



Case Study

The impact of hospitalisation on a visiting family member: A case study and discussion



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ABSTRACT

Evidence suggests that when an immediate family member of a spouse is hospitalised, the partner's risk of death significantly increases. Hospitalisation can represent a time of great vulnerability and imposed stress for both the patient and their family members. Family members have been reported to give priority to the welfare of their ill relative and in their heightened emotional state, often adversely put their own health at risk. The paper presents a case study highlighting how an intensive care hospitalisation and discharge to rehabilitation experience for a patient's mother triggered an episode of myocardial infarction for her adult son. Discussion focuses on the caregiving burden and potential mechanisms for how hospitalisation may contribute to the health risk of immediate family members of hospitalised patients. Discussion also highlights the importance of family members receiving clear, continuous and consistent information from a limited number of clinicians to help reduce the stress associated with caregiving during acute hospitalisation.

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1. Introduction

Hospitalisation represents a time of great vulnerability and imposed stress to both the patient and their family member.¹ A landmark study published in 2006 by the Harvard Medical School highlighted the interconnectedness of people's health in that the health of one person influences the health of another.² In this study, 518,240 couples who were enrolled in Medicare in 1993 were assessed for hospitalisations and deaths using Cox regression analysis and fixed-effects methods, during a nine year follow-up. This study reported that when an immediate family member of a spouse is hospitalised, the partner's risk of death significantly increases and remains elevated for up to two years, although the period of greatest risk appears within 30 days of the spouse's hospitalisation.² Interestingly, from this study, hospitalisation alone of a partner can

confer almost as much mortality risk to the other partner (spouse) within the first 30 days as that observed if the hospitalised partner had actually died.²

Family members in a heightened emotional state have been reported to give priority to the welfare of their ill relative, thereby often adversely putting their own health at risk.¹ Fear of death, uncertainties related to the prognosis and treatment, emotional conflicts, concerns about financial conditions, and changes of roles and disruption of routine and family bonds can cause family members to experience negative symptoms of anxiety and depression after a family member becomes ill.³ Studies from the intensive care environment have shown that family members who adopt the role of informal caregiver for their hospitalised relative are at an increased risk of psychological morbidity, including symptoms of anxiety, depression and post-traumatic stress symptoms.^{4,5} This cluster of family complications in response to critical illness, which is collectively termed "post-intensive care syndrome-family",⁴ contributes to secondary social stressors, including burden and lifestyle interference.⁶

The following case study exemplifies the potential impact of hospitalisation of a close family member on an individual admitted to an acute tertiary referral hospital following myocardial

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infarction (MI), where symptom onset occurred while he was visiting his hospitalised mother at a local district hospital. Informed written consent was obtained from the patient for inclusion in the study and ethical approval was obtained from the Northern Sydney Local Health District Human Research Ethics Committee.

2. Case history

A 59-year-old man (John, not his real name) experienced the sudden onset of central crushing chest pain and clamminess during a visit to his hospitalised mother in a local district hospital. John was transferred to the emergency department where an electrocardiograph showed inferolateral ST elevation and anterior ST depression, consistent with an acute coronary occlusion. He was treated with dual antiplatelet therapy and transferred to a tertiary referral centre for a coronary angiogram. Coronary angiography revealed mid-right coronary artery plaque rupture and occlusion of the posterior left ventricular branch. An intracoronary stent was inserted without complication and John has had no further cardiac problem.

2.1. Chronic risk factors

John is caucasian, married, university educated and at the time of MI, a retired manager. He reported a sedentary lifestyle with a BMI of 35 and a history of hypertension. He reported no family history of cardiovascular disease (CVD), and no previous episodes of angina or MI. He also reported being compliant with prescribed anti-hypertensive medication, which he had taken 6 h prior to MI.

2.2. Caregiving challenges prior to myocardial infarction

Three weeks prior to experiencing his MI, John reported experiencing significant stressors attributed to his 98-year-old mother's post-surgical complications for a fractured hip. He stated that his mother '*medically deteriorated*' due to post-surgical complications in the Intensive Care Unit (ICU) and felt that her care was '*rushed* [and that she was] *pushed out of the acute ward to make space*'. As one of 4 siblings, he had taken on the role of informal caregiver for his mother during her hospitalisation, and expressed sustained mild anger in his numerous interactions with his siblings. On the day of his MI, he reported experiencing '*moderate anger*' in the 5 h prior, although the causative factor for this was not volunteered by the patient. He did however report that he had also expressed frustration with the hospital staff for the lack of information regarding the recovery and future discharge of his mother.

