiopulmonary resuscitation. N Engl J Med. 2013;368:1008-18.
- Kynoch K, Chang A, Coyer F, McArdle A. The effectiveness of interventions to meet family needs of critically ill patients in an adult intensive care unit: a systematic review update. JBI Database System Rev Implement Rep. 2016;14:181-234
- Liu V, Read JL, Scruth E, Cheng E. Visitation policies and practices in US ICUs. Crit Care. 2013;17:R71.
- Ludmir J, Liu X, Gupta A, Ramani GV, Liu SS, Zakaria S, Verceles AC, Shah NG, McCurdy MT, Dammeyer JA, Netzer G. Cardiologist perceptions of family-centred rounds in cardiovascular clinical care. Open Heart. 2018;5:e000834.
- Meert KL, Clark J, Eggly S. Family-centered care in the pediatric intensive care unit. Pediatr Clin North Am. 2013;60:761-72
- Mitchell ML, Aitken LM. Flexible visiting positively impacted on patients, families and staff in an Australian Intensive Care Unit: A before-after mixed method study. Aust Crit Care. 2017;30:91-7.
- Pardavila M.I, Vivar C.G. Necesidades de las familias en las Unidades de Cuidados Intensivos. Revisión de la literatura. Enferm Intensiva. 2012;23;51-67.
- Paul RG, Finney SJ. Family satisfaction with care on the ICU: essential lessons for all doctors. Br J Hosp Med (Lond). 2015;76:504-9.
- Pun BT, Balas MC, Barnes-Daly MA, Thompson JL, et al. Caring for Critically Ill Patients with the ABCDEF Bundle: Results of the ICU Liberation Collaborative in Over 15,000 Adults. Crit Care Med. 2019;47:3-14.
- Quenot JP, Ecarnot F, Meunier-Beillard N, Dargent A, Large A, Andreu P, Rigaud JP. What are the ethical issues in relation to the role of the family in intensive care? Ann Transl Med. 2017;5(Suppl 4):S40.
- Riley BH, White J, Graham S, Alexandrov A. Traditional/restrictive vs patient-centered intensive care unit visitation: perceptions of patients' family members, physicians, and nurses. Am J Crit Care. 2014;23:316-24.
- Rosa RG, Falavigna M, Robinson CC, et al and ICU Visits Study Group Investigators and the BRICNet. Study protocol to assess the effectiveness and safety of a flexible family visitation model for delirium prevention in adult intensive care units: a cluster-randomised, crossover trial (The ICU Visits Study). BMJ Open. 2018;8:e021193.
- Santiago C, Lazar L., Jiang D, Burns KE. A survey of the attitudes and perceptions of multidisciplinary team members towards family presence at bedside rounds in the intensive care unit. Intensive Crit Care Nurs. 2014;30:13-21.
- Schmidt M, Azoulay E. Having a loved one in the ICU: the for- gotten family. Curr Opin Crit Care. 2012;18:540-7.

- Turnbull AE, Chessare CM, Coffin RK, Needham DM. More than one in three proxies do not know their loved one's current code status: An observational study in a Maryland ICU. PLoS One. 2019;14(1): e0211531.
- Van den Broek JM, Brunsveld-Reinders AH, Zedlitz AM, Girbes AR, de Jonge E, Arbous MS. Questionnaires on Family Satis- faction in the Adult ICU: A Systematic Review Including Psychometric Properties. Crit Care Med. 2015;43:1731-44.
- Velasco Bueno JM, Prieto de Paula JF, Castillo Morales J, Merino Nogales N, Perea-Milla López E. Organization of visits in Spanish ICU. Enferm Intensiva. 2005;16:73-83.
- Westley ME, Ching JM, Sherman SA, Smith IA. Opening the ICU doors. Healthc (Amst). 2014;2:258-62.
- Zaforteza C et al. Improving the care of critical patient family members: Agreed on strategies. Enferm Intensiva. 2010;21:11-9.

STRATEGIC LINE 2

COMMUNICATION

Like other healthcare departments and complex institutions, ICUs may also experience communication issues. In particular, we can highlight 3 problems that we believe must be addressed: 1) communication within the multidisciplinary team; 2) quality information for patients and families; and 3) patient communication with the team and family, especially regarding their last wishes.

Firstly, in terms of communication within the multidisciplinary team, in healthcare services in general it is known that suboptimal communication creates conflicts in the team, it threatens patient safety, burns out professionals and undermines team cohesion. In ICUs, this is especially relevant, and it is a priority to establish clear and effective structured processes to transfer information and responsibility (procedures to change shifts/on-call shifts, transferring patients to other units, etc.). It is also relevant to establish structured spaces for professionals to talk with the aim of sharing key information and agreeing on treatment and care with patients and families. Here communication skills and support strategies play a decisive role. It is necessary to use tools that enable multidisciplinary participation, as when the team has a meeting, nurses and nursing assistants often have difficulties in putting their extensive knowledge of the patient/family on the table.

Secondly, access to quality information is one of the main needs expressed by ICU patients and their families and it is the healthcare team's responsibility to guarantee their right to it. Nonetheless, this task is not easy, especially in an environment where different factors make it difficult.

These factors are both characteristic of the patient's situation and factors derived from the way in which intensive care units have been historically constructed. Therefore, critical patients do not often have the ability to receive information and/or make decisions, so this right is transferred to their families. Providing information in a suitable manner in highly emotional situations requires communication skills, yet many professionals have not received specific training in this field. In general, there are no specific policies on how this information process should be carried out in ICUs. Information is still limited to once a day and is not adapted to the specific needs of the patients and their families. In addition, joint information from the doctor and nurse is often not considered. Involvement from nurses regarding regulated information is generally insufficient and not clearly defined, despite the essential role they play in caring for critical patients and their families.

Finally, many patients who pass away in the ICU do so without being able to report their needs or wishes at the end of their lives or do not have the chance to give messages to their loved ones. Therefore, it is essential to improve communication processes with patients with difficulties or limitations to express themselves, encouraging the use of augmentative communication systems (which complement oral language when it is not enough for effective communication) and alternative communication systems (which replace oral language when it is not comprehensible or is absent).

HUCI Humanizando los Cuidados Intensivos

Strategic line 2	**COMMUNICATION**	COMMUNICATION IN THE TEAM
		COMMUNICATION AND INFORMATION FOR THE FAMILY
		COMMUNICATION WITH THE PATIENT

Strategic line 2	COMMUNICATION	COMMUNICATION IN THE TEAM

Correct transfer of relevant information regarding the patient and their family among all team members is ensured and tools that promote teamwork are used.

Good practice 2.1	There is a structured protocol to transfer information when shifts/on-call shifts are changed.	
Good practice 2.2	There is a structured protocol to transfer information when the patient is moved to a ward.	
Good practice 2.3	Training activities are carried out for ICU professionals on teamwork and effective communication, using tools such as clinical simulation and CRM (Crisis Resource Management).	
Good practice 2.4	Joint sessions and/or daily rounds are carried out by the healthcare team.	
Good practice 2.5	Specific tools are used to improve effective communication: daily goals/verification lists/briefings/real-time randomised security analysis/SBAR technique.	
Good practice 2.6	There are tools to identify conflicts among ICU professionals.	

Strategic line 2	COMMUNICATION	COMMUNICATION AND INFORMATION FOR THE FAMILY

Enable elements that help to have suitable and empathetic communication with families by all team members in order to have satisfactory assistance, as well as access to information.

Good practice 2.7	There are adequate physical spaces to give families information.	
Good practice 2.8	There is a joint doctor-nurse information protocol for patients and families, and it is often used.	

Good practice 2.9	Training activities are carried out on non-technical and relationship skills that include giving bad news, difficult situations and grief.	
Good practice 2.10	As well as the programmed information, there are other strategies that facilitate communication and giving information to patients and families, such as making visiting and information times flexible, as well as providing information on the telephone or other digital means in selected cases.	
Good practice 2.11	In the case of competent patients, the will that families or relatives be informed is enquired with the patient themselves.	

Strategic line 2	COMMUNICATION	COMMUNICATION WITH THE PATIENT
Provide information to patients and encourage the use of augmentative and/or alternative communication systems when necessary.		
Good practice 2.12	Augmentative/alternative communication systems are available. [7.14]	
Good practice 2.13	There is a protocol in place to favour communication with patients who have difficulties to communicate.	
Good practice 2.14	There is a procedure in place to assess patients with language difficulties and their needs in this sense.	
Good practice 2.15	There is an interprofessional team that can support communication strategies for patients with language limitations (ENT specialists, speech therapists).	
Good practice 2.16	Professionals, patients and families are taught to use augmentative and alternative communication systems.	
Good practice 2.17	There is a system in place for patients to call healthcare professionals when needed.	

