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REQUIREMENT FOR THE DEGREE OF MASTER OF SCIENCE IN NURSING
UNIVERSITY OF THE WITWATERSENAAND, JOHANNESBURG. AS A
RESEARCH REPORT SUBMITTED TO THE FACULTY OF HEALTH SCIENCES.

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INTENSIVE CARE UNIT EXPERIENCES OF CRITICALLY ILL ADULT PATIENTS
Date: 04/05/03

Stella Sarah Bokaba

| Signature |

For the Degree of Master of Science (nursing) in the University of Zimbabwe,

I, Stella Sarah Bokaba, hereby declare that this research report is my own work. It is submitted

DECLARATION
Neurosurgical ICU who participated in this research.

To all patients in General ICU, Trauma ICU, Cardiobolic ICU, Coronary care ICU, and

DEDICATION
and management of hospital.

A sincere thank you to all patients who participated in this research and all the ICU staff.

I would like to thank Dr. Becker (Satisfaction) for the substantial analysis of data.

for her motivation and support.

In this research, I would also like to thank my critical care lecturer, Dr. Shelley Schmuller.

A special thank you to your valuable input, time and patience during this research.

I wish to thank my husband, Thabo, my sons, Thabo and Molele, for their support during

ACKNOWLEDGMENTS.
The study and the findings will be published in the recognised nursing journal.

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Experience Questionnaire: Data was analysed descriptively to determine the incidence of

A simple random sampling was used. Data was collected using the Inpatient Care

the period 1 March 2007 to 31 May 2007.

A descriptive comparative study was used. The sample comprised 98 patients selected

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ABSTRACT

v

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Introduction and Background to the Study

This is a very challenging and stressful experience, and totally dependent on nurses and doctors because they cannot do anything for themselves. Intensive care units (ICUs) are designed to admit patients with life-threatening illnesses. Therefore, careful planning and maintenance of physical and mental health are very critical. Most patients in ICUs are very ill, usually undergoing multiple procedures and interventions, which are necessary to overcome their critical illnesses. Such stressful procedures and interventions include: insertion of intravenous lines; mechanical ventilation; medications used to optimize mechanical ventilation such as morphine (intravenous); and medication (an analgesic) and medication (a nonsteroidal blocker).
not all dreams. Hallucinations and hallucinations among ventilated ICU

dreams, nightmares, and hallucinations (Grundges, Schmeling, Weger, et al., 2002). In a prospective clinical study conducted in Germany on ventilated ICU patients who were

headache, dizziness, and confusion (Atchambele et al., 2005; 25).

Narcotics are a neuro muscular block that causes skeletal muscle relaxation. It is used to

pronounced when used in combination with sedatives like the benzodiazepines (diazepam, et al.,

narcotic causes central nervous system depression which becomes more

perception can be in the brain. The side effects of morphine include: mood changes, dizziness

mood, relatively, anxiety, headache, confusion and hallucinations (Poirer, 1999). Have no recall of events following its administration. It also causes decreased

interventions. The side effects include: amnesia of short or long duration, causing patients to

that may be caused by the ICU environment. It may cause other side effects like sedation and sleep producing properties. It is mostly used on ICU patients to relieve anxiety.

placebo patients in ward dreams, nightmares, and confusion (Grundges, et al., 2002; 31).
Reduced quality of life both in physical and emotional domains was reported in Western Cape (Roberts & Chaboyer, 2004:174; Lo & Berenson & Alphonse, 2003:161). Reduction in health experiences because such factors could contribute to confusion, delirium and hallucinations. Patients with severe sensory, olfactory, and eye damage have more troubles. Of discomfort, pain, confusion, disorientation and fear of death (Henderson & Ellison, 2001:34). A qualitative study that was conducted in ICUs in Gauteng province, South Africa, patients expressed similar experiences. Quality of life later (Kinsella, Hamerton & Prince, 2006:42). In a qualitative study, there was stress and lead to frustration in patients, which may have an impact on their health-related quality. All these together with the uncertainty of the prognosis and the fear of death also produce discomfort, where patients could not recognize parts of their body as their own (Hoare & Lyons, 2009:367). Other experiences include feelings of being alone, confusion or delusions. Patients experienced emotional instability, a feeling of loss of self-control, hallucinations. The experiences appeared real and occurred when they were awake. Ventilated patients in ICUs have been known to express experiences of vivid dreams and absence of sedatives and analgesia. United States, 40% of ICU patient reported dreams, hallucinations and hallucinations in the United States, 40% of ICU patient reported dreams, hallucinations and hallucinations in the United States, 40% of ICU patient reported dreams, hallucinations and hallucinations in the United States, 40% of ICU patient reported dreams, hallucinations and hallucinations in the United States, 40% of ICU patient reported dreams, hallucinations and hallucinations in the United States, 40% of ICU patient reported dreams, hallucinations and hallucinations in the United States, 40% of ICU patient reported dreams, hallucinations and hallucinations.
The researcher worked in ICU for the past ten years and informal interviews conducted with nurses, for basic self-care activities. Ventilated patients are known to experience dreams, on average, for basic self-care activities. Ventilated patients are known to experience dreams, it is clear that the ICU is far more than people. Critically ill patients are completely dependent on ICU environment insofar as most patients. Patients in ICU are critically ill, and some have to undergo musculoskeletal procedures and often undergo their fears, because they have to undergo musculoskeletal procedures and often undergo their fears, because they are conscious and stable, or when they regain consciousness and are stable, in order to help them understand all the dynamics involved in ICU, as well as other conditions. Reasons for this will ease their frustrations and possible long-term psychological impact that could affect their health related quality of life. Communication remains the cornerstone of nursing.}

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and in some patients required further interventions 12 months after discharge (Kavchen et al. 2000:42)
The objectives of the study were to:

1.6 RESEARCH OBJECTIVES

- What recommendations can be made for clinical practice and education of critical care nurses?
- Do patients with lower SAPS II scores encounter worse experiences than those with higher SAPS II scores?
- What are the characteristics of adult patients' experiences of the Intensive Care Unit?

1.5 RESEARCH QUESTIONS

- Group II with high SAPS II score (p-value 0.00 to 0.05)
- Group I with low SAPS II score (p-value of 0.00 to 0.05)

According to the Simplified Acute Physiology score (SAPS II score):

Intensive Care Unit admission. The study is based on the patient's severity of critical illness. The aim of the study was to describe and compare critically ill adult patients' experiences of delusional, nurses working in ICU need to be aware in order to improve the quality of life of results confirm the existence of such experiences. Whether these memories were related to
I. DEFINITION OF TERMS

Health-related quality of life: holistic care, enhancing speedy recovery and preventing long-term adverse effects on patients. This information may be used as a basis for decision-making in order to provide individualized prevention of long-term consequences related to admission in ICU.

The outcome of this study will fill an important practice gap in this context and thereby experiences on discharge from ICU, and to distinguish between what is real and unreal, will assist the nurses to prepare their patients and families to understand and interpret such experiences. The outcomes of this study will contribute to the body of knowledge of critical care nurses.

I.7 SIGNIFICANCE OF THE STUDY

In order to address the identified problems:

- Make recommendations for clinical practice and education for critical care nurses in SAPS II score.
- Compare critically ill adult patients with high SAPS II score with those having low care.
- Describe critically ill adult patient's experiences with reference to their awareness of
Until patient is discharged (date until 2000.2357).

The nursing act 50 of 1978,
amended by regulation R75 (South African Nursing Council Regulations under Nursing Council(1996)SANCO), in accordance with regulation number R212 as nursing and who is registered as a critical-care nurse with the South African nursing and who has undergone an accredited course in critical care.

Intensive Care Unit nurse:

Critically ill patients (Burke & Melander 1999:39).

A specially designated area offering facilities for care and management of

Intensive Care Unit:

This may include terms, dreams and influences (Burke & Melander 1999:62).

Daily occurrences and incidents in the Intensive Care Unit that have a direct

Intensive care experience:


Patients with an SAPS II score of 0.00 to 0.5 (Burke & Melander 1999:39). Le

Severely ill patients with an SAPS II score of 0.5 to 1.00, and less severely ill
of terms. In the following chapter, a review of relevant literature will be presented, problem statement, research questions and objectives, significance of the study, and definition. An overview of the study has been given, which includes the background of the study.
Physiological needs are inherent in all human beings, among them are needs for shelter, oxygen, food, fluids, sleep and comfort (Gillis & Nowlis, 2004:80). Maslow regarded these physiological needs as vital, however, due to circumstances originating from their disease conditions and medical interventions, some needs are violated, resulting in some physiological and psychological imbalances. Patients in the ICU have basic needs like any other individual. These needs are ranked in order of relative importance: physiological needs, safety needs, love and affection needs, self-esteem and self-actualization needs (Lauv, Edwards, Feser, Cillett, Law, John, Phillips, Simulated-Jordan & Spence). Previous studies conducted on this area were used to guide the literature review and

2.2 PHYSIOLOGICAL NEEDS

2.1 INTRODUCTION

LITERATURE REVIEW

CHAPTER TWO
Washing them, they feel as if they have been robbed of their privacy and dignity. They have lost control over their immediate environment and over their bodies. Nurses because they cannot perform basic self-care activities such as washing. They feel as if some ICU patients cannot do anything for themselves. They are completely dependent on nurses, et al., (2002:245) further indicated that owing to the nature of their critical illness, syringed secretion and sores and the fear of life, giving them hope to live again.

