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AN OBSERVATIONAL STUDY ON NURSING CARE OF ICU (INTENSIVE CARE UNIT) PATIENTS

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ABSTRACT

Intensive care units (ICUs) are used to treat seriously ill patients who require cutting-edge medical and technical care. Sometimes concerns are expressed about whether treatment should be withheld or stopped since certain patients do not seem to profit from it. To gain a deeper grasp of what appropriate nursing care entails for these patients, this study used the experiences of ICU nurses. The study design was based on interpretive phenomenology, and focus-group methodology-inspired group interviews were used to gather data. Two groups of the participants were formed, and four interviews were conducted with each group. The Colaizzi model was employed during the analysis. The findings demonstrate how several fundamental elements—continuity, knowledge, competence, and cooperation—were necessary for providing quality nursing care. Clearly defined objectives to provide appropriate end-of-life care or life-saving treatments. Verbal communication and the use of hands by nurses were cornerstones of quality nursing care. In order to improve nurse care for patients on the verge of passing away, the study emphasises several implications for future ICU nursing practise and education.

KEYWORDS - Intensive care units (ICUs), Nursing Care, Patient Care, etc.

INTRODUCTION

Patients who are critically sick are admitted to intensive care units (ICUs) to benefit from cutting-edge medical equipment and nursing care. Despite the ICUs' primary focus on survival and recovery, many patients there also pass away there. According to a record examination, 87% of the 1327 patients during a 12-month period lived to be released from the intensive care unit, while 13% passed away before being transferred to the ward. 79% of the dying patients passed away within 4 hours or less after therapy was stopped or discontinued (Hall and Rocker, 2000). This might mean that occasionally, cutting-edge medicines are used to prolong patients' suffering rather than save their lives. Overtreatment rather than undertreatment is a bigger issue in ICUs, according to Solomon et al. (1993).[1]

Critically sick individuals' deaths will most likely result from the repercussions of non-treatment. But occasionally, people do live after curative treatment has been stopped or discontinued, or after a protracted period of therapy with no apparent improvement. As a result, switching from curative to palliative care is a tough decision that has been found to be complicated by disagreements and delays (Badger, 2005). Patients may get an uneven mixture of medicines when death is imminent and nursing care should be palliative because of conflicting objectives (Scanlon, 2003). Since it has been shown that having defined goals for patient treatment is a need for providing high-quality nursing care, this might have a detrimental impact on nursing care (Chapple, 1999; Hov et al., 2007).[2]

Human autonomy is a basic concept in western society. It follows that seriously sick and dying individuals have the freedom to choose the type of treatment they want (ICN, 2001). However, ICU patients are rarely included in making decisions about their treatment near the end of life (Owens, 2005; Seymour, 2000). Because of the intensity of their sickness, their agony, suffering, or altered level of consciousness, they may be incapable of making sound decisions. Furthermore, it might be difficult to learn firsthand about their preferences for treatment and nursing care due to their incredibly upsetting and perplexing experiences (Bergbom Engeberg, 1991; Russell, 1999) and poor recollection from their time in the intensive care unit.[3]

Although there are differences in the documentation and application of such directive's, advanced directives have been shown to identify the patient's preferences, which may help in goal planning (Kirchhoff et al., 2004).[4]

Studies on end-of-life care in ICUs demonstrate that patients and their loved ones are quite happy with the quality of treatment, but they also point out areas for improvement (Burfitt et al., 1993; Mayer and Kossoff, 1999). (Baker et al., 2000; Beckstrand et al., 2005; Kirchhoff and Beckstrand, 2000). It is crucial to increase nurse understanding on how to give this group of ICU patients the best care possible (Rubenfeld and Curtis, 2006). When the issue of whether to treat patients curatively was brought up, the literature study failed to produce any results pertaining to the patients' needs for nursing care. Therefore, the purpose of this study was to gain a deeper knowledge of what constitutes effective nursing care for these patients in their circumstance.[5]

