Deshumanización de la atención en tiempos de pandemia

HUCI Humanizando los Cuidados Intensivos

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Jefe SMI Hospital Universitario Torrejón. Madrid
Miembro del proyecto HU-CI
Ex presidente SEMICYUC. Presidente electo FEPIMCTI

Los avances tecnológicos, la especialización creciente y la investigación han mejorado la salud y el bienestar.

Todres, L., Galvin, K., & Dahlberg, K. (2007).

Las dimensiones humanas de la atención sanitaria se han visto relegadas por un foco mas centrado en la tecnología y la especialización

Dehumanization of ICU patients

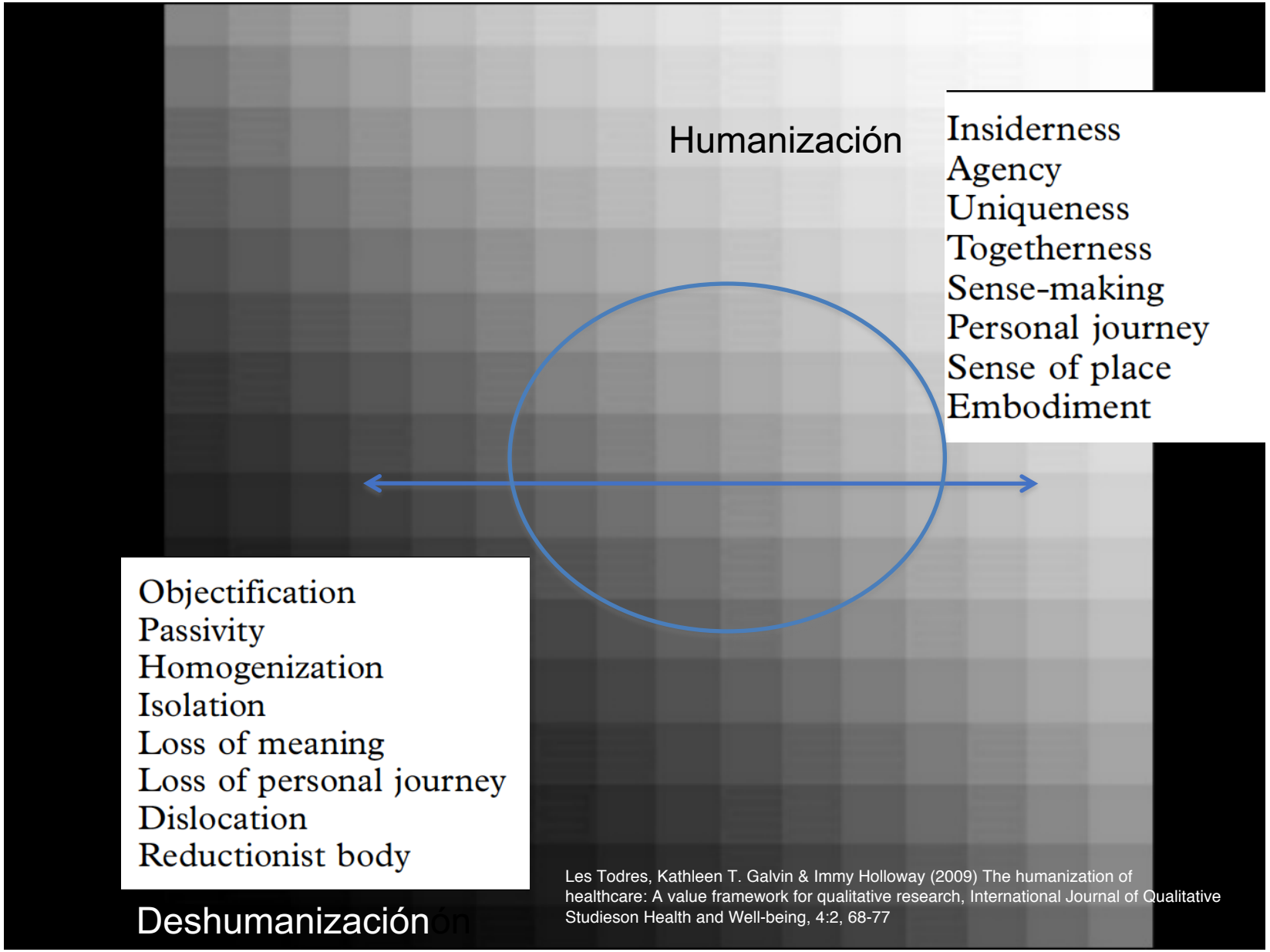
- Loss of identity (and appearance)
- Loss of ability to communicate
- Loss of ability to advocate for one's self
- Loss of family presence
- Loss of control
- Loss of respect
- Loss of modesty/privacy
- Purposeful shaming/mocking
- Purposeful exploitation (e.g. for research)

Humanizing behaviors

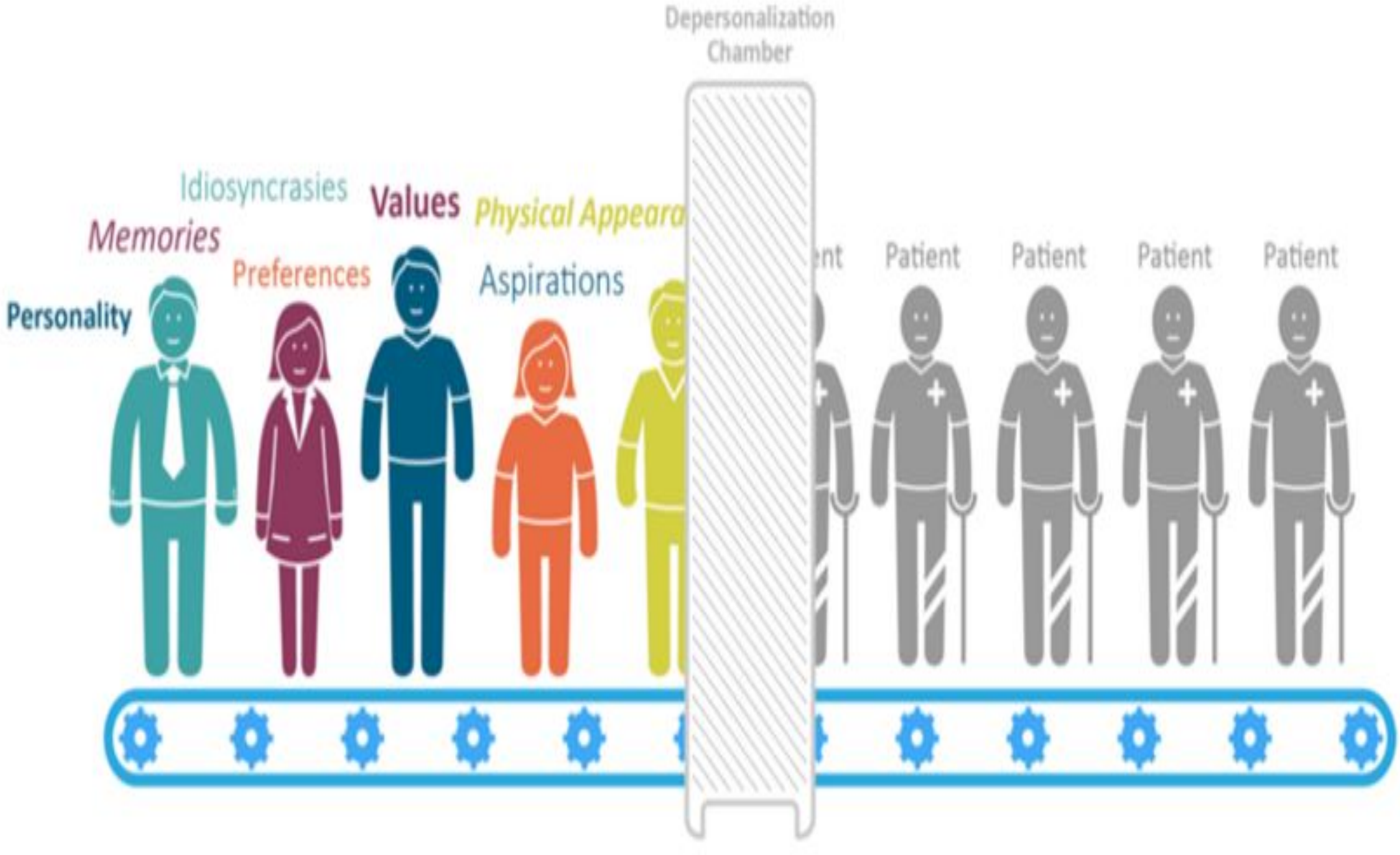
- Unrestricted family visitation
- Knowing the patient as a person (non-medical facts)
- Physical touch (e.g. holding a hand)
- Communicate with the patient (not just about or above the patient)
- Common courtesy communication, especially to delirious/comatose patients (introduction, explanation of what is about to happen, permission to touch)
- Attending promptly to patient needs
- Individualizing communication modalities
- Giving patients some locus of control of their environment
- Use eyeglasses, hearing aids, dentures as feasible
- Personal hygiene (hair care, oral care, etc.)

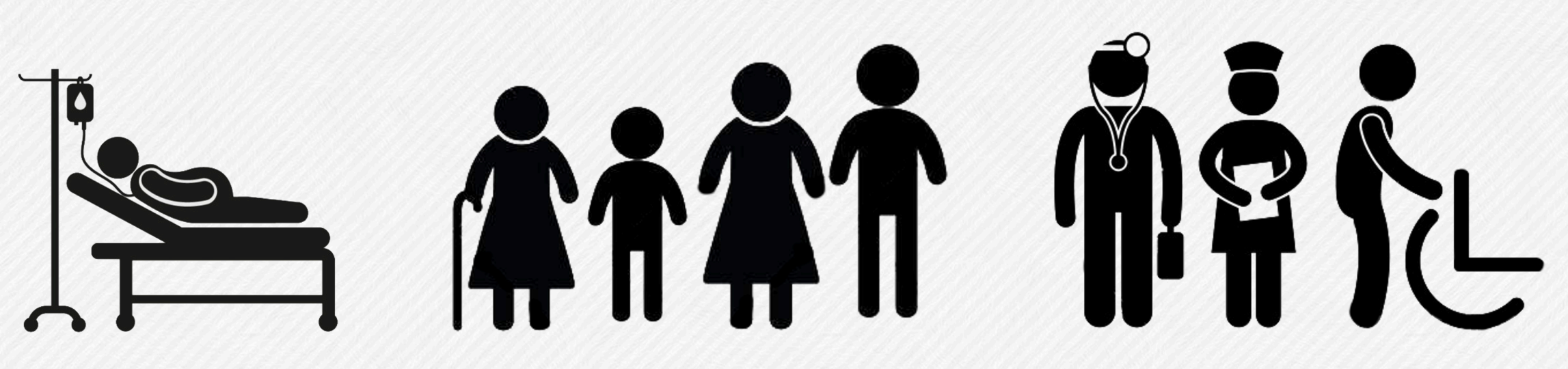
Wilson et al. Critical Care (2019) 23:32

Campo conceptual de las dimensiones de la humanización



Les Todres, Kathleen T. Galvin & Immy Holloway (2009) The humanization of healthcare: A value framework for qualitative research, International Journal of Qualitative Studieson Health and Well-being, 4:2, 68-77


Depersonalization Chamber
Idiosyncrasies
Memories
Values
Physical Appeara
Preferences
Aspirations
Personality
Patient
Patient
Patient
Patient



Modelo centrado en la persona

- Modelo centrado en el paciente
- Modelo centrado en la familia
- Modelo centrado en la persona

HUCI Humanizando los Cuidados Intensivos

www.proyectohuci.com

Our team and endorsements

This is the beginning of an ambitious project to **humanise the health care system**, and we are achieving it.

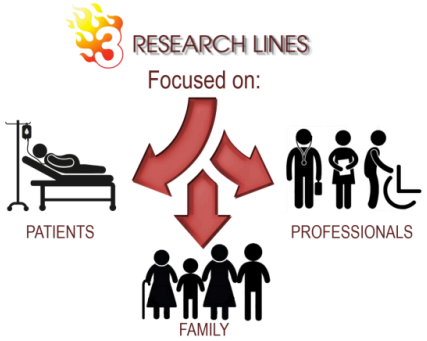
For this, we have a **multidisciplinary team** of 27 experts committed to developing the eight research lines of the project.

By the moment, nine Scientific Societies and a Nursing College endorse our Organization:

SEMICYUC Los profesionales del enfermo crítico · SEEIUC Sociedad Española de Enfermería Intensiva y Unidades Coronarias · Asociación Colombiana de Medicina Crítica y Cuidado Intensivo · Sociedad Chilena Medicina Crítica y Urgencias (Red Intensiva) · Sociedad Peruana de Medicina Intensiva · Fepimcti Federación Panamericana e Ibérica de sociedades de medicina crítica y terapia intensiva · Sociedad Chilena de Medicina Intensiva · Excmo. Colegio Oficial de Enfermería de Cádiz

Dr. Gabriel Heras La Calle. Initiative promoter

Research areas of Proyecto HU-CI



Intensive Care Med
DOI 10.1007/s00134-017-4705-4

WHAT'S NEW IN INTENSIVE CARE

A plan for improving the humanisation of intensive care units

Gabriel Heras La Calle[1,2*], Ángela Alonso Oviés[1,3] and Vicente Gómez Tello[1,4]

Care Design: The H-Evolution of Intensive Care Units

Source: The International Research Project for the Humanization of the Intensive Care Units (Proyecto HU-CI)
NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society