Petersson, L., & Nygren, S. (2000:128) revealed that for some patients mechanical ventilation is the last resort. However, a phenomenological study conducted in Sweden by Gräp, al., (1999:52) indicated that due to feelings of frustration and helplessness, patients begin to lose hope. They are therefore unable to move freely as they wish, (Emster & Melander, 1999:91). This is compounded by the fact that most are unwell (Söderberg & Mehlander, 1999:151). In ICU patients feel isolated because they have been moved away from their families. Every individual needs a comfortable relaxed physical environment (Lewy, et al., 2005:46). 2.2.1 PHYSICAL SAFETY

Other need (Lewy, et al., 2005:46) physiological needs are the most basic for every individual, and should be satisfied before any
2.2.3 Anxiety and Fear

An emotional component is a basic need for every individual. If violated, anxiety may be the result of improper patient communication and patient's decreased ability to concentrate (Buckner & Melander, 1999;32). Nursing literature suggests that patients in ICU experience anxiety (Buckner & Melander, 1999;32). Anxiety is a psychological condition characterized by worry, restlessness, irritability, and decreased ability to concentrate. Anxiety may also result in decreased ability to communicate effectively with other medical staff.

2.2.2 Severity of Illness

The severity of illness, together with other contributing factors such as age, social factors, and patient experience, contribute to the anxiety and fear experienced by the ICU patients. The ICU environment, with its high-tech equipment and procedures, can also cause anxiety among patients. Understanding and addressing these factors can help reduce anxiety and improve patient outcomes.

2.3.1 Rest and Sleep Disturbances

In a review of both physical and emotional safety (Fiske & Nordstrom, 2001:80), all humans beings share a need to feel physically and emotionally safe. Trauma and illness

2.3 Safety Needs

Caring relationships and reassurance from nurses which revealed that patients verbalized that their fears and anxieties were reduced by the effects. This was confirmed in a hermeneutic study conducted by Chardburt, et al., (2002:22), patients could help to ease their fears, anxieties and prevent such long-term psychological may affect patient's quality of life (Soll, et al., 1999:699). An ongoing reassurance to ICU hostility (Moser, et al., 2004:218). Anxiety can lead to long-term psychological effects that some patients displayed lack of co-operation, such as pulling of tubes, nails, water and a descriptive study conducted in Europe on ICU patients cited that as a result of anxiety, 2004:218) suggested that anxiety in some patients in ICU is related to lack of co-operation.
Six months after discharge, eighty-six percent of patients reported that they experienced
issue healing (Nordier et al., 1999). Discomfort may lead to excessive fatigue that may interfere with
their disease condition. Discomfort may lead to excessive fatigue that may interfere with
position on their own, which in turn may cause patients to adopt a particular position, owing to
unstable interactions, and sleeping in one position for a long time because they cannot change
experience various forms of discomfort from a range of procedures, including medical and
physical discomfort is important for every human being (Law, et al., 2005). ICU patients

2.3.2 Discomfort

This prevents further psychological complications and unwanted discomfort.

This prevents further psychological complications and unwanted discomfort.

Procedures that cannot be avoided. This will allow patients to have enough rest and sleep and
Note: Explanations should be given to patients about the need for alarms and other disturbing
answer the telephone, and promptly attending to alarms to prevent continuous disturbing
Noise levels in ICUs should be kept as low as possible by lowering voices when talking or
Although it was argued, they experienced a relief after being in sections

By noise from machines and alarms, disturbing of the airway did not bother them either,
in Sweden by Karlsson and Forsberg (2007). They revealed that some patients were not bothered
to rest and sleep as they wished. However, a phenomenological study concluded
participants were also not appreciated by patients because the procedures made it difficult for them
to breathe. This study showed that inappropriate procedures like suctioning, remaining and
conducted at the Royal North Shore Hospital in Sydney, Australia on ICU patients six months

Six months after discharge, eighty-six percent of patients reported that they experienced
issue healing (Nordier et al., 1999).
remained expressions in the presence of unbearable pain (Klopper, Vandersmissen, McKinnon, 1999). Work for all patients because some patients still maintain normal vital parameters and assessed worth as a measure in blood pressure and pulse, facial or verbal expression. This did not experienced worse pain than did non-ventilated ones. Nurses relied on their own pain conducted on ICU patients in North West Province, South Africa, ventilated patients 1999:33). It is common in ICU patients, according to a qualitative study with literatures and emotional experience associated with issue damage (Dunster 

\textbf{2.3.3 Pain and Ventilation.}

Pain and discomfort are often reported to give patients better understanding, build trust on nurses and increase cooperation and adherence of discomfort and pain (Huang & Tsui, 2005:170). Explanations to patients about the importance of different procedures and interventions have pneumogena and subsequent increase in hospital stay.

translation of sub-pulmonary sections into the lungs, thus increasing ventilation-associated and restless with subsequent movement or displacement of the ET tube. This allowed easy (2002:45) further indicated that the discomfort from the ET tube made patients very agitated, choking or a gagging sensation, which made it difficult for them to breath. Crying, et al., discomfort from irritation by the endotracheal tube in their throat. It was described as a
A nightmare is an extreme form of a dream that can be very distressing, causing fear and
DREAMS AND NIGHTMARES

2.3.5

Also, a warm, professional and caring environment is important in ICU so that patients can feel
only once or twice a day. If patients were lucky enough (Gillilith & Jones, 2004:44),
noisy environment then be in a ward where there is no individualised care, and doctors came
patients reported that they would rather be in that busy,
To some patients, ICU was some form of the security where every category of health

Gillilith & Jones (2004:44) in their study reported that patients verbelised that they felt very

2.3.6 SAFETY AND SECURITY

depth. Anxieties are important in the ICU for pain control
Gillilith & Crowder, 2005:45). Some patients felt as though they were much closer to
pain was so severe that it was often reported as one of the major experiences (Gardner, Elliott,
ICU nurses who were admitted as a patient in an ICU reported that they
were not as familiar with ICU
nursing. Dreams have been reported even on participants who are familiar with ICU
their dreams, could see themselves die, but not completely because they were transformed into
gas and heard voices from far away. Planning bad things about them. Some patients, in
baloons. Some felt as if they were in a strange, faceless plane, and they were suspended in
persons and could see their bodies change into different shapes, feeling overburdened like
Dreams included seeing themselves as if they were being transformed into completely
disappearance. Participants in this study reported to have dreams six months after discharge.
patients who were ventilated, in an academic hospital in Greece, one to six years after
De Pauw (2004:174) conducted a phenomenological study on ICU
been reported to continue even six months after discharge (Granbois et al., 2002:23).
poisonous injections and feeling as if they were shrinking into a deep hole. These dreams have
patients included seeing people dying in relation to killing them, doctors lying to them with
these drugs include sedation, weird dreams, and nightmares. Dreams that were reported by
reduce anxiety and fear, control pain, and to induce unconsciousness. Known side effects of
domains, analgesics. The morphine are given to ventilated patients to achieve ventilation.
The study indicated that neuromuscular blocks work more effectively than
permissive approach, in Helsinki Hospital, Sweden, four to eight weeks after discharge.
Granbois et al. (2002:23) conducted a qualitative study on ICU patients, using a
analgesics, sedatives and neuromuscular blockers that are prescribed to patients in ICU.
Dreams and nightmares are common in ICU and literature relates these to the side effects of
Increased mortality and morbidity. In ICU, seventy percent of cases were undiagnosed or unrecognized. Delirious patients have months after discharge from ICU, delirium was reported in 85% of patients that were admitted to ICU patients at the University of London hospital in the United States of America, six months after discharge from ICU, delirium was reported in 99.9% of patients that were admitted to ICU patients at the University of London hospital in the United States of America.

According to Elwy, Honey, Perera, and Gorton (2004: 210), in a prospective cohort study on depression as well as use of various medications (vitamin B, melatonin, 1999: 22), multi-system illness, use of psychoactive drugs, surgical and medical interventions, sleep disruption, associated with poor hospital outcomes (Roberts, 2004: 207). It is a serious form of organ process, since it is not related to information (Roberts, 2004: 207). Delirium refers to a disturbance of consciousness and mental status characterized by an acute onset and fluctuating impairment of cognitive functions that disrupt the ability to receive, store, and recall information. A delusional phase with the patients and the health-care professionals is important upon.

Delirium refers to a disturbance of consciousness and mental status characterized by an acute onset and fluctuating impairment of cognitive functions that disrupt the ability to receive, store, and recall information. A delusional phase with the patients and the health-care professionals is important upon.

Dreams and nightmares could have long-term effects on patient's health-related quality of life. Delirium refers to a disturbance of consciousness and mental status characterized by an acute onset and fluctuating impairment of cognitive functions that disrupt the ability to receive, store, and recall information. A delusional phase with the patients and the health-care professionals is important upon.