NEED OF STUDY

There may be a connection between nursing care and the rise in hospital mortality, according to several prior large-scale research. Recent research has demonstrated that factors like as nurse staffing, nursing performance, work environment, and amount of experience all have an individual or combined impact on patients. For instance, it has been discovered that a nurse's performance increases with age and job experience. Based on their expertise from advanced study, nurses with greater education tend to make better judgements on patient care. However, because to an emphasis on individual characteristics, and methodological flaws, the evidence supporting nursing resource for patient outcomes in ICU is still uncertain or inconsistent.

AIM & OBJECTIVES

To evaluate the study on Nursing care in ICU Patients

To evaluate the Role of Nurses in Quality of life of patients

METHODOLOGY

The study's focus group comprised individuals whose acute illness and vulnerability prompted concerns regarding the appropriateness of curative treatment. Data was gathered from ICU nurses' descriptions of their experiences caring for these patients due to methodological and ethical considerations.

Good Nursing Care

Anaesthetists were in charge of the patients' medical care, working closely with physicians from the patients' primary ward. ICU nurses and doctors oversaw the patients' daily treatment and care. Most nursing care was provided on a one-to-one basis (Manthey, 1992). Some patients kept notebooks in which the nurses recorded significant events that occurred while they were receiving ICU care and informed the patients and their loved ones.[6]

A problem in phenomenological research is to produce a study that accurately captures the experiences of the participants rather than the researchers. In this study, objectivity, appropriateness, and auditability are all connected to rigour (Sandelowski, 1986). Several tactics were used to increase credibility. RH performed the interviews, transcribed them, and listened to the recordings multiple times while conducting the data analysis in order to be in intimate contact with the information. The research method was examined through constant conversation among the researchers, getting feedback on the conduct of each interview from the observer, and keeping records throughout the research process in order to prevent "going native" (Sandelowski, 1986).[7]

According to Sandelowski (1986), the fittingness requirement is satisfied when the results of a research are seen as significant and applicable in settings other than the study circumstance. Since the findings were acknowledged and appreciated when given to other nurses, this study's suitability was reaffirmed. Additionally, fittingness concerns the similarity of conclusions and data (Sandelowski, 1986). As a result, the researchers collaborated during the analytic procedure by comparing claims, interpretations.[8]

The nurses emphasised the significance of continuity as being required to make informed decisions and lessen the patient's stress. This was made better by the proper organisation of nursing care, personnel, and rooms. The importance of continuity was highlighted as being demonstrated by the care given to the same patient over time, writing in his or her journal, as well as paperwork and reports.[9]

Cooperation between family members, nurse co-workers, and doctors was considered crucial in order to establish goals as early as possible in order to guarantee the best possible treatment and care for the patients, who were usually unconscious. The nurses also discussed the stress that families experienced while caring for the patient and their need for help to deal with their own circumstances.[10]

It was assumed that nurses had complete knowledge and competence, which was a requirement for making appropriate observations, evaluations, plans, and decisions in daily nursing care. The dedication of nurses was viewed as essential to being vigilant, comprehending patients' needs, and treating patients with respect. As a result, the nurses needed support in order to deal with their grief and provide high-quality treatment.[11]

Patient Misperception

However, the nurses noted that waiting was a remarkable phenomenon for many patients since it frequently took a long period until healing or death happened. The condition for some patients was marked by dramatic shifts. There did not appear to be anything that could divert the patients' focus from their ailments and daily treatment. Particularly for individuals who were just somewhat sedated, time was seen as being lengthy and stressful. To either get their lives back or be permitted to pass away, they were waiting for a turning point. They were also anticipating people; many patients appeared to offer lingering glances to those doctors who visited less frequently after prolonged durations of illness.[12]

