Diaries for Recovery From Critical Illness

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Objective

To assess the effect of a diary versus no diary during a patient’s recovery from admission to the intensive care unit (ICU).

Type of Review

This article is a summary of a Cochrane review of three randomized, controlled trials.

Relevance for Nursing

Annual estimates suggest that more than 20 million patients require treatments in ICUs worldwide to manage critical illnesses, injuries, or exacerbations of chronic conditions. During ICU admission, patients experience extreme physical and psychological stressors, including delirium, fear, lack of privacy, noise, pain, sedation administration, sleep deprivation, and the abnormal ICU environment. These experiences affect a patient’s recovery from critical illness and may result in physical and psychological disorders. The psychological stressors do not go away upon discharge or transfer and may still affect patients when they are under the care of an oncology nurse. One strategy that has been developed and implemented by clinical staff to treat the psychological distress prevalent in patients in the ICU is the use of patient diaries. These provide a background to the cause of the patient’s ICU admission and an ongoing narrative outlining day-to-day changes and a final note on discharge or transfer.

The patient diaries generally are structured with a summary outlining the reason and event of admission to the ICU, daily entries, and the final note on discharge or transfer. Primary authorship is predominantly the responsibility of the bedside ICU nurse. Diaries were authored by a multidisciplinary group of ICU staff with or without member involvement. Some ICUs encourage the participation of the patient’s family, reporting the diaries as a potential focus for family empowerment and family-centered care.

Evidence-based information about the value of diaries will assist the ICU staff in deciding whether to provide diaries for their patients. Although this Cochrane review is of particular interest to nurses employed in an ICU, it still is of value to non-ICU nurses because they may be able to ask about this service if a patient with cancer is admitted or transferred to the ICU. In addition, nurses who are qualified and experienced in the ICU may be asked to work an occasional shift in that unit.

Summary of Key Evidence

Authors stated that because of the small number of studies eligible for inclusion in their review and the diverse outcomes reported, they were not able to undertake a meta-analysis. They identified three eligible studies—two describing patients in the ICU (N = 358) and one describing relatives of patients in the ICU (N = 30). The study involving relatives of patients in the ICU was a sub-study of family members from one of the studies of patients in the ICU. A mixed risk of bias existed within the included studies. Blinding of participants to allocation was not possible, and blinding of the outcome assessment was not adequately achieved or reported. Overall, the quality of the evidence was low to very low. The patient diary intervention was not identical between studies. However, each provided a prospectively prepared, day-to-day description of the participants’ ICU admission.

No studies reported their first primary outcome measure describing the risk of post-traumatic stress disorder (PTSD) in patients recovering from admission to ICU using a structured clinical interview. They applied this definition a priori because the American Psychiatric Association supports it as the gold standard for the diagnosis of PTSD. When attempting to reduce the risk of detection bias in the diagnosis of PTSD, the interviewers were trained in the administration, but not the meaning.