Mourners who wanted to kill her (Powers, 2004: 174). was haunted by dreams more than six months after discharge, seeing colleagues as potential
outcomes and post traumatic stress disorder.

and needed in advance in order to prevent complications that may lead to poor patient outcomes. If we could identify these precursors, then early intervention may be possible before they escalate.

ICU patients' (Bermes, Dobos, Dumont, 2001; 1-62.) All these factors are common in stressful situations. Respiratory distress, elevated blood glucose levels, azotemia, and respiratory distress syndrome, hyporeninsimia, hyponatremia, hyponatremia, metabolic abnormalities associated with delirium include pain, smoking, fever, hypotension, and from ICU.

Factors that can precipitate or may affect patients to return to their full potential after discharge non-delirious patients' Konstantinou et al. (2004) is of the view that delirious patients experience more severe dreams than do

Flominger et al. (2002; 4) is of the view that delirious patients experience more severe dreams than do

(Jones, et al, 2001; 1-75.) and self-injuries (Fry, et al, 2001; 270-3). Some patients may develop insomnia upon recovery. Most serious complications of delirium include respiratory difficulties, prolonged ventilation patients' health-related quality of life, hospital stay and increased costs for the patients. The increase in length of hospital stay may impact on the increase their stress of condition. The length of the hospital stay may impact on the longer in ICU, and are exposed to a risk of nosocomial infections. These factors further increase the delirium in ICU and become difficult to discharge them. Such patients are kept
Ahmed, 2004; Ahmed, 2004; 2004:356) further reported that unconscious and sedated patients can hear, but they
about inappropriate self-communication, and communication about other patients. Ahmed &
 informed them about different interventions and procedures. Some patients were depressed
ventilated in these ICUs reported high levels of stress and anxiety because nurses never
of Jordan hospitals, in the city of Amman, indicated that most patients were unconscious or
Ahmed and Ahmed, 2004; 2004:356) in a qualitative study conducted in these Intensive Care Units


Critical patients, communication can easily be missed or understated (Hemelrijk, 2001) in
affect the patient's ability to communicate (Ahmed & Ahmed, 2004; 2004:356). When caring for
diseases, stress, and psychological stress (Baskin et al., 1999; 2000). The critical nature of patients, the
psychological impact (Baskin et al., 1999:2000). The critical nature of patients, the
and healthcare professionals, communication with patients is very important for their
Communication refers to both verbal and non-verbal interpersonal strategies between patients

2.4.1 COMMUNICATION WITH CRITICALLY ILL PATIENTS.

2.4.1 COMMUNICATION WITH CRITICALLY ILL PATIENTS.

Reaffirm a sense of security to patients (Elia & Nowlis, 2001:81).
other people. A warm, loving and caring relationship from relatives and staff is likely to
Every human being has a uniquely meaningful relationship with
Mastery describes love and affection as needs to be loved, understood, and accepted in a group

2.4 LOVE AND AFFECTION
In planning of some aspects of their care, it is important. This will help reduce their fears and clear explanation about patients’ diagnosis, condition and prognosis, as well as involving them of family members has beneficial effects in reducing stress. Giving sufficient information andEdinburgh in social conversations with ICU patients can be very beneficial. The involvement

communication like using gestures, writing and hand movements.

verbal communication would not be possible, but we were happy with alternative means of reported that patients verbalised that communication was not a problem, they understood their

However, studies by (Akech, Z. & Liljegren, M., 2002; Ludden, C., & Forsberg, 2007:43),

solution, but that would make them feel better.

personal problems. They wished that someone could listen even if they did not offer any

Province, South Africa, reported that some patients were so frustrated because of their

Klopper, C. et al., (2005:10), in a qualitative study conducted on ICU patients in North West

medical part.

psychological, and spiritual aspects, but concentrated too much on the physical and the

They also complained that nurses were not giving them enough attention on the social,

acceptance information about their conditions. They felt left out in aspects of their own care.

Patients reported that they felt as if they were infinitely read because they were not given

South Africa, cited that communication with the critically ill patients in ICU is a problem.

Gowla (2000:69) in an exploratory survey conducted on ICU patients in Kwazulu Natal, and procedures done on them, as well as their progress.

cannot respond verbally. It is important that ICU patients be informed of any interventions
Intensive Care Unit of Tygerberg Academic Hospital, South Africa, also indicated a gross observational study conducted on ICU patients twelve months after discharge from the different stressfull experiences of ICU stay. Karmak et al. (2005:42) in a prospective psychological ability of an individual. HRQL is mostly affected in critical illness because of human experience relating to health, business, (2000:1703), as the maximum physiological and tolerance of chronic (2004:74) defines health-related quality of life (HRQL) as all aspects of life.

2.5 EFFECTS ON HEALTH-RELATED QUALITY OF LIFE

needs may be violated in ICU patients due to some psychological effects of their condition. well as the feelings of being valued by others (Hollis et al., 2001:8). The psychological well-being of a person’s own adequacy and competency, as well as the feelings of being valued by others (Hollis et al., 2001:8). The psychological well-being of a person’s own adequacy and competency, as well as the feelings of being valued by others (Hollis et al., 2001:8). The psychological well-being of a person’s own adequacy and competency, as well as the feelings of being valued by others (Hollis et al., 2001:8).

2.5 SELF-ESTEEM

maximize recovery.

verbal communication can help to decrease patients’ anxieties, facilitate their co-operation and Communication remains an essential part of caring for critically ill patients. Verbal and non-

esteem, which will in turn enhance their well-being (Almeida et al., 2004:360).

Giving information and support may help patients to preserve their self-esteem and self-

(Almeida, 2004:360).

Auxiliary intervention may experience as a result of the critical illness of their loved ones.
It appears that complete recovery is a process and the convalescence stage is a challenge, with

2003:1375

patients with multiple organ failure have been reported to perform poorly (Combes, et
al.,
Clinical Gastroenterology, 2003:1375), acute respiratory distress syndrome survivors and cardiac
reduced quality of life than the general population (Combes, Costa, Terrill, Baudet, Mathieu,
University Hospital of Paris, Mechanically ventilated patients experienced worse health- in
a prospective cohort study conducted on ICU patients three years after discharge from the
and depression, 37.4% had mobility problems and 22% experienced self-care deficits.
experience of reduced quality of life. 54% of patients interviewed showed signs of anxiety
common study in Portugal conducted six months after discharge, patients reported worse
according to Gervilla, Lopez, Moreno, Dias et Costas-Pereira (2003:97), in another prospective
imbalance and poverty (Gertler, Tawiera-Pirina, et Cosma-Pereira, 2002:965).
previous levels of activity, most of them had to give up their jobs, leading to socio-economic
showed signs of anxiety, depression and self care deficits. Some could not return to their
Shields conducted between 6 months to 12 months after discharge indicated that patients
the physical domain.
reduction of health-related quality of life in the psychosocial and domain and 48% reduction in
especially in trauma patients. Of the patients that were interviewed, 53% showed significant
dramatic decrease in the total functional economy. Basic self-care was totally impossible,
effect on the overall health-related quality of life of patients after discharge. Patients suffered a.
the worst form being repeated thoughts of death.

ince months after discharge from ICU, and reported that 52% of patients developed PTSD.

patients in an academic hospital in North Scotland investigated post traumatic stress disorder

Christensen, Hjull, Stroebel et Scott, (2003;43), in a prospective cohort study on General ICU

2001:77)

experience that patients recall from their stay in ICU (Jones, Griffith, Humphries et al. 2001)

enumeate stress disorder in ICU patients has been related to a number of stressful moments of

wilt, hospital, anxiety, depression and reduced self-care activities. The development of post

muse of previous traumatic experience (Griffith & Jones, 2001:35). It is characterized by

Post traumatic stress disorder is a condition of disrupted mental and physical functioning as a

2.6.1 Post traumatic stress disorder (PTSD)

admission may disrupt the fulfillment of potentials and reaching set goals after discharge.

and develop one's unique values (Ellis & Nowlos 2001:8). The effects of illness and ICU

Mastorow describes self actualisation as an effort to fulfill one's potential, experiencing the fully

2.6 SELF ACTUALISATION

coming skills after their critical illness.

Returning patients to rehabilitation programs and support groups could help them with

depression (Griffith & Jones, 2001:35).

living and the inability to support the family and perform expected roles. Number leads to
CONCLUSION

In this chapter, literature about experiences of the critically ill adults in the ICUs has been reviewed. The severity of the critical illness, the multi-organ failure, trauma, drugs used in ICU as well as age, may worsen the experiences of patients in ICU. The following chapter will address details of the methadology used to conduct the study.

