INTRODUCTION

Communication with conscious, intubated patients is an often overlooked aspect of care, yet one that has profound effects on both the patient and the nurse. Effective communication establishes not only a relationship of trust, but also fosters a partnership in the patient’s journey to recovery. Current methods of communication which rely on the patient’s ability to mouth words or point to letters on an alphabet board have proved time-consuming, ineffective, and frustrating to both. Technology has enhanced our ability to physically care for our ICU patients, but often at the cost of this basic human need. With education, commitment to care planning, and intervention with augmentative communication aids, we can shatter this silence and offer our patients a simple, yet powerful gift: their voice.

LITERATURE REVIEW

(A all articles were key to our research proposal)

• Critical illness is often unexpected, and temporarily renders patients unable to communicate their basic physical and emotional needs due to intubation, and mechanical ventilation (1)
• Most interactions are nurse-initiated, short in duration, and limited to explanations of care or procedures (2)
• Nurses receive limited training in communication assessment, care planning, or use of alternative communication aids (4,11)
• Few actual studies have been done using communication boards or electronic aids within the ICU environment (16)
• Gaps identified included:
  - Need for further study of the effectiveness of communication aids to improve patient outcomes (7)
  - Further study into methods of training communication assessment techniques and interventions to health care providers (11).

PLANNED APPROACH TO COMMUNICATION

Speech Language Pathologist (SLP) is specially trained to assess, diagnose, and treat/manage communication and swallowing.

A planned approach to communication

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Referral Process

• Any member of the Interdisciplinary Team may request an SLP referral
• Referral processes are typically similar across all Rehabilitation Services departments within a site (order entry, fax).
• Once referred, the SLP will obtain a patient history and review the current medical status, select the appropriate assessment(s), make a diagnosis, and treat/manage the impairment.
• Communication and documentation of the care plan is key for all members of the Interdisciplinary Team.

Augmentative and Alternative Communication (AAC)

• The SLP will assess for, prescribe, and train an individual on the use of an AAC device.
• AAC devices vary from low-tech to high-tech.
• The appropriateness of a device is dependent upon:
  - the speech/language assessment results
  - the patient
  - current medical status
  - current level of cognitive functioning
• Education/hierarchical levels
  - Devices may be as simple as writing materials, written and/or pictorial communication boards (i.e., benign boards, phrase to letter boards), or may be complex digital or electronic.

INABILITY TO COMMUNICATE – THE IMPACT ON PATIENTS

• Patients identify inability to communicate as the most significant problem for them while ventilated (4,7), leading to feelings of frustration, anxiety, panic, sleeplessness, depersonalization, loss of control, and unrecognized pain.
• Patient’s efforts to communicate are often misunderstood, creating patient/nurse frustration, increased sedation use, showing impatience, annoyance, or anger (3).
• In a technical environment, communication is often not prioritized (11).

ABILITY TO COMMUNICATE

Methods

• Experimental 6 month Pilot Trial: June 1 – November 30, 2013.
• Block randomization assignment into groups:

<table>
<thead>
<tr>
<th>Group 1: Control Group (mouthing words/ alphabet boards)</th>
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<tbody>
<tr>
<td>Group 2: Vidatalk EZ Board (5)</td>
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<tr>
<td>Group 3: iPad SmartTalk ICU (6)</td>
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Participants

Inclusion Criteria

• Designed to assess & include patient’s capacity to consent
• Richmond Agitation Sedation Scale (RASS) of -1/-1
• Delirium score <5
• Medically stable
• Minimal to no intropes
• Adequate mobility in one limb with associated dexterity to point
• Adequate vision (with or without eye glasses)
• Endotracheal or trachial tube
• No other primary language
• Normal pre-illness speech/language function

Exclusion Criteria:

• Patients who are part of a ‘double’ RN assignment
• Patients who have previously participated in the study (i.e., those who have been discharged from ICU, and who subsequently re-admitted to the unit)

Recruitment & Data Collection

• Goal = minimum 38 patients (6 per group)
• Patient census assessed daily by ICU Team member or PCC
• Invitation to Participate package offered to eligible patients: Brochure & Consent Form
• Follow up within 24 hours by Team member for consent & enrolment

Syrup, L., Tate, J., & Happ, M. (2012).
12. Bandeali, Virginie Constantin, Laureanne Khouri, Michael Smith Foundation for funding this project
13. Bandeali, Virginie Constantin, Laureanne Khouri, Karen Jensen RN CNCC(C), Kathie Alary RN CNCC(C), Patricia Berger RN, Theresa Chipperfield RN, Gurmee Mann RN CNCC(C), Luana McCartney RN BScN, Reena Parhar MSc RSLP CCC-SLP

SUMMARY OF OUR PILOT STUDY

OVERALL OBJECTIVES:

Overcoming Communication Barriers with Non-verbal Patients in the Intensive Care Unit

Karen Jensen RN CNCC(C), Kathie Alary RN CNCC(C), Patricia Berger RN, Theresa Chipperfield RN, Gurmee Mann RN CNCC(C), Luana McCartney RN BScN, Reena Parhar MSc RSLP CCC-SLP

lessons learned to date

SUCCESSES

• Strong collaboration within the ICU Interdisciplinary Team
• Greater awareness of care planning and available communication strategies for staff
• Raised public awareness of available communication tools for families

CHALLENGES

• Wear, tear, extubate creates narrow window for recruitment
• Significant language barriers in our patient population
• Overwhelming amount of information for patients to process
• iPad technology intimidating to some candidates