It would be impossible for patients to distinguish between one day and another, nights and days, and delusions and realities, for example. Additionally, the patients may find it difficult to distinguish between their bodies, lifestyles, and the machines: It is extremely impersonal, in my opinion. What remains when you are a patient in the ICU and are restrained by all the equipment? Then, it could be challenging to distinguish between the beginning and the end of your body.[13]

Patient Aloneness

Even though family mainly looked after them and a nurse stayed by the patient's bed day and night, from the nurses' perspective, the patients were, as one nurse put it, "very lonely in such a bed." The nurses believed that loneliness frequently followed patients who were extremely sick and dying, and that this loneliness was exacerbated by the patients' infrequent disclosure of their condition. This might occur when the patients tended to withdraw and develop what the nurses referred to as "depressions," which were communicated by their vacant eyes, lack of willpower, or desire to give up, making it difficult for the carers and/or relatives to handle the situation. Even though the nurses said that they did not often discuss the dire scenario with patients who were anticipated to pass away.[14]

Patient Control and Self-respect

Maintaining patients' meaningful relationships and emotions of not being abandoned was the goal of good nursing care for patients who were lonely. Nurses' attendance and promises that they wouldn't leave the patient were evidence that this was confirmed. The nurses emphasised the patient's right to privacy and to not be coerced into communicating with them. However, it was unclear how much information was sufficient and how it would influence the patient. To better understand the patients' desires, use their awake state. It was thought that the patients' withdrawal and depression symptoms were normal reactions to their circumstances. The nurses also discussed how they looked for items the patients were interested in to try to break up the patients' condition of withdrawal.[15]

When a patient was deemed to be receiving excessive care, such as when family wanted the patient to live on for their benefit or certain doctors opted to keep treating terminally ill patients, the nurses believed that the patient's dignity was in jeopardy. The nurses also emphasised how patients' loss of dignity considering physical changes: Every single cell must be forced out, they lay there and like fish on land, and it is so depressing, unworthy, and enormous; swelled.[16]

The nurses explained how they conveyed safety, acceptance, and respect in their care by using their hands. The patients needed to be shielded from contact with those who were not involved in their care. The cleanliness, ventilation, and organisation of the patient's surroundings were considered as contributing to his dignity. Maintaining a patient's autonomy was important for upholding his dignity. This involves providing end-of-life care or life-saving measures for patients for their own benefit. However, since the patient's relatives would still be alive, it was important to strike a balance when the patient and their desires diverged.[17]

ICU PATIENTS CARE BY NURSHING STAFF

1. obtaining clinical information

- obtaining and citing the sources of clinical information,
- introducing oneself to the critical care team,
- using nonverbal communication techniques,
- systematic clinical information collection,
- general nursing knowledge,
- intensive care nursing knowledge,
- maintaining vigilance in dangerous situations
- Patients who damage themselves or others - Patients who are harmed by others
- Hazardous equipment and moving it through the critical care setting.
- Critical care nurses interpreting clinical data. Information about the family and attention to situations.
- Considering the psychological, social, and economic needs of patients' families

2. **Nursing clinical examination**

- collecting, recording, and reporting precise vital signs
- Acquiring the knowledge and abilities required for intrusive observation
- Systematic assessment and holistic nursing
- Gathering information from mechanical ventilators
- Correct clinical data interpretation
- Identification and analysis of unforeseen occurrences
- Making the proper decisions in line with care intervention priorities
- appropriate nurse intervention; timely contact with critical care doctors and other multidisciplinary team members.

3. **Environmental observations**

- Entry and exit of critical care units in relation to environmental cleanliness: Hygiene and cleanliness of the critical care setting
- The freshness, warmth, and humidity of the air
- The organisation and cleanliness of the medical equipment
- Medical equipment accessibility
- Routine check of medical equipment performance

4. **Infection observation**

- Correct patient and staff sample collection
- accurate environmental sampling, and accurate infection assessment
- Identifying infection control elements
- Infection control strategy
- Infection control principles
- Infection control policy formulation
- Solutions to commitment in infection control
- Recognizing risky behaviours in the transmission of infection
- Correct environmental and human sampling in infection management and identifying variables in infection epidemic.
- Identifying hazardous behaviours in transferring infection to you, patients, medical staff, and visitors.