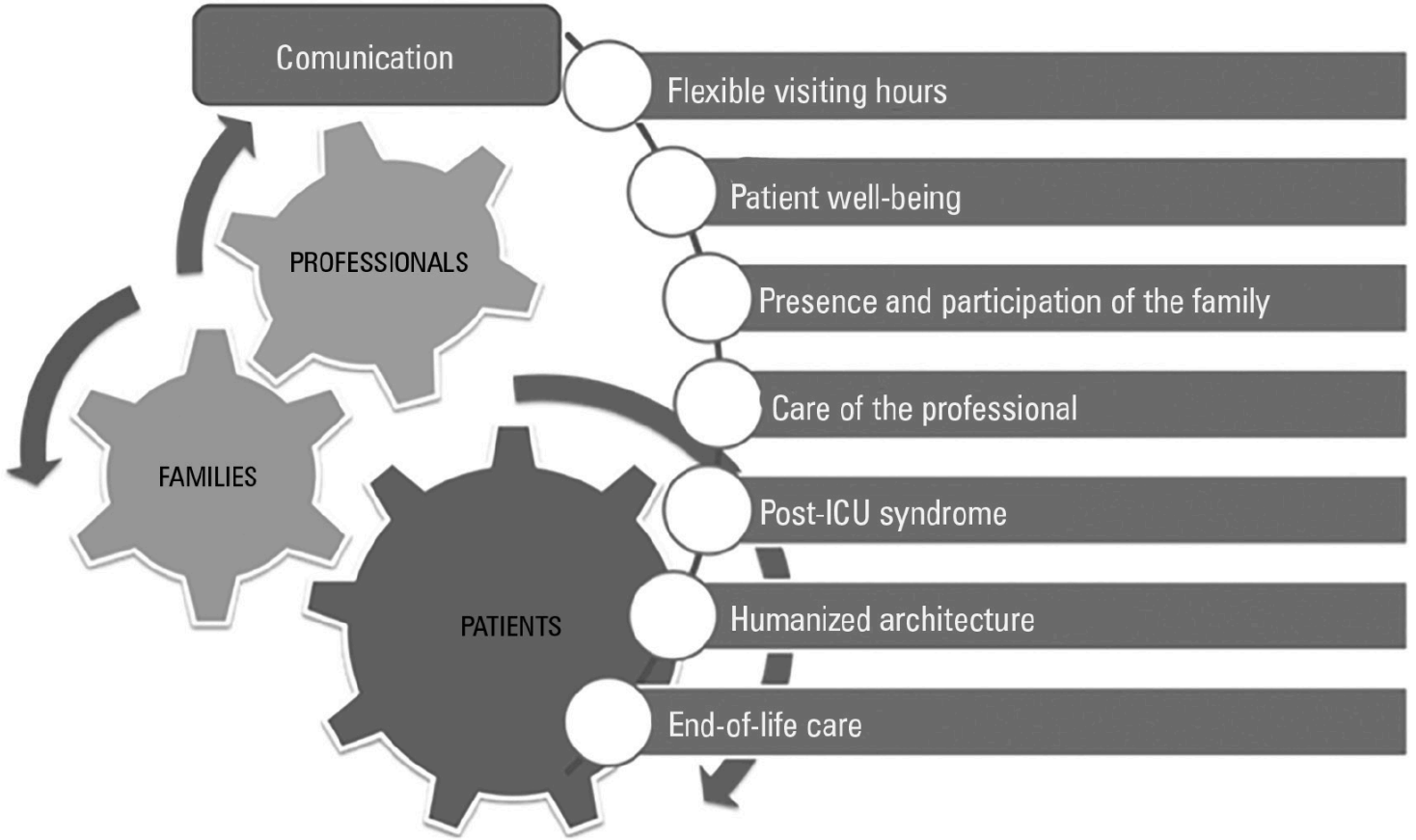


Figure 1 - Conceptual framework for the humanization of critical care. ICU - intensive care unit.

Gabriel Heras La Calle, Mari Cruz Martin, Nicolas Nin

Rev Bras Ter Intensiva. 2017;29(1):9-13

Seeking to humanize intensive care

Buscando humanizar los cuidados intensivos

TABLE 1. Humanization Plan Objectives in ICU

Open-door policy
Make professionals aware of the benefits for patients, relatives, professionals in implementing the ICU open-doors policy
Facilitate ICU accessibility to patients' relatives
Promote contact between patients and their families during their stay in ICU
Communication
Develop tools that ensure the correct transfer of relevant information on a patient among all team members and that improve teamwork
Facilitate aspects that help establish appropriate and empathetic communication with relatives on behalf of all team members, in order to reach a satisfactorily helpful relationship, and facilitate the accessibility of information
Facilitate the giving out of information to patients and promote the use of augmentative and/or alternative communication systems where necessary
Psychologic and spiritual comfort: Promote actions that lead a reduction in the patient's psychologic suffering and attend to spiritual demands
Patient autonomy: Establish measures that promote patient autonomy and facilitate his/her connection to the outside world
Environmental comfort: Promote measures that facilitate waking-sleeping rhythms and nighttime rest, as well as other environmental wellbeing measures
Presence and participation of relatives in intensive care
Offer the family the opportunity to participate in the primary care of the patient and specific procedures
Detect and support the emotional and psychologic needs of the families
Care for the healthcare professional
Improve knowledge on professional burnout syndrome and work to make it more visible
Evaluate the impact of professional burnout syndrome in ICU
Analyze the factors related to professional burnout syndrome, such as job satisfaction, anxiety, depression, and engagement in the work
Prevention, management, and monitoring of PICS
Prevent and detect the appearance of PICS early
Improve the quality of life of patients identified to be pre-discharge from the ICU while they are monitoring on the ward and/or when they are discharged and sent home
Assess and implement possible organizational measures appropriate to the situation in each hospital
Humanized infrastructure
Ensure the patient's privacy
Ensure the patient's environmental comfort
Foster communication and focus on the patient
Encourage entertainment for the patient
Make available spaces in gardens or patios and ensure patient access to them
Guarantee the education process for school-age patients during their stay in ICU
Ensure comfort and functionality in the treatment area
EOL care
Have an EOL protocol
Control physical symptoms of patients in EOL situations
Facilitate the accompaniment of patients in EOL situations
Cover the emotional and spiritual needs of patients and family members in EOL situations
Have a LST protocol that follows the recommendations of scientific communities
Ensure that patients' needs and autonomy in LST decision-making are respected
Ensure the participation of all the professionals involved in the LST

EOL = end of life, LST = life-sustaining treatment, PICS = post-intensive care syndrome.

Humanizing Intensive Care: Toward a Human-Centered Care ICU Model

Nicolas Nin Vaeza, MD, PhD[1,2,3]; María Cruz Martin Delgado, MD[2,4,5]; Gabriel Heras La Calle, MD[2,3,4,5]

Critical Care Medicine: March 2020 - Volume 48 - Issue 3 - p 385-390
doi: 10.1097/CCM.0000000000004191


LÍNEAS ESTRATÉGICAS
SENSIBILIZACIÓN DE LOS PROFESIONALES
Manual de buenas prácticas
de Humanización en las
Unidades de Cuidados Intensivos
HUCI

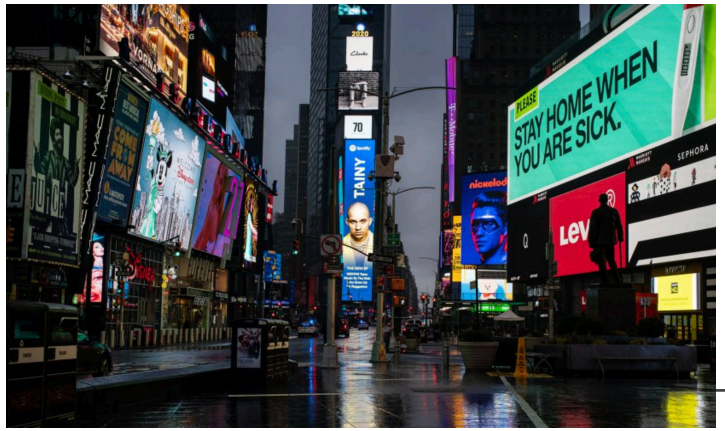
HUMANIZANDO
LA JUSTICIA

HURGE
Humanizando
las Urgencias
y Emergencias

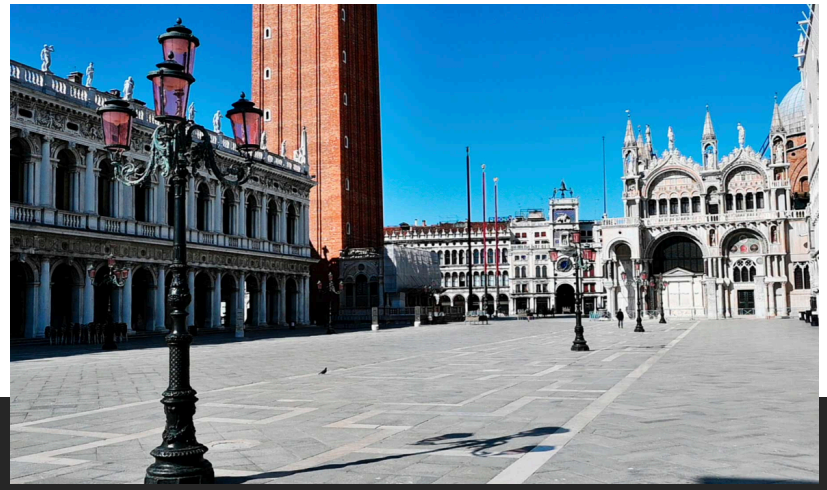
HONCOR
Humanizando la
Oncohematología
y Radioterapia

HUGES
Humanizando
la Gestión
Sanitaria

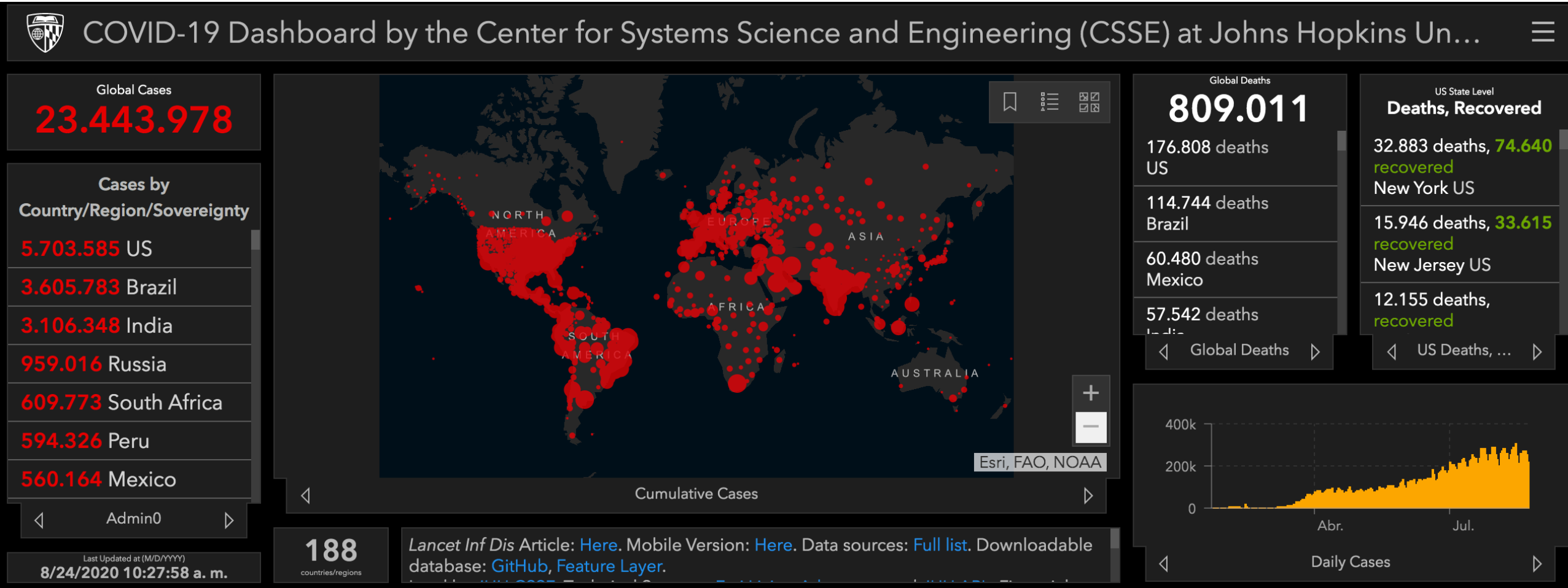
Impacto COVID 19 en el Sistema Sanitario


PLEASE
STAY HOME WHEN
YOU ARE SICK.
TAINY
SEPHORA


MEGAN THEE STALLION
Spotify
DON TOLIVER
HEAVEN OR HELL
THE NEW ALBUM



Pandemia COVID-19 (24 agosto 2020)



Previsiones de UCI pandemia COVID

- 278.435 ingresos hospitalarios en 12 semanas.
- Pico de demanda en la semana 7.
- Necesidad > 9.000 camas de UCI en los momentos de mayor demanda.
- Necesidad >5.000 respiradores en las semanas de mayor demanda.

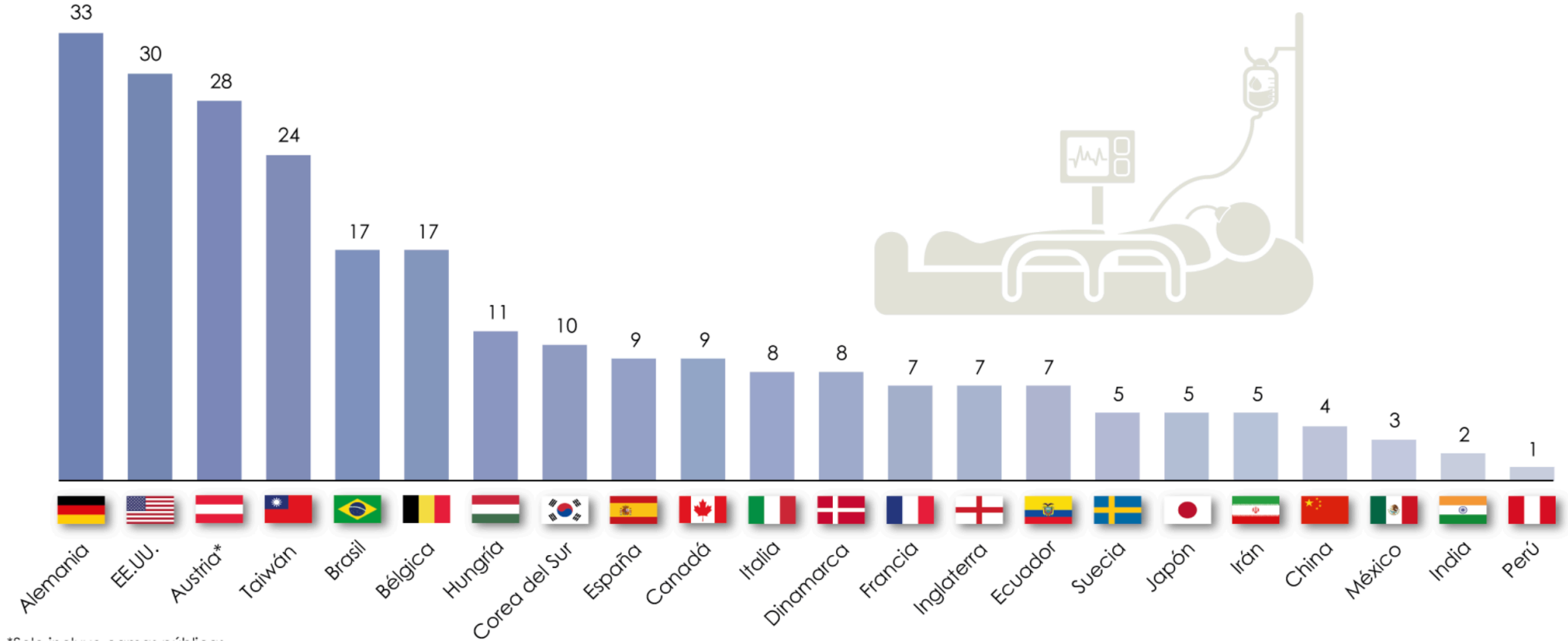
a) TA 25% Y 8 SEMANAS: DEMASIADO PESIMISTA