2.7 CONCLUSION

Several memories in order to make sense of what happened to prevent their long-term psychological Jones et al. (2001:575) proposed interviewing strategies to discuss the experiences and short-term memory. Symptoms included anger, anxiety, reduced concentration, reduced attention span, and poor after discharge. Farley et al. (2001) reported that 43.5% of patients were found to have symptoms of PTSD. The syndrome in the intensive care units of Crozer-Keck University Hospital, USA, eight years follow-up study conducted on long-term patients who survived acute respiratory distress syndrome in a psychiatric

that they would have an anger and just stop breathing. sure that they would be healthy and normal again. Many were scared to be left alone learning experienced anxiety and panic attacks owing to the uncertainty of their condition, not being traumatic stress disorder and episodes of conflict and these extended to their families. They in a qualitative study, Critelli & Jones (2001:355) reported that some patients with post
3.2 RESEARCH DESIGN

Reliability and data analyses are described. Data collection procedures and the pilot study are described. Ethical considerations are addressed. The data collection instrument, which is used for this study, is described. The study design is described.
The study population consisted of critically ill adult patients with low SAPS II scores. A - value of

3.4 Population

Discharge criteria:

between 0900 to 1600 in ICU, when they were physically and emotionally stable before

The interviews were conducted at the patients’ bedside during weekdays, Mondays to Fridays

unless preceded for specific procedures.

The design is similar in each ICU. The glass doors allow the staff to view patients at all times.

Continuous service to their patients day and night.

central feed pumps, Nurses’ doctors and other members of the health team provide a
technical equipment next to each bed like: ventilators, monitors, intravenous fluid pumps, and

be near the central nurses’ desk making it easy for the staff to view the patients. There are

screens in between beds for privacy. The front area of the room is made of glass, mostly

twelve. Each ICU is divided into rooms of different sizes ranging from one to six beds, with

thirteen ICU and the Neurosurgical ICU. The number of beds in the ICUs range from six to

injuries. The five ICUs were: General ICU, Trauma ICU, Coronary care ICU, Cardiac

The research took place in the Guangxi Province in five different ICUs of a tertiary hospital in

3.5 Research Setting

0.51 - 1.00

II scores (p-value of 0.00 - 0.5) are compared with those of higher SAPS II scores (p-value of

In this study, experiences of ICU admissions of critically ill adult ICU patients with low SAP
Group I or Group II depending on the p-value (0.00 to 0.5) Group I, and (0.5 to 1.0) Group II. The severity score (SAPS II) was done and was either allocated to a separate slip and put in a bowl. One slip was selected at a time, noted and put back into the bowl. The same procedure was repeated until the total number of 98 was reached. Once a subject in the sample frame were assigned research code numbers, each was written on a slip and put in a bowl. Simple random sampling was used following the fish-bowl/shuffling technique. The sample size was achieved. Simple random sampling was used following the fish-bowl/shuffling technique. The possibility for inclusion in the study, patients were randomly selected and interviewed. In order to establish the reasons for admission, diagnosis, to determine length of stay and the records of critically ill adult patients in the intensive care units. Central ICU, Cardiothoracic ICU, Coronary Care ICU, Trauma ICU and Neurosurgical ICU were reviewed.

3.6 SAMPLING

An Attitude was an additional criterion applied. In hospital, for both groups was not more than two weeks. The ability to speak either English. All patients were previously ventilated for a short period (2 to 7 days). The total length of stay.

Both Group I and Group II consisted of adult males and female patients over the age of 18.

3.5 INCLUSION CRITERIA

Candidate. That fulfill the inclusion criteria in the intensive care units of a tertiary hospital in a value of 0.51 to 1.00 (Group II) and those with high SAPS II scores: p-value of 0.00 to 0.5 (Group I)
Once verbally, consent was requested and permission continued in writing (Anon. Ex. III). In all relevant information about the study was given in writing (Anon. Ex. II) and charted informed consent (Anon. Ex. III). The topic of the research, the significance of the study and introduced himself 24 to 48 hours after stability, as after the initial phase, to obtain an committee and the CEO of the hospital. The researcher approached the patients in the ICU's. Prior to visiting the research site, the researcher first sought permission from the ethics

37 DATA COLLECTION

Indicate having mortality (ICD-9, Lecomte and Santher [1993:2957-2962]).

calculation. A p-value of 0.01 to 0.05 indicates low mortality and a p-value of 0.01 to 1.00 of admission. Each variable is allocated a score, then all scores are added up and a p-value obtained in 24 hours. serum urea and creatinine, while cell count, serum potassium, serum sodium, serum bicarbonate, serum bilirubin, Glasgow Coma Scale, chronic diseases and type systolic blood pressure, body temperature, FIO2/PAO2, core ventilation of CPAP, number of SAPS II points. The data and physiological variables include: age, heart rate, be recorded. The worst value was defined as the value that would be assigned the greatest that data of physiological variables of a patient be collected in 24 hours, and the worst value in a European and American multicenter study (Anon. Ex. XII). The scoring system requires

The SAPS II is a score of estimating the probability of hospital mortality that was developed with the statistician.
Experiences (6 items):

Relative’s feel safe in control and able to let people know what they wanted. Relative’s were also asked whether they remembered their relatives’ response to the presence of someone near, whether they knew when they were or when any recollection of being in ICU. They were asked whether they were able to recognize their immediate environment. The researcher also wanted to know whether the patients had their immediate environment. Under this construct the researcher wanted to explore whether the subjects were aware of

Awareness of Surroundings (9 items):

The questionnaire consisted of 24 items scored in four constructs:

was developed and validated by Ratcliff, et al (2004:44-73).

The researcher used the Intensive Care Unit Experience Questionnaire (Avenue), which

3.8 DATA COLLECTION INSTRUMENT


The patients’ beside. Data were collected over a period of three months (from 1st March). The interviews were conducted during weekdays, Mondays to Fridays from 09:00 to 16:00, at value 0.05. 49 patients with high SAPS II score (p-value of 0.51 - 1.00).

A total of ninety eight (98) patients were interviewed: 49 patients with low SAPS II score (p-value of 0.51 - 1.00). The consent was granted, data were collected using an intensive care experiences

questionnaire (Avenue).
Data collection was done by the researcher alone, using an ICE questionnaire which was developed and validated by Hartley et al in 2004. The researcher asked the same questions as permitted to use the instrument was obtained by the researcher from the authors (Anencure). The minimum score was 24 and maximum score, 120. Scores ranged from 1 to 5: Never (1), Rarely (2), Sometimes (3), Most of the time (4), All the time (5). The items were considered individually in their entirety. Good perception was defined by the outcome, All of the time, and most of the time (positive items) and bad perception was defined by the outcome, Never and Rarely (negative items).

The researcher wanted to know if subjects were satisfied with the care they received and to whether they could differentiate between day and night, about what was happening to them, also to find out more about their sleep patterns and about their experiences if their memories were clear, whether they wished to remember more.

In this context, questions were designed to elicit if the subjects wished to remember more things, feeling helpless, feeling pain and thoughts of possibilities of death.

The researcher conducted an investigation on the subjects to get an understanding of the recall of experiences that they had in ICU like bad dreams, feeling scared, seeing strange things, feeling helpless. The recall was elicited in the interview with the subjects as they recalled experiences that they had in ICU.
were encountered. The researcher received maximum co-operation from subjects and no problems
instrument and the methodology were found to be applicable, so no alterations were
II scores of 0.00 to 0.5, and two from Group II with high SAPS II scores of 0.51 to 1.00. The
A total of four subjects were used to conduct a pilot study (two from Group I with low SAPS
methodology, data collection instruments, and the feasibility of the study.
A pilot study was conducted following receipt of a letter of permission from the management

3.10 Pilot Study

Scale demonstrated construct and discriminant validity (Karnofsky et al., 2004: 64-73).

analysed with the subscales of Hospital Anxiety and Depression scale and Impact on Everyday
Correlation’s alpha statistics were acceptable for each component (0.77 - 0.93).

Satisfaction with care (four items);
Recall of experiences (six items);
Peer review experiences (six items);
Awareness of surroundings (nine items);

Factor analysis identified four components of intensive care experience:

update literature review in the original two-part study. From a set of 31 items, exploratory
instruments were generated, developed (n = 39) and evaluated (n = 109) through an extensive,
on the ICG questionnaires in exactly the same manner to all the subjects. The items of the
3.12 ETHICAL CONSIDERATIONS

Four.

In view of the lack of significant differences that were found, the details presented in chapter

3.11 DATA ANALYSIS
and the results of the study will be presented and interpreted.

The research methodology was described. This included the research design, the research

3.13 CONCLUSION

Confidentiality and anonymity were maintained by using research-assigned code numbers.

No problems were encountered and no psychiatric referrals were made.
There indicated a high degree of internal consistency of the research instrument. In analyzing
the data, the Cronbach's alpha was used to test the internal consistency of the research instrument. The
Cronbach's alpha was used to test the internal consistency of the research instrument. The
results were analyzed and compared to determine differences between the mean values of Groups I and
II. When analyzing the internal consistency of the instrument, the values of the Cronbach's
alpha were high for all constructs in both Group I and Group II, ranging from 0.710 to 0.968.

Data were entered into a Microsoft Excel spreadsheet. Descriptive and inferential statistics were used to analyze data. The
results were checked and verified.