5. **Observation of nervous system**

- Homodynamics
- Non-invasive observations
- Conciseness assessment and observation of level
- Paying attention to words and thought 12 nerve
- Sensory system observation, motor system observation, and non-invasive nerve system observation technology
- Accurate clinical data interpretation and nursing interventions.
- Invasive observation
- Intracranial pressure principles and indicators
- Getting the observational data on intracranial pressure

6. **Observation of cardiovascular system**

- Non-invasive cardiovascular observations
- Accurate electrocardiogram (ECG) acquisition
- Accurate ecg observation
- Non-invasive measurement of cardiac factors
- Observation of the peripheral vascular system
- Non-invasive observation of blood pressure
- Observation of central venous pressure and maintenance of central catheters
- Pulmonary artery catheter maintenance
- Venous artery catheter and getting associated data
- Interpretation of pulmonary artery catheter data
- Controversial instances of pulmonary artery catheter

7. **Observation of pulmonary system**

- Observation of the airway tract, number, and depth of breaching patterns
- signs and symptoms of breathing problems
- assessment of breathing
- accurate clinical data analysis
- nursing intervention.
- Principles of pulse oximetry
- data collection
- non-invasive carbon dioxide observation
- arterial blood gas principles
- advanced breathing observation
- arterial blood gas interpretation
- The principles of oxygen and how it reaches tissues
- Regular testing of arterial blood gases;
- Findings of exhalation in ventilator data
- an introduction to the idea of pulmonary function testing in critical care nursing
- an analysis of the data, and nursing intervention

8. **Observation of analgesia, sedative and muscle relaxant in critical care unites**

- Acute pain treatment principles
- pain intensity assessment
- data analysis
- appropriate nursing intervention
- Sedative principles in critically sick patients
- Sedative levels classification
- Data analysis
- Appropriate nursing intervention
- Muscle relaxant principles in intensive care units
- Classification of muscle relaxant levels
- Data analysis
- Appropriate nurse intervention

9. **Nutritional observation**

- Principles of nutrition in critically ill patients
- nutritional evaluation in critical care units
- nutritional assessment factors
- types of nutrition and feeding techniques in a critical care environment

10. **Laboratory and radiography skills**

- Correct and methodical sampling
- radiography types for critically sick patients
- preparing medical equipment for patient transfer
- data analysis
- appropriate nurse intervention

DISCUSSION

The four themes that the nurses identified as capturing the patients' predicament were "Waiting in perplexity," "Exhaustion in agony," "Loneliness," and "Loss of control and dignity." Even though it was occasionally challenging to provide appropriate nursing care since it depended on a number of factors, the nurses believed they knew what it included.[18]

It took consistency in nursing care, nurses' knowledge, competence, and cooperation to provide effective nursing care for this group of patients. These results are consistent with several previous research that stress the value of collaboration between medical experts, family members, and patients wherever feasible (Coombs and Ersser, 2004; Heyland et al., 2000; Hov et al., 2007; Kirchhoff and Beckstrand, 2000). Even though studies constantly point out suggestions for changes, it seems that ICU nurses still must deal with patients who suffer as a result of ineffective systems.[19]

