A walk around the ICU: Important aspects of coronary patients during their stay at the Intensive Care Unit

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From a millimetric obstruction to a great problem
Nowadays Ischemic Cardiopathy is one of the main pathologies worldwide. It is a problem with top priority in Western society. Historically, its study is broken down into three main categories: heart attack, angina pectoris and Ischemic Chronic Cardiopathy. Recently, at the proposal of a committee of the European Society of Cardiology and the American College of Cardiology, there has been a change in the definition of Heart attack (IAM). This fact has been a source of controversy and scepticism among Spanish cardiologists [1]. In any case, apart from the difficulties when establishing definitions, the two first categories, that is, IAM and Angina pectoris are those which compose the acute form of the coronary illnesses or SCA (Acute coronary syndrome). The origin of both lies in a occlusive and millimetric problem on the coronary arteria which might have serious consequences on the functioning of the rest of the organism.

In Spain, according to data from 2002, mortality due to cardiovascular illnesses remained as the first cause of death, representing approximately 34% of deceases [2]. In Andalucia data are similar to those from the rest of the country. Despite this fact, in recent years there has been an outstanding improvement regarding mortality in hospital. This is mainly due to the introduction of coronary units and to the widely use of aspirins, fibrinolithic and coronary interventions [3,4].

The seriousness of a coronary illness makes patients require attention in Intensive Care Unit (ICU) where the acutest part of the process is dealt with. The speed in detecting the set of symptoms and the beginning of the treatment is a top priority in this moment.

Due to several causes, not all patients benefit from this care. Although the frequency with which patients with IAM are not admitted in ICU it is not exactly known, it is considered that in Spain it fluctuates between 11% and 35% [5]. From this data we learn that a vast majority of patients who suffer a coronary illness enjoy what we will call a walk around the ICU. It is a walk that can be considered from several points of view, depending on how we attend on either the physio-pathological process or to the emotions, sensations and experiences lived by patients or their families.

In Andalucia, the Intensive Care Unit Services are integrated into the Critic Care and Emergency Services (SCCU). They are a central service of the hospital which includes several areas whose central point of organisation is the gradation of the assistance according to the seriousness of the patient’s condition and the health care intensity. This creates a multidisciplinary atmosphere. As in every medical unit, a good operation depends on the appropriate technical qualities and on the humaneness of its staff.

Several documents have highlight the necessary training and responsibility that infirmary staff of Coronary Care Unit requires in order to solve promptly potential extreme situations [6]. The nurses must apply their knowledge and skills so that they are able to interpret the most common arrhythmias and be accurate at decision-making when facing serious situations. These decisions might be the resuscitation and the defibrillation.

It is also worth to point out how necessary it is nurses’ ability to give patients and their families psychological support during crisis periods.

The most usual ratio nurse/number of beds in the ICU is 1/2-3 by shift, although temporarily ratio can be 1/1, particularly in patients with unstable hemodynamics and artificial respiration.
Walk around the ICU

The patients usually stay in the ICU about three days [7]. During this time some important problems may appear and endanger patient’s security.

Pain usually is one of the first signs that the nurse must deal with [8]. The pain may be evident in different ways, it may turn up accompanied with a sensation of nervous tension and vagal symptoms such as diaphoresis, nauseating, etc [9].

Physical assessment, observation and health care are the beginning of the process. At the same time, the appropriate actions must be carried out in order to rectify the artery obstruction and the lack of blood flow to the heart. An adequate treatment must be applied and the patient must be prepared in case he/she should undergo some type of coronary operation.

Hemodynamic complications that might arise, bloodshed or peripheral perfusion defects are the basis of health care. We must not forget, though, responses as pain or discomfort, lack of information, self-help mechanisms and the effects feeling menaced by the atmosphere of the place [10].

Any studies have revealed that the necessities of breathing, security, realization, mobility and learning get altered in this kind of patients. This makes them require special health care. This care may increase if there appear frequent complications as mentioned above, as well as responses related to the fact that the patient feels menaced by the atmosphere of the place. Emotions, knowledge impairment and health risks are also factors that may create the necessity of more care.

