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Critical Care of Nurses Perception in Intensive Care

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Abstract

To describe critical care nurses' perception of moral distress during the second year of the COVID-19 pandemic. Critical care nurses experienced the intensity of moral distress as the highest when no one decided to withdraw ventilator support to a hopelessly ill person (Futile care), and when they had to assist another physician or nurse who provided incompetent care (Poor teamwork). Thirty-nine percent of critical care nurses were considering leaving their current position because of moral distress. During the COVID-19 pandemic, critical care nurses, due to their education and experience of intensive care nursing, assume tremendous responsibility for critically ill patients. Throughout, communication within the intensive care team seems to have a bearing on the degree of moral distress. Improvements in communication and teamwork are needed to reduce moral distress among critical care nurses.

Keywords: COVID-19; Ethics; Intensive care; Moral distress nursing

Introduction

The COVID-19 pandemic has placed extraordinary pressure on health systems around the world and many people have become critically ill and required care in intensive care unit (ICU). Before the COVID-19 pandemic, patients' relatives were welcomed to be with the patient in the ICU. This was seen as benefits for the patient, the patient's relatives, and the ICU staff. During the COVID-19 pandemic, the World Health Organization (2020) recommended that health systems not allow relatives to visit critically ill patients with COVID-19 due to the highly contagious nature of the illness [1]. To improve critical care nurses' (CCNs) ability to care for patients requiring intensive interventions, hospitals have increased the number of available ICU beds and have sometimes also set up temporary ICUs CCNs have worked with general care nurses to meet care demands and to increase the total number of patients they are able to treat. CCNs had to quickly adapt to new physical workspaces, co-workers, limited resources, hospital guidelines and treatment protocols. They were also forced to contend with inadequate personal protective equipment and their obligations to provide nursing care for patients. Recent researches have described health care professionals such as CCNs experiencing moral distress because COVID-19 pandemic created new challenges for CCNs [2]. Moral distress may affect moral integrity, ability to deliver care with quality and intention to resign. Moral distress arises when an individual knows what the right thing to do is, but institutional constraints make it nearly impossible to pursue the right course of action and to act in accordance with their ethical values. Jameton definition describes moral distress in psychological–emotional–physiological terms and is linked to the presence of constraint on nurses' moral agency. The intensity of the experience of moral distress increases to a point and then decreases as the acute phase of the moral distress situation passes – the crescendo of moral distress [3]. However, the feelings and personal discord from the moral distressing situation continue after the situation is over and this residual distress acts as a new baseline from which the next crescendo of moral distress builds. This might cause damage over time, especially when the person is repeatedly exposed to moral distressing situations [4]. Moral distress triggers have been identified at three levels: patient-level factors, which include the patient and/or their relatives; unit/team-level factors, such as poor communication or inadequate collaboration between team members; and system-level factors, which include actions that occur outside the unit, such as poor staffing, pressure to reduce costs and inadequate resources. Being forced to compromise on patient safety or the quality of care due to lack of time or resources could trigger moral distress [5]. Intensive care units are described as 'the frontline of a war' against the COVID-19 disease, and CCNs serving on the frontlines of this war are engaged with some of the most challenging ethical issues of our time. Given the increasing demand on an already overstretched healthcare workforce, it is essential that the magnitude of moral distress during the COVID-19 pandemic is assessed. The aim of this study was to describe critical care nurses' perceptions of moral distress during the second year of COVID-19 pandemic [7]. A cross-sectional study involving an online questionnaire was conducted with a sample of Swedish CCNs. The study used a convergent mix-method design, and followed the checklist for reporting results of internet surveys. The study was also used to pilot test the questionnaire's construct validity and psychometric properties and is a manuscript under review. The study was conducted in Sweden and focused on CCNs who were working in ICUs during the second year of the COVID-19 pandemic. In Swedish ICUs, the nurse-to-patient ratio is normally 1:1-2 and the ICU team caring for critically ill patients consists of CCNs, enrolled nurses, specialist physicians, and physiotherapists [8]. During the COVID-19 pandemic several ICUs in Sweden temporarily needed to change the competence mix in the ICU team and include anesthesia nurses and registered nurses without post-graduate education. The participants received information concerning the study's aim, confirmation that participation was voluntary and that their identity would be kept confidential. By answering the questionnaire, participants agreed to the terms of publishing. This procedure corresponds to the World Medical Association's (2020) ethical principles. There was no need for studies that handle sensitive data and patient data. Participants were CCNs working in ICUs who met the following inclusion criteria: They were employed as a registered nurse and had a post-graduate education within intensive care on an advanced level [9]. A total of 135 participants responded to the questionnaire and of those, 71