It has been demonstrated that verbal interaction with patients reduces delay and confusion. Other investigations have backed up these advantages of verbal contact with uncon- scious and/or critically sick individuals (Elliott and Wright, 1999; Margarey and McCutcheon, 2005). It has also been demonstrated that these individuals may find a conversation unpleasant if they are not involved (Holland et al., 1997). In the current study, nurses also spoke with patients to reassure them that they were not alone. The assumption is that loneliness is an ontological element in human existence.[20]

however, when someone has a strong sense of abandonment, it might be accompanied by anguish (Nilsson et al., 2006). Iatrogenic pain is the term for the loneliness that can be caused by inadequate communication between patients and medical staff while they are severely sick or dying (Kuhl, 2002). This may have happened in this study because the patients were rarely asked about their circumstances. According to McClement and Degner (1995), nurses' dread of dying or of being exposed to unpleasant emotions may be the root of their failure to communicate with patients who are dying. The results of this study demonstrate that nurses had trouble determining whether to speak with a patient because they tended to display indications of despair.[21]

They remained silent while the staff emphasised the proper time of communicating, such as to maintain optimism. This is consistent with results indicating the degree of attentiveness of patients affected how nurses interacted with them (Alasad and Ahmad, 2005). In the study described here, the patients could have suffered iatrogenic injury as a result of the nurses' silence. The nurses' attention to corpses was one notable discovery. This is hardly unexpected considering that nursing traditionally has been concerned with bodies, both the bodies of the patients and the nurses themselves as the sites of that work (Short, 1997).[22]

The nurses' emphasis on dealing with patients' bodies as essential to their everyday patient care was noteworthy, despite claims that nurses have been excluded from that line of work (Sandelowski, 2002). Additionally, the nurses were aware of how the patient's body worked and how it could recall, see, hear, and feel. These stand in contrast to the Cartesian and medical views, which separate the body from the mind and consider it as a physical object like a machine (Lawler, 1997; Parker, 1997). The nurses in this study revealed a concept of the body that is consistent with the phenomenological idea, even if an objectifying and technologizing of the body may be anticipated given that it was combined with a high-tech setting (van der Riet, 1997).[23]

The nurses discussed how they utilised their senses to read patients' physiological experiences, their demands for intensive and "trifling" nursing care, and whether their acts had the intended consequences. This might be contrasted with Lawler (1996)'s call for a somological approach to nursing practise, which offers a unified viewpoint of the experienced lived body and the object body. To provide competent care, nurses must use their hands in a variety of ways and alternate between objects and subjects. Since nurses have knowledge, experience, skills, and attitudes, their hands can be therapeutic and caring, as opposed to nurses' inexperienced and uncertain hands, which run the risk of missing important information and cause the patient stress and problematic feelings. Touch can be seen as the primordial medium to overcome separation and relational distance (van Manen, 1999). To provide effective nursing care to the patients who were the subject of this study, a comprehensive understanding of touch is essential.[24]

CONCLUSION

Good nursing care for ICU patients on the verge of death depends on nurses' comprehension of each patient's incredibly complicated and distressing circumstance. Continuity, knowledge, competence, and teamwork are just a few of the fundamental requirements for providing quality nursing care, which also includes clear objectives to provide life-saving or end-of-life treatment and care in a timely and efficient way. The use of hands to focus on patients' bodies as objects and subjects and vocal communication between nurses are essential components of successful nursing care. This study supports the notion that ICU nurses are essential personnel for maintaining compassion toward ICU patients who are near death. ICU nurses must have extensive training in touch and in having "the uncomfortable" conversations with terminally sick and very ill patients in order to manage this. ICU nurses should be sufficiently prepared to handle medical and technological obstacles without being prevented from providing comprehensive nursing care. ICU nurses should be encouraged to have conversations about nursing practise that are relevant to the humanistic essence of nursing in order to prevent viewpoint displacement.

FUTURE APPROACH ABOUT NURSING CARE

When the decision is made to withhold or remove curative therapy from the patients, it may be beneficial to do further study that focuses on the status of the families and their care-giving requirements. Given that nurses' experiences with caring for these patients are known (Hov et al., 2007), it is crucial to learn more about how teamwork and collaboration have grown in ICUs in relation to circumstances like these. Research on how ICU nurses communicate with critically sick patients through their bodies might be beneficial.

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