John's primary residence was 65 km from the rehabilitation unit where his mother was hospitalised. On the morning of his MI, he awoke at 6 am, commuted by bus and train, a trip of almost 3 h in duration, during which he reported feeling '*irritation*' with the crowded train commute. Having skipped his usual breakfast due to his anticipated long commute, he drank coffee at the rehabilitation hospital while his mother was being showered by the assigned nurse. On this day of his MI, he expressed feeling tense, irritated and actively worried with his mother's rehabilitation progress stating that it had been '*a stressful time caring for [his] mother after her admission three weeks ago*'. He attributed his heart attack to the '*build-up of stressful events*' and the experience of negative '*emotions*'. These stressful events involved two differing hospital settings beginning with ICU and ending in the rehabilitation unit.

John reported multiple caregiving responsibilities with his mother, his siblings, and his immediate family, including his wife and two unemployed adult children. The recent acute stressor of his mother's complicated hospitalised recovery (additionally impacted by her worsening dementia), coupled with his sense of shared duty of care with his siblings was in addition to 5 years of chronic stress

related to his children's unemployment. The patient reported having to relinquish significant aspects of his family life by opting to stay at and manage his mother's house three times per week during her hospitalisation which separated him from his wife (a potential support system), and influenced his resort to eating '*quick meals*' and experiencing '*interrupted sleep*' (attributed to stated feelings of worry). Hospitalisation of his mother therefore created a break in his personal everyday family life relationships and activities.

3. Discussion

As exemplified in this case study, the hospitalisation experience for a patient's significant family member can be perceived as a trigger for an acute health episode. A '*difficult disruption*' was the expression used by the family member to describe his experiences with the caring and visiting of his hospitalised mother. He had modified his family life, responsibilities and lifestyle factors including diet and sleep, in order to prioritise his mother's care needs. Her unexpected medical complications, which resulted in admission to ICU and her transition to a rehabilitation unit, triggered emotional distress and numerous health impacting behaviour changes. John's experience of new acute stressors related to the impact of the hospitalisation on his mother's health and recovery, coupled with his existing chronic risk factor of hypertension and his ongoing emotional stress with his mother's previous diagnosed dementia, collectively increased his risk for acute coronary syndrome.

Allostatic load is the term coined to define the load or total burden of multiple stressors,⁷ such as those experienced by family members who take on the role of informal caregivers for hospitalised relatives. A large allostatic load is a potential mechanism linking caregiving to adverse health outcomes.⁸ Studies have shown that as the needs of families are addressed and ameliorated, better outcomes result for patients and the family system.^{9,10}

Symptoms of anxiety, anger and depression impacted by the hospitalisation of a relative, may trigger adverse cardiovascular events.^{11,12} Higher levels of stress, hostility, and depressive symptoms are associated with significantly increased risk of incident stroke or transient ischaemic attacks in middle-aged and older adults.¹³ Psychological stress can elicit measurable changes in sympathetic-parasympathetic balance and the tone of the hypothalamic-pituitary-adrenal axis, which can negatively affect the cardiovascular system both acutely—by precipitating myocardial infarction, left-ventricular dysfunction, or dysrhythmia; and chronically—by accelerating the atherosclerotic process.¹⁴ The prevalence of takotsubo cardiomyopathy, the "broken heart syndrome" in patients clinically presenting with a supposed MI is typically observed in the wake of intense emotional stress, whereby a spill over of stress hormones seems to literally stun the myocardium.¹⁵ In this case study, the family member's experience of the hospitalisation of his mother culminated in his suffering a MI. His MI now becomes an impacting factor on his long-term future health that will require lifestyle modification and lifelong medication.

3.1. Caregiving burden and cardiovascular disease

Caregiver burden is a term used to describe the load resulting from a person adopting a caregiver role.¹⁶ It has been associated with an increased risk for the development of CVD^{17,18} and raised overall mortality risk over a 4 year period.¹⁹ The mechanisms through which this associated increased risk is conferred remain to be established¹⁶ however increased emotional stress, suboptimal self-care and an adverse CVD profile due to poor health behaviour are potential mechanisms linking caregiving to CVD.^{20,21}

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