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participants met the inclusion criteria and completed every question in the questionnaire. It was not possible for single participant to fill in the same questionnaire multiple times. Participant characteristics were gender, age, household, and the number of years of experience in ICU [10]. CCNs perceived "Continuing to participate within the care of a dispiritedly unwell person…" as a virtuously distressing state of affairs with high frequency (Mean a pair of.23 SD 1.13) and intensity (Mean three.06 SD 1.23). There have been things once CCNs have raised queries concerning continuing care and prognosis that the physicians were unprepared. The physicians typically listened to those issues and mentioned them with different physicians, or they were unheeded, and coverings continuing till modification of shift [11]. CCNs additionally represented experiences of, "Initiating in depth life-saving actions…" (frequency = Mean 1.99 SD 1.06; intensity = Mean a pair of.91 SD 1.15). This usually occurred before all the facts were famed or before the accountable was gift. Prolonged care was viewed as one thing that benefited relatives, as a result of it provided the mandatory time for them to mention so long to dearest. CCNs explained that intensive care unit team usually had an honest understanding of the patient's condition and background and an honest dialogue with each other once selections associated with treatment limitations required to be created. However, the CCNs were typically defendant by physicians of getting a bearish read of patients' recovery. CCNs perceived that many patients World Health Organization had received long-run care within the intensive care unit died after they received hospital wards, and this caused ethical distress among CCNs. However, they realized that it absolutely was tasking for a Dr. to predict whether or not a patient would be able to recover or not [12]. CCNs perceived frequency (Mean a pair of.04 SD 1.22) and with high intensity (Mean three.01 SD 1.30) within the item "Assist another Dr. or nurse World Health Organization, in my opinion…" especially, CCNs intimate that general care nurses World Health Organization lacked a complicated education in medical care weren't continually able to severally offer nursing interventions severally, and this might need affected the standard of care. CCNs represented feeling eased, once physicians while not medical care competency complete their shifts and physicians with medical care competency began their shifts, as a result of it absolutely was easier to debate intensive care-related issues with these physicians. However, CCNs represented a positive and useful geographical point cultures during which CCNs secured less-competent nurses and physicians. The combination {information |of knowledge |of information} consisted of mixing the quantitative data with the qualitative the combination will be achieved by news results along within the discussion section. The qualitative information allowed participants to explain their perceptions of ethical distress in their own words and were accustomed expand understanding of the quantitative measures of ethical distress intensity and frequency. The analysis and synthesis of the form responses associated with ethical distress offer a lot of comprehensive understanding of every facet of the ethical matrix in medical aid and is given at intervals the dimensions: Futile care, moral misconduct, Deceptive communication and Poor cooperation [13].

Conclusion

CCNs represented feeling ethical distress associated with futile care and once nobody determined to withdraw ventilator support to a dispiritedly unwell person. Previous analysis known that CCNs reported higher ethical distress in these things than before the COVID-19 pandemic. CCNs ought to assume responsibility for the opposite, and this moral responsibility may be a duty CCNs should not refuse [14]. Whereas Levinas outlined care as aobligation, Ricœur represented care as daring to satisfy the patient in his and her suffering. Ricœur's philosophy contrasts with Levinas' notion of care, wherever the initiative for these conferences continually rests on the caregivers. Within the gift study, CCNs intimate ethical distress once nobody created the choice to withdraw life support and after they required summoning the courageousness to lift 'difficult' queries. In line with an inspiration analysis, ethical courageousness is that the 'true presence, ethical integrity, responsibility, honesty, advocacy, commitment and perseverance, and private risk', which might be represented as reflective nursing values and principles. The CCNs represented things of moral misconduct once either they or a colleague wished to try and do what they believed would be the most effective course of action for his or her patient their patient's relatives, however they were prevented from doing therefore due to a scarcity of resources and organization. If medical aid is thought to be an ethical activity and nurses, got to feel as if they're doing one thing that's virtuously sensible and right, it's essential that the ways that during which organizational structures hinder nurses from performing arts well square measure scrutinized [15].

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