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ORIGINAL ARTICLE

Critical care nurses and relatives of elderly patients in intensive care unit — Ambivalent interaction

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Summary
Objective: The objective was to explore the experiences of CCNs in relation to relatives of elderly patients 80 years and older admitted to ICU.
Design and setting: Through methods grounded in phenomenology, six CCNs were purposefully selected for their experiences with relatives of elderly patients admitted to an ICU in Norway. Each CCN participated in semi-structured personal interviews. Using content analysis, interviews were coded and categories and themes were identified.
Findings: An overall theme emerged: ''CCNs ambivalent interactive struggle with the relatives of elderly patients'', which reflected the mixed feelings that CCNs recalled having towards relatives. Two themes emerged during the analysis. These were: ''relatives are a resource for CCNs and the patient''; and ''relatives are seen as challenge''. Six sub-themes were identified: (1) CCNs are relying on relatives, (2) relatives and their understanding of the situation, (3) relatives are committed, (4) relatives have high expectations, (5) relatives can be seen as burden and (6) relatives with cultural differences are a challenge.
Conclusion: CCN's experiences with the relatives of elderly patients in ICU represent a significant personal, mixed struggle.
Relevance to clinical practice: The findings indicate that development of communication, education, reflection and a more structured organization of intensive care unit can improve results for CCNs and may improve the possibilities for CCNs to promote an excellent family nursing for the elderly patient and his relatives.

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Implications for clinical practice

- Critical care nurses need to understand their crucial role in meeting the needs of relatives of elderly patients.
- CCNs need to reflect on how to interact with relatives of elderly patients in ICU settings.
- There is an urgent need to have more focus on family nursing education for CCNs.
- There is also a need for transcultural nursing, and this is a positive practice worth striving towards.

Introduction

The number of patients aged 80 years and older admitted to the intensive care unit (ICU) has increased during the past decade. By 2050, people aged 80 years and older will represent 9.6% of the populations in Europe, 9% in North America, 6.5% in Oceania, 5.5% in Latin America and Caribbean, 4.4% in Asia and 1.1% in Africa (UN: World Population Ageing, 2009). In Norway, the number of elderly over 80 years will increase markedly. According to Statistics Norway (2011) the population 80 years and older will more than double from 221.153 (4.5%) on 1 January 2011 to 450.719 (7.1%) person by the year 2040. We are thus facing an increase in demand for health-care services, both in terms of number of beds and number of healthcare workers, including ICU.

A large cohort study from Australia and New Zealand reported that by 2050 the rate of patients aged 80 years and over admitted to ICU will increase by 72% representing roughly 1in 4 admissions to ICU (Bagshaw et al., 2009), and that among 120.123 admissions to 57 ICUs, 13% were patients over 80 years, showing an annual ICU admission increase of 5.6% per year (Bagshaw et al., 2009). In a recent retrospective observational study, Fuchs et al. (2012) showed that the proportion of elderly is high. They found that 45% of ICU patients were over age 65; 10.35% were age 85 years and over. These findings show that the elderly 80 years and over constitute a great proportion of ICU admission. This growth is projected to continue and will have important implications on health resources in terms of triage, decision-making and expansion of ICU capacity and care.

Furthermore the admission of patients 80 years and over in the ICU and their long length of stay generate a tremendously high level of emotional stress and pressure for both the patients and the relatives (Ågård and Harder, 2007; Chaboyer et al., 2005; Hupcey and Penrod, 2000; Williams, 2005). Admission to ICU often comes with no warning and the unfamiliar environment has a significant impact on family function, creates emotional upset and causes considerable stress among relatives.

Relatives of patients 80 years and over in ICU experience emotional challenges and uncertainty. They perceive the admission of their loved ones to an ICU as a crisis that often manifests itself in the form of shock, helplessness, anger, stress, emotional pain, disbelief, confusion, anxiety, guilt, despair, depression (Azoulay et al., 2005; Davidson et al., 2007; Davidson, 2009; Heyland et al., 2002; Holden et al., 2002; Johansson et al., 2002; Linnarsson et al., 2010; McAdam and Puntillo, 2009; Neabel et al., 2000; Olsen et al., 2009; Paul and Rattray, 2008; Pillai et al., 2010; Verhaeghe et al., 2005; Williams, 2005). Similar findings have been reported in previous studies from United States (Anderson et al., 2008), France (Azoulay et al., 2005; Kentish-Barnes et al., 2009; Pochard et al., 2005), Iran (Hosseinrezaei et al., 2014). Critical Care Nurses (CCNs) thus have to be concerned not only with the patients' health status, but also with the well-being and psychosocial needs of relatives.

Having critically ill patients in ICU remains an extremely stressful life event and difficult experience for relatives (Frid et al., 2007) because many relatives of elderly patients feel vulnerable and powerless when loved ones suddenly get critically ill. Studies in ICU have shown that the majority of relatives report severe symptoms of anxiety and depression (Fumis and Deheinzelin, 2009; Siegel et al., 2008). Earlier studies for American hospitals have reported anxiety symptoms in 10—42% and depression symptoms in 16—35% of relatives of critically ill patients (Anderson et al., 2008). A similar French study reported a higher prevalence, 73% of relatives had anxiety symptoms and 35% depression symptoms (Pillai et al., 2006, 2010). It has also been reported that family members who were more involved in decision-making were more likely to have posttraumatic stress symptoms 3 months later (Azoulay et al., 2005). Gries et al. (2010) found significantly more symptoms of posttraumatic stress disorder (PTSD) and depression (prevalence, 14% and 18%, respectively) in family members 6 months after a loved one's death in the ICU. Siegel et al. (2008) found that even up to 12 months after ICU experience, one third of family members who lost a loved one in the ICU were still experiencing complicated anxiety disorder and major depression.

Previous studies have shown that patients aged 80 years and older were less likely to receive the recommended medical care and intervention care such as thrombolysis and percutaneous coronary intervention when admitted to ICU with an acute myocardial infarction (Schoenenberger et al., 2008). In a recent study, Rodriguez-Molinero et al. (2010) showed that the decision to admit an elderly patient to the ICU was essentially based on age and the physician's estimation of functional and mental status.

There also are differences between young and old in terms of intensity of treatment in the ICU provided (Schoenenberger et al., 2008) which cause a great ethical challenge for nurses, doctors and relatives. A retrospective cohort Norwegian study comparing ICU patients between 50 and 79.9 years with patients over 80 years registered in the Norwegian Intensive Care Register from 2006 to 2009 showed that the elderly received less mechanical support (40% versus 56.1%) (Andersen and Kvåle, 2012). A recent observational French study, conducted in 15 Emergency Departments between 2004—2006, by Garrouste-Orgeas et al. (2006) found out that patients aged 80 years or over were often refused ICU admission. According to Nguyen et al. (2010) the elderly were likely to have a longer prehospital delay than younger patients. In a Swedish retrospective cohort study Brandberg et al. (2013) reported that