

BECAUSE YOU NEED TO...

TALK MUIR

Passy-Muir® News, Events and Education

Passy-Muir, Inc. | Winter 2011

Communication Issue

A Tribute to David A. Muir

Communication and the
Critical Care Patient

Interview:
Mary Beth Happ, RN, PhD

Patient Spotlight

Joint Commission Standards

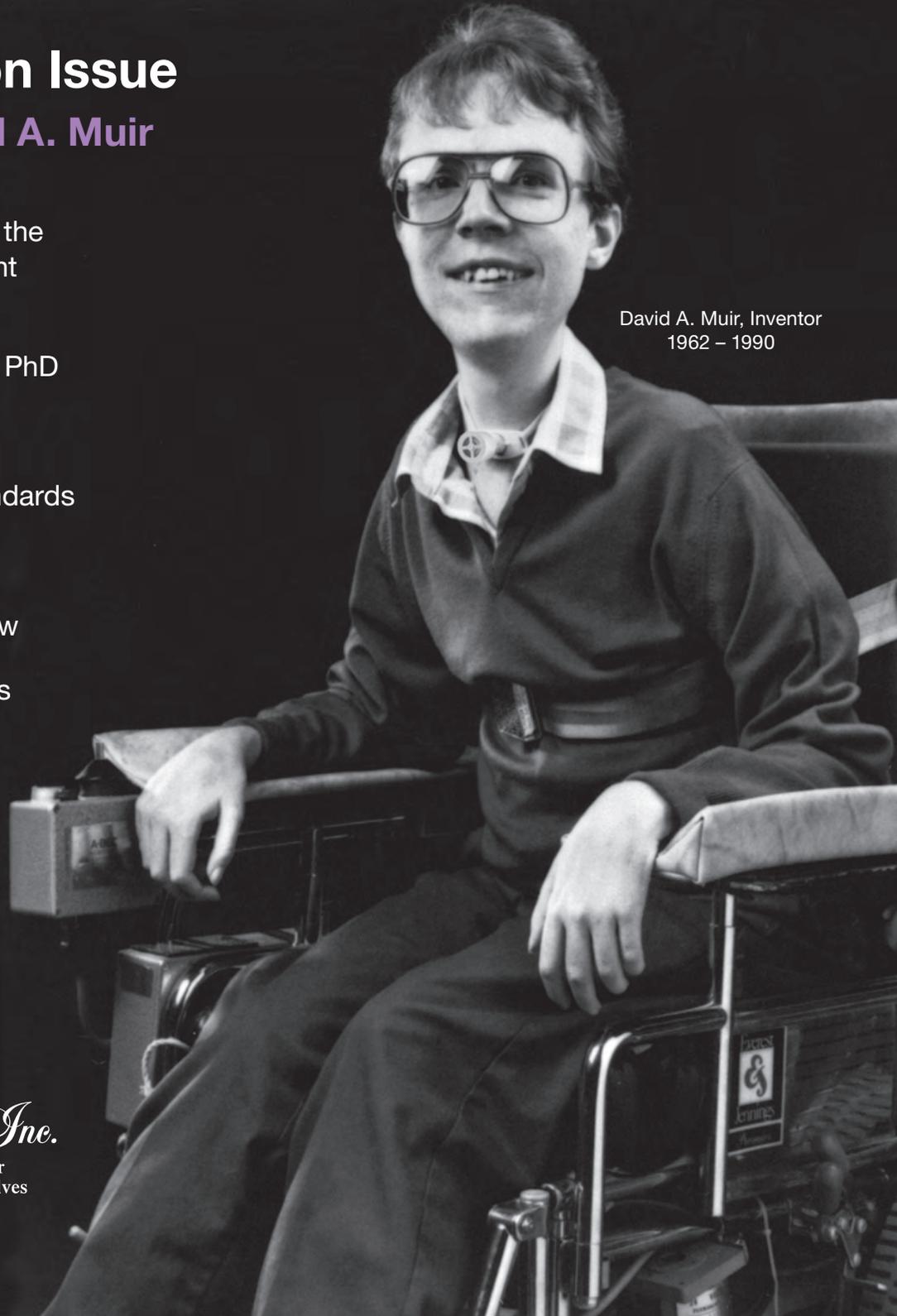
AAC in the ICU

2010 Year In Review

Calendar of Events

David A. Muir, Inventor
1962 – 1990

Passy-Muir Inc.
Tracheostomy & Ventilator
Swallowing and Speaking Valves





Communication Issue

We have dedicated this issue which focuses on communication to David A. Muir, the inventor of the Passy-Muir® Swallowing and Speaking Valve.