Recommended bibliography:

- Abraham J, Kannampallil TG, Almoosa KF, Patel B, Patel VL. Comparative evaluation of the content and structure of communication using two handoff tools: implications for patient safety. J Crit Care. 2014;29:311.e1-7.
- Alonso Ovies A, Heras La Calle G. Tell me what you need. I hear you. Med Intensiva. 2019;43:193-4.
- Alonso-Ovies A, Álvarez J, Velayos C, García MM, Luengo MJ. Expectativas de los familiares de pacientes críticos respecto a la información médica. Estudio de investigación cualitativa. Rev Calidad Asistencial. 2014;29:325-33
- Azoulay E, Timsit JF, Sprung CL, Soares M, Rusinová K, Lafabrie A, Abizanda R, Svantesson M, Rubulotta F, Ricou B, Benoit D, Heyland D, Joynt G, Français A, Azeivedo-Maia P, Owczuk R, Benbenishty J, de Vita M, Valentin A, Ksomos A, Cohen S, Kompan L, Ho K, Abroug F, Kaarlola A, Gerlach H, Kyprianou T, Michalsen A, Chevret S, Schlemmer B; Conflicus Study Investigators and for the Ethics Section of the European Society of Intensive Care Medicine. Prevalence and factors of intensive care unit conflicts: the conflicus study. Am J Respir Crit Care Med. 2009;180:853-60.
- Azoulay E, Chevret S, Leleu G, Pochard F, Barboteu M, Adrie C, Canoui P, et al. Half the families of intensive care unit pa- tients experience inadequate communication with physicians. Crit Care Med. 2000;28:3044-9.
- Bermejo JC. Humanizar la asistencia sanitaria. Bilbao. Ed.: Desclée De Brouwer. 2014.
- Bermejo, JC. Introducción al counselling (Relación de Ayuda). Maliaño (Cantabria): Sal Terrae. 2010.
- Bodí M, Olona M, Martín MC, Alceaga R, Rodríguez JC, Corral E, Pérez Villares JM, Sirgo G. Feasibility and utility of the use of real time random safety audits in adult ICU patients: a multicentre study. Intensive Care Med. 2015;41:1089-98.
- Curtis JR, Cook DJ, Wall RJ, Angus DC, Bion J, Kacmarek R, et al. Intensive care unit quality improvement: a "how-to" guide for the interdisciplinary team. Crit Care Med. 2006;34:211-8.
- Daly BJ, Douglas SL, O'Toole E, Gordon NH, Hejal R, Peer- less J, et al. Effectiveness trial of an intensive communica- tion structure for families of long-stay ICU patients. Chest. 2010;138:1340-8.
- Gaaeni M, Farahani MA, Seyedfatemi N, Mohammadi N. Informational support to family members of Intensive Care Unit patients: the perspectives of families and nurses. Glob J Health Sci. 2014;7:8-19.
- Garry J, Casey K, Cole TK, Regensburg A, McElroy C, Schneider E, et al. A pilot study of eye-tracking devices in intensive care. Surgery. 2016;159:938-44.
- Giordani, B. La Relación de Ayuda: De Rogers a Carkhuff. Ed.: Desclée De Brouwer. 1998
- Gross B, Rusin L, Kiesewetter J, Zottmann JM, Fischer MR, Prückner S, Zech A. Crew resource management training in healthcare: a systematic review of intervention design, training conditions and evaluation. BMJ Open. 2019;9:e025247.
- Happ MB, Tuite P, Dobbin K, DiVirgilio-Thomas D, Kitutu J. Communication ability, method, and content among nonspea- king nonsurviving patients treated with mechanical ventilation in the intensive care unit. Am J Crit Care. 2004;13:210-20.
- Hwang DY, Yagoda D, Perrey HM, Tehan TM, Guanci M, Ananian L, Currier PF, Cobb JP, Rosand J. Consistency of communication among intensive care unit staff as perceived by family members of patients surviving to discharge. J Crit Care. 2014;29:134-138.
- Kim MM, Barnato AE, Angus DC, Fleisher LA, Kahn JM. The effect of multidisciplinary care teams on intensive care unit mortality. Arch Intern Med. 2010;170:369-7.
- Rhodes A, Moreno RP, Azoulay E, Capuzzo M, Chiche JD, Eddleston J, et al. Task Force on Safety and Quality of Euro- pean Society of Intensive Care Medicine (ESICM). Prospectively defined indicators to improve the safety and quality of care for critically ill patients: a report from the Task Force on Safety and Quality of the European Society of Intensive Care Medicine (ESICM). Intensive Care Med. 2012;38:598-605.
- Sirgo Rodríguez G, Chico Fernández M, Gordo Vidal F, et al; Grupo de Trabajo de Planificación, Organización y Gestión de la Sociedad Española de Medicina Intensiva Crítica y Unidades Coronarias (SEMICYUC). Handover in Intensive Care. Med Intensiva. 2018;42:168-179.
- Ten Have EC, Nap RE, Tulleken JE. Measurement properties and implementation of a checklist to assess leadership skills during interdisciplinary rounds in the intensive care unit. ScientificWorldJournal. 2015;2015:951924.
- Van Sluisveld N, Hesselink G, van der Hoeven JG, Westert G, Wollersheim H, Zegers M. Improving clinical handover between intensive care unit and general ward professionals at intensive care unit discharge.Intensive Care Med. 2015;41:589-604.
- Velasco Bueno J, Alonso-Ovies A, Heras La Calle G, Zaforteza Lallemand C. Principales demandas informativas de los familiares de pacientes ingresados en Unidades de Cuidados Intensivos. Med Intensiva. 2018; 42:337-345.
- Weaver JL, Bradley CT, Brasel KJ .Family engagement regarding the critically ill patient. Surg Clin North Am. 2012;92:1637-47.
- White DB, Curtis JR. Establishing an evidence base for physician-family communication and shared decision making in the intensive care unit. Crit Care Med. 2006;34:2500-01.
- Young GB, Plotkin DR. ICU: Ineffective communication unit. Crit Care Med. 2000;28:3116-7.

STRATEGIC LINE 3

PATIENT WELL-BEING

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Patient well-being should be just as an important goal as curing them, even more important if the latter is not possible.
Being ill generates discomfort and pain and, if we add interventions that have already been carried out, some of which are painful (techniques, implanting devices, immobility, etc.), it is obvious that this discomfort increases.
There are many factors that cause critical patients suffering and discomfort. Patients feel pain, they are thirsty, hot and cold, they find it difficult to rest due to excess noise and light, they cannot move properly (often due to unnecessary limitations) or they find it difficult to communicate. Assessing and controlling pain, dynamic sedation in accordance with the patients' condition and preventing and managing acute delirium are essential parts of improving their well-being.

Apart from the physical causes, emotional and psychological suffering can also be high. Patients are afraid, feel lonely, isolated, a loss of identify, privacy and dignity, have feelings of dependency, uncertainty due to a lack of information, and a lack of understanding, among others. Assessment and support of these needs must be considered as a key element for quality care. Guaranteeing professionals have appropriate training and promoting measures to deal with or mitigate these symptoms to ensure patient well-being are the main goal when caring for critical patients.
The working conditions in our ICUs do not often favour us in terms of being able to prioritise these aspects, although it has been significantly addressed in recent years.

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Strategic line 3	PATIENT WELL-BEING	PHYSICAL WELL-BEING
		PSYCHOLOGICAL WELL-BEING
		PROMOTING PATIENT AUTONOMY
		ENVIRONMENTAL WELL-BEING AND NIGHT-TIME REST

Strategic line 3	PATIENT WELL-BEING	PHYSICAL WELL-BEING
Promote measures that avoid or decrease physical discomfort and favour early motor recovery.		
Good practice 3.1	There is an updated protocol on analgesia and sedation. [5.2]	
Good practice 3.2	Levels of analgesia and sedation are monitored by means of validated scales. [5.3]	
Good practice 3.3	There is an updated protocol on preventing and managing delirium. [5.5]	
Good practice 3.4	Therefore is a protocol on physical restraints.	
Good practice 3.5	There is an early respiratory physiotherapy protocol in place for critical patients. [5.6]	
Good practice 3.6	There is an early mobility protocol in place. [5.7]	
Good practice 3.7	A physiotherapist is part of the healthcare team. [5.8]	
Good practice 3.8	There is a hygiene protocol (washing and hydration) in place for bedridden patients.	

Strategic line 3	PATIENT WELL-BEING	PSYCHOLOGICAL WELL-BEING
Promote actions aimed at reducing patients' psychological suffering and meet spiritual needs.		

Good practice 3.9	The use of entertainment media is enabled for patients with regulated use (reading, games, multimedia devices, radio, TV ...). [7.32]	B A E
Good practice 3.10	Interventions are applied to support the patient's spiritual needs.	B A E
Good practice 3.11	Psychologists are part of the healthcare team.	B A E
Good practice 3.12	A protocol is available for selected patients to walk outside the ICU when they can benefit from it. [5.10]	B A E
Good practice 3.13	The possibility is given for self-care (hairdressing, make-up, hair removal ...) to improve the patient's self-perception.	B A E

Strategic line 3	PATIENT WELL-BEING	PROMOTING PATIENT AUTONOMY
Patient autonomy: establish measures that promote patient autonomy and enable being connected to the outside.		
Good practice 3.14	Controlled walking is encouraged.	B A E
Good practice 3.15	Use of bathroom/toilet is facilitated in selected cases.	B A E
Good practice 3.16	Regulated use of mobile phone and other technologies is facilitated to favour contact with family and friends.	B A E
Good practice 3.17	There is a guide that includes indications for self-care aimed at patients or the main carer.	B A E
Good practice 3.18	Occupational therapy is available as a prevention measure and delirium treatment for critical patients. [5.12]	B A E
Good practice 3.19	Fun and entertaining activities are allowed in the unit.	B A E

