

With the advent of the most vital speciality, the critical care medicine, life threatening emergencies and major surgeries, which require external support and control over the vital functions could be managed successfully. On the other hand helping the patient to cope with the nature of illness and sophisticated, mechanized, dehumanizing critical care environment still remains a challenge to Nurses all over the world. ICU Psychosis is the term applied to a patient

demonstrating a range of cognitive, emotional or behavioural derangement in intensive care unit. The term implies that the patient's behavioural derangements are predominantly related to the environment in the critical care unit.

In spite of all the deliberate efforts taken, a very high percentage of patients manifest mild to major features of psychological derangement. A random review of the records of thirty patients who underwent CABG in Shri Chitra Tirunal Institute of Medical Sciences & Technology, SCTIMST revealed that 23% patients had features of ICU Psychosis. A retrospective chart review of 195 patients, who underwent IABP placement in Massachusetts General Hospital during 1988, documents that 34% of patients developed delirium. Various factors both controllable and uncontrollable are contributing to the occurrence of ICU Psychosis.

Critical care environment is a unique environment in which the most sophisticated medical, Nursing and technical interventions can be integrated to combat life-threatening illness. The environment provides maximum security and protection with its sophisticated electronic equipment, highly competent and attentive staff members. The ever changing condition of the patient demands vigilant observation quick identification of problems and appropriate therapies and interventions to prevent or correct life threatening situations.

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Hence, patient's physiological needs often assume priority over psychological needs. The patient's needs as a social being is virtually ignored. The appearance of special environment. Flashing light buzzing machines, painful procedures, brightly lit, crowded and hy-

from an environment with familiar people and routines. Isolation is made worse when staff assumes that patient is not able to respond or unconscious. Verbal communication is often affected by intubations and tracheotomy. Nonverbal communication is affected by movement difficulties and effect of sedations and relaxant drugs. If a patient cannot communicate that may result in depersonalisation as he is being treated like an object neglecting the need for autonomy and privacy.

✓ ICU PSYCHOSIS - NURSES' CHALLENGE

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perative environment induce immense stress on the patient. The explosion of computerized automated monitoring system that provides minute to minute data on multiple physiological responses has created a physical barrier, preventing meaningful Nurse patient contact. Bombardment with continuous high-level stressors can be devastating both physically and psychologically to a triply stressed critically sick patient. Patient may quite often prevent the difficulty in coping with the crisis as derangement of emotion, cognition and behaviour that require prompt attention.

Etiology :

Central nervous dysfunction; Hypoperfusion status of central nervous system; Hypoxia; Metabolic derangement; Medication side effects; Alcohol or drug withdrawal.

Subject interpretation of illness: Feeling that life is over; Frustration to drive; Sense of personal failure.

Environment induced psychological torture : According to Amnesty International the cause of ICU Psychosis are sensory and sleep deprivation, enforced stimuli, use of psychotropic or paralyzing drugs, immobility isolation, reduced or forced communication and change in bio-rhythm pattern.

Isolation:

ICU admission keeps the patient away

Monopolisation of perception:

ICU patient may experience both sensory deprivation and overload. Sensory deprivation results from inability to differentiate day and night, unfamiliar environment and personnel, inability to talk or respond to verbal stimuli, immobility to appreciate smell and taste food.

Threat:

Threat is induced by fear of death, being in the midst of busy ICU environment, threat of bodily harm; loss of something valuable, visualization of unpleasant scenes like life saving, intervention, CPR, intubations may engender fear and feeling that I will be the next.

Degradation

Nudity (Partial or complete) lack of privacy, depersonalization (behaving as an object) are the expressions of insensitivity to the individuality of the patient.

Clinical manifestation Psychosis

Behavioural problems, Anxiety, Delirium, Depression, Behavioural problems can be visible as passive or aggressive behaviour, demanding, irritable, entitled, may cause conflict with staff members.

Expressions of anxiety are outbursts of anger, impatience, threat to leave against medical advice, paranoia, and frequent call for Nurse and silent withdrawal.



Delusions are manifested as fluctuating levels of consciousness, arousal disorientation, diminished ability to concentrate, agitation or stupor. Delirium jeopardizes the safety of the patient who may try to leave the ICU bed remove intravenous catheters arterial lines or even an attempt to self-extubate. At times inappropriate behaviours like playing with the intravenous tubing putting nasal canula into the ear etc.

Nursing interventions for effective coping

Isolation:

Allow the visitors, Address the patient by name. Self-identity is the last sphere of orientation. Introduce yourself by name. Acknowledge your presence all the time. Nurse represents a non-threatening reality to the patient, inform when you leave and return. Always be accessible to the patient. Anticipate his needs and feeling and act appropriately. Place a call bell in a convenient position. Ensure consistency of care, communicate with every patient as if they are able to understand. Lack of response does not mean lack of awareness. Provide writing pad. Be sensitive to the non-verbal cues and expressions. Dim lights at night. Reinforce progression of day in relation to specific events. Position large numeral clock within the vicinity. Provide wall calendar. Allow wristwatches if possible.

Explanation about interventions, clinical status, plans of management will foster reality orientation.

Alienation of technological environment can be minimized by explanation about the equipment, its sound therapeutic purpose, if possible allow them to handle the equipment. Ensure consistency with the personnel caring the patient. Soothing, familiar sounds and rhythm will minimize monotony and induce relaxation. Audiocassette with recordings of family conversations music, judicious use of radio and television are the measures to provide soothing sounds. Use alphabet or picture boards - Thirsty; Hungry; Pain

Monopolisation of perception

If the hospital permits, allow the close relative to see the patient. Be a messenger between the patient and relative. Encourage the patient to be communicable. Convey empathy and love through therapeutic touch. It is a universal language of care and comfort. It can be used as a means of distraction from painful stimuli and discomfort. Holding hands, placing the hands over the forehead, gentle massage are expressions of caring touch.

Limit the noise levels. But audible alarms should not be silenced. Insist on well-enforced noise control during night. Re-adjust alarm units as the patient condition improves. Staff conversations should be kept inaudible to the patient. Conversation about the patient and not to him, foster depersonalization or delusions of reference. Avoid laughter or whisper within the view of the patient.

Day light cycles should be simulated with environmental lighting. Never turn overhead fluorescent light to the patient as continuous light sustains anxiety and causes sleeplessness. Encourage using blinds.

Threat

Always ensure your physical presence and vigilance observation. Preparatory sensory information and explanation of clinical status helps to minimize anticipatory fear and anxiety. Patient is interested to know the issues related to his sufferings rather than the actual diagnosis.

To the extent possible shield the patient from viewing urgent or emergent events. This may engender fear and a sense of instability and vulnerability (e.g. I am the next')

Degradation

Ensure privacy, physical exposure and nudity are the primal indignities in all the individuals. When it becomes necessary to expose the patient, the Nurse should apologize for its necessity.

Ensure absolute cleanliness and give

due importance to personal grooming. Never keep the patient in soiled linen. Dress should be of appropriate size. Keep the hair combed.

Being a Nurse in a critical care unit is a challenge and matter of prudence. The opportunity for crisis intervention and decision-making can be very satisfying. The best ICU Nurse sees the patient first, patient's condition second and the equipment lastly. The effective means to counteract or prevent the occurrence of psychological derangement of patients in critical care unit is through the practice of holistic approach of care by giving due consideration to the data from psychological, culture and spiritual realm to formulate Nursing interventions. Implementation of this approach with utmost priority is a challenge before today's critical care Nurse.

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