BENCHMARKING A NURSE-LED ICU COUNSELLING INITIATIVE

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Background: Specialist counselling services for critical care are in their infancy. Both patients and their families report problems during recovery that would benefit from counselling. The ICU counselling service was established in 2005 using two nurse counsellors.

Aim: To benchmark the new ICU counselling service against other established services and to explore differences in the case-mix.

Method: The benchmarking exercise was a prospective audit. It examined the change in symptom severity and clients’ perception of the effect of counselling.

Results: Forty-six clients were recruited, 26 from Whiston ICU and 20 from the community-based service. Thirty-nine completed follow-up questionnaires. The ICU service had a higher percentage of clients with severe symptoms but most felt significantly better at the end of counselling.

Discussion: The ICU service had more clients with severe symptoms, as the PCT service had moved to a stepped-care model. In this model, clients with severe symptoms were seen by cognitive behavioural therapy staff within the service at step 4 and not by counsellors included in the benchmarking exercise.

Conclusion: As the ICU service was a new one, this shows other units establishing such services need to think about client triage.

BACKGROUND

Awareness of the psychological problems faced by patients recovering from critical illness has grown over recent years. Brief screening tools are now available to help identify people who need further help (Twigg et al, 2008). However, only a few hospitals in the UK have set up psychological services specifically to help patients and their families come to terms with experiences of critical illness (Jones and Griffiths, 2007).

The counselling service at Whiston ICU was established in January 2005 and is provided by two former ICU nurses with further qualifications as counsellors/ psychotherapists.

Help is offered to both patients and families, including bereaved relatives. Most clients self-refer to the service, although GPs make occasional referrals.

A wide range of problems are seen in this client group, including complicated grief, severe depression, panic attacks and post-traumatic stress disorder (PTSD).

LITERATURE REVIEW

PTSD has a major impact on quality of life and can become long-term and life-destroying, with high co-morbid rates of alcohol misuse to cope with symptoms.

Mental health professionals are beginning to develop an understanding of the triggers for developing mental health problems in ICU patients. Many patients experience vivid delusional memories from the critical illness, such as hallucinations and nightmares, after they recover. These can be extremely traumatic (Jones et al, 2007; Ringdal et al, 2006; Capuzzo et al, 2005; Cuthbertson et al, 2004; Jones et al, 2001).

A recent example of this was reported to us by a young patient who described his memory of ICU as being made to watch as three young men were hanged and then he himself being dragged by his feet towards the tree and thinking that he would be next to be hanged. The terror attached to that memory made him panic-stricken when he returned to the hospital and the memory was replayed over and over each night in repeated nightmares.

Patients may make strenuous efforts to block distressing memories such as these but this strategy only makes them occur more (Wegner et al, 1990). Patients may accept intellectually that the memory could not have happened but it remains their deeply felt experience of ICU.

The American Psychiatric Association (2000) has categorised symptoms of PTSD into three groups:

Avoidance;
Re-experiencing;
Physiological arousal.

Patients try to avoid thinking about their traumatic memories and, when reminded of them, for example when returning to the hospital, they can become overwhelmed by the feelings and physiological arousal triggered by this reminder.

Learning to moderate and control these feelings to reduce physiological arousal is the first step towards recovery. However, so far no studies have examined the effectiveness of psychological therapy to
help patients deal with these problems.

Counselling within the NHS has, until recently, been criticised for its lack of research on client outcomes. Practice-based evidence of clinical effectiveness from routine settings has become important due to the emphasis from the Department of Health on clinical governance and effectiveness (DH, 2001, revised 2003). Benchmarking new services against existing services can lead to improved practice.

Another area largely ignored until recently is drop-out rates from therapy or clients who ‘did not attend’ (DNA) their initial appointment (Self et al, 2005). One factor that appears to be related to this is socioeconomic status.

It is difficult to assess the impact of mode of referral on DNAs but it would be reasonable to surmise that patients who refer themselves to counselling services may be more likely to attend the initial appointment than those who are referred by their GP.

One of the commitments of ‘the new NHS’ is to deliver high-quality, better-integrated services that reduce health inequalities. In addition, the NHS performance assessment framework suggests care can be improved by examining patients’ views of service delivery, including responsiveness to individual needs and waiting times, accessibility and the physical environment (NHS Executive, 1999).

METHOD

Inclusion and exclusion criteria

All clients – whether self-referring, referred by their GP or community health workers for counselling – were eligible for inclusion in the study.

