

Competency of Critical Care Nurses to Meet Patient's Psychological Needs: Debate Essay

Moawia Eid, RN, MSN, CNS.
Jordan Ministry of Health, New Zarqa Governmental Hospital

Abstract

Critical ill patients have the high incidence to develop psychiatric illness and psychological imbalance such as anxiety, depression, sleep disorders, stress and stress related disorders. The physical disorder itself and environmental and functional factors within intensive units are most common predictors for these disturbances other than demographics traits. The purpose of the current paper is to take possible sources to developing psychiatric competency of critical care units among general hospitals. Search strategies database of Pub Med, Google Scholar, and American Psychiatric Association was used; they provided many studies about the current topic with using some words as Competency, psychological needs, critical ill patient and psychiatric qualification. Different possible solutions were donated, mostly were concerned about psychiatric qualification and training/education of health care staffs. First possible source of solution included psychiatric training/education of critical care staffs over assessment, intervention or psychotherapies and evaluation of patient psychological aspects and needs. Second possible source recommended for availability of psychiatric qualifications within critical care area to improve this aspect of holistic care other than specialty of appropriate referral and follow up of long term complications. Psychiatric training/education or qualification are considered effective sources of modification and improvement of biopsychosocial care among critically ill patients. Ignoring psychiatric qualification of this medical area can be considered as malpractice or negligence of patient's care.

Keywords: Bio-psycho-social care, Psychiatric Competency, Psychiatric Qualification.

Introduction

Different physical illnesses usually triggers psychological needs or imbalance and may complicate with psychiatric disorders, the chronic medically ill patients have about 40-50% higher rate of psychiatric disorders (Tusaie & Fitzpatrick, 2013). Moreover, chronic and terminally ill patients such as cancer, stroke, Acquired Immunodeficiency Syndrome (AIDS), cardiopulmonary, hepatic and renal disorders or acute traumatic disorders are most likely incidents for psychiatric illnesses as mood, anxiety, stress or substances abuse (Boyed, 2012). This condition under the term of comorbidity, which is occurrence of two syndromes in the same patient (Tusaie & Fitzpatrick, 2013). Specifically, different of acute or chronic previous physical illness can be available in Intensive Care Unit (ICU) as critical area of care. One of four patients required psychiatric intervention during and after discharge from critical units especially during first year that to treat Post Traumatic Stress Disorder (PTSD), anxiety or depression (Myhren, Ekeberg, Toien, Karlsson & Stokland, 2010).

The purpose of the current paper is to take possible sources to developing psychiatric competency of critical care units among general hospitals.

Background

The ICU environment, for different causes, is considered vulnerable area to imply many psychological disturbance and psychiatric symptoms such as anxiety, agitation, delirium, PTSD and behavioral manifestations in about 75% as incidence rate (Tate et al., 2012). Critically ill patients have high risk to develop mental illness in prevalence of 45%, that meet at least one criteria of DSM-IV, these disorders included major depression, anxiety, alcohol use disorder, delirium, insomnia, PTSD, stress related disorder and organic psychosis (McKinley et al., 2012, Rukundo, Musisi, & Nakasujja, 2013). Moreover, these symptoms are commonly developed among ICU patients during and after discharge with long term period of time, which affect on patient's general health and treatment adherence as most common consequences of this psychological disturbance (McKinley et al., 2012).

These symptoms and disturbances are developed for different factors that are summarized as disease itself, lack of family contact, disability to communication, environmental factors as alarms, lights, lines and machines, Mechanical Ventilator (MV) use, weaning or sound and health care staff interaction with patient, sleep disturbance, staff-patient interaction and malpractice of assessment and management of these symptoms due to lack of knowledge and skills of psychiatric competency (McKinley et al., 2012; Rukundo et al., 2013, Tate et al., 2012). Furthermore, as most of ICU patient under MV connection, these patients have more risky to psychological disturbances and need to meet psychological needs and psychiatric care as depression, hallucination and anxiety for many causes related to staff communication, ICU environment and basic daily needs loss (McKinley et al., 2012). Briefly, sever physical illness and critical care unit experience during period of stay are considered as predictors for psychological imbalance (Myhren et al., 2010).