There is often a misperception that patients are **“too sick”** to be able to utilize a Passy-Muir Valve when in the ICU. When it is thought that patients will recover from a serious illness, early intervention with these patients will help to reduce muscle disuse atrophy imposed by intubation and immobility. However, if patients are at the end of life due to a progressive illness, preserving communication ability or facilitating brief periods of verbal communication may allow the patient and their families to have the much needed conversations and the ability to say good-bye. Safely managing these patients takes the skills of a team of professionals who are able to bring technical knowledge and compassion to the bedside. Because our continued mission at Passy-Muir, Inc. is to provide patients with dignity and independence through speech, we have made communication the focus of this issue of Talk Muir.

Communication & the Critical Care Patient

By Mary Spremulli, MA, CCC-SLP, Clinical Consultant, Passy-Muir, Inc.
Julie Kobak, MA, CCC-SLP, Vice President of Clinical Education, Passy-Muir, Inc.

Clinical recovery from critical illness may present serious physical, psychological, and social problems for both patients and their families which may last for months or years. Patients may seem completely oriented and seem to understand information about their illness when in the ICU. However, when questioned a few days later, they often have little memory of their ICU stay, and only remember pain, suctioning, or lack of sleep. Nearly 40% of seriously ill patients who die in the hospital spend their last days and hours in medical intensive care receiving mechanical ventilation. Many patients die in pain without the ability to fully express their needs, wishes about end-of-life care, or final messages to loved-ones (Happ, 2004).

Nearly 40% of seriously ill patients who die in the hospital spend their last days and hours in medical intensive care and receiving mechanical ventilation.

Significant relationships between inability to talk and feelings of panic and insecurity have been described. Even after short term intubation, patients have described the inability to speak as “scary,” “frustrating,” and “horrible” (Fowler, 2004). In a 2004 descriptive study conducted by Nelson and colleagues, they found that 90% of their sample rated difficulty in communicating as the most distressful aspect of the ICU stay.



This highlights the importance of addressing the communication needs for our patients. Early intervention from a team of medical and rehabilitation professionals is critical for reducing the physical and psychological problems in these patients (Griffith, 1999).

Did you KNOW?

90%

of ICU patients rated “difficulty in communicating” as the most stressful aspect of their ICU stay

When writing this article for the newsletter we were reminded of an article that was written by David Muir, the inventor of the Passy-Muir® Tracheostomy and Ventilator Swallowing and Speaking Valve. It was published in “A Positive Approach,” a magazine for disabled persons and their families in January 1990, five years after David invented the valve. The following quotes from David’s personal experience resonate with the intense psychological impact that losing the ability to communicate can have on a patient.

"They intubated me and rushed me to the hospital. A day or two later, I woke up. I was wondering 'what was I doing here?' and 'why I couldn't talk?' My mouth was incredibly dry and my nose and throat were sore from being intubated. I became painfully aware of the importance of speech when I wasn't able to communicate even the simplest of needs.

I was intubated for a few days and it was decided that a tracheostomy was necessary. It was definitely not what I wanted. I had accepted that I was not able to walk, I had accepted that I had lost arm strength after an operation to correct a curvature of my spine, but I felt that I couldn't take any more. I became more and more withdrawn as it seemed my world had ended. I said to myself, 'Wait a minute! You've never given up this easily before and you're not going to this time. There has to be a way around this problem.'"

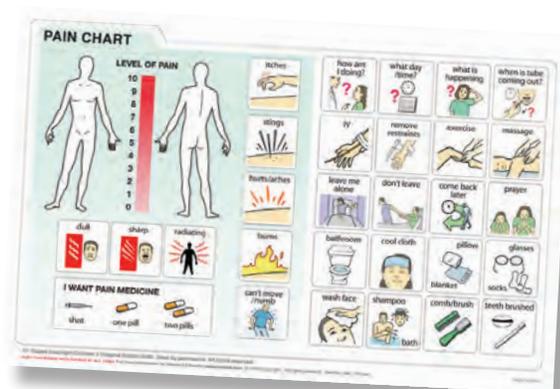
David's motivation to solve his problem resulted in the invention of a one-way valve that would redirect air into his airway and allow him to speak while on the ventilator. Since 1985, David's valve has enabled patients to regain their own voices and improve the quality of their lives.

Passy-Muir, Inc. believes that communication is the essence of the human spirit. It is essential to individual rights and dignity. We are committed in our efforts to offer tracheostomized and ventilator dependent patients a step towards independence and dignity through speech. We hope that through the education of all clinicians we can further this mission.

