

Psychological Effects of Sedative on Critical Ill Patients at Saidu Teaching Hospital Swat

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Abstract:-

➤ Objective

To access the psychological effect in patients admitted in intensive care unit.

➤ Method

This cross-sectional study was carried out in the Saidu Teaching Hospital's ICU from January 2023 to December 2023 after receiving ethical approval. Age over 18, a 24-hour intensive care unit stay, mental ability during assessment, and informed consent for research participation were the requirements that needed to be fulfilled in order to be included. Being moved out of the ICU and not completing the assessment satisfied the trial's exclusion criteria. The findings were analyzed using a non-probability sampling technique with the SPSS-24 version. Chi-square values below 0.5 were regarded as significant.

➤ Result

A total of 161 patients' data were assessed. Medical cases accounted for 89 (55.2%), and depression patients made up 72 (44%). The ratio of males to females was 94:67, or 58:42%. Compared to 135 (83%) who were seen within two weeks of the complaint length, 26 (17%) were present in >two weeks with significant value. Ten (6%) had positive anxiety scores, while 151 (93%) had negative scores. 152 persons did not test positive for amnesia out of 161, while 9 did. Six persons were certain they had

hallucinations, but 155 did not. 87 patients reported having PTSD, whereas 74 patients had negative test results. Of the ICU hospitalizations, 27 cases (16.7%) involved surgery, and 89 cases (55%) involved medicine.

➤ Conclusion

Using a bedside screening instrument and getting approval from a doctor will lead to better identification and early detection. The initial stage of prevention, aimed at establishing an ICU free from psychological fallout in the future, is the identification of incidence and risk factors. Critically sick ICU patients deal with a complex array of psychosocial consequences.

Keywords- Critical Care, Intensive Care Unit, Psychological Effect, Anxiety, Depression, Post-Traumatic Stress Disorder.

I. INTRODUCTION

Negative effects are observed in the psychological and physical well-being of critically sick patients as well as the emotional well-being of the family caregivers. Research examined how family caregivers dealt with patients who were delirious and found that they displayed symptoms of discomfort¹. There is little data to suggest that ICU patients' psychological and familial outcomes are impacted by sensory stimulation. A new systematic analysis discovered very low certainty evidence from only two studies, however narrative synthesis showed improvements in psychological recovery for

patients and satisfaction among families with the care they received. As such, the effects of a sensory stimulation intervention on the psychological, clinical, and family outcomes of critically ill patients cannot yet be determined². The psychological impacts of pain, anxiety, delayed weaning, immobilization, and sleep deprivation are often linked³⁻⁴. Being deeply sedated and immobilized for an extended length of time can cause chronic psychosocial, clinical, and cognitive issues in critically ill patients.⁵ ICU patients expect prompt assistance when needed and specialized care from the medical team. Patients need to be aware of their medical problems in order to prioritize their therapies and concurrently lessen their anxiety, fear, and panic episodes. Having a secure environment is essential for fostering self-worth, stability, and recovery drive⁶⁻⁷. Understanding the needs of the families and making an effort to meet those needs would help the families cope better with their loved one's ICU admission. The needs of family members change slightly depending on where they are. Families in Malaysia and Hong Kong needed to know that their loved ones were getting top-notch care⁸⁻¹⁰. Their stay in the ICU has an impact on them both mentally and physically. Among the common physical aches and pains are pain, exhaustion, discomfort, inactivity or overexertion, noise, thirst, headaches, discomfort from endotracheal tubes, and trouble swallowing. Their psychological health is affected by the nature of their illness, the medical care they get, and how they feel about the behavior of the ICU staff. Patients¹¹ stated experiencing hallucinations, fear, worry, anxiety, melancholy, loneliness, and thoughts of death, panic, unease, uncertainty, and despair. When the managing team's primary focus is on treating the patient's critical problems, it can be easy to overlook these parts of the patient experience. Family members are angry when they learn that their loved ones have been admitted to the intensive care unit. Family members experience emotional helplessness when their needs for information, reassurance, help, and support are not met. They experience loneliness, uncertainty, and a lack of control. They go through severe emotional changes each time there is a significant shift in their relationship. Family members get unhappy when their experiences don't live up to their expectations, which are shaped by their cultural background¹².