At this level, critical care nurses and medical staff members have insufficient knowledge and skills to meet this psychological aspect and psychiatric symptoms among these patients; they lack adequate competencies of these practices (Rutledge, Wickman, Cacciata, Winokur, Loucks, Drake, 2013). In addition, there are needs to comprehensive assessment of critically ill patients and provide more comprehensive care in term of biopsychosocial approach that to enhance well being and quality of life (Needham et al., 2012).

The World Health Organization in 1948 defined health as state of complete physical, mental/psychological and social well being and not merely the absence of disease or infirmity. Accordingly, nursing staff are expected to provide holistic care approach that included physical, psychological and mental aspects to improve health and quality of life. However, critical care staff lack the ability of psychiatric assessment, diagnosis and management intervention that assist to control over this gap in patient's care (McKinley et al., 2012).

First Source

Psychiatric training/education of critical care nurses and medical staff depending on patient's physiological, psychological and behavioral response were effective in detecting early response and directions of anxiety, agitation or other psychological symptoms (Tate et al., 2012). Managing those symptoms depending on Cognitive Behavioral Therapy (CBT) as effective approach, also that assisted in reducing other physical complications (Tate et al., 2012). Furthermore, critical nurses staff can improve their communication skills with critically ill patients and provide appropriate psychological support throw both verbal and non verbal communication, depending on patient's body language (Skogstad, Hem, Sandvik, & Ekeberg, 2015).

Psychiatric training/ education of critical care nurse on psychotherapy especially who care of physically traumatic patient added vital role of nursing care included psychological intervention for different distress as PTSD, anxiety and depression, in addition that integrated approach enhanced patients personal traits to be optimistic and active daily functioning (Skogstad et al., 2015). The training reflected positive effect over both psychological and physiological well being of critical patients (Agren, Evangelista, Hjelm, & Stromberg, 2012).

Second Source

On other hand, critically ill patients and their family may require referral resource for appropriate psychiatric care that enhance their well being and assist in coping with current general health situation (Boyed, 2012). At this level, psychiatric qualification can serve as effective role in improvement of psychological and mental health among these patient with most appropriate aspects of psychiatric care as assessment, diagnosis, planning, intervention and evaluation, that valuable the importance of qualified psychiatric nurses in medical care process (Tusaie & Fitzpatrick, 2013).

The integration of psychiatric qualification in medical and critical care environment is recommended from different evidence. The randomized control trial about this topic considered that psychiatric qualification as collaborative approach of care had the biological improvement of general health status and resolving of psychological distress as depression (Katon, et al., 2010). The qualified psychiatric nurse has more advanced ability to assess, detect, diagnose, intervene and rehabilitate of psychiatric symptoms related to medical disorder, additionally this qualification ads using of more advanced psychotherapy as CBT, Motivation Therapy and sufficient awareness of psychotropic medication comparing to general care to be more efficient (Needham et al., 2014).

On other hand, as these psychological distress can be timely long, patients may search for appropriate coping process or referral resource for management, so qualified nurse can assess and evaluate effectiveness of using these resources in regard needs for more support and management or providing another manners of psychiatric interventions (Tusaie & Fitzpatrick, 2013). Moreover, psychiatric nurse also has appropriate application of family support and psychological concern to resolve negative feelings and inappropriate behaviors, this principle add beneficial effect of patient's family support and patient well being (Needham et al., 2014). According to Boyed, 2012, the main concerns and scope of qualified psychiatric nurse summarized as:

- Promotion of optimal mental and physical health and prevention of illness.
- Function impaired related to physiological or psychological distress.
- Alterations in thought, perception and communicating due to psychiatric disorders or mental health problems.
- Behaviors and psychological signs that indicate potential danger to self or others
- Emotional distress related to illness, pain, loss and disabilities.
- Management of side effects/toxicities associated with self-administered drugs, intervention and other treatment modalities.
- The treatment's barriers posed by alcohol and substance abuse and dependence.