Strategic line 3	PATIENT WELL-BEING	ENVIRONMENTAL WELL-BEING AND NIGHT-TIME REST
Environmental well-being: promote measures that help the wake-sleep rhythm and night-time rest, as well as other measures for environmental well-being.		
Good practice 3.20	Measures to control environmental noise are defined and encouraged. [7.11]	B A E
Good practice 3.21	There are decibel meters with a light warning when the established limits are exceeded.	B A E
Good practice 3.22	There is a protocol for night-time rest measures.	B A E
Good practice 3.23	The volume of alarms and other devices are adjusted according to the time of day.	B A E
Good practice 3.24	Night-time light is adjusted with the possibility of decreasing general intensity at night in communal spaces and customising them in each room.	B A E
Good practice 3.25	Times of interventions are adapted to the rest periods of the patients and included in the night-time rest protocol.	B A E
Good practice 3.26	Quality of sleep is assessed and monitored.	B A E
Good practice 3.27	Outdoor lighting is favoured during the day (rooms with natural light).	B A E
Good practice 3.28	Interventions with music and/or music therapy are carried out.	B A E

Recommended bibliography:

- Acevedo-Nuevo M, González-Gil M. T, Solís-Muñoz M, et al. Manejo de la inmovilización terapéutica en Unidades de Cuidados Críticos: aproximación fenomenológica a la realidad enfermera. Enferm Intensiva. 2016; 27: 62–74.
- Adler J, Malone D. Early mobilization in the intensive care unit: a systematic review. Cardiopulm Phys Ther J. 2012;23:5-13.
- Alonso-Ovies Á, Heras La Calle G. ICU: a branch of hell? Intensive Care Med. 2016;42:591-2.
- Barr J, Fraser GL, Puntillo K, Ely EW, et al. American College of Critical Care Medicine. Clinical practice guidelines for the management of pain, agitation, and delirium in adult patients in the Intensive Care Unit: executive summary. Am J Health Syst Pharm. 2013;70:53-8.
- Benbenbishty J, Adam S, Endacott R. Physical restraint use in intensive care units across Europe: the PRICE study. Intensive Crit Care Nurs. 2010;26:241-5.
- Bradt J, Dileo C, Potvin N. Music for stress and anxiety reduction in coronary heart disease patients. Cochrane Database Syst Rev. 2013 Dec 28;12:CD006577. doi: 10.1002/14651858.CD006577.pub3.
- Bradt J, Dileo C. Music interventions for mechanically ventilated patients. Cochrane Database Syst Rev. 2014;12:CD006902. doi: 10.1002/14651858.CD006902.pub3.
- Chamorro C, Romera MA. Pain and fear in the ICU. Med Intensiva. 2015;39:442-4.
- Cutler LR, Hayter M, Ryan T. A critical review and synthesis of qualitative research on patient experiences of critical illness. Intensive Crit Care Nurs. 2013;29:147-57.
- Darbyshire JL, Young JD. An investigation of sound levels on intensive care units with reference to the WHO guidelines. Crit Care. 2013;17(5):R187.
- Denehy L, Lanphere J, Needham DM. Ten reasons why ICU patients should be mobilized early. Intensive Care Med. 2017;43:86-90.
- Escudero D, Viña L, Calleja C. For an open-door, more comfortable and humane intensive care unit. It is time for change. Med Intensiva. 2014;38:371-5.
- García Sánchez M, Caballero-López J, Ceniceros-Rozalén I, Giménez-Esparza Vich C, Romera Ortega MA, Pardo Rey C, et al. Management of analgesia, sedation and delirium in Spanish Intensive Care Units: A national two-part survey. Prácticas de analgosedación y delirium en Unidades de Cuidados Intensivos españolas: Encuesta 2013-2014. Med Intensiva. 2019;43:225-233.
- Gómez-Carretero P, Monsalve V, Soriano JF, De Andrés J. Alteraciones emocionales y necesidades psicológicas de pacientes en una Unidad de Cuidados Intensivos. Med Intensiva. 2007;31:318-25.
- Guillén F, Bernal M, García S, García MJ, Illán C, Alvarez MC et al. Calidad del sueño de los pacientes ingresados en UCI: relación con estresores ambientales. Enfermería Docente 2013;100:34-39.
- Hu RF, Jiang XY, Chen J, Zeng Z, Chen XY, Li Y, Huining X, Evans DJ. Non-pharmacological interventions for sleep pro- motion in the intensive care unit. Cochrane Database Syst Rev. 2015 Oct 6;10:CD008808. doi: 10.1002/14651858. CD008808.pub2.
- Laurent H, Aubreton S, Richard R, Gorce Y, Caron E, Vallat A, et al. Systematic review of early exercise in intensive care: a qualitative approach. Anaesth Crit Care Pain Med. 2016;35:133-49.
- Little A, Ethier C, Ayas N, Thanachayanont T, Jiang D, Mehta S. A patient survey of sleep quality in the Intensive Care Unit. Minerva Anestesiol. 2012;78:406-14.
- Profit J, Typpo KV, Hysong SJ, Woodard LD, Kallen MA, Petersen LA. Improving benchmarking by using an explicit fra- mework for the development of composite indicators: an example using pediatric quality of care. Implement Sci. 2010;5:13.
- Raurell-Torredà M, Arias-Rivera S, Martí JD, Frade-Mera MJ, Zaragoza-García I, Gallart E, Velasco-Sanz TR, San José-Arribas A, Blázquez-Martínez E; Grupo MOviPre. Degree of implementation of preventive strategies for post-ICU syndrome: Multi-centre, observational study in Spain. Enferm Intensiva. 2019;30:59-71.
- Rose L, Nonoyama M, Rezaie S, Fraser I. Psychological wellbeing, health related quality of life and memories of intensive care and a specialised weaning centre reported by survivors of prolonged mechanical ventilation. Intensive Crit Care Nurs. 2014;30:145-51.
- Schaller SJ et al. Early, goal-directed mobilisation in the surgical intensive care unit: a randomised controlled trial. Lancet. 2016;388(10052):1377-1388.
- Schweickert WD, Pohlman MC, Pohlman AS, Nigos C, Pawlik AJ, Esbrook CL, et al. Early physical and occupational therapy in mechanically ventilated, critically ill patients: a randomised controlled trial. Lancet. 2009;373:1874-82.
- Stiller K. Physiotherapy in intensive care: an updated systematic review. Chest. 2013;144:825-47.
- Vincent JL, Shehabi Y, Walsh TS, Pandharipande PP, Ball JA, Spronk P, et al. Comfort and patient-centred care without excessive sedation: the eCASH concept. Intensive Care Med. 2016;42:962-71.

- Wade DM, Moon Z, Windgassen SS, Harrison AM, Morris L, Weinman JA. Non-pharmacological interventions to reduce ICU-related psychological distress: a systematic review. Minerva Anestesiol. 2016;82:465-78.

STRATEGIC LINE 4

CARING FOR PROFESSIONALS

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Healthcare professionals mainly perform their work from a deep vocational perspective. Daily dedication to the unit and helping critical patients requires great commitment and involvement, which leads to enormous job satisfaction when expectations are met, quality work is carried out, patients improve, suffering is avoided, the deserved recognition is given, etc. However, when things do not go well, emotional drain is significant. When this emotional drain appears alongside not looking after their own health and well-being, the so-called "Burnout Syndrome" emerges. Burnout syndrome is a psychosocial syndrome characterised by three basic aspects: emotional drain, depersonalisation and feelings of low professional self-esteem. It is generally considered a response to chronic work stress with negative connotations, as it implies harmful consequences for the individual and organisation.

From an individual perspective, this can lead to post-traumatic stress disorder and other serious psychological disorders, even suicide. From a professional view, it influences the quality of care, the results on the patient and their satisfaction.

For the institution, it is related to professional turnover at organisations.
The contributing factors include individual personal characteristics, as well as environmental and organisational factors. These factors, directly or through intermediate syndromes such as moral distress, the perception of offering inappropriate care or compassion fatigue, can lead to occupational burnout.
Recently, different scientific associations have sought to discuss and bring visibility to occupational burnout by providing recommendations to reduce its appearance and mitigate its consequences, establishing specific strategies for an adequate response to the physical, emotional and psychological needs of intensive care professionals resulting from the dedication and effort of their work.
We can now admit today that society and organisations have a moral duty, an ethical imperative and a legal obligation to "take care of their carers". In order to comply with this obligation, a series of basic and priority objectives should be set to guide us towards preventative and therapeutic actions.

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Strategic line 4	CARING FOR PROFESSIONALS	AWARENESS OF OCCUPATIONAL BURNOUT AND ASSOCIATED FACTORS
		PREVENTING OCCUPATIONAL BURNOUT AND PROMOTING WELL-BEING

Strategic line 4	CARING FOR PROFESSIONALS	AWARENESS OF OCCUPATIONAL BURNOUT AND ASSOCIATED FACTORS
Improve knowledge on occupational burnout by favouring its visibility.		
Good practice 4.1	Training activities are carried out on understanding and managing stress, occupational burnout, as well as promoting engagement, emotional competences and psychosocial skills at work.	
Good practice 4.2	The process of occupational burnout and engagement are assessed frequently using validated tools.	

Strategic line 4	CARING FOR PROFESSIONALS	PREVENTING OCCUPATIONAL BURNOUT AND PROMOTING WELL-BEING
Prevent occupational burnout and promote engagement.		
Good practice 4.3	There are plenty of staff, therefore current recommendations are complied with.	
Good practice 4.4	Newly incorporated staff: a welcome programme is offered to all ICU healthcare staff (with adequate explanation of its organisation, internal ICU dynamics, expectations of new professionals, motivation, dissemination of humanisation proposals, etc.).	
Good practice 4.5	Staff over 55 years of age are offered the possibility to reduce/be exempt from being on call.	
Good practice 4.6	The chance to change shifts or adapt schedule to the professionals' individual needs is enabled.	
Good practice 4.7	There are pre-established and frequent meetings with the ICU team in order to establish participatory guidelines for action and organise work.	
Good practice 4.8	Learning, training and research is enabled.	