Pandemic Influenza Impact / Weeks		1	2	3	4	5	6	7	8	9	10
Hospital Admission	Weekly admissions	11.933	19.888	29.832	37.788	37.788	29.832	19.888	11.933		
	Peak admissions/day				6.037	6.037					
Hospital Capacity	# of influenza patients in hospital	11.933	27.095	41.844	55.805	60.992	59.994	47.975	33.609		
	% of hospital capacity needed	13%	30%	46%	61%	67%	65%	52%	37%		
ICU Capacity	# of influenza patients in ICU	1.313	3.500	5.469	7.438	8.313	8.310	7.124	5.155		
	% of ICU capacity needed	36%	97%	152%	207%	231%	231%	198%	143%		
Ventilator Capacity	# of influenza patients on ventilators	776	2.068	3.232	4.395	4.912	4.910	4.209	3.046		
	% usage of ventilator	23%	62%	98%	133%	148%	148%	127%	92%		
Deaths	# of deaths from influenza			2.399	3.999	5.999	7.598	7.598	5.999	3.999	2.399
	# of influenza deaths in hospital			2.399	3.999	5.999	7.598	7.598	5.999	3.999	2.399

b) TA 25% Y 12 SEMANAS: DEMASIADO OPTIMISTA

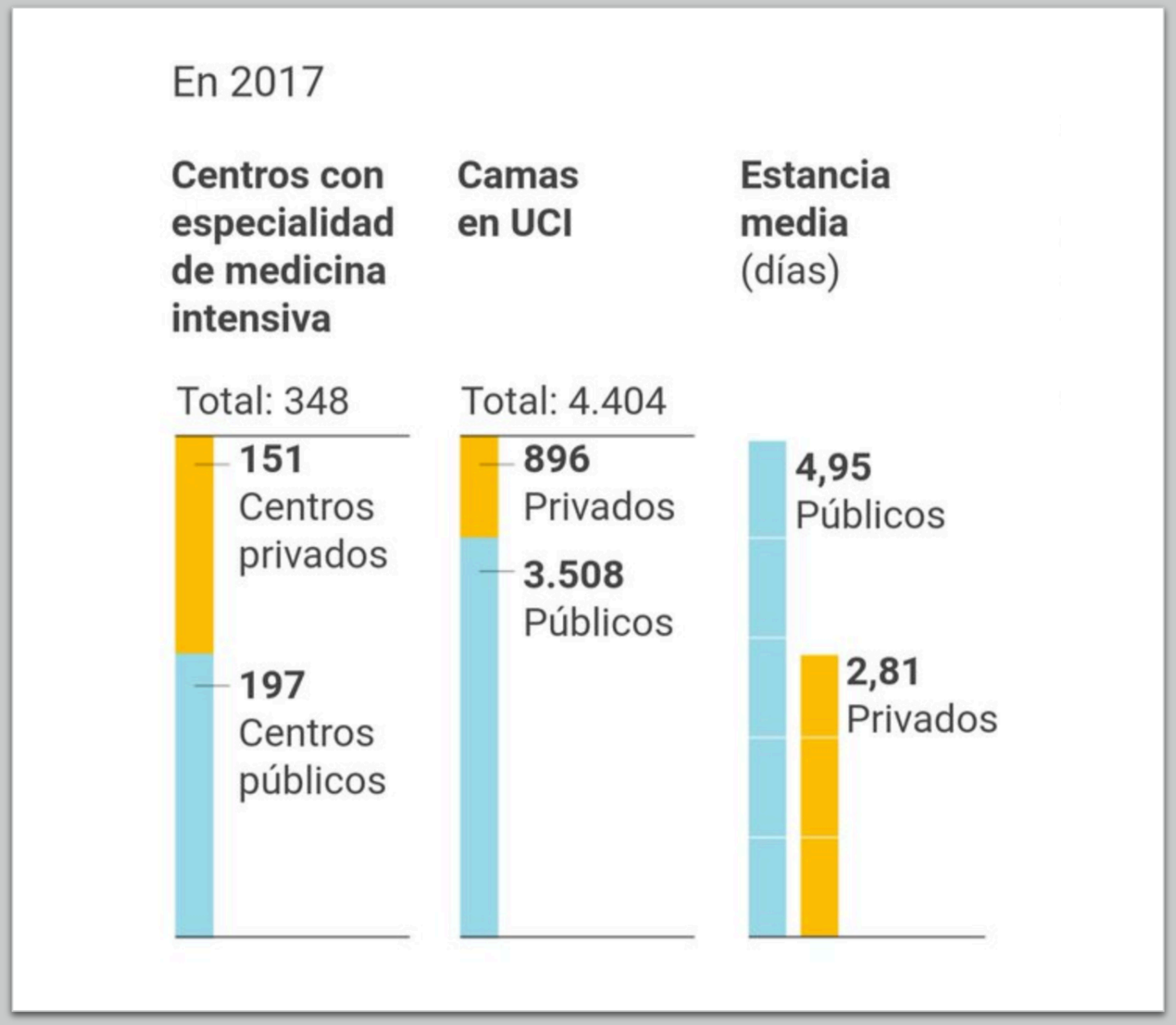
Pandemic Influenza Impact / Weeks		1	2	3	4	5	6	7	8	9	10	11	12	13	14
Hospital Admission	Weekly admissions	1.989	7.955	13.922	19.888	25.855	29.832	29.832	25.855	19.888	13.922	7.955	1.989		
	Peak admissions/day						4.766	4.766							
Hospital Capacity	# of influenza patients in hospital	1.989	9.156	18.726	28.297	37.867	45.448	48.151	47.731	40.847	32.352	23.069	13.787		
	% of hospital capacity needed	2%	10%	20%	31%	41%	50%	53%	52%	45%	35%	25%	15%		
ICU Capacity	# of influenza patients in ICU	219	1.094	2.406	3.719	5.032	6.126	6.605	6.605	5.951	4.822	3.509	2.197		
	% of ICU capacity needed	6%	30%	67%	103%	140%	170%	184%	184%	165%	134%	98%	61%		
Ventilator Capacity	# of influenza patients on ventilators	129	646	1.422	2.198	2.973	3.620	3.903	3.903	3.516	2.849	2.074	1.298		
	% usage of ventilator	4%	20%	43%	66%	90%	109%	118%	118%	106%	86%	63%	39%		
Deaths	# of deaths from influenza			400	1.600	2.799	3.999	5.199	5.999	5.999	5.199	3.999	2.799	1.600	400
	# of influenza deaths in hospital			400	1.600	2.799	3.999	5.199	5.999	5.999	5.199	3.999	2.799	1.600	400

Recursos de UCI disponibles



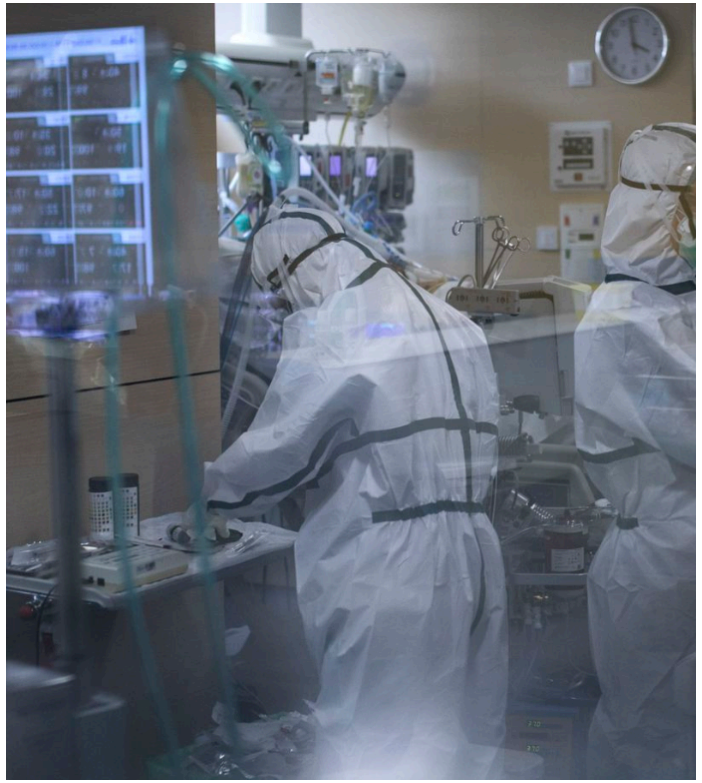
Recursos de UCI

- Hospitales generales: 284 públicos; 204 privados
- Nº de ingresos /año: 155.292 publicas + 50.600 privadas
- Nº de intensivistas: 2628
- Nº de residentes: 718