AAC for the Critical Care Patient

The following are a few AAC options for the critical care patient that were suggested by our speech-language pathologist clinical consultants.

Communication Boards:



Vidatak EZ Board™
www.vidatak.com

EyeLink
 (for the patient unable to use their hands)
www.cini.org

Apps for Mobile Devices:

Lingraphica®
www.aphasia.com

For a comprehensive listing of over 350 choices of low-cost equipment that includes both non-voice and voice output communication tools, refer to:

The Resource for Lite Tech Low Cost AAC

30 day download at www.aactechconnect.com

Clinical Expert Interview

Mary Beth Happ, RN, PhD, FAAN, University of Pittsburgh School of Nursing

Dr. Happ is a professor in the Acute and Tertiary Care Department at the University of Pittsburgh's School of Nursing, Critical Care Medicine and the Center for Bioethics and Health Law. Her research is focused on developing and testing interventions to improve communication with nonspeaking, critically ill patients. She received the 2010 Eastern Nursing Research Society's John A. Hartford Geriatric Research Award for her significant contributions to nursing research directed toward older adults.



Question #1: *What in your personal experience as a nurse led you to be interested in the communication abilities of patients, in particular in the critical care setting?*

I practiced in a critical care step-down unit with patients on prolonged mechanical ventilation and rarely felt comfortable with my ability to read lips or interpret silent speech. It was agonizing to watch patients when they tried unsuccessfully to communicate a message and to be unable to resolve these communication breakdowns. I became particularly concerned about the plight of older patients who were dependent on critical care technologies, such as mechanical ventilation, and about the person-technology interface in that setting. I was frustrated that rehabilitative care was so separate from standard critical care.

I pursued doctoral study at the University of Pennsylvania School of Nursing combining coursework in gerontology, critical care and social science research. My dissertation research focused on the problem of medical device disruption (also known as "treatment interference") among older adults in the ICU. The patients' inability to speak (or "voicelessness") was the context in which the behaviors of device disruption occurred. It became clear to me that the patients' "disruptive" behaviors had communicative meaning. The problem of communication impairment was more pressing and of greater scope and significance than device disruption. So, the dissertation centered my work on care and communication with seriously ill adults.

For the past 12 years, my work has focused primarily on problems of patient-caregiver communication in the ICU. This work has encompassed communication in acute and usual care situations as well as communication around life sustaining treatment and end of life decision making.

Question #2: *The Joint Commission has approved new and revised hospital accreditation standards to improve patient-provider communication, including identifying and addressing patient communication needs (see sidebar). Do you see opportunities for nursing and other allied team members to work collaboratively in developing policies and procedures to meet these requirements?*

Absolutely. The new standards provide an excellent opportunity for collaborative planning and creation of interdisciplinary policies and procedures for systematic assessment of communication ability and needs, and the provision of appropriate augmentative and alternative communication (AAC) strategies and tools. Nurses can expand their routine neurocognitive and motor assessments to include simple performance tests of communication ability, such as asking patients to point to letters or icons on a communication board, and/or to write the name of their pet or favorite color on paper.

The new standards present the perfect opportunity to integrate delirium-sedation screening with routine assessment. Patient cognition and attention fluctuate rapidly during critical illness and much of the patient's communication ability, and our ability to engage with them and interpret their messages, hinges on accurate assessment of the patient's cognitive level.

Finally, assessment findings should be linked to appropriate assistive communication strategies. New documentation guidelines will promote the transfer of information between clinicians, and to family visitors, regarding each patient's unique communication abilities and communication care plan. Interdisciplinary teams will be required to operationalize documentation and information transfer. Collaboration among nursing, speech language pathology, audiology, respiratory and occupational therapy services will be needed to determine



responsibilities and processes for communication consultation and the provision of communication supplies. The new standards address disparity in services to patients with language and cultural differences as well as patients with communication disabilities. I think that most hospitals will have work to do to address the full scope and intent of these standards.

Question #3: *You have expanded your research to focus on older adults in the ICU. What are some of your research findings and recommendations?*

Critically ill older adults are particularly vulnerable to communication disability because they are more likely to have vision and hearing impairments, upper extremity weakness or limited dexterity; and they are at greatest risk for delirium. However, older adults are able to successfully use multiple AAC modalities, including electronic speech generating devices (Happ, et al. 2007). Our research refutes assumptions that older adults are not interested in communication devices or services to improve communication during critical illness.