The high use of technology in health care together with the important technological advances achieved in ICU, contributes to create a narrow vision of the patients by the nursing staff. This fact can lead to an excessive stress on certain aspects related with the pathology rather than with the patient own experience.

Patients who suffer from Ischemic Cardiopaty might be misled by false beliefs regarding their illness that might negatively determine their experience. These misconceptions arise in the context of a special unit with strict rules and movement limiter.

These kinds of units have proved their effectiveness when treating this kind of pathology, specially with regard to its acute stage. However, once the technical part of the problem has been overcome, one should wonder if certain gaps could be solved by dealing with other more existential aspects of the patient.

Patients’ expectations

Several qualitative studies based on interviews to patients who now suffer or have suffered some of the conditions mentioned above have served as a base to establish the patients expectations toward the Health System. This analysis appears to be very useful to evaluate the Health System service and quality. It also serves to draw up a plan to satisfy their demands.

The Cardiopaty Attention Plan of Andalucia takes into account the patient expectations in order to promote a continuous evaluation of the assistance quality. By means of analysis of the content and discourse, the information obtained has been categorised into 8 variables of quality perceived: tangibility, accessibility, ability to reply, politeness, understanding, communication, competence and confidence.

These expectations should be taken into account. They are related to the stay at the ICU as the offed below:

- Reduce the waiting time at the Emergency Department to be admitted in the ICU as soon as possible, where they will feel safer and better cared.
- A better coordination among the different care levels and health centres.
- An adequate technology in every health centre which intervenes in the different stages of the process, so that patients are well attended.
- To address patients in a pleasant and humane way in every point of the process.
- The nursing staff, having a technical qualification, should care for the patients as people rather than only thinking in terms of 'sick person' and his/her symptoms.
- The health staff should be careful and considerate when expressing their opinions and comments. They must try not to talk in the presence of the patient as if he/she were not there.
- The health staff should show understanding of the patients’ problems and put themselves in their position.
- Doctors and nurses should explain their malady in detail as well as the treatment that they are
going to receive, the health-care that will be needed and the repercussions and risks that the illness might provoke.

- Information given to the patient must be the same given to his/her family
- Contradictory information about special treatment must not be passed
- More information should be received (both oral and written) about the devices implanted to the patient, for instance defibrillators and pacemakers.
- It is advisable for the patient to talk to his/her doctor about subjects of which he/she is worried about, including sex.
- It is advisable to prepare material as books or information leaflets about healthy habits and care that patients might need in the future.
- Relatives should get feedback in the first hours of care until the patient get stable; at least each 3 hours during the patient stay at ICU and Observation Unit.
- Health staff should pay more attention to the families, talking to them taking some time, providing them with information, attending their needs.
- Health staff should appreciate the role of the family when caring for the patient.
- It should be considered the possibility that a member of the family accompanied the patient to ICU.
- Health staff should do their best so that the relatives feel comfortable, especially those who stay a long time with the patient: toilets for relatives, a place to keep all their personal belongings, a comfortable seat, a cafeteria opened 24 hours or at least coffee machines for the night.
- Psychological support for patients and their partners to face and adapt themselves to the new situation (Acute Myocardial Infarction –AMI–, pacemaker, defibrillator, etc) and to get the best life span.
- Constant presence of a person in the sickbay to whom one can address at any time.
- Centres organisation (meal, moves, etc) should be meant to provide a service to the patient and must not be based on the interests of the centre or its stuff.
- The quality of the food served at hospitals must be improved. Meals must be adapted to each patient and it is also important that it is still at an appropriate temperature when it gets to the room.
- More comfortable rooms
- Patients should be resting by night and it is not advisable to wake them up at 6 AM to measure his/her temperature.
- Room cleanliness should be overseen very carefully

Up to this point one may observe that, on the one hand, satisfactory results can be appreciated in regard to the decrease in mortality and morbidity related with these types of pathologies. On the other hand, one finds that sometimes patients feel a lack of attention in regard to aspects that they feel important for them. It is worth considering how the Health System might be overlooking certain aspects and experiences of the patient and his/her relatives through their stay at the ICU.