Ingresos en UCI

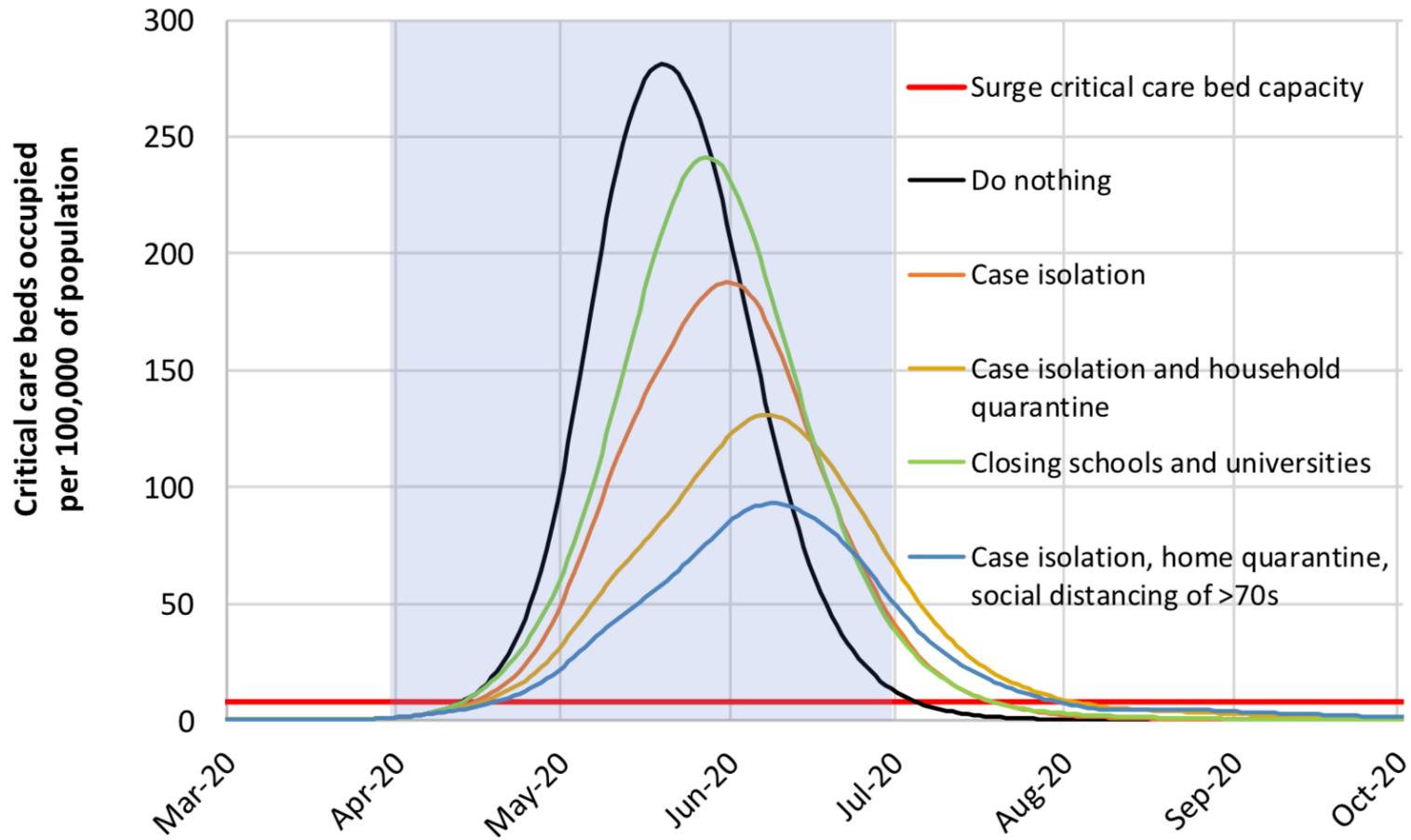
8 de julio 2020



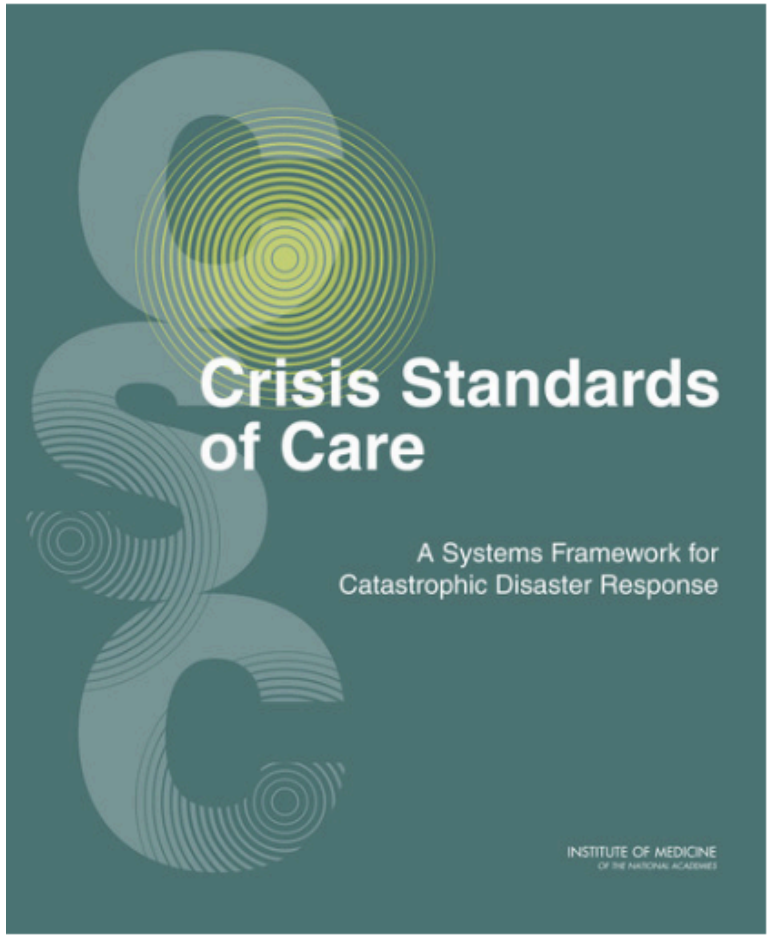
CCAA	Casos que han precisado hospitalización		Casos que han ingresado en UCI		Fallecidos	
	Total	*Con fecha de ingreso en los últimos 7 días*	Total	*Con fecha de ingreso en UCI en los últimos 7 días*	Total*	*Con fecha de defunción en los últimos 7 días*
Andalucía	6.355	15	795	1	1.434	1
Aragón	2.724	12	274	0	913	1
Asturias	1.117	0	129	0	334	0
Baleares	1.173	0	169	0	224	0
Canarias	954	1	186	1	162	0
Cantabria	1.057	0	80	0	216	0
Castilla La Mancha	9.470	24	664	0	3.029	0
Castilla y León	8.804	8	631	1	2.788	1
Cataluña	29.387	9	2.993	2	5.675	0
Ceuta	14	0	4	0	4	0
C. Valenciana	5.830	10	744	0	1.432	0
Extremadura	1.774	1	138	0	519	0
Galicia	2.941	4	336	0	619	0
Madrid	42.747	39	3.641	0	8.441	4
Melilla	45	0	3	0	2	0
Murcia	688	2	113	1	148	0
Navarra	2.051	4	137	0	528	0
País Vasco	7.009	7	579	0	1.562	2
La Rioja	1.490	1	91	0	366	0
ESPAÑA	125.630	137	11.707	6	28.396	9

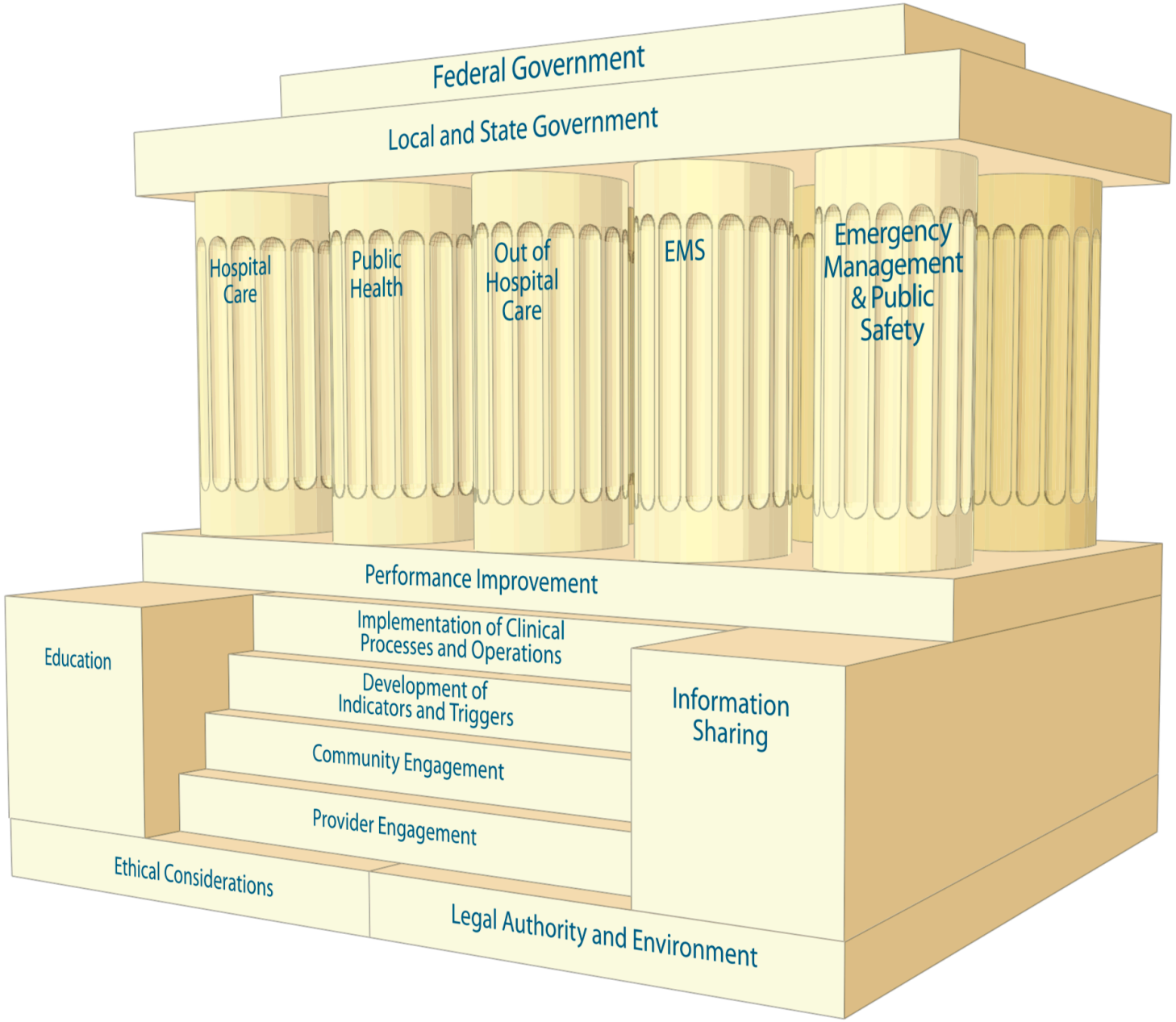
https://www.mscbs.gob.es/profesionales/saludPublica/ccayes/alertasActual/nCov-China/documentos/Actualizacion_158_COVID-19.pdf

Report 9: Impact of non-pharmaceutical interventions (NPIs) to reduce COVID-19 mortality and healthcare demand



A systems framework for catastrophic disaster response.



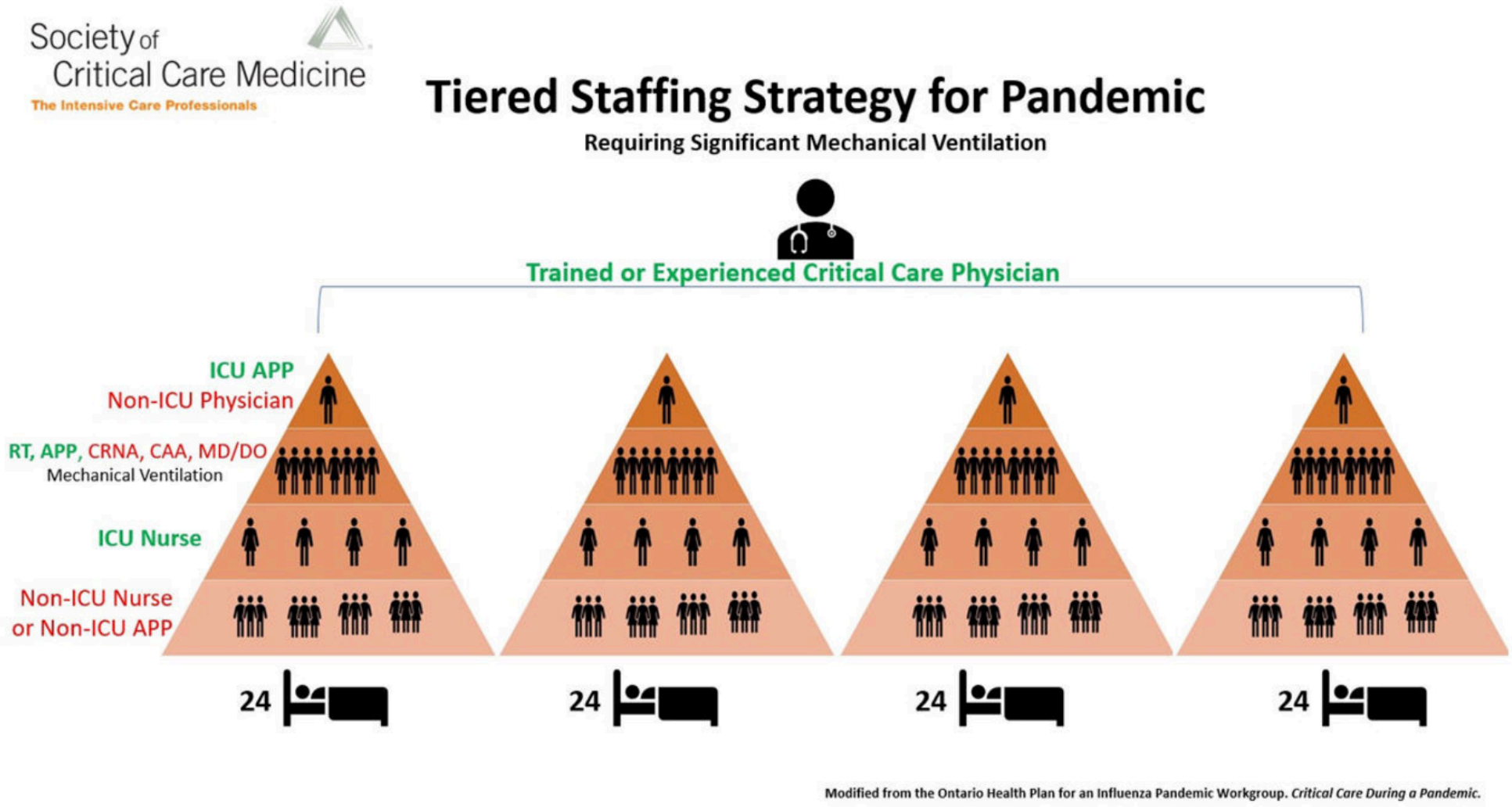


Intensive care management of coronavirus disease 2019 (COVID-19): challenges and recommendations

Jason Phua, Li Weng, Lowell Ling, Moritoki Egi, Chae-Man Lim, Jigeeshu Vasishtha Divatia, Babu Raja Shrestha, Yaseen M Arabi, Jensen Ng Charles D Gomersall, Masaji Nishimura, Younsuck Koh, Bin Du, for the Asian Critical Care Clinical Trials Group

- Low threshold for suspecting COVID-19
- Full PPE for ICU staff
- Consider critical care triage to ration scarce resources in pandemic; prioritise patients who will benefit from ICU care
- Admit to single airborne infection isolation room with negative pressure in ICU
- If negative-pressure room unavailable, admit to normal-pressure single room in ICU
- If single room unavailable, cohort similar cases in shared room with beds spaced apart in ICU
- If ICU unavailable, consider surge beds outside of ICU
- If surge beds unavailable, consider transfer to designated hospitals and ICUs
- Collect respiratory tract samples for RT-PCR, preferably sputum or endotracheal aspirates
- If negative, repeat as appropriate based on index of suspicion

Extensión de los equipos



Profesionales

- Intensivistas
  - Reducciones
  - Turnos / 12 horas
  - Nuevos contratos
  - Jubilado
- Anestesistas
- ORL
- Enfermera UCI
- Enfermera quirófano / URPA/ áreas especiales

Ventilación mecánica

Ventiladores de UCI: 92%

Ventiladores de quirófano

American Society of Anesthesiologists | apsf Anesthesia Patient Safety Foundation — *Updated: April 16, 2020*

APSF/ASA Guidance on Purposing Anesthesia Machines as ICU Ventilators

Ventiladores de transporte

Ventiladores otros usos

Ventiladores diseñados “ad hoc”

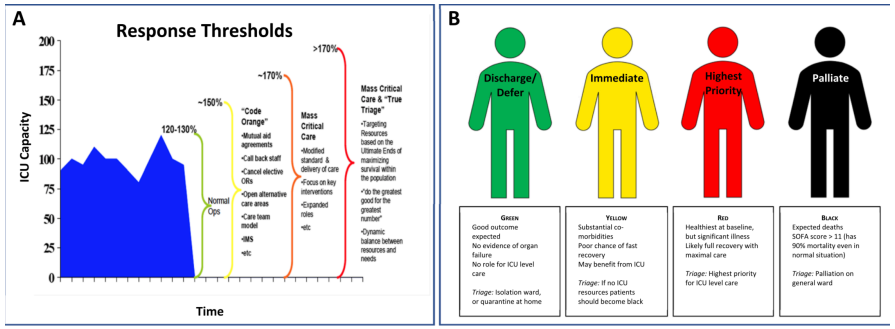
Ventiladores múltiples pacientes

Consensus Statement on Multiple Patients Per Ventilator

Issued: March 26, 2020, 12:00 p.m.