We recently published three exemplars of bedside case conferences conducted by a speech language pathologist (SLP) with nonspeaking, critically ill patients (Happ, et al. 2007). The cases illustrate the application of “low tech” communication aids and individual accommodations for common communication difficulties of critically ill older adults. For instance, adaptations to materials and assistive devices, such as extra-large print communication boards and a hearing amplification device, were needed to accommodate hearing and vision deficits.

Our research has confirmed previous studies showing that patients of all ages prefer natural methods of communication, thus, approaches like the Passy-Muir® Speaking Valve that restore natural speech are optimum.

We recommend SLP consultation, particularly for complex communication problems, and individualized assessment and planning for communication assistance when hospitalized patients are unable to speak or have hearing, vision or language deficits. We have found most nurses to be receptive and appreciative of basic communication skills training, communication supplies and the input of SLPs as specialists in communication disorders. It is a bit of a culture shift for ICU nurses who are accustomed to consulting the SLP only for dysphagia and swallowing evaluations.

Our interdisciplinary research team is currently testing a multi-level practice improvement intervention that includes nurse training, communication supplies, and bedside SLP communication rounds implemented sequentially on 6 critical care units in the University of Pittsburgh Medical Center system. The study, funded by the Robert Wood Johnson Foundation Interdisciplinary Nursing Quality Research Initiative, aims to determine the impact of the program on nursing care quality and patient outcomes in the ICU.

Happ, M.B., Roesch, T.K., Kagan, S.H., Garrett, K., Farkas, N. (2007). Aging and the use of electronic speech generating devices. In F.R. Lewis (ed). Focus on Nonverbal Communication Research. Nova Science Publishers.

Happ, M.B., Baumann, B.M., Sawicki, J., Tate, J.A., George, E.L., Barnato, A.E. (2010). SPEACS-2: intensive care unit “communication rounds” with speech language pathology. *Geriatric Nursing*, 31(3), 170-7.

The Joint Commission has published a comprehensive **Roadmap for Hospitals** which contains recommendations to help hospitals meet the new Patient-Centered Communication standards and comply with existing Joint Commission requirements.

The Patient Provider Communication Forum is a national and international effort to promote information sharing, cooperation and collaboration among individuals who are committed to seeking improvements in patient-provider communication across the entire health care continuum, from a doctor’s office, emergency room, clinic, ICU, acute care and rehabilitation hospital, home health service and hospice.

Visit www.patientprovidercommunication.org

Thank you to **Kathryn Garrett, Ph.D., CCC-SLP**, Specialist in Augmentative Communication (AAC) for the above recommendations.

Patient Spotlight

By Linda Dean, RRT, Clinical Specialist, Passy-Muir, Inc.



Charlotte Mills, 54 years old, arrived in the emergency room quite ill. She was admitted to the ICU with a diagnosis of urosepsis that quickly progressed to respiratory failure, secondary to an acute onset of *Adult Respiratory Distress Syndrome* (ARDS) (see sidebar). Charlotte required emergency intubation, and was quite unstable for many days. Extubation was unsuccessful twice, so after two weeks the decision was made to perform a tracheotomy.

Shortly after the tracheotomy, the speech-language pathologist and the respiratory therapist evaluated Charlotte and placed the Passy-Muir® Valve. The staff and the Mills family began to see a rapid turnaround in her condition. After 21 days in the ICU, Charlotte could once again communicate effectively with everyone, and participate in her rehabilitation. She confessed that the ability to talk enabled her to orient herself to time and place. She stated, “I could finally speak and have a say in my care. The Passy-Muir Valve let me communicate my needs and express my desire to move as quickly as possible through rehab and get home. My children were so emotional, so glad to hear my voice, and amazed at how natural and real it was to my original voice.”

Her husband said “getting the tracheostomy tube was the turning point in her ICU stay. In fact, looking back, I wish we had made the decision to perform the tracheotomy sooner. Charlotte had tried unsuccessfully to say many things to us, and it was pretty aggravating actually when she could not. Once the Passy-Muir Valve was placed, we began to see a real change. It was a turning point in the healing process to hear her voice again, especially for the children. I got to hear her voice and it brings you back to who that person is.” He further expressed, “It was as significant for the family as it was for Charlotte to be able to speak again.”



Charlotte at home

Approximately 29 days after her admission, Charlotte was discharged to home without a tracheostomy tube and without need for supplemental oxygen or medications, and was eating a regular diet! She’s an amazing lady!

[Click to see a video and hear Charlotte’s story](#)

Charlotte in the ICU with the PMV® 2001

What Is ARDS?

