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Meeting the challenge: ICU-nurses' experiences of lightly sedated patients

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ABSTRACT

Background: Sedation of intensive care patients is necessary for comfort and to implement appropriate treatment. The trend of sedation has gone from deep to light sedation. The topic is of interest to intensive care nursing because patients are generally more awake, which requires a different clinical approach than caring for deeply sedated patients.
Purpose: The aim of this study was to describe intensive care unit (ICU) nurses experiences of caring for patients who are lightly sedated during mechanical ventilation.
Methods: A qualitative approach was used. Semi-structured interviews with nine intensive care nurses were conducted. The interview texts were subjected to qualitative content analysis, resulting in the formulation of one main category and six sub-categories.
Findings: The nurses' experience of lightly sedated patients was described as a challenge requiring knowledge and experience. The ability to communicate with the lightly sedated patient is perceived as important for ICU nurses. Individualised nursing care respecting the patients' integrity, involvement and participation are goals in intensive care, but might be easier to achieve when the patients are lightly sedated.
Conclusion: The results reinforce the importance of communication in nursing care. It is difficult however to create an inter-personal relationship, encourage patient involvement, and maintain communication with deeply sedated patients. When patients are lightly sedated, the nurses are able to communicate, establish a relationship and provide individualised care. This is a challenge requiring expertise and patience from the nurses. Accomplishing this increases the nurses satisfaction with their care. The positive outcome for the patients is that their experience of their stay in the ICU might become less traumatic.

Introduction

Sedation of intensive care patients is necessary for comfort, to provide relief from anxiety and pain and to implement appropriate treatment, e.g. mechanical ventilation (MV).[1] Recently there has been a trend towards using lighter levels of sedation in the management of intensive care patient[2–5] because there is increasing evidence to suggest negative patient consequence of deep sedation including severe agitation, anxiety, stress, delirium, fear and inability to communicate.[5–8] Deeply sedated patients have prolonged hospital stay which might increase the risk of complications such as ventilator associated pneumonia.[3,9] Several clinical practice strategies may negate the routine use of deep sedation including use of modern ventilators that more readily accommodate patient interaction, intention to mobilise patients and, in some cases, nurse patient ratios that permit continuous patient observation.[2,3,8]

Ongoing assessment of sedation levels in the context of the patient's medical and psychosocial condition is necessary to determine optimal sedation for any intensive care patient.[10–13] Before starting treatment with sedative drugs, the nurses need to identify the causes of patients' discomfort (e.g. stress, anxiety, pain and agitation).[3,11,13] The aim is to use nursing interventions first and sedative drugs as a second option. Non-specific use of sedative drugs could then be avoided and adequate sedation can be evaluated.[14] Inappropriate administration of sedation has

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potentially serious consequences. Patients are affected both physiologically (increased pain, metabolism and oxygen needs) and psychologically (anxiety) with insufficient sedation.[3,12,15] Excessive sedation may, on the other hand, create prolonged alteration of consciousness and increased duration of mechanical ventilation and with it increased risk for VAP.[16]

Sedation level 0 to −2 on the Richmond Agitation Sedation Scale (RASS) is light sedation and −4 on RASS is deep sedation.[17,18] When investigating if light sedation favourably affects subsequent patient mental health compared with deep sedation, Treggiari et al.,[19] found that a strategy of light sedation affords benefits with regard to reduction of ICU stay and duration of ventilation without negatively affecting subsequent patient mental health or patient safety. Deeply sedated patients tended to have more posttraumatic stress disorder symptoms and more disturbing memories from the ICU. A calm and awake patient who is able to cooperate and express his/her level of pain and anxiety[6,11] is a prerequisite for better mobilisation and rehabilitation and will reduce the ICU stay.[9,20] Furthermore, the patient has the ability to communicate and have contact with staff and next of kin[14] when they are lightly sedated which could improve the patient's condition both short and long term.[8,11,15]

Lightly sedated patients are aware of what's happening around them and that's what they remember. It is also more beneficial for the patient to have real, but perhaps unpleasant, memories of intensive care, rather than unreal dreams. Real memories of the intensive care stay have been shown to reduce the severity of post-traumatic stress disorder symptoms.[21] Deep sedation may cause fragmented, unreal and unpleasant memories. These memories may potentially affect sleeping patterns and anxiety after the patient is discharge from ICU.[10,11,15]