42 APPROACH TO DATA ANALYSIS

0.051 (to 1.00) were labeled as Group II, value of 0.05 to 0.05 (d) were labeled Group I, and those with high SVAP II scores (p-value of
recall of experiences and satisfaction with care; Particpation with low SVAP II scores (p-

Intraosseous Care Experience Questionnaire: Awareness of surroundings: Physician's experiences;

Experiences. Data will be presented, analyzed, and described to meet the set objectives and the

À quantitativo, descriptivo, comparativo design was used to achieve the set
experiences of critically ill adult patients, according to the severity of illness as rated by the

In this chapter, the results of the study are presented relating to the Intensive Care Unit

41 INTRODUCTION

CHAPTER FOUR

RESULTS OF THE STUDY
shows that Group I had more males than Group II females: n = 22 (42.8%) in Group I also, the majority of participants were males: n = 28 (57.2%) than females: n = 26 (46.3%) in Group I consisted of more males n = 34 (67.3%) than females n = 62 (62.6%) and The sample consisted of both males and females in both groups: males n = 62 (62.6%) and females: n = 26 (36.3%)

<table>
<thead>
<tr>
<th>Group I</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>n=62</td>
<td>n=34</td>
</tr>
<tr>
<td>females</td>
<td>females</td>
</tr>
<tr>
<td>Total</td>
<td>Total</td>
</tr>
</tbody>
</table>

Table 4.1 Gender distribution for Group I and Group II

4.3.1 Gender

The demographic data of subjects (gender and age) for Group I and Group II were presented.

4.3 DEMOGRAPHIC DATA

not significant. Significant differences from 0.05 to 0.099 indicate marginal significance and 0.1 and above, items were analyzed individually. In this research, a p-value of 0.05 and below indicated the participants' responses to the questions on all constructs of the dysfunctional and their
4.4.4 AWARENESS OF SURROUNDINGS (n=99)

and taken as negative responses.

positive responses and responses to "never", "rarely", and "sometimes" were grouped together.

Responses to "most of the time" and "all the time" were grouped together and taken as

4.4 RESULTS AND DISCUSSION

Groups indicated that Group II had more of the older subjects than Group I.

In Group II, 14.28% (n = 7) were in the age range of 40 to 49. 42.86% (n = 21) were in the age

range of 41 to 60. 44.8% (n = 2) in the age range of 61 to 64.

In Group I, 36.74% (n = 18) were in the age range of 40 to 49. 59.19% (n = 29) in the age range

<table>
<thead>
<tr>
<th>Age (Years)</th>
<th>Group I</th>
<th>Group II</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>40-49</td>
<td>21 (42.8%)(n=49)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50-60</td>
<td>29 (59.19%)(n=49)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>61-64</td>
<td>7 (14.28%)(n=49)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4.4 Age distribution for Group I and Group II

4.3.2 Age
<table>
<thead>
<tr>
<th>Item</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>Not available</th>
</tr>
</thead>
<tbody>
<tr>
<td>I know when I heard it</td>
<td>6 (12.2%)</td>
<td>4 (8.16%)</td>
<td></td>
</tr>
<tr>
<td>I was able to let people</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td></td>
</tr>
<tr>
<td>I felt in control</td>
<td>6 (12.2%)</td>
<td>4 (8.16%)</td>
<td></td>
</tr>
<tr>
<td>I felt safe</td>
<td>2 (4.2%)</td>
<td>2 (4.2%)</td>
<td></td>
</tr>
<tr>
<td>Remember my address</td>
<td>9 (18.2%)</td>
<td>5 (9.9%)</td>
<td></td>
</tr>
<tr>
<td>Happening to me</td>
<td>6 (12.2%)</td>
<td>4 (8.16%)</td>
<td></td>
</tr>
<tr>
<td>I knew what was</td>
<td>6 (12.2%)</td>
<td>4 (8.16%)</td>
<td></td>
</tr>
<tr>
<td>I knew where I was</td>
<td>11 (22.45%)</td>
<td>1 (2%)</td>
<td></td>
</tr>
<tr>
<td>Real to me</td>
<td>12 (24.9%)</td>
<td>1 (2%)</td>
<td></td>
</tr>
<tr>
<td>I was aware of someone</td>
<td>12 (24.9%)</td>
<td>1 (2%)</td>
<td></td>
</tr>
<tr>
<td>I recognized my relatives</td>
<td>11 (22.45%)</td>
<td>1 (2%)</td>
<td></td>
</tr>
<tr>
<td>Less critically ill Group I</td>
<td>2 (4%)</td>
<td>0 (0%)</td>
<td></td>
</tr>
<tr>
<td>Less critically ill Group II</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td></td>
</tr>
</tbody>
</table>

Table 4.2: Results on awareness of surroundings

Remembered above the (CU environment, the people, and what was happening to them.

Under "Awareness of surroundings", subjects were interviewed to find out what they
remember their relatives. The p-value was 0.461 when it increased that the groups did not differ significantly (p=0.279)

shows that the two groups did not differ significantly (p=0.279). COMPARASON (12.24%) in Group I which was slightly lower than in Group II (20.41%). COMPARATION (12.24%) in Group I which was slightly lower than in Group II (20.41%). found that a low percentage of subjects in both groups knew what was happening to them; 6 When Groups I and II were compared about knowing what was happening to them, it was also found that a low percentage of subjects in both groups knew what was happening to them; 6

There was a slight difference between the two groups, which was not significant (p=0.488). showed that in Group II (28.97%) and in Group I (22.95%) knew where they were. Comparing the two groups about knowing where they were, the responses of the subjects differed existed between Group I and Group II where some of subjects were near them. Hence the p-value was 0.697, which indicated that no significant difference existed between Group I and Group II on this item. 14 (28.97%) in Group II and 12 (24.95%) in Group I were

A low number of subjects in both groups were aware of someone near them. Comparing who recognized their relatives. However, the differences were not significant with 11 (22.49%) in Group I and 14 (28.97%) in Group II. There was a slight difference between the two groups. The subjects were asked whether they recognized their relatives, and it was found that a low
Subjects were interviewed to find out what experiences were frightening and how they felt about them.

4.42 PERCEIVING EXPERIENCES

In group I had recollection of ICU, and none (0.00%) in Group II had recollection of ICU. Subjects were asked about their recollection of ICU admission, and only 1 (2.4%) of subjects. The differences between the two groups were insignificant (p = 0.907).

Subjects who knew what they wanted, Group I with lower percentage (8.16%) than Group II (12.4%). Responses indicated that only a few percentage of subjects from both groups could let people know what they wanted, and the control

In Group I fell in control and none (0.00%) of the subjects in Group II fell in control. Both groups did not feel in control. The scores showed that only 17 subjects from both groups felt safe. Group II felt safer. Comparison of the two groups indicated that Group I had a higher percentage of subjects who felt safe in ICU indicated that a fair percentage in
Significant (p = 0.060).
(26.53%) of subjects in Group II who felt scared. However, the differences were marginally
insignificant.
A higher percentage in Group I (22 (44.90%) felt scared as compared with 13
The p-value was 0.034, which indicated that differences between Group I and Group II were
subjects in Group II (21 (42.85%) had bad dreams as compared with 11 (22.43%) in Group II.
The responses of the subjects about having bad dreams indicated that a high percentage of

<table>
<thead>
<tr>
<th>Item</th>
<th>No. (%)</th>
<th>36 (73.47%)</th>
<th>36 (73.47%)</th>
<th>36 (73.47%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I seemed to be in pain</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I thought I was dead</td>
<td>0.10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt depressed</td>
<td>0.31</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I saw strange things</td>
<td>0.06</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I fell scared</td>
<td>0.06</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I seemed to have bad</td>
<td>0.13</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| p-value               | 0.034            |             |             |             |

Table 4.4 Results on nightmares experiences
experiences in ICU, and whether they wanted to remember the experiences or not. In this item, the researcher wanted to find out whether the subjects could recall all their

4.4.3 Recall of experiences

were no differences between the two groups (p = 1.00). Group II, with equal percentile (73.47%) verbalised that they seemed to be in pain. Therefore investigations about recalling pains in ICU revealed that the majority from both Group I and Group II (69.64%) indicated that they had similar thoughts. These results indicate that there were differences, but they were not statistically significant. The p-value was 0.166.

The responses on thoughts of death indicated that more subjects in Group I: 26 (34.06%) thought that they would die as compared with Group II: 18 (36.73%) who had similar thoughts. The difference was significant (p = 0.012).

Group I: 25 (31.02%) felt helpless than in Group II: 20 (40.82%). The differences were not significant between the two groups. They were marginally significant (p = 0.096).

Although the differences were noted between the two groups, they were not remarkable. Although the differences were noted between the two groups, they were not remarkable. In Group I: 14 (21.74%) responses about seeing strange things showed that more subjects in Group I: 22 (44.90%) saw
The response of the subjects to the question of blurred memories indicated that only a small percentage in both groups had blurred memories. In Group I, only 2 (4.02%) had blurred memories, whereas in Group II, only 3 (6.12%) wished to remember more about it. In Group I, only 2 (4.08%) and in Group II, only 3 (6.12%) wished to remember more about their experiences. A power percentage from both groups' data suggested that 6 (12.24%) of Group I and 6 (12.24%) of Group II wished to remember more about their experiences in particular concerning whether they were happy or not.