II. METHODOLOGY

Cross-sectional study carried out from January 2023 to December 2023 at the intensive care unit (ICU) of the Saidu Teaching Hospital in Swat. The goal of the study was to look into specific diseases that ICU patients had. Below is a summary of the methodology's main ideas. An ethical committee approved the study, certifying that the protocols and research design meet ethical requirements. The study was carried out at the ICU of the Saidu Teaching Hospital in Swat over the designated period of January 2023 to December 2023. The study's inclusion requirements were that participants had to be over the age of eighteen, have spent a minimum of twenty-four hours in the intensive care unit (ICU), be cognizant during the evaluation, and give their informed consent before they could be included in the study.

Exclusion Criteria: Participants who were transferred out of the intensive care unit or who were unable to finish the assessment were not allowed to participate in the study. Descriptive statistics were used in the data compilation process. For data that were continuously distributed and regularly dispersed, the mean and standard deviation were used. The categorical variables were summarized by frequency and percentage. The dataset contained no missing values, and the data processing did not alter it in any manner. All 166 patients who were enrolled in the study had data included in it. The sample was created via non-probability sampling. The data analysis was conducted using SPSS version 24. Using a chi-square test, statistical significance was determined by setting the chi-square statistic's threshold at 0.5. This suggests that if a chi-square value was less than 0.5, it was considered important. The investigation adhered to ethical guidelines, using a precisely defined methodology, and presented and interpreted the findings using a range of statistical approaches. The findings might provide insight into the characteristics and prevalence of the illnesses being studied in the particular ICU group.

III. RESULTS

After getting ethical approval & written informed consent from the patients the data was analyzed through spss 24 versions.

TABLE 1 AGE AND COMPLAINT DURATION

	N	MEAN	ST DIV
AGE	161	28.6	11.811
COMPLAINT DURATION	161	16.83	4.242

TABLE 2, AGE AND GENDER GROUP VERSUS intensive care unit stay

AGE AND GENDER DISTRIBUTION	Intensive care unit stay			P-VALUE
	YES	NO	TOTAL	
LESS THAN 50 YEAR	42 56%	33 44%	75 100%	0.641
GREATER THAN 50 YEAR	45 52.3%	41 47.7%	86 100%	
MALE	52 55.3%	42 44.7%	94/161 58%	0.669
FEMALE	35 52.2%	32 47.8%	67/161 42%	

TABLE 3 Different Variables Studied Against intensive care unit stay

NO	Variables Studied		Intensive care unit			P VALUE
			YES	NO	TOTAL of 161	
1	Duration of complaints	<02 WEEKS	71 52.6%	64 47.4%	135 83%	0.400
		>02 WEEKS	16 61.5%	10 38.5%	26 17%	
2	depression	YES	54 75%	18 2%	72 44%	0.00
		NO	33 37.1%	56 62.9%	89 56%	
3	anxiety	YES	7 70%	3 30%	10 6%	0.287
		NO	80 53%	71 47%	151 93%	
4	Amnesia	YES	6 66.7%	3 33.3%	9 100%	0.428
		NO	81 53.3%	71 46.7%	152 100%	
5	Hallucination	YES	5 83.3%	1 16.7%	6 100%	0.123
		NO	82 52.9%	73 47.1%	155 100%	
6	Post-traumatic stress disease	YES	51 58.6%	36 41.4%	87 100%	0.206
		NO	36 48.6%	38 51.4%	74 100%	
7	Medical cases	YES	71 79.8%	18 20.2%	89 55.2%	0.00

		NO	16 32.3%	56 77.8%	72 44.8%	
8	Surgical cases	YES	12 44.4%	15 55.6%	27 16.7%	0.274
		NO	75 56%	59 44%	134 83.2%	