Good practice 4.9	Professional participation and opinion in the unit's organisational culture is promoted, as well as management and goals.	
Good practice 4.10	Prevention strategies are available regarding emotional problems and professional support, including being able to talk to a psychologist.	
Good practice 4.11	Regarding critical incidents or difficult/traumatic situations for the healthcare team (due to unexpected complications with a patient, mistakes, violent attitudes from relatives, etc.), actions are carried out to help process the situation, promote the well-being of the team and detect emotional disturbances in the professionals early.	
Good practice 4.12	Professionals have an appropriate resting area.	
Good practice 4.13	Work material and devices are available to move patients, therefore minimising injuries.	
Good practice 4.14	Group activities are promoted to encourage positive relationships within the group.	

Recommended bibliography:

- Azoulay E, Herridge M. Understanding ICU staff burnout: the show must go on. Am J Respir Crit Care Med. 2011;184:1099-100.
- Bianchi R. What is "severe burnout" and can its prevalence be assessed? Intensive Care Med. 2015;41:166.
- Burghi G, Lambert J, Chaize M, Goinheix K, Quiroga C, Fariña G, et al. Prevalence, risk factors and consequences of severe burnout syndrome in ICU. Intensive Care Med. 2014;40:1785-6.
- Bustinza Arriortua A, López-Herce Cid J, Carrillo Álvarez A, Vigil Escribano MD, de Lucas García N, Panadero Carlavilla E. Situación de burnout de los pediatras intensivistas españoles. An Esp Pediatr. 2000;52:418-23.
- Chuang CH, Tseng PC, Lin CY, Lin KH, Chen YY (2016) Burnout in the intensive care unit professionals: a systematic review. Medicine (Baltimore) 95:e5629.
- Comisión de las Comunidades Europeas. COM-2002 118 final: "Cómo adaptarse a los cambios en la sociedad y en el mundo del trabajo: una nueva estrategia comunitaria de salud y seguridad (2002-2006)". 2002. Bruselas.
- Panagioti M, Panagopoulou E, Bower P, Lewith G, Kontopantelis E, Chew-Graham C, et al. JAMA Intern Med. 2017;177:195-205.
- Embriaco N, Papazian L, Kentish-Barnes N, Pochard F, Azoulay E. Burnout syndrome among critical care healthcare workers. Curr Opin Crit Care. 2007;13:482-8.
- Epp K. Burnout in critical care nurses: a literature review. Dynamics. 2012;23:25-31.
- Fizth-Cozens J, Moss F. Hours, sleep, teamwork, and stress. BMJ. 1998;317:1335-6.
- Frade Mera MJ, Vinagre Gaspar R, Zaragoza García I, et al. Síndrome de Burnout en distintas Unidades de Cuidados Intensivos. Enferm Intensiva. 2009;20:131-40.
- Fuentelsaz-Gallego C, Moreno-Casbas T, Gómez-García T, González-María E; Consorcio RN4CAST-España. [Work set- ting, satisfaction and burnout of the nurses in critical care units and hospitalization units. RN4CAST-Spain project]. Enferm Intensiva. 2013;24:104-12
- Gálvez M, Moreno B, Mingote JC. El desgaste profesional del médico. Revisión y guía de buenas prácticas: El vuelo de Ícaro. Editorial Díaz de Santos. 2009.
- Guntupalli KK, Wachtel S, Mallampalli A, Surani S. Burnout in the intensive care unit professionals. Indian J Crit Care Med. 2014;18:139-43.
- Hall LH, Johnson J, Watt I, Tsipa A, O'Connor DB. Healthcare Staff Wellbeing, Burnout, and Patient Safety: A Systematic Review. PLoS One. 2016;11:e0159015.
- Humphries N, Morgan K, Conry MC, McGowan Y, Montgomery A, McGee H. Quality of care and health professional burnout: narrative literature review. Int J Health Care Qual Assur. 2014;27:293-307
- Klopper HC, Coetzee SK, Pretorius R, Bester P. Practice environment, job satisfaction and burn-out of critical care nurses in South Africa. J Nurs Manage. 2012;20:685-95.
- Losa Iglesias ME, Becerro de Bengoa Vallejo R. Prevalence and relationship between burnout, job satisfaction, stress, and clinical manifestations in spanish critical care nurses. DCCN. 2013;32:130-7.
- Maslach C, Jackson S. Maslach Burnout Inventory Manual. Palo Alto, CA: Consulting Psychologists Press, 1986.
- Maslach C, Jackson S. The measurement of experienced burnout. J Occup Behav. 1981;2:113.
- Maslach C, Jackson S. MBI: Maslach burnout inventory; manual research edition. Palo Alto, CA: Consulting Psychologists Press; 1996.
- Miller MN, Mc Gowen KR. The painful Truth: Physicians Are Not Invincible. South Med J. 2000;93:966-74.
- Mingote Adán JC. Síndrome "Burnout". Síndrome de desgaste profesional. Monografías de Psiquiatría. 1997;5:1-44.
- Moreno-Jiménez B, Gálvez M, Garrosa E. Personalidad Positiva y Salud. In L. Flórez, M.M. Botero y B. Moreno (Eds). Antología de Psicología de la salud. Cartagena: 2003. Barranquilla: Ediciones Uninorte.
- Moss M, Good VS, Gozal D, Kleinpell R, Sessler CN. An Official Critical Care Societies Collaborative Statement-Burnout Syndrome in Critical Care Health-care Professionals: A Call for Action. Chest. 2016;150:17-26.
- Murphy LR. Stress management in working settings: a critical review of the health effects. Am J Health Promot. 1996;11:112-35.
- Myhren H, Ekeberg O, Stokland O. Job Satisfaction and Burnout among Intensive Care Unit Nurses and Physicians. Crit Care Res Pract. 2013;2013:786176.
- Pastores SM, Kvetan V, Coopersmith CM, et al; Academic Leaders in Critical Care Medicine (ALCCM) Task Force of the Society of the Critical Care Medicine. Workforce, Workload, and Burnout Among Intensivists and Advanced Practice Providers: A Narrative Review. Crit Care Med. 2019;47:550-557.
- Pérez, JI. El apoyo psicológico a profesionales de emergencia. Asesoramiento psicológico. Available from: http://coepsique.org/wp-content/uploads/2011/12/Apoyo-Psicológico-a-los-profesionales-de-la-laemergencia.pdf

- Poncet MC, Toullic P, Papazian L, Kentish-Barnes N, Timsit JF, Pochard F. Burnout syndrome in critical care nursing staff. Am J Respir Crit Care Med. 2007;175:698-704.
- Protección Civil España. Intervención psicológica con intervinientes en emergencias. Available from: http://www.proteccioncivil.es/catalogo/carpeta02/carpeta25/guiadidac_ipc/data/pdfs/unidad_didactica_07.pdf
- Reader TW, Cuthbertson BH, Decruyenaere J. Burnout in the ICU: potential consequences for staff and patient well-being. Intensive Care Med. 2008;34:4-6.
- Santana Cabrera L, Hernández Medina E, Eugenio Robaina P, Sánchez-Palacios M, Pérez Sánchez R, Falcón Moreno R. [Burnout syndrome among nurses and nurses' aides in an intensive care unit and admission wards]. Enferm Clin. 2009;19:31-4.
- Shoorideh FA, Ashktorab T, Yaghmaei F, Alavi Majd H. Relationship between ICU nurses' moral distress with burnout and anticipated turnover. Nurs Ethics. 2015;22:64-76.
- Silva JL, Soares RS, Costa FS, Ramos DS, Lima FB, Teixeira LR. Psychosocial factors and prevalence of burnout syndrome among nursing workers in intensive care units. Rev Bras Ter Intensiva. 2015;27:125-33.
- Teixeira C, Ribeiro O, Fonseca AM, Carvalho AS. Burnout in intensive care units-a consideration of the possible prevalence and frequency of new risk factors: A descriptive correlational multicentre study. BMC Anesthesiol. 2013;13:38.
- Van Emmerik A, Kamphuis J, Hulsbosch A, Emmelkamp P. Single session debriefing after psychological trauma: A Meta-Analysis. The Lancet. 2002;360:766-771.
- Van Mol MM, Kompanje EJ, Benoit DD, Bakker J, Nijkamp MD. The Prevalence of Compassion Fatigue and Burnout among Healthcare Professionals in Intensive Care Units: A Systematic Review. PLoS One. 2015;10:e0136955.
- West CP, Dyrbye LN, Erwin PJ, Shanafelt TD. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. Lancet. 2016;388:2272-2281.
- West CP, Dyrbye LN, Rabatin JT, Call TG, Davidson JH, Multari A, et al. Intervention to Promote Physician Well-being, Job Satisfaction, and Professionalism: A Randomized Clinical Trial. JAMA Int Med. 2014;174:527-33.
- Zhang XC, Huang DS, Guan P. Job burnout among critical care nurses from 14 adult intensive care units in northeastern China: a cross-sectional survey. BMJ Open. 2014;4:e004813.

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STRATEGIC LINE 5

POST-INTENSIVE CARE SYNDROME (PICS)

Post-intensive care syndrome (PICS) affects a significant number of patients (30-50%) after overcoming a critical illness. It is characterised by physical symptoms (persistent pain, weakness from being in the ICU, malnutrition, pressure ulcers, sleep disturbances, need to use devices), neuropsychological symptoms (cognitive deficits, such as alterations in memory, attention, mental process speed) or emotional symptoms (anxiety, depression or post-traumatic stress). This can also affect families and lead to social problems.