<table>
<thead>
<tr>
<th>Item</th>
<th>Group I</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td>I never knew whether I was day or night</td>
<td>6 (12.24%)</td>
<td>6 (12.24%)</td>
</tr>
<tr>
<td></td>
<td>much</td>
<td>5 (10.20%)</td>
</tr>
<tr>
<td></td>
<td>I seemed to sleep too</td>
<td></td>
</tr>
<tr>
<td></td>
<td>the things that happened to me</td>
<td></td>
</tr>
<tr>
<td></td>
<td>about what was</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I wish I had known more</td>
<td></td>
</tr>
<tr>
<td></td>
<td>than or my memories are</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I wish I remembered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>more about it</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I wish I remembered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(n=19)</td>
<td>(n=19)</td>
</tr>
<tr>
<td>Less objectively</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(p-value)</td>
<td></td>
</tr>
</tbody>
</table>

Table 4.5: Results on recall of experiences
The subjects were interviewed to determine whether they were satisfied with the care they received in ICU.

**Satisfaction with Care**

were not significant. The p-value was 0.507, thus indicating that the differences between the groups were not significant.

whether it was day or night, as compared with 4 (8.16%) in Group II who knew whether it was day or night, with only a slight difference between the two groups. In Group I: 6 (12.4%) knew when and Group II could differentiate between day and night and percentage from both Group I and Group II were very low much, as compared with 5 (10.2%) in Group I. The difference between the two groups were very significant.

0.375 which indicated that the differences between the two groups were statistically significant. who wished they had known more about it than in Group I: 8 (16.33%). The p-value was 0.003. Group II had slightly lower percentage: 5 (10.2%) of subjects knew during their stay in ICU. Group II had slighty lower percentage: 5 (10.2%) of subjects.

A lower percentage in both groups wished they had known more about what was happening to memories as compared with 3 (6.12%) of Group II who had blurred memories. There was a slight difference between the two groups which was insignificant. The p-value was 0.648.
compared with 14 (28.57%) in Group I. However, the differences were not statistically significant. More subjects in Group I: 23 (46.94%) felt that they were completely satisfied as groups. The question of being consistently disturbed, some differences were noted between the two.

To the question of being consistently disturbed, some differences were noted between the two groups: 1: 6 (12.24%) and Group II: 5 (10.21%), which was of no significance (p = 0.74).

It could have been seen that a low percentage of subjects from both groups felt that their care was as good as expected. The responses of the subjects to the item, "My care was as good as expected, could have been seen to be significant:"

The p-value was 0.029, which indicated that the differences were not significant in Group II. The p-value was 0.059, which indicated that the differences were not significant in Group I. When both Group I and Group II felt that their care could have been much better, in Group I, 7 (14.29%) of subjects felt that their care could have been much better. In Group II, 5 (10.20%) of subjects felt that their care could have been much better.

When subjects were interviewed about how they felt about their care in ICU, a low percentage of subjects were interviewed about how they felt about their care in ICU.

<table>
<thead>
<tr>
<th>p-value</th>
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<th>0.029</th>
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<tr>
<td>1 (28.57%)</td>
<td>(28.57%)</td>
<td>(46.94%)</td>
<td>6 (12.24%)</td>
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<tr>
<td>2 (6.94%)</td>
<td>(6.94%)</td>
<td>5 (10.20%)</td>
<td>5 (10.20%)</td>
<td>7 (14.29%)</td>
</tr>
<tr>
<td>3 (6.94%)</td>
<td>(6.94%)</td>
<td>2 (4.90%)</td>
<td>1 (0.90%)</td>
<td>1 (0.90%)</td>
</tr>
</tbody>
</table>

Table 4:6 Results on satisfaction with care
mean score was 10.4489. The difference between the means was 1.2244. The p value was
for satisfaction with care, in Group I the mean score was 11.6734.7, and for Group II the
animal groups did not differ significantly.

between the two means was 2.44989. The p value was 0.6947, which indicated that the two
mean score for Group I was 13.79592, and for Group II was 13.55102. The difference
when comparing the means of the two groups on recall of experiences, it was noted that the

when comparing the means of the two groups on recall of experiences showed that the mean score for Group I was 19.8714.

The least on frightfulness experiences showed that the mean score for Group I was 20.2831, and for Group II was
in awareness of surroundings, the mean score for Group I was 20.7929, and for Group II was
The t-test was performed for the two groups on each of the four constructs (retest anxiety X)

4.5 T-TEST ON BOTH GROUPS

not significant (p=0.693).

who responded that it was always too noisy, however, the difference between the groups were
(46.94%) responded that it was always too noisy as compared with 14 (28.74%) in Group I
When asked about the noise in ICU, a fairly high percentage of subjects in Group I: 23
In the following chapter, results and main findings will be discussed, conclusions as well as recommendations will be made.

In this chapter, data was presented, analyzed and discussed. In comparing the two groups, II adult patients with low SAPS II scores (Group I) with those with high SAPS II scores (Group II), the purpose of this study was to compare the intensive care unit experiences of critically ill significantly with regard to the total questionnaire.

The total score for the total questionnaire in Group I was 66.12245, and the mean score for the total score of the total questionnaire was 52.85714. The p-value was 0.294 which indicated that Groups I and II did not differ significantly with regard to the total scores for satisfaction with care. 0.925, which means that the differences between (Groups I and II) were marginally significant.
To compare critically ill adult patients of low SAPS II scores with those of high SAPS II score, the following research objectives were developed to achieve the purpose of the study:

- To describe critically ill adult patients' experiences of ICU, regarding awareness of ICU surroundings, frightening experiences, recall of experiences, and satisfaction with care.

The aim of this study was to describe and compare critically ill adult patients' experiences of ICU admissions, based on the severity of illness, according to the Simplified Acute Physiology Score (SAPS) and Group II score (SAPS II score): Group I with low SAPS II score (p-value of 0.00 to 0.05) and Group II with high SAPS II score (p-value of 0.05 to 1.00).

Summary of Study

Recommendations for clinical practice, nursing education, and further research are presented. In this chapter, a summary of the research findings, conclusions, and implications are presented.
Feeling in control, being able to let people know what they wanted and having no recollection

was happening to them, remembering their relatives being with them, feelings of safety,

Recognising relatives, awareness of someone near, knowing where they were, knowing

The conscious awareness of surroundings was discussed under the following items:

3.4. AWARENESS OF SURROUNDINGS

Items under each construct will be discussed individually where necessary.

surroundings, sightseeing experiences, recall of experiences and satisfaction with care. The

The findings of this study are discussed under the four constructs: Awareness of

3.5. MAIN FINDINGS

Data were collected via a Microsoft Excel spreadsheet. Descriptive statistics were used to

and from the patients before the commencement of data collection.

and from the patients after the commencement of data collection. Consent was obtained from the healthcare professionals at the institutions

patients. 49 in each group. Data collection was carried out using a structured interview

patients over a period of three months. The sample consisted of 98 critical care adult

population consisted of all patients admitted in the type ICUs at an academic institution in

A descriptive, comparative design was used to achieve the set objectives. The study
Ventilated patients can hear what is said to them. Previous research (2005:170) further confirms that patients in ICUs hear and are aware of what is happening around them. The subject of what was happening was not the focus of our study, but the group II did not know where they were, and did not know where people around them were located.

Of people around or not, depending on where the study was conducted, the background. It appears that there are differences in the loudness about whether patients are aware of people around them by voices and noise in conducted in Australia (Kroes, et al., 2007:1669), and in Sweden (Klarström, et al, 2007:47) seem to indicate that patients are aware of people around them by voices and noise in group II (28.7%) slightly higher than group I (22.4%). The p-value was 0.047, which shows that a higher percentage of patients were aware of someone near them, with the majority of subjects from both groups were not aware of anyone near them. Statistics did not recognize their relatives.

Conducted on ICU patients by Jones, et al. (2001:575), who found that some ventilated ICU patients did not recognize their relatives. These results are similar to a study conducted on ICU patients by Jones, et al. (2001:573), who found that some ventilated ICU patients did not recognize their relatives.

In this study, it was found that a low percentage of patients in both groups (22.4%) in group I and (28.7%) in group II recognized their relatives. The use of sedatives, analgesics, neuromuscular blockers or the severity of other critical illness of ICU, whether the ICU patients are aware of their surroundings or not could be related to sedation may cause memory gaps.

At the time (Refer page 2), it was seen that the sedations be
This may help to reduce their fear.

The results of the study by Capuzzo et al. (2003:50), which indicated that many ventilated patients never remembered their relatives being with them, showed that most patients did not remember their relatives being with them. This is in contradiction to the study by Capuzzo et al. (2003:50), which indicated that many ventilated patients never remembered their relatives being with them.

The results of the study show that most patients did not remember their relatives being with them. This is in contradiction to the study by Capuzzo et al. (2003:50), which indicated that many ventilated patients never remembered their relatives being with them.