Inpatient crisis counselling or sudden-death counselling represents a different client population and counselling technique. While the outcome of these clients was examined, therefore, this data was not used as part of the benchmarking exercise.

As the Knowsley primary care mental health service has a large number of referrals, two part-time female therapists were chosen at random to match the two ICU counsellors who were also women and part-time therapists, and their clients used for the benchmarking exercise.

Further counselling services within the same trust, provided for patients and families coping with cancer, recruited some clients but unfortunately did not collect follow-up data and so were not included in the results.

We sought ethical approval from the local ethics committee. However, the committee felt we did not require approval as the study revolved around service improvement and audit of effectiveness. The appropriate trust research and development departments were informed.

Data collection

We used two outcome tools. The first was a PSYCHLOPS (Psychological Outcome Profiles) (Ashworth et al, 2005), which assesses clients’ perceptions of the change in their problems as a result of counselling. Clients completed this at the start and end of counselling.

The second tool was the CORE-OM (Clinical Outcomes in Routine Evaluation – Outcome Measure) (Barkham et al, 2001). This is designed to evaluate the quality of a service by allowing benchmarking using pre and post-therapy evaluations. The CORE-OM lends itself to reflection on practice both at the individual level as well as collectively as practitioners (Mothersole, 2004). It can also be used to profile the referrals received by a service. Using both instruments ensured the two gold standards for benchmarking of psychological treatments – the individual level and the service level – were assessed.

We assessed clients’ views of the responsiveness of each service using an in-house tool, exploring issues such as difficulty in accessing the service, waiting times and the flexibility of appointments. This tool was designed as no instrument was available in the literature to examine these factors.

Data analysis

We analysed the data using SPSS for Windows version 14. The questionnaire data had a non-normal distribution and analysis using non-parametric statistical techniques was required.

Results

A total of 46 subjects were recruited to the study, 26 from Whiston ICU and 20 from the community-based service. Thirty-nine of these completed follow-up questionnaires. Unfortunately, those who were recruited from the ICU service and were bereaved...

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tended not to complete their finishing questionnaires but only made up eight of the total clients).

Client characteristics
As might be expected, there is a statistically significant difference in the median number of sessions and the number of DNAs between the services. Neither service is time-limited in terms of the number of sessions offered; both are driven by client need during the counselling process.

The ICU service clients required fewer sessions (median five versus nine) and were less likely to fail to attend, with a median DNA rate of zero versus one for the PCT service. DNAs were not related to age, sex, initial symptom severity or the individual therapist but may be higher because the PCT service takes GP/other health professional referrals, while the ICU service is predominantly self-referral. One other difference between the services is that the ICU service can see clients at home if necessary due to mobility problems. This may have contributed to the difference in the DNA rate.

The CORE-OM has published norms for symptom severity, allowing clients to be categorised by severity of their presenting symptoms. We used the total CORE-OM score to divide them into recognised groups of severity of presenting symptoms. At initial assessment, clients showed considerable variation between the two services, which was statistically significant (Fisher’s exact test p=0.026). Those from the ICU were more likely to be in the severe category.

The results of the exercise demonstrated that the ICU counselling service provided by nurse counsellors was effective in improving clients’ symptoms. It was perceived by recipients as having helped to change how they felt and had a low rate of non-attendance.

CONCLUSION
The vast majority of clients rated themselves as feeling much better at the end of counselling. There were some differences between the centres. The initial symptom severity displayed by clients at assessment varied between the two centres, with one counsellor in the ICU service seeing a higher percentage with moderately severe and severe symptoms compared with the others. This can be explained by the high number of patients with a diagnosis of PTSD seen by this counsellor.

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The PCT counselling service now uses a stepped-care model (steps 2–4), based on symptom severity using the CORE-OM, for triaging which counsellors work with which clients. The two therapists used for the benchmarking exercise are now in step 3, seeing clients with moderate to moderately severe symptoms. Clients in step 4 in this service are referred to other therapists with specialist skills; this would include clients with a diagnosis of PTSD. However, the ICU service, as a relatively new service, took all referrals and many clients are in step 4 with severe symptoms.

When the ICU service was set up, both nurse counsellors had only recently gained their counselling qualifications and had a steep learning curve, although both were very experienced nurses. With hindsight, routinely using a tool such as the CORE-OM to triage clients and refer on where necessary to other services would have been useful.

REFERENCES