Reducción tiempos de ventilación mecánica: traqueotomía, rehabilitación

Triaje

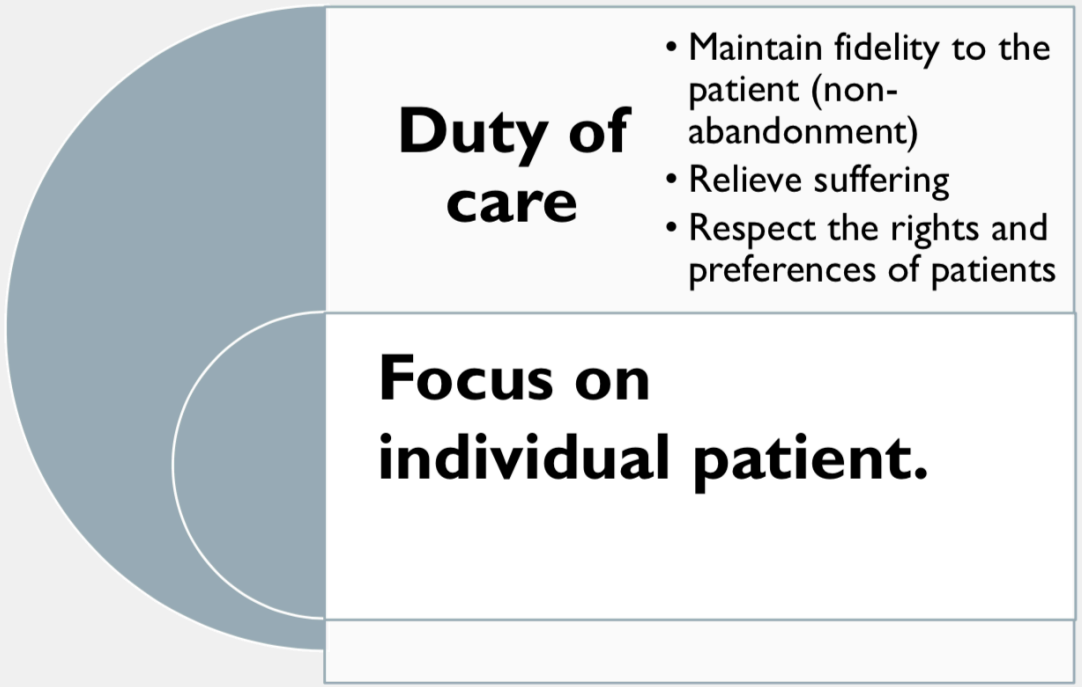


Equipos de protección individual

- Protección profesionales
- Ajustados a cada procedimiento y escenario
- Recomendaciones dinámicas
- Optimización recursos escasos
- Entrenamiento
- Supervision
- Fatiga
- Anticipación necesidades
- Centralización. Control existencias y consumos

Clinical Ethics and Public Health Ethics

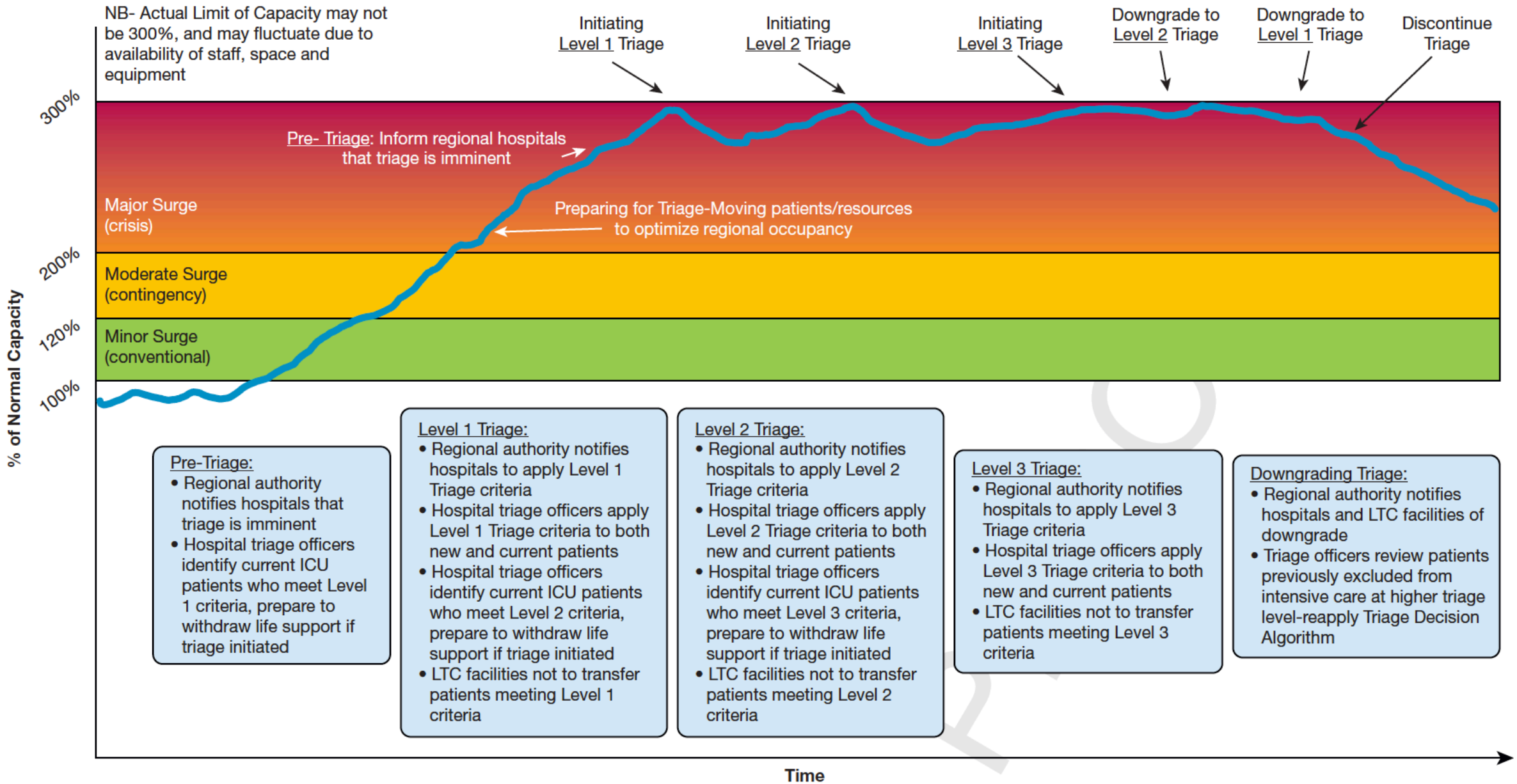
Duties of Clinical Ethics



Duties of Public Health Ethics

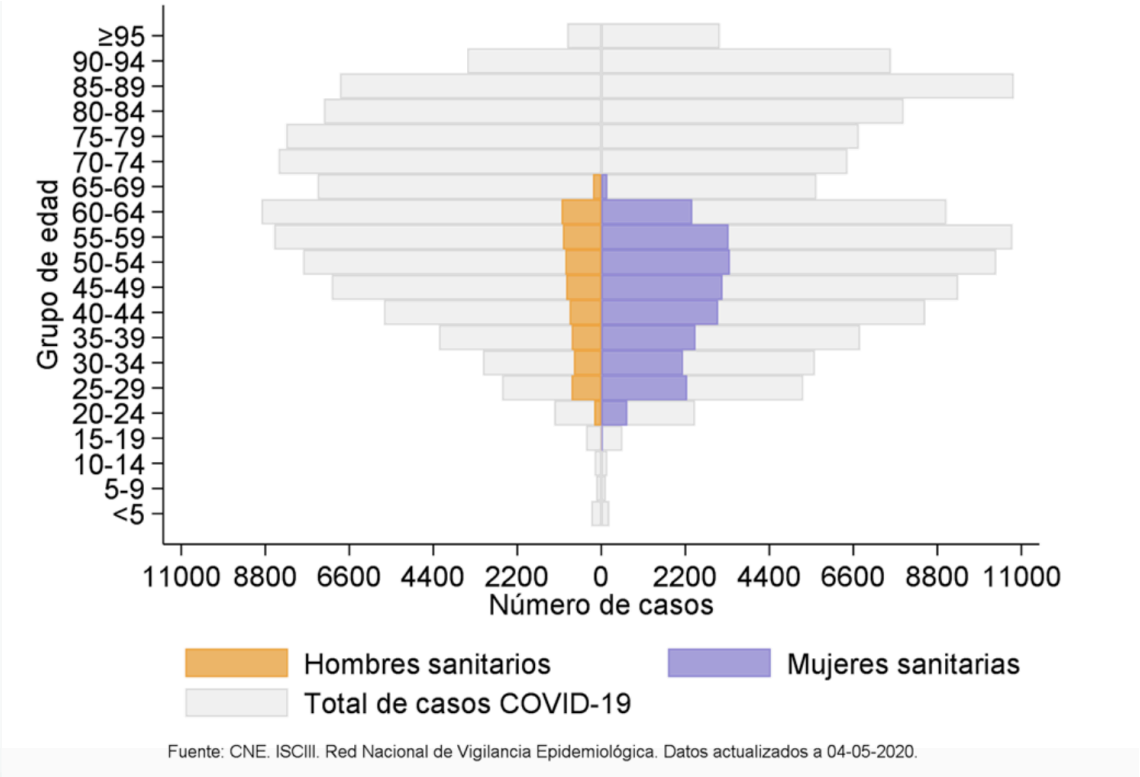
The Hastings Center

Surge and Levels of Triage in a Pandemic



Profesionales contagiados

Diagnostico precoz asintomáticos.
> uso de PCR
Serologías
Uso de EIPI, entrenamiento
Respuesta en el tiempo a los test



- 43.965 profesionales (20% SARS-CoV-2 por PCR)
- 11% en algunas comunidades: Madrid y Barcelona
- 40 fallecidos
- Índice de letalidad bajo (0,1%-7,8%)

HUT 30% profesionales contagiados

Impacto de la pandemia de COVID-19 sobre la actividad asistencial en cardiología intervencionista en España

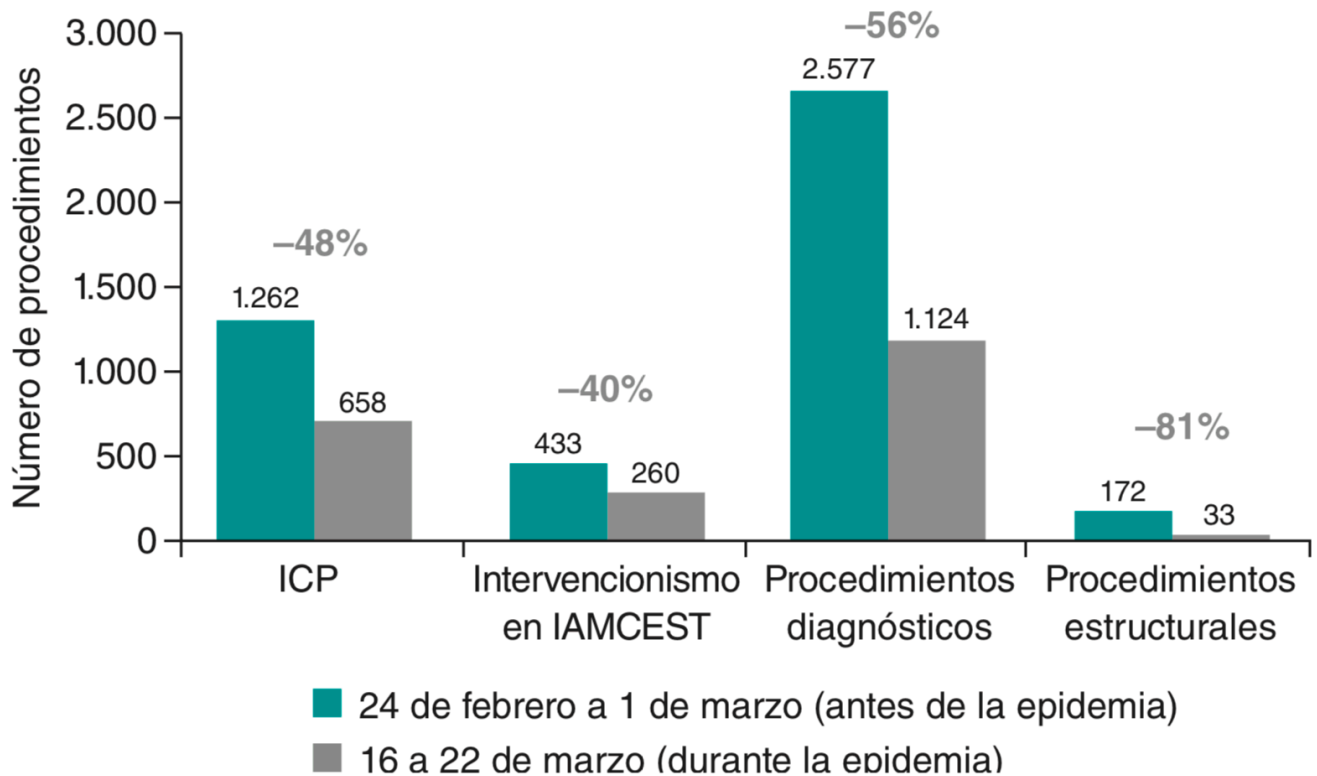


Figura 3. Cambios de las distintas actividades asistenciales durante la epidemia de COVID-19 en España. IAMCEST: infarto agudo de miocardio con elevación del segmento ST.

Rodríguez-Leor O, et al. Impacto de la pandemia de COVID-19 sobre la actividad asistencial en cardiología intervencionista en España. *REC Interv Cardiol*. 2020. https://doi.org/10.24875/RECIC.M20000120

Actividad asistencial + investigación clínica

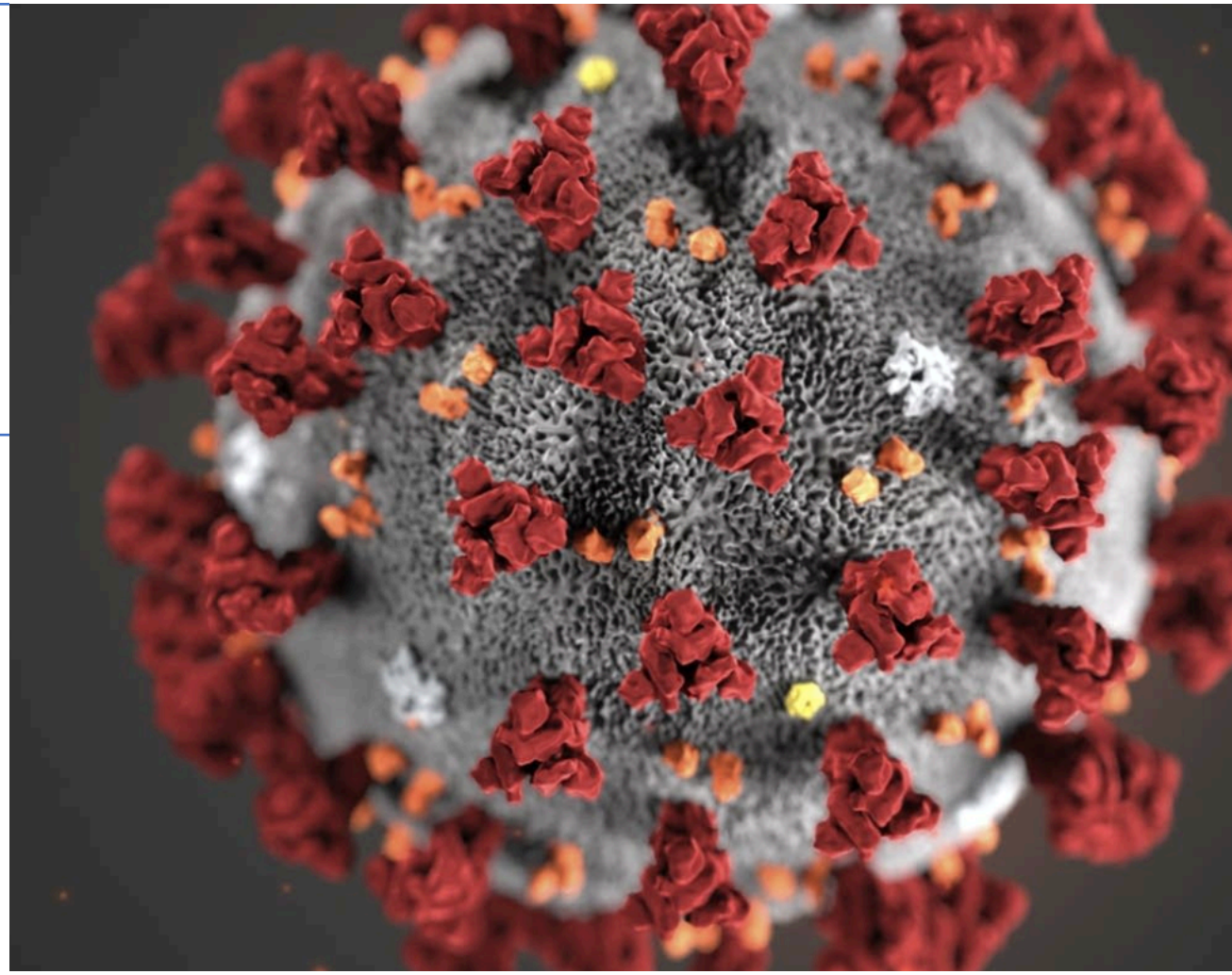
Care Design: The H-Evolution of Intensive Care Units

Source: The International Research Project for the Humanization of the Intensive Care Units (Proyecto HU-CI)

Humanizar en tiempos de pandemia

La reciente pandemia ha puesto en jaque al sistema sanitario a nivel mundial y ha tambaleado muchas de estas políticas que habían ido incorporándose de forma paulatina en muchas unidades.