These problems can start to appear when the patient is in the ICU and can continue when they return home. Their medium and long-term consequences impact the quality of life of both patients and their families.

Interprofessional teams with specialists in intensive medicine, rehabilitation, physiotherapists, nurses, psychologists, psychiatrists, occupational therapists, and phoniatrists should provide the necessary continuous care to support these needs. Families are also an essential part of minimising PICS by being involved in caring for patients, helping them to stay orientated and, therefore, reducing stress.

As well as PICS, the critical patient's illness leads to a family crisis, and feelings of worry (making decisions, evolution of the illness) and confusion can lead to families not looking after themselves. Therefore, the healthcare team should also support families who need to both deal with stress and to make decisions to stay healthy (rest, sleep hygiene, eating, hydration, strategies to maintain personal space, etc.).

Strategic line 5	POST-INTENSIVE CARE SYNDROME	PREVENTION AND MANAGEMENT
		FOLLOW-UP

Strategic line 5	POST-INTENSIVE CARE SYNDROME	PREVENTION AND MANAGEMENT
Prevent, detect and address post-intensive care syndrome (PICS), both for patients and families.		
Good practice 5.1	There is an interprofessional protocol in place to prevent and deal with PICS for patients and families.	B A E
Good practice 5.2	There is an updated protocol for analgesia and sedation. [3.1]	B A E
Good practice 5.3	Levels of analgesia and sedation are monitored by means of validated scales. [3.2]	B A E
Good practice 5.4	There is an updated protocol to disconnect mechanical ventilation.	B A E
Good practice 5.5	There is an updated protocol to prevent and manage delirium.[3.3]	B A E
Good practice 5.6	There is an early respiratory physiotherapy protocol in place for critical patients.	B A E
Good practice 5.7	There is an early mobility protocol in place.[3.6]	B A E
Good practice 5.8	A physiotherapist is part of the healthcare team. [3.7]	B A E
Good practice 5.9	Other measures to prevent and treat neuromuscular diseases are applied (adequacy of myorelaxant medication, use of foot drop prostheses ...).	B A E
Good practice 5.10	A protocol is available for selected patients to walk outside the ICU when they can benefit from it.	B A E
Good practice 5.11	There is a protocol in place to use ICU diaries in the unit.	B A E

Good practice 5.12	Occupational therapy is available as a prevention measure and delirium treatment for critical patients.	O E D

Strategic line 5	POST-INTENSIVE CARE SYNDROME	FOLLOW-UP

Improve quality of life of patients and families identified before leaving the ICU to follow up on the ward and/or at home. Assess and introduce possible organisational measures in accordance with the reality of each hospital.

Good practice 5.13	A physical functional assessment is conducted that is reflected in the patient's discharge report.	B A E
Good practice 5.14	A psychological assessment is conducted that is reflected in the patient's discharge report.	B A E
Good practice 5.15	A cognitive assessment is conducted that is reflected in the patient's discharge report.	B A E
Good practice 5.16	There is an intrahospital follow-up protocol for patients and families with PICS after being discharged from the ICU.	B A E
Good practice 5.17	There is a specific follow-up consultation with patients at risk of PICS when they have been discharged from hospital.	B A E
Good practice 5.18	Validated instruments are used to assess quality of life of the patient before and after being in the ICU.	B A E
Good practice 5.19	Support groups are organised for former ICU patients and their families.	B A E

References:

- Álvarez EA, Garrido MA, Tobar EA, Prieto SA, Vergara SO, Briceño CD, González FJ. Occupational therapy for delirium management in elderly patients without mechanical ventilation in an intensive care unit: A pilot randomized clinical trial. J Crit Care. 2017;37:85-90.
- Anderson BJ, Mikkelsen ME. Bringing the ABCDEF Bundle to Life and Saving Lives Through the Process. Crit Care Med. 2017;45:363-5.
- Azoulay E, Vincent JL, Angus DC, et al. Recovery after critical illness: putting the puzzle together-a consensus of 29. Crit Care. 2017;21:296.
- Bäckman CG, Walther SM. Use of a personal diary written on the ICU during critical illness. Intensive Care Med. 2001;27:426-9.
- Balas MC, Vasilevskis EE, Burke WJ, et al. Critical care nurses' role in implementing the "ABCDE bundle" into practice. Crit Care Nurse. 2012;32:35-8.
- Barr J, Fraser GL, Puntillo K, Ely EW et al. Clinical practice guidelines for the management of pain, agitation, and delirium in adult patients in the Intensive Care Unit: executive summary. Am J Health Syst Pharm. 2013;70: 53-8.
- Barr J, Fraser GL, Puntillo K, et al. Clinical practice guidelines for the management of pain, agitation, and delirium in adult patients in the intensive care unit. Crit Care Med. 2013;41:263-306.
- Beg M, Scruth E, Liu V. Developing a framework for implementing intensive care unit diaries: a focused review of the literature. Aust Crit Care. 2016;29:224-234.
- Brummel NE, Balas MC, Morandi A, et al: Understanding and reducing disability in older adults following critical illness. Crit Care Med 2015;43:1265–75.
- Care Quality Commission (2010) NHS staff survey 2010 [On- line]. Available from: http://www.cqc.org.uk/_db/_documents/NHS_staff_survey_nationalbriefing_final_for_DH.pdf
- Care Quality Commission (2011) The essential standards of quality and safety you can expect [Online]. Available from: http://www .cqc .org .uk/usingcareservices/ essentialstandardsofqualityandsafety .cfm
- Centre for Clinical Practice at NICE (UK). Rehabilitation After Critical Illness. NICE Clinical Guidelines, No. 83. London: National Institute for Health and Clinical Excellence; 2009.
- Change-Management-Coach.com (2011). Kurt Lewin Change Management Model [Online]. Available from: http://www .change-management-coach .com/kurt_lewin .html
- Collet MO, Caballero J, Sonneville R, Bozza FA, Nydahl P, Schandl A, Wøien H, Citerio G, van den Boogaard M, Hästbacka J, Haenggi M, Colpaert K, Rose L, Barbateskovic M, Lange T, Jensen A, Krog MB, Egerod I, Nibro HL, Wetterslev J, Perner A; AID-ICU cohort study co-authors. (MC Martin) Prevalence and risk factors related to haloperidol use for delirium in adult intensive care patients: the multinational AID-ICU inception cohort study. Intensive Care Med. 2018;44:1081-9.
- Connolly B. Describing and measuring recovery and rehabilitation after critical illness. Curr Opin Crit Care. 2015;21:445-52.
- Coulter A. What do patients and the public want from primary care? BMJ. 2005;331:1199-201.
- Curtis JR, Treece PD, Nielsen EL, et al: Randomized trial of communication facilitators to reduce family distress and intensity of end-of-life care. Am J Respir Crit Care Med 2016;44:154-62.
- Davidson JE, Harvey MA, Bernis-Dougherty A, et al. Implementation of the pain, agitation, and delirium Clinical Practice Guidelines and promoting patient mobility to prevent post-intensive care syndrome. Crit Care Med; 2013;41(9 Suppl 1):S136-45.
- Davidson JE, Jones C, Bienvenu OJ. Family response to critical illness: postintensive care síndrome-family. Crit Care Med. 2012;40:618-24.
- Davidson JE. Facilitated sensemaking: a strategy and new middle-range theory to support families of intensive care unit patients. Crit Care Nurse. 2010;30:28-39.
- Department of Health (2010). The NHS constitution: the NHS belongs to us all [Online]. Available from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113645 .pdf
- Department of Heath (2010) Equality and excellence: liberating the NHS [Online]. Available from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794 .pdf
- Desai SV, Law TJ, Needham DM. Long-term complications of critical care. Crit Care Med. 2011;39:371-9.
- Devlin JW, Skrobik Y, Gélinas C, Needham DM, Slooter AJC, Pandharipande PP, et al. Clinical Practice Guidelines forthe Prevention and Management of Pain, Agitation/Sedation, Delirium, Immobility, and Sleep Disruption in Adult Patients in the ICU. Crit Care Med. 2018;46:e825-e873.
- Ely EW, Margolin R, Francis J, May L et al. Evaluation of delirium in critically ill patients: validation of the Confusion Assessment Method for the Intensive Care Unit (CAM-ICU). Crit Care Med. 2001;29:1370-9.
- Ely EW. The ABCDEF Bundle: Science and Philosophy of How ICU Liberation Serves Patients and Families. Crit Care Med. 2017;45:321-30.
- Fuke R, Hifumi T, Kondo Y, et al. Early rehabilitation to prevent postintensive care syndrome in patients with critical illness: a systematic review and meta-analysis. BMJ Open. 2018;8:e019998.