IV. DISCUSSION

Critically sick patients in the intensive care unit (ICU) may have complex and long-lasting psychological repercussions. These results are influenced by a number of variables, such as the patient's particular psychological profile, the intensive care unit setting, the intensity of the disease, and the necessary medical interventions. The main psychological impacts that are covered in this study are those that critically ill patients can encounter in the intensive care unit. An intensive care units (ICU) intense lights, incessant machine noise, and routine patient care can make the place feel unsettling and alien. This can lead to a rise in fear and worry, which is often exacerbated by the severity of the sickness. In contrast, out of 89, 33 (37.1%) were positive and 56 (62.9%) were negative for not having depressed symptoms. Of 72, 54 (75%) were positive and 18 (2%) were negative for having depression. Intense pain, suffering, and uncertainty about the result might intensify these feelings. The study found a large degree of variance in sedative patterns in a real-world ICU. Clinical setting. Despite advice to stick to light sedation instead of severe sedation¹³. On the other hand, of the 151 individuals, 80 (53%) were thought favorably and 7 (47%) negatively for not exhibiting symptoms of anxiousness. Of the ten, seven (70%) reported being positively anxious, while three (30%) reported negatively. Critically sick individuals can endure unbearable misery, pain, and worry as a result of their illnesses, exams, and treatments. Early deep sedation may reduce pain and anxiety, improve mental and physical well-being, improve patient compliance, and reduce operation times¹⁴⁻¹⁶. Early deep sedation also enhances sleep efficiency in critically ill patients who often have significant sleep fragmentation and disordered sleep architecture, which is beneficial to patients' clinical outcomes¹⁷. Three (33.3%) of the nine were found to be negative, and six (66.7%) had amnesia. On the other hand, 81 (53.3%) of the 152 individuals had amnesia symptoms, while 71 (46.7%) did not. Some survivors experience PTSD symptoms as a result of horrific things that happened to them while they were in the intensive care unit. Hallucinations, delirium, and vivid dreams can be distressing and cause lifelong psychological damage.

Prolonged stays in the critical care unit, being away from family, and having trouble performing simple self-care duties can all intensify feelings of helplessness and grief. Patients may also experience issues with losing control over their bodies and healthcare decisions. Families and ICU personnel expressed difficulty understanding patients' needs¹⁸⁻¹⁹. 82 (52.9%) of the 155 respondents were found to be positive and 73 (47.1%) to be negative for not having hallucination symptoms, while 5 (83.3%) of the 6 respondents were found to be positive and 1 (16.7%) to be negative for experiencing hallucinations. Family members commended the ICU staff, stating that they were crucial in fulfilling the patients' psychological needs and providing them with psychological treatment. 36 (48%), out of 87, tested negative for not having PTSD symptoms, whereas 51 (58.6%) tested positive for having PTSD symptoms. Conversely, of the 74, 36 (48.6%) were determined to be positive for not having symptoms of PTSD, and 38 (51.4%) to be negative. This means encouraging ICU personnel to share information with patients in a thoughtful way in order to give them hope. It has been shown that offering psychological support (coping strategies, stress management, and psychotherapy) to patients in the critical care unit lowers their risk of developing post-traumatic stress disorder and their requirement for psychiatric medication²⁰. By contrast, 36 (77.48%) of the 72 cases were found to be negative for medical cases, while 16 (32.3%) of the 72 cases were found to be medical cases. 71 (79.8%) of the 89 instances were determined to be medical, while 18 (20.2%) were found to be negative for non-medical situations. Likewise, out of the 134 cases, 75 (56%) involved surgery, and 59 (44%) did not; similarly, out of the 27 cases, 12 (44.4%) involved surgery, and 15 (55.6%) did not. Certain patients may have psychological side effects, such as anxiety, hopelessness, and trouble adjusting to their new surroundings, even after they are released from the intensive care unit (ICU). Counseling and continued psychological treatment may be required as a result of these impacts. In addition to the patient, families and workplaces may experience psychological impacts from a loved one's critical illness, which can lead to distress, anxiety, and emotional suffering.

V. CONCLUSION

It has a major impact on mortality and duration of stay and is quite common in intensive care units. A physician's consent and the use of a bedside screening tool will improve identification and early detection. Finding incidence and risk factors is the first stage in preventative care, which aims to construct an ICU without psychological effects in the future. ICU patients who are critically ill have a wide range of complex psychosocial effects. These effects are contingent upon several elements, such as the characteristics of the patient, the intensity of the disease, and the ICU setting. It is critical to identify and treat these psychological components if ICU patients and their families are to receive complete and comprehensive care.

VI. LIMITATIONS

There isn't a single, approved instrument to evaluate how intensive care unit patients' psychological states are affected. As a result, the manner in which psychological results are reported and quantified varies according on the study. There aren't enough long-term follow-up studies to determine the long-term impact on patients' psychological health and quality of life, despite growing knowledge of the short-term psychological repercussions of ICU admissions. Many healthcare facilities find it difficult to offer complete psychological treatment to patients in the intensive care unit (ICU) due to resource restrictions. This could make it more difficult to put rules into place that could lessen psychological suffering.

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