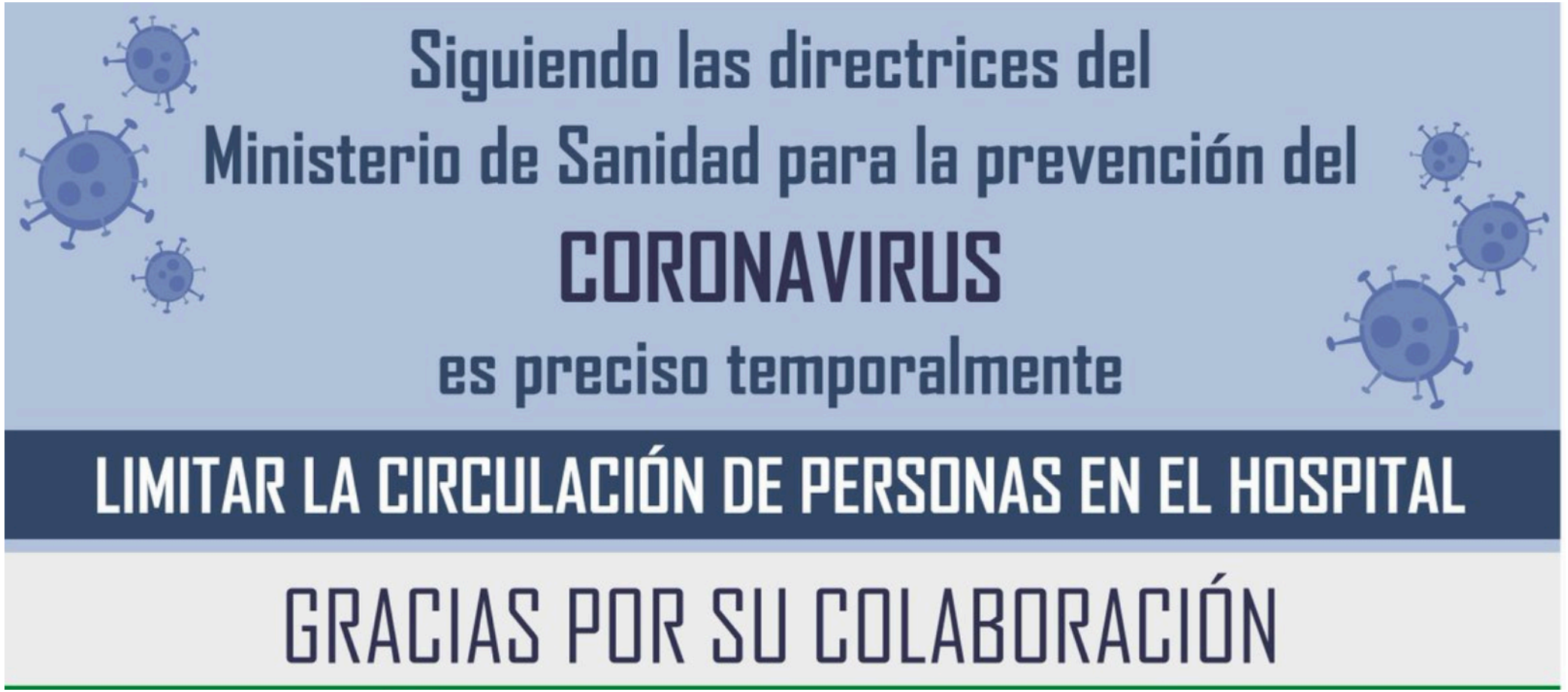
Pero por otro lado ha puesto en relevancia la importancia de **preservar estas estrategias dirigidas a humanizar** los cuidados intensivos al mostrar el brutal impacto no solo físico sino especialmente emocional que ha supuesto esta enfermedad para los pacientes, familias y profesionales sanitarios



La separación de los pacientes más graves de sus familias muestra la cara más cruel de la pandemia

Newyorktime. https ://www.nytim es.com/2020/03/29/health/coronavirus-hospital-visit -ban.html. Accessed 6 July 2020

La respuesta a la pandemia de COVID-19 ha incluido restricciones drásticas de visitas al hospital con el objetivo bien intencionado de distanciamiento social y de reducir el riesgo de contagio



Lewnard JA, Lo NC. Scientific and ethical basis for social-distancing interventions against COVID-19. Lancet Infect Dis 2020. https://doi.org/10.1016/S1473-3099(20) 30190-0.

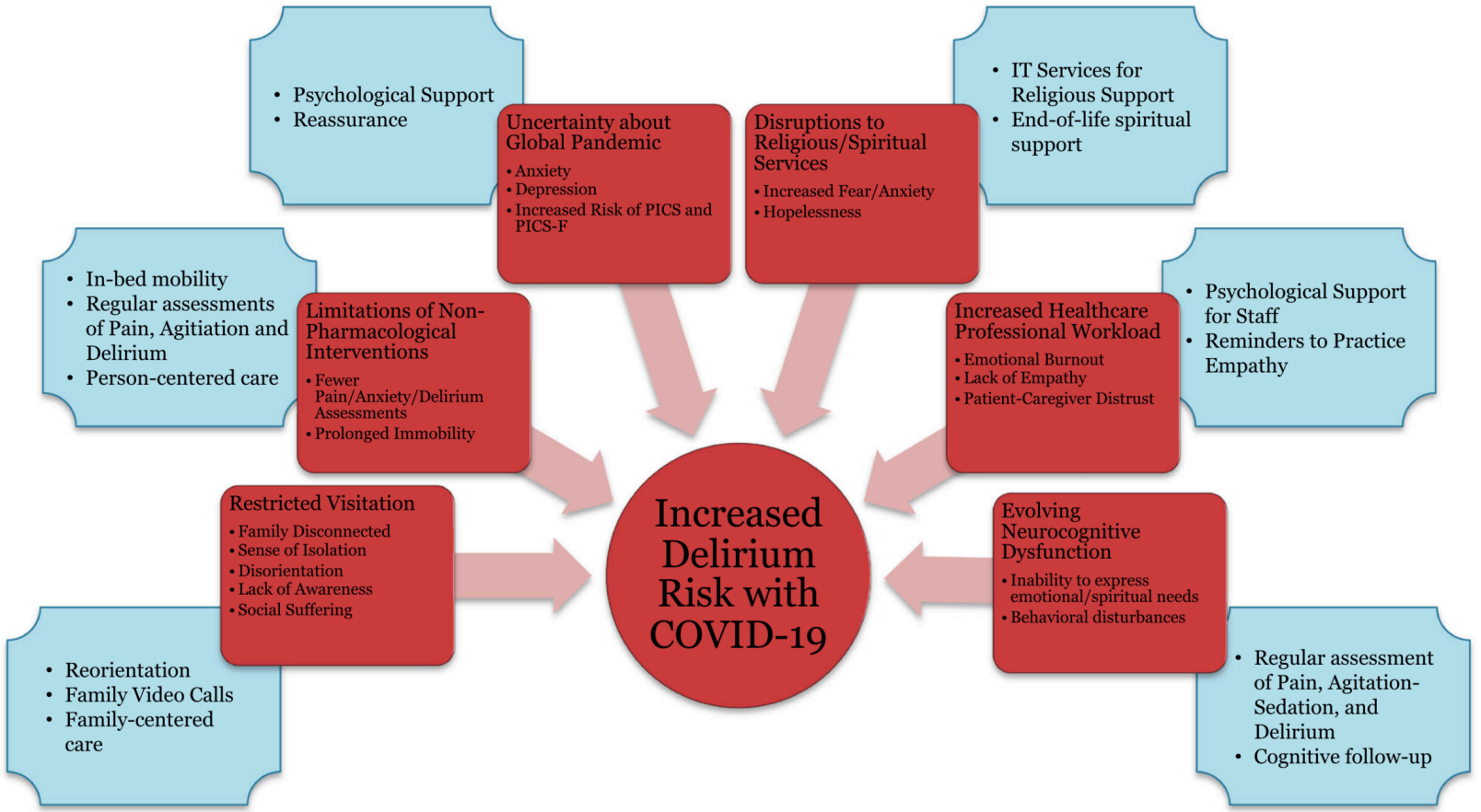
Los pacientes ha permanecido separados de sus familias, incrementando no solo el miedo y la ansiedad ante una enfermedad grave que podía llevarlos a la muerte, sino la soledad y asilamiento durante muchos días de ingreso en las UCI

Las familias han tenido que vivir con la incertidumbre de lo que ocurría en estas unidades mientras los medios de comunicación mostraban recursos saturados e insuficientes para atender a todos los pacientes graves.

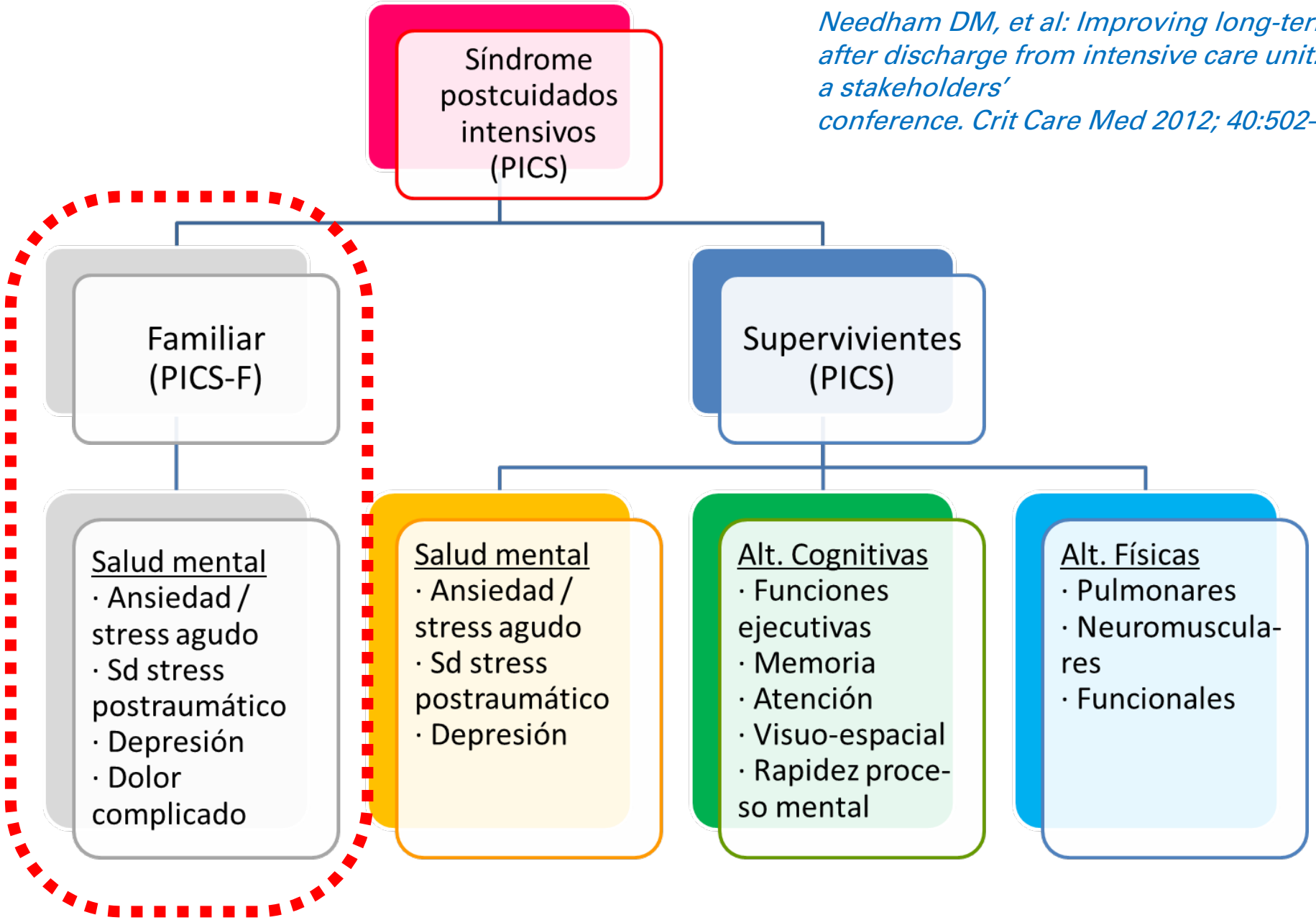
El proceso de comunicación y toma de decisiones se ha visto dificultado reduciendo hasta un límite insospechado hace unos meses, la comunicación directa con los profesionales.