- Haines KJ, Denehy L, Skinner EH, et al: Psychosocial outcomes in informal caregivers of the critically ill: A systematic re- view. Crit Care Med 2015;43:1112-20.
- Harvey MA, Davidson JE. Postintensive Care Syndrome: Right Care, Right Now…and Later. Crit Care Med. 2016;44:381-5.
- Martín Delgado MC, García de Lorenzo Y Mateos A. Sobrevivir a las Unidades de Cuidados Intensivos mirando a través de los ojos de la familia. Med Intensiva. 2017; 41:451-3.
- Meyer J, Brett SJ, Waldmann C. Should ICU clinicians follow patients after ICU discharge? Yes. Intensive Care Med. 2018;44:1539-41.
- Morandi A, Brummel NE, Ely EW. Sedation, delirium and mechanical ventilation: the 'ABCDE' approach. Curr Opin Crit Care. 2011;17:43-9.
- Morandi A, Piva S, Ely EW et al. Worldwide Survey of the "Assessing Pain, Both Spontaneous Awakening and Breathing Trials, Choice of Drugs, Delirium Monitoring/Management, Early Exercise/Mobility, and Family Empowerment" (ABCDEF) Bundle. Crit Care Med. 2017;45:e1111-e1122
- Needham DM, Davidson J, Cohen H, Hopkins RO et at. Improving long-term outcomes after discharge from intensive care unit: report from a stakeholders' conference. Crit Care Med. 2012;40:502-9.
- Pandharipande PP, Ely EW, Arora RC, et al. The intensive care delirium research agenda: a multinational, interprofessional perspective. Intensive Care Med. 2017;43:1329-39.
- Pandharipande PP, Girard TD, Jackson JC, et al. Long- term cognitive impairment after critical illness. N Engl J Med. 2013;369:1306-16.
- Pun BT, Balas MC, Barnes-Daly MA, Thompson JL, Aldrich JM, Barr J, et al. Caring for Critically Ill Patients with the ABCDEF Bundle: Results of the ICU Liberation Collaborative in Over 15,000 Adults. Crit Care Med. 2019;47:3-14.
- Schweickert WD, Hall J. ICU-acquired weakness. Chest. 2007;131:1541-9.
- Stollings JL and Caylor MM. Postintensive care syndrome and the role of a follow-up clinic. Am J Health Syst Pharm. 2015;72:1315-23.
- Strandberg S, Vesterlund L, Engström Å. The contents of a patient diary and its significance for persons cared for in an ICU: A qualitative study. Intensive Crit Care Nurs. 2018;45:31-36.
- Ullman AJ, Aitken LM, Rattray J, et al. Diaries for recovery from critical illness. Cochrane Database Syst Rev. 2014;2014:CD010468.
- Van Der Schaaf M, Bakhshi-Raiez F, Van Der Steen M, Dongel- mans DA, De Keizer NF. Recommendations for intensive care follow-up clinics; report from a survey and conference of Dutch intensive cares. Minerva Anestesiol. 2015;81:135-44.
- Vasilevskis EE, Ely EW, Speroff T, et al. Reducing iatrogenic risks: ICU-acquired delirium and weakness—crossing the quality chasm. Chest. 2010;138:1224-33.
- Vincent JL, Shehabi Y, Walsh TS, Pandharipande PP et al. Comfort and patient-centred care without excessive sedation: the eCASH concept. Intensive Care Med. 2016;42:962-71.
- Walsh TS, Salisbury LG, Merriweather JL, et al; RECOVER Investigators: Increased hospital-based physical rehabilitation and information provision after intensive care unit discharge: The RECOVER randomized clinical trial. JAMA Intern Med. 2015;175:901-10.
- Warlan H, Howland L: Posttraumatic stress syndrome associated with stays in the intensive care unit: Importance of nurses' involvement. Crit Care Nurse. 2015;35:44-52.
- Wintermann GB, Petrowski K, Weidner K, Strauß B, Rosendahl J. Impact of post-traumatic stress symptoms on the health-related quality of life in a cohort study with chronically critically ill patients and their partners: age matters. Crit Care. 2019;23:39.
- Wolters A, Bouw M, Vogelaar J, Tjan D, van Zanten A, van der Steen M. The postintensive care syndrome of survivors of critical illness and their families. J Clin Nurs. 2015;24:876-9.

STRATEGIC LINE 6

END OF LIFE CARE

Palliative and intensive care are not exclusionary options, but should coexist throughout the critical patient care process.

Although the main aim of intensive care is to restore the patient's health previous to admission, sometimes this is not possible and care must be dynamically modified to reduce suffering and offer the best possible care, especially at the end of a patient's life. Palliative care intends to provide comprehensive care for patients and their surroundings, with the aim of having a death free from discomfort and suffering for the patient and families in accordance with their wishes and clinical, ethical and cultural standards.

Limiting life-sustaining treatment is frequent in critically ill patients and should be performed in line with the guidelines and recommendations established by scientific associations.

It must be applied as part of a global palliative care plan, in a multidisciplinary way with the aim of meeting the physical, psychosocial, emotional and spiritual needs of patients and their families. Specific protocols and frequent assessments of the offered care are basic requirements.

Complex decisions made regarding critically ill patients at the end of their lives can cause discrepancies between healthcare professionals, patients and families. Professionals should have the necessary skills and tools to solve these conflicts by having open and constructive discussions, using strategies to reduce emotional burden caused by the situation.

Strategic line 6	END-OF-LIFE CARE	PROTOCOL FOR END-OF-LIFE CARE
		CONTROLLING PHYSICAL SYMPTOMS
		END-OF-LIFE ACCOMPANIMENT
		COVERING EMOTIONAL AND SPIRITUAL PREFERENCES AND NEEDS
		LIMITATION OF LIFE-SUSTAINING TREATMENT PROTOCOL
		MULTIDISCIPLINARY IMPLICATION IN DECISION AND DEVELOPMENT OF MEASURES OF LIMITATION OF LIFE-SUSTAINING TREATMENT

Strategic line 6	END-OF-LIFE CARE	PROTOCOL FOR END-OF-LIFE CARE
Have an end-of-life care protocol in place.		
Good practice 6.1	There is an interprofessional protocol for end-of-life care for critical patients that is adapted to the recommendations provided by scientific associations.	B A E
Good practice 6.2	There is a procedure in place to identify palliative needs in ICU patients.	B A E
Good practice 6.3	The appropriate signs are used so professionals can identify the rooms of patients who are in an end-of-life situation.	B A E

Strategic line 6	END-OF-LIFE CARE	CONTROLLING PHYSICAL SYMPTOMS
Detect and support physical symptoms in end-of-life patients.		
Good practice 6.4	Appropriate palliative sedation is used for end-of-life patients according to an established protocol.	B A E
Good practice 6.5	There is a record of the decision made to use palliative sedation (informed consent, medication, indications ...).	B A E

Strategic line 6	END-OF-LIFE CARE	END-OF-LIFE ACCOMPANIMENT
Allow end-of-life patients to be accompanied by someone.		
Good practice 6.6	Continuous accompaniment with the patient's families is facilitated for end-of-life care.	B A E
Good practice 6.7	Training on end-of-life accompaniment and grief support is provided to professionals involved in caring for the patient/family.	B A E

Strategic line 6	END-OF-LIFE CARE	COVERING EMOTIONAL AND SPIRITUAL PREFERENCES AND NEEDS
Detect and support emotional and spiritual needs of patients and families in end-of-life situations.		
Good practice 6.8	Emotional support strategies are applied for patients and families in end-of-life situations.	B A E
Good practice 6.9	The record of advance directives is systematically checked for patients admitted to the ICU, especially those wanting limitation of life-sustaining treatments.	B A E
Good practice 6.10	Advance directives are included in the decision-making process, with a record of the process being made in the patient's medical record.	B A E
Good practice 6.11	When no advance directives exist, the decision is made jointly with the patient and their family.	B A E
Good practice 6.12	Emotional and supportive help is offered to professionals involved in end-of-life care with the aim of reducing syndromes such as moral distress, the perception of inappropriate care and compassion fatigue.	B A E
Good practice 6.13	A representative for decision-making in incompetent patients is identified.	B A E
Good practice 6.14	A consultation with the palliative care service is possible.	B A E

Strategic line 6	END-OF-LIFE CARE	LIMITATION OF LIFE-SUSTAINING TREATMENT PROTOCOL
There is a limitation of life-sustaining treatment protocol in place that follows the recommendations of scientific associations.		
Good practice 6.15	There is a limitation of life-sustaining treatment protocol in place.	B A E

Good practice 6.16	There is a specific record for limitation of life-sustaining treatment.	
Good practice 6.17	There are procedures to solve conflicts related to treatment considered potentially inappropriate.	
Good practice 6.18	Organ and tissue donation in end-of-life care is included when indicated.	
Good practice 6.19	Specific training is provided for professionals on bioethics and legal aspects related to decision-making and end-of-life care.	
Good practice 6.20	Satisfaction on end-of-life care of relatives of patients who passed away in the ICU is measured.	

Strategic line 6	END-OF-LIFE CARE	MULTIDISCIPLINARY IMPLICATION IN DECISION AND DEVELOPMENT OF MEASURES OF LIMITATION OF LIFE-SUSTAINING TREATMENT
Guarantee participation by all professionals involved in limitation of life-sustaining treatment.		
Good practice 6.21	Decisions on limitation of life-sustaining treatment are made with all the professionals involved in caring for the patient, seeking the highest possible consensus from the healthcare team.	
Good practice 6.22	Protocols and tools are available that facilitate prognostic assessment and decision-making in patients with a high probability of passing away.	
Good practice 6.23	A consultation procedure is available with the Healthcare Ethics Committee in the event of disagreement.	

