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Profiling Physiotherapy in Australian and New Zealand Intensive Care

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Past Present and Future
Sydney Convention & Exhibition Centre
Darling Harbour, Australia
30 October - 2 November 2008

Congress Guide
Abstracts: Friday

multi-disciplinary teams

Results: 86 questionnaires were completed 71 (83%) considered
their experience in the study to be very valuable, and the
same number said they would definitely wish to be involved
in this form of study again. 74 (89%) rated the simulated
scenarios as being very useful. All but one participant found
the scenarios either moderately or very realistic. Participants
identified key aspects of communication, leadership, mutual
performance monitoring, and assertion as remarkable areas
of teamwork learnt and transferable to their practice.

Conclusion: Simulation based teamwork training is well received
by multidisciplinary intensive care teams. Further objective
evaluation of simulation as a means of team training, with blinded
assessments of both technical and non-technical performance,
will support this data and is the focus of our ongoing research.

1. Institute of Medicine To Err is Human Washington D.C :
National Academic Press 2000 pg 173

2. Institute of Medicine Crossing the quality chasm –
a new health system for the 21st century National Academic
Press 2001

3. Grainger AC, Kneebel E, eds Health professional education:
a bridge to quality Washington DC: National Academic
Press, 2003

Abstract – Friday 30 October
Room: Bayside 106
Time: 1430 – 1445

PROFILING PHYSIOTHERAPY IN
AUSTRALIAN AND NEW ZEALAND
INTENSIVE CARE

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Physiotherapy for ICU patients is considered essential by many
health professionals and professional bodies, yet the evidence
base for this service is insufficient. No published research
outlining optimal management of this service exists. Effective
evaluation and implementation of best practice ‘critical care
physiotherapy’ requires knowledge of the current profile of ICU
physiotherapists.

This study aimed to establish current service and staffing
characteristics of physiotherapy in level two and three ICUs within
Australia and New Zealand. An online questionnaire was sent to
150 facilities identified from the ANZICS database targeting the
most senior physiotherapist with a clinical load in ICU. Survey
topics included: respondent and facility demographics, respondent
qualifications and job descriptions, after-hours ICU physiotherapy
services, physiotherapist to ICU beds ratios, and practices and
decision making processes of ICU physiotherapists.

Ninety-two responses (61%) were received; 64% from level
three units and 74% being public facilities. Average respondents
were: female (77%), aged 36 (+/-10), working fulltime (73%)
graduated 13 (+/-10) years, with entry-level physiotherapy degree
as highest formal qualification (71%), 10 (+/-8) years experience
within the cardiorespiratory specialty, and 60 (+/-6) years in the
ICU leadership role. Evening ICU physiotherapy services were
unavailable in 41% of facilities, with 46% of ICUs reporting no
overnight service. Variences were evident between level two and
three units for evening (p=0.05) but not night (p=0.24) services;
such differences were not apparent between public and private
units.

Abstract – Friday 30 October
Session: Free Papers - General
Room: Bayside 106
Time: 1430 – 1445

THE EFFECT OF CRITICAL ILLNESS ON
LONG TERM NEUROPSYCHOLOGICAL
FUNCTION.

In 2006 patients in a single centre tertiary ICU were enrolled for
long term follow up if they had an ICU length of stay of over 48
hours. Patients with head injuries, or a history of brain injury
were excluded. Ethics approval was obtained, with consent and
enrolment occurring on discharge from ICU. Baseline ICU data
was collected as well as estimates of pre-morbid IQ, and scores
for function and independence. Follow up consisted of a battery
of tests and questionnaires which were performed face to face
where possible, at 28 days and 3, 6, 12 and 24 months.

To date there have been 9 deaths out of 71 patients. The median
age at ICU discharge was 65.5. Other median results include a
hospital stay of 22 days; ICU stay (LOS) of 7.3 days; Hours of
Mechanical Ventilation (HMV) of 118; APACHE III of 63; and Risk
of Death of 0.124.

Four neuropsychological tests were conducted, and results
adjusted for age and sex. Impairment was defined as being
below 2 SD from the population average.

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There was no correlation between impairment and AP III score,
LOS, or HMV (Mann-Whitney)

The results suggest that long term brain impairment is common in
survivors of critical illness, across a wide spectrum of admission
diagnoses, and is independent of severity of illness.

Abstract – Friday 30 October
Session: Free Papers - General
Room: Bayside 106
Time: 1500 – 1515

USE OF A FORMAL STUDY RUN-IN PHASE
TO REDUCE RECRUITMENT ERRORS
IN A MULTI-CENTRE RANDOMISED
CONTROLLED TRIAL: IS QUALITY
BETTER THAN QUANTITY?

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Introduction. Major protocol violations occur more frequently
during the early stages of a clinical trial, when investigators are
less familiar with study processes. Recruitment errors arise when
study eligibility criteria are violated and can account for 50% of all
major protocol violations.