ARDS, sometimes referred to as “shock lung”, is not itself a specific disease, but rather a syndrome characterized by a group of signs and symptoms that inevitably leads to respiratory failure, including:

- acute onset of dyspnea
- severe hypoxemia
- diffuse lung infiltrates
- decreased lung compliance from alveolar-capillary membrane breakdown

The causes of ARDS are many: aspiration, inhalation injury, toxic drugs, viral or bacterial infections, and trauma to name a few.

Treatment is generally supportive care with mechanical ventilation, fluids, and antibiotics.

Even with proper treatment, mortality rates for ARDS remain high at 50%. For those patients who do survive, a full recovery is usually made.



Congratulations!

Denise Stats-Caldwell
Arizona State University

For winning the Discover the Difference Contest
in the Fall 2010 Issue of Talk Muir



Answers:

1. A syringe is in the clinician's hand (for cuff deflation)
2. The Passy-Muir® Valve is in the ventilator circuit
3. The Passy-Muir Valve warning label is present
4. The tube feeding equipment has been removed
5. Food and drink are on the table
6. Communication board has been removed
7. Telephone is on the table
8. Oxygen saturation reading has changed from 93 to 98
9. The box of tissues has been removed

Calendar of Events

February

- 11 Kentucky Speech and Hearing Association Convention Presentation
- 24 South Carolina Speech and Hearing Association Convention Presentation
- 25 Kansas Society of Respiratory Care Convention Presentation



March



- 8 Case Management Society of America/Hampton Roads Presentation
- 3 – 5 Dysphagia Research Society Exhibit
- 25 Case Management Society of America/Dallas Fort Worth Presentation
- 26 Children's Hospital of Philadelphia Parent Conference Presentation
- 27 – 29 Veterans Association Speech Language Pathologists Conference Exhibit
- 28 Alabama Society of Respiratory Care Presentation

April

- 2 Case Management Society of America/Southern Ohio Presentation
- 9 – 10 ASHA Healthcare Business Institute Exhibit
- 13 Case Management Society of America/Connecticut Presentation



2010 Year IN REView

New Clinical Specialists

Introducing our latest additions to the Passy-Muir Clinical Education Team!



Joanna Spain, MA, CCC-SLP from St. Agnes Medical Center, Fresno, CA shares her experience of starting a tracheostomy and ventilator team at her own hospital during the ASHA Convention.

Laurice Henry, MS, CCC/SLP, CASLPA (on right) from Children's Hospital of Eastern Ontario, shares her expertise working with pediatric tracheostomized patients at the ASHA Convention.



Mark D. Taylor, RRT from Alliance Community Hospital, Alliance, Ohio, uses his expertise with Passy-Muir® Valves to teach a group of nurses at a clinical workshop.





New Educational Tool



Pocket T.O.M.™

Tracheostomy Observation Model

All the features of the full-sized Tracheostomy T.O.M.® designed to fit your pocket and your budget.

Includes:

- Pocket T.O.M.
- Cuffed tracheostomy tube
- Passy-Muir® Valves (PMV® 2000, PMV® 2001, PMV® 007)
- 5 cc syringe
- Simulated nasogastric tube
- Storage case

Pre-Order On-line:
store.passy-muir.com

Order by phone:
800-634-5397

Notable Highlights

13,916

Passy-Muir webinars were taken in 2010

Our positive feedback:

"The whole layout of the webinars is fantastic! The flow of the presentations and the visuals were easy to understand. This was great and felt like I was really in person at a continuing education course!"

"I truly appreciate this webinar. I have been working in an acute care setting for 10 years and love having a place to go to brush up on my skills. Thank you!"

"Since I have taken 6 webinars I feel I have a new understanding of the uses and benefits of the Passy-Muir Valve. Thank you for making these webinars available. I have also informed others of the benefits of this program!"

"I can access and learn from these presentations while in my Sock Monkey flannel pjs. Thank you so much for these webinars! These courses are terrific. I look forward to the new ones every year. Please continue your important work, and bless all of you and David Muir."

Visit our website to see our popular special event webinars from last year.

Make sure to check out all 16 recorded webinars at www.passy-muir.com/ceu

To schedule a webinar for your facility email: clinicalspecialist@passy-muir.com

Passy-Muir Inc.

Tracheostomy & Ventilator
Swallowing and Speaking Valves

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David Muir
Inventor

BECAUSE YOU NEED TO...

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Talk-Muir is published by Passy-Muir, Inc. for tracheostomy and ventilator-dependent patients, their caregivers and medical professionals in an effort to provide:

- ✿ Interesting news and stories
- ✿ Resources and clinical tips
- ✿ Information about new educational opportunities
- ✿ Upcoming events and more

Story contributions and comments are welcome.

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- Pediatric
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