Recommended bibliography:

- Arauzo V, Trenado J, Busqueta G, Quintana S. Grado de conocimiento sobre la ley de voluntades anticipadas entre los familiares de los pacientes ingresados en un servicio de medicina intensiva. Med Clin (Barc). 2010;134:448-51.
- Aslakson RA, Curtis JR, Nelson JE. The changing role of palliative care in the ICU. Crit Care Med. 2014;42:2418-28.
- Australian and New Zealand Intensive Care Society. ANZICS Statement on Care and Decision-Making at the End of Life for the Critically Ill (Edition 1.0). Melbourne, ANZICS, 2014.
- Cabré Pericas LL, Abizanda Campos R, Baigorri González F, Blanch Torra L, Campos Romero JM, Irribarren Diarasarri S, et al. Grupo de Bioética de la SEMICYUC. Código ético de la Sociedad Española de Medicina Intensiva, Crítica y Unidades Coronarias (SEMICYUC). Recomendaciones del grupo de Trabajo de Bioética de la SEMICYUC. Med Intensiva. 2006;30:68-73.
- Clarke EB, Curtis JR, Luce JM, Levy M, Danis M, Nelson J, et al; Robert Wood Johnson Foundation Critical Care End-Of-Life Peer Workgroup Members. Quality indicators for end-of-life care in the intensive care unit. Crit Care Med. 2003;31:2255-62.
- Cook D, Rocker G. Dying with dignity in the intensive care unit. N Engl J Med. 2014;370:2506-14.
- Curtis JR. Palliative care in critical illness: challenges for research and practice. Palliat Med. 2015;29:291-2.
- Downar J, Delaney JW, Hawryluck L, Kenny L. Guidelines for the withdrawal of life-sustaining measures. Intensive Care Med. 2016;42:1003-17.
- Estella Á, Velasco T, Saralegui I, Velasco Bueno JM, Rubio Sanchiz O, Del Barrio M, Martín Delgado MC Multidisciplinary palliative care at the end of life of critically ill patient. Med Intensiva. 2019;43:61-2.
- Iribarren-Diarasarri S, Latorre-García K, Muñoz-Martínez T, Poveda-Hernández Y, Dudagoitia-Otaolea JL, Martínez-Alutiz S et al. Limitación del esfuerzo terapéutico tras el ingreso en una Unidad de Medicina Intensiva. Análisis de factores asociados. Med Intensiva. 2007;31:68-72.
- Lanken PN, Terry PB, DeLisser HM et al. An official American Thoracic Society clinical policy statement: palliative care for patients with respiratory diseases and critical illnesses. Am J Res- pir Crit Care Med. 2008;177:912-27.
- Lesieur O, Leloup M, Gonzalez F, Mamzer MF; EPILAT study group. Withholding or withdrawal of treatment under French rules: a study performed in 43 intensive care units. Ann Intensive Care. 2015;5:56.
- Martín-Delgado MC, Martínez-Soba F, Masnou N, et al. Summary of Spanish recommendations on intensive care to facilitate organ donation. Am J Transplant. 2019;19:1782-91.
- Mathews KS, Nelson JE. Palliative care in the ICU of 2050: past is prologue. Intensive Care Med. 2017;43:1850-2
- Miller SJ, Desai N, Pattison N, Droney JM, King A, Farquhar-Smith P, et al. Quality of transition to end-of-life care for cancer patients in the intensive care unit. Ann Intensive Care. 2015;5:59.
- Monzón JL, Saralegui I, Molina R, Abizanda R, Cruz Martín M, Cabré L, et al. Grupo de Bioética de la SEMICYUC. Ética de las decisiones en resucitación cardiopulmonar. Med Intensiva. 2010;34:534-49.
- Monzón Marín JL, Saralegui Reta I, Abizanda I Campos R, Cabré Pericas L, Iribarren Diarasarri S, et al. Grupo de Bioética de la SEMICYUC. Recomendaciones en el tratamiento al final de la vida del paciente crítico. Med Intensiva. 2008;32:121-33.
- Mosenthal AC, Weissman DE, Curtis JR, Hays RM, Lustbader DR, Mulkerin C, et al. Integrating palliative care in the surgical and trauma intensive care unit: a report from the Improving Palliative Care in the Intensive Care Unit (IPAL-ICU) Project Advisory Board and the Center to Advance Palliative Care. Crit Care Med. 2012;40:1199-206.
- Myatra SN, Salins N, Iyer S, Macaden SC, Divatia JV, Mucka- den M, et al. End-of-life care policy: An integrated care plan for the dying: A Joint Position Statement of the Indian Society of Critical Care Medicine (ISCCM) and the Indian Association of Palliative Care (IAPC). Indian J Crit Care Med. 2014;18:615-35.
- Nelson JE, Azoulay E, Curtis JR et al. Palliative care in the ICU. J Palliat Med. 2012;15:168-74.
- Nelson JE, Puntillo KA, Pronovost PJ, Walker AS, McAdam JL, Ilaoa D, et al. In their own words: patients and families define high-quality palliative care in the intensive care unit. Crit Care Med. 2010;38:808-18.
- Penrod JD, Pronovost PJ, Livote EE, Puntillo KA, Walker AS, Wallenstein S, et al. Meeting standards of high-quality intensive care unit palliative care: clinical performance and predictors. Crit Care Med. 2012;40:1105-12.
- Poyo-Guerrero R, Cruz A, Laguna M, Mata J; Comité de Ética del Hospital Son Llatzer de Palma de Mallorca (España). Preliminary experience with the introduction of life-sustaining treat- ment limitation in the electronic clinical record. Med Intensiva. 2012;36:32-6.
- Rubio O, Sánchez JM, Fernández R. Life-sustaining treatment limitation criteria upon admission to the intensive care unit: results of a Spanish national multicenter survey. Med Intensiva. 2013;37:333-8
- Sprung CL, Cohen SL, Sjokvist P et al. End-of-life practices in European intensive care units: the Ethicus Study. JAMA. 2013;290:790-7.
- Truog RD, Campbell ML, Curtis JR, Haas CE, Luce JM, Rubenfeld GD, Rushton CH, Kaufman DC; American Academy of Critical Care Medicine. Recommendations for end-of-life care in the intensive care unit: a consensus statement by the American College [corrected] of Critical Care Medicine. Crit Care Med. 2008;36:953-63.
- Truog RD, Campbell ML, Curtis JR, Haas CE, Luce JM, Rubenfeld GD, et al; American Academy of Critical Care Medicine. Recommendations for end-of-life care in the intensive care unit: a consensus statement by the

American College [corrected] of Critical Care Medicine. Crit Care Med. 2008;36:953-63.
- Truog RD, Cist AF, Brakett SE, Burns JP, Curley MA; Danis M et al. Recommendations for the end of life care in the intensive care unit: The ethics Committee of the Society of Critical Care Medicine. Crit Care Med 2001;29:2332-48.
- Velasco-Sanz TR, Estella-García A, Del Barrio-Linares M, Velasco-Bueno JM, et al. The Importance of an interprofesional palliative approach for the critical patient. Enferm Intensiva. 2019;30(1):1-3
- Velasco-Sanz TR, Rayón-Valpuesta E. Instrucciones previas en cuidados intensivos: competencias de los profesionales sanitarios. Med Intensiva. 2016;40:154-62.
- Vincent JL, Schetz M, De Waele JJ et al. "Piece" of mind: end of life in the intensive care unit statement of the Belgian Society of Intensive Care Medicine. J Crit Care. 2014;29:174-5.
- Visser M, Deliens L, Houttekier D. Physician-related barriers to communication and patient and family centred decision making towards the end of life in intensive care: a systematic re- view. Crit Care. 2014;18:604.

STRATEGIC LINE 7

HUMANISED INFRASTRUCTURE

The physical ICU environment must allow the care process to be carried out in a healthy setting that helps to improve the physical and psychological state of patients, professionals and their families. There are published guidelines (evidence-based design) that aim to reduce stress and increase well-being by focusing on architectural and structural improvements in the ICU. They include proposals that adapt to the needs of the user of the space, working in the best possible location, designing work flows by process and establishing ergonomic conditions in terms of light, temperature, acoustics, materials, finishings, furniture and decoration.

Therefore, this promotes creating spaces where technical efficiency goes hand in hand with quality care and the well-being of all users, taking into account that an adequate design can help to reduce professional errors, improve patients' results (reducing their stay in the ICU) and play a possible role in cost control.

These modifications can positively influence feelings and emotions, favouring human spaces adapted to the functionality of the units. Spaces adapted to the processes that take place in them with the maximum possible functionality and considering the needs of all users involved. This concept is also applicable to waiting rooms that should be redesigned so they can be "lounge areas" and offer maximum comfort and functionality for families.

