

Treating ICU patients of final stage and dealing with their family

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Abstract

Introduction: Advanced and progressive illness that does not respond in therapeutic interventions, results in various repercussions concerning temperament adaptation of the sick person and his/her family. The patient experiences intense distress with regard to the pain, as well as alienation and isolation while being led to an experience that cannot "be shared" with somebody.

Objective: The study's purpose was to explore the needs of both Intensive Care Unit patients and their relatives.

Methodology: The method of this study included bibliography research from both the review and the research literature. A Medline and a Google search was conducted. Bibliography review was made with key words: "final stage psychological support, ICU patients, quality of life, patient-ICU nurse interaction".

Results: According to the literature, the aim of comforting care provided by the ICU medical and paramedical personnel is about achieving the best possible quality of life for the patients and their families through control of pain, control of symptoms, psychological and intellectual support, support of family and support in bereavement.

Conclusions: Psychological support of final stage patients is based on human rights, human dignity, solidarity and the freedom of choice. Patients' participation in making decisions, family as a part of the care and various intellectual questions should be kept in mind.

Keywords: Final stage psychological support, ICU patients, quality of life, patient-ICU nurse interaction

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Introduction

Intensive care is related to a big rate of mortality varying from one week to another; nevertheless it is focused in 15-20% of ICU patients. In some cases death comes as a sudden and consequent event of an urgent ICU transport, so the patient and family are not given sufficient time to prepare themselves emotionally. In the majority of these cases, death happens as an expected result of staying several days or months in the Unit. Emerging facts in other cases are that the continuation of therapeutic intervention is also disruptive for the patient as well as ineffective or useless¹.

It is widely acceptable that from the moment of decision that additional medical intervention can not help the patient, care priorities change from the nurse point of view. Up to that moment, administration of analgesics and repressive substances could have contributed to the restriction of cardio respiratory side effects and techniques such as suction or physiotherapy were systematically used to cure the patient. However, from the moment the pause or restriction of treatment is decided, then care takes over, constituting a nurse priority. Moreover, fulfilling physiologic and psychological needs of patient should also be a major priority. Analgesics should be administered only up to the point of patients' pain relief and unnecessary interventions such as suction should be limited in order to maintain the patient's comfort²⁻³.

From the nurse point of view, the estimate of pain felt by the patient is proved to be influenced by many variables such as the degree of lung oxygenation, the time stage of ICU stay after the surgery and the patient's ability to communicate⁴⁻⁵. In an environment of intensive treatment, this estimate becomes an exceptionally difficult work, specifically in cases where there is no oral communication between the patient and his/her entourage. In such a case, the nurse has to rely on physiological variables like tachycardia and arterial blood pressure, as well as on psychical estimate of the patient,

for example if he/she shows increased perspiration or alterations on the face. However, in case where the patient is able to communicate, any decisions that have to do with pain alleviation, movements, his/her personal hygiene and comfort should be discussed with him/her. A nurse is supposed to give the patient a sense that he/she makes everything so that he/she can communicate with his relatives as much as possible. However, even then, a bearable level of pain should be maintained, avoiding situations of drowsiness and disorientation that result from excessive quantities of analgesics and repressive substances⁶.

Patient's pain could be alleviated, based on what Tittle and McMillan reported, by using alternative methods. These are: administrating of narcotics and opiates. Dosage depends on age, weight and the patient's hemodynamic state as wells as on his/her clinical side effects; local analgesia; apply of specific physiotherapy equipment known as Transcutaneous Electrical Nerve Stimulator to alleviate pain; cold or hot compresses depending on the circumstance; therapeutic massage; and, personal contact with the nurse⁷.

One the other hand, because of the fact that relatives and friends influence significantly the patient's life - greater influence in patient's last stage of illness- a nurse has to wonder which are the needs of relatives and how they can be handled.

Approaching the family

Firstly, the term "family" includes all those that constitute the sovereign structure of the patient's social support with which he/she maintains important and essential relations⁸. The needs of patients' families have been determined by an abundance of studies⁹⁻¹². Indicatively, the study of Molter in the United States was focused in three main needs of the relatives: to hope, to feel that ICU personnel attend their own patient, and to be informed about the course of their patient's health¹³. On the other hand, in Great Britain, Dyer¹⁴ categorized the needs as they were reported by patients' relatives

who constituted the sample of his research, with the following sequence: a) essential needs - that is to say those related with the patient's entourage of care in the ICU and the effective communication of information between these and the nurses, b) sentimental needs- personal contact and contribution in the treatment of the patient, and c) personal needs -possibilities, that is to say of personal hygiene and comfort of relatives.

Another research, conducted by Leske¹², distinguished five main patient needs: support, comfort, information, directness and reciprocity. It is reasonable not to be able to satisfy all these needs, the knowledge however of what these needs are, will guide our efforts to support the family of our patient in the better possible way.

