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POINT OF VIEW

Humanizing care reduces mortality in critically ill patients☆

Humanizar los cuidados reduce la mortalidad en el enfermo crítico

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The actual trend of humanizing care we have witnessed over the last few years at the ICU setting all over the world has not happened at random, and it isn't a fashion. It is just a necessity. The evolution and «update» of our units requires combining technical and scientific advances and healthcare focused on the people (patients, families, and professionals).[1,2]

It should be a holistic, quality, and multidisciplinary healthcare including not only the traditional ICU triad (intensivists, nursing team, and assistant nurses), but also opening the door to other disciplines, whose presence has been almost incidental to this day: physical therapists, psychologists, and occupational therapists. Families should play an important role in this team work, not only as an active part in the management of neurocritically ill patients, but also as the goal of our entire healthcare process.

In this sense, the work done in and out of Spain has been tremendous. In Spain, the HU-CI Project (https://humanizandoloscuidadosintensivos.com) has been the catalyst of the humanization of Spanish ICUs. With its 8 lines of study and research[3] (Fig. 1) and 159 good practices for the humanization of the intensive care setting.[4] It has been helping ICUs all from across the world to initiate and/or improve the challenge of transforming the hospital most highly technified places into nicer and close environments where people can regain their prominence and benefit from the highest scientific-technical standards available.

Over the last few years, there has been a new area of interest in intensive medicine, the so-called post-intensive care syndrome (PICS). The growing survival at the ICU setting has been considerable over the last few years. However, many of the critically ill patients who survive and are discharged from the ICU do so with important physical, psychological, and cognitive consequences. This makes it impossible to go back to their normal life over a long period of time, sometimes even for life. Not only patients can suffer these side effects, but also relatives can experience a complex clinical sign called family-PICS.[5]

Several multidisciplinary organizations, particularly in the English-speaking world, have been working to prevent these syndromes from happening, improve their diagnosis, treatment, and follow-up. The collaborative

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Table 1 Scheme of «ICU Liberation ABCDEF bundle» including symptoms, monitoring tools, and ABCDEF bundle checklist.

Symptoms Guidelines for the management of pain, agitation, delirium (PAD clinical guidelines)	Monitorization Tools	Care ABCDEF bundle	Done
Pain	Critical Care Pain Observation Tool (CPOT) Numeric Rating Scale (NRS) Behavioral Pain Scale (BPS)	«A» Assess, prevent and manage pain «B» Both spontaneous awakening trials (SAT) and spontaneous breathing trials (SBT)	☐ ☐
Agitation	Richmond Agitation-Sedation Scale (RASS) Sedation-Agitation Scale (SAS)	«C» Choice of sedation and analgesia «D» Delirium: assess, prevent and manage	☐
Delirium	Confusion Assessment Method for the Intensive Care Unit (CAM-ICU) Intensive Care Delirium Screening Checklist (ICDSC)	«E» Early mobility and exercise «F» Family engagement and empowerment	☐ ☐ ☐

Source: taken from Ely EW.[6]

Fig. 1 H-evolution of intensive care units. Eight (8) research lines from the international research project for the humanization of intensive care at the ICU setting (HU-CI Project). Source: taken from Heras la Calle G.[3]

programs *ICU Liberation* (www.iculiberation.org) and *Thrive* (www.sccm.org/MyICUCare/THRIVE) are one of these initiatives. Both are associated with the Society of Critical Care Medicine (SCCM) and both present innovative strategies for the implementation of the evidence published on restructuring healthcare at the ICU and post-ICU settings, respectively, in order to mitigate the PICS.

The goal of *ICU Liberation*, implemented in 76 ICUs of the United States is to mitigate the adverse events of patients admitted to the ICU like pain, agitation, delirium, sedation, immobility, and sleep interruption. The ultimate goal is to improve disease progression during the ICU stay and minimize the risk of long-term side effects after ICU discharge. This is done by implementing the clinical guidelines on the management of pain, agitation, and delirium and using the ABCDEF Bundle[6,7] («A» Assessment, prevention, management of pain; «B» Both spontaneous awakening trials and spontaneous breathing trials; «C» Choice of sedation and analgesia; «D» Delirium assessment, prevention, and management; «E» Early mobility and Exercise; «F» Family engagement and empowerment) (Table 1).

The ABCDEF bundle is based on the former ABCDE Bundle[8,9] (Awakening and Breathing Coordination of daily sedation and ventilator removal trials; Choice of sedative or analgesic exposure; Delirium monitoring and management; and Early mobility and Exercise). Its goal was the early release of patients from mechanical ventilation, and avoid side effects from prolonged sedation, delirium, and immobility. These bundles do not have a fixed but evolutionary and dynamic construct on which new ideas can be added.

Recently, Pun et al.[10] published a study that shows the benefits of implementing the measures of the ABCDEF bundle in significant endpoints related to the patient (ICU discharge, hospital discharge, mortality), the symptoms (mechanical ventilation, coma, delirium, pain, use of mechanical support), and the organization (ICU readmission, destination after ICU discharge). The study that included over 15 000 patients reveals that the total implementation of the bundle measures improved significantly all endpoints (except for pain) compared to the partial implementation of the bundle (lower percentages of measures being implemented). Although it did not have statistical significance and even at low percentages, the partial implementation of the

bundle has a positive effect on the evolution of the different items measured.

And a question then arises here: if this can be achieved with 6 measures only, what could we achieve with 159?

This study confirms something we already anticipated and waited for, that humanizing care improves our patients' progression at the ICU setting and after ICU discharge. But, is it really necessary to show or test everything in medicine? Sometimes we feel the need to validate our results into conventional measurable results that intrinsically benefit the patient and the human being in general.

Even if humanizing measures did not reduce mortality, the average ICU stay or time on mechanical ventilation, would we not use them despite their net benefit on the patients and families' wellbeing, satisfaction, and fewer psychological, cognitive or physical side effects? Could we get rid of them? Would we stop the families from staying at the ICU setting? Would we terminate early mobilization, physical, and cognitive therapies? Would we avoid providing psychological and spiritual care to patients and their families? Would we ignore the benefits of respecting and promoting night sleep? Would we decide to not improve our ICU setting by making it more comfortable and intimate with natural light, serenity, and silence? Would we decide to not promote respect and dignity for the suffering and dependent human being? Would we turn our backs on pain and suffering? Would we reject quality palliative care at the ICU setting? Would we neglect care during the process of dying? Would we decide to not perfect the best tools health professionals have: communication, active listening, empathy, and compassion? The answer that all experts in the management of critically ill conditions (patients, families, and healthcare providers) would give to these questions would probably be «no». And this is so because there is no going back, there is no alternative. Present and future ICUs, that is, modern and futuristic ICUs, is spelled with an *H*.

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Conflicts of interest

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