Strategic line 7	HUMANISED INFRASTRUCTURE	PATIENT PRIVACY
		COMFORTABLE SURROUNDINGS FOR PATIENTS
		PATIENT ORIENTATION
		COMFORTABLE FAMILY AREAS
		COMFORTABLE AND FUNCTIONAL CARE AREA
		COMFORTABLE ADMINISTRATION AND STAFF AREA
		PATIENT DISTRACTION
		CREATING SPACES IN GARDENS OR PATIOS

Strategic line 7	HUMANISED INFRASTRUCTURE	PATIENT PRIVACY
Guarantee patient privacy.		
Good practice 7.1	There are individual rooms.	B A E
Good practice 7.2	Individual rooms have windows and translucent doors that staff can darken when doing tests, procedures or anything else required for the patient and family's privacy.	B A E
Good practice 7.3	There are screens, curtains and separation elements to offer privacy and made from antibacterial materials that can be easily cleaned.	B A E
Good practice 7.4	There is an accessible bathroom or portable toilets for patients to ensure privacy and avoid embarrassment.	B A E

Strategic line 7	HUMANISED INFRASTRUCTURE	COMFORTABLE SURROUNDINGS FOR PATIENTS
Guarantee comfortable surroundings for patients.		
Good practice 7.5	Natural light is available so there is enough quality and quantity for patients, with the option of darkening the room.	B A E
Good practice 7.6	Colours and images are included for patients. Ceilings and the top of the walls in front of the patient are paid attention to.	B A E
Good practice 7.7	Appropriate furniture is available and correctly distributed to create a functional space, with optimal circulation and avoiding unnecessary obstacles.	B A E
Good practice 7.8	Space customisation options are available (photos of family, pictures, cards with loving messages, photos of bands or football teams, etc.).	B A E
Good practice 7.9	There is an independent and individualised control in each room in terms of temperature, humidity and ventilation, according to the published UNE and ISO standards.	B A E

Good practice 7.10	Light control systems are in place, with sufficient quantity in all rooms.	B A E
Good practice 7.11	Environmental noise control measures are defined and promoted. [3.20]	B A E

Strategic line 7	HUMANISED INFRASTRUCTURE	PATIENT ORIENTATION
Patient orientation and communication is promoted.		
Good practice 7.12	Visual connection with the outside is available (window at the right height) to not lose orientation and regulate the circadian rhythm.	B A E
Good practice 7.13	There are elements that facilitate time orientation that are easily accessed and visible (such as a clock and/or a calendar).	B A E
Good practice 7.14	There are augmentative/alternative communication systems available.[2.12]	B A E
Good practice 7.15	There is a system in place so patients and families can call professionals when necessary.	B A E
Good practice 7.16	When the room does not have natural light and/or a window, there are digital windows or a vinyl that resemble landscapes.	B A E

Strategic line 7	HUMANISED INFRASTRUCTURE	COMFORTABLE FAMILY AREAS
Guarantee comfortable family areas.		
Good practice 7.17	There are appropriate and visible signs for the rooms indicating how to access them and in line with the aesthetics established for the unit.	B A E
Good practice 7.18	There is a guide on the use of “lounge areas” where family members stay when they are not in the unit.	B A E

Good practice 7.19	There are rooms for families when special situations arise, guaranteeing privacy, when possible.	B A E
Good practice 7.20	There is a farewell room where a person can accompany the patient who is dying in private, without any pressure regarding time or space.	B A E

Strategic line 7	HUMANISED INFRASTRUCTURE	COMFORTABLE AND FUNCTIONAL CARE AREA
Guarantee comfortable and functional care area.		
Good practice 7.21	Adequate acoustic control is carried out in the work area.	B A E
Good practice 7.22	Adequate access to documentation is made possible with plenty of computers to check medical records and monitor alerts in doctor's and nurse's rooms.	B A E
Good practice 7.23	There is a clinical information system (CIS) adjusted to the unit's work flow that enables working on the Internet.	B A E
Good practice 7.24	There is a central monitoring system that includes all monitors in the units and controlled by doctors and nurses from an easily accessible place.	B A E
Good practice 7.25	There are appropriate visualisation systems of the patient from the control area.	B A E

Strategic line 7	HUMANISED INFRASTRUCTURE	COMFORTABLE ADMINISTRATION AND STAFF AREA
Guarantee comfortable administration and staff area.		
Good practice 7.26	There are appropriate work spaces with the necessary facilities to look after patients.	B A E
Good practice 7.27	There are rooms for staff on call, with appropriate spaces and in line with the unit's aesthetics.	B A E

Good practice 7.28	There is a lounge area for professionals that is quickly accessed from the unit.	B A E

Strategic line 7	HUMANISED INFRASTRUCTURE	PATIENT DISTRACTION
Promote patient distraction.		
Good practice 7.29	Light for reading is available.	B A E
Good practice 7.30	Wi-Fi connection is available to use tablets and mobile phones to allow patients to communicate with relatives and be in touch with the outside world, therefore favouring distraction.	B A E
Good practice 7.31	Mobile phones can be used in the room.	B A E
Good practice 7.32	The use of entertainment media is enabled for patients with regulated use (reading, games, multimedia devices, radio, TV ...). [3.9]	B A E

Strategic line 7	HUMANISED INFRASTRUCTURE	CREATING SPACES IN GARDENS OR PATIOS
Create spaces in gardens or patios for patients, guaranteeing access to them (wheelchairs, beds, etc.).		
Good practice 7.33	Gardens, patios or terraces are available for patients when indicated, guaranteeing access to them (wheelchairs, beds, etc.).	B A E

Recommended bibliography:

- Bazuin D, Cardon K: Creating healing intensive care unit environments: physical and psychological considerations in designing critical care areas. Crit Care Nurs Q. 2011;34:259-67.
- Berman MG., Jonides J., Kaplan S. The cognitive benefits of interacting with nature. Psychol Sci. 2008;19:1207-12.
- Berto R. The Role of Nature in Coping with Psycho-Physiological Stress: A Literature Review on Restorativeness. Behav Sci (Basel). 2014; 4:394-409.
- Caruso P, Guardian L, Tiengo T, et al. ICU Architectural Design Affects the Delirium Prevalence: A Comparison Between Single-Bed and Multibed Rooms. Crit Care Med 2014;42:2204-10.
- Chalom R, Raphaely RC, Costarino AT Jr. Hospital costs of pediatric intensive care. Crit Care Med. 1999;27:2079-85.
- Diette GB, Lechtzin N, Haponik E, Devrotes A, Rubin HR. Distraction therapy with nature sights and sounds reduces pain during flexible bronchoscopy: a complementary approach to routine analgesia. Chest. 2003;123:941-8.
- Downey LV, Zun LS. The impact of watching cartoons for distraction during painful procedures in the emergency depart- ment. Pediatr Emerg Care. 2012;28:1033-5.
- Evidence based environmental design for improving medical out- comes. Proceedings of Healing and design: Building for Health Care in the 21st Century Conference. Montreal March 2000.
- Gabor JY, Cooper AB, Hanly PJ. Sleep disruption in the intensive care unit. Curr Opin Crit Care. 2001;7:21-7.
- How design impacts wellness. Healthcare forum Journal. 1992. Scientific Research and Sky Image Ceilings. Available from: www .theskyfactory .com
- Jongerden IP, Slooter AJ, Peelen LM et al. Effect of intensive care environment on family and patient satisfaction: a before-after study. Intensive Care Med. 2013;39:1626-34.
- Kahn PH, Friedman B., Gill, B, et al. A plasma display window? The shifting baseline problem in a technologically-mediated natural world. Journal of Environmental Psychology. 2008;28:192-9.
- Kaplan S, Berman MG. Directed attention as a common resource for executive functioning and self-regulation. Perspect Psychol Sci. 2010;5:43-57.
- Keep P, James J, Inman M. Windows in the intensive therapy unit. Anesthesia. 1980;35:257-62.
- Lee J, Lee J, Lim H, Son JS, Lee JR, Kim DC, Ko S. Cartoon distraction alleviates anxiety in children during induction of anesthesia. Anaesth Anal. 2012;115:989-90.
- MacKerron G, Mourato S. Happiness is greater in natural environments. Global Environmental Change. 2013;23:992-1000.
- Ministerio de Sanidad y Política Social. Unidad de Cuidados intensivos. Estándares y recomendaciones. Available from: http://www .msssi .gob .es/organizacion/sns/planCalidadSNS/ docs/UCI .pdf
- Rashid M. Two decades (1993-2012) of adult intensive care unit design: a comparative study of the physical design features of the best practice examples. Crit Care Nurs Q. 2014;37:3-32.
- Santos Redondo P, Yáñez Otero A, Al-Adib Mendiri M. Atención profesional a la pérdida y el duelo durante la maternidad. ISBN: 978-84-606-7510-5 Edita: Servicio Extremeño de Salud. April 2015. Available from: http://saludextremadura .gobex .es/documents/19231/562422/libro+duelo+SES .pdf
- Schweitzer M, Gilpin L, Frampton S. Healing spaces: Elements of environmental design that make an impact on health. J Altern Complement Med. 2004;10 Suppl 1:S71-83.
- Senquiz AL. Los Efectos Curativos de la Música [Internet], [cited 2016 march 13]. Available from: http://www .saludparati .com/musica1 .htm
- Smith HA, Boyd J, Fuchs DC et al. Diagnosing delirium in critically ill children: Validity and reliability of the Pediatric Confusion Assessment Method for the Intensive Care Unit. Crit Care Med. 2011;39:150-57.
- The Role of the Physical Environment in the Hospital of the 21st Century: A Once-in-a-Lifetime Opportunity. Available from: https://www .healthde- sign .org/chd/research/role-physical-environmenthospital-21st-century
- Thompson DR, Hamilton DK, Cadenhead CD, Swoboda SM, Schwindel SM, Anderson DC, et al. Guidelines for intensive care unit design. Crit Care Med. 2012;40:1586-600.
- Ulrich RS. View through a window may influence recovery from surgery. (Benefits of nature: View from a Hospital bed). Science. 1984;224:420-1.
- Valentin A, Ferdinande P; ESICM Working Group on Quality Improvement. Recommendations on basic requirements for intensive care units: structural and organizational aspects. Intensive Care Med. 2011;37:1575-87.
- Zaal IJ, Spruyt CF, Peelen LM et al: Intensive care unit environment may affect the course of delirium. Intensive Care Med. 2013;39:481-8.

Good practices to humanise intensive care units

Assessment Manual

2019

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English translation of the manual funded by the Humanisation of Healthcare Chair (Valencian International University, ASISA Foundation, HUCI Project).

Cátedra de Humanización de la Asistencia Sanitaria

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