- Self-concept and body image changes, life process changes, end of life issues and developmental issues.
- Physical symptoms that occur along with altered psychological status and contrast.
- Interpersonal, organizational, sociocultural, spiritual or environmental circumstances or events which have an effect on the mental and emotional well-being of the individual and family or community.
- Elements of recovery including the ability to maintain housing, employment and social supports that help individuals re-engage in the seeking of meaningful lives.

Summary and Conclusion

The purpose of the current paper was to take possible sources to developing psychiatric competency of critical care units among general hospitals.

Psychiatric education/training or qualification in critical care setting could be provide more advanced practice to health care providers. It can fill gaps of comprehensive care of ignored psychological aspect of the care. Psychiatric practice is essential to improve well being of critical care patients due magnitude of psychological consequences of ICU environment even after discharge. Ignoring psychiatric qualification of this medical area can be considered as malpractice or negligence of patient's care. It is important to bring this issues to the light, that to improve of patient care as biopsychosocial approach.

Recommendations

The current author recommends for the following, firstly, integration of psychiatric intervention with general health care as effective comprehensive approach of critical care patients. Secondly, encourage stakeholders and policy makers to establish health care policies that valuable this integration and enhance of therapeutic communication among health care providers. Thirdly, applying this integration among other hospital's units and departments as E.R, gynecology, O.R in pre and post for patient and patient's family or general departments. As researchability, this paper can be incorporated into nursing curricula and lay the foundation for future research with other psychiatric competency groups.

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References

- Agren, S., Evangelista, L., Hjelm, C., & Stromberg, A. (2012). Dyads affected by chronic heart failure: a randomized study evaluating effects of education and psychosocial support to patients with heart failure and their partners. *J Card Fail*, 18(5), 359-366.
- Boyd, M.A. (2012). *Psychiatric Nursing: Contemporary practice* (5th Ed). Lippincott Williams & Wilkins; Philadelphia, PA.
- Katon, W., Lin, E., Korff, M., Ciechanowski, P., Ludman, E., Young, B., Peterson, D.,... McCulloch, D. (2010). Collaborative care for patients with depression and chronic illnesses. *N Engl J Med*, 363(27), 2611-2620.
- McKinley, S., Aitken, L., Alison, J., King, M., Leslie, G., & Elliott, D. (2012). Sleep and other factors associated with mental health and psychological distress after intensive care for critical illness. *Intensive Care Med*, 38, 627-633.
- Myhren, H., Ekeberg, O., Toien, K., Karlsson, K. & Stokland, O. (2010). Posttraumatic stress, anxiety and depression symptoms in patients during the first year post intensive care unit discharge. *Critical Care*, 14:R14.
- Needham, D., Davidson, J., Cohen, R., Hopkins, R., Weinert, C., Wunsch, H., Zawistowski, C.,... Harvey, M. (2012). Improving long-term outcomes after discharge from intensive care unit: Report from a stakeholders' conference. *Society of Critical Care Medicine*, 40(2), 502-509.
- Rutledge, D., Wickman, M., Cacciata, M., Winokur, E., Loucks, J. & Drake, E. (2013). Hospital Staff Nurse Perceptions of Competency to Care for Patients With Psychiatric or Behavioral Health Concerns. *Journal for Nurses in Professional Development*, 29(5), 255-262.
- Rukundo, Z., Musisi, S., & Nakasujja, N. (2013). Psychiatric morbidity among physically ill patients in a Ugandan regional referral hospital. *African Health Sciences*, 13(1), 87-93.
- Skogstad, L., Hem, E., Sandvik, L., & Ekeberg, O. (2015). Nurse-led psychological intervention after physical traumas: A randomized controlled trial. *J Clin Med Res*, 7(5), 339-347.
- Tate, J., Dabbs, A., Hoffman, L., Milbrandt, E., & Happ, B. (2012). Anxiety and agitation in mechanically

ventilated patients. *Qual Health Res*, 22(2), 157-173.
Tusaie, K. R., & Fitzpatrick, J. J. (2013). *Advanced Practice Psychiatric Nursing*. Springer Publishing Company, New York, NY.
World Health Organization (1948). Constitution of the WHO. WHO Basic Documents, Geneva.