The results of the study show that most patients did not remember their relatives being with them. This is in contradiction to the study by Capuzzo et al. (2003:50), which indicated that many ventilated patients never remembered their relatives being with them.
may occur at a point of awareness or wakefulness and sleep. Patients reported seeing strange
2005:708). (Grundeort et al., 2002:23) highlighted that these visual or auditory phenomena
seem to have residual memories and may have difficulties separating real from unreal (Frankson,
dreams and nightmares; whether real or unreal is not a matter for discussion. Patients in ICU
dreams exist between the two groups. Literature on ICU patients is inundated with reports on
5.2% (22.459%), the p-value was 0.003, which indicated that significant differences
A higher percentage of patients in Group 1: (42.869%) experienced bad dreams, compared with
and nightmares.
should not be heavily sedated, as this may help them to have real memories and less dreams
experiences (Keller paper 2), Cheesman et al., 2004:177) suggested that the ICU patients
critical name of the patients condition could also be related to the frightening
strange things, feeling helpless, thoughts of death and pain. The effects of drugs and the
Prolonged experiences that were discussed included bad dreams, feeling scared, seeing

3.2 PRONING EXPERIENCES

gestures, lip reading, communication charts and hand squeezing are effective.
communication is not always possible, and alternative means of communication like using
shown in Braddock (2002:175) revealed that ventilated patients understood that verbal
about every situation, every intervention and reasons for such
controlled to bed. Perfusion (2005:709) further suggested that patients should be kept informed
satisfactorily insignificant. These results could be attributed to restricted movements and being
The feeling of loss of control and the inability to let people know what was happening were

“3.2 Proning Experiences”
reported the ICG patients often verbalised that they felt scared and anxious due to
differences were noted. They were marginally significant (p = 0.066), whereas and secretion
(94.90%) felt scared compared with (62.33%) in Group II who felt scared. Although some
Response about feeling scared in ICG showed that a thirty-high percentage in Group I
experiences.

and support to help patients to cope or deal with their constantly present visions and emotional
movements be needed for a closer relationship between nurses and patients with ongoing care
changes may help to make sense of dreams and deal with anxiety issues. The result of this study
reassured patients, if any make some difference after the critical stage, the crucial care follow-up
in the present study. Lawson (2005:711) indicated that unfortunately not all dreams are
where patients reported seeing still images to kidnapping and kill them. Similar results were found
in their study and dreams following treatment with sedatives, analgesics and neuromuscular
surroundings (Kowser 2004:174). Rundshagen et al. (2001:40) reported that 70% of patients
some dreams are persistent in nature and disturbing to patients. Some involve familiar
2001:40), different medications given (Grandlapper et al, 2002:23; Rundshagen, 2001:40);
without medication might disturb patients and might have multifactorial causes that include sedation
delusions, hallucinations and nightmares have multifactorial causes that include sedation
they never even reached and they fell very hard as if they were really walking. Dreams
them. Patients also reported seeing images walking on air to a far away destination that
study patients think all patients reported included seeing people trying to kidnap and kill
things deal for them scared and anxious (De Pappinmassie & Pielka, 2003:17). In this
Convoluted processes until they are stable, is important.

Informing them that nurses are there to help make up for their decades throughout their
time spent in hospital. Confidence in nurses because nurses had to wash them. Confidence in nurses because nurses had to wash them. Confidence in nurses because nurses had to wash them. Confidence in nurses because nurses had to wash them. Confidence in nurses because nurses had to wash them. Confidence in nurses because nurses had to wash them.

In the study, patients also experienced feelings of helplessness in being washed by nurses and having no privacy. Patients in the experimental group were significantly more likely to experience feelings of helplessness because they could not engage in basic self-care activities, having to be washed by nurses and having no privacy. In previous studies by Czaja et al. (2005:10), it was found that patients in the control group were significantly less likely to experience feelings of helplessness because they could not engage in basic self-care activities, having to be washed by nurses and having no privacy.

The outcome of the study showed that the

majority of patients in the study felt helpless with a higher percentage in Group I.

By ICU patients

and their families use of self-care also beneficial in reducing stress and anxiety experienced

will stay longer with them. Parkinson (2005:7) highlighted that the use of electronic touch

patients' fear, reducing their fear, and anxiety in patients. Parkinson (2005:7) highlighted that the use of electronic touch

patients reported that their fear and anxieties were reduced by the care pathways. Patients reported that their fear and anxieties were reduced by the care pathways. Patients reported that their fear and anxieties were reduced by the care pathways. Patients reported that their fear and anxieties were reduced by the care pathways. Patients reported that their fear and anxieties were reduced by the care pathways. Patients reported that their fear and anxieties were reduced by the care pathways. Patients reported that their fear and anxieties were reduced by the care pathways. Patients reported that their fear and anxieties were reduced by the care pathways.

may worsen the health-related quality of life. Schulze et al. (2002:176) pointed out that

reported that the long term implications of anxiety arising from memories of critical illness

anxiety rating scale that may help to identify signs of anxiety, as is seen in Parkinsons patient

diagnosis. Meltzer et al. (2005:31) highlighted that this calls for a development of patient

occur both at the time of their critical illness or after discharge, and it is sometimes difficult to

(2005:10) reported that more than half of critical care patients experience anxiety, which may

worse of death and disability when they realized the severity of their critical illness. Parkinson
Recall of experiences was discussed under the following items: Wishing to remember more

5.3.3. Recall of experiences

Focused on patients as well as their family members.

Schmolckberger (2006:44) suggested that at the end of life, the pain of death must be communicated, ethical and
the issue was discussed that patients’ dignity is maintained until death. Furthermore, it
suggested that nurses working in ICU be given psychological support in dealing with end of
with pain, anxiety, and anger towards the health care personnel and family. Goodridge et al.,
patients in ICU were aware of their critical condition and the prognosis. Some of them present
Goodridge, D. (2008:163) reported that most of the critically ill

complained

Relief medications be given appropriately without sedation in order to promote physical
was one of the major experiences in ICU. Roberts et al., (2007:1676) suggested that pain
study conducted by Kropper et al., (2005:171) on ventilated ICU patients indicated that pain
ventilated patients were interfered by severe pain, severity of the condition, and weakness. A
thousands of deaths. Schon & Egerod (2007:176) reported that thoughts of death among
The differences between group I and group II about thoughts of death and pain were

Statistically insignificant. Majority of patients from both groups combined (89%) had reported

being
needed to ensure that patients' environment and nursing practices allow opportunity for rest and
and nurses confirmations were very disturbing. Peterson (2005;173) suggested that ICU nurses
(9p=0.749). According to Gwena (2000:26) nose from telephone, buzzer, machines, showers
sleep disturbances were reported in both groups and no significant differences were noted
there stay in ICU.

sessions may be helpful to fill in the missing gaps of memories from admission through
things that occurred while in ICU. Roberts et al. (2007:1676) suggested that depression
with memories about their admission and stay in ICU, but they could not remember many
between the two groups. However, according to Loe et al. (2005:156), most patients had
higher than Group I. The p-value was 0.468 which and no statistically difference existed
a low percentage of subjects in both groups had blurred memories with Group I slightly

effects.

and determining from nurses and family could help to overcome the negative psychological
psychological recovery is as important as the physical recovery, therefore, ongoing support
because it was all traumatic and depressive. Roberts et al. (2007:1676) further reported that
majority of patients which they could never remember anything about their stay in ICU
(2005:1744) and Pindel et al. (2006:350) on ventilated ICU patients, who found that the
were statistically insignificant. This was confirmed with the studies conducted by Roberts et
which was happening to them while in ICU were similar in both groups and the differences
The results on wishing to remember more about their stay in ICU, and knowing more about
in this study reported the procedures the interns, scientists, and patients were very
However, differences noted were related to be of marginal significance (p = 0.063). Subjects
A higher percentage (76.94%) in group I was consistently discharged than in group II: (58.57%).
exceptional
2007:177), who indicated that in their studies ICU patients expressed their care was
in ICU. Similar findings were reported by Grundy & Jones (2001:344), Schoon & Eggerd
admission and stay. Patients still verbaled that they were happy about the care they received
differences were noted between group I and group II. Despite the negative experience of ICU
The care received in ICU was expressed as satisfactory in both groups and no significant
better, care was as good as it could have been, consistent disturbance, and noise.
Satisfaction with care was discussed under the following items: Care could have been much,

5.3.4 SATISFACTION WITH CARE.

differentiate between day and night (2007:177), which reported that patients had distorted perceptions of time, and could not
These results are consistent with the findings of the previous studies by Schoon & Eggerd
when new nurses took over, but they did not really know whether it was day or night. What's
perception (p = 0.07). Some patients said they could notice that it was the end of shift only
No significant differences were found between group I and group II with respect to time
psychological impact.
sleep. Therapy minimizing the precursors to delirium and anxiety, which may have long term
The recommendations are described according to practice, education, and research.

5.5 RECOMMENDATIONS

multi-disciplinary ICU

The research was conducted in a single hospital, although it was in several

The following was identified as limiting:

5.4 LIMITATIONS

compared to Group II

Higher mean experiences of ICU. Group I experienced more bad dreams and night terrors than Group II.

The overall findings of this study indicate that Group I and Group II differed in terms of their

Kardsson and Forsberg (2007;44) patients were not bothered by noise. Patients were not bothered by noise, especially from the night shift. According to

Kardsson and Forsberg (2007;44, 2003:91) reported that differences were not significantly significant (P=0.063). McGinley et al., (2003:76) reported that

More of Group I subjects (64.9%) complained of noise than in Group II (25.97%), and the

by such noise, but they experienced a real after getting rid of seizures.