Many researchers observed that relatives trembling about imminent death of their close person are those who enter the process of an advanced bereavement before even hearing that the situation in patient's health worsens^{12-13,15-17}. A characteristic case is that of relatives of patients with coronary disease. Their sentimental stability is distressed due to an overwhelming lamentation with a sudden and unexpected intake of their relative in a ICU¹⁸.

The question that legitimately results in this point is whether the nurse of an ICU is specially capable of appreciating not only the needs of patients but also those of their relatives. If we wish to offer effective and therapeutic nursing, then and the patients' family should be incorporated in the planning providing care to them, so as to help the relatives to reconcile faster and more effectively with the idea of their patient-relative collapsing and also to promote an odor of familial stability, should something like that is possible¹⁹.

The role of the Nurse

The primary objective of nurses in the ICU should be the creation a calm and gentle entourage, which will be catalytic in order to establish a conscious and supporting relation with the relatives. Often, the sudden intake

of an individual in the ICU, renders his/her relatives incompetent to conceive precisely what has happened due to the initial shock that overwhelms them. In this point the nurse is supposed to help them comprehend the critical situation of the patient providing them at the same time with essential clarifications, using simple vocabulary and avoiding medical or nursing terms. At the same time they have to be reassured that they will be informed immediately about the progression of the situation in the patient's health²⁰.

A main question that arises when things go from bad to worse, is who is the most capable of reporting such news to the relatives. It is recommended that this duty is undertaken from a doctor acquainted to the patient and his family and a member of the ICU nursing personnel who has already acquired an intimate relation with them. The place of discussion should be essentially private for as long as it takes and certainly not close to the ICU chaotic entourage²¹.

Unfortunately, this whole situation destroys the last hope of relatives about the improvement of the patient's health, consequently shocking them and making them to collapse emotionally varying from pain and deep sadness to refusal and anger. A lot of relatives use the refusal as mechanism of reaction as they cannot actually accept the truth. In this case, frequent communication of the nurse is required as well as an open and sincere relation with them as ideal ways of support. Any discussion with them might include elements that will offer help, information and support²².

The use of non-oral means of communication as hearing, physical contact with the relatives and the simple meeting of nurse and relatives in the same location is equally important. Besides, most of the times, silence is a way that speaks and helps by itself²³.

Another issue that should be discussed by the nurse along with the family is whether they wish a little personal time with the patient or they wish supplementary presence of him/her. In case where the

relatives wish to remain alone with the patient, then the nurse should immediately walk away reassuring them however that he/she will be at their disposal as soon as they will ask for him/her²³.

Additionally, the nurse is supposed to know whether the family wishes to be present at the moment the patient dies as well as if they would like the presence of other individuals there, such as a priest. The shift nurse is supposed to channel this information to the ICU nursing personnel, so that the wish of relatives should be satisfied whenever the death of patient befalls²⁴.

Emotional cost for the personnel

The experience of an individual's death is undoubtedly a stress factor for everyone. Glaser and Strauss²⁵ characteristically ascertain that the majority of nurses working in ICUs present unwillingness of contact with patients the moment they die because they have been emotionally tied up during hospitalisation. This reaction is easily interpreted based on what Menzies reported, by determining the relation of nurse - patient as the core of distress and stress that often possesses all nurses²⁶.

The longer this relation lasts the more intense it becomes. Subsequently, the probability of the nurse feeling stressed and weak to face fatality is larger. Sadness, weeping or mourning by relatives are equally stressful factors, and a lot of nurses often avoid contact with them in such moments²⁷⁻²⁹. According to Walsh³⁰, a mechanism of defence widely used is rejecting sympathy to the relatives and maintaining certain distance from them.

In these cases, psychologists available for the personnel in daily base could play a most important role, working inside ICU or inside the hospital in general, functioning as a useful, exterior source of alleviation for nurses and at the same time maintaining their intact right of what is said between them a secret. A spirit of common collaboration and sympathy should be adopted and realised simultaneously because

each member of the ICU personnel can express his/her feelings and share his/her thoughts with the rest (who may even feel the same) only in an atmosphere of confidentiality. Of course, a safety net is essential and supposed to be provided by the supervisors and directors of ICUs to all those that feel subject to stress caused by taking care of patients dying or about to die³¹.

Conclusions

Obviously, the quality of care provided in these individuals will have an enormous impact and effect on their lives, not only during their stay inside ICU, but also during many years after the sad event. The psychological support of ICU patients and their related and friendly entourage is of main importance. It is a main concern of Nursing Science to ensure the fact that the situation these individuals will experience from dealing people and circumstances inside ICU will be as temperate as possible and less painful because of the critical nature these circumstances have.

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