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Background

Survival from critical care is increasing (1). With this increase in survival, there is now mounting evidence demonstrating the challenging recovery trajectory which many patients and caregivers face, following a critical care admission (2-4). As a result, many clinicians have implemented follow-up and aftercare to support this vulnerable group (5). Strategies which have been implemented include formal outpatient follow-up (multi-disciplinary and nurse led) and formal and informal peer support groups; each of which take various forms (6-8). At present there is limited evidence which describes any benefits of these services for patients or caregivers (9).

To date, no research has explicitly sought to understand the effect that this aftercare has on the critical care Multi-disciplinary Team (MDT). We wanted to understand the feasibility of creating a non-clinical forum for survivors and critical care staff to meet after hospital discharge. Further, we aimed to explore what impact that this forum had, not just on patients/caregivers, but uniquely the impact that it could potentially have on staff.

Aim

The aim of this quality Improvement (QI) initiative was to understand the impact, if any, of a non-clinical forum for critical care survivors and the critical care MDT.

Methods and Materials

Ethics

After discussion with the Chairman of our local Ethics Committee, this project was deemed a QI initiative as it did not meet the criteria for clinical research. All participation from both staff and patients/caregivers was voluntary. Data collected and presented in this report was anonymous.

Participants

All members of the critical care team including Allied Health Professionals (AHPs), nursing, medical, administrative and domestic staff were invited alongside patients/caregivers. Our hospital is a large inner city teaching hospital; it has 20 critical care beds and accepts medical and surgical patients.

All patients/caregivers who were invited had attended the follow-up programme within our critical care unit. There was a wide range of follow-up timeframes for those invited; with patients having been discharged from critical care between 6-48 months previously. Patients were screened before an invitation was sent to their home address via mail, to ensure that they were still alive and not

currently an in-patient. Individually named invitations were sent to all staff members in the unit. Posters were also placed across the critical care unit staff areas to advertise the event.

Methods:

We ran a staff and patient event. This non-clinical forum was run over an afternoon; it was deliberately kept informal. The organisers had a loose structure to the day, with a number of patients and caregivers speaking throughout the afternoon about their experience of critical care and recovery to encourage discussion. Staff facilitated informal discussion where it was necessary. The event was held in a hall in a venue close to the hospital grounds. We deliberately chose premises out with the hospital setting to encourage participation from all groups and to ensure participants knew it was not a formal hospital appointment.

Data Analysis:

To evaluate the afternoon, we asked all people who attended the event to complete a feedback questionnaire. This questionnaire included details about: basic demographics (staff or patient/caregiver); what the most important aspects of the day were; what could be improved; the suitability of the venue; how the day made people feel and an overall rating of the day. There was also space for free text. Likert scales were utilised, with a scale of one-five (one being poor and five being excellent) for two questions (venue and overall rating of the day). Qualitative comments left in the free text box and for all other questions were analysed using content analysis by two critical care clinicians (CR and LJ) (10). Themes were initially analysed separately between patients/caregivers and staff members. Common and differing themes were then explored between the two groups. Peer review was undertaken by a separate clinician (TQ).

Results

A total of 73 individuals attended the day (combination of both patient/caregivers and staff). 56 evaluations were completed (77% response rate, 25 staff and 31 patients/caregivers). When asked about the day, 100% patients/caregivers and 88% of staff, stated that they thought the day was either very good or excellent (total 31 responses). Five themes were generated from the free text data from all groups: Peer Support; Understanding the Journey; Feeling Valued/Demonstrating Appreciation; Role Change and Further Opportunity. **Table One** details themes alongside supporting quotes.

Patients/caregivers discussed how they valued meeting other people who had been through similar experiences and how they appreciated learning from this. For example, one patient/caregiver stated:

'Not Alone. Hearing other people's stories and all the chit chat is very good.'

Staff articulated that they felt the day demonstrated a role change for them, initially feeling apprehensive and unsure, and then overwhelmingly, positive:

'Initially nervous, but thought provoking and joyful'

For staff they aligned this positive experience with the ability to hear experiences from critical care patients/caregivers about the entirety of their journey, not just exposure to the critical care environment:

'Hearing all the stories of past patients and also to meet the people I looked after.'

Patients and staff both explored how they felt the day was worthwhile from a standpoint of feeling valued and being able to show appreciation:

'You all do a great job and are very much appreciated for all of the time and effort you put in.'

Finally, there was an overwhelming desire for further opportunity for staff and patient/caregiver engagement in this type of context. Participants documented that they wanted more opportunities such as this one:

'More people coming along and joining in!'

Discussion

This small scale evaluation has demonstrated that a patient/caregiver and staff non-clinical forum is feasible. Further, it has presented preliminary evidence to suggest that this type of event benefits patients/caregivers and staff alike.

There is growing evidence around burnout and its impact on the MDT in critical care (11). Staff burnout increases absenteeism and can effect emotional, physical and mental health (12). Drivers of burnout include poor work-life balance, de-personalisation of the situations which staff experience and the emotional exhaustion of the workload within critical care (11). This event provided staff the

opportunity to understand the patient journey and feel valued in their role- this could potentially have a positive impact on staff wellbeing, and improve Joy in Work. More research is required in this field.

Consistent with previous research the significance of peer support emerged as a theme (13). Work around peer support as a mechanism for recovery is currently being developed by the Society of Critical Care Medicine's THRIVE initiative (8). This data would suggest that peer support has a positive effect on patients' wellbeing, but more research is required in this area before it can be recommended as an intervention.

This small scale evaluation has limitations. Its single centre nature limits the generalizability of its findings. Further, only those patients who had attended the critical care follow-up programme available in the centre were invited to the event. This tight inclusion criteria, may also limit the generalizability of the findings.

Conclusion

In conclusion, this single centre QI project has demonstrated that a non-clinical forum for previous critical care patients/caregivers and staff is feasible and may offer tangible benefits for all participants. Further rigorous evaluation of the impact of such an intervention is warranted.

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