



OT PRACTICE DOCUMENT: INTENSIVE CARE UNIT (ICU)

WHAT IS THE INTENSIVE CARE UNIT CLINICAL CONTEXT?

The Intensive Care Unit (ICU) is a highly specialized area for the advanced monitoring and treatment of individuals who are severely ill, unable to breathe on their own, or are experiencing multi-organ failure. Life threatening conditions admitted to the ICU can include pulmonary conditions, cardiac disorders, post-surgical complications, systemic infections, and neurologically based conditions.

Clients in the ICU require interprofessional healthcare services that monitor vital signs and bodily functions, and provide recovery supports and services. Survivors of critical illness often experience long-term physical, neuropsychiatric, and quality of life changes¹.

THE ROLE OF OCCUPATIONAL THERAPY IN THE ICU

Given the physical, cognitive, and psychological challenges experienced by ICU survivors, occupational therapists can play an important role in their recovery². The occupational therapist in the ICU is an expert in synthesizing complex clinical information including medical diagnoses and history, mental health issues, medical complications, and other variables in order to understand the impact on function. Guided by the therapist's chosen frame of reference, assessment findings are used to develop an appropriate intervention plan based on a collaborative medical and rehabilitation approach. This information can also contribute to an interprofessional rehabilitation prognosis.

An occupational therapist in the ICU has expertise in critical care medical rehabilitation, which includes restoring function in individuals with various conditions and disorders (e.g., mental health, neurological, cardio-respiratory, musculoskeletal, and orthopedic conditions). To support clients in the ICU, occupational therapists combine diverse knowledge-based skills, treatment modalities, theoretical orientations, and frame of references to improve the individual's function.

In addition, the role of the occupational therapist in the ICU may include²:

1. Assessing the client's functional status and rehabilitation potential in context of the individual's functional baseline, medical diagnoses, and other relevant clinical information.
2. Assessing intrinsic (e.g., physiological state, neuro-behavior, cognition, mental health, and the musculoskeletal system) and extrinsic (e.g., social support, cultural values, and environmental factors) factors to support recovery.
3. Using assessment findings to provide a person-centered objective and realistic expectation of what quality of life could look like for the client. This information, in conjunction with assessments from other team members, informs the decision-making process of whether further life-saving medical care or withdrawal of such care is recommended due to concerns of poor quality of life outcomes.
4. Providing or recommending appropriate wheelchair seating.
5. Contributing to/informing medical diagnoses and interventions including the possible impact of pharmacological treatment on the individual's rehabilitation process.
6. Updating the medical team on the client's activity tolerance while on specified ventilation support parameters to inform the process of weaning the individual off mechanical ventilation.
7. Consulting with the individual and/or their substitute decision maker to obtain a better understanding of their preferences and goals.
8. Assessing and addressing mental health and neuropsychiatric conditions.
9. Providing cognitive rehabilitation.
10. Preventing and addressing delirium as appropriate.
11. Making or recommending environmental modifications and adaptations.
12. Facilitating independence in feeding / eating / swallowing (often in collaboration with speech language pathology professionals).
13. Optimizing positioning and comfort, while assessing for and minimizing the risk of pressure ulcer development.
14. Providing education, skills training and/or behavioural compensatory strategies as appropriate.



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15. Using exercise and therapeutic activities to induce changes and build capacity to engage in functional activities (usually in collaboration with physiotherapists).
16. Engaging the individual in functional activities (e.g., ADL practice) in the context of medical precautions and environmental limitations of the ICU.
17. Working collaboratively with physiotherapy to initiate early functional mobility care plan.
18. Providing and/or recommending assistive devices and orthotics.
19. Providing augmentative and alternative communication (often in collaboration with speech language pathology professionals).
20. Developing and/or implementing sensory stimulation interventions.
21. Collaborating with the interdisciplinary team to inform and implement a plan for discharge once medically appropriate.
22. Involving and collaborating with other hospital teams and resources when appropriate (e.g., ethics, complex pain management, etc.).

REFERENCES

1. Desai, S., Law, T., Needham, D. & Sevransky, J. (2011). Long-term complications of critical care. *Critical Care Medicine*, 39(2), 371-379.
2. Costigan, F. A., Duffett, M., Harris, J. E., Baptiste, S., & Kho, M. E. (2019). Occupational therapy in the ICU: A scoping review of 221 documents. *Critical care medicine*, 47(12).

All Occupational Therapy Practice Documents have been developed and reviewed in collaboration with diverse occupational therapists with lived experience and expertise in the respective areas of practice. For any feedback, contact practice@caot.ca.