Contrary to a study by Kardsson and Forsberg (2007;44) revealed that patients were not disturbed

Patients in this study, some patients from both groups fell disturbed by such procedures. In

disturbance. These results were similar to a study by McGinley et al., (2002:32).
ICU patients is recommended for the critical care curriculum. More emphasis on the psychological and the spiritual aspect of counselling and debriefing. There is a need to emphasise holistic care in the critical care curriculum, as well as skills for high-quality care and the nature of knowledge and skills required from nurses in a highly technical environment. While it often appears that critical care nurses are working in a highly technical environment, S&2 Education helpful.

Helpful to reduce stress and anxiety. A brief orientation of patients and relatives may also be useful. Relating to the procedure, and ICU as a unit, which to expect during admission may be beneficial. For patients that are admitted for elective procedures, information pamphlets with all the details relating to the procedure, and ICU as a unit, which to expect during admission may be helpful. Prevent the development of psychological conditions and post-traumatic stress disorder. Follow-up interviews of patients after discharge and continued rehabilitation may help to offset the critical illness and ICU experiences. Between what is real and not real. This may help to prevent the long-term psychological effects of ICU patients, thus the presence of relatives around a critically ill patient should be encouraged, and in some units, the relaxation of visitation rights to families is recommended. Care and caring relationships of family members have an effect on the reduction of fear and S&2 Practice.
Remember any of the family members coming to visit, as if they were reflected by their loved ones. Remember events of the previous days, as if they were mentally unstable. Some could not how they came to ICU. Some patients reported that they fell back when they could not themselves in a strange environment, with strange people. Most of them had no memories of being violated. When they regained consciousness, or became oriented, they found patients who were admitted in ICU were in a critical state, in most cases unconscious or

Group II with high SAPS II score.

Simplified acute physiology score (SAPS II score) Group I with low SAPS II score and of Intensive Care Unit admission, based on the patient’s severity of illness at the time of admission. The purpose of this study was to describe and compare critically ill adult patients’ experiences

5.6 CONCLUSION

recommended with bigger samples.

than the critically ill ones. Further studies to establish the reason for such differences is

The outcome of the study showed that less critically ill patients experienced more bad dreams

impossible.

As the present study was conducted in only one hospital, making generalisation impossible, a

553 Research
However, when the test was performed for the entire questionnaires, the p-value was 0.294. Higher mean experiences in ICU than those with high SAPS II scores (0.15 to 1.00) means that critically ill patients with low SAPS II scores (0.00 to 0.05) experienced worse were all not significant except on higher mean experiences. The p-value was 0.021. This components of the questionnaire for groups I and II. Some differences were noted, but they were not significant. The test was performed and differences between the mean values compared for all. The p-value was 0.34.

Although some differences were found between Group I and Group II, most of them were not significant. However, most patients still regarded ICU as the safest place because nurses and doctors were known on psychological effects that can impact on their health. Physical problems, especially in post-operative surgical patients. All these experiences may predispose something as the allergy was completely closed. Pain was also reported as a major discomfort from the endo-tracheal tube was described as being unbearable, especially during

conditions of interventions made. taken for granted by both nursing and medical staff because they were not informed of their mostly in ventilated patients, as they were not able to talk. Problems fell neglected or being were scared to talk about them. Lack of communication was also reported as a major problem, and some patients reported that they experienced bad dreams and nightmares in ICU, and some
Group I (less critically ill) experienced more bad dreams compared to Group II (critically ill).

Critically ill patients admitted to ICU do differ in terms of their frightening experiences.

In conclusion, the responses from both Group I and Group II shows that critically ill and less critically ill scores (0.00 to 0.5) and those with intermediate level of severity with low SAPS II scores (0.5 to 1.0) do not differ.

Indicates that critically ill adult patients with low SAPS II scores (0.00 to 0.05) and those with intermediate level of severity with low SAPS II scores (0.5 to 1.0) do not differ. Therefore, the differences between Group I and Group II were statistically not significant. This
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<td>5</td>
</tr>
<tr>
<td>2</td>
<td>Know when I wanted</td>
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<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Feel in control</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Recalled my relatives being with me</td>
<td></td>
<td>2</td>
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<tr>
<td>5</td>
<td>I remember my happening at me</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>I feel safe</td>
<td></td>
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### Awareness of Surroundings

| Time | All the time | Most of the time | Sometimes | Rarely | Never | Experience
<table>
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<td></td>
<td></td>
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<td></td>
</tr>
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<td>---------------</td>
<td>---</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Care could have been much better</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Would you recommend?</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
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<td>Recall of experiences</td>
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<td>I thought I would die</td>
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Is there anything else you would like to add or discuss with me?

OPEN ENDED QUESTION:
Thank you

For more information or queries, I can be reached at 083 661 8434.

I therefore invite you to participate in the study, and would like to assure you that all information will be kept confidential and anonymous, no names will be mentioned. You have the right to withdraw from the study at any moment should you wish to.

The outcomes of the study will contribute to the body of knowledge of critical care nurses.

The study will be conducted at the intensive care units of the Johannesburg Hospital for a period of three months.

The research focus on the intensive care unit experiences of critically ill adult patients.

As part of my course requirements, I am expected to conduct a clinical research under supervision.

My name is Shepard Bogeba, a nursing student at the University of Witwatersrand.

NAME OF PATIENT/CURABIDIAN

INFORMATION LETTER

Intensive Care Unit experiences of critically ill adult patients

MS Nurse Student

ANNEXURE II
PATIENT CONSENT FORM

I am aware of the risks and benefits of the procedure and have been given the opportunity to ask questions. I understand the consent sheet and have signed it. Name: ____________________________

I give permission to be included in the study.

Signature: ____________________________

Date: ____________________________

Witness: ____________________________
Dear Miss Bokaba,

Approval of protocol entitled intensive care unit experiences of critically ill adult patients

I should like to advise you that the protocol and title that you have submitted for the degree of Master Of Science in Nursing (Part-Time) (Coursework) have been approved by the Postgraduate Committee at its recent meeting. Please remember that any amendment to this title has to be endorsed by your Head of Department and formally approved by the Postgraduate Committee.

Mrs. AA Tjah has/have been appointed as your supervisor/s. Please maintain regular contact with your supervisor who must be kept advised of your progress.

Please note that approval by the Postgraduate Committee is always given subject to permission from the relevant Ethics Committee, and a copy of your clearance certificate should be lodged with the Faculty Office as soon as possible, if this has not already been done.

Yours sincerely,

[Signature]

S. Bress (Mng)
Faculty Registrar
Faculty of Health Sciences
Telephone 717-2075/2076

Copies - Head of Department Supervisor/s
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1. Is the life of the research project suitable?
   - X

2. Comment on the proposal:
   - Original work
   - New ideas
   - Complete outline
   - Potential influence
   - Known data and comparisons of limited importance
   - Exceptional significance
   - Contribution of novelty

3. Department or Health Key Policy Proponents/Extenders?
   - X

4. Is this research project within the scope of the
   - Yes
   - No
   - N/A

Section A: Evaluation

Type of Research: Non-Trial
Research Site(s): Government Hospital.
Project Investigator: Ms. A. M. J.
Purpose: Investigation into health's benefits.

Patents

By the Head of the Department.

Research Proposal Evaluation Form for Approval

Provincial Research Committee.
Section II: Proposal Revisions

1. COMPARATIVE ANALYSIS

The project is accepted without change.

REVIEWER'S FINAL CONCLUSION

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6. Writing Style

5. Could the objectives be limited to better focus on the project's main objectives? |   | X |

4. Are the objectives of the research project adequate? |   | X |

3. Are the research questions sufficiently clear and well-defined? |   | X |

2. Are the research questions sufficiently comprehensive? |   | X |

1. Are the research questions sufficiently relevant? |   | X |
The Ethics Clearance Certificate from the University Ethics Committee is hereby

fully pay for her study project.

The study is carried out for a Bachelor degree in the Department of Nursing Education.

The objectives of this study will contribute to the body of knowledge of critical care

as they could not communicate with nurses and required the key words to

with patient experiences of extreme vulnerability, helplessness, and empathy.
Dear [Name]

[Signature]

[Date: 2 February 2027]

Esteemed: [Recipient’s Name]

Your encouragement has been a source of inspiration to us throughout the process of our research.

We are pleased to inform you that the results of our study on [specific topic] have been successfully completed.

Key findings from our study included:
1. [First finding]
2. [Second finding]
3. [Third finding]
4. [Fourth finding]

The findings are now being analyzed and will be further refined before the final report is submitted.

We would like to express our gratitude for your support and guidance throughout this project.

Sincerely,

[Your Name]
Good luck with your study and I would be interested in your results.
I received and am attaching a copy of this.

Thank you for your efforts. I am happy to give you permission to use the ICD in your

Dear [Name],

Director

ICD Request

October 14

2000

[Signature]

From:

[Signature]
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**Recall of experiences, satisfaction with care and the total questionnaire.**

Results of the test on awareness of surroundings, frequency of experiences.

**T-TEST ON BOTH GROUPS**

**ANNEXURE X**
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Satisfaction