

The Power and Importance of Accommodation for Communication Impairment in the Intensive Care Unit

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Accommodation for existing or acquired communication impairment is an essential and powerful component of patient-centered critical care. Although the body of work is limited, research on the development and testing of augmentative and alternative communication tools (i.e., computer applications, communication boards) (1–5) and multicomponent interventions (i.e., combinations of clinician training programs, communication tools, and expert consultation) (6, 7) designed for use in intensive care units (ICUs) is growing. As mechanically ventilated patients are managed in a more-wakeful, less-sedated state, attention to communication, psychoemotional, and spiritual care needs becomes imperative. Little to no research, however, has been devoted to refining and applying communication tools for clinical assessment and specialty service consultation and intervention with communication-impaired ICU patients.

In this issue of *AnnalsATS*, Berning and colleagues (pp. 1333–1342) present the iterative development and preliminary testing for usability and acceptability of a novel picture communication board designed to elicit spiritual/religious affiliation, preferences, and spiritual care needs (8). The tool was based on established criteria of the Association of Professional Chaplains' Standards of Practice and the authors' clinical experience. Importantly, this intervention was not restricted to English-speaking patients, as a Spanish language version was also developed and used by 20% (n = 10) of the 50 awake, nondelirious mechanically

ventilated adults who participated in this study (8). This is significant because, although several communication boards and mobile apps for the medical setting are available in different languages, most research on augmentative and alternative communication tools in the medical setting has been limited to English-language participants.

Among the 25 patients tested for anxiety before and after the initial chaplain-led spiritual care intervention, a statistically and clinically significant reduction in anxiety was detected from a mean (SD) visual analogue scale score of 64 (± 29) to 44 (± 28) ($P = 0.002$) (8). Regrettably, patients at end of life received less benefit in anxiety reduction than survivors.

Further work on communication and psychoemotional suffering for patients at high risk of dying in the ICU setting is clearly needed. Although these results should be interpreted with caution because of small sample size and lack of an attention-control comparison group, the study is important in demonstrating the feasibility, acceptability, and beginning utility of the chaplain-led picture guide for spiritual care in this vulnerable population. The authors' picture-guided communication tool may also open the door to targeted psychoemotional assessments and interventions previously ignored or deemed "inappropriate" due to communication barriers in this population. In a broader sense, this work has applicability beyond the ICU to the provision of spiritual assessment and care for a wider group of hospitalized patients with communication impairment, such as those recovering from

stroke or head and neck surgeries and trauma.

Good communication skills are certainly essential for the provision of spiritual care, and I commend Berning and colleagues (8) for overcoming the barriers to communication with mechanically ventilated patients in the development and implementation of this important innovation. It is not enough, however, to provide new and improved communication tools for therapeutic assessment and interactions with communication-impaired patients. In their introduction, the authors point to failures of other modes of communication (writing, gesture, alphabet board spelling) with nonvocal mechanically ventilated patients. Additional barriers to effective communication in this setting include clinician knowledge and skills, minimal access to speech language pathologists for communication assessment, and care planning and availability of communication tools or supplies (10).

In the Study of Patient–Nurse Effectiveness with Assisted Communication Strategies (SPEACS), our research team demonstrated the impact of training clinicians on the use of a variety of communication tools and techniques matched to nonvocal, mechanically ventilated patients' communication abilities (alertness, cognitive status, arm/hand strength, dexterity, etc.) and individual preferences (6). The intervention included the provision of communication supplies and consultation with a speech language pathologist. Importantly, the intervention was associated with improvements in communication frequency and successful

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communication exchanges about pain and other symptoms. Patients who received speech language pathologist consultation reported less difficulty with communication and greater use of augmentative and alternative communication strategies (6). The training is based in communication disorders science and evidence from observational research in the ICU. The course has been condensed to a 1-hour online continuing education program

(SPEACS-2) accompanied by an assessment-intervention algorithm, PDF versions of communication boards, communication care plans, resources, and supply lists (7).

Unfortunately, communication competencies and use of assistive communication tools are not yet incorporated into the standard of care in ICUs. Given the burgeoning evidence that implementation of training, tools, and

consultation is feasible, acceptable, and relatively low cost, and that at least half of mechanically ventilated patients meet basic communication criteria at some point during their ICU stay (9), it is time for development of patient communication guidelines and widespread practice implementation in critical care. ■

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