

Experience Report

Occupational therapy in a private adult Intensive Care Unit (ICU): an experience report¹

Terapia ocupacional em unidade de terapia intensiva (UTI) adulto privada: relato de experiências

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Abstract

Introduction: The treatment of critically ill patients has gained prominence in recent years. The health demands of these patients are specific and require hospitalization in intensive care unit (ICU), confirming the need for a specialized, qualified, and multidisciplinary team as recommended by resolution RDC No. 7 of 2010, which addresses the need for the presence of an occupational therapist in ICUs. **Objective:** This study aims to report the experiences of the first year of an occupational therapist in the adult general ICU in a private high-complexity tertiary hospital located in the city of São Paulo, and to reflect on this field of action. **Method:** This is an experience report conducted through the analysis of medical records and occupational therapeutic assessment for later reading of the existing literature. **Results:** The identification of occupational therapeutic interventions involves the use of assistive technology, reception actions, and (re)habilitation of occupations in the ICU environment. **Conclusion:** Occupational therapy has been gaining ground in the context of adult general intensive care unit, where the demonstration of real occupational therapy actions has led to the recognition, by high hospital management, of these approaches with critical patients and the role of this profession in the multiprofessional team.

Keywords: Occupational Therapy, Intensive Care Unit, Adult, Hospitalization.

Resumo

Introdução: O tratamento de pacientes críticos tem ganhado notoriedade nos últimos anos. As demandas de saúde desses pacientes são específicas e

¹This is an experience report based on the knowledge and consent of the hospital's clinical board, respecting the ethical aspects in this construction.



requerem internação em unidade de terapia intensiva (UTI), confirmando a necessidade de equipe multiprofissional especializada e qualificada, como preconiza a resolução RDC nº 7 de 2010, a qual aborda a necessidade da presença de terapeuta ocupacional nas UTIs. **Objetivo:** Este estudo visa relatar as vivências do primeiro ano de atuação de uma terapeuta ocupacional na UTI geral adulto de um hospital privado de nível terciário de alta complexidade localizado na cidade de São Paulo e refletir sobre este campo de atuação. **Método:** Trata-se de um relato de experiência realizado através da análise de prontuário e avaliação terapêutica ocupacional para posterior leitura da literatura existente. **Resultados:** A identificação das intervenções terapêuticas ocupacionais perpassa por uso de tecnologia assistiva, ações de acolhimento e (re)habilitação das ocupações no ambiente de UTI. **Conclusão:** A terapia ocupacional vem ganhando espaço no contexto de unidade de terapia intensiva geral adulta, onde a demonstração das reais ações terapêuticas ocupacionais ocasionou o reconhecimento, pela alta gestão hospitalar, dessas condutas junto ao paciente crítico e do papel dessa profissão na equipe multiprofissional.

Palavras-chave: Terapia Ocupacional, Unidade de Terapia Intensiva, Adulto, Hospitalização.

Introduction

The treatment of critically ill patients has gained notoriety in recent years, resulting in a decrease in mortality in intensive care units (ICU). However, the process of ICU hospitalization is associated with critical illnesses - which are illnesses that cause dependence on some support to maintain life (Loss et al., 2017), increased length of stay, use of continuous sedation and physical restrictions (Cavalcanti et al., 2019).

The demands of critically ill patients in the ICU confirm the need to form a qualified health team with differentiated prior knowledge to work in this environment (Thomas et al., 2017), where the specialties and qualifications of the multidisciplinary team working reduce the length of stay in the ICU and in the hospital institution (Wu et al., 2019).

For the hospital context, specifically the ICU environment, on February 24, 2010, the National Health Surveillance Agency (ANVISA) approved resolution RDC No. of a multiprofessional team with the presence of an occupational therapist (Brasil, 2010b).

The work of the occupational therapist in the ICU environment aims to rehabilitate self-care activities, cognitive approaches, use of adaptation devices, bed positioning, participation in early mobilization and setting (Costigan et al., 2019; Provancha-Romeo et al., 2019).