COVID-19: ICU delirium management during SARS-CoV-2 pandemic

Katarzyna Kotfis[1*], Shawniqua Williams Roberson[2,3,4], Jo Ellen Wilson[2,5,6], Wojciech Dabrowski[7], Brenda T. Pun[2] and E. Wesley Ely[2,6,8]



Kotfis et al. Critical Care (2020) 24:176 https://doi.org/10.1186/s13054-020-02882-x



Needham DM, et al: Improving long-term outcomes after discharge from intensive care unit: Report from a stakeholders' conference. Crit Care Med 2012; 40:502–9

Grief During the COVID-19 Pandemic: Considerations for Palliative Care Providers

Resource List for Providers Navigating Grief Through the COVID-19 Pandemic

Topic Area	Organization, Author(s)	Title (With Hyperlink)	Purpose/Description
Communication	Vital Talk	COVID-Ready Communication Skills[33]	Practical advice on how to talk about difficult topics related to COVID-19
	Serious Illness Conversations—Kelemen, Altilio, & Leff	Specific phrases and word choices that can be helpful when dealing with COVID-19[34]	Resources include the following: helpful responses during times of restrictive visiting; guide to virtual family meetings; end-of-life topics that may arise; supporting staff; team support
	SWHPN[a]—Halpern	Working with families facing undesired outcomes during the COVID-19 crisis[35]	Tip sheet of suggestions and considerations when communicating with families
Telehealth guidance	CAPC[b]	CAPC COVID-19 Response Resources[36]	Toolkit includes communication tips, symptoms management protocols, palliative care team tools, using telehealth, among other resources
Advance care planning	Respecting Choices	COVID-19 Resources[37]	Resources include the following: those to help clinicians have conversations about treatment preferences before a medical crisis; tools to support specific treatment decisions in high-risk individuals (CPR, breathing assistance—ventilator, user guide); resources for high-risk individuals and their agents/loved ones
	NHPCO[c]	COVID-19 Shared Decision-Making Tool[38]	Includes information related to likelihood of survival, along with symptoms, statistics and facts. The tool also prompts a "decision point" about advance directives
	Aging with Dignity — Five Wishes	Five Wishes Advance Directive[39]	A complete approach to discussing and documenting care choices; document meets legal requirements for directives in 42 states
Self-care	CDC[d]	COVID-19: Stress & Coping[40] Emergency Responders: Tips for Taking Care of Yourself[15]	Provides tips and resources for reducing stress Includes information on preparing for a response; understanding and identifying burnout and secondary traumatic stress; getting support; self-care techniques; and resources
	AAHPM[e]	Resilience and Well-Being[41]	Includes self-care tips, videos and presentations, articles, and other resources
	University of Buffalo, School of Social Work	Self-Care Starter Kit[42]	Includes foundational information about self-care; self-care assessments, exercises, and activities; and resources for developing a self-care plan (including for use during an emergency)

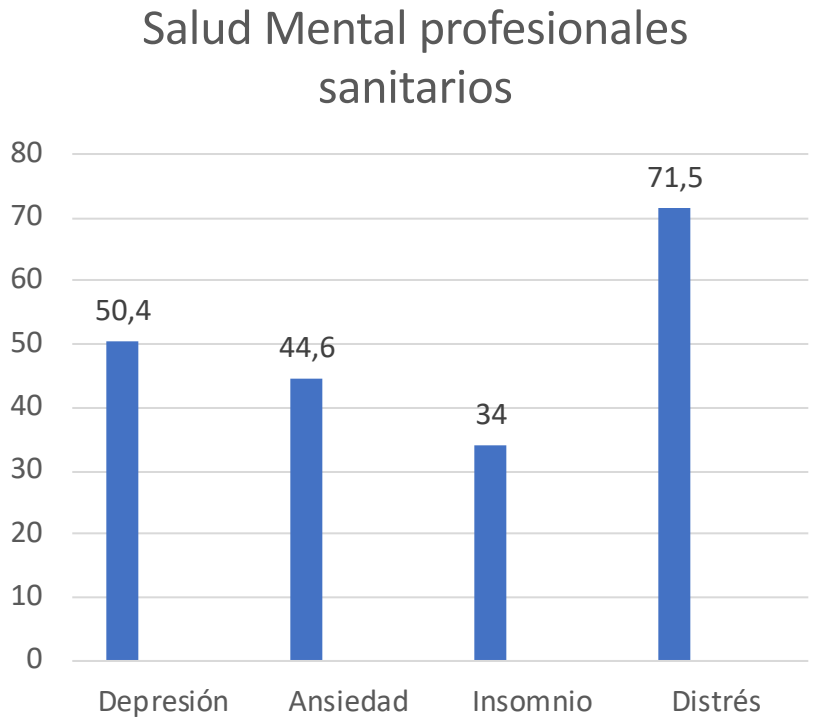
https://doi.org/10.1016/j.jpainsymman.2020.04.012

Finalmente, muchas familias no han podido acompañar a sus seres queridos al final de la vida e incluso han tenido dificultades para disponer de su cuerpo o tener la oportunidad de despedirse con los rituales habituales fuera de esta pandemia.

Wakam GK, Montgomery JR, Biesterveld BE, Brown CS. Not Dying Alone - Modern Compassionate Care in the Covid-19 Pandemic. N Engl J Med. 2020 Jun 11;382(24):e88. doi: 10.1056/NEJMp2007781. Epub 2020 Apr 14

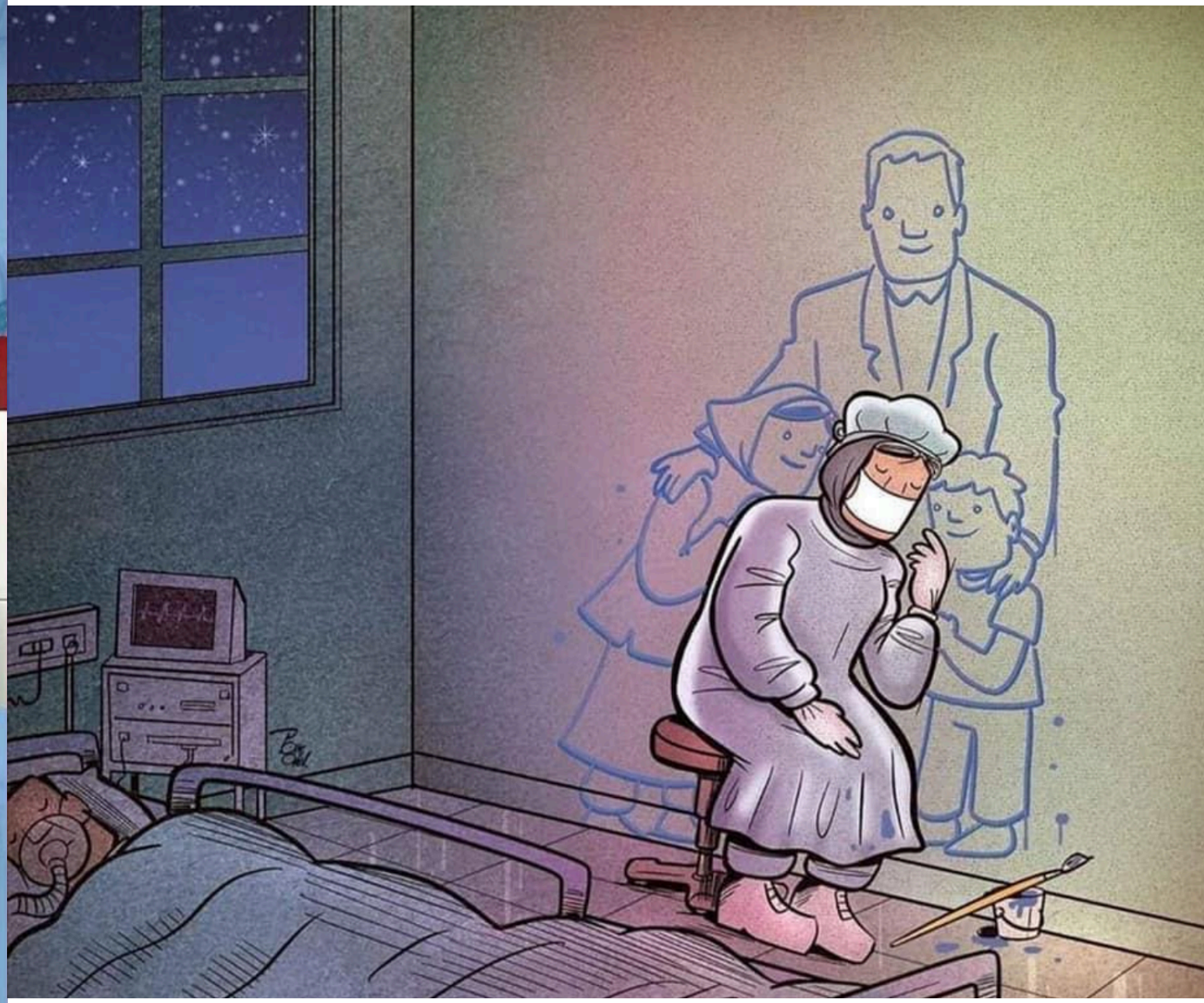
Factors Associated With Mental Health Outcomes Among Health Care Workers Exposed to Coronavirus Disease 2019

JAMA Network Open. 2020;3(3):e203976. doi:10.1001/jamanetworkopen.2020.3976



		Occupation			Sex			Working position			Type of hospital			Geographic location			
		Median (IQR)			Median (IQR)			Median (IQR)			Median (IQR)			Median (IQR)			
Scale	Total score, median (IQR)	Physician	Nurse	*P* value	Men	Women	*P* value	Frontline	Second-line	*P* value	Tertiary	Secondary	*P* value	Wuhan	Hubei province outside of Wuhan	Outside Hubei province	*P* value
PHQ-9, depression symptoms	5.0 (2.0-8.0)	4.0 (1.0-7.0)	5.0 (2.0-8.0)	.007	3.0 (0-7.0)	5.0 (2.0-8.0)	<.001	6.0 (2.0-9.0)	4.0 (1.0-7.0)	<.001	4.0 (1.0-7.0)	5.0 (2.0-9.0)	<.001	5.0 (2.0-8.0)	4.0 (1.0-7.0)	3.0 (0-7.0)	<.001
GAD-7, anxiety symptoms	4.0 (1.0-7.0)	3.0 (0-7.0)	4.0 (1.0-7.0)	.008	2.0 (0-6.0)	4.0 (1.0-7.0)	<.001	5.0 (1.0-7.0)	3.0 (0.0-6.5)	<.001	3.0 (0-7.0)	4.0 (1.0-7.0)	.005	4.0 (1.0-7.0)	3.0 (0-6.0)	2.0 (0-6.0)	<.001
ISI, insomnia symptoms	5.0 (2.0-9.0)	4.0 (1.0-8.0)	5.0 (2.0-10.0)	<.001	3.0 (1.0-8.0)	5.0 (2.0-9.0)	<.001	6.0 (2.0-11.0)	4.0 (1.0-8.0)	<.001	4.0 (2.0-9.0)	6.0 (2.0-10.0)	.008	5.0 (2.0-10.0)	4.0 (1.0-8.0)	3.0 (1.0-8.0)	<.001
IES-R, distress symptoms	20.0 (7.0-31.0)	18.0 (5.0-30.0)	20.5 (8.0-32.0)	.009	14.0 (3.0-28.0)	21.0 (9.0-32.0)	<.001	22.5 (9.0-35.0)	17.0 (5.5-28.5)	<.001	19.0 (7.0-32.0)	20.0 (6.0-31.0)	.46	21.0 (8.5-34.5)	18.0 (6.0-28.0)	15.0 (4.0-26.0)	<.001


PERSON OF THE YEAR
TIME
THE MEDICAL WORKERS



Estas decisiones adoptadas de forma generalizada y en ocasiones con prohibiciones absolutas, podrían considerarse éticas en base a priorizar la protección de la salud pública pero es indudable que impiden ofrecer una atención humanizada centrada en la familia, especialmente en las situaciones más graves y al final de la vida.

Una reflexión crítica ha llevado a posicionamientos alternativos en los que se da mayor relevancia a los derechos normativos reconocidos de los pacientes tales como el acompañamiento o el apoyo espiritual o religioso y cuestiona que esta limitación pueda ser de tal intensidad que se convierta *de facto* en una **absoluta privación de estos derechos**

Rogers S: Why can't I visit? The ethics of visitation restrictions—Les- sons learned from SARS. *Crit Care* 2004; 8:300–302

No deberíamos permitir que esta restricción excepcional se convierta en una rutina y arraiguen en la UCI debilitando la corriente de humanización de los últimos años

La respuesta de los profesionales sanitarios ha sido en general reconocida por la población y estos se han volcado en la atención de los pacientes y de sus familias buscando alternativas a los límites que ha puesto la propia pandemia, innovando y ofreciendo herramientas como la comunicación telemática en un intento de minimizar la distancia entre los pacientes y sus familias.

The NEW ENGLAND JOURNAL of MEDICINE

Es posible que las familias no puedan dar la mano o abrazar a los pacientes mientras mueren, pero con el cuidado y la compasión de los profesionales sanitarios de primera línea, tal vez podamos aprovechar soluciones creativas para ayudarlos a sentir cierta conexión, sin dejar de mantener a todos a salvo.

Perspective

JUNE 11, 2020

Not Dying Alone — Modern Compassionate Care in the Covid-19 Pandemic

Glenn K. Wakam, M.D., John R. Montgomery, M.D., Ben E. Biesterveld, M.D., and Craig S. Brown, M.D.