The disadvantages are that lightly sedated patients may sometimes harm themselves e.g. removing catheters or tubes.[22] Lightly sedated patients have also described unpleasant encounters with the staff whom they experienced as disrespectful since the nurses did not listen to what the patients tried to communicate.[23]

Providing nursing care for lightly sedated, ventilated patients is potentially difficult and time consuming. The treatment regimen makes new demands on ICU nurses, who must develop their communication skills, empathy and imagination to meet and provide care based on the patients' needs.[23–25] Previous research has focused on the practice of sedation for adult ventilated patients,[26,27] ICU nurses' experience of using different instruments to assess depth of sedation,[13,28] nurses' personal beliefs, attitudes and their goals for sedative practice,[29] nurses' perception of their role in sedation management[30] and factors influencing nurse sedation practices with MV patients.[31] The aim of this study was to describe ICU nurses' experiences of caring for patients who are lightly sedated during mechanical ventilation. This investigation is of interest to intensive care nursing as patients are more lightly sedated and therefore require a different approach to clinical management.

Methods

Participants were recruited from three intensive care units. One intensive care unit was located in a central hospital and two were located in district hospitals. The units are four to eight bedded general units that receive both surgical and medical admissions. The experience of caring for lightly sedated patients varied from months to years. Convenience sampling was used.[32] The inclusion criteria for the study were that participants had at least two years' of experience as a specially trained ICU nurse, had experience providing care to patients who were lightly sedated and were working on a day shift. Nine female nurses were recruited, aged from 36 to 55 (mean 44 years) with 5–34 years (mean 13 years) of ICU experience. All of the ICUs used sedation scales to score the level of sedation and clinical guidelines to guide sedation for patients in MV.

Ethical approval was granted from the local Research Ethics Committee and from the hospitals. The participants were informed about the aim of the study by email and also verbally at the time of the interview. All participation was voluntary and all the ICU nurses gave their informed consent. Full anonymity was guaranteed according to The Helsinki Declaration.[33] Each respondent was identified by a number and was assured that neither her identity nor that of the ICU would be disclosed in the final report.

Semi-structured interviews were conducted in 2010. A question guide was used so that all the researchers asked the same questions to the participants, and also to help the researchers stay close to the topic. Two pilot interviews were conducted to validate the question guide (minor adjustments were made), and these are included in the total nine. In the information letter, participants were asked to reflect on lightly sedated patients they had cared for and bring such cases to the interview. The authors (CT, EB and AA) conducted three interviews each. All participants were asked questions about demographic and sedation data, and also the main question "Could you, please, tell me about your experiences regarding nursing of a lightly sedated patient on MV?" The interviewer (CT, EB and AA) actively listened to the nurse's narrative and clarified or explored the nurses' responses as required.[32] Additional open ended questions were asked, if necessary: "what benefits or disadvantages have you experienced with lightly sedation for patients on MV?" or "what general experience do you have of lightly sedated patients?"

All interviews were conducted at a place and time decided by the participants. All chose their place of work. In connection with the interviews, the researchers were guided by a nurse through the ward in order to create rapport between participant and interviewer[34,35] and to receive information about routines and guidelines for sedation. The interviews were recorded and lasted on average about 20–25 min and were transcribed verbatim. All interviews were listened to and read through afterwards by all authors.

The interviews were analysed using qualitative content analysis, inspired by Burnard.[36] The various steps of the analysis were carried out as an iterative process by the first three authors. After performing the analysis independently of each other all three discussed the interviews jointly to reach an agreement. The authors (CT, EB and AA) listened to each interview and read the transcripts in order to immerse oneself in the data and become familiar with the participants' narratives. The transcripts were initially read independently in order to identify meaning units related to the aim and then further coded. Similar codes were assembled into preliminary subcategories. The first three authors then met with the co-author (MH), and shared their analysis. Adjustments were made and a final list seven sub-categories and one main category was created. Each meaning unit and coded section was cut out and pasted within the appropriate subcategory and category to validate the analysis. Quotations that illustrated the subcategories were identified.

Rigour

To ensure trustworthiness the Lincoln and Guba framework[37] was used. In order to establish *credibility*, the authors dealt with their pre-understanding (all four are ICU nurses) by writing it down, peer debriefing and communicating with colleagues and researchers with no experience in intensive care. Perceptions about the topic were based on the authors' experience of caring for deeply and lightly sedated patients over ten years' in intensive care. The authors had no relationship to the three ICUs or the participants in the study. Objectivity was also achieved by audio taping interviews,