Several emotional signs as anxiety or fear are very common in these patients. Nurses are aware of that, as they include in their care plans diagnosis as the following:

- Deficient knowledge about the illness, self-care and therapeutic diet
- Deterioration of the adaptation
- Fear to the change produced by the new health state
- Risk to low self-esteem

It is also true that nurses tackle the health problems depending on the level of attention [11]

- Thoracic pain
- Activity intolerance
- Infection risk
- Constipation risk

**Another approach**

As in every aspect of life, adaptive responses to face this frequently unexpected crisis vary depending on the resources of each individual to confront the situation. Researches developed in order to investigate on these responses prove that patients in these units often live numerous negative situations, but these appear isolated and sometimes are even assumed as usual, as they take place in a very technical context which is favourable to dehumanize the health care. Despite the negative feelings, this gives cause for evaluations that use to be positive. Even it inspires confidence on them.

These responses vary depending on whether it is their first experience with this coronary illness or they have already experimented similar situations in the past.
With regards to patients in a first ACS (Acute Coronary Syndrome) episode one may notice that there is a great variability of responses which covers from a complete playing down of the symptoms to the perception of a prompt death or a future disability. These responses use to be consequences of the lack of information about the process in which the patient is involved.

On the one hand, the responses of those patients who have already experienced these kinds of situations will be influenced depending on whether their experience has been positive or negative. Those who had had a negative experience will speak of fear and anxiety. This would be caused by their own memories or even by the death of a close relative. On the other hand, those patients whose experience has been positive will feel that this unit is trustworthy and safe.

Some patients with medical antecedents raise doubts about the treatment they had received, as they have suffered later episodes despite having followed therapeutic advice and having changed their habits.

Regardless of whether we are dealing or not with the first experience of a coronary illness, some authors underline 2 main categories after their stay at the ICU: sensations lived by the patients at the moment of their admission into ICU, when they use to underline that they do not get much feedback [2]; as well as the sensations lived during the first stay at the ICU, feelings of frustration, despondency, injustice, fear, etc. [12].

At the moment of the admission contradictory situations may take place. Very often sensations of worrying, seriousness and fear of a prompt death are mixed together. However, some patients describe sensations of confidence, peace perceived by the technical atmosphere of the scene and the presence of professional stuff [13].

During the stay at the ICU responses become more calm and seem to have been thought over. Patients have more time to observe and reflect on what happens around them. This gives to them cause for thinking over many aspects of their lives. They show fear for becoming disabled and about the possibility of becoming a burden to their families. Loneliness, despondency and fear often assail them. After some time after their admission, due to the absence of pain sensation and to a hint of improvement, one may notice how in some cases there are doubts about the seriousness of the incident. Before this sensation of overcoming the problem, the patient feels the need to amuse himself and fancies the presence of relatives and even asks for moving to a room.

During this period they may express boredom and a sensation described by some as “a crocodile lying in wait under water” [14], keeping an eye on every movement around them. They become onlookers of everything that happens. This sometimes leads them to appreciate the stuff work but it also leads them sometimes to increase the sensation of fear and insecurity. This is influenced by some behaviours observed by the critical state of other patients around them.

The request of more time to spend with relatives to relieve the lack of connection with the scene may lead to question the visiting policy in these types of unities, which is still very restrictive with no apparent justification.

After the critical phase, the feeling of improvement provokes better spirits. However, there are certain aspects as the sudden appearance of the malady which makes one to keep an attitude of continuous surveillance.

Subjects as death, sexuality, obstacles to keep the same lifestyle as before the illness uses to be left out to be dealt with later.

During the process in general, 3 of the categories already mentioned (pain perception, how the patients experience the illness, and provide with information) are crucial and must be analysed by the professional stuff in the ICU, as it will have repercussions on the process of hospitalization and rehabilitation.

Despite the shortages in certain aspects of the health care, patients show themselves in general satisfied with the attention received and they appreciate due to the procedure deployed for them that they are considered a priority. However, they also express their doubts which were not resolved by the professionals who attended them. This shows the need of facing the health education in special units as a priority [15].

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