Family-Centered Care During the COVID-19 Era

Joanna L. Hart, MD, MSHP, Alison E. Turnbull, DVM, MPH, PhD, Ian M. Oppenheim, MD, and Katherine R. Courtright, MD, MS

Strategies for Communication With and Engagement of Families During Physical Distancing

Domain of family-centered care	Strategies
Engagement of families with patients: synchronous communication	Encourage patient and family to call, text, and videoconference with one another using their preferred methods as often as desired
	Facilitate delivery of communication devices, including charging equipment, from the family to the patient
	Provide free internet access to inpatients and assist them in connecting their personal devices
	Use speakerphone to facilitate communication from family members to the patient even if the patient is not able to communicate[a]
Engagement of families with patients: asynchronous communication	Help the patient record and send audio, video, or written messages to their family members
	Encourage the patient to journal about family memories and feelings during the hospitalization
	Use videoconferencing, including using hospital-owned devices through windows or doors for patients on isolation, to show family members their loved one and the environment[a]
	Read, print out, or play messages from the patient's family to the patient[a]
	Request pastoral care support for prayer as desired, or facilitate patient's external faith leader prayers or services via videoconferencing[a]
Engagement of families with patients: environment	Create a system to have limited personal effects delivered to patients' room such as children's art, sports memorabilia, or religious items (reinforce that nothing of monetary value should be delivered and that it may be difficult to return items to the family)[a]
	Customize the patient's environment after learning favorite food, music, audiobooks, and television preferences from family members[a]
	Describe the patient's environment to family members, including the presence of items sent from the family[a]
Communication between clinical team and family	Contact family at the time of transfer or admission to establish primary contact, legal health-care decision-maker, and communication plan
	Define and document the plan for family contact, including the responsible clinical team member, on a daily basis
	Daily videoconferencing (or telephone contact) with a primary family contact as standard unless otherwise requested
	Document daily communication for transparency, accountability, and consistency
	Attempt to include families in rounds as possible but recognize that this may be infeasible under clinical strain
	Clearly communicate and reiterate the role of the clinical team member contacting the family, including when obtaining consent
	Promote consistency in who contacts family members when possible (e.g., primary clinical team member participates when consultants discuss care with family members)
	Ask family members to describe the patient's past times and life story, including important people in their life, to facilitate conversation between the clinical team and the patient

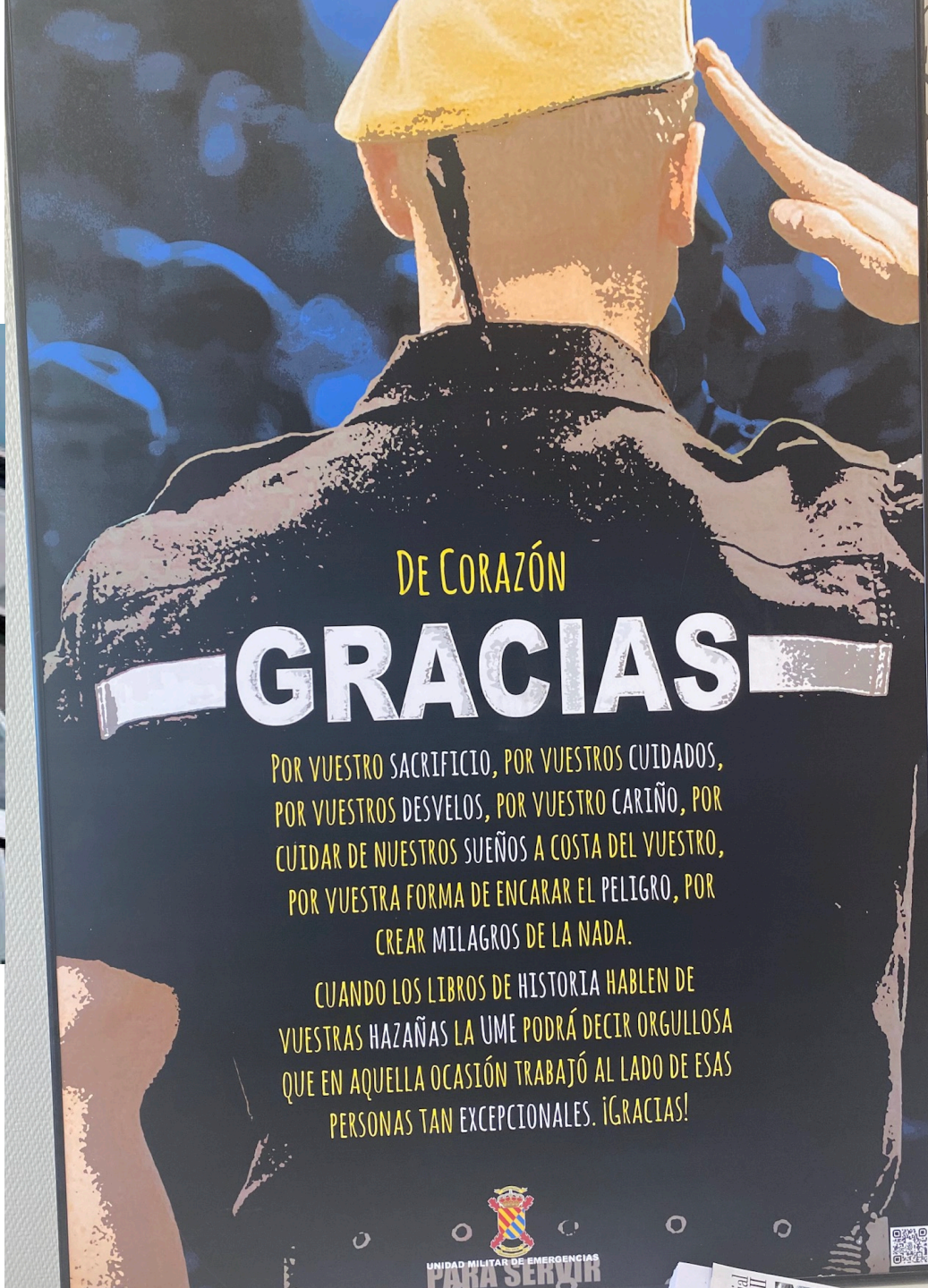
Azoulay E, Kentish-Barnes N. A 5-point strategy for improved connection with relatives of critically ill patients with COVID-19. Lancet Respir Med. 2020;8(6):e52.

Panel: A 5-point (5S) strategy to maintain the connection with relatives of critically ill patients with COVID-19

1. Stimulate family visits by restricting them to the closest relative who is asymptomatic and able to apply optimal personal protective measures.
2. Standardised written information for the relatives. This letter is sent to the relatives but also discussed during the first remote call between the health-care professionals and the family.
3. Schedule routine telephone calls with the relatives to maintain continuity of communication. The calls could be made by a medical student, a non-ICU physician, another health-care professional, or a volunteer. In addition to these calls, family members are invited to call the physician and bedside nurse once a day to receive basic information. More detailed information is to be provided during a face-to-face meeting when the relative visits the patient. For conscious patients, smartphones and digital tablets can allow video calls or virtual ICU visits.
4. Stay in touch by encouraging the family to find ways to improve the link with the relative (web-based remote family conferences, diaries, drawings, text messages, and media groups).
5. Switch to a different approach in end-of-life situations to avoid depriving family members of the opportunity to say goodbye to a relative. For example, family conferences should be organised, remotely if needed, to meet family needs and prepare for the bereavement.[7] The relative should be allowed to stay in the room as much as possible. However, safety of the relative is a primary concern, and the health-care professionals must provide the relative with training in the use of personal protective equipment.

Seguimiento postUCI

HUCI Humanizando los Cuidados Intensivos

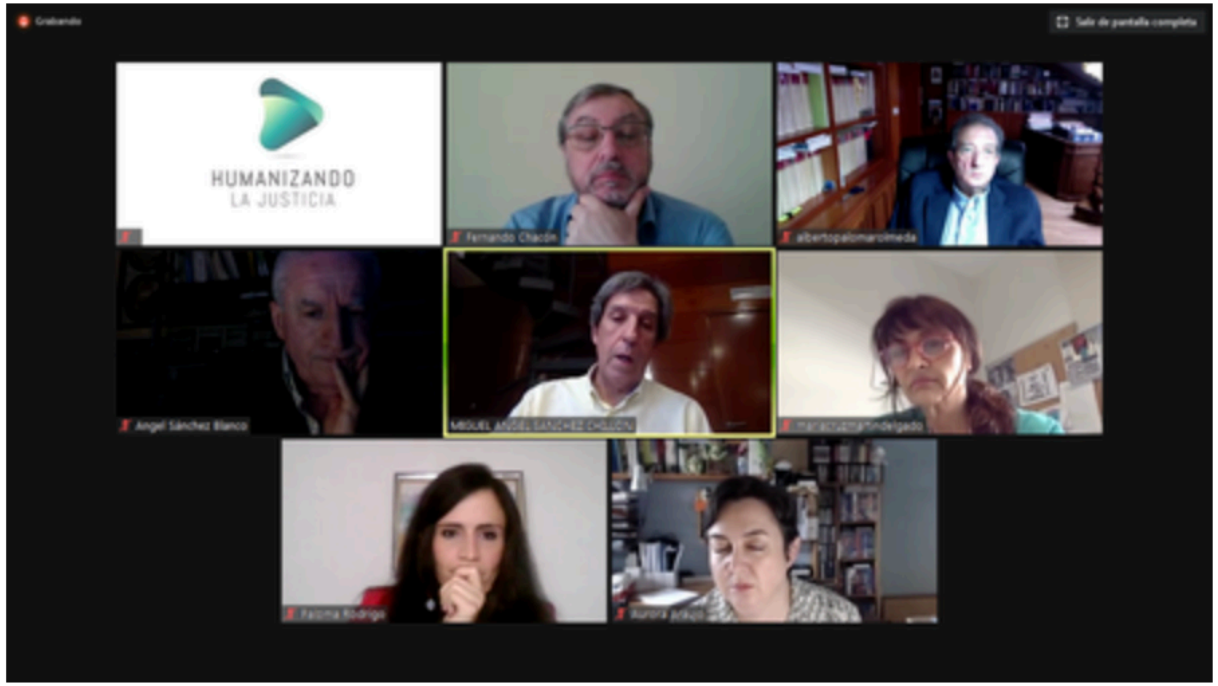

De Corazón
GRACIAS
Por vuestro sacrificio, por vuestros cuidados, por vuestros desvelos, por vuestro cariño, por cuidar de nuestros sueños a costa del vuestro, por vuestra forma de encarar el peligro, por crear milagros de la nada.
Cuando los libros de historia hablen de vuestras hazañas la UME podrá decir orgullosa que en aquella ocasión trabajó al lado de esas personas tan excepcionales. ¡Gracias!
Unidad Militar de Emergencias
Para Servir

No somos héroes, somos profesionales

Villanos

En el momento actual, la asistencia sanitaria se enfrenta a un escenario de praxis diferente al habitual y los profesionales actúan en el marco de una organización sanitaria condicionada por la crisis asistencial derivada de la pandemia y por nuevas regulaciones

Rev Esp Med Legal. 2020;**46(3)**:119-126



NOTICIAS

Los Colegios profesionales se reúnen para dar un #AplausoJurídico en favor del personal sanitario

#AplausoJurídico abogados Covid-19 HumanizandoLaJusticia Medicos

Los colegios profesionales se reúnen para dar un #AplausoJurídico al personal sanitario y defender su exclusión en las demandas de reclamación por los perjuicios sufridos por Covid19. "Ahora mismo se está debatiendo el pase a una situación de más permisividad y relajo social, pero si observamos los datos de ingresados y hospitalizados en UCI o incluso fallecidos, veríamos que estamos todavía peor que cuando se decretó el estado de alarma" ha manifestado el presidente de los médicos madrileños

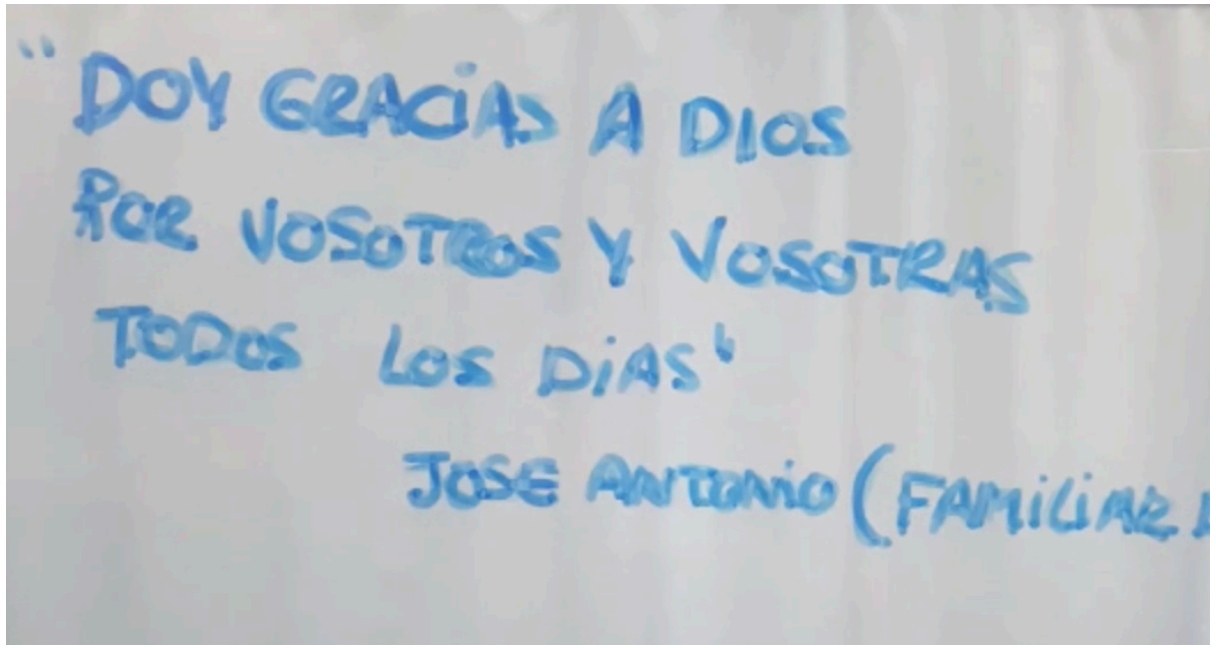
Que se valore **la posibilidad de excluir expresamente de sus reclamaciones a los sanitarios.** Dicha exclusión **no perjudica la viabilidad de la reclamación contra los responsables del hipotético perjuicio causado en su caso**

El alud de causas judiciales salpica ahora a los médicos que afrontaron la pandemia

Los sanitarios se ven abocados a una "segunda batalla" por el covid, esta vez en los juzgados. Advierten de que si hay segunda ola, quizá no se entregarán a derrotarla con tanto arrojo

Conclusiones

- El COVID 19 ha tambaleado el avance en la humanización de la atención sanitaria
- Ha puesto en evidencia la importancia de esta dimensión, incluso por encima de la tecnológica
- Necesidad de trabajar firmemente y de forma multidimensional en asentar los pilares para consolidar estas estrategias
- Ahora y siempre una atención sanitaria con **H**


" DOY GRACIAS A DIOS
POR VOSOTROS Y VOSOTRAS
TODOS LOS DIAS "
JOSE ANTONIO (FAMILIAR