



Research Article

Cardiovascular Surgery Patients: Intensive Care Experiences and Associated Factors



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SUMMARY

Purpose: The purpose of this study was to determine the intensive care unit (ICU) experiences of cardiovascular surgery (CS) patients and to define the associations between their ICU experiences and related factors.

Methods: The study used a descriptive design. In total, 106 CS patients were interviewed at least 24 hours after discharge from an ICU in an educational research hospital in Ankara, Turkey between January and July 2012. Data were collected using the Intensive Care Experience Scale (ICES), a sociodemographic and clinical characteristics data form and two open-ended questions inquiring about smells and light. Statistical analyses were conducted using SPSS 15.0.

Results: The patients were moderately aware of their ICU environments, partly recalled their ICU experiences, highly recollected frightening experiences, and expressed good satisfaction with care. Age, education, marital status, and pain were associated with ICU experiences. Patients who sensed smell had higher scores of frightening experiences than those who did not. Patients who were annoyed with excessive light reported less satisfaction with care than those who were not.

Conclusions: The results suggest that measuring the patients' characteristics and environmental factors may be beneficial for healthcare teams to improve the recovery of CS patients in the ICU.

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Introduction

Intensive care patients are faced with unusual and unfriendly environments [1]. Longer recovery times from any critical illness and long-term and short-term patient outcomes may be related to the patients' perceptions of their intensive care unit (ICU) experiences [2]. Traumatic cardiovascular surgery experiences cause disturbing recollections and post-traumatic stress disorder [3].

Research on intensive care experiences of cardiovascular surgery (CS) patients is very limited [4–7]. The ICU experiences of patients other than cardiovascular surgery have been primarily reported in the scientific literature [8–13]. Additionally, standardized measurement tools were not used in the majority of these studies, and there were many differences concerning the ICU characteristics and the time interval between the ICU experiences and interview [14–16].

CS patients insufficiently recalled or did not recall at all their stay in the ICU. While all the ICU patients recollected some of their

experiences [17], sudden illness, unusual intensive care environments, and feelings of uncertainty made it difficult to interpret patient experiences [12]. Some patients had bright and strong memories [5], whereas longer durations of mechanical ventilation were associated with a significant decrease in environmental awareness [18]. Additionally, older patients were more aware of the ICU [19]. In total, 44% of patients remembered their dreams during their stay in the ICU; there was a significant association between the length of stay in the ICU and patients' dream experiences [11]. A total of 15.0% of patients did not recall events in the ICU, and some of them remembered real memories, such as visits from family members [10].

Patients generally had negative experiences in the ICUs. CS patients reported apprehension, fear, anxiety, confusion and hallucinations related to their stay in the ICU [20]. Postoperative coronary artery bypass graft patients expressed themes including a lack of comfort, damaged communication, loss of control, loneliness, being transitory and human interaction [21]. Mechanically ventilated patients expressed themes such as being in an unusual environment, physically and psychologically suffering [9], feeling helpless, and feeling abandoned and powerless [8]. There was a significant

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relationship between the patients' perceptions of their ICU experiences and their scores for depression, anxiety, avoidance and intrusion [2].

There are limited studies reporting that patients had positive experiences when staying in the ICU [13,22,23] such as emotional, perceptual and environmental comfort [13]. Cardiovascular surgery patients in the ICU expressed positive themes in addition to negative ones. Some of the positive themes were comfort, getting better and hope [5]. Another study determined that ICU patients remembered pleasant memories in addition to unpleasant ones [13].

ICU patients mostly recollected frightening experiences [22]. CS patients defined several painful experiences in the ICU, including chest tubes, endotracheal suctioning, being on a bed with an air pattern, and wound dressing changes [4]. Other studies revealed that CS patients felt restless and painful during their ICU stay [24]. Patients indicated that they emotionally drove similarity between staying in the ICU and being dead [25], and a lack of social support was comparable to death [12].

Patients' satisfaction with care was related to various factors. The quality and presence of the nursing personnel was important for patients in the ICU following cardiovascular surgery [15]. Supported by this result, CS patients receiving vigilant and individualized care felt secure in the ICU [20]. The nurses supported their patients by performing preoperative visits, providing continuous and repeated explanations to patients, encouraging family visits, and providing sufficient sleep and pain control. Across these situations, patients remembered that they had felt safe in the ICU [17]. Positive ICU environments positively affected patient recovery [26]. However, increased periods of mechanical ventilation were associated with reduced satisfaction with care [18]. Care in the ICU was perceived as a stressor by the patients [13].