Thus, the intention of this study is to share the experiences of the first year of occupational therapy in an adult general ICU of a private hospital through the

description of practical actions developed in the sector and the interaction with the patient, their families and the multidisciplinary team.

Method

This is an experience report based on the experiences of an occupational therapist technically responsible for the occupational therapy sector within the ICU of a high complexity tertiary-level private hospital located in the city of São Paulo.

With the purpose of contextualization, the occupational therapy sector of this hospital has a professional responsible for the care and data management in this area. The ICU has 61 beds and serves mainly patients with respiratory, neurological, trauma and palliative care.

It is noteworthy that the occupational therapist worked exclusively in the ICU; thus, the elaboration of occupational therapeutic protocols, the creation of bonds with the team and the gain of space became more accessible.

Methodologically, a document analysis of 228 electronic medical records was carried out, from which information was extracted from occupational therapeutic assessments over a period of approximately one year (August 20, 2018 to August 1, 2019). On average, 19 patients were evaluated monthly, which made it possible to demonstrate and present the occupational therapeutic contributions in the ICU.

Therapeutic consultations were performed three times a week, always in the morning, and lasted from 35 to 40 minutes. On average, patients underwent four sessions until hospital discharge. It is noteworthy that, in the institution in question, the average length of stay in the ICU is 3.8 days, with longer stays occurring in cases of individuals with physiological and hemodynamic instability.

In addition, to publicize the presence of occupational therapy, the responsible professional participated monthly in educational activities with the multidisciplinary team, teaching classes, lasting 40 minutes, on the role of occupational therapy in the hospital. All practices were authorized by the institution's board and continuing education service.

Information regarding occupational therapy performance was collected through the analysis of records in medical records, with subsequent interpretation of the findings and correlation with the literature.

Results and Discussion

Hiring of occupational therapist for the ICU

The addition of an occupational therapist in the adult general ICU of this tertiary-level private hospital was primarily due to the institutional board's interest in offering a multidisciplinary team to its patients. With the hiring of a permanent occupational therapist to work exclusively in the adult general ICU, participation activities in meetings to discuss clinical cases associated with therapeutic care for patients and presentations to the hospital's senior management of occupational indicators and the occupational therapy sector were initiated.

The entry into these indicators management spaces favored and allowed exchanges between different professional categories and the approach of team coordinators to the exclusive knowledge of the occupational therapist in the ICU environment.

During one year of work, occupational therapeutic assistance involved patients with a mean age of 56 years (minimum of 18 and maximum of 101). Of the 228 medical records analyzed, 35% were men and 65% women. Referring only to the primary diagnosis, the records more frequently reported respiratory (48.2%), neurological (30.7%) and cardiac (8.6%) diseases and palliative care (12.5%). The main ways of attracting patients included the active search for the reference occupational therapist, the study by Bombarda et al. (2016) and indications from the physiotherapy team.

Occupational therapeutic assistance

The construction of the occupational therapeutic assessment was based on the union of the Theoretical Models of Occupational Performance – MDC (Gritti et al., 2015), Canadian Performance Measure – COPM (Law et al., 2009) and the International Classification of Functioning – ICF (Organização Mundial da Saúde, 2013).

The assessment and care process took place in the following sequence: patient identification, collection of information from medical records, dialogue with a multidisciplinary team and occupational assessment/intervention/reassessment. This dynamic favored the adequacy of the work routine and enabled the participation in educational strategies with the hospital continuing education team.

The main interventions performed and recorded by the occupational therapist were grouped into assistive technology, reception, occupations and activities, multidisciplinary team and caregivers/family members (Table 1).

Table 1. Occupational therapy interventions in the adult ICU setting.

