Aim of Audit: To audit the adherence to local patient diary guidelines and guidelines from the Intensive Care Society. Using this recommendations for improving patient care and a reflection on practice shall be undertaken.

Background: Anxiety and depression caused by memory loss and delusions are reported amongst 40% patients discharged from Intensive Care Unit (ITU) 4. ITU survivors encounter physical and psychological complications during their recovery. Although psychological morbidity is multifactorial, it is associated with complete lack of or delusional recall of what happened in ITU 3. Patient diaries written in chronological order and complete with photos are used to complete memories 1 and reduce the risk of Post-traumatic Stress Disorder in patients (PTSD) in patients 9,15, and relatives 5,12. National Institute of Clinical Excellence (NICE) 11 recommend that services should be developed to meet psychological care needs of patients following critical care. Patients with a history of any psychiatric disorder are at the greatest risk of developing depression and PTSD with long-term impact on quality of life post discharge 14. Mental health definition includes people with alcohol and drug dependencies as well as psychosis, it is estimated that 70% of people accessing homeless services have a mental health problem 10. Hallucinations and delusions are thought to arise during delirium and amnesia, both may be due to sepsis, hypoxia or medication 6.

Discussions: Limitations of the audit include that it is single centre and had a small sample size, due to this the audit could be considered a pilot for future audit. The scope of the audit focused on ventilated patients rather than those for whom a diary may have been beneficial. Part 1 of the audit showed poor adherence to Local Patient diary guidelines. Part 2 suggested inconsistency in patient selection for patient diary. This may be due to clarity of the guidelines. Why did some nurses start a diary for patients that were not ventilated for >72hrs? The Local guidelines state that a diary should be started for patients that are ventilated for >72hrs or anyone where a diary may be beneficial. For whom would a diary be beneficial? Those at greatest risk of developing PTSD, memory loss and delusions include people with a psychiatric history 14, alcohol and drug abuse, people accessing homeless services 10 and those suffering from delirium and amnesia 2. Possible barriers to filling in or starting patient diary: Perceived time to write diary. On average it takes no more than 5min to fill in entry 13. Not high priority in nursing care?

Audit: Use of Patient Diaries in Critical Care

‘Rehabilitation following critical illness starts as soon as possible and addresses psychological as well as physical symptoms’ (NICE 2009)


Methodology: Retrospective audit of 19 patient diaries selected at random from the year 2015/2016, looking at whether writing guidelines were adhered to. Focusing on the following criteria: Is there an introduction? Is the diary filled in every shift? Is there a patient photo? Who has written in the diary; Nurses, Family members or members of Multidisciplinary Team (MDT)? Part two of the audit looked at 3 separate randomly selected days in Feb 2016 and considered adherence to patient selection for a diary. Inclusion criteria: patients ventilated for >72hours or patients for whom a diary may have been beneficial. Exclusion criteria: patients <18 years and patients expected to be ventilated <72hours.

Results: Only 16% of diaries audited were filled in every shift however all diaries had an introduction. Some were unclear and did not include a date for every entry. Only 10% of diaries had a photo. Nurses had written in all the diaries and Family members in 25% of the diaries. No other members of the MDT had written in the diaries. Part 2 of audit: Day 1: 2/10 people that met the criteria had a diary. Day 2: 5 people fitted the criteria, 3 of which had diaries, 2 further people who had a diary did not fit the ventilated criteria (they were ventilated <72hrs), Day 3 all the people that met the criteria had a diary.

Recommendations

• Education across Multidisciplinary team
• Encourage Multidisciplinary team involvement in patient diary- part of ward round checklist
• Include strategies to include patients & relatives

Guidelines

• Clarify Guidelines
• Include for whom starting a patient diary would be beneficial e.g.; patients with delirium, history of mental health problems including alcohol and drug abuse
• Feedback from STEPS follow up clinic from patients around how diaries have been useful
• Include feedback in monthly bulletin?
• Poster in staff room with feedback from patients?
• Involving more staff of all levels in diary focus groups?
• ICUs steps patient diary app