The following items are four essential factors on ICU environment, which frequently affect patients' experience of stay. The factors are (a) the smell factor, which includes eliminating smells and regulating fragrances; (b) the voice factor, which includes pleasant sounds and removing excessive noise; (c) the light factor, which concerns natural lighting; and (d) natural environments and recovery space, where the individuals can feel comfortable [27]. Removing barriers to healing and increasing a patient's feeling of safety are necessary to support patient recovery [1]. Cardiac transplant patients did not recognize their ICU environment [7]. Patients stated that they felt environmental distress while in the ICU [13]. Some ICUs do not have natural light [28]. Additionally, the use of aromatherapy results in improvements in the mood and anxiety levels of ICU patients [29].

Some sociodemographic factors can have an impact on the experiences of patients. It was reported that age and marital status affected patient's ICU experiences positively or negatively [10,19]. Some researchers did not find any associations among these factors [19,22,30].

The ICU contains various biotechnological devices. In this physically complicated setting, the nurses have a key responsibility in the decision-making process with other healthcare team members. The scarcity of research on the ICU experiences of CS patients, not using any standardized tool to measure the ICU experiences of CS patients, unavailability of studies aiming at determining associations between related factors and ICU experiences of CS patients due to different study designs implied a need on further research. Determining patient experiences will provide specific data to healthcare teams to make appropriate arrangements in the CS ICU environment and make successful decisions to support the patients' recovery process.

The aims of this research were (a) to determine the ICU experiences of cardiovascular surgery patients at least 24 hours after discharge from the ICU, and (b) to define the associations between

the patients' ICU experiences and their sociodemographic and clinical characteristics, as well as the smell and light factors in the ICU environment.

Methods

Study design

Descriptive design was used in the study.

Setting and sample

This study included 106 adult CS patients who had been discharged at least 24 hours or more (24–48 hours) from a CS ICU in an education and research hospital in Ankara, Turkey between January and July 2012. The patients were conscious, orally communicable and volunteered to participate in the study. The sample size was determined with regard to the number of items in the Intensive Care Experiences Scale (ICES). The scale is composed of 19 items, with 5-point Likert scales for each item. In accordance with Gorsuch, the subject-to-item ratio of 5:1 was adopted as acceptable [31]. The sample size was determined to be 95 patients.

Ethical consideration

Written permission was obtained from the authors, who adapted the Turkish Version of the ICES. Ethical approval, which agreed with the principles in the Declaration of Helsinki [32], was obtained from the local university ethical council prior to the study. The patients gave their written informed consent to participate in this study.

Measurements/instruments

Sociodemographic and clinical characteristics form

This form included 11 variables (sociodemographic and clinical characteristics of patients, pain levels of patients). Additionally, two open-ended questions on smell and light were prepared. Items regarding smell and light were not available in the ICES.

Visual Analog Scale

The Visual Analog Scale (VAS), first developed in 1921 by Hayes and Patterson [33], is commonly used to measure clinical phenomena, including pain and comfort. The VAS is a method for converting certain qualitative measures to quantitative measures. It is easy to use and requires very little written language [34]. On the two ends of a 10 cm (100 mm) line, extreme definitions of a parameter are written, and the patient is asked to indicate his or her current status. For instance, in dealing with pain, one end of the line is "no pain", and the other end is "severe pain" and the patient indicates his or her current level of pain on the scale. The distance from "no pain" to the patient's mark quantitatively represents the patient's pain level [35].

ICES

The ICES was developed by Rattray, Johnson, and Wildsmith [36] and adapted to Turkish by Demir, Korhan, Eşer, and Khorshid [37]. The ICES consists of 19 questions using a 5-point Likert scale for the responses; patients were required to select only one response per item. The Cronbach α coefficient was .79 in Turkish ICU patients demonstrating the established internal consistency of the instrument [37]. The Cronbach α was found as .73 in our study. Four subscales of the ICES are Awareness of Surroundings, Recalling of Experiences, Frightening Experiences and Satisfaction with Care.

The Awareness of Surroundings subscale scores ranged from 5 to 25; high scores indicate a high environmental awareness. The

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