GROUPS	INTERVENTIONS
Assistive technology	Making, training and counseling of orthoses for upper and lower limbs, augmentative and alternative communication boards, adaptations of devices for feeding and/or self-care. Training and counseling in the use of walkers and canes (along with physical therapy) and fitting and evaluation of orthopedic braces and pads.
Reception	Acceptance and active and qualified listening of the patient's desires, fears and anxieties. Respect and validation of the patient's speeches and gestures.
Occupations and activities	Adaptation and organization of activities of daily living and significant activities of the patient, delirium prevention measures, functional and comfort positioning in bed and early mobilization (in conjunction or not with the physical therapy team).
Multidisciplinary team	Participation in multidisciplinary visits and institutional protocols.
Caregivers/family members	Guidance and care for caregivers from functional and occupational perspectives in the intra and extra-hospital environment.

In the *assistive technology group*, resources and services were used that helped or supported functionality (Sartoretto & Bersch, 2021) in the ICU environment: 91 patients used power adapters and 8 patients used the augmentative and alternative communication resource throughout the 12 months of the study. In this group, individuals with tracheostomy, undergoing extubation and weaning from sedative medications were the main beneficiaries.

The use of augmentative and alternative communication boards and a tablet enabled cognitive training, prevention of delirium, validation of fears, clarification of doubts about invasive procedures and monitoring of sensations such as pain and/or shortness of breath (Pelosi & Nascimento, 2018; Duffy et al., 2018; Hsu et al., 2020), in addition to favoring therapist-patient and patient-family approaches (Gradim et al., 2020).

In the *reception group*, listening actions, emotional and physical support, respect for personal space and bonding were developed, according to Bombarda et al. (2016), who describe that, in many moments, the ICU environment generates feelings of loneliness and helplessness, and these points are described in 225 (98.6%) of the analyzed records.

The guideline of the National Humanization Policy - PNH states that the health professional must welcome the singularities, pains and sensations of each subject's life through qualified listening (Brasil, 2010a), as occurred in the conducts developed by occupational therapy in this ICU, for example, in carrying out training in activities of daily living of interest to patients.

In the *occupations and activities group*, occupations of interest to the patient were stimulated, trained, graded and adapted, as long as possible in an ICU environment, such as using a mirror (self-care), using lipstick and brushing their hair with their own brush. Activities of daily living were trained in 100% of patients with medical clearance, following energy conservation techniques, such as clothing and eating activities (Velloso & Jardim, 2006).

In 39% (89 medical records) of the patients followed up, prefabricated cushions were used for the upper and lower limbs and techniques of functional positioning and comfort in bed to prevent postural pain and musculoskeletal deformities.

In collaboration with the physiotherapy team, an early mobilization protocol was developed, in which rehabilitation actions were standardized and provided improvement in position transfers by the multiprofessional team, preventing falls and favoring the multidisciplinary team-patient interaction, as mentioned by Ratcliffe & Williams (2019). Cognitive and multisensory training and stimuli were performed with 176 patients aiming at mental organization and sensory channels (Carvalho, 2017; Bombarda et al., 2016; Tobar et al., 2017).

In the cognitive set, the main actions employed included organizing nursing care routines and encouraging the performance of possible occupations in the ICU environment, while in the sensory context, adaptation of the environment was carried out, self-care activities were graduated with physical resources and follow-up of post-intubation food selectivity was also carried out.

Tobar et al. (2017) describe that occupational therapy interventions help prevent delirium through the use of targeted activities that stimulate mental functions, such as time-space orientation, problem solving, and visual perception; all these procedures were implemented with 87 (38%) patients.

In the *multidisciplinary team group*, the occupational therapist participated, three times a week, in multidisciplinary visits, when all monitored cases were discussed, enabling occupational feedback from the therapist to the health team about the patients. It is important to mention that, during some group meetings, the team mentioned the importance of the occupational therapist in the unit, as it made it possible to expand the vision of the patients' health status (Campos & Domitti, 2007).

In the *caregivers/family members group*, specifically in this institution, 37% (84) of the patients had formal caregivers (professionals), that is, health professionals who stayed 24 hours a day with their clients, and the family members came to the hospital only for the medical report, signing of documentation and hospital discharge. Thus, only 9% (20) of the family members were guided by the occupational therapist.

