Patient recall after intensive care

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Inter-professional Processes of Care

MONDAY, OCTOBER 26, 2015
Inter-professional Processes of Care

Moderators: M. Herridge – E. Azoulay

• 15:30-15:50 T. Stelfox
  – Evidence-Informed ICU Rounds

• 15:50-16:10 T. Thompson
  – Family Presence during CPR: Who Benefits?

• 16:10-16:30 I. Egerod
  – Patient Recall after intensive care

• 16:30-16:50 J. Downar
  – Bereavement Support

• 16:50-17:00 Discussion
Steve Mccurry: establishing a relationship
Understanding the patient experience

Gadamer: fusion of horizons

- Stories help us to visualize human experience
- Knowledge of the aftermath of critical illness is important in improving patient recovery
Meta-synthesis of 26 qualitative English language papers on patient experiences of critical illness 1965-2011

Eight common themes
1. Transformations of perception: unreal experiences;
2. Proximity to death;
3. Transformation and perception of the body;
4. Transformation and perception of time;
5. The critical care environment: technology and dependence;
6. Communication and relationships with healthcare staff;
7. The support of family and friends and desire for contact;
8. Transfer from critical care and recovery from critical illness.


Five common themes
1. Fear due to *loss of control*;
2. Disconnection with *reality*;
3. Impaired *embodiment*;
4. Construction of *coping* patterns;
5. Trust and caring *relationships*

Autobiographical narratives of critical illness

David Rier (2000): *The missing voice*

On human mortality and the possibility of death

- *I put two and two together and realized that I was dying.*
- *Marveling at what a unique experience death would be.*
- *Dying seemed to involve just relaxing and letting go.*
- *I understood that I might even die that night.*
Autobiographical narratives of critical illness

Cheryl Misak (2005): Thoughts from the inside

On human suffering

• Two sorts of awfulness: the pain, the extreme discomfort that comes with mechanical ventilation, and the physical panic induced by the suctioning process and the inability to breathe.

• Perhaps even worse: that of stepping well over the fuzzy line that separates sanity from madness.
The patient experience of intensive care: A meta-synthesis of Nordic studies

Ingrid Egerod a,*, Ingegerd Bergbom b, Berit Lindahl c,b, Maria Henricson d, Anetth Granberg-Axell e, Sissel Lisa Storli f
Aim

The aim was to systematically review and reinterpret newer Nordic studies of the patient experience of intensive care to obtain a contemporary description of human suffering during life-threatening illness.

Assumptions

- A new paradigm of lighter sedation and early mobilization has changed the patient experience of intensive care.
- A particular emphasis on existential experiences in Nordic studies.
Meta-synthesis of 22 English language Nordic studies in 2000-2013

Contemporary context of intensive care
• Lighter or no sedation
• Earlier mechanical ventilator weaning
• Earlier mobilization
• Nurse-patient ratio of 1:1
• Delirium assessment
• Family presence
• Environment modification: color, sound, light, view

Focus of 22 Nordic papers on the patient experience of intensive care

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<tr>
<th>Body</th>
<th>Mind</th>
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<td>Bodily knowledge</td>
<td>Unreal experiences</td>
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<td>Body awareness</td>
<td>Factual experiences</td>
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<td>Body strength</td>
<td>Meaning of memories</td>
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<th>Relationships</th>
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<td>Dependency</td>
<td>Mechanical ventilation</td>
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<td>Family presence</td>
<td>Noise and light</td>
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<td>Empowerment</td>
<td>Transfer from ICU</td>
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Main theme: When existence itself is at stake

Hermeneutical approach: dialoguing with the texts.

Questions related to existential threat

• What happens to the body when existence is at stake?
• What happens to the mind when existence is at stake?
• What happens to relationships when existence is at stake?
• What happens to the perception of the ICU environment when existence is at stake?
Findings

Four common themes

1. existing in liminality (between life and death)
2. existing in unboundedness (body and mind)
3. existing in mystery (limited by imagination and past experience)
4. existing on the threshold (choosing life or death; transcending with caring others)
Unbounded body and mind
Conclusions

• Our assumption that human suffering would change as the ICU context evolved was not supported (perhaps it was too early to show the impact of changes).

• Our assumption that the findings in Nordic vs. other studies would be more existential in nature was not supported.

• We conclude that the ICU experience is similar across time, ICU environment and culture.
Reflection: so what?

Are our findings new?
• Existential threat is universal across various types of illness (critical illness, cancer, heart disease, etc.)

Does our study add to the existing research?
• Our study supports earlier research
• Qualitative meta-synthesis strengthens the evidence-based statement

What is the clinical impact of our study?
• The importance of preserving personhood and dignity, and understanding suffering.
Thank you