Family members guided by the occupational therapist verbalized fears, internal conflicts and feelings of powerlessness with the hospitalization process, generating distance from the hospital and their loved ones (Pettengill & Angelo, 2005).

Bombarda et al. (2016) describe assistive technologies as one of the great fields of knowledge in occupational therapy. In this ICU, evaluation, counseling and verification of the correct use of upper and lower limb orthoses, braces and orthopedic pads were performed with 48 (21%) patients. Educational and informative leaflets on these resources were made available to patients and caregivers upon discharge from the hospital.

The conducts developed by occupational therapy in the unit with the patient and caregivers/family were based on the premises of the National Humanization Policy - PNH, aiming at a unique, singular care (Brasil, 2010b; Almeida et al., 2002), bringing the actors of the situation: therapist-patient-activity.

Working in a multidisciplinary team

Initially, there were difficulties in the understanding and reception by the multidisciplinary team of the occupational therapist's attributions, since, at times, there was confusion between the care practices of occupational therapy and physical therapy.

To present and bring occupational therapy closer to the multidisciplinary team, the occupational therapist developed on-site training with the team (Silva et al., 2017), addressing topics such as the resources used with patients and the occupational therapeutic contributions to the team's daily life.

Early rehabilitation (mobilization) consultations, when released by the medical team, occurred with 72 individuals over the 12 months of the study, and the conducts were carried out in conjunction with physical therapy or conducted solely by the occupational therapist (Aquim et al., 2019; Hsu et al., 2020; Bittencourt et al., 2021). Fifty-one patients performed motor activities for the first time during the joint mobilization process between occupational therapy and physical therapy, as they were at greater risk of physiological and hemodynamic instability.

The training of activities of daily living and functional tasks was performed following the analysis and grading of activities, in which the patients had their vital signs monitored during and after the consultations. These trainings were carried out with 72% (162) of the patients, who presented hemodynamic stability, medical clearance and interest in the activities.

The mentioned interventions generated requests from the nursing and speech therapy team for multiprofessional follow-up of patients who would perform self-care and feeding activities for the first time, respectively, 15 patients with occupational therapist-nursing assistance and 8 patients with occupational therapist-speech therapy assistance. Instrumental activities of daily living were trained with 12 subjects, and the main tasks stimulated were cellphone use and writing training - findings also mentioned by Bittencourt et al. (2021) in the hospital environment.

The active participation and good performance of the occupational therapist in the ICU environment led to invitations from the medical, nursing, physiotherapy and speech therapy teams to participate in the elaboration of care protocols and in scientific events.

Conclusion

This experience report brings reflections and observations about the actions developed by the occupational therapy with the multidisciplinary team and the interventions with patients-family-caregivers.

The main challenges encountered were the hiring of a single professional to perform care actions, management and multiprofessional training, which resulted in many moments in overload of functions, emotional exhaustion and decrease in the number of visits. The lack of knowledge of the financial sector and hospital management of the resources used by occupational therapy delayed the purchase of resources and limited studies in the area to support the conduct initiated by the therapist.

As positive points, we highlight the fact that the occupational therapist works exclusively in the ICU, enabling the continuity of the therapeutic strategies, the recognition of the multidisciplinary team and the participation in institutional protocols; however, it is known that the reality of other occupational therapists is different.

It is worth mentioning the importance of the occupational therapist's proactive professional posture in the search for knowledge about the specifics of critical patients and resources allowed in the hospital environment, which generated routine appropriation and safety in the health team. In one year of operation, important spaces were conquered and the team was valued, demonstrated in the speeches and invitations to participate in institutional protocols and scientific events.

In this institution, the work of occupational therapy has been recognized by the multidisciplinary team and known to the top management, consolidating an important space for the growth of the category.

Future studies should be carried out to disseminate and standardize occupational therapeutic actions in a hospital environment.

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